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Agenda Item: 13.

Integration Joint Board

Date of Meeting: 2 October 2019.

Subject: Primary Care Improvement Plan.

1. Summary

1.1. Scottish Government requires an updated version of our current Primary Care Improvement Plan to allow them to review progress locally around implementation of the new GP Contract.

2. Purpose

2.1. To review the Plan for 2019 to 2020.

3. Recommendations

The Integration Joint Board is invited to note:

3.1. Progress to date on the Primary Care Improvement Plan.

3.2. Action planning moving forward.

3.3. The risk of being unable to achieve everything within the directives of the Memorandum of Understanding due to predicted underfunding.

It is recommended:

3.4. That, due to the current high risk of predicted underfunding to deliver the new GP contract in its totality, the Primary Care Improvement Plan, attached as Appendix 1 to this report, should not be formally approved, but agreed as a final unapproved paper and sent to Scottish Government.

4. Background

4.1. The new GP contract was voted and approved from 1 April 2018. This change culminated from a national acknowledgement around workload pressures that GPs were experiencing which has had a detrimental impact around GP recruitment and early retirement.

4.2. This new contract was agreed and moves from away from patients always accessing services via a GP consultation. In future GP Practices will provide patient consultations via a skill mix of professionals with the GPs being freed up to concentrate on areas of more complex care.

4.3. As part of the new Contract a directive, a Memorandum of Understanding (MoU) was published that outlined 6 specific key areas of change that are to be implemented by 2021 which would allow the new multi-disciplinary way of working within GP Practices to be in place. This MoU was between Integration Joint Boards, Scottish Government Primary Care, NHS Boards and Scottish Government.

4.4. To date progress has been somewhat hampered with the secondment of key lead clinical professionals. We have however moved forward in areas around pharmacotherapy and community link workers and have options appraisals around the Vaccine Transformation Programme, Musculoskeletal and Mental Health. A paper outlining these and costs associated will be presented separately to IJB for approval to move forward to commission.

4.5. A positive working relationship between OHAC and the GP Sub-committee is in place and is allowing the plan to progress in a pragmatic way that benefits all practices and takes account of our island practices.

4.6. Fundamentally our highest risk to delivering the outcomes as outlined within the MOU is the funding that Orkney has been allocated to deliver this. This is provided via the NRAC formula https://www.isdscotland.org/Health-Topics/Finance/Publications/2014-02-25/Resource-Allocation-How-Formula-works-in-practice.pdf.

4.7. We are required to provide services across an archipelago of islands and this is costly in terms of staffing and travel. In particular we need to ensure that, if these changes as outlined within the GP Contract are implemented, we have a seamless service in place once it is no longer the responsibility of the GP to provide these. In terms of seamless this requires us to ensure we have service staffing that can cope with absence e.g. holidays, sickness etc. Unlike larger board areas we do not have large teams of personnel who can sometimes pick up some slack to cover such things and as such it is vital that we reflect the actual true cost of what it would be to deliver such a service so we can demonstrate this to Scottish Government.

4.8. It is not only Orkney who are highlighting this area of high risk. There are concerns nationally across Scotland around the feasibility of not only having the funding to deliver the MOU but also the ability for all of Scotland to be able to recruit the necessary personnel to provide the services. It is therefore vital that we also take the time to ensure we promote Orkney as a good place to work and take advantage of appropriate conference facilities where we can promote Orkney and any vacant opportunities.

4.9. This is a significant change programme and again to date we have been moving things forward as part of our day to day work. It has been recognised at NHS Board level that additional support is vital and as such funding has been allocated for a 2 year Primary Care Implementation Manager who will lead on project planning this work going forward. The Head of Primary Care has highlighted to Scottish

Government the need for additional project management support especially for small boards and this is currently being considered and it is hoped that some additional funding may come back into the Health Board to offset this post.

4.10. Currently all plans require to be approved by the GP Sub-committee, the Local Medical Committee and then finally the IJB before being submitted to Scottish Government. The Head of Primary Care, in discussion with the GP Sub-committee and the Local Medical Committee, agree that, due to high concerns around the feasibility of being unable to deliver this work within our projected financial envelope, we are not in a position to be able to approve this plan. It is therefore suggested that we can only note and approve work to date and that we send this plan as finalised but unapproved to Scottish Government thus highlighting our continued concerns.

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. As the funding is based on the NRAC formula and as the smallest board we are projecting a high risk of being unable to deliver all services as set out by the Memorandum of Understanding due to the funding allocation received.

