Healthcare Improvement Scotland | ihub

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Community Treatment and Care (CTAC) Services 90 Day Learning Cycle

Final report

21 January – 21 April 2019

NHS SCOTLAND

What we aimed to do

To have a **better understanding** of:

1. what the key components are in implementing Community Treatment and Care (CTAC) services
2. how demographics may affect the implementation of CTAC services, for example urban/rural, and
3. what the benefits of CTAC services are to service users and service providers.

How we did it

Through a **CTAC 90 day learning cycle** – ***Learn more here***

What we found

1. A **Framework of key components** to be considered for CTAC services - ***Learn more here*****.**
2. **For different contexts, different models** may be more suitable - ***Learn more here*****.**
3. Depending on how CTAC services are planned, they could bring a **range of benefits** - ***Learn more here*****.**

How we can help

Providing **QI support** to enable sharing of learning and focus on better outcomes - ***Learn more here***

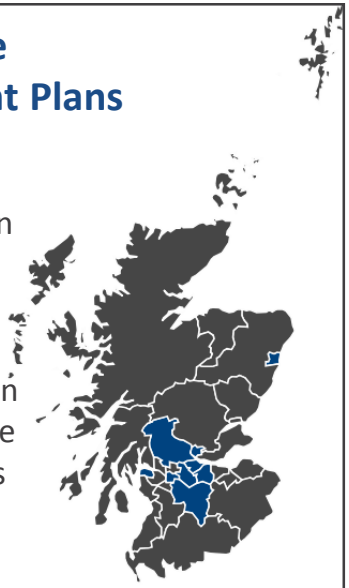
Note: *this is an interactive report – use the hyperlinks and buttons to navigate through it (for example*  *to return to homepage,*  *to return to framework,*  *to return to previous page)*

90 day learning cycle

preparatory work

Primary Care Improvement Plans

Analysis confirmed the wide variation in planning for CTAC services across HSCPs. The blue areas in the map indicate existing services similar to CTAC services.



Survey

Overall there was enthusiasm for the implementation of CTAC services. However, there were also a few comments around potential difficulties. The CTAC provision was patchy, with little or no consistency or uniformity.

The **full report** from the survey can be found here.

60 Completed survey responses

23 HSCPs completed survey

Initial literature review

There is substantial variation in services available in different practice areas across the UK.

There is no common understanding of what a treatment room or a community treatment room is.

Existing services were started for a variety of reasons, with different objectives and with different starting points.

Other countries are also developing similar services, for example in Ireland, Australia, New Zealand and Alaska.

90 day learning cycle

Learn more about the 90 day learning cycle methodology here.

Interviews

97 People interviewed → including **26** Patients

See the **range of stakeholders** and **geographical spread** of our interviewees here.

The **report** summarising the findings from **exploring patients' views** can be found here

Attendance at local CTAC meetings

4 Local CTAC meetings attended

Rapid literature reviews

- Clinical guidelines for **ear syringing** in general practice
- Use of **mobile care units** within remote areas
- Benefits of **electronic requesting and reporting** system for phlebotomy.

Note: Limitations

- Snapshot [Dec 2018-Apr 2019] → things may have moved on since
- Tight timescales → We needed to be quick and responsive (for example, systematic literature reviews were out of scope)
- Validity → consulted a wide range of stakeholders and perspectives but cannot claim to be representative of all, as is the nature of Qualitative research.

Framework for planning CTAC services

1. Planning

Key points

- **Planning will determine the level of success of CTAC services**.
- There is **no right or wrong way** to plan for CTAC. Individual areas have to consider their unique situation.

Data on demand and current activity

- Good planning **requires understanding** of current demand and population needs, current services provided and current staffing levels and roles.
- Gathering data from current IT systems is challenging. Teams are overcoming this using different approaches:
  - ***Week of Care audits*** (for example in Perth and Kinross, Dundee, East Lothian).
  - ***Questionnaires sent to practices*** (for example in Ayrshire and Arran, Highlands).
- **LIST analysts** can be of great help to decide what data to collect, provide advice on collection methods and then assist with the analysis.

Leadership

- Planning requires good leadership and the **leadership capacity to think** and drive changes. Some interviewees reported challenges in finding thinking space given the pressures to deliver the GMS contract. Consider investing in leadership capacity.

Design – joined up thinking

- The GMS contract indicates 6 priority areas to be addressed. Most areas have created different groups and subgroups to address them. There is a risk of silo working. Cross-communication among different groups should **ensure joined-up thinking** and identified synergies.
- A **shared vision of CTAC services should be developed through open and honest conversations with key stakeholders**, including representatives from all staff groups. Existing relationships will influence how easily this shared vision can be achieved. New relationships may need to be developed.

Resources

- Read the **Perth and Kinross GP Nursing Week of Care Audit** case study for a full explanation of what they did in detail and for useful tips and resources.

  They found that at least 726 hours of nursing time support could be provided to GP practices by CTAC services.

- See here the nurse audit template used by **Ayrshire and Arran** to understand the services provided by nursing staff and at what level.

you need to quantify the activity

…you can't move forward without it [thinking time]

Examples

See here for some examples of how teams are approaching planning for CTAC services and individual visions of CTAC services.

2. Patients

Key points

'At the heart' of the system

- **Patients should be at the centre** of planning for CTAC services.
- It is important to **understand what is important for patients** and engage them to inform CTAC services.

Patient engagement

- Chapter 6 of the GMS contract sets out **the critical role of meaningful patient engagement** in ensuring services are designed in ways that meet the needs of individuals and communities. However, none of the teams we spoke to had engaged with patients when planning CTAC services. The main reasons provided were the tight timescales to deliver the contract and not knowing how to do it.
- **26 patients currently using CTAC services across Scotland were interviewed** using discovery conversations to understand their care experience. Overall their experiences were very positive. See here the visual representation which maps out the positive, neutral and negative comments that they identified about their treatment room.
- The **Scottish Health Council local officers** can help teams to engage patients and the community. You can approach them here.
- The Primary Care Improvement portfolio could facilitate contact with the **person-centred health and care team** who could assist you in working with patients to improve services.

