Edinburgh Integration Joint Board

REPORT

Edinburgh Primary Care Improvement Plan Update

Edinburgh Integration Joint Board (EIJB)

27 October 2020

Executive Summary	1. The EIJB requested an update on the Edinburgh Primary Care Improvement Plan (PCIP) 3 through the Rolling Actions list. 2. The annual reporting cycle for PCIP is set by the Scottish Government. 3. The latest report is at Appendix 1 dated July 2020.

Recommendations	It is recommended that the **EIJB:** 1. Notes the report on the full year 2019/20 at Appendix 1. 2. Notes the submission template to the Scottish Government covering the period up to 31 August 2020 at Appendix 2 (due 15 October).

Directions

Direction to City of Edinburgh Council, NHS Lothian or both organisations		
	No direction required	✓
	Issue a direction to City of Edinburgh Council	
	Issue a direction to NHS Lothian	
	Issue a direction to City of Edinburgh Council and NHS Lothian	

Main Report

1. The Edinburgh PCIP was first agreed by the EIJB in 2017 and is the primary care element of the Strategic Plan 2019-2022.

2. Edinburgh has a Primary Care Support Team (PCST) that covers all aspects of primary care including the PCIP. EIJB invested authority for the development

and implementation of the PCIP in the Primary Care Resources and Leadership Group, chaired by the EIJB Clinical Director.

3. The report at Appendix 1 (2019/20) followed the structure originally requested by Scottish Government in early 2020 and addresses areas such as 'Alignment to Population Needs,' and 'Premises,' which have not previously been directly associated with the PCIP. This report was developed in anticipation of the annual reporting cycle and was used to update the LMC/GP Sub meeting in August 2020, where it was well received.

4. The annual reporting cycle for PCIP progress is set by the Scottish Government. It requires Local LMC/GP Sub and IJB approval to both year-end reports and the plan for the following year. The annual cycle was interrupted by COVID-19, but the Scottish Government has requested an update on progress. The submission, due on 15 October 2020, is produced on a standard template and is at Appendix 2.

5. It should be noted that whilst some HSCPs are reported to have paused their PCIP plans during COVID-19, or even withdrawn staff from direct GMS support, Edinburgh took the opportunity to accelerate the implementation process.

6. The responsibility for implementation of the adult flu programme shifted from NHS Lothian to the Edinburgh Health and Social Care Partnership (EHSCP) as part of the PCIP. In June 2020, the EHSCP Executive Management Team supported the proposal to bring forward implementation from 2021 to 2020 in response to COVID-19 conditions and at the behest of City GPs. Arrangements to deliver c80,000 adult flu vaccinations in an 8-week period (Oct/Nov) have subsequently dominated the capacity of the PCST. It has also provided a potential blueprint to assist future planning in the provision and delivery of COVID-19 vaccines.

Implications for Edinburgh Integration Joint Board

Financial

7. The further availability of planned investment funds was confirmed by the Scottish Government in September 2020.

8. The understanding around payment for the additional costs of flu delivery remain fluid, but there is enough funding to cover the 2020/21 costs.

9. Edinburgh PCIP investment potentially rises to £9.2M during 2020/21 dependant on demonstrating appropriate application in line with the MOU (2018).

10. The full amount has been requested this financial year.

Legal / risk implications

11. See Appendix 1.

Equality and integrated impact assessment

12. A full equality and integrated impact assessment was completed for all aspects of the PCIP.

Environment and sustainability impacts

13. It is recognised that all future models of care and delivery must take due cognisance of the impacts on the environment and in respect of climate change targets, including those associated with the Edinburgh 2030 programme.

Quality of care

14. The PCIP seeks to improve the quality of care and people's experience and access to care in Edinburgh.

Consultation

15. The PCIP was widely consulted upon.

Report Author

Name: Tony Duncan

Head of Strategic Planning, EHSCP
Email: tony.duncan@edinburgh.gov.uk Telephone: 07935208040

Contact for further information:

Name: David White

Strategic Lead: Primary Care and Public Health, EHSCP

Email: david.white@nhslothian.scot.nhs.uk Telephone: 07974185419

Appendices

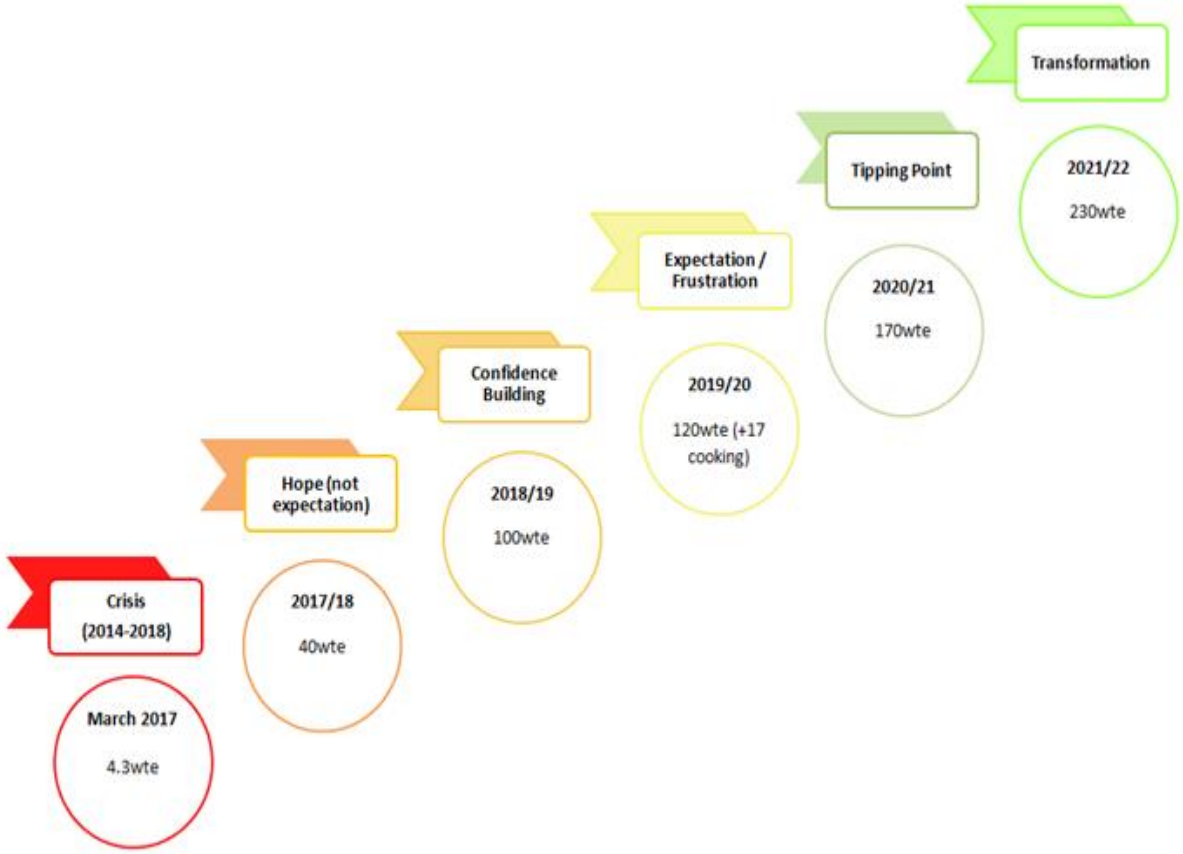
Appendix 1	Edinburgh PCIP 3 Update Report 31 July 2020.
Appendix 2	COVID-19 PCIP 3 August 2020.

