

1.19.1 Resource Plan

Please provide details of your proposed workforce resource plan to meet the requirements of the Contract including current resources available, future resources proposed, staffing structure (operational/management/clinical/non-clinical) and justification for the number of staff in each role.

(Maximum Word Count – no limit but be concise)

1.19.1.1-Resource plan design

To develop the Staffordshire OOHs model, our multidisciplinary team reviewed each specification element with knowledge/experience of operating within the Staffordshire area but also several other OOH services across the country.

Since our OOHs service and modelling can vary by volume, access routes, rurality and with the benefit of being the incumbent provider, our proven methodologies can flex and adapt to local needs and partner requirements.

Using historical information from specifically Staffordshire but also learning from all other OOHs services, we followed a process to develop a self-delivery structure and staffing profile. A draft profile flexible enough to accommodate planned/unplanned absence (including training) was created.

The staffing profile adopted will deliver all elements of the specification

a)-Skill sets required

This contract requires a cohesive multi-disciplinary team to ensure the highest level of patient care can be provided for the patients. We have provided a model that is medically led (GP) with clear oversight and responsibility with the multi-disciplinary team and placed around this to provide capacity and depth to the offer.

GPs have oversight and the ability to deal with the most complex cases which ensures their skillset is best used for those patients.

We have Advanced Nurse Practitioners and Advanced Clinical Practitioners that work autonomously and have the ability to prescribe and see a wide range of patients.

Urgent Care Practitioners are skilled clinicians who work under the guidance of senior clinicians and use PGDs for prescribing.