Care navigation

- Depending on how CTAC services are designed, the way care is accessed may be different.
- **Patients should know how and when to use the different services** and be able to access the services easily.

Resources

- See here the report summarising the findings from **exploring patients care experience by interviewing** 26 patients currently using CTAC services. This was done with the help of colleagues from the person-centred health and care team and colleagues from the Scottish Health Council local offices.
- See here Inverclyde's **patient satisfaction survey** which they run every 6 months.
- The Care Opinion website is a valuable resource available to enable patients to provide feedback on any service.
- See here the Practice Administrative Staff Collaborative care navigation toolkit.

As long as the design is an improvement and doesn't add complexity to the process for the patient.

Examples

See here the journey points and areas for consideration for CTAC services based on the responses of the 26 patients interviewed as part of the 90 day learning cycle.

3. Delivery models

Key points

- **No delivery model suits all contexts**. The local context must be considered during the planning phase.
- **Potential models** for the delivery of CTAC services are:
  - **centralised** (for example as part of a hub of care services)
  - **peripatetic**
  - **augmented community teams**
  - **co-located within a GP practice,** and
  - **mobile units.**

  Often models are **blended** (for example peripatetic + augmented community teams, centralised services + co-located within GP practices if the practices are located in a health centre).
- HSCPs might want to **consider a mixture of models** to address their multiple demographic conditions and needs.
- There is an **opportunity to share the learning** from testing different models of delivery to accelerate improvement and innovation.

Remote and rural

- The planning and delivery of CTAC services is considered challenging in **remote and rural Scotland**, which accounts for 98% of the land mass of Scotland and 17% of the population – see a map of rural Scotland here.
- A mixture of a **peripatetic and augmented community nursing team** model may suit this context better. However **other options should also be explored**.
- The Remote and Rural Short Life Working Group stated in their March 2019 bulletin "*the need for flexibility in delivering primary care redesign*." They also issued guidance to Integration Authorities (IAs) "*encouraging them to explore **flexibility**, supported by **strong evidence** to deliver redesign in rural areas*".

Resources

- See the Remote and Rural bulletin (no. 3) which includes the **Primary Care Improvement Plan Guidance** (Mar-19) here
- Summary pages for each model:
  Centralised - summary page.
  Peripatetic - summary page.
  Augmented Community Teams - summary page.
  Co-located within a GP practice - summary page.
  Mobile units - summary page.

It has to be designed on a locality basis, on what the area looks like

flexibility and convenience for patients should adapt based on location.

Examples

Centralised - example.
Peripatetic - example.
Augmented Community Teams - example.
Co-located within a GP practice - example.
Mobile units - example.
Mixed models – example.

4. Services provided

Key points

Planning the services to be provided by CTAC

- The **GMS contract** defines CTAC services as – "These services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate. Phlebotomy will be delivered as a priority in the first stage of the HSCP Primary Care Improvement Plan."
- HSCPs are **starting at different points**. Some have established CTAC services which have grown organically and deliver specific services (not always phlebotomy services) depending on local requirements.
- There is variation in the range of services provided, even within the same areas. There is an **opportunity to standardise** services. Some areas (for example Lothian and Greater Glasgow and Clyde) are developing a service specification for CTAC services.
- There is **big potential for services to be expanded** in the future (for example to incorporate more nursing interventions, services provided by the MDT (e.g. AHPs), health improvement and traditionally secondary care tasks (e.g. pre-ops).

Ear syringing

- Ear syringing requires **specialist skills** and adequate equipment. It was reported that ear syringing causes **high levels of litigation**. Quantification of rates of litigation may be useful to inform the planning for CTAC services.
- Some HSCPs are doing **specific planning** for ear wax removal (for example a centralised service for ear care, working closely with ENT).
- Some questioned the clinical need for ear syringing vs patient preference. Also, some questioned the appropriateness of ear syringing as a method (manual syringing should not be offered). **More clear guidance** on ear wax removal would be beneficial.

Resources

- See NHS QIS Ear Care Best Practice Statement (2006) here.
- See NICE guideline [NG98]: Hearing loss in adults: assessment and management on here.

If we had a magic wand, a Physiotherapist would be a God sent'.
Healthy Hoose (run by ANPs)

20% of the litigation we get is due to ear syringing

Examples

- See examples of how specific services such as leg ulcers and ear wax removal are/will be delivered in some areas.

5. Workforce

Continues on next page

Key points

- Workforce is one of the key enablers for delivering the GMS contract. However, concerns about the workforce issues were raised in the majority of our interviews.

Workforce planning

- Workforce planning for CTAC services is **paramount** to determine the staffing levels required for CTAC delivery.
- There needs to be an **understanding of the demand, current workforce and their roles**. Requirements for **admin support** should not be overlooked.
- 4 out of the 6 priority areas of the **contract** involve nursing staff. A **joined approach** should be considered.
- **Concerns** were raised about **recruitment** and the **risk of destabilising** the workforce across the system.
- There is an **opportunity to share and learn** how workforce planning is being approached by different areas.

Right skill mix

- The **right skill mix** for delivering CTAC services should be defined. Decision makers need to be part of the skill mix. Many areas are considering a mixture of nursing bands and healthcare assistants to staff the services.
- **Concerns** were raised around CTAC services being task based rather than viewing patients holistically and therefore **potentially de-skilling nurses**. On the other hand, there were also concerns about **not having the 'right skills'** for CTAC services.
- At the same time, CTAC services could enable **development opportunities** and a **career pathway**, which would make recruitment for these posts more attractive.

Resources

- See the CNO Transforming Nursing, Midwifery and Health Professions (NMaHP) roles papers here.

Recruitment issues, not enough staff to go round, taking staff from every area (this will result in) major workforce issues

We will all be fighting for the same people

We are already doing stuff that is expected of these PN of the future but can't necessarily prove qualifications

CTAC need to be staffed by people competent to fulfil the role (competency based) rather than role based (task orientated) so staff can holistically treat the patient rather than just fulfil tasks.

CTAC will provide a better career pathway for current treatment room nurses with better opportunities to progress and more access to training.

5. Workforce

Key points

Clinical governance

- Regardless of the model chosen to deliver CTAC services, **clear governance structures** and **appropriate clinical decision making** should be ensured.
- Appropriate skills and processes should be available to **escalate** issues when required.

Change management / staff engagement

- The **human side of change** can be hard to navigate and having difficult conversations may be required. Some of the already established CTAC services mentioned that from conception of the idea to fruition took much longer than expected and generated more opposition than they anticipated.
- **Uncertainty around change** is normal but **should be managed properly** to prevent unintended consequences (for example early retirement). These are some examples of what could be done to ease the transition:
  - staff engagement and involvement
  - clear communication of shared vision and plans
  - visible and supportive leadership, and
  - providing additional capacity.
- The philosophy of the contract is to free up practice capacity so that they can focus on the management of chronic diseases. However, some expressed **concerns that GPs may reduce the staff employed within practices**.

Transfer of staff

- Some practice staff might need to have their employment transferred (**TUPE***) to the Health Board. This can be challenging both technically and emotionally. However, TUPE could also bring new opportunities, including career development opportunities.
- There is an **opportunity to share and learn** how teams are addressing TUPE.

** **TUPE** refers to the "Transfer of Undertakings (Protection of Employment) Regulations 2006"*

How do you get the balance: robust central governance and clarity of service provision but with a level of devolved responsibility?

People are moving on because of uncertainty. Nobody knows what's happening and that breeds unrest

My job will be completely taken away if CTAC services are running

Vital to provide training and helpline and re-training if necessary. Convince them what they are going to do is not going to take up any more time

Team is very visible so people are used to seeing them and communication is open

Examples

See here for examples of what people are doing to manage change.

6. Premises

Key points

- **Lack of premises** to site CTAC services was raised as a **concern** by many.

Infrastructure planning

- The GMS contract suggests CTAC services be located in existing GP practices but not all GP practices will have the space. One interviewee raised the issue of the HSCP potentially having to 'rent' space in GP practices.
- **Mapping out the potential options** for premises could help with planning (for example healthcare related premises including community hospital buildings).
- **Creative solutions** are being explored to overcome capacity issues, (for example speaking to local **councils** about their portfolio of buildings to see if any can be utilized, approaching **care homes,** approaching bus companies to modify route).
- Other creative solutions could be approaching **community pharmacies**, using **mobile units** and even locating premises in **shopping centres**.
- There is an **opportunity to share and learn** how teams are planning infrastructure.

Estate infrastructure is a major issue across the board…

Location and premises need to be right – it needs to be convenient, with parking or on a bus route

Premises and IT are the main barriers (to CTAC)

Suitability

- Premises for CTAC services must meet **health and safety, infection control and clinical care requirements**. More specialised adaptations such as foot baths for ulcer clinics may require alternative premises.

Convenient for patients

- CTAC services should be **convenient for people**. It is important to **understand their needs and lifestyle preferences**.
- Most areas aim to provide patients access to multiple CTAC services within the same board area to suit their needs (for example the ability to access services close to their workplace).

Examples

See here for examples of what teams have been doing in relation to premises.

7. IT systems

Key points

- Current IT systems are seen by some as a **barrier** to the development of effective CTAC services. Improving IT is seen as a key enabler of successful CTAC services.

Current IT landscape

- IT systems in Health Boards and GP practices still **lack the connectivity required** by multi-disciplinary teams.
- CTAC service providers may have to **access multiple systems using different log ins, use paper-based communication or re-enter data** to find patient information and/or to record information. Or they may not have access to they systems at all. This has the potential to affect communication and collaboration between team members, leading to fragmentation of care and a negative impact on patient safety.
- The **lack of a single patient record view** may deter staff from providing truly patient centred care at the right time and in the right place.

Electronic requesting of lab tests and imaging (Order Comms)

- **Order Comms (ICE)** is commonly used by GP and hospital clinicians across Scotland. However, a hospital clinician typically cannot use the software to request that an investigation is carried out at a remote community site.
- Order Comms systems and processes should be developed for CTAC services to enable **safe requesting and results handling**.

National Digital Platform (NDP)

- The **National Digital Platform** (being developed by NHS Education for Scotland) aims to allow a single view of patient records. The NDP will be capable of collating and presenting data back and forth via portals or dashboards.
- The **timeframe** for roll out is over the next three years for Health Boards and four years for GP Practices.

Resources

- More information about the **National Digital Platform** (NDP) can be found here.
- Information about the **New Core GP (Re-provisioning) IT system** can be found here.

…IT will be the biggest headache

We need seamless integration of technology, it can be done, cytology do it well

An electronic shared care record view visible to both primary and secondary care was created in Canterbury, New Zealand,

Examples

See here examples of the IT systems used in Health Boards and GP practices.

8. Technology

Key points

Technological solutions

There are examples of how **technology could support the delivery of CTAC services**, by improving outcomes for patients and/or improving efficiencies:

- **cutting edge technology for ear wax removal**
- **centrifuge equipment** allows blood samples to be spun and kept in a fridge overnight for collection the next day
- **self-monitoring technology** for chronic diseases such as heart disease, blood pressure and diabetics
- **Florence** is an app that contains links to signpost to health-related services and information, that patients can access in their own homes, for self-management reducing surgery visits and hospital admissions
- **Attend Anywhere -** used for virtual consultations, saving travel time and allowing quick access to clinical expertise. This technology could also be used by CTAC staff to communicate with primary and secondary care physicians, and for remote consultations for secondary care. Microsoft teams are also working on a similar platform for group consultations for Windows 10/Office 365. This is currently being tested and roll out is anticipated in the coming years, and
- **robotic process automation** can replace manual tasks (for example patient registration and creating patient records on mobile devices while on the move).

Our priority is to find which technologies makes a difference to patient care, what things reduces pressure on staff

Simple things like we use text messages to remind patients of appointments

Our patients do home blood pressure monitoring themselves and then they bring the data into their GP for discussion

Technology can play a transforming role in how care services are delivered. There is an **opportunity to explore further** how technology could be used to support CTAC services safely and efficiently.

Examples

See here examples of how technology is being or planned to be used in CTAC services.

9. Funding £

Key points

- The funding available to support the planning and implementation of CTAC services was raised by many. Two key points were highlighted:

  1. **Insufficient funds** to implement all elements of the contract.

     This might be more evident in delivery of CTAC services in remote and rural areas. If supported by strong evidence, CTAC services could be '*provided in the form of …expenses for the required practice employed staff capacity or the deployment of NHS Board employed staff.*' (Contract)**.**

  2. Views that **secondary care** should contribute to the funding to set up CTAC services given that the services will support them as well. This point was mentioned multiple times and was reported to be widely held. However, some acknowledged the difficulty in clearly defining the boundaries around primary and secondary care.

- **More clarity** about the practicalities of funding may be required. One interviewee mentioned being unclear about the ability to carry over funding from one year to another given the underspend in year one as a result of spending time assessing requirements and planning services. In some cases, recruitment was being delayed until confirmation of funding was received.

GPs are not happy to be funding CTAC from primary care. Secondary care work has never been included in GP contract.

Secondary care work… difficult to define. What is secondary care work for one practice is primary care for another

Tendency for rural practices to absorb costs as think it's best for their patients

we don't know how much it will cost, but we have committed to setting up these services

Benefits and concerns

Benefits for patients

- Increased choice
- Convenience
- Clear patient pathways
- Uniformity and consistency of services across Scotland
- Continuity of care?
- Right time / right place / right person

Benefits for staff

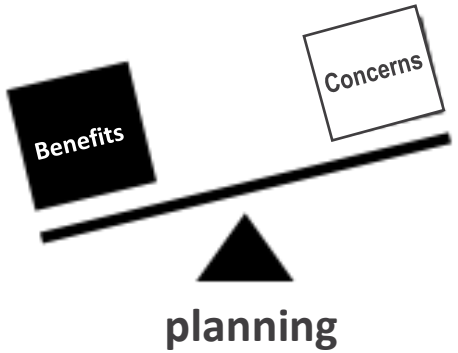
- Clear career pathways for nursing staff
- Opportunities for staff to develop and become specialists
- Free up time for staff to work on QI projects

Benefits for primary health care

- More capacity in GP practices
- Opportunity to overhaul community and practice nursing
- Strengthening of community resources
- Potential for growing CTAC services to take on more secondary care work
- GP practices more sustainable

Concerns raised by practitioners

- Risk of fragmentation of care
- Risk of destabilising the workforce
- Potential for rural areas to be disadvantaged
- Risk of reduced access for patients depending on delivery model
- Risk of moving away from a holistic approach
- Demand is shifting, not freeing up
- Changes in relationships and culture – patients may not see why changes have been made
- Concerns about primary care funding being used to meet secondary care demand
- Concerns from staff around moving workplace or employer
- Concerns from staff about changes to roles and responsibilities



Quality Improvement support

Key points

- All HSCPs are working on the priority areas of the Contract. Although some have access to their local QI support, generally people saw the benefit of having national quality improvement support.
- The two main areas mentioned were: developing a national measurement framework and supporting the sharing of learning.

National measurement framework

- The Contract is mandatory but the changes introduced should always translate into **improved outcomes** for patients, staff and the system.
- Teams should measure the impact of their changes to ensure that they are improvements. However, **measuring the impact** is an area **often overlooked**.
- Having a national measurement framework could help to create a **common aim**.
- The framework should include both **quantitative and qualitative data**, from a **whole system approach**. Also it should include **options** as not all CTAC services will provide the same services.

All share, all learn

- Many interviewees requested **opportunities to link with peers** for sharing progress stories and to learn from each other. The importance of having **safe thinking spaces** was also highlighted.
- There are different means to facilitate the sharing of learning: developing a network, running collaboratives, though WebEx's, meetings and/or coaching calls, etc.
- The topics should focus on what matters to people.
- It is important to look across the overall patient pathway (e.g. acute and primary care).
- Healthcare Improvement Scotland could set up a learning system to enable the sharing of learning.

Resources

- See the **Primary Care Evaluation Framework** here
- See **Improving Together Interactive portal** (ITi) here

Service redesign should accord with 7 key principles: Safe, Person-centred, Equitable, Outcome focused, Effective, Sustainable, Affordability and value for money (MOU)

Focusing conversations around the concept of wastage of patient's time helped us [in Canterbury] align everyone's interest

You could help to make this whole process visible

Examples

See here for the Canterbury Outcomes Framework.

A data and measurement plan for PCIP is being developed and will include key measures for treatment room services across Lanarkshire.

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Thanks to… All who spoke to us.

60 Completed survey responses

23 HSCPs completed survey

4 Local CTAC meetings attended

97 People interviewed

including

26 Patients

Our next steps

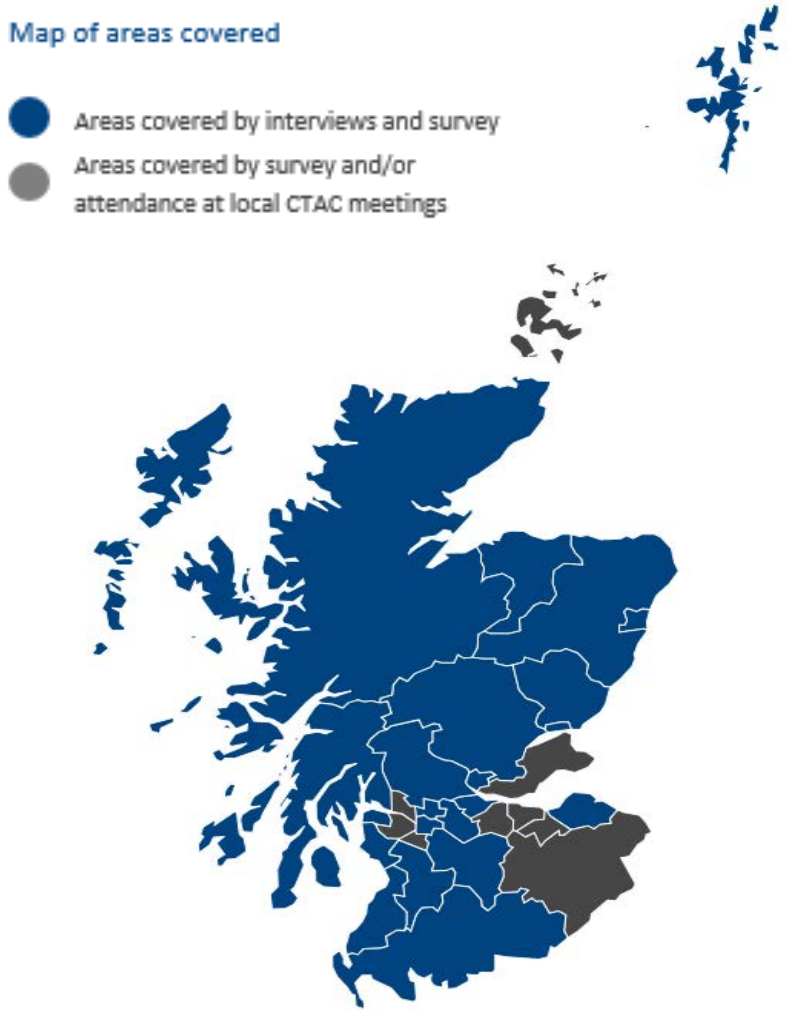
- **Share the learning** from the CTAC services 90 day learning cycle with stakeholders at the event on 11 June 2019.
- **Agree the next steps for national Quality Improvement support** with key stakeholders.
- Consider demand and feasibility for providing a **CTAC services network** for peer learning and support.

Appendices

Range of stakeholders engaged with and geographical spread

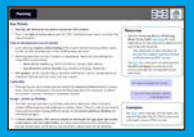
Role Group	Description	Number of interviewees
Academic	Includes subject matter experts and Professors in primary care and nursing	4
Allied Health Professionals	Allied Health Professionals and Leaders	2
GPs	Includes GPs on Sub Committee and Clinical Leads	7
Improvement Staff	Improvement Advisors and Managers	2
IT	Includes Business Analysts, NSS, Practice Staff spoken to specifically about IT systems	7
Nursing	Includes Community Nurses, Practice Nurses, Nurses in managerial roles	12
Policy	Includes representation from Scottish Government and the BMA	5
Practice Managers	Practice Managers	3
Strategy	Includes managerial and leadership roles within HSCPs and NHS Boards, including Chief Officers, Heads of Services, Programme Managers, Professional Advisers	18
Treatment Room Staff	Includes Treatment Room Nurses, Team Leads and Phlebotomy	5
Other	The Scottish Rural Medicine Collaborative (SRMC), HIS Unit Heads, LIST Analysts	5
Grand Total		70

Map of areas covered



We also had interviewees from England and New Zealand.

Examples of how teams are approaching planning



Lothian – Lothian CTAC group has representatives from Edinburgh City, Midlothian, East Lothian and West Lothian. They have developed and agreed a core minimum CTAC service specification that ensures equitable services across Lothian. Also, they have agreed to follow a phased approach to incorporate secondary care priorities. Initial tests will focus on the transfer of bloods to CTACS from three areas (for example Rheumatology, GI and Lipids)

Forth Valley –have established treatment rooms to provide wound care but not phlebotomy services. They have decided to do some tests of change to see how phlebotomy services could be delivered.

This isn't just about CTAC being a room in a building offering specific services, redistributing work from GP Practices, but about incorporating Out of Hours service, minor injury units, offering a daytime and evening service (potentially a scaled down over night version) and diverting CTAC work away from all these other services where currently there is a lot of crossover of tasks

It might not be very different from current delivery, just that staff will be employed by the HSCPs . But I can see the potential of expanding CTAC remit

Example of areas for consideration based on patients' views

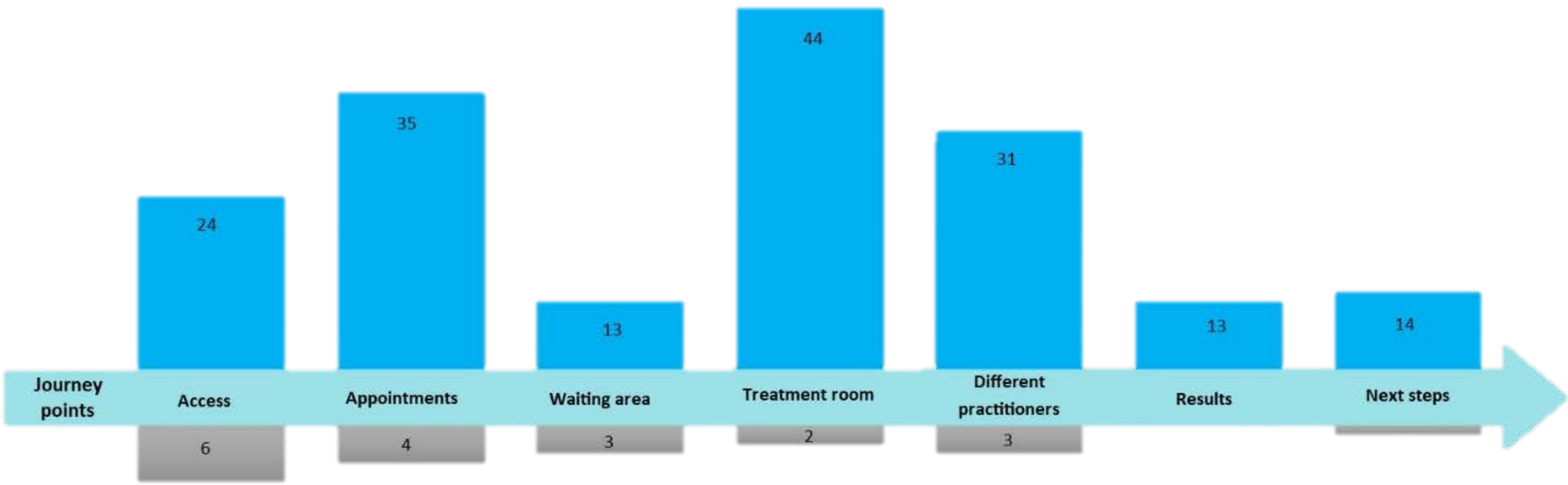
The table below summarises the journey points and areas for consideration for CTAC services, based on the responses of the 26 patients interviewed as part of the 90 day learning cycle.

Journey points	Areas for consideration
Access	Location, transport, convenience, and accessibility i.e. drop-in, and or straightforward flexible appointments system that fit in with people's lives beyond being a patient.
Relationships and professional trust	Friendly, welcoming staff who are able to provide CTAC treatments quickly and or regularly.
Continuity of care	Ability to 'get to know' the staff providing CTAC services.
Communication of results and next steps	Patients understand what happens after the treatment room visit for results and or return visits.

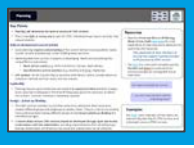
The journey points identified during this work should be considered in the development of future CTAC-type services that will be developed across Scotland in the coming years.

However **the list is not comprehensive** - this engagement process did not tell us anything about the specific treatment's that these patients were receiving, consider the views of people not accessing treatment rooms for task based healthcare, or consider what other patient's and service users may feel about moving from their current GP Practice into future CTAC services.

Overall CTAC interview journey map



Centralised



Description	Where multiple GP practices are serviced by shared CTAC services, either delivered within a Health Centre (shared by multiple GP practices) or in an alternative building. This could be part of a **hub of care services** in which multiple services (i.e. physio, dietician, and other AHP services) are brought together alongside CTAC services, under one roof, such as in a Health Centre or a Care Hub.
Advantages	• Economies of scale • Allows centralisation of services which require specific staff skills or specific specialist equipment • Opportunities to locate the service in easily accessible spaces • Opportunities for expansion to MDT • Run by dedicated staff of different bands, which allows career progression opportunities • Easier access to clinical expertise to consult and escalate care when required • Can be set up to offer walk in slots and / or appointments to suit population preferences
Disadvantages	• Location may not be convenient for all – consideration must be given to parking or accessibility by public transport • Need dedicated space for CTAC services • IT issues with accessing GP records if practices are not in the same building • Time issues – patients may need a double appointment to see GP and then transfer to CTAC services for treatment – potential for less streamlined or joined up services
Suitability	Best suited for **urban or semi-urban areas** with a high population demand and shorter distances to travel. In **urban areas with high SIMD** (Scottish Index of Multiple Deprivation) services must be as close as possible to the community, as transport options for people may be limited. Walk in appointment seem to work well for this group.
Example	Houldsworth Health Centre, North Lanarkshire Aberdeen Healthy Village Aberdeen Healthy Hoose Inverness Investigation Treatment Rooms

Centralised - examples

Aberdeen Health Village – the Aberdeen Community Health and Care Village, known as the 'Health Village' is an example of a Hub of Care Services. This is an urban community hospital, without inpatient beds, delivering diagnostic and treatment services. It provides a wide range of services including cardiac rehabilitation, dental, dietetics, minor procedures, out-patients, physiotherapy, podiatry, radiology, sexual health services and speech and language therapy.

Aberdeen Healthy Hoose – this is a service run by Advanced Nurse Practitioners, providing a range of healthcare treatments and services. Located in a community centre, alongside other services such as a nursery and a café , the healthy Hoose provides a drop in centre for patients registered with local GPs.

A case study about the Health Hoose model can be found here.

Houldsworth Health Centre (Lanarkshire) – is a new building situated in Wishaw, North Lanarkshire. It is one of 10 health centres that hosts treatment room services with dedicated rooms.
A case study about the Treatment Rooms at Houldsworth Health Centre can be found here.

Inverness Treatment Room Service - this service grew organically to remove tasks which were being requested by local secondary care, which GPs felt should not be actioned by primary care. The investigations include blood tests, dressings and a number of other possible tests. Read more about Inverness Treatment Rooms here.

Peripatetic

Description	This model provides individual or groups of healthcare workers who take services to the patients, either in their own homes or by running off-shoot clinics
Advantages	• Better utilisation of resources where local demand is not great enough to justify full time employment of staff • Takes services closer to patients thus reducing transport issues • Some areas are familiar with this model from school vaccination services so have a starting point to building CTAC services • It does not need dedicated space for CTAC services • Can be provided by augmented community teams with all the advantages of that specific model
Disadvantages	• Staff intensive – traveling between clinics or patients takes time • Expense of traveling • Lone working • Less accessible to clinical expertise to consult and escalate care when required • IT systems not being connected with other sectors (for example GP practices and secondary care, which means limited access to patients records and communication frequently conducted via paper-based methods
Suitability	Best suited when the **demand for services is low** (for example remote, rural and semi-rural areas).
Example	Luton Phlebotomy Service

Peripatetic - example

Luton Community Phlebotomy Services – this service has 2 elements:

1. A clinic based phlebotomy service for patients registered with Luton GPs
2. A domiciliary phlebotomy service for patients registered with Luton GPs.

The latter is an example of a pure peripatetic service. This service was established to meet local demand and has grown over time. It currently employs 6 phlebotomists and 4 Health Care Assistants, providing home visits (on average 50 visits a day) and a phlebotomy clinic. 98% of patients are seen the same day.

Learn more about Luton Phlebotomy Service here.

