AGENDA ITEM

15

Falkirk
Health and Social Care
Partnership

Title/Subject:	**Primary Care Improvement Plan - Delivering the New 2018 General Medical Services Contract**
Meeting:	**Integration Joint Board**
Date:	**1 June 2018**
Submitted By:	**Associate Medical Director**
Action:	**For Decision**

1. INTRODUCTION

The purpose of this paper is to update the Integration Joint Board on progress with developing the Forth Valley Primary Care Improvement Plan for delivering the new 2018 General Medical Services Contract and sets out the principles and priorities which will be included in the draft plan.

2. RECOMMENDATION

The Integration Joint Board is asked to:

2.1. note the Primary Care Improvement fund element of the wider primary care fund is to be used by Integration Authorities to commission primary care services and is allocated on an NRAC basis through Health Boards to Integration Authorities

2.2. agree a Forth Valley approach to develop a single plan and that this should clearly set out the use of the Falkirk allocation

2.3. delegate authority to the Chief Officer, Chief Finance Officer and IJB Chair to sign-off the draft plan and note that the NHS Chief Executive will sign-off on behalf of the NHS FV Board

2.4. note that the Board will receive the submitted plan at the September IJB meeting.

3. BACKGROUND

3.1. This paper outlines the requirement for all Integration Authorities to produce a Primary Care Improvement Plan in response to new General Medical Services Contract, which was introduced in January 2018, and progress with preparing the Primary Care Improvement Plan for Forth Valley.

3.2. The Chief Officer report to the Board in December 2017 outlined the requirements to produce the plan and submit to the Scottish Government by 1 July 2018.

4. NEW GENERAL MEDICAL SERVICES CONTRACT FOR SCOTLAND 2018

4.1. The new 2018 General Medical Services Contract for Scotland describes a number of benefits for patients to help people have access to the right person, at the right place, at the right time in line with the Scottish Government Primary Care Vision and Outcomes. In particular this will be achieved through:

- Maintaining and improving access
- Introducing a wide range of health and social care professional to support the Expert Generalist (GP)
- Enabling more time with the GP for patients when it is really needed
- Providing more information and support for patients.

4.2. The benefits of the proposals in the new contract for the profession are:

- A refocusing of the GP role and improve on being a GP
- Sustainable funding and practice income, including new minimum earning expectation from April 2019
- Manageable workload – additional Primary Care staff to work alongside and support GPs and practice staff to reduce GP workload and improve patient care
- Improving infrastructure and reducing risk, including management/ ownership of premises, shared responsibility as data controller for information sharing and responsibilities for new staff
- Improve recruitment and retention.

4.3. As an Expert Medical Generalist, the GP will focus on:

- Undifferentiated presentations
- Complex care
- Local and whole system quality improvement
- Local clinical leadership for the delivery of general medical services under GMS contracts.

4.4. Expert Medical Generalists will strive to ensure robust interface arrangements, connection to and coherence with other parts of the wider primary care team e.g. nurses, pharmacists and physiotherapists, the health and social care community based services and with acute services when required. They will be supported by a multi-disciplinary team and the contribution of clinical and non-clinical staff in medicine, allied health professional, links workers, practice management, administration and others will be maximised.

4.5. The Memorandum of Understanding between the Scottish Government, the British Medical Association, Integration Authorities and NHS Boards builds on these arrangements and represents a landmark statement of intent. It recognises the statutory role of the Integration Authorities in commissioning primary care services and service redesign and of NHS Boards in service delivery, employers and partners to General Medical Service contracts.

4.6. The development of primary care service redesign should be in the context of delivery of the new GMS contract and should accord with seven key principles:

- Safe
- Person Centred
- Equitable
- Outcome Focussed
- Effective
- Sustainable
- Affordability and Value for Money.

4.7. The Memorandum of Understanding identified key priorities which should be included in the health and social care Primary Care Improvement Plans:

- Vaccination Transformation Programme
- Pharmacotherapy Services
- Community Treatment and Care Services
- Urgent Care (advanced practitioners)
- Additional Professional Roles
- Community Link Worker.

5. DEVELOPMENT OF A PRIMARY CARE IMPROVEMENT PLAN

5.1. The Primary Care Improvement Plan Working Group has been working to produce a single Primary Care Improvement Plan for Forth Valley. The Improvement Plan will identify how additional funds are implemented in line with the Contract Framework and will outline how services will be introduced until March 2021, to establish an effective multi-disciplinary team model at Practice and Cluster level.

5.2. A Primary Care Improvement Plan Working Group has been established with representation as below:

- NHS Forth Valley Chief Executive
- Chief Officers, Clackmannanshire & Stirling and Falkirk Health and Social Care Partnerships
- Medical Director
- Associate Medical Director, Primary Care
- 7 GP representatives
- Senior representatives from Planning, HR, Finance, Estates & Facilities, Community Nursing, Pharmacy, AHPs and General Management.

5.3. The Plan is being developed in collaboration with local GPs and others, including the GP Sub-Committee, Local Medical Committee and Area Partnership Forum. A GP Information Evening on the new GMS Contract, including a workshop on the Improvement Plan took place on 9 May and a CREATE session explored the Improvement Plan options in greater depth on 23 May.

5.4. The draft Forth Valley plan is attached at Appendix 1 for information, and this remains under development and is subject to further change. The Board are asked to agree a Forth Valley approach to develop a single plan and that this should clearly set out the use of the Falkirk NRAC allocation.

5.5. As the plan needs to be submitted to the Scottish Government by 1 July 2018, the Board are asked to delegate authority to the Chief Officer, Chief Finance Officer and IJB Chair to sign-off the draft plan and note that the NHS Chief Executive will sign-off on behalf of the NHS FV Board. The Integration Joint Board will receive a report at their September meeting on the submitted plan.

5.6. Whilst it is expected that Integration Authorities will prepare a 3 year Primary Care Improvement Plan, for the period 2018 to 2021, in reality it is likely that implementing the new models of care will not be fully in place by 2021 and will continue to be implemented beyond this date. The main reasons for this are the scale and complexity of the changes required, the availability of additional people to take on the new roles and the time it will take to develop the right skills and competencies in the existing and additional workforce.

6. PRIMARY CARE SUSTAINABILITY

6.1. The development of the Primary Care Improvement Plan in Forth Valley requires to be viewed in the context of continuing challenges with sustaining GP practices in the area. This issue is recognised in the Board Corporate Risk Register and more specific practice issues are reflected in the Primary Care Risk Register.

6.2. The move towards a new GMS Contract is set against a background of ongoing sustainability issues recognising that less doctors are choosing to become GPs and over 50% of our current GPs in Forth Valley are over 50 with 23-25% aiming to retire or significantly reduce their clinical commitment in the next 3-5 years.

6.3. While Forth Valley issues in relation to GP recruitment and retention are mirrored nationally, the scale and potential impact of the local problem is recognised currently to be very significant. It is estimated nationally that 25% of GP practices are experiencing recruitment difficulties. These challenges also bring additional risks of destabilising neighbouring practices.

6.4. Kersiebank, Bannockburn, Slamannan and Hallpark practices are currently managed by the NHS Board and operating through a multi-professional primary work model. These Practices continue to carry vacancies despite a continuous rolling recruitment programme.

6.5. Emerging sustainability issues are also being reported in respect of a number of practices. An option appraisal process to manage individual practice circumstances is established and is led by the Associate Medical Director of Primary Care.

6.6. All Forth Valley practices are required to complete the Primary Care Sustainability Framework Tool as part of the Whole System Working Project for 2018/19 to help identify sustainability challenges and needs for support at an early stage.

7. TRANSFORMATION PROGRAMME

7.1. The Primary Care Transformation programme was initiated to test new ways of working in advance of the new General Medical Services Contract. As indicated in this paper, implementation of this contract will see a significant change in the model of general practice in Scotland. This will enable GPs to be expert generalists, develop a multidisciplinary primary care team approach and reduce non essential GP workload.

7.2. The attached end of year report 2017-18 (Appendix 2) provides an overview of the Primary Care Transformation Programme in the Falkirk and Clackmannanshire and Stirling Partnerships which is focused on 3 areas:

- Urgent GP Out of hours transformation
- Primary care transformation – working collaboratively in clusters of GP practices
- Mental Health in Primary Care.

8. PRIMARY CARE IMPROVEMENT PLAN PRIORITIES

8.1. Six priority areas were identified in the Memorandum of Understanding for improvement, and these will form the basis of the 3 year plan for Forth Valley.

8.2. **Vaccination Transformation Programme**
The Vaccination Transformation Programme was announced in March 2017 to review and transform vaccine delivery in light of the increasing complexity of vaccination programmes in recent years, and to reflect the changing roles of those, principally GPs, tasked historically with delivering vaccinations.

8.3. In the period to 2021 change will be delivered in a phased way as part of the Primary Care Improvement Plan to meet a number of nationally determined outcomes including shifting work to other appropriate professionals and away from GPs. This has already happened in Forth Valley for school-aged childhood immunisation and vaccinations. It is expected that this change will be managed, ensuring a safe and sustainable model and delivering the highest levels of immunisation and vaccination uptake. There may be geographical or other limitations to the extent of any service redesign.

8.4. In Forth Valley the following phased implementation is proposed:

2018/19 - Travel vaccination moves from GP practice to NHS service
Pilot pre-school vaccination programme

2019/20 - Implement NHS managed pre-school vaccination programme

2020/21 - Implement NHS managed vaccination programme for older adults and vulnerable groups

8.5. **Other Priorities**
It is proposed to implement the other 5 improvement priorities on a phased basis, with each GP cluster gaining at least 1 new NHS provided service in 2018/19. Each priority will then be rolled out to the other clusters, over the 3 year period of the Improvement Plan.

8.6. This phased approach recognises that there will be the need to recruit additional staff and to train and develop people to take on new roles, over this 3 year period and beyond. The approach also recognises the requirement to ensure that the new models which are being introduced, deliver the desired outcomes.

8.7. The priority areas outlined below will require new and innovative ways of working and therefore alongside implementation of these priorities will be significant work to test the models and adapt these to local circumstances. Further scoping will be required during 2018/19 to ensure that these are effective and efficient and offer best value.

8.8. Implementation of the Plan will also take into consideration any local requirements or developments, in shaping how the priorities will be implemented in each Practice and Cluster. For example, development of the new services needs to acknowledge and complement the wider work taking place in the Partnerships such as “place based care” and further integration of health and social care teams.

8.9. **Pharmacotherapy Services**
Pharmacotherapy services are in three tiers, divided into core and additional activities, to be implemented in a phased approach.

8.10. By 2021, phase one will include activities at a general level of pharmacy practice including acute and repeat prescribing and medication management activities and will be a priority for delivery in the first stages of the Primary Care Improvement Plan. This is to be followed by phases two (advanced) and phase three (specialist) which are additional services and describe a progressively advanced specialist clinical pharmacist role. However in order to ensure successful recruitment and retention of staff, roles will require to include a balance of activities, between providing the most appropriate service model to support practices and making roles suitably attractive.

8.11. **Community Care and Treatment**
These services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate. Phlebotomy will be delivered as a priority in the first stage of the Primary Care Improvement Plan.

8.12. This change needs to be managed to ensure, by 2021, a safe and sustainable service delivery model, based on appropriate local service design.

8.13. **Urgent Care (advanced practitioners)**
These services provide support for urgent unscheduled care within primary care, such as providing advance practitioner resources e.g. nurse or paramedic for GP clusters and practices as first response for home visits, and responding to urgent call outs for patients, working with practices to provide appropriate care to patients, allowing GPs to better manage and free up their time.

8.14. By 2021, it is expected that there will be a sustainable advance practitioner provision in both Partnership areas, based on appropriate local service design. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.

8.15. **Additional Professional Roles**
Additional professional roles will provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting (as part of the wider MDT). For example, but not limited to:

- Musculoskeletal focussed physiotherapy services.
- Community clinical mental health professionals (e.g. nurses, occupational therapists) based in general practice.

8.16. By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. Service configuration may vary dependent upon local geography, demographics and demand.

8.17. **Community Link Worker**
Community Link Worker (CLW) is a generalist practitioner based in or aligned to a GP practice or Cluster who works directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of (for example) the complexity of their conditions or rurality. As part of the Primary Care Improvement Plan, Health and Social Care Partnerships are expected to develop CLW roles in line with the Scottish Government's manifesto commitment to deliver 250 CLWs over the life of the Parliament.

The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models/systems of care and support.

9. Resources

9.1. The funding available to the Partnerships to implement the Primary Care Improvement Plan in the Forth Valley area has just been announced by the Scottish Government (23 May 2018). This is attached at Appendix 3 for information.

9.2. The overall figure for Forth Valley in 2018/19 is £2,479,354. However this amount includes funding for services already in place, as per previous Scottish Government directions and therefore the actual amount available to Forth Valley for investment in Primary Care Improvement in 2018/19 is around £1,800,000. This amount will not be sufficient to fund all of the improvements identified against the 6 priority areas for 2018/19.

9.3. An assessment of the improvements identified for each of the priority areas for 2018/19 will be made against the available funding and any gaps will be identified and highlighted in the draft plan and will be reported to the IJB.

10. Infrastructure, Enablers and Workforce

10.1. The Primary Care Improvement Plan will also consider the impact of the new GMS contract on the infrastructure, including premises, enabling factors and workforce.

10.2. The National Code of Practice for GP Premises sets out how the Scottish government will support a shift, over 25 years, to a new model for GP premises in which GPs will no longer be expected to provide their own premises. The measures outlined in the Code represent a significant transfer in risk of owning premises away from individual GPs to the Scottish Government. Therefore, premises and location of the workforce are an important component on the 3 year Improvement Plan for Forth Valley.

10.3. A detailed review of current Primary Care premises will be undertaken, once further direction is received from Scottish Government, in order to identify the current condition and use, future suitability for use and any changes required to create positive environments for patients and staff (investment, vacation etc).

10.4. An understanding of other suitable community based premises is also required in order make best use of facilities, for example to establish locality / cluster treatment hubs and resource centres. Opportunities to use the premises of partner organisations should be considered.

10.5. The National Health and Social Care Workforce Plan Part 3 – Improving Workforce Planning for Primary Care in Scotland was published in April 2018. This Plan sets out recommendations and the next steps that will improve primary care workforce planning in Scotland. These complement the recommendations in parts one and two and, taken together, will form the basis of the integrated workforce plan in 2018. The recommendations set out how the expansion and up-skilling of the primary care workforce will be enabled, the national facilitators to support this, and how this will complement local workforce planning.

10.6. An assessment of the current Primary Care workforce in Forth Valley is underway and will inform the workforce plan which will form part of the Primary Care Improvement Plan. Areas of development already underway include a review of recruitment with the aim of making Forth Valley an attractive place to work in and early recruitment to key posts.

10.7. The availability of additional suitably skilled and trained staff to recruit is a significant risk factor in implementing the Primary Care Improvement Plan in Forth Valley. All Health systems in Scotland will also be seeking to expand their multi-disciplinary workforce to support Primary Care services at the same time, and therefore the ability to recruit staff will be a major concern.

11. CONCLUSIONS

11.1. This report provides an overview of the new GMS Contract and specifically work in progress to prepare a Primary Care Improvement Plan for the Forth Valley area. The draft Primary Care Improvement Plan will be finalised in June and submitted in draft form to the Scottish Government in July.

Resource Implications
Over the period of implementation (2018-2021), the Scottish Government has advised that £250M of new funds will be invested to support General Practice. In 2018/19 it is indicated that £110M will be allocated nationally to support Primary Care Improvement in line with the Memorandum of Understanding. An assessment of the improvement priorities for 2018/19 against the available funding of around £1,800,000 for Forth Valley will be made and any gaps will be identified.

Impact on IJB Outcomes and Priorities
This report and associated recommendations, relates to the Falkirk Health and Social Care Partnership Strategic Plan local outcomes and priorities.

Legal & Risk Implications
As noted in sections above.

Consultation
Consultation and engagement with GPs has included an Information Evening, CREATE session and formal meetings. This will continue as the development and implementation of the Plan progresses.

Equalities Assessment
The contents of this report do not require an EQIA. The benefits of the proposals in the new contract for patients are to help people access the right person, at the right place, at the right time in line with the Scottish Government Primary Care Visions and Outcomes.

Approved for submission by: Patricia Cassidy, Chief Officer

Author – Janette Fraser, Head of Planning, NHS Forth Valley
Date: 17 05 18

List of Background Papers:
The 2018 General Medical Services Contract in Scotland
Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards

Clackmannanshire Council

Stirling Council

Falkirk Health and Social Care Partnership

NHS Forth Valley

DRAFT

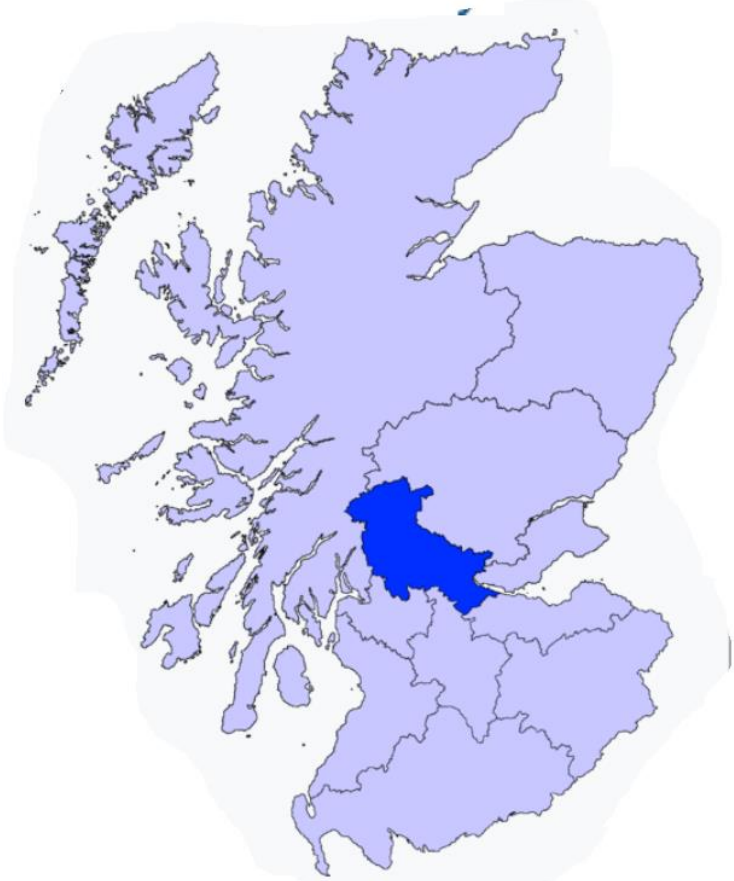
Forth Valley Primary Care Improvement Plan

2018 to 2021



Version 7 – 150518

Table of Contents



Forth Valley is located in the heart of Scotland and has two Health and Social Care Partnerships, Clackmannanshire and Stirling and Falkirk, across 3 local authority areas. Whilst the majority of the population live in towns in the South East, there is a large rural area with small communities situated to the West and North of Stirling with the most remote villages towards the boundaries with Highland and Tayside.

