Appendix 2 – Central North PCN

NHS Rotherham Clinical Commissioning Group

PCN Innovation Fund - Bid Template

PCN name:	**Weighted list size:**
Central North	35650
Bid submitted by:	**Amount of money bid for:**
	£31478.20

Name of project:

Pharmacy technician

Commissioning plan priorities:

Please indicate which of the CCG commissioning plan priorities this project will work to address:

1 Primary Care	X	7 Mental Health	
2 Unscheduled Care	x	8 Learning Disabilities	
3 Cancer		9 Medicines Management	x
4 End of Life Care		10 Maternity and Children	
5 Clinical Referrals		11 Continuing Healthcare	
6 Community Services		12 YAS and Patient Transport	

And highlight which areas of clinical focus for the CCG will be covered:

Cancer		Diabetes	x
Cardiovascular Disease	x	Respiratory Disease	x
Stroke Care	x		

Project brief:

- The network has successfully recruited and embedded a pharmacist within the network.
- Recruiting a pharmacy technician would allow the practices and clinicians to get better support with repeat dispensing and medicines reconciliation.
- Could allow better conversations with local pharmacies especially around supply issues but also liaison with them and their cooperation as part of the new community pharmacy contract.
- Appointing a technician would release the clinical pharmacist to see more patients reducing the need for patients to see their GP or nurse releasing valuable clinical time for other patients and their clinical need.

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Financial breakdown:
Band 5 pharmacy technician £31478.20 FTE including on costs
Key issues and risks:
Recruitment of suitable technician
Patient, public and stakeholder involvement:
None needed at present but proof of value of this level of post would need to be spread across other networks
Equality impact:
Technician would offer services to all aspects of population.
Human resource implications:
Would work within existing network structure.
Additional information:
The ccg prescribing team would be able to offer more background if needed. The new gp contract allows primary care networks to employ pharmacists to release other clinician's time to see other patients. This has already been a great success with the value of a clinical pharmacist becoming apparent to both existing practice clinical staff and more importantly to patients. However their role is two parts with one part being direct patient contact reviewing of medication and its effectiveness for the patient and the other being dealing with prescription queries and problems with repeat issuing of medication. This was perhaps an underappreciated function of clinicians in primary care. The proposal to appoint a pharmacy technician to work alongside our clinical pharmacist will allow us to more further and faster with the clinical pharmacist allowing them to concentrate on the patient while supporting a technician to deal with prescribing issues, updating medications for patients discharged from hospital and liaising with local pharmacies to help identify and deal with medications that are in short supply. The technician would be able to allow the practices to move more rapidly towards full electronic prescribing, rapid reviewing of discharge medication would reduce errors and reduce chances of an error in medication causing harm to patients. It would release more clinical pharmacist time to work with individual patients and their medications. Outcomes we would expect to see would be a significant rise in medication review done by clinical pharmacist, reduction in inappropriate repeat medications and also unused medications left on repeats. Reduction of inappropriate long term prescribing especially around analgesia in chronic pain.

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PCN name:	Weighted list size:
Central North	35650
Bid submitted by:	**Amount of money bid for:**
	£34160

Name of project:

Joint policies and procedures

Commissioning plan priorities:

Please indicate which of the CCG commissioning plan priorities this project will work to address:

1 Primary Care	x	7 Mental Health	
2 Unscheduled Care	x	8 Learning Disabilities	
3 Cancer	x	9 Medicines Management	x
4 End of Life Care		10 Maternity and Children	
5 Clinical Referrals	x	11 Continuing Healthcare	
6 Community Services	x	12 YAS and Patient Transport	

And highlight which areas of clinical focus for the CCG will be covered:

Cancer	x	Diabetes	x
Cardiovascular Disease	x	Respiratory Disease	x
Stroke Care	x		

Project brief:

- Four practices have come together to form Rotherham north primary care network. Each practice has slightly different policies and procedures both clinical and non-clinical which cause variation in care and working practices.
- This will reduce the ability of cross practice working either by our current staff or by the new network spanning employees.
- The project will employ a clinicians and non-clinicians to develop common policies and procedures and better understanding between practices of common working patterns.
- We are looking to have two clinical sessions per week one of doctor time and one nursing time alongside a full time band 6/7 to both help with clinical policies and procedures and also unify non clinical policies and procedures where possible (recognising that employment policies etc could not be changed in the time frame of the project)

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- The project will last for six months.
- We would expect the project to reduce variation of care within primary care, including prescribing, referrals and chronic disease management.
- It will allow better utilisation of staff that are working across the network and improve retention as there will be no variation in expectations.
- It will provide a platform to enable changes in clinical pathways across the network and allow better innovation to a larger population.
- As we move to more online access it will allow better uniformity of appointment types and allow easier on line navigation.

