AGENDA ITEM NO: 8

Report To:	**Inverclyde Integration Joint Board**	**Date: 6 November 2018**
Report By:	**Louise Long Corporate Director, (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No: IJB/53/2018/AS**
Contact Officer:	**Allen Stevenson Head of Service: Health and Community Care, Inverclyde Health and Social Care Partnership (HSCP)**	**Contact No: 01475 715283**
Subject:	**UPDATE ON IMPLEMENTATION OF PRIMARY CARE IMPROVEMENT PLAN AND NEW GENERAL MEDICAL SERVICES (GMS) CONTRACT 2018**	

1.0 PURPOSE

1.1 The purpose of this report is to update the Integration Joint Board on the implementation of the new GMS Contract and the associated Primary Care Improvement Plan.

1.2 The report outlines the development and implementation of the plan and the associated finances.

2.0 SUMMARY

2.1 The new GMS Contract is one of the biggest ever changes to the way primary care services are delivered in Scotland and includes changes to GP reimbursement, responsibility for premises and the development of a wider multi-disciplinary team to support the GP as the Expert Medical Generalist.

2.2 The responsibility for developing the multi-disciplinary team lies with the HSCP through the delivery of an agreed Memorandum of Understanding (MOU) supported by a Primary Care Improvement Plan (PCIP) and associated budget. The IJB had early sight of the PCIP in May, prior to sign off by the GP Sub-Committee.

2.3 There are challenges around the finances released by the Scottish Government to enable Inverclyde HSCP to sustain the legacy of New Ways. The Primary Care Division plan to release funding for delivery of the MOU incrementally from 2018/19 – 2021/22. Essentially, as Inverclyde HSCP has already developed the multi-disciplinary team ahead of the rest of Scotland, we are in year 3 of implementation but are receiving year 1 funding.

2.4 Such is the demand in primary care that many local GP practices are relying on the multi-disciplinary team we already have in place to sustain an adequate level of service. Finances permitting, the vision is to maintain current multi-disciplinary team levels with a view to increasing these in later years.

3.0 RECOMMENDATIONS

3.1 That the Integration Joint Board notes the progress made in implementing the Primary

Care Improvement Plan as part of the new GMS Contract

3.2 That the Integration Joint Board authorises the Chief Officer to finalise discussion with Scottish Government to secure additional one off funding to implement our PCIP as planned, as described at 5.1 of this report.

Louise Long
Corporate Director, (Chief Officer)
Inverclyde HSCP

4. 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. A Primary Care Improvement Fund (PCIF) has been made available to IJBs to support this and will be released incrementally from 2018/19 to 2021/22.

4.3 The MOU requires the development of a HSCP Primary Care Improvement Plan (PCIP) developed in partnership with GPs and other key stakeholders. This process is co-ordinated within NHSGG&C by a Primary Care Programme Board chaired by the Chief Officer responsible for Primary Care and consists of representatives from each HSCP and each involved service area. Inverclyde HSCP has developed a PCIP which was agreed by the GP Sub-Committee in August. The Integration Joint Board saw a draft of this plan in May and the final agreed plan is appended with this report.

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).

4.4.1 **Progress on Priority Areas**

<u>The Vaccination Transformation Programme (VTP)</u>

The VTP aims to transfer responsibility for routine vaccination across a number of clinical indications including seasonal vaccination programmes and routine childhood vaccinations. This programme is managed by a project board within NHSGG&C who are currently scoping requirements and making recommendations for future delivery outside of general practice.

Inverclyde HSCP is already delivering routine childhood vaccinations via a clinic based model with all GP practices having shifted childhood vaccinations. Uptake rates of childhood vaccines are now higher than in the previous model. This model will be managed centrally within NHSGG&C and requires some additional funding for nursing posts. There is also a requirement to contribute to the NHSGG&C Project Manager post overseeing the whole VTP.

Costs for the VTP will rise incrementally as vaccination programmes shift, there is currently an estimate of between £4-5 million to deliver the whole of this programme across NHSGG&C and these costs are taken into account in our projections.

