AGENDA ITEM NO: 9

Report To:	**Inverclyde Integration Joint Board**	**Date: 14 May 2019**
Report By:	**Louise Long Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No: IJB/36/2019/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**	

1.0 PURPOSE

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

1.2 The report outlines the implementation of the plan, the associated finances and includes the implementation tracker to be submitted to Scottish Government.

2.0 SUMMARY

2.1 The IJB has previously been advised of the responsibility for developing the multi-disciplinary team through the delivery of an agreed Memorandum of Understanding (MOU) supported by a Primary Care Improvement Plan (PCIP) and associated budget.

2.2 There have been challenges around the finances released by the Scottish Government to enable Inverclyde HSCP to sustain the legacy of New Ways and an update on the re-phasing of the Inverclyde Primary Care Improvement Fund was provided to the IJB by the CFO at the January meeting.

2.3 Despite this re-phasing of funding, there is still a challenge for the HSCP to develop an MDT which can manage the demand required within primary care and meet the commitments contained in the MOU.

2.4 Reporting arrangements to the Scottish Government Primary Care Division have now been agreed and include the completion of a twice yearly self-assessment template - the implementation tracker.

3.0 RECOMMENDATIONS

3.1 That the Integration Joint Board notes the progress made in implementing the Primary Care Improvement Plan during 2018/19 and agrees further plans for development in 2019/20.

3.2 That the Integration Joint Board notes the reporting arrangements to the Scottish Government Primary Care Directorate.

3.3 That there be a further update report to Integration Joint Board in November following reporting to the Scottish Government Primary Care Directorate.

Louise Long
Chief Officer

4.0 BACKGROUND

4.1 The development and implementation of a Primary Care Improvement Plan resulting from the Memorandum of Understanding (MOU) was agreed by the GP Sub-Committee and the Integration Joint Board in 2018. This MOU will cover an initial 3 year period from 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. The Primary Care Improvement Fund (PCIF) will be released incrementally from 2018/19 to 2021/22.

4.2 An implementation plan to support delivery of the Primary Care Improvement Plan was developed in 2018 and agreed with the GP Sub-Committee. An updated plan has been developed which is subject to approval by the GP Sub-Committee, and is appended to this report for review. The local governance process is via the Primary Care Implementation Group chaired by the Clinical Director.

4.3 There is also an NHSGG&C Primary Care Programme Board chaired by the Chief Officer responsible for Primary Care which consists of representatives from each HSCP and each involved service area. This group aims to make connections with a wide range of stakeholders and enablers and to ensure that Primary Care Improvement is embedded in the Moving Forward Together Programme.

4.3.1 **Progress on Priority Areas**

The Vaccination Transformation Programme (VTP)

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. Regular updates are received at the Primary Care Programme Board including updated financial resources required from each HSCP which relate to staff, equipment (fridges), administration and IT costs. Inverclyde is also required to contribute towards planning and coordination costs of the VTP.

Routine Childhood Programme

This is already fully operational in clinics delivered within Inverclyde Health Centres and there has been an increase in vaccination rates since this model began. Additional recruitment to fully deliver the structures required for managing this service on an NHSGG&C basis is underway.

Adult Programmes, Travel Vaccinations and Pre-School Flu

There are proposed service models for testing each of these areas later in 2019 with an expected full service delivery of October 2020.

There are significant cross system challenges to delivering all of the above which include availability of staff at key times (such as during flu season), clinic accommodation and IT infrastructure.

4.3.2 Pharmacotherapy Services

As previously reported, there is good evidence to show both the shift in GP workload and the increase in patient safety that our local model has enabled and a paper was published in the British Journal of General Practice.

There are 3 levels of service outlined in the MOU and all practices benefit from some level of support at each of these levels however full delivery of all 3 levels is not yet in place. We are moving into a challenging period of recruitment and retention with a number of Pharmacists moving to posts elsewhere in the board alongside three maternity leaves within the team, requiring us to continually forward plan.

The extended Minor Ailments Scheme, *Pharmacy First,* has continued to be well used by the population of Inverclyde and is promoted as part of our *Choose the Right Service Campaign*. Registrations to the service have increased from below the NHSGG&C average in 2013 to 50% higher than average in 2019. There are also around 30% more prescriptions dispensed monthly in Inverclyde under the MAS than NHSGG&C average with 3501 being dispensed in January 2019.

4.3.3 Community Treatment & Care Services (CTCS)

We continue to progress our plans to deliver additionally phlebotomy and to expand wherever possible availability of CTCS services to enable the shift in workload from general practice. Pace and capacity is determined by availability of the Primary Care Improvement Fund and will continue to be a limiting factor in our availability to fully develop this service in line with the MOU commitments.

4.3.4 Urgent Care (Advanced Practitioners)

It remains our intention to continue to roll out the ANP model to cover all practices by the end of 2021 where workforce allows. The 1.5wte ANP workforce in East Cluster is now employed on a permanent basis.

The pilot with the Scottish Ambulance Service has been in place since July 2017 however due to vacancies there have been no specialist paramedics in Gourock practice since November 2018. Whilst we had expected this pilot to come to an end shortly we have been advised by SAS that it will be extended for a further year and replacement specialist paramedics are being recruited to again cover the 2 practices. This is completely funded by SAS with no contribution from the Inverclyde Primary Care Improvement Fund and as with other HSCPs within NHSGG&C there is at present no agreement to roll out or fund this service within the lifetime of the plan.

4.3.5 Additional Professional Roles (Physiotherapy & Mental Health Professionals)

Recruitment and retention has been a particular issue for delivery of the Advanced Physiotherapy service due to post holders leaving to work elsewhere in Glasgow and the most experienced post holder taking up the overall development lead post across NHSGG&C. There is an agreement that the current model in place can only support practices with over 3,000 patients and due to this Dorema practice in Kilmacolm no longer have an APP service. A model which can support such practices is being developed on an NHSGG&C wide basis. There will be no further increase in APP service across more practices until 2020/21.

Our approach to supporting primary care mental health and in particular distress and recovery is supported by Action 15 of the National Mental Health Strategy 2017-2027 and the NHSGG&C 5 year Adult Mental Health Strategy. Local planning is integrating with developments in primary care overseen by both the Primary Care Implementation Group and the newly formed Inverclyde Mental Health Programme Board which is actively seeking a GP representative. Our first primary care workshop will be held in June 2019 with an open invite to all GPs in Inverclyde to participate in planning an approach which builds on current multi-disciplinary primary care mental health support. Community Links Workers are also supporting individuals with a range of mental health needs.

4.3.6 Community Links Worker (CLW)

The CLW role was tested within 6 practices throughout 2018 and despite some initial reservations around clinical practice, supervision, competency frameworks and accessing GP records, an evaluation has shown how beneficial GPs find having the CLW within their MDT.