Financial breakdown:

1x 3 hr gp session/week £7560
1x band 5 hr nurse session/week £100.00 per 5 hr session X 26 weeks
1x grade 6 full time six months £24,000 for 6 months FTE

Key issues and risks:

Risks- failure of practices to engage in the process.
No being able to recruit to a temporary band 6 job for six months
Releasing gp and nurse time from existing practices.

Patient, public and stakeholder involvement:

At present no need for patient and public involvement unless process causes the need to change current practice working pattern at which point patient engagement will be essential.
We would expect the clinical director to be feeding back results of this project to the other PCN clinical directors

Equality impact:

This project will improve equality across the network

Human resource implications:

As detailed above
The team will need to spend some initial time in engagement with the member practices to ensure both clinician and non-clinician involvement.

Additional information:

Practices are individual organisations who traditionally work to their own policies and procedures. Increasingly with the use of population health we need to be addressing the health of populations that cover more than one practice. The increasing use of clinicians that work across a network will not allow differences in common policies and procedures due to the conflicting instructions that the clinician would be expected to adhere to which results in less productive members of staff. With the increased digitisation of primary care patients will expect to be able to manage their own conditions more and also communicate differently with their clinician. Uniform

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policies and procedures across the network will allow clinicians to manage patients more effectively across multiple organisations which in itself is innovative as this is one of the fundamental problems of the health system in the UK.

While there will be a general movement towards this over the coming years use of the innovation fund will allow us to go faster and further and demonstrate to other networks the value of brining alignment amongst practices. It will also allow us to have innovative pathways of care that involve clinicians from more than one practice involved in the direct care of individual patients while at the same time maintaining if not improving the quality and effectiveness of that care. Examples of which will be LARC, minor surgery and diabetic care. it will also allow us to plan and develop our workforce more effectively as we can develop individuals to take leads across a larger population.

It will allow us to quickly change in response to our populations needs either identified through patient feedback or in response to population health information. Outcomes we would expect to be able to demonstrate would be difficult in the short term as unifying clinical policies will have more effect on long term outcomes and the reduction in variance of this, but we would expect to be able to demonstrate pathways of care that run across practices allowing the same care to be provided to our network population.

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PCN name:	Weighted list size:
Rotherham Central North PCN	35,600
Bid submitted by:	**Amount of money bid for:**
Dr N Rajagopal and Dr N R Ravi	£34,320

Name of project:

Community Dermatology Triage Clinic

Commissioning plan priorities:

Please indicate which of the CCG commissioning plan priorities this project will work to address:

1 Primary Care	x	7 Mental Health	
2 Unscheduled Care		8 Learning Disabilities	
3 Cancer	x	9 Medicines Management	
4 End of Life Care		10 Maternity and Children	
5 Clinical Referrals	x	11 Continuing Healthcare	
6 Community Services	x	12 YAS and Patient Transport	

And highlight which areas of clinical focus for the CCG will be covered:

Cancer	x	Diabetes	
Cardiovascular Disease		Respiratory Disease	
Stroke Care			

Project brief:

Provide enough detail for us to be able to understand:

- Who your project relates to, including how population health management has been used to identify the patient cohort
- What it aims to achieve, using measurable objectives
- The anticipated timescales and milestones throughout
- How it will be managed and delivered
- How the outcomes will be measured

Background

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NHS
Rotherham
Clinical Commissioning Group

The NHS is experiencing significant pressure and unprecedented levels of demand for Elective Dermatology care. This has been the national picture and is reflected in the Rotherham Area.

The pressure has been to such an extent in certain areas like Bradford, the Secondary care services provide only cancer care to meet the 2 week wait referrals demand. This means that the patient with non-malignant conditions wait much longer periods than 16 weeks or no care at all in their local areas.

