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Agenda Item: 14.

Integration Joint Board

Date of Meeting: 2 October 2019.

Subject: Primary Care Improvement Plan Budget.

1. Summary

1.1. The new GP Contract requires additional services to be put in place to allow greater multi-disciplinary team working as part of GP Practices by 2021.

2. Purpose

2.1. To review current budget and potential for spend during 2019 to 2020.

3. Recommendations

The Integration Joint Board is invited to note:

3.1. Budget spend 2019 to 2020, attached as Appendix 1 to this report.

It is recommended:

3.3. To approve the posts identified in section 6.2 of this report showing the full year cost.

3.3. To direct the Board of NHS Orkney to commission the services identified in section 4.7 of this report.

4. Background

4.1. The new GP Contract was agreed in 2018 and moves away from patients predominantly accessing services via a GP consultation. In future GP Practices will provide patient consultations via a skill mix of professionals with the GPs being increasingly freed up to concentrate on patients requiring more complex care.

4.2. As part of the new contract a directive (Memorandum of Understanding (MoU)) was published outlining 6 specific key areas of change. Boards are required to implement these changes by 2021 which will see increased new multi-disciplinary ways of working within GP Practices in place.

4.3. Representatives from Orkney Health and Care and Voluntary Action Orkney, together with the Chairs of the GP Sub-committee and the Local Medical Committee (LMC), meet on a monthly basis to ensure ongoing improvement in Primary Care is in a timely basis.

4.4. Some Practices have preferences around specific areas where they feel increased service delivery would make most difference. The GP Sub-committee works closely to ensure that all practices' views and preferences are taken into account.

4.5. The GP Sub-committee and the LMC are aware and are working with Orkney Health and Care representatives closely around the budget considerations and are likewise raising at a national level their concerns about the feasibility of being able to deliver all services within our current projected budget. Given the restrictive budget, all parties have taken great care to discuss options which provide the greatest potential for reducing workload for GPs but also potential reduced waiting times and enhanced experience for patients.

4.6. Any additional service which is commissioned by the Integration Joint Board will be required to develop smart objectives and governance processes. Updates will be given on a yearly basis to the Integration Joint Board on progress as part of the GP Contract updates.

4.7. For this year the GP Sub-committee and the LMC are requesting support to move forward with employing additional personnel in Musculoskeletal, Mental Health and Vaccine Transformation Services.

5. Contribution to quality

Please indicate which of the Council Plan 2018 to 2023 and 2020 vision/quality ambitions are supported in this report adding Yes or No to the relevant area(s):

Promoting survival: To support our communities.	Yes.
Promoting sustainability: To make sure economic, environmental and social factors are balanced.	No.
Promoting equality: To encourage services to provide equal opportunities for everyone.	Yes.
Working together: To overcome issues more effectively through partnership working.	Yes.
Working with communities: To involve community councils, community groups, voluntary groups and individuals in the process.	Yes.
Working to provide better services: To improve the planning and delivery of services.	Yes.
Safe: Avoiding injuries to patients from healthcare that is intended to help them.	Yes.
Effective: Providing services based on scientific knowledge.	No.

Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.	No.

6. Resource implications and identified source of funding

6.1. There have been additional funds which also include the Pharmacy baseline funding of £75,000.

Year.	**2019/20.**
Fund Allocation.	£266,311.
Earmarked Reserves.	£68,618.
2nd Tranche (within SG).	£27,026.
Total Funding.	**£361,955.**

6.2. Agreed Proposed Budget Spend 2019/20.

Resource/Practitioners.	**Full Year Costs.**
2 x Band 7 MSK Physiotherapists.	£121,258.
1 x Band 6 Mental Health Primary Care Worker.	£51,649.
1 x 0.75 Band 5 Vaccine Transformation Nurse.	£31,308.
On Costs (Travel, Telephone etc) working on 3% of cost.	£6,126.
Total	**£210,341.**

6.3. Although the table represents the yearly costs, these are seen as ongoing costs in the improvement of primary care services in Orkney.

7. Risk and Equality assessment

7.1. There are no risk or equality implications directly arising from this report.

8. Direction Required

Please indicate if this report requires a direction to be passed to:

NHS Orkney.	Yes.
Orkney Islands Council.	No.
Both NHS Orkney and Orkney Islands Council.	No.

9. Escalation Required

Please indicate if this report requires escalated to:

NHS Orkney.	No.
Orkney Islands Council.	No.
Both NHS Orkney and Orkney Islands Council.	No.

10. Author

10.1. Maureen Firth, Head of Primary Care Services.

11. Contact details

11.1. Email: maureen.firth@nhs.net, telephone: 01856888066.

12. Supporting documents

12.1. Appendix 1: Primary Care Improvement Plan Budget Spend.

12.2. Appendix 2: Draft Direction.

Appendix 1.

Primary Care Improvement Plan

Proposed Budget Spend 2019 – 2020

Situation

The Memorandum of Understanding as part of the GP Contract outlines the key priorities to be covered over a three year period (April 2018 - March 2021) within the Primary Care Improvement Plan and these remain in place:

i. Vaccination services (staged for types of vaccinations but fully in place by April 2021).

ii. Pharmacotherapy services – made up, by 2021, of level one core (acute prescribing, repeats, discharge letters, medication compliance reviews); followed by level two additional advanced (medication review, resolving high risk medication problems); level three additional specialist (polypharmacy reviews, specialist clinics).

iii. Community treatment and care services (e.g. minor injuries and dressings, phlebotomy, ear syringing, suture removal, chronic disease monitoring) with phlebotomy delivered as a priority in the first stage.

iv. Urgent care (advanced practitioners, nurses and paramedics) undertaking home visits and unscheduled care.

v. Additional professionals for multi-disciplinary team dependent on local geography, demographics and demand (e.g. physiotherapists focusing on musculoskeletal, mental health services).

vi. Community Link Workers.

- New staff will be employed predominantly through the NHS Board and work in models and systems agreed between each Health and Social Care Partnership (HSCP) and local GPs.
- New staff should, where appropriate, be aligned to GP practices or groups of practices.
- Where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices.

