INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 7

Report To:	**Inverclyde Joint Integration Board**	**Date:**	**15 May 2023**
Report By:	**Kate Rocks, Chief Officer Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/25/2023/AS**
Contact Officer:	**Alan Best Interim Head of Health and Community Care Inverclyde Health & Social Care Partnership**	**Contact No:**	**01475 715212**
Subject:	**Impact of the Primary Care Improvement Plan (PCIP)**		

1.0 PURPOSE AND SUMMARY

1.1 ☐For Decision ☒For Information/Noting

1.2 The purpose of this report is to demonstrate the impact of the Primary Care Improvement Plan through the advancement of our Multi-Disciplinary workforce and how this contributes to the progression of the Transformation of Primary Care Services.

2.0 RECOMMENDATIONS

2.1 The Integration Board is asked to note the positive impact on patient care through the delivery of Primary Care Improvement Plan (PCIP).

2.2 The Integration Joint Board agree proposals for continued implementation of the Primary Care Improvement Plan.

Kate Rocks
Chief Officer
Inverclyde Health and Social Care Partnership

3.0 BACKGROUND AND CONTEXT

3.1 The new contract for provision of General Medical Services in Scotland commenced in April 2018; this contract was formed on some of the successes from Inverclyde's New Ways of working pilot during period 2016 – 2018.

3.2 A contract which had a vision for the establishment and development of multi–disciplinary professionals working to support GP Practices, under the employment of HSCPs. A pioneering task, with the objective to release GP clinical time, in order to take on the role as Expert Medical Generalists. A role that would see GPs focusing on care for patients with the most complex needs.

3.3 Delivery for HSCPs was based on a defined Memorandum of Understanding (MOU). The MOU established a national agreement between the BMA, Scottish Government, integration authorities and health boards to implement the 2018 Scottish GP contract. The MOU was refreshed in August 2021 producing a revised MOU, one that confirmed particular areas of focus between periods 2021 – 2023; and included Vaccination Transformation, Pharmacotherapy and Community Treatment and Care Services (CTAC).

3.4 Inverclyde had an earlier starting position which provided an opportunity to develop our local Primary Care Improvement Plan, in partnership with our key stakeholders. Our original New Ways of Working Steering Group naturally evolved into our PCIP Implementation Group. The group had responsibility for the strategic direction, governance and progression of priorities in order to achieve the MOU.

3.5 The group and supporting structures were reviewed at regular intervals, with the most recent in September 2022 proposing the rebranding of our PCIP Implementation group. To provide a wider remit; we advanced to the Primary Care Transformation Group; where PCIP sits within this overarching structure.

Adapting the format of the meetings, provided two critical elements:

1. Normal Business, containing discussion on programme status, finances, enablers and blockers
2. Followed by a "Deep Dive" approach to allow for specific focus of individual service areas in greater detail to lead further developments.

3.6 Since inception, the IJB have been regularly informed and sighted on the progress of the implementation of the plan.

3.7 As at January 2023, we are nearing our fully implemented original PCIP plan and have employed an additional 46.13 wte staff to PCIP services.

3.8 We currently await clarification from Scottish Government on proposed funding moving forward, to enable further expansion of our MDT workforce, development of service and continue our improvement journey in the transformation of primary care services.

4.0 REPORT

4.1 Inverclyde has 13 GP practices with a registered patient population of 80,202 (jan 2023). The average Practice list size is 6,169, ranging from 2,978 patients to 14,606 patients in our largest practice. Although our registered practice population has decreased by 2,901 (83,103) since 2014; we have adopted a more complex population which is having a significant impact on General Practice. With the additional required capacity to support Ukrainian, Asylum Seekers and Non UK Student Visa Nationals.

4.2 Our PCIP implementation has enabled practices to support patients in alternative settings, by experts which is built on a multidisciplinary team model underpinned by seven key principles: safe, person-centred, equitable, outcome focussed, effective, sustainable, affordable and value for money.