1. Background and National Context

Proposals for a new GP contract were published in November 2017 and agreed in January 2018. The new contract aims to support the development of the Expert Medical Generalist role for GPs, with a shift over time of workload and responsibilities to enable this. A key enabler for this is investment in a wider multi-disciplinary team in support of general practice.

The new contract offer is supported by a Memorandum of Understanding which requires the development of a Primary Care Improvement Plan agreed by the NHS Board and Health and Social Care Partnerships in collaboration with GPs and the LMC. It was expected that the Improvement Plan would be prepared in collaboration with other key stakeholders and supported by an appropriate and effective MDT model at both practice and Cluster level to reflect local needs.

The Primary Care Improvement Plan needs to be developed recognising ongoing strategic and transformational work and support management of the current significant challenges of sustainability of general practice and primary care services.

The Memorandum of Understanding identified key priorities which should be included in the Primary Care Improvement Plan:

- Vaccination Transformation Programme
- Pharmacotherapy Services
- Community Treatment and Care Services
- Urgent Care (advanced practitioners)
- Additional Professional Roles
- Community Link Worker

The Memorandum of Understanding between the Scottish Government, Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards represents a statement of intent recognising the roles of the Integration Authorities and NHS Boards in commissioning and delivering primary care services.

The development of primary care service redesign should be in the context of delivery of the new GMS contract and should accord with seven key principles:

- Safe
- Person Centred
- Equitable
- Outcome Focussed
- Effective
- Sustainable
- Affordability and Value for Money

Further key enablers for change identified are:

- Premises – a shift over 25 years to a new model for GP premises in which GPs will no longer be expected to provide their own premises
- Information sharing arrangements – reducing risk to GPs by a shift to GPs and their contracting Health Boards having joint data controller processing responsibilities towards to the GP patient record
- Workforce – national workforce plan will set out a range of options at national, regional and local level for the recruitment and retention of GPs and the expansion of the capacity and capability of the multi-disciplinary team

The Memorandum of Understanding covers an initial 3 year period, from 1 April 2018 to 31 March 2021 and NHS Boards / Integration Authorities are expected to submit Primary Care Improvement Plans by 30 June 2018 for this 3 year period.

The benefits of strengthening Primary Care are summarised below:

2. Forth Valley Context

Within the Forth Valley area there are 54 GP practices, of which 4 are 2C practices currently managed by NHS Forth Valley. There are 9 GP practice Clusters and the approach being taken to implement the Improvement Plan aims to ensure that all Clusters have the opportunity to develop at least one aspect of the plan initially, while the new models are tested, evaluated and then rolled out to other Clusters.

An agreement has been made with the two Integration Authorities (Clackmannanshire and Stirling, and Falkirk Health and Social Care Partnerships) to prepare a single Primary Care Improvement Plan for the Forth Valley area. However, where appropriate, aspects of the plan and implementation will be tailored to the specific local requirements of Partnerships and the Clusters or Localities within the Partnerships.

A Primary Care Improvement Plan Development Group was established (membership is shown in Appendix 1) with reference to the GMS Contract and Memorandum of Understanding with the remit to:

- Enable the development of the expert medical generalist role through a reduction in current GP and practice workload.
- Agree a primary care and community services multi-professional workforce and recruitment plan to support the expert medical generalist role and enable delivery of safe and sustainable primary care services. This will include the need to recruit and develop a pharmacotherapy team with capacity to support practices as per the GMS Contract requirements.
- Ensure delivery of the Vaccination Transformation Programme (VTP)
- Agree priorities informed by population and professional need
- Agree use of additional resources across Forth Valley
- Determine a communication plan and timeline for delivery of key milestones

A writing group with designated leads has been established to prepare the Primary Care Improvement Plan (appendix 2). The proposed reporting arrangements and structure are shown in appendix 3.

For each of the priority areas included in the Memorandum of Understanding and described in chapters 5 to 8 in this Improvement Plan, colleagues were are asked to consider a 3 horizon approach.

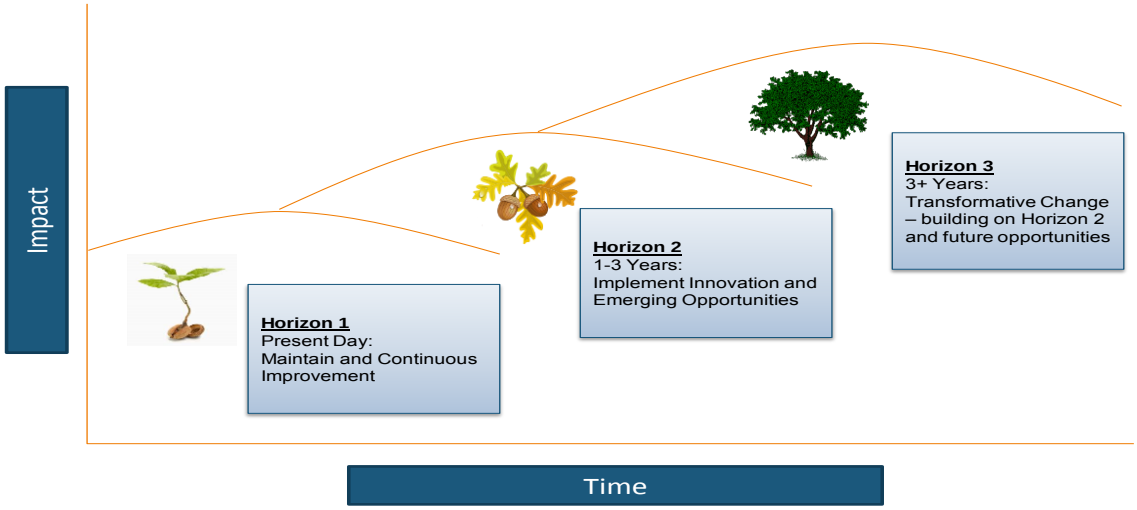
Horizon 1 – Present Day: Maintain services and continuous improvement

Horizon 2 – 1 to 3 years: Implement innovation and emerging opportunities, work towards implementing the 3rd Horizon

Horizon 3 – 3+ years: Transformative change, building on Horizon 2 and future opportunities

A template was prepared for each of the priority areas, which is used to capture the key changes, impacts and outcomes associated with the 3 horizons.

The Three Horizons:
Developing a Sustainable and High Quality NHS



Sustainability

The development of the Primary Care Improvement Plan in Forth Valley requires to be viewed in the context of continuing challenges with sustaining GP practices in the area. This issue is recognised in the Board Corporate Risk Register and more specific practice issues are reflected in the Primary Care Risk Register.

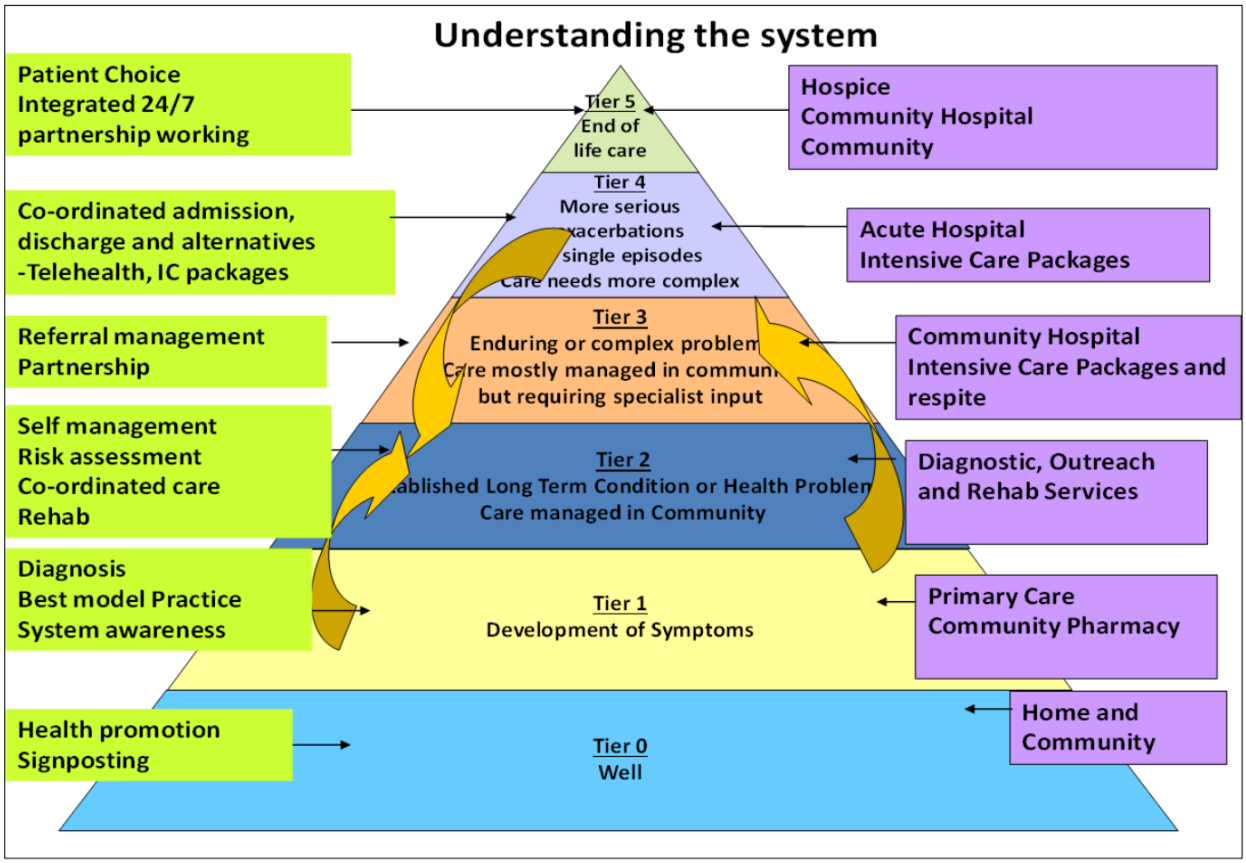
The move towards a new GMS Contract is set against a background of ongoing sustainability issues recognising that less doctors are choosing to become GPs and over 50% of our current GPs in Forth Valley are over 50 with 23-25% aiming to retire or significantly reduce their clinical commitment in the next 3-5 years.

While Forth Valley issues in relation to GP recruitment and retention are mirrored nationally the scale and potential impact of the local problem is recognised to currently be very significant. It is estimated nationally that 25% of GP practices are experiencing recruitment difficulties. These challenges also bring additional risks of destabilising neighbouring practices.

Kersiebank, Bannockburn, Slamannan and Hallpark practices are currently Board managed and operating through a multi-professional primary work model. These Practices continue to carry vacancies despite a continuous rolling recruitment programme.

Emerging sustainability issues are also being reported in respect of a number of 17J practices. An option appraisal process to manage individual practice circumstances is established.

All Forth Valley practices are required to complete the Primary Care Sustainability Framework Tool as part of the Whole System Working Project for 2018/19 to help identify sustainability challenges and needs for support at an early stage.



Primary Care Transformation

There are 3 strands of the Transformation Programme in place in Forth Valley:

Urgent Primary Care (GP) Out of Hours Transformation: with the aim of implementing the recommendations of the "Report of the Independent Review of Primary Care Out of Hours Services", Nov 2015 a comprehensive multiagency GP out of hours case review was conducted in 2017. An OOH implementation plan developed to deliver on the aim of creating a safe and sustainable multidisciplinary approach to Urgent Out of Hours Care in Forth Valley. This new model will be delivered by significantly increasing the capacity for Advance Nurse Practitioners to work with fewer GPs, supported by Mental Health Nurses, Paramedic Specialists and improved integration with other over night supports.

Primary Care Transformation: aims to encourage GP practices to work together in clusters, taking a multi-disciplinary approach to care within practice and the community. This involves developing the role of health professionals such as pharmacists, physiotherapists, mental health professionals and advanced nurse practitioners in delivering aspects of patient care – freeing up GPs to focus on more complex cases and provide clinical leadership. Across Forth Valley we are focussing on the following:

Supporting the development of locality models of care

The Primary Care Transformation Fund is supporting the delivery of locality priorities within both HSC Partnerships which aim to improve outcomes through enhanced primary and community or secondary care interfaces. In South West Rural Stirling through development of a Model of Neighbourhood Care and in Falkirk through provision of pharmacy support to care homes.

Development of multidisciplinary approaches
This is the primary focus of the programme and focuses on testing out new ways of working which will inform the service redesign required for the new General Medical Services Contract proposal to reduce GP workload.
Seven mental health primary care nurses and additional pharmacy sessions per week will provide an additional 400 triage and face to face mental health appointments and eight clinical sessions of pharmacy per week across 14 GP practices over the next two years. Baseline data has been collected with 10% of GP appointments found to be for mental health support alone. A further 10% of consultations include a mental health component presented alongside other complaints.

Enabling Primary Care Transformation
A number of enabling supports are also in place including education and training for advanced practice, Practice Administration Optimisation and signposting, Technology based alternatives to appointments and development of Cluster Quality Improvement.

Mental Health in Primary Care: The investment for mental health services aims to improve access for people with mental health needs to the most appropriate support as quickly as possible, in the most appropriate setting. This aligns with the new mental health strategy for Scotland 2017-2027.

The Primary Care Transformation fund is funding 1.5 additional link workers for 18 months in Clackmannanshire and Stirling and supporting the development of a more efficient and integrated model which will bring Alzheimer Support Workers, the Dementia Outreach Team and a PCTF funded social care dementia resource together to improve the matching of support to the needs of users.

Aligning with Autism Strategy recommendations, we are also developing an area wide resource to support the diagnostic pathway and post diagnostic support for people with autism spectrum disorders and their families.

General Practice Sustainability
See previous section

Stakeholder Engagement

Set out how this will be achieved during preparation of the Improvement Plan and also how engagement will continue during the 3 year implementation phase.

3. Infrastructure and Enablers

The National Code of Practice for GP Premises sets out how the Scottish government will support a shift, over 25 years, to a new model for GP premises in which GPs will no longer be expected to provide their own premises. The measures outlines in the Code represent a significant transfer in risk of owning premises away from individual GPs to the Scottish Government. Therefore, premises and location of the workforce are an important component on the 3 year Improvement Plan for Forth Valley.

A detailed review of current Primary Care premises will be undertaken (dates?) in order to identify the current condition and use, future suitability for use and any changes required to create positive environments for patients and staff (investment, vacation etc).

An understanding of other suitable community based premises is also required in order make best use of facilities, for example to establish locality / cluster treatment hubs and resource centres. Opportunities to use the premises of partner organisations should be considered.

JONATHAN PROCTOR / MORAG FARQUHAR

Other enablers and infrastructure requirements to support delivery of the Primary Care Improvement Plan will include:

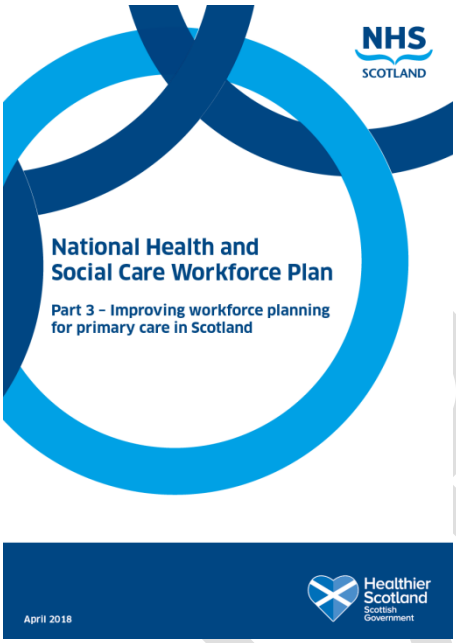
Digital Health – replacement of Primary Care system JONATHAN
IT requirements of vaccination programme
Other IM&T
Provide a digital health plan to support implementing Primary Care Improvement Plan

Equipment - What is required in practices and in “hubs”

4. Workforce

The National health and social care workforce plan published in June 2017 noted that Part 3 of the Plan, which would determine the Scottish Government's thinking on the primary care workforce would be published in early 2018. The Plan will set out a range of options at national, regional and local level for the recruitment and retention of GPs and the expansion of the capacity and capability of the multi-disciplinary team. This will include plan for recruitment, training and development of specific groups and roles.

As part of their role as Expert Medical Generalists, GPs will act as senior clinical leaders within the extended MDT as described in the Memorandum Of Understanding (MOU). Many of the MDT staff deployed in the six priority areas outlined in the MOU i.e. Vaccination Transformation, Pharmacotherapy, Community Care and Treatment Services, Urgent Care, Additional Professional Roles and Community Links Worker will be employed by the NHS Board and work with local models and systems of care agreed between the HSCP, local GPs and others.



Staff will work as an integral part of local MDTs. NHS Boards, as employers, will be responsible for the pay, benefits, terms and conditions for these staff. Some MDT members will be aligned exclusively to a single GP practice while others may be required to work across a group of practices (e.g. Clusters). Workforce arrangements will be determined locally and agreed as part of the HSCP Primary Care Improvement Plans.

Existing practice staff will continue to be employed directly by practices. Practice Managers, receptionists and other practice staff will continue to have important roles in supporting the development and delivery of local services. Practices Managers should be supported and enabled to contribute effectively to the development of practice teams and how they work across practices within Clusters and in enabling wider MDT working arrangements.

National Health and Social Care Workforce Plan
Part 3 – Improving workforce planning for primary care in Scotland

SUMMARY OF KEY RECOMMENDATIONS AND NEXT STEPS

This Plan sets out recommendations and the next steps that will improve primary care workforce planning in Scotland. These complement the recommendations in parts one and two and, taken together, will form the basis of the integrated workforce plan in 2018. The recommendations below set out how we will enable the expansion and up-skilling of our primary care workforce, the national facilitators to enable this, and how this will complement local workforce planning.

Facilitating primary care reform

Recommendations and Commitments:

1. Reform of primary care is driven by developing multidisciplinary capacity across Scotland. Workforce planners including NHS Boards, Integration Authorities and General Practices will need to consider the configuration of local multidisciplinary teams that offer high quality, person-centred care.

2. In recognition of an ageing workforce, local planners have responsibility for workforce planning and managing anticipated levels of staff turnover.

