**ITEM No …7……..**

**REPORT TO:** **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 25 AUGUST 2021**

**REPORT ON:** **DUNDEE PRIMARY CARE IMPROVEMENT PLAN UPDATE**

**REPORT BY:** **CHIEF OFFICER**

**REPORT NO:** **DIJB40-2021**

## 1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to provide an update on the implementation of the Dundee Primary Care Improvement Plan for 2020/21 and seek approval for the implementation of the Dundee Primary Care Improvement Plan for 2021/22.

## 2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the progress to implement the Dundee Primary Care Improvement Plan 2020/21 in the third year of delivery (attached as Appendix 1) and the key achievements as described in section 4.3.3.

2.2 Approves the proposed actions for Dundee Health & Social Care Partnership for 2021/22 as described in Appendix 1 and notes the proposed allocation of funding as detailed in Section 3.

2.3 Notes that aspects of the Plan will not be fully implemented by March 2022, and that practices will receive transitionary payments after that time point for services they are still delivering as outlined in section 4.

2.4 Instructs the Chief Officer to issue directions to NHS Tayside to implement the specific actions relevant to them in Appendix 1.

2.5 Notes the previous agreement to delegate the monitoring of the Dundee allocation of the Primary Care Improvement Fund as noted in Section 3.6.

2.6 Instructs the Chief Officer to provide a further report on progress made in the fourth year of delivering the Dundee Primary Care Improvement Plan to a future IJB.

## 3.0 FINANCIAL IMPLICATIONS

3.1 Funding for delivery of the Dundee Primary Care Improvement Plan (the Dundee Plan) for 2020/21 was agreed by the Integrated Joint Board in 2020 (Article XIII of the minute of meeting of 25th August 2020 and report no DIJB36-2020 refers). There has been significant increase in delivery and spend in year 3 (2020/21), however this was still lower than planned, in part due to the impact of the pandemic, and part workforce and premises issues. The actual spend is detailed in Table 1 below.

Table 1 2020/21 spend against allocation

| | *Approved PCIF Allocation* | Actual Funding / Expenditure |
|---|---|---|
| | *£'000* | £'000 |
| **Scottish Government Allocation*** | ***3,419*** | **3,413** |
| **Plus B/F underspend** | ***1,288*** | **1,288** |
| | | |
| Forecast Expenditure - | | |
| Vaccine Transformation Programme (VTP) | *166* | 171 |
| Pharmacotherapy | 825 | 494 |
| Community Treatment and Care Service (CT&CS) | 761 | 772 |
| Urgent Care | 579 | 241 |
| First Contact Physio / Musculoskeletal | 288 | 255 |
| Mental Health | 270 | 157 |
| Link Workers | 202 | 192 |
| Other | 154 | 247 |
| **Total** | **3,244** | **2,529** |
| | | |
| **(Over)/Underspend** | ***1,463*** | **2,173** |

*After receipt of locally agreed inter-IJB reallocation of funding from Angus IJB and Perth & Kinross IJB

3.2 The development of the Dundee Plan and the associated financial plans for 2021/22, and the recurring cost of this plan, are summarised in Table 2 below. These figures continue to be refined as learning is gained from the tests of change that are taking place and the models being developed. Table 2 details the proposed allocation for 2021/22 and full year cost of the current plan, along with a comparison of figures prepared in January 2020 to highlight estimated full scale implementation. (The latter figures noted as optimum implementation have not yet been revised but may require to be updated as learning over the past 18 months will have an impact on this.) The 2021/22 costs include non-recurring elements which are either one off projects to support this work or maybe required longer term for which other funding will need to be identified, such as through redesign of current services. There is a recurring shortfall in funding of £210k, which is an underlying risk in the longer term that needs to be addressed albeit carried forward reserves can potentially meet this cost for c 4-5 years, if not utilised for other aspects of delivery. The issue of potential funding shortfalls in fully implementing the plan is not unique to Dundee and has been raised with Scottish Government nationally for future funding considerations. There is a further underlying risk regarding pay uplifts from 2022-2023 onwards which will increase the costs year on year above the levels shown below.

Table 2 Proposed 2021/22 Financial Plan

| | 2021/22 | Full Year Cost (Recurring) | *Optimum Implementation* |
|---|---|---|---|
| | £'000 | £'000 | *£'000* |
| **Scottish Government Allocation *** | **4,716** | **4,716** | ***4,716*** |
| | | | |
| **Forecast Expenditure -** | | | |
| Vaccine Transformation Programme | 378 | 378 | *488* |
| Pharmacotherapy | 829 | 1,061 | *2,047* |
| Community Treatment & Care Service | 1,078 | 1,578 | *1,354* |
| Urgent Care | 781 | 937 | *1,828* |
| First Contact Physio / Musculoskeletal | 450 | 482 | *535* |
| Mental Health | 280 | 280 | *535* |
| Link Workers | 210 | 210 | *290* |
| **Total Recurring** | **4,006** | **4,926** | ***7,077*** |
| | | | |
| **Additional Non-Recurring** | | | |
| Additional First Contact Physio / Musculoskeletal | 121 | | |
| Digitilisation of paper GP Records | 350 | | |
| Other** | 154 | 154 | 194 |
| **Total Non-Recurring** | **625** | **154** | **194** |
| | | | |
| **Total Projected Annual Spend** | **4,631** | **5,080** | ***7,271*** |
| | | | |
| **In year (Over)/Underspend - recurring only** | **710** | **(210)** | ***(2,361)*** |

| | | | |
|---|---|---|---|
| **In Year (Over)/Underspend** | **85** | **(365)** | ***(2,555)*** |

*After receipt of locally agreed inter-IJB reallocation of funding from Angus IJB and Perth & Kinross IJB
** Expenditure levels being reviewed and alternative sources of funding being sought

3.3 The formal Scottish Government Allocation letter has been received. There is a small decrease in funding to Dundee due to changes in National Resource Allocation Committee (NRAC) allocations.

3.4 At this stage plans remain fluid as the ongoing impact of the pandemic, including the current wave, is still unclear. Many of the teams were asked to prioritise and support other areas of work during the last 18 months and may be asked to do so again. The risk of this is much lower than it was previously. As a result, the financial implications continue to evolve as project plans develop.

3.5 Recruitment of sufficient staff at the appropriate skill-mix continues to be a significant risk, and this has been a major contributing factor in slippage to date.