4.4.2 <u>Pharmacotherapy Services</u>

Inverclyde HSCP has had additional prescribing support pharmacists based within practices, over and above those traditionally available, since April 2016. There is good evidence to show both the shift in GP workload and the increase in patient safety.

In January 2018, engagement with GPs evidenced their desire to maintain the current

level of prescribing support and at January IJB it was agreed to utilise New Ways reserves to maintain this. Continuing this level of pharmacy input currently represents the biggest area of spend within the Primary Care Improvement Fund.

4.4.3 Community Treatment & Care Services

There is an expectation that the scope and availability of Community Treatment & Care Services will expand. Inverclyde HSCP completed a review of Community Treatment Room services during 2017 and the recommendations from this are currently being implemented, including additional capacity for phlebotomy and extending coverage to those practices which do not routinely utilise treatment room services. A pilot treatment room model has been tested within Kilmacolm and we are currently considering the evidence from this in order to deliver a permanent, sustainable service going forward.

4.4.4 Urgent Care (Advanced Practitioners)

Inverclyde currently has two models of responding to unscheduled primary care by way of Specialist Paramedics (still in pilot format funded by SAS) and Advanced Nurse Practitioners (ANP) undertaking home visits on behalf of GPs. Whilst not completely comparable, both have evidenced significant impact on GP workload. It is our intention to continue to roll out the ANP model to cover all practices by the end of 2021 where workforce allows.

SAS continue to pilot different models across Scotland and are currently promoting a rotational model for Specialist paramedics who would work across primary care, triage in SAS control rooms and home visits for SAS where a 999 crew is not required. There is little appetite across NHSGG&C for this model and it is unlikely that Inverclyde HSCP will commission SAS to deliver within primary care when the current pilot ends in June 2019. We will however continue to consider the opportunities available for primary care through SAS over the medium and longer term as funding increases.

4.4.5 Additional Professional Roles (Physiotherapy & Mental Health Professionals)

There are currently seven practices in Inverclyde benefitting from the addition of Advanced Physiotherapists offering a more appropriate alternative to people with musculoskeletal conditions. Our plan will be to offer these to all practices as funding allows.

The aspirations of the new contract align closely with Action 15 of the Mental Health Strategy and as such a working group is considering how best to develop this area. It is recognised that 2018/19 is a scoping and planning phase considering how best to support distress and recovery in particular. No funding is allocated during this year.

4.4.6 Community Links Worker

The Community Links Workers (CLWs) are employed by CVS Inverclyde and funded through the PCIF. Evidence to date shows the complexity of the individuals they are supporting and includes issues related to housing, mental health, benefits, debt, domestic violence. The Minister for Mental Health recently visited to meet with two CLWs and a service user and was very impressed with the support available and how this clearly links with the Mental Health Strategy. It is not intended to increase the number of staff but to roll out the current staff to cover all practices and to move towards a commissioning process for this service.

4.5 Other key elements of the new contract include reducing the risk of owning GP premises through sustainability loans and transitioning privately leased premises to NHS Board leasing arrangements. The Primary Care team in Inverclyde HSCP is working with individual practices and the NHS board to support interested practices.

4.6 Evidence from GPs suggests that our supportive approach and the building of the

multi-disciplinary team in Inverclyde, allowing extra capacity, is making a real difference both to workload, patient safety and governance. There are currently some significant risks which are unique to Inverclyde due to the advanced stage of implementation. Many of our additional staff have been on secondments or temporary posts within the area and as recruitment opportunities open up across other HSCPs we are seeing experienced staff moving to other areas. GP practices are also choosing to employ a wider range of staff, often on a higher salary, and again we are experiencing a movement of staff to be directly employed by practices. Recruitment and retention will remain one of the most significant challenges.

5.0 FINANCE

5.1 **Financial Implications**:
Due to the success of the New Ways project Inverclyde is ahead of other HSCPs in relation to some PCIP deliverables. This means that for some areas of key investment, such as Pharmacology, Inverclyde is already providing a service which is in excess of the initial start up funding. Rather than pull back on our current services the IJB was able to fund this gap in year 1 from carried forward New Ways monies held within IJB Reserves.