3. The implementation of the new GP contract will require services to be reconfigured to maximise workforce competencies and capabilities, and ensure people see the right person, at the right time and in the right place.

4. The National Workforce Planning Group will play a strategic role in implementing the recommendations of part three of the plan, and strengthen the development of approaches for the primary care workforce.

5. An integrated workforce plan to be published later in 2018 will move towards a better articulated joint vision for health and social care workforce planning.

Building primary care workforce capacity
Recommendations and Commitments:

6. Significant investment will be made available over the next 3-5 years, as part of the First Minister's commitment to an additional £500 million for community health services, to plan for, recruit and support a workforce in general practice, primary care and wider community health, including community nursing.

7. Scotland's multidisciplinary primary care workforce will become more fully developed and equipped, building capacity and extending roles for a range of professionals, enabling those professionals to address communities' primary healthcare needs.

8. As part of national, regional and local activity to support leadership and talent management development, planners will need to continuously consider staff training needs in their workforce planning exercises; invest appropriately so that leaders in primary care are fully equipped to drive change; and enhance opportunities for the primary care workforce to further develop rewarding and attractive careers.

Improving data, intelligence and infrastructure in primary care
Recommendations and commitments:

9. More integrated workforce data for primary care is required, in the context of the workforce data platform being developed by NHS Education for Scotland.

10. Local planners should consider workforce planning tools (such as the six step methodology) in developing their workforce strategies to address local population needs.

11. Planning for future staffing in primary care should identify and make use of

available guidance and intelligence on local recruitment and retention issues, and of wider developments in workforce data and scenario planning.

12. The Scottish Government will publish the Primary Care Monitoring and Evaluation Strategy 2018-2028 by summer 2018.

ALISON / LINDA

- Review of current workforce to provide a baseline
- Workforce profile
- Early recruitment to key posts
- 3 year workforce plan (linked to each of the priority areas in the strategy) – the workforce plan will require to be both multi-professional and multi-agency.
- Making FV an attractive place to work

Risk Assessment

This Improvement Plan includes an assessment of the risks associated with delivery and actions required to mitigate the risks identified using a risk assessment methodology:

Risk No.	Risk Description	Likelihood	Impact	Score High Medium Low	Mitigation	Likelihood	Impact	Score High Medium Low	Closing Mitigation

Likelihood = 1 to 5
Impact = 1 to 5
Score = likelihood X impact
High = 10 to 25
Medium = 4 to 9
Low = 1 to 3

5. Vaccination Transformation Programme

Extract from Memorandum of Understanding

The Vaccination Transformation Programme was announced in March 2017 to review and transform vaccine delivery in light of the increasing complexity of vaccination programmes in recent years, and to reflect the changing roles of those, principally GPs, tasked historically with delivering vaccinations.

In the period to 2021 change will be delivered in a phased way as part of the Health and Social Care Primary Care Improvement Plan to meet a number of nationally determined outcomes including shifting work to other appropriate professionals and away from GPs. This has already happened in many parts of the NHS system across Scotland for childhood immunisation and vaccinations. It is expected that this change will be managed, ensuring a safe and sustainable model and delivering the highest levels of immunisation and vaccination uptake. There may be geographical or other limitations to the extent of any service redesign.

Horizon 1 - Where are we now ?	
Current Service Model	All pre-school immunisations and adult influenza, shingles and pneumococcal programmes are delivered in General Practice. School age immunisation programmes are delivered by the Forth Valley immunisation team. Travel advice and NHS travel immunisation are provided by practices in line with the regulations in the 2004 GMS contract. A number of practices also provide additional travel immunisation services. This includes a number of practices that are recognised Yellow Fever centres.
Redesign work already underway	A Vaccination Transformation Programme Working Group has been established with input from Primary Care, Planning, Public Health and the Women and Children's Directorate. It has been agreed that the latter will host immunisation services in the future. A phased plan is being developed that aims to initially transfer travel immunisation from General Practice to the Immunisation Team in 2018/19. It is anticipated this will be followed by transfer of pre-school immunisation in 2019/20 and other immunisations including influenza by 2020/21. The Plan recognises the need for tests of change and pilot work that is centred in hubs aligned with current GP clusters and locality areas.
Issues and Challenges	• Current immunisation programmes are complex. • Patient safety is paramount.

	• Current uptake of childhood and adult immunisations delivered through General Practice in Forth Valley is very high. • The current uptake rates are achieved through effective practice call/recall systems and opportunistic interventions. An alternative service requires to be equally effective. • Public, patient and professional expectations need to be considered and managed. • GP IT systems support immunisation delivery and are the most complete record of an individual's medical history which reduces risk of inappropriate immunisation. • Development of a workforce with skills and capacity to deliver the previous level of service and immunisation uptake from an appropriate base may be challenging. • There is a need for option appraisal to agree optimal service delivery across Forth Valley. This should be appropriately flexible recognising a single model may not be appropriate for all areas of Forth Valley. For example, it may be more appropriate to retain historical ways of working in rural localities. • Service delivery bases require to be identified. This may be challenging acknowledging current primary care premises capacity issues • Delivery of the VTP has significant financial implications

Horizon 2 – How will we progress towards Horizon 3?

	2018-19	**2019-20**	**2020-21**
Potential Models / new ways of working / workforce / premises	Agree VTP delivery and workforce plan for Forth Valley. Scope current service. Complete option appraisal for all 3 main elements of VTP. Agree workforce plan, develop job descriptions, recruit and provide necessary training Identify test areas and premises that are appropriately accessible, equipped and have capacity to	Continued evaluation of developing model recognising premises, workforce and delivery options Roll out Forth Valley Childhood immunisation and service from June 2019. Test models for providing influenza, pneumococcal and shingles immunisation in selected cluster areas from Sept 2018.	Continued evaluation of developing model. Roll out Forth Valley Influenza Pneumococcal and Shingles immunisation service from August 2020.

	deliver the service Evaluate tests of change Determine areas where historic expertise and/or capability and capacity to continue to deliver the service may be preferred option Roll out Forth Valley Travel immunisation and advice service from September 2018.		
Testing the new models - **How?** - **engagement**	Test hub-based models for travel immunisation and advice from June 2018. Test model for providing childhood immunisation in selected cluster areas from Sept 2018. Provide adequate communication to stakeholder groups.	Evaluate initial changes from year 1.	Evaluate changes to date Ongoing service review
Implementing the changes - **Impact Assessment** - **Expected outcomes** - **Expected benefits**	Ongoing transfer of work away from General Practice to help manage workload and support aspiration to improve GP recruitment and retention.		

Horizon 3 – where will we be in 2021 and beyond	
Future Model of Care	Development and delivery of immunisation services that are safe, accessible and have high uptake that are co-ordinated by a central immunisation team providing immunisation services outside General Practice unless it is mutually agreed to continue to do so.
Further developments required	• Detailed finance and workforce planning • Option appraisal • Stakeholder engagement • Recruitment and Training
Sustaining change	Ongoing evaluation and development of the model to reflect local organisational and population needs and national priorities and needs and service developments

6. Pharmacotherapy

Extract from Memorandum of Understanding

Pharmacotherapy services are in three tiers divided into core and additional activities, to be implemented in a phased approach.

By 2021, phase one will include activities at a general level of pharmacy practice including acute and repeat prescribing and medication management activities and will be a priority for delivery in the first stages of the Primary Care Improvement Plan. This is to be followed by phases two (advanced) and phase three (specialist) which are additional services and describe a progressively advanced specialist clinical pharmacist role.

Horizon 1 - Where are we now ?	
Current Service Model	Pharmacy services in GP practices currently consists of a mixture of Band 5 techs, Band 7 and 8a pharmacists. Most of the technician (4.6WTE) resource is allocated to making efficiency savings and undertaking other traditional prescribing support work. Roughly 12 WTE pharmacists are working across all GP practices. Currently ~ 6 WTE are within 2C practices or those which require a more intensive level of daily support due to sustainability issues. They help with daily issuing of special requests for acute prescriptions, medicines reconciliation for Immediate Discharge Letters and outpatient medication recommendations, answering medicines information enquiries from community pharmacists, care homes, patients, and other members of the multi-disciplinary team. The remaining resource is spread as evenly as possible over the remaining practices, allowing on average half a day of ad hoc pharmacist support per practice to undertake polypharmacy reviews or other quality improvement prescribing related work. Within the majority of independent practices currently all acute and repeat prescribing and medication management activities are carried out by GPs and their admin staff using various different models.
Redesign work already underway	PCTF monies have been used to explore, challenge and to create "top of license" working for pharmacists to develop into an advanced practitioner role within the primary care MDT. One pharmacist has gone through the ACE course and another is undertaking a more focussed in house training programme in order to free up capacity by developing an extended set of skills in order to comprehensively manage diabetic patients in the primary care setting and release GP capacity.

	Engagement with community pharmacists and investment of pharmacy resource (focusing on areas where sustainability practices exist) to pump prime the use of serial prescribing where possible. Promotion of community pharmacy services (focusing on areas where sustainability practices exist) to ensure appropriate signposting of patients. Promoted posts on social media of 'meet the expert', radio campaign, leaflets, posters. Investment of pharmacy resource in struggling practices to look at all aspects of repeat prescription management processes including the monitoring of medicines and use of emis functionality. Scoping questionnaire send to GP practices to establish those of greatest need now and in the coming 12 months to ensure that pharmacy services can be mapped to those areas of greatest need fairly and effectively. Review of skill mix and training of technicians to undertake medicines reconciliation within practices and other prescribing support roles traditionally done by the pharmacist in order to release pharmacist capacity to undertake more clinical patient facing roles which in turn will release GP capacity. Investigating possibility of community pharmacy having remote emis pcs and docman access in order to do medicines reconciliation for practices from their pharmacy. Pharmacy team structure is now based around a cluster model of Band 8a, 7 and Band 5 technician within each cluster and a named lead cluster pharmacist. Nearly every pharmacist within the team is now an Independent Prescriber and can use their qualification in circumstances which allow a patient consultation to take place. Plan for next pharmacy recruitment drive beginning of June. Use innovative methods of advertising. **There are further redesign developments underway looking at supporting patients within care homes and vulnerable patients within their own homely settings. ('Care at home' and care home pharmacy support)**
Issues and Challenges	• Currently we are trying to provide all practices with their 'fair share' of pharmacy resource, however this is challenging as we are using ~50% of pharmacists in a small number of sustainability practices:- - GP expectations of limited numbers of staff - Competing priorities around making efficiency savings target, patient safety work and supporting GP practices.

	• Decreasing job satisfaction as fewer GP's therefore increasing pressure on pharmacists and risk of recruitment and retention issues cascading from GPs to pharmacists. • Recruitment of pharmacy staff:- - from existing pharmacist pool, could lead to pressures in other areas – hospital and community pharmacy services. - Clarity of funding routes required - Competition from neighbouring health boards. • Potentially there will be substantial training and mentorship requirements, as well as educational and clinical supervision. - Prescribing qualification is currently an additional postgraduate qualification • Level of risk that a pharmacist is willing/able to accept when issuing prescriptions • Patient safety should remain at least at current levels. • Turnaround time for prescription requests must meet current timescales –may need to set out board wide time scales. • Some of this work will likely be best carried out remotely so this may need IT support and possibility of central hub based work to be explored. • Collation of activity data from sustainability and 2C practices to inform how service can be delivered at scale.
Horizon 2 – How will we progress towards Horizon 3	
Year 1 2018-19 Implementation	
In year 1, we will select 3 clusters to focus our Pharmacotherapy service on. Pharmacists will provide an acute and repeat prescribing service which will include as a core:- • Authorising/action all acute prescribing requests • Authoring/action all repeat prescribing requests • Authoring/action all hospital immediate discharge letters • Medicines reconciliation • Medicines safety reviews/recalls • Monitoring high risk medicines • Non-clinical medication review • Medication compliance reviews • Formulary adherence • Prescribing indicators and audits Acute & repeat prescribing requests includes/authorising/auctioning:-	

- Hospital outpatient requests,
- Non-medicine prescriptions,
- Instalment requests,
- Serial prescriptions,
- Pharmaceutical queries,
- Medicine shortages,
- Review use of specials and off licence requests.

Practices will work closely with the pharmacists to develop and standardise this service.

Workforce Required

As mentioned above there are 12WTE pharmacists working in Primary Care. The funding for these should continue from out with the PCIP money. 6 WTE are currently spread across practices so we will assume 2 WTE pharmacists will be provided to the first 3 clusters from historical funding.

We think there will be a requirement for pharmacy provision of 1 per 5000 patients. This is based on what is needed in our current 2c practices and from output from practices in other areas. For 3 clusters (100 000 patients) this equates to 20 WTE pharmacists. We suggest a mixture of band 7 and band 8a pharmacists spread evenly, initially, across the 3 clusters. An additional 12 Band 7 and 6 band 8a pharmacists will be required to be recruited (to work alongside the 2 WTE already in post). This will give a total of 20 pharmacists for the 3 clusters at a cost from the PCIP of £1056 871 annually.

In year two we will expand the pharmacotherapy service to another 3 clusters. This will require additional pharmacist recruitment from April 2019. The numbers required will be similar to year 1 but may be amended following learning from the first 3 clusters.

Locating New Staff

In year 1 practices will be expected to find space for the pharmacists within their current practice area. If this is not possible for any practices we will want them to highlight this at a very early stage. In year 2 we will evaluate the arrangements and may need to look at other options such as extending premises or some of the pharmacotherapy work being done remotely – this will require the ability for remote computers to print prescriptions in the practice.

Clinical Leadership and Line Management Arrangements

Practices and their GPs will be expected to take an active part in supporting the pharmacists. They will be expected to integrate them into their practice clinical teams, advise them on practice processes and provide senior clinical leadership to the pharmacists. There will be a MOU around role and remit to allow local ownership within clusters/practices for service delivery. Their employment will be with NHS Forth Valley and as such they will report, also to a line manager within the trust. NHS Forth Valley will be responsible for making arrangements to cover absence/holidays etc.

Training Requirements

The pharmacotherapy team will be expected to have a protected learning time session on a weekly basis. This would be pro rata for part time workers. By starting with 3 clusters we hope that the operational learning can be cascaded to other clusters as the workforce/ recruitment will allow. There will need to be ongoing investment in advanced clinical training for pharmacists and support opportunities for specialist primary care clinics in order to ensure job satisfaction and therefore encourage recruitment and retention. The current pharmacy team will create an educational support structure for training of junior pharmacists (not previously employed in primary care).

Monitoring Success

It will be important to try to capture the impact of the pharmacotherapy service. Practices will be asked to complete a medicines related workload questionnaire pre and post pharmacy input. It will also be possible to monitor the pharmacy team KPIs (read codes) to assess Use of IP qualification (prescriptions signed) and number of polypharmacy reviews undertaken. Practice prescribing costs will be evaluated pre and post pharmacotherapy service, with the expectation that prescribing costs would at worst stay the same. There will be an ongoing collation and monitoring of agreed activity data set.

Horizon 3 – where will we be in 2021 and beyond

Future Model of Care	All practices will have access to a pharmacotherapy service which will provide the core elements of the New Contract to patients within GP practices, resident in care homes and vulnerable patients in their home setting. Each cluster will influence how their pharmacy team resource is best utilised, there will not be a uniform approach. How they use the pharmacists and technician's skills will be dependent on the needs of the local population, the GP practices and the skills of the pharmacy team. For example, some will utilise the skills of the pharmacist prescribers for polypharmacy reviews and complex care of patients with long-term conditions and some will focus technician resource more on improving practice's medicines management systems.
Further developments required	• Detailed finance and workforce planning. • Stakeholder engagement. • Recruitment • Investment in training and Education. • Liability arrangements need to be in place.
Sustaining change	Ongoing monitoring and evaluation of proposed cluster based model to meet the needs of service users and national priorities.

7. Community Treatment & Care and Urgent Care

Extract from Memorandum of Understanding

Community Care and Treatment
These services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate. Phlebotomy will be delivered as a priority in the first stage of the HSCP Primary Care Improvement Plan.

This change needs to be managed to ensure, by 2021 in collaboration with NHS Boards, a safe and sustainable service delivery model, based on appropriate local service design.

Horizon 1 - Where are we now ?	
Current Service Model	• NHS Forth Valley Community Nursing Service already deliver the majority of Treatment Room care, delivering over (x000 tbc) appointments a week in primary care each week for (Insert Treatment room inclusion document). The model of care is a mix of treatment room hubs and practice based sessions. Demand is increasing and provision of urgent access to appointments can be challenging at times • GP practices pick up an unquantified level of "treatment room" activity, this seems to vary between practices • All monitoring activity is delivered at practice level led largely by practice nurses and supported by health care support workers to varying degrees across practices. • Existing GP employed healthcare support workers often do other tasks that were nursing in the past, ECG, spirometry, vaccination and BP reviews, for example, but again this is very variable; from those that only do blood, to those who have the capability to train to become nurses (example from Tillicoultry of 2 HCAs having done this). • We have local enhanced services with practices for near patient testing and delivery of a limited amount of phlebotomy via the Shifting The Balance of Care LES. • Chronic Disease monitoring, disease data and biometrics such as blood pressure monitoring have been QOF driven and delivered at practice level • There is an enhanced service for minor injuries but a significant amount of this is dealt with at our minor injuries and Emergency departments
Redesign work already underway	Minimal– there is continuous dialogue between GPs and Treatment room services regarding level of provision. We are at the very early stages of technology enabled monitoring for blood pressure

	The Shifting The Balance of Care LES was updated last year to clarify the balance of responsibilities between primary and secondary care for ordering and acting on investigations e.g. 2y care to make requests via order comms
Issues and Challenges	Phlebotomy/Monitoring of Blood Tests is a significant issue in primary care and between primary and secondary care. Demand is significant and most GP practices have invested in their practice workforce to enable a model of phlebotomy to support individual practice needs. There is currently no collective understanding of the workforce hours or demand / activity nor the collective capacity provided across practices. Re-provision of phlebotomy / monitoring will be complex and is possible that HCSW currently employed by practices will need to be transferred into a community phlebotomy service model. We have a significant demographic challenge with regards practice nursing and community nursing workforce GPs and Secondary care services which rely on monitoring services would both aspire to a model which is responsive to patients need locally however, delivering and resourcing a model which meets the needs of both primary and secondary care will require a partnership approach in terms of process and resourcing

Horizon 2 – How will we progress towards Horizon 3

	2018-19	**2019-20**	**2020-21**
Potential Models / new ways of working / workforce / premises	By end of year 1 practices in 3 clusters will no longer provide phlebotomy and basic biometrics. Including for housebound patients By end of year 1 in addition to employing HCSWs to deliver the monitoring service, we will have Initiated a band 5 workforce pipeline model for nursing in primary and community care. We will initiate a rolling recruitment of 10 x band 5 posts which will support the provision of additional treatment room capacity and also enable a bridging model of training and development within wider primary care	By end of year 2 the initial 3 clusters will also no longer provide annual (QOF LTC) monitoring tests Practices in 3 further clusters will no longer provide phlebotomy and basic measures Rolling bridging model of recruitment of primary care nursing posts to balance demographic shift and anticipated loss of practice and community nursing Increase Technology based solutions for	All practices will no longer provide phlebotomy, basic measures and QOF based LTC annual monitoring tests. We aim to have in place an interface model of monitoring appropriately resourced between

	including practice nursing and community nursing. By end of year 1 Florence Text based Home monitoring of BP offered to all practices	monitoring e.g. Blood pressure, weight We will scope the need for and develop a business case for incorporating secondary care monitoring and near patient testing into the community monitoring service	primary and secondary care
Horizon 3 – where will we be in 2021 and beyond			
Future Model of Care	• All GP practices will be supported through a model of Community Treatment and Monitoring Hubs within or near to GP practices. • An interface model will be in place which works for all patients – accessible, timely, safe, clear etc. • Redirection of primary care monitoring activity Reducing GP / clinical workload, providing access for monitoring / treatment, driven by safe operating procedures, clear clinical responsibilities and best use of electronic process such as order comms. • Practice nurse time will be freed up to enable focus on chronic disease management and role development • Transforming Community Nursing – Primary Care Career pipeline in place for Primary Care Nursing • Role development for existing practice nurses, creating opportunities to value our existing workforce, facilitating career extension where possible		
Further developments required	Work with Secondary care regarding meeting whole system demand with appropriate alignment of clinical responsibilities. Work with laboratories to streamline processes and ensure viable delivery model		
Sustaining change	Developing the workforce in advance / in alignment with anticipated loss through retirement. Primary Care needs to be a desirable and fulfilling place to work <u>Resource Request (subject to available funding)</u> Health Care Support Workers (tbc) - both from existing primary care staff where practices wish to transfer roles with service and additional recruitment to meet demands of service 10 x band 5 primary care development roles – with 6 month rolling recruitment of bridging / training posts (sustaining a pipeline of circa 10 -15 training posts as nurses move on to fill practice nursing, treatment room or community nursing roles) 2 primary care Team lead posts – band 7 – to lead at locality level		

Urgent Care (advanced practitioners)
These services provide support for urgent unscheduled care within primary care, such as providing advance practitioner resource such as a nurse or paramedic for GP clusters and practices as first response for home visits, and responding to urgent call outs for patients, working with practices to provide appropriate care to patients, allowing GPs to better manage and free up their time.