6.2. Projected Income from PCIF.

Year.	**2018/19.**	**2019/20.**	**2020/21.**	**2021/22.**
Fund Allocation.	£220,754.	£266,311.	£530,775.	£747,910.
Earmarked Reserves.	£0.	£68,618.	£0.	£0.
2nd Tranche (within SG).	£0.	£27,026.	£0.	£0.
Total Funding.	**£220,754.**	**£361,955.**	**£530,775.**	**£747,910.**

6.3. Funding Implemented Workforce by 2021.

	Projected Workforce Costing.	**Seamless Service.**
Total Cost.	£1,065,362.	£1,598,045.
Anticipated Funding.	£747,910.	£747,910.
Anticipated Shortfall.	**£317,452.**	**£850,135.**

7. Risk and Equality assessment

7.1. There is a high risk that, in Orkney we will not be able to implement the improvements to Primary Care due to funding provided not being adequate. There is also a risk that the perceived new workforce in Primary Care will prove difficult to recruit.

8. Direction Required

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

NHS Orkney.	No.
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

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12. Supporting documents

12.1. Appendix 1: Primary Care Improvement Plan.

Orkney's Primary Care Improvement Plan

2019 – 2021.

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Foreword

This plan sets out the key elements for change in Primary Care services linked to the Scottish Government's new GMS Contract policy documents. It provides a high level outline of how the transformation will take place in Orkney and what we expect the final outcomes to be.

This is an update based on our first Primary Care Improvement Plan (PCIP) and it will continue to link with the new Orkney Health and Care Strategic Plan for Health and Care services, the developing Strategic Commissioning Implementation Strategy and other ongoing plans relating to improving Primary Care Services in Orkney. This plan is a dynamic document which will be updated as we move forward.

This document, PCIP version 2, is intended to provide an update on the PCIP agreed by the IJB and the GP Sub-committee in 2018. Progress has been made in some areas, with new staff employed to develop the new models of working around pharmacotherapy and community link working as required by the new GP Contract by 2021. It is evident however that there are significant challenges to be addressed if we are to deliver the plan in its entirety by April 2021. While some of the challenges can be addressed at a Health and Social Care Partnership (HSCP)/NHS Board level, a number will require national level discussion to agree on a way forward.

Taking in to consideration the workforce projections within this document, it will not be possible to deliver all the required services due to a significant funding shortfall. It is therefore very likely that Orkney Health and Care (OHAC) will need to prioritise some work streams over others, over the next 24 months. The Local Medical Committee (LMC)/GP Sub-committee will not agree a plan which will not deliver the GP Contract in full as agreed in 2018.

It is agreed that OHAC is committed to delivering on all elements of the plan and GP Contract/Memorandum of Understanding by April 2021 but clearly this is contingent on funding and workforce issues being addressed both locally and nationally.

As can be seen from the LMC/GP Sub letter attached as Appendix 1, the LMC and GP Sub have said they cannot agree to a plan which does not yet show the clear path to delivery but does accept that the plan, as it is at present, can be sent to Scottish Government without their full agreement. The reasons for this are detailed in the letter which is attached to the plan as an appendix. This letter, in addition to describing the position reached by the LMC and GP Sub regarding the plan generally, details any outstanding areas where spend of Primary Care Improvement Fund (PCIF) is not agreed.

Introduction

Orkney Health and Care recognises the fundamental importance of primary care services in Orkney.

On 13 November 2017 the new GP contract was published and this centres around four key documents:

- The Scottish GMS Contract Offer Document.

- The National Code of Practice for GP Premises.
- The National Health Service (GMS Contracts) (Scotland) Regulations 2018.
- Memorandum of Understanding (MoU) – to cover the transition period between 2018 and 2021.

Background

The first iteration of our Primary Care Improvement Plan covered the period 1 April 2018 until 31 March 2019.


PCIP.docx

The Orkney plan has now been updated to reflect progress that has occurred to date and planning assumptions that will take us through to March 2020.