By year 3 the PCIP funding will catch up with where Inverclyde is now but that means for Year 2 and part of Year 3 Inverclyde is underfunded for the currently planned service.

There are options available to us:

Option 1- Pull back, reduce current service levels to bring them in line with available funding or charge for the additional services provided. If we reduce the service, this would mean we would lose the momentum of the current programme and services currently in place and delivering.

If GPs wish to keep the current service levels they would have to contribute to funding for this directly and through supporting the work on delivering Prescribing savings through regular reviews with Pharmacy services.

Option 2 - Seek additional one off funding from the Scottish Government through PCIP overall project slippage for 2019/20 and 2020/21 to realign our funding to our current service. This is our preferred option.

We have made some initial contact with Scottish Government officers to confirm whether this might be an option and have had positive feedback so far. Approval is sought to pursue this formally with the Scottish Government.

<u>Spend against current Primary Care Improvement Fund allocation</u>

Financial Year	Total Budget	Total Planned Expenditure	Funds still to be allocated/ (Funding Gap)
2018-19	755	1,031	(276)
2019-20	907	1,266	(359)
2020-21	1,815	1,904	(89)
2021-22	2,557	2,116	441
Total Expenditure	**6,034**	**6,318**	

Breakdown by MOU item

Vaccination Transformation Programme	Pharmacotherapy	Community Treatment and Care Services	Urgent care (advanced practitioners)	Additional Professional roles	Community link workers	Other
38	463	15	70	192	242	11
112	491	35	85	199	277	69
175	519	36	430	397	277	70
332	545	36	443	412	277	71
657	**2,018**	**121**	**1,028**	**1,200**	**1,073**	**220**

We are required to report directly to the Primary Care Division on spend and the trajectory of staff wte. This was done in October 2018.

6.0 IMPLICATIONS

LEGAL

6.1 There are no legal issues within this report.

HUMAN RESOURCES

6.2 Recruitment, retention, training and education will be significant factors over the next 3 years. Wherever appropriate and agreed at the NHSGG&C Primary Care Programme Board, recruitment will be done centrally for the board area. This has been the case for Pharmacy and Physiotherapy.

EQUALITIES

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

7.0 CLINICAL OR CARE GOVERNANCE IMPLICATIONS

7.1 The HSCP will take responsibility for clinical and care governance around any services delivered via any Memorandum of Understanding.

8.0 NATIONAL WELLBEING OUTCOMES

How does this report support delivery of the National Wellbeing Outcomes

There are no National Wellbeing Outcomes implications within this report.

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	None
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.	None
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.	None
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.	None
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:

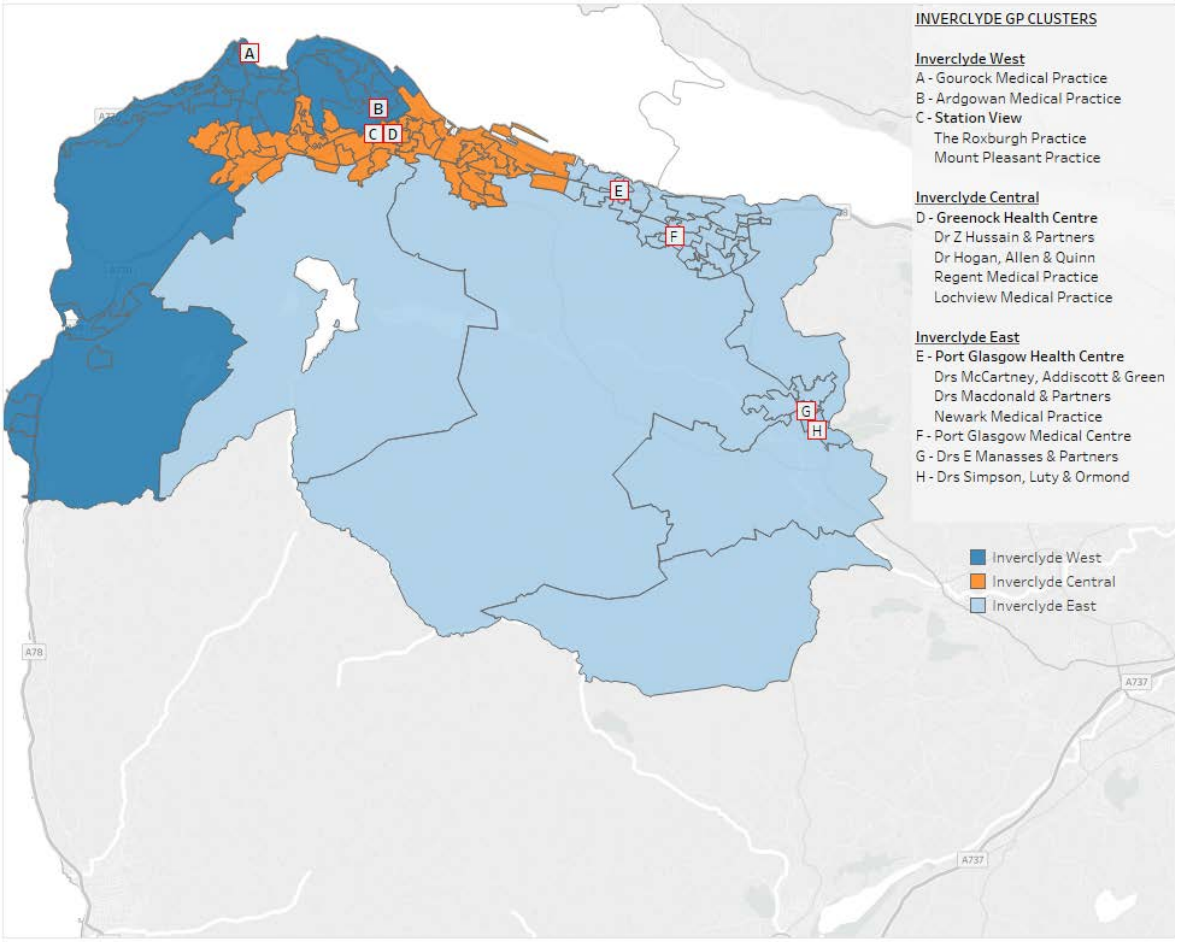
- Local General Practitioners and their teams.
- Primary Care Implementation Group (previously New Ways Governance Group).
- Service Managers and Professional Leads.

10.0 LIST OF BACKGROUND PAPERS

10.1 Inverclyde HSCP Primary Care Improvement Plan.

INVERCLYDE HEALTH AND SOCIAL CARE PARTNERSHIP
PRIMARY CARE IMPROVEMENT PLAN 2018-2022
Version 3.1 21.08.18

A	**Local context**
	Inverclyde Health and Social Care Partnership has a long standing, well established relationship with the primary care contractors throughout the locality. General Practice in Inverclyde is made up of fourteen Practices covering Kilmacolm, Port Glasgow, Greenock, Gourock and their surrounding areas. There have been a number of changes to general practice in Inverclyde in the last few years including a merger and a practice closure. The merger in 2016 resulted in the formation of the largest single practice in the area. 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. 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. <u>Inverclyde GP Clusters</u> 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 review appointments. • Approximately 4% (about 250) of the total consultations are home visits (This increases in winter). 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. Inverclyde Health and Social Care Partnership will create a Primary Care Improvement Plan (PCIP) that will enable the development of the role of the GP moving forward into the expert medical generalist. The agreement that PCIPs should reflect the 4th year of funding as set out in the allocation letter, while noting the specific contractual commitments which must be met by April 2021 is noted. The plan 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. 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. Additional staff will be either NHSGG&C Board, Inverclyde Council or Third Sector employed professionals who will form part of a transformational service redesign over the next three years further developing the multi-disciplinary team to support general practice. The HSCP will work with the employing partners 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. 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: • Undifferentiated presentations

	• Complex care in the community • Whole system quality improvement and clinical leadership The 2018 Scottish GMS contract is intended to allow GPs to deliver the four Cs in a sustainable and consistent manner in the future. • Contact – accessible care for individuals and communities • Comprehensiveness – holistic care of people - physical and mental health • Continuity – long term continuity of care enabling an effective therapeutic relationship • Co-ordination – overseeing care from a range of service providers **Priorities** 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. Years 2 and 3 will be used to continue to define models and approaches in areas where this is not yet fully developed. This includes: • Pharmacotherapy services • Additional Professional Roles • Urgent Care • Community Links Worker (CLW) • The Vaccination Transformation Programme (VTP) • Community Treatment and Care Services • Additional Professional Roles Community (with a focus on Clinical Mental Health Professionals) 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. 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). Specific and focussed engagement has, and will continue to be through: • Clinical Director • New Ways Core Group • Primary Care Implementation Group (includes staff partnership rep) • GP Sub Committee of the AMC

	• GP Forum • PQL/CQL meetings • Practice Nurse Forum • Profession and care group specific management and leadership structures (nursing, AHP, Mental Health service etc) at both local and board level • Local Community Pharmacy, Optometry and Dentistry forums • NHSGG&C Primary Care Programme Board 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 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: ***(1) The Vaccination Transformation Programme (VTP)*** ***(2) Pharmacotherapy Services*** ***(3) Community Treatment and Care Services*** ***(4) Urgent Care (advanced practitioners)*** ***(5) Additional Professional Roles*** **(6) *Community Links Worker* (CLW)** ***(1) The Vaccination Transformation Programme (VTP)*** 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. <u>Scope</u> The scope of the VTP includes all NHS vaccination programmes: • Routine childhood immunisation programme_delivered by GP practices both with and without support from NHS Board/HSCP employed staff • School immunisation programmes, both in primary and secondary schools delivered by HSCP employed staff • Adult immunisation programmes, primarily delivered by practices without NHS Board support • Travel immunisation and advice, primarily delivered by GP practices 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.

(2) Pharmacotherapy Services

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. 8wte Prescribing Support Pharmacists (PSPs) band 7 and 2wte Prescribing Support Technicians (PSTs) band 5 were added to the existing Team of 4wte PSPs band 8a and 2wte PSTs to test new models of care. 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 taking in to account individual practice needs. As resources allow and with GP agreement, the model will provide 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 in support of primary care.

Due to staff turnover and maternity leave, as at June 2018 the local Prescribing Team resource includes 3.36wte PSP band 8a, 6.52wte PSP band 7, and 4wte PST. The model to allocate pharmacy staff to practices on a fair shares basis was agreed via GP Forum, and is currently made up of 0.2wte PSP per 5000 list size for traditional prescribing support work and HSCP priorities, and 0.4wte PSP per 5000 list size for new pharmacotherapy activities such as medicines reconciliation and acute requests, plus 0.2wte PST per 5000 list size. Continuing on from the pilot arrangements, the two elements of the service are combined to allow flexibility in practice and to better allow clinical supervision and support, with the balance of practice priorities for both elements of the service agreed and defined at individual GP practice level. We will continue to engage with GPs via GP Forum on the model and outcomes as additional resource becomes available, 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 specialist clinics.

At the time of writing we await confirmation of changes to the funding stream surrounding Pharmacy First. The expectation is for this funding to be removed from the overall PCIF monies and due to this, Pharmacy First is acknowledged in this plan with the ring-fenced money identified. Any spend on Pharmacy First will be discussed at GP Forum and agreed with GP sub-committee.

(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. GPs were represented on the

review group. 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 incudes regular updates and discussion at GP forum and practice manager's meetings. 2018/19 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%. There is strong GP support for 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 we have identified potential trainees), 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.

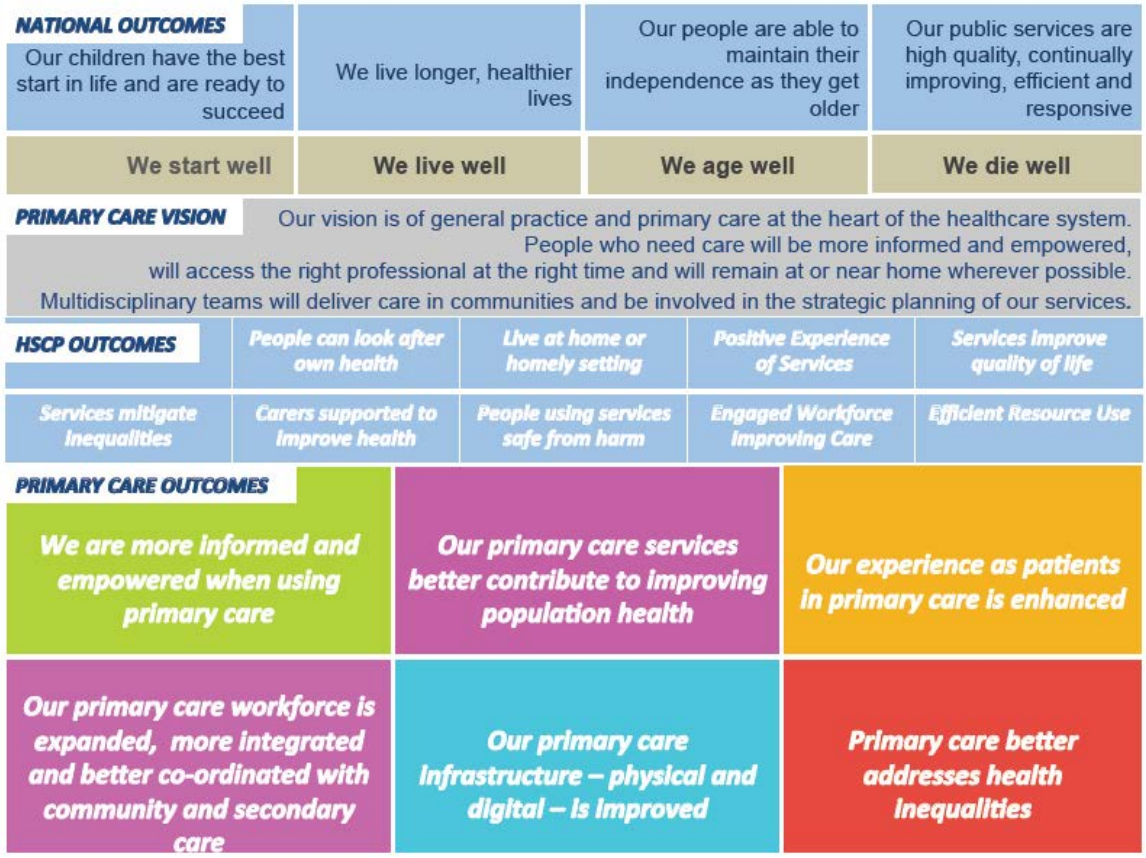
Community Clinical Mental Health Professionals

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 Action 15 of the National Mental Health Strategy 2017-2027 and the launch of the new NHSGG&C 5 year Adult Mental Health Strategy which have a clear focus on Primary Care, distress and recovery. Recurring funding is available in support of

	the objective to introduce an additional 800 mental health workers nationally and local planning will integrate with developments in primary care. The involvement of the third sector will be crucial in supporting improved outcomes and developing a wider range of support and it is expected that there will be a broad range of roles including peer and support workers. **(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 for direction of work as agreed. Professional advice, leadership and clinical supervision will be available as per NHSGG&C policies. GPs will provide clinical leadership to the extended MDT as per the role outlined in the new contract.
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. 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

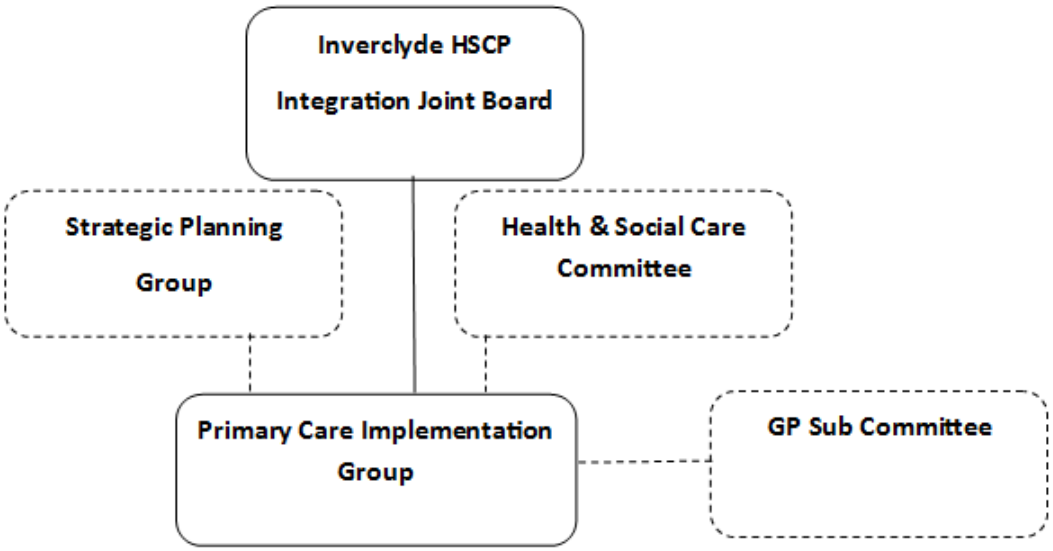
	be offered as a first point of contact in primary care. This led to our established culture change campaign *Choose the Right Service* which has been widely publicised using a variety of printed and social media and is beginning to be evaluated. We have plans to continue this campaign across the lifetime of the plan utilising a number of avenues and will link this to our work around unscheduled care. 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. 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 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. All 16 Inverclyde Community Pharmacies have piloted the extended Minor Ailments Scheme on behalf of Scottish Government and we await the evaluation report. **Interface with Acute Services** 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. 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. **Community Services** 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

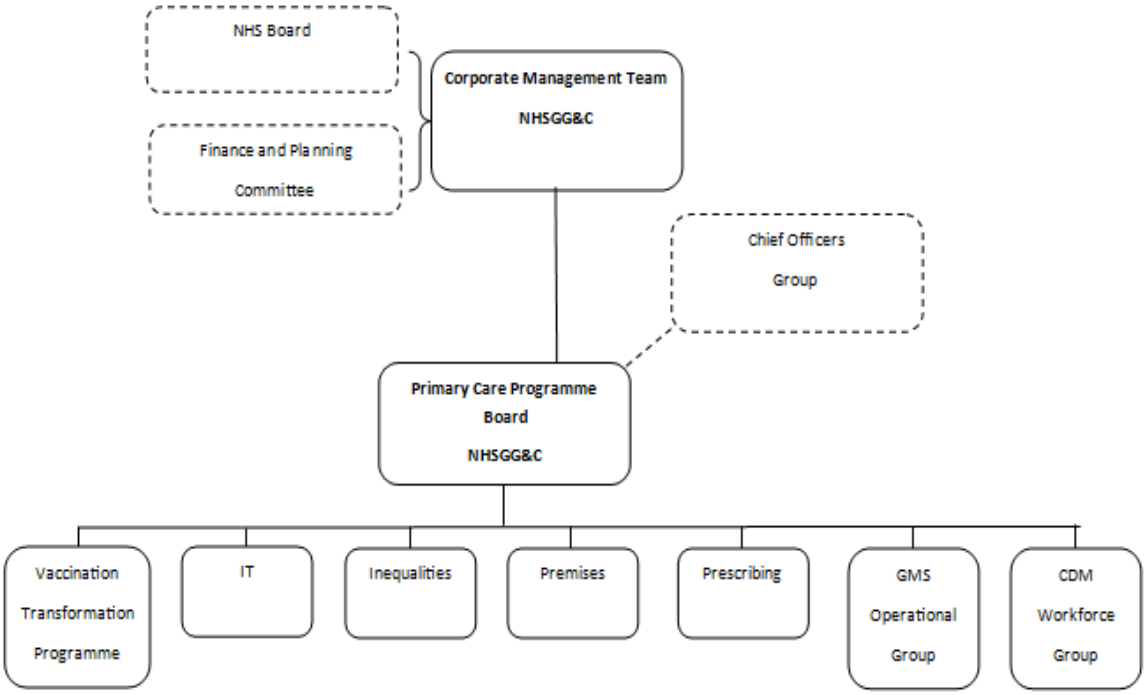
	will be fundamental. In addition to ANPs working to support unscheduled care, the Community Learning Disability Nurse Team Lead is undertaking this additional training and will use this extended role to support primary care, in particular access to primary care for residents in Quarriers village. **Mental Health** 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 potential reduction of GP workload may allow practices to configure their services that will best meet the needs of those individuals with the most complex conditions and co-morbidities. 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. 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. 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.

