**AGENDA ITEM NO: 9**

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| **Report To:** | **Inverclyde Integration Joint Board** | **Date:** | **15 May 2018** |
| **Report By:** | **Louise Long<br>Corporate Director (Chief Officer)<br>Inverclyde Health and Social Care Partnership (HSCP)** | **Report No:** | **IJB/25/2018/AS** |
| **Contact Officer:** | **Allen Stevenson** | **Contact No:** | **715283** |
| **Subject:** | **NEW GENERAL MEDICAL SERVICES (GMS) CONTRACT IMPLEMENTATION** | | |

## 1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board of progress made towards implementing the new General Medical Services (GMS) Contract 2018-2021.

## 2.0 SUMMARY

2.1 The Integration Joint Board was updated in January 2018 on the outcomes from the New Ways pilot and future planning for the new GMS contract, based on consultation with local GPs.

2.2 Inverclyde HSCP is required to develop a Primary Care Improvement Plan which must be approved by the Integration Joint Board and the GP Sub-Committee of the Local Medical Committee.

2.3 An overarching NHSGG&C Primary Care Programme Board is in place, as is a local Primary Care Implementation Group (formerly New Ways Governance Group).

## 3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to:

1. Note progress towards delivery to date;

2. Note the risks associated with implementation; availability, recruitment and retention of appropriately skilled staff;

3. Delegate responsibility for implementation for primary care plan to the Chief Officer; and

4. Note regular updates will be provided to the IJB at the meeting in November.

**Louise Long**
**Corporate Director, (Chief Officer)**
**Inverclyde HSCP**

## 4.0 BACKGROUND

4.1 The new General Medical Services (GMS) Contract 2018-2021 was implemented in Scotland on 1st April 2018. The contract aims to transform the role of the General Practitioner by improving being a GP, providing income security, reducing workload, reducing risk and improving patient outcomes and experience.

4.2 A Memorandum of Understanding (MOU) has been agreed between the Scottish Government, British Medical Association, Integration Authorities and NHS Boards. This MOU will cover an initial 3 year period 1 April 2018 to 31 March 2021 and sets out the key aspects relevant to facilitating the commissioning of Primary Care Services and service redesign to support the role of the GP as the expert medical generalist.

4.3 The MOU requires the development of a HSCP Primary Care Improvement Plan (PCIP) developed in partnership with GPs and collaborating with other key stakeholders including NHS Boards, supported by an appropriate and effective MDT. NHSGG&C has developed a framework and guidance for developing these plans.

4.4 Key Priority areas for the PCIP are:

1. The Vaccination Transformation Programme (VTP)
2. Pharmacotherapy Services
3. Community Treatment and Care Services
4. Urgent Care (Advanced Practitioners)
5. Additional Professional Roles (Physiotherapy & Mental Health Professionals)
6. Community Links Worker (CLW)

4.5 Inverclyde HSCP has been at the forefront of testing these priority areas through the New Ways programme and as such is at an advanced stage in planning and beginning to deliver the multi-disciplinary model of primary care. In January 2018 the Integration Joint Board agreed to utilise earmarked reserves from New Ways to continue the current pilots during the transition from New Ways to Primary Care Implementation (Pharmacy, MSK Physiotherapy, and Advanced Nurse Practitioners).

4.6 It is likely going forward that there will be a requirement for the HSCP to contribute either to centrally delivered services (delivery of vaccinations) or to reimburse for staff employed directly by a hosting HSCP or other central arrangement (Prescribing Support Unit). These elements are all currently being reviewed.

4.7 To date there is no confirmation from the Scottish Government on the funding available to implement the PCIP however it is expected that the funding for Inverclyde HSCP will be in the region of £830,000 in 18/19 rising incrementally until 2021.

4.8 The main implications for the HSCP in delivering the PCIP will be workforce related. The cohort of professionals who can work at an advanced practice level is still relatively small and the skills, experience and academic training required take considerable time to undertake and develop. Whilst we have been lucky in being able to train and recruit to the New Ways tests of change locally, this will become more difficult as the demand further outstrips supply - something which we are already experiencing. For this reason, we will now move to recruit on a permanent basis to the 1.4wte Advanced Nurse Practitioner Posts within East Cluster.

4.9 All HSCPs across Greater Glasgow are working on a consistent format for Primary

Care Implementation Plans to support implementation. Inverclyde is in a different position and has the Primary Care Implementation Plan focused on sustaining and building on the test of change within Inverclyde rather than starting the processes. Appendix 1 highlights the draft Primary Care Implementation Plan due for submission to the Board and Scottish Government in July 2018.

## 5.0 FINANCE

5.1 **Financial Implications**:
As noted above, NHSGG&C is still awaiting final confirmation of funding from the Scottish Government.

One off Costs

| Cost Centre | Budget Heading | Budget Years | Proposed Spend this Report £000 | Virement From | Other Comments |
|---|---|---|---|---|---|
| | | | | | |

Annually Recurring Costs/ (Savings)

| Cost Centre | Budget Heading | With Effect from | Annual Net Impact £000 | Virement From (If Applicable) | Other Comments |
|---|---|---|---|---|---|
| | | | | | |

## 6.0 IMPLICATIONS

6.1 **LEGAL**
There are no legal issues within this report.

6.2 **HUMAN RESOURCES**
As above, recruitment, retention, training and education will be significant factors over the next 3 years.

6.3 **EQUALITIES**
There are no equality issues within this report. Has an Equality Impact Assessment been carried out? No.

## 7.0 CLINICAL OR CARE GOVERNANCE IMPLICATIONS

There are no governance issues within this report.