The criteria for the plan remain as per the memorandum of understanding (MoU) for the GP contract, which noted the following for the development of the PCIP:

- IJBs will set out a PCIP to identify how additional funds are implemented in line with the contract framework.
- The plan will outline how these services will be introduced before the end of the transition period at March 2021, establishing an effective multi-disciplinary team model at practice and cluster level.
- These plans will be developed in collaboration with local GPs and others and should be developed with GP Subcommittee as the formally agreed advisors on general medical service matters. Any specific contractual elements must be agreed with the Local Medical Committee.
- Integration Joint Boards (IJBs) have a statutory duty and the infrastructure established to consult in relation to strategic planning and stakeholders should be engaged in the plan's development.
- Local and regional planning will recognise the statutory role of IJBs as commissioners. IJBs will give clear direction to the NHS Board on its function to secure these primary care services.
- In developing and implementing these plans, IJBs should consider population health needs and existing service delivery.
- IJBs will be accountable for delivery and monitoring progress for the local plan.

The MoU outlined 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 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.

Progress to date

Pharmacology

These services are in three tiers divided into core and additional activities, to be implemented in a phased approach.

By 2021, phase one will include activities at a general level of pharmacy practice including acute and repeat prescribing and medication management activities. This is to be followed by phases two (advanced) and three (specialist), which are additional services and describe a progressively advanced specialist clinical pharmacist role.

To date we have appointed 2 additional Senior Primary Care Pharmacists (8B and 8A) who will both be in post by July 2019. It is anticipated that we will require further pharmacist support going forward to be able to deliver the full range of activities as laid out in the new contract.

Community Treatment and Care Services

These services include, but are not limited to, basic disease data (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear syringing, and suture removal.

It was recommended that phlebotomy be prioritised in year one. There was however some confusion about the need to TUPE across staff from general practice which caused some initial concern. This has now been clarified and current staff will remain employed with the practice unless there is a specific TUPE request from a practice. It is anticipated that we will be looking to implement a phlebotomy service within the next 12 months whilst we scope the additional changes.

iHub has published a report this month around a 90 day learning cycle they undertook around this area which we will take account of as part of our planning process: https://ihub.scot/media/6380/ctac-final-report-v017.pdf.

The Vaccination Transformation Programme (VTP)

GP Practices will no longer be responsible for immunisations. This change needs to be managed, ensuring a safe and sustainable model and delivering the highest levels of immunisation and vaccination take up. Currently a VTP programme manager was funded for 12 months to scope this. A scoping paper has been produced outlining proposed changes and we are currently also looking at feasibility of combining this service change with the community treatment model provision to allow elements of shared workforce and sustainability.

Additional Professional Roles

By 2021 specialist professionals will work within practices to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment.

Currently Mental Health / Musculoskeletal are the main areas being recognised as fundamental to assist with GP workload. There has been a successful test of change regarding first point of contact physiotherapy access at Stromness surgery around the MSK work and both clinical leads for Allied Health Professional (AHP) and Mental Health have been asked to scope and submit papers by beginning of July outlining their proposals for first point of contact in each of their respective areas.

Urgent Care

GP Practices will in future no longer be responsible for providing urgent unscheduled care within primary care. IJBs will be required to commission a service to provide an advanced nurse practitioner or paramedic service for practices as first response for home visits, and responding to urgent calls from patients, allowing GPs to better manage and free up their time. Not all GP Practices in Orkney have identified this area as a priority and there has been no clinical lead from OHAC available to drive this area forward (due to secondment elsewhere). However, it is recognised that there is potentially considerable benefit to be gained from developing an urgent care service and that this area must be developed along with all the other workstreams.

Community Link Workers

Community Links Worker (CLW) is a generalist practitioner based in or aligned to a GP practice who works directly with patients to help them navigate and engage with wider services, often assisting patients who need support because of (for example) the complexity of their conditions or rurality.

Voluntary Action Orkney has been commissioned to provide this service and 1.5 WTE CLWs are now in post. These posts are being piloted in two of the GP Practices before being rolled out to the remaining GP Practice locations. It is important that we recognise the links with the IJBs community led support initiative and we see close collaboration between both these areas going forward.

Where we are now?

There will be a requirement to become joint data controllers with GP Practices going forward and there is a national template due to be released soon to assist boards with the legislation around this. Meetings have been held to date with practices around this change and NHSO has commissioned OIC to provide Data Protection advice and support.

A GP Sub Committee was formed last year. It is well attended, and Drs Cole and Wilkinson are representatives at our Primary Care Improvement Plan meetings. We need to ensure public representation going forward and these meeting will move under the proposed new programme board “Community First” approach outlined within the draft Strategic Plan.

We realise that progress has been hampered without dedicated programme manager support. Additional funding for a two year post has been agreed by NHSO.

