Primary Care Allied Health Professionals Service (PCAHPS)

Service Model for delivery of Musculo-skeletal and Mental Health services in Primary Care

**1 Background**

1.1 Primary Care Improvement Plan (PCIP) recognises in Paragraph 19.9 the need to develop a bespoke Primary Care Access pathway for practices who have chosen not to adopt the CWIC (Collaborative Working for Immediate Care) model

1.2 During the consultation process and drafting of the PCIP, it was agreed that the focus of this should be on delivery of services for patients presenting with Musculoskeletal (MSK) and Mental Health (MH) symptoms. This approach has since been further discussed and agreed at the relevant PCIP working group (Access and Service Delivery Group). Direct discussions and engagement with GP Contract Holders has also been continuing over this period

1.3 MSK and MH service delivery was implemented in CWIC as part of the “Musselburgh Model” (see attached summary) in January 2018

1.4 Evaluation of this model has so far shown reduced analgesic prescribing, as well as a reduction in outpatient secondary care referrals to orthopaedics and General Adult Psychiatry. It is worth noting, however, that MSK and MH provision in this evaluation is embedded with the overall Musselburgh Model, and this new proposal would require a separate evaluation

1.5 The intention is to test a new model of access and service delivery in East Lothian, which delivers on the identified priorities of patients presenting acutely with MSK and MH symptoms. The model should draw on the changes already tested elsewhere and incorporate the following:

* A care navigation model which allows suitable patients to be identified at the point of contact and appointment allocated accordingly
* The MSK component will incorporate telephone assessment of patients with self-care advice or face to face assessment being possible outcomes
* Ability to work with patients regarding employment issues and, when indicated, issue AHP “fit notes”
* A service which is deliverable across more than one GP Practice population
* A service which is managed by ELHSCP, but works in parallel with, and in collaboration with, the GP Practice
* A “virtual clinic” to ensure a seamlessness between services and to optimise continuity of information within the patient journey. This mechanism allows shared patient records to be used across GP practices and ELHSCP services, and allows safe communication when more complex decision-making situations arise
* An effective IT model which ensures seamless exchange of clinical information between stakeholders involved in patient care
* The potential to expand the role of practitioners during patient management to further reduce the need for secondary care referrals (an example might include Physiotherapist –initiated joint injections)
* Patient pathways which rely less on the prescribing of medications as an outcome to assessment
* Allows stakeholders to work together on a test of change as equal partners for the benefit of patients

1.6 While not directly referenced within the PCIP, but not inextricably linked, there is need to consider waiting list times for initial appointment to outpatient Physiotherapy services, something which may result in patients seeking access to Primary Care recurrently during the wait period

**2 Description of Service**

2.1 The service will be staffed by clinicians and an administrative support team

2.3 MSK service will delivered by team comprising a Band 8a, a Band 7, and Band 6s

2.4 One band 8a post to clinically lead East Lothian Physiotherapy services will be created to develop this service. This role will carry governance for the development of Primary Care MSK delivery going forward.

2.5 The total staffing to deliver Primary Care MSK services across all models will comprise

* 1 Band 8a training post
* 1 WTE Band 7 APP, looking to build on these roles in time with potential Annex U posts
* 6 Band 6 Specialist Physiotherapists

2.6 These posts will comprise rotational work to allow staff to continue to work in secondary care physiotherapy services

2.7 PCIP implementation funding is specifically required to deliver the services as agreed by the PCIP, but further consideration will be given to investment in enhancing secondary care Physiotherapy services

2.8 Mental Health assessment will we delivered via a Mental Health Occupational therapist

2.9 Mental Health Nursing will be developed separately and aim to bridge the gap between Primary and Secondary Care for patients with more severe illness, and for those suffering problems related to substance misuse

2.91 The Mental Health OT team to deliver additional Primary Care services across the county will initially comprise five WTE Band 6

2.92 Patients will be referred directly to appointments via a process of care navigation at the point of contact with Primary Care

2.93 Following assessment and formulation of a management plan, the patient will then be discharged or referred onwards, possibly having received a brief intervention as part of the appointment. There is potential at this stage to increase the options available at this stage for more detailed management or procedure during the same visit, or on a single review visit. (an example might be MSK joint injection)

2.94 Appointments for MSK and MH will be allocated by a similar process of care navigation and will, for the purposes of the test, involve at least two GP practices

2.95 The service will be delivered for the purposes of the test, from a single site. This is to facilitate professional development, governance, staff management, suitability of premises, cost efficiency, consistency of staffing numbers, amongst other things. It will also facilitate expansion of the service, should evaluation produce favourable outcomes, to other patient populations with greater ease

2.96 Mental Health assessment will be delivered by scheduled appointments

2.97 MSK services will be delivered by a “walk-in” clinic. Patients requiring face to face assessment will be advised to attend this clinic following triage. Following an initial test phase, this service will then become open access, allowing patients to self-refer for assessment. This will allow patients to either access MSK services directly, or via a care-navigation route by contacting their usual Primary Care provider

**3 Constraints**

3.1 IT. ELHSCP are continuing to work with partners in NHSL eHealth to seek support for implementation of a fit for purpose IT solution to provide a seamless exchange of information between GP Practices and ELHSCP services. While a solution has been proposed, this has not so far been progressed

3.2 Telephony. Until an agreed route of care navigation has been confirmed, requirements of a telephony solution cannot be defined. The PCIP is committed to improving access experience for patients

3.3 Transport. There is the possibility, depending on the agreed model and GP Practice location, that some patients may make a journey for an clinical contact that had not previously been required. ELHSCP is already working directly with East Lothian Council to seek opportunity to improve transport options for new journeys, but for patients who already have transport constraints affecting access to Primary Care Services. Other options are being explored

3.4 Recruitment. There is a degree of uncertainty surrounding availability of trained staff

**4 Project timescales**

4.1 The new model should be ready to test by September 2019

4.2 The first phase will incorporate at least two GP practices. A third will join either at the outset, or soon after. A second phase 6 months later will see the MSK part become open access

**5 Strategic context**

5.1 This model should seek to meet the IJB strategic objectives for 2019-2022

5.2 The service should allow patients improved Primary Care access by ensuring the choice to see a clinician most relevant to their presenting problem from the outset of their journey. Both MSK and MH should allow patients to better self-manage and be less reliant on Health and Social Care services, specifically move towards a model of wellness

5.3 By improving access to the right clinician patients should expect a more meaningful early intervention leading to avoidance of crises

5.4 The model should demonstrate a seamlessness between Primary and Secondary care services, and by bringing Secondary care clinicians into a Primary Care environment, patients should be less likely to need referral into formal Secondary Care Services

5.5 By managing this cohort of patients in a different way, traditional GP services should be better able to manage more complex and frail patients in the home environment and ensure ELHSCP can keep its commitment to provide care closer to home, rather than resorting to admission

5.6 The model delivers the promise to deliver services within an integrated team

5.7 Access to this service should demonstrate a model designed around patient need

5.8 Inequalities, particular those experienced with access, should expect to be reduced by this model

**6 Scope of request**

6.1 To agree a model and location for delivery and evaluation of a test project

6.2 To agree a staffing model and recruitment plan

6.3 To design patient pathways

**7 Evaluation**

This will consider outcomes including

* Patient experience
* Prescribing
* Secondary Care Outpatient Referrals
* Patient Participation Group feedback

**8 Initial steps**

8.1 Identify and liaise with suitable GP Practices, prioritising smaller practices

8.2 Design access pathway and ensure IT and telecoms suitability and support

8.3 Seek to ensure that implementation of this project meets aims of both the PCIP and AHP strategic plans