4.3 We have progressively recruited and trained staff to deliver services across the six Memorandum of Understanding (MOU) areas. Over the course of implementation we have reflected on lessons learned and adjusted our plan accordingly. This has included the implementation of a skill mixed workforce; which has provided opportunities for efficiencies, and built greater resilience into some services.

4.4 Despite a recruitment pause during the pandemic, we are now in pre-Covid position and beyond. New delivery models of care and recruitment of multi-disciplinary professionals has allowed the transfer of work from GP practices to HSCP staff within the context of Primary Care transformation. The ongoing impact of the pandemic has made it difficult to demonstrate impact and evidence this capacity shift. However the access to a range of services is clearer and the new GMS contract has enabled patients to access the right professional, at the right place, at the right time.

4.5 In line with the revised Memorandum of Understanding, our priorities will focus on advancing and accelerating our multidisciplinary models of care across CTAC, Pharmacotherapy, Vaccination Transformation Programme followed by Urgent Care as defined. Specific attention will be given to the creation and further development of a Single Point of Access for both Pharmacotherapy and Urgent Care.

5.0 Progress on MOU priority areas

5.1 All vaccinations within the Vaccination Transformation Programme (VTP) have been in place since April 2022, transferring delivery responsibility from a GP based model to an NHSGGC board model. This approach has successfully removed vaccination workload from General Practice, with delivery models detailed as follows:

i. Significant early developments in years 2018-20 resulted in childhood vaccinations (pre-school and school based) being transferred from GP practices to a model delivered in HSCP community clinics and schools. NHS GGC/HSCP hosted staff are employed to deliver children's vaccinations across Inverclyde.

ii. The midwifery model for delivery across GGC has been developed for pregnant women and sits with Maternity Services.

iii. Responsibility for Travel Health vaccinations transferred to the Board on 1st April 2022. Initial guidance and travel advice is accessible through the NHS Scotland Fit for Travel website. The commissioned Citydoc service provides travel health advice, risk assessment and delivery of travel vaccinations. Clinics are currently accessible in Glasgow, with ongoing discussions around the feasibility of a local delivery model.

iv. Transfer models incorporate adults over 65s and target groups for influenza. The Adult flu programme accelerated during the pandemic with the transfer of vaccinations from GP practices to HSCPs. The arrangements for previous years were established in the context of Covid19 physical distancing, PPE constraints, additional Covid vaccinations and additional eligible cohorts. Mixed models of delivery continue and include community pharmacy, home visits and community clinics. Winter Flu vaccinations up to period 5th December 2022; achieved a vaccination uptake rate of 61.7% (27,643) across our eligible population (44,834).

v. Currently GGC are responsible for the vaccination of all mobile patients by a central vaccination team and HSCPs have responsibility for the vaccination of our vulnerable populations within their own home and care home environments. Our housebound service is delivered by a temporary vaccination team; supported by bank staff vaccinators. Moving forward as per Memorandum of Understanding, HSCPs will assume overall responsibility for the Vaccination Programme. We will focus on building a sustainable vaccination workforce to deliver permanent arrangements and align this service with community nursing.

vi. There will be learning from current delivery models which will influence the future establishment of a robust, efficient and sustainable long term vaccination programme in line with the needs of patients and the terms of the GMS 2018 contract.

vii. Eligible at risk and age group programmes including Pneumococcal, Shingles and adhoc vaccinations are currently invited to central clinics for vaccinations or vaccinated at home. Our vaccination programme from period 1st April to 5th December 2022 delivered 1505 Shingles and 570 Pneumococcal Vaccinations. Further mass clinics for Shingles took place over January with Pneumococcal clinics continuing over the months of February and March.

viii. Due to the complexity of the changes in parameters of the VTP programme during the pandemic it has been difficult to evidence the impact for the various elements of VTP. It is however important to note that all 13 GP Practices in Inverclyde have benefited from the transfer of VTP services. Without this direct transfer from General Practice, our populations would be facing an increased difficulty in accessing care; as would our clinicians experience an increasing demand for care without the capacity to delivery.

ix. Formal notification is yet to be received from Scottish Government around the continuation and arrangements for COVID vaccinations and boosters. COVID-19 Winter 22/23 Boosters up to the 5th of December 2022 shows an update rate of 69.8% (28,424) across our eligible population.(40,729). With Spring and Autumn Campaigns announced; GGC and local planning plans are afoot. Our HSCP are not in the financial position at present to absorb this additional public protection vaccination programme within our existing resources.