## 8.0 NATIONAL WELLBEING OUTCOMES

How does this report support delivery of the National Wellbeing Outcomes:

| National Wellbeing Outcome | Implications |
|---|---|
| People are able to look after and improve their own health and wellbeing and live in good health for longer. | None |
| People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community | GPs will have added capacity to spend more time with those patients with the most complex needs in future. |
| People who use health and social care services have positive experiences of those services, and have their dignity respected. | None |
| Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. | None |
| Health and social care services contribute to reducing health inequalities. | The expanded MDT will include Community Links Workers and others directly involved in supporting those with a range of socio-economic issues including financial. This will positively impact the social determinants of ill health and inequalities. |
| People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing. | None |
| People using health and social care services are safe from harm. | The expanded range of professionals and other supporting services will ensure that patients are able to see the right person, in the right place, first time. |
| People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide. | The enhanced relationship with primary care and associated expected increased job satisfaction for GPs is expected to deliver a positive environment aiding recruitment and retention of primary care workforce. |
| Resources are used effectively in the provision of health and social care services. | None |

## 9.0 CONSULTATION

9.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation with:

- Local General Practitioners and their teams.

- Primary Care Implementation Group (previously New Ways Governance Group).
- Service Managers and Professional Leads.

## 10.0 BACKGROUND PAPERS

10.1

- The 2018 General Medical Services Contract in Scotland
- Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards
- Inverclyde HSCP Primary Care Improvement Plan
- Appendix 1 – Primary Care Implementation Plan

**INVERCLYDE HEALTH AND SOCIAL CARE PARTNERSHIP**
**PRIMARY CARE IMPROVEMENT PLAN 2018-2021**
**Version 2.2 2.5.18**

| A | **Local context** |
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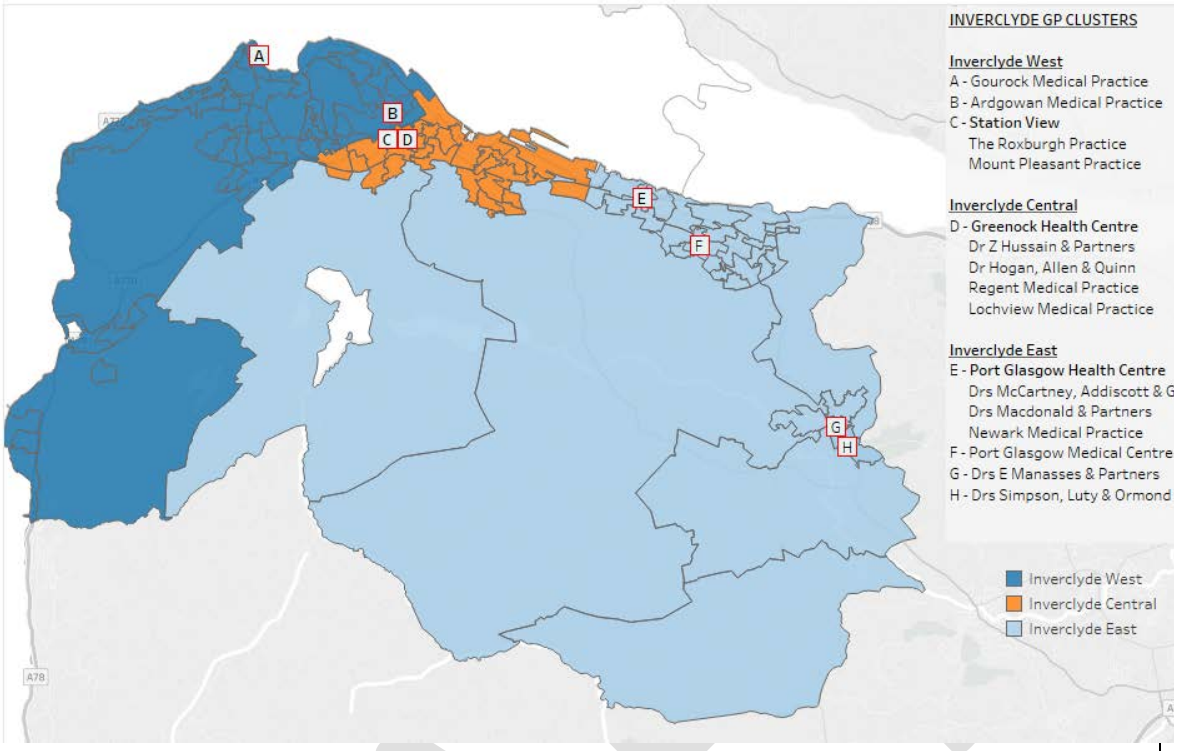
| | Inverclyde Health and Social Care Partnership has a long standing, well established relationship with the primary care contractors throughout the locality.<br><br>General Practice in Inverclyde is made up of fourteen Practices, (until recently, there were fifteen practices) covering Kilmacolm, Port Glasgow, Greenock, Gourock and their surrounding areas. The fourteen practices cover a population of 81,354 patients. Whilst the overall practice population has been falling since 2010 (down 4.5%) the number of patients on the lists who are over the age of 65 has steadily increased. In 2010 17% of the practice lists were aged 65 and above but by 2017 this had increased to 20%.The current average list size is 5800, the sizes of practices in Inverclyde range from 2,873 to 10,434 patients. The average list size for Scotland is 6000 patients.<br><br>There have been a number of changes to general practice in Inverclyde in the last few years. In 2016 there was a practice merger in Greenock resulting in the formation of the largest single practice in the area with a population of 10,434. At the end of 2017 there was a closure of a two partner practice following the inability to recruit a GP partner, resulting in the retirement of the remaining partner and subsequent termination of the practice contract. This practice was based within Port Glasgow Health Centre and the 1,800 patients were allocated a new General Practice, increasing the list size of the remaining Port Glasgow practices on average by 10%. Thus Inverclyde now has fourteen GP practices.<br><br>There are 68 General Practitioners in Inverclyde (headcount) with 6 of these being doctors in training. The overall number of GPs has not varied greatly over the last five years however in line with other areas across Scotland, there are particular challenges recruiting new GPs when vacancies arise.<br><br><u>Inverclyde GP Clusters</u><br>GP clusters were introduced in Scotland with the 2016/17 GMS agreement between the Scottish GP Committee and the Scottish Government. GP clusters bring together individual practices to collaborate on quality improvement projects for the benefit of patients. Each practice now has a Practice Quality Lead (PQL) and each cluster a Cluster Quality Lead (CQL). |




In Inverclyde there are 3 clusters that align with our planning localities: Inverclyde East, Inverclyde Central, and Inverclyde West. The East cluster is comprised of 6 practices with a total population of 23,608. Central cluster has 4 practices and a total population of 28,509. West cluster has 4 practices and a total population of 29,237. The clusters in Inverclyde were established early due to the *New Ways of Working* pilot and have been in operation for around 2 years with good evidence of successful working in the clusters. Clusters communicate regularly through meetings or online tools and also provide feedback on activity and projects to the HSCP at a scheduled quarterly meeting. Quality Improvement work in one cluster has included reviewing and improving identification of Sepsis and using cluster money to support the on-going development of this project. Innovative ways of communicating across a cluster have been supported using Trello, a web based project management app.