Augmented community teams

Description	A model which builds on existing Community Nursing teams. Teams can be augmented with both staff (for example nurses and healthcare assistants) and skills (for example by adding advanced nursing practitioners, working within their scope of practice, who can offer more diagnostic and advanced treatment service)
Advantages	• Management and Governance structures already in place • IT structure already in place • Potential skill and career development opportunities • Patients used to this set up • It does not need dedicated space for CTAC
Disadvantages	• May need staff from practice to be TUPE'd to Health Board employment • Office space for the larger team
Suitability	Flexible model that could be implemented in **multiple contexts** depending on local needs and available resources.
Example	Western Isles phlebotomy services

Augmented community teams - example

Western Isles – in this area it was decided to combine Vaccinations and Treatment Room services as they viewed the services as having the same workforce. Western Isles already had community teams embedded locally working between geographically located GP Practices. Given their context, they decided to augment their existing peripatetic community teams (as well as school nursing and training for maternity staff) to provide vaccinations services.

Since the services are being transferred from the practice to the health board, GP staff are being TUPE'd over to health board employment as required. It is envisioned that the team will be a mix of Band 3 HCA, Band 5, 6 and 7 nurses. Band 7 nurses will be able to provide leadership and advanced sills such as prescribing.

Learning from this experience, they are testing the provision of phlebotomy services using the same model. The logistics of how CTAC services will function and the practicalities of how they will be run will be established using a House of Care model.

Co-located within GP practices

Description	A model where a room(s) within an existing GP practice or practices is allocated to CTAC, staffed by Health Board employees rather than GP employees
Advantages	• Patients already use the building and are familiar with it • Seamless transition between services in GP practice and CTAC services • CTAC staff should be able to access GPs for advice easily • CTAC staff should have access to GP IT system
Disadvantages	• A proportion of practice healthcare staff may need to be TUPE to Health Board employment. TUPE'ing staff is complicated and can have a negative impact on staff if not well managed. They may need to upskill current staff. • Health and Social Health Partnership may have to rent infrastructure from the GP practices.
Suitability	Best suited for where GP practices or Health Centre has **sufficient space** to accommodate the CTAC services
Example	Inverclyde Treatment Room

Co-located within GP practices - example

Inverclyde Treatment Room – the treatment room started 20 years ago to help GPs in the area. The treatment room is co-located with 3 GP practices which allows easy access to GPs if required (for example for prescriptions).

The treatment rooms uses an appointment system with a drop-in slot every hour and a drop-in service for phlebotomy.

They provide a wide range of services: ear syringing, ECG, doppler, catheter care, HVS, BP monitoring, Blood glucose monitoring, leg ulcer, dressings, skin care including eczema and psoriasis, eye care, self care and general advice, infection control, contraception, injections e.g. B12, tetanus (only under prescription by GP) tracheostomy care and PEG tube care.

Mobile units

Description	A model which allows services to be taken to patients in remote and outlying areas
Advantages	• No need for space • Flexibility to take the service to anywhere in the community (for example areas with high foot fall or local gathering places) • It helps to build relationships with older people in remote areas, people who often have limited opportunities for day to day social interactions. • Such services can provide a useful way to provide holistic care to the elderly, the chronically unwell or those with mental health issues. • It provides flexibility to adapt to the demand • It could be used to provide services that require expensive equipment without compromising access • It could be combined with other social and care services.
Disadvantages	• High cost to set up and maintenance costs • Practical issues need to be considered (for example driving license type required)
Suitability	Flexible model that could be implemented in **multiple contexts** depending on local needs and available resources.
Example	CHiP van in Ayrshire (although not providing CTAC services as such the model could be adopted)

Mobile units - example

East Ayrshire Council's CHiP Van – The CHiP Van is a mobile healthy living centre which provides access to information about health lifestyles, advice and information and can carry out basic health checks such as BMI, body fat measurements, blood pressure, lung capacity and if required sign post users onto other services. The Van, along with team members, also offers a service to local businesses and groups to provide targeted health care services such as blood pressure checks and cholesterol checks. They have collaborated with other established services such as the 'See Me' Mental Health programme, Needle Exchange Services and Sexual Health Programmes.

Although the CHiP Van does not currently provide CTAC services the model could be considered.