Background

Clinical Leads from each area have submitted scoping plans to the GP Sub-committee and Local Medical Committee (LMC) which set out options for delivering care to patients as part of a multi-disciplinary working approach within GP Practices.

For 2019-2020 the papers submitted concentrated around Musculoskeletal, Vaccine Transformation and Mental Health (Appendix 1). New personnel have just commenced in post for pharmacy and Community link workers and work is now commencing on these new services with the potential for further scoping papers and request for additional budget for 2020-2021. To date due to clinical lead postholders

not being in place scoping options around community treatment centres and urgent care has yet to be carried out.

Funding for delivery of new services is received through a Primary Care Improvement Fund by the Integration Joint Board (IJB) on a yearly basis with any underspend being able to be held in reserves until the following year. This funding is new recurring money which must only be spent on services directly in support of the new GP contract and any such spend and new service delivery must be agreed by GP Sub-committee, Local Medical Committee and IJBs. IJBs have been made aware through the Primary Care Improvement Plans for the projected predicted shortfall in funding that we anticipate will prevent us currently being able to implement the contract in full.

For 2019-2020 it is proposed to fund:

- 2 WTE Band 7 Primary Care First Point of Contact Physiotherapists (option 3 of scoping paper).
- 1 WTE Band 6 Primary Care Mental Health Worker.
- 0.75 WTE Band 5 Vaccine Transformation Nurse (option 1 of scoping paper).

Careful consideration should be given when creating job descriptions around base of work and projected future work requirements. This is particularly important for the Vaccine Transformation Nurse as we see this role joining up within a community treatment centre working going forward.

Travel costs do likewise need to be taken into account and currently the Head of Primary Care is awaiting confirmation from Scottish Government around where the funding for any IT infrastructure should be sourced if not from the Primary Care Improvement Fund.

Assessment

Clinical Leads were asked to submit options papers:

- Musculoskeletal, Appendix 1.
- Vaccine Transformation, Appendix 2.
- Mental Health, Appendix 3.

Budget

Please see Appendix 4.

Recommendation

It is recommended that we approve budget spend and commission the proposal from GP Sub-committee and LMC whose decision is endorsed by the papers submitted by relevant clinical leads for each area.

Appendix 1: First Point of Contact Physiotherapy (MSK)/ Primary Care Improvement Plan

Meeting: Tuesday 16th July 2019.

Author: Lynne Spence, Lead AHP, NHS Orkney and Christopher Ireland, MSK First Point of Contact Physiotherapist, NHS Orkney.

Reviewing and establishing a First Point of Contact Physiotherapist service within Orkney GP Practices.

1. Aim

This paper will explore the role of First Point of Contact, Musculoskeletal (MSK) Physiotherapy Services within the context of the General Medical Service Contract and Primary Care Improvement Plan for Orkney.

2. Situation

The new General Medical Services contract in Scotland (2018) offers a refocusing of the GP role as "Expert Medical Generalists". This new role is to ensure GPs are best equipped to do the job they are trained to do, and builds on the core strengths and values of general practice – expertise in holistic, person-centred care.

As part of this national service redesign (2018 -2021) local areas are exploring options of redistributing functions to the wider primary care multi-disciplinary team, as alternatives to GP appointments. This will continue to ensure that patients have the benefit of the range of expert advice needed for high quality care. 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.

To deliver improved levels of local care in the community, there must be a clear benefit for patients and this delivery must rely on effective collaboration between GPs, NHS Boards and other Health Professionals. As stated in the new General Medical Services contract in Scotland (2018), the development of the primary care redesign should be in accord with the seven key principles listed below:

- Safe.
- Person-Centred.
- Equitable.
- Outcome focussed.
- Effective.
- Sustainable.
- Affordable.

Musculoskeletal problems frequently cause repeat appointments and are a significant cause of sickness absence in Scotland. The majority of a GP's musculoskeletal caseload can be seen safely and effectively by a physiotherapist without a GP referral. However the existing patient pathway often includes an unnecessary delay while initial non-physiotherapeutic solutions are attempted prior to access to a musculoskeletal physiotherapy service. There are variable waiting times across the country for access to face-to-face physiotherapy.

Physiotherapists are already well situated to work collaboratively with primary care multi-disciplinary teams and support the GP role as a senior clinical leader. Physiotherapists are an expert professional group. They have a high safety record and are trained to spot serious pathologies and act on them. Physiotherapists utilise their wider knowledge and skills as part of their assessment. A first point of contact service could also be seen in the context of the wider musculoskeletal pathway.

Under the new contract, 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.

Extracted - The 2018 General Medical Services Contract in Scotland.

3. Background

In Orkney, since October 2018 there has been a pilot of one First Point of Contact physiotherapist at Stromness GP Practice.

This Stromness pilot has allowed patients to assess services directly without having to make a GP appointment first. It has used the same booking system in place for the GP's, with a few person-centred questions asked by the receptionist to gage if the patient is appropriate for a First Point of Contact appointment. After assessment of the patient by the physiotherapists, a range of outcomes are possible, including onward referral to routine Physiotherapy appointments.

What makes the First Point of Contact Physiotherapist a unique service, is that the patient is seen at the GP surgery, and the post holder is part of the GP practice as well as the Physiotherapy team. It must be noted the First Point of Contact does not replace or to be confused with community physiotherapy services.

Detailed below is the Orkney data collected from the pilot since October 2018. This data, positive evaluation and patient's outcomes are also closely reflected in the recently published paper by Downie et al (2019) at Forth Valley, full details at https://bjgp.org/content/bjgp/69/682/e314.full.pdf.