The health and socio-economic circumstances of Inverclyde are well documented in the HSCP Strategic Plan and Health Needs Assessment however there are some key factors impacting on the delivery of primary care locally.

**Deprivation**

7 of the 14 practices in Inverclyde have practice lists where more than half of the patients live in places that are in the 20% most deprived in Scotland. Patients in the most deprived areas often present to general practice with multiple complex health and social care needs and the impact of deprivation and inequalities on mental and physical health is well documented.

**Mental Health, alcohol and problem drug use**

Residents of Inverclyde report poor levels of emotional wellbeing and quality of life and referral rates to the Primary Care Mental Health Team (per 1,000 pop of over 18) are higher than elsewhere in NHSGG&C. There is a strong association between mental illness and alcohol misuse with the rate (per 10,000 pop) of discharges from hospital for an alcohol related condition being higher in Inverclyde than the rest of NHSGG&C and the rate of male discharges being three times higher than that of females. The majority of alcohol related deaths in NHSGG&C occur in the

most deprived groups with rates (per 100,000 pop) in Inverclyde higher than those of Scotland.

Rates of antidepressant drug prescribing are widely used as an indicator of the overall mental health of the population with a clear SIMD quintile gradient being evident in rates (per 10,000 pop) of prescribing. This gradient is also seen in the rate (per 10,000 pop) of discharges from psychiatric hospital which is higher in Inverclyde than the rest of NHSGG&C, again with males being higher than females. Rates (per 100,000 pop) of suicide in males are more than three times higher in Inverclyde than females with the overall rate being the highest in NHSGG&C.

Prevalence rates (per pop 15-64) of problem drug use are higher than the cumulative Scottish rate with males aged 15-24 and 25-34 having the highest prevalence. Drug related hospital stays and deaths are the third highest in Scotland (per 100,000 pop).

There is growing evidence around the impact of Adverse Childhood Events (ACEs) such as trauma or neglect on child development and the risk of mental illness or substance abuse. Given the stark deprivation, inequalities and drug and alcohol misuse in Inverclyde, children and young people are at significant risk of ACEs and the subsequent consequences.

**Disease prevalence**

Data based on the Quality Outcomes Framework (QOF) shows that the majority of practices in Inverclyde have higher prevalence rates for asthma, CHD, CKD, COPD, depression, diabetes, hypertension, and stroke than the NHS Greater Glasgow & Clyde and Scotland averages. This indicates that practices in Inverclyde treat more patients with multiple co-morbidities, problems, and needs than other areas.

**Older People**

All except one of Inverclyde's practices has a higher number of older people than the Scottish (17.8%) and NHSGG&C average ( 19.5%). In some areas such as Kilmacolm this is as high as 26.4%. Age increases co-morbidity and the number of potentially frail and housebound patients. Estimated rates of dementia are higher than the NHSGG&C average.

There are 16 residential and nursing homes in Inverclyde accounting for around 640available beds, some of which will be occupied by privately funded individuals and others supported by HSCP funding. Not all practices participated in the Care Home Local Enhanced Service (LES) and a number of practices have withdrawn over the past year. The approach to supporting care homes across Inverclyde will require review to consider the best practice approach.

**Primary Care Activity**

As part of the *New Ways* pilot, Inverclyde HSCP has carried out a quarterly week of care audit since mid- 2016, to get an impression of activity in practices. From the analysis of this data we estimate that 6,300 consultations take place in primary care in Inverclyde on a weekly basis.

- 50% of the weekly presentations are acute presentations
- 22% involve long-term conditions
- 6% mental health
- 22% other issues including administration, immunisations and injections, and advice and

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| | review appointments.<br><br>• Approximately 4% (about 250) of the total consultations are home visits (This increases in winter).<br><br>This data has enabled us to analyse and assess the impact of the pilot projects and shows that work has shifted from GPs to other professions. |
| **B** | **Aims and priorities** |
| | *HSCP Primary Care Improvement Plans will enable the development of the expert medical generalist role through a reduction in current GP and practice workload. By the end of the three year plans, every practice in GGC should be supported by expanded teams of board employed health professionals providing care and support to patients.*<br><br>Inverclyde Health and Social Care Partnership will create a three year Primary Care Improvement Plan that will enable the development of the role of the GP moving forward into the expert medical generalist. This will be approved by the GP Sub Committee of the Area Medical Committee (AMC) with implementation overseen by the Local Medical Committee (LMC). The new GP role will be achieved by embedding multi-disciplinary primary care staff to work alongside and support GPs and practice staff to reduce GP practice workload and improve patient care.<br><br>No practice will be disadvantaged with all practices having access to the new model which will be extended to both 17C and 17J Practices, allowing the general practitioner to fulfil their new role of leading a wide range of clinical professionals, working as an expert medical generalist and senior clinical decision maker within multi-disciplinary community teams.<br><br>Additional staff will be Board employed health professionals which will form part of a transformational service redesign over the next three years with the development of the multi-disciplinary team to support general practice. The HSCP will work with the Board and staff partnership in the co-ordination of recruitment of staff and potential re-design of existing roles. Staffing appointments will be consistent across NHSGG&C in terms of grading, and role descriptors.<br><br>The consultation will remain the foundation of general practice where the values of compassion, empathy and kindness combine with expert scientific medical knowledge to the benefit of patient care and mental and physical health. The key contribution of GPs in this role will be in:<br><br>• Undifferentiated presentations<br>• Complex care in the community<br>• Whole system quality improvement and clinical leadership<br><br>The 2018 Scottish GMS contract is intended to allow GPs to deliver the four Cs in a sustainable and consistent manner in the future.<br><br>• Contact – accessible care for individuals and communities<br>• Comprehensiveness – holistic care of people - physical and mental health<br>• Continuity – long term continuity of care enabling an effective therapeutic relationship<br>• Co-ordination – overseeing care from a range of service providers |

