AGENDA ITEM

24

Forth Valley Primary Care Improvement Plan

2018 to 2021



Version 20 – 13 07 18

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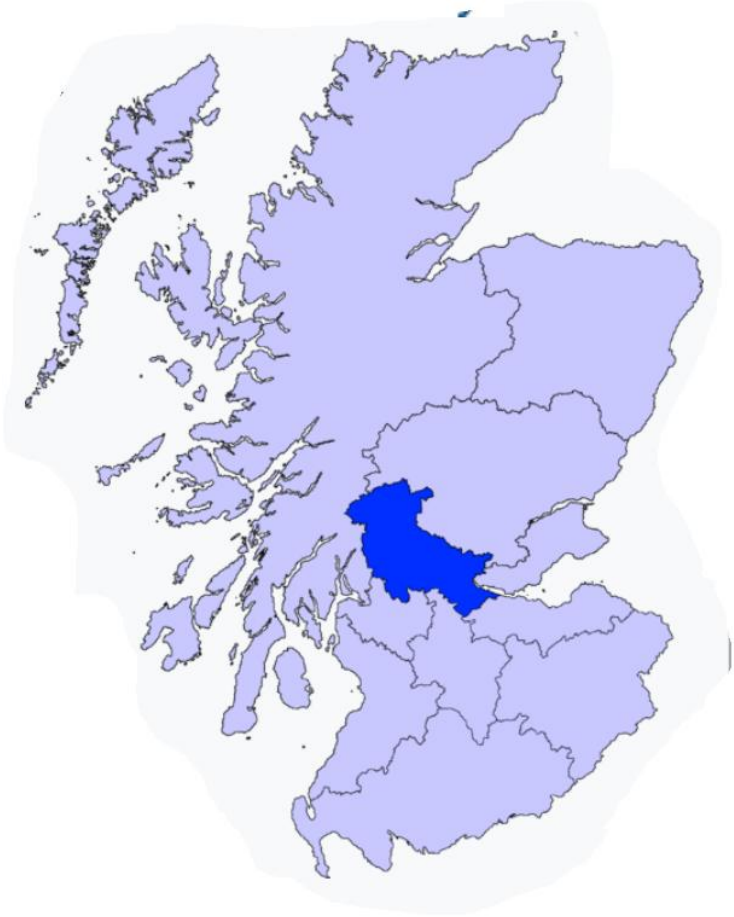


Forth Valley is located in the heart of Scotland and has two Health and Social Care Partnerships, Clackmannanshire and Stirling and Falkirk, across 3 local authority areas. Whilst the majority of the population live in towns in the South East, there is a large rural area with small communities situated 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 (MDT) 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 Integration Joint Boards, in collaboration with GPs and the Local Medical Committee (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 Forth Valley Primary Care Improvement Plan has been developed recognising ongoing strategic and transformational work and to support management of the current significant sustainability challenges in 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 sets 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, with NHS Boards / Integration Authorities expected to submit Primary Care Improvement Plans by 31 July 2018 for this 3 year period.

The benefits of strengthening Primary Care are summarised below:

The Primary Care Improvement Plan offers the opportunity to undertake transformational changes in the way we provide Primary Care to the population of Forth Valley. It must be recognised however that this Primary Care Plan is ambitious and aspirational, whilst there are a number of factors which will impact on our ability to deliver this plan including recruitment, retention, funding and the short timescale.

1.1 Approval of Plan

This plan has been approved through a governance process agreed with the Falkirk Integration Joint Board, Clackmannanshire and Stirling Integration Joint Board, NHS Forth Valley, GP Sub-Committee and Local Medical Committee.

The plan will be reviewed every 6 months to enable progress to be tracked and to identify if any adjustments or amendments require to be made as implementation progresses. This approach recognises the potential challenges with recruiting the additional workforce described in this plan and the need to consider alternatives, should recruitment fall short of the required numbers and skill mix, alongside the other risks described in section 2.9.

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 was made with the two Integration Joint Boards (Clackmannanshire and Stirling, and Falkirk) 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.

The Primary Care Improvement Plan must also be viewed in the context of the NHS Forth Valley Healthcare Strategy – Shaping the Future and the Strategic Plans of the two Health and Social Care Partnerships, all of which have priorities associated with supporting people to keep well, improving health, reducing health inequalities and providing care as close to home as possible. The development of the Community Front Door, providing a single point of access to care and support, will also align with the Primary Care improvement.

An Equalities Impact Assessment of this Plan has been undertaken and submitted to the Equalities Advisor of NHS Forth Valley for evaluation.

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:

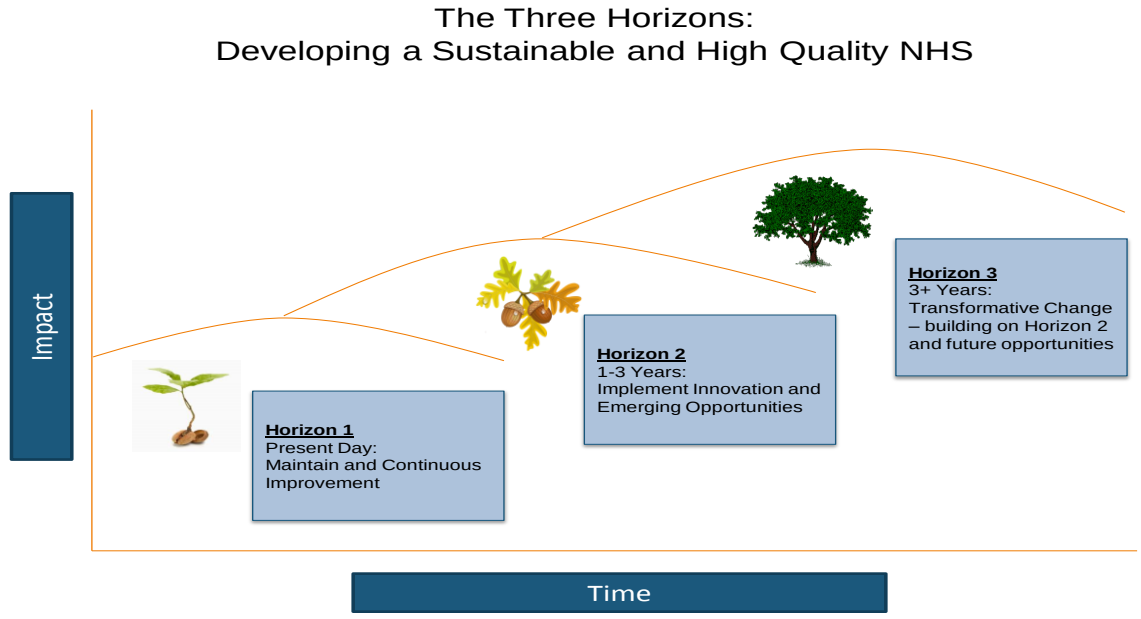
- Enable the development of the expert medical generalist role through a reduction in current GP and practice workload.
- Agree a primary care and community services multi-professional workforce and recruitment plan to support the expert medical generalist role and enable delivery of safe and sustainable 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 was established to prepare the Primary Care Improvement Plan (appendix 2). The 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 and to be ambitious and aspirational in their proposals for transformational change.