5.2 Pharmacotherapy Services

5.2.1 Through New Ways of Working, Inverclyde was a test site and early adopter of a new model to deliver Primary Care Pharmacy services within General Practice. Early 2017 started to see the expansion of existing pharmacy teams to introduce this new way of working. The establishment of the new GMS Contract in 2018 brought the term pharmacotherapy, which accelerated our shift from traditional pharmacy activities and seen HSCPs adopting a tiered model approach to Primary Care Pharmacy service.

5.2.2 This new approach was embedded on a phased basis. By increasing pharmacists and pharmacy technicians working within GP Practices we were able to provide a new medicines management service, referred to as the Pharmacotherapy Service delivering both core (level 1 activity) and additional (level 2 & 3 activities) services.

5.2.3 After receiving the joint letter in December 2020 to prioritise level 1 activity, this revealed our planned workforce modelling level 2 and 3 activity was top heavy. Moving forward, we revised the skill mix by introducing further Pharmacy Technicians and Pharmacy Support Workers which has allowed more flexibility in workforce roles, movement in skill mix, the development of a hub model and pharmacist provision for a minimum of 0.5wte/5,000 patients.

5.2.4 Present workforce of 14.1wte delivering pharmacotherapy service across Inverclyde with direct transfer of pharmacy activity from GPs to Advanced Pharmacists and Senior Pharmacists.

5.2.5 The establishment of a hub since November 2021; has now seen the onward transfer of level 1 activities; data evidencing the shift of activity now largely delivered by technicians and more complex activity being undertaken by Pharmacists:

5.2.6 **Level 1 Activity**

Immediate Discharge Letters (IDL)

- September 2021, 632 of which 46.2% by a technician; 53.8% by a Pharmacist prior to the development of the Hub.
- September 2022, 971 of which 80.6% by a technician; 19.4% by a Pharmacist, demonstrating the shift. This is expected to decrease for Pharmacist input as the hub continues to develop.
- Average of 5 minutes of GP time saved per IDL.

Outpatient letters (OP)

- September 2021, 389 of which 78.6% by a Pharmacist, 21.4% actioned by technician prior to Hub implementation.
- September 2022, 887 of which 68.6% by a Pharmacist, 31.4% by technician. With standardised approach, and Out Patient list for technicians working in the hub environment. The Pharmacist input is expected to continue to decrease as the Technician role continues to absorb the transfer of Level 1 activity.
- Average of 3-4 minutes of GP time saved per OP.

Acute Requests (DMARDs, analgesics)

- September 2021, 963 of which 81.1% were completed by a Pharmacist and 18.9% by a Technician. At this point, one GP Practice had a technician actioning dressings, sundries, acute requests.
- September 2022, 1329 of which 91.4% by a pharmacist, 8.6% by Technician. Most acute requests are now undertaken by the Pharmacist in Practices and are targeted by type of medicine e.g. high risk or amount of time.
- Average of 2-3 minutes of GP time saved per acute.

Serial Prescribing

- Number of items dispensed as serial prescriptions compared to all items dispensed in 4 week rolling period:
- Target of 10%
- July 2022, 4.61%
- September 2022, 12.31%

All GP practices receive support via the hub providing core level 1 activity as above; in addition to medication reconciliation, medication queries and prescribing quality improvement.

5.2.7 **Levels 2 & 3**

The hub approach has released Pharmacist time to conduct Level 2 & 3 medication reviews including Polypharmacy, Frailty Medication Reviews and specialist clinics including analgesics.