3.6 The financial management of the Primary Care Improvement Plan is delegated to the Chief Officer, Chief Finance Officer and Clinical Director, as agreed previously, with the monitoring of this budget overseen by the Dundee Primary Care Improvement Group. The Local Medical Committee remain core to this process and have to agree all plans, including finance.

3.7 There was a significantly increased cost to support GP recruitment and retention. There were a number of factors for this, including a higher than anticipated number of GPs in the career start pathway. This funding was agreed retrospectively, but is not feasible longer term, so other sources of funding are being sought.

3.8 Brought forward underspends from previous years totalling £2,173k are held in Earmarked IJB reserves and continue to be available for the Primary Care Improvement Plan purposes. These underspends will be reviewed and spend planned in conjunction with the Local Medical Committee to ensure they are used consistent with the Primary Care Improvement Plan, and reflecting that this is non-recurring funds. This process will be managed by the Primary Care Improvement Group.

3.9 The financial implications of reimbursing practices after April 2022 for areas of the plan which have not been fully implemented are not yet known.

## 4.0 MAIN TEXT

### 4.1 Context

4.1.1 The IJB has previously considered papers setting out the context and challenges within primary care (report DIJB51–2017, article IX of the minute of the meeting held on the 19th December 2017 refers) and the implications of the General Medical Services (GMS) contract and related memorandum of understanding (report DIJB9-2018, article IX of the meeting held on the 27th February 2018 refers) and subsequently the plans for years 1-3. The Primary Care Improvements Plans consists of a Tayside wide Primary Care Improvement Plan (the Tayside Plan) which sets out the high level regional and local improvements. This Tayside Plan is expressed locally at a Dundee level through the detailed Dundee Primary Care Improvement Plan (the Dundee Plan). These plans have previously been discussed and agreed with the most recent plan for 2020/21 being on the 25th August 2020 (report DIJB36-2020, article XIII of the minute of the meeting held on 25th August 2020 refers).

4.1.2 This paper details the progress against the actions set out in year 3 of the Dundee Plan, associated expenditure, and details the proposed actions and spend for year 4 (2021/22). The Tayside Plan, incorporating the Dundee Plan, was approved by each Integration Authority, the Local Medical Committee (LMC) and NHS Board. The Tayside Primary Care Improvement Plan and the Dundee Plan for each of years 1 to 3 were previously approved. This report updates these plans and sets out the priorities for implementation in year 4.

4.1.3 The following are the nationally agreed priorities for the primary care improvement plans which must be delivered between 2018 -2021:

- The Vaccination Transformation Programme (VTP)
- Pharmacotherapy Services (PCT)
- Community Treatment and Care Services
- Urgent Care (now due 2023)
- Additional professional roles - such as musculoskeletal focused physiotherapy services and mental health
- Community Link Workers (referred to as social prescribers).

4.1.4 The Scottish Government and British Medical Association released guidance in December 2020 which reinforced their commitment to delivery of the 2018 GMS contract, but noted that the timeframe had been reviewed with delivery deferred to 2022, other than for urgent care which is deferred to 2023.The policy position is noted in table 3 below. The following table describes the revised programme.

Table 3

| **Priority Area** | **Policy Position** |
|---|---|
| Vaccinations | Those vaccinations included in the Additional Serviced Schedule, such as childhood vaccinations and immunisations and travel immunisations to be removed from GMS Contract regulations by 1st October 2021.<br><br>Where GPs remain involved in the delivery of some vaccinations on 2022-23 this will be covered by a nationally negotiated Transitionary Service arrangement |
| Pharmacotherapy | NHS Boards are responsible for providing a level One Pharmacotherapy service to all practices for 2022-23, with a nationally negotiated Transitionary Service arrangement in place where this is not achieved. |
| Community Treatment and Care Services | A Community Treatment and Care Service must be provided by the Board by 2022-23 with a nationally negotiated Transitionary Service arrangement in place where this is not achieved. |
| Urgent Care | Legislation will be amended so that NHS Boards are responsible for providing an Urgent Care service to practices for 2023-24 with recognition this must fit with wider urgent care redesign work regionally and nationally. |
| Additional Professional Roles | Further work will be undertaken to articulate the 'end point' for the additional professional roles by the end of 2021. |

A number of these service developments are at risk of not being fully implemented by the revised deadline of March 2022.

**4.2 Dundee Governance**

4.2.1 The Dundee Primary Care Improvement Group (DPCIG) was established in 2018 with a remit to develop the Dundee Plan and take responsibility for implementation going forward. The Tayside General Medical Services Contract Implementation and Advisory Group supports work at a regional level, ensuring sharing of practice and coordination, particularly of the regional aspects of the contract delivery. This group feeds into the Tayside Primary Care Board. There are also a number of regional and local sub groups which lead the development of the service areas. Given the breadth of the range of services that sits within this overall context this is broad ranging and a number of these have much wider links.

4.2.2 The financial management of the Primary Care Improvement Plan is delegated to the Chief Officer, Chief Finance Officer and Clinical Director. The DPCIG has responsibility for the distribution and monitoring of the use of the Dundee allocation of the Primary Care Improvement Fund. Planning is in conjunction with the GP Sub Advisory Committee, and funding is approved by the Local Medical Committee.

4.2.3 Reporting to the Scottish Government continues every 6 months for both financial governance and more detailed progress of delivery.

**4.3 Progress**

4.3.1 Overall there has been significant progress in year 3 with most of the 7 work streams, however some work streams, such as urgent care, have reduced and are unlikely to regain the previous workforce for some foreseeable time.

4.3.2 In line with others services Scottish Government guidance on consultations has meant that many of the services have moved from face to face, often to phone, unless there was an urgent need for face to face. The increased use of phone, and to a lesser extent video, technology has been positive for many people accessing services, but not universally, and for some patients has been a significant barrier. This is not unique to Primary Care Improvement. Patient feedback is important and some services have been able to assess this change and have used that to inform plans for remobilisation and longer term delivery of the service. The change has also impacted on staff satisfaction with their roles, and it has added to the challenges teams have faced over this very difficult period.