We need to agree priority areas for 2019/2020. Due to the significant change arena around the GP contract and subsequent need to up skill Nursing and AHP provision, our clinical leads were seconded to provide expertise to national groups. This did result in a delay around progressing our areas but we now have dedicated named clinical leads for each priority area again and are moving forward in a positive way. To assist these leads further, the GP Sub Committee has put forward names of GPs who will act as a point of contact for advice and support to these clinical leads.

We further need to agree where and how we deliver all these services. Some can be delivered from within GP Practices, others may need to be delivered by a hub approach or indeed delivered and supported by technological solutions.

Orkney Health and Care, as part of their Strategic Plan, have been accepted on the National Development Team for Inclusion as a partner in their Community Led Support Programme. We believe this will additionally enhance different ways of working with our communities, will link in with the community link worker programme of works and will help us to consider best ways of providing locality hub working going forward.

Current Risks

The most significant risk is in relation to funding. Orkney being the smallest board in Scotland receives the lowest funding allocation based on the NRAC formula. This will make implementation of all the principles as laid out in the MOU extremely challenging. Although the smallest board the complexity of recruiting a skill mix of professionals to provide care across an archipelago of diverse and scattered islands is one of the most difficult and costly. We are currently estimating a shortfall of over £350,000 which does not include interview, relocation, or IT equipment costs for new staff.

During Year One we saw the secondment of our Lead Clinical Professionals to national programmes of work. These roles are currently being reviewed and filled but this has had a detrimental effect on the progress of implementation to date.

The lack of dedicated programme manager support to lead on this has again been a major drawback with current staff having to add this major change programme onto their current workload. This has recently been recognised and steps are being taken to recruit a dedicated manager to lead on this as part of a two year post being financed outwith the PCIF monies.

The workload associated with the planning and move into our new Hospital and Healthcare facility has also been immense. We are in the process of moving into this new build in June 2019. This new facility will however result in many services working together going forward and will support out of hours and potentially urgent care services with increased collaboration between acute sector, Scottish Ambulance Service (SAS) and out of hours GP services.

Despite the new build there are still issues around where and how joint Multi-Disciplinary Team (MDT) working will take place going forward. Physical capacity within some premises is at capacity and thoughts and discussions are taking place around community hub approaches going forward.

To allow remote and MDT working between practices we will require excellent broadband speed and connectivity. Currently our links are very poor, particularly on our outer islands, and this will hamper new collaborative and technological ways of working if not addressed.

To date, we have met regularly with representatives of the GP Sub Committee to allow progress on some areas of the MOU. We have identified that we require a more formal programme board approach to this going forward. This will form part of our new Strategic Plan and the programme board will be chaired by the Chief Executive Officer of Voluntary Action Orkney, as we value the importance that the third sector can bring to Primary Care going forward. We also recognise the importance of increased patient involvement and again this will addressed through this programme board approach.

Some of the national programmes of works have yet to be finalised and agreed particularly around Travel Health Advice and healthcare Support workers.

There is a national and local risk that all areas as outlined within the MoU will not be in place by end of current projected end date of Phase 1.

Workforce

Nationally all Board areas are in the same position and are likewise trying to recruit personnel for all changes outlined. Therefore recruitment to posts can be difficult and we need to be creative where possible both how we create posts but also how we advertise and attract people.

Workforce projections are difficult as this is a significant change and all areas continue to adapt and update these as they progress. In Orkney it is difficult to cover posts and it is vital to recognise that as from 2022 GP Practices will no longer be required to provide these services. For patient care we need to ensure we have seamless care for patients in the event of sickness, holidays etc. It is problematic providing cover from small teams across the wide geographical spread of islands.

After discussion with the GP Sub Committee they have requested that profiling is included around average data in line with other boards of Scotland but also include what in reality we may need to provide a seamless service during holidays etc.

To provide seamless cover may not require additional posts in all areas but IJBs will be commissioning services based on this and it is important that we are sighted on this issue.

Workforce Profile

Projected Workforce Analysis (additional administrative posts not yet factored).