There is currently a high demand for elective care in Rotherham Dermatology services. It is important to reduce pressure on Secondary service, in our area, to retain services for all conditions, by optimising referrals to Secondary care.
Primary care is also under unprecedented pressure due to increasing demand on primary care services.

Rotherham CCG introduced Teledermatology services, which has made not so significant an impact on Dermatology referral to secondary care. The waiting times for non-malignant Dermatology clinics are quite long, thus causing considerable distress to the patients and increased demand on the scarce GP appointments due to repeat attendances by patients waiting to be seen by the Dermatology service.

RCN PCN have been inspired by the recent NHS England document: Transforming Elective Care Dermatology by NHS England, to provide a solution for easier access and rethinking referral processes to ensure they are safe, efficient and effective.

Aims and provision principles of Primary care Dermatology triage service:

Primary care Dermatology triage service would enhance the care patients receive in primary care, by improving assessment, treatment and care in the community, within few weeks. This service would be an average of 1 session on weekly basis, for 12 patients. These clinics would be managed by experienced GP with an interest in Dermatology.

This would enhance clinical management options for primary care clinicians for benign conditions, reducing workload on primary care and reduce secondary care referral rates. This would also enhance the quality of referral for secondary care, overall reducing work load on both primary and secondary care.

This clinic would be provided by GP with specialist interest in Dermatology who has 8 years experience in providing a similar service in Leeds and Bradford.

This service is not intended for suspected malignant conditions, which should be dealt with in the usual 2WW process
Also, this service is not a replacement for Teledermatology service.

The service is intended as a Triaging service for all intended Face-to-Face non-malignant

dermatology referrals.

The patient journey

The patient having seen the primary care clinician can be directly booked into the Triage Clinic on System One. There is no specific need for referral letter as long as the primary care clinician has documented clearly regarding the reason for referral to Triage clinic.

Here the patient can receive assessment and advice on investigations and treatment options. The treatment advice note would be given to the patient, to be passed on to the registered practice, which would detail any medication or blood tests needed. The patient's practice can view the consultation on System One as well.

The patient would receive follow up, to assess the impact of treatment, if necessary.
If the patient needs Minor Surgery, they would be referred back to their GP, as there is a LES for minor Surgery provision in every practice.

If the patient's condition warrants secondary care referral, the triage clinician would task the General practice administration with appropriate referral content for onward referral to secondary service.

Outcomes

a) Patient Feedback: The outcomes would be measured using patient satisfaction questionnaire which would detail regarding access and satisfaction with the clinician consultation.
b) Practice feedback: Monthly feedback from the practices involved for the first 3 months and then Quarterly feedback to the service detailing ease of access, clinical pathway and any administrative issues regarding further referral to secondary care.
c) Secondary care feedback: Monthly/Quarterly meetings with secondary care for feedback regarding quality of referrals

Financial breakdown:

Include details of all costings to indicate how the monies bid for have been

calculated.

The costs relate to payment of GP with interest in Dermatology, room costs , reception, nurse/health care worker assistance and administrative costs.

There is Nationally agreed AQP Dermatology GPsWI contract which currently recommends £85 for first referral and about £55 for review.

This is significantly lower than Hospital specialist referral rates which are at least £120 or higher.

The clinic would be trialled on first referral rate of £65 and follow up rate of £45, which is significantly lesser than Nationally agreed AQP provision for Dermatology.

A minimum of 1 session/week payment for 6 new patients and 6 follow up patient would be paid, during the trial period of 12 months. Hence the average total cost would be £34,320.

Key issues and risks:

Specify what issues and risks you foresee to delivering the project on time and to budget, including any potential unintended consequences e.g. negative impact on other services.

The IT service needs to be set up like hub service with access for the practices involved. This may have one off set up cost and would need liaising with Rotherham NHS CCG and register with Information Commissioner.

This service would need to be discussed with Clinical Indemnity services like crown indemnity, or other providers like MDU/MDDUS.

Patients may sometimes be suspected to have malignant conditions by the Triage Clinician. In these cases a 2 Week Wait letter would be completed by Triage clinician and sent as an Urgent task/email to the patient's registered practice, with a follow up telephone call to the practice. It would be responsibility of the practice to make 2 Week Wait booking.

In case the patient needs admission, the triage clinician would arrange further care by discussion with secondary care.