Polypharmacy Reviews:

- September 2021, 34 done by a pharmacist
- September 2022, 54 done by a pharmacist
- With All GP Practices as at January 2023 receiving input for the Polypharmacy reviews.
- Referrals although small numbers, are received from Practices for Post MI Heart Failure.
- Covid 19 antiviral prescribing referrals albeit small numbers, can be referred from any Practice.
- Referrals are accepted from all GP Practices for medication reviews to both our Care Home Pharmacist and Interface pharmacist.
- Chronic Pain/Medicines at high risk of dependence reviews are currently conducted in 15% of our GP Practices with Pharmacist Respiratory medication review clinics within 8% of GP Practices locally.

Pharmacist reviews across period April to September 2022 saw 241 across 92% of our GP Practices, resulting in

- 117 medications being stopped
- 67 medications started
- 111 medications changed

5.2.8 Specialist Clinics

- Medication review for patients on long term analgesics and medicines at risk of dependence across 2 GP Practices.
- Snapshot of 45 patients reviewed taking opiates, benzodiazepines or gabapentinoids.
- 51% of medicines dose reduced or stopped
- Support was provided to GP Practices in managing the prescribing of these medicines.
- Links with third sector organisations and services continue to strengthen with 31% of patients reviewed being referred to the Link worker/Community Connector for support.
- Naloxone received positively in the few patients where it was appropriate to prescribe and ongoing work taking place to support this being made available to others in the HSCP and GG&C e.g. financial analysis, training needs.
- Feedback from patients describing improvement in quality of life

5.2.9 We have invested in, enhanced and advanced our workforce, working environment, equipment and training to support delivery. The continued expansion of the new pharmacotherapy service provides scope for GPs to focus on their role as expert medical generalists; improve clinical outcomes; more appropriately distribute workload; enhance practice sustainability; and support prescribing improvement work. There have also been positive impacts in terms of effective and efficient prescribing and polypharmacy all of which have real outcomes for patients. Full Memorandum of Understanding delivery of Levels 1, 2, and 3 will however be difficult to achieve without further significant investment.

5.2.10 Cost efficiencies, quality prescribing and formulary compliance are all areas of focus in the months ahead. An HSCP Prescribing Management and Pharmacotherapy Group has been established to review both clinical and cost effective prescribing and a governance structure around the prescribing across Inverclyde HSCP.

5.3 Community Treatment and Care Services (CTAC)

Initial scoping and testing of models took place during our New Ways of Working period, with the introduction of Phlebotomy clinics through our existing Treatment Room Service; supported by an additional workforce to conduct these health care assistant duties.

5.3.1 The creation and implementation of CTAC services provides the opportunity to transfer activity in General Practice including minor injuries, chronic disease monitoring and other services suitable for delivery within a community setting.

5.3.2 Our existing treatment room models located in Gourock, Greenock and Port Glasgow Health Centres, placed Inverclyde in a strong position to develop CTAC activities. Enhancing services for our GP Practices incorporating basic disease data collection and biometrics (such as blood pressure), the management of minor injuries and dressings, suture removal, ear syringing.

5.3.3 Our additional workforce supporting CTAC development is currently 12.67wte. With all GP Practices now having access to CTAC services; creating a more equitable service for patients. With a total 6 treatment rooms x 3 phlebotomy room across our three sites in Gourock, Greenock and Port Glasgow. With our recent refurbishment of the Lithgow Wing in Port Glasgow Health Centre, now providing additional clinical space. One room is now operational for Phlebotomy and plans are in development for the remaining clinic rooms.

5.3.4 Treatment Room appointment times vary from 15 to 40 minutes; averaging 21 appointment slots per Treatment room and 19 per Phlebotomy room. Activity transferred from General Practice over period January 2022 – December 2022 is evidenced as follows:

- 29,529 procedures were carried out.
- 3,649 bloods were taking through our Phlebotomy clinics
- 30,800 appointments offered, with 28,135 patients attending.

5.3.5 Current focus is on the development and introduction of a chronic disease monitoring model and engagement is taking place with our key stakeholders through a CTAC development group, monthly engagement sessions and our existing networks to ensure we have a direction that is fit for both General Practice needs and our local population.

5.3.6 Other enhanced services will include leg ulcer management, Doppler assessment, over and above our traditional Treatment Room activities including wound dressings and suture/staple removal.