4.3.3 The progress against all the key areas is outlined in Appendix 1. Key achievements include:

- Aspects of the Vaccination Transformation Programme have continued, especially for children and young people. The extended adult flu programme in 2020/21 was delivered jointly with NHS Tayside, Dundee HSCP with all practices supporting the delivery. In addition to the 24 practice teams delivery there were 3 sites used by HSCP staff in Kings Cross, Royal Victoria Hospital and McKinnon Centre (Broughty Ferry). The centralised team also vaccinated staff and residents in nursing homes, with support for the care home staff, while the adult community nursing team vaccinated those in residential care homes. This work has also informed the huge scale of the Covid Vaccination Programme and a similar methodology had been used, albeit with a mass vaccination centre in the Caird Hall.
- The First Contact Physiotherapy (FCP) team who assess for musculoskeletal issues expanded to all clusters last year, and recruited to all previously planned posts. However increased demand is currently exceeding capacity and impacting on service delivery. (Noting that not all Musculoskeletal (MSK) presentations will move from general practitioners even longer term because of frequency and complexity.) The FCP team sits within the wider Musculoskeletal team, which was deployed for much of the last 18 months, with an impact on that aspect of the service ie those patients who require a physio intervention. Elements of the phone and video consultations used during covid will be retained, but as an option rather than for the majority of consultations.
- The Pharmacy Locality Team provided a lot of support to practices, and wider teams, as they coped with the demands of the pandemic. The service was maintained and additional roles were undertaken, but there was limited expansion of PCT because of this, and recruitment issues.
- The Care and Treatment Team have rolled out wound care and some phlebotomy. In the early phase of the pandemic they supported patients who were shielding by undertaking bloods, and other care, in people's homes, to minimise risks. This was a significant, but very positive, impact. The lack of clinical space continues to create access issues for people, although there are now 9 sites across Dundee. Some planned areas have not yet started due to other demands and premises issues.
- The Integrated Care Home Team continued to assess patients in care homes rather than a GP, for some practices and some care homes. There has been both recruitment and staff leaving so that there has been an overall loss of capacity. The trainee advanced paramedics were withdrawn by Scottish Ambulance Service at the start of the pandemic

to support demand within the core service and they have not returned and seem unlikely to do so in the foreseeable future.

- The Patient Assessment and Liaison for Mental Health Service (PALMS), led by the psychology team, is seeing patients who present with mental health and wellbeing issues in some practices, with an increased skill mix being tested and using telephone for most consultations. There have been a number of workforce challenges which has led to a review of the delivery model.
- The Social Prescribing Link Workers have been able to support all practices, albeit in a different way, with the impact of Covid, rather than the 14 practices they supported before. They are testing a new support role in the team, and looking at different criteria. It was anticipated that in the autumn there would be a large increase in referrals as restrictions eased but this has not materialised, despite the known impact of Covid on people's health and wellbeing, including social circumstances such as finance and housing.

4.3.4 Workforce recruitment, retention and development has impacted on some services more than others. Currently for example the pharmacy team have managed to recruit to most vacant posts, but turnover remains relatively high. Creating jobs which retain staff is key going forward. For new staff developing their role and relationships in virtual teams has been challenging. A small number of staff have moved to care and treatment services under a TUPE process. An external recruitment microsite has been developed with a commercial company, and to support across Tayside. The impact of this is not yet known, but roles across primary care are promoted.

4.3.5 Suitable clinical space has continued to impact on service delivery. Any capacity in practices has now been utilised either because the requirements of the practice have changed with the need for a "Covid" assessment room, or because of social distancing. A small amount of clinical space has become available and is now used, particularly for care and treatment services. A number of small projects were identified to upgrade or create space in practices, but this had limited progress due to a lack of technical resource in NHS Tayside. Patients can access the site that is most convenient to them, which may be near where they live rather than their practice. This has been positive for many people. However where people live close to their practice and there is no alternative site for health use with capacity, the geographical aspects of access have not been maintained with the changing service.

4.3.6 The constraints of physical buildings for a number of services will impact on the pace of development over the next year. There is also considerable interest from other teams, particularly in secondary care, of using care and treatment services to deliver aspects of care locally for people. There is broad support for this intention but there is currently not space, or resource, to progress this significant shift in workload from secondary care and specialist teams. It would require budget transfer to allow this to progress . Plans to develop further health and care centres as part of any new developments is key to this. A review of the current general practice buildings, and how they fit into a longer term primary care premises strategy needs developed to inform future investment.

**4.4 Plans for 2021/2022**

4.4.1 Work stream leads have been developing their plans and this is reflected in Appendix 1 in the detailed plans. However the recent increase/wave 3 of people with Covid has impacted on the ability to progress some of these plans. This may continue to be the case for some time.

4.4.2 Plans in Dundee are evolving and are outlined in Appendix 1, with the current estimate of costs. Key aspects of this include:

- The transfer of vaccinations, including travel, have been impacted by covid and the covid vaccine in particular. The Joint Committee on Vaccination and Immunisation (JCVI) have released guidance for planning purposes which suggests that a likely covid booster will be given at the same time as flu vaccination to a very similar cohort, noting that the guidance on flu vaccinations has been broadened for 2021/22. The cohort for flu and covid which was not part of the original scope of Vaccine Transformation Programme (VTP) will be funded from other sources not the PCI funds. It is anticipated regional planning will progress this, building on the blended model of general practice delivery and a centralised

team. Travel vaccines also need to be transferred by autumn from practices. A model has not been agreed for this but it is anticipated demand will be low initially.

- Expansion of the team to consolidate delivery for those elements already moved, including wound care, and some monitoring, including bloods. Ear care pathway to be tested from July. Lack of space is a key issue for expansion of this service.
- For pharmacotherapy consolidate new posts and develop the teams who have had significant change. If suitable premises develop a cluster model, and progress pharmacy assistant role.
- Expand the delivery of the care home team of advanced practitioners more broadly and review the wider urgent care team, recognising the role of other teams.
- First Contact Physiotherapy Service will recruit further staff and reassess if capacity and demand are in line before further decisions are made.
- The Link Worker team will develop the new support worker role in the team, and continue to consider skill mix going forward. Given the impact of Covid it is anticipated demand will increase for this team.
- The PALMS service will review the roles in the team and how to work in a cluster model. There is unlikely to be full roll out by March 2022 given the current position.

4.4.3 As noted above in section 4.1.3 services should be in place by March 2022, or March 2023 for urgent care. Further information is awaited from the Scottish Government in relation to the revised Memorandum of Understanding (MOU2) (which was received early August) to clarify expectation and the financial impact of practices being funded if service not fully transferred. Three services have been prioritised in the MOU2, vaccination transformation programme, pharmacotherapy and care and treatment services. Other workstreams should progress and be developed where there is funding available to do so.