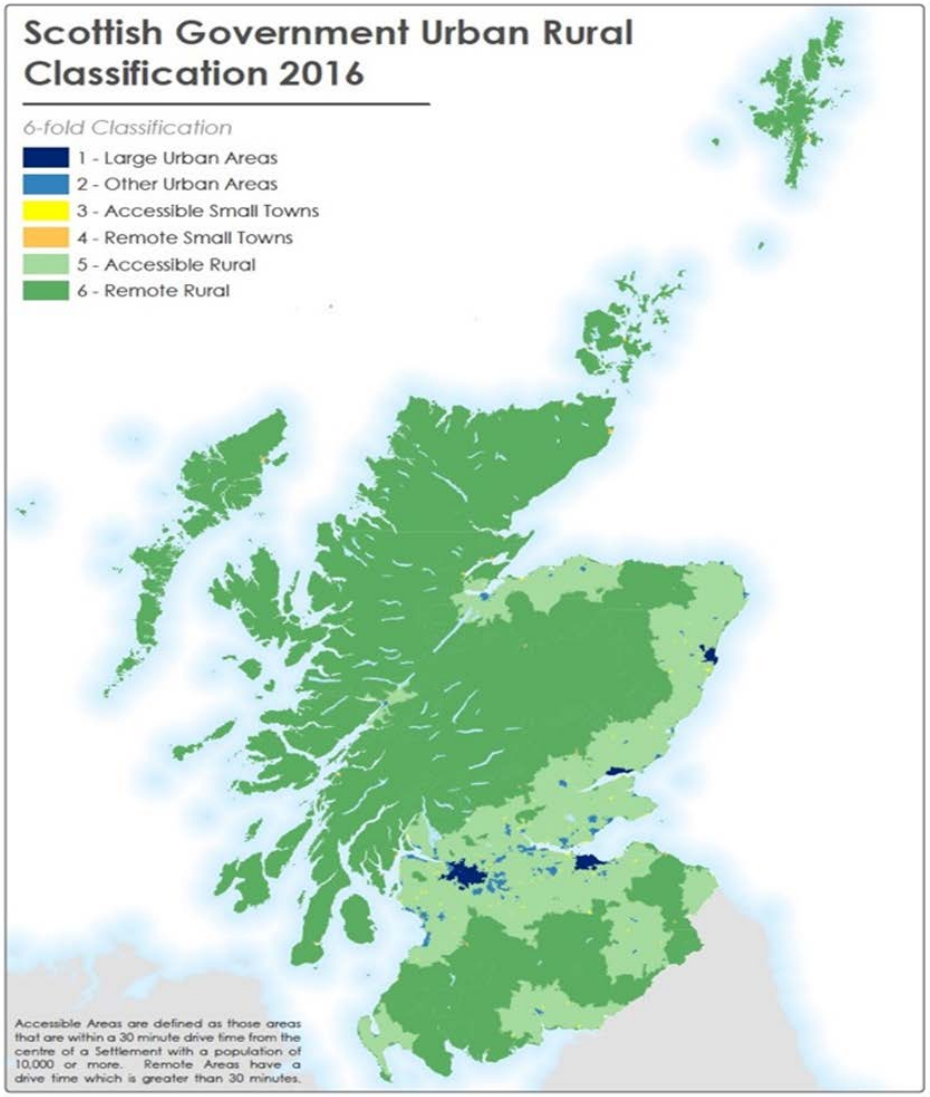
Mixed model - example

Perth and Kinross – this HSCP covers multiple demographic conditions and they considered a mixed model to meet specific local requirements. This diversity is being catered for, within the model being developed, so that the patient is able to see the right healthcare provider in a location which is close to their home, or in a location of their choosing such as near their place of work. This should significantly improve patent access to services.

The model is based on a 'hub and spoke' approach with services based within Perth City, Community Hospitals and individual GP practices.

However, this model does not suit all types of services. For example where patients need regular appointments for leg ulcer treatment, these treatments may be within a local hub.

Map of rural Scotland



Source: [1] https://www.gov.scot/publications/rural-scotland-key-facts-2018/

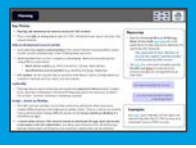
Services provided will influence the model of delivery

Dundee - a specialist standalone clinic for leg ulcers has been rolled out. This grew organically due to local demand. Monitoring has shown improved healing times and high patient satisfaction. Dundee practices are now using that standalone service rather than using in-house Practice Nurses.

Lothian - agreed to explore the potential for small number of CTACS to offer ear suction (a safer method used in ENT that requires complex training and specialist machinery).

Angus – colleagues in Angus started work in January 2019 around ear care with a model linked in with ENT and audiology at Ninewells Hospital. They have been looking at micro suction (considered the gold standard care for removal of earwax), trained Nurses with the support of ENT colleagues and are now seeking the equipment to test roll out within community. Looking at initially testing with one cohort of GP practices.

Examples - managing change



Lanarkshire - have a dedicated Primary Care Improvement Team that supports the ongoing improvement work across treatment room services. This compliments the operational development that is lead by local management teams

Ayrshire & Arran - ran a series of workshops to engage with and reassure their nursing staff.

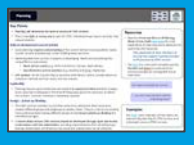
Examples – being creative about premises

Glasgow City - did a mapping exercise to ascertain where services are being provided and assess possibilities for accommodating additional CTAC services

Inverness - *"…we tried to get Stagecoach to move a bus route for us so patients could get a bus to the ITR in Inverness. They wouldn't do it!"*

East Ayrshire spoke to local councils about their portfolio of buildings to see if any can be utilised

Examples of IT Systems used in primary and secondary care



Not connected

Interface

GP IT systems

EMIS PCS and Vision are the main two IT systems GP Practices used for electronic patient records and appointment diaries.

The **GP IT reprovisioning** project is led by National Services Scotland (NSS) and and will provide modern clinical IT to GP practices. Three suppliers (VISION, EMIS, Microtest) have been selected and cohorts of practices across Scotland will choose which system to use. The roll out is anticipated to start in late 2020.

Health Board IT systems

TrakCare is the main Patient Management System used in Scottish hospitals. This includes electronic patient records, investigation results and appointment schedules. Hospitals typically also make extensive use of Clinical Portals such as those provided by Orion Health and Intersystems. Some portals show GP and social care data by many don't.

Community IT system

There is a wide range of systems used by NHS community services across the country. Some use TrakCare, som use EMIS Web and others use locally developed software. Many are reliant on paper records. In some boards portals used to create a partial view..

IT systems locally developed/adapted for CTAC services

TRIX and **MRBS** (Meeting Room Booking System) are systems locally developed/adapted for Inverclyde and Lanarkshire treatment rooms respectively. They are used for appointment diaries and do not contain electronic patient records.

However, both areas are **moving away from them.** Inverclyde is testing **EMIS web** and Lanarkshire is carrying out testing of **TrakCare.**

Examples – how technology could support CTAC services

Lothian – discussed the use of technology for Ambulatory Brachial Pressure Index ABPI (e.g. using the Dpplex® machine these can be done in a few minutes rather than the best part of an hour)

Lanarkshire – to support the expansion of phlebotomy centrifuge equipment has been invested in.

Fife - Fife HSCP has been testing and rolling out mobile technology to ensure they are able to continue to support people in their own homes. They have deployed solutions from Totalmobile, including mobile workforce management and dynamic scheduling to approximately 900 home carers. This allows them to balance supply / demand and respond to changes. In financial terms Fife Council will save approximately £2.35m per year.

Technology Enabled Care Programme – scaling up the remote hypertension monitoring at home programme, computerised CBT service for mental health, working on Kardia app for checking ECG on phone and sharing with consultants. Work is also underway in social prescribing for over 65s with long term conditions through the mPower programme.

Greater Glasgow and Clyde – Glasgow has built a Chronic Obstructive Pulmonary Disease (COPD) tool which will allow data from home monitoring equipment to be seen by staff via existing portals

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