By 2021, in collaboration with NHS Boards there will be a sustainable advance practitioner provision in all HSCP areas, based on appropriate local service design. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.

See Section 8

8. Additional Professional Roles (including Community Link Worker)

Extract from Memorandum of Understanding

Additional Professional Roles

Additional professional roles will provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting (as part of the wider MDT); this would be determined by local needs as part of the HSCP Primary Care Improvement Plan. For example, but not limited to:

- Musculoskeletal focussed physiotherapy services.
- Community clinical mental health professionals (e.g. nurses, occupational therapists) based in general practice.

By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. Service configuration may vary dependent upon local geography, demographics and demand.

Community Links Worker

Community Links Worker (CLW) is a generalist practitioner based in or aligned to a GP practice or Cluster who works directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of (for example) the complexity of their conditions or rurality. As part of the Primary Care Improvement Plan HSCPs will develop CLW roles in line with the Scottish Government's manifesto commitment to deliver 250 CLWs over the life of the Parliament. The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models/systems of care and support.

Horizon 1 - Where are we now ?	
Current Service Model	• GPs generally deal with all urgent and complex care demands in terms of same day appointments, house calls and care home calls. Although Several General Practices have now employed ANPs directly and our 2C practice model relies on ANPs to deliver daily capacity for practice based urgent care. PSPs are occasionally used within 2C practices. • Role replacement / development is inconsistent. The current general practice service model is largely traditional practice team, with some practices now employing ANPs directly. • We have a high degree of variation in support to practices across FV, ie Clacks have done very well from Transformation Fund tests of change, unlike Stirling City, but there is also historical inequity around attached staff and configuration of e.g. mental health services • In respect of wider MDT, supports are limited to 2C practices, isolated innovative practice (social prescribing) and transformation funded tests of change as outlined below.

	• Paramedic Specialist Practitioners already play a key role out of hours in Rural North West Stirling, working successfully for several years as part of the out of hours model. They have also been used successfully but not sustainably in our 2C practices. • Community Link Workers • There is no standard or planned model of link worker in Forth Valley. Falkirk District Association for Mental Health have been working with a small number of GP practices over the last few years supporting mental health social prescribing model which is very well received by GPs. We have had not direction from SG regarding the national link worker programme and await information on the role and learning from early implementation sites.
Redesign work already underway	We have good learning from both our OOH case review and General Practice (2C and others). This experience has demonstrated that highly skilled nurses (and other MDT such as paramedic specialist practitioners) including ANPs in particular can safely deliver a significant proportion of urgent GP/out of hours care autonomously. • The OOH Transformation funding is being used to develop a training pathway for an additional 5wte ANPs • ANP capacity to triage and offer same day urgent appointments is in place within in some (X?) practices • We have successfully trialled community nursing support to care homes within Clackmannanashire which has been very successful in reducing GP demand • Some practices with ANP capacity are testing out alternative approaches to House Calls. • 2C – we have two large multidisciplinary practices in Forth Valley where over 50% of day to day activity is provided by ANPs, PCMHNs and Extended Scope Physiotherapists. We also draw in support from paediatric and palliative care ANPs • Paramedics also support our 2C practices on a regular basis. • Mental Health ANP team have already commenced a test of change in partnership with the OOH service. This means that all calls triaged by NHS 24 requiring a local OOH telephone follow up between 9am and 9pm are picked up by the Hospital based mental health ANPs. • Primary Care Mental Health Nurses – we have now embedded PCMHNs in 3 clusters /14 practices in Forth Valley. Baseline data indicating that 10% of GP appointments are for mental health issues alone. The current PCTF funded model is testing 7wte posts at a level of 1WTE per 15000 population for approx 1/3 of the Forth Valley population. • Extended Scope/Advanced Practice Physiotherapists provide direct access for musculoskeletal issues in two 2C practices. Evaluation of this approach has been extremely positive with only 1% of patients requiring to see a GP. Additionally referrals to secondary care orthopaedic services reduced significantly.

	• Best in Class – Joint Pain Advisor / Request for Assistance model. Supported by Scottish Government and the Improvement Fund (i-hub) we are testing a preventive approach for people with lower limb joint problems. This involves direct access to a physio joint pain advisor, group based education and community supported lifestyle supports where necessary. The aim of this being to reduce GP activity, referrals to formal physiotherapy service and orthopaedics through direct early advice, signposting and support • Practice Administration Collaborative • Focussing on care navigation and workflow optimisation, the practice admin team play a critical role as first point of contact, in most instances, within general practice. Three clusters are currently involved in the national collaborative working to reduce the GP administration burden and increase the effectiveness of care navigation at first point of interaction with patients. • Link Workers3 (?)practices in Falkirk are/ have been? supported by mental health social prescriber model provided by FDAMH funded through integration funding.
Issues and Challenges	• There is a current GP vacancy rate with up to 25% of practices unable to recruit • Practice nurse and district nursing demographic is similar to that of GPs • Limited Resource, lack of standardised model, risk of developing specialist primary care roles rather than general practitioner roles. • Lack of supply – new roles means reliant on MDT clinicians who are interested in new opportunities and development, recent recruitment experience tells us that there is a very limited supply of people ready / willing to take up these new roles, particularly with short term funding. • Lack of opportunity to test other roles such as OT or dietetic

Horizon 2 – How will we progress towards Horizon 3

	2018-19	**2019-20**	**2020-21**
Potential Models / new ways of working / workforce / premises	By end of year 1 Build advance practice capacity in three clusters, with rolling employment and training of 10 ANP roles. By end of year 1 – evaluate the impact of our PCTF funded Primary Care Mental Health Nursing roles within 14 GP practices in 3 clusters at approx	By end of year 2 we will continue to support ANP development support We will develop with willing practices, at least one urgent care hub model in each of 3 clusters. Working with interested practices to develop a shared care approach to urgent	By end of year 3 .....we will have access for mental health and MSk for all practices and have grown an urgent care model in partnership with interested clusters and practices.

	level of 1:15,000 By end of year 1 Increase immediate direct access to advance practice physiotherapists for all practices in three clusters, Link Worker Generate a Link Worker development plan with with Third sector colleagues, taking direction from national guidance anticipating the initiation of link worker model with 5 of practices in our most deprived areas by start of year 2	care with potential to support • Same day appointment including ANP, MSK and Mental Health • Care Home Support • House Calls Linked with urgent care approach - Implement Primary Care Mental Health Practitioner access to all practices within three more clusters Implement Cluster Based approach for musculoskeletal assistance for all practices within in three clusters Implement and embed link worker role in 5 most deprived practices in Forth Valley	
Horizon 3 – where will we be in 2021 and beyond			
Future Model of Care	By 2021 we aim to have increased the level of trained ANP capacity whilst also developing and testing an urgent care model of MDT support for General Practice which provides day to day capacity for non complex illness, mental health and MSK in partnership with practices at cluster / part cluster level to reshape how we manage non complex urgent demand. This model would support interested practices to work more collaboratively to design a new model of clinical capacity, increase provision and divert urgent care pressures to a multidisciplinary team of Practice Nursing, ANP, Mental Health and Physiotherapy provision working with potential for shared GP supporting role(s).		
Further developments	We also should consider non traditional workforce opportunities e.g physician assistants, recognising skills and competencies of other		

required	existing MDT in terms of urgent care – e.g. Occupational Therapists expertise in mental health, frailty etc, Dieticians with Diabetes, Gastro Intestinal medicine and recognising that physiotherapists not only have expertise in MSK but many have clinical expertise in acute medicine, ITU, cardio respiratory, frailty etc.)
Sustaining change	In the near / mid term we will require to think more innovatively. Considering the interfaces with core community services at cluster and locality level. Developing innovative primary care practitioner roles; broadening opportunities to the wider workforce and supporting primary care MDT roles to be less "uniprofessional" (e.g. Explore the role(s) of *The* "primary care practitioner" perhaps supporting a workforce with core clinical expertise and developing a common training. **Workforce Planning, training and development** **Linkages with local and national strategies for effective and efficient transformation -**

9. Financial Plan

Three year financial plan - JILLIAN

Priority	2018/19	2019/20	2020/21
Vaccination Transformation			
Pharmacotherapy			
Community Treatment & Care and Urgent Care			
Additional Professional roles (including community links worker)			
Other			

Appendix 1

Forth Valley Primary Care Improvement Plan Development Group

Role and Remit

Background

Proposals for a new GP contract were published in November 2017 and agreed in January 2018. The new contract aims to support the development of the Expert Medical Generalist role for GPs, with a shift over time of workload and responsibilities to enable this. A key enabler for this is investment in a wider multi-disciplinary team in support of general practice.

The new contract offer is supported by a Memorandum of Understanding which requires the development of a Primary Care Improvement Plan agreed by the NHS Board and Health and Social Care Partnerships in collaboration with GPs and the LMC. This should be done in collaboration with other key stakeholders and supported by an appropriate and effective MDT model at both practice and Cluster level to reflect local needs.

The Primary Care Improvement Plan needs to be developed recognising ongoing strategic and transformational work and support management of the current significant challenges of sustainability of general practice and primary care services.

The Primary Care Improvement Plan Development Group with reference to the GMS Contract and Memorandum of Understanding should:

- Enable the development of the expert medical generalist role through a reduction in current GP and practice workload.
- Agree a primary care and community services multi-professional workforce and recruitment plan to support the expert medical generalist role and enable delivery of safe and sustainable primary care services. This will include the need to recruit and develop a pharmacotherapy team with capacity to support practices as per the GMS Contract requirements.
- Ensure delivery of the Vaccination Transformation Programme (VTP)
- Agree priorities informed by population and professional need
- Agree use of additional resources across Forth Valley
- Determine a communication plan and timeline for delivery of key milestones

Membership:

- Cathie Cowan, Chief Executive
- Dr Andrew Murray, Medical Director
- Dr Stuart Cumming, Associate Medical Director & Clinical Lead
- Shiona Strachan, Chief Officer Clackmannanshire & Stirling Health & Social Care Partnership
- Patricia Cassidy, Chief Officer, Falkirk Health & Social Care Partnership
- Kathy O'Neill, General Manager
- Lesley Middlemiss, Programme Manager, Primary Care Transformation Clackmannanshire & Stirling and Falkirk HSCP
- Janette Fraser, Head of Planning
- Jillian Thomson, Senior Finance Manager & Interim Primary Care Contracts Manager
- Dr James King, Clinical Lead
- Dr Scott Williams, Clinical Lead
- Dr David Herron, Clinical Lead/GP Sub Committee
- Dr Graeme Lyons, GP Sub Committee Representative
- Dr Neil Duthie, GP Sub Committee Representative
- Dr Teresa Cannavina, GP Sub Committee Representative
- Alison Richmond-Ferns, Interim HR Director
- Linda Donaldson, Interim HR Director
- Scott Mitchell, Pharmacy Director
- Lesley Thomson, Senior Nurse Community Nursing
- Bette Locke, Interim Lead AHP
- Morag Farquhar, Programme Director, Estates and Facilities

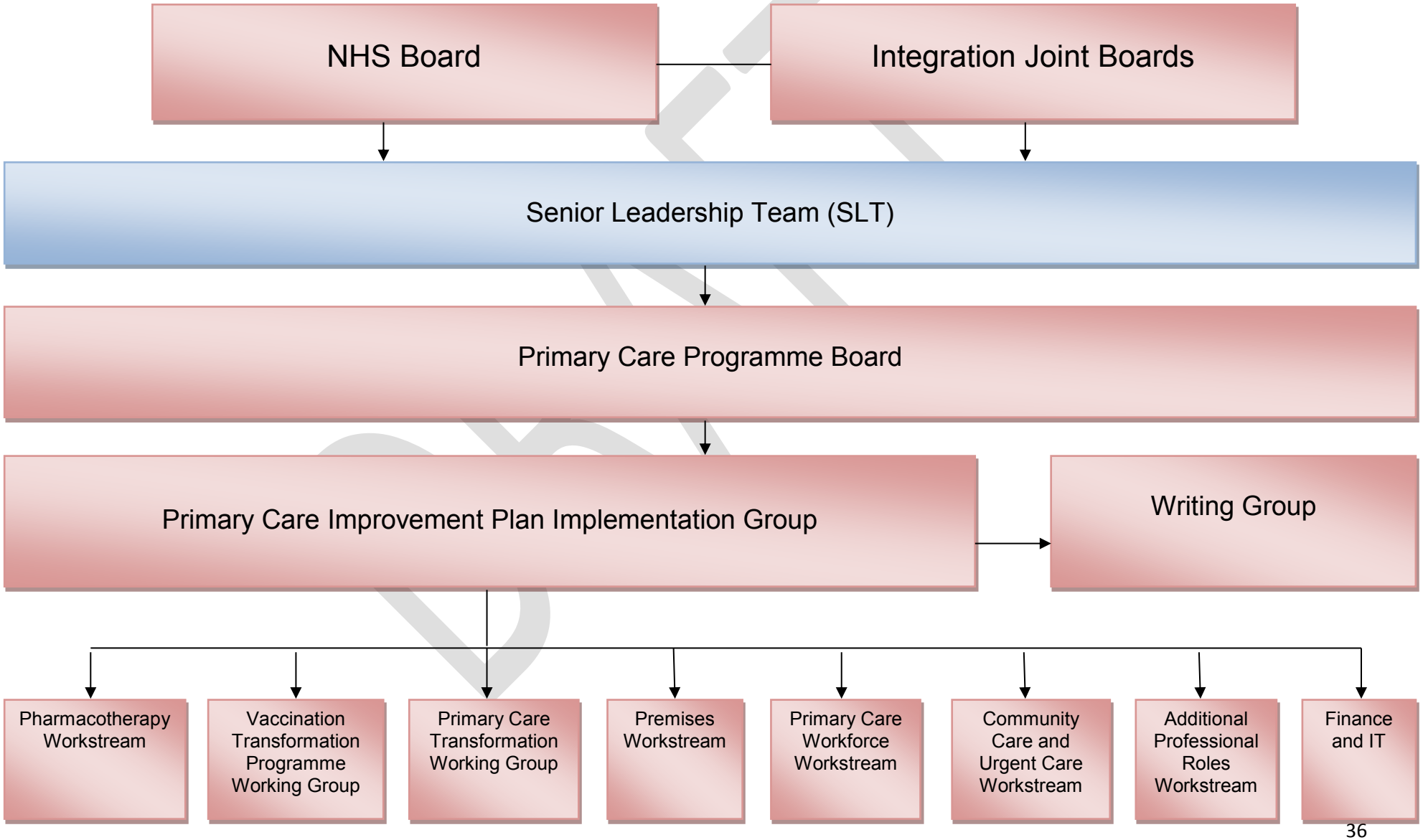
Meetings will be held monthly

Appendix 2

Writing Group (Leads and Contributors)

Section	Leads	Contributors
Background and Context	Janette Fraser	Stuart Cumming Lesley Middlemiss
Forth Valley Context	Janette Fraser	Stuart Cumming Lesley Middlemiss
Infrastructure and Enablers	Janette Fraser	Jonathan Procter Morag Farquhar Stuart Cumming Lesley Middlemiss
Workforce	Linda Donaldson	Alison Richmond-Ferns Stuart Cumming and Improvement Plan Leads
Vaccination Transformation Programme	Gillian Morton Stuart Cumming	Janette Fraser Helen Bauld Ann McGregor
Pharmacotherapy	Scott Mitchell David Herron	Gillian Cook Graham Lyons
Community Treatment & Care and Urgent Care	Lesley Thomson Scott Williams	Lesley Middlemiss Chris Mair Teresa Cannavina
Additional Professional Roles (including Community Link Worker)	Bette Locke James King	Neil Duthie Lesley Middlemiss Jim Crabb or representative
Financial Plan	Jillian Thomson	Link in with all workstreams above

Forth Valley Primary Care Improvement Plan Implementation Group



APPENDIX 2

Primary Care Transformation Group
May 2018

Primary Care Transformation
End Of Year Update

Lesley Middlemiss, Programme Manager Primary Care Transformation

For Discussion

Author	Lesley Middlemiss
Date:	15th May 2018
List of Background Papers / Appendices:	
Plan on Page Updates from Core workstream Leads	

Title/Subject: **Primary Care Transformation**

Date: **24th May 2018**

Submitted By: **Lesley Middlemiss, Programme Manager Primary care Transformation Fund**

Action: **For Discussion**

1. Introduction

1.1. THE ATTACHED PAPER GIVES AN OVERVIEW OF THE PROGRESS MADE THROUGH THE PRIMARY CARE TRANSFORMATION FUND SINCE THE PROGRAMME WAS APPROVED BY BOTH IJBS IN AUGUST 2018.

