Local Implementation Tracker Guidance

The following tracker should be used by Integration Authorities in collaboration with Health Boards and GP sub-committees to monitor progress of primary care reform across their localities, and in line with service transfer as set out within the Memorandum of Understanding.

The **MoU Progress tab** should be used through local discussions between Integration Authorities and GP sub-committee to agree on progress against the six MoU priority services as well as that the barriers that areas are facing to full delivery. Integration Authorities should provide information on the number of practices in their area which have no/partial/full access to each service. The sum of these should equal the total number of practices in each area. Please only include numbers (or a zero) in these cells; comments boxes have been provided to supply further information.

If you are funding staff through different funding streams, for example, mental health workers through Action 15 funding, please include this information in the relevant section so we are aware that you are taking steps to recruit staff in this area.

The **Workforce and Funding Profile tab** should allow Integration Authorities to consider financial and workforce planning required to deliver primary care improvement, and reassure GP sub-committee of progress.

For the workforce numbers and projections, we are limiting our questions to WTE numbers, but are also asking you to provide headcounts for community links workers so that we can monitor progress towards the commitment to 250 additional CLWs.

If you are funding staff through different funding streams, for example, recruiting mental health workers in Action 15, do not record these in Table 1. However, they should be included in Tables 2 and 3 to inform workforce planning.

We have included new rows this time at the foot of Tables 1 and 3 (shaded in red). Please include here your estimate of total required spend (Table 1), and total required staff (Table 3) in order to reach full delivery across each of the services.

We would also ask that this local implementation tracker be updated and shared with Scottish Government by **31st May 2021.**

Covid PCIP 4

Health Board Area: NHS Lanarkshire
Health & Social Care Partnership: North Lanarkshire HSCP and South Lanarkshire HSCP
Total number of practices: 100

MOU PRIORITIES

2.1 Pharmacotherapy	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices with NO Pharmacotherapy service in place	0	0	0	0	0	0
Practices with Pharmacotherapy level 1 service in place	0	100	0	0	100	0
Practices with Pharmacotherapy level 2 service in place	0	100*	0	0	100*	0
Practices with Pharmacotherapy level 3 service in place	0	0	0	0	0	0

What assumptions are you using to determine full delivery, and what specific barriers are you facing in achieving this? Assumptions for full service delivery are based on delivering all tasks from the Level 1 pharmacotherapy table outlined in the GMS 2018 contract. Barriers to this include insufficient funding structure and workforce nationally (as pharmacists are now on national shortage profession list), Board specific barriers include identifying premises to accommodate staff and IT solutions to enable remote working (such solutions are required due to challenges in basing all staff required to deliver a full level 1 service physically in practices). The national delays in progressing digital prescribing directly impact on achievement of pharmacotherapy Level 1. We are using workforce to manage tasks that could be supported by better digital solutions, this is inappropriate and undermines the ability to eliver Level 1 and retain and recruit staff. These would need to be agreed nationally eg. electronic prescribing.
*Aspects of Level one and level two pharmacotherapy are interlinked. For example, whilst clinically assessing the appropriateness of high risk medications under level one, if any issues are identified, the pharmacist has a professional responsibility to resolve these issues (categorised under level 2 in the pharmacotherapy table) in the interest of patient safety. A national view on where this sits with the L1 delivery would be welcome.

2.2 Community Treatment and Care Services	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices with access to phlebotomy service	0	100	0	0	0	*100
Practices with access to management of minor injuries and dressings service	0	100	0	0	0	*100
Practices with access to ear syringing service	**100	0	0	0	0	*100
Practices with access to suture removal service	**100	0	0	0	0	*100
Practices with access to chronic disease monitoring and related data collection	**100	0	0	0	0	*100
Practices with access to other services	0	100	0	0	0	*100