In case, if patient has been referred without primary dermatology condition, the patient would be discharged back to his GP with reasons.

Patient, public and stakeholder involvement:

Detail any conversations and consultations e.g. with other services and PCNs.

We have not had any formal discussions with other stakeholders as yet.
We believe that this would be welcomed by Patients, Practices and Secondary Care.
Following Informal discussion with patients and clinicians we feel this would be a truly

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Innovative service.

The clinician developing the services has worked extensively in Leeds and Bradford areas for many years and carefully considered the clinical challenges faced over years providing a similar service.

Equality impact:

Detail how the project ensures equality e.g. if a targeted short-term service offer, how it will meet the needs of the working population.

The service is for all the PCN population.

As stated above, we strongly believe that the service provision would reduce the workload for primary care clinicians, reduce elective referral rate to Dermatology which would help reduce the unnecessary referral to secondary care, relieving their time to concentrate on their current workload.

This service would reduce referral burden of individual practices, help in Secondary care provide efficient care and potentially save referral money for Rotherham CCG.

Human resource implications:

Specify the requirements and time needed to manage and deliver the project, and how this will work practically.

The service would need to develop IT infrastructure. Informal discussion with IT has mentioned that similar IT provision has been made for the Out of the hour hub.

Discussion with Rotherham CCG is necessary to take this provision further which we hope the process would be completed by February.

The clinician necessary to provide minimum of one clinical session of work has been agreed in principle. He is currently working with two GPsWI providers in Leeds and Bradford area. His clinical Governance needs are currently met by continuing service with the providers.

Depending on demand for the triage services, the services may need to be expanded to provide more sessions necessitating more clinician.

The service would support Clinical Governance activities of the clinician including prorate Study leave and Annual leave.

Additional information:

Any other information you would like to add to support the bid.

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We would be keen to support Dermatology PCN Triage for every Rotherham PCN, if funding is available.

We believe that this would pave the way for GPwSI Dermatology services by Rotherham CCG, for long-term funding.

We believe our PCN should develop a truly innovative service based on NHS England transforming elective care Dermatology and help in providing safe, timely, efficient care for our patient population.

Appendix 1 . Treatment Advice note

Community
Dermatology Triage C

Appendix 2. NHS England transforming elective care Dermatology

Transforming
Elective Care Dermat

1. How does this link with Advice and Guidance that can essentially provide a direct virtual service for GPs without the patient needing to visit another clinician?
This service would increase the options for GP. GP's have varied skills and it is often difficult to construct picture of dermatological problem based on its description, as it varies significantly between Gp's . Physical examination including Dermoscopy, is an important examination which gives significant information for a Dermatologist to arrive at diagnosis. Dermatology has significant variation in differential diagnosis and can often be tricky to advice based heavily on history like in advice and guidance . Hence we feel this Service enhances the options for GP and it would be time efficient for both patient and GP. We know that Patient satisfaction is better, when seen by clinician with expertise, rather than remote advice .

2. The model described could mean the patient has to see their own primary care clinician, is then referred to the triage clinic, and could then potentially have to go back to their own practice for surgery / treatment.
This Service is modelled similar to the out-patient service/GPsWI, when the clinician would hand over Treatment advice note to the patient for benign condition. As you aware any prescription from this new service would add costs and would be the similar level of GPsWI service. This service is based on costs considerably cheaper than GPsWI service. We have cut down costs to trial an innovative service, to facilitate patient , GP , Secondary Service by potentially cutting down their work load and CCG would potentially benefit by reduced referral cost.

3. How will the clinic slots be divided amongst the practices in the PCN? Will it be first come first served, or will each practice have an allocation?
There would be 12 clinic slots of fifteen minutes each which would be divided as 6 first appointments and 6 follow up appointment.
The four practices would be able to book slots on first cum first serve basis, as we have based it that every patient should have equitable access to service, to be seen

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as soon as possible. Hence for this above reason, we have not based it on practice population.
However the service would revisit about three month time and make suitable amendments based on practice feedback.

4. How will the patient record sharing be managed? The costs of creating access via an IT hub have ongoing revenue implications.
We currently have winter pressure hub by our Central North PCN based in a practice. This service is based on the same model . We consider this essential to run a service at the Network level. However if there are other options, we would be open to consider any other option CCG may suggest.