AGENDA ITEM NO: 10

Report To:	**Inverclyde Joint Integration Board**	**Date:**	**18 November 2024**
Report by:	**Kate Rocks Chief Officer Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/41/2024/AB**
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Subject:	**Progress 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 provide an update on progress on the delivery of the Primary Care Improvement Plan (PCIP) and how this contributes to the overall progression of the Transformation of Primary Care Services

2.0 RECOMMENDATIONS

2.1 Members of the Integration Joint Board are asked to note the successes and progress achieved in delivering a multi-disciplinary approach to complement General Practice care through the delivery of the Primary Care Improvement Plan (PCIP).

2.2 Members are also asked to note the allocation of the Primary Care Improvement Fund in the continued development of innovative Practice in Primary Care, communication and engagement, recruitment and retention and premises development to support our multi-disciplinary workforce.

Kate Rocks
Chief Officer
Inverclyde Health and Social Care Partnership

3.0 BACKGROUND AND CONTEXT

3.1 Prior reports to the Integration Joint Board have described the background and context of the new contract provision of General Medical Services in Scotland. Our Primary Care Transformation journey in Inverclyde HSCP commenced in 2016 when the Scottish Government selected Inverclyde to test multi-disciplinary models of care in General Practice (GP) settings. Following successful delivery, the outputs and evaluation was the foundations on which the new GMS contract was built upon.

3.2 The contract maintains a vision of multi–disciplinary professionals working to support GP Practices, under the employment and direction of HSCPs. A programme of innovation and transformation across General Practice, with the objective of supporting GPs provided a new way of working across Primary Care at a critical time were GP recruitment and retention was challenging. This continues to be the case into the present day, placing significant pressures on the delivery of GP Practice services. Allowing patients to be seen by the most appropriate professional, this new way of working was intended to support GPs to focus on care for patients with the most complex needs.

3.3 Delivery for Inverclyde HSCP continues to be based on the defined Memorandum of Understanding (MOU). The MOU which 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 areas of focus on Vaccinations, Pharmacotherapy and Community Treatment and Care Services (CTAC).

3.4 Funding has been challenging to date, with Scottish Government confirming allocations late into the financial year. This places the Programme Management Team under considerable pressure to achieve delivery of the defined Scottish Government expectations. Funding for financial year 2024 – 2005 is the first year that full funding has been received as of July 2024. This allows us to fully commit spend at an earlier point in the year. We await further discussions with Scottish Government on arrangements for baseline funding, with an expected aim for implementation by April 2026.

3.5 As of September 2024, we have 51.31wte staff contributing to the delivery of Primary Care Transformation. Given the continued financial commitment from the Scottish Government to Primary Care Services and General Practice and that full funding allocation is received, the IJB are asked to not the utilisation of the Primary Care Improvement Fund (PCIF) in the continued delivery and development of the agreed Memorandum of Understanding (MOU) service areas. Also to support the progression of PCIF related posts to allow for further advancement of this transformation programme.

3.6 Inverclyde has a registered patient population of 80,931 across 13 GP practices spanning from Gourock to Kilmacolm. Registration data shows a steady increase each quarter in the overall number of practice registrations in Inverclyde, showing an increase of 1016 registrations since April 2022. The average practice list size is 6225, ranging from 2,846 patients to 14,698 patients in our largest practice.

3.7 Primary Care Transformation has enabled GP practices to support patients in alternative settings. The introduction of experts based on a multidisciplinary team model it is underpinned by seven key principles: safe, person-centred, equitable, outcome focussed, effective, sustainable, affordable and value for money. The multi-disciplinary approach has allowed the transfer of some work from GP practices to HSCP staff within the context of Primary Care transformation

3.8 In line with the revised Memorandum of Understanding, our priorities continue to focus on advancing and accelerating our multidisciplinary models of care across CTAC, Pharmacotherapy, VTP followed by Urgent Care as defined. We continue to commit support to those valued models including Community Link Workers and Advanced Practice Physiotherapists.

3.9 **VACCINATION TRANSFORMATION PROGRAMME**

The Vaccination Transformation Programme (VTP) is deemed one of biggest models of care transferred from General Practice to NHS Board and HSCPs. This approach has removed vaccination workload from General Practice.

The Vaccination Transformation Programme is divided into different workstreams:

- Pre-school programme
- School based programme
- Travel vaccinations and travel health advice
- Influenza programme
- At risk group programme (Shingles pneumococcal)

The Primary Care Team continues to work closely with GGC Public Health colleagues to modernise vaccination services. Review and refinement of current delivery models continues in order to bring vaccinations to our community, rather than our community to the vaccinations. Building an effective delivery model for the future is of key focus over the coming years, local developments include the presence of the Scottish Ambulance Vaccination mobile unit in areas of high deprivation including Port Glasgow and Greenock Health Centres.