Practice	List size	%	Pharmacist 2 WTE	Pharmacy technician 3.5 WTE	VTP/Community Treatment 7 WTE	Urgent care 2 WTE	MSK 2 WTE	Mental health 2 WTE	Link worker 2.6 WTE
Skerryvore	8400	38	0.76	1.33	2.66	0.76	0.76	0.76	1.00
Heilendi	3800	17	0.34	0.60	1.19	0.34	0.34	0.34	0.44
Stromness	3000	14	0.28	0.49	0,98	0.28	0.28	0.28	0.36
Dounby	2800	14	0.28	0.49	0.98	0.28	0.28	0.28	0.36
St Mgt Hope	1500	6	0.12	0.21	0.42	0.12	0.12	0.12	0.15
Orcades	2000	10	0.2	0.35	0.70	0.2	0.2	0.2	0.26
Rousay	245	1	0.02	0.03	0.07	0.02	0.02	0.02	0.03

Projected Workforce Analysis (based on providing a seamless service.) (Additional administrative posts not yet factored).

Practice	List size	%	Pharmacist 3 WTE	Pharmacy technician 5.25 WTE	VTP/Community Treatment 10.5 WTE	Urgent care 3 WTE	MSK 3 WTE	Mental health 3 WTE	Link worker 3.9 WTE
Skerryvore	8400	38	1.14	1.995	3.99	1.14	1.14	1.14	1.5
Heilendi	3800	17	0.51	0.9	1.785	0.51	0.51	0.51	0.66
Stromness	3000	14	0.42	0.735	1.47	0.42	0.42	0.42	0.54
Dounby	2800	14	0.42	0.735	1.47	0.42	0.42	0.42	0.54
St Mgt Hope	1500	6	0.18	0.315	0.63	0.18	0.18	0.18	0.225
Orcades	2000	10	0.3	0.525	1.05	0.3	0.3	0.3	0.39
Rousay	245	1	0.03	0.045	0.105	0.03	0.03	0.03	0.045

Based on the projected workforce profile the Head of Primary Care has carried out some initial costings. These are based on “worst case” i.e. post holders being at top of the salary scale and have included all board costs. It is vital that we take into account that these costings do not currently include any additional travel costs or administrative and IT support that may be required for postholders. These would require to be considered as part of any recruitment planning.

Projected Workforce Costings (based top of band).

Title	WTE	Board Costs per WTE (£)	Total Cost (£)
Pharmacist – Band 8B	1	84,385	84,385
Pharmacist – Band 8A	1	70,357	70,357
Pharmacy Technician Band 5	3.5	41,744	146,104
VTP/Community Treatment Band 5	7	41,744	292,208
Urgent Care Band 7	2	60,629	121,258
MSK Band 7	2	60,629	121,258
Mental Health Band 7	2	60,629	121,258
Link Workers Band 5	2.6	41,744	108,534
Total Staff Cost	21.1	461,861	1,065,362

Projected Workforce Costings (based on seamless service).

Title	WTE	Board Costs per WTE	Total Cost
Pharmacist – Band 8B	1.5	84,385	126,578
Pharmacist – Band 8A	1.5	70,357	105,536
Pharmacy Technician Band 5	5.25	41,744	219,156
VTP/Community Treatment Band 5	10.5	41,744	438,312
Urgent Care Band 7	3	60,629	181,887
MSK Band 7	3	60,629	181,887
Mental Health Band 7	3	60,629	181,887
Link Workers Band 5	3.9	41,744	162,802
Total	31.65	692,792	1,598,045

Projected Income from PCIF.

Year	18/19	19/20	20/21	21/22
Fund Allocation	220,754	266,311	530,775	747,910
Earmarked Reserves	0	68,618		
2nd Tranche (within SG)	0	27,026		
Total Funding	220,754	361,955	530,775	747,910

Fully Implemented Workforce by 2021.

	Projected Workforce Costing £	Seamless Service £
Total Cost	1,065,362	1,598,045
Anticipated Funding	747,910	747,910
Anticipated Shortfall	317,452	850,135

Summary

This continues to be a significant change programme that requires to be implemented by 2021/22. Scottish Government is aware that across Scotland concerns are being raised around the risk of underfunding and being able to implement all changes outlined. It is the view of the Head of Primary Care, supported by the GP Sub Committee and the LMC that we need to raise this from an Orkney perspective as part of our updated plan. Whilst being realistic in our financial projections it is viewed strongly that we need to ensure that Scottish Government is sighted on the challenges of providing care across an archipelago of islands which is complex and expensive.

Representatives from Scottish Government visited Orkney in August and this gave us an opportunity to explain further our issues and the financial and workforce risks we are facing. The IJB should note that to date there has been no mention of island proofing as part of GP contract directives from Scottish Government and the IJB may wish to consider how to approach Scottish Government to reflect their concerns around this.

