HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 31 Brighton & Hove City Council

Subject:		**GP Sustainability: December 2017 Update**
Date of Meeting:		**06 December 2017**
Report of:		**Executive Lead, Strategy, Governance & Law**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 01273 295514**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 Pressures on GP practices have continued to increase over recent years, with a number of Brighton & Hove practices closing in the past two years. The HOSC has been monitoring the situation, and this report is the latest update on GP sustainability.

1.1 This paper provides an update on the situation and members may wish to request a further update at the February 2018 meeting. Information supplied by the CCG is attached as **Appendix 1-5** to this report.

2. RECOMMENDATIONS:

2.1 That members note the information contained in this report and the appendices supplied by the CCG.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 Demand on GP services has been increasing nationally for some years, with problems including: the recruitment and retention of GPs and other practice staff; increasing workload; the suitability of premises; and the sustainability of the current GP partnership model.

3.2 All of these issues have been experienced locally. Brighton & Hove has lost eight GP practices in the past two years, with each closure impacting on surrounding practices.

3.3 City GP services were previously commissioned by NHS England with input from Brighton & Hove CCG, but from April 2017 the CCG has taken on full responsibility for GP services. Additional information, supplied by the CCG, on the current state of GP practices in the city and on the work being undertaken to understand and improve local GP practice sustainability is included as **Appendix 1-5** to this report.

3.4 The appendices deliberately do not provide complete answers or a fully worked up vision and strategy at this stage because the CCG's intention is to co-design these in partnership with member practices, patients/the population and key stakeholders (including the council).

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 None to this report which is for information rather than decision.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None undertaken in regard to this report for information.

6. CONCLUSION

6.1 Members are asked to note this report and to consider whether this issue requires further scrutiny.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications

7.1 None to this report for information

Legal Implications:

7.2 There are no legal implications to this report.

Lawyer Consulted: Elizabeth Culbert Date: 02/10/2017

Equalities Implications:

7.3 None arising directly from this report for information.

Sustainability Implications:

7.4 None arising directly from this report for information.

Any Other Significant Implications:

7.5 None arising directly from this report for information.

SUPPORTING DOCUMENTATION

Appendices:

1. Outline for a Primary Care Strategy provided by Brighton & Hove CCG
2. National Tends in Primary Care Workload graph (provided by CCG)
3. Comparative Workforce Data graph (provided by CCG)
4. Indicators used to assess practice vulnerability under the QAT
5. Categories under which Practices will be considered for the Practice Support Toolkit

A Strategy for Primary Care – Initial Outline

1. National Context

Primary care is pivotal to any health and care system. Primary care is under significant and sustained pressure across the country and this is reflected in the series of recent national documents and requirements that have been issued over the last few years, the main one of these being the GP Forward View (GPFV), which stresses the need to address the triple challenge of population health, service quality and finance. The GPFV sets out a requirement for CCGs to address:

- service development
- access
- workload
- workforce and
- premises

Dr Arvind Madan, Medical Director of the Department of Health, refers in the GPFV documentation to the need to "reimagine the clinical model, the business model and the career model of General Practice".

2. Local Context

Caring Together is the Brighton and Hove single strategic programme to transform health and social care. Its five Care Programmes and Enabling Programmes set out the framework for this transformational work to be done. A key outcome of this programme will be to shift CCG service delivery (and, therefore, expenditure) away from acute settings into community settings, to improve patient care/experience and enable the CCG to meet its financial targets.

To date, issues concerning primary care development have been included in the Urgent Care/Primary Care Access Care Programme. A new Care Programme specifically for primary care will now be established to ensure that the underlying structural weaknesses in primary care are addressed in the context of Caring Together overall, thus enabling primary care to take a greater role in demand management as a vehicle for the delivery of financial balance.

3. The Current State of Play in Primary Care

There is no "one size fits all" approach to primary care in Brighton and Hove. Some practices are successful, stable, profitable and able to recruit. Generally speaking, these practices:

- have larger populations
- are in less deprived areas
- teach/train
- are innovative in their approach (e.g. to demand and capacity planning)
- use skill mix in new ways
- have strong management
- have a successful business model that brings the necessary funding into the practice

However, there are an increasing number of practices that are to some extent vulnerable and struggling, which tend to be smaller, in more deprived areas, find it hard to teach and train and therefore to recruit. The majority of these are in the east of the city. This has the effect of reducing their ability to innovate, or claim funding for work undertaken with a resulting reduction in morale, service quality and future resilience.
Of the recent practice closures in the City, most have been smaller practices that have become increasingly unviable for either staffing or financial reasons. Their closure could therefore be deemed to have had a positive impact on the quality of service that local patients receive and in terms of achieving a sustainable future model of primary care.