3.1. Orkney Data from October 2018 – End June 2019 (Stromness Practice).

282 Appointments 1 Oct 2018 – 30 Jun 2019

Appointment types

- 282 appointments made
- 262 face to face appointments
- 20 failed to attend (DNA Rate 7%)

Patient Presentation

Acute conditions – 85
Chronic conditions – 177

Types of Conditions

Condition	Number
Back and leg pain	32
Shoulder pain	47
Knee pain	44
Hip pain	24
Neck and arm pain	19
Non MSK	5
Neck pain	17
Elbow pain	7
Low back pain	39
Wrist/hand pain	10
Widespread pain	8
Foot/ankle pain	16
Other spine pain	4
General deterioration/mobility	3
Potential serious pathology	1

(n=276 – some multiple conditions)

Appointment outcomes

Outcome	Number	
Advice face to face	259	99% of patients seen received advice
Refer to physio	50	19% of patients seen were referred to physiotherapy
Refer to ortho	6	2.3% of patients seen were referred to orthopaedics
Refer to rheum	1	less that 1% of patients seen were referred to rheumatology
Refer podiatry	5	2% of patients seen were referred to podiatry
Refer spinal team	1	less that 1% of patients seen were referred to spinal team
Signposting, issuing booklets	40	15% of patients were issued booklets
X-Ray request	10	4% of patients seen were referred for X-Ray
Bloods request	2	less than 1% of patients seen were referred for bloods
Discussion with GP	15	6% of patients seen were discussed with GP
Medicines advice	14	6% of patients seen were advised on medication
Supplied with an aid/support/stick	21	8% of patients seen were issued an aid, support or stick.

(more than one option could be chosen)

3.2. Patient Feedback from Stromness Practice (October – December 2018).

29 feedback forms returned • 24 rated as excellent • 5 rated as very good
Positive feedback from question to patient "what did we do well?" • Spoke through stretches well • Everything • Relaxed feeling to session, not overloaded with information but feel like I know everything i need to progress • Everything was well explained, very professional • Explained things clearly • Very clear and informative • Clear and concise information • Good communication, explained everything well • Clearly explained issues, immediate treatment plan and very friendly • Everything went well • Sourcing the problem and explanation
Feedback from question to patient "what could we do better?" • All good • Nothing in my eyes, all very well • Nothing • N/A • I do not know • N/A • Not much, seems to be good but could be made aware to people more that you can make an appointment themselves than wait on referrals. • Not much • Nothing • I'm very satisfied with it

3.3 Stromness Practice GP Feedback – (June 2019).

Below are some direct quotes from GPs at the Stromness practice regarding the pilot:

"The pilot has given far quicker access to physiotherapy first appointment usually resulting in better self-management because it is guided. A number have not needed anything else. This is a massive improvement on before."

"I think this service has been an excellent development. My impression is that we are already seeing fewer patients stuck in the chronic cycle of established pain/analgesic dependence and sick role. It reduces appointments and improves outcomes. Early input with good team working between physio and GP has without doubt improved the service we are providing to our patients. I have little doubt too that, once we have removed the backlog of the waiting list, it will prove a far more cost effective way to provide a service. Thanks Chris. Keep it going!! Best wishes"

“Having access to first contact physiotherapy has been a very positive experience which helps ease pressure on our surgeries particularly when a knee or back pain is the 4th or 5th issue for a 10 minute appointment! Myself and patients are very grateful to have timely access to physiotherapy input, patients are very happy to go to these appointments and I am reassured by the comments of patients who have been and also the fact Chris writes his notes in our clinical notes too. I know GP friends in other surgeries keenly await the service being available to all.”

3.4. Within the context of Primary Care.

Prior to the First Point of Contact pilot, the Stromness GP referrals to MSK physiotherapy service ranged from 15 to 32 referrals per month, averaging 22.33 per month (from December 2017 to May 2018).

However, since the First point of Contact pilot this has decreased to the average of 4 per month waiting for MSK Physiotherapy service (January 2019 to June 2019).

This local Orkney pilot data aligns with the data in the larger Forth Valley evaluation where a total of 8417 patient contacts were made, with the majority managed within primary care (n = 7348; 87.3%) and 60.4% (n = 5083) requiring self-management alone. Referrals to orthopaedics were substantially reduced in both practices. Practice A from 1.1 to 0.7 per 1000 patients; practice B from 2.4 to 0.8 per 1000 patients. Of referrals to orthopaedics, 86% were considered ‘appropriate’ (Downie et al 2019).

This data from Forth Valley and Orkney results suggest that patients with musculoskeletal conditions may be assessed and managed independently and effectively by First Point of Contact physiotherapists instead of GPs.

4. Assessment

After considering the data, learning from the local pilot and observing how the majority of patients were managed within primary care, offering the First Point of Contact Physiotherapist to other GP Practices within Orkney would be advantageous.

4.1. Benefits.

Equitably establishing the First Point of Contact Physiotherapy service as an alternative to a GP appointment for musculoskeletal conditions across all Orkney GP practices should bring benefits for:

- Patients.
- GPs.
- The Local Health Economy.
- Physiotherapists.

Benefits For Patients
• Quick access to expert assessment, diagnosis, treatment and advice • Prevention of short-term problems becoming long-term conditions • Improved patient experience • A shorter pathway, so patients have fewer appointments to attend • Simple logistics, so patients are less likely to miss appointments, or to suffer administrative errors • Timely appointments • Shorter waiting times • Opportunity to gain lifestyle/physical activity advice • Longer appointment times, meaning patients feel listened to, cared for and reassured • Reduce analgesic use and dependence • Pathways will be more seamless, involving less steps for people to go through to get to the right point of care
Benefits for GPs • Release of GP time through re-allocating appointments for people with MSK problems • Reduced prescription costs • In-house MSK/ physiotherapy expertise gained • Increased clinical leadership and service development capacity • Support in meeting practice outcomes and targets • The service requires minimal GP support
Benefits for the local health economy • Reduced number of MSK referrals into secondary care; this includes reducing demand and waiting times for MSK physiotherapy, orthopaedics, pain services and rheumatology • Improved use of imaging • Improved conversion rate to surgery when referrals are required • Improved links with local voluntary sector and patient groups to ensure universal support for individuals with MSK conditions • More appropriate referrals to orthopaedics • Equipment and resources can be shared and will provide consistency across Orkney • Service evaluation and ongoing Quality Improvement
Benefits for physiotherapists • Professionally stimulating and rewarding role and use of their professional knowledge and skills, including through stronger links with the MDT • Providing effective treatment, and quality patient care • Opportunities to develop and make use of their scope of practice and skills, including those relating to independent prescribing, injection therapy and imaging referral rights • Opportunities to develop experience, lead to and skills in service development, quality improvement and implementation science • Part of the Primary Care Team • Physiotherapist will be part of a wider service with established training, support and local governance

This has the potential to significantly reduce workload for GPs as the service requires minimal GP support. The majority of patients were managed within primary care, with low referral rates and highly appropriate referrals to orthopaedics. Patients reported positive views regarding the service.