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| | **Priorities**<br><br>The Initial plan will be available by July 2018 with priority for year 1 focusing on locally tested approaches and evidence where there has been a positive impact on GP workload. This includes:<br><br>• Pharmacotherapy services<br>• Additional Professional Roles<br>• Urgent Care<br>• Community Links Worker (CLW)<br><br>Years 2 and 3 will be used to continue to define models and approaches in areas where this is not yet fully developed and include:<br><br>• The Vaccination Transformation Programme (VTP)<br>• Community Treatment and Care Services<br>• Additional Professional Roles Community (Clinical Mental Health Professionals)<br><br>There is a commitment to sustainability of services however the extent and pace of change to deliver the changes to ways of working over the three years (2018/21) will be determined largely by workforce availability, training, competency and capability and the availability of resources through the Primary Care Fund.<br><br>Delivery of the Primary Care Improvement Plan will be supported by the Primary Care Team/Innovation team. |
| **C** | **Engagement process** |
| | Inverclyde Health and Social Care Partnership's three year Primary Care Improvement Plan has been developed through learning from the *New Ways* pilot and robust existing engagement mechanisms. The individuals involved in the draft of this Implementation Plan include our Primary Care Innovation Lead, Primary Care Project Manager, Senior Information Analyst and Primary Care Support Coordinator with support from the Primary Care Implementation Group (formerly New Ways Governance group).<br><br>Specific and focussed engagement has, and will continue to be through:<br>• Clinical Director<br>• New Ways Core Group<br>• Primary Care Implementation Group (includes staff partnership rep)<br>• GP Forum<br>• PQL/CQL meetings<br>• Practice Nurse Forum<br>• Profession and care group specific management and leadership structures (nursing, AHP, Mental Health service etc) at both local and board level<br>• Local Community Pharmacy, Optometry and Dentistry forums<br>• NHSGG&C Primary Care Programme Board<br>• GP Sub Committee of the AMC<br><br>In partnership with *Your Voice Community Care Forum* and *The Alliance* we will also engage the public, staff and local partners on changes to Primary Care at a series of events focusing on the |

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| | new GP Contract, localities and NHSGG&C *Moving Forward Together* programme. It is anticipated that this will take place during spring and early summer. We will also develop a communication and implementation plan. |
| **D** | **Delivery of MOU commitments** |
| | There are 6 priority areas:<br><br>***(1) The Vaccination Transformation Programme (VTP)***<br>***(2) Pharmacotherapy Services***<br>***(3) Community Treatment and Care Services***<br>***(4) Urgent Care (advanced practitioners)***<br>***(5) Additional Professional Roles***<br>**(6) *Community Links Worker* (CLW)**<br><br>***(1) The Vaccination Transformation Programme (VTP)***<br><br>Scottish Government announced a three year (2017-2020) Vaccination Transformation Programme (VTP) in early 2017, with the aim of ensuring the health of the Scottish public through the modernisation of the delivery of vaccinations, empowering local decision making and supporting the transformation of the role of the General Practitioner. There is an existing GGC wide co-ordinated approach for the Vaccination Transformation Programme (VTP) with phased implementation of the programme to be fully complete by April 2021.<br><br><u>Scope</u><br>The scope of the VTP includes all NHS vaccination programmes:<br>• Routine childhood immunisation programme delivered by GP practices both with and without support from NHS Board/HSCP employed staff<br>• School immunisation programmes, both in primary and secondary schools delivered by HSCP employed staff<br>• Adult immunisation programmes, primarily delivered by practices without NHS Board support<br>• Travel immunisation and advice, primarily delivered by GP practices<br><br>Inverclyde HSCP has already moved to a 'corporate clinic' model of delivering childhood immunisations and school immunisation teams hosted by Glasgow are in place. The move towards delivery of adult immunisations will be developed by the VTP Board of which Inverclyde Clinical Director is a member and it is anticipated that the delivery of this will be in year 2 and 3 of the plan. During 2018 the VTP board will agree the future management arrangements for childhood immunisations and scope each vaccination programme for adults, pregnant women and travel advice & vaccination.<br><br>***(2) Pharmacotherapy Services***<br><br>Inverclyde HSCP has had the benefit of additional funding since 2016 allowing a significant increase in the local Prescribing Support Team to enable the development of a new model of working based within each General Practice. Feedback highlights the increased patient safety aspects of these additional practice based Pharmacists and quantitative data shows the |

significant reductions in GP time spent on prescribing related activity. The initial model delivered from 2016 – 2018 has been based on allocation of staff through practice bids for the use of Pharmacy Transformation Funding however moving in to 2018/19 we will review these allocations to ensure a population/ list size approach and to ensure that moving forward, we are able to deliver a more standardised service and assess a model which affords some cover for leave in practices without reducing the total whole time equivalent across the HSCP. There are also a number of local priorities which include ensuring adherence to prescribing indicators support to care homes, analgesic reviews and disease specific focussed work. We will continue to engage with GPs on the model and outcomes with the additional staffing establishment remaining employed and deployed to Inverclyde by the PPSU at this time.

We will explore opportunities to use the skills of the Pharmacists where evidence suggest these can be most beneficial, for example through delivering targeted pain and addictions management clinics focussing on long term high dose opioid use in primary care.

***(3) Community Treatment and Care Services***

The Community Nursing Service provides a Community Treatment Room service in Port Glasgow, Greenock and Gourock Health Centres. A review of the service was undertaken in the latter part of 2017 and the recommendations are now being implemented. These recommendations are aimed at ensuring the ability to meet future primary care service demand by making the best use of current resources including a separate phlebotomy service within the Treatment Room, better management of on the day- walk in appointments and standardising hours to GP practice opening where these do not already exist. Engagement with primary care around this is on-going and 18/19 will see the initial development of a stand- alone phlebotomy service. Further development is expected across the lifetime of the plan.