Locally we have looked at innovative ways of reaching both our workforce and population through digital platforms, screens and billboards. We have also adopted traditional approaches including the development of materials to highlight vaccination importance and signposting our community.

We have focused on bringing vaccinations to our population, moving away from bringing our population to the vaccinations. Our vision is one that is community based, inclusive and varied. We have secured community accommodation at Broomhill Community Gardens in Greenock and Port Glasgow Health Centre. The continued use of both Greenock Town Hall and Gourock Gamble Halls was no longer financially sustainable. In partnership with the Scottish Ambulance Service, the mobile vaccination unit will visit sites across Inverclyde each month. The drop-in mobile units are planned to visit car parks at Greenock's Ravenscraig Activity Centre, Craigend Resource Centre, Gourock Pool, Tesco Port Glasgow and exploration for Kilmacolm is underway. We will continue to listen to feedback from our population to best suit the needs of our localities.

Care Home resident and housebound patients continue to be vaccinated by our local team. With permanent vaccinators in place as of August 2024 this brings stability to our local service delivery model, which will be overseen by our Vaccination Co-ordinator joining the team at the end of October.

Winter Vaccination programs across 2023/2024

Covid vaccinations -16,946 persons (87% of care home residents vaccinated)

Flu vaccinations - 20,903 residents (89% of care home residents vaccinated)

3.10 PHARMACY AND PHARMACOTHERAPY

Adopting a tiered model approach to Primary Care Pharmacy has seen the expansion of existing pharmacy teams to introduce a shift from traditional pharmacy activities into one where we are able to provide a new medicines management service, referred to as the pharmacotherapy Service.

The implementation of mix of pharmacy professionals 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. With a workforce of 13.73wte delivering pharmacotherapy service across Inverclyde supporting the transfer of Pharmacy activity from GPs to advanced pharmacists and Senior Pharmacists.

The Hubs focus on medication changes from Immediate Discharge Letters (IDLs), Outpatients Letters (OPL), Acute Requests (DMARDs, analgesics) and Serial Prescribing, medication reconciliation, medication queries and Prescribing quality improvement.

The immediate focus is to bring consistency across the practices and standardise prescribing processes and approaches to prescribing activity. Cost efficiencies, quality prescribing and formulary compliance continue to be areas of focus moving ahead. A Prescribing Management & Pharmacotherapy Group, Pharmacy Development Group and Pharmacy Locality Group have been established locally to drive forward the required changes, review clinical and cost-effective prescribing, governance structure around the prescribing and prescribing education across Inverclyde HSCP.

3.11 COMMUNITY TREATMENT AND CARE (CTAC)

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.

Existing treatment room models located in Gourock, Greenock and Port Glasgow Health Centres have naturally integrated under the umbrella of Community Treatment and Care.

Building on existing good practice and enhancing services for our GP practices allows the incorporating of basic disease data collection and biometrics (such as blood pressure), the management of minor injuries and dressings, suture removal, and ear care within this delivery model. 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.

As a combined Treatment Room and CTAC model, the service received over 12,000 referrals between January – August 2024. In that same period 24,425 appointments took place at our CTAC centers.

On a monthly basis, a further 193 clinical hours of Health Care Support Worker appointments are available in total across General Practice. GP practices book patients directly into these clinics to suit practice demand.

Upskilling of our workforce, enabling Community Treatment and Care to develop, test and pilot innovative practice including:

- blood pressures remote home monitoring,
- ear care pathway,
- leg ulcer assessment clinic,
- diabetic foot clinic

- Lifestyle change conversations to support patients.
- Forming strong links with local services to make every contact count us by encourage signposting to local, national services or information to support patients manage their conditions independently.

3.12 **ADVANCED NURSE PRACTITIONERS (ANP)**

The Advanced Nurse Practitioner role is one that is utilised in a variety of settings, in the case of PCIP delivery this is through an Unscheduled Care Home Visit model. An ANP workforce of 6.8wte responding to a proportion of home visits for General Practitioners.

The current ANP model is GP practice assigned with a coverage of 12 of the 13 GP Practices. The population area is approximately 60,000.

It is worth highlighting that only 3wte of our workforce are fully trained ANPs, with the remainder of the team nearing completion of training early 2025. With more than 50% of our workforce employed in a training capacity this places significant pressure on the service and our ability to meet demand.