2. Executive Summary

2.1. There has been much progress within the three core work streams of the primary care transformation programme since the programme was approved at IJB in August 201. The three work streams consist of Urgent GP Out of Hours, Primary Care Sustainability and mental health in primary care. This paper outlines the highlights from each workstream and anticipated achievements for the next six months. Workstream updates on a page can be seen within the appendices.

3. Recommendations

The Primary Care Transformation Group is asked to:

3.1. Note the progress of the Primary Care Transformation Fund

3.2. Note that the future transformation work will be driven by a new Primary Care Improvement Plan which is currently under development and will support the implementation of the General Medical Services Contract

4. Background

The Primary Care Transformation programme was initiated to test new ways of working in advance of the new General Medical Services Contract, which has now been agreed. Implementation of this contract will see a significant change in the model of general practice in Scotland. This will enable GPs to be expert generalists, develop a multidisciplinary primary care team approach and reduce non essential GP workload.

5. Main Body Of The Report

5.1 After a period of review and primary care consultation, the outline plan for our local approach to implementation and governance of the Primary Care Transformation Programme was approved by both Falkirk and Clackmannanshire and Stirling IJBs in August 2017. The three strands of the programme being:

- Urgent Care GP Out of Hours Transformation: Implementing the recommendations of the “Report of the Independent Review of Primary Care Out of Hours Services”.
- Primary Care Transformation: This strand aims to encourage GP practices to work together in clusters, taking a multi-disciplinary approach to care within practice and the community.
- Mental Health in Primary Care: The investment for mental health services aims to improve access for people with mental health needs to the most appropriate support as quickly as possible, in the most appropriate setting.

Since August the following progress has been made

5.2. Urgent Care Out of Hours

Following a multidisciplinary case review of out of hours care the following aims were confirmed:

- Transform the provision of OOH primary care to a sustainable, multidisciplinary model, that provides care to the highest standard
- Shift the balance of multidisciplinary workforce so that 30% of the current OOH service will be provided by advanced nurse practitioners, Mental Health practitioners and Paramedic Practitioners within 1 year

Achievements since September 2017 include:

- We have implemented and evaluated a test of change for mental health support between 9pm and 8am: successfully introducing Mental Health nurse practitioners to the OOH service
- We have recruited 5 wte Advanced Nurse Practitioner training posts into the service
- These posts are currently progressing through a bespoke training schedule alongside general practice teams, paediatrics and other skilled ANPs and GPs.
- We have had a poster accepted for the NHS Scotland event in June

Anticipated Achievements in the next 6 months:

- A staff survey is due to be sent in the next month, which will form a baseline for staff satisfaction rates
- A service design and delivery plan will be completed and shared with IJBs
- Plan to develop an improvement approach to Tests Changes to support for care homes that could potentially reduce the number of repeat requests for home visits
- Testing the role of the paramedic practitioner within the service – this has proved difficult to date because of the training time required
- We will see productive shift of service delivery to ANPs from mid July when the first 2 ANP staff members will be joining the OOH rota fully independently

5.3. **Primary Care Transformation: Multidisciplinary Team Development**

In partnership with the Cluster Quality Lead and Locality Lead GP in Clackmannanshire and West Falkirk Clusters we have focussed the core of transformational work in this locality. Initial exploration of priorities with all of the practices resulted in a clear set of aims:-

- To introduce primary care mental health practitioner capacity to 7 GP practices in, offering more than 400 new appointments per week.
- To test the model of training a pharmacist in an extended set of skills so they can comprehensively manage diabetic patients within a primary care setting and free up GP capacity.
- To provide alternative support model to care homes which will reduce the need for GP call outs to care homes in Clackmannanshire initially for two practices
- To introduce Home Blood Pressure Monitoring to 5 practices and 100 patients

Achievements since August 2018 include

- We have baseline measures for mental health activity in Clacks and Denny/Bonnybridge practices, identifying 10% of all appointments being for mental health alone and 18% in total including a mental health consultation.
- Recruitment of 5 of 7 Primary Care Mental Health Nurses, although this has taken 3 rounds of advertising, late withdrawal of 2 people from an initial recruitment of 7 and one post prioritised to support pressures from emerging 2C practices. We remain 3 post short and are again recruiting although recruiting to temporary posts remains challenging.
- Ongoing pharmacy training and initiation of pharmacy led clinics for pain management and diabetes with 50 pharmacy clinical consultations since February
- Implementation of nurse led support for care homes for two GP practices for two days per week with immediate positive outcomes for both care homes and GPs. GP visits to care homes have become a rarity and a proposal to scale this up to all GP practices is developed.
- A partnership with Ayrshire and Arran TEC hub has been generated, via a successful national Technology Enabled Care bid, has meant a delay to initiation of Home BP testing, however, the result will be a much simpler process for practices and a faster roll out post initial testing.
- We have also been successful in applications for other national programmes.
    - Securing £50,000 for three years from Scottish Government and £75,000 for one year from the I-HUB improvement fund to test a community support model for people with lower limb arthritis in partnership with Active Clacks as

part of a wider “Best in Class” approach to lower limb arthritis across Forth Valley and elective surgery.

- Securing one of four partnership places in the national Practice Administration Staff Collaborative which will see Clackmannanshire, Polmont and the Braes and North West Stirling endeavour to meet their aim of reducing administration workflow to GPs by 50% and improving care navigation / signposting at point of contact for assistance.

Anticipated Achievements in Next Six Months

- 400 additional mental health appointments across the 14 GP practices
- All practices and care homes in Clackmannanshire having nurse led primary care support. Similar model in a Falkirk locality to be initiated.
- Pharmacy clinical role tested and evaluated
- Home Monitoring of Blood Pressure being the norm for diagnosis and medication titration in 10-15 practices across both partnerships
- Enhanced access to Joint Pain Advice and community based wellbeing supports
- Increased Practice Administration efficiency in three clusters.

5.4 Mental Health in Primary Care

In addition to the Primary Care Mental Health Nurse practitioner roles the focus of the mental health fund was to support the overarching partnership aims of

- Provide Post Diagnostic Support to all patients diagnosed with Dementia in the first year following diagnosis. Aiming for 80% by March 2019.
- Provide person-centred, joined up support and care for all patients with Dementia.

Achievements since September 2017 include:

- Multiagency Redesign of Dementia Services scoped and proposed. Now approved by both HSCPs and NHS Forth Valley.
- Linking with Health Improvement Scotland, Alzheimer Scotland and Scottish Government innovation support sources (CAN-DO) to develop a second application for innovation funding to explore alternative ways of delivering PDS
- Additional 1.5wte Link Workers have been employed to deliver PDS in Clackmannanshire and Stirling.
- Redefined criteria for PDS models, ensuring a matched care approach.
- Working with ISD and collaborating with colleagues nationally around the measurement of PDS performance including standardisation of recording of PDS across the system

Anticipated Achievements in the next 6 months

- Agree a structure for the specialist team which will hold PDS
- Recruit Social Workers to the PDS / Dementia Team
- Develop systems of working for the new team to ensure efficient and person centred responses to patient and carer need
- Evidence of improved service to users from investment in PDS link workers and service redesign

5.5 Enablers

In addition to the core work above, there are many other enabling activities ongoing, including:

- Development of resource and support model to improve post diagnostic support for Autistic Spectrum Disorders
- Advance Practice Training for nurses, District nurses and Physiotherapists
- Cluster based tests of change including the introduction of dermoscopy assessment for potential skin cancers within two GP practices
- Outcome Focussed Communication education and development
    - Developed and facilitated set of workshops with podiatry staff in Clacks
    - Facilitated set of workshops with DN staff in Clacks
    - change idea development following CREATE Signposting for Administration Staff
    - Liaison with national Personal Outcomes Network to share practice

- Liaison with NES Practice Manager Education Lead to promote inclusion of signposting/ communication skills on education agenda
- Liaison with NES Psychology department to include MAP: Health Behaviour Change eLearning resource as skill development tool

6. Resource Implications

An overview of Primary Care Transformation Fund Spend is outlined in a separate paper

Appendices – PCTF Workstream Plan on a Page Updates

alkirk
ealth and Social Care

PCTF – A3 Plan on a Page - Annual Update **Date: May 2018**

Workstream: Advanced Pharmacist Practitioner Development

Reconfirm your improvement aim?

- To test the model of training a pharmacist in an extended set of skills so they can comprehensively manage diabetic patients within a primary care setting and free up GP capacity. (Dollar HC)
- To free up GP capacity by pharmacists undertaking practice based clinics in the areas of chronic pain (Viewpoint , Clackmannan HC) and mental health (Bonnybank HC)

What actions have you taken to achieve your aim?

- Pharmacists selected from within existing team with suitable skill set and interest.
- Scoping exercise to select suitable practices for pharmacist training to be provided and clinics to be based.
- PCTF money used to recruit backfill for posts. (0.8 WTE Band 7) Started Feb '18
- Agreement with pharmacists on activity data set to be collected to aid evaluation.
- Peer review and ongoing training requirements e.g OU diabetes module, identified and arranged.
- Dollar health centre – training started in Feb 18. (0.3 WTE)
- Viewpoint – clinic started March 18 (0.2 WTE)
- Clackmannan – clinic started Feb 18 (0.1WTE)
- Bonnybank – clinic started May 18 (0.2WTE)

What have you learned from your actions since starting your improvement work?

- Consideration to be given to competing priorities within practices in conjunction with changing circumstances such as sustainability issues, can lead to delays in clinics starting due to fluctuating engagement.
- Patient engagement and therefore attendance at appointments could be improved .

PLAN

What are your planned key actions for the next 6 months to generate improvement?

- Ongoing monitoring of clinic activity.
- Regular reviews with Dollar pharmacist to ensure learning objectives and competencies are being met through training.
- Promote understanding of role of pharmacist at clinics within practice and patient community.
- Obtain multisource and patient feedback of clinics.

What evidence do you have regarding generating improvement so far?

- 50 Patient consultations to date at clinics. (21 sessions) Last minute cancellation rate is high. Number of patients booked in ~150.
- Interventions include : initiating medicines, trial stops, increase and decrease doses, identifying side effects, signposting , promotion of self care, referral to physio, provision of written and verbal information, using Independent Prescriber qualification.

Because of limited resource spread over three clinics at different practices, difficult to quantify impact on GP capacity. Assumptions made that appointments have been avoided as a result of pharmacist interventions, qualitative multisource and patient feedback will be obtained for end of year evaluation.

What further improvement do you anticipate in the next 6 months?

- Increase in patients engagement with consultations at mental health and pain clinics as understanding of pharmacists role increases.
- Pharmacist at Dollar to have learnt the required assessment skills and have started to autonomously manage diabetic patients within the practice and release GP capacity.

PCTF – Annual Update **Date: 14/05/18**

Workstream: Autism Project

Reconfirm your improvement aim?

By February 2018 here will be a clear assessment and diagnostic pathway.

By December 2018, 100% of Adults diagnosed with Autism by secondary care will be offered post diagnostic support and signposted to 3rd sector services

By February 2019, 80% of frontline staff across primary and secondary care will have accessed training (Learn Pro) on recognising and responding to people with ASD.

What actions have you taken to achieve your aim?

- Autism project team have met and drafted an initial pathway.
- Alison has met with various 3rd sector providers to scope out venues for holding the PDS groups.
- Alison has met with IMHT's to inform them of the project and also to scope what the teams are currently doing in FV in terms of assessing, diagnosing and providing support to those with ASD.
- Alison has met with the learn pro facilitator to start the process of developing learn pro modules.
- Alison has been in discussion with various speakers to look at developing a CPD day.
- Survey has been sent out to staff to determine training needs.
- Alison has plans to begin shadowing the PDS group programme in Fife on the 17thMay.
- Speech therapy secured a therapist for 1 day PW to augment the project. Chantelle Dobson was successful in this post.
- Alison has commenced developing an information document for those newly diagnosed with Autism. Chantelle has joined this piece of work.

What have you learned from your actions in the last 30 days?

- There is a definite desire within FV to develop PDS and also to have a clearer pathway for assessment.
- Some areas already have begun to develop their own assessment pathway.
- Staff confirm the need for gaining more knowledge and in general are keen to learn.
- The assessment process in FV is inconsistent. There is very little in the way of support for adults with ASD in FV within the NHS and this is similar in the 3rd sector.
- Colleagues in other areas of Scotland are keen to share knowledge and also in agreement to share documents they have already completed for us to work with.

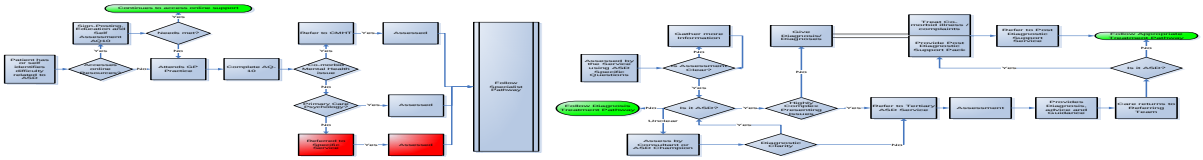
PLAN

What are your planned key actions for the 6 months to generate improvement?

- Complete a pathway for GP's to use to aid with the referral process and ensure consistency across FV
- Securing venues to carry out group work.
- Shadow the Fife PDS groups and setting up a group programme in FV
- Develop the Learn Pro modules
- Develop the post diagnostic information pack and ask for Service user feedback

How do you know if your changes generate improvement?

- *Survey staff feedback after training commences.*
- Service user feedback form the group programme
- GP feedback will be sought after the pathway is agreed and in situ



PCTF – A3 Plan on a Page - Annual Update **Date:** 09.05.18

Workstream: Personal outcomes approach / Outcomes focused communication

Reconfirm your improvement aim?

Improve What for whom by when?

• Support staff develop communication skills that underpin a personal outcomes approach

• Identify effective educational input strategies which could support changes in practice across the workforce

What actions have you taken to achieve your aim?

• Developed and facilitated set of workshops with podiatry staff in Clacks

• Facilitated set of workshops with DN staff in Clacks

• Supported change idea development following CREATE Signposting for Administration Staff sessions

• Liaison with national Personal Outcomes Network to share practice

• Liaison with NES Practice Manager Education Lead to promote inclusion of signposting/ communication skills on education agenda

• Liaison with NES Psychology department to include MAP: Health Behaviour Change eLearning resource as skill development tool

What have you learned from your actions since starting your improvement work?

• Face to face training, peer support and reflective practice is essential for skill development and changes in practice.

• A basic content to include within facilitated workshops for clinical staff

• Increasing self awareness of existing communication style, values and beliefs is essential to affecting change.

• Motivation to change is variable across MDT with scepticism of impact contributing to poor engagement.

• CREATE (signposting) session provides useful information but localised improvement support is needed to influence change in beliefs/behaviour

PLAN

What are your planned key actions for the next 6 months to generate improvement?

• Support clusters with PASC

• Contact individual practices in relation to supporting change following CREATE session / use PASC examples

• Devise facilitator pack for clinical teams

• Revise workshop plan for DNs and test validity of data collection tools used with podiatry team

• Finalise development of prompt cards

What evidence do you have regarding generating improvement so far?

Podiatry team:

• 100% increase in participant knowledge and confidence in using a personal outcomes approach

• Documentation changed to capture personal outcomes and agreed aims

• Process and outcome measure data collection tools developed (patient & staff experience, documentation)

• 100% participants commenced the journey from being a fixer to an enabler, working more in partnership with the service user

•Poster accepted for NHSScotland conference

Adminstration staff:

Data collected at the end of CREATE sessions suggests individual change ideas focused on practicalities of signposting rather than ability of staff to engage with patients to enable effective signposting

What further improvement do you anticipate in the next 6 months?

•Inclusion of approach within PASC improvement work, leading to enhanced administration staff engagement.

•DNs engaged and motivated to test changes in practice

PCTF – A3 Plan on a Page - Annual Update **Date: 10.05.18**

Workstream: Post diagnostic Support – Dementia

Reconfirm your improvement aim?

Improve What for whom by when?

- Provide PDS to all patients diagnosed with Dementia in the first year following diagnosis. Aiming for 80% by March 2019.
- Provide person-centred, joined up support and care for all patients with Dementia.

What actions have you taken to achieve your aim?

- Mapping exercise to standardise recording of PDS across the system
- Redesign of Dementia Services proposed and approved by both HSCPs and NHS Forth Valley
- Implementation Group formed of multi-agency staff
- Data cleansing process underway
- Linking with innovative funds to explore alternative ways of delivering PDS
- Additional 1.5wte Link Workers have been employed to deliver PDS in Clackmannanshire and Stirling.
- Redefined criteria for which model of PDS is used to ensure a matched care approach.
- Working with ISD and collaborating with colleagues nationally around the measurement of PDS performance

What have you learned from your actions since starting your improvement work?

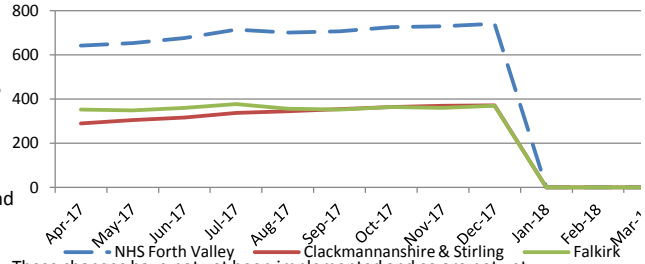
- The ISD reports on the performance of local services in delivering PDS underestimates the access to PDS which is being delivered.
- There has been unnecessary variance in the delivery of groups
- There is a great will to make positive change

PLAN

What are your planned key actions for the next 6 months to generate improvement?

- Agree a management structure for the specialist team which will hold PDS
- Agree and move to an appropriate base
- Recruit Social Workers to the PDS / Dementia Team
- Develop systems of working for the new team to ensure efficient and person centred responses to patient and carer need

What evidence do you have regarding generating improvement so far?



These changes have not yet been implemented and so are not yet demonstrable. To offset this data cleansing is underway to enable us to forecast performance

What further improvement do you anticipate in the next 6 months?

•Closer links between all professionals delivering PDS.

