Edinburgh Integration Joint Board

REPORT

Edinburgh Primary Care Improvement Plan Update

Edinburgh Integration Joint Board

26 October 2021

Executive Summary	The purpose of this report is to inform the Edinburgh Integration Joint Board (EIJB) on the progress of the Primary Care Improvement Plan (PCIP) as at 31 March 2021, before submission to the Scottish Government.

Recommendations	It is recommended that the Edinburgh Integration Joint Board: 1. Endorses the attached report which was consulted on across the City as a fair reflection of the current status of PCIP implementation, before being finalised through the Edinburgh Primary Care Leadership and Resources Group in August 2021. 2. Note that the progress was previously reported to Lothian GP Sub / Lothian Medical Committee and the City progress supported. 3. Approves the Report and SG template to be reported to SG

Report Circulation

1. The PCIP has reported to the following committees/groups:

   a) NHS Lothian Local Medical Committee/GP Sub Committee
   b) NHS Lothian New Contract Oversight Group

Background

2. A paper was previously brought to the EIJB in June 2017, requesting support for primary care resources made available by NHS Lothian, to be used to address what was increasingly regarded as a crisis across (GMS) primary care in Edinburgh.

3. The EIJB then supported the implementation of the Edinburgh Primary Care Transformation (and Stability) Programme. In January 2018, GPs across Scotland voted to accept Phase 1 of the new (GMS) contract proposals, complementing the work already begun in Edinburgh.

4. In February 2018, Scottish Government issued the 'Memorandum of Understanding' (MOU) on the new contract implementation process and asked that each HSCP produce a PCIP which set out how the new resources would be implemented. £12.9M would become available for investment directly into Edinburgh GMS related provision over 4 years.

5. The PCIP was widely discussed in Edinburgh, and as required by the MOU, was supported through both the tripartite NHS Lothian Oversight Group and the Lothian GP Sub Committee and LMC.

6. The EIJB considered the PCIP in June 2018 and gave enthusiastic support to the proposals and recommendations presented.

7. EIJB established the Edinburgh Primary Care Leadership and Resources Group (L&R) in August 2018, to lead the Primary Care Transformation Programme.

8. The sequencing of PCIP resources has materially affected the implementation process:

2018/19	£4.5M (with considerable portion already in place)
2019/20	£5.1M – restricted recruitment
2020/21	£9.1M – recruitment unrestricted with underspend generated
2021/22	£12.9M – recruitment unrestricted until budget limits reached currently pharmacotherapy only.

9. To end March 2021, the attached 'Primary Care Transformation Report' details 170wte additional staff employed, with a further 20wte employed to the end of September 2021.

Main Report

10. During the period August 2018 to April 2021 all parts of the MOU have been helpful in support of Edinburgh Practices. There remains a high degree of variability in the impact on workload.

11. An important outcome of the 2018 consultation and subsequent implementation in Edinburgh, was the strong preference for practices to have as much of the available resources (workforce) embedded within practice teams, in preference to being organized on behalf of groups of Practices.

12. In addition, the resources available to '17J' City practices were enhanced by both the re-investment of 17C funding (c£1M) and excluding (largely) our 8 x 2C practices from PCIP funds. (Instead, they were given an equivalent proportion of T&S funds).

13. Almost three years in, we know and understand much more about what works most effectively. Going forward, we will ensure that the new workforce is supported to work in a way which carefully balances impact on workload and sustainable staffing.

14. In July 2021 MOU(2) arrived and emphasized the importance of three areas in particular; pharmacotherapy, vaccination transfer and CTACS (Community Treatment And Care Services).

15. MOU(2) also raised the possibility of 'compensatory payments' to practices which had not had the benefit of these services in particular. Scotgov have indicated that further national guidance on this is likely to be forthcoming. In the meantime, Leadership & Resources have agreed a possible City position, should this be left to local determination.

16. In addition, we were able to use the 'T&S' funds to invest c£500K in 'clinical admin' principally to relieve medical staff of the burden of an appropriate portion of routine 'Docman' (clinical administration).

17. We have benefitted greatly from the early investment in an 'Evaluation and Insight Manager' post, which helps all MOU areas systematically assess what impact they are making on workload.

18. The original definition of 600 'missing' medical sessions (a quantifiable workload 'currency') remains controversial but has provided one way to describe where we are with the implementation process.

19. In simple terms, the attached report describes that around 500/600 sessions of extra capacity have been created but acknowledges the important difference between the resource being in place and being effectively deployed and trained to reach the potential contribution.

20. Evaluation of the individual workstreams has demonstrated direct impact on GMS workload, improved access to expert clinical advice and some reduction of referrals to secondary services.

21. From the EIJB perspective overall implementation progress can justifiably be described as 'steady'. At the individual practice level, this description might be quite unrecognizable.

22. The experience and perspective of individual practices is markedly different. A practice with well embedded and experienced additional staff

will see a more substantial and consistent contribution to workload, compared to a practice where staff are new to primary care and may require additional qualifications and training. In the latter, the practice perspective of the PCIP contribution may be marginal.

23. The question of COVID impact on the PCIP implementation process is frequently asked. Each of the new areas of Primary Care capacity has an interesting perspective, but the highlights are;

24. Recruitment was not paused, and new members of staff continued to take up vacancies overall

25. The Community Link Worker service adapted its service hugely to the new circumstances, with much more working with local organisations and known clients rather than new referrals.

26. Mental health nursing, where available, offers improved access, but the Primary Care perspective is that secondary and related mental health services offer little additional capacity or flexibility. The number of requests for help from Primary Care by distressed people is reported to have increased markedly – and continues to do so.

27. Our early success in attracting c15wte Primary Care Mental Health Nurses was able to be sustained, but has not grown to the 35.wte we (and practices) wanted

28. We have set aside some underspend to be used to fill this requirement and are working to try to secure additional capacity to meet this additional demand

29. A huge proportion of the PCST capacity has been absorbed in delivering the flu/covid vaccination programme, and this will continue until the end of this calendar year.

30. The 2020 flu programme was reported through our Clinical Governance Committee and widely praised for its effective and innovative delivery, alongside recognition of the steep learning curve involved.

31. During the early few months to June 2020, the demand for primary care appointments was suppressed by an estimated 5%. Thereafter, demand quickly re-established and - we hear from practices - surpassed previous levels and is currently unsustainable.

32. GPs in particular find themselves more available than ever, working in a way which forces even greater risk management and simultaneously finding, for the first time in their careers, an outspoken proportion of patients unsupportive or even hostile. This has been widespread and intensely de-

moralising for staff.

33. This has been particularly exhausting for everyone since the attached report was compiled in May

34. Looking forward, we are very conscious of the gulf between what capacity we originally estimated was required to rebalance the workload/capacity equation in Primary Care, and what is still required. The underlying direction and progress is positive, despite the frustrations. The persistent concern is whether, after the turbulence of the implementation period, sufficient resources are there to ensure Primary Care is able to remain the solid preventive and locally responsive foundation of health and social care delivery.

35. We need to be cautious about describing 'transformation' rather than relatively modest expansion of capacity at a critical time. Nevertheless, there are now a wide variety of examples where the PCIP staff have become much more than 'bolt-on' parts to the existing teams, but have offered insight, expertise and improvement to patient experience, beyond additional capacity. Transformation requires not only fully trained, experienced, confident staff able to work in the fast-paced Primary Care setting, but also practice staff who actively incorporate them into their team in a supportive environment. The next period will therefore increasingly convert from our previous focus on growing and deploying the workforce, to the optimal deployment of the PCIP workforce

36. We continue to advocate for an assessment of the additional investment required, despite our acute awareness of the wider challenges to public services.