From the beginning of 2019, CLWs have spread across a further 5 practices and now

cover all 11 Inverclyde practices ranked in the top 200 most deprived within Scotland. For those patients with less complex social needs, the existing Community Connector model remains in place and a new role of Social Prescribing Coordinator (part of a lottery funded pilot) is available to support the 3 practices currently without a CLW. We will continue to analyse data and explore the most appropriate model for these remaining practices. The CLWs are currently employed by CVS Inverclyde within the third sector and there will be a commissioning exercise held during 2019/20.

4.3.7 Additional Support

The HSCP Primary Care Team is continuing to offer a range of support to practices including:

- Workflow optimisation processes - embedding a member of staff into the practice for a number of weeks to improve roles and responsibilities for checking and recording such things as letters and results
- Scoping use and availability of space in order that practices can make the required shifts in roles and responsibilities within their own teams – including prioritising backscanning notes to free up space for the MDT
- Supporting practices to uptake innovations in self management and self monitoring through technology in order for patients to take control of their own conditions and with the added effect of reducing the need for appointments
- Continuing to develop *Choose the Right Service* to include children and young people specific information and education for the New Scots refugee community
- A range of short term actions which enable sustainability during times of crisis

4.3.8 An agreed Local Implementation Tracker is now required to be submitted to Scottish Government Primary Care Directorate in April and November each year and these will also form the basis for reporting to the NHSGG&C Board by the Chief Officer responsible for primary care.

It is suggested that the Integration Joint Board receives this report twice yearly as an update on performance and the first tracker is appended to this report.

5.0 IMPLICATIONS

FINANCE

5.1 An update on the allocated Primary Care Improvement Fund (PCIF) was presented to the Integration Joint Board in January 2019 by the Chief Financial Officer. Despite this agreement to rephase the Inverclyde PCIF challenges on delivering the scale of reform required will continue to remain across the lifetime of the plan. We have also been informed that whilst the uplift of 6% in employers costs will be funded for posts in place on 1 April 2019, this is not the case for all additional posts created subsequently. This places further challenges on the finances available to meet the commitments of the MOU.

Original and Revised Primary Care Improvement Fund Profile 2018-2022

	Original PCIF Investment Profile £'000	Revised PCIF Investment Profile £'000	Actual/ Projected Spend
2018-19	755	755	1,005,257
2019-20	907	1,266	1,514,314
2020-21	1,815	1,904	1,982,922
2021-22	2,557	2,109	2,037,722
Total	6,034	6,034	6,540,214

We await final indications of funding in 2019/20 to cover the 6% increase in employer's costs which is contained in the above figures.

LEGAL

5.2 There are no legal issues raised in this report.

HUMAN RESOURCES

5.3 There are no specific human resources implications arising from this report.

EQUALITIES

5.4 Has an Equality Impact Assessment been carried out?

	YES
X	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

5.4.2 How does this report address our Equality Outcomes?

Equalities Outcome	**Implications**
People, including individuals from the above protected characteristic groups, can access HSCP services.	Through better availability and signposting of the range of primary care support/ professionals, availability of appointments with the right profession at the right time should improve.
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None

Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	Specific education and sessions around the range of primary care services is underway.

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

5.5 There are no clinical or care governance implications arising from this report.

5.6 **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	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

6.0 DIRECTIONS

6.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	X
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

7.0 CONSULTATION

7.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care

Partnership (HSCP) after due consultation with

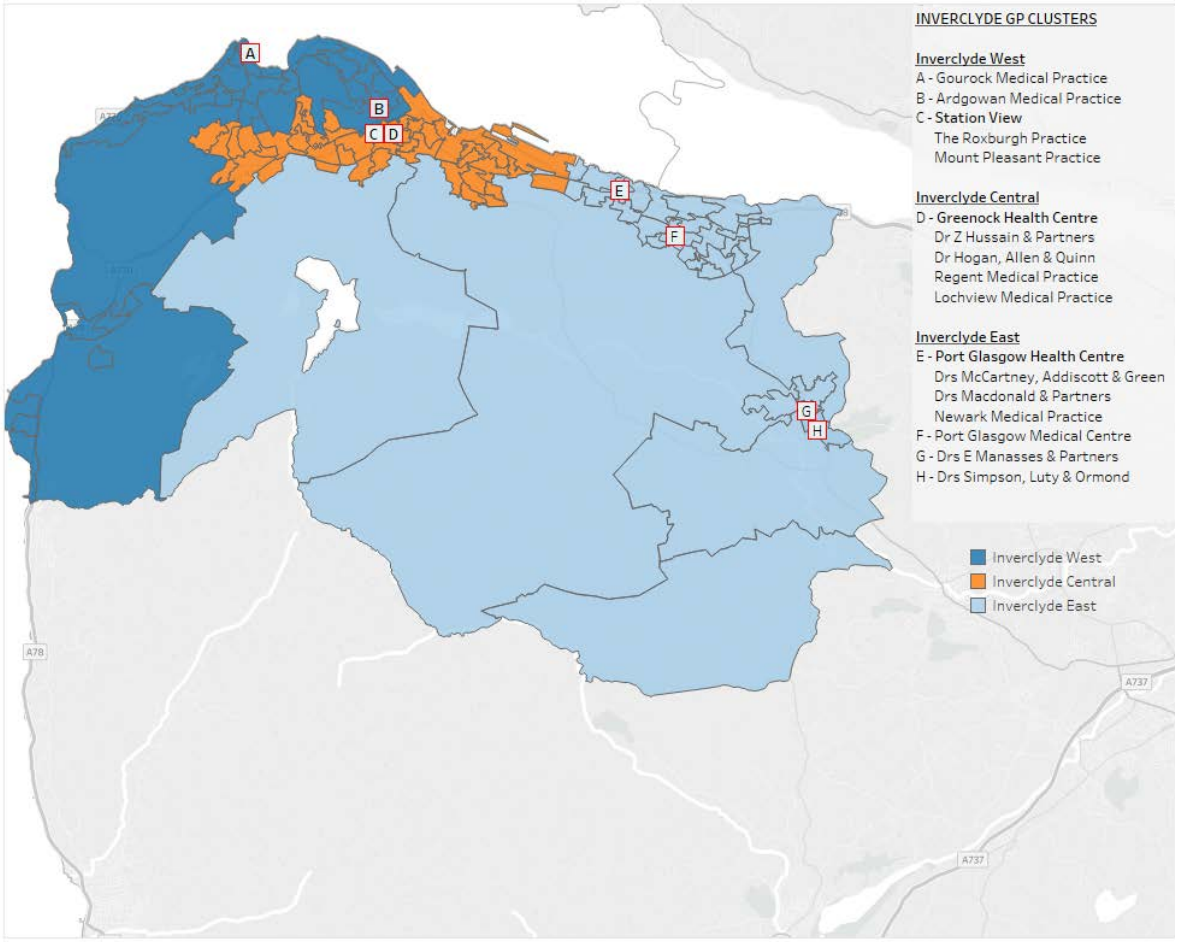
- Local General Practitioners and their teams
- Primary Care Implementation Group

8.0 BACKGROUND PAPERS

8.1 Updated Primary Care Improvement Plan – Draft April 2019
Primary Care Implementation Plan April 2019
Completed Local Implementation Tracker April 2019

INVERCLYDE HEALTH AND SOCIAL CARE PARTNERSHIP
PRIMARY CARE IMPROVEMENT PLAN 2018-2022
UPDATED 15.4.19
DRAFT Version 4

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 63 General Practitioners in Inverclyde (headcount) with 7 of these being doctors in training. This is a slight reduction from last year and in line with other areas across Scotland, there are particular challenges recruiting new GPs when vacancies arise. More detailed information on whole time equivalents and sessions will be available following completion of the national primary care workforce survey. <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: 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 whilst there is evidence of progress, support is still required to maintain and drive improvement. Support has been in the form of QI ideas, training opportunities, cluster development, data support and sharing good practice.