4.4.4 The developments within information systems for PCI teams have been positively received and provide an opportunity for wider teams to ensure care delivered remains part of the core patient record. Other teams who link with practices are keen to use this system, but this needs managed. The planned GP IT reprovisioning which will progress over the next 2 years, and may result in a new IT system, offers opportunities for this to be more integrated.

4.4.5 Ongoing review and feedback from patients using the developing services has and continues to influence how services develop. There have been a number of challenges because of the limited access to suitable premises for some people, while others have benefited from access more quickly with improved pathways of care. There has been limited communication around the evolving nature of the primary care team because of the variability of the services across practices. However most practices and patients are now supported by most of the services and we are awaiting finalised communications materials that can be shared widely to increase awareness of the public to the specialist services now available.

### 4.5 Next Steps

4.5.1 The Primary Care Improvement Group will continue to support and monitor the development of the programme and its impact. Plans will be progressed on the assumption that there will not be a significant impact of Covid, beyond what is already known, and this will be revised if required. Actions will be progressed as outlined to implement the plan, noting that for a number of key areas the target of March will not be achieved.

## 5.0 POLICY IMPLICATIONS

5.1 This report has not been screened for any policy implications in respect of Integrated Impact Assessment. More detailed assessments will be part of each service development, noting this is a national policy.

## 6.0 RISK ASSESSMENT

6.1 Risks 1 – 3 were identified in 2018 and remain current with risk 4 added in 2020 and risk 5 in 2021. There has been some change in risk and mitigating actions. More detailed operational risks will be identified and managed within each service in more detail and managed by the Dundee Primary Care Improvement Group. More detailed risks and issues are noted in appendix 1.

| | |
|---|---|
| **Risk 1 Description** | There is a significant risk that Dundee may not recruit or develop the workforce to deliver all of the commitments in this plan given the scale and breadth of the plan. This applies across a number of professions, including pharmacy, nursing (advanced nurse practitioners) and mental health practitioners This will directly impact on the delivery of services described. |
| **Risk Category** | Workforce, operational |
| **Inherent Risk Level** | Likelihood (5) x Impact (4) = Risk Scoring 20 - Extreme |
| **Mitigating Actions** (including timescales and resources ) | All services are planning with this risk at the forefront and looking to maximise skill mix as much as possible to reduce this. Longer term national work to provide increased undergraduate training will support this but not within the timescales of the year plan. NHS Tayside Advanced Care Academy will also help support development of urgent care practitioners.<br><br>The most significant risk currently is with the PALMS teams and advanced practitioners with key risks to both areas of not meeting deadlines. |
| **Residual Risk Level** | Likelihood (4) x Impact (4) = Risk Scoring 16 - Extreme |
| **Planned Risk Level** | Likelihood (3) x Impact (4) = Risk Scoring 12 - High |
| **Approval recommendation** | The level of risk is deemed to be acceptable given the mitigating actions being put in place |

| | |
|---|---|
| **Risk 2 Description** | There is a risk that we will have inadequate infrastructure to support the delivery of the Plan, both in terms of IT infrastructure and systems, and buildings/premises. This risk remains but the premises risk is now greater than the IT risk as a number of aspects of the IT issues have been resolved. The risk re lack of suitable premises is increasing as teams develop towards planned capacity, and with the impact of covid for distancing and cleaning. |
| **Risk Category** | Technological, Environmental, Financial |
| **Inherent Risk Level** | Likelihood (5) x Impact (4) = Risk Scoring 20 - Extreme |
| **Mitigating Actions** (including timescales and resources ) | The test of change for IT infrastructure has been positive and will be rolled out at scale. This reduces the risk for IT and data. Covid has impacted on the roll out of the new systems to some teams, with a linked impact to developing services effectively.<br><br>There is an ongoing, and increasing, pressure for space to deliver services from. It is anticipated that some planned minor works with capital allocated by NHS Tayside which did not progress in 2019 will progress in 2021. However the impact of Covid and requirements to both reduce footfall and ensure safe environments for staff and patients mean that there is less space which can be accessed than previously. There are ongoing concerns raised by patients who are currently having to travel further than previously due to lack of local access in some areas. |

| | |
|---|---|
| | This risk includes the risk of not indentifying suitable premises required for the flu (and covid) vaccination programmes. |
| **Residual Risk Level** | Likelihood (5) x Impact (4) = Risk Scoring 20– Extreme |
| **Planned Risk Level** | Likelihood (3) x Impact (3) = Risk Scoring 9 - High |
| **Approval recommendation** | The level of risk is deemed to be acceptable given the mitigating actions being put in place |

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|---|---|
| **Risk 3 Description** | There is a risk that the finance allocated via the primary care improvement fund will not adequately meet all the costs to implement the plan, and that resource will have to be identified from other sources, or services will need to be smaller than anticipated. The impact of Covid has reduced the risk for 21/22 as a number of developments have been delayed, but the longer term risk remains the same. The risk levels are unchanged since the last report. However there is a related risk linked to underspends also now noted below. |
| **Risk Category** | Financial |
| **Inherent Risk Level** | Likelihood (5) x Impact (4) = Risk Scoring 20 - Extreme |
| **Mitigating Actions** (including timescales and resources ) | Other sources of funding will be identified as opportunities arise. Finance is a key component of planning and ensuring the most cost effective models are progressed. Where models with variation in costs are tested in different parts of Tayside there will be a judgement made as to cost effectiveness of these models prior to roll out. |
| **Residual Risk Level** | Likelihood (4) x Impact (4) = Risk Scoring 16 - Extreme |
| **Planned Risk Level** | Likelihood (3) x Impact (4) = Risk Scoring 12 - High |
| **Approval recommendation** | The level of risk is deemed to be acceptable given the mitigating actions being put in place |

| | |
|---|---|
| **Risk 4 Description** | The current Covid-19 pandemic has delayed aspects of implementation of the PCI plan locally and increased further the risk of the commitments in the MOU not being achieved by March 2022 (March 23 for urgent care) as planned. |
| **Risk Category** | Operational, Political |
| **Inherent Risk Level** | Likelihood (5) x Impact (4) = Risk Scoring -20 -Extreme |
| **Mitigating Actions** (including timescales and resources ) | There are limited actions that can be taken at this time point to reduce this risk given the uncertainty of the future occurrence of the coronavirus and the ongoing competing demands for both clinical and managerial capacity. . |
| **Residual Risk Level** | Likelihood (5) x Impact (4) = Risk Scoring -20 - Extreme |
| **Planned Risk Level** | Likelihood (3) x Impact (4) = Risk Scoring 12 - High |
| **Approval recommendation** | The level of risk is deemed to be acceptable given the mitigating actions being put in place |