Implications for Edinburgh Integration Joint Board

Financial

37. All investment funds currently available are now in place.

38. There is continuing uncertainty about the status of 17C funds which are embedded in Edinburgh Practices

39. There is a continuing requirement to carry over underspent funds into 2022/23 and into 2023/24.

40. The situation with the expansion of the adult flu programme and the COVID programme requires clarification, to ensure that PCIP resources are not eroded by the expansion of the original target group.

41. Conversely, if additional permanent recurring resources are available for

vaccination, this could be harnessed to boost the delivery of our CTACS programme.

Legal / risk implications

42. None identified

Equality and integrated impact assessment

43. CTACS were subject to an EQA but not the overall programme. This will be undertaken in 2022.

Environment and sustainability impacts

44. None identified

Quality of care

45. As per individual MOU investment area evaluations

Consultation

46. The attached report was consulted on across Primary Care (GMS) in Edinburgh during May & June 2021.

Report Author

Judith Proctor
Chief Officer, Edinburgh Health and Social Care Partnership
Email: Judith.Proctor@edinburgh.gov.uk

Contact for further information:

Name: David White, Strategic Programme Manager – Primary Care
Email: david.white@nhslothian.scot.nhs.uk Telephone: 07974 185419

Background Reports

1. Primary Care Transformation Report (August 2021) – Appendix 1

Appendices

Appendix 1 Primary Care Transformation Report (August 2021)

Edinburgh Health and Social Care Partnership

APPENDIX 1

Primary Care Transformation Report

AUGUST 21

EDINBURGH PRIMARY CARE LEADERSHIP & RESOURCES GROUP

Edinburgh **Health and Social Care** Partnership

Contents

Edinburgh Health and Social Care Partnership

EHSCP Report

Edinburgh Primary Care progress to end of 2020/21 and future priorities (following consultation May-June 21)

1. Purpose

This report summarises our position with Primary Care investment in Edinburgh and the associated 'transformation' anticipated as part of the New GMS (2018) contract investment. The report also confirms answers to some questions about future direction, which required the input of GPs, Clusters and MDT (multi-disciplinary team) representatives.

Tables 1&4 give a quick summary of where the funding has been invested to March 2021, and what is proposed for the final implementation phase this year.

2. Background

PCIP funding was first made available in mid-2018, so we are 3.5 years into implementation. This substantial investment added to NHS Lothian funding made available the previous year ('Transformation and Stability (T&S) funding) and long established 17C funding directly to specific practices. We have used the PCIF to appoint c170wte new MDT posts, of which approximately 150wte will be filled at any given time. These figures do not include the original Community Link Workers (see section 5.3 for further detail). The MDT staff were anticipated to make an **average** workload contribution equivalent to augmenting 3 sessions of GP time 'injected' into practices across the City. Some newly recruited MDT staff had the background to make an immediate impression and exceeded our expectations, others reminded us that the pace and management of clinical risk in Primary Care requires careful acclimatisation, training and supervision, to be successful.

Scottish Government took a welcome leap of faith in prioritising substantial public investment into Primary Care, and BMA negotiators promised they would see results. In Edinburgh, a ring-fenced fund of c£13M was to be made available over a 3-year period, now extended to 4, and delegated to the Health and Social Care Partnership as part of a 'tripartite' system of accountability with the Health Board and LMC. We are now in the last year of that period.

The pandemic changed our delivery of service to the public overnight. We still need to assess together, how much of that change should be retained, and how much essential healthcare was pushed even further out of reach of some of our most vulnerable people. The relationship with our patients has also changed, and not all of this is positive. Mental health demands seem to have reached a 'tipping point' with natural resilience and self-reliance breaking down for a significant minority, but Primary Care remains a trusted place of safety

and help. The worst may not be over.

The pandemic has brought renewed enthusiasm for 'localism' in Edinburgh. There are few public services more local than General Practice, and there are opportunities for us to link more closely with key local partners such as primary schools, libraries and established third sector partners. The public health aspiration to create healthy neighbourhoods, could be given credibility and impetus with the more obvious support and involvement of Primary Care.

Responding to the pandemic demands has absorbed a huge amount of capacity over the last 18 months. The starting position was a city which has welcomed an average of c6000 new patients per year for more than a decade. This rate has barely slowed with 4000 additional in 2020/21, and each year the mismatch between patient numbers and physical capacity becomes more stretched. Our hope of a national infrastructure fund to acquire and re-purpose buildings for required public services has found no traction and this is now negatively impacting on PCIP delivery.

Primary Care remains the service foundation of all health & social care, yet we are so busy with daily demand, it can be difficult to make the opportunities of integration work for our population. Joined up thinking, planning and provision is a long-held ambition for public services. Our engagement with communities in listening and demonstrating our responsiveness to their needs, ideas and capacities will help to define the next period.

Interesting times.

3. Funding

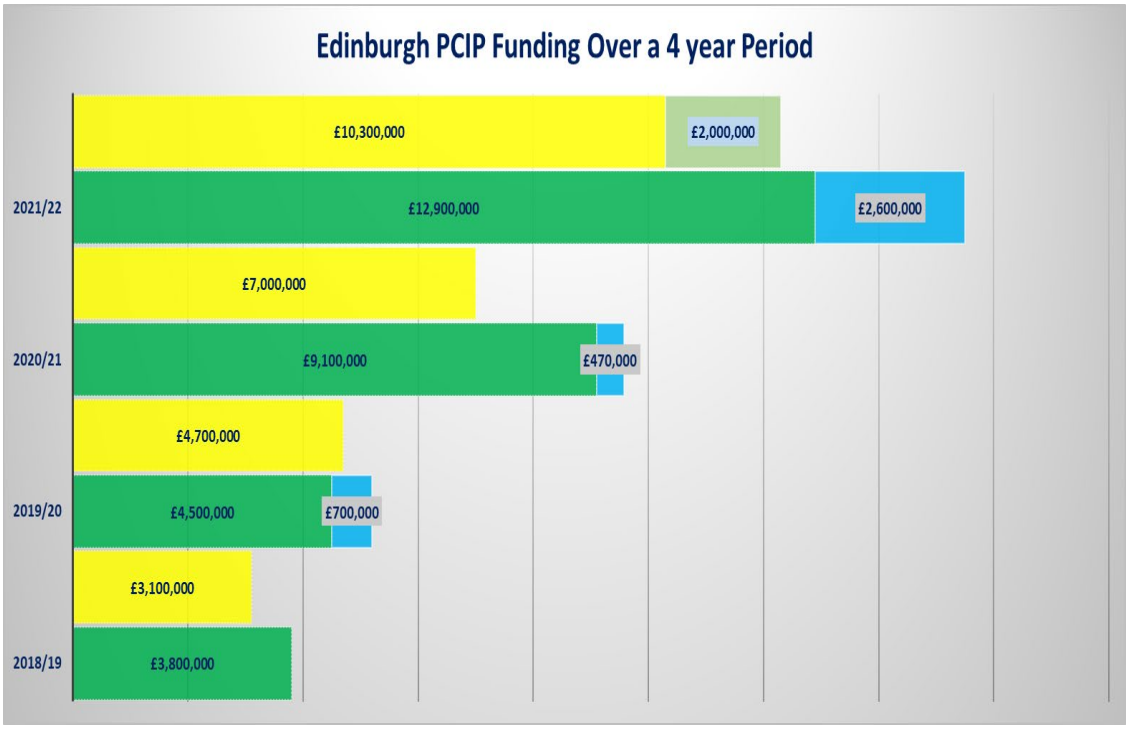
What we did and why?