1.19.1 Resource Plan

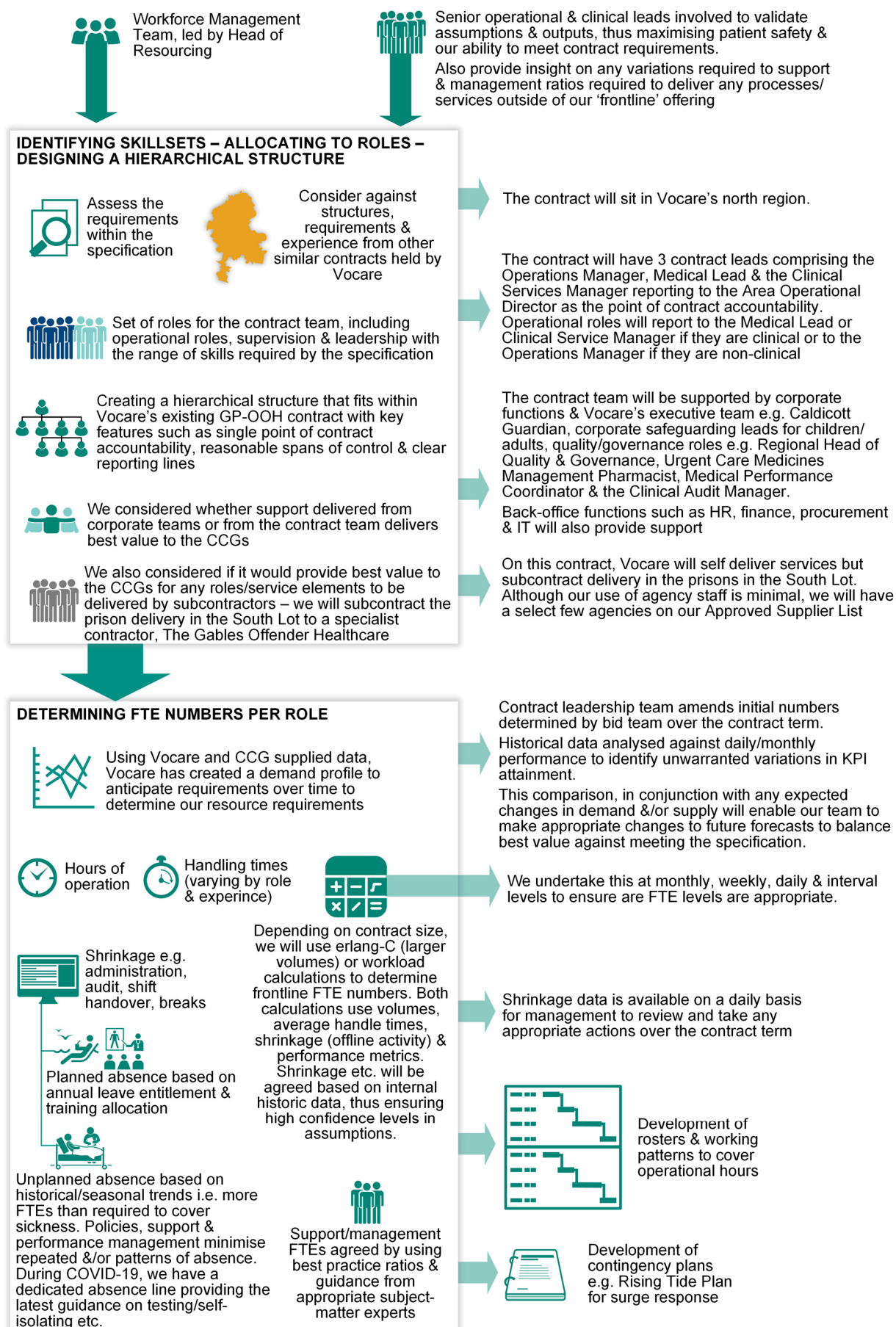


Figure 1: Workforce development process

b)-Contract team structure development

The single point of contract accountability will be the Staffordshire Operational Director. This role will be supported by the other two Area management roles, the Staffordshire Clinical and Medical Directors.

Wholly within the contract will be three contract leads, the Operations Manager, Clinical Services Manager and the Medical Lead. The Medical Lead will have day-to-day clinical responsibility and the Clinical Services Manager will manage clinician recruitment, training/supervision, competency assessments, audits and incident/complaint investigations. The service-delivery roles will report into relevant contract lead roles (The contract will receive support from various corporate roles and functions and Area (Staffordshire) and divisional level such as HR, finance, rota management, quality and safeguarding and Business Intelligence.

Figure 2 and Figure 3). The approach ensure an appropriate span of control and accountability to provide structured support and development with a clear career path.

This approach details clear accountability and oversight by discipline while providing a single point of contract accountability that supports delivery of the service to achieve all quality and quantitative targets. The clinical mix of staff employed has been assessed against the skills matrix to ensure patients are seen by the most appropriate clinician based upon the condition.

We have chosen to continue to subcontract the prison deliver element of the service, as we do now, to The Gables Offender Healthcare, as a specialist contractor. The Gables has arranged remote and direct access to the SystmOne clinical record system of the in-hours provider Practice Plus Group. This ensures patients are seen with a full understanding of the care record and previous medical history, leading to better outcomes and interactions. In addition, its clinicians also work with the prisons in hours, which increases continuity of care for the patients.

We have a long-standing history of partnership with The Gables and review monthly this subcontract to ensure quality and performance expectations are met.

The contract will receive support from various corporate roles and functions and Area (Staffordshire) and divisional level such as HR, finance, rota management, quality and safeguarding and Business Intelligence.