5.3.7 All GP Practices have been offered and can now access Phlebotomy support within their Practice in additional to domiciliary Phlebotomy. Provision for Phlebotomy is 20 clinics per week, ranging from 5 hours – 42 hours input across Practices. Appointment times are allocated for 15 minutes with 970 bloods slots available per week across our Practice settings. Incorporated into our overall activity; Phlebotomy over period January 2022 – December 2022 was 11,545 in Treatment Room settings and 3,649 within our Practice environments. We continue to review and adapt our models in place

5.3.8 We have invested in, enhanced and advanced our working environment, equipment, training and workforce to support delivery of this Memorandum of Understanding area. CTAC services have further potential to streamline and improve pathways for chronic disease monitoring, shift of acute phlebotomy to community settings. Future direction will consider as per Memorandum of Understanding, alignment of our Vaccination Transformation Programme.

5.4 Urgent Care (Advanced Nurse Practitioners)

5.4.1 As an early adopter of the advanced practitioner model through New Ways of Working, we employed a Nurse; which with enhanced and advanced clinical training created our first Advanced Nurse Practitioner role. This in line with the GMS contract has allowed progression and scale up of trainee ANP roles with a current team workforce of 6.55wte responding to home visits.

5.4.2 Our ANP team is directed by our original Nurse, now in the position of Lead ANP. The new GP Contract has allowed us to strengthen our Advanced Nursing Practitioner model which continues to grow in an incremental approach.

5.4.3 Our most recent focus has been on the refurbishment of accommodation at Port Glasgow Health Centre to create a single point of access (SPOA) model. This will allow the routing of referrals to an ANP led Urgent Care Hub to effectively triage and manage urgent care. We have invested in, enhanced and are advancing our working environment, equipment, training and workforce to support urgent care.

5.4.4 Our current model has input to Practices to support the management of home visits, with data demonstrating direct transfer of activity from GPs to our Advanced Nursing Practitioners. Over period September 2021 to September 2022 the ANP team covered in the region of 2,460 visits. With an average of 205 visits per month, ranging from 141 to 320 visits in any given month. A total of 90% of patients seen by the ANP required a prescription.

5.4.5 We have experienced significant movement of staff within the ANP team and challenges with recruitment. We are now in a more stable position with our urgent care hub operational in Port Glasgow Health Centre. It is worth highlighting that only 1.8wte of our workforce are fully trained ANPs, with the remainder of the team nearing completion or remain in training. This requires significant investment with regards to time out from clinical duties for shadowing, mentoring, university and study leave, over and above their clinical patient facing role and clinical note write up.

5.4.6 Even with these challenges, we have overcome them and managed to achieve a service that has supported general practice with home visits and directly transferred this activity to our Advanced Practitioners.

5.4.7 Future focus will explore roles that would complement the ANP team through the introduction of a skill mix approach. Locally we will continue to review, shape and adapt models for responding to urgent care locally.

5.5 Additional Professional Roles

5.5.1 The role of Advanced Practice Physiotherapist (APP) was developed during New Ways in 2016, the GMS contract allowed us to accelerate this workforce to 2.6wte (excluding time in

MSK) with service provision now delivered to 61% of our GP Practices population. This model allows patients to benefit from access to a physiotherapist within a GP practice setting, with the majority of patients signposted directly to the APP reducing unnecessary GP attendances,

5.5.2 The APP (Advanced Practice Physiotherapist) role consists of a 20 minute appointment with each patient allowing for an average of 14 per day. Post pandemic learning presented opportunities to shape this model, which now allows for face to face, telephone and virtual consultations driven by patient choice.

5.5.3 As a comparator; demonstrating the benefit of the MSK APP role; baseline data from 2017 forming part of New Ways of Working pilot, evidenced those cases seen by GPs, that:

- 45.6% of MSK cases were referred onto mainstream physiotherapy services.
- 62.2% of MSK cases received a prescription for medication.
- 16.7% of MSK cases were referred for imaging for further investigation.
- 12.2% of MSK cases were referred to orthopaedics for further review.