4. Underlying Causes

To penetrate below the surface of the above reveals the following key underlying issues:

4.1 – Workload/Workflow

- There has been a relentless increase in workload over a sustained period (much shifted from acute settings with little or no resource following it); there are very few local data to evidence this but some national data are set out in Appendix 2. Also, the number of patients with complex needs per GP/practice has increased.
- There is also an increasing mismatch between practices' capacity and patient expectation.

4.2 – Workforce

- There are increasing numbers of vacancies in our practices for both GPs and nurses. At the time of writing, our most up to date understanding of the vacancies are as follows:
  - As of 31/10/2017 across Brighton and Hove, there are a total of 11 GP, 3 Practice Nurse and 1 Advanced Nurse Practitioner vacancies advertised online [source: LMC website, BMJ Careers and NHS Jobs]. The data to develop any kind of trend analysis of this are simply not available to us at this stage.
  - According to the workforce Minimum Data Set (wMDS), there has been a decrease in the total number of reported vacancies across NHS England South (South East) since 2015-16. During 2015-16, there were a total number of 264 vacancies, including 116 GP vacancies. This reduced to 248 vacancies overall, with 98 GP vacancies during 2016-17.
  - NHS England South (South East) reports the second highest number of vacancies across England, with NHS London recording the highest number of vacancies. [source: workforce Minimum Dataset, NHS Digital, General Practice Vacancy Tables, 2015-16 and 2016-17].
- Younger GPs are often reluctant to take on partnerships because the commitment and risks involved do not appear to be outweighed by the advantages.
- Older GPs see little hope for the future except retirement, with 55 being the optimum retirement age from a personal financial perspective for most GPs.
- Locums earn more and work less than partners.
- Teaching and training are loss making.
- Pathways from GP and practice nurse training institutions into practices are not well developed.
- There is a lack of data on workforce.

The actions that the CCG are taking to manage these vacancies in the short term are as follows:

- Working with the local universities and the medical school to establish clearer career pathways into Primary Care for GPs, Nurses, Pharmacists and other new roles (i.e. Paramedics, Physiotherapists).

- Brighton and Hove CCG are part of an STP wide bid to attract international doctors to work in Brighton.
- Engaging with the Community Education Provider Network (CEPN), practices, and local GP and Nurse education networks, to create a standardised package of mentorship and preceptorship provided to attract newly qualified GPs and Nurses to general practice.
- Understanding the career aspirations of newly qualified GPs and Nurses to help practices improve their recruitment processes by engaging with those in training.
- Establishing a Locum Nurse and GP bank to help retain clinicians who are looking to retire.
- Supporting practices to introduce new roles into practices and upskill existing staff to manage increasing workload demands, whilst also helping to retain staff (and learning from practices which are already doing this).
- Engaging with local schools and colleges to promote careers in primary care.

4.3 - Finance

- Nationally, practices' profits have been falling since 2006, because costs (e.g. superannuation) have increased and contract values have fallen behind inflation.
- The Global Sum capitation payment for Essential Services was originally intended to cover practices' costs, with Enhanced Services entailing additional work for additional funding. However, the national adjustment formula to payment of the Global Sum does not always reflect the additional workload associated with deprived populations.
- 8-9% of CCGs' funding is spent in primary care, even though undertakes considerable more of the activity.

4.4 - The Overall Model

- The Independent Contractor status model has brought advantages to many for a considerable period – especially the registered list, which creates a strong sense of mutual loyalty between patients and their practice/clinical staff. However, with the changes described above, the model would appear to work for some practices and not always for others.
- Too much variation in service provision is allowed under the same contract – i.e. a practice that invests in staff, training and premises receives the same funding as a practice that does not.
- Stronger practices have little incentive to change their business model, whilst weaker practices are open to change because there appear to be few alternatives.
- This has led to considerable inertia in many cases, with many practices so overwhelmed with work that they are unable to think beyond the day to day and cannot imagine a different future.