Having a First Point of Contact physiotherapist based within a Practice has the potential to reduce workload for GP and ensure good quality care.

Furthermore, to ensure this provision of a new service has a patient- centred approach the following must also be considered carefully:

- Capacity backfill for Annual leave (and where possible sickness).
- Peer Support will need to be available, along with time for Clinical Supervision.
- Need for ensuring Practice Development, education along with local governance.
- The physiotherapist will be part of the GP Practice and the wider physiotherapy department.
- Service evaluation and ongoing Quality Improvement must be under taken (as stipulated in the Primary Care Improvement Fund allocation letter of 23 May 2018 which asked local partners to include in their PCIPs consideration of how changes will be evaluated locally.).
- Any GP practice participating in a wider roll-out of the First Point of Contact, would be required to provide a clinic space, use of printer, storage (for leaflets, joint support etc..), access to a telephone, reception support (including booking appointments).
- Physiotherapist would require training in order to use any relevant IT systems within the Practice.

5. Recommendation

The roll-out of First Point of Contact Physiotherapists based within primary care can be a positive alternative to seeing a GP for Musculoskeletal conditions, but requires resources and investment.

Based on 1 WTE per 8000 population (from the published paper Downie et al 2019). Orkney would require 3 WTE First Point of Contact Physiotherapist (not including annual leave, training and development, clinical supervision or attending MDT meetings).

Translating this into local individual practice numbers and their sessional requirements, leads to a conclusion that requirements would be:

Practice Name	Number of session 1 WTE per 8000 population
Skerryvore Practice	10 sessions (8200)
Heilendi Practice (Including Shapinsay and North Ron Patients)	5 sessions (3800)
Stromness (including Flotta Patients)	4 sessions (3000)
Dounby (including Evie and Rousay Patients)	4 sessions (3000)
Daisy Villa	2 session (1500)
Orcades (Sanday /Eday, Stronsay, Hoy, Westray/Papay Westray) (must include travel time)	3 sessions including travel time (2000) Sanday – Eday - 570 Stronsay - 370 Hoy – 400 Westray – Papay - 585

Option table.

Option 1	**3.8 WTE First Point of Contact Physiotherapists, providing seamless care.** (This would include annual leave cover, Practice Education Development, clinical supervision, CPD, attending MDT meetings etc). (Board Cost £60,629.42 37.5 hours – Band 7 x 3). (Board Cost £56,327.90 - Band 8a x 0.8).
Total Year 1 Cost.	£181,888.26 plus 0.8 WTE £56,327.90 = **£238,217.16.**
Further Information.	**First Point of Contact Physiotherapists:** **POST 1 – Band 7:** • 0.5 WTE Skerryvore (5 sessions per week). • 0.4 WTE Dounby (including Evie and Rousay patients at Dounby) (4 sessions per week). • 0.1 WTE non-clinical time (1 session). (Total 1 WTE) (41 days annual leave – based on 10 years' experience). **POST 2 – Band 7:** • 0.5 WTE Skerryvore (5 sessions per week). • 0.4 WTE Stromness (including Flotta patients at Stromness) (4 sessions per week). • 0.1 WTE non- clinical time (1 session). (Total 1 WTE) (41 days annual leave – based on 10 years' experience). **POST 3 – Band 7:** • 0.5 Heilendi (5 session per week).

	• 0.4 WTE (plus travel time) Orcades (A monthly rotation of Sanday /Eday, Stronsay, Hoy, Westray/Papay Westray (4 session per week must include travel time). • 0.1 WTE non-clinical time (1 session). (Total 1 WTE) (41 days annual leave – based on 10 years' experience). **POST 4 – Band 8a (senior position):** • 0.2 WTE Daisy villa (2 sessions). • 0.5 WTE (cover for holidays, CPD and when not covering leading on evaluation and service improvement). • 0.1 WTE non clinical time. (Total 0.8 WTE) (41 days annual leave – based on 10 years' experience.
Option 2	**3 WTE Band 7 – Capacity to cover 27 out of 28 identified clinical sessions, but no holiday cover, therefore not seamless care.** Each 1 WTE - 9 session per week and 1 session non clinical time. Total 27 sessions per week and 3 sessions non clinical time. (Board Cost £60,629.42 37.5 hours – BAND 7 x 3).
Total Year 1 Cost.	**£181,888.26.**
Option 3	**2 WTE Band 7 – Capacity to cover 18 out of 28 identified clinical sessions, but no Holiday cover and reduced service to GP Practices. Challenges regarding equitability and seamlessness of care.** Not all GP Practices would receive a service, it would need to be decided which ones. Total – 18 sessions per week and 2 sessions non clinical time. (Board Cost £60,629.42 hours – Band 7 x 2).
Total Year 1 Cost.	**£121,258.84.**
Option 4	**1 WTE Band 7 – Capacity to cover 7 out of 28 identified clinical sessions, but no Holiday cover and reduced service to GP Practices. Challenges regarding equitability and seamlessness of care.** Not all GP Practices would receive a service, need to decide which ones. Total - 1 WTE - 9 session per week and 1 session non clinical time. (Board Cost £60,629.42 hours – Band 7 x 1).
Total Year 1 Cost.	**£60,692.42.**

Note: Board costs includes Basic pay, Distant Islands Allowance (DIA), Employers National Insurance (NI) and Employers Superannuation (SUPER).