- **East** cluster developing their QI with secondary care and their Practice Nurses now working on QI projects
- **Central** using educational sessions to direct their QI activity
- **West** progressing a mixed approach to QI with long and short term QI projects

Deprivation

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.

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

	Analysis of data from previous *Week of Care Audits* estimated that 6,300 consultations take place in primary care in Inverclyde on a weekly basis and this currently remains the most accurate source of local data. • 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).
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 created a Primary Care Improvement Plan (PCIP) which was approved by the GP Sub Committee of the Area Medical Committee (AMC) in August 2018. 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. This document provides an updated PCIP as at April 2019 which will again be agreed by the GP Sub Committee and overseen by the Local Medical Committee (LMC). 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 focussed on locally tested approaches and evidence which showed a positive impact on GP workload. Priorities for years 2 and 3 were to continue to roll out the tested approaches across all practices and to continue to define models in areas where these were not yet fully developed. An Inverclyde Mental Health Programme Board has been convened which is overseeing the range of improvements in mental health and working closely with the Primary Care Implementation Group, a Primary Care Workshop will take place in June 2019. 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) is currently determined by the availability of resources allocated to Inverclyde through the Primary Care Fund. Delivery of the Primary Care Improvement Plan will continue to 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 was developed through learning from the *New Ways* pilot and robust existing engagement mechanisms. 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 • Public, staff and local partnership events
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)

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. Regular updates are received at the Primary Care Programme Board including updated financial resources required from each HSCP which relate to staff, equipment (fridges), administration and IT costs. Inverclyde is also required to contribute £15,606 in 19/20 towards planning and coordination costs of the VTP.

Routine Childhood Programme
This is fully operational in clinics delivered within Inverclyde Health Centres and there has been an increase in vaccination rates since this model began. Additional recruitment to fully deliver the structures required for managing this service on an NHSGG&C basis is underway.

Pregnant Women Immunisation Service Transformation
It is proposed this be delivered by Maternity Care Assistants hosted within Maternity Services. Piloting will begin in October 2019 with full service to be in place by October 2020.

Pre-School Flu Immunisation Service Transformation
It is proposed this be a children & families hosted service utilising routine childhood vaccination clinic venues and running across 10 weeks during October, November & December. There is an expectation that this will be delivered in part using bank staff which poses a risk to delivery. Piloting will begin in a limited number of clinics across NHSGG&C in October 2019 with full service to be in place by October 2020.

Adult Immunisation Service Transformation
The proposal is for a partially centralised and geographically dispersed service model with HSCP hosted immunisation clinics and the formation of HSCP adult/ older people immunisation teams. There will also be a partnership with Community Pharmacy which may aid opportunistic immunisation. There are significant risks to delivery of this service including availability and capacity of accommodation, availability of staffing including bank staff during the flu season and admin/ IT issues related to call & recall in particular for those under 65.
A pilot is proposed starting in October 2019 with the locations within NHSGG&C yet to be identified:

- Pilot October 2019- Subset clinic venue to include Adult under 65 flu 'at risk' 65 and over mobile and housebound
- October 2020- Full service launch including Pneumococcal, travel vaccines, shingles and additionally Vitamin B12

(2) Pharmacotherapy Services

Inverclyde continues to benefit from 8wte Prescribing Support Pharmacists (PSPs) band 7 and 2wte Prescribing Support Technicians (PSTs) band 5 working as a blended team with the existing Prescribing Support Pharmacists: 4wte PSPs band 8a and 2wte PSTs. This is higher than the allocated wte per population elsewhere in NHSGG&C and this has been maintained due to the increased patient safety aspects of these additional practice based Pharmacists and the significant reductions in GP time spent on prescribing related activity.

The model to allocate pharmacy staff to practices on a fair share basis was agreed via GP Forum in 2018/19, 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. There will be challenges to delivering this model during 2019/20 due to a number of staff taking maternity leave and we will continue to work with individual practices in ensuring they continue to receive support which will include developing the role of technicians.

- Level 1 – all practices have some input to acute requests, medicines reconciliation, care homes, prescribing indicators, special requests, PST home visits/reviews. We do not currently have capacity to take on all level 1 work within every practice. No practices have input to repeat prescribing.
- Level 2 – there is some input to PSP ad hoc medication review, DMARDs, queries and shortages in all practices but again there is currently not enough capacity to deal with all level 2 work within every practice. DMARD monitoring takes place in 13 out of 14 practices (one practice has chosen to continue with their previous arrangement).
- Level 3 – all 14 practices have falls reviews and heart failure review clinics undertaken by PSPs. There are also clinics for polypharmacy in 3 practices, respiratory in 6 practices, pain in 2 practices, care home med review in 2 practices. We do not currently have capacity to take on all level 3 work within every practice.

The extended Minor Ailments Scheme, *Pharmacy First,* has continued to be well used by the population of Inverclyde and is promoted as part of our *Choose the Right Service Campaign*. registrations to the service have increased from below the NHSGG&C average in 2013 to 50% higher than average in 2019. There are also around 30% more prescriptions dispensed monthly in Inverclyde under the MAS than NHSGG&C average with 3501 being dispensed in Jan 2019.

(3) Community Treatment and Care Services

Inverclyde is fortunate in that a Community Treatment Room Service has existed and been well used by most of our local practices for many years. Patients can choose to attend any of the 3 treatment room sites which best suit them. Development of the service has been dictated by availability of funding in 18/19 however many of the recommendations outlined in the 2017 review have been implemented including better management of on the day walk- in appointments and standardising hours to GP practice opening times in Port Glasgow Health Centre. Additional capacity for phlebotomy is available however we recognise that this is limited (1.34wte across 3 sites) and will not at present meet the challenge of transferring phlebotomy from general practices.

A limited treatment room service of 3 sessions per week has been set up within New Surgery KIlmacolm for the use of both practices who are located next door to each other. Capacity from

with the existing Community Nursing Service is being used to deliver this and the HSCP has funded a small renovation and equipment required. This implementation is being monitored as to the acceptability for both practices and patients.

Improved data recording and a recent move to EMIS web recording now allows us to interrogate activity within the treatment rooms and all practices and CQLs will now receive a quarterly report. Improved IT links with EMIS PC would enhance recording and reporting between practices and the treatment rooms particularly the recording of medicines administration.