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 was used to capture the key proposed changes, impacts and outcomes associated with the 3 horizons.



2.1 Sustainability

The Forth Valley Primary Care Improvement Plan 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.

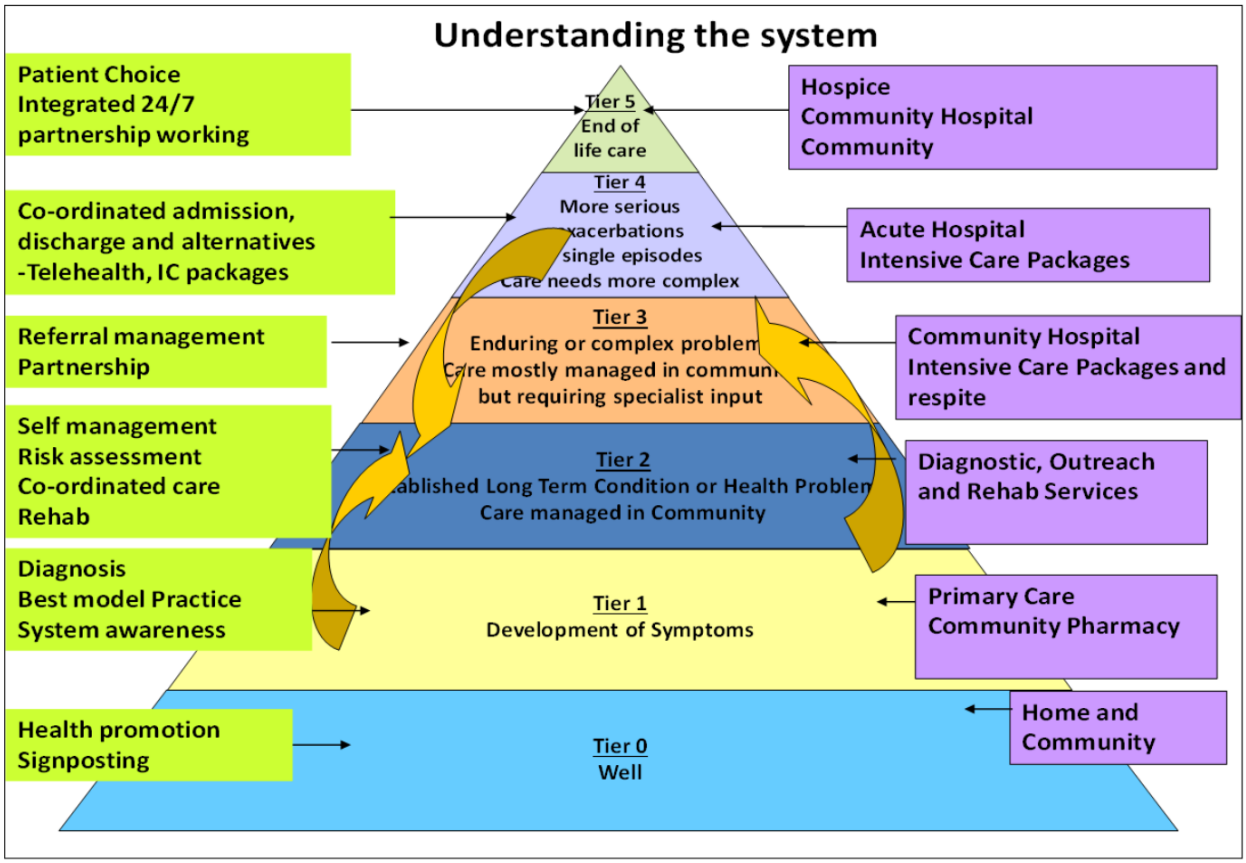
The move towards a new GMS Contract is set against a background of ongoing sustainability issues recognising that less doctors are choosing to become GPs and over 50% of our current GPs in Forth Valley are over 50, with 23-25% aiming to retire or significantly reduce their clinical commitment in the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

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.



2.2 Out of Hours

The Primary Care Improvement Plan is focused on the services provided in the 2018 General Medical Services Contract in Scotland. The provision of GMS evenings, overnight and at weekends is not included in the new contract. However, it is essential for in-hours services that out of hours services run efficiently and effectively, therefore specific actions to improve continuity of patient care which will reduce pressure on the local out of hours service should be incorporated into the implementation of the PCIP. Consideration should also be given when developing any new services as to what impact they may have on current out of hours services.

2.3 Primary Care Transformation

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

Strand 1
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", November 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.

Strand 2
Primary Care Transformation

This 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 Health and Social Care Partnerships (HSCP) which aim to improve outcomes through enhanced primary and community or secondary care interfaces. In South West Rural Stirling this will be delivered 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 mild to moderate mental health support alone. Up to one third of GP 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.

Strand 3
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 (PCTF) 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.

2.4 Forth Valley Approach

In Forth Valley we have agreed that a phased approach to implementation is essential. This will enable the new models of care to be implemented, tested and evaluated in some areas and then, once the learning from the initial sites is used to adapt the models, these can then be rolled out to other areas.

For the Vaccination Transformation Programme, the phasing will be based on parts of the programme being rolled out in all areas. For the other 5 priorities, these have been drawn into three delivery areas which will be tested and implemented in clusters. We have 9 clusters in Forth Valley, and each will be given the opportunity to test and commence implementation of one delivery priority in each year of the three year implementation.

We will work closely with the clusters to determine which area they will adopt first and this has been informed by the questionnaire which was issued to all practices (see section 2.5 below)

2.5 Stakeholder Engagement

During the preparation of this draft Primary Care Improvement Plan there has been extensive engagement with stakeholders including the following:

- GP Information Evening about the new GMS contract including a workshop on the Primary Care Improvement Plan, attended by over 110 delegates.
- CREATE session on the Forth Valley Primary Care Improvement Plan with 90 participants.
- GP Sub-Committee meetings.
- Cluster Quality Lead meetings.
- Primary Care Improvement Plan Working Group meetings.
- NHS Forth Valley Senior Leadership Team, with health and social care senior leaders in attendance.

A questionnaire was completed by all practices in Forth Valley in May 2018, following the CREATE session, on their preferences for early implementation of the different priorities in Primary Care Improvement Plan. This is being used to inform how the plan will be implemented and which priorities will be the focus of development in each cluster initially. The questionnaire is attached in Appendix 4.

In Forth Valley, we have had the opportunity to test many of the models of care described in the Memorandum of Understanding, as outlined above in section 2.2 and elsewhere in this Plan, in the 2c practices which are managed by the NHS. Extensive engagement with patients and staff has taken place in these practices around delivering the new models of care over the last 4 years.

2.6 Rural Practices

Within the Clackmannanshire and Stirling Health and Social Care Partnership area, there are rural communities to the South, West and North West of Stirling city. Some of these rural communities, particularly those in the North West around Killin, Crianlarich and Tyndrum can also be described as remote.