IJB's will be required to commission these services and will be required to ensure such commissioned services can provide seamless care for patients once these services are no longer provided by GP Practices. It is proposed that IJB members have development session in the near future to everyone is fully supported to understand the changes, challenges and commissioning processes that require to be in place.

The updated GP contract continues to have the ability to provide the opportunity for transformation in Primary Care services across Orkney. It is important to note that this plan will be fluid and will continue to develop and change as we move forward. It is highly unlikely that the current funding streams will not allow all developments to proceed as we would require and this will be highlighted on our OHAC risk register. The Head of Primary Care will continue to ensure that robust business plans and costings are developed around each contract service area, ensuring that we accurately understand what full service provision under the Contract will look like to avoid underestimating the requirements for Phase 2 of the Contract.

Good communication, transparency, collaboration and programme management is vital if these contract changes are to be achieved. It is fair to state that year one has been a learning curve but we are progressing forward together both with additional supportive roles and programme board approaches. It is also vital that we take opportunities for peer learning from our other board area colleagues who are likewise going through this change process. Given the current projected shortfall in funding it will be vital that we work closely with all colleagues to ensure we take full advantage of collective ideas around potential different ways of working that may also go some way to delivering current services differently which would achieve some of these contract areas in a cost efficient way.

Finally given the current funding shortfall the Head of Primary Care does not feel she can commit this plan for approval to the IJB . She does however wish the IJB to review and note this plan in the context of current progress against the GP contract directions.

Primary Care Improvement Plan – Implementation

It should be noted that this is a strategic overview of the plan. A more detailed project plan will be used to record continued developments, risk, measurable targets and performance monitoring.

Workstream 1: Lead - Sara Lewis, Public Health Consultant.

Priority set out in Memorandum of Understanding.	Objective from the contract and workstreams.	Year 1 Objectives.	Year 2 Objectives.	Year 3 Objectives.
Vaccination Service.	The aim is to reduce workload for GPs and their staff. Other parts of the system may begin to deliver vaccination services instead of GPs, if this is the agreed model. This will be a step towards enabling GPs to focus their time on expert medical generalism, whilst ensuring that patients' needs are met through the reconfiguration of services which will make the best use of the mix of skills in primary care. How this programme is delivered will vary regionally, depending on local circumstances and factors.	The VTP working group will be established and will be actively involved in the planning and implementation of the programme. Evaluation of the school vaccination programme will have been undertaken and any recommendations implemented. Evaluation of the Maternity delivered vaccination programme will have been undertaken and any recommendations implemented.	Options appraisal for the preschool immunisation programme will have been developed. Options appraisal for the at risk population immunisation programme will have been developed. Options appraisal for the travel immunisation programme will have been developed (including travel advice). Baseline figures and options appraisal for the seasonal flu programme will have	The preferred option for the preschool immunisation programme will be operational. The preferred option for the travel immunisation programme will be operational (including travel advice). The preferred option for the seasonal flu programme will be operational. The preferred option for the at risk populations immunisation programme will be operational (including shingles and

Priority set out in Memorandum of Understanding.	Objective from the contract and workstreams.	Year 1 Objectives.	Year 2 Objectives.	Year 3 Objectives.
	The Vaccination Transformation Programme will take three years to complete. It has the following work streams: • Pre-school. • School based. • Travel vaccines. • Influenza. • At risk groups (shingles, pneumococcal, Hep B).	Baseline figures of preschool immunisation uptake will be mapped. Baseline figures of the at risk populations immunisation uptake will be mapped (including shingles and pneumococcal vaccines). Baseline figures of the travel immunisation uptake will be mapped (including travel advice).	been mapped and developed.	pneumococcal vaccines).

Workstream 2: Lead - Wendy Lycett, Pharmacist.

Priority set out in Memorandum of Understanding.	Objective from the contract and workstreams.	Year 1 Objectives.	Year 2 Objectives.	Year 3 Objectives.
Pharmaotherapy Services.	From April 2018, there will be a three year trajectory to establish a sustainable pharmacotherapy service which includes pharmacist and pharmacy technician	Engage stakeholders to ensure alignment of objectives including national and regional post outlines.	Review Services from Year 1 and Three Horizons Model. Identify in year funding (including additional).	Review Services from Year 2 and Three Horizons Model. Agree in year funding