6. Conclusion and proposal

Having considered the success of the Stromness pilot, and the alignment with the larger, Forth Valley study, there are clear benefits to Patients, GPs, Physiotherapist, NHS Boards and the wider health community of the First Point of Contact Physiotherapy service.

In order to provide a seamless and equitable service to all GP Practices in Orkney it is proposed that Option 1 is approved.

Reference

Downie F., McRitchie C., Monteith W., Turner H., (2019) Physiotherapist as an alternative to a GP for musculoskeletal conditions: a 2 – year service evaluation of UK primary care data. British Journal of General Practice 69 (682) e314-e320.

Example Person Specification for First Point of Contact (MSK) Physiotherapist.

PERSON
SPECIFICATION First

Appendix 2: Vaccination Transformation Programme

Immunisation Service Option 1 - July 2019.

Author: Sara Lewis, Consultant in Public Health.

1. Introduction

The purpose of this paper is to provide information on one potential option for the delivery of the Scottish immunisation programme across the mainland practices of NHS Orkney including preschool, adult, influenza vaccination programmes and travel vaccinations. The option is for a board delivered immunisation service using qualified nursing staff working within GP practice settings with support from GP administration staff for call/recall.

2. Background

The Scottish Government announced a review of the delivery of vaccinations in Scotland in March 2017, the Vaccination Transformation Programme (VTP). The programme will review and transform vaccine delivery. The review has been prompted by a number of developments, including transformation in Primary Care and by recent significant extension of the vaccination schedule. Delivery will move away from the current position of General Practitioner (GP) practices being the preferred provider of vaccinations on the basis of national agreements. The expectation is that General practices will only be involved in the delivery of vaccinations under exceptional circumstances.

The scope of the programme extends only to those vaccines provided by the NHS to protect individuals or populations against infectious disease, and travel vaccinations including:

- Routine infant and childhood vaccinations.
- School-age vaccinations delivered in schools (already complete in Orkney).
- Adult vaccinations.
- Vaccinations delivered to individuals on the basis of specific clinical need or identified risk factors (for example, people who are immunocompromised), Pertussis vaccination for pregnant women.
- NHS funded travel vaccinations diphtheria, polio and tetanus (combined booster), typhoid, hepatitis A and cholera, and those which are provided privately and from which the NHS may derive income.

The VTP commenced 1st April 2018, from then and until March 2021 there will be a phased process of service change in which models of delivery will be developed, tested and implemented based on a locally agreed plan the Primary Care Improvement Plan.

3. Aims

The overall aim of the national immunisation programme is to protect the population from vaccine preventable diseases reducing the associated morbidity and mortality.

4. Objectives

The aim will be achieved by delivering an evidence-based, population wide immunisation programme that:

- Identifies the eligible population and ensures effective, timely delivery with optimal coverage based on the target population.
- Is safe, effective, of a high quality and is independently monitored.
- Is delivered and supported by suitably trained, competent and qualified prescribers, clinical and non-clinical staff who participate in recognised ongoing training and development.
- Delivers, manages and stores vaccines in accordance with national guidance e.g. Chapter 3 of the Green Book https://www.gov.uk/government/publications/storage-distribution-and-disposal-of-vaccines-the-green-book-chapter-3.
- Is supported by regular and accurate data collection at local and national level using the appropriate returns e.g. Child Health Surveillance Programme, (Scottish Immunisation Recall System (SIRS) and Child Health System (schools) and GP systems.

5. Direct health outcomes

The direct health outcomes the national immunisation programme strives to achieve include:

- Protect the health of individuals and the wider population.
- Reduce the number of preventable infections and their onward transmission.
- Achieve high coverage in the target cohorts.
- Minimise adverse physical/psychological/clinical aspects of immunisation (e.g. anxiety, adverse reactions).
- Reduce hospital admissions.
- Reduce the use of antimicrobials.

6. Reduction of health inequalities

Reducing health inequalities means that NHS services must be easily accessed by those more disadvantaged and vulnerable groups.

Local users shall be consulted who reflect the diversity in the local community including those with protected characteristics.

The programme shall be delivered in a way which addresses local health inequalities, tailoring and targeting interventions where necessary e.g. looked after and accommodated children and young people, gypsy travellers.

The service shall be delivered in a way that is culturally sensitive to meet the needs of the population e.g. offering alternative vaccines to those that contain porcine gelatine.

At this time the paper doesn't consider the various models of delivery required to meet the needs of those individuals requiring an alternative offer of vaccination. To fully understand the potential options available further engagement is required with members of the multidisciplinary team (MDT), third sector partners and local service users.

7. Local Service Delivery

Board staff members currently deliver the Scottish Immunisation Programme throughout the Orcades practices and within Island View practice. This paper will not consider those practices it will focus is on the five practices on the mainland of Orkney.

7.1. Current limitations on potential options.

Currently there are several limitations which prevent this paper providing a full options appraisal for service delivery transformation as outlined below.

7.1.1. Local limitations.

At a local level the transformation of the community treatment and care services has not yet made sufficient progress for the consideration of a combined service to be presented as an option at this time.

7.1.2. National limitations.

Clinical leadership

The NHS (Scotland) Act 1978 legislates for the provision of vaccination and immunisation. Section 40 states:

40.— Vaccination and immunisation.

(1) The Secretary of State shall have power to make arrangements with medical practitioners for the vaccination or immunisation of persons against any disease, either by medical practitioners or

by persons acting under their direction and control.

National Health Service (Scotland) Act 1978 Page 142.

(2) **[…]1.**

(3) The Secretary of State may, either directly or by another person, supply free of charge to medical practitioners providing services under this section, vaccines, sera or other preparations for vaccinating or immunising persons against any disease.

