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NHS Highland

Note of Meeting of the North Highland Primary Care Modernisation Project Team, Boardroom, Assynt House

Monday 11th February 2019
2.00pm – 4.00pm

Present:	Georgia Haire, Project Director (Chair) (GH) Kenny Rodgers, Project Manager (KR) Andrew Devlin, Communications Manager (AD) Dr Iain Kennedy, GP Sub Committee & LMC Medical Secretary (IK) Paul McAleer, Primary Care Accountant (PMcA) Alister McNicoll, E-Health Representative (AMcN) Dr Stewart MacPherson, Workstream Lead – Community Treatment (SMcP) Dr Jonathan Ball, GP Sub Committee, LMC Chair (JB) Michael Perera, Workstream Lead, Mental Health (MP) Kate Patience-Quate, Lead Nurse Representative (KPQ) Thomas Ross, Workstream Lead, Pharmacotherapy (TR) Cathy Steer, Workstream Lead – Community Link Workers (CS) Margaret Moss, Lead AHP Representative (MM)
In Attendance	Amanda Trafford, AHP Lead (AT) Kirsty Arnott, Committee Administrator
Apologies::	Dr Ken Oates, Workstream Lead – Vaccination Transformation Lorraine McKee, Workstream Lead – Vaccination Transformation Brigitte Johnstone, Human Resources Representative Claire Wood, Workstream Lead - AHP Dr Jim Docherty, E-Health Clinical Lead Dr Antonia Reed, Workstream Lead – Urgent Care

1. Welcome and Apologies

GH welcomed everyone to the meeting noting apologies from Dr Jim Docherty, Brigitte Johnstone, Antonia Reed, Ken Oates, Lorraine McKee and Claire Wood.

2. Note of Last Meeting (10.01.19) & Action Points:

The note of the previous meeting held on the 10th January 2019 was **approved** as an accurate record subject to the following amendment:

"CS confirmed the need to deliver an equitable service and identify how equality is being measured for each workstream", should read "CS questioned defining what we mean by equality".

Actions:

1. To be discussed in agenda item 4.2.

2. To be discussed in item 8 on the agenda.
3. To be discussed in item 4.4 of the agenda.
4. To be discussed in item 4.6 of the agenda.

3. Assurance Report

KR updated the Committee on the status of the Assurance Report, reporting the project had a status of Green, however further progress of Mental Health was required to deliver in year outcomes. The budget status was updated to a status of red noting £7.1M would be available by 2021 to develop services associated with the programme. It is still unclear as to whether this funding will deliver all of the services across the 6 workstreams but this should become clearer as the workstreams progress. It was commented Communications was still red however work was progressing.

Risk Register

KR gave a short summary of the risk register and highlighted issues around funding of e-health and the equity of delivery. Funding has now been used for both the MSK and pharmacotherapy workstreams. Some risk can be mitigated however not all. Discussion took place on how e-health could be moved to green. It was noted TR and CW have been working with Lynne Clarke from e-health to look at combined solutions for pharmacotherapy and MSK. Clarification was sought on which IT model was proposed which TR commented model 1 was felt to be a best option however remote access has been requested. 40 practices need changes to configuration of services for this project. Clarity was sought on whether there was capacity to deliver in N&W or whether there were additional risks. EB to feedback any issues to the next meeting.

4.1 Pharmacotherapy

TR introduced the pharmacotherapy update to the meeting and explained a third round of advertising had taken place. Gap analysis will be undertaken once the third round has been completed to identify where the gaps in service remain across the 65 practices. TR outlined desk space was an issue in some practices therefore remote access would be required.

IK questioned the total number of pharmacists being low and asked when the numbers would grow. TR assured the total number of pharmacists would be recruited by the end of year 3, which is reflected in the funds available. IK indicated he was a member of the Dispensing Short Life Working Group and asked whether dispensing would be part of the pharmacotherapy role in Highland.

TR updated Findlay Hickey was working on equitable access to every practice however dispensing was not in the GP contract and therefore not in MoU. IK's view was the pharmacotherapy posts should be generic across Scotland therefore dispensing should be part of the pharmacotherapy workstream. TR agreed to look at rewording a paragraph to be put within the document to reflect dispensing. This is to be considered at the Pharmacy Working Group.

4.2 MSK

MM introduced the MSK implementation plan and outlined the two band 8a management posts are now in place. Work will now progress to plan and recruit to the First Contact Practitioner posts.

IK spoke to national discussion around cuts in secondary care services if MSK is moved to primary care. EB commented on practices not getting additional help beyond the workstreams, the variations and who does MSK in these areas. Re-design of MSK is required to ensure equity across localities and practices. Questions were raised around the funding to achieve this.

GH asked how this proposal would be communicated to patients. It was noted a national release may be imminent. AD will discuss with Jane McGirk.

SMcP questioned the use of Band 7 physiotherapists to deliver the workstream asking whether Band 6 staff would help make the costs more achievable. MM commented an advanced level of physiotherapist was required to provide first contact treatment and to reduce GP workload.

4.3 Community Treatment and Care

SMcP introduced the report for community treatment and care to the meeting and explained the workstream had progressed. A combined questionnaire has been developed and will be turned into a survey monkey questionnaire with support from Public Health and distributed to all NH practices. Questions were raised around ITR being developed in this workstream however it was agreed ITR did not form part of this workstream therefore should be removed for the next meeting.

4.4 Mental Health

MP spoke to the Mental Health delivery model report which was circulated to the group prior to the meeting.

JB questioned whether there would be linkage between the Mental Health Workers and the CMHT. It was confirmed the Mental Health and Wellbeing Workers service is an effective model and works well highlighting workers will have a distinct workload.

Questions were raised over equality and resource. IK proposed Mental Health Workers are the same as MSK and pharmacotherapy. Two models were proposed, one within the allocated budget and one being the ideal proposed service.

Questions were raised over whether staff would have access to Vision. It was noted there would be a cost element for e-health. It was envisaged there would be a team of 15 workers supported and supervised in practices.

Questions were also raised over the travel costs which were deemed to be too high. MP reflected the £3,500 per WTE is a standard costing for community posts but this would be honed in more detail as it was clear where posts would be placed.

4.5 Vaccination Transformation

Discussion took place around the vaccination transformation plan including public health. KPQ spoke to the expectation of transferring Highland Council staff into the NHS however this had not been agreed. Concerns were raised over the governance of this staff transfer linked to the modernisation plan.

CS spoke to issues having existing skilled staff and training staff. There was a general lack of agreement with what was in the report. This is to be raised at the next meeting.

4.6 Community Link Workers

CS spoke to her report on Community Link Workers and explained the rating was amber due to the timescale. A worked up model is being produced for North Highland and they were reaching a point of equity and allocation of resource. It was agreed a generic Community Link Worker would be linked to practices however a Third Sector delivery model was being proposed. It was proposed approximately 12–15 WTE link workers could be employed within the allocated budget. CS to look at a proposal for the March meeting.

KJ spoke to waiting lists being created and the expectations of GP's. EB spoke to the ability to challenge this situation.

4.7 Urgent Care

GH spoke to the urgent care report on behalf of AR. Different models are being considered. Standardisation of workforce against practices is being looked at. Funding was deemed less than what is useful.

5. GP Premises – Sustainability Loan Scheme

KR informed the Committee the applications for the loan scheme had been completed and forwarded to the Scottish Government. It was expected an announcement would be made in the near future. It is expected all standard applications for 2018-19 will be funded. Applications under the exceptional circumstances criteria will be subject to further discussion.

6. E-Health

AMcN commented recruitment was underway for a further mentor to support the project. Questions were raised over remote desktops for pharmacy and MSK however this would accrue additional costs. Dial in was being looked at as an option.

7. Finance

PMcA spoke to the finance report explaining not much had changed since the previous meeting. GH questioned with TR whether there were costs which were not anticipated when he went through the process of recruiting to the pharmacotherapy workstream which he could not identify.

PMcA made the Committee aware of the changes to Agenda for Change 3 year pay deal and associated increase in costs. He spoke to the additional funds required for this including employer superannuation costs which will increase by 6%. He made the committee aware what is achievable on the workstreams presently will go down due to the increased costs. There was uncertainty to the board's position on this. The workstreams were made aware this should be factored into plans going forward. Primary Care Leads should be made aware, as the assumption is funding will not be increased by the government for this reason.