Edinburgh **Health and Social Care** Partnership

Report

Edinburgh Primary Care Improvement Plan Update
31st July

Edinburgh PCIP Development



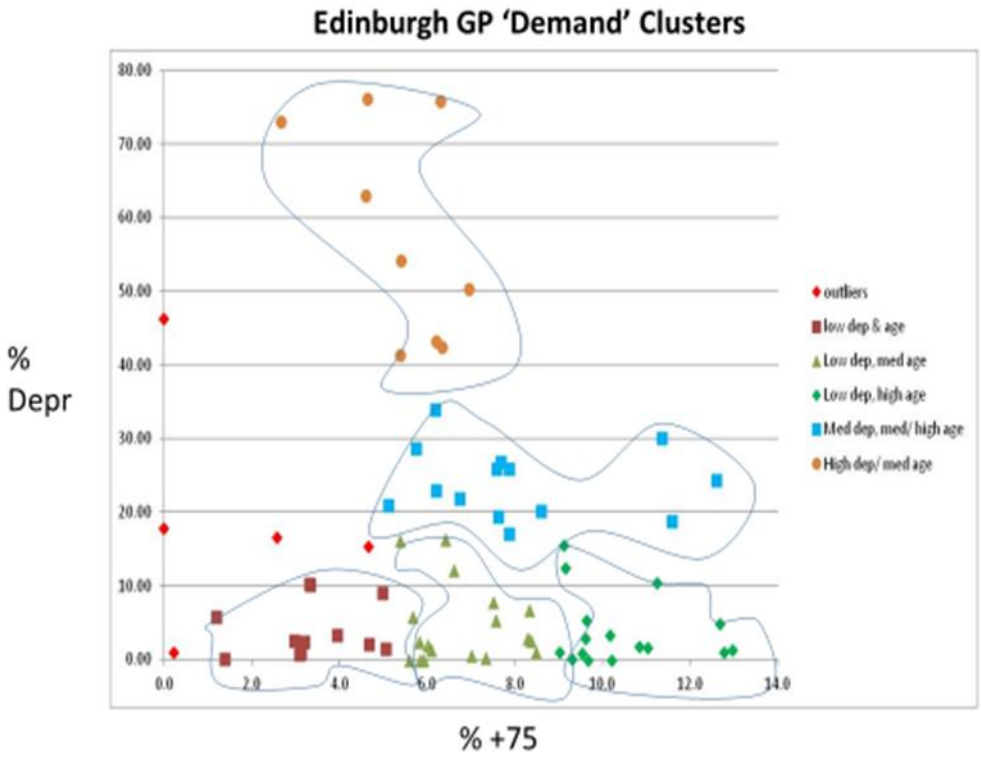
1.0 Introduction

This third Edinburgh PCIP covering the (pre COVID) period up to the end of March 2020 describes a positive picture overall. Additional population to the City continued to be able to be supported and no further GP contracts had to be surrendered during 2019/20. Significant progress has been made, but it has been far from steady and the primary care community have continued to deliver despite the inevitable frustrations that we cannot ensure everyone benefits from the PCIP investments equally, or at the same time.

The nature of the challenge changes each year. In 2019/20, there was little additional resource, and the new MDT capacity established in 2018/19 was beginning to feel the strain of relentless demand and make adjustments to ensure sustainability. The other key feature of 2019/20 was the turbulence in the new workforce, which although predicted, was nevertheless an additional pressure on teams trying their best to support new colleagues. These frustrations were tempered by increasing confidence, built on the ingenuity and hard work of colleagues, that the new workforce could be deployed effectively to allow Primary Care to flourish again..

