REPORT TO ABERDEENSHIRE INTEGRATION JOINT BOARD - 3 February 2021

PRIMARY CARE IMPROVEMENT PLAN – YEAR 3 IMPLEMENTATION PLAN 2020-2021

1 Recommendation

It is recommended that the Integration Joint Board (IJB):

1.1 Acknowledge the progress in delivery of the Primary Care Improvement Plan (PCIP) for 19/20 and up to December 2020 (appendix 1); and

1.2 Acknowledge the challenges of delivery of the Primary Care Improvement Plan, particularly within required timescales, funding and recruiting workforce.

2 Directions

2.1 No direction requires to be issued to Aberdeenshire Council or NHS Grampian as a result of this report.

3 Risk

3.1 IJB risk 2 – Health and Social Care policy. Aberdeenshire IJB will be required to implement the new GP contract and develop services, responsive to local need in line with the Memorandum of Understanding.

4 Background

4.1 The IJB agreed the Primary Care Improvement Plan to support the implementation of the new General Medical Services (GMS) contract prior to its submission to Scottish Government in July 2018. This plan although an evolving document outlines the actions that will be taken in the coming 2 years, acknowledging the 1-year extension given by Scottish Government, to develop and redesign services within Primary Care. Appendix 2 – GMS Medical Services Contract in Scotland, A Short Guide prepared by Audit Scotland.

4.2 Scottish Government have outlined that they require an annual review of the progress made under the PCIP and indication of where the workstreams will be progressed in the coming year. We are also advised that this should include not only the plan itself but an indication of the financial and workforce challenges which may present.

In line with the Memorandum of Understanding, the Primary Care Improvement Plan Year 2 Implementation Plan was agreed by IJB and

subsequently by GP Sub Committee on 19th June 2019. The PCIP Plan Year 2 plan has now been submitted to Scottish Government

5 Updates on the Six Workstream the HSCP must deliver on

In some streams the whole of a service should move to the HSCP (vaccination, pharmacotherapy, community treatment, link workers) and in others the HSCP is required to employ staff to support work (Urgent Care and Additional Professionals). The GPs will continue to provide clinical leadership

5.1 Vaccination Service

The new arrangements are in place for the pre-school and flu immunisations.

Pertussis for pregnant women who do not attend AMH is in place.

Delivery of flu for the over 65 years and at risk, commenced in 2020. Shingles and pneumococcal vaccination programme still to be arranged. Aim to commence during 2021.

Outcomes:

- **Record uptake in the population being immunised (above Grampian and Scottish averages)**

5.2 Pharmacotherapy

The model of delivery of this service has been reviewed and will now be more of a cluster model than providing individual practices with pharmacist input. This will be more resilient, allowing gaps in provision to be covered.

Standard Operating Procedures and Practice Agreements have been established and guidance around the definition of tasks for Bands 5, 7 and 8A staff which are reasonable for them to undertake has been developed.

Difficulty remains recruiting and retaining staff to some areas across Aberdeenshire. Accessing prescribing courses, releasing staff to attend and gaining GP mentorship (no funding available to support this) and the commitment required by GPs to support are risks and barriers to moving forward. There is a fragility in the service owing to the inability to finance cover for sick leave and maternity leave.

Example of Outcomes:

- **Standardised processes/system ensuring patient safety**
- **Reducing GP workload and improving patient care**

5.3 Community Treatment Centres

HCSWs in 3 practices have been TUPEd as a pilot of the process. This has been successful, but has raised some questions about equity. Several more practices have now started the TUPE process for their HCSWs.

Where vacancies arise for HCSW, the partnership has begun recruiting to these vacancies. To date there are 7 posts at different stages in the process. Where necessary vacancies have been covered by bank staff.

Example of Outcomes:

- **Delivered close to the patient where possible**
- **Equitable service is provided**

5.4 Urgent Care

A second cohort of Advanced Clinical Practitioners came into post in November 2019, providing a service to a greater number of practices. The service has tested models of change; however, this has been challenging due to Covid with the practitioners being pulled to support the home visiting arm of the Covid response for a period of time during 2020. A third cohort are coming into post during January 2021. The aim is to work towards a cluster-based approach to provide this service moving forward.

Currently in the process of appointing a dedicated Professional Lead for the Advanced Practice Practitioners. It is hoped that we can recruit to this post as soon as circumstances allow.