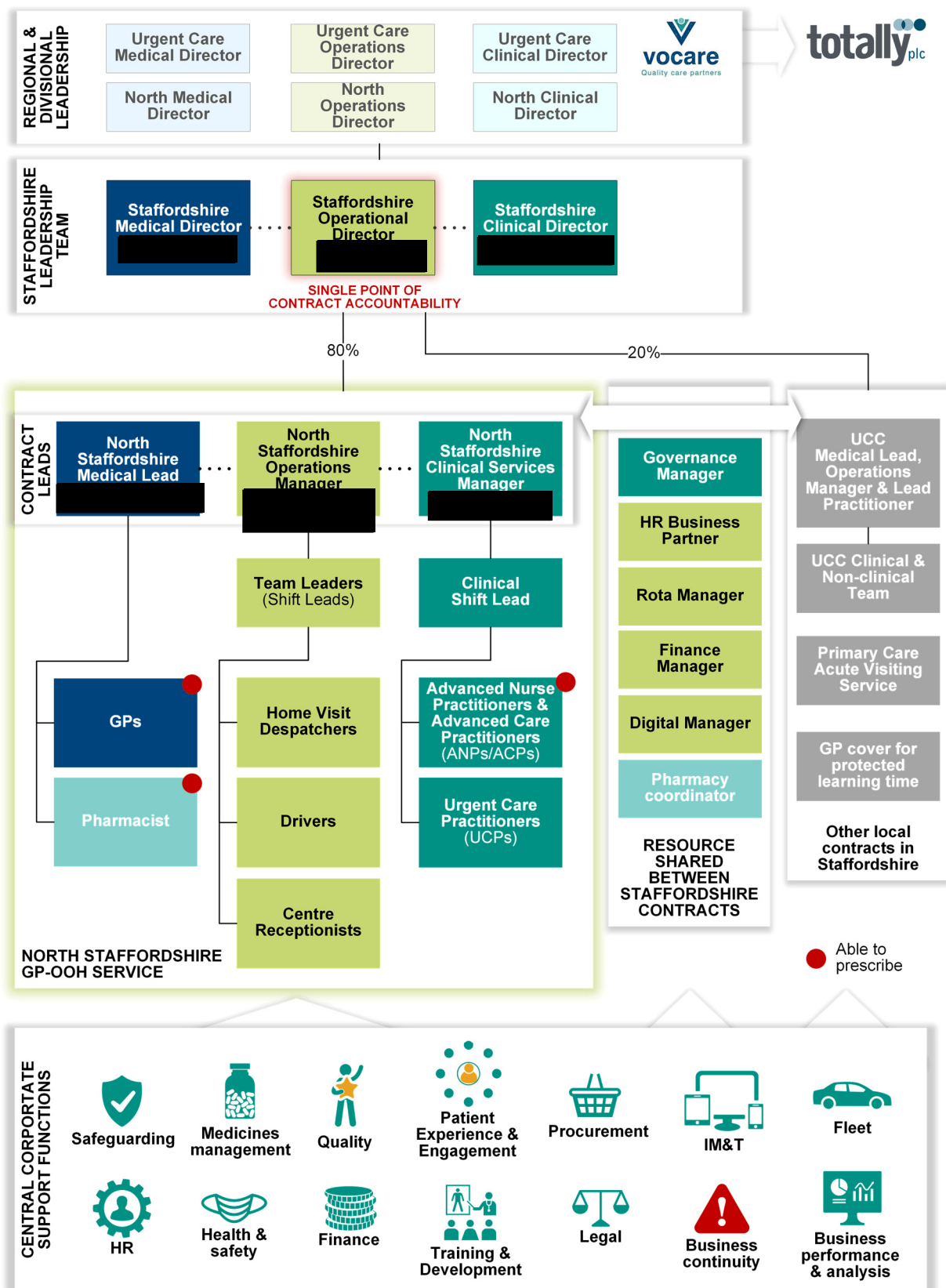


Figure 2: Lot 1 team structure

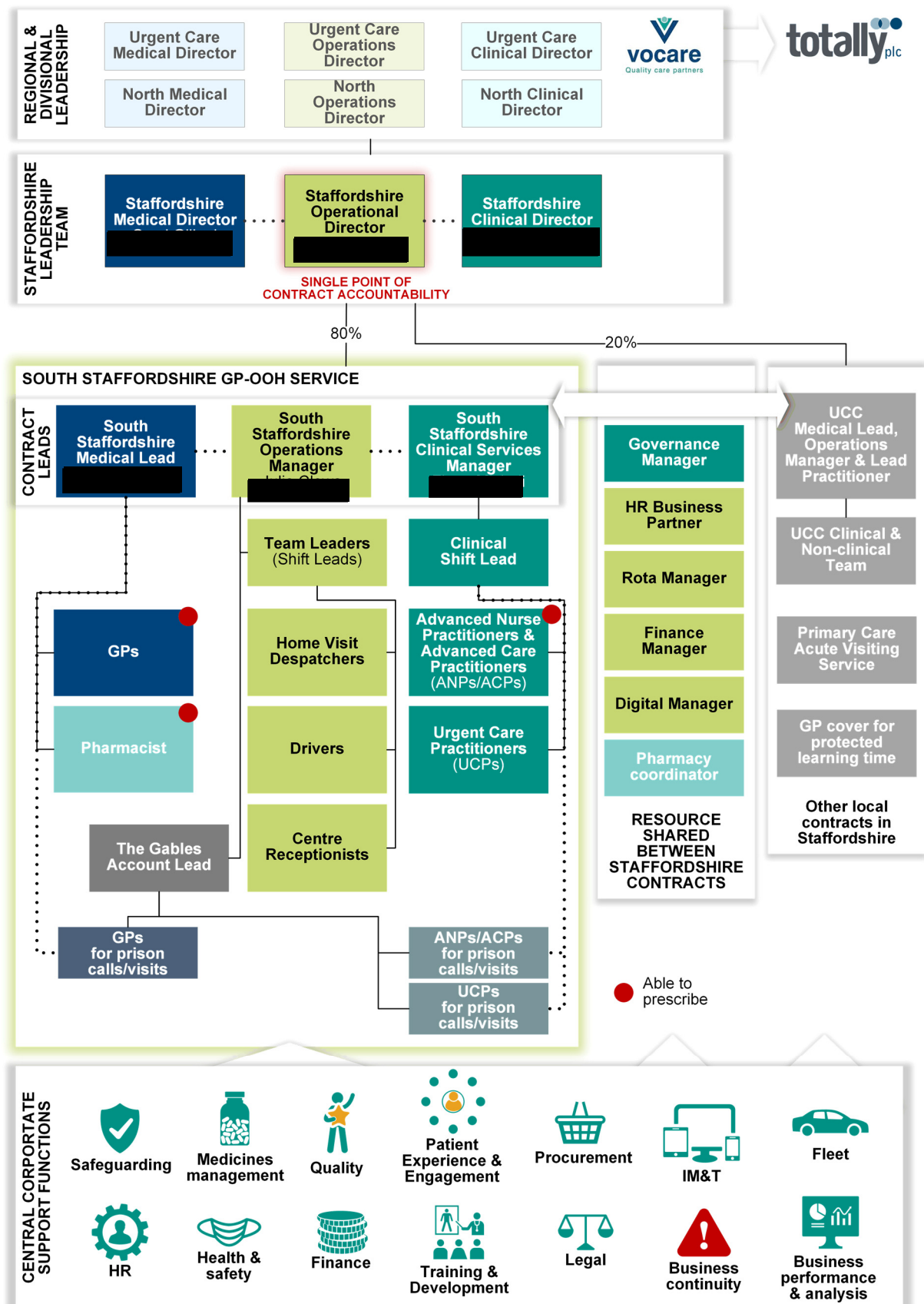


Figure 3: Lot 2 team structure

c)-FTEs required

A variety of factors influence the model and the requirements to effectively deliver the patient outcomes in a timely manner. We have used the experience of the management team, alongside historical technical data from our GP-OOH contracts to establish the required staffing and productivity assumptions. Analysis of the data and volumes indicate the best shift profile pattern considering the intraday arrival activity alongside the expected number of patient interactions. We have modelled a balanced productivity basis for telephone/video consultations and centre visits based on 4 patients per hour.

Home visits are modelled differently to consider the travel time and administration, this enables sufficient resources to be allocated to achieve the patient expected timeframes. Productivity expectations for home visits are 1 per hour.

Prisons are modelled completely separately based on the requirements such as time to clear security and obtain entry. They are worked into the overall modelling and provide flex to the service for surge/spikes in activity. The case length for the prison visit is substantially longer than all other episodes due to this.

c.1)-Refining for efficiencies and shrinkage

Absence monitoring and on shift non-productive time is managed closely. Assumed non-productive time is factored into the modelling undertaken. Sensitivity and trend analysis is key to understand likely impacts, especially considering the Covid-19 pandemic.

Normally we would look at a 13-week average for absence and non-productive time, however, this has been shortened to 4 weeks due to the large variation in Covid-19 absence.

We can flex the services to accommodate short surges in activity and focused work changes e.g. call volume spikes. We actively manage breaks and offline time aligned to the actual demand on the day to ensure alignment against patient arrival patterns.

c.2)-Staffing profile for Lot 1

Role title	FTEs
GP	■
ANP	■
UCP	■
Clinical Shift Lead	■
Driver	■
Receptionist	■
Dispatcher	■
Team Leader	■
Operations Manager	■
Clinical Services Manager	■
Governance Admin	■

1.19.1
Resource Plan

Role title	FTEs
Governance Manager	
Rota Coordinator	
Rota Manager	
Area Operational Director	
Area Clinical Director	
Area Medical Director	
Pharmacy Coordinator	