What assumptions are you using to determine full delivery, and what specific barriers are you facing in achieving this?
Prior to Covid, Lanarkshire was delivering Treatment Room Services to some extent in all ten localities. For the majority of practices, this included all aspects on this return except chronic disease monitoring and related data collection. All GP practices had been surveyed to identify tests and task activities still being carried out by practices, rather than by CTAC, with a view of addressing historical arrangements through levelling up of provision. Early scoping around long term conditions, chronic disease monitoring and related data collection had begun.
Treatment and care services activity altered during the first wave of the pandemic and an urgent/ emergency service was put in place through domiciliary services. Currently, treatment and care services are being 'stood up' on a phased basis across Lanarkshire; phlebotomy, dressings and injections being the first provisions to recommence. Capacity has been greatly reduced by the need for physical distancing and the increased infection prevention and control measures required. Scoping of long term conditions and chronic disease monitoring and related data collection has recommenced and testing commenced during October 20 for 3 conditions with the aim to scale and spread across all of Lanarkshire. The CTAC Operational Group has reconvened regular meetings from end April 21 to begin progressing this workstream requirements.
* Access to treatment and care services by 31/03/22 is dependent on the ongoing pandemic and the responses required to manage it.
** This was a reduction compared to previous returns due to the impact of Covid.

2.3 Vaccine Transformation Program	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Pre School - Practices covered by service	0	0	100	0	0	100
School age - Practices covered by service	*catch-up - various 100	0	* Flu 100	0	0	100
Out of Schedule - Practices covered by service	100	0	0	0	0	100
Adult imms - Practices covered by service	100	0	0	0	0	100
Adult flu - Practices covered by service	0	0	100	0	0	100
Pregnancy - Practices covered by service	0	0	100	0	0	100
Travel - Practices covered by service	100	0	0	0	0	100

What assumptions are you using to determine full delivery, and what specific barriers are you facing in achieving this?
Full delivery will be on those cohorts that were identified in the original contract offer. For all vaccines other than travel health, full delivery will be dependent on pulling information from GP systems in the first instance to identify patients who are to receive vaccine. Travel health cannot deliver in this way as these vaccines are ad hoc in nature and as such will be patient identified. Our initial modelling was on cohort uptake until 19/20 and a provision for 75% uptake, but over the 20/21 flu season, we saw an increased uptake in all three GP / PCIP cohorts, which is to be welcomed, but modelling for future years will need to consider this. The flu programme was achieved through a mass vaccination model for flu season 2020-2021, as such the 20/21 staffing requirement and accommodation requirement was impacted by social distancing, and careful consideration will need to be given to the possible need for revision of funding allocations which were informed on pre-covid uptake levels.

A VTP SLWG has progressed project plans to map out the remainder of the vaccination services that require to be transferred to Board managed services. This exercise has identified a number of areas where we are awaiting national information on or where local solutions are required, these are detailed below.
Barriers:
Travel Health - require clarification the Fit for Travel has been updated to be the source of initial information and point for linking into Board vaccination service.
Travel Health– require clarification if provision of national initial call handling provision (NHS24) will be available, or indeed if not immediately, in future as this would inform the selection of local solutions.
Travel Health – require confirmation that national PGDs will be provided including when they will be provided, if not, will require to locally develop.
VTP / IT – access to patient records to ensure patient safety specifically for Shingles, Travel Vaccinations, and Pneumococcal.
VTP – National IT system provision, require confirmation of what will be made available and by when. Require confirmation that future proofing of IT solutions includes certification of vaccine module in national IT system provision.
VTP – increased pressure on available accommodation due to covid response limits options of where vaccination clinics can be delivered.
There is a need for clarification regarding timelines detailed in joint BMA/Cabinet Secretary Letter with full implementation to be October 21 or by March 22?
There is an assumption that recently announced additional cohorts are not to be funded by PCIP, nor indeed shall they default to GPs to deliver.

2.4 Urgent Care Services	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices supported with Urgent Care Service	89	11	0	*79	*21	0

What assumptions are you using to determine full delivery, and what specific barriers that you are facing to achieving this?
Currently there are ANPs in training across 11 practices in NHSL, and progress towards the planned urgent care model continues. The team of ANPs have been supporting the Covid community assessment centres since March 2020, the CACs remain reliant on this redeployment. NHS Lanarkshire continues to recruit training and qualified ANPs, in addition to Senior ANPs, who will support the delivery of urgent care going forward. Potential barriers: ANPs being available to support urgent care model will vary depending upon ongoing response required to the pandemic. Furthermore, there remains a concern that the redeployment to Covid Assessment Centres could detrimentally affect recruitment and retention of ANPs. The Covid pandemic and changing ways of working has given us an opportunity to revisit the urgent care model, and this will be further explored in the coming months. The numbers are indicative of the current funding for ANPs. Wider modelling is being undertaken to review how more practices can be supported with an urgent care service, however, even with this access, will remain partial without further funding for Advanced Practitioners in Urgent Care .

