Agenda Item 12

Primary Care Improvement Plan: Iteration 3

Agenda Item 12

Falkirk Integration Joint Board

19 June 2020

Primary Care Improvement Plan: Iteration 3

For Approval

1. Executive Summary

1.1 Iteration 3 of Forth Valley's Primary Care Improvement Plan (PCIP) (Appendix 1) reports on the progress towards implementation of the new General Medical Services (GMS) contract and highlights minor areas of revision from Iteration 2 for the next two years.

1.2 All priorities outlined in PCIP Iteration 2, year 2, were delivered and remain on track despite the significant disruption of Covid-19. 125 additional clinical roles are now in place, demonstrating significant flexibility in sustaining direct access to primary care, often through virtual consultations and directly at Covid-19 assessment centres. Progress includes the delivery of more than 3,500 consultations and in excess of 2,500 acute prescription authorisations now being redirected to additional professional roles in general practice on a weekly basis, across Forth Valley GP practices.

1.3 PCIP: Iteration 3, whilst continuously reviewed, proposes to maintain the plan and pace, largely, as set out in Iteration 2. Whilst the GMS contract delivery date is end of March 2021, it should be noted that full delivery of our PCIP remains over the four year funding timeline. This means that some final commitments remain on trajectory for delivery immediately post April 2021.

1.4 Notably, the NHS Board, Integration Joint Boards and the Local Medical Committee agreed on Iteration 2 for 2019/20 planned activities only. This was due to insufficient funding being assured for future years and, whilst iteration 3 represents significantly reduced costs since Iteration 1 and year 3 activities are affordable within the available recurring budget the cost of fully delivering the requirements of the new GMS contract continues to exceed the indicative revenue funding allocation provided by Government.

2. Recommendations

The Integration Joint Board is asked to:

2.1 agree the Primary Care Improvement Plan Iteration 3 subject to the tripartite statement (Paragraph 8, page 2), from the GP Local Medical Committee, Clackmannanshire and Stirling IJB and NHS FV Board.

2.2 note that the draft plan needs to be submitted to the Scottish Government by 23 June 2020.

2.3 note that the government has rejected a business case for additional PCIP funding and that full delivery of the Primary Care Improvement Plan continues to exceed the indicative recurring funding provided by Government by circa £1.3m, in total, across both partnerships. All current (2020-21) year commitments are, however, now sustainable.

3. Background

3.1 The paragraphs below outline the background to Primary Care improvement plan and form the proposed Tripartite Statement to Scottish Government (Appendix 1, page 3).

3.2 "Forth Valley's Primary Care Improvement Plan (Iteration 3) is submitted to Scottish Government on behalf of our tripartite partnership of Clackmannanshire and Stirling, and Falkirk Health and Social Care Partnerships, NHS Forth Valley Health Board and the Forth Valley Local Medical Committee. All partners recognise and commend the significant achievement in delivering all of the commitments of PCIP Iteration 2 to date. This level of progress has been achieved through highly effective local collaboration and with significant additional, but non-recurrent, investment support from Health Board funding and primary care partnership reserves.

3.3 The tripartite partners unanimously agree that the priorities and revised service specifications described in Iteration 3 of Forth Valley's PCIP continue to set out what we believe is essential to enable delivery of the commitments of the MoU beyond April 2021. Our partners agree that Iteration 3 continues to reflect the revenue costs associated with our assessment of what is required to adequately deliver commitments of both the GMS Contract and the supporting MoU.

3.4 We have consistently highlighted a significant recurring shortfall (£1.3m) in the funding provided and are extremely disappointed that our detailed business case seeking additional funding was rejected with no explanation or feedback. In the absence of additional funding for 2020/21, we have implemented a number of non-recurring measures to enable us to progress some elements of the plan and ensure we do not lose GP engagement. This includes prioritising and re-phasing the planned recruitment programme and securing additional non-recurring funding through NHS Forth Valley. These actions do not address the underlying funding gap and it is clear that we will not be able to fully implement the contract by 31 March 2021.

3.5 While the focus of work in recent months has centred on our response to the Covid-19 situation our tripartite group is strongly aware of the importance of maintaining the momentum and progress of our PCIP work. We are therefore having a renewed focus on the priorities being taken forward by our three key PCIP working groups. This is considered essential as we recognise that the new models of care supported by the PCIP have been integral to supporting a level of sustainability in primary care that has allowed our rapid mobilisation response to the Covid-19 situation. Practices have been enabled to work collaboratively to engage with and support our Community Assessment Centres, Triage Hub, Care Home Response Team and Enhanced Community Team. This level of support during the pandemic would not have been practical without our PCIP workforce being in place. They will also play a vital role in practices being able to deliver on their recovery plans as we move forward.

3.6 Looking to the near future we will also have additional challenges due to Covid-19 including the delivery of the influenza immunisation programme in the context of pandemic restrictions through alignment with the Vaccine Transformation Programme (VTP) with the flu programme. There remains a position across Forth Valley that the primary care flu programme will be the responsibility of the practices this year in line with the Direct Enhanced Service (DES) requirements but that the programme for this year, due to the impact that Covid-19 will have on our ability to deliver the usual approach to mass vaccination clinics will require a collaborative approach between the Board and the practices. There is no available funding in our plan that can support this in 2020/21.

3.7 This plan does not commit IJB or NHS Board funds beyond that set out in the finance plan and Forth Valley Tripartite Partnership, therefore, remain of the view that without additional recurring Scottish Government funding, sustainable delivery of the plan by April 2021 remains unfeasible. This presents significant risks to service resilience, ongoing sustainability of primary care and losing the high level of collaborative engagement between services, partners and primary care. Clarity on the funding position is required as a matter of urgency.

3.8 The IJB is asked to support the plan subject to the content of the tripartite statement above.

4. Primary Care Improvement Plan: Interation 3

4.1 Delivering local health and social care services including primary care through enabled communities and workforce is the first priority within Falkirk's HSCP Strategic Plan. Primary care transformation and delivery of the primary care improvement plan are core actions of the delivery plan for the strategy

4.2 Iteration 3 of the Primary Care Improvement Plan is set out in full in Appendix 1.

4.3 **What is new in Iteration 3?**
Whilst the document outlines more information which has been set out in the government's guidance for Iteration 3, the plan reiterates the intentions for year 3 and 4, largely as set out in Iteration 2. Specific changes are highlighted below.

4.4 Of note, we achieved our Iteration 2 workforce plan with more than 120 new roles now in post. Forth Valley is also recognised as one of the few boards who are on plan and believe that we can deliver our PCIP; if the funding we seek is put in place.

4.5 **Maintaining Momentum**
A business case for significant additional funding was submitted to the Scottish Government in December 2019.

4.6 The case highlighted the pace, scale and strength of collaboration and implementation achieved in Forth Valley to date. This has been achieved through the enormous efforts of practice teams, clusters, new services, GP sub and programme team. Also with support of significant, non-recurring, additional funding from NHS FV and HSCP Partnerships reserves.

4.7 We now know that SG has declined the business case. However, whilst we continue to make the case for additional £1.2m recurring funding, we have £500k non recurring funding from NHS FV, increased Action 15 funding for mental health posts, some slippage and through extremely detailed budgeting of actual salary scales and revision of likely start dates. This means that we do have the majority of funding available for the coming year. We also have a prioritisation plan which was informed with GP sub representatives late 2019, in order for us to maintain momentum with the immediate priorities of our plan and MoU. The outcome of this exercise has enabled us to progress with pharmacotherapy and additional professional roles as first call on available funding for year.

4.8 Whilst still evolving, four clusters have full pharmacotherapy resource is in place. Iteration 2 proposed to continue a cluster by cluster role out of full pharmacotherapy resource over 2020 and2021. Iteration 3 now proposes that all practices will have at least partial pharmacotherapy service by autumn 2020 with full service available in 2021.

4.9 The interim partial pharmacotherapy service specification, for implementation in 5 remaining clusters, has been agreed with GP sub and shared with the relevant clusters.

4.10 **Do we have funding in place?**
Yes, Pharmacotherapy is a clear priority for the contract and for GPs. We already have a significant number of the workforce in place and the partial service has started in Slamannan and the Braes, and Bo'ness and Grangemouth. Practices are now starting preparatory work for service to start in Clackmannanshire in May and Stirling and West Stirling in September / October 2020.

4.11 **Vaccine Transformation**
Iteration 2 proposed that re-provision of under 5 years immunisations would extend into 2020/21. Aside from rural practices, Falkirk central cluster will be the last to conclude childhood vaccinations by July 2020.

4.12 More than 12,000 vaccinations were delivered in the last year with pre-transfer uptake rates for the 0-5 Primary Immunisation Programme being maintained.

4.13 Iteration 2 also proposed that: subject to available funding, it is anticipated that the transfer of all immunisations except Travel vaccinations will conclude in 2020/21, with Flu and final transfer of travel vaccinations completing in year 2021.

4.14 **Children's Flu**
Iteration 3 proposes that a staged transfer of children's flu will commence in winter 2020 concluding winter 2021. The scale and target populations for the first stage are yet to be defined

4.15 **Travel**
Iteration 3 proposes that Travel Vaccination service in scope for 2020/21 will, aside from a potential test of service, likely be deferred to 2021/22 it will cover NHS routine immunisations only with the expectation that the service will grow to cover yellow fever and non NHS immunisations, generating an income stream, in future years.

4.16 **Adult Flu**
Iteration 3 maintained the objective of flu transfer in 2021, with practices delivering this in 2020. In light of the likely implications of Covid-19 on delivery of mass flu vaccinations, the issue of flu immunisation programme is recognised as a particular challenge which requires urgent organisational consideration. The additional challenge of delivering flu considering likely social distancing and shielding constraints is not seen as a direct issue for PCIP to resolve, but for wider organisational change as a consequence of Covid -19.

4.17 **Do we have funding in place for this?**
Progression of children's flu, travel and any flu immunisations this year relies on additional funding becoming available. Year 4 funding will require to be prioritised to vaccinations above other, currently, higher GP priorities to ensure delivery post April 2021.

4.18 **Additional Professional Roles**
All additional roles planned for 2019/21 are recruited, 17 primary care mental health nurses (PCMHN) working in 40 GP practices, 9.4 Advanced Practice Physiotherapist's (APP) in 28 practices, 21 Advanced Nurse Practitioners (ANP) working / training across 5 clusters and care homes across Forth Valley

4.19 Iteration 3 proposes to implement 14 of the remaining 26 additional roles in 2020/21 with the aim that all practices in NW Stirling, Falkirk, Denny / Bonnybridge and Stenhousemuir will have at least one additional professional role by July. Most will have new roles between May and July 2020 with some posts in addition to these by autumn.

4.20 It is recognised that the Care Home model requires review, particularly in light of Covid-19 and recent direction from Scottish Government. The current balance of support to care homes will require to be reviewed at cluster level.