New staff into these posts have already left the service for a number of reasons. There is a risk of destabilisation of partner workforce (community nursing teams). No backfill for sick leave and maternity leave.

Example of Outcomes:

- **Dedicated Advanced Clinical Practitioners on hand to deal with urgent /emergency requests between the hours of 8am and 6pm with the aim to keep patients in their homely setting as far as practicable and avoiding admissions to secondary care.**
- **Free up GP capacity**

5.5 Additional Professionals

Redesign of the physiotherapy/MSK service has allowed for an innovative approach to provision of first contact physiotherapists in practices. All practices except one now have some physiotherapy cover and a recent survey indicated that the service is well received.

Example of Outcome:

- **Access to physiotherapists within the practice setting without the need to be referred by GP/clinician, low waiting times resulting in reduction in GP consultations/medication requirements.**

5.6 Link Workers

18 wte mental health and wellbeing – providing a universal service across all practices. As a result of competing pressures on a variety of essential staff to move the commissioning process forward the service is in the process of going out to tender.
7 wte specialist link workers now in post, but have been pulled to provide financial assistance to GCAH. Aim is that this service will be implemented by April 2021.

These posts are funded through Action 15, Primary Care Improvement Plan and Council housing/money advice services.

Example of Outcomes:

- **Support people to access/use community resources and services to improve their health and wellbeing**
- **Support for low level mental health issues locally**

6 Summary

6.1 Work continues to progress the implementation of the Primary Care Improvement Plan as set out in this report.

6.2 The Chief Officer, along with the Chief Finance Officer and the Legal Monitoring Officers within Business Services of the Council have been consulted in the preparation of this report and their comments have been incorporated within the report.

7 Equalities, Staffing and Financial Implications

7.1 There is still concern that we will have a shortfall in funding to achieve full implementation of the plan and also the recruitment of the staff required, especially in areas that we have sustainability issues.

7.2 An equality impact assessment is not required at this stage however will be required during the development of the new services.

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Aberdeenshire Health and Social Care Partnership
Report prepared by Jean Pirie & Aileen Wilson, Primary Care Development Managers
11 January 2021

General Medical Services contract in Scotland

A short guide

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Prepared by Audit Scotland
May 2019

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Introduction

The new General Medical Services contract sets out new plans to improve the way healthcare is delivered to patients in the community and the way GPs will work and be paid in Scotland

Background

Most GP practices are run as independent businesses and provide services for NHS boards.

NHS boards specify what healthcare services they need and then fund the GPs to do this work through an arrangement called the General Medical Services contract.

The role of the GP is changing in the context of health and social care integration and the policy ambition to move care from hospitals to the community.

Increase in average practice lists

2014	2018
5,673	6,073

Increase in practices run by NHS boards

2014	2018
48	58

Decline in the number of general practices

2014	2018
987	944

Introduction

The new contract aims to support a more sustainable approach to the delivery of general medical services in Scotland

To improve stability and reduce risks to the delivery of general medical services in the future, the new contract focuses on the following areas:

Funding for general practice

GP owned premises

The role of the GP

Workload pressures

Improvements to primary care services

These areas will now be presented in more detail. (Click on the above links to move directly to the page.)

This short guide provides a summary of the key aspects of the new contract.

Further information will be presented in the NHS Primary Care Workforce audit due to be published in August 2019.

Funding for general practice

As well as aiming to improve GP earning, a new way of funding general practices, based on workload, has been introduced

The Scottish Government is investing an additional **£250 million** in direct support of general practice by 2021-22. This forms part of an overall commitment to invest an additional £500 million in primary care by 2021/22.

Phase 1 (2018–20)

The Scottish Government provided additional immediate investment of £23 million to provide practice income stability and improve funding where GP workloads are at their highest.

A new funding formula will be used to calculate practice funding that aims to ensure that additional funding is provided to practices with higher elderly and deprived populations.

April

From April 2019 it is proposed that a minimum income of £84,630 will be introduced for independent contractors. Based on a 2017 income and expenses review, around a fifth of GPs earned less than a full-time equivalent income of £70,000.

Phase 2 (2020–21)

It is planned that GP pay will change to an agreed income range with pay progression (like hospital consultants) and that financial risk is reduced through direct reimbursement of practice expenses, ie premises and staff costs.

Further negotiations and polling will be conducted with GPs during 2018-20 to ensure that these proposed arrangements are beneficial and agreed. It is also planned that data will be collected to fully understand the current costs of running a practice; the income of GPs and the hours worked by GPs. The aim is that this will help inform the development of the new funding model.