* Practices with access may differ as a result of ongoing urgent care model review/provision.

Additional professional services

2.5 Physiotherapy / MSK	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices accessing APP	94	3	3	95	3	3

Comment / supporting information
Current practice allocation is on a ratio of 1 wte APP to 15,000 practice population. We have a desire to have a service across all practices but will be dependent on further additional funding from Scottish Government. Access to MSK provision across the community system has been significantly adversely affected with the standing down of the national number. This has impacted negatively on practice workload.

2.6 Mental health workers (ref to Action 15 where appropriate)	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices accessing MH workers / support through PCIF/Action 15	61	0	39	20	0	80
Practices accessing MH workers / support through other funding streams	81	0	19	20	0	80

What are the specific barriers to your practices receiving a full MH service? Please attach a copy of your Mental Health action plan if you have one.
We have a total of 20wte staff for the PCMH&Wellbeing service which is mainly Mental Health Nurses. Our plan has always been to recruit to the full complement of additional mental health staff working in primary care (which is approximately 50) by end of Action 15 programme in 2022 & we have a recruitment plan in place to achieve that. We have MH Liaison Nurses in 39 GP practices which should increase to 45 by early summer. The 39 practices that have a mental health liaison nurse have allocated sessions per week. Some practices have 1 session, some have 2 sessions and a few have 4 sessions.
The 19 practices that have access to the mental health workers have full access to the resources being provided. We are hopeful that we will be in all GP practices (depending on recruitment) by the middle of 2022.

R:\
onal\GMS 2018 - 2

2.7 Community Links Workers	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices accessing Link workers	0	0	*10	0	0	100

Comment / supporting information
Model is:
2wte co-ordinators who are in post.
18wte GP Community Link Workers.
10wte Financial Welfare Advice workers (via a SLA with 3rd sector partners) - this provision was in place for 1 April 2021.

* as of 31/03/21, 10 practices had full access to a GP Community Link Worker. Phasing of availability of capacity across 100 practices is in line with recruitment detailed below.
As of 30/04/2021, 22 practices had full access. We continue to engage directly with all GP practices with a view to going live at a time that works best for them within the constraints of the phasing detailed below.

18wte GP Community Link Workers = 180 half day sessions across 100 practices.
As of 31/03/2021 10.6wte (106 sessions - 59%) was in place and available.
By July 21 a further 4wte (40 sessions - 22%) will be available.
A final 3.4wte (34 sessions - 19%) will be added by September 21.

2.8 Other locally agreed services	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices accessing service	0	0	0	0	0	

Comment / supporting information -
Phase 2 testing of the delivery of the **Occupational Therapy Service in Primary Care** **Test of Change** was initiated in January 2020, however, this service is not funded by PCIP but through transformation funding. There is no substantive funding stream at the current time. In this second phase of testing, it was proposed that occupational therapy services be aligned with GP services across the Hamilton and Bellshill localities, (25 GP Practices). The planned roll out of Primary Care Occupational Therapy Service across Hamilton and Bellshill localities was suspended W/B 16th March 2020 in response to the COVID pandemic. Primary Care Occupational Therapists (n = 7) were redeployed to community rehabilitation teams, in response to NHS Lanarkshire's COVID service re-design. Primary Care OT staff (n=4), continued to support 2 general practices (from phase 1), providing a remote early intervention and prevention service. They were able to offer support and therapeutic interventions to people with significant complex co-morbidities and long term health conditions and those who were shielding or experiencing negative effects of lockdown. A combination of telephone consultations, Near Me and other digital resources such as online materials and apps were utilised. Approval for the Occupational Therapy Primary Care recovery was granted by RRROG on 11th June, to enable the occupational therapy staff to return to GP practice. Currently Occupational Therapy provision is aligned to 18 practices, supporting GP colleagues, who are experiencing a period of high activity and increased workload demands. Occupational Therapy offers essential supports to patients, experiencing occupational performance difficulties due to mental or physical health or combination of both, whether COVID related or pre-existing or newly diagnosed long term condition.