Whilst the Primary Care Improvement Plan seeks to implement the 6 priorities in a phased way across all clusters in Forth Valley and make available the new services to all practices over time, it is recognised that there will need to be some flexibility in the arrangements in remote and rural areas, to acknowledge local circumstances. We will work in partnership with the relevant Clusters and Practices to put in place arrangements which are pragmatic and appropriate.

2.7 Building Capacity and Capability

Clinical leadership capacity to deliver the aspirations of the Primary Care Improvement Plan will be built on the existing leadership infrastructure led and co-ordinated by the Associate Medical Director for Primary Care. This support will be augmented through the Primary Care Improvement Plan Group which has representation from Board GP Clinical Leaders and GP Sub Committee. We recognise that to ensure GP sub-committee input there will need to be sessional funding available and meeting times that accommodate availability of GPs.

It is also essential to put in place a suitable infrastructure to lead implementation of this plan and to ensure that the new models we deliver are efficient, effective and fit for purpose. Therefore a Programme Team will be established to work with partners and service providers to support delivery of transformational change in Primary Care.

The Forth Valley Cluster Quality Lead (CQL) network involving the 9 GP Cluster Leads and other key clinicians have discussed and been invited to contribute to the Primary Care Improvement Plan. The CQL network reports to the Primary Care Quality Improvement Group, and links in with the Professional Advisory Committee.

GP Clinical Leadership development is facilitated by the NHS Education for Scotland Associate Adviser working with GP Clinical Leads and Cluster Leads through the CQL network and Quality Improvement Group.

Primary Care Leads groups have multi-disciplinary membership to support delivery of a multi-professional model.

The Associate Medical Director, GP Leads and GP Sub Committee co-ordinate communication with the wider GP body through, for example, information evenings and CPD events attended during May 2018 by over 200 participants.

2.8 Evaluation

It is noted that the Scottish Government will publish a 10 year Primary Care Monitoring and Evaluation Strategy in June 2018 and a Primary Care Outcomes Framework mapping out planned actions and priorities against the changes we are working towards. This will inform how implementation of the Forth Valley Primary Care Improvement Plan will be monitored and evaluated.

It is proposed that the Primary Care Improvement Plan will be evaluated by assessing the delivery of the different work stream elements in accordance with the defined timelines and in line with the Three Horizons model, which we have developed. A formal review process will be established, with 6 monthly reviews led by the Primary Care Programme Board.

The Vaccination Transformation Programme has a proposed timeline for testing the delivery models and the subsequent transfer of responsibility for immunisation services to the NHS Board.

It has been agreed that in year 1 of the Primary Care Improvement Plan implementation (2018/19) clusters will each test, evaluate and recommend further modification of either pharmacotherapy, community care and treatment or urgent care services including new professional roles.

- For pharmacotherapy services evaluation will focus on delivery of a three tiered approach and development of the pharmacy support workforce and proportional transfer of medicine related services.
- Community Care and Treatment will be evaluated through assessment of the impact of delivery of an area-wide phlebotomy service. Currently there is no such service in primary care and work is shifted to General Practice.
- The impact of MDT urgent care model will assess the shift of GP urgent care clinical activity including visits to care homes, house calls and re-provision of same day appointments which can be managed by Advance Practitioners: Nursing, Mental Health, Physiotherapy.

2.9 Risks

In preparing the Primary Care Improvement Plan, we have acknowledged that this is both ambitious and aspirational, therefore there are a number of risks associated with implementing the priorities we have set out in the Plan.

The four highest risks we have identified are:

- Financial – in 2018/19 most of the costs incurred in implementing the Plan will be for only part of the financial year and the allocation from Scottish Government is adequate to cover the expected additional costs in this first year. However in 2019/20 and 2020/21, when the anticipated additional funding is set alongside the expected

costs of delivering years 2 and 3 of the Improvement Plan, the additional funding is insufficient to cover the level of investment required. This has the potential to impact significantly on our ability to make the additional investments in the workforce we have identified for years 2 and 3. We also require reassurance that the additional funding is recurring in nature.

- Workforce – recruiting the additional workforce identified in this plan, in order to deliver the multi-disciplinary team in Primary Care, may be challenging. Our ability to recruit to the additional posts is also predicated on providing suitable access to training and mentoring new recruits. We will review progress regularly in order to make any adjustments necessary to the Improvement Plan and the associated Workforce Plan.
- Engagement – it is essential that we continue to engage with GPs and their staff, in order to deliver the new service models effectively and to develop the multi-disciplinary Primary Care Teams.
- Timescale – the timescale to deliver this ambitious change and improvement programme is short, and whilst every effort will be made with implementation by 2021, it is anticipate that the service improvement programme will continue through 2021 and beyond.

3. Infrastructure and Enablers

3.1 Premises

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 Programme for Forth Valley.

A detailed review of current Primary Care premises will be undertaken once further information, including dates, are provided by 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). A timeline and resource allocation requires to be agreed to enable primary care premises to be developed to an agreed standard for delivery of clinical services.

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

In 2015/16, a survey of all premises was undertaken in Forth Valley, as a local initiative to provide an indication of the physical condition of premises.

For the premises currently owned by NHS Forth Valley, a more detailed understanding of the quality of the premises and risks was prepared, and this has informed investment decisions. A prioritised plan for investment in NHS Forth Valley premises has been prepared, however this will require to be revisited once there is a nationally determined assessment of all Primary Care premises.

The Stirling Health and Care Village will open in 2018, and this includes provision of new accommodation for 3 GP Practices currently located in the Stirling City area. In addition, the Full Business Case for re-providing Doune Health Centre was approved by the Scottish Government Capital Investment Group in May 2018, providing replacement accommodation for the local practice.

It is essential in reviewing existing accommodation, to consider how premises can support delivery of the NHS Forth Valley Healthcare Strategy and the Strategic Plans of the Integration Joint Boards. These strategic plans, along with this Primary Care

Improvement Plan, expect there to be an extended health and social workforce providing Primary Care and Community Care across Forth Valley and greater integration between and across teams. This will have an impact on Primary Care and Community premises and will require consideration of options across health, social care and other available premises in communities to meet the space requirements of this growing workforce.

The impact of planned housing developments in Forth Valley, including those planned for Jury's Hill near Stirling, the Eastern Villages, Denny and Bonnybridge, on the availability of Primary Care services will require careful consideration.

A timeline and resource allocation requires to be agreed to enable primary care premises to be developed to an agreed standard for delivery of clinical services.

3.2 IM&T

In order to ensure that the extended Primary Care workforce can work effectively and efficiently, there are implications for IM&T systems. The impact of the 6 priority improvement areas on IM&T will be identified as implementation progresses, aligned where possible to Shaping The Future – A Supporting Digital and eHealth Strategy.