•Ease of access to services with a single point of access for patients and carers

Authors: Bryony Murray, Dr Chris Mair, Dr Karyn Webster, Lesley Middleniss, Cheryl Johnson, Sharon Oswald, Ross Cheape

NHS Forth Valley

Primary Care Out of Hours pulling together

Primary Care Transformation

The Challenge

The GP workforce which supports overnight and weekend Out of Hours Care is increasingly difficult to recruit. Unfilled shifts are now commonplace and the experience of working out of hours can be less than ideal.

The need to Transform Out of Hours Care to a safe and sustainable multidisciplinary model is clear.

"..... as older GPs retire from OOH services, this could have disproportionately adverse effects on service delivery"
The Report of the Independent Review of Primary Care Out of Hours Services, "Pulling Together"

"...all Boards face challenges and the service is fragile and unsustainable in its current form"

The Aim

We aim to transform the provision of Urgent Out of Hours Primary Care (OOH) to a sustainable multidisciplinary model that provides care to the highest standards of quality through a delivery approach which offers robust alternatives to direct medical input where possible within one year.

We will shift the balance of multidisciplinary workforce so that 30% of the current OOH whole service capacity will be provided by Advanced Nurse Practitioners and Paramedic Specialist Practitioners within 1 year

PHASE 1

METHODOLOGY

Understanding the Service Need

1. Appointment Data Collection

- We gathered a multi-agency group of health professionals
- We involved public representatives
- ***70 cases from consecutive overnight periods*** were reviewed to determine if they could have been seen by a clinician other than a GP

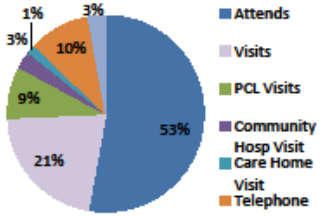
2. Data used to Map the Service

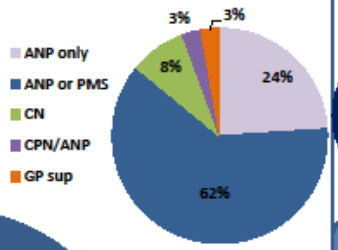
- We determined the number of patients that could be seen by someone other than a GP, without any detriment to their level of care.
- A Venn Diagram (figure 3) was created to show what a multi-disciplinary service would look like and how demand could be met by different clinicians.

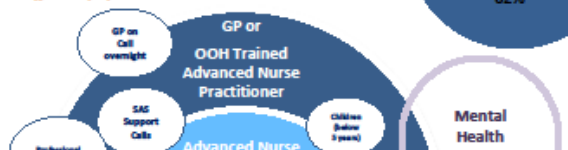
During the 70 overnight sessions, 17% of patients (12 people) were aged over 75 years. 10 out of 12 could have been managed effectively by an ANP or Paramedic

OUTCOMES

Figures below:
1. Percentage of appointment types across the 70 cases:
2. A Feasible Alternative to the Current GP Model







PHASE 2

METHODOLOGY

Creating a sustainable Workforce

1. Introduction of Specialist Mental Health Practitioners into OOH

- The data showed that although a small volume, mental health advice calls took up a large amount of GP time.
- Mental Health Nurse Practitioners (MHNP) work as part of the emergency service overnight.
- 6 of these MHNP were trained to use the OOH IT system and have taken 73% of MH calls since 18th December 2017

"Our nurse practitioners are enthusiastic and essential to the smooth running of the service"

"Our MHNP's have access to Care Partner in which MH contacts are recorded, allowing them to communicate with their team and best advise patients. This has been extremely positively received by other clinicians in the service"
Dr. Karyn Webster, Clinical Lead OOH

Tests of Change

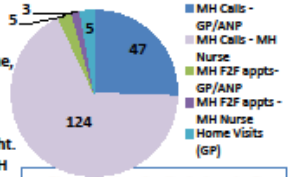


Figure 4: No. of calls during the 3 month pilot between 9pm and 8am – 73% of MH advice calls were taken by MH professionals with an average time of 24 minutes

2. Recruitment of 5 Advanced Nurse Practitioners

- The review indicated that OOH skilled ANP's were able to see over 90% of patients that would traditionally be seen by a GP.
- NHS Forth Valley recruited 5 ANP's to the OOH service at the start of 2018.
- They bring a wide variety of skills including paediatric and mental health experience
- After completing their OOH training programme they will join the rota delivering 30% of weekly OOH hours of care

OUTCOMES

Next Steps

Introduce Paramedic Practitioners to OOH Service

Conclusion

- The introduction of a multi-disciplinary team has started to shift workload from GPs, decreasing the number of unfilled hours

PCTF – A3 Plan on a Page - Annual Update **Date: 7th May 2018**

Workstream: Practice Administration Staff Collaboration #PASC

Reconfirm your improvement aim?

Improve What for whom by when?

1. We aim to achieve an average 50% reduction in documentation (not results) being seen by GPs across the 18 practices involved in PASC by January 2019.

2. We aim to introduce and develop signposting within Forth Valley clusters to allow practice administrative staff to direct patients to the right person at the right time and the right place. We aim provide a consistent and person centred approach. Signposting will be to both resources internal and external to the practice and will include self care.

What actions have you taken to achieve your aim?

- **Create PLT session – 23rd May 2018**
- **30, 60 & 90 day plans being developed in Practices: including baseline data for each**
- **Implementation of a trello board**
- **Qube virtual meeting option being explored**
- **Making Dr Who famous!**

What have you learned from your actions since starting your improvement work?

- Varying level of buy-in from practices
- GP and clinical staff have been very supportive so far
- Cluster-driven activity seems to work best as it is difficult to resource events when large teams have to travel
- Signposting training done previously was well received

PLAN

What are your planned key actions for the next 6 months to generate improvement?

- Working with each cluster to determine 30 day activity plans
- Making collaboration 'easy' – we will work with clusters to plan events/training/education that allows us to share – without causing resource issues
- Use of Qube – getting at least one cluster online and using Wube regularly
- A set of 'resources' that practices are able to use to educate patients as part of signposting – these will be designed collaboratively

How will you know your change is an improvement?

Signposting:

-Measurement of the here and now
-Feedback from staff (clinical and admin team)
- Monitoring the patient journey
- Patient satisfaction
- Feedback from third parties (i.e. Dentists, opticians, third sector)
- Engagement with communication

Workflow Optimisation:

- Measurement documentation coming into practice each day
- Categorization of documentation and monitoring of each
- Measurement of time spent on paperwork (GP and admin)
- Feedback from GP and admin staff

What further improvement do you anticipate in the next 6 months?

Improved patient understanding: Alongside a strategic educational communications campaign, we hope to see improved understanding of the health system in patient groups. This will be measured by patient surveys to determine if people have been redirected to the best place.

PCTF – A3 Plan on a Page - Annual Update **Date:**

Workstream: Title Florence

Reconfirm your improvement aim?

Establish and mainstream an efficient and accurate technology enabled BP monitoring service across Forth Valley.
Improve self management of BP
Reduce time individuals have to take off work to attend appointments
Reduce GP/PN associated appointments
Improve diagnosing of hypertension and titration of medication
Improve compliance with treatment

What actions have you taken to achieve your aim?

- Engaged with practices who will be adopting Florence
- Compiled a Risk Assessment around BP monitors
- Agreement from NHS Ayrshire & Arran to work with their Regional Hub
- Project plan in place, Risks and Issues identified
- 5 Early adopter practices identified and informed

What have you learned from your actions since starting your improvement work?

- Keeping practices engaged in crucial
- Sys Admin/Lead Contact role is key

PLAN

What are your planned key actions for the next 6 months to generate improvement?

- Procure monitors with Ayrshire and Arran
- 5 early adopter GP sites to go live
- Look at what practices will be part of scale up
- Implement 2 protocols within Dietetics

What evidence do you have regarding generating improvement so far?

Evidence from other Health Boards so far is showing that Flo is reducing face to face visits as well as leaving patients feeling more engaged in their healthcare.

What further improvement do you anticipate in the next 6 months?

Benefits will be realised in Forth Valley as we commence on both Hypertension protocols as well as 2 newly developed weight management protocols. Patients will feel more engaged in their own health as well as taking more responsibility. Clinicians will feel that they are better able to manage conditions as well as reducing face to face appointments (with Hypertension Protocols)

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Primary Care Division
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Integration Authority Chief Officers
NHS Board Chief Executives

23 May 2018

Dear Colleagues,

PRIMARY CARE IMPROVEMENT FUND: ANNUAL FUNDING LETTER 2018-19

I am writing to confirm the 2018-19 funding allocations for the Primary Care Improvement Fund element of the wider Primary Care Fund, which will be used by Integration Authorities to commission primary care services, and allocated on an NRAC basis through Health Boards to Integration Authorities (IAs).

This letter should be read in close conjunction with two other letters due to issue, which will set out additional ring-fenced resources being made available to IAs in 2018-19:

- A second letter from my Division covering the allocation and use of an additional £5 million for Out of Hours primary care; and
- A letter from Penny Curtis, Deputy Director Mental Health Division, regarding funding of 'Action 15' of the Mental Health Strategy. Action 15 is a four-year commitment to deliver 800 more mental health workers in a range of settings, including primary care, and £11 million is being made available to IAs for this in the first year[1].

Background

Last year we brought together the Out of Hours, Primary Care Transformation Fund and Mental Health Funds into a single funding allocation, referred to as the Primary Care Transformation Fund (PCTF). My colleagues Penny Curtis and Linda Gregson wrote to you on 9 August 2017 to set out the 2017-18 allocation in your area and associated deliverables. An End of Year template for your completion is at Annex F.

[1] Note: for the avoidance of doubt, SG is also continuing to fund the development of primary care mental health services, in a similar way to previous years. This funding for primary care mental health now forms part of the Primary Care Improvement Fund. The £11m Action 15 funding referenced in the section above is additional to it.

Several key developments have taken place since then. These include:

- Scottish Government and BMA agreement to proceed with the 2018 General Medical Services contact following a poll of the GP profession – January 2018[2].
- Publication of the Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards – draft published November 2017 and finalised 19 April 2018[3]. This determines the priorities of Integration Authorities over the next period and should be read in conjunction with this funding letter.
- Primary Care National Workforce Plan – published 30 April 2018[4].
- Passing of Scottish Government Budget Bill in February 2018 confirming increase in Primary Care Fund from £72m in 2017-18 to £110m in 2018-19.
- Wider contextual developments (e.g. the new Oral Health Action Plan and ongoing work by the Health and Justice Collaboration Improvement Board to further develop 'Action 15' of the Mental Health Strategy, which committed to 800 new mental health workers in health and justice settings).

Taken together, these set the terms of the main deliverables we expect in 2018-19 and beyond. Further information on them is at Annex C.

2018-19 approach

The Scottish Government is investing a total of £115.5 million in the Primary Care Fund (PCF) in 2018-19. There are a number of elements to the overall Primary Care Fund:

- Primary Care Improvement Fund (the subject of this letter);
- General Medical Services;
- National Boards; and
- Wider Primary Care Support including Out of Hours Fund.

These are described in more detail in Annex B.

Primary Care Improvement Fund (PCIF)

An in-year NRAC allocation to IAs (via Heath Boards) will comprise £45.750 million of the £115.5 million Primary Care Fund. This in-year allocation is hereafter referred to as the *Primary Care Improvement Fund*.

[2] British Medical Association and Scottish Government (2017), *The 2018 GMS Contract in Scotland* http://www.gov.scot/Resource/0052/00527530.pdf

[3] *Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards - GMS Contract Implementation in the context of Primary Care Service Redesign*, published in draft 13 November 2017 and published as final 19 April 2018: http://www.gov.scot/Resource/0053/00534343.pdf

[4] http://www.gov.scot/Publications/2018/04/3662

Primary Care Improvement Plans should set out how this additional funding will be used and the timescale for the reconfiguration of services. Further information is at Annexes D and E.

Total PCIF allocation by Board area

The 2018-19 funding allocation for the PCIF is £45.750 million.

Allocation of the fund, by Health Board and IA, is shown in Annex A. All figures are calculated using NRAC. The money must be used by IAs for the purposes described in this letter. The PCIF (including £7.800 million baselined GP pharmacy funding being treated as PCIF) is not subject to any general savings requirements and must not be used to address any wider funding pressures.

The fund must be delegated in its entirety to IAs. We do not anticipate any adjustment to these figures locally except in two circumstances:

- Marginal changes may be made with the agreement of the Health Board and Integration Authorities to reflect local arrangements, for example in relation to management arrangements within and between Integration Authorities.
- Health Boards and IAs may work collaboratively within their area to jointly resource pre-existing commitments which clearly fall within the scope of the MoU. An example of this would be early adopter link workers who are already in post in areas of higher socio-economic deprivation. This joint working to deliver the overall commitment to links workers (or other MoU related area(s)) can be appropriately reflected in PCIPs for all the IAs concerned. Such a joint approach should be considered especially where it is considered that continuation of such a service in an IA could disproportionately impact on funding available for other activities under the MoU.

Integration Authorities should set out their plans on the basis that the full funds will be made available and will be spent by them within financial year 2018-19. In this initial year of funding, the funding will issue in two tranches starting with allocation of 70% of the funding in June 2018. A high level report on how spending has been profiled must be submitted to SG by the start of September and, subject to confirmation via this report that IAs are able to spend their full 100% allocation in-year, the remaining 30% of funding will be allocated in November 2018. An outline template for making the start-September report is at Annex G. A final template will be issued before September.

I look forward to continuing to work with you in this pivotal year for primary care transformation.

Yours faithfully,

RICHARD FOGGO
Deputy Director and Head of Primary Care Division

Copy: Local Authority Chief Executives
COSLA Chief Executive
Integration Authority Chief Finance Officers
Health Board Directors of Finance
Health Board Directors of Pharmacy
Health Board Directors of Planning and Policy
Health Board Medical Directors
Primary Care Leads
Health Board Out of Hours Clinical Leads
Scottish Executive Nurse Directors (SEND)
Health Board AHP Directors
Health Board Directors of Public Health

ANNEX A

PRIMARY CARE IMPROVEMENT FUND: ALLOCATION BY BOARD AND INTEGRATION AUTHORITY

Allocation By Territorial Health Board

Allocations by Territorial Board 2018-19				
	2018-19 Target share	2018-19 NRAC Share	2017-18 Allocation now in 18-19 Baseline	2018-19 Allocation
NHS Ayrshire and Arran	7.41%	£3,389,685	£569,300	£2,820,385
NHS Borders	2.10%	£962,647	£161,300	£801,347
NHS Dumfries and Galloway	2.98%	£1,363,090	£229,100	£1,133,990
NHS Fife	6.81%	£3,113,646	£521,800	£2,591,846
NHS Forth Valley	5.42%	£2,479,354	£415,000	£2,064,354
NHS Grampian	9.87%	£4,516,701	£755,400	£3,761,301
NHS Greater Glasgow & Clyde	22.34%	£10,219,379	£1,718,200	£8,501,179
NHS Highland	6.44%	£2,947,380	£494,100	£2,453,280
NHS Lanarkshire	12.35%	£5,648,985	£947,700	£4,701,285
NHS Lothian	14.80%	£6,772,970	£1,132,000	£5,640,970
NHS Orkney	0.48%	£220,754	£75,000	£145,754
NHS Shetland	0.49%	£224,204	£76,200	£148,004
NHS Tayside	7.85%	£3,590,567	£601,900	£2,988,667
NHS Western Isles	0.66%	£300,639	£103,000	£197,639
Total	100.00%	£45,750,000	£7,800,000	£37,950,000

**Pharmacists in GP Practices funding was a recurring allocation in 2017-18 and will be included in Boards' 2018-19 baseline funding.*

Allocation by Integration Authority: overview of full £45.750 breakdown

Total Bundle £45.750m			
NHS Board	**2018-19 NRAC Share**	**IA Name**	**IA Share**
Ayrshire & Arran	3,389,685	East Ayrshire	1,111,935
		North Ayrshire	1,245,806
		South Ayrshire	1,031,944
Borders	962,647	Scottish Borders	962,647
Dumfries & Galloway	1,363,090	Dumfries and Galloway	1,363,090
Fife	3,113,646	Fife	3,113,646
Forth Valley	2,479,354	Clackmannanshire and Sti	1,166,827
		Falkirk	1,312,527
Grampian	4,516,701	Aberdeen City	1,793,412
		Aberdeenshire	1,935,573
		Moray	787,716
Greater Glasgow	10,219,379	East Dunbartonshire	830,888
& Clyde		East Renfrewshire	713,977
		Glasgow City	5,529,498
		Inverclyde	754,813
		Renfrewshire	1,553,435
		West Dunbartonshire	836,768
Highland	2,947,380	Argyll and Bute	847,966
		Highland	2,099,414
Lanarkshire	5,648,985	North Lanarkshire	2,939,438
		South Lanarkshire	2,709,546
Lothian	6,772,970	East Lothian	839,311
		Edinburgh	3,806,420
		Midlothian	720,229
		West Lothian	1,407,010
Orkney	220,754	Orkney Islands	220,754
Shetland	224,204	Shetland Islands	224,204
Tayside	3,590,567	Angus	985,878
		Dundee City	1,355,476
		Perth and Kinross	1,249,213
Western Isles	300,639	Eilean Siar (Western Isles	300,639
Total	**45,750,000**		**45,750,000**

Allocation by Integration Authority: IA share of £7.8m baselined funding[5]

£7.8m from Boards' Baseline Funding			
NHS Board	**Baselined funding**	**IA Name**	**IA Share**
Ayrshire & Arran	569,300	East Ayrshire	186,750
		North Ayrshire	209,234
		South Ayrshire	173,316
Borders	161,300	Scottish Borders	161,300
Dumfries & Galloway	229,100	Dumfries and Galloway	229,100
Fife	521,800	Fife	521,800
Forth Valley	415,000	Clackmannanshire and S	195,306
		Falkirk	219,694
Grampian	755,400	Aberdeen City	299,941
		Aberdeenshire	323,717
		Moray	131,742
Greater Glasgow	1,718,200	East Dunbartonshire	139,698
& Clyde		East Renfrewshire	120,042
		Glasgow City	929,683
		Inverclyde	126,908
		Renfrewshire	261,181
		West Dunbartonshire	140,687
Highland	494,100	Argyll and Bute	142,153
		Highland	351,947
Lanarkshire	947,700	North Lanarkshire	493,134
		South Lanarkshire	454,566
Lothian	1,132,000	East Lothian	140,278
		Edinburgh	636,186
		Midlothian	120,376
		West Lothian	235,161
Orkney	75,000	Orkney Islands	75,000
Shetland	76,200	Shetland Islands	76,200
Tayside	601,900	Angus	165,266
		Dundee City	227,223
		Perth and Kinross	209,410
Western Isles	103,000	Eilean Siar (Western Isle	103,000
Total	**7,800,000**		**7,800,000**

[5] Being treated as part of the PCIF. Note that there is no difference between the use for PCIP purposes of the baselined £7.8 million and the remainder of the PCIF this year.