Regional Administrator	
Medical Lead	

c.3)-Staffing profile for Lot 2

Role title	FTEs
GP	
ANP	
UCP	
Clinical Shift Lead	
Driver	
Receptionist	
Dispatcher	
Team Leader	
Ops Manager	
CSM	
Governance Admin	
Governance Manager	
Rota Coordinator	
Rota Manager	
Area Operational Director	
Area Clinical Director	
Area Medical Director	
Pharmacy Coordinator	
Regional Administrator	
Medical Lead	

1.19.1.2-Current resources available

As the incumbent provider we have a variety of staff that can move to the new service model through a management of change function as TUPE will not apply. This is essential to align expectations and delivery requirements for the roles. A benefit of this approach is a continuity of the clinical workforce and understanding of the GP-OOH requirements. Front-facing clinical and operational posts will continue to see patients, albeit, in a refined geography or new location.

We are ideally placed to enact the changes to maximise the positive impact of the new GP-OOH structure including additional locations to benefit the rural and hard to reach patient cohorts.

We expect the experienced workforce will transition across to the appropriate Lots and delivery model under a management-of-change function, therefore retaining our experienced employees.

1.19.1.3-Future resources proposed

We will innovate throughout the life of the contract (as we have in the existing service) identifying new roles and patient pathways. For example, utilising video consultation in a local pharmacy will enhance patient experience, reduce travel time and provide any appropriate medication in one visit. This level of integration and alliance approach is focusing on place-based care.

1.19.1.4-Provider of both Lots

We would look for service efficiencies that would benefit the CCG and patients if we are successful in both lots. This would be worked through with the appropriate teams with the main focus on non-patient focusing roles.

1.19.1.5-Ongoing review of the resource plans

During the delivery of the contract, we will continuously monitor and assess the resource plan and patient arrival volumes to ensure the delivery model is finely tuned against this. We undertake a 13-week review to assess the core assumptions but also monitor closely through the day-to-day management and business intelligence reports e.g. breach reports. This approach provides both strategic and tactical reviews of the resourcing plan.