5.5.4 The introduction of the MSK APP role as at September 2022 has seen a shift in those same areas, averaging:

- 51% of patients provided with condition specific advice/exercises to support self-management.
- 22% to mainstream physiotherapy services.
- 9% receiving a prescription for medication.
- 4% for GP review.
- 4% to orthopaedics for further review and investigation.
- 9% referred to imaging for further investigation.

5.5.5 This translates as a:

- Reduction in Imaging referrals, Prescriptions and Orthopaedic referrals
- Increase in exercise, advice and self-management
- April 2022 – September 2022, 2273 APP Appointments were available (averaging 454 monthly), 2399 of these were filled, giving average fill rate 88%.

5.5.6 This model of care has again experience significant workforce challenges with a great deal of staff movement. This is one of the most challenging areas of the Memorandum of Understanding with regards to sustainability of workforce. As an advanced pilot site, we have attracted a number of staff out with Inverclyde wishing to ‘train and develop into the APP role, as this is a very different role to that of our mainstream MSK physiotherapist. Our experience has been that those individuals once trained, unfortunately moved to similar roles within their own locality.

5.5.7 Although this service is rated well by both GPs and patients, we are unable to invest any additional APP input to spread service provision and create an equitable share of resource across all of our GP practices. This a direct result of our focus remaining on the investment of funds in priority Memorandum of Understanding areas. Essentially 39% of GP Practices are not gaining the benefits of this physiotherapy model of first point of contact model for musculoskeletal (MSK) conditions. NHSGGC have recognised the board-wide impact this has had, and are considering alternative models to ensure greater equity across practices.

5.6 Community Link Workers (CLW)

5.6.1 The Community Links Workers Programme for our HSCP was initially piloted prior to the New GP Contact, and ran in tandem with our New Ways of Working programme.

5.6.2 The development and implementation of the CLW model, was built around a partnership between the HSCP and our Voluntary Sector Partner (CVS). CVS is an umbrella organisation for voluntary organisations and are our Third Sector Interface.

5.6.3 It was acknowledged that there is a significant cohort of patients who sought recurring and regular support from GPs, for what were often issues associated with loneliness, social isolation, a lack of community connection and associated ‘social’ issues. For this purpose, the

CLW model was established to support individuals with a variety of social, financial, mental health and practice issues.

5.6.4 Following the success of this programme through New Ways, we invested in a workforce to provide Link Worker input to all GP Practices across Inverclyde. At present we have a workforce consisting of 8.4 wte directly attached to General Practice. Evidence demonstrates the activity that CLW model has transferred from GPs:

5.6.5 The support of the Community Link Worker (CLW) is not time limited, however, we need to always ensure our aim is to 'link' to appropriate resources to promote independence and support patients to feel empowered so that they know how to combat similar issues if they arise again.

5.6.6 Over a period of 12 months from 1st April 2021 – 31st March 2022 the Community Links Workers received 1396 new referrals. Of this 9 patients were referred from external sources and patients could not be contacted to provide consent for data entry:

- 1,387 individuals were referred to the CLW by GP Practices averaging 115 patients per month.
- Of which 1,089 (78%) patients were seen
- Creating a total of 2,159 encounters, including telephone calls and text messages.
- With 1,327 onward referrals including advice given. This was in addition to a number of patients who were receiving ongoing support prior to this date.
- With support and onward referral for the following top 5 reasons for referral including:

  - Financial matters
  - Mental Health
  - Stress Related issues
  - Housing issues
  - Carer Support

5.6.7 Our Community links worker model is a valued asset attached to and based in all our 13 GP Practices in Inverclyde. They are now firmly embedded within the practice teams which has enabled relationships to grow, both with partners and with patients. Although much of the Community links worker role is 'unseen', they are very much actively out in the community providing support to patients, often with complex issues, to remove barriers and to link with resources and services to improve their overall wellbeing.

6.0 IMPACT SUMMARY

6.1 A national Primary Care Reform survey, with additional local NHS board questions, has been developed and was issued to GPs in March 2022 which aims to capture the transfer of workload from GPs to PCIP staff and to explore whether these additional staff are making a positive difference to GPs across Scotland. Scottish Government are aware that evidencing demand and measuring impact as a direct result of PCIP Implementation has been extremely challenging due to the lack of data sources.