Allocation by Integration Authority: tranche 1 and tranche 2 of £37.950 million in-year allocation[6]

£37.95m split into Tranche 1 and Tranche 2							
NHS Board	2018-19 Board Allocation	Tranche 1 (70%)	Tranche 2 (30%)	IA Name	IA Share	Tranche 1 (70%)	Tranche 2 (30%)
Ayrshire & Arran	2,820,385	1,974,270	846,116	East Ayrshire	925,185	647,629	277,555
				North Ayrshire	1,036,572	725,600	310,972
				South Ayrshire	858,629	601,040	257,589
Borders	801,347	560,943	240,404	Scottish Borders	801,347	560,943	240,404
Dumfries & Galloway	1,133,990	793,793	340,197	Dumfries and Galloway	1,133,990	793,793	340,197
Fife	2,591,846	1,814,292	777,554	Fife	2,591,846	1,814,292	777,554
Forth Valley	2,064,354	1,445,048	619,306	Clackmannanshire and Stirling	971,521	680,065	291,456
				Falkirk	1,092,833	764,983	327,850
Grampian	3,761,301	2,632,910	1,128,390	Aberdeen City	1,493,471	1,045,429	448,041
				Aberdeenshire	1,611,857	1,128,300	483,557
				Moray	655,973	459,181	196,792
Greater Glasgow & Clyde	8,501,179	5,950,825	2,550,354	East Dunbartonshire	691,189	483,832	207,357
				East Renfrewshire	593,935	415,754	178,180
				Glasgow City	4,599,815	3,219,871	1,379,945
				Inverclyde	627,905	439,534	188,372
				Renfrewshire	1,292,253	904,577	387,676
				West Dunbartonshire	696,081	487,257	208,824
Highland	2,453,280	1,717,296	735,984	Argyll and Bute	705,813	494,069	211,744
				Highland	1,747,467	1,223,227	524,240
Lanarkshire	4,701,285	3,290,899	1,410,385	North Lanarkshire	2,446,305	1,712,413	733,891
				South Lanarkshire	2,254,980	1,578,486	676,494
Lothian	5,640,970	3,948,679	1,692,291	East Lothian	699,032	489,323	209,710
				Edinburgh	3,170,234	2,219,164	951,070
				Midlothian	599,854	419,898	179,956
				West Lothian	1,171,850	820,295	351,555
Orkney	145,754	102,028	43,726	Orkney Islands	145,754	102,028	43,726
Shetland	148,004	103,603	44,401	Shetland Islands	148,004	103,603	44,401
Tayside	2,988,667	2,092,067	896,600	Angus	820,612	574,428	246,184
				Dundee City	1,128,253	789,777	338,476
				Perth and Kinross	1,039,803	727,862	311,941
Western Isles	197,639	138,347	59,292	Eilean Siar (Western Isles)	197,639	138,347	59,292
Total	**37,950,000**	**26,565,000**	**11,385,000**		**37,950,000**	**26,565,000**	**11,385,000**

[6] Total PCIF minus the £7.8 million baselined amount. Note that there is no difference between the use for PCIP purposes of the baselined £7.8 million and the remainder of the PCIF this year.

ANNEX B

OVERVIEW OF NATIONAL PRIMARY CARE FUNDING ARRANGEMENTS

Primary Care Fund 2018-19

The Scottish Government is investing a total of £115.5 million in the Primary Care Fund (PCF) in 2018-19. There are a number of elements to the overall Fund:

- Primary Care Improvement Fund;
- General Medical Services;
- National Boards; and
- Wider Primary Care Support including Out of Hours.

The full Primary Care Fund breakdown is below.

Primary Care Fund £m	2018-19	Notes
Primary Care Improvement Fund: Service redesign through Primary Care Improvement Plans	**45.750**	Wider MDT development across 6 priority areas in the GMS contract/ MoU, including Pharmacy, CLW, Vaccination Transformation Programme, primary care mental health and Pharmacy First.
GMS: Income & Expenses Guarantee Professional Time Activities Rural package GP Additional support GP clusters (PQLs) **GMS Total**	 23.000 2.500 2.000 3.075 5.000 **35.575**	Additional support includes oxygen, occ health, parental leave, sickness, appraisal and GP retainers scheme
National Boards	**16.569**	Cluster support (HIS and LIST), SAS Strategy/national board transformation, practice nurse training
Wider Primary Care Support: National Support Primary Care Infrastructure Out of Hours GP Recruitment and Retention **Wider Primary Care Support Total**	 5.606 2.000* 5.000 5.000 **17.642**	National support includes primary care development, GP sustainability reccs, community eyecare review, evaluation
Total: Primary Care Fund *£10m Premises Fund available in 2018-19 from a separate funding source	**115.500**	

The table above demonstrates the allocation of the entirety of the Primary Care Fund. A separate letter will be prepared and copied to IAs in due course providing a

breakdown of which elements of the Primary Care Fund are in direct support of General Practice, contributing to the Scottish Government's commitment to invest an additional £250 million in direct support of General Practice by the end of this Parliament.

Primary Care Improvement Fund

An in-year NRAC allocation to IAs (via Heath Boards) will comprise £45.750 million of that £115.5 million Primary Care Fund. This in-year allocation is hereby referred to as the Primary Care Improvement Fund (PCIF). Primary Care Improvement Plans should set out how this additional funding will be used and the timescale for the reconfiguration of services.

In 2018-19, for the PCIF, we are continuing the process of radical simplification we began last year. As agreed with the *Scottish Government – Chief Officer Advisory Group on Primary Care*, we are making a single broad allocation, to provide maximum flexibility to local systems to deliver key outcomes. This is a successor fund to activities previously funded including:

- Pharmacy teams in General Practice
- Vaccination Transformation Programme
- Primary Care Transformation Fund
- Community Links Workers
- Mental Health Primary Care Fund
- Pharmacy First

Primary Medical Services

A separate Primary Medical Services (PMS) revenue allocation letter will issue in due course, which will include the elements of the Primary Care Fund that relate to General Medical Services (GMS) such as the £23 million income guarantee associated with the new GMS contract.

National NHS Boards will also receive letters setting out the outcomes associated with their funding allocations.

Out of Hours Fund

IAs will be expected to maintain and develop a resilient out of hours service that builds on the recommendations set out in Sir Lewis Ritchie's report *Pulling Together*, building effective links and interface between in and out of hours GP services.

Therefore, IAs will receive an in-year NRAC allocation *additional* to the Primary Care Improvement Fund of £5 million for investment in Out of Hours.

A separate letter will set out further detail before the end of May on the allocation and use of the £5 million.

Wider Elements of Primary Care Fund

Funding from the Primary Care Fund outwith the IA-led allocation includes:

- Support to GP sustainability recommendations and national evaluation;
- Support to GP Recruitment and Retention; and
- Funding for National Boards to support primary care transformation.

Future funding profile

To aid in preparation of the Primary Care Improvement Plans, IAs and Health Boards should note that the Primary Care Fund is expected to increase substantially over the next three years. The Scottish Government has announced its commitment to increase the overall PCF to £250 million by 2021-22. The detail of the funding breakdown within that is a matter for Ministers and the annual Parliamentary budgeting process.

However – *strictly as a planning assumption, and subject to amendment by Ministers without notice* – IAs may wish to note our expectation that the Primary Care Improvement Fund will increase to approximately £55 million in 2019-20, £110 million in 2020-21, and £155 million in 2021-22. This will, as this year, be distributed on an NRAC basis.

All PCIF in-year allocations should be considered as *earmarked recurring* funding. It should be assumed therefore that staff may be recruited on a permanent basis to meet the requirements set out in the MoU. We will engage with IAs and others on any plans to baseline these funds.

Linked non-Primary Care Fund funding

Linked funding from outwith the Primary Care Fund in 2018-19 includes:

- The £10 million annual Premises Fund to fund interest-free secured loans to GP contractors who own their premises, as set out in the National Code of Practice for GP Premises.
- The £11 million Mental Health 'Action 15' fund, which will be the subject of a separate letter this month from Penny Curtis.

National trends in funding for primary care

In March 2017 the Cabinet Secretary for Health and Sport announced that in addition to the funding for the provision of general medical services, funding in direct support of general practice will increase annually by £250 million by the end 2021-22. In 2017-18 £71.6 million was committed through the Primary Care Fund in direct support of general practice. Further investment will see this increase over the three financial years from 1 April 2018 to £250 million in 2021-22.

This forms part of the commitment during this Parliament to extra investment of £500 million per year for Primary Care funding. This will raise the primary care budget from 7.7% of the total NHS frontline budget in 2016-17 to 11% by 2021-22.

ANNEX C

SUMMARY OF KEY POLICY DEVELOPMENTS IN PRIMARY CARE 2017-18

GMS contract offer: key elements

The contract offer to GPs[7], jointly negotiated by the BMA and the Scottish Government, sets out a refocused role for GPs as Expert Medical Generalists (EMGs) and recognises the GP as the senior clinical decision maker in the community. This role builds on the core strengths and values of general practice, involves a focus on undifferentiated presentation, complex care, and whole system quality improvement and leadership.

This refocusing of the GP role will require some tasks currently carried out by GPs to be carried out by members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care. Integration Authorities, the Scottish GP Committee (SGPC) of the British Medical Association (BMA), NHS Boards and the Scottish Government have agreed priorities for transformative service redesign in primary care in Scotland over a three year planned transition period. These priorities include vaccination services, pharmacotherapy services, community treatment and care services, urgent care services and additional professional services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services. GPs will retain a professional role in these services in their capacity as expert medical generalists. The contract offer also sets out new opportunities for GP-employed practice staff.

The contract improves the formula used to determine GP funding, and proposals for the next phase of pay reform, and proposes significant new arrangements for GP premises, GP information technology and information sharing. The effect of these arrangements will be a substantial reduction in risk for GP partners in Scotland, and a substantial increase in practice sustainability.

Practice core hours will be maintained at 8am-6.30pm (or as previously agreed through local negotiation). Online services for patients will be improved, and online appointment booking and repeat prescription ordering will be made available where the practice has the functionality to implement online services safely.

The contract sets out how analytical support from Information Services Division of NHS National Services Scotland will be further embedded. Practices will supply information on practice workforce and on demand for services to support quality improvement and practice sustainability.

Memorandum of Understanding

The Memorandum of Understanding (MoU) with Integration Authorities, the British Medical Association, NHS Boards and the Scottish Government[8] set out the

[7] British Medical Association and Scottish Government (2017), *The 2018 GMS Contract in Scotland* http://www.gov.scot/Resource/0052/00527530.pdf
[8] http://www.gov.scot/Resource/0053/00534343.pdf

principles underpinning primary care in Scotland, including respective roles and responsibilities.

The seven key principles for service redesign in the document are:

- Safe
- Person-Centred
- Equitable
- Outcome focused
- Effective
- Sustainable
- Affordability and value for money

The MoU provided the basis for the development by IAs, as part of their statutory Strategic Planning responsibilities, of clear IA Primary Care Improvement Plans, setting out how allocated funding will be used and the timescales for the reconfiguration of some of the key services currently delivered under GMS contracts.

The MoU underpins the new Scottish GMS contract; and enables the move towards a new model for primary care that is consistent with the principles, aims and direction set by the Scottish Government's National Clinical Strategy (NCS) and the Health and Social Care Delivery Plan.

Workforce Plan

The third section of the National Workforce Plan[9] was published on 30 April 2018.

Scottish Ministers have committed to a significant expansion of the wider Multi-Disciplinary Team (MDT), including the training of an additional 500 advanced nurse practitioners, 250 Community Links Workers to be in place by 2021 in practices serving our poorest populations, and 1,000 paramedics to work in the community. General Practice will further be supported by ensuring all practices are given access to a pharmacist by the end of this parliamentary period. An additional investment of £6.9 million will be made in nursing in primary care, particularly general practice nursing and district nursing.

The publication of *National Health and Social Care Workforce Plan: Part 1 – a framework for improving workforce planning across NHS Scotland*[10] last June signalled the beginning of a process to further improve workforce planning across health and social care. It set out new approaches to workforce planning across Scotland, within a framework for wider reform of our health and care systems. Part 2 of the Workforce Plan – *A framework for improving workforce planning for social care in Scotland*[11] – published jointly by the Scottish Government and COSLA, set out a whole system, complementary approach to local and national social care workforce planning, recognising our new integrated landscape.

[9] http://www.gov.scot/Publications/2018/04/3662
[10] http://www.gov.scot/Resource/0052/00521803.pdf
[11] http://www.gov.scot/Resource/0052/00529319.pdf

Part 3, the primary care workforce plan, marks an important further step in that journey. It addresses the following main issues:

- how primary care services are in a strong position to respond to the changing and growing needs of our population, alongside the evidence of the significant benefits that will be delivered through focusing our workforce on prevention and self-management.
- The shape of the existing primary care workforce, including recent trends in workforce numbers
- The anticipated changes in the way services will be reconfigured to meet population need
- How the MDT will be strengthened to deliver an enhanced and sustainable workforce
- Our approach to recruiting 800 more doctors into general practice over the next decade and supporting and retaining the existing workforce
- How we will work with partners to ensure that better quality and more timely data is developed to drive effective local and national workforce planning.
- A commitment to work alongside partners including the RCN to understand the requirements for sustaining and expanding the district nursing workforce. By September 2018 we will better understand the requirements and investment needed to grow this workforce.

Other key policy developments

GP Clusters

The approach to quality which began with the move away from the Quality and Outcomes Framework introduced in the 2004 GMS contract will continue. Following the publication of *Improving Together: A National Framework for Quality and GP Clusters in Scotland*[12] in January 2017, work is now underway to continue to develop the collaborative learning role of GP clusters, to help identify and improve the quality of services in their locality. Healthcare Improvement Scotland and National Services Scotland, through Local Intelligence Support Teams (LIST) will continue to support clusters to gather intelligence to establish what these priorities are, and how to collect and evaluate data to determine what action is needed. Work is now underway to further refine the National Framework, with input from Integration Authorities, and this work will continue in 2018/19. Support should be made available from Public Health locally to help identify suitable cluster outcomes for improvement.

Community Eyecare

As indicated in last year's letter, the Community Eyecare Services Review[13] required Integration Authorities to consider the full eyecare needs of their communities when planning and commissioning services. Work is now underway in taking forward the recommendations, particularly around revising the General Ophthalmic Services Regulations. We would expect Integration Authorities to continue to work with

[12] https://beta.gov.scot/publications/improving-together-national-framework-quality-gp-clusters-scotland/documents/00512739.pdf?inline=true
[13] http://www.gov.scot/Publications/2017/04/7983

optometrists and NHS Board Optometric Advisers in considering how eyecare services can be delivered more effectively in their area, as work to implement further recommendations around clinical and quality improvement will continue in 2018/19.

Oral Health

On 24 January 2018, the Scottish Government published the *Oral Health Improvement Plan* (OHIP)[14]. The OHIP sets the direction of travel for oral health improvement and NHS dentistry for the next generation, and has a strong focus on preventing oral health disease, meeting the needs of the ageing population and reducing oral health inequalities. This does not form part of the PCIF, but appropriate links should be identified where possible.

Pharmacy

Our strategy 'Achieving Excellence in Pharmaceutical Care'[15]. was published in August 2017, and sets out the priorities, commitments and actions for improving and integrating NHS pharmaceutical care in Scotland over the next five years. It is driven by two main priorities: Improving NHS Pharmaceutical Care and Enabling NHS Pharmaceutical Care Transformation.

Achieving Excellence emphasises the important role the pharmacy team in NHS Scotland has to play as part of the workforce, making best use of their specialist skills and much needed expertise in medicines. It describes how we see pharmaceutical care evolving in Scotland along with the crucial contribution of pharmacists and pharmacy technicians, working together with other health and social care practitioners, to improve the health of the population, especially for those with multiple long term and complex conditions.

[14] http://www.gov.scot/Publications/2018/01/9275
[15] http://www.gov.scot/Resource/0052/00523589.pdf

ANNEX D

CORE REQUIREMENTS OF PRIMARY CARE IMPROVEMENT PLANS REQUIREMENT 1: PREPARATION OF PRIMARY CARE IMPROVEMENT PLANS (PCIPS)

The MoU requires IAs to:

1. Develop three-year Primary Care Improvement Plans (PCIPs), consulting NHS Boards and other partners. These must be agreed with the local GP Subcommittee of the Area Medical Committee, with the arrangements for delivering the new GMS contract being agreed with the Local Medical Committee (LMC),and
2. Through the Plans, commission, deliver and resource (including staff resources) the six priority services identified in the MOU and the Contract document ("Blue Book") in support of the new GP contract.

Process

Initial Plans, with evidence of appropriate local consultation and agreements, will be completed by 1 July 2018 and shared with the National Oversight Group by the end of that month. They should be kept under review and updated at least annually.

The Plans are to be developed collaboratively with advice and support from GPs; and explicitly agreed with the local GP Subcommittee of the Area Medical Committee (and, in the context of the arrangements for delivering the new GMS contract, explicitly agreed with the Local Medical Committee).

Key partners and stakeholders (including patients, carers, and representatives of service providers such as the third sector) should be as engaged as possible in the preparation, publication and regular review of the Plans. There will also be a need for appropriate engagement with specific professionals and groups. For example, on the pharmacotherapy service, Directors of Pharmacy and others such as area pharmaceutical committees (or area clinical forums) and local pharmacy contractors committees will have a strong need for engagement on its implementation locally.

We appreciate that achieving full engagement within the challenging initial timescale for the PCIP may be difficult, and some of the more detailed dialogue may take place after the plans are submitted. They will be living documents, and regularly reviewed and updated.

Content

The transfer of services in the six priority areas (detailed under Requirement 2 below) will be a major component of PCIPs, and we expect that PCIPs will show a funding profile for each area.

Good communications and understanding across the wider health and social care interfaces with both services and professional groups (e.g. primary/secondary, community health and social care services, district nursing, out of hours services,

mental health services) will also be required to address direct patient care issues, such as prescribing, referrals, discharges, follow up of results and signposting. An important principle here is that each part of the system respects the time and resources of the other parts. There should not be an assumption that patient needs or work identified in one part of the service must be met by another without due discussion and agreement. This should ensure that patients do not fall through gaps in the health and care system.

Wider spending on those services should form part of IAs' broader strategic planning and commissioning role, and it would be helpful if PCIPs could reference how these services will work together.