The Scottish Government has set up the Remote and Rural General Practice Working Group to further explore some of the challenges experienced by rural GPs. This work will include seeking further information about rural workforce issues, expenses and income needs.

GP owned premises

The National Code of Practice for GP premises aims to reduce the risk associated with owning premises

In April 2018, alongside the new contract, a National Code of Practice for GP premises was introduced that sets out how the Scottish Government will support a shift, over the next 25 years, to a new model in which GPs will no longer be expected to provide their own premises.

By 2021, the Scottish Government will provide an extra

£50 million

to

GP Premises Sustainability Fund

helps GPs with the cost of running their practices

The new fund includes interest free loans to assist GPs who own their premises. This aims to allow GP partners to release capital without destabilising their practice, reduce the upfront cost of becoming a GP partner, and make general practice more rewarding.

A total of **172 practices** have applied for loans – around **50 per cent** of the total eligible.

The role of the GP

The new contract aims to give GPs more time with their patients and lead improvements in the provision of health and care in their communities

People are living longer and more people have multiple long-term conditions, so the amount of care needed, and its complexity, has been increasing

This change has meant that GPs need to spend:

less time on more routine tasks

more time focusing on caring for patients, particularly those with complicated conditions and those with conditions that are hard to diagnose

GPs also need to lead change by:

- participating in quality improvement
- influencing decisions about the planning and delivery of new health and social care services in their area

New

Protected time

0.5 days

To allow GPs to be more involved with this type of work, **protected time** (around half a day per month in each practice, where the GPs do not see patients) has also now been introduced.

Central to the development of the new contract are the **4 Cs of primary care:**

Contact: accessible care for individuals and communities.

Comprehensiveness: holistic care of people that includes physical and mental health.

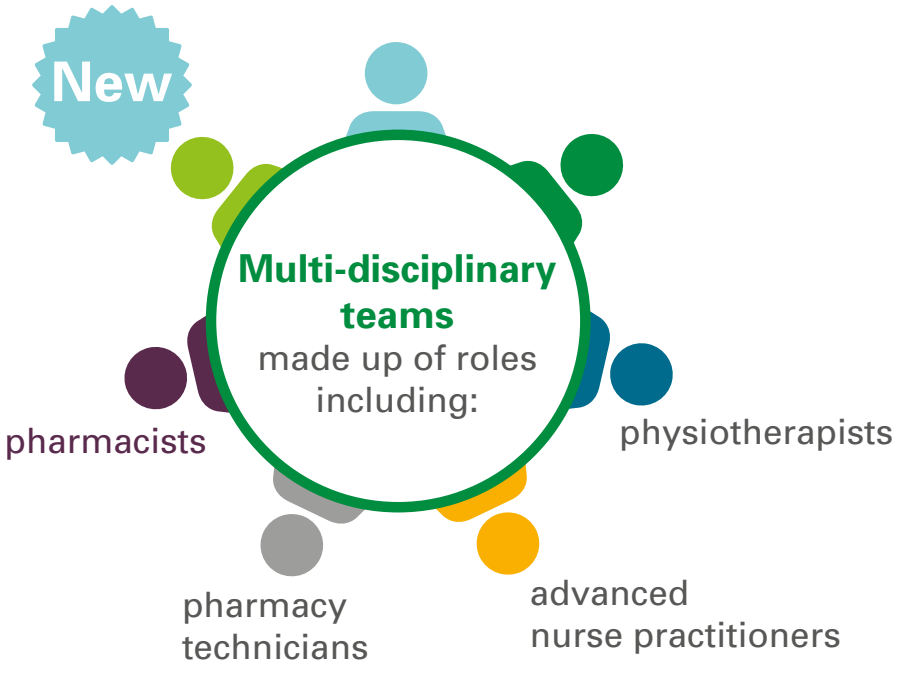
Continuity: long-term continuity of care, supporting an effective, therapeutic relationships with patients.

Coordination: overseeing care provided by an expanded multi-disciplinary team.

The new contract aims to create an environment that supports the GP to fulfil these principles.

Workload pressures

The contract includes plans to expand the multi-disciplinary workforce in primary care so they can work alongside GPs to share the delivery of care



Teams will be based in GP practices and the community and most will now be employed by NHS boards and not by GPs.