5. Opportunities

However, there are significant opportunities to turn this situation around:

- The CCG may be able to find additional funding for primary care out of its current allocation, now that the allocation includes primary care under co-commissioning, (with the caveat that the CCG's overall financial position through QIPP is strong enough to support this). [QIPP: Quality, Innovation, Productivity and Prevention is a national NHS improvement programme that provides additional funding for local areas that are able to make measurable quality improvements.]
- There is additional Access funding due to reach us (£3.34/pt for 170,000 pts in 2018/19, rising to £6/pt for 170,000 pts by 2019/20).

- Co-commissioning offers local flexibility over the use of Quality and Outcomes Framework – QOF - (a national framework for rewarding practices for providing systematic high quality services) and DES (Directed Enhanced Services – nationally mandated services over and above essential primary care services) funding
- A Medical School and Universities are within the City, giving easy access to the organisations that train the next generation of clinical staff.
- The Community Education Provider Network (CEPN) is now established, which provides a forum to bring together those involved in training and education; the CEPN holds budgets for workforce development that the CCG can bid to receive and leads on overseas recruitment.
- New patterns of service delivery are beginning to develop (e.g. Practice Assist).
- Primary care at scale is also emerging (through the relaunched clusters and the nascent Federation).

6. The New Way Forward for Primary Care – Structural Solutions

The situation summarised above is multi-faceted and long standing. The solutions to address this need to be both bold and ambitious on the one hand but also locally-sensitive and carefully planned on the other.

An overall approach for addressing the above structural problems in our practices is set out below in the form of eight key, interdependent interventions. Because of their interdependence, they will need to be quantified and costed in such a way that allows us to assess their impact intelligently, as far as possible.

The eight interventions are consciously not worked up in detail at this early stage but are put forward for discussion, on the understanding that they need:

- The overall support of the membership, patients/the public and other key stakeholders (e.g. Council); and
- Detailed planning before any firm commitments are made.

The next iteration of the strategy document will include an engagement plan, setting out the process and timescales by which we will seek the views of the key stakeholders.
It should be noted that many of the proposals below are already developing and that several practices are well advanced with work in several areas (e.g. workflow, workforce, informatics). We should build on the expertise we have locally available and make it easy for it to be shared easily and consistently.

6.1. - Identify vulnerable practices and establish interventions to bring resilience and stability

The Quality Assessment Tool (QAT) is the tool we use to identify vulnerable practices, along with local intelligence. The indicators used to assess practice vulnerability are set out at Appendix 4.

This will be supported by a Practice Support Toolkit, which will set out the different interventions that the CCG can offer and/or facilitate for vulnerable practices, in order to establish them as strong and viable for the long term future (and avoid them becoming dependent on constant bail outs). The overall categories under which practices will be considered are attached at Appendix 4.

This will be the focus of our initial work on the strategy.

6.2 – Service Model Redesign

Through Caring Together, we need to describe a future that will enhance patient care/experience and of which Practices and their staff want to be a part. This applies both to the new Primary Care Programme and to the other Care Programmes (Mental Health, Urgent Care/Access, Medicines Optimisation, Community/Prevention), which all need to interact in a way that is coherent for patients, providers and commissioners alike - and which need to add up to an overall model for out of hospital care as a whole. A proposed method of doing this will be developed through Caring Together because the ways that other areas of the health and care system work or do not work have a significant impact on the sustainability and resilience of primary care.

Equally, co-designing the new system with patients is important, so that they trust it enough to use it in the way it is designed to be used. Steps for engaging patients/the public are set out below.

Access will be a key element of this work. We should predicate relevant aspects of the service redesign on primary care at scale, with the Federation and clusters as key vehicles for delivery. One possible example could be to differentiate between patients who need to see “A GP” as opposed to those who need the continuity of seeing “My GP”. Services for the latter should be maintained and supported at practice level, whereas front line primary care services for the former could be provided at cluster or even City-wide level, building on any lessons derived from Practice Assist.

6.3 – Workflow/Workload

We need a far better understanding of how work flows through the primary care part of the system. We should therefore undertake a structured and consistent Demand and Capacity analysis (building on existing work in some local practices) to put numbers behind how patients flow through the system and understand the balance of how many patients require contact with “A GP” and how many require contact with “My GP” (or other healthcare professional) – i.e. we are developing population stratification that is professionally relevant and resonant with those who will use it (primary care, community services, social care, mental health, third sector).

On the basis of this analysis, we should then be able to match agreed need with evidence based interventions. Under Caring Together, we envisage significant numbers of patients with self-limiting illness being diverted away from accessing their practice in the traditional way, which will mean that clinical staff will spend their time with their sickest/most needy patients. A key priority for this work will be the need to develop intensive support for practices to manage complex patients – perhaps setting a target maximum no. of complex patients per WTE GP over time – and to shift the balance of the most expert clinical capacity away from 10 minute appointments towards longer appointments.

We should also support all practices to undertake the Productive General Practice and Active Signposting training and embed the “lean” mind-set behind this in all we do (e.g. in monitoring and claims for Locally Commissioned Services - LCS).

6.4 – Create a Step Change in the Contribution that Informatics makes to our practices

We need to ensure that the three components of Informatics (Information Management, Information Governance and Information Technology) are aligned in a whole systems way, which works smoothly for providers. Considerable expertise already exists in our practices that we should celebrate and exploit to the maximum. The suggestions below are merely a starting point for the work that is needed.

The CCG should take and communicate clearly the strategic decision that the Summary Care Record – Additional Information (SCRAI) is the basis for ALL shared record keeping and interoperability work across the entire health system.

We should design templates, claims etc. such that clinicians just have to enter the right clinical code into the computer, with the system automatically generating claims, activity monitoring information etc.

We should develop the systems to generate centrally searches of practices' systems (e.g. to refer patients to existing health promotion services, make formulary changes, launch new pathways, produce patient information leaflets, search for drug interactions etc).

6.5 - Workforce

6.5.1 – Short Term

All Clinical staff will need to work at the "top of their licence" (i.e. the most skilled staff see the most needy patients) with skill mix to support this. (This has been piloted in some local practices and there is considerable local learning to be derived from this.)

We should commence strong engagement with Brighton and Sussex Medical School/the Universities to create pathways into our practices for trainee doctors and nurses (partner pathway, salaried GP pathway, local locum pathway, fellowship pathway etc.).

We should offer to employ retiring GPs and practice nurses in a local "agency" (see section 7 below).

We should undertake (possibly through the Federation) an advertising campaign to attract GPs and practice nurses to Brighton, starting with work with the practices who wish to attract staff to help them understand how to make themselves attractive to the market place they are now in.

6.5.2 – Longer Term

The CCG should work with Health Education, Kent, Surrey and Sussex (HEKSS), the medical school and universities (as well as its own internal training capacity) to ensure that training supports and enables the new ways of working (especially for GPs who will see all the complex patients).

The CCG should use the CEPN to commission the new workforce we need to fill the gaps on a whole systems basis.

We should amalgamate all the money spent on teaching and training placements and commission the new Federation to provide an overall programme of teaching and training placements across the City, with a shared approach to workload/finance and the benefits of growing our own staff.

6.6 – Estates

We have an emerging Estates Strategy. This is now being structured to function on three levels:

- Central Sussex and East Surrey Alliance/Sustainability and Transformation Parntership level, to assess the future state of hospital care and the quantum of care that can be shifted from hospital to community
- Caring Together level, as health and social care learn how to plan premises developments together to support and enable the delivery of Caring Together. (A

multi-agency Caring Together Estates forum has already been established to begin this work, building on the work of the Greater Brighton Operational Estates Forum.)

- Cluster level, as clusters develop their own estates plans, using the existing estate to its maximum potential and sharing facilities where possible – the "Hub and Spoke" approach.

The early work on our Estates strategy – informed by a "Six Facet Survey" earlier this year - has identified possible hub sites at Hove Polyclinic, Preston Barracks/ Moulsecoomb Neighbourhood Hub and Palace Place, using the Caring Together model of integrating out of hospital services (community/mental health/social/third sector care). This will involve a debate over the balance to strike between quality and quantity of premises. This debate will need to be informed by analysis of travel times and will take different forms across the different communities that make up our City.
For existing premises, we should develop an offer to digitise paper notes and store them off site to free up space in practices where space is lacking.

6.7 – Facilitating Primary Care at Scale

In order to address some of the key challenges set out in section 4 above, we need to create/foster/commission an NHS organisation to provide an offer of infrastructure support to those practices who want/need it. (This could enable medium sized practices to continue to exist but be more resilient.) The options offered to practices could include:

- Employ staff/provide back office functions (IT, finance, HR, BI etc.)
- Employ those GPs who wish to be salaried
- Add its Medical Director as a signatory to practices' contracts to provide resilience and easy succession planning
- Hold leases for those practices for whom this is a challenge, in exchange for involvement in the practices' work as providers
- Subsidise/negotiate down indemnity rates by representing large numbers of GPs and providing them with infrastructural backup for their work
- Harmonise pay rates across Out of Hours, 111, Extended Hours Services etc. by coordination and representation of large numbers of clinical staff.

The Federation could be or be a key part of this organisation and it will need to be a key part of any future Accountable Care System.

Cluster development will also facilitate this form of working, with relaunched clusters developing primary care's role as both provider and commissioner over the coming months.

6.8 – A new investment model for Practices in Brighton and Hove

The relationship between the CCG's management team and its member practices needs to be re-set in many ways, with a greater recognition of the interdependence between the provider and commissioner functions that come together in primary care. We should therefore develop a "New Deal" for this, with two components:

Component 1 - Strengthen Core Funding in our Practices

This could include:

- Work on practices' core funding to reflect the additional workload associated with deprivation.
- A streamlined or single payment for QOF and LCSs
- A Care Homes LCS

Component 2 – Strategic Practice Development

In return for the above offers, our practices should commit to an agreed programme of development at both practice and cluster/Federation level. There should be two key elements to this:

6.8.1 - Provider Role Development:

This will ensure practices are all strong and vibrant and could include a commitment to:

- Minimum staffing levels/investment in the business, to ensure that the new investment is focussed on patient care
- Succession planning for key staff and the practice overall,
- Involvement in teaching and training,
- Enhanced reporting of activity and staffing data (see section 6.4 above),
- Data Sharing Agreements/consistent and accurate recording and coding,
- Active participation in cluster/Federation working.

6.8.2 - Commissioner Role Development

This will both feed and feed off practices' role as commissioners through CCG membership and could include a commitment to:

- Take responsibility/ownership of a cluster based budget for the majority of NHS spending;
- Participate in CCG wide and local demand management programmes (including Clinically Effective Commissioning and Peer Review) to support the above;
- Work with the CCG to create savings to be ploughed back into community-based services.

6.8.3 - Schematic Summary

The read across from the challenges identified in section 4 to the interventions in section 6 could be summarised as in the table below:

	QAT/ Toolkit	Service Redesign	Workflow/ Workload	Workforce	Infor matics	Estates	PC at Scale	'New Deal'
Practice Closures	**Y**	**Y**	**Y**	**Y**		**Y**	**Y**	**Y**
Work load	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Work force	**Y**	**Y**	**Y**	**Y**			**Y**	**Y**
'Haves' vs 'Have nots'	**Y**	**Y**		**Y**		**Y**	**Y**	**Y**
Overall model		**Y**	**Y**	**Y**		**Y**	**Y**	**Y**
Finance	**Y**		**Y**	**Y**			**Y**	**Y**
Culture		**Y**		**Y**	**Y**	**Y**	**Y**	**Y**

7. Engagement/Governance

As indicated above, there are a large number of "moving parts" in primary care and its interfaces with the rest of the health and care system. We need to balance the following:

- Careful planning, to avoid unintended consequences
- Member ownership and engagement
- Patient/public and other stakeholder engagement
- Conflicts of interest
- The need for a rapid impact in key areas, to prevent some of our current vulnerable practices from becoming crisis practices.

7.1 – Contextualising the Work within Caring Together

Primary Care is now a Care Programme in its own right within Caring Together. As with all Care Programmes, Project Plans are being developed, which will set out the outcomes, processes and success criteria for each of the eight key interventions.

7.2 – Membership Engagement

At the locality meeting on October 17th 2017, the underpinning assessment of primary care and the eight proposed key interventions were tested out with member practices. The overall response was positive, indicating that the eight intervention areas are appropriate and should be developed with the membership and key partners. This will be done through the relaunched clusters. The Organisational Development element of the New Deal (see 6.8.1 above) will also begin to be worked out through the clusters

7.3 – Patient/Public Engagement

Considerable engagement has occurred with Patients/the Public - most recently through the Big Health and Care Conversation – on the subject of primary care. Key themes that have emerged to date include: access, self-care and communication (especially for those with special needs).

A further series of engagement meetings will take place in the coming months, including the creation of a special reference group, constituted via Patient and Public Group chairs, to provide feedback to specific points of the strategy as it develops.

7.4 – Wider Stakeholder Engagement

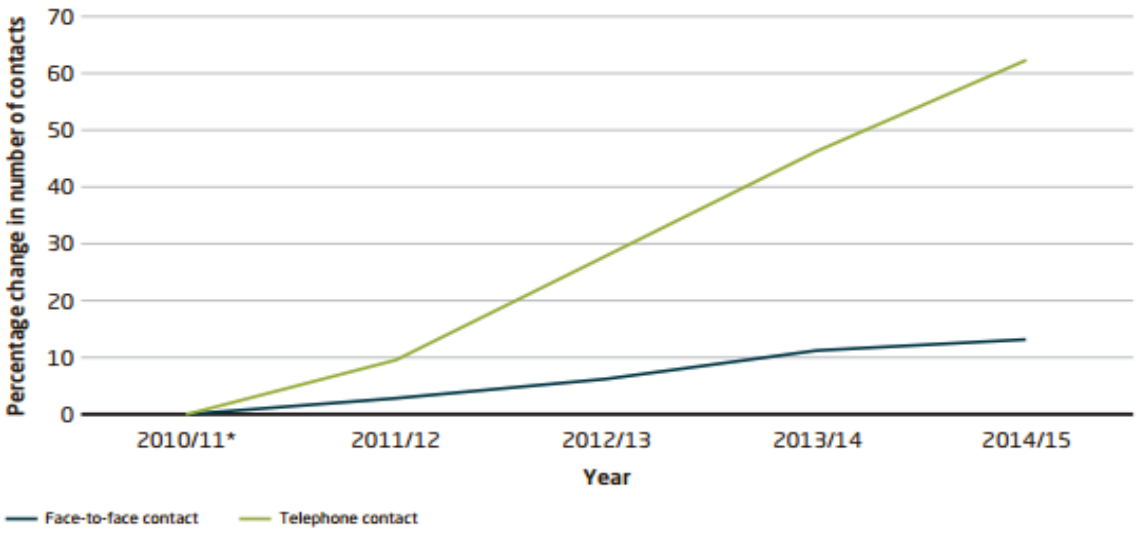
The Caring Together infrastructure provides the ideal opportunity for engagement with key partners – both commissioners and providers. As the Primary Care Programme develops, it will feature in the Care Programme Board, Programme Executive Group and Partnership Board meetings. This will enable key partner organisations in the Council and third sector to provide input and thinking to the strategy.

7.5 - Next Steps

Once the Governing Body's input and support have been secured, an intensive process of planning will begin, with underpinning analysis, to ensure the quickest but best possible delivery of the strategy. Given that the CCG's management team's capacity is already stretched, innovative ways of increasing capacity and/or getting the best from the existing capacity will need to be found for the work to progress at pace. It is hoped that the team will begin to spend less time on firefighting and more on strategy as we bring increasing stability to the system.