2.0 Alignment to population needs

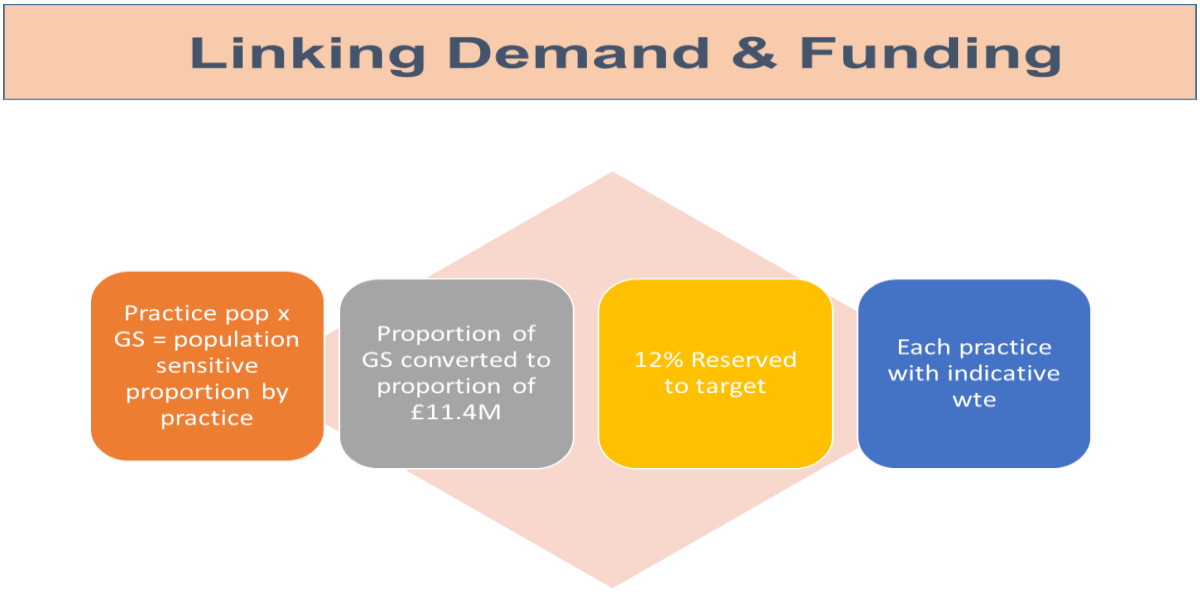
Edinburgh H&SCP have differentiated their 70 practices into 5 'demand groupings' (Figure 1 below) to compliment the local geographical focus provided by GP Quality Clusters.



These five groupings allow us to look at key available indicators, eg prescribing costs or admissions, across practice populations with broadly similar demographic characteristics. The demands associated with the high deprivation group and the elderly/affluent group are well understood, but the variation between and

within each of the other groupings is less well appreciated. An example is the high turnover inner city populations which are a variable mix of the very vulnerable, students, young and affluent and concentrations of ethnic groups. Student populations are also a group needing specific consideration, with significantly changing geographical presence coupled with burgeoning mental health needs.

Understanding variations at this level and appreciating the very different challenges and likely solutions for our practices, led to a PCIP allocation methodology which was based on the national Global Sum allocation. This allowed us to indicate to each practice a defined expectation of resource (in wte not £). We then asked practices to choose which MDT members they would most value for their practice teams. 88% of the available PCIP(following agreed top slices) has been allocated to be used in this way. Our understanding of the national formula in relation to deprivation and workload, led us to propose that 5% of the total PCIP was top-sliced and re-distributed across practices, depending on the proportion of each practice list in SIMD category 1. A further 2% was allocated across practices according to the number of +85 year olds. We proposed that a further 5% was set aside to be used by Quality Clusters to encourage collaboration across practices. This final tranche is being reconsidered as we are likely to need this funding to support CTACS as their relevance to providing direct support gains understanding and support.



In Edinburgh, our overall PCIP starting point was mixed. We were disadvantaged by historically poor investment in pharmacotherapy and community treatment rooms and coverage of childhood imms (which were still delivered directly in a significant number of City practices) – but advantaged by a group of practices which had been allocated 17C funding. The opportunity was taken during our consultation over the fair distribution of the PCIP, to ensure that 17C investments were taken into account as we allocated the PCIP resource. It was agreed that, over time, the 17c resource will be absorbed into the PCIP.

The major concern for Edinburgh remains sustainability in the face of continued population increase. In the eleven years since 2009, the practice registered population of the city has grown by 67,000 (Table1). This steady increase of c6000+ new patients per year is predicted to continue for the next 20 years and beyond. The main impact of this is that much of the PCIP resource is effectively picking up the additional impact of the non-directly population-sensitive funding allocations. Whilst GMS and prescribing allocations are tied to practice population increase, the entire surrounding primary care infrastructure (midwives, district nursing, physiotherapy, mental health etc) is not, with the additional workload

consequently often picked up by GP practices. The fact that the PCIP is neither population sensitive, nor (completely) tied to pay increases, will ultimately result in gradual deterioration of the impact of the PCIP after the implementation phase.

The table below shows the increase in population experienced together with the number of practices. Our approach has been to support our existing practices to grow rather than to establish new practices, except where agreed as the only realistic option. Edinburgh practices now have an average list size of 8000+, and at least three new practices will need to be established to meet planned population growth over the next decade.

Edinburgh GP List Sizes & Population Growth

Year (October)	Edinburgh GP List Sizes)	Edinburgh Estimated Total Population (Source: NRS) *mid year estimates 2016 based	% Difference	Restricted Lists	Number of practices	Number of premises
2009	505,000	463,240	9.0%		79 (as at 2000)	75 (as at 2000)
2010	510,000	469,940	8.5%			
2011	512,000	477,940	7.1%	3		
2012	519,000	482,630	7.5%	2		
2013	525,000	487,460	7.7%	7		
2014	530,000	492,610	7.6%	10		
2015	535,000	498,810	7.3%	12		
2016	542, 000	503, 805*	7.6%	24		
2017	548,000	512,912*	6.8%	41	72	67
2018	552,000	518,100*	6.5%	43		
2019	565,000	522,472*	8.1%	42		
2020 (January)	567,000	526,474*	7.69%	36	70	62
	Assuming 5k growth per annum					
2033	632,000	566,086*	6.8%			

3.0 Evaluation and evidence

This has been a major focus of attention for us from the beginning. One of the investments made to strengthen the H&SCP Primary Care Support Team was the appointment of an Evaluation Officer, initially on a 2 year basis. The underlying hypothesis was that Edinburgh was short of around 600 medical sessions per week and we set out to invest the PCIP to augment those. This relied, on the assumption that the medical workforce, whilst unlikely to grow to match increasing population, would not decline in real terms. The role of the Evaluation Officer is to look at the PCIP investments after the implementation phase, and assess to what extent each investment has contributed to the augmentation of the 600 'missing' GP sessions. Thus far, we have undertaken initial assessments on practice-embedded Primary Care Mental Health Nurses, Link Workers, Physiotherapists and are currently looking at pharmacists. Each of these evaluations is fed back to the Edinburgh Primary Care Leadership and Resources Group. The Group agrees what further funding is to be released for an MOU area, based on these evaluations and the associated impact. It must be stressed that at this stage these evaluations are relatively light – but nevertheless have been sufficiently convincing and informative to continue the cycle. The expectation is that all evaluations will be repeated with broader scope and depth as part of a second cycle.