| | |
|---|---|
| **Risk 5 Description** | Delays with implementation mean there is a financial underspend which is increasing due to further delays with recruitment and in some cases finding appropriate space. There are a number of reasons for this, including covid. This also means that transitionary payment to practices will be required next year and no budget has been identified for this. It is unclear at this time if underspends can be utilised for this purpose. |
| **Risk Category** | Operational, Political |
| **Inherent Risk Level** | Likelihood (5) x Impact (4) = Risk Scoring -20 -Extreme |
| **Mitigating Actions** (including timescales and resources ) | .Increasing numbers of staff who can be recruited beyond the recurring budget on a short term basis will allow expansion of teams to support the wider primary care team and capacity. Longer term funding shifts will be required to sustain this longer term.<br>Underspends may be used to support practices who are still delivering services until moved.<br>Options for use of any underspends which fit with the ethos of the contract will be progressed. |
| **Residual Risk Level** | Likelihood (5) x Impact (4) = Risk Scoring -20 - Extreme |
| **Planned Risk Level** | Likelihood (3) x Impact (4) = Risk Scoring 12 - High |
| **Approval recommendation** | The level of risk is deemed to be acceptable given the mitigating actions being put in place |

## 7.0 CONSULTATIONS

7.1 The Clinical Director, Chief Finance Officer, Head of Service, Health and Community Care and the Clerk were consulted in the preparation of this report. The Dundee Primary Care Improvement Group has developed the paper at appendix 1.

## 8.0 DIRECTIONS

8.1 The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

| Direction Required to Dundee City Council, NHS Tayside or Both | Direction to: | |
|---|---|---|
| | 1. No Direction Required | |
| | 2. Dundee City Council | |
| | 3. NHS Tayside | ✓ |
| | 4. Dundee City Council and NHS Tayside | |

## 9.0 BACKGROUND PAPERS

9.1 None.

Vicky Irons
Chief Officer

DATE: 12 August 2021

Shona Hyman
Senior Manager
Service Development & Primary Care
Dundee HSCP

David Shaw
Clinical Director
Dundee HSCP

# DIRECTION FROM DUNDEE CITY INTEGRATION JOINT BOARD

| | | |
|---|---|---|
| 1 | Reference | DIJB40-2021 |
| 2 | Date Direction issued by Integration Joint Board | 25 August 2021 |
| 3 | Date from which direction takes effect | 25 August 2021 |
| 4 | Direction to: | NHS Tayside |
| 5 | Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s) | Yes – DIJB45-2018 and DIJB33-2019 and DIJB36-2020 |
| 6 | Functions covered by direction | Specific actions relevant to NHS Tayside in the Tayside Primary Care Improvement Plan and Dundee action plan. |
| 7 | Full text of direction | Dundee IJB directs NHS Tayside to implement, with immediate effect, the specific actions relevant to them in the Tayside Primary Care Improvement Plan as outlined in the Dundee Action Plan (Appendix 1). |
| 8 | Budget allocated by Integration Joint Board to carry out direction | The provision of premises and the implementation of IT systems by NHS Tayside as required by this Direction are not specifically funded from the IJB/PCI budget. |
| 9 | Performance monitoring arrangements | Performance will be reviewed on a regular basis, (currently 2 monthly,) by the DPCIG |
| 10 | Date direction will be reviewed | March 2022 (or earlier if required). |

**APPENDIX 1**

**Dundee Primary Care Improvement Plan 2021-22**

| Commitment | Actions Delivered 20-21 (to July 21) | Comment | Lead Officer | 20-21 Spend (£k) | Actions to be Delivered 21-22 | 21-22 spend – Estimated (£k) | Risks/ Issues |
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| **1. Vaccination Transformation Programme (regional approach)** | **Actions completed**<br>A joint approach to flu delivery was taken with NHS Tayside, HSCPs and practices all supporting this. The flu programme in Dundee was delivered by all practices and across 3 NHS sites. New staff cohorts were included in this. Uptake of flu was higher than in previous years. There was significant learning for this which informed the covid vaccine programme.<br><br>**Actions partially completed**<br><br>**Actions outstanding**<br>No progress with other adult vaccines or travel advice and immunisation. (As noted in plan for 20/21) | Limited progress in this area as the pandemic and covid vaccination impacted on staff being able to focus on this. | Daniel Chandler, Consultant in Public Health Medicine | £171k | Detailed action not yet agreed due to the evolving picture with the covid vaccine. However it is anticipated that a blended model with practice team and central teams will deliver both flu and any further covid vaccines. The flu cohort for 21/22 has been expanded further, for both patients (adults and children) and staff groups The wider cohort group will not be funded via PCIF.<br><br>Once advice re any national element to travel service and immunisations is known a local model will be developed to support this. This is due to commence in the autumn so concerns re timescales for recruiting and training staff. Anticipated travel will be low. | 378k | It is anticipated that covid and flu vaccine programmes will become more integrated but this is not clear, nor is the model going forward given the size of workforce for a part of year<br><br>Community pharmacy is one option being explored for travel vaccines |

