Integration Joint Board 26.03.20
Agenda Item: 7.7.1
Purpose: Information

Update to 2019/20 PCIP – Planning Information for March 2021

For each section ("Projected delivery by March 2021" and "Mitigating Actions to Keep Programme on Track") please include key information in short, concise, bullet points and /or only a few paragraphs.

Workstream	**Vaccination Transformation Programme**
The Vaccination Transformation Programme can be divided into different work streams: 1. pre-school programme 2. school based programme 3. travel vaccinations and travel health advice 4. influenza programme 5. at risk and age group programmes (shingles, pneumococcal, hepatitis B) We expect HSCPs and NHS Boards to have all of these programmes up and running by the end of the 3-year transition period - in April 2021	
Projected delivery by March 2021. In the Western Isles, we have built generic community nursing capacity in order to deliver holistic, integrated care, which will cover both vaccination activity and community treatment. Although still in development, we are confident this is the best model within a remote and rural context. We expect to have fully delivered on the vaccination transformation by April 2021. Almost all vaccination work has now transferred from practices to community teams. Additional capacity requirements will need to be built in to support the flu season, given our integrated model. This year, our vaccination rates were good, boosted through Saturday clinics and a highly cooperative environment between practices and community teams. This will be funded from within the existing envelope of resources allocated to VTP/CTAC (£340k per annum) from 2020/21. Travel vaccinations remain outstanding because we await further national guidance on this matter. However, we are confident that travel vaccinations will be transferrable by 2021 and anticipate having two centres across the islands that will undertake the work. We will need to cost new activity and develop learning and training arrangements. Travel advice would ideally be supported through national arrangements but we recognise that we may need to build some of this capacity locally. Call and recall remains a central outstanding issue to resolve. Insofar as the responsibilities for call and recall did not transfer this year, it placed a significant burden on practices and mitigated gains that might otherwise have been made in liberating practice time. We are unable to wait for a fully formed national solution and have therefore sought to develop local arrangements to take this forward. The administration of call and recall will be supported from PCIP monies (circa £20k per annum).	
Mitigating Actions to Keep Programme on Track. Awaiting national developments in relation to travel vaccinations and call and recall	

Workstream	Pharmacotherapy
By April 2021, every practice will benefit from the pharmacotherapy service delivering the core elements as described below. Level one (core) Pharmacists: Authorising/actioning all acute prescribing requests; Authorising/actioning all repeat prescribing requests; Authorising/actioning hospital Immediate Discharge Letters; Medicines reconciliation; Medicine safety reviews/recalls; Monitoring high risk medicines; Non-clinical medication review Acute and repeat prescribing requests includes/authorising/actioning: hospital outpatient requests; non-medicine prescriptions; instalment requests; serial prescriptions; Pharmaceutical queries; Medicine shortages; Review of use of ‘specials’ and ‘off-licence’ requests. Pharmacy Technicians: Monitoring clinics; Medication compliance reviews (patient’s own home); Medication management advice and reviews (care homes); Formulary adherence; Prescribing indicators and audits	
Projected delivery by March 2021. Although we have a detailed delivery proposal, it has taken time to build capacity as a result of a wider restructuring of our pharmacy department and delays in the job matching process. We have allocated £260k to this agenda, to support each of our nine practices with additional primary care pharmacy input. We currently have around £100k of primary care pharmacy capacity deployed. Our delivery proposal is currently being refined by our Chief Pharmacist and this is likely to involve: a Band 8a lead primary care pharmacist; two Band 7 primary care pharmacists; and two Band 5 technicians. Subject to recruitment challenges (a systemic challenge in the Western Isles), we would hope to have this capacity fully deployed by April 2021. This will be a highly prized resource when fully formed and it is likely that our practices would ideally seek additional capacity, should further central funding be provided. This is especially important in a remote and rural context.	
Mitigating Actions to Keep Programme on Track. No specific measures are required beyond the effective recruitment to posts. The technicians may be developed locally rather than recruited from the open labour market.	

Workstream	**Community Treatment and Care Services**

Community treatment and care services include many non- GP services that patients may need, including (but not limited to):

•management of minor injuries and dressings
•phlebotomy
•ear syringing
•suture removal
•chronic disease monitoring and related data collection.