Appendix 2 – National Trends in Primary Care Workload

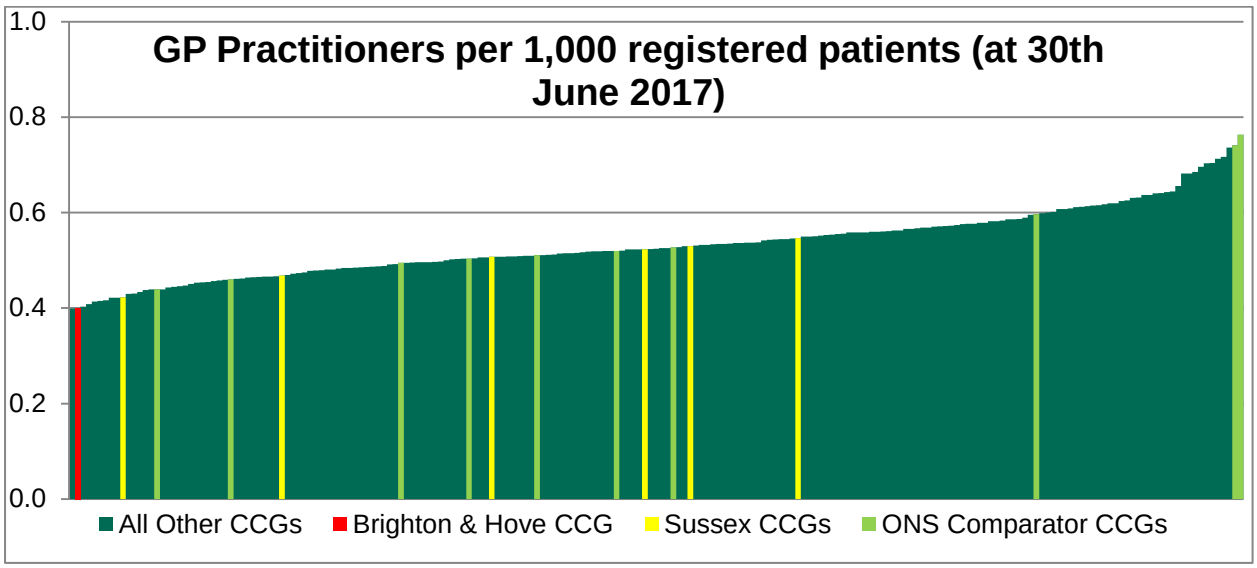
Figure 2 Percentage change in number of contacts with clinical staff by activity type



* Apr/May 2010 contact count estimated based on other years' data

Source: King's Fund analysis of ResearchOne sample data

Appendix 3 – Comparative Workforce Data



Appendix 4 - Indicators used to assess practice vulnerability under the QAT

The data are calculated, where appropriate, using the Carr-Hill weighted capitation data. The indicators include:

Workforce:

- *Clinical Staff per 1,000 patients*
- *Single handed/Two handed or larger*

Quality/Patient Experience:

- *CQC status*
- Friends and Family Test
- GP Patient Survey
- QOF
    - Total achievement
    - Exception reporting

Access:

- List open, closed or capped?
- EHS practice?
- Provides Extended Hours?
- Participates in full range of DESs
- Participates in full range of LCSs
- IC24 usage

Public Health:

- Flu Imms
- Cervical Cytology
- Childhood Imms

Uptake of Acute Services:

- GP referrals to OPD
- A&E usage
- Non-elective admissions
- RMS referrals

Digital Maturity

Estates

Medicines Optimisation

Local Intelligence

These are kept under review.

Italics indicate that this indicator carries a double weighting.

Appendix 5 – Categories under which Practices will be considered for the Practice Support Toolkit

These are as follows:

- System Surveillance
- Early Intervention
- Structured Support
- Rapid Response Intervention
- Crisis Management

The proposed interventions include:

- A visit by a CCG GP, Practice Manager, Practice Nurse and CCG manager to facilitate a diagnostic around a specific area of identified vulnerability
- A visit by a champion of Productive General Practice (PGP) to facilitate a PGP approach to a specific area of identified vulnerability.
- Short term support (such as Practice Assist remote GP appointments to cover a short term clinical staff shortage).
- Short term support using a locum practice manager.
- Short term use of roles to alleviate workload for example an accredited locum Pharmacist or Advanced Nurse Practitioner.
- Reminder to practices of funding that can be claimed, such as funding for GP absence through sickness.
- Free training and coaching from the NHS Leadership Academy[1] for all practice staff to support practice redesign.
- Promotion of Health Champion Training[2].
- Access to Care Navigation training for receptionist staff to direct patients to self-help online tools. In most practices, this has increased job satisfaction for receptionists and released more of the GPs time.
- Promotion of the free confidential NHS GP Health Service[3] to improve access to mental health services for GPs and trainees.
- Advice and guidance on workforce planning issues, for example, help with succession planning and managing upcoming retirements.

[1] NHS Leadership Academy https://www.leadershipacademy.nhs.uk/resources/coaching-register/
[2] Becoming a Health Champion: https://www.healthwatchbrightonandhove.co.uk/news/become-a-ccg-health-champion/

[3]NHS GP Health Service: http://gphealth.nhs.uk/