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| **2. Pharmacotherapy Services (regional approach)** | **Actions completed**<br><br>Processing of IDLs, outpatient and non medication requests, medicine shortages, review of specials, compliance reviews in own homes, formulary compliance/prescribing indicators, and support for medicine safety recalls are delivered to all practices, (but not for all of the workload). Acute prescribing requests, pharmaceutical queries and non clinical medication reviews are also being undertaken in some practices..<br><br>Career start post developed and being tested.<br><br>Test of recruitment of newly qualified pharmacists completed and will be further rolled out.<br><br>**Actions partially completed**<br>Pharmacy First continues to be well promoted but not yet data to assess if increased use.<br><br>Increase in pharmacists prescribers in community, pharmacy who support common clinical conditions, but still small numbers and minimal impact.<br><br>Some increase in serial prescriptions.<br><br>**Actions outstanding**<br>Pharmacotherapy assistant post not yet started<br>Hub model started in Angus but not yet in Dundee. Angus learning will be built on. | Some elements of this section (level 1 PCT) are being delivered by practices as this allows the pharmacy locality team to focus on other tasks that have a bigger impact on GP workload<br><br>Small number of practices in one cluster have some areas not fully delivered due to localised issues.<br><br>Premises suitable for this is a constraining factor and now impacting on further development | Elaine Thomson, Locality Team Leader/ Jill Nowell, Associate Director of Pharmacy – Primary Care & Medicines Governance | £494k | Develop further work in conjunction with practices, recognising that current recruitment projections means that not all of PCT will be delivered by March 22. Additional activity may vary between practices to reflect priorities in the practice.<br><br>Continue to recruit staff as able, with a degree of flexibility in the overall budget, and noting that there are already a high number of pharmacy technicians in the Dundee team.<br><br>Evaluate the career start programme and assess its ability to expand.<br><br>Further develop, and support implementation of, education and training frameworks for all staff.<br><br>Test and develop a hub model in Dundee, based on Angus learning.<br><br>If the hub progresses develop a pharmacy assistant role. | 829k | The pandemic has had a significant impact on demands for the locality pharmacy team, who have worked very flexibly to support in a range of ways, both within practices, linking to community pharmacy and also supporting secondary care. Changes to the way secondary care worked has resulted in a significant increase in out-patient's communications and issues with discharge communications that has put additional pressure on the pharmacy team.<br><br>Space is an issue both within practice and for a hub model.<br><br>Time to train and develop newly recruited staff is required. This will limit further roll out in the short term but needs to be built into workforce plans with an agreement that it is an integral part of PTS. In order to sustain service delivery and aid staff retention. |

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| **3. Musculoskeletal (MSK) Services First Contact Physio** | **Actions completed**<br>All staff recruited as per FCP/PCIP plan for 20/21.<br><br>FCP now in place for GP practices across all 4 clusters. Monthly reports generated via the Vision 360 federated appointment system demonstrate a very high utilisation of FCP appointments; c95%<br><br>In response to Covid, local factors and Scottish Government guidance, the FCP service adapted its model to deliver a current virtual first approach via telephone and Near Me consultations. Patients are invited for in-person appointments as required.<br><br>Vision Anywhere roll out has been successful for FCP practitioners, enabling them to write directly into the GP record.<br><br>Patient feedback on virtual first model collected via Survey Monkey.<br><br>**Actions partially completed**<br>Covid has delayed the full evaluation of the impact of FCP on other areas of the MSK pathway. It is anticipated that a level of MSK resource will be released to support FCP expansion in the future. However, MSK waiting lists have increased during Covid (due to deployment | Consultations have been delivered by phone or video during the pandemic in line with guidance, unless face to face essential. This will shift back.<br><br>Demand has exceeded capacity over the last few months. This had led to delays and/or a higher use of GP time.<br><br>There is still no mechanism to record to EMIS directly. | Matthew Perrott, Integrated Manager (Occupational Therapy & Physiotherapy – Outpatients) | £255k | Review impact of FCP on other parts of the MSK pathway / service.<br><br>Complete data collection to assess impact of FCP on GP appointments.<br><br>Establish accurate data on demand for FCP service across all Dundee GP practices. Use data to inform capacity required.<br><br>Work with practices to improve appropriate use of FCP service and develop role as part of an extended primary care MDT.<br><br>Continue to work with e-health colleagues to develop Vision Anywhere FCP templates and outcome reports, as well as developments in RMS referrals / electronic prescribing.<br><br>Qualitative patient experience survey (by questionnaire & interviews) to evaluate and influence development. This was delayed during Covid. | 450k | Lack of capacity to meet demand from GP practices.<br><br>Providing a service which can replicate the accessibility of general practice for acute presentations will be challenging 5 days/week, 52 weeks/year<br><br>Lack of identified permanent space, particularly within cluster 2 locality, specifically Broughty Ferry. Patients can access virtual service but will have to travel to other parts of the city for in person appointments if no space found.<br><br>The evolving role of practice reception staff as care navigators is key to effective utilisation of the FCP service.<br><br>Assess how best to utilise technology used during Covid to support a range of ways of offering appointments. |

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| | of AHP staff to support inpatient Covid activity) and some time is required to re-establish the expected demand/capacity. | | | | | | |
| **4. Mental Health Services** | **Actions completed**<br>PALMS has **r**ecruited additional Band 6 CMHN posts (Action 15 monies) working in two practices, demonstrating increased skill mix and appropriate competencies to support further roll out of PALMS.<br><br>There are 7 GP practices with full access to PALMS and 4 practices with partial access to PALMS.<br><br>Updated training has been delivered to practice admin staff to increase skills and confidence in determining the best clinician for patients' presenting needs.<br><br>Listening Service maintained in all practices (with Action 15 monies) except in one practice with no space.<br><br>1 year report for practices with established PALMS resource is complete and 6 month report completed for further practices.<br><br>**Actions partially completed**<br>A small test of change, with anticipated duration of 6 months, has commenced in 1 practice. This offers 'light touch' brief intervention for up to 4 sessions | There are therefore 13 practices with no support yet. | Helen Nicholson-Langley, Consultant Clinical Psychologist | £157k | Transition to a hub and spoke model of delivery is anticipated by March 2022.<br><br>Increasing the skill mix to include a greater proportion of Band 6 CMHN resource, with Band 8a oversight for each Cluster is also anticipated. Establish a sustainable model of delivery with sufficient workforce.<br><br>To work with other Mental Health & Wellbeing (MH&W) practitioners and services to establish low intensity group based interventions at community/practice level to increase access, and speed of access to appropriate interventions.<br><br>To work with other MH&W practitioners/services to influence and develop pathways of care for people presenting with MH difficulties in primary care – the right person to the right service at the right time. | 280k | Recruitment of mental health staff, across professions remains a significant challenge.<br><br>PALMS development must be integrated with wider MH&W strategic work in Tayside.<br><br>Physical space in Practices remains a practical constraint however remote working has been successful. There are anticipated challenges relating to admin and IT systems should PALMS move to the hub & spoke model.<br><br>It is recognised that banding or grading of staff is not necessarily reflective of competence and confidence to practice safely in PALMS. Any proposed changes to the structure of PALMS must consider |

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| | with a PALMS practitioner to investigate whether this reduces onward referral for formal psychological therapy. This is anticipated to offer further valuable information about the model which can best meet the needs before extending PALMS to the remaining practices in all 4 clusters.<br><br>Some previously provided sessions have been withdrawn from 2 clusters temporarily due to workforce challenges. Some Practices are therefore receiving reduced sessions until we can recruit appropriately.<br><br>**Actions outstanding**<br>A HUB model has not been tested nor established but is proposed for later this year to help increase flexibility and adopt a more sustainable model of delivery. | | | | | | carefully how all staff will be supported.<br><br>Given current staffing challenges the PALMS service will not be in all practices by March 2022 |
| **5. Link Workers / Social Prescribing** | **Actions completed**<br><br>The link workers now provide a service to all GP practices in the city fulfilling this commitment in the Primary Care Improvement Plan. (Noting lower demand during the last year.)<br><br>**Actions partially completed** | A move to telephone/ online support has enabled the link workers to extend their support to an additional 9 practices.<br><br>A band 6 vacancy has arisen and the likelihood is that this post will | Sheila Allan, Community Health Inequalities Manager | £192k | Introduce greater skill mix.<br><br>Work with practice staff to develop appropriate triage system and support signposting/ referral.<br><br>Develop and enhance current promotions across new and existing practices.<br><br>Work with E-health to formulate new systems for the link worker | 210k | A decrease in referral numbers has assisted the team to extend coverage to additional practices. Capacity may become an issue if numbers increase significantly.<br><br>Care is required to ensure that staff at different bands are assigned to appropriate patients in |

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| | Work is ongoing to introduce a skill mix in the team which over time will enable patients to be supported at different levels of need more efficiently.<br><br>**Actions outstanding**<br><br>Support for wider practice teams to signpost patients to services directly has stalled due to the Covid situation. The link worker team has plans in place to pick this work up with practice staff when guidelines/ restrictions allow. | be filled by a band 4 support worker.<br><br>The team has a resource pack and training session in place ready to use once practices are ready to explore their referring/ signposting potential. | Sheila Allan<br><br>Sheila Allan | | team and finalise a move to Vision Anywhere.<br><br>Work with the Scottish Government and PHS on the next phase of the national core data set.<br><br>Participate in the development and implementation of the new national Community Link Worker Network | | terms of interventions required, needs and complexity.<br><br>Needs to be managed carefully to ensure that patients who need to see link workers benefit from the service, and similarly, those who do not require that level of support are signposted directly. In addition, there may be other pressures on practice staff and this work might be deprioritised. |
| **6. Urgent Care** | **Actions completed**<br><br>Nurse Consultant appointed<br><br>Roll out of Care Home Urgent Care to 11 practices<br><br>**Actions partially completed**<br><br>Review of Urgent Care (Home visiting) model following withdrawal of SAS staff<br><br>**Actions outstanding**<br>Implementation of new Urgent Care (Home visiting) model | | Allison Fannin, Integrated Manager (Urgent Care) | £241k | Care Home Roll out to continue as planned, aiming to support all care homes by April 21 (assuming successful recruitment)<br><br>New model aligned with Cluster focussed urgent care teams to be partially implemented<br><br>All practices to have access to either care home or home visit urgent care teams.<br><br>Recruit further Advanced practitioners from a range of professional backgrounds.<br><br>Continue to assess pathways and skill mix to ensure people | Recruit additional 6 ACPs<br><br>781k | There is limited availability of specialist paramedics, ANP's, or a nurse consultant, who can undertake this work. These may need to be developed as trainee roles initially which will delay implementation to the degree planned.<br><br>There is significant demand for roles at advanced practice level in a range of settings, including practices, out of hours and core ambulance service.<br><br>NHST does not have a well-developed |

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| | | | | | are seen by the person with the right skills.<br><br>Continue to work with e-health to develop information systems that support managing the increasing workload in a way which supports urgent care team delivery.<br><br>Review if current training for advanced practice is appropriate for the developing service, and link across Tayside to progress this if not. | | infrastructure to support the development of advanced practitioners in the numbers required to support PCIP, across workstreams. However urgent care is the area most reliant on this. Work to develop a framework for advanced practitioners (AP's) has been delayed due to COVID |
| **7. Care and Treatment Services** | **Actions completed**<br>• Phlebotomy service city wide but not all of phlebotomy is able to transfer – nor planned to in current funding.<br>• Community Leg ulcer service city wide<br>• Wound care rolled out city wide<br>• Providing some injections.<br>• Providing some chronic disease monitoring<br><br>**Actions partially completed**<br>Ear care service planning in place, Test of change in cluster 1 for ear care starting July 21 | The team provided significant support during the start of the pandemic by seeing patients at home for phlebotomy who were shielding, was a significant workload for a number of months.<br><br>Although these services have been transferred to care and treatments services they are available in a smaller number of locations with | Cath Cook, Community Care and Treatment Service Team Leader | £772k | Scoping/evaluation of services to be prioritised by GP practices i.e. ear care service or additional phlebotomy to ensure services delivered are reflective of GMS contract and beneficial to patients and General Practice<br><br>Recruitment of additional staff to undertake services agreed<br><br>Work with colleagues in property team to identify space which is suitable, and secure funding to upgrade this where required. | 1,078k | Securing additional suitable accommodation is a key risk.<br><br>Ongoing staff absence as a result of COVID-19 and T&T (assumption that full vaccine roll out will minimise this)<br><br>Potential delays in recruitment<br><br>There are significant requests from secondary care for phlebotomy, and other care delivery, in community to be part of care and treatment services. There is no staff capacity for this |