A copy of some slides from the recent (November 2019) MSK evaluation is shown below. What the slides show is the appointment workload of c4-5 sessions redirected from the GPs, and high job and patient satisfaction. What the slides do not show is a marked drop in the number of patients sent for an orthopaedic out-patient appointment, and the reduction in associated prescriptions. It is interesting to note that these 'unintended benefits' have been particularly significant at an early stage in all of the evaluations undertaken to date. We remain cautious about 'over-claiming' as the sustainability of these investments has yet to be proven.

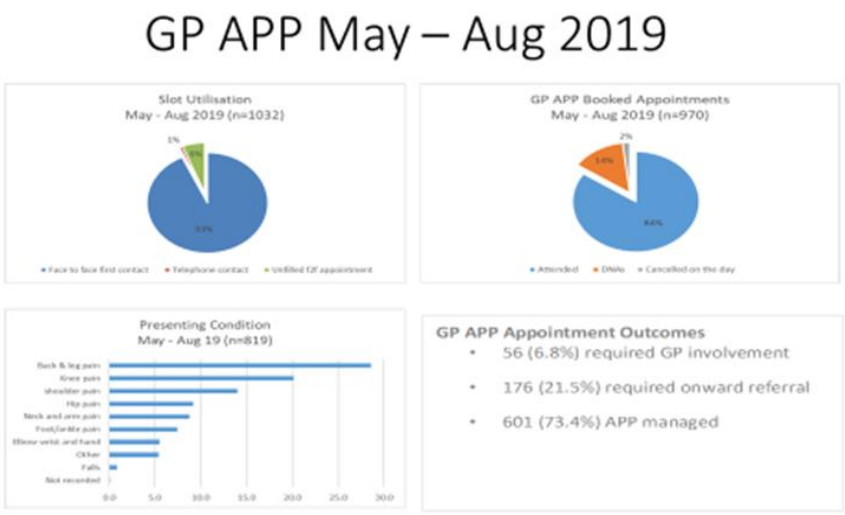


Table 2 shows our best understanding of the impact of the investments made thus far, converted into medical sessions augmented.

Table 2.

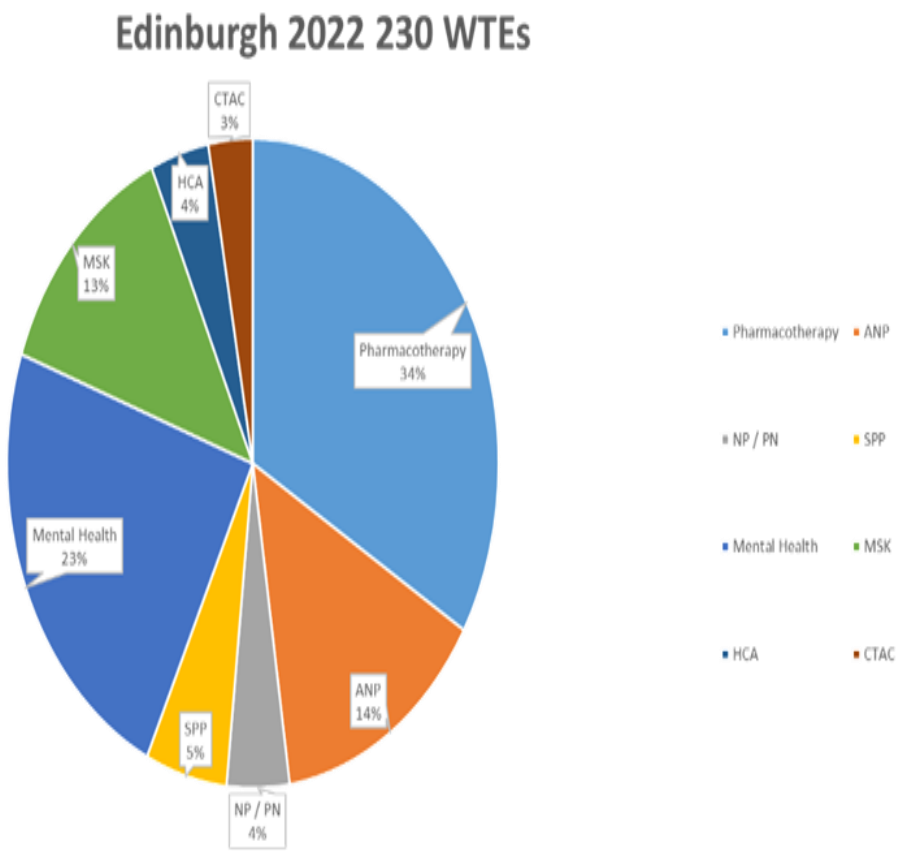
Edinburgh Primary Care Transformation Programme Impact Tracker Feb 20

	Practices Benefitting	Wte in post	Sessional Equiv (est)	Funding Origin
Pharmacotherapy	60	38.0	114	PCIP
Linkworking	29	18.0	18	PCIP/T&S/17c
Vaccs	29	3.4	10	PCIP
Nursing	19	18.8	60	PCIP/T&S
Mental Health	17	14.4	58	PCIP
MSK	12	6.0	24	PCIP
CTACS	4	3.0	9	PCIP
CL. Admin	60	-	70	T&S
Tech	63		TBC	PCIP
TOTALS		101.6*	363	

The table shows the key relationship between the investments made and how this correlates to a number of medical sessions augmented. It should be noted that the assertion of a current total of 363 sessions (c40 wte GPs) is not yet 'real,' as a number of these posts will be vacancies or in training. Nevertheless, it is important that expectations of impact on workload are set for both the incoming MDT members and for the practices.