IAs, in preparing PCIPs, should also consider the underpinning need for strong collective leadership from all parts of the local system, and how best to support it. Measures to build the leadership capability of GP Sub-Committees, and Cluster Quality Leads, as well as wider capability and capacity, should form a key part of Plans. NHS Education for Scotland is likely to be a key partner for IAs in delivering programmes to support that capacity-building. PCIPs may also address practical support to the programmes of work, such as coordination or programme management.

Wider considerations

Connection to Action 15 of the Mental Health Strategy

Primary Care Improvement Plans should show clear connections to the plans being prepared under Action 15 of the Mental Health Strategy for delivery of 800 more mental health staff in general practice, Accident and Emergency, prisons and police custody suites over the next three years. Penny Curtis will be writing to you separately on this matter.

Some of the same staff may be counted both as part of the MOU delivery (for example as part of the development of primary care mental health and/or the work on links workers) and the delivery of the general practice element of the 800. This is acceptable, and Penny Curtis's letter will set out how we expect additionality to be accounted for in terms of the 800. It would be helpful to see any cross-over clearly articulated in both PCIPs and existing plans (or those in development) regarding Action 15 of the Mental Health Strategy.

Inequalities

Whilst we recognise that the key determinants of health inequality lie outside general practice services and health care generally, there remain opportunities to strengthen the role of general practice and primary care in mitigating inequality. All PCIPs should include a section on how the services will contribute to tackling health inequalities. The community links worker service will be one aspect of this, as will the developing quality improvement role of GP Clusters, but IAs will wish to consider what more can be done to ensure there is parity of access for all groups, and that the workload of GPs in the most deprived areas is manageable.

IAs are also subject to the new Fairer Scotland Duty which came into force from April 2018. Guidance on the new duty is available on the SG website[16]. The duty aims to ensure that public bodies take every opportunity to reduce inequalities of outcome, caused by socio-economic disadvantage, when making strategic decisions. We would therefore strongly encourage IAs to consider how they can meet their obligations under the duty as they develop their PCIPs. In particular, all IAs should have completed an inequalities assessment, and make reference to this in their PCIP.

Sustainability

All IAs should also consider the sustainability of general practices in their area including the recruitment and retention of local GPs. Where there are specific sustainability issues, these should be discussed with GP representatives, and consideration given to how the PCIP can best support the sustainability of general practice locally.

National support will continue to be made available through the multi-partner Improving General Practice Sustainability Advisory Group which, over the past year, has made significant progress in delivering the practically focused recommendations for reducing workload pressures, including actions to improve interface working and improved signposting of patients to appropriate primary care services and to self-care. During 2018 the Group will focus on supporting local partners to address local sustainability issues.

Rural, remote and island communities

The needs of rural, remote and island communities should be addressed in PCIPs if they form part of the IA area.

The expectation is that the contract workload reduction measures and new services must be made available to *every* practice where it is reasonably practical, effective and safe to do so.

The service redesign requires practices to be involved via their GP clusters, so they have a say in how services will work locally.

Governance

A new National Oversight Group with representatives from the Scottish Government, the SGPC, Integration Authorities and NHS Boards will oversee implementation by NHS Boards of the GMS contract in Scotland and the IA Primary Care Improvement Plans, including clear milestones for the redistribution of GP workload and the development of effective MDT working, including with non-clinical staff.

At local level, Integration Authorities will hold Health Boards and Councils to account for delivery of the milestones set out in the Plan, in line with the directions provided

[16] http://www.gov.scot/Publications/2018/03/6918

to the Health Board and Council by the Integration Authority for the delivery of Strategic Plans.

Directors of Pharmacy will be leading on the implementation of the pharmacotherapy services during the three year trajectory, to ensure governance arrangements are in place, workforce planning and capacity issues are addressed, and the initial momentum is maintained. This will be taken forward through the recently established Pharmacotherapy Service Implementation Group which will form part of the governance arrangements under the new National Oversight Group.

The Vaccination Transformation Programme is overseen by a Programme Board with representatives from the Scottish Government, SGPC, Trade Unions, Health Protection Scotland, Health Boards, and Directors of Nursing. It is responsible for realising the benefits of vaccination transformation nationally, and managing, monitoring and evaluating progress made by each Health Board. The Vaccination Transformation Programme Board links into the National Oversight Group by reporting to the Primary Care Programme Board.

Other stakeholder groups such as dentistry and optometry should also be engaged with.

Evaluation

At local level, all PCIPs should include consideration of how the changes will be evaluated locally.

Healthcare Improvement Scotland and LIST analysts from National Services Scotland will work with IAs to provide support and learning in development of the new services.

At the national level, the Scottish Government plans to publish a 10-year Primary Care Monitoring and Evaluation Strategy in June 2018, setting out our overarching approach to evaluating primary care reform.

We will also publish a Primary Care Outcomes Framework before then, which maps out planned actions and priorities against the changes we are working towards. The Framework was co-produced by the Primary Care Evidence Collaborative, which includes NHS Health Scotland, the Scottish School of Primary Care, Healthcare Improvement Scotland, NHS Education for Scotland, National Services Scotland, the Alliance, and the Scottish Government.

ANNEX E

CORE REQUIREMENTS FOR PRIMARY CARE IMPROVEMENT PLANS 2018-21 REQUIREMENT 2 – SERVICE TRANSFER

The MoU requires IAs to:

1. Develop three-year Primary Care Improvement Plans (PCIPs), consulting NHS Boards and other partners. These must be agreed with the local GP Subcommittee of the Area Medical Committee, with the arrangements for delivering the new GMS contract being agreed with the Local Medical Committee (LMC),and

2. Through the Plans, commission, deliver and resource (including staff resources) the six priority services identified in the MOU and the Contract document ("Blue Book") in support of the new GP contract.

This Annex sets out the six core requirements for service transfer in PCIPs over the three year period.

IAs should work with a range of professionals in NHS Boards and practices, reflecting the service priority areas, to plan and manage service transfers in a way that ensures patient safety and maximises benefits to patient care. The nature and speed of delivery at a local level will vary based on local factors such as the extent to which comparable services are already in place, upon local geography, and prioritisation based on local demographics and demand. The new services should be provided within GP practices or clusters of practices, or be closely located.

Delivery of the Vaccination Transformation Programme, pharmacotherapy service and community treatment and care service (and within that, specifically phlebotomy) have been identified as the key immediate priorities, in that responsibility for these services will be fully transferred to IAs by the end of the transition period in April 2021. However, the other aspects of service transfer should also be considered urgent, and requiring of significant progress over the three years of Plan to deliver the arrangements set out in the MOU and the new GMS contract document.

Service 1) Vaccination Transfer Programme

High level deliverable: All services to be Board run by 2021.

By 2021, vaccinations will have moved away from a model based on GP delivery, to one based on NHS Board delivery through dedicated teams.

The Vaccination Transformation Programme can be divided into different work streams:
1. pre-school programme
2. school based programme
3. travel vaccinations and travel health advice
4. influenza programme
5. at risk and age group programmes (shingles, pneumococcal, hepatitis B)

We expect IAs and NHS Boards to have all five of these programmes in place by April 2021. The order and rate at which IAs and NHS Boards make the transition may vary but progress is expected to be delivered against locally agreed milestones in each of the 3 years, including significant early developments in financial year 2018-19.

The Vaccination Transformation Programme includes all vaccination work in primary care, whether previously delivered by IAs or not. For the avoidance of doubt, this includes childhood immunisations in every case.

Governance and oversight

The Vaccination Transformation Programme is overseen by a Programme Board with representatives from the Scottish Government, SGPC, Trade Unions, Health Protection Scotland, Health Boards, and Directors of Nursing. It is responsible for realising the benefits of vaccination transformation nationally, and managing, monitoring and evaluating progress made by each Health Board. The Vaccination Transformation Programme Board links into the National Oversight Group by reporting to the Primary Care Programme Board.

Service 2) Pharmacotherapy services

High level deliverable: Pharmacotherapy Service to the patients of every practice by 2021.

The GP contract includes an agreement that every GP practice will have access to a pharmacotherapy service. To date, investment from the GP Pharmacy Fund has meant that we have exceeded the initial target to recruit 140 wte pharmacists, together with a number of wte pharmacy technicians. The combined skill mix of these pharmacists and technicians are supporting over one third of GP practices across Scotland. An outturn exercise will be completed shortly confirming the total recruitment figures over the three year period up to the end of March 2018.

The PCIP should set out a three year trajectory from April 2018 to April 2021, to establish a sustainable pharmacotherapy service which includes pharmacist and pharmacy technician support to the patients of every practice. Pharmacists and pharmacy technicians will become embedded members of core practice clinical teams and, while not employed directly by practices, the day-to-day work of pharmacists and pharmacy technicians, will be co-ordinated by practices and targeted at local clinical priorities. Implementation of the pharmacotherapy service will be led by Directors of Pharmacy during the three year trajectory period through the Pharmacotherapy Service Implementation Group.

Pharmacists and pharmacy technicians will take on responsibility for:

a) Core elements of the service, including: acute and repeat prescribing, medicines reconciliation, monitoring high risk medicines
b) Additional elements of the service, including: medication and polypharmacy reviews and specialist clinics (e.g. chronic pain)

By the end of the three year period, PCIPs should be able to demonstrate appropriate delivery of both the core and additional elements of the service in response to local needs.

There will be an increase in pharmacist training places to support this work.

Chronic Medication Service

In addition, PCIPs should also take into account the contribution of the Chronic Medication Service (CMS) available in all local community pharmacies, and ensure the appropriate links between the pharmacotherapy service and CMS are embedded to make best use of total capacity.

Under this centrally funded service, community pharmacists can carry out an annual medication review, as well as regular monitoring and feedback to the practice for patients registered for this service. Involving community pharmacists in the medication review of people with a stable long term condition will support pharmacists in GP practices and GPs to concentrate on more complex care. Making full use of the clinical capacity within community pharmacy can improve the pace and efficiency of delivery of the pharmacotherapy service in GP practices.

Other Centrally Funded Community Pharmacy Services

GP practice teams should also make full use of the other NHS services available through local community pharmacies as part of local triaging arrangements.

Community pharmacists can provide self-care advice on a range of common (uncomplicated) clinical conditions. Children, the elderly, people with medical exceptions, and those on low incomes can also make full use of the Minor Ailment Service (MAS). We will be looking to see how we can develop the MAS on a national basis, based on the outcomes of the extended MAS pilot in Inverclyde.

Smoking cessation support and sexual health advice (including access to Emergency Hormonal Contraception) are also available through the community pharmacy Public Health Service.

Pharmacy First

Also included in your 2018-19 funding allocation are monies to support the continuation of the Pharmacy First service introduced in community pharmacies across Scotland from winter 2017-18.

Linked to the MAS, Pharmacy First allows community pharmacists to treat uncomplicated urinary tract infections in women and impetigo in children without the need for a GP appointment or prescription, opening access to treatment both in and out-of-hours.

Taken together, the NHS Services available through the network of community pharmacies at both local and national levels builds on the role of pharmacists as part of the multidisciplinary team in primary care, making the best use of their clinical skills and providing convenient routes of access to appropriate primary care.

Service 3) Community Treatment and Care Services

High level deliverable: A service in every area, by 2021, starting with phlebotomy.

These services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate.

Phlebotomy should be delivered as a priority in the first stage of the PCIP.

There will be a three year transition period to allow the responsibility for providing these services to pass from GP practices to IAs. By April 2021, these services will be commissioned by IAs, and delivered in collaboration with NHS Boards that will employ and manage appropriate nursing and healthcare assistant staff.

Community treatment and care services should be prioritised for use by primary care. They should also be available for secondary care referrals if they would otherwise have been workload for GPs (i.e. if such use means they are directly lifting workload from GPs). It is essential that the new funding in direct support of General Practice is only used to relieve workload from General Practice. Work from secondary care sources should be funded from other streams.

IAs should consider how this service might best be aligned with wider community treatment and care services used by secondary care.

Service 4) Urgent care (advanced practitioners)

High level deliverable: A sustainable advanced practitioner service for urgent unscheduled care as part of the practice or cluster based team, based on local needs and local service design.

The MoU sets out the benefits of utilising advanced practitioners to respond to urgent unscheduled care within primary care, including being the first response to a home visit or responding to urgent call outs, freeing up GPs to focus on their role as expert medical generalists. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.

Where service models are sufficiently developed, advanced practitioners may also directly support GPs' expert medical generalist work by carrying out routine assessments and monitoring of chronic conditions for vulnerable patients at home, or living in care homes. These advanced practitioners may be advanced paramedics or advanced nurse practitioners. It is for the IAs, in collaboration with GP clusters, to determine the best provision for their locality.

By 2021, there should be a sustainable advanced practitioner provision in all IA areas, based on appropriate local service design.

Service 5) Additional Professional roles

High level deliverable: In most areas, the addition of new members of the MDT such as physiotherapists or mental health workers acting as the first point of contact.

By 2021 specialist professionals should be working within the local MDT to see patients as the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. Service configuration may vary dependent upon local geography, demographics and demand.

Physiotherapy services focused on musculoskeletal conditions

IAs may wish to develop models to embed a musculoskeletal service within practice teams to support practice workload. In order to provide a realistic alternative for patients, access times must be comparable to those of general practice. Priority for the service, such as focusing on elderly care, will be determined by local needs as part of the PCIP.

Mental health

As indicated in last year's letter, the Mental Health Strategy 2017-27[17] commits to action 23, "test and evaluate the most effective and sustainable models of supporting mental health in primary care, by 2019". It describes the primary care transformation that will improve this - up skilling of all Primary Care team members on mental health issues, the roles of clinical and non-clinical staff, and the increased involvement of patients in their own care and treatment through better information and technology use.

In previous years, nearly £10m was invested via the Primary Care Mental Health Fund (PCMHF) to encourage the development of new models of care to ensure that people with mental health problems get the right treatment, in the right place, at the right time. In 2018-19, further mental health funding is included within the £45.750 million for IAs, and Primary Care Improvement Plans must demonstrate how this is being used to re-design primary care services through a multi-disciplinary approach, in conjunction with how other mental health allocations are being managed (including that of Action 15 within the Mental Health Strategy).

Action 15 of the Mental Health Strategy 2017-2027 is to increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next 5 years we have committed to additional investment which will rise to £35 million in the final year for 800 additional mental health workers in those key settings. The first tranche of funding for Action 15 is set at £11 million in 2018-19. Following detailed consideration of this matter by the Health and Justice Collaboration Improvement Board, a separate letter will be issued to you regarding funding for Action 15, which should be read in conjunction with this letter. It will include a requirement to count

[17] http://www.gov.scot/Publications/2017/03/1750

and monitor the number of additional mental health workers needed to deliver this commitment.

Others

A link could be made, if wished, with community pharmacy as part of Pharmacy First and in support of the GP Sustainability report actions.

Service 6) Community Link Workers

High level deliverable: Non-clinical staff, totalling at least 250 nationally, supporting patients who need it, starting with those in deprived areas.

Community link workers are based in or aligned to a GP practice or cluster and work directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of (for example) the complexity of their conditions, rurality, or a need for assistance with welfare issues.

As part their PCIP, IAs should assess local need and develop link worker roles in every area, in line with the Scottish Government's manifesto commitment to deliver 250 link workers over the life of the Parliament. The roles of the link workers will be consistent with assessed local need and priorities, and function as part of the local models/systems of care and support. However, the primary intention of this work is to act as one of the ways in which local systems can tackle health inequalities, and therefore the expectation is that the first priority for link workers will be more deprived areas.

It is essential that IAs work together to ensure that they have identified a **national trajectory towards 250 additionally-provided staff** (which could include upskilled staff or those receiving new contracts) by the end of the period. It will be for the national Oversight Group to maintain oversight of this national trajectory.

The 53 'early adopter' link workers who are already in post in areas of higher socio-economic deprivation are the foundation of the build-up towards 250, and continuation of these posts should be considered to be a priority. It is, however, entirely for IAs to decide whether any changes to the scope, oversight, employer or lead responsibility for these posts are required in the light of emerging learning and the developing PCIPs.

The 'early adopter' posts were not initially distributed on an NRAC basis, so Health Boards and IAs should, where necessary, work collaboratively within their area to jointly resource early adopter link workers. This is also the case for additional link workers that may in future be specifically jointly targeted by IAs on areas of the highest deprivation within a Health Board.

This joint working in support of the overall commitment to link workers can be reflected in PCIPs for all the IAs concerned, and will be welcomed.

Such a joint approach should be considered especially where it is considered that continuation of the early adopter service in an IA could disproportionately impact on funding available in that IA for other activities under the MoU.

Support for this work is available to IAs from ScotPHN (Kate Burton) who can support IA work to develop and implement the role of link workers during 2018-19; and from NHS Health Scotland on the development of local evaluation and learning.

ANNEX F

END YEAR REPORT

We would be grateful for a high level report on spend, impact and plans for any carry forward for your overall spending from the Primary Care Transformation Fund in 2017-18. This should include a high level breakdown of the outcomes achieved in 2017-18 across in hours, out of hours and mental health funded by your 2017-18 Primary Care Transformation Fund allocation. When responding, it would also be helpful if this could also include an explanation of how any underspend from 2016-17 that your Integration Authorities were able to carry forward into 2017-18 was spent.

A template for your use is below.

Test of Change Summary Table		
IA Name		
Primary Care Outcome[18]	*Select from the table of primary care outcomes that best fits your test of change*	
Primary Care Outcome	*add a secondary outcome if appropriate.*	
Section 1: 2017-18 actual spend		
Funding allocated to this test of change in 2017-18		£
High level breakdown of actual spend incurred:		
Actual spend		£
Total underspend carried forward to 2018-19		£
Plans for use of the underspend in support of Primary Care Improvement Plans:		
Impact & key learning points:		

[18] Primary Care Outcomes:

1 We are more informed and empowered when using primary care
2 Our primary care services better contribute to improving population health
3 Our experience as patients in primary care is enhanced
4 Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care
5 Our primary care infrastructure – physical and digital – is improved
6 Primary care better addresses health inequalities

ANNEX G

OUTLINE 2018-19 INTEGRATION AUTHORITY FINANCIAL REPORTING TEMPLATE, DUE FOR RETURN BY SEPTEMBER 2018

IA area

Confirmation that PCIP, agreed with the local GP Subcommittee of the Area Medical Committee, is **in place (date submitted)**

Summary of agreed spending breakdown for 2018-19 by service area, with anticipated monthly phasing

Actual spending to date against profile, by month, by service area

Remaining spend to end 2018-19, by month, by service area

Projected under/ over spend by end 2018-19

Is it expected that the full second tranche will be required in 2018-19?

Please return to:

Laura Cregan
Primary Care Division
1ER, St Andrew's House, Regent Road, Edinburgh EH1 3DG

Or by email to:
Laura.cregan@gov.scot