Priority set out in Memorandum of Understanding.	Objective from the contract and workstreams.	Year 1 Objectives.	Year 2 Objectives.	Year 3 Objectives.
	support to the patients of every practice. By April 2021, every practice will benefit from the pharmacotherapy service delivering the core elements as described below. This will be dependent on PCIP funding being allocated against this: • Level One (core). • Level Two (additional advanced). • Level Three (additional specialist). Pharmacy services will be integrated to promote patient centred, seamless care and ensure cross sector service provision.	Agree in-year funding for service provision. Design service model for practices within allocated resources. Consider logistics for service delivery to multiple remote and rural sites. Recruit to any agreed posts. Identify and address training and development needs. Work with individual practices to prioritise work streams as defined in GMS contract. Introduce Services Level 1 minimum.	Consider opportunities and challenges associated with New Balfour. Identify Service gaps areas for improvement / development. Develop interface with care in community technician role. Consider potential Community Pharmacy roles. Prioritised level 2 / level 3 services where staff experience and qualifications allow. Assess additional training and development needs. Develop potential technical services (if funding permits). Appoint to additional posts. Introduce additional advanced and specialist	Additional regional / national drivers. Identify service gaps from all three levels defined in GMS contract, areas for improvement / development. Consider logistics of full service delivery. Appoint to any agreed additional posts. Introduce any additional service provision. Review.

Priority set out in Memorandum of Understanding.	Objective from the contract and workstreams.	Year 1 Objectives.	Year 2 Objectives.	Year 3 Objectives.
			services where appropriate.	

Workstream 3: Lead - Clinical Nurse Manager (not yet in post).

Priority set out in Memorandum of Understanding.	Objective from the contract and workstreams.	Year 1 Objectives.	Year 2 Objectives.	Year 3 Objectives.
Community Treatment and Care Service.	There will be a three year transition period to allow the responsibility for providing the services noted below to pass from GP practices to community based services. By April 2021, these services will be commissioned by IA's, and delivered in collaboration with NHS Boards that will employ and manage appropriate nursing and healthcare assistant staff. Scottish Government sees Phlebotomy as a priority in the first stage of PCIPs. Currently based on local priorities our GP Practices are looking at alternative areas of the contact as a higher priority. An options appraisal will be carried out on the following work streams to consider the best way to take these areas	Ensure Staff are supported around the current GPNs educational requirements for Transforming roles, safe staffing, excellence in care.	Having an ongoing shared and detailed understanding of current situation and activity for Orkney. Ensure consultation and discussions with appropriate groups/people using existing structures where possible. Workforce considerations to include training and development/recruitment and retention and different ways of working across professional boundaries. Training needs analysis for HCSW. Consult/agree on work bases/premises and workforce.	Arrange for any agreed Minor Injury, Dressings, suture removal and Ear Syringing changes to be transferred by July 2020. Ensure areas of duplication are scoped i.e. A and E/ Community/GP /audiology and develop pathways that meets needs as well as ensure financial aspects and budgets are considered and aligned.

Priority set out in Memorandum of Understanding.	Objective from the contract and workstreams.	Year 1 Objectives.	Year 2 Objectives.	Year 3 Objectives.
	forwards based on local priority setting: • Phlebotomy. • Minor injuries and dressings. • Ear syringing. • Suture removal. • Chronic disease monitoring.		Arrange for any agreed Phlebotomy changes to be transferred by April 2020.	

Workstream 4: Lead - Dawn Moody, Clinical Director.

Priority set out in Memorandum of Understanding.	Objective from the contract and workstreams.	Year 1 Objectives.	Year 2 Objectives.	Year 3 Objectives.
Urgent Care.	Alternative ways of providing urgent unscheduled care are to be explored and developed. The potential staff resource to deliver this may be Advanced Nurse Practitioners, Paramedics, General Practice Nurses and Community Nurses. This will allow GPs to focus on scheduled appointments with patients most in need of their	Develop closer working between relevant professional groups	Develop detailed options around the development of urgent care services with focus on advanced practitioner role. Identify professional groups to undertake urgent care assessments.	Embed new ways of working (Ensure good public engagement and awareness of the changes.

Priority set out in Memorandum of Understanding.	Objective from the contract and workstreams.	Year 1 Objectives.	Year 2 Objectives.	Year 3 Objectives.
	skills as expert medical generalists. It has the following workstreams: • First response for home visits. • Assessment and treatment of urgent or unscheduled care presentations.		Delineate training requirements. Identify appropriate training programmes.	

Workstream 5 and 6: MSK Lead - Lynne Spence, Lead AHP. Mental Health Lead – Lynda Bradford, Acting Head of Health and Community Care. Community Link Workers – Gail Anderson, Voluntary Action Orkney.