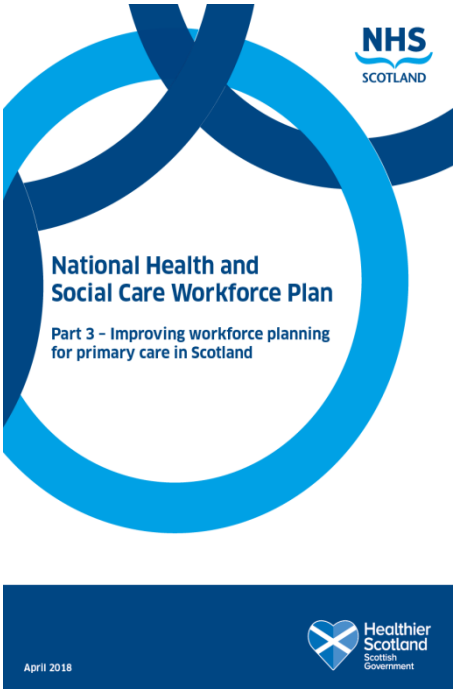
The commitments in Shaping the Future – A Supporting Digital and eHealth Strategy, which are associated with Primary Care include the following:

- Implementing a community ICT system which will incorporate Single Shared Assessments, Anticipatory Care Plans and Carers' Assessments.
- Providing enablers for data sharing between NHS and local partners including the voluntary sector where appropriate.
- Rolling out the national Patient Portal in collaboration with the national programme.
- Implementing online appointment booking.
- Implementing the national CHI and Child Health information redesign programmes.
- Providing services with tools for developing and recording treatment summaries.
- Providing person-held maternity records on smart phones and tablets.
- Continuing to develop use of mobile devices.
- Rolling out self testing and home monitoring for patients in collaboration with partner organisations.
- Implementing proven technology enabled care (TEC) devices in collaboration with national providers.
- Rolling out a refreshed GP IT system to support community hub and GP Cluster working.

4. Workforce

The National health and social care workforce plan published in June 2017 noted that Part 3 of the Plan, subsequently published in May 2018, would determine the Scottish Government's thinking on the primary care workforce. The Plan sets 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 includes plans 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 (May 2018)

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*:**

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

- 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.
- 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.
- 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:

- More integrated workforce data for primary care is required, in the context of the workforce data platform being developed by NHS Education for Scotland.
- Local planners should consider workforce planning tools (such as the six step methodology) in developing their workforce strategies to address local population needs.
- 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.
- The Scottish Government will publish the Primary Care Monitoring and Evaluation Strategy 2018-2028 by summer 2018.

4.1 Forth Valley Primary Care Workforce Plan

A survey of the existing workforce employed in all GP Practices in Forth Valley has been undertaken, providing numbers and hours worked of GPs, practice nurses, support staff and administrative staff. This will be used to provide a greater understanding of the existing Primary Care workforce and will be built upon as the Primary Care Workforce Plan is developed. The next steps include identifying the age profile of the current Primary Care workforce and an understanding of likely retirements over the next 5 years.

The implementation proposals associated with the 6 priorities outlined in this plan will inform the preparation of an associated Forth Valley Primary Care Workforce Plan, which will be published in September 2018.

4.2 Recruitment

Early work has been undertaken to review advertising materials associated with recruitment, in order to promote the Forth Valley area as an attractive place to work. Learning from other employers in Scotland and internationally has shaped this work which is now being tested.

Recruitment is already underway for pharmacy and advanced nursing posts.

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.

Three Horizon Aspirations

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. The current team comprises 1 wte Band 6 nurse, 5 wte Band 5 nurses, 1 wte Band 4 Vaccination Team Coordinator and 2 wte Band 2 support staff, plus administrative support from Child Health. 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 some practices which 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 which aims to transfer immunisation from General Practice to the Immunisation Team from 2018/19. It is anticipated that the transfer of all immunisations except influenza will concluded in 2019/20, with influenza transferring in 2020/21.

	The Plan recognises the need for tests of change and pilot work including testing 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. Option appraisal is required to consider how existing services can be supported to adapt to allow capacity for support and delivery of the VTP. • 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 and 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.	Continued evaluation of developing model recognising premises, workforce and delivery options. Current assumption is a requirement for additional 5 wte Band 5 nurses in year 2 and further 4 wte Band 5 in year 3.	Continued evaluation of developing model. Roll out Forth Valley Influenza, Pneumococcal and Shingles immunisation service from August 2020.

	Identify test areas and premises that are appropriately accessible, equipped and have capacity to 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. The Vaccination Transformation Programme will be underway for all elements, except flu, by the end of year 1. Extend the current immunisation team with the appointment of 1 wte team leader (Band 7), 1 wte Senior staff nurse (Band 6), 1 wte Midwife (Band 6), 5 wte Band 5 nurses and 2 admin staff. Discussions are underway with the Maternity Service to identify the preferred model for delivering vaccinations to pregnant women.	Conclude roll out of Forth Valley Childhood immunisation and service from April 2019, including review of workforce model. Test models for providing influenza, pneumococcal and shingles immunisation in selected cluster areas from Sept 2019. Identify preferred staffing model for the seasonal flu programme, with the initial assumption that bank staff will be used, with 5 wte Band 5 nurses required from October to December and 2 wte Band 5 during January and February.	
Testing the new models • How? • engagement	Test hub-based models for travel immunisation and advice from December 2018.	Evaluate initial changes from year 1.	Evaluate changes to date. Ongoing service review.

	Commence implementation of Childhood programme. Provide adequate communication to stakeholder groups.		
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.

Three Horizon Aspirations

<table>
<tr><th colspan="2">Horizon 1 - Where are we now ?</th></tr>
<tr><td>Current Service Model</td><td>The Pharmacy and Prescribing support unit provides two key functions, namely:
1. Area wide activities in relation to the cost effective and safer use of medicines, together with direct line management support for the primary care pharmacy team.
2. A core clinical pharmacy function providing support to GP practices and GP Clusters to improve quality and cost effective prescribing through multifaceted strategies. In particular, the team will carry out technical switches, polypharmacy reviews and local quality improvement initiatives including implementing safer prescribing strategies and processes across all GP practices. At present, there is a limited pharmacotherapy related service provided in selected practices (mainly 2C practices and those 17J practices experiencing GP sustainability challenges). However in the vast majority of cases all acute and repeat prescribing, together with any medication management activities, are carried out by GPs and their admin staff using various different models.