***(4) Urgent Care (advanced practitioners)***

Two models have been tested in Inverclyde since July 2017: Specialist Paramedics (2 practices West & Central cluster) and Advanced Nurse Practitioners (East cluster), responding to unscheduled care home visits at a rate of around 40%. GPs have told us that they would like support from an ANP in every practice to be prioritised and we will do this in year 1 and 2 according to the availability of appropriately trained nurses locally (2 local trainees will qualify in 2018), and the ability to recruit. Further testing of the pilot with Scottish Ambulance Service will take place in year 1 providing additional time for SAS and the HSCP/ Primary Care to reflect on any future model which may involve a multi-disciplinary team approach rather than a single profession specific approach.

ANPs will be employed by NHSGG&C on the agreed ANP Job Description, managed by Inverclyde HSCP Community Nursing Service and available to support all practices.

***(5) Additional Professional Roles***

**MSK**

Inverclyde New Ways of Working provided an opportunity to develop and test a model to use an Advanced Practice Physiotherapist (APP) within the GP practice as first point of contact for patients presenting with MSK conditions. The APP role has been shown to offer a safe, cost effective alternative to the GP and brings additional patient and organisational benefits including improved self- management, and a reduction in prescribing, imaging and orthopaedic referrals.

Delivery of the current model will continue in year 1 of the Primary Care Implementation Plan whilst discussions take place with the hosting HSCP (West Dunbartonshire) around the recruitment of future staff and how the model links to, and impacts on, mainstream MSK services and how these are delivered.

The ability to deliver on commitments for Urgent Care and Additional Professional Roles depends not only on the availability of trained staff but also the ability to offer long term/ permanent contracts in line with funding associated with the MOU commitments.

**Community Clinical Mental Health Professionals**
There has been recent development of the Primary Care Mental Health Team however no specific tests of change supported by the Primary Care Mental Health Fund in Inverclyde. The Head of Mental Health, Addictions and Homelessness is a member of the Primary Care Implementation Group and in year 1 we will work with primary care to identify any opportunities for development. This will be supported by the launch of the new NHSGG&C 5 year Adult Mental Health Strategy which has a clear focus on Primary Care and recovery. The involvement of the third sector will be crucial in supporting improved outcomes and developing a wider range of support.

**(6) *Community Links Worker* (CLW)**

During an early implementation, 6 wte Community Link Workers (CLWs) were recruited in late 2017, employed initially by CVS Inverclyde on behalf of the HSCP.

The Community Links Workers support people to live well through strengthening connections between community resources and primary care. Individuals are assisted to identify issues and personal outcomes then supported to overcome any barriers to addressing these, linking with local and national support services and activities. Community Links Workers support the GP practice team to become better equipped to match these local and national support services to the needs of individuals attending for health care. They will also build relationships and processes between the GP practice and community resources, statutory organisations, other health services and voluntary organisations.

This complements our existing Community Connector model in place since summer 2016. Feedback from GPs is positive and it is evident that the CLWs are working with some very complex cases. Early data shows that 33% of individuals seen reported finance/ benefits issues and 33% Social Isolation. During year 1 we will continue to analyse emerging data, establishing the model and strengthening the relationship with the Community Connectors in order to evidence any further roll out in subsequent years. There is good evidence to show the significant benefit of Welfare Rights workers based within primary care, embedded in practices. The idea of a mixed model approach will be explored.

Nationally, the CLW model has been delivered in areas of greatest deprivation however we will explore the possibility of extending the links worker approach to parts of Inverclyde with higher levels of older people who may be most at risk of social isolation.

**Management and Leadership**
Management of the extended MDTs will be through a combination of local arrangements (Senior Nurse, Lead Nurse- Treatment Rooms) and board/ hosted structures (existing hosted arrangements, PPSU) and third sector (CVS Inverclyde- CLWs) with local/ practice arrangements

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| | for direction of work as agreed. Professional advice, leadership and clinical supervision will be available as per NHSGG&C policies. |
| **E** | **Existing transformation activity** |
| | Primary Care Improvement and implementing the new GP Contract is just one element of developing health and care services in Inverclyde HSCP. These include improving access to services and in particular improving digital access and online self- assessment for services.<br><br>We recognise that in order to deliver on the outcomes of the new GP contract, a culture change in how primary care services are used is required. Building on the theme of *Working Better Together*, in 2016 we successfully engaged Pharmacists, Optometrists and Dentists alongside GPs and the wider practice teams to better understand roles and the range of support which could be offered as a first point of contact in primary care. This led to our established culture change campaign *Choose the Right Service* which has been widely publicised using a variety of printed and social media and is beginning to be evaluated. We have plans to continue this campaign across the lifetime of the plan utilising a number of avenues and will link this to our work around unscheduled care.<br><br>Crucial to this is investing time in training staff in General Practice on appropriate care navigation to provide them with the confidence and tools to signpost patients appropriately. We recognise this is an on-going process and despite being unsuccessful in the HIS practice administration collaborative, we will use every opportunity to learn from those who are participating in order to continue to support the development of the practice teams.<br><br>A further element of support to administration and business processes within practices is workflow optimisation. Support to improve workflow includes developing processes, training, troubleshooting and collating data. Based on evidence and experience elsewhere this has been successfully implemented in one local practice with support from the Primary Care Support Co-ordinator who has developed protocols and processes in partnership with the practice. These are now available for all practices to utilise. |
| **F** | **Additional Content** |
| | **Community Pharmacy, Optometry and Dentistry**<br><br>We have long established links with all our primary care contractors and hold profession specific educational and information forums throughout the year. As noted in Section E, we have engaged with these professional groups throughout the life of our New Ways pilot particularly around culture change and have recently circulated a survey to understand the impact of Choose the Right Service on their practices. This will inform any future engagement.<br><br>All 16 Inverclyde Community Pharmacies have piloted the extended Minor Ailments Scheme on behalf of Scottish Government and we await the evaluation report.<br><br>**Interface with Acute Services**<br>We have a planning manager from Clyde acute on our Primary Care Implementation group who will advise on how best to engage as required, particularly where any change could or may be perceived as having an impact on acute services. Regular updates are also provided to our Strategic Planning Group and Integrated Joint Board. We have worked with our colleagues to raise awareness on specific projects, for example where ANPs are using existing referral pathways for acute assessment. |