This means Scottish Ministers (who have replaced the Secretary of State) can enter into arrangements with any medical practitioners for vaccination and immunisation programs. The interpretation of "medical practitioner" is any doctor who is licensed. Whilst the process does not need to be overseen by a GP it does require a doctor,

although the immunisation can be administered under the doctor's direction and control e.g. by a nurse.

The primary legislation would have to change if arrangements were to be made which were not overseen and controlled by a doctor.

Information technology.

In order to deliver an effective service access to GP IT systems is required to identify individuals requiring vaccination; to assess their appropriateness for vaccination and to provide timely information to other members of the MDT of vaccinations administered in case of any adverse events. Currently an IT solution isn't available to facilitate this level of access to GP data for both of the primary care IT systems used in the mainland practices out with the patients GP practice. A national solution is being sought.

The Scottish Immunisation Recall System (SIRS) has the functionality to undertake call/recall and for recording of all immunisations administered to children up to the age of six years. Until the national CHI and Child Health Transformation Project has been implemented SIRS is the system the Board relies on to support the administration of preschool vaccinations. However this system does not link with GP IT systems so does not provide all the functionality required to facilitate vaccination delivery out with the GP practice setting.

The current IT limitations preclude the implementation of safe and effective vaccination delivery out with the GP practice setting without the implementation of a significant paper based work around and therefore community based delivery options are not considered within this paper.

Skill mix.

Health care support workers (HCSWs) support the delivery of adult vaccinations within general practice freeing up practice nurses to undertake other pieces of work and providing additional capacity to manage the surge in workload the seasonal influenza programme demands.

Boards currently make very limited use of HCSWs in the delivery of immunisations due to the constraints of working within the legal framework of Patient Specific Directions (PSD). A PSD is an instruction to administer a medicine to a list of individually named patients where each patient on the list has been individually assessed by that prescriber. The prescriber must have adequate knowledge of the patient's health, and be satisfied that the medicine to be administered serves the individual needs of the patient on the list.

The General Medical Council (GMC) provides guidance for remote prescribing (see link below) which can guide decision making when considering skill mix within the vaccination clinic setting.

GMC guidance for remote prescribing.

60. Before you prescribe for a patient via telephone, video-link or online, you must satisfy yourself that you can make an adequate assessment, establish a dialogue and obtain the patient's consent in accordance with the guidance at paragraphs 20-29.

61. You may prescribe only when you have adequate knowledge of the patient's health, and are satisfied that the medicines serve the patient's needs. You must consider:

a. the limitations of the medium through which you are communicating with the patient.

b. the need for physical examination or other assessments.

c. whether you have access to the patient's medical records.

The prescriber has a duty of care and is professionally and legally accountable for the care he/she provides, including tasks delegated to others. The prescriber must be satisfied that the person to whom practice is delegated has the qualifications, experience, knowledge and skills to provide the care or treatment involved.

The Scottish Executive Nurse Directors (SEND) Group is considering the role of HCSWs in supporting the delivery of immunisations including the legal framework (PSD's) and the related governance, accountability and training required. The current SEND position is that HCSW's are not administering vaccines and immunisations. It has been agreed that Scotland wide guidance needs to be developed.

For this reason an immunisation service delivered by trained nurses is being considered at this time.

Travel vaccinations.

Work continues at a national level to develop an options appraisal for a national travel health service. Negotiations are underway with NHS 24 and Fit for Travel on the provision of a centralised service to triage travellers and identify their travel health requirements. Potential options will then need to be considered as to how this will link with local service provision for the administration of any vaccines required.

It is recognised travel health services are currently underutilised; work is underway at a national level to try to gain a more comprehensive understanding of future workload. In the interim modelling work has been undertaken locally to identify travel vaccination workload. Vaccination prescription data from 2014 to 2018 indicates approximately 368 appointments are required per year.

7.2. Staffing Requirements.

The staffing requirements have been broken down to facilitate consideration of a phased implementation process.

7.2.1. Preschool immunisations and core adult vaccinations (Option 1).

This option covers the provision of the core childhood and adult immunisations included in the Scottish Immunisation programme. It does not include seasonal influenza vaccinations, school based immunisations or travel vaccinations.

Modelling.

Modelling for preschool immunisation delivery has been completed based on 100% uptake rates allowing 15 minutes per appointment.

Modelling for core programme adult vaccinations (herpes Zoster and pneumococcal) has been based on 85% uptake rates allowing 10 minutes per appointment. An example timetable is available below.

Example timetable:

Nurse.		Monday.	Tuesday.	Wednesday.	Thursday.	Friday.
A.	Skerryvore.	9am-5pm.				
	Daisy Villa.					9am-12md.
B.	Stromness / Heilendi.			9am-4pm*.		
	Dounby.		9am-12.30pm.			

Note: * Allows for travel time between practices.

Nurse Staffing.

The delivery of preschool immunisations and core adult immunisations requires approximately 25 hours of band 5 clinic nursing time per week (0.64 WTE).

Allowing for annual leave cover, CPD etc the total time required to be funded is 0.75 WTE.

This staffing assumes access to clinical support via the GP Practice and management within the community nursing structure.

7.2.2. Full immunisation service for all core vaccinations delivered across mainland Orkney (Option 2).

This option covers the provision of the core childhood and adult immunisations included in the Scottish immunisation programme along with the seasonal influenza vaccinations, school based immunisations and travel vaccinations.

Modelling.

Full service modelling includes the following vaccination programmes:

- All childhood immunisations (pre and school).
- All core adult vaccinations.
- Seasonal influenza vaccinations modelled on 85% uptake rates allowing 10 minutes per appointment for all ages.
- Travel vaccinations modelled on previous vaccination prescription data, which indicates on average approximately 368 appointments are required per year, with each patient being allocated 20 minutes of nursing time.

Based on the assumptions above, access to clinical support via the GP practice and management within the community nursing structure the service could be delivered by:

- 19 (0.51 WTE) (core and annualised hours).
- 18.5 (0.49 WTE) (core and annualised hours).
- 13.5 (0.36 WTE) (annualised hours).
- 13.5 (0.36 WTE) (annualised hours).

Allowing for annual leave cover, CPD etc the total time required is 1.72 WTE.

The modelling above uses a mixture of core and annualised hours contracts to allow work undertaken on a weekly basis (childhood and adult vaccinations) to be administered along with the additional surge capacity required at peak times e.g. school vaccinations and seasonal influenza vaccination programme. The nurses would be working full time hours during the peak seasonal influenza vaccination period, October to December.

Nursing Staffing Costs (Band 5).

The table below outlines the costs for option 1 and option 2; current costs are provided for comparison.

The current costs include those payments made to mainland practices for the delivery of vaccinations in 2018/19 in addition to the global sum.

Immunisation Programmes.	Option 1.	Option 2.	Current.
Pre School.	Y.	Y.	Y.
Herpes Zoster.	Y.	Y,	Y.
Pneumococcal.		Y.	Y.
Schools (inc flu).		Y.	Y.
Influenza.		Y.	Y.
Travel*.		Y.	Y.
HPV Boys.		Y.	
Costs.	**£30,475.34.**	**£72,946.82*.**	**£87,998.31.**

Note: * Current travel health services costs/income is not known. ** Figure includes £12,680.20 for school vaccination delivery.

Additional funding considerations:

- Clinical leadership.
  - Anticipated this function will be undertaken by GP during the interim phase.
- Administrative support.
  - As the interim solution agreed with GP sub is for practice administrators to support the work administrative costs have not been considered.
- Rescue medication.
  - The cost of rescue medication packs have not been included it is anticipated the immunisation nurse would have access to general practice resuscitation equipment.
- Consumables.
  - Not included currently an NHS Board cost.
- Travel.
  - Costs for travel have not been included based on the assumption pool cars will be used for travelling between practice sites.
- Service management.
- Accommodation.
- Office equipment.
- Stationary.

Conclusion

The paper outlines the considerations that have led to the current recommendation for a board delivered immunisation service using qualified nursing staff working within GP practice settings. The service will require support from GP administration staff for call/recall and GPs for clinical leadership.

In order to facilitate effective recruitment it is proposed option 2 is approved.

Appendix 3: Community Psychiatric Nurse model / Primary Care Improvement Plan

Meeting: Wednesday 14th August 2019.

Authors: Lynda Bradford and Val Stonehouse.

Introducing community psychiatric nurses into Orkney GP Practices.

1. Aim.

This paper will explore the potential role of community psychiatric nurses with GP Practices as part of the overall Primary Care Improvement Plan for Orkney.

2. Situation.

The new General Medical Services contract in Scotland (2018) offers a refocusing of the GP role as “Expert Medical Generalists”. This new role is to ensure GPs are best equipped to do the job they are trained to do, and builds on the core strengths and values of general practice – expertise in holistic, person-centred care.

As part of this national service redesign (2018 -2021) local areas are exploring options of redistributing functions to the wider primary care multi-disciplinary team, as alternatives to GP appointments. This will continue to ensure that patients have the benefit of the range of expert advice needed for high quality care. 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.

To deliver improved levels of local care in the community, there must be a clear benefit for patients and this delivery must rely on effective collaboration between GPs, NHS Boards and other Health Professionals. As stated in the new General Medical Services contract in Scotland (2018), the development of the primary care redesign should be in accord with the seven key principles listed below:

- Safe.
- Person-Centred.
- Equitable.
- Outcome focussed.
- Effective.
- Sustainable.
- Affordable.

3. Background

Study in 2017 by Mind, UK.

A survey of more than 1,000 GPs has revealed rising demand for mental health support in primary care. GPs say that two in five (40 per cent) of their appointments

now involve mental health, while two in three GPs (66 per cent) say the proportion of patients needing help with their mental health has increased in the last 12 months.

GPs want to offer the best possible care to their patients and are working hard to do so, despite the challenges created by a decade of underfunding. At the same time, the number of patients needing help with mental health problems is increasing. The study stated:

We not only need greater investment in community-based training to give GPs more opportunity to develop their skills but also a significant increase in mental health therapists directly linked to practices. This would reduce the unacceptable delays many patients currently face getting access to the care they need. Today's GPs are expert generalists and exceedingly competent, but the GP caseload has increased exponentially in both quantity and complexity in recent years. Patients with mental health issues deserve parity of esteem with those with physical health issues. It is recognised that there is an increase in patients seeking help for depression and anxiety in particular.

Our proposal is to introduce additional support for patients who may have mild/moderate mental health difficulties. At the present time there are around forty individuals on the Generic Team waiting list. Over 30 of those have been on the list more than two months and it is assumed that any ongoing support will currently be coming from their GP Practice.

4. Assessment

As stated above our proposal is to introduce high quality support for patients who do not have acute and enduring mental health illness but who display mild/moderate mental health difficulties. We would be able to accept referrals from many professionals within the health centre such as GP's, ANP's and health visitors. We would also accept self-referrals from patients who have called the practice seeking advice. The CPNs would aim to provide short term psychological support for patients who present with difficulties such as anxiety, depression, stress and bereavement. This intervention may include things such as:

- Sleep hygiene.
- Relaxation.
- Mindfulness.
- Anxiety management.
- Emotional regulation.
- Safety planning for times of crisis.
- Illness education.
- Medication review (Antidepressant and Anxiolytic).
- Referral to further services such as CMHT.

Recommendation

It has not been possible to find any publication which states a recommended CPN to population ratio. Based on information from another Partnership it is proposed to

seek 1 WTE per 15 000 population. a complement of 2.0 WTE Band 6 CPN would therefore be required to cover both mainland and isles with leave cover included.

It is proposed that these CPNs work in a peripatetic fashion with practices receiving an allocation of time based on practice size. The scope of the service would be as follows:

- The CPNs will provide enhanced capacity for primary care access for people with mild to moderate mental health problems.
- The CPNs use a telephone triage system. The day will be split across 15 minute telephone triages and 30 minute face to face appointments in addition to admin time factored across the day.
- Whilst employed through the PCIP and therefore the NHS, it is crucial that the CPNs identify themselves not only as part of the CMHT but also as part of the practice team and therefore embed in practice systems and processes.
- They will have professional leadership and direct operational management from the Operational Manager of the CMHT.
- They will deliver evidence based interventions when required over a short number of appointments and can refer to all parts of the mental health system (for example Psychology, Third Sector Secondary Care MH Services).