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. 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. During year one we will work with practices to identify practical support and one-off spend which frees up space or better utilises existing space to accommodate new roles and team members. 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. 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

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.

Moving forward, this team will:

- Support progression of the GP role as expert medical generalist ensuring a refocus of activity is applied within practices, as workload shifts.
- Ensure allocation of new staff and resources are agreed at GP forum.
- Continue to work with LMC colleagues to ensure the plan achieves the desired outcomes for General practitioners.
- Support the delivery of improved patient care by achieving the principles of contact, comprehensiveness, continuity and co-ordination of care.
- 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 improve care for those patients with more complex needs.
- 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.
- Engage with NHS GG&C Board in the financial aspects of the contract to support the introduction of the new funding model and investment.
- Engage with NHS GG&C Board to improve the infrastructure and reduce risk for General Practice.
- Encourage peer led discussions and value driven approach to quality improvement to

create better health in our communities and improve access for our patients.

- Ensure that all local Practices will benefit from additional support and no exclusions are made.

The Primary Care Team/Innovation Team will work with the Continuous Professional Development Group (CPD) continuing to:

- 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).
- Support Practice Managers in developing the interface between their practice and the extended multi-disciplinary team.
- Work with Practice Nursing colleagues in the development and enhancement of their roles within General Practice.
- 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.
- Continue to develop and enhance a primary care multi-disciplinary workforce in delivery of the new contract.
- 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.
- 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**

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 support the implementation of the PCIP. Any additional funding during year 1 would be used initially to support the roll out of 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.

Inverclyde will receive funding of £754,813 in 2018/19 on an NRAC basis with £126,908 of this being baseline funding for Pharmacy in practices and going directly to NHSGG&C board. The remainder will be released to Integration Authorities as 70% in June 2018 and 30% in November 2018 dependant on each area showing their ability to spend the total funding in year.

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

		2018/19 £000
	Vaccinations Transfer Programme	38
	Pharmacotherapy	463
	Community Treatment and Care Services	15
	Urgent care (advanced practitioners)	70
	Additional Professional roles	192
	Community link workers	242
	Other	11
	TOTAL PLANNED SPEND	1,031
	FUNDING	
	Scottish Government - PCIP	755
	Brought Forward New Ways	277
	(Over)/Under Spend	0

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 and we recognise that we will not require this level of data moving forward. Wherever possible data collection will be electronic and we will agree the approach to any data collection with GPs, this will include a review of the current week of care audit in order to ascertain any information which would still be useful for GPs to collect. Any resources that may be required to evidence workload reduction will be kept to a minimum.

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 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.
Continue to monitor activity, workload shift and progress of additional members of staff when they roll-out.

I. Pharmacy
GP time released- Activity data, workload shift

J. Improving Health and Inequalities
Population and practice data- disease prevalence, use of secondary care, key health outcome indicators.