8. Communication and Engagement:

AD introduced the draft Communication and Engagement Plan. Extensive discussion took place around the best way to communicate with both the public and GP colleagues. It was suggested social media was currently the most effective communication media used. A further suggestion was with a drop in event. Timing was felt to be critical in dealing with any query coming in regarding the project. It was agreed engagement with GP colleagues was a high priority and it was suggested meeting each practice personally would be the best way forward. A single point of contact from practices would be effective.

It was agreed a series of You Tube videos would be created on primary care modernisation, no longer than 5 minutes each. This would be an effective way of reaching individual GP's. AD to progress.

AD to lead on the communication of the project with support from EB and KR.

9. Date of Next Meeting:

Monday 11th March 2019
2.00pm – 4.00pm
Boardroom, Assynt House

Actions

No	Action	By When	Responsible
1.	Changes required to IT configuration. Clarity required on whether there is capacity to deliver in N&W or additional risk.	March 2019	EB
2.	How will new MSK model be communicated to patients. AD to discuss with Jane McGirk	March 2019	AD
3	Further clarity required on Mental Health proposal.	March 2019	MP
4	Vaccination Transformation report. Clarity required from last meetings report.	March 2019	KO/LMcK
5	CS to bring proposal for Community Link Worker to next meeting	March 2019	CS
	Workstream updates 1 week ahead of meetings using standard template	Ongoing	W/S Leads

North Highland H&SCP – Primary Care Modernisation Programme

Project Manager's Assurance Report 28/02/2019

Issued By Kenny Rodgers, Project Manager

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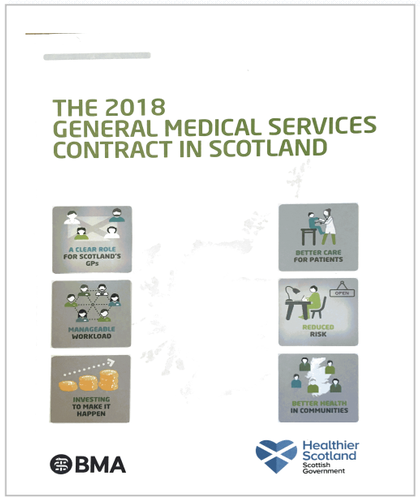
Employer Address NHS Highland
Assynt House
Beechwood Business Park,
Inverness, IV2 3BW

Report No 6
Date 28/02/2019



1. INTRODUCTION

This Assurance Report has been prepared in relation to the **implementation of the 2018 General Medical Services Contract in Scotland**. This strategic document is supported by a memorandum of Understanding and proposes a refocusing of the General Practitioner role as expert medical generalists. This refocusing of the GP role will require some tasks to be carried out by members of the wider primary care team where it is safe, appropriate and improves patient care. It is expected that these new arrangements will see a reduction in risk for GP partners and a substantial increase in practice sustainability.

David Park , Senior Responsible Officer has executive responsibility for the delivery of the programme and co-chairs the Programme Board alongside Dr Paul Davidson (Associate Medical Director – Primary Care).

Georgia Haire, Project Director is responsible for delivering the programme of work, and is supported by a core project team of Kenny Rodgers (Project Manager), Stewart MacPherson (Associate Medical Director) and six workstream leads. Highland GP Sub and LMC are key partners in the development of the programme. Dr Jonathan Ball (GP Sub and LMC Chair) and Dr Iain Kennedy (GP Sub and LMC Medical Secretary) are the nominated leads supported by the GP Sub/LMC Chairs Group.

This document provides a summary in relation to progress achieved on the project to date, activity in the previous period and forecast for the coming period. This progress report covers the period to **28/02/2019**.

2. Project Status - RAG

	Previous RAG	Current RAG	Comments
Timeline	Amber	Green	Progress is being made against year 1 programmes of pharmacotherapy and MSK physiotherapy. Further development of Mental Health model is required to be progressed to deliver in year outcomes.
Scope	Green	Green	Year 1 scope is now defined and agreed. Workstream outputs continue to be developed and agreed broadly in line with the plan. Work is ongoing to develop workstreams in years 2 and 3.
Budget	Amber	Red	Estimate that £7.1m will be available by 2021 to develop services associated with the programme. It is not yet clear if this funding will deliver all of the services across the 6 workstreams. Clarity on service delivery against funding will become clearer as workstreams develop. There is an emerging pressure regarding changes to superannuation costs that may impact on budget.

3. PROJECT PROGRAMME

Current Programme:	Rev Date: 28/02/2019	Rev: 6	**Current Status:**	Accepted	Accepted

Milestone Activity	Due date	Estimated / actual date	RAG Status
Develop Communications Plan	September 2018	January 2019	Complete
Progress pharmacotherapy recruitment	December 2018	February 2019	Green
Progress MSK physiotherapy recruitment	January 2019	March 2019	Green
Develop and agree Links Worker model	February 2019	March 2019	Green
Develop and agree MH business case	November 2019	January 2019	Amber
Progress sustainability loan scheme applications	January 2019	January 2019	Green

4. KEY PROJECT DELIVERABLES COMPLETED THIS PERIOD (TO 28th February 2019)

Description	Status	Owner
Process sustainability loan scheme applications – letters to practices	Green – In Progress	Kenny Rodgers
Develop E-Health Plan – Claire Wood/Thomas Ross/Alister McNicoll	Amber – In Progress	Alister McNicoll
Progress MSK and Pharmacotherapy recruitment	Green – In Progress	Thomas Ross/Claire Wood
Propose Mental Health business case	Amber – In Progress	Michael Perera
Develop and implement communications plan	Amber – in progress	Andy Devlin

5. KEY PROJECT DELIVERABLES TO BE COMPLETED IN NEXT PERIOD (TO 31st March 2019)

Description	Status	Owner
Further develop E-Health plan	Amber – In Progress	Alister McNicoll
Finalise Mental Health workstream in line with year 1 plan	Amber – In Progress	Mike Perera
Liaise with SG and NHSH on strategy for managing premises code of practice	Green – In Progress	Kenny Rodgers
Implement communications plan	Amber – In Progress	Andy Devlin/Kenny Rodgers

6. KEY PROJECT RISKS IN THE REPORTING PERIOD

Current Risks:	Rev Date: 28/02/2019	Rev: 6	**Current Status:**	Accepted	Accepted

Key Risks in the period include:

Description	Risk Level Current	Mitigating Actions	Risk Level target	Next Review
Identification of e-health requirements when service models are not yet fully developed	Red	Develop workstream models to better define actual e-health requirements.	Green	Mar-19
Engagement with Practices and General Public requires a developed communication plan	Amber	Development and auctioning of communication plan.	Green	Jan-19
Funding by 2021 outline by SG may not be sufficient to meet the resources required to deliver the aims of the strategic framework. There is an emerging pressure regarding changes to superannuation costs that may impact on budget.	Red	Budget management structure and monitoring arrangements in place around the plan. Further discussion with PC leads group	Green	Jan-19
Delivery of an equitable service across Highland to all GP Practices	Red	Close monitoring by Programme Board and Project Team. Representation at Remote and Rural Working Group	Amber	Jan-19
Workstreams are at different stages of development potentially resulting in delivery based inequitable resource allocation.	Amber	Work to be progressed during August to seek clarity of ownership, probably through a questionnaire.	Green	Jan-19
Lack of synergy in the 6 workstreams resulting in missed opportunity for joined up services.	Amber	Workstream updates to every Project Team meeting and workstream leads all on the Project Team.	Green	Jan -19

7. ADDITIONAL PROFESSIONAL ROLES – MSK PHYSIO

Current Programme:	Rev Date: 28/02/2019	Rev: 3	**Current Status:**	Update	GREEN

Current Plan	Progress	Due date	Estimated / actual date
Submit Business case to Programme Board	Programme Board approved	October 2018	Complete
Develop implementation plan 1:13,000 patients	In development with Districts	December 2018	March 2019
Recruit Senior FCP posts	Appointments made	February 2019	Complete
Identify E-Health requirements	Requires more development	October 2018	March 2019
Recruit to FCP posts across Highland	In development	March 2019	March 2019