A summary of the key functions currently provided by the unit is outlined in the table below:

<table>
<tr><th>Board wide:</th><th>Primary Care:</th></tr>
<tr><td>• Develop strategies and programmes to support delivery of the boards Medicines Governance & Safety agenda (e.g. ADTC, New Drugs, Medicines Safety Group etc)
• Support financial planning for medicines across primary and secondary care</td><td>• Direct line management of the Primary care Pharmacy Team
• Professional Development / Leadership for pharmacy across primary care
• Co-ordinating pharmacy support to GP practices
• Development and monitoring</td></tr>
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• Develop and co-ordinate board wide prescribing efficiencies • Development of prescribing resources & tools • Maintain the board wide Medicines Formulary • Developing Prescribing Reports/Reporting Tools • Prescribing Information / Enquiries (central database) • Monitoring and Review of all Non medical prescribing • Lead, develop and maintain the Strategy for Non Medical Prescribing • Manage and maintain a governance process for Patient Group Directions (113 PDGs for the board) • Board wide monitoring and approval of medicines specials e.g. melatonin formulations for paediatrics	of Primary Care Prescribing Indicators and efficiencies • Quality control and maintenance of primary care prescribing resources & tools

The unit is currently comprised of 25.66 WTE staff including qualified pharmacists, technicians and admin support as outlined below:

Band	WTE/Funding source		
	Core RRL	2C GMS	PCA2017(P)04
AfC band 4	1.00	0.00	0.00
AfC band 5	2.60	0.00	3.00
AfC band 6	1.00	0.00	0.00
AfC band 7	1.63	2.00	2.90
AfC band 8A	2.52	2.50	6.51
	8.75	**4.50**	**12.41**

Note that 12.41 WTE staff form part of the Scottish Government commitment to fund 140 WTE pharmacists to work with GPs in GP practices across Scotland (circular PCA2017(P)04 refers). This supports progress towards the Programme for Government objective that every GP practice in Scotland should have access to a pharmacist with advanced clinical skills. The original funding for these posts (£12m nationally) is now subsumed within the Primary Care Improvement Fund

Pharmacy First

The Pharmacy First service was piloted in Forth Valley during financial year 2016-17 enabling community pharmacists to treat certain common clinical conditions under Patient Group Directions

	in a bid to improve patient access and reduce pressure on GP practices and out of hours services. The service was rolled out nationally during 2017-18, supported by £1m of funding, focusing on uncomplicated urinary tract infections and impetigo. This funding has now been subsumed within the Primary Care Improvement Fund. Locally, we have recently extended the service to include vaginal candidiasis, conjunctivitis and mild skin conditions/infections. This second phase is currently being evaluated.
Redesign work already underway	Primary Care Transformation Fund 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, with the potential over time to extend this to other long term conditions. 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 and CMS. 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. 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. In order to understand and inform the potential opportunities of CMS in community pharmacy, scoping work will be undertaken to identify the benefits of the scanning technology that Bannerman's Pharmacy operates in Dunblane with a view to quantify the time saved to release pharmacist capacity. 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. Next pharmacy recruitment drive commenced in June 2018, using 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 the 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 GPs, therefore increasing pressure on pharmacists and risk of recruitment and retention issues cascading from GPs to pharmacists. Recruitment of pharmacy staff:- o from existing pharmacist pool, could lead to pressures in other areas of hospital and community pharmacy services. o Clarity of funding routes required o 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 and 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 to 2 2018-20 Implementation

In year 1, we will seek to provide 4 clusters with a focus for our Pharmacotherapy service. Whilst it may be difficult to recruit to the level of additional pharmacists required, recruitment is underway and the service will be rolled out as the posts are filled, on a cluster by cluster basis.

Pharmacists will provide an acute and repeat prescribing service which will include as a core a desire to provide the following:-

- Authorising/action all acute prescribing requests
- Authorising/action all repeat prescribing requests
- Authorising/action all hospital immediate discharge letters
- Identifying patients suitable for serial prescribing
- Medicines reconciliation
- Medicines safety reviews/recalls
- Monitoring high risk medicines
- Non-clinical medication review
- Medication compliance reviews
- Formulary adherence
- Prescribing indicators and audits

Acute and repeat prescribing requests including authorising/actioning:-

- 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 and ensure prescribing is effective and efficient.

Chronic Medication Service (CMS)

A key implementation part of the Pharmacotherapy Service is for the GP Pharmacy Team to identify stable patients suitable for 6 or 12 month serial prescribing (part of the CMS service). Methods will be explored to develop the community pharmacy CMS annual medication reviews. The aim will be to create a pathway for recommendations to inform and link with the Pharmacotherapy Service and the GP pharmacy staff.

Other Centrally Funded Community Pharmacy Services

A key element of the Pharmacotherapy Service will be triage and signposting to community pharmacy services included MAS, Pharmacy First, Pharmacy First extension service and smoking cessation. Forth Valley have invested in a “meet the expert” video, leaflets and posters promoting community pharmacy services to

encourage the public to access pharmacies first for common clinical conditions and healthcare advice. The message will be targeted via social media within areas experiencing greatest sustainability issues.

Workforce Required

The long term aim for pharmacy provision will be 1wte per 5,000 to 10,000 patients. We recognise full recruitment to our aspiration will initially be a challenge. We will aim to roll out of the services in a phased way, on a cluster by cluster basis as posts are filled.

Of the pharmacists already working in Primary Care, 12.41 wte of these are funded from the Primary Care Improvement Fund. All pharmacists already working in the selected clusters will move all their current pharmacotherapy related activity to the delivery of the pharmacotherapy service. The number and wte will be confirmed once the initial clusters are selected given the different population size in each area.

In addition to the Primary Care Pharmacy resource already in place, we will aim to recruit an additional 18 wte pharmacists in year 1 to commence delivery of the pharmacotherapy service in 4 clusters.

In years 2 to 3 we will aim to expand the pharmacotherapy service to further clusters. This will require additional pharmacist/pharmacy technician recruitment from April 2019. The numbers required may be amended following learning from the first 4 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 Memorandum Of Understanding 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 NHS Board Pharmacy Service. 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 4

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. There will be an ongoing collation and monitoring of agreed activity data set. The service will support a continued focus on quality prescribing, safety and efficiency.

Horizon 3 – where will we be in 2021 and beyond

Future Model of Care	Over time, 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 technicians' 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 practices' 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 Care & Treatment

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.

Three Horizon Aspirations

Horizon 1 - Where are we now ?	
Current Service Model	• NHS Forth Valley Community Nursing Service already delivers the majority of Treatment Room care (clarification of numbers is being worked through in terms of number of appointments per week). 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 (further work is being undertaken to assess this) • 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 primary care nursing workforce with a 50% retirement rate predicted in the next 3-5 years in both areas. There are increasing demands, complexity and opportunity within primary care nursing. As experienced staff retire, we need to build a workforce that are ready to take on GPN, TR and ANP training roles to prevent significant staffing shortages. Current NES funding bid in addition to PCIP to assist with GPN training will help support a year joint bid for foundation primary care nurse training posts. Any additional posts from year 2 will require separate funding. 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. There are currently significant interface issues caused by uncertainty regarding phlebotomy responsibility for results management. This service provides an excellent opportunity to resolve many of these issues through collaboration with secondary care and investment in a phlebotomy service that is accessible by all healthcare professionals with responsibility for taking action on results, going directly back to the requestor. This would be good for the healthcare professional and the patient.