4.21 **Link workers**
Iteration 2 & 3 aligns 8 link workers with year 3 of the plan. Whilst link workers remain low on General Practice PCIP priorities and can't now be funded this year, we are fortunate that Falkirk partnership, supported by some residual Primary Care Transformation funding, is funding 4 link workers who are in place, supporting practices in Denny / Bonnybridge, Falkirk central and in Grangemouth.

4.22 **Do we have funding for additional professional roles?**
Funding is in place for 14 additional professional roles.

4.23 **Community Treatment And Care – Phlebotomy**
Iteration 2 highlighted that 4 clusters would have phlebotomy service at April 2020 and all practices by April 2021. Stirling, Denny and Bonnybridge, NW Stirling (non rural practices) are in place with Stenhousemuir starting March 2020.

4.24 Iteration 3 confirms the aim for all practices to have access to the phlebotomy only service by April 2021. The phlebotomy service will generally deliver from one or two hubs within a cluster, outreaching to practices with sufficient population or geographical need. The approach for rural practices will be confirmed through an ongoing options appraisal process. The development of wider long term condition monitoring will develop as capacity allows.

4.25 We are now working more closely with secondary care to develop a more integrated approach including maintaining the recently initiated phlebotomy hub in FCH. It is hoped that secondary care elective services will provide resources to enable an area wide phlebotomy service which will meet the needs of all patients regardless of who orders the tests.

4.26 **Community Treatment and Care – Treatment Room**
Unlike many other boards, who are investing PCIP funds to develop core treatment room services, Forth Valley already has an area wide treatment room service. Guidelines for the service are agreed between community nursing and GP sub.

4.27 Building on the existing service, the transfer of a significant number of B12 injections from general practice to treatment room is the only additional treatment room service commitment within the PCIP.

4.28 **Funding for CTAC?**
Recruitment of a further 10 Health Care Support Workers is feasible, which will support Clackmannanshire and Grangemouth and Bo'ness in first instance. It is hoped that secondary care will sustain the new Falkirk phlebotomy hub which was created in response to Covid-19 virtual consultation model, enabling and area wide integrated service. Funding to deliver all Vitamin B12 in community treatment rooms are also in place. A review of B12 protocol is sought (e.g. self administration, oral administration).

4.29 **Infrastructure and Premises Review**
PCIP Iteration 3 also highlights the challenges with infrastructure and the outcome of the primary care premises review which will be submitted as an annexe to the plan. All practices have also recently been surveyed and premises condition reports prepared

4.30 Both the Strategic Plan and PCIP acknowledge and address the significant interdependencies between strategic priorities, local population health and health and care needs. These priorities are informed by strategic needs assessment and include; enabling communities, focusing on early intervention, prevention and harm reduction, supporting carers, mental health and workforce transformation

5. Conclusions

5.1 Delivery of the new GMS contract by April 2021, is an ambitious programme of change, however, Forth Valley are on a clear trajectory, subject to funding availability, to successfully deliver our Primary Care Improvement Plan and achieve practical implementation of the Memorandum of Understanding (MoU) priorities by or very soon after April 2021. Maintaining the early and significant momentum and investment gained in Forth Valley in the first two years of PCIP remains central to achieving this.

5.2 Whilst setting out a plan dependent on additional funding, Iteration 3 PCIP also sets out what will be delivered in 2020/21 within available resource (appendix 1, page 4). This plan is directed by GP priorities but, without full implementation, does not meet the expectations of the MoU and would not be accepted by the Local Medical Committee as a delivery plan for 2020/21.

5.3 It is hoped that in agreeing PCIP Iteration 3 in principle, Forth Valley tripartite partners can maintain their collective representation to Scottish Government that they are united in the view that the priorities and revised service specifications described in Iteration 3 of Forth Valleys PCIP continue to set out what we believe is essential to deliver the commitments of the MoU by (or soon after) April 2021. However, partners also agree that the cost of fully

delivering the requirements of the new GMS contract continues to exceed the indicative revenue funding allocation provided by the Scottish Government, and without further national funding is not fully deliverable.

Resource Implications

The resource implications are set out within the PCIP. Of note:

In line with previous years, Iteration 3 reflects a continual focus on cost effectiveness and best value. In the absence of additional funding from the Scottish Government, the 2020-21 funding gap has been resolved locally through a range of non-recurring measures including re-phasing the timing of planned recruitment and through additional non-recurring funding provided by NHS Forth Valley. Furthermore, current pay costs are lower than anticipated (as a number of the new PCIP staff are not yet at the top of the pay scale).

However this does not address the overall recurring shortfall, which remains at £1.29m assuming all 207 WTEs in the plan are appointed to in 2021-22 and that up to 111,000 adult flu immunisations can be administered at a cost of £750k . This is high risk .

Without additional Scottish Government funding, to address the recurring shortfall it will not be possible to fully deliver the contract. To mitigate this risk, the remaining uplift in 2021/22 would require to be prioritised to the activities in the MoU specified as primary deliverables (Level 1 pharmacotherapy, Vaccinations, phlebotomy / long term condition monitoring) which do not necessarily align with the contract priorities Forth Valley GPs identify as highest priority / most impactful (pharmacotherapy and Multidisciplinary supports).

Impact on IJB Outcomes and Priorities

Implementation of the Primary Care Improvement Plan is one of the core priorities of the Falkirk Health and Social Care Partnerships strategic plan and delivery plan. PCIP has progressed fully in line with the plan to date.

Legal & Risk Implications

The Memorandum of Understanding (“MOU”) between The Scottish Government, the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards sets out a statement of responsibilities for the tripartite partners and the priorities required in terms of delivering the new GMS contract. Non delivery of the contract brings with it significant risk in terms of general practice sustainability and significant challenge to sustaining the strong collaborative relationships between stakeholders.

Consultation

N/A

Equalities Assessment

An EQIA was undertaken on the original PCIP, there are no changes to the plan, which would have additional impact on the local population and service users.

6. Report Author

Approved for submission by: Dr Stuart Cumming, Associate Medical Director, NHS Forth Valley)

Author of report
Lesley Middlemiss, Programme Manager
Stuart Cumming, Associate Medical Director
Kathy O'Neil, General Manager

7. List of Background Papers

n/a

8. Appendices

Appendix 1:	Forth Valley Primary Care Improvement Plan: Iteration 3

Appendix 1

Forth Valley Primary Care Improvement Plan

2018 to 2021

Iteration 3
June 2020



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Tripartite Statement

Forth Valley's Primary Care Improvement Plan (Iteration 3) is submitted to Scottish Government on behalf of our tripartite partnership of Clackmannanshire and Stirling, and Falkirk Health and Social Care Partnerships, NHS Forth Valley Health Board and the Forth Valley Local Medical Committee. All partners recognise and commend the significant achievement in delivering all of the commitments of PCIP Iteration 2 to date. This level of progress has been achieved through highly effective local collaboration and with significant additional, but non-recurrent, investment support from Health Board funding and primary care partnership reserves.

The tripartite partners unanimously agree that the priorities and revised service specifications described in Iteration 3 of Forth Valley's PCIP continue to set out what we believe is essential to enable delivery of the commitments of the MoU beyond April 2021. Our partners agree that Iteration 3 continues to reflect the revenue costs associated with our assessment of what is required to adequately deliver commitments of both the GMS Contract and the supporting MoU.

We have consistently highlighted a significant recurring shortfall (£1.3m) in the funding provided and are extremely disappointed that our detailed business case seeking additional funding was rejected with no explanation or feedback. In the absence of additional funding for 2020/21, we have implemented a number of non-recurring measures to enable us to progress some elements of the plan and ensure we do not lose GP engagement. This includes focussing on priorities identified through an LMC MoU prioritisation exercise and GP survey and phasing of the planned recruitment programme (Table 1, page 5). Also securing additional non-recurring funding through NHS Forth Valley. These actions do not address the underlying funding gap and it is clear that we will not be able to fully implement the contract by 31 March 2021.

While the focus of work in recent months has centred on our response to the Covid-19 situation our tripartite group is strongly aware of the importance of maintaining the momentum and progress of our PCIP work. We are therefore having a renewed focus on the priorities being taken forward by our three key PCIP working groups.

This is considered essential as we recognise that the new models of care supported by the PCIP have been integral to supporting a level of sustainability in primary care that has allowed our rapid mobilisation response to the Covid-19 situation. Practices have been enabled to work collaboratively to engage with and support our Community Assessment Centres, Triage Hub, Care Home Response Team and Enhanced Community Team. This level of support during the pandemic would not have been practical without our PCIP workforce being in place. They will also play a vital role in practices being able to deliver on their recovery plans as we move forward.

Looking to the near future we will also have additional challenges due to Covid-19 including the delivery of the influenza immunisation programme in the context of pandemic restrictions through alignment with the VTP with the flu programme. There remains a position across Forth Valley that the primary care flu programme will be the responsibility of the practices this year in line with the DES requirements but that the programme for this year, due to the impact that COVID 19 will have on our ability to deliver the usual approach to mass vaccination clinics will require a collaborative approach between the Board and the practices. There is no available funding in our plan that can support this in 2020/21

This plan does not commit IJB or NHS Board funds beyond that set out in the finance plan and so without additional recurring Scottish Government funding, sustainable delivery of the plan by April 2021 is not feasible. This presents significant risks to service resilience, ongoing sustainability of primary care and losing the high level of collaborative engagement between services, partners and primary care. Clarity on the funding position is required as a matter of urgency.

Clackmannanshire and Stirling Integrated Joint Board
Falkirk Integrated Joint Board
NHS Forth Valley Board
Forth Valley Local Medical Committe

Table 1: (Tripartite Statement). Resource requirements and risks to programme delivery.