Whilst good progress has been made since the service recovered, the stepped introduction of occupational therapy services into the 25 GP practices has been impacted upon. A small number of staff were again deployed to the Vaccine Programme in March 2021. A combination of accommodation pressures and IT difficulties, such as remote access to Vision and service re-design in response to COVID have impacted at times, on progress. Therefore the target of 25 practices has not been reached by March 2021, as initially planned. Phase 2 funding initially expired in July 2021 but this had been temporarily extended to December 2021. This should enable the remaining 7 GP Practices in the Hamilton and Bellshill Localities to be given access to the Primary Care Occupational Therapy service. Data collection from phase 2 is currently being evaluated and will be presented in June 2021. Opportunities will be sought to link with appropriate stakeholders, explore funding opportunities/work streams in effort to secure permanent funding to enable the PCOT service to continue.

2.9 Issues FAO National Oversight Group

Please detail the impact of Covid on the PCIP process and where you are in that process. How has Covid impacted previous projected delivery.

There is a need to ensure a more coordinated approach to workforce planning at a national level.

Clarification is needed as to whether funding for workforce and maintenance of GP premises which have been taken over by the board is to come from PCIP funding or another funding stream, noting that this will affect different boards differently. In Lanarkshire, 14 possible lease transfers have been identified, of which 10 have submitted applications registering leases they wish to transfer and 4 assignations have been completed.

Delays in progressing sustainability loans is causing concern. For example, sustainability loans processing was initiated by NHSL / practices nearly two and a half years ago - we are not aware of any practices being paid out for these - the delays in pay out has hindered planning at a practice / board level further reducing confidence in sustainability of General Practice as a partnership entity - given the new covid environment, we would expect that this process should be delivered on a timeous basis remotely or otherwise.

We are expecting at some time that boards will be expected to take practice premises wholly into public ownership as the loan schedule increments - given this, clarity around timescale would allow both boards and practices to plan for the future post covid world with confidence.

The pandemic is likely to continue to impact on the delivery of PCIP.

Review of funding offered against PCIP ask is required. It is evident from the detail in the return under workforce and funding profile (lines 13 -19), that the current funding envelope does not cover the ask.

The on-going pandemic beyond May 2021 will affect PCIP delivery. This will impact on timescale for delivery due to continued Covid response and time required to recover from providing Covid support.

There is a need for a clearer definition of 'in direct support of general practice', better acknowledgement and articulation of the transformational vs transactional aspects of

2.10 Health Inequalities

Covid has highlighted existing health inequalities and without mitigation the response to Covid is likely to increase health inequalities. Ministers are keen to see all sectors renewing their efforts on this and will be encouraging all sectors to work together. HSCPs and GPs are already taking significant actions to close the gap. HSCPs are using their position to bring sectors together to help take a whole-system approach to big issues. GPs are playing their part - whether through referrals to services for weight management or smoking cessation, or through outreach to the communities which are hardest to reach and where most inequality is experienced.

Please provide any comments on the impact of Covid on health inequalities and any measures taken to mitigate this impact. Please attach a copy of your EQIA/Fairer Scotland Duty Assessment /Health Inequalities Assessment if you have them.

See embedded Word document below for wider Health Promotion activities and programmes:

R:\CrossFunctional\GMS 2018 - 21\Governance\Scot

Funding and Workforce profile

Health Board Area: NHS Lanarkshire
Health & Social Care Partnership: North Lanarkshire HSCP

Table 1: Spending profile 2018 - 2022 (£s)
Please include how much you spent in-year from both PCIF and any unutilised funding held in reserve