Horizon 2 – How will we progress towards Horizon 3

	Year 1 to 2 (2018-2020)	**2020-21**
Potential Models/new ways of working	In year 1 we will commence implementation to provide all practices with enhanced access to Health Care Assistant (HCA) services that	All practices will have community based phlebotomy

/workforce/ premises	will support practices locally, including for housebound patients. The requesting healthcare professional will still monitor the results for individuals who undergo community phlebotomy/ monitoring To help shift work from GP and Practice Nursing, scoping work will be progressed to determine the range of services and options for delivery. The Treatment Room Guidelines will be updated and a set of principles agreed. This will then determine any additional requirement for qualified nurses to support treatment rooms. HCA will be recruited or may be TUPE transferred from GP practice staff to the Health Board. This will require scoping and consideration of standardised processes. HCAs will deliver phlebotomy and on an incremental basis, over time will begin to deliver e.g. BP measurement, height/weight checks, pulse checks, urine dip testing, processing stool and sputum samples, support for patients to complete questionnaires and sats checks. This will initially be reliant on successful recruitment. Test ordering must align with existing practice lab request and results reconciliation arrangements and must maximise the effectiveness of the Order Comms system. The HCA service, additional treatment room posts and GPN training posts will be aligned to the current Community Nursing/Treatment room management structures. This will require the creation of additional leadership posts to support the transfer and ongoing leadership of this growing workforce. Implement then evaluate the impact of the NES programme to provide future Practice Nurses, with an initial bid for 10 posts submitted. Increase Technology based solutions for monitoring e.g. Blood pressure, weight. The Florence Text based home monitoring for blood pressure should be offered to all practices by the end of year 1.	support which will deliver blood monitoring, basic measures and QOF based LTC annual monitoring tests. We aim to have in place an interface model of monitoring appropriately resourced between primary and secondary care.

	By end of year 2, 6 clusters will also no longer provide annual long term condition monitoring tests 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. In year 2 we will look to build on the capacity of the HCA workforce as is required. We will scope potential additional monitoring services and agree how this will be implemented, with appropriately trained staff. This may include spirometry, diabetic foot checks, ECG, asthma/COPD monitoring, cognitive questionnaires etc. There will also be a need to evaluate secondary care use of the service, with appropriate funding.	

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, whilst recognising that this may not be feasible for all practice areas. • 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. • Foundation in community nursing career pathway posts – these posts will be part funded if successful by NES bid related to GPN training for new graduates in year one. Following evaluation, any subsequent posts would be fully supported by the PCIP to ensure there is a workforce trained and able to take up GPN posts, provide treatment room care or undertake ANP training. This will help mitigate the risk of the high retirement rate in addition to increased complexity and specialist skill set required across primary care/community 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. Work to establish availability of rooms within practice and Health centre to allow for additional treatment room provision and HCA clinics.
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> During years 1 and 2 move towards recruitment of Health Care Support Workers i.e. 24 wte Band 3 staff - both from existing primary care staff where practices wish to transfer roles and additional recruitment to meet demands of service. 10wte band 5 GPN/foundation primary care nursing posts in year 1, with NES support 4.7wte funding required for 2 years. Further scoping to determine the number of additional Band 5 nurses required to support increased demand for treatment room service and to transfer workload from GPs and Practice Nurses. Further scoping of the leadership required to support the management of additional nursing and HCA staff, with 1 wte Band 7 post to be recruited in Year 1.

8. Delivering Urgent Care support Through Additional Professional Roles (including Community Link Worker)

Extract from Memorandum of Understanding

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

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.

Three Horizon Aspirations

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, Extended Scope Physiotherapists and Primary Care Mental Health Nurses to deliver daily capacity for practice based urgent care. • Multidisciplinary Role development is inconsistent. The current general practice service model is largely traditional practice team, with a few practices now employing ANPs directly. • We have a high degree of variation in support to practices across FV, i.e. Clacks have done very well from Transformation Fund tests of change but there is also historical inequity around attached staff and configuration of local community 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 transformation and General Practice (2C and others). This experience has demonstrated that highly skilled nurses and other MDT such as Mental Health Nurses, Physiotherapists and paramedic specialist practitioners can safely deliver a significant proportion of urgent GP including 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 practices • We have successfully trialled community nursing support to care homes within Clackmannanshire 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 with one post per 10,000 providing a fully supported service. 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 Workers, 3 practices in Falkirk 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		
	Years 1 to 2 2018-20	**2020-21**
Potential Models / new ways of working / workforce / premises	Build advance practice capacity for urgent care in five clusters initially. Generate a rolling employment and training model with 10 ANP roles. Evaluate the impact of our PCTF funded Primary Care Mental Health Nursing roles within 14 GP practices in 5 clusters at approx level of 1:15,000 Provide urgent care access to advance practice physiotherapists for all practices in 5 clusters initially, at a level of between 1:10,000 (optimal model for full practice support e.g. 2C) and 1:20,000.(proposed lowest rate to ensure functional impact at practice level) We will look to develop a shared care approach to urgent care with potential to support • Same day appointment including ANP, MSK and Mental Health. • Care Home Support. • House Calls. Through this model increase direct access to Primary Care Mental Health Practitioners and Advanced Practice Physiotherapy access to all practices within more clusters. Generate a Link Worker development plan 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 3 and consider how this can align with the development of the Community Front Door.	By end of year 3 we will have increased urgent care access for ANP, mental health and MSK and have grown an urgent care model in partnership with interested clusters and practices.

Horizon 3 – where will we be in 2021 and beyond	
Future Model of Care	By 2021 we aim to provide a level of trained ANP, Mental Health practitioner and Advanced Practice Physiotherapy capacity. These would be sufficient to support an efficient urgent care model of MDT support for General Practice which provides a level of day to day capacity within practice and community 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. The level and model of delivery of this support will be determined at local level and may be increased in partnership with local practices. The approach will be different in different areas, for example a solution for Stirling or Falkirk is unlikely to suit the needs of rural Stirling. 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 required	We also should consider non traditional workforce opportunities, e.g. Physician Assistants, recognising skills and competencies of other existing MDT in terms of urgent care, 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 / midterm 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 "uni-professional" (e.g. Explore the role(s) of *The* "primary care practitioner" perhaps supporting a workforce with core clinical expertise and developing a common training. We require a long range Workforce Plan and must take into account training and development needs and linkages with local and national strategies for effective and efficient transformation**.**

8.1 National Mental Health Strategy

The actions associated with national Mental Health in this Primary Care Plan are aligned to the Mental Health Strategy, and particularly the work associated with Action 15 (additional mental health workers). A Forth Valley Plan to deliver Action 15 is to be prepared and submitted to Scottish Government at the end of July 2018 and will be cross-referenced to the relevant actions in this plan including the following:

- The Emergency Mental Health Services are undergoing a period of redesign, which aims to improve the efficiency of requests for emergency mental health assessments by providing ANPs in Mental Health throughout the 24hour period and combing discreet services to form a hub. This work will examine those able to refer into the Specialist Service, taking account of a changing primary care workforce.
- 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 9pm and 8am are picked up by the Hospital based

mental health ANPs. Building on this learning the service plans to extend this arrangement to cover all out-of-hours periods.