The table below provides a high level PCIP summary or required workforce and delivery timelines. It also highlights the MoU commitments by GP priority, as defined with GPs and other stakeholders through a workshop and practice survey. This enabled targeting of available resources to priorities which were valued as having most impact for general practice. Delivery of the PCIP relies, however, on funding beyond the current allocation and so the table also highlights the likliehood of delivery in current financial envelope: **Confirmed funding (GREEN), no confirmed funding (RED), MoU priorities for residual funding (Amber)**

priority	MoU Priorities	Wte @ 03/19	Iteration 3 Plan to March 2021	20/21 + WTE	April 21 –March 22	Finall WTE
1	Pharmacotherapy	38.5	Full service already in place to 4 clusters / 23 practices, In 20/21 an agreed partial level of Pharmacotherapy to all 54 GP practices	13	Full Pharmacotherapy in all 54 GP practices	60 (+ 3.75 ps)
1	Urgent Care / Additional Roles	47.8	Full allocation of additional roles in 31 practices and MH role in additional 9 practices is in place. In 20/21 at least one additional role for NW Stirling, Falkirk, Stenhousemuir, Denny and Bonnybridge. A level of resource for care home support is in place (3.6).	14	(Circa 1wte equivalent role(s) in place per 5000 practice **(+12wte)**	73
3	CTAC / CDM Phlebotomy	14.6	Phlebotomy service to 4 clusters 20/54 practices in place to be scaled up to phlebotomy service to all GP practices (some assumption of secondary care support to complete area wide bloods model this year)	8	Phlebotomy with base level CDM (+6.4wte)	29
3	CTAC Treat Room	0	Treatment Room service in place delivering services to existing guideline extended to include V B12 injection provision	2	Treatment room service in place	3
3	Children's /mat Vacs in 19/54 practices	13.8	Conclude Childhood immunisations increase from 19 practices to all practices (aside from rural). Maternity vaccines by midwife in place.	1	Complete As 20/21	18.9
			Under 5 years Flu service to x clusters (temp B5 workforce)	60wks		
6	Link workers	0	4 link workers are funded by Falkirk partnership	0 (4)	Link worker to 15 practices embedded	4
			8 Link workers in place supporting approximately 15 practices	4		4
6	Chron Disease Monitoring	*0*	*CDM level limited to bloods, BP, weight, pulse and urinanalysis (included in phlebotomy provision above) No further increase to service in year*	0	Broader CDM model (e.g. spirometry)	3
8	Travel and other Vacs	0	A yet to be defined travel vaccination service tested at HB level. Ad hoc/ shingles and pneumococcal vaccinations	Tbc 2	Travel and all adult immunisations	tbc3.6
8	Flu Vacs - nil	*0*	*options for delivery of flu are under consideration – delivery planned 2021*		Flu Solution tbc place	Tbc
Tot	Incl GPN/PM	125	Additional workforce 2020/21	45	Further 25-30 posts	**195-205**

1 PCIP Iteration 3: Background

The early and significant momentum gained in Forth Valley in the first two years of PCIP remains central to maintaining the conditions currently in place. We are on a clear trajectory, subject to funding availability, to successfully implement Forth Valleys four year Primary Care Improvement Plan. These include:

- excellent collaboration and engagement with GPs at LMC, GP sub, cluster and practice level in the development and implementation of the plan
- significant collaboration, commitment and dedicated leadership at an early stage for all new services and supports
- hugely supportive and engaged practice teams, particularly practice managers preparing the foundations for change at practice level.
- successful early and broad ranging recruitment to posts which have been generated and promoted as modern, well supported, innovative and fulfilling roles. Growing our own workforce has been key with many training posts.
- significant additional in year funding contribution from NHS Board and Partnership Primary Care related reserves

In addition, we are making significant progress in developing a capital case to support and develop a primary care premises programme/management case in line with SCIM requirements.

1.1 Progress to Date

At January 2019, 126 of 119 planned posts are in place with a further 3 currently under appointment (mainly health care support workers). All practices (54) are now receiving additional “in practice” additional services:

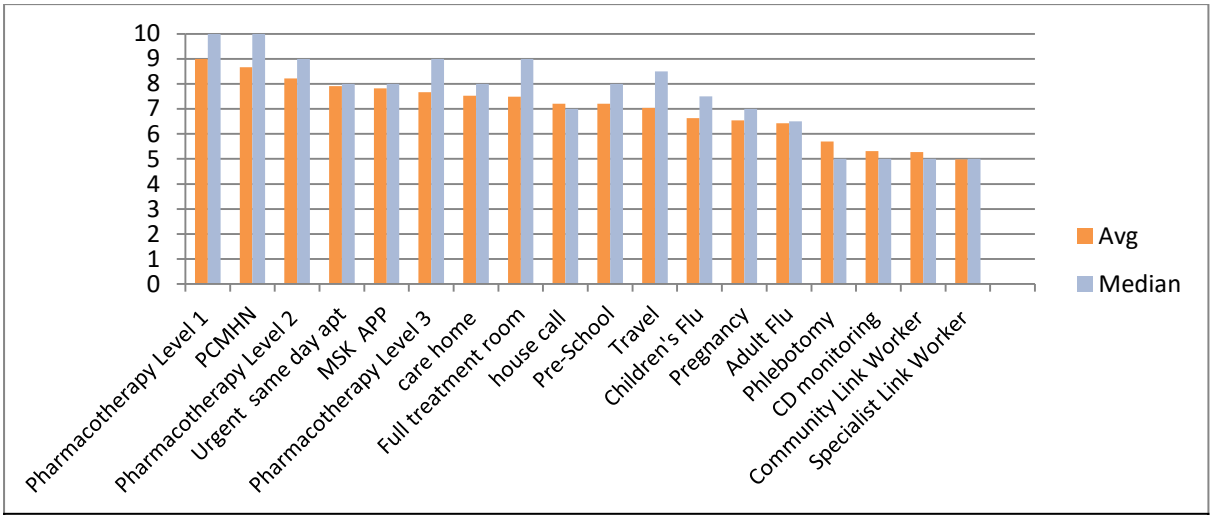
- 23 practices with full pharmacotherapy resource (a further 9 practices with partial service initiated)
- 31 practices with additional professional roles (up to 3 additional roles per practice: Advanced Nurse, Paramedic, Advanced Physiotherapy, Mental Health Practitioners)
- 9 practices with both pharmacotherapy and additional professional role (mental health practitioner).

Additionally

- All practices have access to an agreed range of treatment room services already in place at 2018
- 17 practices are being supported through phlebotomy service provision
- 20 practices have childhood immunisation service re-provided
- Approximately half of GP practices have a level of care home workload supported by Care Home Liaison Nurses

1.2 Iteration 3 Review

In planning Iteration 3 of our PCIP we continue to commit to fulfilling delivery of each of the priority work streams largely as outlined in Iteration 2. In order to re-confirm timescales and phasing, particularly with the prospect of insufficient funds, we sought, through the survey, an understanding of what is most important to practices in the next 12-18 months. 44 of 54 practices responded and the table below outlines our findings.



Summary Graph:
"How Important PCIP Services are To Practices": 0 of no Importance, 10 of utmost importance

In order to maintain momentum whilst uncertain about any additional funding, a workshop with LMC representatives was held in Dec 2019 to ascertain the priorities for available funding in 20/21. Whilst being clear that all deliverables are necessary, it was proposed to maintain momentum with Pharmacotherapy and additional professional role services. The summary table of page 3 is informed by this process.

1.3 Workforce and Skill mix Planning

Each priority area has been continuously reviewed as we learn from early phases of implementation. From this we have taken significant learning from our first phase across all priorities. This has also informed a reduction in PCIP costs for Iteration 3.

- The pharmacotherapy workload is better understood, a quality improvement approach is now core to service development and the team skill mix has been revised with a plan to increase pharmacy technicians and reduce pharmacists. With low technician availability comes the need to train technicians and the 2 year lead in time to "grow our own technicians"

- Our ANP training pipeline has been very successful. Despite losing some trained ANPs to salaried practice posts, most were retained in Forth Valley. We have learned much with regards to workforce availability and the significant level of training support required to create a capable workforce.

We have an agreement to recruit in excess of the plan in light of anticipated attrition, however also revised and phased our remaining ANP training timeline in line with the capacity to train nurses now over two years rather than one with necessary support from practices and dedicated ANP trainers.

- We have successfully implemented childhood vaccinations with an effective and increasingly efficient workforce. There is significant concern regarding the feasibility of re-providing adult flu services and further work is ongoing around this.
- We already have a staffed community treatment room and all additional posts have been band 2 HCSWs to date
- Additional professional roles are a mix of band 6 and band 7. At this early stage of service development we see no further opportunity to skill mix.

1.4 Population health needs

The MoU sets out an agreed understanding that the nature of implementation and related service redesign is required to reflect local circumstances. While the contract offer[1] and the MoU set out six key priorities for service redesign, the MoU states:

> *"Plans must determine the priorities based on population healthcare needs, taking account of existing service delivery, available workforce and available resources".*

Implementing Forth Valleys PCIP is a priority in both HSCP partnership strategic plans which highlight the significant interdependencies between strategic priorities and local population health and care needs. These priorities are informed by strategic needs assessment and include; enabling communities, focusing on early intervention, prevention and harm reduction, supporting carers and a particular focus on mental health in Clackmannanshire and Stirling.

Significant engagement and planning at cluster level has helped to tailor PCIP provision to local needs. For example the balance of provision of additional supporting roles and urgent care models have been delivered in line with cluster and practice needs. Some informed by caseload study to help determine the right balance of support for practice populations.

The specific needs of maintaining locally delivered services to rural populations has also been considered and options for CTAC and VTP in particular considered.

Chronic disease prevalence has also been a key driver in both pharmacotherapy model and CTAC with the aim of improving and supporting self care with people who have long term conditions

[1] *The 2018 General Medical Services Contract in Scotland. https://www.gov.scot/publications/2018-gms-contract-scotland/*

2 Implementation of the six key MOU commitments

2.1 Vaccine Transformation

In the period to 2021 change will be delivered in a phased way as part of the Primary Care Improvement Plan to meet a number of nationally determined outcomes including shifting vaccination work to other appropriate professionals and away from GPs. It is expected that this change will be managed, ensuring a safe and sustainable model and delivering the highest levels of immunisation. There may be geographical or other limitations to the extent of any service redesign.

Timeline

At April 2019

Pre-school childhood immunisations (0-5 years)	7/54 practices

By April 2020

Pre-school childhood immunisation (0-5 years)	38/54 practices
Maternity Immunisations (Influenza and Pertussis)	54/54 practices

By April 2021 (*subject to available funding*)

Pre-school childhood immunisation (0-5 years)	45/54 practices
(Subject to clarification of rural practice arrangements (9 practices))	
Travel Immunisations and advice	54/54 practices
(Vaccines covered within the NHS routine immunisation schedule)	
2-5 years Flu -Pilot in advance of 2021 full implementation	1 Cluster

April 2021 and beyond

Adult Programmes (Shingles and Pneumococcal)	45/54 practices
2-5 years Flu Immunisation	45/54 practices
Ad Hoc Vaccinations	45/54 practices

(Each programme is subject to clarification of rural practice arrangements (9 practices))

Workforce

In place at April 2019 11.0 WTE

In place by April 2020 14.8 WTE (13.8 WTE in post, 1.0 WTE to 20/21l),

Workforce required to be in place prior to April 2021

service delivery level will depend on resource availability - anticipate 3wte for travel, 3 wte seasonal posts for childrens flu. Additional Administration resource also sought

Projections for Flu Programmes will be covered in a separate options appraisal for consideration at PCIP

Learning and Analysis To Date:

Patient –Centred : Service user feedback has been positive.:

- Patients like the specialised service.

- Patients appreciate appointment flexibility and a choice of where to attend
- Patients have not been keen to have to travel further for the service than before
- Parking can be challenging in new Hub locations
- Request to increase the accessibility of baby changing and feeding facilities within new service sites.
- Waiting areas in Hubs are busier than previous due to increase in footfall as an impact of combining practice lists.