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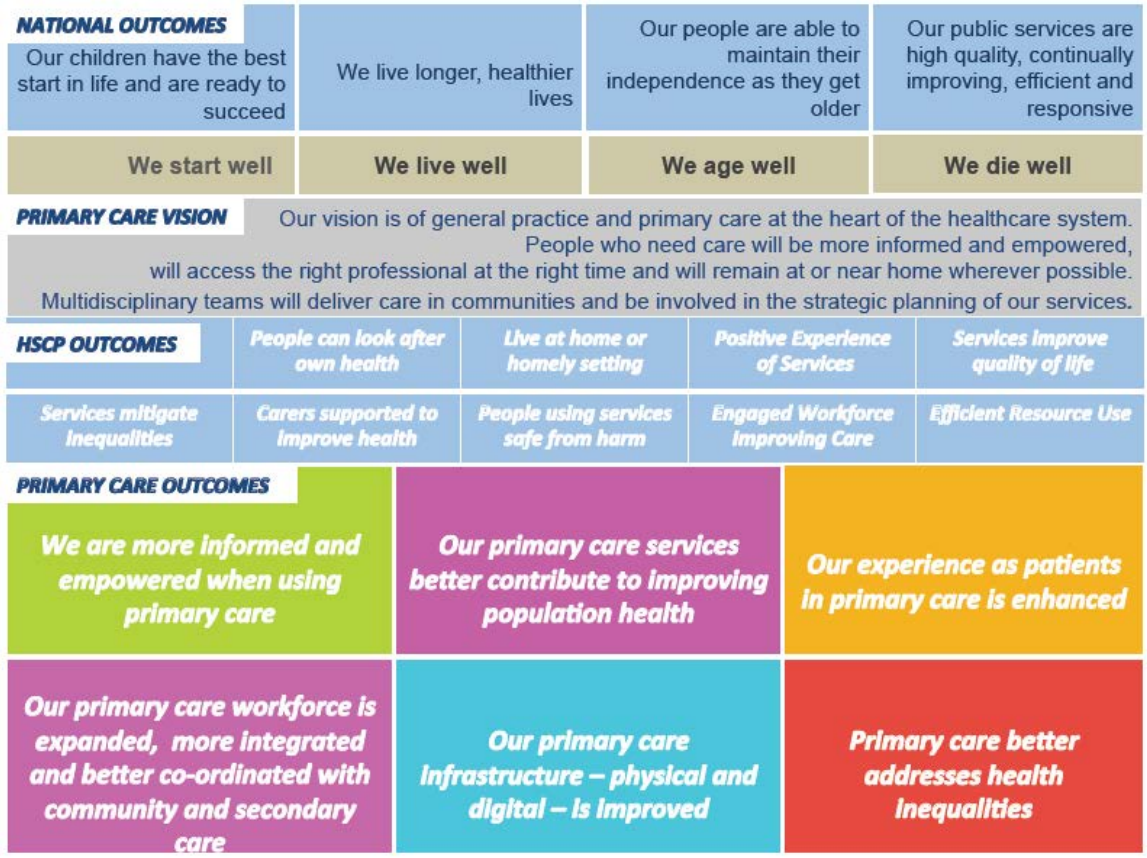
| | When benchmarked against similar partnerships, Inverclyde HSCP has higher levels of Emergency Department attendance and has the highest rate per 1,000 population (371.4) of all partnerships in NHSGG&C with 40.6% of these being Flow 1- minor injury and illness. More interrogation is required to determine the reasons for this however as the majority of these attendances do not result in an admission it is likely that alternative care pathways (health, social or third sector) could be more appropriate for a proportion of these.<br><br>**Community Services**<br>Many of our services already work in a practice aligned or a locality aligned way. As services develop we will engage with partners to determine the best way to deploy staff for example within a single practice or across a cluster as appropriate. The development of a team approach will be fundamental. In addition to ANPs working to support unscheduled care, the Community Learning Disability Nurse Team Lead is undertaking this additional training and will use this extended role to support primary care, in particular access to primary care for residents in Quarriers village.<br><br>**Mental Health**<br>The draft NHSGG&C 5 year Adult Mental Health Strategy and Inverclyde's approach to Recovery has an impact across all service areas and is recognised as one of the key commissioning strategies within the HSCP strategic plan. The concept of Recovery includes connectedness, hope & optimism, identity, empowerment & meaning, none of which can be achieved through the support of statutory services alone. Community Link Workers will have a large part to play in this as will the HSCP in enabling the commissioning of services which deliver outcomes for individuals requiring this support. |
| **G** | **Inequalities** |
| | As highlighted in Section A, Inverclyde has high levels of deprivation and associated physical and mental ill health. There are areas of high primary and secondary care service use and some areas have high populations of more affluent and older people. Evidence suggests that poor socio-economic circumstances affect opportunities for good health and access to services. The reduction of GP workload will allow those individuals with the most complex conditions and co-morbidities to have longer consultations when it is necessary to see a GP. There is the potential to deliver a range of services differently including mental health and addictions services within primary care which allow improved access. The relationships built across the wider multi-disciplinary team including health, social care, children & families services, housing, third sector and others will be the lever with which to address the health inequalities of local populations.<br><br>Cluster working is one aspect of this, improving local population health through an emphasis on better intelligence supported by LIST Analysts. Agreed quality improvement projects will focus on improving outcomes for individuals and subsequently communities.<br><br>The National Primary Care Outcomes are described below in the context of wider national outcomes. Population health, inequalities and care close to home are explicit across all of these. |




Services will be developed with a focus on equality, ensuring fair and equitable access across Inverclyde and where appropriate an EQIA will be undertaken.