A trainee model requires significant investment with regards to time out from clinical duties for shadowing, mentoring, university and study leave, over and above clinical patient facing role and clinical note write up. For that reason, a local decision has been made to employ fully qualified ANPs moving forward to bring stability to the service.

The team have carried out 1,112 home visits from May 2024 until August 2024. With a further 98 care home visits and 5 frailty visits.

3.13 **COMMUNITY LINK WORKER (CLW)**

Inverclyde's Community Link Worker model is built on 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.

There is a significant cohort of patients who seek recurring and regular support from GPs, for what are often issues associated with loneliness, social isolation, a lack of community connection and associated 'social' issues. The CLW model was established to support such individuals with a variety of social, financial, mental health and practice issues.

The success of this programme allows a GP attached workforce of 8.4wte (1.8wte temporary) to provide a vital link service to all GP Practices across Inverclyde.

The support of the Community Link Worker (CLW) is not time limited, however, we CLW always ensure the 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. With support and onward referral, the main reasons for referral continue to include financial matters, Mental Health support, stress related issue, housing assistance and legal issues.

Period 1st April – 1st June 2024, the service had 1708 encounters and contacts: seeing 348 patients and accepting 382 referrals. The number of reasons for referrals during that quarter was 546, demonstrating patients being referred to the service for multiple issues. As part of the team assessment, they made onward referrals of 1004 to support patient's non-medical needs.

3.14 ADVANCED PRACTICE PHYSIOTHERPIST (APP)

The role of Advanced Practice Physiotherapist (APP) is delivered by 3 wte (excluding time in MSK) with 62% of our GP Practices population accessing a Physiotherapist within a GP practice setting.

The majority of patients signposted directly to the APP therefore reducing unnecessary GP attendances. This model of care has again experienced significant staff movement which has proved challenging to maintain a robust and sustainability service and no opportunity to expand to our wider GP community. This creates an inequitable service provision for practices and patients.

Patient awareness of support and resources available to aid the management of muscle, joints and aches remains priority. The launch of the Physiotherapy Website provides helpful re-direction of patients to support early and self-management advice regarding their condition.

A further development in Physiotherapy has enabled Advanced Practice Physiotherapists in Primary care to issue fit notes if appropriate as part of their patient assessment. This will bring great benefit to General Practice with GP still providing support to discuss any issues arising as this new competency develops.

3.15 POPULATION ENGAGEMENT

Through population engagement, explaining the true meaning of Primary Care and the range of professionals and services that work alongside our General Practitioners (GP), we will ensure our population are accessing the right care in the right place.

Our local population engagement programme complemented our existing Choose the Right Service brand; raising further awareness of services and resources accessible and one that supports a culture of appropriate use of our health and social care services.

Our Primary Care Transformation journey has been shared through a variety of formats and activities including the development of Primary Care Transformation Branding, Population Knowledge Survey, Community Engagement, Group Sessions, Information Stalls, Workforce Engagement sessions, social media, Transformation Webpage, appropriate signposting training for our workforce.

Engagement has been supported by our overarching Primary Care Transformation film. This film is one that takes our population on a Transformation journey, explaining the new roles and professionals our population may now attend or speak to other than a GP, and the reasoning behind this transformation.

The Primary Care Team and Your Voice workforce collaborative is engaged with multiple businesses, third sector partners, health and social care facilities, community-based settings including libraries, foodbanks and community centres. The prime focus to maximise engagement and raise awareness of the Transformation of Primary Care and how to access services, embedding our Right Care, Right Place ethos.

Some key achievements are captured as follows:

- Engagement with 35 community groups and 28 public information stalls
- Primary Care Guides delivered to 39,367 households
- Dissemination of 36,698 Service flyers across our community.
- Distribution of 7683 other materials including business cards, pocket guides, and surveys.

- 85,720 social media impressions in relation to the programme
- Primary Care film running on all 13 GP Practices media screens
- QR codes set up linking our communities to resources and materials
- Digital Board across Inverclyde displaying transformation messages. Total Impacts across the 5 sites is 2,201,292 with an average frequency across the 5 sites of 3.4 times an individual saw our adverts.
- Development of a digital platform via link tree hosting all resource, videos and details of Primary Care Transformation.
- Engagement and feedback achieved through 1004 surveys completed via social media platforms, community group sessions and information stalls.
- Feedback from population surveys will shape existing models and allow us to further improve and develop our services locally.

We continue to engage with partners and patients on this work and will follow up with Population Engagement Summary Report which will be available in April 2025.