Financial Year	Service 1: Vaccinations Transfer Programme (£s)		Service 2: Pharmacotherapy (£s)		Service 3: Community Treatment and Care Services (£s)		Service 4: Urgent care (£s) * see comment box under Table 3		Service 5: Additional Professional roles (£s)		Service 6: Community link workers (£s)	
	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)
2018-19 actual spend		274	1548969	86922	913705	286928	0	0	304930	160230	0	0
2019-20 actual spend	682231	31968	3234717	55506	2387398	248372	0	0	478792	258064	28202	8012
2020-21 actual spend	2175240	264862	5219653	5905	3877380	106256	0	0	445246	-46728	173536	19441
2021-22 planned spend	1576000	50000	7514000	150000	7282000	150000	0	0	662000	160000	1080000	20000
Total planned spend	4433471	347104	17517339	298333	14460483	791556	0	0	1890968	531566	1281738	47453
Total additional spend required for full delivery	112200	36000	9178000	106000	2644800	1499000	0	0	12002000	175000	135000	20000

Table 2: Workforce profile 2018 - 2022 (headcount)

Financial Year	Service 6: Community link workers
TOTAL headcount staff in post as at 31 March 2018	0
INCREASE in staff headcount (1 April 2018 - 31 March 2019)	0
INCREASE in staff headcount (1 April 2019 - 31 March 2020)	2
INCREASE in staff headcount (1 April 2020 - 31 March 2021)	11
PLANNED INCREASE staff headcount (1 April 2021 - 31 March 2022) [b]	7
TOTAL headcount staff in post by 31 March 2022	20

[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Table 3: Workforce profile 2018 - 2022 (WTE)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a] - Senior ANPs	** Mental Health workers	MSK Physios	Occupational Therapists* Not funded from PCIP, Test of Change only	
TOTAL staff WTE in post as at 31 March 2018	20	6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.08	1.2	0.0
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	20.0	3.0	0.0	55.0	24.5	9.0	0.0	0.0	0.0	0.0	0.0	0.0
INCREASE in staff WTE (1 April 2019 - 31 March 2020)	40.0	2.4	38.7	0.0	0.0	7.0	0.0	2.0	0.0	0.0	8.6	2.0
INCREASE in staff WTE (1 April 2020 - 31 March 2021)	11.5	0.0	21.0	0.0	0.0	9.0	0.0	2.0	20.0	0.0	2.6	10.8
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	0.0	64.0	31.0	22.9	5.0	6.0	0.0	1.0	30.0	0.0	0.0	7.2
TOTAL staff WTE in post by 31 March 2022	91.5	75.4	90.7	77.9	29.5	31.0	0.0	5.0	50.0	2.08	12.4	20.0
Total staff (WTE) required for full delivery	170.5	85.0	100.7	89.9	29.5	68.5	0.0	10.0	142.0	56.0	61.2	20.0

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

Comment:
Pharmacotherapy - The 66WTE planned increase in technicial workforce in 2021/22 is a broken down into 2 senior technicians, 15 trainee technicians and 49 pharmacy support workers. 2 WTE senior technician posts have been filled and recruitment will commence for student technicians and pharmacy support workers in 2021/22. The staff in post before 31st March 2018 were funded under GPCP which has now evolved into pharmacotherapy. *85 includes all technical staff (Band3 Pharmacy Support Workers, Band 4 Student Technicians, and Band 5 technicians).
ANPs - It takes two full academic years to train an ANP and support them to attain the Post Graduate Diploma in Advance Practice. If we are to deliver the urgent care model in time, we would need to pull forward the recruitment of trainee ANPs now and double run some of the modules to have a fully trained and equipped workforce to deliver by March 2023. If we do not recruit to the additional 37.5 posts just now, to begin academic programme in September 2021, there is a significant risk that we will not be able to deliver urgent care.
*** Urgent Care funding** is included in the Community Treatment and Care figures in Table 1.
Community Link Workers - commitment of 30 WTE has been spread across a combined delivery between health & social care partnership members. NHL Lanarkshire has recruited against 20 wtes and the funding for 10 wtes has been released via SLAs to third sector partners to provide specialist financial advice. As such, it is not possible to define a headcount for the SLA component but it relates to a provision of service rather than the employment of posts.
Premises - there will be additional costs in relation to securing sufficient premises across the Board estate to host PCIP workforce, and this is further increased by ensuring that this is Covid secure.
IT infrastructure/equipment - there will be additional costs in relation to providing an IT infrastructure for all services and equipment ie. laptops and phones for all PCIP staff.
** **Mental Health** - In Lanarkshire, the current Mental Health provision sits under Action 15, if we wished to fully develop this across all practices under PCIP the increased numbers and finance would be needed.