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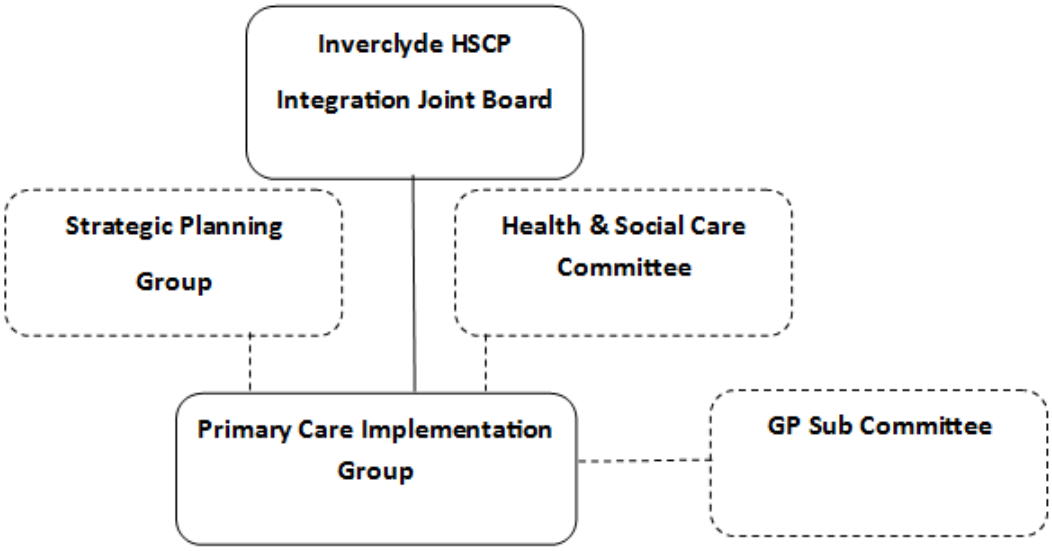
| **H** | **Enablers** |
| | Work has been underway for some time to develop Inverclyde's People Plan which embraces all local partners involved in supporting health and care, including third and independent sector. Workforce to support the transformation of Primary care will be a crucial element of this moving forward. Learning from *New Ways* has identified the type and number of staff required to deliver the tested services. This has been used to design our future commitments and also shared across NHSGG&C and wider. For each staff group, discussions with appropriate service managers and professional leads will continue in order to plan at a local team level. This includes the Practice Nurse Support & Development Team.<br><br>Appropriate accommodation is crucial to delivering primary care and to establishing good team working. Space within existing premises is at a premium and we have already experienced the challenges of placing new staff into practices. IT and remote access in particular can be a challenge. Planning for the new Greenock Health Centre is underway and takes into account a potential increase in HSCP employed staff working predominantly within practices but who will also require agile working space and the ability to access recording systems remotely as well as meet with line managers.<br><br>Inverclyde's Participation in the NHSGG&C Primary Care Programme Board will allow discussion of particular themes around IT which can be addressed by the IT sub group. |
| **I** | **Implementation** |
| | **Inverclyde Governance Arrangement** |

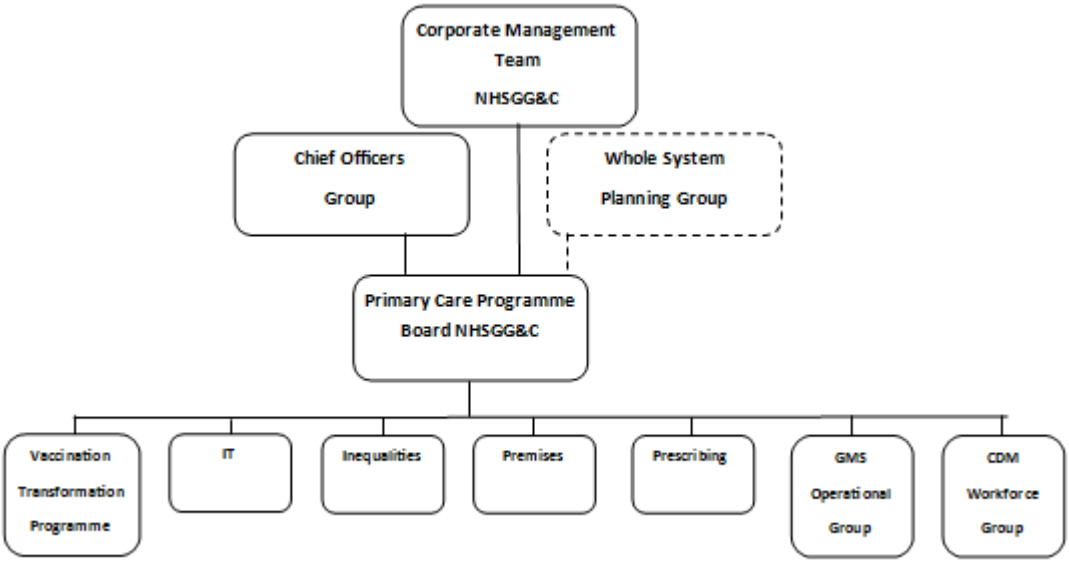
Development and Implementation of the Primary care Improvement Plan will be overseen by the Primary care Implementation Group (formerly New Ways Governance group) reporting directly to the Integration Joint board.




**NHS Greater Glasgow & Clyde Structure**

Inverclyde HSCP is represented on the NHSGG&C Primary Care Programme Board which aims to

- Ensure delivery of contractual changes in line with new contract agreement
- Enable sharing of good practice and consistent approaches to PCIPs where appropriate




The programme board has a number of sub groups and interfaces with a wide-range of associated groups and forums.