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| | **Actions outstanding**<br><br>CC&TS phlebotomy services under review to integrate secondary care phlebotomy | limited local access.<br><br>Lack of premises is currently hampering expansion of some services.<br><br>Single pathway and additional resource required for all phlebotomy services to be integrated | | | | | currently and no space to develop this. The wider system should review its requirements and feed this into longer term plans. |
| **8. Premises, Infrastructure and IT Systems** | **Actions completed**<br><br>**Actions partially completed**<br>Near me had increased in practices in the early phase of the covid pandemic but this has reduced over time.<br><br>**Actions outstanding**<br>No progress in any scoping of space in practices and potential for minor works or premises development to increase space, due to lack of capacity across teams.<br><br>A Primary Care Premises Strategy has not progressed and will be carried forward into 21/22.<br><br>Vision Anywhere has been used to support the covid vaccination programme and this has limited the ability of the team to develop | No actions have been fully completed as the manager who led on premises work retired and was not replaced by the property team, and the senior manager for Primary care was redeployed to support the covid assessment centre and then flu and covid vaccinations. | | | Work with practices to identify if there is underutilised space which could be used for clinical service delivery with small investment of resources. This will inform any decisions re further SG investment at a local level for premises.<br><br>Review longer term plans and develop a Dundee Primary Care Plan for premises.<br><br>Work with colleagues in NHS Tayside property teams, and PC Department, re a range of actions which will inform premises planning, including surveys which are being completed for practices.<br><br>Work with colleagues in e-health to roll out Vision Anywhere (VA), and test new functionality which is expected over the coming months, | 40k | Premises reprised for primary care will be part of the wider HSCP property strategy. |

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| | the ongoing areas for PCI work. This will be progressed in 21/22. | | | | including reporting for clinical outcomes. Where there are gaps in what VA can deliver work with colleagues to identify how these can be managed.<br><br>Work with colleagues in NHS Tayside, Dundee City Council and the 3rd sector to develop a plan for future development of primary care sites, including general practice and health and community care centres, based on the premises survey to be undertaken, and building on the Dundee H&SCP Property Strategy, once completed.<br><br>Work with clusters to consider boundaries for general practice to ensure all areas of the city have adequate access to general practice and care and treatment services, recognising that teams are increasingly geographically based<br><br>Build on the shift seen with Near me and other technologies, (including medilink) during covid to promote technology as an option for care delivery across practices.<br><br>Work with the third sector to support access to devices to allow Near Me for those who would be digitally excluded normally. | | Practice boundaries and how practices and clusters link to and communicate with a range of teams is important as wider teams are formed. |

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| | | | | | Work with colleagues in Angus to assess the impact of Flo for BP management and how links to other technologies and software programmes which can support this area of care. | | |
| **9. Workforce Planning and Development** | **Actions completed**<br>Work was completed to review practice based nurses/HCA's who could be TUPEd to care and treatment services. This impacted on a small number of staff.<br><br>A microsite was developed to support recruitment and has been up and running for some time now. It is being reviewed and refined as learning is gained on its impact.<br><br>There is a Tayside programme around recruitment and retention of GP's. This has a range of interventions including retaining staff at the end of their career, and recruiting new GPs once qualified via a career start programme. The latter was more successful than anticipated and so there was an increased cost. This is no longer funded nationally and so cost this year met within PCI funding.<br><br>**Actions partially completed**<br><br>**Actions outstanding** | | | 6k<br><br>241k | Develop a shared culture where the focus is on teams who can support people with their health and care, and which communicates effectively in a range of ways, adapted to the range of settings that the primary care team will work from.<br><br>Work with colleagues leading on developing advanced nurse practitioner roles to ensure we have a clear pathway for ANP training and role development in the context of PCI.<br><br>Work with organisational development colleagues to consider how to create cohesive teams, focussed on the person at the centre of a pathway, which also recognises the pivotal role of the GP as a leader.<br><br>Work with colleagues to look creatively at new roles which will be seen to attract staff to this area, as they are innovative and attractive. | 114k | Recurring funding for recruitment and retention of GP's, including carer start, needs identified. |

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| | Most actions were not completed due to the impact of covid and have been carried forward to 21/22. | | | | Consider in any training and development programmes if a wider range of training experience will help recruit and retain staff locally. | | |
| **10. Sustainability / scalability** | **Actions completed**<br>None<br><br>**Actions partially completed**<br>A range of evaluation work that had been planned was unable to be undertaken because of the significant impact of covid on delivery.<br><br>**Actions outstanding**<br>All actions outstanding | | | | Review evidence base for models and the impact they are having as we gain that information to assess if they are effective and efficient.<br><br>Consider roll out across all clusters and if the service being provided can be fully implemented at scale.<br><br>Identify other sources of funding which may be able to support the shift of some of the work within PCI, recognising that money can not be transferred from practices | | A national PCI leads group has recently been set up by Scottish Government which will share learning and consider issues. This should give opportunities to learn from elsewhere in a way that has not been possible until now. |
| **11. Practice Staff Development** | **Actions completed**<br><br>**Actions partially completed**<br>Although the PASC work was put on hold nationally some of the workflow and care navigation was used as part of how practices looked at their processes during covid.<br><br>**Actions outstanding** | The increased use of initial triage by a range of staff in the practice has changed initial contact with the practice. Some of this is likely to be longer term change. | | | Review progress with care navigation and workflow as practices start to remobilise services.<br><br>Review the impact of changes in service delivery particularly on those in the nursing team, and ensure opportunities to develop roles in the practice team are optimised. | | |
| **12. Evaluation** | **Actions completed**<br>Formal evaluation was not feasible during the last year due to demands on both delivery | | | | Undertake audits, both within services and with support from the LIST team, or via VA | | |

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| | teams and those in a more formal evaluation role. However ongoing review of feedback, including complaints, has influenced how services have developed over the year, where possible.<br><br>**Actions partially completed**<br><br>**Actions outstanding**<br><br>More formal review and evaluation is outstanding and actions have been carried forward. | | | | reporting when it is available, to assess the impact of changes.<br><br>Work with colleagues across Tayside to share learning and knowledge as that develops, and use this learning to influence change.<br><br>Undertake qualitative evaluation as well as quantitative to provide more in-depth feedback on both patients and staff perceptions of changes.<br><br>All workstreams to have a clear evaluation plan in place with timescales for this. | | |
| **13. Communication and Engagement** | **Actions outstanding**<br><br>None of the actions from 20/21 are complete and most are ongoing, with limited progress. These have therefore been carried forward. | | | | Teams will share across PCI and with practices methods of effective engagement.<br><br>Comms team will work with PCI teams to agree key messages and branding to be used to increase public awareness.<br><br>Develop information on NHST public website with colleagues across Tayside, linking to social media where appropriate. Use this information on practice websites as well.<br><br>Work with a range of groups to engage and consult with the public going forward around | | |

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| | | | | | service delivery, where there are options around delivery.<br><br>Share examples of how service change has had a positive impact on people who have received support. All teams will create patients stories, considering if video can be used as part of this.<br><br>Use learning from the PASC care navigation work, and learning from across all workstream, to ensure a coordinated approach to this change and how communicated. | | |