The CPNs will liaise with the GPs and practice managers to provide specific high quality and comprehensive mental health nursing assessments and interventions to those with a mild to moderate mental health problem. In most cases the CPN will be the first point of contact in the practice, patients do not require to be seen by GPs before seeing the CPN.

The CPNs will support those presenting in the practice with mild to moderate mental health problems such as: **Low Mood/ Depression, Anxiety / Panic, Stress, Bereavement / Grief, Crisis Intervention, Anti-Depressant Reviews**.

Excluded from the CPN remit are: **Those individuals open to secondary care mental health services (including CADS), Addictions as primary presentation, Severe Mental Health Issues, Under 18 Years of Age, Those diagnosed with dementia not identified with depression.**

It is proposed that supporting roles are divided as follows:

The Integrated Mental Health Service will:	The GP Practice will:
• Provide clinical supervision. • Provide professional guidance and leadership. • Ensure professional development and skills are maintained. • Manage professional issues in relation to registration with the NMC. • Manage pay, expenses, administration of leave and non-day to day operational matters. • Ensure that time for supervision and development time varies through the week so that the impact on clinical activity is distributed between all practices. • Complete TURAS, Training Plan and Personal Development Plans. • Provide a day-to-day operational support e.g. manage time keeping, appointments, workload etc, communicating with Practices in the event of any concerns. • Be a point of contact for practice managers and GPs for support and service development.	• Provide induction to practice and integration with the rest of the practice team. • Provide a GP mentor for practice based clinical support and guidance. • Provide training and access to primary care processes and systems. • Ensure the allocation of appropriate work space. • Direct clinical workload to the CPNs via agreed protocols for triage and appointments. • Provide safe systems of working. • Ensure time for supervision and development is protected. • Ensure CPNs are included in team processes (e.g. practice meetings).

Cost

2 WTE Band 6 CPNs, costed at top of scale with Distant Islands Allowance will be in the region of £110,000 per annum. This includes sufficient capacity for annual leave and admin time and mileage costs due to the peripatetic nature of the work proposed.

There would be one off cost of phones and laptops, costs to be confirmed. Ongoing running costs would be contained within the £110,000.

Appendix 4

PCIP Funding Allocation.	2019/20.			
	Income.	**Expenditure.**	**Total.**	**Comment.**
Initial Budget.				
	£266,311.			
Reserves.	£68,618.			
2nd tranche.	£27,027.			
			£361,955.	
Less Expenditure.				
VTP.		£7,632.		
Musculoskeletal.		£29,488.		
Mental Health Worker.		£12,560.		
Pharmacy.		£147,796.		
Community Link Worker.		£1,236.		No finding spend in 2019/20, paid for in previous year, but will resume in 2020/21.
			£161,592.	
Closing Budget.			**£200,363.**	
Pharmacy 18/19.			44,799.	£245,162*.

Note: * Pharmacy spend for 18/19 still under consideration.

PCIP Funding Allocation.	**2020/21.**			
	Income.	**Expenditure.**	**Total.**	**Comment.**
Initial Budget.				
	£530,775.			
			£530,775.	
Less Expenditure.				
VTP.		£30,526.		
Musculoskeletal.		£117,950.		
Mental Health Worker.		£50,240		
Pharmacy.		£147,796.		
Community Link Worker.		£60,017.		
			£207,813.	
Closing Budget.			**£322,962.**	

PCIP Funding Allocation.	2021/22.			
	Income.	Expenditure.	Total.	Comment.
Initial Budget.				
	£747,910.			
			£747,910.	
Less Expenditure.				
VTP.		£30,526.		
Musculoskeletal.		£117,950.		
Mental Health Worker.		£50,240.		
Pharmacy.		£147,796.		
Community Link Worker.		£60,017.		
			£207,813.	
Closing Budget.			**£540,097.**	

Working together to make a real difference

SS/SJ/41

October 2019

Mr Gerry O'Brien
Chief Executive
NHS Orkney
The Balfour
Forelands Road
Kirkwall
Orkney
KW15 1NZ

Dear Gerry

I write on behalf of the Integration Joint Board (IJB), following its meeting on 2 October 2019.

At the meeting the Board considered a report on Primary Care Improvement Plan Budget. The report recommended a spend for improvement in Primary Care in relation to:

- Musculosketal Services.
- Mental Health Services.
- Vaccine Transformational Services.

The IJB agreed with the recommendation and due to this the IJB is issuing a direction to NHS Orkney in line with the Public Bodies (Joint Working) (Scotland) Act 2014.

I attached the unapproved minute of the meeting and would like to draw your attention to item 14.

The direction will be to employ:

- 2 x MSK Physiotherapists.
- 1 x Mental Health Primary Care Worker
- 1 x Vaccine Transformation Nurse.

DRAFT

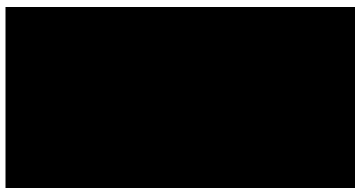
ORKNEY ISLANDS COUNCIL

NHS Orkney

Resource/Practitioners.	Full Year Costs £.
2 x Band 7 MSK Physiotherapists.	121,258.
1 x Band 6 Mental Health Primary Care Worker.	51,649.
1 x 0.75 Band 5 Vaccine Transformation Nurse.	31,308.
On Costs (Travel, Telephone etc) working on 3% of cost.	6,126.
Total	**210,341.**

As Chief Officer accountable to you for matters of service delivery, I will proceed to implement this direction on your behalf unless you advise otherwise.

Yours Sincerely



Sally Shaw
Chief Officer / Executive Director
Orkney Health and Care

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