Priority set out in Memorandum of Understanding.	Objective from the contract and workstreams.	Year 1 Objectives.	Year 2 Objectives.	Year 3 Objectives.
Additional Professional Services.	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	Evaluation of new MSK 1st point of contact Physiotherapist in Stromness. Scope work of Community Link workers and explore examples from other areas.	If evaluates well potential for extension to other areas of Orkney explore County-wide models. Agree pilot and local evaluation. Scope work around Primary Care Mental Health Nurses.	Alternative models of MDT in Primary Care evaluated for potential spread and sustainability. Implement Primary Care Mental Health Service with improved GP referral routes.

Priority set out in Memorandum of Understanding.	Objective from the contract and workstreams.	Year 1 Objectives.	Year 2 Objectives.	Year 3 Objectives.
	limited to) the following work streams: • Physiotherapy services for MSK. • Community mental health services. • Community Link Workers.	Commission Voluntary Action Orkney to deliver this service.	Establish expectations and demand for role and develop a deeper understanding of how this would work in Orkney. Explore examples from other areas. Establish pilot sites for workers and governance processes. Establish close working with mental health, public health and third sector agencies.	Review pilot and establish requirement for further staffing to allow spread and sustainability.

Appendix 1

(Orkney LMC and GP Sub Committee request that this forms part of the PCIP as we are allowing these plans to be submitted to SG without LMC/GP Sub approval of the plan and it is essential that the LMC/GP Sub reasoning behind this remains attached to the PCIP as otherwise there is a risk that these plans are regarded as agreed).

Orkney LMC/GP Subcommittee commend the staff of the HSCP for working so hard on this plan.

The PCIP is intended to describe how the new 2018 GP Contract will be implemented locally in Orkney.

It is necessary that the PCIPs demonstrate a clear progression to full delivery by April 2021 as required by the MOU between HSCPs and Scottish Government. If the plan does not show a clear pathway to delivery, then it is essential that all necessary steps are taken locally and by Scottish Government to ensure delivery of all of the Contract commitments while there is still time to take action. There are now less than 24 months to deliver the contract. It is clear that our HSCP have identified difficulty in describing a plan which confidently delivers the Contract agreement mainly around funding, availability of appropriately trained and experienced staff locally and recruitment of new staff.

The LMC and GP Sub Committee cannot agree to a plan which does not yet show the clear path to delivery but do agree that the plan, as it is at present, can be sent to Scottish Government without our full agreement.

We wish to allow continuing progress in implementation of the new contract and, for the reasons given above, it is necessary for Scottish Government to have sight of the essential information contained in the PCIPs. We are content therefore for the plan to be submitted without LMC and GP Sub agreement on the understanding that the Primary Care Improvement Funding is not spent on activities where this is not supported by the LMC and GP Sub.

We have outlined below specific aspects of the Orkney PCIPs to date where we wish to highlight particular issues:

Lateral Cost Shift

The funding of existing services that were being delivered by HSCP prior to the Contract implementation must not be supported by the new PCIF budget. We will not accept the PCIF to be used to fund these existing services such as the pre-new contract primary care pharmacy services.

The 6% Employers superannuation rate increase

We are clear that the increase in staff cost pressure due to change in the employers' contribution should not fall onto the PCIF. The PCIP funding plans should reflect the previous contribution rate as was in place when the PCIF budget was calculated and the additional 6% cost must be met by other funding streams.

Premises and IT

There is national agreement and guidance that the costs of IT infrastructure and equipment necessary to deliver on the Contract should not fall onto the PCIF. This applies also to improvements or developments to premises to enable MOU/new contract services to be delivered.

Training and travel costs

We are clear that the PCIF should fund only the salaries of the new workforce required to deliver the PCIP. Additional costs such as training budgets and travel costs should not come from the PCIF. It is not common practice across the HSCP for these costs to be included when employing new members of staff so a different set of rules should not apply to the workforce required to implement the new GP contract.

Our rural location and island based geography means that costs to attend training and travel from base to various workplace locations will be disproportionately high compared with other areas of the country. We will have a small workforce undertaking a lot of travel including by air and sea. As this has not been factored into the PCIF allocation Orkney has received these costs should be covered from other budgets and highlighted to Scottish Government.

Dr Kirsty Cole.

Chair, Orkney GP Sub.

Dr Tony Wilkinson.

Secretary, Orkney LMC.