4.0 PROPOSALS

4.1 IJB members will be aware that PCIP funding has enabled the successful introduction of a range of multi-disciplinary professionals within Primary Care. This has both directly and indirectly diverted workload away from GPs and routed to the most appropriate professional or service. Without this investment, our GPs would not be able to focus on the complexity of the Expert Medical Generalist role due to the needs of our population post pandemic.

The IJB is asked to note the following PCIP highlights:

- Population engagement continues to be key to delivering Primary Care Transformation, raising awareness of alternative services and professionals to complement GP care will deliver the best outcomes for our Transformation Journey.

- Engaging with our workforce and partners around Primary Care Transformation is our most valuable assets in changing the culture of use of services. The onward dissemination of the role of extended multi-disciplinary teams, services that complement GP care and information and support available, becomes as natural topic of discussion throughout our communities.

- Transfer of vaccinations has seen the largest General Practice workload shift, it is to be acknowledge that we are making good progress on local delivery models and will continue to work with Public Health colleagues in the onward development of these to suit local need.

- Community Link Worker activity continues to increase and support our communities with non-medical and social prescribing needs. This role working across all GP Practices reduces the need for GP involvement in aspects of non-medical care.

- Advanced Nurse Practitioners provide an alternative to home visits, reducing the need for GP visit. Review of overall model and approach to urgent and unscheduled care in this context and will continue to achieve maximum coverage and impact.

- Community Treatment and Care services have enhanced and expanded nursing care, which has seen a natural shift of activity from Practice Nurses and ultimately GPs to allow that focus on more complex care.

- Advanced Practice Physiotherapist (APP) model, although limited spread, has allowed patients to see a specialist for MSK conditions, again something as a Generalist, GPs value.

- Skill mix within our multi-disciplinary teams adds a balance to our models of care, enabling clinicians to focus on complex care, whilst support staff delivery lower level activity and care.

5.0 IMPLICATIONS

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

SUBJECT	YES	NO
Financial	x	
Legal/Risk		x
Human Resources	x	
Strategic Plan Priorities	x	
Equalities, Fairer Scotland Duty & Children and Young People		x
Clinical or Care Governance		x
National Wellbeing Outcomes	x	
Environmental & Sustainability		x
Data Protection		x

5.2 **Finance**

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report	Virement From	Other Comments

Annually Recurring Costs/ (Savings)

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

5.3 **Legal/Risk**

There are no legal issues raised in this report.

5.4 **Human Resources**

Workforce remains a significant challenge, driving additional pressure on delivery of PCIP services. MEMORANDUM OF UNDERSTANDING2 states a Task and Finish group will be convened to oversee planning and pipeline projections.

5.5 **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.

5.6 **Equalities**

(a) Equalities

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) Equality Outcomes

How does this report address our Equality Outcomes?

Equalities Outcome	**Implications**
We have improved our knowledge of the local population who identify as belonging to protected groups and have a better understanding of the challenges they face.	Ensures people with protected characteristics are included in the development of Primary Care Services
Children and Young People who are at risk due to local inequalities, are identified early and supported to achieve positive health outcomes.	Primary Care Services are focused on inequality in health care and promotes taking services to the community
Inverclyde's most vulnerable and often excluded people are supported to be active and respected members of their community.	Primary Care Services supports inclusion.
People that are New to Scotland, through resettlement or asylum, who make Inverclyde their home, feel welcomed, are safe, and able to access the HSCP services they may need.	People who are New to Scotland are supported through Primary Care services Clinically appropriate.

(c) Fairer Scotland Duty

If this report affects or proposes any major strategic decision:-

Has there been active consideration of how this report's recommendations reduce inequalities of outcome?

	YES – A written statement showing how this report's recommendations reduce inequalities of outcome caused by socio-economic disadvantage has been completed.
x	NO – Assessed as not relevant under the Fairer Scotland Duty for the following reasons: Provide reasons why the report has been assessed as not relevant.

(d) **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.

5.7 **Clinical or Care Governance**

There are no clinical or care governance implication from this report.

5.8 **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 and 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.

5.9 **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.

5.10 **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.

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 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.

7.2 Our culture change journey commenced during New Ways of Working in 2017. 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 we developed our branding of Transforming our Services, Transforming Primary Care. Our branding is not only recognisable but clearly visible within our communities. We will continue to work with partners and our population to raise awareness of appropriate services and support to ensure that our patients receive the 'right care in the right place'.

8.0 BACKGROUND PAPERS

8.1 None