Outcome-Focussed: There has been no significant change to uptake rates post transfer of pre-school vaccinations across the Clusters. Patients who have opted out of the programme have been given the opportunity to re-engage with the service at point of transfer. There has been a temporary increase in clinic demand as a result of a recall backlog in a number of clusters. This is expected to reduce in the long term. Flexibility has been built in to the new model to allow for an element of patient choice and improve accessibility helping to maintain pre-school rates.

	By age 12 mths	**By age 24 mths**	**By 5 years**	**By 6 years**
2018 uptake	95.7%	95.2%	95.5%	95.6%
2019 uptake	97.1% (+1.4)	95.5% (+0.1)	95.2% (-0.3)	96.3% (+0.7)

Safety: SOP and clinical guidelines to support governance and promote quality improvements have been developed for the pre-school programme. Access to GP patient records (via EMIS) has been essential in supporting delivery of safe clinical care at the point of contact and ensuring GP health records are kept updated.

What is new or altered from Iteration 2

The revised timescales between Iteration 2 and 3, reflect resource available from PICP during 2019/2020. Delivery of VTP is expected to carry into 2021/22. In particular the model for adult flu will not be delivered in 20/21 as per Iteration 2.

Full and final delivery as per the MOU will be dependent on both funding and essential infrastructure being in place to ensure services are safe and sustainable. At January 2020 there remains ambiguity around rural practice arrangements and the extent to which they should be included in any future planning.

Vaccination programmes in scope for 2020/21 have been revised as follows:

1. Childhood Flu 2-5 years (pilot)
2. Routine NHS Travel Vaccinations and Advice
3. Completion of Children's pre-school (0-5 years) schedule

A feasibility study for the transfer of the Adult Flu Programme from GP to the Board led Service for winter 2021, is being prepared separately. The complexity of challenges that exist in delivering a programme of its size and scale will be explored and options for delivery will be fed back in March 2020. Feedback will be included from the National VTP Programme Board, currently collating learning from a number

of Boards piloting Seasonal Flu this year. This will help inform development of local solutions which are both practical and realistic.

The Travel Immunisation Service in scope for 2020/21 will cover NHS routine immunisations only. Current data does not provide the level of detail necessary to accurately scope the potential demand or workforce. As a baseline for moving forward, a workforce estimate will be based on 2% of population as per feedback from similar sized Boards running pilots.

A number of private companies offering travel immunisations currently exist within Forth Valley and will continue to compete with any local NHS run service however there is an expectation that the Board led service will grow in future years to include Yellow Fever and non- NHS vaccinations and provide a level of income generation.

The proposal for the coming year will require continual review post implementation to determine if the resource allocated is sufficient to deliver a safe and equitable service

Key Performance Measures

There is ongoing formal evaluation as each programme transfers to the NHS service.

- Service user feedback is sought through patient questionnaire given out in each clinic within the first few weeks of transfer.
- Feedback is requested from Practice Managers within the 6 weeks post transfer.
- Vaccination uptake rates
- Moving into 2020- Supplementary read codes will be added to EMIS Childhood Vaccination Templates to collect data on clinic capacity and DNAs. The data will inform where best to make improvements.

Challenges and Constraints to Implementation of VTP

- Maintenance of Cold Chain: There has been significant loss of vaccine and impact on the pharmacy service over the last 12 months.
- Pharmacy Infrastructure: It is anticipated that pharmacy support workforce, additional transport vans and additional cold storage facilities will be required.
- IT: The absence of a dedicated IT system has slowed and limited the roll out of the VTP. A comprehensive IT system is critical for delivering the VTP.
- Accommodation:
- Sustainability: Sourcing an appropriately trained workforce to deliver seasonal programmes has highlighted a very limited bank workforce of staff availability.
- Administrative Burden: Links with the National VTP forum are highlighting that the true admin and clerical component required to successfully deliver VTP is much greater than originally scoped, posing a risk to developing programmes beyond pilots when not adequately factored in as part of the infrastructure.
- Affordability/Value for Money: Taking into account all of above, the value risk around VTP is significant.

2.2 Pharmacotherapy

Extract from Memorandum of Understanding

By 2021, phase one will include activities at a general level of pharmacy practice including acute and repeat prescribing and medication management activities.

At April 2020 – All practices in six of nine clusters have a pharmacotherapy service (four with full service and 2 with core service). There are 42.6 WTE Pharmacists and Technicians in post in a range of bands from 5 to 8A.

Workforce in place April 2019	28 WTE staff
Workforce by April 2020 (It. 2)	40 WTE staff (skill mix 3:1 Pharmacist: Technician)
Actual workforce April 2020	42.6 WTE (38.5 + 2c PCIP) skill mix ~5:1 Pharmacist: Technician) incl 1 service lead post.
Planned Workforce April 2021	51.6 WTE (includes 1WTE 8b Pharmacist)
Final Planned workforce 2021	60 WTE PCIP (+ 3.75 WTE from Prescribing Support)
Current Planning Assumption WTE ratio:	Remains at 1 WTE per 5000 overall (6,000 accounting for cover) *However this may vary slightly practice to practice as service need is better understood.*

Variance from Iteration 2: In order to enable deliver a level of service to all remaining clusters there is an additional 1.6 wte posts in Iteration 3 for 2020-21. (final workforce remains as it was in Iteration 2)

Pharmacotherapy Implementation

What have we learned from implementation and/or service analysis to date?

a) Most practices with pharmacotherapy are experiencing a positive impact from the service and are reporting a measurable reduction in daily GP workload.

> *"Having pharmacy support from fully trained and experienced pharmacists has made a huge difference to GP workload daily. We are still to establish clinics for the pharmacist but Acute scripts and most Docman medication requests and reconciliation is done daily." GP Practice Survey, 10/19*

b) Most practices initially require a significant amount of resource to streamline their prescribing workload.

c) The number of acute requests varies significantly from practice to practice (from 1 per 1000 to 19 per 1000 patients, mean/median = 8). Some of this can addressed by implementing a robust programme of patient reviews which enables a proportion of unscheduled work to be safely transferred to scheduled work, facilitating a manageable workload for pharmacy staff.

d) Service leadership across the pharmacotherapy service is critical to driving service forward and evaluating progress.

Any Changes in Iteration 3?

a. **All GP practices will have at least partial pharmacotherapy service in place by March 2021**. An already agreed level service will be provided to the four remaining clusters, the plan, previously, of rolling out cluster by cluster would mean no provision for two clusters until 21/22. The service will then be increased to practices in these four clusters in 2021/22
b. The partial service will be a defined provision and split between Level 1 and Level 2 tasks as detailed in the 2018-21 GMS contract in an attempt to move some of the unscheduled workload such as some acute requests to scheduled care, with assurance that patients will be reviewed. This will make the service more planned and less reactive as is the case at the moment.
c. The Pharmacotherapy Collaborative will delve further into prescription processes to determine best practice. Benefits identified from this will be scaled to all.
d. The ratio of Pharmacist to Technician for a full Pharmacotherapy Service is being tested at a ratio of 3:1. It is hoped that in time, with more experienced staff, the role of the technician can be further developed with the aim of having a Pharmacist to Technician ratio of 3:2.
e. The number of patients who have their medicines managed utilising the Medication, Care and Review service from Community Pharmacy will increase.
f. Support for rural practices will be developed including utilising remote access into practice records and systems, and harnessing the skills of the local Community Pharmacist to carry out core Pharmacotherapy functions such as processing hospital discharge letters and recommendations from specialist clinicians.

How will we know if these changes lead to improvement?

Key performance indicators will capture

a. number of acute requests actioned by Pharmacy Team as a proportion of total acute requests
b. Variation in pharmacotherapy workload between practices
c. number of patients reviewed by Pharmacy Team

- Practice satisfaction survey
- Patient satisfaction survey
- Cost per patient

Describe any particular issues and constraints which are directly impacting on our ability to deliver service as per PCIP and MOU

d. Lack of experienced workforce to deliver a new service, coupled with expectation to deliver full service in a short time frame
e. Financial constraints around service.

To date, recruitment of pharmacists has been successful; however technicians remain difficult to recruit. A plan has been submitted to recruit student technicians to train over a 2 year period to increase workforce.

2.3 Community Treatment and Care

AIM: Extract from Memorandum of Understanding

By 2021 a safe and sustainable service delivery model, based on appropriate local service design for services including, but not limited to; basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate. Phlebotomy will be delivered as a priority in the first stage of the HSCP Primary Care Improvement Plan.

Workforce in place April 2019	8 WTE (6 HCSW and 2 team leads) initiating phlebotomy in 2 clusters. 7 non recurring GPPN training posts part funded by NES. Existing NHS funded treatment room in place providing most treatment room services to all practices.
Planned Workforce by April 2020	**12.6wte HCSW: Phlebotomy service to 19 practices (4/9 clusters)** **Chronic disease monitoring to 6/54 practices (2/9 clusters)** **Treatment Room Core Service 54 / 54 GP practices (Existing Service)** **Treatment Room Enhanced Service (with B12) - additional x patients see in year - no additional resource**
Actual Workforce at April 2020	*12.6 HCSW in place (tbc)– 12.6 funded + 2 team lead posts.(14.6) Phlebotomy initiated for 19 practices in 4/9 clusters. 7fixed term GPN trainees. No additional resource for treatment room.*
Planned Workforce By April 2021	*22 HCSW and 2 additional band5 RN – All practices offered GP Phlebotomy service including CDM bloods, weight, BP and Pulse only to all practices. 2 Band 5 Treatment room nurse to enable capacity for B12*
Final Workforce in 2021	*29 HCSW and x ?5RNs + 2 team lead (this may be adjusted for preferred rural option) extension of CDM to be confirmed*

Variance: As per Iteration 2: Phlebotomy delivery now phased to Sept 2021. All practices to be offered phlebotomy service (incl CDM bloods, BP, weight, urinalysis) by March 2021. Subject to Funding.

What have we learned from implementation and/or service analysis to date?

Based on labs and chronic disease prevalence data, is estimated that Forth Valleys phlebotomy service will require to support at least 3000 phlebotomy appointments weekly plus provide capacity for around 65000 annual chronic disease management appointments annually.

- 1300 new phlebotomy service appointments are now scheduled weekly across the first three clusters Stirling, non rural NW Stirling, Denny and Bonnybridge with service to Stenhousemuir cluster starting by March 2020. To date, although demand varies between practices, the predicted resource has proved, overall, to be adequate. However, in one or two cases CDM as an indicator of need has not been appropriate e.g. university practice.
- The existing community treatment room service also provides over 2700 10 minute appointments weekly across Forth Valley.

Implementation of phlebotomy has been more complex than first imagined. Whilst practices who have not had phlebotomy provision, or have had vacant HCSW posts, have embraced the service as a more accessible option for patients, others have been reluctant to move away from reliable and flexible practice based models.

Both a Hub model and Practice based model have been tested with different issues and interdependences arising. Also different experiences for staff and patients. The Hub model appears to engender better peer support and staff morale and a greater percentage of utilised appointments. Whilst the Practice Model provides closer working relationships with patients and practice staff and less risk in relation to IT systems and accessing patient information.