There will be a three year transition period to allow the responsibility for providing these services to pass from GP practices to HSCPs. By April 2021, these services will be commissioned by HSCPs, and delivered in collaboration with NHS Boards that will employ and manage appropriate nursing and healthcare assistant staff. Phlebotomy will be delivered as a priority in the first stage of the Primary Care Improvement Plans.

Projected delivery by March 2021.

In the Western Isles, we have built generic community nursing capacity in order to deliver holistic, integrated care, which will cover both vaccination activity and community treatment. Although still in development, we are confident this is the best model within a remote and rural context.

This transition is partially complete, with our community nursing teams taking on responsibility for the management of wound care and phlebotomy. The next phase will focus on delivery of CDM Monitoring adopting the principles of Personalised Care, which is currently being piloted by one of the practices. However, this needs more capacity and wider reforms to be adopted within practices.

Additional capacity required to deliver ear syringing, injections, ECGs, Spirometry/PFR Breath tests etc. We’re proposing to bring forward capacity earmarked for Year 4 to deliver fully on this by the end of Year 3, utilising unspent PCIF resource. A total of £340k is allocated to VTP/CTAC but even with a focus on reform and the implementation of realistic medicine, we anticipate that this will continue to require additional resource into the future.

Mitigating Actions to Keep Programme on Track.

We have reprofiled our PCIF resource to ensure we can bring forward the delivery of CDM in particular. We believe that much of this activity will be deliverable by March 2021 but we will continue to assess demand and consider any future capacity building requirements.

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Workstream	**Urgent Care**

Urgent unscheduled care including the provision of advanced practitioner resource as first response for home visits.

This will involve the implementation of sustainable advance practitioner provision in all HSCP areas, based on local service design. These practitioners will assess and treat urgent or unscheduled care presentations. This will allow GPs to focus on scheduled appointments with patients most in need of their skills as expert medical generalists. Where service models are sufficiently developed, advanced practitioners will also directly support GPs expert medical generalist work by carrying out routine assessments and monitoring of chronic conditions for vulnerable patients at home, or living in care homes.

It is expected that the workload for advanced practitioners would mean that most GP practices would not have sole access to advanced practitioners. It is likely that advanced practitioners would work across a number of GP practices to meet patient needs. GP clusters will play an important role in enabling this service to ensure effective working and good patient outcomes.

Projected delivery by March 2021.

We have brought together the reform of Out of Hours and the transference of urgent care through the day to develop a plan for a new urgent care service for Lewis and Harris which:-

- Provides advanced clinical assessment capacity on a 24/7 basis;
- Delivers on the terms of the new GP Contract, with home visits normally being undertaken by ANPs employed by the Health Board;
- Secures more effective care coordination through the establishment of Virtual Community Wards;
- Supports GPs to develop in their roles as Expert Medical Generalists, leading Multi-Disciplinary Teams focused on supporting complex presentations in community settings and triage and direct home visits
- Streamlines bureaucracy and referral mechanisms between GPs, community nurses, AHPs, and social care assessors
- Supports the delivery of realistic medicine and promotes holistic and integrated patient care

The new service specification will be developed over the next few months, and refined thereafter. TUPE issues are likely to arise again in relation to practice nursing staff (this was one of the challenges around VTP/CTAC). We will also need to undertake staff consultation with existing Out of Hours Staff.

Our proposals for Uist and for Barra are less well developed but will be considered over the next three months.

Mitigating Actions to Keep Programme on Track.

We anticipate that we will have delivered on this agenda by March 2021, albeit that it will hinge on wider practice/system reform. We will continue to assess demand and consider any future capacity building requirements.

Workstream	Additional Professional Roles

Additional professional roles will provide services for groups of patients with specific needs that can be delivered by clinicians other than GPs, serving as first point of contact in the practice setting as part of the wider multi-disciplinary team. These include (but are not limited to) physiotherapy services, community mental health services and community links worker services.

HSCPs will develop models to embed a musculoskeletal service within practice teams to support practice workload. In order to provide a realistic alternative for patients, access times must be comparable to those of general practice. Priority for the service, such as focusing on elderly care, will be determined by local needs as part of the Primary Care Improvement Plan.