6.2 The impact of the pandemic on General Practice has been really significant and the current pressures and sustainability challenges which practices are reporting are very much linked to the pandemic rather than a failure of impact of the PCIP. Prior to the pandemic Inverclyde HSCP had made significant progress in many of the key MOU areas. Latterly coming out of Covid, we have managed to sustain momentum, continued to advance our plans; whilst coping with the adversities and aftermaths of a global pandemic, significant workforce pressures and substantial financial constraints.

6.3 Whilst we have been able to display the work we have transferred from General Practice, it has been extremely challenging to evidence the direct GP 'time saved'. This impact report does demonstrate the successful shift of care from General Practice; however it is equally important to acknowledge that our population have become one with more complexities; requiring greater health input and care from our GPs. Time saved is therefore not the area of focus; more that the introduction of PCIP services has enabled our General Practitioner

workforce to focus on those individual patients that required that more complex, undifferentiated care.

6.4 Funding has enabled us to introduce a range of Multi-disciplinary professionals, which has both directly and indirectly diverted workload away from GPs and routed to the most appropriate professional or service. It is therefore worth noting that without this investment that our GPs may not have been able to focus on the complexity of the Expert Medical Generalist role due to the significant impact the pandemic had had on our population and these new demands.

6.5 We are therefore drawing awareness to the highlights that:

- The transfer of vaccinations has seen the largest General Practice workload shift.
- CLW activity has increased; reducing the need for GP involvement in social elements.
- ANPs have provided limited alternative to home visits, reducing the need for GP visit.
- CTAC services have enhanced and expanded which will naturally see a shift of activity from Practice Nurses and ultimately GPs to allow that focus on more complex care.
- APP model, although limited spread, has allowed patients to see a specialist for MSK conditions, again something as a Generalist that a GPs value.

6.6 Recent data from our Community Links Worker model shows strong evidence of an increasing demand for support, advice and guidance as a result of fuel poverty, cost of living, which are placing significant demands for both clothing and food banks. The average CLW intervention in 2018 was 1 per person, this is currently averaging 4 per person and is expected to rise.

6.7 It is also important to highlight that there are added pressures and demands to support Ukrainian, Asylum Seekers and Non UK Student Visa Nationals communities. Further resource, investment and capacity is required to support this population and the additional complex demand and increased interventions this is placing on our Community Links Workers, Contractor Services and extended Multi-disciplinary Teams.

6.8 Acknowledgement should be made that the demands our services are now experiencing is from a population that post COVID, lacks resilience and the ability to cope with circumstances and the life as we now know it.

7.0 IMPLICATIONS

7.1 The table below shows whether risks and implications apply if the recommendation(s) is(are) agreed:

SUBJECT	YES	NO	N/A
Financial	x		
Legal/Risk		x	
Human Resources	x		
Strategic Plan Priorities	x		
Equalities		x	
Clinical or Care Governance		x	
National Wellbeing Outcomes	x		
Children & Young People's Rights & Wellbeing		x	
Environmental & Sustainability		x	
Data Protection		x	

7.2 Legal/Risk

There are no legal issues raised in this report.

7.3 Human Resources

Workforce remains a significant challenge, driving additional pressure on delivery of PCIP services. MEMORANDUM OF UNDERSTANDING 2 states a Task and Finish group will be convened to oversee planning and pipeline projections.

7.4 **Strategic Plan Priorities**

Relates to HSCP Strategic Plan, Big Action 4:

- Key Deliverable: Access 4.13:
- By 2022 we will have implemented the Primary Care Improvement Plan (PCIP) delivering the expanded MDT to offer a wider range of choice for support to both acute and chronic illness.

7.5 **Equalities**

(a) This report has been considered under the Corporate Equalities Impact Assessment (EqIA) process with the following outcome:

	YES – Assessed as relevant and an EqIA is required.
x	NO – This report does not introduce a new policy, function or strategy or recommend a substantive change to an existing policy, function or strategy. Therefore, assessed as not relevant and no EqIA is required. Provide any other relevant reasons why an EqIA is not necessary/screening statement.