Describe briefly what is new or altered from Iteration 2

Timelines and overall workforce remain the same as Iteration 2. **All practices, opting for phlebotomy, will have access a local phlebotomy service by April 2021.** The operational approach going forward will include:

- Co-location of phlebotomy workforce at one or two hubs within a cluster, outreaching to practices with sufficient population or geographical need.
- The service will work via EMIS and practices will manage patient app'ts into dedicated practice phlebotomy appointments until IT solution improves.
- All bloods must be booked onto Ordercomms by practice OR for annual CDM phlebotomy – Practices must note CDM reason in appointment slot note and Phlebotomy service will add agreed group tests to ordercomms (E-health will work with service to create validated "group tests" for CDM on Ordercoms
- CDM to include BP, weight, urinalysis and pulse as appropriate to review will be provided to the 21 practices in 3 clusters who have phlebotomy service at April 21. Remaining practices will receive this post phlebotomy implementation in 2021.
- CDM reviews are limited to one appointment annually.
- CDM will be limited, under current resource, to bloods for all practices.
- GP practices can opt to use the service wholly, in part or not at all.
- NPT, warfarin, coagucheck will be part of the service
- Wider CDM model will be reviewed and Rural practices will conclude options.

By 2021 the CTAC service will deliver all B12 injections, *estimated at an additional 22000 B12 injections annually.*

How will we know if these changes are leading to improvement?

We are continuing to collate data on a monthly basis to assess capacity and demand and to ensure that we are delivering an equitable service. We are also encouraging feedback in relation to service improvement from patients, staff and GP Practices.

Issues and constraints: Lack of IT interoperability, Recruitment and accommodation.

2.4 Urgent Care (Advanced Nurse and Paramedic Practitioners)

By 2021, there will be a sustainable advance practitioner provision, based on appropriate local service design, available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.

At March 2020 - slightly increased ANP workforce in place. Training ongoing.

Workforce in place April 2019	Practice ANP 13.2wte (2019 – some loss to IP and other boards). 1 x 8a only + 1 vacancy Care Home ANP x 3.6 recruited
Planned Workforce by April 2020	Practice ANP /PP 15.2 ANPs in 5 clusters Care Home ANP 4.1 wte
Actual Workforce at April 2020	*16.7wte plus 2 8A trainers and 4.3 care home. 1.8ANPs for 2C practices will now need to be recruited. (leaving14.9).*
Planned Workforce By April 2021	*23.5wte (B-7) (3-8a, 1 of which fixed term))* *4.1wte care homes (incl 0.5 Clacks ANP)*
Final Workforce in 2021 (No change from Iteration 2)	33.6wte (cluster adjustment from 32.6) ANPs including care home and 2 x 8a (29urgent care+ 3.6 Care Home wte) Balance of resource between practice and care home / home visits determined by cluster assignment of resource

Variance from Iteration 2: Total workforce remains the same, cluster preferences currently indicate +1wte ANP in lieu of other mdt. Recruitment is now, phased.

What have we learned from implementation and/or service analysis to date?

All ANP resource is in place for the first phase clusters, however, placement to final practices will conclude in May when trainees qualify and move from host training practices. It is likely however, that we see a continued attrition of trained staff to practice employed posts and other boards. An agreed level of over recruitment has helped mitigate this and will continue to be required.

Most ANP recruits require significant education, support and supervision to achieve the required skill set and ANP qualification. Trainees, however, still contribute significantly to managing urgent care workload and evidence grows that ANPs can competently manage a significant proportion of on the day, urgent appointments. Supporting and assuring training continues to be challenging, however we now have part time qualified practitioners in addition to a full time trainer in Falkirk cluster.

Care Home Liaison (CHL) service, although limited in scale, has evidenced significantly reduced GP visits to care homes.

Changes, if any, being made to the planned model of care in Iteration 3?
All practices have been offered APP, ANP and PCMHN resource and choice with regards phasing and balance of each. All practices will have at least one of the three

additional supports by mid 2020. The total ANP/ CHL workforce remains the same, however, recruitment is now phased over the next two years in line with our ability to support and train new staff. Our first cohort of trainees on a two-year programme and those subsequently employed on a one-year programme will complete the competency frameworks in May 2020. The remainder of our current workforce will be qualified during 2021 (4.6 WTE), this includes two paramedic practitioners (16.4 WTE in total). It is likely that most of the next two cohorts will require at least 1 year of supported training to complete competency frameworks.

The Care Home team will integrate with the urgent care ANP model and the balance of Urgent care workforce between practice based urgent care and community based support including care home, residential home and house calls will be determined by cluster preferences. It is anticipated that some practices will prioritise urgent care resource to community based support in the next phase. This will influence recruitment towards practitioners with an interest in community based medicine.

A unified urgent care model will allow an equitable and standardised approach to competency training and supervision, creating a resilient and flexible workforce. Flexibility is also being explored with the GP OOH ANP service. ANP resource allocation within the clusters is quite fragmented (small allocations of e.g. 0.2 WTE to a practice). This makes assignment of ANP resource very difficult. Having a flexible workforce would allow ANPs to undertake dual roles such as daytime practice and OOH or CHL. With appropriate management of resource from both services improvements can be made which would benefit the workforce and patients.

Iteration 2 assumed that no additional MDT recruitment would be required for 2C practices as PCIP funding would align to support existing NHS employed MDT at April 2020. Three 2C practices are, however, now returning to 17J status which means that 1.8 additional ANPs require to be recruited and likely trained.

How will we know if these changes are leading to improvement?

Quantitative - measuring appointments undertaken by ANP / APP impact on GP e.g. ANP/GP workload study, 2C Analysis, Week of Care Audit (See Evaluation Section)
Comparative Qualitative Data: complaints, compliments, adverse events, experience
Measurement of staff experience / service resilience:
Recruitment and retention – equitable supervision and educational opportunities.

Describe any particular issues and constraints impacting on implementation.

- Lack of / loss of administration support to management ANPs in PC (2C support)
- Fragmented workforce linked to fragmented practice allocation in clusters
- Constraints to scaling: sustainable training placements, space and supervision.
- Expectations of practices due to the restricted no of qualified ANPs and variation in trainee experience, in particularly if trainee unable to prescribe
- Lack of IT flexibility, Room availability, Recruitment and Retention (See Risks)

2.5 Additional Professional Roles; Advanced Practice Physio (APP)

AIM: Extract from Memorandum of Understanding

By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care.

At April 2020: Delivery of APP continues to 28/54 practices (5/9 clusters) 3.8 additional APPs planned for 2020 to support around half of remaining practices /clusters as part of integrated and phased role out of all professional roles to all practices (14 of final 23 APP, PCMHN, APP roles to be delivered in 2020)

Workforce in place April 2019	**9.4wte**
Planned Workforce by April 2020	**9.4wte**
Actual Workforce at April 2020	**9.2wte** (adjusted to cluster preferences)
Planned Workforce By April 2021	**13.2WTE (incl 1 8A lead)**
Final Workforce in 2021	**16** (cluster adjustment from 17WTE)

Variance from Iteration 2 :1 Wte final variance due to cluster preferences. (1+ANP)

Advanced Practice Physiotherapy Implementation: Learning to Date:
The APP service has now been fully operational in the majority of practices in 5 clusters since May 2019 with a few Practices commencing from July 2019.

- APPs now have the capacity to offer approximately 685 MSK appointments per week across 28 practices.
- Capacity v fill rate analysis (August 2019) highlighted that in 20 out of 28 Practices, APP clinician appointments are utilised in excess of 80% capacity.
- With additional support and education and support for enhanced signposting from reception and other Practice staff, those with lower fill rates have risen to comparable levels.

A 3 month audit by APP clinicians highlighted that:

- 80.4% of patients seen by an APP were dealt with solely in Primary Care and did not require any onward referral.
- 8.7% patients were referred to mainstream MSK Physiotherapy services.
- 1.7% of patients were referred to Orthopaedics.
- 9.2% patients were referred to other Secondary Care services such as Podiatry and Orthotics or referred to Third sector services.

The main learning from the first phase of implementation has been around the APP skills and educational needs. An initial need for training and support was consistently required which required time out of practice. This has been mostly resolved in the initial 3 months.

- Networks are established to support governance and training in Injection Therapy, Radiology and Non Medical Prescribing.
- A further 4 APPs have recently completed Injection Therapy qualification with another 3 clinician's with completion due in April 2020.
- 3 APPs are Non Medical Prescribers and commenced prescribing in 3 Practices. Further staff will be supported through this process in the later part of 2020.
- All APP staff have now completed NHS Forth Valley Radiology IR(ME)ER training and have the ability to refer for all agreed diagnostic imaging

What is New in Iteration 3?

There are no changes from Iteration 2. All practices have been offered APP, ANP and PCMHN resource and choice with regards priority and balance of each. All practices will have at least one of the three additional supports by mid 2020.

The remaining 22 GP Practices are scheduled for APP implementation during 2020 and 2021. It is anticipated that half of the remaining practices will be supported in 2020. The majority of the APP workforce in 2020 will be released from existing 2C Practices which return to 17J status from April. APP resource is allocated to GP Practices equitably (1:20,000) as part of an integrated approach with ANPs and PCMHNs. Phasing of roles will be aligned to Practice preferences where possible.

What are we measuring?

Daily data collection of

- patients seen and their management and intervention outcome.
- daily logs for Radiology requests *(as per IR(ME)R 2017 requirements)*
- Injection Therapy records.

In 2020 a National APP Data Collection template on EMIS/Vision will commence and be automatically reported through SPIRE.

Patient / Service user feedback is being collected at practice / cluster level with a view of understanding awareness and satisfaction of new professional roles.

NHS Forth Valley (Viewfield Practice) has been selected to take part in the APP FRONTIER Study led by Bristol University (2020: 12 months). The study aims to measure: patient satisfaction, analyse cost effectiveness practice staff experience.

Issues and Constraints

- **IT: Recruitment**: **Accommodation:** See Risks – common issues
- **Workload variation**: Levels of APP appointment fill rate varies and is linked to practice signposting systems but also to variation in need between practice populations.
- **GP expectations**: Not only around the capacity of MSK patients the APP service can accommodate, but also understanding the role as first contact service as opposed to historical models which provided a Practice Physiotherapist.

2.6 Additional Professional Roles; Primary Care Mental Health

By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care.

At April 2019: In line with PCIP 1, there were 15.7 WTE Mental Health Nurses in post with 1 WTE (2 headcount) acting as Leads and 13.7 in MHN posts. Delivery of MHN support is happening in 40/54 practices (7/9 clusters).

At April 2020: Delivery of APP continues to 40/54 practices (7/9 clusters).