Community clinical mental health professionals (e.g. nurses, occupational therapists), based in general practice, will work with individuals and families assessing their mental health needs, providing support for conditions such as low mood, anxiety and depression. The outcome sought is improved patient care through rapidly accessible, appropriate and timely mental health input.

Projected delivery by March 2021.

Our primary focus on this agenda has been to build physiotherapy capacity to divert MSK patients from GPs. However, having allocated the majority of the PCIF monies to the first four priorities (VTP / CTAC / Pharmacotherapy / Urgent Care), we have less resource than we believe is required to deliver on this agenda effectively. While we recognise that it will necessitate wider reforms within our physiotherapy department, the creative practice of realistic medicine, and the reform of the orthopaedic pathway, the proposed resource of £100k falls short of requirements. We are operating on the assumption that to successfully divert patients from GPs, we need to ensure physiotherapy is as accessible as general practice, meaning appointments within two to three days of request. To build sufficient capacity, we would require, at minimum, three Band 6 physiotherapists and 2 x 0.5 WTE Band 7 first contact practitioner physiotherapists (circa £220k).

New mental health capacity is being developed through the application of Action 15 monies. However, these are not exclusively focused on primary care. While we are also focused on a stronger alignment between community mental health teams and the primary care system, and while our wider redesign of mental health is creating new capacity, this remains work in progress. We have invested in a psychological therapy post, which will support practices in the delivery of therapeutic interventions, focusing on people who have experienced trauma.

In respect of the wider aspiration to deliver practice based multi-professional teams, we are using the new contract to leverage change across the wider system. There has been a traditionally strong relationship between GPs and community nursing and we are now focused on thinning-out bureaucratic referral processes to bring key health and care colleagues (AHPs, social work/care, mental health) into MDT arrangements.

Mitigating Actions to Keep Programme on Track.

Our constraint is primarily resource led. We will have added £100k of new capacity but this is unlikely to secure the desired outcomes. We will do what we can to creatively utilise existing capacity.

Workstream	**Community Links Workers**
HSCPs will develop CLW roles in line with the Scottish Government's manifesto commitment to deliver 250 CLWs over the life of the Parliament. The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models of care and support.	
Projected delivery by March 2021. We are currently participating in an EU-funded project that seeks to embed social prescribing routes within primary care through community navigators (link workers) but with an additional digital focus. Our intention had always been to use this to test working practices and capacity building requirements but its further development and implementation is now endangered by the ending of EU funds and the full utilisation of the PCIF monies on the first five priorities. As a small partnership area, we took a conscious decision not to spread the monies too thinly, otherwise the new services and arrangements being developed would lack resilience and sustainability. The consequence of that strategy is that we have no further PCIF monies to support this national action, despite our ambition to see new link worker capacity in place.	
Mitigating Actions to Keep Programme on Track. This is the only one of the national priorities that will not be delivered, either wholly or in part, by 2021.	

New ways of working.

We also recognise as part of mitigating actions innovative models are being developed. Please share any examples of models of service redesign that would be of value to the wider system. It would also be helpful to provide links to (or copies of) any evaluation and the details of contacts from who further information can be obtained. Going forward we intend to develop a system to share this learning to areas who are perhaps not as advanced as others. Any other activities being undertaken to reduce workload for GPs may be detailed here.

We believe that we have developed an effective approach for the delivery of the new contract in a remote and rural context. Important factors include:

- **A commitment to openness and transparency of decision making and the operation of a fair share principle to ensure practices benefit in proportion to their size;**
- **A commitment to transformation. Rather than seeing the new contract in transactional terms, we have used it to leverage change across our health and social care system;**
- **The development of integrated models. Given our remote and rural context, we have built capacity into existing community healthcare teams rather than developing new stand-alone/specialist capacity, thereby improving integration with the mainstream system and improving service resilience and sustainability;**
- **The develop of an approach that was flexible enough to adapt and change in light of experience and an openness to problem-solve with practices as issues emerged.**
- **With the right support, these reforms will improve patient outcomes, liberate GPs as clinical leaders and situate an empowered primary care service at the heart of our local system – but it is worth underlining that it will require additional investment in order to realise the full potential of our endeavours**