Inverclyde is represented on the NHSGG&C Community Treatment and Care Services Development Group which is a working group of the Primary Care Programme Board and is aimed at ensuring clinical, governance and delivery standards pan NHSGG&C. Regular updates take place at GP forum and practice manager's meetings.

(4) Urgent Care (advanced practitioners)

Advanced Nurse Practitioners continue to respond to unscheduled care home visits in East Cluster with a slight increase to 1.5wte permanent posts. Further roll out across Inverclyde will not be possible until 2020/21 within the current financial framework however It is anticipated that by the end of 2021 there will be 7.5wte ANPs across Inverclyde funded and working directly within primary care MDTs. Within the wider adult community services, a number of nursing roles are being reviewed with the potential of developing to ANP level, this includes the Gerontology Nurse role which already supports primary care to access fast track geriatric assessment at home and within the day hospital.

The pilot with Scottish Ambulance Service has been in place since July 2017 however due to vacancies there has been no specialist paramedics in Gourock practice since November 2018. Whilst we had expected this pilot to come to an end shortly we have been advised by SAS that it will be extended for a further year and replacement specialist paramedics are being recruited to again cover the 2 practices. This is completely funded by SAS with no contribution from the Inverclyde Primary Care Improvement Fund and as with other HSCPs within NHSGG&C there is at present no agreement to roll out or fund this service within the lifetime of this plan.

(5) Additional Professional Roles

MSK

The Advanced Physiotherapy Practitioner (APP) role has continued 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. There have been a number of vacancies and recruitment challenges over the past few months resulting in practices experiencing a reduction in sessions for a short period of time. These have now been increased with the exception of one practice who have a small list size and it has been agreed that across NHSGG&C the current model is only sustainable in practices with over 3,000 patients. The MSK sub group which our Clinical Director is a member of will be agreeing a model which can be tried within these practices. There will be no increase in APP staffing in 2019/20 however we expect to increase by a further 2wte during the lifetime of the PCIP in order to cover all practices.

As per agreement at NHSGG&C Primary Care Programme Board APPs now spend 10% of their

clinical time within the mainstream MSK service to maintain clinical skills, this is funded by the mainstream MSK service.

Community Clinical Mental Health Professionals

Our approach to supporting primary care mental health and in particular distress and recovery is supported by Action 15 of the National Mental Health Strategy 2017-2027 and the NHSGG&C 5 year Adult Mental Health Strategy. Recurring funding is available in support of the objective to introduce an additional 800 mental health workers nationally and local planning is integrating with developments in primary care overseen by both the Primary Care Implementation Group and the newly formed Inverclyde Mental Health Programme Board which is actively seeking a GP representative. Our first primary care workshop will be held in June 2019 with an open invite to all GPs in Inverclyde to participate in planning an approach which builds on current multi-disciplinary primary care mental health support. Community Links Workers are supporting individuals with a range of mental health needs.

(6) *Community Links Worker* (CLW)

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 also build relationships and processes between the GP practice and community resources, statutory organisations, other health services and voluntary organisations.

This model was tested within 6 practices throughout 2018 and despite some initial reservations around clinical practice, supervision, competency frameworks and accessing GP records, an evaluation has shown how beneficial GPs find having the CLW within their MDT.

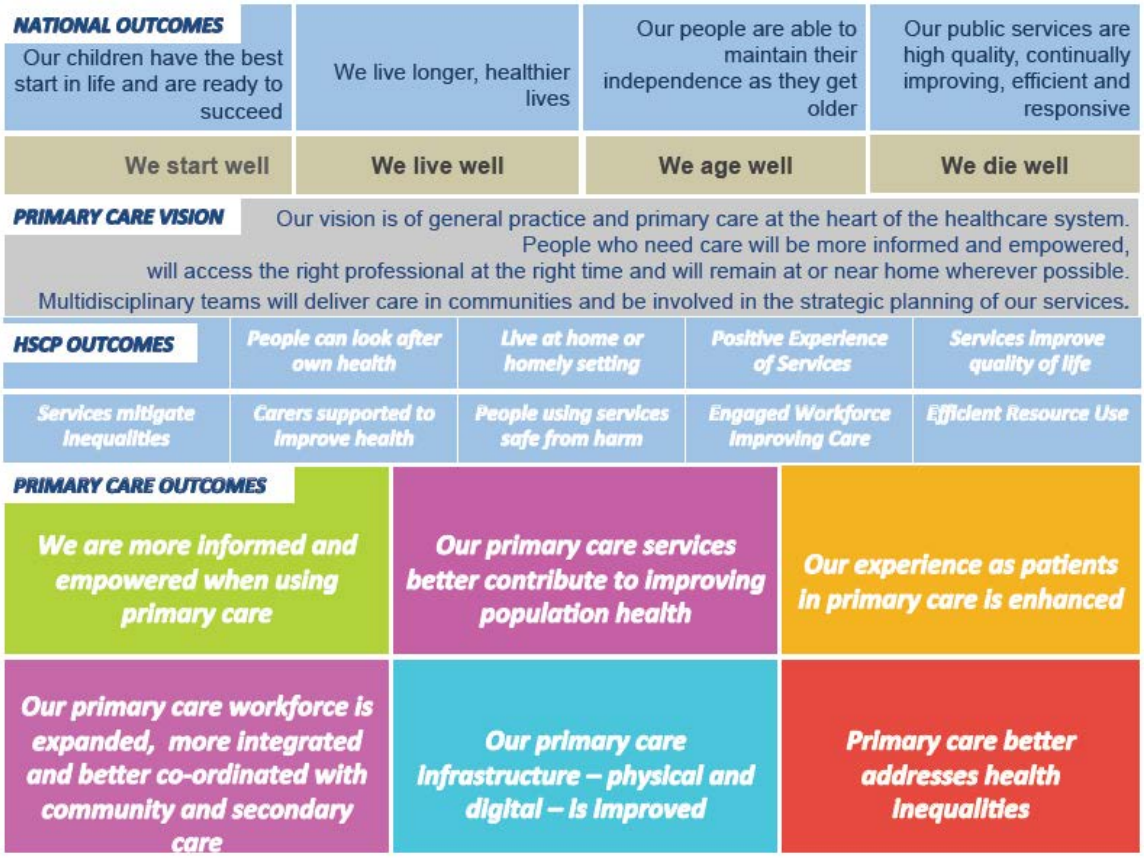
"We're trained in a lot of things, but we're not experts in community resources and for us to offer the same kind of support we'd have to spend lots of time looking up different resources. Before the CLW I was pulling my hair out dealing with the sad lives of others. Spending time looking for services that can help these people – I know of one or 2 like Money Matters but there's more out there. Now I can refer to the CLW who can help them, and therefore also help me. Often what starts off as a medical issue has a social connection and I can then ask the CLW to follow up. When these people come back to me, they've all said the CLW was a great support. We're only now beginning to see the cumulative benefits of New Ways taking some pressure of us as GPs."

From the beginning of 2019, CLWs have spread across a further 5 practices and now cover all 11 Inverclyde practices ranked in the top 200 most deprived within Scotland. For those patients with less complex social needs, the existing Community Connector model remains in place and a new role of Social Prescribing Coordinator (part of a lottery funded pilot) is available to support the 3 practices currently without a CLW. We will continue to analyse data and explore the most appropriate model for these remaining practices. The CLWs are currently employed by CVS Inverclyde within the third sector and there will be a commissioning exercise held during 2019/20.

There is good evidence to show the significant benefit of Welfare Rights Officers (WRO) based

	within primary care, embedded in practices. Supported by Health Improvement Scotland, a WRO from the existing HSCP team has been based 1 day per week within our biggest practice for the last 6 weeks. Whilst this is early days in relation to evidence, anecdotal feedback from the practice is extremely positive. Reviewing the impact of this test of change will inform the model and deployment of HSCP WROs going forward. **Management and Leadership** Management of the extended MDTs will continue to be through a combination of local arrangements (Senior Nurse, Lead Nurse- Treatment Rooms) and board/ hosted structures (existing MSK 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 clearly outlined in the new HSCP Strategic Plan 2019- 2024. 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. Our established culture change campaign *Choose the Right Service* continues to be widely publicised using a variety of printed and social media and has developed in number of ways: *Choose the Right Service for our Children and Young People* literature, engagement with education and delivery of sessions within primary schools and a programme supporting our *New Scots* refugee communities to better understand and navigate primary care across the range of services. We will continue this campaign across the lifetime of the plan utilising a number of avenues and this has also been linked to our unscheduled care and winter planning workstreams. 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. Funding has been secured separately to provide such training to all first contact/ frontline staff within both primary care and HSCP services during 2019/20.
F	**Additional Content**
	Community Pharmacy, Optometry and Dentistry We continue to link with all our primary care contractors through profession specific educational and information forums throughout the year. All 16 Inverclyde Community Pharmacies continue to participate in the extended Minor Ailments Scheme and we have a Community Pharmacy representative on our Primary Care Implementation Group. **Interface with Acute Services** We continue to have a planning manager from Clyde acute on our Primary Care Implementation group and utilise all avenues to ensure Secondary Care are aware of and where appropriate involved in developing the interfaces required. Unscheduled care and use of the Emergency Department for minor injury and illness continues to dominate the local agenda and our culture change programme remains committed to promoting alternative care pathways (self, health, social or third sector) where appropriate. Clusters have also engaged directly with Consultants

	around improving referral pathways. **Community Services** The development of a team approach continues to be fundamental and we will continue to engage with practices and clusters to determine the best way to deploy staff. The increased use of Home and Mobile Health Monitoring (HMHM) is providing alternatives to primary care appointments/ visits with our existing COPD self- management hubs having been upgraded and a working group with secondary care consultants ensuring appropriate monitoring, processes and pathways. The introduction of FLORENCE text messaging has been taken up by several practices to support diagnosis and monitoring of hypertension. Support and training to uptake either of these systems is available from Primary Care support team in the HSCP and evidence suggests a reduction in both appointments and acute admissions for patients. A Long Term Conditions nurse has been employed within Community Nursing and will support a greater shift towards self- management and monitoring across a range of conditions.
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 and NHSGG&C Public Health. 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

Workforce Planning

Workforce planning is one of the most significant challenges highlighted in the development and implementation of the Primary Care Improvement Plans, both in terms of availability of workforce at a sufficient scale to support all practices across GGC and in terms of the change process required to support effective working for new teams. In order to meet all requirements of the new contract and develop the MDT across all practices in Greater Glasgow and Clyde, an estimated additional workforce of between 800-1000 posts may be required.

Within the GG&C areas HSCPs are committed to the following principles:

- Approaches across GGC should share consistent principles and pathways, role descriptors and grading, scale (numbers of staff per practice/ patient population)
- Recruitment should be co-ordinated across GGC where appropriate taking account of existing professional lead and hosting arrangements.

Across NHSGGC, workforce planning for the Primary Care Improvement Plans is being considered in conjunction with the Board's wider Moving Forward Together strategy which sets a vision and direction for clinical services in the future. Staff Partnership representatives are involved at all levels. Specifically for the PCIPs, the key aspects of the approach include:

- Modelling to identify the work, tasks and skills required for the new roles

- Assessment of the numbers of staff required to fill those roles
- Modelling of the existing workforce including turnover
- Consideration of changes in other services and competing demands
- Reviewing different skill mix models and creative approaches to delivery both within and across professions.
- Developing approaches to supporting Multi- Disciplinary Team working within practices and between practices and wider community services

This approach is being tested initially within Pharmacy as one of the early priority areas, but will be adapted to other professional groups as part of year 2 and 3 implementation.

The availability of key staff groups continues to require action at national level, particularly to ensure sufficient training places and development of skills for primary care.

Premises

The NHSGGC Property and Asset Management Strategy includes independent contractor owned and leased premises. Oversight of GP premises developments is provided through the Board's GMS Premises Group which reports to the overarching Primary Care Programme Board.

In year 1 of the PCIPs, existing mechanisms such as improvement grant funding have been used explicitly to support the requirement for additional space as part of PCIPs and this will continue.

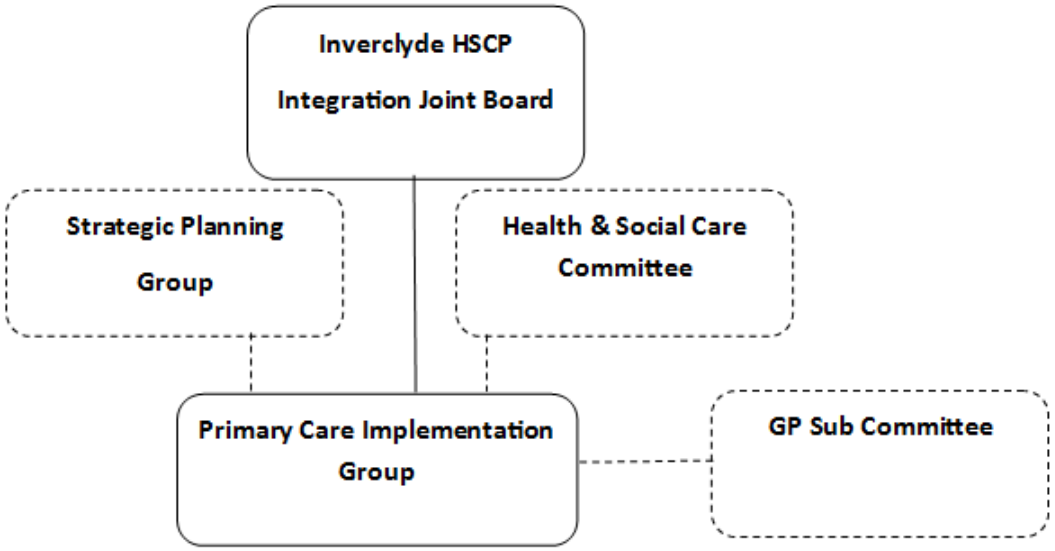
There is a comprehensive programme of backscanning underway to free up space within practices to enable more clinical and administrative space to be provided, as well as supporting digital infrastructure through the removal of paper records.

The national survey of GP premises will report shortly and will be used to inform future planning and investment including prioritisation for premises improvement grants and planning for capital developments, and will also support the due diligence and impact assessment process where there is a request for the Board to consider taking on an existing lease or an option to purchase.

Specific challenges have been noted in ensuring sufficient accommodation for services within small practices, and also for services being provided in one location for several practices in a locality. Supporting new developments to create additional space and accommodate Board employed staff is also challenging within independent contractor owned/ leased premises in line with the existing Premises Directions.

During years 2 and 3 of the Primary Care Improvement Plans, there will be a further focus on strategic planning for primary care premises in the medium and long term, in the light of the new GP contract, Primary Care Improvement Plans and the wider context of Moving Forward Together (the Board's long term strategy for clinical services) which sets out ambitions for the development of an extended range of community services based around virtual or actual community hubs. The strategy for GP premises will be developed in conjunction with the wider property strategy for community services and included within the capital plan associated with the Moving Forward Together programme.
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

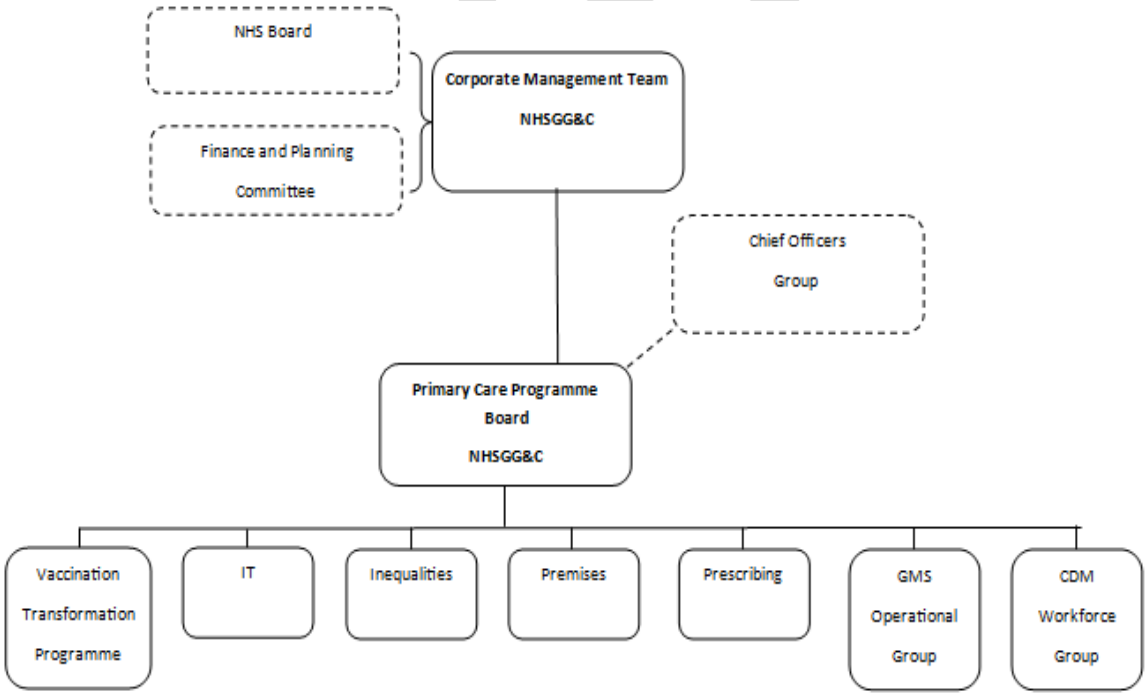
	spend which frees up space or better utilises existing space to accommodate new roles and team members. Planning for the new Greenock Health Centre is underway and takes into account a potential increase in HSCP employed staff working predominantly within practices but who will also require agile working space and the ability to access recording systems remotely as well as meet with line managers. **Digital Infrastructure** Within NHSGGC, the eHealth team works in conjunction with HSCPs in the introduction of new services and processes within practices. This ensures where possible the standardisation of approach, fit to the Digital Strategy, use of core enterprise systems and minimal cost overhead. Costs have been supplied by EHealth to HSCPs to enable this to be incorporated into overall costs for new MDT members. eHealth maintain an inventory of IT assets and software deployed to practices and for wider HSCP and Board operations. Development staff and eHealth joint working will ensure that as new services are deployed to support the MOU, and as significant estate changes occur (i.e. GP Practice Back scanning of records, New Premises) that these are reflected in the introduction of new technology solutions and amendments to operational processes and Business As Usual working. 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. **Data Sharing Agreements** The new GP contract introduced a joint data controller arrangement between Health Boards and GP Contractors relting to personal dat contained within GP NHS patient records. Sharing of information between the people who are involved in the care of patients is increasingly important to the safe and effective delivery of health and social care, and to the delivery of services by the new Multi Disciplinary Teams working within and with practices. the PCIP plans for development of MDTs need to be supported by robust information sharing agreements with all practices for the delivery of clinical care, for audit and review purposes and for service, workforce and public health planning. An information sharing agreement which sets out the rules to be applied by a Health Board and a GP Contractor when sharing information with each other is being developed. This is a key enabler and is required as a matter of urgency to support the implementation of the PCIPs.
I	**Implementation**
	Inverclyde Governance Arrangement Development and Implementation of the Primary care Improvement Plan is overseen by the Primary care Implementation 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

Inverclyde continues to be challenged by the funding available to deliver the PCIP. Engagement with Primary Care Directorate at Scottish Government led to a re-profiling of funding across the 4 years taking in to account the progress already made in Inverclyde due to *New Ways.* The actual/ projected spend below includes the increase of 6% in employers costs in 2019/20 which it is currently expected will be covered by Scottish Government for all posts in place prior to April 1st 2019 but not new posts thereafter.

Original and Revised Primary Care Improvement Fund Profile 2018- 2022

	Original PCIF Investment Profile £'000	Revised PCIF Investment Profile £'000	Actual/ Projected Spend
2018-19	755	755	1,005,257
2019-20	907	1,266	1,514,314
2020-21	1,815	1,904	1,982,922
2021-22	2,557	2,109	2,037,722
Total	6,034	6,034	6,540,214

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. The Inverclyde Mental Health Programme Board is ensuring that connections are made between funding available in PCIF and Action 15.

Estimated Funding Profile per Priority Area 2018- 2022

Financial Year	Service 1: Vaccinations Transfer Programme (£s)		Service 2: Pharmacotherapy (£s)		Service 3: Community Treatment and Care Services (£s)	
	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)
2018-19 actual spend	45900	0	442677	19950	15600	0
2019-20 planned spend	270299	63750	516174	19950	35722	0
2020-21 planned spend	266915	62952	547131	19950	36794	0
2021-22 planned spend	266915	62952	574703	19950	37897	0
Total planned spend	850029	189653	2080685	79800	126013	0

Financial Year	Service 4: Urgent care (£s)		Service 5: Additional Professional roles (£s)		Service 6: Community link workers (£s)	
	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)
2018-19 actual spend	68300	0	170962	12400	259688	0
2019-20 planned spend	84902	0	293504	20280	277000	0
2020-21 planned spend	466400	0	360432	20280	277000	0
2021-22 planned spend	480392	0	371245	20280	277000	0
Total planned spend	1099994	0	1196144	73240	1090688	0

K	**Evaluation and outcomes**

Key success indicators over the life of the plan will continue to be agreed with primary care and any resources that may be required to evidence workload reduction will be kept to a minimum. Inverclyde will also contribute to the NHSGG&C overall evaluation being commissioned by Public Health. Below is the suggested range of information which will allow us to show local progress:

A. Workload shift for GPs
Workload shift for other practice staff
Continual measurement over the life of the plan using primary care software 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.
Complaint reviews/ incident recording.

D. Patients have access to the right professional at the right time
Self- reporting
Waiting times for appointments/ assessment/ review.
Impact of re-direction/ culture change eg. Choose the Right Service- evidence from other professional groups

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

Local Implementation Tracker Guidance

The following tracker should be used by Integration Authorities in collaboration with Health Boards and GP sub-committees to monitor progress of primary care reform across their localities, and in line with service transfer as set out within the Memorandum of Understanding.

The **MoU Progress tab** should be used through local discussions between Integration Authorities and GP sub-committee to agree on progress against the six MoU priority services as well as enablers required to deliver these. This tracker should be completed using a RAG system, and comments boxes have been provided to supply further information.

If you are funding staff through different funding streams, for example, mental health workers through Action 15 funding, please include this information in the relevant section so we are aware that you are taking steps to recruit staff in this area.

The **Workforce and Funding Profiles tab** replaces the Template C returns that were provided to Scottish Government in 2018/19. These tables should allow Integration Authorities to consider financial and workforce planning required to deliver primary care improvement, and reassure GP sub-committee of progress. These tables will also support Integration Authorities in requesting the second tranche of the Primary Care Improvement Fund allocation in October 2019.

If you are funding staff through different funding streams, for example, recruiting mental health workers in Action 15, do not record these in Tables 1 and 2. However, they should be included in Tables 3 and 4 to inform workforce planning

We would also ask that this local implementation tracker be updated and shared with Scottish Government by 30th April 2019 for the period July 2018 to March 2019 and by 30th October 2019 for the period April to September 2019.

Primary Care Improvement Plans: Implementation Tracker

Health Board Area: NHSGG&C	**Completed by:**	**Emma Cummings**
Health & Social Care Partnership: Inverclyde	**HSCP/Board**	**HSCP**
Number of practices: 14	**GP Sub Committee**	**Gayle Dunnett**
	Date: 6/4/19	
Implementation period		
From: April 18		
To : March 19		

	fully in place / on target	partially in place / some concerns	not in place / not on target
Overview (HSCP)			
MOU – Triumvirate enabled - GP Sub Engaged with Board / HSCPs	R	A	G
Comment / supporting information			
PCIP Agreed with GP Subcommittee	R	A	G
Comment / supporting information (date of latest agreement)	Last agreed August 2018		
Transparency of PCIF commitments, spend and associated funding	R	A	
Comment / supporting information	concerns over 6% NI contribution & impact on finance		

Enablers / contract commitments			
BOARD			
Premises			
GP Owned Premises: Sustainability loans supported	R	A	G
comment / supporting information	Applications	No..	51
	Loans approved	No..	51 (provisional)
	narrative:	Funding available for all applications subjection to finalisation of loan agreement	
GP Leased Premises: Register and process in place	R	A	G
comment / supporting information	Applications	No..	17 expressions of
	Leases transferred	No..	0
	narrative:	Process for developing the register under development: 17 expressions of interest from practices seeking assignation of lease.	
Stability agreement adhered to	R	A	G
comment / supporting information	Enhanced Services agreed annual in line with stability agreement; local arrangements developed in relation to vaccination prior to national guidance. Some concerns expressed about changes to wider community services (e.g. Sandyford)		
GP Subcommittee input funded	R	A	G
comment / supporting information	Additional sessions and HSCP reps funded in 18/19 to support new contract and PCIP processes, in addition to core GP Subcommittee funding. Final agreement re balance of new 18/19 funding still to be confirmed. To move to a more standardised approach in 19/20 supported by new funding.		
Data Sharing Agreement in Place	R	A	G
comment / supporting information	Awaiting national data sharing agreement. This is required as a matter of urgency to support local agreements.		

HSCP			
Programme and project management support in place	R	A	
comment / supporting info			
Support to practices for MDT development and leadership	R	A	

comment / supporting info			
GPs established as leaders of extended MDT	R	A	G
comment / supporting info			
Workforce Plan reflects PCIPs	R	A	G
comment / supporting info	WE are currently ensurng our wider people plan supports the PCIP and reviewing some key posts as to how they support primary care, for example Gerontology Nurse		
Accommodation identified for new MDT	R	A	G
comment / supporting info	backscanning/space utilisation/time in motion survey		
GP Clusters supported in Quality Improvement role	R	A	G
comment / supporting info	training/support. some capacity issues to carryout role.		
EHealth and system support for new MDT working	R	A	G
comment / supporting info	Move to standardise across GGC. Work with ehealth/IT to progress		

MOU PRIORITIES			
Pharmacotherapy			
PCIP pharmacotherapy plans meet contract commitment	R	A	G
Pharmacotherapy implementation on track vs PCIP commitment	R	A	G
Practices with PSP service in place (80,908)	**14**		
WTE/1,000 patients	0.1wte PSP & 0.025wte PST		
Pharmacist Independent Prescribers (as % of total)	80%		
	Level 1	Level 2	Level 3
Level of Service	14	14	14 have some level of LTC clinic or formal/ adhoc reviews eg falls but not yet consistent across
comment / narrative	further development of skills and roles/developing skill mix team. Standardising processes. The Original HSCP Prescribing Team has combined together with additional PCIP staff. Level 1 – all practices have some input to level 1 (e.g. acutes, meds rec, care homes, prescribing indicators, specials, PST home visits/reviews), but do not have capacity currently to deal with all level 1 work in any practice. No practices have input to repeat prescribing. Level 2 – includes some input to ad hoc medication review, DMARDs, queries and shortages in all practices but do not have capacity currently to deal with all level 2 work in all practices. DMARD monitoring in 13 practices. Level 3 – clinics for polypharmacy in 2 practices, respiratory in 5 practices, pain in 2 practices, care home med review in 2 practices plus Falls reviews and HSCP Heart Failure clinic for all 14 practices. Skill mix development - technician input to meds rec following a PSP clinical check. Do not currently have capacity to deal with all level 3 work in all practices.		
Community Treatment and Care Services			
PCIP CTS plans meet contract commitment	R	A	G
Development of CTS on schedule vs PCIP	R	A	G
Practices with access to phlebotomy service	13		
Practices with access to CTS service	13		
Range of services in CTS	management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, limited chronic disease monitoring (BP etc), Catheter care, ECG, Administration of medications (injections)		
comment / narrative	All practices have had access to some level of phlebotomy within CTS however have not all ustilised this previously and we are currently ensuring capacity will meet demand in year2 for this shift. A hybrid model CTS within DN team for 2 practices who previously did not use CTS is now underway and continues to develop.		
Vaccine transformation Program			
PCIP VTP plans meet contract commitment	R	A	G
VTP on schedule vs PCIP	R	A	G
Pre-school: clinic model in place since 2017- moving to central board management structure (flu still to be tested 2019 and fully implemented 2020)	R	A	G
practices covered by service	14		

School age:	R	A	G
practices covered by service	14		
out of schedule: model agreed		A	G
practices covered by service	14		
Adult **imms: Board VTP propose roll out 2020**	R	A	G
practices covered by service	0		
Adult Flu **: Board suggested model to be tested Oct 2019, full roll out 2020, significant risks identified by board VTP costs are still estimates**	R	A	G
practices covered by service	0		
Pregnancy: Agreed board model to be tested **2019 and full roll out 2020, costs are still estimates**	R	A	G
practices covered by service	0		
Travel: **Board VTP proprose to implement 2020, significant risks identifed**	R	A	G
practices covered by service	0		
comment / narrative			
Urgent Care Services -			
Development of Urgent Care Services on schedule vs PCIP	R	A	G
practices supported with Urgent Care Service	ANP covering East Cluster - 6 practices		
comment / narrative	on schedule for ANP model and in place at this point in time. Specialist Paramedic pilot will continue for a further year covering 2 practices funded by SAS.		
Additional Services (complete where relevant)			
APS – Physiotherapy / MSK	R	A	
Development of APP roles on track vs PCIP	R	A	G
Practices accessing APP (42,980)	**6**		
WTE/1,000 patients	0.18		
comment / narrative	on schedule for APP model		
Mental health workers			
On track vs PCIP	R	A	G
Practices accessing MH workers / support	14		
WTE/1,000 patients	check		
comment / narrative	As per commitment workshop in place for May to explore future additional options for distress & recovery. Our Primary care Mental health Teams are already based in practices.		
APS – Community Links Workers			
On track vs PCIP	R	A	G
Practices accessing Link workers (66,564)	**11**		
WTE/1,000 patients	0.12		
comment / narrative	Part of a range of services dedicated to social prescribing including community connectors which will be developed through life of plan		
Other locally agreed services (insert details)			
Service			
On track vs PCIP	R	A	G
practices accessing service	1		
comment / narrative	Commenced testing a model of welfare rights officer based in 1 GP practice		

Overall assessment of progress against PCIP	R	A	G
Specific Risks ***Recrutiment & retention remain critical issues and we have seen gaps in service due to professionals moving around the system in GG&C***			
Barriers to Progress ***- Level of funding does not allow for futher roll out until 20/21. Inverclyde due to being the biggest Test of Change site in development of the contract are effectively in year 4 of our plan.Our funding however doesn't reflect this and is making progress and even sustaining current devlopments challenging.***			
Issues FAO National Oversight Group - ***If we are required to fund the 6% Employers Superannuation uplift costs without requisite increase in funding this accounts for overspend of £248,000.***			

Funding and Workforce profile

Table 1: Spending profile 2018 - 2022 (£s)
Please include how much you spent in-year from both PCIF and any unutilised funding held in reserve

Financial Year	Service 1: Vaccinations Transfer Programme (£s)		Service 2: Pharmacotherapy (£s)		Service 3: Community Treatment and Care Services (£s)		Service 4: Urgent care (£s)		Service 5: Additional Professional roles (£s)		Service 6: Community link workers (£s)	
	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	training, equipment, infrastructure etc.)	Staff cost	training, equipment, infrastructure etc.)	Staff cost	training, equipment, infrastructure etc.)
2018-19 actual spend	45900	0	412457	19950	15600	0	68300	0	170962	12400	259688	0
2019-20 planned spend	137757	191051	515874	19950	35722	0	84902	0	202338	49720	277000	0
2020-21 planned spend	137841	185995	547131	19950	36794	0	466400	0	266531	45280	277000	0
2021-22 planned spend	141977	185995	574703	19950	37897	0	480392	0	274527	45280	277000	0
Total planned spend	463474	563041	2050165	79800	126013	0	1099994	0	914358	152680	1090688	0

Table 2: Source of funding 2018 - 2022 (£s)

Financial Year	Total Planned Expenditure (from Table 1)	Of which, funded from:		
		Unutilised PCIF held in IA reserves	Current year PCIF budget	Unutilised tranche 2 funding held by SG
2018-19	1005257	266400	754813	
2019-20	1514314		1266000	
2020-21	1982922		1904000	
2021-22	2037722		2109000	
Total	6540214	266400	6033813	0

Comments: Have included 6% increase in employer's superann contribution to pay costs from 19/20 pending confirmation of hov

Table 3: Workforce profile 2018 - 2022 (headcount)

	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
Financial Year	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL headcount staff in post as at 31 March 2018	10	2	0	1	0	2	0	0		3	1	7
INCREASE in staff headcount (1 April 2018 - 31 March 2019)	0	0	0	0	0	0	0	0	1	0	0	0
PLANNED INCREASE in staff headcount (1 April 2019 - 31 March 2020) [b]	0	0	0	1	0	0	0	0	n/a	0	0	
PLANNED INCREASE in staff headcount (1 April 2020 - 31 March 2021) [b]	0	0	0	0	0	6	0	0	n/a	2	0	
PLANNED INCREASE staff headcount (1 April 2021 - 31 March 2022) [b]	0	0	0	0	0	0	0	0	n/a	0	0	
TOTAL headcount staff in post by 31 March 2022	10	2	0	2	0	8	0	0	1	5	1	7

[a] please specify workforce types in the comment field below
[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Table 4: Workforce profile 2018 - 2022 (WTE)

	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
Financial Year	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL WTE staff in post as at 31 March 2018	8.1	2.0	0.0	0.7	0.0	1.5	0.0	0.0		2.3	1.0	6.0
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0
PLANNED INCREASE in staff WTE (1 April 2019 - 31 March 2020) [b]	0.0	0.0	0.0	0.7	0.0	0.0	0.0	0.0	n/a	0.0	0.0	0.0
PLANNED INCREASE in staff WTE (1 April 2020 - 31 March 2021) [b]	0.0	0.0	0.0	0.0	0.0	5.9	0.0	0.0	n/a	2.0	0.0	0.0
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	n/a	0.0	0.0	0.0
TOTAL WTE staff in post by 31 March 2022	8.1	2.0	0.0	1.3	0.0	7.4	0.0	0.0	1.0	4.3	1.0	6.0

[a] please specify workforce types in the comment field
[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a