- Primary Care Mental Health Nurses – we have now introduced PCMHNs in 3 clusters /14 practices in Forth Valley s a test for change. One in three contacts with primary care has a mental health element and around 10% of contacts are for mild to moderate mental health alone. With appropriate triage, 10% of patient contacts could be seen by a Mental Health professional with suitable skills. 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. We will look for partial funding for additional Mental Health Nurses in GP Practices to come from the national mental health strategy funding.

9. Financial Plan

A high level 4 year financial projection has been prepared in line with the principles and assumptions outlined in the "*Primary Care Improvement Fund: Annual Funding Letter 2018-19*" issued by Richard Foggo dated 23rd May 2018.

Due to the scale and nature of the overall Primary Care Improvement Programme, the projection is considered as a live document which will be continually refined and updated as the new multi disciplinary Primary Care team is established and longer term funding is confirmed.

Funding assumptions

Forth Valley's NRAC share of the Primary Care Improvement Fund (PCIF) is confirmed at £2.479m for financial year 2018-19, and is expected to rise by £5.922m to £8.401m by 2021-22.

It is recognised that certain elements of the PCIF have already been included within core baseline funding and/or have been committed against other Primary Care transformation initiatives and therefore these items must be accounted for as first call against the fund. This relates specifically to two areas:

- *Pharmacy First*: £0.064m received in 2017-18 and fully committed on a recurring basis;
- *Pharmacists Working in GP Practices* as per circular PCA2017(P)04: £0.636m[1] received in 2017-18 and fully committed on a recurring basis;

A summary of the overall net funding position is therefore outlined below:

PRIMARY CARE IMPROVEMENT FUND	2018-19 confirmed £m	2019-20 estimate £m	2020-21 estimate £m	2021-22 estimate £m
PCIF - Forth Valley NRAC share	2.479	2.981	5.962	8.401
Less Pharmacy in GP Practices fund	(0.636)	(0.636)	(0.636)	(0.636)
Less Pharmacy First	(0.064)	(0.064)	(0.064)	(0.064)
Balance available	**1.779**	**2.281**	**5.262**	**7.701**

An initial allocation of £1.445m was received in June (which represents the first tranche of funding, equal to 70% of the total). The remaining balance of £0.619m is expected to be received in November. Note that the remaining balance will only be issued if it can be demonstrated that it will be fully spent in year.

Proposed Expenditure

The Primary Care improvement programme will be undertaken on a phased basis to deliver key outcomes across the 6 priority areas presented within the MOU. Clearly the

[1] £0.636m is comprised of £0.415m now included in the baseline plus a further £0.221m allocated on an earmarked recurring basis in Dec 2017.

timing of expenditure will be heavily influenced by the length of the recruitment process and availability of skilled staff/suitable candidates.

A summary of the proposed expenditure is outlined in the table below. Costs are based on the top of 2018-19 Agenda for Change salary scales, inclusive of employers on costs. A 3% pay award is assumed for financial years 2019-20 and 2020-21 only (no pay award is included in 2021-22).

The current projection suggests that there is recurring shortfall of £2.79m at the end of the 4 year period. Significant non-recurring pressures are expected during year 2 and 3 as the timing of funding increases are out of sync with the expected pace of recruitment.

NHS FORTH VALLEY - PRIMARY CARE IMPROVEMENT PLAN	**2018-19 £m**	**2019-20 £m**	**2020-21 £m**	**2021-22 £m**	**2021-22 WTE**
Vaccination Transformation Programme					
Programme Management & admin support	£0.051	£0.078	£0.080	£0.080	2.50
Nursing staff	£0.168	£0.538	£0.801	£0.801	26.00
Non pay costs	£0.025	£0.020	£0.020	£0.020	
	£0.244	£0.636	£0.901	£0.901	28.50
Pharmacotherapy Service					
Pharmacist & Technician support	£1.195	£2.781	£3.617	£3.617	60.00
Non pay costs	£0.032	£0.071	£0.090	£0.090	
	£1.227	£2.851	£3.707	£3.707	60.00
Community Treatment & Care Services					
Treatment Room Nursing	£0.027	£0.288	£0.652	£0.890	21.00
Practice Nurse trainee pipeline	£0.088	£0.181	£0.397	£0.397	10.00
Healthcare Assistants	£0.317	£0.653	£0.672	£0.672	24.00
	£0.432	£1.122	£1.721	£1.960	55.00
Additional professional roles & Urgent Care					
Care Home Liasion Nurse	£0.085	£0.173	£0.178	£0.178	3.60
Advanced Nurse Practitioners	£0.664	£1.366	£1.990	£1.990	33.00
Mental Health Nurses	£0.341	£0.834	£1.156	£1.156	23.00
Extended Scope Physiotherapists/MSK	£0.179	£0.670	£1.001	£1.001	17.00
	£1.268	£3.043	£4.324	£4.324	76.60
Other					
Community Link Workers	£0.000	£0.000	£0.318	£0.318	8.50
Pharmacy First	£0.064	£0.064	£0.064	£0.064	N/A
Programme Management & support	£0.060	£0.123	£0.126	£0.126	2.00
	£0.124	£0.187	£0.509	£0.509	10.50
TOTAL EXPENDITURE	**£3.294**	**£7.839**	**£11.162**	**£11.400**	**230.60**
Primary Care Improvement Fund Allocation	£2.479	£2.981	£5.962	£8.401	
Underspend/(Overspend)	(£0.815)	(£4.858)	(£5.200)	(£2.999)	

Glossary

ANP	**Advanced Nurse Practitioners**
BMA	**British Medical Association**
CHI	**Community Health Index**
CMS	**Chronic Medication Service**
CPD	**Continuing Professional Development**
GMS	**General Medical Services**
HCSW	**Health Care Support Worker**
HSCP	**Health and Social Care Partnership**
GPN	**General Practice Nurse**
ICT	**Information and Communications Technology**
IT	**Information Technology**
IM&T	**Information Management and Technology**
IP	**Independent Prescriber**
KPI	**Key Performance Indicator**
LMC	**Local Medical Committee**
MAS	**Minor Ailment Service**
MDT	**Multi-disciplinary Team**
MOU	**Memorandum of Understanding**
NES	**NHS Education for Scotland**
OOH	**Out of Hours**
PCTF	**Primary Care Transformation Fund**
TEC	**Technology Enabled Care**
TR	**Treatment Room**
TUPE	**Transfer of Undertakings Protection of Employment**
VTP	**Vaccination Transformation Programme**
WTE	**Whole Time Equivalent**

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
- 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