By April 2021: 48/54 practices to have PCMHN resource

Workforce in place April 2019	**15.7wte**
Planned Workforce by April 2020	**15.8wte**
Actual Workforce at April 2020	**17.2 wte (incl 2 team leads 0.5 clinical)**
Planned Workforce By April 2021	**20.3 WTE**
Final Workforce in 2021	**23 WTE (circa 1:15,000)**

Variance From Iteration 2: Small adjustments in MDT as requested by practices.

What have we learned from implementation to date?

Primary Care Mental Health Nurses now provide service within 40 GP practices with a weekly combined Appointment Capacity of:

- Face to Face scheduled weekly capacity = 870 (leave adjusted = (696)
- Telephone Call scheduled 348 (Leave adjusted = 278)
- Stirling/Clacks Face: to Face: 470 (423) | Telephone Call: 188 (170)
- Falkirk: Face to Face: 400 (360) | Telephone Call: 160 (144)
- Capacity of 2 posts on maternity leaves in Falkirk not factored in. (110)

Whilst resource is allocated by practice population, practice demand doesn't always correlate to the practice population size. Health inequalities and practice demographic significantly impacts on the mental health needs of each practice.

There can be some challenges in rural areas – small amounts of time in small practices. In the future this may benefit from a hub format.

Each practice can have different expectations of the PCMHN. This can vary depending on the population; skills of each staff member, pressure on staff etc. The development off of a working agreement between practice and service has been of great benefit in terms of integration, implementation and managing expectations of practice and nursing staff.

What, if anything, has changed from Iteration 2?

Iteration 3 plan is not substantively changed. Remaining practices have been consulted on their MDT preferences and it is hoped to place PCHMNs in all remaining practices which opt for the service this year.

Additional action 15 funding has been secured to support this, however, funding will not fully be in place until 21/22.

The practices have been given the choice to adjust allocation of professional groups to incorporate a core practice needs approach, so in some cases more mental health support is desired from the practices, some less.

How will we know if these changes are leading to improvement?

The PCMHN's have been completing audit work with the second large scale audit due to be completed in February 2020. This looks at

- capacity,
- attendance
- objective mental health data which helps us to measure outcomes from consultations and against the aims of this post
- Impact on GP mental health workload.

- Practice survey for staff feedback.
- Patient feedback. feedback regarding the service has been very positive.
- PCMHN's completing I-Matters for team leaders.

Describe any Particular Issues or Constraints

- Ability of team leads to support existing and new staff across so many practices
- The recruitment of staff: as the team expands we may have less candidates applying or more impact on other areas of MH provision in Forth Valley.
- Mental health nurses are employed based on a 1wte to 15K population which can mean that staff are spread thinly across 3 sometimes 4 practices. Pressure on the team as there is a high demand for the service so staff can have full clinics with high expectation.
- Lack of flexibility to provide cover during times of prolonged absence is a real challenge: a clear working agreement with practices which sets out expectations around short and long term leave at the outset has helped. The aim by 2021/22 is that there will be a small amount of flexibility to support this (circa 5%).

2.7 Link workers

The PCIP proposes 8 link worker posts to support 15 practices in most deprived communities. Funding for link workers is aligned to 2020/21/22.
Falkirk Partnership has provided 2 year funding of four link worker posts who will support:

- Falkirk Cluster: In place extension of FDAMH social prescribing model
- Grangemouth practices : Link worker to be employed by the Kersiebank project
- Denny / Bonnybridge Cluster : Link worker employed by Strathcarron Hospice. Appointed and in early stages.

Stirling Council are also supporting a two year model of welfare support link workers in two Stirling Practices (Fallin/Cowie and Orchard House) and a rural link worker in West Stirling supporting the model of neighbourhood care.

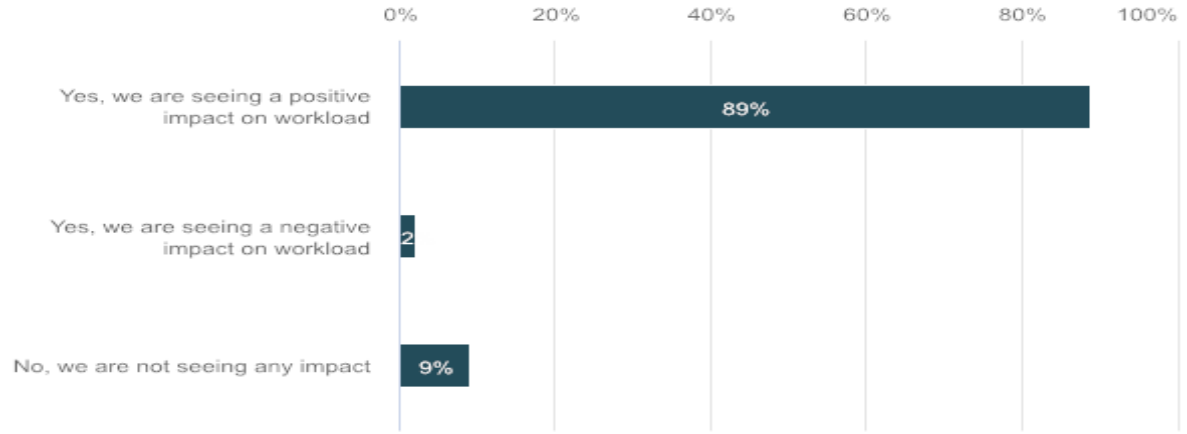
3 **Evaluation:** Are these changes making a difference?

3.1 GP Workload:

All practices were surveyed in October 2019 as part of our Iteration 3 engagement and planning process. Practices were asked, amongst other things:

"Do you think the support from additional services has had an impact on GP workload to date?"

39 out of 44 practices responded "Yes, we are seeing a positive impact on workload"



Comments from practices include

"The GPs feel that the additional services have made a great impact on the practice and their workload. The MH Nurse and ANP in particular have made a great impact to their workload. They are great additions to our team."

"Every patient that is seen by the APP or MHN is freeing up valuable time for our GPs. Having these specialists in Practice is excellent"

"Having pharmacy support from fully trained and experienced pharmacists has made a huge difference to GP workload daily. We are still to establish clinics for the pharmacist although we are keen to do so but Acute scripts and most Docman medication requests and reconciliation is done daily."

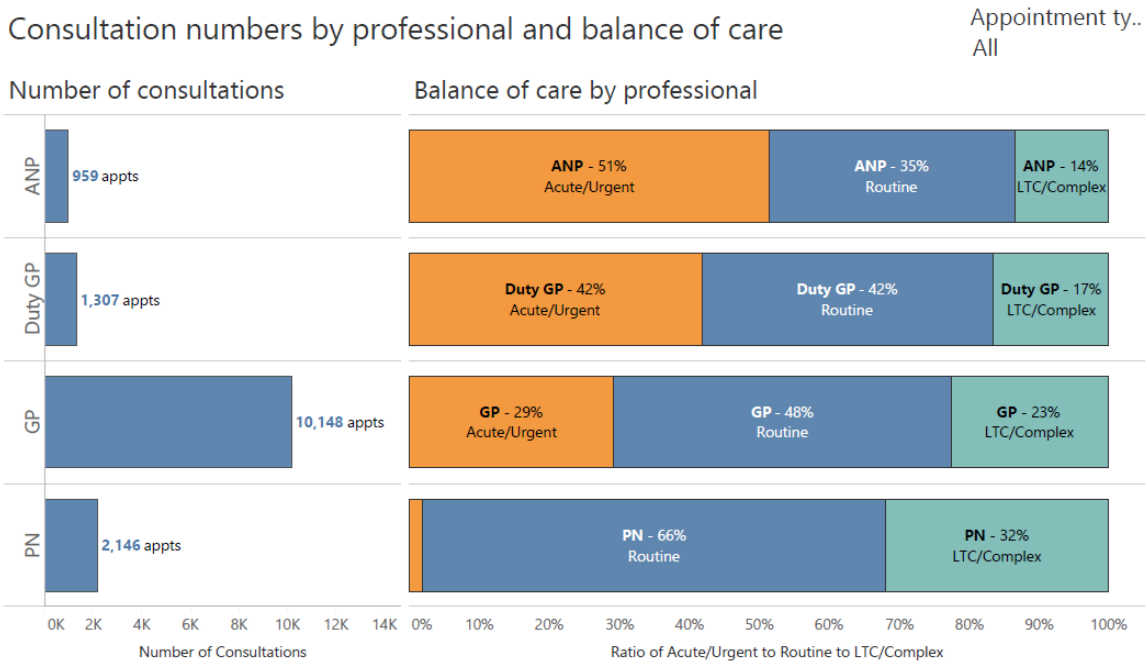
GPs also have concerns

"Concerned that there may not be full implementation of the contract by April 2021"

"It is disappointing that this far into the new Contract we are only seeing one new service provided to the Practice."

3.2 Week of Care Baseline Study

In February 2019 22 GP practices took part in a two week caseload analysis exercise. The aim of this was to understand complexity and nature of clinical workload prior to implementation of additional professional roles. Over 14000 consultations were recorded by practitioners, mainly GPs with a consultation reporting rate of 62-84% on each of 10 days. The indicative balance of consultations by acute/ urgent, routine and Long term care/complex/ undifferentiated is outlined below. This exercise is being repeated in March 2020 to help ascertain whether GP workload is changing.



Note: The bar on the right shows the ratio of Acute/Urgent to Routine to LTC/Complex consultations where given. In some cases multiple options were selected by the professional completing the form, and in rare cases no option was selected.

3.3 Safe and Effective Transfer of Workload: ANP

As part of the plan, Advanced Nurse Practitioners (ANP) will form a key part of the general practice workload with a primary role in managing urgent care; particularly on the day appointments and in some cases house calls and care home visits. As a relatively new role, it is not known whether patients seen by an ANP are more likely to return or return sooner to see a GP for same issue. A retrospective study conducted in Polmont Park medical practice looked at all GP urgent care presentations to the practice in one month (417 patients) and a comparative analysis between GP and ANP care was conducted on outcome of triage and number of follow ups within 7 and 28 days.

The study concluded that although ANPs are more likely to offer an appointment from telephone triage (80% v's 60%), those seen by an ANP for same day assessment were no more likely to return within 7 or 28 days than if they had been seen by a GP.

- ANPs are a safe and effective alternative to GP for face to face consultation of patients who request same day urgent appointments.

- ANPs provide a significant transfer of urgent demand away from the GP allowing them to focus on their new role as an Expert Medical Generalist.