The Scottish Government commitment:

Increase the number of GPs in Scotland by at least **800** over the next decade.

It is intended that these changes will help to reduce GP workload and allow the GP to focus on their role, improve patient outcomes, community health and practice sustainability.

Improvements to primary care services

The new contract is part of the Scottish Government's plans to transform primary care services through a programme of reform

A number of primary care services have been prioritised for reform by the Scottish Government. The primary aim is to increase multi-disciplinary team working and improve access to care and treatment at the right time, with the right person and closer to home. Some of these redesigned services may be in the community and no longer within GP practices. It is intended that this will help reduce the practice workload. The new services will become the responsibility of NHS boards.

The six priorities for services redesign are:

vaccination services

pharmacy and prescribing services

Including: prescribing; repeat prescriptions and medication reviews.

community treatment and care services

Including: minor injuries; phlebotomy; chronic disease monitoring.

urgent care services

Including: advanced practitioners, nurses, paramedics; home visits and unscheduled care.

additional roles as part of multi-disiplinary team

Creating roles including community mental health professionals and physiotherapists to see patients as a first point of contact.

community link workers

They will help patients navigate and engage with wider services.

General Medical Services contract in Scotland

A short guide

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APPENDIX 2

Covid PCIP 3

Health Board Area: Grampian

Health & Social Care Partnership: Aberdeenshire

Number of practices: 30

MOU PRIORITIES

2.1 Pharmacotherapy	Practices with no access by 31/8/20
Practices with PSP service in place	
Practices with PSP level 1 service in place	3
Practices with PSP level 2 service in place	
Practices with PSP level 3 service in place	

Comment / supporting information: ***27 out of 30 practices receiving partial service - no cover for annual leave or other cover. Very small Pract***
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous pro

2.2 Community Treatment and Care Services	Practices with no access by 31/8/20
Practices with access to phlebotomy service	22
Practices with access to management of minor injuries and dressings service	**we do have MIU dpts and practcies with minor injury local enhanced contracts but this is not funded through**
Practices with access to ear syringing service	30
Practices with access to suture removal service	30
Practices with access to chronic disease monitoring and related data collection	22
Practices with access to other services	

Comment / supporting information: ***Audit of workload had just taken place and TUPE process for 3 practices for the healthcare support worker little/no alternatives. Planning/meetings were on hold during the initial stages of the the pandemic and the first re-setting meeting was held c communities from Community Hospitals, Minor Injury Units taking into account the Unscheduled Care and Home First projects as part of our re***
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous pro

2.3 Vaccine Transformation Program	Practices with no access by 31/8/20
Pre School - Practices covered by service	0
School age - Practices covered by service	0
Out of Schedule - Practices covered by service	
Adult imms - Practices covered by service	30
Adult flu - Practices covered by service	30
Pregnancy - Practices covered by service	15
Travel - Practices covered by service	30

Comment / supporting information ***Due to the pandemic there has had to be a siginificant change in how we now plan to deliver the mass flu p Grampian we are striving to undertake the majority of this workload with minimal reliance on general practice and we will be stepping down s This also has an impact on fridge capacity due to being locality delivered and not within practices.***
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous pro

2.4 Urgent Care Services	Practices with no access by 31/8/20
Practices supported with Urgent Care Service	16

Comment / supporting information
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous pro
Due to the change in delivery of services with more remote consultation, which in turn takes experienced practitioners who have consolidated around cluster models with Advanced Practice Band 8A input and practice bursaries. The loss of the majority of our fellows to other roles who are delaying interviews meantime as we re-set and re-build.

Additional professional services

2.5 Physiotherapy / MSK	Practices with no access by 31/8/20
Practices accessing APP	4

Comment / supporting information ***During Covid we accelerated the provision of FCP phyio to the practices in order to take some of the burden FCP phyio. Whether this is enough for their requirements remains to be seen. One of the remaining practices will come on line on 21/9/20, and work related accidents. Total triage for most practices now makes it easier to direct right patients to them.***

Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous pro

2.6 Practices accessing MH workers / support	0

2.7 Community Links Workers	**Practices with no access by 31/8/20**
Practices accessing Link workers	30

Comment / supporting information

Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous pro

The Short Life Working group was finalising comissioning documentation to enable the HSCP to go out to tender for the Universal PCLW (ment Data Protection Impact assessment and service agreement as elements of service delivery require to be ammeded as we 'live with Covid' - mo joint work with Aberdeenshire Council to introduce the Specialist Link Worker (money advise) service was put on hold in March 2020, the recru commence Oct 2020. A second recruitment phase is now underway to recruit the remaining WTEs.