There are three funding sources under our local (Edinburgh) management which are increasingly referred to as the 'PCIF' but which have different stipulations attached. These are managed on behalf of Edinburgh HSCP by the Leadership and Resources Group (L&R) which was established by the IJB for this purpose. Ultimately, the intention is that these three will be able to be used as flexibly as possible to support GMS under the governance of our Leadership and Resources Group.

3.1 PCIP

The PCIP funding became available from mid-2018, aimed at satisfying the Government MOU (Memorandum of Understanding) covering 6 broad clinical MDT areas where the funding was to be invested.

Figure 1. Build Up of PCIP Investment over Implementation Term.



The planned funding (green) is augmented by underspend carried forward (blue). The Yellow Bar shows what we spent in each year (as previously reported). The £10.3M shown for the current year is what we had committed to by April 2022, with a projected further c£2.0M investment proposed over the course of 2021/2. The first tranche of funding received in 2018 was applied in part to pre-existing commitments which were without recurrent funding, but which clearly lay within the MOU. For example, Edinburgh had been given funding before other areas of Scotland to create a Link Worker Network, and this became part of the PCIP investment. Similarly, central funding had been available to support pharmacotherapy development, which became part of the PCIP. (These investments and others can be seen in the first year of funding in Table 4 later in this paper).

An important local understanding about expectations was rehearsed throughout our local 2019 PCIP consultation and preceding discussions. An illustrative calculation was used to emphasise that to meet the expectations of the new GMS contract, at least c£18M would be required for Edinburgh. The question which was therefore addressed in the 2019 Edinburgh GP consultation was 'what is the best possible use of the £13M funding, within the parameters of the New Contract'. Three years on, we understand much more about what feasible, and about realistic timescales for full implementation is, and about what capacity and associated benefits each post can bring. For the Edinburgh PCIP the initial understanding that £18M investment remains a good indication of proportionate funding, now requires updating. It is likely that this estimate is at the lower end of what is required whilst many in the Primary Care community would advocate a more substantial investment.

3.2 17C funding

Edinburgh was awarded this second GMS funding source in 2004 to encourage innovation in Primary Care. The funding was mainly applied across practices in North West Edinburgh, with two further City practices benefitting from concentrated resources. The 2019 Edinburgh consultation established that these practices would not benefit from additional PCIP resources as a priority, and that 17C funding would gradually be withdrawn as PCIP resources were put in place. The 17C funding released would then be re-invested in the PCIP fund. The value of this re-investment is around £1M, which will be added to our PCIP resource ensuring equal benefit across all City practices.

Practices have asked about the process of withdrawal of 17C funds, and considerable unhappiness expressed by some, who have indicated that the loss of staff would destabilise the practice. This has not been a priority to date, but we will consider PCIP status of each practice and discuss before proceeding. We anticipate this process will begin with adjustments to the 2022/23 17C allocations, where practices have substantial PCIP resources in place.

3.3 Transformation & Stability (T&S)

This third funding source was recurrent funding given by Lothian Health Board to each HSCP in Lothian in 2017, in response to the Primary Care crisis which had been developing since 2014, and before the shape of the New Contact was known. £2.3M was allocated with a further recurrent tranche of £0.6M made available from April 2021.

A summary of the investments made is in Table 1 below.

Table 1 T&S Investments

T&S		2020 / 2021 £2.3m (£2,279,589)		
07/05/2021		20/21 FYE Committed	Actual 2020/21	21/22 FYE Committed
PCST: TPM & PA		£100,000	£90,022	£100,000
A&C Investment		£500,000	£406,482	£500,000
Diabetes LES		£204,000	£203,490	£204,000
Test of Change		£100,000	£0	£100,000
CQL		£100,000	£21,000	£100,000
External Support		£20,000	£0	£20,000
GP Mentor		£5,000	£0	£5,000
Street Pharmacy		£30,000	£30,000	£30,000
Additional Leg Ups		£100,000	£0	£100,000
Infrastructure		£100,000	£100,000	£100,000
Outstanding SLA*		*£210,000*	£102,000	£210,000
2Cs (Including Cluster)		£800,000	£800,000	£800,000
2Cs PM & B2 1.8wte Support		£100,000	£90,000	£100,000
Impact Nurses		£100,000	£0	
Clinical T&S Staff			£490,341	
Total		£2,469,000	£2,333,335	£2,369,000
			-£53,746	

*FYE – Full Year Effect

Explanatory notes are offered below on three of the investments shown in Table 1. Further information is available on all elements where requested.

Firstly, in 2018/19 we were aware that the funding of the **original** 2C practices seemed generous in comparison with 17J/C practices, and that the new 2C practices were not settled enough to judge what additional support they required on a transitional rather than permanent basis. We were reluctant therefore, to give PCIP shares on the same basis as the 17J/C practices. Instead, we allocated £800K from T&S on a potentially recurrent but unconfirmed basis. This £800K approximated to the amount of PCIP fund which the combined 2c practices would otherwise have been allocated through the PCIP. Work continues to understand where additional funding should be applied recurrently. All 2C practices are now stable and delivering all relevant elements of GMS. The clear intention is that 2C practices should not be disproportionately advantaged by transformation resources, unless these are explicitly tied to additional expectations. In three of the 'new' 2C practices for example, we have left a proportion of what was originally crisis funding in place, due to rapidly increasing list sizes which are providing much appreciated local capacity for patients to continue to register. An example of additional expectations is the funding of 'street pharmacy' in the Access (homeless) practice in response to the specialised needs of this vulnerable population.

Secondly, ahead of the New Contract we had offered 'T&S' posts funded 50% through T&S and 50% through the requesting practice. Where these staff had originally been employed under NHS contracts, we were able to move them across to PCIP funding and where the practice employed, they were (are) subject to TUPE. We have now completed all the TUPE transfers, except for those few practices which have decided to keep practice employment arrangements in place and continue to fund 50% of the post. (These appointments will be honoured until the staff concerned leave, after which PCIP arrangements will apply).

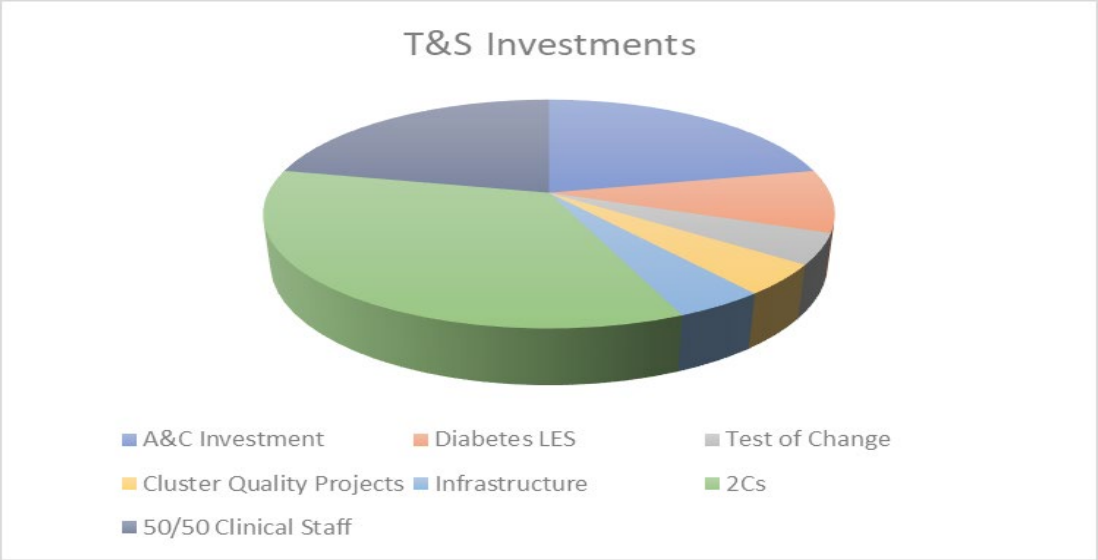
Thirdly, we invested c£500K into encouraging all practices to progress their clinical admin arrangements. The original intention was to ensure that all practices were able to have 50% of results and clinical letter handling ('Docman')undertaken by non-medical staff, and this has been achieved in all but a very small number of practices which did not wish to take advantage of this funding. The offer is still open to those practices. There is a longstanding aspiration for this element of support to be recognised nationally as part of the New Contract arrangements, and in support of the overall transformation of primary care. GPs report this has significantly helped their workload, and we have data to support this. We note that some practices feel they may be penalised for not reporting 50% achievement, when they assess that more than 50% of the associated workload has been removed. We will look again at the impact of this investment and ensure that any disincentives or potential disincentives are mitigated against. Reported numbers are a guide to performance, not necessarily the sole determinant.

It should be noted that £100K was set aside for the development of Cluster working capacity (not cluster services). Relatively little of this funding has been accessed to date due to other

pressures, but we remain committed to this investment, and are keen to find new ways of encouraging Cluster GPs to using this

The final share of recurring T&S funding is available from April 2021. The original intention was to use this funding to extend the availability of the 50/50 funded staff for practices which required more than the PCIP allocation. Practices made some suggestions which included the additional support required by teams

Figure 2 Summary of Transformation and Stability Fund Application (2020/21)



3.4 Summary of Funding available for Primary Care Transformation

In the 2019 City consultation, the PCIP and 17C funds were put together and 'top-sliced' for defined commitments e.g. Link Worker Network, phlebotomy & ANP central training contribution, evaluation support etc. The remaining sum was then divided amongst City practices according to their population size and Global Sum per head (excluding new patient premia and Care Home income). This calculation was weighted by 5% towards SIMD 1 patients and by 2% towards patients aged 80+ years (again, excluding care home patients who are funded separately). In addition, it was determined that 5% would be set aside to give each Cluster some resource to begin to develop locally relevant services. This latter recommendation was subsequently dropped as the case for CTACS grew and the funding was required for this. The total amount available across 17J practices was further inflated by the decision not to allow 2C practices access to PCIP allocations. Instead, funding was allocated to 2C practices from the Transformation and Stability Fund (see **Figure 3** below).

The funding available per practice was then converted to a range of wte staff equivalence, (band 6) which each practice could expect to be in place over the course of the PCIP implementation process. The use of a range rather than a fixed number was to allow some flexibility where population increased/decreased substantially or when highly or modestly graded staff were recruited into a practice. A 'rule of thumb' was that for each additional 2500 patients a practice would be allocated another 1.0wte, but the allocation was not so sensitive that the allocation would be increased simply because a practice list grew by another 300-500 patients (for example). AS part of the consultation we decided not to fund staff to cover absences and illness, though that would be in line with the GMS contract, simply as it would dilute the resource available to each practice. This does mean, however, that practices are sometimes considerably disadvantaged for unpredictable and varying lengths of time, as they manage absences internally.

The total affordable staff (excluding the original government stipulated Link Workers who are top-sliced) to be distributed across the sixty-two 17J/C practices, was calculated as **c211wte across the City**. Colleagues will note that this figure can vary slightly across reports in response to the grade of staff able to be recruited. For example, the decision to employ a cohort of B5 pharmacy technicians in 2020, will benefit the total number of PCIP staff we can afford.

The simple table below notes the total funding available to Edinburgh Primary Care on a recurrent basis from April 2021.

Table 2 Summary of dedicated recurrent local funds for Edinburgh Primary Care

PCIP	T&S	17C reinvest	Total
£12.9M	£2.9M	c.£1M	£16.7M

In addition, c£400K of pharmacotherapy baseline funding will be added to the PCIP pharmacotherapy fund, reflecting the original pharmacotherapy resource which has been fused with the PCIP pharmacotherapy investment. This takes the total funding available to £17.1M.

3.5 Underspends

Scotgov has been very consistent in its insistence that any PCIP underspends must be retained for application within GMS and consistent with the New Contract implementation. The underspends have therefore been preserved and carried forward for future application. This insistence prevents any incentive for HSCPs to delay implementation of the PCIP and use the funding elsewhere. Not using the full government and health board transformation funds as they were intended to support practices, may lead to additional costs elsewhere – in supporting practices which have become unstable, in rising prescribing costs, increasing acute admissions and so on. In Edinburgh, this equilibrium has worked well to date.

Ideally, this non-recurrent element would be relatively minor as we would already have invested fully in the PCIP and agreed L&R commitments. Although there has always been commitment to PCIP investment from Scottish Government, we need to have assurance before the beginning of each subsequent year, that the additional planned funding will be available. This means that we receive funds for each full year, (notably in 2020/21 when this increased from £4.5M to £9.1m) which we cannot fully use in that year as the personnel take time to employ. We have therefore mainly carried forward this funding. It is important that the use of this source, both past and future, remains open to scrutiny.

The application of underspend to minor premises improvements was reported to all practices for both 2019/20 and 2020/21. The list of practices supported from underspend with 'tech 50/50' (or 100%) grants is available to all, as is a record of LEGUPs since their introduction. In addition, practices have benefitted from underspend funded 'tests of change' such as Link Workers in non-deprived practices, in supporting the local Practice Managers network and equipping CTACS. We are more circumspect about openly reporting funding given to individual practices for stability support. These are very individual circumstances and all practices appreciate the importance of discretion during periods of instability, to avoid difficult situations deteriorating as Partners leave or are reluctant to join partnerships. All the funding given on this basis to individual practices is under the oversight of both the locality GP Lead and both LMC/GP Sub representatives. It is important that any misgivings about the use of these discretionary applications are voiced to LMC/GP contract oversight colleagues, to allow us to respond and maintain confidence in the fairness and appropriateness of these discretionary applications. The total spent on this basis is likely to be in the region of £50K in any one year and across several practices.

4. Overall position on PCIP Implementation Progress

Figure 4 (below) shows the steady growth of the MDT workforce employed into Edinburgh. This reports all posts recruited to and filled at some point since mid-2018 and therefore is not sensitive to vacancy which will affect MOU areas differentially. (Again, this does not include the original Link Worker posts which were originally awarded from government funding).

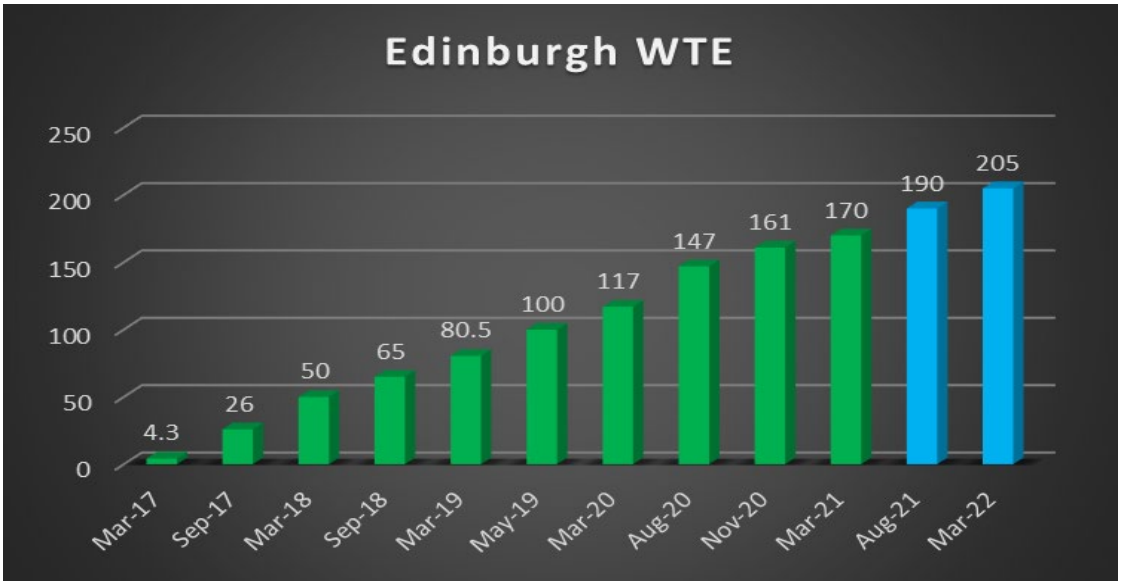
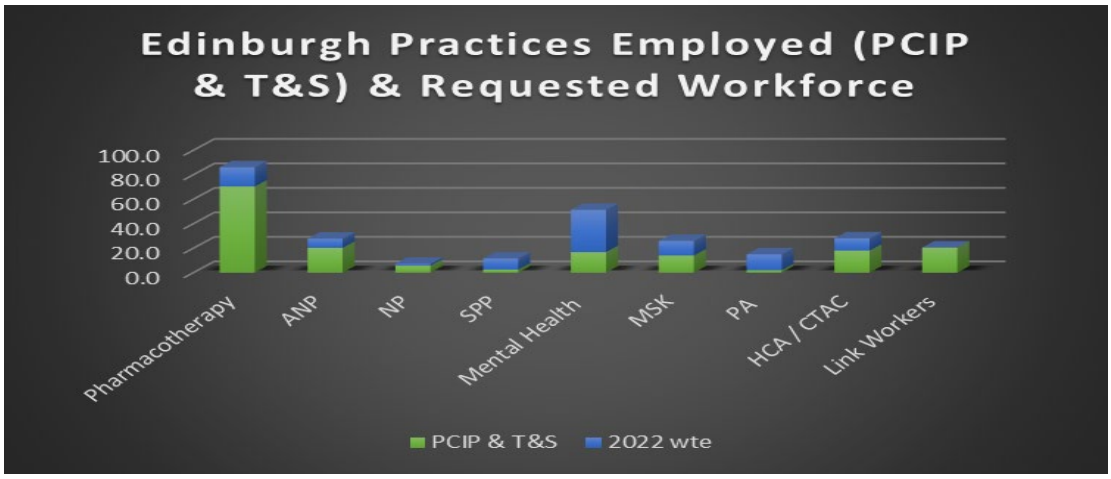


Figure 5 (below) shows the progress by MOU area against what practices advised us they wanted during the 2019 consultation. This will be updated as practices confirm or change their aspirations, in response to experience of the new MDT members and what they bring to a practice. It should be noted that practices interpreted the question of choice differently in response to the 2019 local consultation. Some advised us of their ideal application and others were more tactical; not asking for an ANP for example, knowing they were very scarce. Practices should already be aware that their preferences can be updated at any time and the latest version of our (PCST) understanding is always on the PCST website.



As can be seen in Figure 5, the early success of mental health appointments was not able to be sustained, and we are only starting the introduction of Physicians Associates in 2021. All other areas of the MOU have been successful in recruiting staff, and whilst that falls far short of the GMS promise, we are nearing the planned March 2022 position for the monies available.

5. Workforce development by MOU area

5.1 Pharmacotherapy

The development of the Edinburgh Pharmacotherapy workforce has been one of the successes of the PCIP. Edinburgh has made £3.8M available to date from the PCIP. This investment is augmented by £0.4M which was the pre PCIP team who have been absorbed into the same workforce. This total investment of £4.2M has been converted into MDT staff who provide service to each practice. The strength of this area and the success of skill mix have prompted proposals about how this service might be adjusted to provide cover and better consistency in the core pharmacotherapy service delivered to all practices.

The impact of this workforce when organised into cluster teams, with named pharmacists continuing to be embedded in practice teams is an attractive potential development of our current arrangements. This will be subject to a **dedicated proposal to be discussed through clusters**. An important element of the proposals will be that practices will retain a pharmacist firmly embedded in their practice. Adjusted arrangements will aim to provide more consistent cover which can largely be provided by technicians. By organising across clusters and building upon the new ways of working developed during the covid pandemic, these teams could be utilised to remove non-clinical and duplicated workload from practices. This will then free up clinical pharmacy capacity within practices to undertake more complex roles. Once everyone has this level, we can begin to consider where some practices wish to explore using more of their PCIP allocation to provide an enhanced level of pharmacotherapy, whilst being sensitive to the consequences for other parts of the system.

It is important to note that Edinburgh currently has c25 technicians at a variety of stages of their training. By autumn 2021, around half will be fully trained, with the remainder expected to be fully trained and registered January 2022.

We calculated that to remove ALL acute prescriptions ONLY from GPs, would require c170 wte pharmacotherapy staff across Edinburgh ie three times the total intended pharmacotherapy investment. Pursuing the removal of all Level 1, would mean having to withdraw funding from other embedded programmes which GPs have indicated that they want (ie. other MDT members). We also understand that exclusively undertaking level 1 tasks will not support pharmacy recruitment and retention. We have aimed instead for skill mix and are keen to share learning about effective systems which allow routine activities to be undertaken in a more cost-effective way: indications from elsewhere are that increased use of pharmacy technicians and administrative staff working alongside pharmacists, is key to capacity expansion.

The question has always been about the best-balanced application of the funding available, and not a misleading expectation that 100% of anything would be removed.

An additional important feature of the transformation of pharmacotherapy support is the adoption of efficient prescribing systems, including review of acute/repeat prescribing ratios and increasing adoption of serial prescribing[1] arrangements. Edinburgh practices are increasingly adopting these proven systems. Workload and safety benefits should shortly be obvious to all.

The available investment into pharmacotherapy in Edinburgh is almost complete and we anticipate only a further £100-200K being invested in this area. This adds to the funding agreed in July 2021 by L&R to support the opportunity to increase the technician workforce. It should be noted that the pharmacy team have a compelling case for additional investment of c£500k, should additional PCIP funding become available, aimed at enhancing the skillmix and pharmacotherapy offer available at cluster wide level. (This reflects our overall assessment of the PCIP fund available as being significantly short of what is required to satisfy a proportionate interpretation of the New Contract).

5.2 CTACS (including vaccination supplementation)

Edinburgh practices have gradually warmed to the potential of CTACS, although we remain constrained by site availability. We have plans with varying timescales to have a network of 8 across the City to give reasonable access to over 50 practices. Inevitably this means c.20 practices will gain access to significant CTAC support on a longer timescale.
CTACS development has been hampered by Covid, unlike some of our other programmes of work (eg extending the MDT where we have managed to successfully recruit throughout). We have agreed a range of procedures to be provided for all practices and another range which will be open to some local interpretation. The financial mechanism which supports this has still to be fully developed, but we envisage a standard calculation of wte against the level of service available to the practice. For example, a practice with 10,000 patients which

uses the core CTAC service might have 0.4 wte attributed to their PCIP practice allocation. We have currently set aside a £1.1m investment across all Edinburgh practices, and need to consider how to increase this as the service is able to develop. Lack of premises is a significant, and growing, problem. We also need to consider how best to provide agreed phlebotomy for specialist bloods (funded by secondary care)

In terms of the practice capacity which CTACS create, we are keen to develop the work of PNs in parallel and chronic disease monitoring is an obvious initial focus. We are developing Healthcare Support Workers to work at a more advanced level offering vaccinations and wound management, for example.

The **vaccinations programme** merits its own section, but we have increasingly seen this responsibility as being best managed from within and as part of the CTAC programme. Both CTACS and vaccination programmes are overwhelmingly nurse-led, and CTAC staff will continue to help with delivery, working alongside their Practice Nursing colleagues who are the mainstay of our delivery capacity. We have accounted for the amount spent in 2020/21 (£550k adult prog.) and made provision for 2021/22 (£450K). These numbers have already been subject to change as the adult programme increases its reach and combines with the COVID booster delivery. We have been assured that extra funding will be available for the additional work required.

In 2020 the Edinburgh HSCP delivered the adult flu programme, in close association with GMS. The experience of 2020 emphasised the shortcomings of attempting a surgical removal of all flu vaccination activity from General Practice. The 'opportunistic' delivery of vaccines by practice staff whenever patients attend practices or are visited at home makes sense to everyone, including the GP body. The practice plays a vital role in communications with patients, and the HSCP delivery workforce is mainly Practice Nurses. If GMS played no role in delivery the flu programme would be both more expensive and less effective, using up PCIP resources which would otherwise be available for other MOU areas. Similarly, Community Pharmacies across Edinburgh participated enthusiastically in local delivery, which was much appreciated by many citizens.

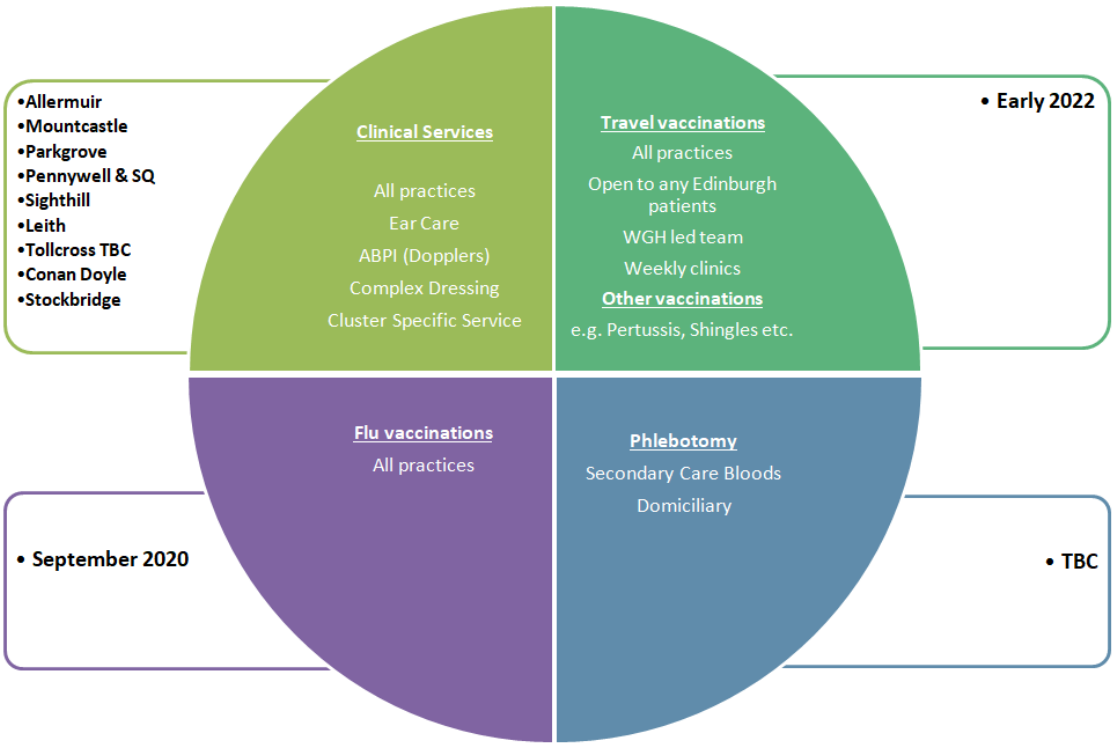
Travel Vaccination is subject to a Lothian wide arrangement with a central clinic at WGH and local access through CTACS. The model has been costed using a £10 charge to each patient and the net cost to Edinburgh is currently noted as c.£175K pa. This is planned to be available to all practices as early as possible in 2022.

Children Vaccinations were carried out and funded by NHS Children's services for c50 City practices prior to the PCIF being available. The service was extended to all 70 practices through a PCIP 'top-slice' of £190K.

Adult and Students Vaccinations will be carried out via CTAC and this relatively small transfer has yet to be costed and may simply be absorbed as part of the CTACS workload and funding.

We propose retaining flexibility for the application of further funding to this area from PCIP in this financial year and from T&S as site opportunities develop.

Figure 5 CTACS Development in Edinburgh



5.3 Link Working and Welfare Rights Network

This network was an early implementation success with funding provided by Scotgov prior to the PCIP. When the New Contract was agreed this funding became part of the PCIP fund available to Edinburgh, together with the expectation that Edinburgh implemented its 'share' of the national 250 Community Link Worker (CLW) posts ie c.23 wte for the City. The original Scotgov funding paid for each of our (19) practices with +20% deprivation to be awarded proportionate capacity (1 day per 1000 patients in SIMD 1). This original network of generic Link Workers was subsequently augmented by investment into the City Welfare Rights Network, in place of additional Link Workers. The original network, its management support and the welfare rights investment satisfy the government stipulation to ensure c23 generic Link Workers across the City as part of the PCIP implementation (c.£1.1M). The 2019 City consultation established that this funding is top-sliced because the original practices had no choice, they were simply offered their share of this national allocation.

Subsequently, several 'non-deprived' practices have chosen to use some of their PCIP allocation on Link Workers, following a successful trial period funded by PCIP underspend.

All Community Link Workers have a role with their practices to encourage and facilitate 'social prescribing/signposting' amongst the wider team and non-deprived practice have developed more 'specialised' support to respond to practice needs eg. isolation in older people/dementia. These additional CLW posts are therefore not top-sliced and count against a practice's PCIP allocation. Any of the original practices which wish additional Community Link Worker resource to complement their top-sliced allocation, need to take this from their PCIP allocation.

Further (non – PCIP) government funding is available to strengthen the presence of Welfare Rights Workers in practices during 2021. This is relatively modest at c£60K across Edinburgh but will allow an additional session in each of our eight most deprived practices.

Future development includes the consideration of a software application which could give a 'curated' choice of social prescribing options for all primary care staff (and others) and improve the recording of both activity and patient outcomes. A proposal was supported through Leadership and Resources in July 2021.

We are not proposing further expansion of the network as the Scotgov stipulation has already been satisfied. Individual non-deprived practices may continue to request Community Link Worker support as part of their discretionary application.

5.4 Advanced Nurse Practitioners and associated Nursing roles

Edinburgh struggled to employ fully trained ANPs during the first two years of implementation. These were amongst the most sought-after staff and where practices did have them, their contribution was highly effective in augmenting the practice workforce. During 2020 we began to place prospective trainee ANPs into practices where they would need training support. Workplace-based assessments required for the ANP course require considerable GP input and dedicated time. We therefore gave retrospective payments (using PCIP underspend) to practices which undertook this work during 2020-21. Future arrangements for 'Training Academies' have been developed and agreed by Leadership and Resources (July 2021). The requirement for training of the extended team, or the mechanism for resourcing it, were not anticipated by the new GMS contract.

We are proposing a further investment of c£200K in this area with room for flexibility should the opportunity present to employ more than 4.0wte colleagues into this area. A professional Primary Care Nursing group has been developed to ensure that all nursing roles are developed and enhanced, including Practice Nursing and including District Nursing.

5.5 MSK

MSK APPs began to be appointed in 2019 and their steady growth has been welcomed by all practices which choose this supplement. As always, the balance between demand and capacity is very practice specific, but it seems that 3-5 sessions per week per 10,000 patients

in an average demand practice is well used and appreciated. We aim to continue to recruit actively this year in accordance with practice choices. APP leads undertook an assessment of this work and, in particular, showed high levels of patient satisfaction.

A further £350K is ear-marked for this area for this year.

5.6 Mental health

The employment of mental health nurses into practices was started in 2017, and quickly spread in large part due to the very experienced nurses who took the first jobs and whose practices were very appreciative of the contribution they were able to make. The job descriptions were subject to the formal evaluation process, and this held up the employment of further colleagues until this year. It is clear from the latest responses to advertisements that Edinburgh is not going to be able to meet the original PCIP intention of c35wte Primary Care Mental Health Nurses for some years. It is proposed that our response to this has three main elements (in addition to periodic advertisement);

- Building on the experience of developing B5 nurses to take on the extended Primary Care Mental Health Nurse role, we will ensure we have 4 x B5 training opportunities running continuously to build this workforce internally and offer an improved career structure to nurses interested in this option.
- We have started discussions with Third Sector colleagues about the possibility of quickly providing some local capacity over the next two years. Depending on the success of this there is opportunity for a blended approach in the longer term. This would seem an ideal use of Action 15 monies which are to provide additional support for every GP practice.
- We also plan to explore the possibility of Mental Health OTs who may wish to work in Primary Care.

  As with pharmacotherapy, it is important to emphasise the limits of the additional capacity a Primary Care Mental Health Nurse can offer. In a practice of c10,000 with average patient demand, we would expect at least 30% of appointment requests will be mental health based, but following the pandemic, this has risen significantly (and was always higher in deprived settings) An experienced mental health nurse with V300 training and well embedded into the practice team, will augment capacity by the equivalent of c5 medical sessions.

  We have set aside £550K of the remaining PCIP to invest in this area, alongside underspend to secure additional capacity for at least the next 2 years.

5.7 Urgent Care

The Scottish Ambulance Service has provided welcome capacity for a pilot and another City

practice has strong positive experience of the direct employment of paramedics. The feedback from the pilot is very positive, but we have continued to raise with the SAS the relative cost of this particular investment. The service provided includes provision for all the equipment, transport and training, but nevertheless is around £40 per hour compared to £25 per hour for a B7 pharmacist or ANP.

We believe the capacity which they can provide may be particularly relevant for certain large practices with high elderly populations during defined periods each morning, and also to provide locality wide capacity for unscheduled visits in the afternoons.

We have set aside a further £300K, allowing for the tests of change which have been funded from the LAS to date, and the expansion which is already being implemented.

5.8 Supporting investments

The first Physician's Associates began work in two Edinburgh practices this year. The feedback from other Scottish sites where they have worked in Primary Care is positive, and we are hopeful they will develop into a recognised and sustainable part of the primary care workforce.

We have set aside a further £200K this year in anticipation of some further expansion of this workforce.

5.9 Management Support (PCIP and T&S funded)

The L&R Group are sensitive to the extent to which funds intended to be for direct workload capacity are invested in additional management support. There is a 'quid pro quo' in that there are several (PCST) roles which contribute substantially to the PCIP, but which are not funded from this source, or the T&S funds. As the workforce grows, the support required will grow and it is important that we are transparent about this. To date;

- PCIP Transformation Manager
- PCIP Evaluation & Insight Manager
- Clinical Nurse Manager for ANPs/CTACs
- Clinical Nurse Manager for Mental Health (Agreed but not yet appointed)
- Quality Cluster Administrator
- Asst. Primary Care Service Manager for 2C practices
- Link Worker and Social Prescribing Network Manager
- Physiotherapy Manager (0.64wte)
- Edinburgh Head of Pharmacy (Agreed but not appointed)
- In addition, there are several roles, notably with the more senior pharmacy roles, mental health team leads and also CTAC leads where management responsibilities are combined with a patient facing role.
- Funding to support the City Practice Managers Network

- We envisage that part of the c£450K we have recommended for the adult flu delivery is invested in some permanent additional capacity which will cover the 6 months during which the programme is designed and delivered.

In total, this element reflects a modest level of investment (c£400k from total £17M) in primary care management support.

No further investment is currently proposed.

6. Impact to date and projected

6.1 Original capacity gap definition

Our first PCIP described a sessional demand for GPs across Edinburgh as c2900 per week, with actual capacity available and supplied as c2300. This gave us a crude starting definition of 'missing capacity' as 600 medical sessions per week. The GMS contract promises more than this eg most of the savings offered by CTACS and the VTP save PN rather than GP time. Each time we make an investment using the PCIP we ask what sessional augmentation has been achieved, and we recognise both that the augmentation of workload and 'value' to the PCIP and the practice team are not the same thing. On initial evaluation, Community Link Worker can only be expected to augment capacity by one session per week, but we maintain that their contribution to linkage and understanding of local resources and the Third Sector in particular, goes far beyond clinical capacity provided (or 'saved' in this case).

As the table below shows, we believe we are now providing overall capacity of c500 sessions out of the 600 envisaged and affordable. There are two very important considerations which accompany this healthy progress. Firstly, we count any post filled as contributing to the 500, even although the post may have subsequently become vacant. The vacancy rate overall is c15%. Secondly, in the last four years the population of Edinburgh has increased by c24,000, and the PCIP allocation does not increase with our steadily increasing population. This is not material whilst we have PCIP underspends available, but from 2023/24 will constrain the support available to practice and begin to erode the equity equation on which the PCIP distribution was founded.

One of the investments we agreed from the beginning was an 'evaluation' post dedicated to understanding and recording the links between capacity put in place and impact on GMS workload. Table 3 indicates where an evaluation is available to substantiate these impacts and where we anticipate further work coming forward this year. To date the evaluations have been convincing, not only in respect of workload but of unintended and additional benefits realised by expanding the MDT and bringing different clinical approaches and skill sets. All evaluations are scheduled to be re-run every 2-3 years to reflect the changing nature of the MDT contribution and its direct and indirect impacts on workload, safety, and quality.

Table 3 Impact on GMS workload of MOU investment

Edinburgh Primary Care Transformation Programme Impact Tracker March 21					
	Practices Benefitting	Wte in post	Sessional Equiv (est)	Funding Origin	Evaluation
Pharmacotherapy	69	69	207	PCIP	Jun-21
Linkworking	37	21	21	PCIP/T&S/17c	Sep-19
Vaccs	70	-	15	PCIP	Feb-21
Nursing	28	34	84	PCIP/T&S	TBC
Mental Health	19	16	64	PCIP	May-19
MSK	22	14	56	PCIP	Nov-19
CTACS	33	15	33	PCIP	Oct-19
Clinical Admin	60	-	22	T&S	Mar-20
Tech	66		TBC	PCIP	
TOTALS		169	502		

Note: All sessional equivalent subject to ongoing structured assessment, actual workload equivalence lower.
WTE total excludes pharmacy techs in training, WRW and LW ToC as workload impact currently marginal.

It should be noted that within each of the MOU evaluations taken thus far, the patient reaction to MDT working has been very positive. High patient satisfaction with the MDT clinical service has been reported.