**Inverclyde Approach**

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| | The Innovation & Primary Care Team will lead the primary care teams through the management of change, re-design and develop a workforce that will position quality improvement at the forefront in delivering improvements in the safety, effectiveness and quality of care and treatment.<br>**Moving forward, this team will:**<br>• Support the development of a clearer role of the General Practitioner and the progression of the GP role as expert medical generalist ensuring a refocus of activity is applied within practices, as workload shifts.<br>• Support the delivery of improved patient care by achieving the principles of contact, comprehensiveness, continuity and co-ordination of care.<br>• Support the re-design of services and embedding of multi-disciplinary primary care teams to create a more manageable GP workload and release GP capacity to deliver longer consultations for those patients with more complex needs.<br>• Identify and disseminate the contribution of 'non-traditional' multi-disciplinary team members such as third sector (Community Links Workers and others) and support these to become embedded within the practice team.<br>• Engage with NHS GG&C Board in the financial aspects of the contract to support the introduction of the new funding model and investment.<br>• Engage with NHS GG&C Board to improve the infrastructure and reduce risk for General Practice.<br>• Encourage peer led discussions and value driven approach to quality improvement to create better health in our communities and improve access for our patients.<br>• Ensure that all local Practices will benefit from additional support and no exclusions are made.<br><br>**The Primary Care Team/Innovation Team will work with the Continuous Professional Development Group (CPD) continuing to:**<br>• Engage with our established Clusters through discussions with our Cluster Quality Leads (CQL) and Practice Quality Leads (PQL); utilising established forums to provide a platform for further embedding the cluster model across Inverclyde. (GP forum, Practice Managers Forum, Practice Nurse Forum, CQL/PQL meeting, CPD group and other contractor forums).<br>• Support Practice Managers in expanding their role into leading and co-ordinating the developing multi-disciplinary team.<br>• Work with Practice Nursing colleagues in the development and enhancement of their roles within General Practice.<br>• Support the reception workforce in the new care navigation role to help with the re-direction of patients and the changing role of front line staff in Practice.<br>• Continue to develop and enhance a primary care multi-disciplinary workforce in delivery of the new contract.<br>• Continue to educate and inform our population of alternative services/professionals to attending a GP through our culture change work and Choose the Right Service campaign.<br>• Commit to working collaboratively with neighbouring Health and Social Care Partnerships and with our advisory structures and representative bodies in sharing learning, experiences and gain feedback. |
| **J** | **Funding profile** |
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It was agreed by Inverclyde Integration Joint Board on 30th January 2018 that residual PCTF/ *New Ways* funding will be used during 2018/19 to maintain the current establishment of Prescribing Support Pharmacists, Advanced Practice Physiotherapists and to extend the contract of the 1.0wte Advanced Nurse Practitioner. Any additional funding during year 1 would be used initially to support the roll out of these as priorities identified through GP engagement alongside the enhanced community treatment and care services including phlebotomy. Other areas will be prioritised in Year 2 and 3.

At the time of writing, it is anticipated that Inverclyde will receive £830,000 in 18/19 however there has as yet, been no formal notice of this from Scottish Government and it is not clear when funding will be received or if this will be phased.

**Commitment in 18/19**

| Service | Suggested development 18/19 | Estimated cost 18/19 |
|---|---|---|
| Advanced Nurse Practitioners | Begin to roll out- Recruit 1.5wte initially in Spring 2018 | £90,000 |
| Advanced Practice Physiotherapists | Continue current model 2.3wte | £140,000 |
| Pharmacotherapy Services | Continue current model and develop sustainability 4wte | £200,000 |
| Community Links Workers | Continue 6 wte in post employed by CVS | £277,000 |
| Treatment Room Phlebotomy | Additional 2wte staff to deliver service | 32,670 |
| Co-ordination of implementation & delivery of MOU commitments | Review primary care support available in HSCP | TBC |
| Potential costs associated with accommodation/IT/set up costs | Review accommodation available | TBC |
| Total | | 739,670 |

Whilst we will endeavour to fulfil this aspiration, the ability to do so will depend largely on the ability to recruit and retain appropriately qualified staff or to support the training and mentorship of staff to reach the required level of practice.

There may be other sources of funding which become available across the lifetime of this plan such as that associated with strategy implementation or transformation funds.

**K** **Evaluation and outcomes**

Key success indicators over the life of the plan will be agreed with primary care. Measurement of that success will rely in part on the supply of the necessary information. Inverclyde, in conjunction with the List Analyst has developed systems to collect data around local tests of change and the week of care audit. We continue to collect this data whilst refining and strengthening the data definitions and format. A key challenge will be to ensure that the all data can be collected electronically which is not currently possible and limits what can be collected and can affect quality.

**A. Workload shift for GPs**
**Workload shift for other practice staff**
Continual measurement over the life of the plan using week of care data and SPIRE in comparison with activity data from other professionals (ANP, Pharmacy etc.)
Additional evidence which shows the freeing of GP time

**B. Primary care is an attractive area of work for all healthcare professionals**
Wellbeing scores/survey responses throughout the period of the plan. Track if there are any changes across the 3 year implementation
Recruitment & retention of GPs
No of GP sessions available in Inverclyde

**C. Effective integration of additional healthcare professionals within the practice team.**
***How will we know they are working effectively? This may include:***
Activity Data.
MDT meetings and minutes.
Multi-disciplinary quality improvement projects – common goals.
Progress and achievements of working documented.
Examples and case studies of positive collaboration/relationships and how they benefit patients.
Utilise similar qualitative questionnaires to current Clinical Effectiveness evaluation of *New Ways.*
Complaint reviews/ incident recording.

**D. Patients have access to the right professional at the right time**
Self- reporting/ questionnaire.
Waiting times for appointments/ assessment/ review.
Impact of re-direction/ culture change eg. Choose the Right Service, potential decrease of A&E attendance for minor illness/ injury
Week of care audit

**E. The vaccination transformation plan will result in the majority of vaccinations being removed from practice workload**
Evidence of shift that will rely on activity data.
Track progress in years 1,2 and 3.
Monitor uptake rates to ensure no deterioration.

**F. Community links workers are successfully embedded in practices, providing an alternative point of contact for patients with financial, social, or personal issues and helping them to engage with organisations that can help them**
Evaluation based on the principles established by the Scottish Government as part of the link worker programme using quantitative (collected by EMIS template) and in particular qualitative data such as case studies and self- reporting.

**G. MSK Physiotherapy**
Continue to monitor activity, workload shift and progress of current tests of change.
Percentage of MSK cases seen by APP rather than GP.

**H. Urgent care**
**Maximising home visits undertaken by ANPs.**

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| | Continue to monitor activity, workload shift and progress of additional members of staff when they roll-out.<br><br>**I. Pharmacy**<br>GP time released- Activity data, workload shift<br><br>**J. Improving Health and Inequalities**<br>Population and practice data- disease prevalence, use of secondary care, key health outcome indicators. |
| | |