(b) 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.	None

7.6 **Clinical or Care Governance**

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

7.7 **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.	Through better availability and signposting of the range of primary care support/ professionals, availability of appointments with the right profession at the right time
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	A wider MDT approach with additional/ extended skills to positively supporting individuals
People who use health & social care services have positive experiences of those services, and have their dignity respected.	Improved access to a wider range of professionals/education on services available within the wider primary care/ community setting.
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Improved access to a wider range of professionals and education on services available within the wider primary care/ community setting.
Health and social care services contribute to reducing health inequalities.	Improved access to a wider range of professionals and education on services available within the wider primary care/ community setting.
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.	Development of the MDT and additional investment will support practices and GPs to continue deliver primary care consistently and effectively.

7.8 **Children and Young People**

Has a Children's Rights and Wellbeing Impact Assessment been carried out?

	YES – Assessed as relevant and a CRWIA is required.
x	NO – Assessed as not relevant as this report does not involve a new policy, function or strategy or recommends a substantive change to an existing policy, function or strategy which will have an impact on children's rights.

7.9 **Environmental/Sustainability**

Summarise any environmental / climate change impacts which relate to this report.
Has a Strategic Environmental Assessment been carried out?

	YES – assessed as relevant and a Strategic Environmental Assessment is required.

x	NO – This report does not propose or seek approval for a plan, policy, programme, strategy or document which is like to have significant environmental effects, if implemented.

7.10 **Data Protection**

Has a Data Protection Impact Assessment been carried out?

	YES – This report involves data processing which may result in a high risk to the rights and freedoms of individuals.
x	NO – Assessed as not relevant as this report does not involve data processing which may result in a high risk to the rights and freedoms of individuals.

8.0 DIRECTIONS

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	

9.0 CONSULTATION

9.1 This report has been prepared by the Head of Health and Community Care, Inverclyde Health and Social Care Partnership (HSCP) under the direction of the Primary Care Transformation Group.

9.2 Engagement through our New Ways, PCIP and now Primary Care Transformation journey; has been inclusive ensuring our key stakeholders are engaged in the development and shaping of our services.

9.3 In supporting our transformation agenda, it is recognised that in order for successful transfer of care; from GP to extended multidisciplinary professionals that population engagement is key.

9.4 Our culture change journey commenced during New Ways of Working. It was at that point our 'Choose the Right Service' brand and campaign was created. Working in partnership with our third sector partners and led by Your Voice; this model has advanced, and embedded in our communities. As we now know it, patients were seen for the 'right care in the right place'.

9.5 On the next phase of our transformation journey, we have:

- Commissioned further population engagement through the third sector, focusing on the 'Transformation of Primary Care'.
- Created Development Groups for areas of the Memorandum of Understanding to ensure our stakeholders are represented and have input to the onward development of our services.
- Monthly drop in sessions for GP Practice workforce to engage and contribute to focus session on specific Memorandum of Understanding areas.

Population engagement will take place through a variety of approaches including face to face, social media.

10.0 CONCLUSIONS

10.1 The headline messages from our Inverclyde's Primary Care Implementation Plan journey, at endpoint January 2023, is that:

- An additional 41.67 wte staff have been recruited to the MDT roles.
- The additional workforce capacity has increased support for General Practice; as well as managing both existing and new workload in a sustainable way.
- The implementation of the new models and extended multidisciplinary teams are now an established part of core general practice provision; which has allowed a significant transfer of work from GP practices to the HSCP across all of the MOU as demonstrated above in each of the priority areas.

10.2 PCIP was developed within the available funding, with a focus on those areas most closely linked to contractual commitments. The Memorandum of Understanding confirmed that investment should be focused on the three priority areas linked to direct transfer of service responsibility.

10.3 Inverclyde HSCP has embraced these opportunities to utilise an innovative approach to skill mix, creating efficiencies and maximising impact. As a partnership, Inverclyde has exceeded beyond this; and have significantly progressed all Memorandum of Understanding defined areas and should be commended on this success.