4.0 Steps to deliver PCIP

In simple terms Edinburgh has turned its total PCIP resources (£12.9M) into c230wte staff (+c14.0wte link Workers) distributed across the 70 practices, together with all agreed central investments. The 230wte cover all parts of the MOU, and we are actively recruiting to attract any available candidates. Progress is therefore incremental, with a small number of practices benefitting from any available staff at any point. Assessment on this progress is made available on a continuous basis to all practices together with our subjective assessment of whether they are 'red/amber/green'. Our main steps – described in greater detail below, are simply to support the effective introduction of one member of staff after another into practice teams. An important part of the Edinburgh approach is the expectation that a GP Partner takes personal responsibility for the integration of each new team member into the practice. This ensures the critical dialogue about expectations, workload management and phasing takes place in a supportive relationship.



This diagram shows how Edinburgh GPs (in mid 2018) indicated they wanted to see their allocated PCIP resource deployed across the MOU areas (excluding Link Workers). This remains a very useful guide, but we are well aware that sufficient numbers will not be available, even towards the end of 2022, to fulfil these expectations. We are optimistic that 200wte can be secured by the end of 2021/22.

5.0 MOU areas

Pharmacotherapy

- 52.3wte pharmacists appointed to 31.3.20 (includes 17.wte technicians)
- 10.0 more per year over next 2 years
- Now embedded in 68 out 70 City practices, with 0.7wte the City practice average.
- 55% Pharmacist Independent Prescribers
- Practices with PSP level 1 & 2 & 3 (61 / 48 / 34)

CTACS

- CTAC established to serve one cluster area (10 Practices with c86,000 population)
- Despite initial reservations across City, a second and third CTAC will be established in 2020/21 with a possibility of a fourth.
- Ear irrigation, complex wound dressings & ABPI measurements are the most popular activity requested to date which would release most time for Practice Nurses. New procedures will be gradually introduced in 20/21 in discussion with Practices i
- Secondary Care phlebotomy IT still a challenge, but active work being undertaken, (with new pressure because of COVID)
- Equalities Impact Assessment undertaken to consider any negative impacts in terms of access and inequalities

ANPs (NPs & HCAs)

- 16.3wte ANP, ANP Trainees and NPs across 20 Practices
- 3.1wte HCA across 4 Practices
- 20.0wte more by March 2022

Vaccinations

- Childhood immunisations have now moved out of Practice delivery in all Practices in Edinburgh An Out of schedule Model for Childhood immunisations has been agreed and a pilot was commenced in 6 Practices to test the model. The expectation is that this will move to children services in 20/21

- Shingles Vaccination was tested within CTAC and will be moved to CTAC's when established in 20/21

- Student Vaccination model agreed for 20/21 delivery
- Adult and child flu vacs due to be delivered by EH&SCP in 2020/21 with exception of 'opportunistic' vaccinations which will continue to be delivered by Practices in 20/21
- c93,000 is current target (subject to anticipated change as at july)
- Detailed change plan available to describe intended programme
-

MSK (physio)

- 5.35wte across 12 Practices
- 22.0wte more planned by March 2022
- Initial evaluation very positive

Practice Mental Health Nurses

- 15.7wte across 16 Practices
- 35.0 more by March 2022 (Concern as at July 2020 about whether this is achievable)
- Discussing the re-design of the model of delivery to incorporate a skill mix of Nursing Bands.

6.0 Mental Health and Action15

The detailed MOU on Primary Care Mental Health Nurses (above) emphasised our confidence in this new role as a substantive increase in the capacity of primary care, together with introduction of new expertise, improved relationships and resource usage with secondary mental health services. An innovative approach to the parallel investment of Action15 Mental Health monies based on the 'Thrive' methodology was agreed by the IJB. The concept of a range of supportive investments being developed to augment community support is understood, and the initial pilot (from Feb 2020) is at a very early stage. It is not yet clear what impact this might have on GMS, or whether this will be part of the Thrive evaluation. The use of Action 15 Primary Care Mental Health funding remains outside the scope of the Edinburgh PCIP delivery arrangements.

7.0 Workforce and Skill Mix planning

The actions being taken to deliver each MOU area have been addressed in the section above, together with the mitigating actions. What has not been described is the challenge presented by turbulence in the new workforce, which we anticipate to remain acute for the next 2-3 years.

The example of pharmacotherapy is offered;

At 31.1.20 Edinburgh PCIP had funded and allocated, 38.0wte to named practices. In real terms, only c32 of these pharmacists were in post and of those approximately 50% did not yet have their V300 independent prescribing qualification, and so could not make their full contribution. In addition, across all pharmacists (with or without V300), many had not been in post long, were new to primary care or were re-considering primary care as a career choice, having appreciated the workload and risk management involved. As outlined in the evaluation section each pharmacist could theoretically augment clinical capacity by c4-5 sessions per week (+other benefits). A workforce of 38 would therefore inject capacity of around 160 sessions. In reality, the actual capacity currently being injected due to turbulence is estimated at much less, possibly around c100 sessions.

Several things are being done to mitigate this, following the example of pharmacotherapy;