3.4 Physiotherapists as an alternative to GP for musculoskeletal consultations

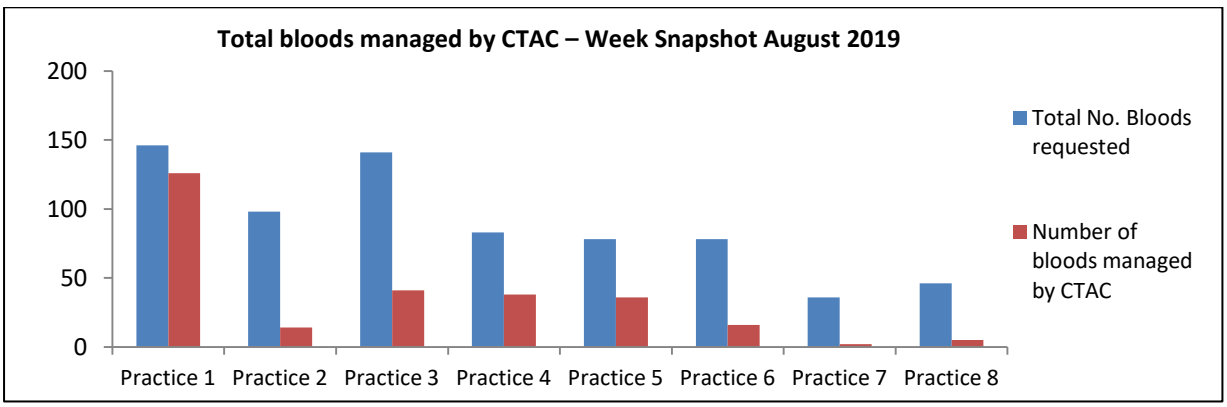
Advanced practitioner physiotherapists (APP) are now providing around 700 weekly appointments in 30 practices in Forth Valley. Providing a longer consultation time (20 mins) for people with muscle and joint pain or movement problems. APPs have expertise in assessing, diagnosing and managing musculoskeletal issues and are well placed to manage primary care MSK demand. A realistic estimate of msk demand in primary care with potential to be redirected is around 6-10% of GP workload (week of care).

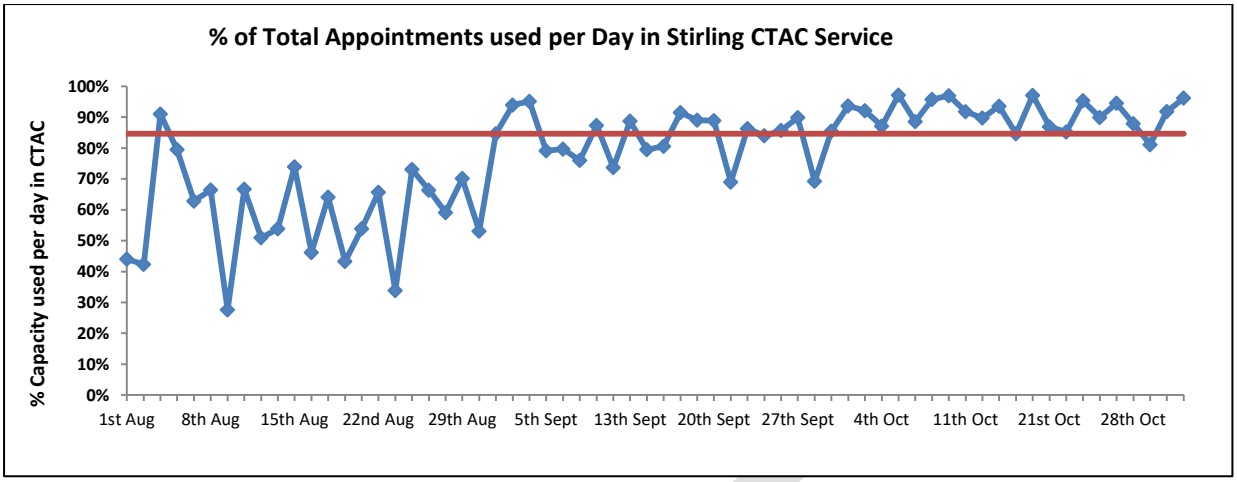
A 2 year cohort study of more than 8000 appointments in two practices in Forth Valley was published in the British Journal of General Practice in 2019. This study highlighted that 64% of people who saw a physiotherapist as alternative to a GP appointment received self care only. 1% required a GP review and 29% had a return appointment within 3 months. Satisfaction rates were very high.

A three month audit of the newly expanded APP service found similar results with 80% of people being managed by APP without need for onward referral or second opinion. 1.9% of people being referred to orthopaedics and 8% to physiotherapy.

3.5 Community Treatment and Care

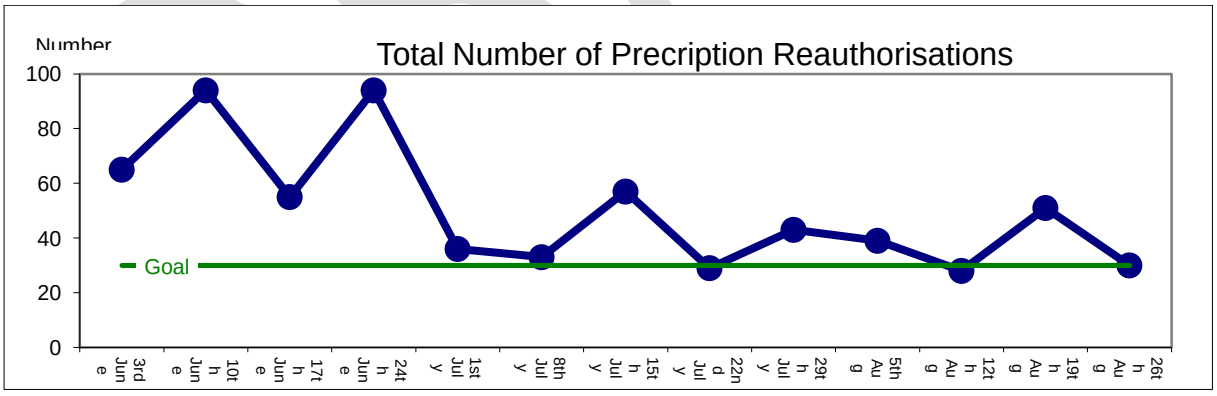
If successfully implemented the CTAC service will manage most blood tests ordered by GPs which can be identified via the ordercomms service. The chart below shows the variance in uptake of service within one cluster in August 2019 and graph below the increase in use of service from September. 700 weekly bloods appointments are offered in Stirling Cluster.





3.6 Pharmacotherapy

The pharmacotherapy implementation group are continuosly reviewing the impact of the new pharmacotherapy services. This includes analysing the impact on GP and pharmacy team workload, measuring quality outcomes for patients and efficiency and effectiveness of pharmacotherapy processes. An example of success has been demonstrated by a pharmacy technician model, applying practice based improvement methodology to analyse practice prescribing systems and processes and evidencing added value to the repeat prescribing process as highlighted in the graph below.



Ten GP practices are currently involved in the national pharmacotherapy collaborative with the aim of developing and utilising similar methodology to optimise and ultimately reduce current level 1 pharmacotherapy processes.

4 PCIP3s should set out how local partners are ensuring that patient engagement is a key part of their plan.

The work of the practice administration collaborative and subsequent scale up across Forth Valley has been key to service user and engagement. Primarily through the significant work supporting and developing models of improved signposting to "Right Care". Communications materials, administration training and user engagement and awareness activities have been central to the change process. Each priority work stream also engaging and taking feedback about service delivery and design.

A user survey including public engagement officer discussions with 478 service users across 14 practices with new professional roles was conducted in November 2019. Findings included:

Public Awareness

60-77% of respondents were aware of the specific new roles in practices, with more people being aware of ANPs (77%) than APPs (64%), PCMHNs (63%) or Clinical pharmacists (60%).

21% reported that they don't feel informed about new services

Public Acceptability

88% of respondents did not mind being asked, by the receptionist, for a summary of their health concern in order to signposted to the most appropriate healthcare professional.

95% of respondents agree that they will be happy to see the most appropriate professional.

Experience of New Services

71% of respondents said that they had experience of contact with new clinical roles
89% of respondents reported positively on all four experience measures, 3-5% responding neutrally and 7% reporting negatively.

When asked "What matters most to you when making an appointment?"

People said:

Getting seen as soon as possible/speed of appointment/quick response	196
Being seen by the appropriate person	53
Length of time waiting for an appointment	45
Being listened to/treated considerately/finding out the problem	31
Getting the right information/care advice/get better	13
Taken on time/GPs need to be in the practice more	10
Continuity of care/seeing the same GP	10

5 Programme Support

PCIPs should describe what administrative capacity is allocated to developing and implementing plans, any specific administrative challenges to implementation (e.g. HR issues) and what actions are being taken to address these challenges.

PCIPs should describe what change management capacity is in place to facilitate implementation of the contract

The PCIP is supported by a dedicated Improvement Programme manager and Improvement Advisor post who support the development, implementation and reporting of plans. Additional quality improvement support has been received for week of care data support and survey support. The Programme manager and improvement advisor work very closely with the senior LIST analyst in supporting the plan and cluster quality work.

Each work stream area has service leadership resource funded, team leads and service leads play a key role in the implementation and service design, working very closely between work stream delivery group and practical delivery with practice managers and GP clusters to ensure optimal implementation and delivery.

The development of a cluster improvement facilitator role has been supported and funded at one day per month for each cluster. seven of nine clusters have a practice manager identified as taking on this role. These roles play a key consultative and facilitative role in planning and delivery of the plan.

The impact and engagement of practice admin teams through the Practice Administration Collaborative and subsequenet scale up accross Forth Valley has been instrumental in creating the conditions for change within GP practices. Preparation and training for signposting and evidence of reducing the administrative workload for GPs.

All leadership and improvement roles are connected via a Primary Care Improvement Network which, largely virtually, shares information and updates and meets approximately quarterly with a focus on evaluation and service design.

LMC GP Sub Committee representation on all working and governance groups is supported through NHS funding. The GP sub plays a central role in assuring service specifications and supporting the implementation interface between PCIP and general practice.

6 Primary Care Premises Review

A review of primary care services and premises, taking account of the implementation of the new GMS contract and primary care implementation plan and proposed new housing developments was commissioned by NHS Forth Valley in 2019. This review had the objective of identifying investment priorities for primary care estate.

The approach included the following key stages:

- Data Gathering - national, local, board level and practice level information
- Establishing Trends - demographic, housing, impact of new models of care
- Future Capacity Planning - identification of new models of care within PCIP, increased use of information technology and smarter working
- Prioritisation of Investments - identifying the investments both short term minor modifications and long term investment required.

The review outlined and prioritised 8 primary care premises with long term major investment need (listed by priority below) and a range of additional immediate, short term and mid term priorities.

1. Cowie
2. Alva
3. Tor (Plean)
   Kersiebank (Grangemouth)
5. Creation of a Falkirk Primary Care and community services hub
6. Bonnybridge
7. Meadowbank
8. Dollar

Early estimates of the financial implications indicate circa. £30M required to facilitate the long term major investment in new build primary care premises, that includes a Falkirk Hub which will be linked with the development of the Community Hospital.

In the short term, funding of £1.25M has been proposed in the Capital plan for FY 2020/21 to progress the works identified in the Primary Care Services and Premises Review.

There is also a requirement to identify funding for a separate strand of work that focuses on those premises not subject to redevelopment but which require investment to be brought to and maintained at the required quality and compliance standards.