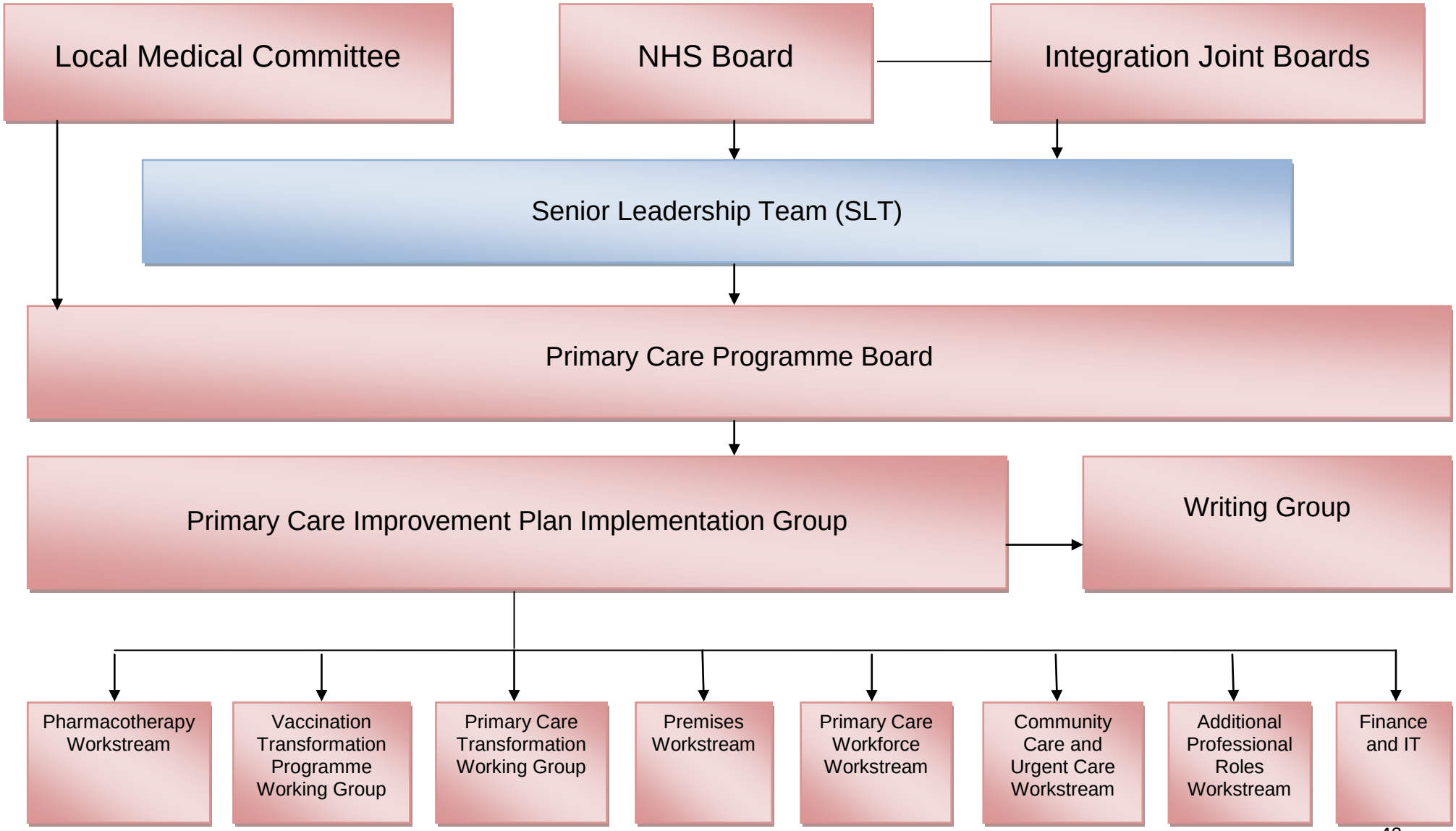
Appendix 2

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	Stuart Cumming and Improvement Plan Leads
Vaccination Transformation Programme	Gillian Morton Stuart Cumming	Janette Fraser Helen Bauld
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

Appendix 3

Forth Valley Primary Care Improvement Plan Implementation Group – Proposed Organisational Structure



Appendix 4

2018 GMS Implementation Practice Preferences

We are preparing a Forth Valley Primary Care Improvement Plan, which will implement new services as part of the new GMS contract. Practices are asked to consider the following three new services, which, the contract suggests, should be delivered to all practices by 2021. The aim would be to implement each of the new services in 3 clusters each, so that all practices should see the impact of one of the services. Then as recruitment and funding allow, the services will be spread out to all areas with the aim of all practices having access to services by 2021. The phased approach will enable the new service models to be evaluated, and the models will evolve as our learning and understanding of the impact and benefits grows. The availability of funding and the ability to recruit staff with the right skills and experience will have to be taken into consideration in the planning and implementing the new services.

Pharmacotherapy Service

Pharmacists will provide an acute and repeat prescribing service, which will include as a core:

- Authorising/action all acute and repeat prescribing requests
- Authorising/action all hospital immediate discharge letter
- Medicines reconciliation
- Medicines safety reviews/recalls
- Monitoring high risk medicines and medication compliance reviews
- Non-clinical medication review
- Formulary adherence, prescribing indicators and audits.
- Acute & repeat prescribing requests includes authorising/actioning hospital outpatient requests
- Non-medicine prescriptions
- Instalment requests and serial prescriptions

Practices will work closely with the pharmacists to develop and standardise this service. The aim would be for 100% of this work to go through the pharmacotherapy service, with the understanding that some will still need to be then passed on to a GP. Depending on recruitment you may not reach 100% implementation. Practices will be expected to engage significantly with the pharmacotherapy team to optimize prescribing processes.

Community Treatment & Care Service

This service will continue to provide all current Treatment room services to all areas. For 3 early adopter clusters there will be a focus on the early addition of a full Phlebotomy service. In addition there will be an aim to have this service start to deliver basic monitoring (e.g. BP, pulse, height, weight), followed by more comprehensive chronic disease monitoring and related data collection. Practices will work closely with the NHS Board to develop an efficient service that meets the needs of patients and practices. Note practices will still need to manage the results of any monitoring undertaken.

Urgent Care Service and Multi-Disciplinary Team

This service will aim to provide significant assistance with urgent and unscheduled care. A number of allied health professionals will be recruited to work in 3 clusters. Practices will be invited to provide support for ANP development. It is anticipated that newly recruited ANPs will require significant support but will progress within practices or clusters to greater levels of service delivery. We will discuss with willing practices an urgent care hub model for each of 3 clusters. The scope would include ANPs, MSK physiotherapists and Mental Health Nurses, in addition to Care Home Support and House Calls.

Questionnaire

(To be Completed and Returned by 4th June 2018)

Each cluster will have one service implemented initially and we are keen to understand the preferences of the practices in each cluster. Please rate how interested you are in being an early adopter for these services. Note a cluster will initially only be able to adopt one of the 3 new services.

Name of Practice:	
Practice Number:	

Pharmacotherapy									
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Not Interested									**Very Keen**

Community Treatment & Care Service									
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Not Interested									**Very Keen**

Urgent Care/Multi-Disciplinary Team Service									
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Not Interested									**Very Keen**

Completed forms to be returned to Gillian Allan, Planning Team Coordinator, Carseview House, Stirling, FK9 4SW, Tel. 01786 457263, E-Mail gillian.allan2@nhs.net