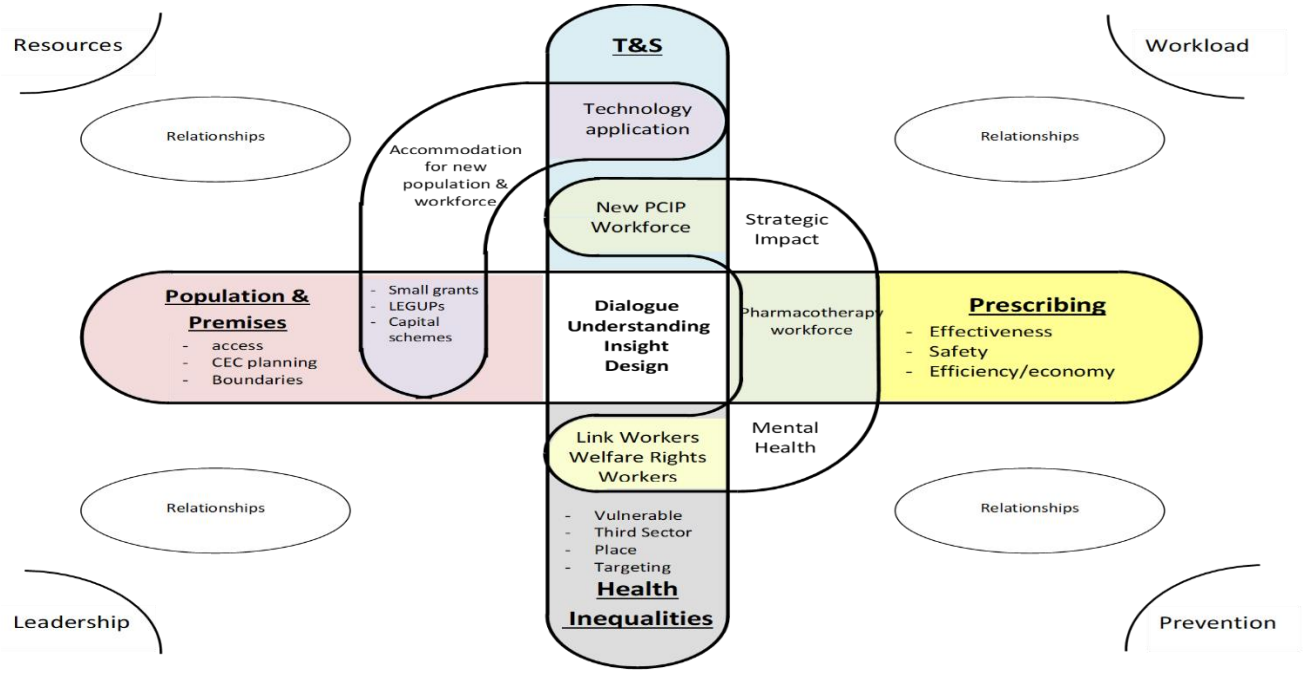
- GPs being paid for supervision of V300 - either within or out with the practice team
- Additional support to new members of staff inexperienced in primary care, and in particular the fast, pragmatic, 'Realistic Medicine' approaches required by a high volume workload
- Named senior GP as mentor for each
- Support for additional places of V300
- Conversation starting through clusters about the potential for a pharmacotherapy cluster team with skill mix and centralisation of some processes – a move away from a single pharmacist fully embedded in each team (where requested/prioritised).
- The intention would be to ensure the consistent delivery of all or part of 'level 1' across all practices, leaving levels 2&3 reliant on the presence of the practice attached pharmacist.
- A substantial investment was agreed across all Lothian H&SCPs to support the training of additional pharmacy technicians. These staff started their training in late 2019 and should begin to make an impact on workload during the latter part of 2020.

8.0 Change management capacity

Edinburgh H&SCP has recognised the strengths of a single dedicated 'Primary care Support Team,'(PCST) able to support the development of GMS primary care and complementing and linking with the contractual role of the NHS Board and its Lothian wide 'Primary Care Contracting Organisation' which covers all independent contractors and the GMS out-of- hours arrangements.

The process of **transforming** the workforce and workload is highly related to cost and quality related **prescribing**, and the introduction of the new workforce needs to be understood and managed in the context of **the population and premises** challenge. We cannot address workload in deprived population practices without an understanding of how **inequalities** manifest at the individual and community level and the co-ordination of public services and the sustained community engagement required to bring about generational change. These **four interlinked areas of support** offered by the PCST are shown below, with the consequent insight and design functions growing through reflective dialogue.

The team offers a single point of contact for most issues relevant to GMS primary care. The 'T&S' function of the team has been built partly through the PCIP and these new elements are described below.



PCIP Programme Manager – this post was required firstly to co-ordinate and report on implementation progress. Secondly, the post provides change management to individual workstreams which are not otherwise supported.

Primary Care Clinical Nurse Manager (from dec 2019) – this post has direct line management responsibility for the new nursing workforce expected to grow to 100+ wte over the course of implementation. This post will also take the lead in implementation workstreams as required.

We have c15wte Practice Mental health Nurses. Of these, three are **team leads** reporting to the Primary Care Clinical Nurse Manager, and devote around one day per week on management (mainly clinical

supervision) – so **0.8wte** in total. (Currently, management responsibilities still with overall Primary Care Service Manager but will be transferred).

Evaluation Officer – reporting to the programme manager this post undertakes the evaluation of all of the investments. In the longer term this post will support our 'demand and workload insight' functions.

Pharmacy Manager – where previously a single manager was able to support a small team of pharmacists encouraging cost effective and quality prescribing across all Lothian practices, the expansion of the workforce has required investment in a dedicated management post for Edinburgh.

In physiotherapy we appointed a team lead post (0.5wte) of around a day per week (0.2) devoted to management responsibilities.

Link Worker Network Manager – the Link Worker Manager was initially recruited to oversee the appointment and establishment of a network of Third Sector partners hosting government funded Link Workers who were not yet part of the PCIP. Since then the post has helped to establish Link Worker 'tests of change' with non deprived and elderly populations, to appoint Link Workers for practices which prioritised this support from their PCIP allocation and to promote and encourage the adoption of 'signposting' across all City practices. (The Edinburgh Link Worker Handbook was a useful resource developed to using our local experience).

Cluster Admin support post - devoted to supporting eight CQLs and providing a role which helps co-ordinate both information and activity. This post also provides support to the Evaluation Officer.

(Edinburgh HSCP made a request to our Leadership and Resources group for additional investment in recruitment support for a two year period to accelerate what is regarded as a very slow process which has now resulted in candidates being lost through avoidable delays. This was not supported mainly due to GP Sub opposition to a PCIP spend on what was considered an NHS Board responsibility. GPs expressed concern about Board performance in ensuring the PCIP recruitment process was effectively supported. The example serves to illustrate the robust scrutiny and debate which underpins all resource based decisions taken through the L&R Group).

A further investment has been made from the PCIP in supporting the **Edinburgh Practice Manager network.** A previous Lothian network had gradually eroded due to lack of support and funding and we ensured that each practice received a token stipend as compensation for their PM being one of the Locality Lead PMs. We gave the group of 4 PM Leads funding to organise 2 conferences per year and the potential to do pieces of work collectively, rather than always through individual practices. These have proved very successful and we believe have supported rapid change.

We have also **funded GP sessions** to be involved, or to lead the various workstreams.

In regard to the exchange of 'what works', Edinburgh and Lothian have several fora in which this happens.