7. Remaining Investment decisions

The table below shows that as we started 2021/22 we had already committed to spend c£10.3M of the £12.9M PCIP funds available (setting aside the additional pharmacotherapy baseline and the 17C reinvestment funds). Secondly, the table shows where we think these funds should be increased in accordance with both the expressed requirements of practices, the availability of staff and the success of existing application through evaluation. **This takes us to a commitment of £12.5M with £0.4M remaining.**

Table 4 Recurring PCIP Commitments Only (FYE) Edinburgh Primary Care PCIP Implementation Plan - Update Summary for GPs (Issue 7 – May 2021). (Appendix 2)

	2018/2019	2019/2020	20/21 FYE of Committed	2021/2022	Estimated Workforce Projection by end of 21/22 (on £12.1m)	WTE 2019 Wish List	Cost
Funding Available(£M) Carry Forward Omitted	£3.80	£4.50	£9.10	£12.90			
	(K)	(K)	(K)	(K)	(WTE)	(WTE)	(K)
1. Pharmacotherapy	£1,101	£1,810	£3,300	£3,500	70	75	£3,500
2. Link working	£770	£1,190	£1,200	£1,250	25	25	£1,200
3.Mental Health	£390	£600	£950	£1,500	33	50	£2,250
4.Vaccination	£109	£190	£900	£900	/	/	£900
5.ANP		£100	£1,550	£1,750	35	30	£1,500
6.MSK	£75	£260	£750	£1,100	22	25	£1,250
7.CTACS	£83	£105	£800	£900	20	/	£1,200
8.Paramedics/Urgent Care		£50	£100	£400	8	10	£500
9.Physicians Associate			£100	£250	5	10	£500
*Support**	£540	£520	£640	£640			£700
TOTAL	£3.06M	£4.83M	£10.3M	£12.2M	218	225	£12.8m

Practices have already asked 'what happens if the money runs out before I receive all the staff I was supposed to get?' Whilst allocations fall short of the GMS promises (due to restrictions in funding and available workforce), all practices should be able to see the original PCIP allocation related to the additional capacity they have access to. The original understanding or wishes of practices may be subject to some refinement, but this should be through mutual agreement. Three common examples are noted below for illustration.

- A practice originally wanted 2.0 pharmacists, but through experience and redesign now has 4 days of on site senior pharmacist and 5 days of (mainly) off site pharmacy technician support.
- A practice wanted an ANP but has been offered a Physicians Associate or Nurse practitioner to offer similar capacity.
- A practice wanted a full time MSK APP but now wishes to adjust that to 4 sessions per week.

We have also made clear that the choice of MOU support by practices may evolve. An obvious opportunity for this presents when a member of staff leaves, but we can also discuss when a practice assesses that MDT capacity support needs to be shaped differently

In summary, we have £2.6M available to invest this year and are suggesting where c.£2.2M of this should be applied across the MOU areas. The remaining £0.4M gives us flexibility to respond where there are opportunities to expand elements of the plans. Where this was to result in any additional investment to an MOU area this will be reported through L&R, with the understanding that investments can be both increased and reduced over time.

8. Governance

8.1 Role of L&R

The role of L&R is to ensure that the investment of the available primary care transformation funds is within the relevant guidance, widely agreed, effectively used and well communicated. L&R has a high level of GP involvement; chaired by the (GP) Medical Director, includes all GP Clinical Leads, both LMC/GP Sub reps/2x CQLs/2x Practice Managers, PN lead. The Edinburgh Primary Care Team is represented, and membership is open to two further members of the EHSCP Senior Management Team. All use of these GMS related funds must be sanctioned through L&R and where this is not possible, reported retrospectively.

8.2 'Rules'

L&R maintains governance Over the use of resources. For example, we recommend that any PCIP staff member should have an appropriate clinical 'mentor' at practice level to ensure their role is actively developed and well understood within the practice. L&R is scheduled to approve the first version of a document which sets out the relevant arrangements and understandings for H&SCP employed staff who work within practice teams. This document builds on the last three years of experience and the underlying intention is to balance the expectation that all MDT staff make an effective contribution to workload capacity, with practice responsibility to ensure these staff are well supported and effectively deployed. **Where this is not happening, MDT staff may be withdrawn.**

Part of the 2019 consultation asked practices if they wanted PCST to retain part of the PCIP resource to provide cover for MDT staff. Understandably at the time, practices were anxious to have all relevant resources embedded in their teams. No cover has therefore been provided for PCIP staff to date, but in response to practice feedback we will revisit this for certain MOU groups.

8.3 Continuing role

L&R was originally conceived as the local group charged by the Edinburgh IJB to oversee the New Contract implementation. The role has widened to all aspects of Primary Care Transformation and has proved a useful mechanism for reaching agreement over non PCIP resources such as Scottish Government premises grants and list growth related grants and Lothian's T&S funds. The value of the funding, the ongoing need to report on its application and the potential for further development of the funds, give the group a clear remit across the next few years.

9. Final thoughts

The application of the primary care transformation funds has not fully satisfied anyone's

expectations. It was clear from the start that the funding could not fulfil the full potential of the possible workforce transformation and augmentation promised by the new Scottish GMS contract. At the same time, the additional capacity has been appreciated and has helped the City to a point where all practices are stable, or able to be quickly re-stabilised without a requirement for the practice to move to a different contractual status.

We are also convinced that all parts of the MOU are effective, and we have learnt the scope and capacity of the new services and staff and have sought to learn from experience. Stabilising practices has brought collective benefit. As we develop, we expect the balance between practice specific and local practice network investments will change. At the beginning of the implementation process many practices were worried about being able to continue, but we are now reaching a stage where the benefits of collaboration are more obvious. Pharmacotherapy is likely to become a strong example of this, whereas ANPs are likely to remain very much embedded in practice teams developing bespoke roles, consistent with their relevant professional boundaries. This is not policy, it's about what works best and what gives City practices a continuing incentive to invest time and attention in the MDT arrangements.

We have set funding aside to encourage the further development of Quality Clusters. To date, this opportunity has been difficult to respond to, given the other pressures on practices. This investment in thinking and co-ordinating capacity combined with our determination to develop our 'insight' function, should help to illuminate areas for further development, new opportunities, and linkages with acute and Third Sector colleagues. We have long thought that harnessing the understanding of GMS to the commissioning of the Third Sector was overdue and the 2021 mental health investment should help to test this. Better understanding and joint working with the acute sector have featured in primary care policy for many decades. Again, there is the potential for Quality Clusters to engage on a mutually satisfactory scale and to better understand where variation might be helpfully and appropriately adjusted.

At each PCIP submission to date we have acknowledged the need for a more structured and consistent approach to an open dialogue with the Edinburgh public about their experience of Primary Care. In the wake of the pandemic this has never been more important. We cannot afford to assume our interpretation of what the public want and need is satisfactory. Whilst a minority of primary care interaction with the public is unsatisfactory and inappropriate, the public have been highly adaptive, understanding and supportive of what we offer, and we must reciprocate.

Best Wishes

Edinburgh Primary Care Leadership and Resources Group

July 2021

Appendices

Appendix 1 Edinburgh PCIP4 - Local Implementation Tracker Template - March 2021 (to be completed & submitted by May 31st)

Edinburgh PCIP4 - Local Implementatio

Appendix 2 Recurring PCIP Commitments Only (FYE) Edinburgh Primary Care PCIP Implementation Plan - Update Summary for GPs (Issue 7 – May 2021).

Recurring Commitments EPCST

Appendix 3 Report 1 Mar21

PCIP Report 1 2020 2021.xlsx

Appendix 4 Edinburgh Employed Resources & Requests

Edinburgh Employed Resources