7 PCIPs should outline what specific steps are being taken to improve the digital infrastructure as well as any specific challenges and actions taken to mitigate these.

Digitial & eHealth work streams

Windows 10

Workstations & Operating Systems – all PC's are being upgraded or replaced to meet the new recommended specification. Approx 25% of all GP based PC's are being replaced, all gain a new hard drive and 8GB of RAM. Double monitors to all consulting room PC's are deployed where they are not already in situe.
Windows 10 is being implemented and Office 2016 (Excel, PowerPoint & Access) and 2013 (Word) are also included. When the GP System refresh is completed Word will be upgraded as well (this is a current GP System requirement)

Office 365

Office 365 will be rolled out to all users in NHS FV, including GMS & Community services. From a GMS Perpective (office aside), they have already seen the benefit of the Teams rollout, by Sept 2020 all email will have been migrated to the Office 365 platform from NHS Mail. Additional functionality around SharePoint for collaboration and sharing of files and content will be available towards the end of the calandar year.

Directory Services

Currently users in Practices access a Practice only domain (i.e. we have 57 separate silos), we are moving to having one GP & Community domain across all GMS & community services. Essentially this will open up access across FV for all users in GMS & Community services. This will allow for the easier sharing of systems, content and ICT Services across Forth Valley.

WiFi

Practice WiFi – We have installed WiFi at appropriate sites for clinical access for community staff in line with Morse project requirements. This covers 26 of our 57 GP Practices.
As GMS Practices and PC sites are refreshed, as a rule the installation of WiFi should be a priority. Each GMS Practice site requires significant investment to implement WiFi, this is currently averaging £15k per practice. If public WiFi access is required additional revenue investement is required, averaging an additional £3k per site per annum.

Unified Telecommunications

With the retiral of traditional telephony systems, VOIP should be emraced as the default technology to deliver voice services. As GMS Practices and PC sites are refreshed, as a rule the installation of VOIP should be the default choice. Introducing this technology allows the convergence of previously separate technologies, namely Data, WiFi and Voice services, moving to unifed communications, this allows NHS FV to leverage the current investement in core communications technology investments already made, which will assist in driving downthe overall cost of moving to this technology.

8 Risks

In preparing the Primary Care Improvement Plan, we have acknowledged that this is both ambitious and aspirational; therefore there are a number of risks associated with implementing the priorities we have set out in the Plan. The highest risks we have identified are:

- **Financial Affordability** of Delivering MOU commitments.
- **Timescale** – the timescale to deliver this ambitious change and improvement programme is short, and whilst every effort will be made with implementation by 2021, it is anticipate that the service improvement programme will continue through 2021 and beyond. The NHS Board has invested in a Forth Valley wide Primary Care Team working alongside the NHS Board's Contracts Team to oversee PCIP implementation including primary care premises and IT developments.
- **Reputational Risk and General Practice Engagement** – inability to deliver PCIP commitments will lead to loss of trust and loss of the high level of engagement we have with GPs and their staff. This will further risk the effective delivery of the new service models and the development the multi-disciplinary team models.
- **Workforce** – Recruitment and Retention of additional primary care staff in line with timescales and required skill sets. Inability to train professionals in new roles within timescales and subsequently retain them within new primary care services.
- **Maintaining General Practice Sustainability** at scale whilst new models are being developed.
- **Physical Infrastructure:** Premises remains significant constraint and the Primary Care Programme Board whose membership includes our Health and Social Care Partnerships, GP leads and other professional multidisciplinary leads oversee this work. A detailed review of current Primary Care premises has been completed and shared with the Programme Board and is currently being costed. This took into account the condition of existing premises, considering needs of additional workforce and potential options for locality / cluster hubs, as well as the impact of new housing developments. A comprehensive primary care premises plan has been developed outlining our short, mid and long term needs with respect to primary care premises.
- **Digital Infrastructure**: Some of the IT barriers to MDT working are significant. IMT MDT infrastructure group is in place and every effort is being made to develop workable solutions to enable new models of working. Ultimately there is a reliance on GP IT re-provision and digital transformation.
- **Rural Feasibility**: Multiple supports are not only inefficient but not feasible to deliver to small practices in rural locations. A rural view is being taken on priority work streams, particularly VTP and CTAC.

9 Financial Projection

The cost of fully delivering the requirements of the new GMS contract continues to exceed the indicative revenue funding allocation provided by the Scottish Government. Our Primary Care Improvement Plan, originally published in July 2018 and updated in May 2019, has consistently highlighted this issue and reports significant projected shortfalls in financial years 2020-21 and 2021-22.

There are 2 key issues:

1. The profile of the allocation over the 4 year period to 2021-22 is out of sync with the timing of when costs will be incurred due to the necessary pace of the recruitment programme if we are to deliver the contract by the end of the agreed 3 year implementation period.

2. The total value of the overall allocation is inadequate to fully deliver all of the agreed MoU commitments.

Whilst significant work has been undertaken to review the proposed service model in terms of skill mix, the phasing of recruitment and our overall assessment of the total number of staff required to adequately deliver the MOU commitments, iteration 3 continues to reflect the revenue costs associated with our assessment of what is required to adequately deliver the MoU commitments. In addition, iteration 3 now also incorporates the estimated capital costs arising from the necessary eHealth/IT and premises upgrades required to facilitate the successful implementation of the contract.

2019-20 – current financial position

The total number of staff in post or in process to be employed by March 2020 is 125 WTEs (v's 119 in plan) at a cost of £5.161m for 2019-20 (see appendix 1 for details of current position). Whilst this represents excellent progress, it has only been possible through significant additional non-recurring funding provided in year by the NHS Board and IJBs over and above our 2019-20 Primary Care Improvement Fund (PCIF) allocation.

At this stage in the roll out of the plan, it is recognised that the current profile of expenditure across both IJBs is not precisely in line with Scottish Governments funding allocations for the IJBs largely due to phasing of e.g. transfer of childrens vaccinations from general practice. However, once the plan is fully implemented, it is anticipated that the overall investment at the end of year 4 will be broadly in line the NRAC funding allocations.

2020-21 and 2021-22 financial projections

This year's PCIF allocation (estimated at £5.962m) requires supplementation of a further £2m additional funding to support the recurring costs of maintaining our plan towards contract delivery in 2020/21. A case, for £1.6m in year and £1.3m recurring, additional funding was submitted to the Scottish Government in December. An email rejection of the case was received at the end of March.

With clarity over our end of year financial position and in light of rejection of our business case, all efforts have been made at tripartite level to maintain and adequately progress PCIP. 2020/21 funding assumptions are outlined in the table below. These unfortunately includes exclusion of lowest priority services (e.g. link workers), detailed revision of costs including individual level pay scales, part year cost alignment with projected start dates, additional support through Action 15 funding, carry forward of under spend and additional board funding. It is clear that without the significant funding in addition to PCIF allocation, further implementation of the plan would not significantly progress during 2020-21 This is a completely unacceptable position to our Local Medical Committee and GP contractors.

NHS FORTH VALLEY PCIP FINANCIAL PROJECTION AS AT MAY 2020	**2020-21 ESTIMATE £m**	**2021-22 ESTIMATE £m**
WTE	**169.55**	**207.02**
Funding assumptions		
PCIF allocation	£5.962	£8.401
IJB reserves & c/f funds	£0.579	£0.150
NES GPPN trainees	£0.068	£0.000
Action 15 mental health	£0.367	£0.462
Other NHS Board funding	£0.699	£0.192
Total	**£7.675**	**£9.204**
Forecast expenditure		
Vaccine Transformation	£0.587	£1.480
Pharmacotherapy Service	£2.663	£3.437
Community Treatment & Care Services	£0.909	£1.140
Urgent care - advanced practitioners	£1.625	£1.819
Additional professional roles	£1.759	£2.238
Other (link workers & programme mgt)	£0.133	£0.381
Total	**£7.675**	**£10.494**
Underspend(Overspend)	**(£0.000)**	**(£1.290)**

All of the costs incurred in 20/21 will be sustainable within the year 4 PCIP allocation (estimated at £8.4m), however a residual recurrent £1.290m gap remains against the plan to deliver all of the required MoU commitments. Of note the board funding includes NHS core funds which the Board have agreed to make available on a non-recurring basis to enable the PCIP to continue to progress at pace during 2020-21 in light that no additional funding has been granted by the Scottish Government. This funding has previously been used to support sustainability in 2C practices on a temporary and gradually reducing basis. This is not part of the General Medical Services funding envelope and is therefore not in scope in term of the IJB delegated budgets. It also includes recurring funding for workforce superannuation uplift.
With respect to financial year 2021-22, it is intended that the final recruitment programme will focus on appointing a further 25 WTE posts during this period. This will increase the total number of PCIP staff to 196 WTEs. In addition, £750k is assigned to adult flu vaccinations for 2021/22. The current situation regarding COVID 19 may bring an additional potential risk if the population cohort for flu immunisation is extended.

Total costs by 2021-22 are therefore estimated at £10.650m, which compare to total available funding of £9.360m, resulting in a longer term **£1.290m** recurring deficit. Note that this projection is subject to change pending confirmation of pay awards (currently estimated at 1.5% for 2021-22) and the impact of incremental drift following changes to the Agenda for Change pay scales.

2019-20 PCIP recruitment summary as at Feb 2020	2019-20 Plan WTE	2019-20 Actual WTE	2019-20 Variance WTE	Comments
Vaccine Transformation Programme				
Admin Support	3.00	3.00	0.00	
Nursing staff	10.80	10.80	0.00	
	13.80	**13.80**	**0.00**	
Pharmacotherapy Service				
Pharmacists	26.98	26.98	0.00	
Rotational pharmacists	5.50	5.50	0.00	
Technicians	6.00	6.00	0.00	
	38.48	**38.48**	**0.00**	
Community Treatment & Care Services				
Primary Care Lead Nurses	2.00	2.00	0.00	
Healthcare Assistants	12.60	7.16	5.44	5.44WTE expected to be in post by 31 Mar
Treatment room nurses	0.00	0.00	0.00	
GP Practice Nurse trainees	7.00	7.00	0.00	
	21.60	**16.16**	**5.44**	
Urgent Care - Advanced Practitioners				
Advanced Nurse Practitioners	**14.20**	**17.56**	**(3.36)**	Out to advert for another 1.64 WTE posts
Additional Professional Roles				
Care home liaison nurses	4.10	3.65	0.45	0.5WTE expected to be in post by 31 Mar
Mental Health Nurses	15.70	17.20	(1.50)	
Physiotherapists	9.40	9.40	0.00	
	29.20	**30.25**	**(1.05)**	
Other				
Community Link Workers	0.00	0.00	0.00	
Programme Management & Support	2.00	1.85	0.15	
	2.00	**1.85**	**0.15**	
TOTAL	**119.28**	**118.10**	**1.18**	
		125.68		Total expected to be in post pending recruitment process