8. PHARMACOTHERAPY

Current Programme:	Rev Date: 28/02/2019	Rev: 5	**Current Status:**	Update	GREEN

Current Plan	Progress	Due date	Estimated / actual date
Develop and agree service specification/MoU	To be finalised in February	February 2019	February 2019
Develop equitable service model	Gap analysis to be undertaken	March 2019	March 2019
Recruit 10 WTE pharmacists from agreed funds	Third round of recruitment - Feb	February 2019	February 2019
Develop technicians/assistants recruitment plan	Posts being advertised in N&W	March 2019	March 2019
Monitor equity of service delivery	Gap analysis to be undertaken	March 2019	March 2019
Develop remote access solutions	Mapping submitted to E-Health	February 2019	February 2019

9. VACCINATION TRANSFORMATION

Current Programme:	Rev Date: 28/02/2019	Rev: 4	**Current Status:**	Update	AMBER

Current Plan	Progress	Due date	Estimated / actual date
S&M and N&W to develop service models	Process mapping day in March 2019	March 2019	March 2019
Develop test of change in Lochaber and E Ross	Process mapping day in March 2019	March 2019	March 2019
Transfer pregnant women vacs to Midwifery	Tests of change in Lochaber & Skye	July 2019	July 2019
Identify E-Health requirements	Being discussed nationally	December 2018	December 2018
Transfer Immunisation team from THC	Agreed in principle	April 2019	April 2019
Identify funding requirements	Business case in development	March 2019	March 2019

10. ADDITIONAL PROFESSIONAL ROLES – MENTAL HEALTH

Current Programme:	Rev Date: 28/02/2019	Rev: 2	**Current Status:**	Update	RED

Current Plan	Progress	Due date	Estimated / actual date
Finalise service plan	Plan to be agreed within Workstream	September 2018	March 2019
Identify funding requirements	Reduced model to fit budget	September 2019	February 2019
Prepare recruitment programme	Can commence once model approved	December 2018	March 2019

11. URGENT CARE

Current Programme:	Rev Date: 28/02/2019	Rev: 5	**Current Status:**	Update	AMBER

Current Plan	Progress	Due date	Estimated / actual date
Agree scope and existing models	Complete	December 2018	Complete
Develop equitable service model	TBA	June 2019	June 2019
Develop questionnaire to General Practice	In progress	February 2019	February 2019
Identify E-Health requirements	In development	April 2019	April 2019
Identify funding requirements	In development	June 2019	June 2019

12. COMMUNITY TREATMENT AND CARE

Current Programme:	Rev Date: 28/02/2019	Rev: 3	**Current Status:**	Update	AMBER

Current Plan	Progress	Due date	Estimated / actual date
Develop and agree equitable service model	Ongoing	June 2019	June 2019
Roll out ITR model (separate project)	Agreed to separate from CT&C programme	March 2019	March 2019
Develop questionnaire to Practices	Being developed with Public Health	March 2019	March 2019
Identify E-Health requirements	In development	December 2018	December 2018
Identify funding requirements	In development	March 2019	March 2019

13. COMMUNITY LINK WORKERS

Current Programme:	Rev Date: 28/02/2019	Rev: 4	**Current Status:**	Update	AMBER

Current Plan	Progress	Due date	Estimated / actual date
Set up workstream group	Initial membership and ToR created	September 2018	Complete
Develop equitable service model	Proportionate Universalism model	December 2018	January 2019
Appraise focus of Link Worker role	Generic Community Link Worker	March 2019	March 2019
Identify E-Health requirements	In development	December 2018	January 2019
Identify funding requirements	In development	February 2019	February 2019

PRIMARY CARE MODERNISATION PROGRAMME - Risk Register

Updated 20.02.2019
Review Date for Risk Workshop **March 2019**

ID	Description	Risk Type	Controls when risk identified	Risk level (current)	Risk level (Target)	Current Mitigation/Action	Next review
1	Ehealth	Organisational	Identification of e-health requirements when service models are not yet fully developed	High	low	Develop workstream models to better define actual e-health requirements	Mar-19
2	Local engagement in the development of the PCIP workstreams.	Organisational		High	Low	Requirement to engage District Managers once the workstream models have been defined. Process started January 2019	Feb-19
3	Funding by 2021 outline by SG may not be sufficient to meet the resources required to deliver the aims of the strategic framework.	Financial	Budget management structure and monitoring arrangements in place around the plan. Formal project terms of reference and levels of delegation.	High	Low	Develop workstream models to better define actual financial requirements. Review of budget to take place in February 2019	Jan-19
4	Funding available for services/posts may be impacted on increased employers superannuation costs (6%) and agred Agenda for Change pay structure.	Financial	Impact analysis being undertaken	UPDATE High	Medium	Further discussion with Programme Board and Primary Care Leads group	Mar-19
6	Capacity within existing workforce resources to deliver the programme. - remove?	Organisational	Agreement to review capacity on an ad hoc basis and agree support required.	UPDATE Low	Low	Current project management arrangements seem sufficent to deliver the programme. Busy diary commitments for key personnel may become an issue	Jan-19
7	Geography of highland is challenging our ability to provide equitable service to all practices as outlined in the contract.	Service delivery	Representation at the Remote and Rural Working Group.	High	Medium	Development of workstreams will identify key challenges with delivery of both urban and rural services equitably.	Feb-19
8	Public engagement and involvement	Communication	Need to develop a communication plan. Patient rep on Programme Board.	Medium	Low	Communication plan agreed by project Team	Feb-19
9	Engagement with GPs	Communication	Newsletter after every project team. Intranet page developed and maintained.	High	Low	Communication plan agreed by project Team	Feb-19
10	Workstreams are at different stages of development resulting in delivery based inequitable resource allocation.	Service delivery	Detailed financial plan for the 3 year period.	Medium	Low	Close monitoring by project team and programme board	Jan-19
11	Unable to recruit to new posts developed as part of the PCIP in an equitable way across North Highland.	Service delivery	Controls are, different recruitment approaches, local and national. Mitigation plans in place.	High	Medium	Close monitoring by project team and programme board	Feb-19
12	Disparate views on how individual workstreams may be delivered effectively in their local area.	Service delivery	Vaccination survey completed, community treatment & care workstream survey planned.	Medium	Low	Development of workstreams will identify key challenges with delivery of models of care for further discussion with local managers and clinicians	Jan-19
13	Lack of synergy in the 6 workstreams resulting in missed opportunity for joined up services.	Service delivery	Professional leads on Project Team. Workstream updates to every Project Team meeting and workstream leads all on the Project Team.	Medium	Low	Close monitoring by project team and programme board	Jan-19
14	Risk of destabilising established services due to new services being introduced within their specialty.	Service delivery		High	Medium	Close monitoring by project team and programme board	May-19
15	Risk of workstreams not delivering the aspirations of the MOU for GPs and patients.	Organisational	Project Structure in place. PCIP agreed.	Medium	Low	Close monitoring by project team and programme board	May-19
16	Failing to delivery workstreams in a timely manner.	Organisational	Continuing collaborative approach to development of the workstreams. Project structure in place. PCIP agreed.	Medium	Low	Close monitoring by project team and programme board	May-19

NORTH HIGHLAND PRIMARY CARE IMPROVEMENT PLAN - UPDATE

WORKSTREAM: PHARMACOTHERAPY

RAG STATUS - GREEN

DATE: 28 Feb 2019

Current Plan

1. Band 7 primary care clinical pharmacists (PCCPs) - Recruit to 10 wte PCCPs across Highland HSCP.
2. Collaborate with eHealth team and MSK Workstream on remote access solutions to GP practice systems.
3. Undertake a gap analysis of pharmacy support to GP practices.
4. Circulate agreed Pharmacotherapy Memorandum of Understanding (MoU) document and communicate pharmacotherapy update to all Highland GP practices.

Progress

1. Band 7 (PCCPs)
   Following three rounds of interviews we have recruited to/made job offers to pharmacists for these posts as follows:
   - Caithness 0.4 wte
   - Lochaber 1.2 wte
   - Skye, Lochalsh & Wester Ross 1.2 wte
   - Nairn, Badenoch & Strathspey 2 wte
   - Inverness 2.7 wte
   - East & Mid Ross 2.6 wte

North & West total = 2.8 wte, South & Mid total = 7.3 wte

2. Have mapped preferred models of eHealth requirements for each practice to deliver in-practice and remote access solutions. Continue to collaborate with eHealth and MSK workstream around remote access solutions.
3. Gap analysis is in progress and is being updated as staff are recruited.
4. Pharmacotherapy MoU document approved at Pharmacotherapy Working Group on 26 February (see copy attached). A joint covering letter is to be drafted to be sent out with MoU document.

Timescales

1. Band 7 (PCCPs) - Most new pharmacists recruited in rounds one and two are now in post or coming into post over next month. Offers have been made (and verbally accepted) to those recruited in round three.
2. Mapping submitted to eHealth. Aim to meet with eHealth in March to review progress.
3. Gap analysis is in progress.
4. Aim to have MoU document distributed to all Highland GP Practices week commencing 4 March. Workstream lead to work with Communications team.

Risks

Unable to recruit to posts. A number of contingencies and alternatives to reduce this risk are being progressed. These have been previously described to the Project Team.

Decision required from the Project Team / Board:

Note update and progress.

NHS Highland
General Practice Pharmacotherapy Service

Memorandum of Understanding

Contents

Section 1: General Service Provision

1.1 General Service Outline

1.1.1 Pharmacy staff will work as integral members of practice clinical teams, working with GPs and practice staff as part of a multi-disciplinary team, utilising their skills to complement those of other team members to improve patient care and support GP practices in new ways to reduce GP workload and allow GPs to develop their role as Expert Medical Generalists.

1.1.2 The day-to-day work of pharmacy staff will be targeted at local (individual GP practice) clinical priorities in line with the Pharmacotherapy Service Specification (see Section 2). There will be initial discussion with each practice to identify and agree priorities and ongoing regular review.

1.1.3 Practice specific priorities will be documented in a written agreement with each practice, with a work plan defining the specific components of the service to be delivered and the roles of pharmacy staff.

1.1.4 NHS Highland will provide registered pharmacy staff (pharmacists, pharmacy technicians and pharmacy assistants) to a GP Practice, who will operate with due care, skill and ability, in a professional manner. NHS Highland shall provide a named pharmacist for the practice who will coordinate the service which will be delivered by members of the pharmacy team.

1.1.5 NHS Highland employed pharmacy staff will have a role in providing pharmacotherapy services to dispensing GP Practices. This will include aspects of quality, effectiveness and efficiency, excluding the process of dispensing medicines which shall continue to be done by Practice dispensing staff.

1.1.6 Pharmacy staff will work within and to the top of their level of competence. The level of complexity will determine whether an assistant, pharmacy technician or pharmacist performs the task (where available) and will depend on the training and skills of individual team members.

1.1.7 NHS Highland will be responsible for the pay, benefits, terms and conditions of those staff engaged in the delivery of the service. Professional leadership and strategic direction is the responsibility of the relevant Lead Pharmacist. Line management of pharmacy staff is the responsibility of the Pharmacy Team Leads/Lead Pharmacist, including individual annual reviews and personal development plans.

1.1.8 On a day-to-day basis, priorities and tasks to be undertaken by pharmacy staff will be agreed with the practice and documented in an agreed work plan (see Section 4).

1.1.9 Pharmacy staff shall comply with all relevant and applicable policies and procedures of NHS Highland. Standard operating procedures and guidance will be in place for each aspect of the service to provide governance and to standardise the work being undertaken by pharmacy staff.

1.1.10 Pharmacy staff will follow NHS Highland or, for Argyll and Bute NHSGGC, Formulary and clinical guidelines.

1.1.11 Delivery of the service may be remote via remote access to GP clinical systems depending on the agreement of the practice, GP Sub Committee and LMC.

1.2 Management of Absence / Staff shortage

Current staffing levels will not allow for cover of the service during leave.

It is the intention to increase staffing levels to a level that would provide backfill for periods of absence.

1.3 Requirements of GP Practices

1.3.1 Practices will agree their priorities for the Pharmacotherapy Service with the pharmacy team, according to areas outlined in the Service Specification, including mutual involvement in regular practice meetings, GP mentoring, support, feedback and review of the service.

1.3.3 The pharmacotherapy service consists of core and additional services to be delivered by pharmacists, pharmacy technicians and assistants working as part of a primary care multidisciplinary team. Practices will need to continue to provide the required administrative functions. These include:

- processing routine repeat medication requests. Examples include selecting and printing prescriptions for medication authorised until next review, work flow of queries to relevant clinician, making changes to records under the direction of clinician and handling queries from patients and pharmacies about report prescriptions.
- managing recalls and appointments
- clinical read coding

1.3.4 Pharmacy staff will be as flexible as possible to work in the space available in each Practice. To facilitate delivery of the pharmacotherapy service, each Practice will be expected to provide pharmacy staff with access to suitable work space and access to practice clinical systems. On some occasions it may be suitable for delivery of the service to be remote via remote access to GP clinical systems to alleviate pressure on space, in agreement with the practice, GP Sub Committee and LMC.

1.3.5 Each Practice will be expected to provide appropriate clinical support to pharmacy staff on a day to day basis e.g. a duty doctor to discuss immediate and urgent clinical problems with. This is to ensure safe and effective working relationships, which maximise the benefit to the practice and patients.

1.3.6 Practices retain the responsibility to process IDLs and refer onto the pharmacy team those requiring medicines reconciliation. As it is unlikely there will be daily pharmacy support to each practice initially, practices will need to retain

responsibility to manage the IDLs timeously. Referral to the pharmacy team must be done appropriately to ensure patient safety is not compromised. It is an aim of the Scottish Patient Safety Programme that 95% of patients will have an accurate medication list within two working days of the IDL being received by a GP practice.

1.3.7 Pharmacy staff will continue to undertake traditional prescribing/pharmacy support tasks e.g. medication queries, review of prescribing in line with Formulary and other indicators, prescribing efficiencies, clinical input to meetings etc. Each Practice is expected to continue to engage with this work and to support delivery of agreed NHS Highland prescribing priorities.

1.4 Staff roles

The local Pharmacy Team will determine the appropriate skill mix and grade of staff best placed to deliver specific aspects of the pharmacotherapy service, depending upon staff recruitment. The following paragraphs describe the different grades of pharmacy staff.

Primary Care Clinical Pharmacist (PCCP)

The PCCP will be regarded as a medicines specialist in the practice and will work to provide a pharmacy service to both patients and the GP practice, coordinating the day-to-day work of pharmacotherapy assistants and pharmacy technicians. Pharmacists are trained to degree level and may have undergone further training to PgDip or MSc level. They have particular knowledge and skills in conducting medication reviews in people with multiple co-morbidities and/or polypharmacy. It must be acknowledge that during a PCCP's training some roles will need to be adapted for a lower level of competence and modified as training progresses. The service may include:

1. Delivery of direct clinical care to defined groups of patients, depending upon the pharmacist's level of clinical competence. Holistically manage patients with a number of co-morbidities. This may involve managing caseloads of patients on an ongoing basis, developing referral pathways and using Independent Prescribing when appropriate.

2. Management and authorisation of acute requests within defined scope of practice, for example:
   - for specific products e,g, DMARDs
   - review of use of 'specials' and 'off-licence' requests
   - for specific groups of patients (e.g. care home, care at home)
   - selection of acute requests from daybook in line with competency

   The number of acute prescription requests processed by the pharmacy staff may needed to be capped depending on time available and other services provided. This is to ensure the workload is manageable within resource available to the practice.

3. Annual medication review of patients on repeat items will include assessment appropriateness for serial prescribing, formulary compliance, cost effectiveness and reauthorising of repeats. Prioritisation of patients for reviews will be based on time allocated to the practice and will be based on risk e.g. high risk medicines, high risk patient groups, overdue or no previous medication review.

4. Medication review following receipt of serial prescription end of treatment summaries and reauthorising of serial prescriptions.

5. Medicines reconciliation by pharmacy team on receipt of hospital discharge letters and clinic letters. Medicines reconciliation carried out by non prescribing pharmacists will require a clinical check. Referral of items out with competency under non medical prescribing regulations will be required.

6. Conduct annual medication/polypharmacy reviews either face-to-face or by telephone consultation.

7. Prescribing for and managing patients with complex medication needs and/or long term conditions from a range of clinical areas, in order to maximise the benefit of medicines whilst minimising harm.

8. Advising GPs and nurses where complex pharmaceutical care issues arise and formulate and implement plans to resolve them.

9. Handling and, where appropriate, resolving general queries related to prescribing for individual patients.

10. Provide clinical oversight within the practice to ensure safe, efficient and effective medicines management systems and processes. This will include contributing to practice meetings, significant event reviews etc.

11. Take a lead role within the practice to promote and oversee the delivery of prescribing efficiencies through:
    - Prescribing data analysis and prescribing audit
    - Implementation of medicines management projects and prescribing efficiency programmes
    - Directly reviewing and making prescribing changes in accordance with medicines management projects and prescribing efficiency programmes
    - Promoting evidence based and cost-effective prescribing and medicines management

12. Provision of medicines related education to patients and carers.

13. Delivery of medicines related and clinical training to clinical and administrative staff.

Pharmacist Independent Prescribers (PIPs)

In addition to the clinical and direct patient-facing roles identified for the PCCP above, pharmacist independent prescribers will prescribe, monitor and adjust treatment as appropriate within their competency. Some new PIPs will likely need to develop their competence in clinical conditions gradually and progressively.

The role of PIPs should be focused on delivery of level 2 and 3 activities, particularly medication review and resolving high risk medicine problems, progressively working towards autonomously treating and managing more complex patients.

Some PIPs will also have clinical assessment and examination qualifications and experience in order to be able to:

1. Take on greater responsibility and autonomy for the on-going prescribing and management of patients with complex medication needs and/or long term conditions from a range of clinical areas.

2. Review acutely unwell patients recently started on new medicines, reviewing their clinical and medication needs in light of response to treatment and tests.

3. Undertake specialist clinics e.g. Chronic pain only referring patients to MDT when necessary.

4. See complex patients for annual medication/polypharmacy reviews, only referring patients to a GP when necessary.

Clinical Pharmacy Technician (CPT)

CPTs are registered with the General Pharmaceutical Council and are trained to SVQ level 3. Their clinical knowledge is above the level of a pharmacotherapy assistant but below that of a pharmacist. Pharmacy technicians cannot prescribe. They will work, as part of the pharmacy team, under the supervision of a pharmacist on a range of medicines management systems and processes within the practice, including:

1. Contributing to safe, efficient and effective medicines management systems and processes, including:
   - Medicines reconciliation, reviewing IDLs etc and discussing changes with patients to assess their understanding. Medicines reconciliation carried out by pharmacy technicians will require a clinical check
   - Systems for all repeat prescriptions, annual medication review and polypharmacy reviews
   - Maximising implementation of serial prescribing
   - Reviewing acute and repeat medication requests and resolving medication queries, referring to a pharmacist if necessary
   - Medicines requiring greater frequency of review
   - Medicines shortages
   - Housekeeping of repeat medication records
   - Non clinical medication review

2. Contributing to the delivery of prescribing efficiencies through:
   - Prescribing data analysis and prescribing audit
   - Implementation of medicines management projects and prescribing efficiency programmes
   - Promoting evidence based and cost-effective prescribing and medicines management e.g. formulary adherence

3. Undertake medication compliance reviews within patient's home.

4. Provision of medicines related education to patients and carers on topics appropriate to competence.

5. Delivery of medicines related training to clinical and administrative staff on topics appropriate to competence.

Pharmacotherapy Assistant: Non clinical staff with an understanding of repeat and acute prescribing processes who work under the direction and supervision of pharmacists and pharmacy technicians. With training may be able to perform certain functions relating to prescribing systems and processes such as screening IDLs, acute and repeat prescription requests etc., actioning medication requests within local protocols, medicines reconciliation within local protocols, a range of non clinical medication review tasks, processing serial and instalment prescribing. Pharmacotherapy assistants can undertake a range of tasks that free up pharmacy technician and pharmacist time e.g. run searches of practice systems, audit data collection e.g. patients on DMARDs, support review of prescribing systems and processes, train practice administrative staff, run prescribing data reports. They can also support review of effective and efficient systems and processes, including training other staff.

1.5 Annual Service Evaluation

1.5.1 A work plan will be agreed in line with the specification and reviewed with the practice in line with agreed timescales. This will include updating of the work plan and suggested amendments to the delivery of the pharmacy service.

1.5.2 The time allocation and service provided to each practice will be agreed annually or sooner if staff levels change.

1.5.3 The service will be evaluated and reviewed annually to demonstrate outcomes. To ensure efficiency, it is the intention that an evaluation data set will be agreed nationally and that evaluation of the service will be centralised and automated as far as possible.

Section 2: The Pharmacotherapy Service Specification

Outline of service	Pharmacists and pharmacy staff will have a key role in supporting safe prescribing processes including authorising repeats and acutes, serial prescriptions and discharge letters. Practices will have an allocation of pharmacy team time during which the service will be provided. There will be a written agreement with individual practices defining the components of service specification to be delivered and the roles of the pharmacy team. In addition the support required from the practice for the pharmacy services and development of pharmacists in new roles will be defined. Standard operating procedures and guidance will be in place for each aspect of the service. Delivery of the service may be remote via remote access to GP clinical systems depending on the geographical location of the practice depending on the agreement of the practice, GP Sub Committee and LMC. The level of pharmacotherapy service will be dependent on the experience of pharmacy staff (e.g. prescriber vs. non prescriber) and, as there is a three year trajectory to establish a sustainable pharmacotherapy service, the allocation of pharmacy staff resource will increase over time.	
	Service	**Specification**
Level One & Level Two	Acute prescribing requests and repeat prescribing management including- • medicines reconciliation receipt of hospital Immediate Discharge Letters. • hospital outpatient requests • non medicine requests • serial prescribing • monitoring of high risk medicines • high risk medicines problems • medication review • medicine safety reviews/recalls, medicine shortages • pharmaceutical queries and review of use of 'specials' and 'off-licence' requests	**Review of systems – a review of systems will be required before introduction of service delivery within a practice and may be selected for improving efficiency and workload within the practice where allocation does not support full service delivery.** Review of practice prescribing processes to standardise repeat prescribing policy and support introduction of pharmacy input. This will include: • Review of prescription processes to introduce standard work. Ensure reauthorisation is part of medication review process. • Non clinical medication review by pharmacy staff or practice admin staff following training. Housekeeping of records supports implementation of serial prescribing as well as improving quality and safety of records. • Increasing serial prescribing and withdrawal from managed repeats • Increase and standardise use of drug defaults and minimum prescription intervals. • Review of acute requests to detect items that could be added to repeats to reduce the acute prescribing workload. • Training for practice admin staff to review appropriateness of acute and repeat requests e.g. if requested within reasonable timeframe. Queries could be forwarded to pharmacy staff for consideration.

		Introduce standard template for prescription requests from e.g. community nurses, specialist nurses, smoking cessation advisors for e.g. wound management products and appliances. The templates will have appropriate information e.g. product code/pack size to reduce workload associated with these requests. Review and amend processes for high risk medicines within practice using standard review template, dependant on standard monitoring guidance. **Service Delivery – The delivery of the service is dependent on the time allocated to the practice and the level of competency of pharmacy staff** (non prescribing pharmacists and items out with competency under non medical prescribing regulations). Pharmacist independent prescribers will prescribe, monitor and adjust treatment as appropriate within their competency. Management and authorisation of acute requests within defined scope for example – • for specific products e,g, DMARDs • review of use of 'specials' and 'off-licence' requests • total number of prescription requests per session • specific group of patients (e.g. care home, care at home) • selection of acute requests from daybook in line with competency Annual medication review of patients on repeat items will include assessment of formulary compliance and cost effectiveness and reauthorising of repeats. Prioritisation of patients for reviews will be based on time allocated to the practice and be based on risk e.g. high risk medicines, overdue or no previous review. Medication review following receipt of serial prescription end of treatment summaries and reauthorising of serial prescriptions Medicines reconciliation by pharmacy team on receipt of hospital discharge letters and clinic letters. Medicines reconciliation carried out by non prescribing pharmacists and pharmacy technicians will require a clinical check. Referral of items out with competency under non

		medical prescribing regulations will be required. Assistance with medicine safety reviews/recalls, medicine shortages and undertaking pharmaceutical queries are already part of pharmacy team role and will continue.
Level three (additional specialist)	Polypharmacy reviews: pharmacy contribution to complex care.	Provision of pharmaceutical care as part of a multidisciplinary team to 10% of practice population e.g. frail patients, care home, care at home, patients on anticipatory care register, frequent hospital admission or high health gain patients. Specialist pharmacist independent prescribers will prescribe, monitor and adjust treatment as appropriate.
	Specialists clinics (e.g. chronic pain, heart failure)	Specialist clinical pharmacist role will prescribe, monitor and adjust treatment as appropriate. Development will be dependent on need and competency.

Section 3: Core Prescribing Support Activities– prescribing support/polypharmacy clinics/care home (level 3)

There are key prescribing support activities that pharmacy teams have supported GP practices with for many years that will need to continue. These include:

Role	Activities
Communication	Prescribing Support Meetings to discuss and agree work plans, prescribing data and reports, and current prescribing priorities
	Cluster meetings to discuss relevant prescribing/medicines related workstreams
	Providing updates to practices on progress with work plans, prescribing data reports (clinical and financial) and outcomes/achievements etc
Medicines Safety and Governance	Provide advice on local prescribing status of medicines e.g. formulary status
	Advice on implementing changes to prescribing e.g. Formulary updates, Prescribing bulletins e.g. Pink One articles
	Advice on actioning MHRA safety updates
	Contribute to Significant Event Reviews and complaints related to prescribing and medicines
	Antimicrobial stewardship
	Advice regarding controlled drugs governance
Teaching and Training	Teaching of other pharmacists and pharmacy technicians in training and foundation posts
	Support to education of GPs and other clinicians in the practice on prescribing/medicines related topics
	Mentoring of others (nurses, pharmacists and AHPs) undertaking Independent Prescriber Training
	Support and train practice staff to undertake non clinical medication reviews (NCMRs) as part of the repeat prescribing system
	Job shadowing for medical students in GP training practices
Facilitating Prescribing Improvement	Facilitating and/or undertaking prescribing audits and quality prescribing projects
	Supporting national clinical strategies
	Provide data and guidance on National Therapeutic Indicators
	Monitor and report practice prescribing budget trends
	Medication queries
	Advice on medication shortages
	Prescribing efficiencies work: • Formulary adherence • Medicines waste • NCMR and prescribing housekeeping

	• Specific prescribing efficiency projects • Generic prescribing
	Simple PRISMS queries to provide practice with prescribing data
Clinical Pharmacy Input	Pharmacist prescriber clinics
	Polypharmacy medication review e.g. care home residents and high health gain patients

Section 4: Template Work Plan

Practice name: **Date:** **Version:**

Area/Topic	Aim/Expected Outcome or Benefit	Specific Actions	Timescale/Date of Review	Comments/Update

Section 5: Agreed services and allocation

This section to include details of:

Time allocation to practice

Named pharmacist and contact details

Services agreed and priority for each aspect - workplan

Signature for GP practice

Signature for NHS Highland

Date

NORTH HIGHLAND PRIMARY CARE IMPROVEMENT PLAN - UPDATE

WORKSTREAM: MSK Physiotherapy

RAG STATUS - GREEN

DATE: 4th March 2019

Current Plan

Business case for clinical staffing model 1wte:13,000 practice population and details of resource required in each district approved for implementation :

To develop and agree implementation plan across all primary care and annual leave cover, recognising the issues within remote and rural services.
Recruit to remaining Band 7 FCP posts across Highland and existing post uplifts to be confirmed once negotiations with primary care and physiotherapy are completed.
Engagement plan for practices to be developed in each operational unit

E-Health aspects of business case:

Work with pharmacotherapy workstream and eHealth to further understand the eHealth requirements to deliver the new service models in primary care

Progress

2wte Clinical lead posts recruited for S&M and N&W respectively, commencing late March. Clinical Leads will develop the implementation plan, lead recruitment and manage the services.
Model for annual leave cover in development
Recruitment plans for remaining clinical posts in development and HR sub- group being set up to support implementation with representatives from staff-side, HR, professional leads (ToR to be developed).

Engagement plans for practices in development. Timescales for recruitment to remaining FCP posts to be agreed
Proforma issued to identify practice system access requirements to be completed as model for each practice developed

Risks

Destabilisation of mainstream MSK service through movement of internal staff to promoted FCP posts
Inability to recruit to remote and rural posts leading to inconsistency of model implementation
Inability to adequately cover planned leave across the Highland geography

Decision required from the Project Team / Board:

NORTH HIGHLAND PRIMARY CARE IMPROVEMENT PLAN - UPDATE

WORKSTREAM: Community Treatment and Care

RAG STATUS - AMBER

DATE: 06/03/19 Dr Stewart MacPherson

Current Plan

Most recent meeting held 08/01/19

- Terms of reference adjusted.
- Membership of group expanded to include practice manager and nurse.
- ITR and CT&C divided into 2 clear work streams with 2 terms of reference ; CT&C (reporting to Modernisation Team), ITR (reporting to Clinical Interface).

Progress

March meeting postponed until April as questionnaire analysis would not be available

Questionnaire

- combined questionnaire (with urgent care workstream) distributed to primary care 5.3.19 with closure date 20.3.19. Results will be analysed and will be presented to the next CT&C meeting 2.4.19.
- data analysis and mapping undertaken by public health almost complete and will be presented at meeting 2.4.19 to inform planning of service

ITR

Will now report to Clinical Interface

Timescales

Next meeting 2nd April 2019

Risks

Time slippage but steady progress so far

Decision required from the Project team:

None required

NORTH HIGHLAND PRIMARY CARE IMPROVEMENT PLAN - UPDATE

WORKSTREAM: Vaccination transformation programme

RAG STATUS - Amber

DATE: 03/03/19

Current Plan:

- **A) Divisional units to develop service models**
- **B) Develop test of change for childhood imms (0-5years)**
- **C) Transfer pregnant women vaccinations to Midwifery**
- **D) Identify E-health requirements**
- **E) Identify funding requirements**

Progress:

- **A&B) Colleagues in North and West Divisional Unit: Process mapping day organised for 07th March 2019 with key players in attendance to highlight the complexities of immunisation programmes and develop local solutions for a delivery model of childhood (0-5yrs) immunisations in the Lochaber area.**
  South and Mid Divisional Unit: Discussion regarding the way forward in delivering immunisations within S&M division has been held with Lead Nurse. Concerns have been raised by the Lead Nurse around governance structures. Request made that the delivery of an Immunisation service is viewed as a cradle to grave service and not as separate children's and adult services.
  No decision as yet regarding the possible transfer of the Highland Council immunisation team.
  The Lead Nurse agreed that we could continue with the development of a case for a test for change in delivery of childhood (0-5yrs) in the Ross-shire area is currently being undertaken. Key stakeholders to be approached by end of March to discuss options.

Work is being undertaken currently to identify the infrastructure required for these tests of change, this will include Child health department staff, IT support, accommodation, staffing establishment required.

- **C) Midwifery services: Two areas (Lochaber and Skye) identified as tests of change. Education has been delivered. The teams will undertake further requirements to meet the standards required for utilisation of PGDs. Fridges have been ordered. Midwifery services currently working to address issues specific to Inverness and the Badenoch and Strathspey areas. Badenoch and Strathspey midwifery team have undertaken to provide flu immunisations as a mop up following completion of GP managed flu clinics. Meeting planned with the Lead midwife for the South and mid-division 06th March 2019 to develop work plan to move forward.**
- **D) E-health requirements for moving forward on VTP encompassing all aspects of the programme are currently being discussed at a national level. National CHI and Child Health system workstream is in the process of being re-established and close links being developed at a national level regarding VTP. Whilst national processes are being undertaken local interim solutions will require development. Arrangements for IT attendance at Lochaber process mapping day confirmed.**
- **E) Funding requirements will be included in business cases. All operational divisions have been requested to provide envisaged workforce numbers and costings to the VTP working group by 31st March 2019**

Timescales:

- **A&B) Lochaber process mapping event to be held on 07th March Stakeholders for Ross-shire area to be spoken with by end March**
- **C) End July 2019 for tests of change, with aim to have full completion by end September 2019 across NHS Highland, though this will be dependent on solutions identified for the Inverness team.**

- **D) For Lochaber test of change commencement end of May 2019. For Ross-shire test of change commencement end of June 2019. For overall VTP will be dependent on national progress in relation to IT infrastructure.**

Risks: there continues to be the risk of NHS Highland falling behind other boards in this work stream.

The lengthy recruitment process of staff required to undertake the tests of change has the potential to delay test of change. It is appreciated that this is not exclusive to VTP.

If tests of change are not undertaken early in the forthcoming year, with time to address lessons learned for other areas there is potential that NHS Highland will be unable to consolidate the 0-5yrs programme across North Highland and then focus on other aspects such as the adult immunisations in year 20/21.

Decision required from the Project Team / Board:

Nil at present

NORTH HIGHLAND PRIMARY CARE IMPROVEMENT PLAN - UPDATE

WORKSTREAM: Community Link Workers

RAG STATUS - AMBER

DATE: 11 March 2019

Current Plan

Develop Community Link Worker roles in Primary Care

Progress

The working group met on 18 February 2019. The outputs of the meeting were:

- a review of the fundamental elements that would inform decisions about the model was undertaken in relation to:
  - Employment options
  - Formula for allocation of resource

The group undertook an options appraisal exercise in relation to employement options and a formula for allocation of resource. Four options were appraised in relation to employment:

- Employed by NHS Highland
- Employed by a single third sector organisation
- Employed by multiple third sector organisations
- Commissioned service

The group debated the options and concluded that:

- If the CLW's were to be employed by the third sector, the service should be commissioned whether or not they were employed by one or multiple organisations.
- A co-ordination role would be necessary to support Community Link Workers across Highland.
- There needs to be sufficient local community/third sector activity for Community Link Workers to support people into.
- Consideration would need to be given to balancing multiple part time posts covering small geographical areas with fewer full time posts covering larger geographical areas, particularly given the issues with recruitment to part time posts.
- Further work was required to develop weighted criteria to assess options more fully
- Recognising that the programme aims to tackle health inequalities and that the group favoured recommending proprtionate universalism as akey principle of the Community Link

Worker service, the group were keen to see what distribution of resource would look like if practice list size was weighted for deprivation.

- The model needs to be based on full cost recovery.
- The group could not make a decision on what to recommend in relation to employment options or resource distribution until further work was undertaken. This work is outlined below in 'next steps'.

The group undertook a stakeholder mapping and analysis exercise and agreed that a seperate communications plan was not required but any communication work should be undertaken under the guidance of the overall PCIP project communication plan. It was agreed that it would be helpful to get information about community link workers out to GP's and options for this were to be explored.

Next steps:

- Work is underway to develop an asessment tool with weighted criteria to allow the group to judge the best option in relation to employment for the Community Link Worker service
- Public Health, Health Intelligence team have agreed to provide information on weighting practice list size for deprivation
- Work on calculating a full cost recovery model will be undertaken
- Development of a CLW bulletin/newsletter with information about the role of the Community Link Worker is underway
- Explore use of video clips outlining the benfits of Community Link Workers to GP's and patients

Membership of the working group is:

- Cathy Steer, Public Health (Chair)
- Miles Mack, GP Sub Committeee/LMC
- Alan Miles, GP Sub Committee/LMC
- Lynne Clark, e-health
- Evan Beswick, Primary Care Manager
- Fiona Mackenzie, Primary Care Manager
- Sandra MacAllister, Public Health
- Joe Reilly, Practice Manager
- Mhairi Wylie, Highland Third Sector Interface
- Michael Pererra, Mental Health services
- Kenny Rodgers, Primary Care Modernisation Project Manager
- District Medical Lead (to be confirmed)

Timescales

- Stakeholder event (Nov 2018)

- Set up Community Link Worker working group (Nov 2018)
- Project plan (Jan 2019)
- Communication and engagement plan (Jan 2019)
- Agree approach and model of service delivery (Mar 2019)
- Develop job descriptions, practice agreements, data sharing agreements, monitoring and reporting requirements, evaluation framework (Mar 2019)

Risks

- Engagement of primary care in new ways of working/adopting a community link worker approach
- Delays caused by issues in relation to data sharing
- Lack of community/third sector provision for onward referral/support
- Adequate funding available for this work stream

Decision required from the Project Team / Board:

None

Author: Cathy Steer, Head of Health Improvement, Public Health

NORTH HIGHLAND PRIMARY CARE IMPROVEMENT PLAN - UPDATE

WORKSTREAM: Urgent Care

RAG STATUS - AMBER

DATE: 27/02/19 Dr Antonia Reed

Current Plan

Second meeting held 31/01/19. Well attended with input from SAS, nursing, general practice in both operational units and GP Sub.
Terms of reference adjusted and agreed to be clear refers to general practice

Progress

Questionnaire

Questions to go in questionnaire to practices discussed and agreed in outline. Combined questionnaire with CCR workstream went out 25/2/18 with results hopefully available for next meeting on 3rd April.

1. Looking at whether practices interested in urgent care support,
2. If not why not
3. If yes, what sort of urgent care would they want support with, home visits, appointments or telephone triage.
4. Any other comments
5. Plus optional question about average number of urgent visits per day.

The GMS contract refers more to home visits but MOU appears to give more flexibility in provision of model or system and types of advanced practitioners

Shared learning from practices using ANPs

That ANPs and paramedics should be part of primary care team and known to teams.

Where teams of ANPs are used, such as in larger urban areas, that those teams are aligned to practices and not geographical.

Vision (or EMIS for those practices) is the preferred electronic system for note recording as it is immediate available to the rest of the primary care team. Although there are technical issues to resolve.

That we should try to make staff as flexible as possible rather than restricting to just home visits or just appointments.

Practices will need some support and guidance where they have not used Advanced Practitioners before to avoid a mismatch of expectations e.g. different comfort and autonomy levels, receptionist training, not using ANPs just for telephone triage (leads to burnout), patient information

Practices may need some help in supporting newly appointed practitioners.

Differences in approach from practices to recruitment, some had open advert and some head hunted individuals.

Clarity on responsibility for job descriptions and training programme support

Resource

Discussion around how resource available is divided to meet needs of practice. Also whether resource in each workstream is limited to each workstream.
Is there any possibility that practices or groups of practices (possibly clusters as mentioned in MOU but not exclusively) could pool resource for what they see as their need? How do we start having this discussion across workstreams?

EB and AR are to produced this information using current Band 7 AfC costing to give outline of number of hours ANP time each practice could expect to get. Clear from this that for small and very small practices the amount of time is negligible.

What is our mechanism for engaging with practices about priorities?

Timescales

Next meeting 3rd April 2019 Meeting Room Laxford House time tbc.

Risks

Time slippage but steady progress so far

Decision required from the Project team:

How do we start having the discussion across workstreams about resource e.g. if practice feels well supported with ANPs can they direct their share of the ANP resource to a different workstream.

How does project team feel about different models in different areas.

What does Team think about approaching practices?

NHS Highland - North Highland HSCP

Primary Care Improvement Fund - Funding Programme

Indicative Funding Profile:	**2017/18 (£000)**	**2018/19 (£000)**	**2019/20 (£000)**	**2020/21 (£000)**	**2021/22 (£000)**	**Total (£000)**
NHS Scotland	7,800	37,950	9,250	55,000	45,000	**147,200**
NHS Highland	494	2,453	596	3,543	2,899	**9,492**
North Highland HSCP (See note 2)	**352**	**1,223**	**949**	**2,524**	**2,065**	**7,113**
Non-recurrent funding	124					
Total funding available	**476**	**1,575**	**2,524**	**5,048**	**7,113**	
Indicative Commitments:	**2017/18 (£000)**	**2018/19 (£000)**	**2019/20 (£000)**	**2020/21 (£000)**	**2021/22 (£000)**	**Total (£000)**
Vaccination Transfer Programme				992		**992**
Pharmacotherapy	475	737		835	1,039	**3,086**
Community Treatment & Care				494	250	**744**
Urgent Care					744	**744**
Additional Professional Roles:						
Musculoskeletal Service		497				**497**
Mental Health Service		416	80			**496**
Community Link Workers			336	160		**496**
E-Health		15	45		See note 1	**60**
Total Indicative Commitments	**475**	**1,665**	**461**	**2,480**	**2,032**	**7,113**
Cumulative commitments	**475**	**2,140**	**2,600**	**5,081**	**7,113**	

Notes:

1. Marker for £151k for E-Health to support MSK workstream, notionally as an offset against Urgent Care workstream in year 4.

2. Only 70% of funding for 2018/19 received with the additional 30% available recurrently from 2019/20.

Vaccination Transfer Programme	2017/18 (£000)	2018/19 (£000)	2019/20 (£000)	2020/21 (£000)	2021/22 (£000)	Total (£000)
Indicative recurrent funding profile				1,000		**1,000**
Top-slice for E-Health				-8		**-8**
Total funding available				992	992	**1,983**
Already Committed						
						0
Approved						
						0
Planned						
Indicative committment				992	992	**1,983**
Balance of Available Funding	**0**	**0**	**0**	**0**	**0**	**0**

Pharmacotherapy	2017/18 (£000)	2018/19 (£000)	2019/20 (£000)	2020/21 (£000)	2021/22 (£000)	Total (£000)
Indicative recurrent funding profile	352	887		835	1,039	**3,112**
Top-slice for E-Health		-26				**-26**
Non-recurrent funding	124					**124**
Total funding available	476	1,212	1,212	2,047	3,086	**8,033**
Already Committed						
Additional pharmacists from previous years	428	428	428	428	428	**2,141**
Pharmacy First	47	47	47	47	47	**234**
Additional pharmacists (Year 1)[1]		96	335	335	335	**1,102**
Approved						
Additional pharmacists (Year 1)[1]		640	402	402	402	**1,845**
Planned						
Additional pharmacists (Years 3 & 4)				835	1,874	**2,709**
Balance of Available Funding	**0**	**0**	**0**	**0**	**0**	**2**

[1] Approved at Project Board 22/08/18

Community Treatment & Care	2017/18 (£000)	2018/19 (£000)	2019/20 (£000)	2020/21 (£000)	2021/22 (£000)	Total (£000)
Indicative recurrent funding profile				500	250	**750**
Top-slice for E-Health				-6		**-6**
Total funding available				494	744	**1,237**
Already Committed						
						0
Approved						
						0
Planned						
Indicative committment				494	744	**1,237**
Balance of Available Funding	**0**	**0**	**0**	**0**	**0**	**0**

Urgent Care	2017/18 (£000)	2018/19 (£000)	2019/20 (£000)	2020/21 (£000)	2021/22 (£000)	Total (£000)
Indicative recurrent funding profile					750	**750**
Top-slice for E-Health					-6	**-6**
Total funding available					744	**744**
Already Committed						
						0
Approved						
						0
Planned						
Indicative committment					744	**744**
Balance of Available Funding	**0**	**0**	**0**	**0**	**0**	**0**

Additional Professional Roles: Musculoskeletal Service	2017/18 (£000)	2018/19 (£000)	2019/20 (£000)	2020/21 (£000)	2021/22 (£000)	Total (£000)
Indicative recurrent funding profile		501				**501**
Top-slice for E-Health		-4				**-4**
Total funding available		497	497	497	497	**1,987**
Already Committed						
MSK physiotherapists (Band 8A posts)[2]		3	110	110	110	**335**
Approved						
Additional MSK physiotherapists[2]		494	386	386	386	**1,653**
Planned						
						0
Balance of Available Funding	**0**	**0**	**0**	**0**	**0**	**0**

[2] Approved at Project Board 02/11/18

Additional Professional Roles: Mental Health Service	2017/18 (£000)	2018/19 (£000)	2019/20 (£000)	2020/21 (£000)	2021/22 (£000)	Total (£000)
Indicative recurrent funding profile		420	80			**500**
Top-slice for E-Health		-4				**-4**
Total funding available		416	496	496	496	**1,903**
Already Committed						
						0
Approved						
						0
Planned						
Indicative committment		416	496	496	496	**1,903**
Balance of Available Funding	**0**	**0**	**0**	**0**	**0**	**0**

Community Link Workers	2017/18 (£000)	2018/19 (£000)	2019/20 (£000)	2020/21 (£000)	2021/22 (£000)	Total (£000)
Indicative recurrent funding profile			340	160	0	**500**
Top-slice for E-Health			-4			**-4**
Total funding available			336	496	496	**1,327**
Already Committed						
						0
Approved						
						0
Planned						
Indicative committment			336	496	496	**1,327**
Balance of Available Funding	**0**	**0**	**0**	**0**	**0**	**0**

E-Health	2017/18 (£000)	2018/19 (£000)	2019/20 (£000)	2020/21 (£000)	2021/22 (£000)	Total (£000)
Indicative recurrent funding profile		0	0	0	0	**0**
Top-slice for E-Health		60				**60**
Total funding available		60	60	60	60	**240**
Already Committed						
						0
Approved						
Additional Mentor covering all 6 workstreams[3]		15	60	60	60	**195**
Planned						
Support for MSK workstream[4]					151	**151**
Balance of Available Funding	**0**	**45**	**0**	**0**	**-151**	**-106**

[3] Approved at Project Board 02/11/18

[4] Subject to formal approval and budget allocation by the Project Board.

Management	2017/18 (£000)	2018/19 (£000)	2019/20 (£000)	2020/21 (£000)	2021/22 (£000)	Total (£000)
Indicative recurrent funding profile		0	0	0	0	**0**
Top-slice for E-Health						**0**
Total funding available		0	0	0	0	**0**
Already Committed						
Backfill including Project Manager[5]		40				**40**
Approved						
						0
Planned						
						0
Balance of Available Funding	**0**	**-40**	**0**	**0**	**0**	**-40**

[5] Approved at Project Board 02/11/18, to be funded from non-recurrent slippage.

GP Sub Committee Funding	**2018/19 £**
Primary Medical Services allocation	35,000
Primary Care Fund: GP Sub Committees for GP Contract	32,059
Total funding for NHS Highland	67,059
Share for North Highland HSCP	**47,766**
Already Committed	
Claims relating to Primary Care Modernisation (up to December)	12,111
Balance of Available Funding	**35,655**

EHEALTH : Primary Care Modernisation

Reporting Period: To February 2019		**Report**
	Author - Alister McNicoll Deputy Head of eHealth	
Risk & Issues		
Technical Capabilities	eHealth working on proposals by each of the work streams. At the moment Urgent Care is not requiring anything and we await first work shop of Vaccination work stream.	
Funding	Funding is required for eHealth solutions to all work streams of the primary care modernisation.	
Activities this Reporting Period		
Work Stream 1 Transforming Vaccination Programme	No current involvement in this work stream. eHealth attending Fort William workshop on 7th March 2019.	
Work Stream 2 Pharmacotherapy	eHealth has worked closely within this work stream and requirements have been specified and progressed. Additional facilitator resource has been identified and being recruited. The remote desktop solution will be required for pharmacy users and the solution and costs are being collated.	
Work Stream 3 Community Treatment & Care	The paragraph below still stands. Stewart MacPherson has been in contact and we will need to discuss options for what they want to do. This will be based on the work developing the Investigation Treatment Rooms (ITR) which eHealth were heavily involved with to develop the electronic processes from referral from secondary care and the response when patients are discharged from the ITR. eHealth will look the appropriate solutions once the processes of how these will operate have been mapped out. There will be a number of possible solutions but the use of SCI gateway for referring from GP and use of formstream for the discharge would seem to be the best way forward. We need to consider how we best record the activity carried out at these treatment sessions.	
Work Stream 4 Urgent Care	No current ehealth involvement in this work stream. Have spoken to Dr Antonia Reed and will contact us when they have further developed their requirements.	
Work Stream 5 Additional Professional Roles	1st Contact Practitioner has developed well and ehealth has contributed to this in terms of full costing for system changes, resources, devices and reporting processes which have been included within the business case. The screen developments for the 1st Contact Practitioner was not approved however it can be confirmed that this development is for physio only. These costs will require to be funding if the Physio's require to work as prescribed in the work stream.	

Work Stream 6 Community Link Workers	eHealth attended work shop on 28th January. Options of processes to be used by Link Workers explored and these will be considered by the eHealth technical teams and provide options required by the service.	
General: eHealth initiatives that encompass more than one work stream.	Data repository has been ordered. Work is progressing to plan the work with the supplier. There is a risk that some hardware costs are required. Reporting processes still to be designed and developed. Additional mentoring staff recruitment is being processed. Through vacancy and closing date for applicants is 1 March 2019. Work is progressing on a remote desktop solution which enables users to work remotely from practices. The costs for these are being collated.	
Resources		
eHealth Trainers / Facilitators	To be reviewed but would include service staff	
Suppliers	Vision and EMIS – GP system suppliers Albasoft – Additional GP application system suppliers	
Reporting	Albasoft – Data warehouse	
Other	To be reviewed	

Alister McNicoll
Deputy Head of eHealth