9.0 Health Inequalities

As described earlier, the PCIP consultation (2018) proposed a top slice of 5% of the total PCIP to be redistributed amongst practices according to the percentage of the list who are SIMD 1 patients. Prior to this, the national allocation of Global Sum does account for deprivation, so this baseline allocation was already sensitised to deprivation. In addition, the £1.1m (ENRAC share) of the contract devoted to a link working network was 'top-sliced' before the remainder was turned into the 230wte posts to be distributed across all practices. Effectively therefore, c£1.7M or 13% of the PCIP was used to specifically strengthen the allocation to practices with economically deprived patients

EH&SCP was allocated recurring funding prior to the New Contract for stability functions ie practices unable to continue without support. As stability gradually returns to the system we have proposed that the equivalent of a further 5% of the PCIP from **these separate funds** is applied to practices which are not able to cope with their routine workload. Practices who want these additional non PCIP resources will need to contribute 50% of the staff costs. Whilst we will restrict applications to those practices which we understand have high workloads and low earnings, we anticipate that most applications will be from practices with high deprivation populations.

The question is often asked in relation to deprivation – did we go far enough in recognising the additional challenge and associated workload. Our answer is that we did not. The fair distribution of resources is a sensitive matter and we took the view that all practices had challenges, and needed to benefit materially. The PCIP alone could not be expected to 'level up' all practices, and we do not **yet** have sufficiently robust workload and demand insight to move far from the national allocation formula.

10.0 Premises

Edinburgh has particular challenges around premises. The diagram below summarises the major premises issues in each locality in 2017. The purple lettering indicates where we have delivered a new scheme and resolved the situation. The white lettering denotes those schemes which remain outstanding and the red lettering those which are currently urgent &/or underway.

- Limited investment in new primary care premises over past 20 years with many obsolete premises (20 out of 60 City premises merit immediate replacement owing to condition or capacity or both). Realistically, NHS Lothian can afford only one development in Edinburgh each year which increasingly forces us into crisis solutions as investment falls further behind.
- Difficulty in identifying opportunities to develop new premises within a City with rapidly growing and competitive market for any site opportunities. When combined with governance stipulations (SCIM), this virtually rules out any open market opportunities.
- In response we have used a series of 'small schemes' over the last four years to support practices with suggestions as to how adjustment of their practice building would allow then to increase their list size by 500+. This has worked for 40+ practices, but we are likely reaching the limits of this approach. (To be revisited with experience of COVID working arrangements).

- Often (but not exclusively) in tandem with the small schemes we have offered prospective 'LEGUP' grants where a practice is given a one off £25k grant to encourage/facilitate practices to grow by 500+ patients within a year and that this increase is maintained for at least 3 years. (This was particularly important in the period of uncertainty prior to the New Contract where many practices understood that increasing their list size could have been financially disadvantageous).
- We also introduced 'intermediate schemes' and had £1.2M ear-marked in the NHS Lothian Capital Plan for this purpose. This has allowed more ambitious augmentation/redesign of existing premises to facilitate population increase. Two of these have been completed, one is underway and another is planned for the coming year.
- An extensive assessment of premises in relation to growing population was completed in early 2014 with extensive GP engagement. This allowed us to understand the position of each practice across the City in relation to population increase likely to impact directly or indirectly and to generate the mechanisms described above. This exercise has been repeated at 2 year intervals to check local understandings and new housing market and planning circumstances.
- The Sustainability loans are a further helpful mechanism to potentially help with financial stability, but they do not address the underlying challenge of lack of investment in premises.
- 23 of Edinburgh's practices are owned by the GP Partners, and in many they will look to release their investments over the next few years, as new partners decline to buy in to a share of the building. Other solutions will be required to avoid the withdrawal of these premises from GMS use.
- Funding was made available by Scottish Government in late 2019 to address minor premises issues. This funding was augmented with some uncommitted small schemes funding and some PCIP under spend and a list was priorities across the City, which directly helped 32 practices make improvements to their practice facilities. (Separate report submitted to Scottish government).

11.0 Digital

Over the last 2 years the Edinburgh PCST has made available 50% contribution funding to encourage use of technology which reduces workload for practice teams. Most of this has been fairly routine; automatic check in/texting/laptops for home visits/larger computer screens. This approach has also allowed us to develop thresholds as appropriate eg we only fund 50% of a surgery pod for practices with lists of 6000+. The vision was to encourage adoption as 'normal' and to fund the enthusiasts 100% to try anything new. 65 of our 70 practices have benefitted to date. We have yet to report on the estimated workload impact which this investment has made, but the scheme has proven popular and some initial evaluation has been

encouraging. We will continue to fund 'tranches' of new technology at 50% through the PCIP using under spend funding.

12.0 Patient Engagement

We looked carefully at the widespread patient information exercises which have been carried out in other parts of the country. This was discussed with both GPs and the Practice Managers. The consensus to date was that the PCIP represents accelerates evolution rather than revolution, and that these changes are much better managed at practice level.

13.0 Looking Ahead

This report was written before the experience of the COVID pandemic, which will be subject to more examination in the 2021/22 report. Briefly, we believe the experience of the pandemic has accelerated and strengthened the MDT relationships and working practices which are the foundation of our Edinburgh

PCIP approach. The resilience of practices undoubtedly benefitted from the MDT staff who were already embedded. It was important that throughout the pandemic there was no attempt to withdraw practice embedded staff – although this happened once with practice agreement for a period of three days only.

David White

Edinburgh HSCP Strategic Lead Primary Care & Public Health

Appendices

- **PCIP implementation detail by practice**

EDI Employed PCIP
& T&S and Requeste

- **Recurring commitments by MOU area**

Recurring
Commitments Only (

Covid PCIP 3

Health Board Area: Lothian
Health & Social Care Partnership: Edinburgh
Number of practices: 70

MOU PRIORITIES

2.1 Pharmacotherapy	Practices with no access by 31/8/20
Practices with PSP service in place	0
Practices with PSP level 1 service in place	0
Practices with PSP level 2 service in place	0
Practices with PSP level 3 service in place	0

Comment / supporting information: **69 practices out of Edinburgh 70 Practices requested PSP as part of their PCIP WTE Allocation.**
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous
soon as this is possible. We have continued to employee further PCIP Pharmacists and develop the service though out the Covid 19 period. A

2.2 Community Treatment and Care Services	Practices with no access by 31/8/20
Practices with access to phlebotomy service	55
Practices with access to management of minor injuries and dressings service	55
Practices with access to ear syringing service	55
Practices with access to suture removal service	
Practices with access to chronic disease monitoring and related data collection	55
Practices with access to other services	

Comment / supporting information: **Edinburgh will have a multi CTACs to support the City prcatices with 1. Complex Dressing 2. Dopller ABI 3**
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous

2.3 Vaccine Transformation Program	Practices with no access by 31/8/20
Pre School - Practices covered by service	
School age - Practices covered by service	
Out of Schedule - Practices covered by service	
Adult imms - Practices covered by service	70
Adult flu - Practices covered by service	
Pregnancy - Practices covered by service	
Travel - Practices covered by service	70

Comment / supporting information: **VaccinationsProgramme is delivered via Edinburgh Primary Care Support Team Management (CTAC Team**
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous
Flu. The delivery of the adult flu programme for Edinburgh has been a huge undertaken for Edinburgh Primary Care Support Team (Target 81,

2.4 Urgent Care Services	Practices with no access by 31/8/20
Practices supported with Urgent Care Service	17

Comment / supporting information: **42 practices out of Edinburgh 70 Practices requested ANPs , NPs & SPP as part of their PCIP Allocation. Da**
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous

Additional professional services

2.5 Physiotherapy / MSK	Practices with no access by 31/8/20
Practices accessing APP	16

Comment / supporting information: **38 practices out of Edinburgh 70 Practices requested MSK APP as part of their PCIP Allocation**
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous

2.6 Mental health workers (ref to Action 15 where appropriate)	Practices with no access by 31/8/20
Practices accessing MH workers / support	37

Comment / supporting information: **53 practices out of Edinburgh 70 Practices requested Mental Health Practice Nurses as part of their PCIP A**
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous
This delayed advertising and appointing further Nurses following the success of the initial phase of appointments.

2.7 Community Links Workers	Practices with no access by 31/8/20
Practices accessing Link workers	3

Comment / supporting information: **Beside the National LW Programme in 21 prcatices 17 Practices out of Edinburgh 70 Practices requested L**
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous
detailed information available

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

Comment / supporting information: : **50/50 Deals in 17 Parctices Clinically (The Plan the 18wte to be part of the PCIP) and Clinical Admin Supp**
Develop Leadership and support to GMS.
Please detail the impact of Covid on implementation and where you are in this process, including the impact of the Covid response on previous

2.9 Overall assessment of progress against PCIP

Specific Risks

Risks are common across Scotland - lack of available professionals to take up the roles/risk of destabilisation of other systems as staff move ANPs away from out - of hours. Potential clinical risks of stretched primary care teams not supporting new roles adequately - so far heavily re primary care posts and developing the roles. Locally, the impact of the PCIP is diluted by the additional capacty being used to support a popu without comensurate investment beyond GMS and prescribing allocation uplifts.

Barriers to Progress

Please detail any barriers to progress and what could be done to overcome those barriers: **lack of investment in primary care premises to matc unable to accommdate anyone else in the building irrespective of the help and capacity they bring.**

Issues FAO National Oversight Group

Still lack of clarity/different understandings over the implementation of the New Contract: Local interpretation has prioritised practice choice beyond city wide removal of vaccinations and the proportion of funds to be spent on a Linkworker network. The extent to which the Action 1 going through GMS remains unclear, as does required 'sign-off' for investments. Helpful if there was a minimum proportion of the Action 15 f the governance for the Primary Care element of Action 15 is aligned with PCIP. Edinb
Investment funds (c£500k) to ensure a base line of 50% of Docman undertaken by Admin Staff. This has been very successful. Consideration s the PCIP (Further details, Data, Evaluation available on request)

Workforce profile

Health Board Area: Lothian
Health & Social Care Partnership: Edinburgh

Table 1: Workforce profile 2018 - 2022 (headcount)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL headcount staff in post as at 31 March 2018	0	0	0	0	0	0	0	0	0	0	0	20
INCREASE in staff headcount (1 April 2018 - 31 March 2019)	25	3	3	4	0	0	0	0	15	5	0	0
INCREASE in staff headcount (1 April 2019 - 31 March 2020)	15	2	2	1	0	5	2	0	3	2	0	4
PLANNED INCREASE in staff headcount (1 April 2020 - 31 March 2021) [b]	24	15	9	3	0	16	6	5	17	12	2	3
PLANNED INCREASE staff headcount (1 April 2021 - 31 March 2022) [b]	20	4	4	4	0	11	6	2	21	14	2	0
TOTAL headcount staff in post by 31 March 2022	84	24	18	12	0	32	14	7	56	33	4	27

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

Table 2: Workforce profile 2018 - 2022 (WTE)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL staff WTE in post as at 31 March 2018	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	15.2
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	21.3	3.0	4.4	3.1	0.0	0.0	0.0	0.0	14.4	3.9	0.0	0.0
INCREASE in staff WTE (1 April 2019 - 31 March 2020)	10.0	18.0	0.0	0.0	0.0	5.0	1.5	0.0	3.0	1.5	0.0	6.1
PLANNED INCREASE in staff WTE (1 April 2020 - 31 March 2021) [b]	14.4	0.0	6.4	2.8	0.0	16.0	4.0	4.0	17.0	8.6	2.0	1.7
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	12.0	3.2	3.0	5.0	0.0	10.0	5.0	1.5	16.0	12.0	2.0	0.0
TOTAL staff WTE in post by 31 March 2022	57.7	24.2	13.8	10.9	0.0	31.0	10.5	5.5	50.4	26.0	4.0	23.0

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

Comment: The numbers will vary as the Recruitment Progress & Staff Cost / Headcount is a an estimate. Vaccinations: is delivered via Edinburgh Primary Care Support Team Management (CTAC Team , Travel Clinic, Practice Nurses through Staff Bank, Midwives, School Nurses & Health visitors)