2.8 Other locally agreed services (insert details)	**Practices with no access by 31/8/20**
Practices accessing service	

Comment / supporting information

Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous pro

2.9 Overall assessment of progress against PCIP

Specific Risks

ACP: HAI - Need to mitigate risk of spread. Reducing footfall in patient's homes, VSH, care homes and community hospitals. Geographical sp deliver a uniform service to all pracitces covering 2500 square miles of rural Aberdeenshire.

Primary Care Link Workers - No capacity within general practices for PCLWs to physically be based with COVID19 restrictions- so moving to vir seen as part of primary care teams - both in terms of building professional relationships and trust with primary care teams but also that patie services.

Barriers to Progress

Please detail any barriers to progress and what could be done to overcome those barriers. ***ACP: All recruitment paused. Training opportunities c activities during lockdown). Patients being seen virtually and telephone triage which has resulted in additional training needs to deliver this a consolidated their learning. Clinical consolidation made difficult due to reduced face to face patient contact.***

Primary Care Link Workers - Complexity in relation to data access and mangement of services requiring IG support to produce DPIAs, data shar PCLWs (MHWB) service - Limited specialist contract management support available to support 'management' of comissioned service due to l Community treatment and Care Services - other national and local workstreams/projects coming onboard and we almost have to prioritise/pla Aberdeenshire to be able to locate the treatment room nurse element in localities and how we jointly support the HCSW element for delivery w agreeing equity and staffing where it doesn't exist.

IT bandwidth in rural areas to enable more remote consultations

FCP - Another barrier is obtaining suitable hardware to run the service remotely at times, in order to ensure social distancing. Ideally we wou of our computers will not support this.

leadership time have been diverted away from PCIP planning into the COVID response

Issues FAO National Oversight Group

Accommodation for staff to be based within GP practices or localities is proving challenging with the added impact of COVID and social distan
Building professional relationships difficult moving forward
The funding allocation is not adequate to be able to fulful the desired MOU outcomes in all of the six workstreams
Recruitment of staff is an issue, with a small pool to draw from therefore after 1st and 2nd round of recruitment there isn't the fully skilled staf
experience, reliance on practices to support and mentor many staff from different workstreams. Difficulties recruiting to smaller/remote areas
the ongoing GP recruitment difficulties, supporting and mentoring new staff members is an added strain.
Access to training courses - competing against workstreams and IJB areas and no funding for this
IT equipment
Bandwidth/wifi access in rural areas to enable virtual working

Workforce profile

Health Board Area: Grampian
Health & Social Care Partnership: Aberdeenshire

Table 1: Workforce profile 2018 - 2022 (headcount)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL headcount staff in post as at 31 March 2018	10	3								0 FCP in post		0
INCREASE in staff headcount (1 April 2018 - 31 March 2019)	9	6								1		0
INCREASE in staff headcount (1 April 2019 - 31 March 2020)	4	0				8	1	0		19		0
PLANNED INCREASE in staff headcount (1 April 2020 - 31 March 2021) [b]	1	2		55		3			11	6 (plus 1 recruiting)		8
PLANNED INCREASE staff headcount (1 April 2021 - 31 March 2022) [b]	0	0	20							0		18
TOTAL headcount staff in post by 31 March 2022	24	11	20	55	0	11	1	0	11	26	0	26

[a] please specify workforce types in the comment field
[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Table 2: Workforce profile 2018 - 2022 (WTE)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL staff WTE in post as at 31 March 2018	3.9	1.4								0 FCP in post		0.0
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	8.2	5.4								0.8		0.0
INCREASE in staff WTE (1 April 2019 - 31 March 2020)	4.0	0.0				8	1	0		9.4		0.0
PLANNED INCREASE in staff WTE (1 April 2020 - 31 March 2021) [b]	0.6	1.2		36.2		3.0			10.5	5.15 (plus 0.26 recruiting)		8.0
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	0.0	0.0	11.1							0		18.0
TOTAL staff WTE in post by 31 March 2022	16.7	8.0	11.1	36.2	0.0	11.0	1.0	0.0	10.5	15.4	0.0	26.0

[a] please specify workforce types in the comment field
[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Comment: