FINAL DRAFT

THE PRIMARY CARE IMPROVEMENT PLAN FOR DUMFRIES & GALLOWAY

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THE PRIMARY CARE IMPROVEMENT PLAN FOR DUMFRIES & GALLOWAY

FOREWORD

INTRODUCTION FROM JULIE WHITE, CHAIR OF THE PRIMARY CARE TRANSFORMATION PROGRAMME BOARD; CHIEF OPERATING OFFICER, NHS DUMFRIES & GALLOWAY & DR GRECY BELL, CO-CHAIR OF THE PRIMARY CARE TRANSFORMATION PROGRAMME BOARD, ASSOCIATE MEDICAL DIRECTOR – PRIMARY CARE, NHS DUMFRIES & GALLOWAY.

This is the initial Primary Care Improvement Plan (PCIP) for Dumfries & Galloway. It sets out the direction of travel for the Primary Care Transformation Programme (PCTP) for Dumfries and Galloway for the period April 2018 – March 2021.

The Primary Care Transformation Programme for Dumfries & Galloway is the method by which the 2018 General Medical Services (GMS) contract will be implemented in Dumfries & Galloway.

The 2018 GMS contract framework[1] sets out the changes that are required to how GP services will be delivered by April 2021 to ensure better care for our patients and the availability of sustainable healthcare services in our communities.

At this time, there are significant pressures in general practice related to the increasing volume and complexity of the GP workload, challenges with locum availability and GP recruitment and retention. The contract is explicitly expected to address these issues.

Over the next three years we will see the development of GPs as Expert Medical Generalists (EMGs), supported by a wider multi-disciplinary team (MDT) made up of a range of professionals, for example pharmacists, mental health workers, paramedics, physiotherapists, nurses and community link workers. Each of these team members can utilise their specialist skills to better manage the care of patients and improve their eventual outcomes. It is hoped that some of the issues around GP sustainability can be addressed through both the reduction of the GP workload and the reduction of risk to the GP as an independent contractor by looking at premises, workforce and information sharing arrangements.

For most people, their GP is the first person they turn to for help in relation to their healthcare requirements most of the time. Therefore, the work of GPs has a huge impact on the wider healthcare system. It is the GP who makes the decision on whether to treat, how to treat, and when to refer on for further specialist investigations and treatment. General practice and primary care are therefore at the heart of our healthcare system.

[1] Available at: https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-scotland/gp-contract-agreement-scotland

Over time, this plan, as it continues to evolve, will determine the priorities based on the population healthcare needs in Dumfries & Galloway in the context of existing service delivery, available workforce and resources.

Across Dumfries & Galloway, the Health & Social Care Partnership is responsible for the strategic planning for the population, including for primary care services. Within each of the four localities in Dumfries & Galloway (Wigtownshire, Stewartry, Nithsdale and Annandale & Eskdale), clusters have been established which bring together groups of GP practices with a focus on quality improvement and engagement with wider Health & Social Care Partnership structures with the aim of delivering service change and improvement. These four cluster groups across Dumfries & Galloway have had a key role in the ongoing development of the plan and will continue playing a key role as we move towards the implementation of the plan over the next three years.

This is only the initial Primary Care Improvement Plan for Dumfries & Galloway. As the final funding allocation letter for 2018/19 has only just been received at the time of writing, the plan will require to be updated regularly. Clusters are currently developing local plans based on evidenced data which will identify local priorities where they believe available funding for year one should be focused. These plans will crystallise over the coming two months so by September we will be able to produce a more detailed plan of our implementation intentions for year one. Thereafter, it is proposed that the plan be refreshed every 6 months.

This is a fantastic opportunity to work collaboratively with the people of Dumfries & Galloway to shape the GP services of the future.

This plan sets out the case for change and a direction of travel over the next three years. We now need to consult and listen to the people who provide, support and use our services, their families and carers to ensure that the implementation of the 2018 General Medical Services contract is taken forward at the right pace with the correct priorities for action being identified and acted upon.

We are delighted to be the Co-Chairs of the Primary Care Transformation Programme Board and look forward to working with staff, partners, and service users to ensure that we deliver GP services that are sustainable and that successfully meet our shared ambition.

Julie White
Chief Operating Office, NHS Dumfries & Galloway
Chair of Primary Care Transformation Programme Board

Dr Grecy Bell
Associate Medical Director – Primary Care, NHS Dumfries & Galloway
Co-Chair of Primary Care Transformation Board

The Primary Care Improvement Plan for Dumfries & Galloway
Executive Summary

This is the initial Primary Care Improvement Plan for Dumfries & Galloway. This plan will be an evolving document over the next three years as the Primary Care Transformation Programme develops.

The Primary Care Transformation Board Programme has agreed the following shared vision for the programme:

> *The Primary Care Transformation Programme will ensure the development of a sustainable model for primary care services ensuring the skills of our workforce are optimised. The model of Primary Care will look different with an expanded team providing care and support to individuals in our communities.*

In Dumfries & Galloway the following four service areas have been identified as the main priority areas of change for Year One:

- Vaccination Transformation Programme
- Pharmacotherapy Services
- Urgent Care
- Mental Health as part of Additional Professional Roles

Within Year One, it is anticipated that following progress will be made:

Vaccination Transformation Programme

- Review of Pre-School Programme
- Scoping of maternity lead delivery models for pertussis (whooping cough) for pregnant women
- Scoping of Hepatitis B service demand
- Work arising from the national options appraisal exercise around Travel Vaccinations and Travel Health Advice

Pharmacotherapy Services

- Review of current pharmacotherapy service provision completed
- Plans developed for the roll-out of pharmacotherapy service across localities

Community Treatment & Care Services

- Scoping work around current service provision to be developed
- Plans developed looking towards implementation in Years 2 & 3

Urgent Care

- Approval will be sought for 26 week pilot in two cluster areas looking at the use of paramedics aligned to GP clusters
- Continue the recruitment of ANPs for General Practice into the training programme

Additional Professional Roles

- Develop implementation plans resulting from the learning of local tests of change around mental health provision across GP clusters
- Scoping work around current physiotherapy service provision across all cluster areas

Community Link Workers

- Production of the regional strategic framework for social prescribing & community link workers
- Identification of future requirements for Community Link Workers aligned to GP clusters

This plan has been produced in a collaborative approach with an Executive Group of the GP Sub Committee working with the executive programme team.

The timeline below sets out the process being followed for the development and approval of the Primary Care Improvement Plan for Dumfries & Galloway and gives timescales for its future development and update.

- **February 2018** – Executive Programme Team Established
- **March 2018** – Governance Structure Developed and Agreed
- **2nd May 2018** – First Meeting of Primary Care Transformation Programme Board
- **24th May 2018** – Final Funding Allocation Letter received.
- **May** – Mapping of current activity and gap analysis
- **May – June 2018** – Development of the Initial Primary Care Improvement Plan
- **19th June 2018** – Initial Primary Care Improvement Plan submitted for approval by GP Subcommittee

- **27th June 2018** – Initial Primary Care Improvement Plan submitted for approval by the Primary Care Transformation Programme Board

- **June – August 2018** Development of Year 1 Proposals re Vaccination Transformation Programme, Pharmacotherapy, Urgent Care and Mental Health Services

- **1st July 2018** - Submission of Primary Care Improvement Plan to the Scottish Government

- **22nd August 2018** – Primary Care Transformation Programme Board Funding Allocation Meeting – Prioritisation of Year 1 Proposals

- **23rd August 2018 onwards** – Year 1 Agreed Proposals commence

- **September 2018** – Submission of Detailed Funding Plan to the Scottish Government with updated narrative implementation plan for Year 1 (2018/19).

- **March 2019** – Update of the Primary Care Improvement Plan for Dumfries & Galloway

-SUMMARY OF FUNDING TO FOLLOW FOR INCLUSION -

There are clearly significant challenges in delivering the 2018 General Medical Services Contract across all practices in Dumfries & Galloway. However there are also tremendous opportunities to be realised through this additional investment and focus on Primary Care Services. By continuing to build on the collaborative process used to create this initial plan, it is hoped that sustainable and meaningful change can be achieved across GP services to make it a better service to access for patients and a better place to work for the workforce.

SECTION A - PROFILE OF PRIMARY CARE IN DUMFRIES & GALLOWAY

This section aims to provide an overview of primary care in Dumfries & Galloway, including some of the key challenges currently being faced by those working in general practice.

There are 33 GP practices across the region, which together operate from 45 GP surgeries. These GP Practices have a combined list size of 154,144. GP practice populations range in size from around 700 people to over 12,000. The average (mean) list size is 4,671, and the median is 3,928[2].

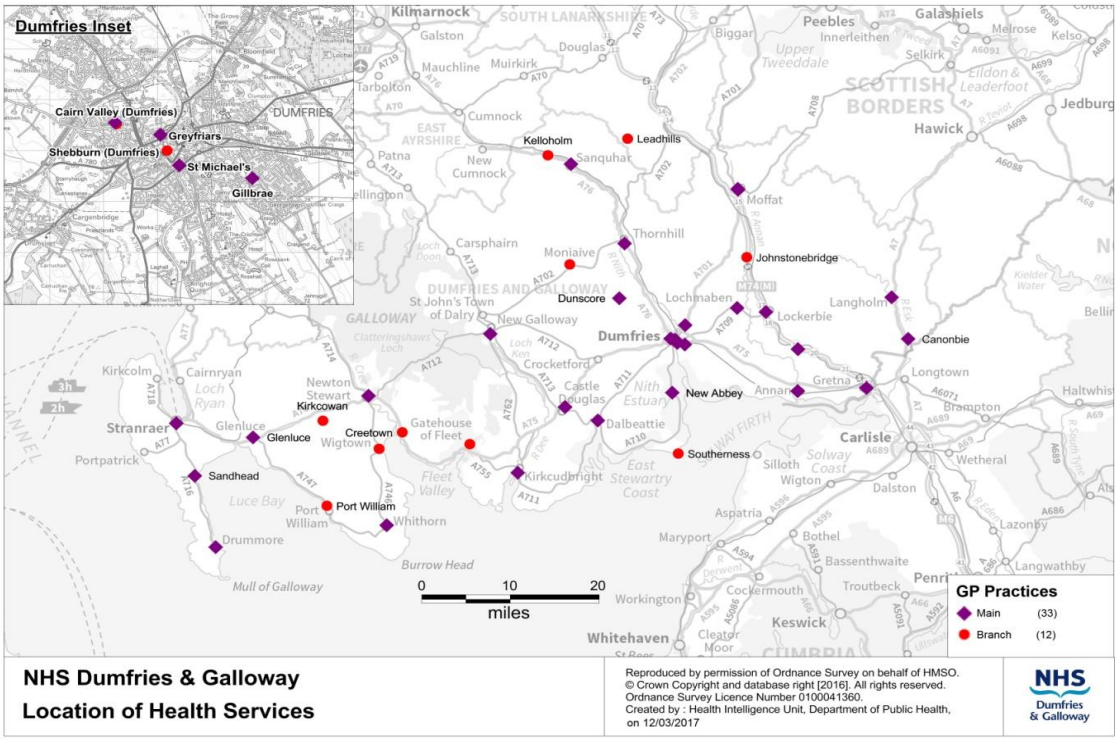
Annandale and Eskdale has 10 GP practices, which together operate 12 surgeries, Nithsdale has 9 GP practices, which together operate 14 surgeries. In the Stewartry, there are 5 GP practices, which operate 6 surgeries and in Wigtownshire there are 9 GP practices, which operate 13 surgeries.

There are a number of communities in which more than one GP practice operates out of the same building. In Annan, Castle Douglas, Newton Stewart and Lochside in Dumfries, there are two GP practices which share a single building. In Stranraer, three GP practices operate from the Waverley Medical Centre.

There are several GP practices which operate branch surgeries in addition to their main base. These branch surgeries provide improved access to primary care services in smaller communities, usually on a part-time basis. There are 12 such surgeries. There are 13 dispensing surgeries which provide local residents with dispensing services closer to home.

[2] ISD Scotland, Practice list size, April 2018

Distribution of GP main surgeries and branch surgeries in Dumfries and Galloway



There were an estimated 116 GPs working in Dumfries and Galloway based GP Practices in August 2017[3] at the time of the Primary Care Workforce Survey, with an estimated 101 whole time equivalents (WTE). This is a reduction on previous audits, when two years earlier (in August 2015) the estimated WTE count was 105 GPs and in an earlier audit (in January 2013), the WTE was 125 GPs.

There were an estimated 6.6 WTE GPs per 10,000 registered patients in Dumfries and Galloway in August 2017 (compared to a Scottish rate of 6.3)[4]. In August 2015 the equivalent figure was 6.8 WTE GPs per 10,000 patients in Dumfries and Galloway.

Dumfries and Galloway's GPs are older than the national average, and their profile is getting older. In the latest audit (August 2017), 30% of Dumfries and Galloway GPs were aged under 45, 47% were aged between 45 and 54, and 23% were aged 55 and over. The same audit showed that across Scotland, 50% of GPs were aged under 45, 32% were aged 45 to 54 and 18% were aged 55 and over. The proportion of Dumfries and Galloway's GPs aged over 55 is rising, from 16% in 2013, to 20% in 2015 and 23% in 2017[5].

[3] ISD Scotland, Primary Care Workforce Survey Scotland 2017, March 2018, table 1.1
[4] ISD Scotland, Primary Care Workforce Survey Scotland 2017, March 2018, table 1.4
[5] ISD Scotland, Primary Care Workforce Survey Scotland 2017, March 2018, table 1.5i

Almost all GPs work at least 20 hours per week, with 11% reporting they worked at least 50 hours per week in the 2017 audit. This compares to 7% saying they worked at least 50 hours per week in the 2015 audit[6].

In addition to GPs, the surgeries have a range of other staff, including nurses, healthcare assistants, phlebotomists, practice managers, receptionists and administrative staff.

The latest audit estimates 125 individuals representing 68 WTE clinical staff employed by GP Practices across Dumfries and Galloway, made up of 13 WTE nurse practitioners / advanced practitioners, 35 WTE general practice nurses and 17 WTE healthcare support workers and phlebotomists. These numbers represent a slight increase on the figure in the 2015 audit when 115 individuals represented 65 WTE posts[7].

National data estimates 17 million GP consultations took place across Scotland in the financial year 2016/17[8]. This would translate into around 467,500 GP consultations per annum in Dumfries and Galloway, or around 1,800 GP consultations per day.

The General Practice Sustainability Survey for Dumfries & Galloway was produced in August 2017. NHS Dumfries & Galloway Board's GP Sustainability Group carried out a survey of general practices in the region. The survey asked practices to report on and assess risk of a range of areas including premises, workforce and supporting local services. All practices successfully engaged with the survey so it is effective in providing a snapshot of the position across the region.

The Risk Matrix used asks practices about different areas of their activity and their responses to each question can be categorised as either 'low', 'medium' or 'high' risk.

Each response is also given a score and these scores can be tallied to provide the practice with an overall assessment of their sustainability. The maximum score is 150. Practices that score 70 or more are considered at high overall risk; a score between 50 and 70 is considered medium overall risk; and a score of less than 50 is considered low risk.

Twelve practices (36.4%) had an overall risk score greater than 70 and were identified as being at 'high overall risk'. One practice (3.0%) was identified as being at 'medium overall risk'. The remaining 20 practices (60.6%) had a score less than 50 and were identified as low overall risk.

[6] ISD Scotland, Primary Care Workforce Survey Scotland 2017, March 2018, table 1.11i
[7] ISD Scotland, Primary Care Workforce Survey Scotland 2017, March 2018, table 2.1i
[8] Audit Scotland, NHS in Scotland, 2017, October 2017

The most common areas practices reported as high risk were providing support to nursing/residential homes and providing support to cottage/community hospitals. 24 practices (72.7%) indicated that they support nursing/residential homes and 14 practices (42.4%) indicated that they support cottage hospitals. The next most frequent areas of high risk to be identified were reliance on locums (12 practices, 36.4%) and the length of time for existing GP vacancies (11 practices, 33.3%).

Two practices (6.1%) responded that their practice lists were currently closed to new registrations.

Approximately 52,500 people from Dumfries & Galloway reside in areas categorised nationally as the 40% most deprived. There were 9 out of 33 practices where more than 50% of people of their lists were resident in the 40% most deprived areas and categorised as 'high risk'. 8 out of the 9 practices in Wigtownshire were categorised as 'high risk' for this indicator.

Of the 33 practices, the majority indicated that the condition of their sites was adequate (24 practices, 72.7%). 5 practices indicated that their site was of 'poor quality/short of space' in their survey responses.

9 practices (27.3%) indicated that their open vacancies accounted for more than 20% of their WTE GP provision usually available at their practice placing them in the 'high risk' category. A further 2 practices (6.1%) indicated that they had vacancies that accounted for between 10% and 20% of the WTE GP provision usually available at their practice placing them in the 'medium risk' category. All 11 of these practices indicated that their vacancies had been open for more than 6 months.

Traditionally, locum GPs have been employed to cover routine GP provision while individuals take leave including annual leave and study leave. Over the last few years it has become more common for some practices to employ locums for longer periods of time where they have had difficulties in recruiting. Out of the 33 practices, 19 (57.6%) indicated that they continue to use locums in a standard ad-hoc fashion to cover leave. However, 2 of these practices annotated their responses and indicated that their use of locums was low only due to not being able to secure locum cover, implying that they would otherwise use locum cover more regularly. 2 practices (6.1%) indicated that they use locums on a regular basis and 12 practices (36.4%) indicated that they use locums on a constant basis.

The challenge for the Primary Care Improvement Plan for Dumfries and Galloway is to set out a realistic, achievable direction of travel which will incorporate all the areas of change outlined in the guidance documentation against the local background and challenges outlined above.

The next section sets out the Aims & Priorities of the Memorandum of Understanding, reflecting the agreed principles set out in the guidance documentation around the 2018 General Medical Services Contract for Scotland.

SECTION B - AIMS & PRIORITIES

The local Primary Care Transformation Programme Board has agreed a Shared Vision for the Primary Care Transformation Programme for Dumfries & Galloway. It states:

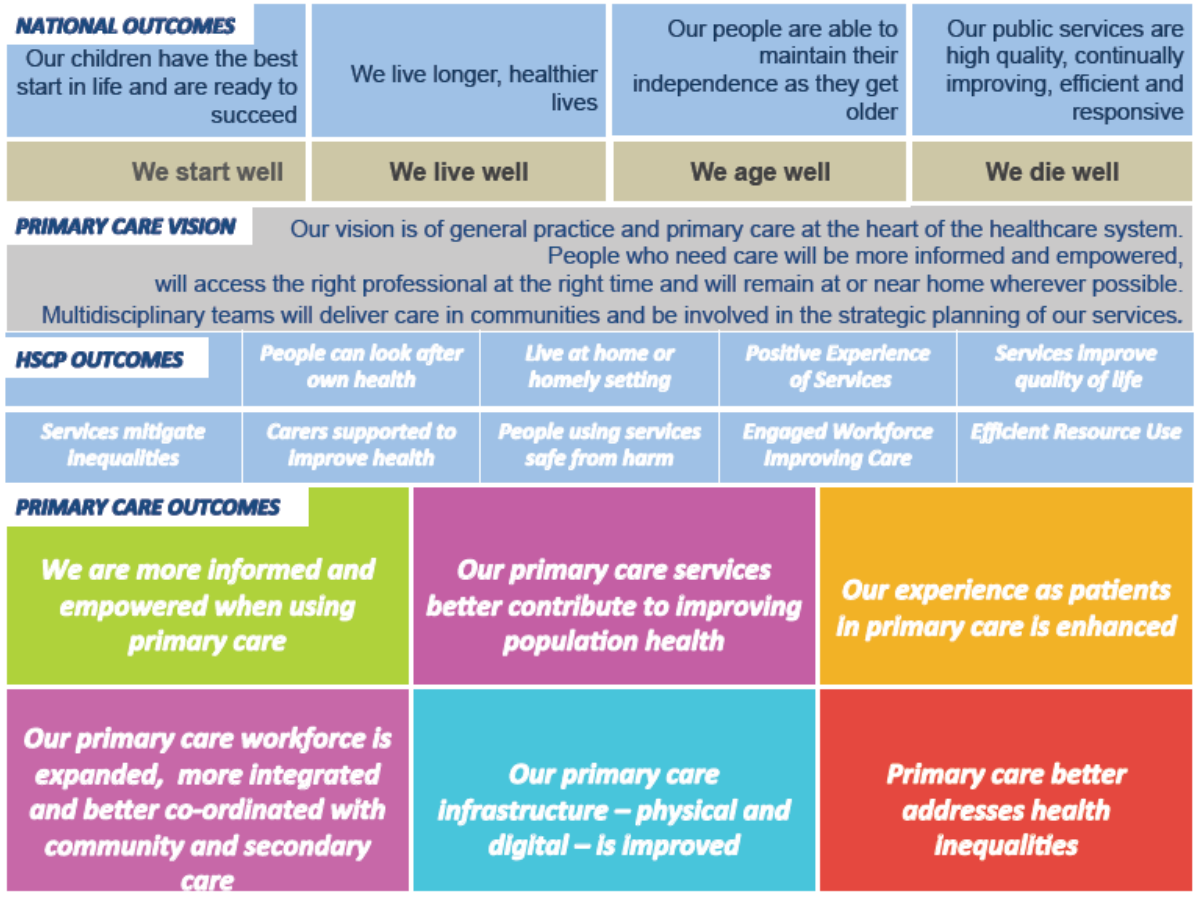
The Primary Care Transformation Programme will ensure the development of a sustainable model for primary care services ensuring the skills of our workforce are optimised. The model of Primary Care will look different with an expanded team providing care and support to individuals in our communities.

This vision will be enabled through the on-going development and delivery of the Primary Care Improvement Plan for Dumfries & Galloway.

The Shared Vision for the Primary Care Transformation Programme also supports the shared vision of the Dumfries & Galloway Integration Joint Board:

"Supporting our communities to be the best place to live active, safe and healthy lives by promoting independence, choice and control".

The national outcomes that the Primary Care Transformation Programme seeks to address are set out in the figure below:



Delivering these outcomes will take time and will involve significant challenges. Getting primary and community care right is an essential component of ensuring the whole healthcare system is sustainable. The Primary Care Transformation Programme will set out to deliver the best outcomes for patients, in line with our vision of care being provided at home or in a homely setting, and help ensure rewarding, well-supported careers for our community healthcare workforce.

The Memorandum of Understanding[9] emphasises that the delivery of the 2018 General Medical Services contract should accord with seven key principles. These are defined as follows:

- **Safe** – Patient safety is the highest priority for service delivery regardless of the service design or delivery model.

- **Person-Centred** – Partnerships between patients, their families and those commissioning and delivering healthcare services work to provide care which is appropriate and based on an assessment of individual needs and values and is outcome focused, demonstrates continuity of care (in the context of both professionals and services), clear communication and shared decision-making. Having regard to the five principles underpinning the Health & Social Care Standards: dignity and respect, compassion, to be included, responsive care and support and wellbeing.

- **Equitable** – fair and accessible to all.

- **Outcome Focused** – making the best decisions for safe and high quality patient care and wellbeing.

- **Effective** – the most appropriate treatments, interventions, support and services will continue to be accessible, provided in the most appropriate place by the right person at the right time to everyone. Changes to service delivery should not result in any diminution of care or outcomes for patients.

- **Sustainable** – delivers a viable long term model for general practice that is resilient in the context of the wider community care setting on a continuous basis; and promotes and supports the development of the skill mix within the practice setting.

- **Affordability and value for money** – making the best use of public funds; delivering the general practice model within the available resources; with appropriate quality assurance processes.

[9] Available at: https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-scotland/gp-contract-agreement-scotland

All programme developments must ensure that they satisfy these identified key principles.

The 2018 General Medical Services Contract Framework[10] is very clear in setting out the Aims of the Primary Care Transformation programme. They are as follows:

- **Improve being a GP** – Development of Expert Medical Generalist, GPs to provide clinical leadership to extended team, GP clusters to have role in quality planning, quality improvement and quality assurance, GPs to have contractual provision for protected learning time.

- **A more manageable workload** – new primary care services to be provided by Board employed staff, development of multi-disciplinary teams.

- **Better care for patients** – the principles of contact, comprehensiveness, continuity and co-ordination of care for patients underpin the proposals. GP time will be freed up for longer consultations where needed. There will be a wider range of professionals available in practices and the community for patient care.

- **Better health in communities** – GPs will be more involved in influencing the wider system to improve local population health in their communities. GP clusters will have a clear role in quality planning, quality improvement and quality assurance. Information on practice workforce and activity will be collected to improve quality and sustainability.

- **Improved infrastructure and reduced risk** - GP Owned Premises – new interest free sustainability loans. GP leased premises – planned programme to transfer leases to NHS Boards. New information sharing agreement reducing risk to GPs with NHS Boards as Joint Data Controllers.

- **A more sustainable funding model** – new funding formula, practice income guarantee and new minimum earnings expectation.
- **Improve recruitment and retention** – through local workforce planning supported by the national workforce plan which was published in May 2018.

- **Strengthening the role of the practice** – General practice nursing will continue to have a vital role under the proposed new contract. There will be new enhanced roles for practice managers and practice administrative staff.

[10] Available: https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-scotland/gp-contract-agreement-scotland

Existing work has shown there are significant benefits to be realised from working with a wider multi-disciplinary team aligned to General Practice.

The priority between 2018 and 2021 will be on the wider development of the multi-disciplinary team services outlined in the priority areas for change set out in the next section below. Changes to services will only take place when it is safe to do so and where the evidence base to support the change can be clearly demonstrated.

The Memorandum of Understanding[11] outlines the priorities of the 2018 General Medical Services contract over a three year period (from April 2018 - March 2021). The six priority new services and staff are:

- **Vaccination Transformation Programme** - staged for types of vaccinations but fully in place by April 2021.

- **Pharmacotherapy Services –** made up, by 2021, of level one care (acute prescribing, repeats, discharge letters, medication compliance reviews), followed by level two additional advanced (medication review, resolving high risk medication problems); level three additional specialist (poly-pharmacy reviews, specialist clinics).

- **Community Treatment and Care Services** - e.g. minor injuries and dressings, phlebotomy, ear syringing, suture removal, chronic disease monitoring with phlebotomy suggested as a priority in the first stage.

- **Urgent Care** - advanced practitioners, nurses and paramedics undertaking home visits and unscheduled care.

- **Additional Professional Roles** - for multi-disciplinary team dependent on local geography, demographics and demand (e.g. physiotherapists focusing on musculoskeletal, mental health services).

- **Community Link Workers** - to increase social prescribing and signposting to relevant partner agencies and support groups.

New staff will be employed predominantly by the NHS Board and work in models agreed between the Health & Social Care Partnership and local GPs. New staff will, where appropriate, be aligned to GP practices or GP cluster groups. Where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices. Existing practice staff will continue to be employed by practices and practice managers will contribute to the development of the wider practice teams.

[11] https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-scotland/gp-contract-agreement-scotland

It is expected that the priorities for development and implementation of the six identified areas for change will be different across the localities reflecting local need and population differences. These conversations will need to be quickly developed as part of the consultation process around this initial Primary care Improvement Plan. Now that there is more clarity around the funding situation, it will become clearer to what extent new pilots, tests of change and service implementations can be planned and taken forward particularly in Years 1 and 2.

The next section will outline the Engagement Process and give more information on how the Primary Care Improvement Plan for Dumfries & Galloway has been developed and who has been involved.

SECTION C – ENGAGEMENT PROCESS

The Primary Care Improvement Plan for Dumfries & Galloway has been developed using a partnership approach.

It has been led by the new Primary Care Transformation Manager who came into post on May 1st 2018. Support has been provided by the Head of Primary Care Development and the Associate Medical Director for Primary Care.

Weekly Executive Team meetings have taken place with the Chair of the Primary Care Transformation Programme Board, Head of Primary Care Development, Associate Medical Director for Primary Care, General Manager for Community Health and Social Care and the Programme Manager.

Monthly meetings have taken place with an Executive Group from the GP Sub-Committee who have provided advice and guidance on the development of the plan.

GP Clusters have been meeting on a regular basis to consider issues relating to the contract, quality improvement initiatives, prescribing data and costs as well as a range of other service management issues relating to the delivery of health and social care. Community based services delivering primary care are largely rooted in the community they serve. Therefore, the starting point for any transformational change programme of this nature has to be that community. It is acknowledged that the localities will require support to assist them to prioritise what is important to them and help to spread and gain acceptance of the idea that change is a requirement and a necessity if primary care is to be sustainable in the future.

The Locality Management teams have also had a key role in developing an understanding of the wider implications of the new contract. They have been briefed on some of the proposed changes but there is a need for strengthening the on-going dialogue about ways of delivering this programme which will inevitably impact on the integrated health and social care team.

Clinical Leads for the six priority areas for change have also been closely involved in the development of the Primary Care Improvement Plan. There are events planned for June 2018 which will see GP Cluster teams and Clinical Leads for the Year 1 priority areas for change coming together for workshop sessions to further develop understanding and future plans for testing and implementation as further clarity is now available on the funding availability for 2018/19.

The Executive Team have also had discussions with the Local Intelligence Support Team (LIST) to explore how best they can support the programme with up-to-date meaningful data that will support positive action and lead to improved outcomes for local service users.

The first Primary Care Transformation Programme Board took place on Wednesday 2nd May 2018. The Board is due to meet again on Wednesday 27th June 2018.

Regular update reports have been provided to the GP Sub-committee of the Local Area Medical Committee, Integration Joint Board, Health and Social Care Senior Management Team and the NHS Board Performance Committee.

An initial mapping exercise took place in January 2018 to identify the width of current activity across the four localities which directly linked with the six priority areas identified in the 2018 General Medical Services Contract. The output from this gave an indication of the key contacts for each of the links identified.

In April 2018, all of these individuals were contacted and asked to provide further detail with a view to the development of the Primary Care Improvement Plan. These contacts were made up from the following groups:

- GP Subcommittee Executive Group
- GP Locality Cluster Leads
- Locality Managers
- Scottish Ambulance Service
- Practice Managers
- Clinical Leads

The input received from this exercise has informed the development of this initial Primary Care Improvement Plan.

Members from the Executive Group have also attended a regional Protected Learning Time event in March 2018 which looked at a prioritisation of the six identified priority areas for change. They also attended the Alliance Public Engagement event and took note of the discussions had by service users from across different areas of Scotland in relation to the new contract.

The production of the initial Primary Care Improvement Plan has been affected by the lack of clarity around the availability of funding for Year 1 and beyond. Despite many of the priority areas for change having developed plans for tests of change in Year 1 e.g. around pharmacotherapy, urgent care and the implementation of a multi-disciplinary team in two co-located GP practices, it was unclear whether these tests of change could proceed given the funding that has already been committed to existing activity from current funding streams. Now the final Funding Allocation letters have been received, plans are now being developed to be presented to the August 2018 Programme Board meeting to allow implementation work to get underway.

Given the very tight timescales around the production of the Initial Primary Care Improvement Plan, it has to be recognised that there will need to be significant further engagement to allow more detailed dialogue with stakeholders and professional groups to take place after the initial plan is submitted in July 2018. This will happen with practitioners in their place of work or at planned development events. It should be recognised that there are still challenges to ensure that all stakeholders fully appreciate the relevance of collaborative working. This is a complex transformation agenda but the opportunities that it presents have to be acknowledged as going beyond the simple delivery of the contract. These opportunities should be seen as part of a whole system transformational programme for integrated health and social care in each of our four localities across Dumfries & Galloway.

Following the planned initial round of engagement activities in Autumn/Winter 2018, there will be detailed consultation with key partners and stakeholders (including patients, carers and representatives of service providers such as the third sector) before each review and update of the Primary Care Improvement Plan. These activities will also involve individuals from local GP Clusters, Locality Teams, Clinical Teams and the Executive Group from the Primary Care Transformation Programme.

Good communication, engagement and understanding across the whole of the health and social care system will be crucial if we are to successfully address issues around patient care and practice sustainability. We need to ensure that clear and consistent messages are used across the four localities to ensure that we minimise any negative impact on patients and mitigate any potential problems arising for the changes which are going to take place.

The scale of this transformation programme cannot be underestimated. The next section introduces the current thinking in Dumfries and Galloway around the approach for the implementation of the six priority areas for change outlined in the Memorandum of Understanding relating to the 2018 General Medical Services contract.

SECTION D

DELIVERY OF THE COMMITMENTS IN THE MEMORANDUM OF UNDERSTANDING

As outlined in Section B, the Memorandum of Understanding defines 6 priority areas for change:

- The Vaccination Transformation Programme
- Pharmacotherapy Services
- Community Treatment & Care Services
- Urgent Care (Advanced Practitioners)
- Additional Professional Roles
- Community Link Workers

At the Protected Learning Time event on Wednesday 14th March 2018 held in Dumfries, Pharmacotherapy, Urgent Care and Additional Professional Roles (particularly in relation to Mental Health) were all identified as local priorities along with some aspects of the Vaccination Transformation Programme i.e. children's vaccinations, those for pregnant women and travel vaccinations.

A key element of the 2018 General Medical Services contract is the development of the role of the GP as an Expert Medical Generalist (EMG) focusing on:

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

The EMG will be supported by a multi-disciplinary team (MDT) which will help to optimise the input of both clinical and non-clinical staff within a practice. Co-location of these MDTs will assist with integration as will the provision of better IT systems. The development of an effective MDT will greatly benefit from good leadership, a common sense of purpose and mutual support.

It has to be acknowledged that the funding allocation for Dumfries & Galloway will probably not be sufficient to deliver everything that is promised in the 2018 GMS Contract to every practice across our four localities and nor will every practice require every element of the services outlined in the contract due to local population need. However, if this Primary Care Transformation Programme is to succeed, it will require the consideration of the totality of the Health and Social Care resource rather than just the additional monies earmarked to support this change programme.

Increased clarity is required across GP clusters and localities around what is actually needed within practices and across clusters and a recognition that this will vary widely from locality to locality. The skill mix required for different roles must also be further considered and a better understanding of this will come from existing and new tests of change over the next three years.

Effective triage and signposting has already been identified as a key requirement which is not currently widely established in GP settings in Dumfries & Galloway. These elements will be absolutely crucial to the success of this new model.

The starting place when considering the Primary Care Transformation Programme has been an appraisal of what developments will make the biggest difference to GP practices in the region. It is now necessary to understand and quantify the work that can be passed to other members of a multi-disciplinary team. This will then allow the identification of what additional team members will be of most benefit to a practice whilst looking at the practicalities around current availability of these individuals or identification of how to develop a pipeline, perhaps involving additional training, that will allow these resources to be available in the right localities at the right time.

The new contract makes it clear that GPs have a key role in leading and supporting these new extended teams. It follows then that more discussion needs to take place to gain a better understanding of what this really means in practice for local GPs.

Ultimately, delivering improved levels of care in the community will have a positive impact on local residents allowing them to more easily see the right person, in the right place at the right time.

The following sections take the six priority areas for change identified in the 2018 General Medical Services contract and set out current activity and what we hope to deliver by April 2021.

SERVICE 1 – VACCINATION TRANSFORMATION PROGRAMME

Overview

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

In the period to March 2021, the contract commits that Health and Social Care Partnerships (HSCPs) will deliver phased service change based on a locally agreed plan to meet a number of nationally determined outcomes including shifting of work to other appropriate professionals and away from GPs. This has already happened in many areas across Scotland for Childhood Immunisations and Vaccinations. This change needs to be carefully managed, ensuring a safe and sustainable model and delivering the highest levels of immunisation and vaccination take up. It is also recognised that there may be geographical and other limitations to the extent of any service redesign.

In Dumfries & Galloway, the following workstreams are included in the Vaccination Transformation Programme (VTP):

- Pre-school Programme
- School-Based Programme
- Influenza Programme
- At Risk and Age Group Programmes (Shingles, Pneumococcal, Hepatitis B)
- Travel Vaccinations and Travel Health Advice

During 2018/19, the main priority is to undertake a process of consultation with stakeholders and the public. A process of participatory appraisal will be utilised to identify the views of the public on the barriers and facilitators for accessing vaccinations which will inform the VTP.

Governance Arrangements

The Vaccination Transformation Programme nationally is overseen by a Programme Board which is comprised of representatives from the Scottish Government, SGPC, Trade Unions, Health Protection Scotland, Health Boards and Directors of Nursing. It is responsible for the national implementation of the Vaccination Transformation Programme, and managing, monitoring and evaluating progress made by each Health Board. The Vaccination Transformation Programme Board links into the National Oversight Group by reporting to the Primary Care Programme Board. Locally, the VTP team will link to the Primary Care Transformation Programme Manager and the Primary Care Transformation Programme Board.

Local Priorities for Delivery in Year One

Through consultation with stakeholders in Dumfries & Galloway, the following priorities for delivery in 2018/19 have been identified:

Pre-School Programme

By end 2018/19 a review of the current pre-school service will have been undertaken. Any recommendations from the review will be implemented along with an expansion of the service as indicated (dependent on additional funding being agreed by the Primary Care Transformation Programme Board).

At Risk and Age Group Programmes

Pregnant women – Pertussis (whooping cough)

- By the end of August 2018, initial scoping of the service demand across localities and potential alternative maternity led delivery models, including implementation challenges, enablers and indicative costs identified for each model. Tests of change will then commence in pilot areas (again dependent on additional funding being agreed by the Primary Care Transformation Programme Board).

Hepatitis B

- During 2018/19, an initial scoping of service demand across localities and potential alternative delivery models, including the implementation challengers, enablers and indicative costs identified for each model.

Travel Vaccinations and Travel Health Advice

- Currently awaiting the completion of the national options appraisal exercise, being led by Health Protection Scotland, for clarification regarding programme scope.

The expectation is that Integration Authorities and NHS Boards will have all five of these programmes in place by 2021. The order and rate and which they make the transition may vary across Scotland but the progress is expected to be delivered against locally agreed plans in each of the three years. This should include significant early developments in 2018-19.

Other VTP workstreams outlined at the start of this section will come forward in Years 2 and 3 as the Vaccination Transformation Programme develops.

This is one of the priorities which are unlikely to significantly impact directly on GP work. However what it may cause is a significant realignment of services within practices where those staff previously doing immunisations are found alternative valuable roles for example in Chronic Disease Management or Anticipatory Care Planning.

SERVICE 2 – PHARMACOTHERAPY SERVICES

Overview

The 2018 General Medical Service contract sets out a commitment that, by April 2021, the patients of every GP practice in Scotland will be provided with pharmacist and pharmacy technician support.

A three tiered pharmacotherapy service is to be implemented in a phased approach in every GP practice by 2021.

Level One is a core service that will be made available to all GP practices, with activities at a generalist level of pharmacy practice focused on acute, repeat and serial prescribing, medication management and prescribing efficiencies.

Levels two (intermediate) and level three (advanced) are additional services and describe a progressively evolving stage of clinical pharmacy practice and experience which includes medication and polypharmacy reviews. The levels of support will take into account the needs of individual practices and practice clusters across Dumfries & Galloway.

It is envisaged at this stage that pharmacists and pharmacy technicians will be embedded members of the core general practice clinical team aligned to clusters but working across one or many practices in the region. Whilst they are not employed directly by practices, their daily workload will be co-ordinated by the practices they are associated with targeting local cluster priorities.

The implementation of the pharmacotherapy service will be lead by the Director of Pharmacy with support from the new Community Health and Social Care Lead Pharmacist.

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

There has been recognition of the requirement to increase pharmacist training places to support this work.

Community Pharmacy

Community pharmacy already fulfils an important role in the provision of NHS pharmaceutical care, providing highly accessible services for individuals both in and out of hours. The aim is to have more people utilising their community pharmacy as a first port of call, not only for the treatment of self-limiting illnesses and medicine related matters, but also for on-going self management support for people with long term conditions. Enhancing these services also expands the clinical role of community pharmacists.

'Achieving Excellence in Pharmaceutical Care'[12] committed to working in collaboration with NHS Education for Scotland and other key stakeholders to understand and address future pharmacy workforce requirements. The document outlines the requirement to further build the clinical capacity within community pharmacy and a commitment to target resources to expand the number of community pharmacists undertaking independent prescribing and advanced clinical skills training. This includes exploring how resources to cover back-fill for the residential training and period of learning in practice can be provided in order to build clinical capacity to deliver an Extended Minor Ailment Service and enhanced Chronic Medication Service.

Given the importance of community pharmacy in helping to transform our primary care services, a national community pharmacy workforce survey has been undertaken to provide the necessary insights into staff numbers and skill mix to meet the challenges of delivering new models of primary care. Crucially, this will inform national workforce planning and the educational needs of the profession in this sector.

Chronic Medication Service

The Chronic Medication Service (CMS) available in all local community pharmacies. CMS can make a significant contribution to pharmacotherapy services. It will be important to ensure that the appropriate links between the pharmacotherapy service, the general practice team and CMS are embedded in the service to make best use of total capacity.

[12] Available from: http://www.gov.scot/Publications/2017/08/4589

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

Other Centrally Funding Community Pharmacy Services

GP Practice Teams should also make full use of the other NHS services available through local community pharmacies as part of local triaging arrangements. Community pharmacists can provide self-care advice on a range of common, uncomplicated, clinical conditions.

Children, the elderly, people with medical exceptions, and those on low incomes can also make full use of the Minor Ailment Service (MAS). There is currently a pilot looking at an extended MAS in Inverclyde and the outcomes of this will inform the future development of a wider MAS on a national basis.

In addition, smoking cessation support and sexual health advice (including access to Emergency Hormonal Contraception) are also available through the community pharmacy.

Pharmacy First

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

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

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

Current Pharmacotherapy Service in Dumfries & Galloway

NHS Dumfries & Galloway currently has a team of pharmacists and pharmacy technicians working across the region in GP practices, providing support in medicines management to GP teams. They help support GP surgeries with prescription requests, medicines reconciliation, polypharmacy reviews, minor ailment clinics and chronic disease management. The focus of the technician team is cost-efficiencies where methods such as medication-switches are employed to reduce prescribing costs.

Due to the limited number of pharmacists and technicians providing support from both the Prescribing Support Team (PST) and the more recently introduced General Practice Clinical Pharmacists (GPCPs), most of the team are unable to provide more than 1-2 days of their working week in any one practice. This leads to the following problems:

- Reduction in productivity due to stopping/starting and refocusing on work load
- Issues around clinic room availability
- Productivity lost through time taken up travelling between surgeries
- Difficulties with imbedding a service which is required over the 5 day working week

So, although the pharmacy team are able to provide advice, guidance and support on appropriate and cost-effective prescribing to GP teams, the majority of the workload associated with the day-to-day prescribing of medicines still falls to the GPs and administration staff.

At a recent local GP cluster meeting, the clear positive impact on prescribing by pharmacists in GP practices was highlighted repeatedly. However, it was also noted that the impact would be much greater if the time in practices was less disjointed.

A documented example of a full-time Independent Prescriber Pharmacist employed in a 4 GP practice in England suggested that GP workload was reduced by 1-2 hours per day per GP.

It is also important to also note the significant cost savings that need to be achieved in prescribing (NHS Dumfries & Galloway CRES targets). Prescribing in primary care faced an overspend of £2 million in 2017/18 which is likely to continue into 2018/19. It is well recognised that Pharmacists and Pharmacy technicians working in GP surgeries can help ensure more cost effective prescribing through reviews of medication, switching or de-prescribing, giving prescribing advice and support and helping to ensure local formulary compliance.

It has recently been suggested that a pharmacist providing a pharmacotherapy service (similar in specification to the tasks listed in the new contract) for as little as 8

hours per week could offer cost savings to prescribing of up to £15,000 per year (after expenses). Providing a full-time pharmacotherapy service, as a comparison, would be expected to produce savings in prescribing costs of more than £50,000 per year.

The Inverclyde New Ways of Working pilot provided an average of 0.5WTE pharmacists per practice alongside some pharmacy technician involvement. Another model, which better accommodates the needs of remote and rural practices, is 1 pharmacist per 10,000 list size.

An evaluation of the workforce aspects of the GP practice based pharmacists and pharmacy technicians should be available by the end of 2018 and the early findings, alongside the Inverclyde evaluation, will be used to inform detailed workforce planning work to identify how many additional pharmacists and pharmacy technicians will be required to deliver full roll-out of the pharmacotherapy service.

Training and Development

When considering the development of the pharmacotherapy service in GP practices, there are a number of additional implementation factors that need to be considered alongside simply the number of pharmacists and pharmacy technicians required to deliver it. The factors include their education and development and importantly securing a pipeline of new pharmacists.

Depending on the experience of the pharmacists and pharmacy technicians working in GP practices, there can be a need for additional training which may include advanced clinical and independent prescribing skills. This will also require appropriate levels of clinical mentorship.

Additionally, the new NES vocational training programme for pharmacists in primary care and community pharmacy will contribute towards ensuring early career pharmacists build skills and capability. A General Practice Clinical Pharmacist Competency and Capability Framework has been developed to underpin the education and training needs of pharmacists supporting GPs going forward.

In order to increase the pool of qualified pharmacists available to provide the pharmacotherapy service, additional funding has been made available to increase the number of NES pre-registration pharmacist training posts from 170 to 200 per year from 2018/19 onwards across Scotland.

This approach clearly recognises the limited supply of appropriately trained pharmacists who may want to come and work in Dumfries & Galloway.

Other Prescribing Staff

It is important to also note that others, including AHPs, can contribute to prescribing with Dietetics, Paramedics (SAS), Physiotherapy and Podiatry all currently having the ability to extend their practice to include prescribing.

In NHS Dumfries & Galloway, there are podiatry independent prescribers in place and there are currently discussions ongoing around extending the cohort to include dietetics and physiotherapists. These practitioners can reduce the number of acute and repeat prescribing requests coming to GP practices where these clinicians are involved already as has been evidenced by the local podiatry progress to date.

Within Nithsdale, we are in the process of training an Advanced Practice AHP who is a physiotherapist. This physiotherapist is training alongside and undertaking the same training as the current cohort of ANPs with an anticipated completion date of summer 2019. As part of this process, she will complete her prescribing component in the autumn of 2018.

Local Priorities for Delivery in Year One

Locally, a review has been initiated to identify current pharmacotherapy service provision and how existing resource could be better deployed to deliver the aims set out in the contract. This work will also identify gaps where additional resource is required. It is hoped this detailed work will be fully completed by August 2018.

At the time of writing, localities are at different stages of this analysis but it is hoped that this can be completed quickly to allow proposals for any additional funding required to support pharmacotherapy implementation to be presented to the GP Subcommittee for advice and guidance before proceeding to the Primary Care Transformation Programme Board.

SERVICE 3 – COMMUNITY TREATMENT AND CARE SERVICES

Overview

The 2018 General Medical Services Contract sets out a commitment that by April 2021, there will be a community treatment and care service in every Integration Authority area, starting with phlebotomy.

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

The contract states that phlebotomy should be delivered as a priority in the first stage of the Primary Care Transformation Programme. However this has not been identified as a local priority in Dumfries & Galloway.

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

Community treatment and care services should be prioritised for use by primary care. They should also be available for secondary care referrals if they would otherwise have been workload for GPs (i.e. if such use means they are directly lifting workload from GPs).

The contract also states that Integration Authorities should consider how this service might best be aligned with wider community treatment and care services used by secondary care.

Dumfries & Galloway context

Development of community care teams for delivering wound care, phlebotomy and post operative checkups amongst other treatment room type activity will again require some further information gathering as to the nature of the activity required. Practices are currently providing these services and the transition from this arrangement to whatever replaces it will need careful planning. Given the lack of clarity around the contract funding, resourcing and how existing staff might be managed through this process, there is some evaluation of activity that requires to take place first. Once this work is completed and the situation is clearer, how the service might be configured can be better considered. This work is now currently underway across all four locality GP cluster teams.

There is a need for close discussions with the Community Nurse teams and how some of this development might support their work and how these teams can work in a more integrated way with primary care.

This change will require careful management to ensure, by April 2021, a safe and sustainable service delivery model, based on appropriate local service design, is available to all practices across Dumfries & Galloway.

SERVICE 4 URGENT CARE

Overview

The 2018 General Medical Services Contract gives a commitment that by April 2021 there should be a sustainable advanced practitioners' service for urgent unscheduled care as part of the practice or cluster based team across all four localities in Dumfries & Galloway, based on an assessment of local population need.

The contract recognises that there are clearly significant advantages in the use of advanced practitioners to respond to urgent unscheduled care within primary care. This includes responding to requests for home visits or urgent call outs. Advanced practitioners have the ability to assess and treat patients requiring a home visit or unscheduled care presentations in the practice. This should allow GPs to focus more on their role as Expert Medical Generalists.

Urgent Care – Scotland-wide Tests of Change

The 2018 GMS contract states that where service models are sufficiently well developed, advanced practitioners may also directly support GPs by carrying out routine assessments and the monitoring of chronic conditions for vulnerable people who are cared for at home or in care homes. In Dumfries & Galloway, these advanced practitioners may be either Advanced Paramedics or Advanced Nurse Practitioners.

A number of tests of change in Scotland over the last two years have focused on the role of paramedics in primary care. Evidence from pilots in Inverclyde, Hawick and Kelso have also shown that this type of support allows GPs to provide more appropriate patient care in the practice.

The Inverclyde pilot, for example found that in the first three months following paramedic support to practices being put in place, the percentages of home visits carried out by GPs reduced by over 60%. Paramedics have vast experience in dealing with unscheduled care presentations, making them an ideal fit to work with primary care colleagues.

This model also supports paramedics to practice their skills at the highest level of their professional competence, consolidate their learning, gain exposure to and experience of patients with acute illness and injury and develop closer relationships with primary care colleagues, becoming part of a wider MDT. These paramedics will be aligned to clusters as appropriate and the requirements based on local service design including working during core practice hours, as well as out of hours. These

paramedics can assess and treat patients in a range of settings, including urgent and emergency care presentations, home visits and Health Centre attendees.

As autonomous practitioners, paramedics will not require regular supervision by the GP within a cluster but will need access to support when issues out with their scope of practice arise. While this will be provided by a clinician, this may not necessarily be the GP. Supervision for paramedics working within a practice will always be agreed under the GPs clinical oversight. Peer supervision with clinical oversight and leadership from the GP will be encouraged under this new model.

Paramedics and advanced paramedics will continue to be employed by the Scottish Ambulance Service (SAS). In Dumfries & Galloway, SAS is working with the Primary Care Transformation Programme Board to quantify what support is required at a local level, using evidence gathered from current tests of change such as in Inverclyde. This will include developing robust clinical governance frameworks and evaluating practice data.

SAS will integrate all existing pilot activity, such as the work being carried out in Inverclyde, into a single national programme of work to transform primary care in a 'Once for Scotland' approach. This will include developing robust clinical governance frameworks and evaluating practice data.

Patient safety will be fundamental in delivering this workforce at scale. At all stages of the roll-out, it is vital that the available workforce is appropriate to ensure the safety of patients requiring urgent unscheduled care is assured, and core ambulance services are not negatively impacted. This will require consistent and reliable provision of paramedic staff working in primary care teams, appropriate training and education, supervision and support arrangements, and, crucially, positive relationships between colleagues in the MDT.

Out of Hours

NHS Boards are responsible for allocating resource to ensure that people are able to access quality healthcare services both in and out of hours.

The particular challenges faced by out of hours services must be acknowledged. The Scottish Government invested £10 million in 2016-7 and provided further investment as part of the £23 million Primary Care Transformation Fund (PCTF) in 2017-8, to deliver the recommendations in Sir Lewis Ritchie's report "Pulling Together"[13]. Going forward, NHS Boards are expected to maintain and develop a resilient out of hours service that builds on the recommendations of Sir Lewis's

[13] Available here: http://www.gov.scot/Publications/2015/11/9014

report, ensuring effective links and interface between in and out of hours GP services. This is also reflected in further work undertaken by Sir Lewis through Improving Health and Social Care Service Resilience over Public Holidays[14], published in December 2017..

A local review has been considering the roles required to meet the needs of individuals utilising the OOH service in NHS Dumfries & Galloway. Based upon these needs it is considered that community nursing has a part to play in the Out of Hours Service.

The testing of Band 5 Staff Nurses in Wigtownshire has come to a halt due to the challenges of lone working, operational change and provision long term of Staff Nurses to the model. The training of two OOH ANPs continues with both ANP trainees due to complete their training in July 2019.

It is accepted that the current medical model for Out of Hours is not sustainable. This roster considers the need for more paramedics in the service, as well as inclusion of District Nurse/Specialist Practitioners. It also suggests a change to the medical model, with Emergency Departments operating differently in Stranraer and Dumfries, with less medical staff in the OOH service.

There are specific challenges owing mainly to the evening, weekend and overnight nature of the service which is considered less family friendly and unsocial when compared to the day time working. Overall this creates service risk when the importance of responding to the growing unscheduled care demand is considered. Alternative shift patterns as such have to be considered in an attempt to offer staff choice. It is also seen to be essential to be able to rotate staff from Day to Night time/weekend service in order to retain them.

Within the Nithsdale locality, an Advanced Practice AHP, who is a physiotherapist, is currently being trained. When this physiotherapist completes her training she will be in a position to provide resources to the urgent care requirements of Nithsdale locality. She will be able to act as first point of contact and manage the whole episode of care including diagnostics, prescribing and admission rights.

This model is one that AHPs are exploring more widely within the national Transforming Roles[15] work which has extended from nursing to include the roles of AHPs. The contribution of a multi-disciplinary team all working at Advanced Practice level has the potential to transform the urgent care agenda as AHPs bring different expert knowledge and approaches into the partnership. It is anticipated that this national work will progress over 2018/19.

[14] Available at: http://www.gov.scot/Publications/2017/12/2391/9

[15] Further information available: http://www.nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/careers-and-recruitment/transforming-nmahp-roles.aspx

There are models of services across Scotland which have AHPs in their out of hours services. Locally, our model is limited to the inclusion of paramedics from SAS but elsewhere models include physiotherapists in the OOH hubs and Occupational Therapists out in the first response vehicles with paramedics with significant impact on outcomes for people particularly around falls.

There is clearly scope available to redesign urgent care across the region to include both In and Out of Hours requirements for urgent unscheduled care requirements. This will allow for the development and upskilling of ANPs and Advanced Paramedics, allowing them to advance to independent prescribing more easily, help them have less unsociable hours and at the same time relieve some of the current pressures on primary care, particularly in Stranraer by providing extra input into struggling practices.

Local Priorities for Delivery in Year One

Here in Dumfries and Galloway, a proposed pilot programme have been developed which will seek approval at the August Programme Board meeting. This pilot proposal has been developed and agreed between NHS Dumfries & Galloway and the Scottish Ambulance Service (SAS). This pilot programme would see paramedics working in primary care in two cluster areas within the region. This programme will help to inform future developments around the Urgent Care Transformation priority area as part of the wider Primary Care Transformation Programme.

It is proposed that the pilot will have a focus on both the East and the West of the region.

Paramedics will provide semi-autonomous assessment and care for patients within the primary care setting. They will also attend home visits on behalf of NHS Dumfries & Galloway. Paramedics will work within their scope of practice and competency whilst complying with NHS Dumfries & Galloway and Scottish Ambulance Service guidelines and protocols.

A group of 14 paramedics (2 of which are Specialist Paramedics in Advanced Practice) will collectively cover a roster to deploy a paramedic 5 days per week, to both the West and East clusters. The paramedic will cover the shifts at the respective cluster on an overtime basis only. This is required to maintain resilience in the core Ambulance resource provision across Dumfries & Galloway.

Following some testing to support urgent care, it is envisaged that the Programme Board will look at how this may be rolled out across all four localities. This may include the use of paramedics in delivering a home visiting service but also possibly

an initial assessment service for patients who present requesting urgent care at the GP surgery. Picking up both aspects of urgent care would generate sufficient work to justify substantive appointments but each part on its own would mean capacity would be spread over a wide geographical area making safety and responsiveness more difficult.

At the same time, the Programme Board will explore the potential role for ANPs to manage Care Home work and in particular to ensure they have consistent approach to Anticipatory Care Planning (Forward Looking Planning in Annandale & Eskdale). The quantification of the extent of the work that could be done by an ANP is underway across all practices and GP locality cluster teams to help inform what capacity may be required in each area. Advertisements for the next intake of ANP training have been placed. The final decision on the number of ANPs to be put in to training in 2018/19 will depend on the quantity and quality of the applicants who express an interest as well as the availability of funding.

Service 5 – Additional Professional Roles

Overview

The Additional Professional Roles priority for change will provide services for groups of patients with specific needs that can be delivered by professionals other than the GP. Exactly how this will look for each cluster in Dumfries & Galloway will be determined by local population requirements.

The 2018 General Medical Services contract makes a commitment that by 2021 in most areas there will be additional new NHS Board employed members of staff working together in new multi-disciplinary teams. It explicitly mentions that these MDTs should involve mental health workers and physiotherapists, as well as potentially others, acting as first point of contact for some patients.

Mental Health

The National Health and Social Care Workforce Plan Part 3 – Primary Care[16] highlights the impact of mental health on primary care services. It states that mental health issues are a common factor in many GP appointments. Scottish research in primary care showed that depression is associated with a wide range of physical health conditions and is a significant burden on primary care.

It is crucial that the primary care workforce is confident in dealing with a wide range of mental health issues. Mental health expertise needs to be rooted in the primary care multi-disciplinary team via specialist mental health workers and by ensuring that other primary care practitioners are mental health trained and aware.

A £10 million Primary Care Mental Health Fund (PCMHF) has allowed different services across Scotland to try different approaches to improving mental health provision. The Scottish School of Primary Care is undertaking an evaluation of a range of projects funding by the Primary Care Transformation Fund and PCMHF. The evaluation will comprise case studies with a geographic and thematic focus and will be published in Autumn 2018.

The Mental Health Strategy for 2017 – 2027 recognises the importance of primary care transformation and views it as an opportunity to develop better services for individuals with mental health issues with parity of esteem between physical and mental health.

[16] Available at: http://www.gov.scot/Publications/2018/04/3662

Action 15 states that there will be an increase in the mental health workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, and every police station custody suite and to all prisons. It commits to increasing additional investment to £35 million per annum across Scotland by 2021-22 (including £12 million in 2018-19) for 800 additional mental health workers in those key settings.

The Mental Health Strategy 2017 – 27 commits to Action 23, which is to 'test and evaluate the most effective and sustainable models of supporting mental health in primary care, by 2019'. It describes the primary care transformation that will improve this: the up-skilling of all primary care team members on mental health issues, the roles of clinical and non-clinical staff and the increased involvement of patients in their own care and treatment through better information and technology use.

To date, nearly £10 million has been invested in the Primary Care Mental Health Fund (PCMHF) across Scotland to encourage the development of new models of care to ensure that people with mental health problems get the right treatment, in the right place, at the right time

The first tranche of funding for Action 15 is set at £12 million in 2018/19. This will be allocated separately to Health Board partners early in the financial year and will include a requirement to count and monitor the number of additional mental health workers needed to deliver this commitment.

Mental Health – work currently underway

There are a number of current pilot programmes taking place across Dumfries & Galloway, details of which are contained in the sections below.

Psychiatry Liaison - work currently underway

Funding has been provided via the Scottish Government's Primary Care Transformation and Mental Health Funds to support the development of a primary care mental health nursing model. 1 WTE Band 6 CMHN and 1 WTE Band 3 HCSW have been recruited to each of 2 localities to deliver a pilot project. The pilots have been running since May 2017.

The service offers mental health assessment and assisted self management for those with mild to moderate mental health issues, who do not fit the criteria for the Guided Self Help Service or secondary mental health services. These conditions can cause marked emotional distress and interfere with daily functioning, but do not usually affect insight or cognition. The emphasis is on early intervention, to prevent worsening of symptoms that would otherwise lead to referral on to secondary services, as well as early identification of more serious mental health issues.

The service offers low intensity, brief, time limited interventions to enable people to manage their difficulties. It provides education and resources and signposts to other services; working closely with the Community Link Workers to ensure co-ordination and appropriate referral and signposting. The Mental Health nurses play a key role in helping GPs to identify early prodromal signs of serious mental illness and act as liaison, taking complex cases to CMHT for discussion and/or facilitating referral to CMHT for assessment where appropriate.

In addition, the service aims to improve the uptake of physical health reviews for people with severe and enduring mental health issues, and to act as a liaison between primary and secondary care. The service now operates within the Castle Douglas Medical Group and the Solway Medical Group in Stewartry and the Lochinch and Lochree Practice in Wigtownshire.

Psychology Liaison - work currently underway

General Practitioners often cite their biggest challenge is patients who attend their surgery with psychological difficulties who are unlikely to make effective use of existing psychological therapies provision. Local evidence shows that those who complete psychological interventions have better outcomes but traditional models of therapy do not suit everyone. GPs have identified the need for psychological practitioners, based in primary care, who can actively guide and facilitate people with moderate psychological difficulties.

These clients, who often do not meet the referral criteria for existing services, could also be directed to a wider variety of mental health-enhancing activities or third sector resources. GPs consistently say they do not have the capacity or enough updated knowledge about alternative resources to advise patients nor to confidently signpost them. These patients often frequently attend with a variety of difficulties which GPs feel unable to either address or refer on to existing services.

The pilot involves one Band 7 and 2 Band 5s operating out of 2 GP practices trialling a service, adapted from the IAPT (England) programme within practices that are keen to have a mental health service in primary care, to complement existing community support workers. The team is overseen by a clinical psychologist from existing resource and a specialist psychological therapist. The therapist oversees all initial psychological assessment and psychological formulation of mental health difficulties. Where appropriate, they create an intervention plan which identifies a need for mental health-enhancing resources online or in the local community supported by support workers. The assistant psychologists deliver the intervention plans and work closely with GP staff. Additional staffing (one Band 7) will be added to cover Nithsdale, triage and frequent attendances.

The team have worked using the following criteria:

- Patients have moderate to complex problems that may be suitable for psychological therapy (e.g. depressed mood; anxiety; obsessional thoughts and/or behaviour; trauma in childhood and as an adult; complex bereavement). Patients need to be motivated to work on making changes in their life.

- Patients have personal or practical obstacles to engaging in a full course of talking therapy or may be experiencing complicating factors such as housing, employment and financial difficulties which may be contributing to or maintaining their psychological distress.

- Patients could benefit from a brief psychological assessment and formulation of their problems to inform direction to appropriate resources including a variety of mental health enhancing activities or community-based services. This will be summarised as a case management plan which will be shared with the patient, referrer and other relevant parties.

Loneliness in Older Adults - work currently underway

Mental Health Services in Dumfries & Galloway have been working collaboratively with primary care around loneliness in older adults piloted in the west of the region but now rolling out across the entire region.

Loneliness, particularly in older adults, is a significant and growing issue. A recent survey of GPs found that 75% of those surveyed believed 1 in 5 GP patients a day present at the GPs primarily because they are lonely. 1 in 5 over 75 year olds live alone and rarely see or speak to someone every day. This impacts on wellbeing and feelings of loneliness. Fixed term funding has been used to improve primary care staff's knowledge and ability to assess and ask about loneliness. Pathways are now in place, awareness raising is ongoing and self-help guides are available. Evaluation of individual cases shows significant improvements in wellbeing.

Community Link Workers - work currently underway

The Mental Health team have been working with localities and public health to improve the effectiveness and consistency of the role of community link workers and community development staff.

Mental Health – Future Work

Pain Management Project – potential for future pilot

GPs report that where there is demand for pain medication, anti-depressant prescribing is also high. Pain management psychological interventions have been shown to reduce the need for medication on a long-term basis, reducing not only the pharmacy costs but also reducing the need for GPs to see patients on a regular basis for review. A pilot programme could be run in primary care to assess the effectiveness of such a service.

Anti-depressant Prescribing – potential for future pilot

There is national guidance that anti-depressant prescribing should be reduced and psychological interventions should be our first line treatment. Due to long waiting times for one-to-one therapy, GPs often prescribe anti-depressants on an interim basis and consequently need to review patients on regular basis.

Psychological interventions in primary care could include rapid access behavioural activation and low-level depression management groups which would reduce the need for anti depressants and regular GP appointments. There is the potential for a pilot programme to test the effectiveness of such an approach.

Psychiatry Liaison – potential for wider roll-out

It is hoped that this can be expanded to include further GP clusters. However analysis of the data shows that the project does not reduce the workload of the CMHT staff and therefore cannot become part of their core business. However, the liaison work has identified that it has significantly reduced GP workload and therefore further development would have to be part of the new primary care transformation model and new GP contract work. The model is beneficial for patients in meeting their needs at an early stage and should be a fundamental part of primary care services for mental health.

However, at the current time, the staff is limited due to fixed term transformational fund money due to end May 2019. The money allows for 2 Band 6s and 2 Band 3s which is insufficient to cover the whole region so further funding would be required for wider spread of the service.

Psychology Liaison - potential for wider roll-out

It is hoped that this service can also spread into additional practices and cluster areas. However staffing is limited due to fixed term Scottish Government money due to end March 2020. This money only allows for 2 Band 7s and 2 Band 5 staff. This is insufficient to give equity of access to the whole region.

In the short term, it is hoped that the service can be spread to Nithsdale and include a component of managing frequent attenders at GP practices and triage of those with longest waits for psychology. Usually those waiting are seen for review by their GP in primary care. Triage allows psychology to review those waiting and redirect if need be thus avoiding using GP time but also, if Psychology is no longer needed, redirecting them to a more appropriate service and reducing the demand on psychology.

Loneliness in Older Adults – future roll-out plans

There are plans are in place to roll out work to other areas of primary care: AHPs, social care providers, district nurses and ANPs. There is an increased likelihood that staff will identify functional difficulties earlier (depression, anxiety etc). This is likely to put more pressure on secondary care mental health services for older adults. Additional thought needs to be given to the management of this demand both within primary and secondary care.

Community Link Workers – further work required

Further work is needed to embed the new training for staff and to clarify roles, particularly in relation to those clients with complex needs. Whilst the demands on community link work staff increase there are risks to maintaining the quality of the service and the support that the staff need.

Work is ongoing with locality managers, PHPs in each locality and public health to standardise and refine the practice of community link work and community development staff across the region. Training is ongoing and supervision structures are under review. From the psychology liaison work, it is clear that community staff need more support, supervision and closer links with mental health staff but the capacity to do this is limited.

Physiotherapy

Neck and back pain generates the second highest burden of disease in Scotland. Early intervention and self-management can have a significant impact in preventing the worsening of these conditions. MSK health issues are a common cause of GP appointments but the majority of a GP's MSK caseload can be seen safely and effectively by a physiotherapist without a GP referral.

Under this proposed new model, physiotherapists could provide first point of contact appointments providing assessment, diagnosis (including access to diagnostics), advice and onward referral to secondary care services if appropriate. Where they have appropriate training and skill mix, MSK physiotherapists could carry out prescribing as well as treatment such as injections. This would enable a faster and more efficient whole system pathway for patients with MSK conditions.

The contract states that a sustainable physiotherapy/advanced practice physiotherapy provision should be considered by all Integration Authorities and the potential of aligning this service to GP clusters. A significant proportion of the current workforce already has the skills required or could be quickly up-skilled to take on these roles. However, the training of new physiotherapists will take time, with undergraduate training currently lasting two to four years. A transitional phase would therefore be required to enable a sustainable model to be achieved.

New models of MSK physiotherapy have been tested across Scotland as part of the Primary Care Transformation Fund. The Scottish School of Primary Care is evaluating selected models on behalf of the Scottish Government. The study will help inform the context in which the new models of MSK physiotherapy were tested and examine the barriers and facilitators to deployment and uptake that were met by the test sites. It will also consider how well, in early sites, the changes have been embedded as part of routine practice, and consider sustainability issues. A report setting out key findings will be published by the end of 2018.

NHS Boards across Scotland have indicated challenges around recruitment across all of the AHP workforce, but particularly affecting physiotherapy. The numbers entering the Allied Health Professions are not currently controlled, and are largely determined by supply and demand factors. The potential for a more managed approach to workforce planning for those training to become AHPs is currently being explored.

Consideration is also being given to the potential for other, faster routes into the profession such as return to practice and post graduate training.

In addition, the Scottish Government is working with a range of stakeholders to consider how best to attract and retain people into AHP careers – particularly for those professions where it is already difficult to recruit to such as physiotherapy. As part of this wider work, the potential need for a marketing and recruitment campaign will be considered.

Physiotherapy – Current work

Direct access to MSK and podiatry general referrals are well established already with the current waiting times for first contact one of the shortest in NHS Scotland. We would wish to maximise on these existing pathways moving forwards to ensure that only those individuals needing to be seen within the GP practice (whether by GP or another professional) are seen in the practice.

Beyond this more general approach, the model of physiotherapy within the GP practice as first point of contact practitioner has a significant evidence base which proves that physiotherapists assess, diagnose, treat and refer on appropriately. The evidence base around referral on indicates that outcomes are better and referral to secondary care from AHPs is more appropriate that than of GP.

There is a mixed economy currently around physiotherapists being based already within GP practices (e.g. Newton Stewart, Lockerbie, Thornhill and Annan) and immediately adjacent to practices (Langholm, Stranraer, Kirkcudbright) and so in many cases we are ideally positioned to support. There have been initial conversations regarding potential models to support Waverley and Moffat GP practice groups as they have come into staffing challenges but these have not been able to progress due to lack of funding.

Whilst the concept does not require proof, there is a need to contextualise this in Dumfries & Galloway given our favourable waiting times. At this point, it is not yet known how much the two cohorts of patient flow overlap and therefore the potential impact. We are currently working towards testing this approach in Annan. It is anticipated that this test will come to fruition in Year 1.

National modelling is currently underway as to the workforce required to support and shift to physiotherapists as first point of contact within GP practice. This will include the recommended numbers and grades by population size and an understanding of the supply chain for developing these posts. It could be that within Dumfries and Galloway we could require 7-8 senior positions across the region and that would outstrip current resource.

Wider Clinical Roles

There are a range of other roles as part of the MDT that can offer high quality care as part of a comprehensive and person-centre service.

Healthcare Scientists

Healthcare scientists are collectively responsible for over 80% or all clinical diagnoses. This workforce covers over 50 different scientific specialities and is the specialist workforce in the health system that responds directly and uniquely to advancing scientific and technological changes.

A more holistic approach to treatment pathways could see scientists integrated into patient pathways and working in MDTs as part of a whole systems approach. The ability to support patients with complex needs at home will increasingly rely on the use of networked medical technology supported by Medical Physics and Clinical Engineering services in collaboration with eHealth. Clinical Engineering services are already experienced in supporting equipment, such as portable ventilators and assistive technology, in the community and this expertise can be utilised to allow the roll out of other medical equipment for use in the non-hospital settings in a safe, controlled manner.

Healthcare Scientists can contribute to reducing out-patient attendance such as for Audiology, Cardiac Physiology and Respiratory Physiology where what are typically “routine” out-patient attendances for investigation and rehabilitation can be delivered in local setting e.g. community hospital type setting. Pharmacists and healthcare scientists are working together to develop models of point of care testing in community treatment centres.

Dieticians

Dieticians can now train as supplementary prescribers and have the skills and knowledge to help manage conditions such as irritable bowel syndrome, reducing referral to secondary care and improving symptoms for 70% of people, type 2 diabetes and food intolerance conditions.

Occupational Therapists

Occupational Therapists (OTs), working as first point of contact practitioners in general practice, are providing quick access to early assessment and intervention for people with emerging mental health problems. When required the therapist can signpost and refer to third sectors and other healthcare professionals as appropriate.

OTs have particular expertise in helping people who are frail or have long term conditions. The benefits of this role include enabling independence and social inclusion; preventing deterioration; and minimising crisis situations, thus reducing demand on GP practices and acute admissions.

Podiatrists

A fully integrated primary care podiatry service can safely diagnose, manage, rehabilitate, and prevent disease related complications of the feet, ankles and lower limbs, particularly around MSK, diabetes, rheumatoid conditions and peripheral arterial disease. They also have a significant role in the public health and prevention agenda specifically around falls prevention, cardiovascular risk reduction, medicines management and reconciliation, antibiotic stewardship and keeping people mobile and active.

Podiatrists have the ability to utilise advanced diagnostic techniques including imaging and can prescribe independently, for a range of lower limb conditions. As the experts in lower limb health and disease, podiatrists have the requisite knowledge, skills and training to work as first point of contact practitioners in primary care.

Speech and Language Therapists

Speech and language therapists have the specialist knowledge and skills to diagnose directly assess and support problems in relation to communication, safe eating, drinking and swallowing. The assessment and management of eating, drinking and swallowing problems has an important role in to prevent malnutrition and dehydration, reduction in the risk of repeated chest infections, urinary tract infections and falls.

SERVICE 6 – COMMUNITY LINK WORKERS

Overview

A Community Link Worker (CLW) is a generalist practitioner based in, or aligned to, a GP practice or cluster who works directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of, for example, the complexity of their conditions, issues of rurality, or assistance with welfare.

In their manifesto, the Scottish Government committed to deliver 250 CLWs across Scotland over the life of the Parliament.

The 2018 GMS contract makes it clear that the roles of the CLWs must be consistent with assessed local need and priorities and function as part of the local models/systems of care and support. As this is intended to be one of the ways in which local systems tackle health inequalities, the expectation is therefore that the first priority for CLWs will be in more deprived areas.

Current Work in Dumfries & Galloway

There is currently a review underway in Dumfries & Galloway which will result in the development of a regional strategic framework to define social prescribing/community link workers as an underpinning early intervention approach to improving population health and wellbeing outcomes.

The purpose of this framework will be to establish a regional approach to community link working to ensure consistency of models and delivery. This will also establish community link workers as a first line approach to promoting health and wellbeing.

This approach has the following objectives:

- Working to a common Community Link Approach
- To build closer working relationships with services that provide community linking support
- To build closer working relationships with Health & Social Care services so that they make best use of the Community Link Resource

There are currently a variety of community link models and approaches within the region and there is a need to develop a unified overarching approach that encompasses both 1-1 community link support as well as wider contextual factors such as community development.

Growing evidence demonstrates that community link is an early intervention approach that can be used to achieve population health and wellbeing outcomes. The term is used to describe the connecting of people to non-medical sources of support within the community including cultural activities, green space, debt advice, physical activity and leisure and learning opportunities. Connecting people with sources of support can potentially lead to improvements in levels of mental wellbeing, greater sense of control, ability to cope with life, increased confidence and reduced loneliness. Evidence also suggests that community link has the potential to alleviate the number of frequent attendances at primary care services and reduce the potential need for prescriptions for anti-depressants[17].

Community link workers as a concept in Dumfries & Galloway was originally taken forward as a 'test of change' project as part of the Putting You First change programme starting in 2012. Currently there are several projects utilising community link approaches within each of the four localities (such as the Community Link Workers in Annandale & Eskdale and Healthy Connections in Stewartry, Nithsdale and Wigtownshire). Each project has developed with a variance in referral routes, staff grading and evaluation and monitoring systems.

At the local Health and Social Care Senior Management Team meeting in January 2017, a paper entitled "Developing our Approach to Supporting People's Health and Wellbeing was presented. This provided a proposal for a project to explore the types of 1:1 interventions being delivered by Locality Health and Wellbeing Teams across the region. This work, led by public health, involved reviewing current social prescribing/community link style interventions as well as more intensive behaviour change interventions, both of which have a focus on personal goals and outcomes. Following on from this initial scoping exercise, the competence and training needs of staff have been identified and the development of a standardised training plan is underway.

External funding has been achieved to test out additional community link models as part of cross-border EU funded projects – CoH-Sync (Dumfries and Stranraer) and MPower (Wigtownshire locality). CoH-Sync will involve third sector organisations taking forward a health facilitation model with links to community resources, whilst MPower is led by NHS 24 to enable the older population to enhance their health and wellbeing through developing wellbeing plans that will link to community sources of support and technological interventions. The two funding streams present opportunities to further test out community link approaches and embed the concept further within health and social care delivery and within the community as a whole.

[17] Mossabir et al (2014) A scoping review to understand the effectiveness of linking schemes from healthcare providers to community resources to improve the health and well-being of people with long-term conditions, Health and Social Care in the Community, doi: 10.1111/hsc.12176

In addition, community link is an important approach to the self management of mental health and wellbeing. It is based on a clear rationale that supporting people to access and use non-medical sources of support can help address poor mental health and contribute to improved mental health. Locally, community link has the potential to be defined as an early intervention to complement traditional mental health service delivery.

It is recognised that community link cannot be taken forward as a standalone entity. There is a need to ensure connections with community development approaches, in particular developing the capacity of community organisations to deliver effective activities and interventions for signposting purposes. Other further considerations include wider workforce development issues and technology innovations.

There is a need to develop a regional strategic framework that defines social prescribing/community link as an approach to addressing health inequalities within Dumfries & Galloway. This will provide a strategic overview of the motivations to invest in community link within the context of the region, the wider conditions required for community link practice such as wider workforce development, technology, use of community development and business models, but also the operational 1-1 delivery such as competency levels, supervision arrangements, training requirements and evaluation and monitoring tools that have been explored as part of the 'Developing our Approach to Supporting Health & Wellbeing' project.

The Dumfries & Galloway Health and Wellbeing Public Health team in partnership with the Wigtownshire Health & Social Care Locality Manager will take a lead role in developing the framework with full collaboration with locality representatives and project stakeholders as appropriate.

SECTION E - ADDITIONAL CONTENT

This section will look at the following additional linked developments and priorities that form part of the Primary Care Improvement Plan for Dumfries & Galloway:

- Community Pharmacy
- Optometry
- Dentistry
- Community Services
- Interface with Acute Services
- Practice Sustainability
- Digital Health and Care

There is a need to have wider understanding around the open access services that other primary care contractors provide. This will be crucial as and when improved signposting mechanisms are developed which will allow better triage of calls within the GP surgery. This will require a consistent message across each locality. Each cluster needs to look at improving their knowledge around local networks of support with of aim of further multi-disciplinary working.

Community Pharmacy

Much of the linked work of Community Pharmacy was covered in Section D in the Pharmacotherapy section.

It is clear much more can be made of the Chronic Medication Services and Minor Ailment Scheme.

Optometry

Community eye care is a contractor service provided by optometrists and ophthalmic medical practitioners (OMPs). This has developed since the introduction of free eye examinations in 2006, to the service being the first port of call for people with eye problems, helping to detect eye diseases early.

Optometrists can become independent prescribers on completion of an additional professional qualification, which is part funded by NHS Education Scotland (NES). Independent prescribing optometrists are able to prescribe licensed medicine for conditions affecting the eye, and the tissues surrounding the eye, within their recognised area of expertise and competence.

More integrated care is being provided in local practices, with community optometry supporting pharmacy, GP, nursing, social care and third sector colleagues to help patients remain within primary care. The development of General Ophthalmic Services (GOS) to support community eye care has reduced the burden on GPs and has allowed more patients to be discharged from the hospital eye service. Age is the greatest risk factor for developing eye conditions, and training is being developed to enable safe and high quality community care for patients with long-term ophthalmic conditions.

The Community Eyecare Services Review was commissioned by the Cabinet Secretary for Health & Sport in 2016 to consider and evaluate community eyecare services currently provided across Scotland, and identify examples of good practice that could be replicated on a national basis. The Review also forms part of the Health and Social Care Delivery Plan. The Review made a number of recommendations, including schemes to reduce geographical differences in services, more tailored arrangements for patients with specific complex needs to support care closer to home and suggested that some eye services traditionally offered in hospitals (such as post-cataract surgery appointments and managing stable glaucoma) should be made available locally. The Scottish Government is in the process of implementing the recommendations of the Review, including the development of the new GOS regulations, and is engaging with a range of stakeholders, including health professionals and patients.

Dentistry

The 2016 dental workforce examined supply and demand for services based on several contributory factors including uptake of services, population projections, changes in demography, country of qualification of the dentists and the years spent in the service post qualification.

On the current trajectory, the Scottish dentist workforce will exceed the needs of the projected Scottish population by 2026. To help counter this potential future over supply of dentists, there has been a reduction in the dental school in-take of Scottish, Rest of the UK and EU dental students to 135 per year. The impact of this reduction will begin from June 2018 onwards.

However, when planning the dentist workforce, it is necessary to consider the make-up of the workforce going forward, in particular the number of EU dentists and the possible impact that Brexit may have. Primary care dental services in remote and rural areas like parts of Dumfries & Galloway have a higher non-UK dentist workforce, made up of EU and international dentists. These areas would potentially feel the effects of any Brexit impact more acutely than other parts of the country.

Dentists wishing to provide NHS General Dental Services in Scotland, unless otherwise exempt, have to complete a vocational training (VT) period of one year duration. Three quarters of dentists who started working in Scotland after finishing VT in the UK were still in NHS Scotland six years later. If, however, they entered NHS Scotland from the EEA only 46% remained after six years. After 10 years more than half of vocational dental practitioners stayed in NHS Scotland. Currently approximately 10% of GDPs in Scotland qualified in the EEA but in recent years there is the beginning of a trend of these numbers reducing. Since the distribution of EEA dentists is skewed towards remote and rural areas, this is a concern for the future.

In relation to oral health, the dental workforce consists of dentists working alongside dental care professionals, i.e. dental nurses, hygienists, therapists, dental technicians, clinical dental technicians and orthodontic therapists. As oral health improves particularly amongst the younger generation, the dental needs of patients will change, focusing more on prevention. There will take several generations to work through and the dental workforce will require to be sufficiently flexible to meet the differing requirements. At the other end of the age spectrum with an increase in the number of frail, elderly patients retaining their natural teeth, other challenges are emerging for clinicians in providing care for frail people, often in the patient's place of residence.

Community Services

Existing community services are already well aligned with GP practices and communities. The relative rurality of the geography in Dumfries & Galloway makes this alignment more straightforward in as much as each area is generally covered by no more than 2 practices at present. There are critical interfaces between all community services and GP practices and there is a need to spend some time understanding for each how things might improve or change through the opportunities presented.

This will best be captured with protected time for each team to discuss the plan for the future from the supported environment of their existing arrangements but will need also to bring the bigger locality view. This development work provides a tremendous opportunity for effective team building and service improvement. This should include Social Services and possibly local Third Sector agencies.

Interface with Acute Services

Interface with acute services – this has sadly fallen by the wayside. There needs to be an investment in time and energy to try and recreate the previous collegiate feel across all health sectors. Eating together helps working together.

The links with acute hospital care, referrals and investigations again requires some exploration in relation to the possible changes in team configuration. Other members of staff will want to have privileges to admit and refer patients without the need for the GP to intervene. Some general agreement regionally on how this should evolve would be helpful. While it is inevitable that there will be variation in what services practices can access in the community at any one time, it is important for consistency that interfaces with other parts of the service are reasonably standardised to avoid confusion.

GP Sustainability

The local GP sustainability group started to look at General Practice Improvement Programme (GPIP) last year to support the local GP sustainability agenda.

GPIP provides fast, practical, practice improvements to help reduce pressures and release efficiencies within General Practice. It is a rapid improvement modular programme over a 3 month period and supports sustainability through productivity gains. As well as providing a range of consistent workplace improvement processes across practices, it also supports collaborative working. Testing has shown that by focussing on some key workload areas practices have released significant GP consultation time, administration time and improved the running of practices and patient outcomes.

The Board has provided funding to support practices that have immediate high risk to future sustainability. Funding has secured a fully facilitated programme and will start with a group based session on 24/4/18 for 6 practices in the Wigtownshire locality.

We are still deciding how we can seek to benefit from the Practice Administrative Staff Collaborative (PASC) work being undertaken by the Scottish Government with a small selection of HSCPs.

Digital Health and Care

The Scottish Government's Digital Health and Care Strategy[18], published in April 2018, brings together telecare, telehealth and eHealth under the term digital health and care.

Telecare is support and assistance provided by remote monitoring and emergency alarms to support vulnerable people to live independently. Telehealth is the remote exchange of data between a person at home and their clinician to assist in diagnostics and monitoring. Telehealth is predominately used to support people with long term conditions. eHealth is the use of information, computers and telecommunications to support people and their health.

One of the ten priority areas of focus in the Dumfries and Galloway Health and Social Care Strategic Plan (2016 - 2019)[19] is making the best use of technology. Digital technology is a key driver to delivering excellent health and social care and has the potential to build capacity within existing services and transform primary care through the promotion of supported self management.

The first video consultations within primary care using NHS Attend Anywhere have already taken place in the region. Two GP practices are already using the system to support Care Homes and people in their own homes and further practices have registered their interest in adopting the system to support patients and Community Hospitals. The OOH Service is planning to test Attend Anywhere between its service bases and Community Hospitals during summer 2018.

The Health and Social Care Partnership has procured the Florence Home and Mobile Health Monitoring (HMHM) system and is providing support to services to make best use of the opportunities that this can offer. As part of the National TEC Programme, the region's GP practices will be invited to participate in a regional test of change with NHS Ayrshire and Arran around diagnosis and management of Hypertension with patients being registered on Florence.

[18] Available at: http://www.gov.scot/Publications/2018/04/3526

[19] Available at: http://www.dg-change.org.uk/our-vision-and-plan/

Through the Primary Care Digital Services Project, the Scottish Government has committed to the 'development of a website solution for every GP Practice in Scotland, offered free of charge, which increases patient access to primary care digital services, online self management and signposting to local services'. In Dumfries and Galloway the Moffat High Street Surgery website (www.moffatdoctors.co.uk) has been redeveloped to promote the digital services available for people to access self care information and promote self management. The site was designed as a 'blueprint' that would enable other GP Practices to easily adopt the layout and content areas to promote national digital tools and services.

The aforementioned services could be combined to offer virtual services through primary care. An example of this could be a Virtual GP Practice that is accessed online through a website. Staff that support the virtual Practice can be located anywhere within or out with the region and would have access to patients records and readings sent in through supported self-management using HMHM.

The challenges we face continue to be the inequality in internet connection speeds across the region and the demographics of our population in rural areas but national initiatives to promote basic digital skills and reduce social isolation are already providing support to address these barriers.

SECTION F - INEQUALITIES

Health inequalities are linked to a range of factors that are complex and interrelated. For example, genetic factors and poor housing can have a major effect on a individual's health over time, and issues can be exacerbated by behaviours such as poor diet, smoking, sedentary behaviour and alcohol misuse. Public services in Scotland can address some of these factors, for example by improving social housing or access to sports and community facilities. Broader UK and global factors, such as levels of economic growth also play a significant role.

Better addressing health inequalities therefore requires continued action beyond primary care but the primary care workforce does have a significant role in focusing activity on prevention, anticipatory care planning and managing complex care to improve patient outcomes. A key aim of the new GMS contract is to focus GP time on complex care as an Expert Medical Generalist, whilst continuing to build capacity in the wider multi-disciplinary team. As patients living in the most deprived areas experience higher levels of ill health earlier in their lives, enabling GPs to address complex care will benefit those patients with greatest clinical need.

A significant proportion of consultations with GPs in areas of very high deprivation are due to experiences of social adversity, especially poverty and financial problems. This can place additional pressures on practices, whose primary aim is to address the clinical needs of their patient population. The Scottish Government have committed to recruiting 250 community link workers by the end of this parliament. The roles of the CLWs will be consistent with assessed local need and priorities. CLWs are one of the ways in which local systems can tackle health inequalities, and it therefore follows that the first priority for CLWs will be more deprived areas.

Services are currently resourced in a way which results in an uneven distribution of care. This is often as much to do with luck as with planning. In any evolving system, there will be different paces of change and we have to accept this as the norm. Critically, the locality should have a shared vision and an agreed plan which supports the delivery of service so long as it is sustainable. Project developments are worthwhile as they allow for the testing of differing approaches but we need robust evaluation and a fairly brutal approach to stopping things not considered to be worthwhile. Equally something that is considered a success needs to be rolled out with the minimum of fuss.

Health and social inequalities have always existed across Dumfries & Galloway and while some parts of the region have obvious recognisable levels of deprivation which register on the normal national measures, there are also pockets of rural deprivation which are far less visible. For example, there are specific needs potentially associated with the population of European citizens who often lack language skills and struggle with negotiating their way through the health and social care system.

There can be particular challenges in recruiting and retaining GPs, nurses, pharmacists, AHPs (particularly paramedics) and other clinical staff in remote and rural areas. Working in rural areas, especially very remote areas can be significantly different from working in more urban areas – e.g. relatively limited options to develop careers, access to updating professional skills, difficulty in meeting employment needs of spouses and partners etc. This is coupled with the often dispersed nature of the practice population, the potential difficulty in recruiting locum cover, wider expectations of the role of health and social care professionals, and the (lack of) availability of other support services such as Care Homes, palliative care etc.

Clinical staff working in these remote areas often need to have a wider or different range of skills to meet the needs of the local population. We must therefore ensure that the workforce that is developed has the appropriate skills and experience to work in our remote and rural areas. This includes supporting professionals working in these areas and ensuring such roles are attractive and rewarding.

The skills required of these new multi-disciplinary teams will be different in each area depending on local need.

The Scottish Government and BMA have committed to setting up a Rural Short Life Working Group which will support the implementation of the new GP Contract in rural areas, both in the short and longer term, and support the sustainability of remote and rural practices, in particular for very small practices in remote areas.

This will work alongside a Dispensing Short Life Working Group which will look at the needs of dispensing practices in Scotland, including workforce development and training needs especially for non-clinical dispensing staff, and the role of pharmacists to support dispensing practices.

The Scottish Government will also continue to fund the Scottish Rural Medical Collaborative to take forward looking at the recruitment, retention and training needs of primary care staff working in rural Scotland.

Section H – Enablers

The Memorandum of Understanding identifies three key enablers for change:

- Premises
- Information Sharing Agreements
- Workforce

This section will look at each of these in turn and explore the opportunities to leverage these enablers to improve primary care services in Dumfries & Galloway.

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 the risk of owning premises away from individual GPs to the Scottish Government.

A wider local review of how the local buildings can be used to support teams is required as a matter of priority. However it is recognised that it will be helpful to have a more comprehensive understanding of the service needs before accommodation requirements are fully defined. It is important that the buildings are not driving the service delivery model if at all possible.

The buildings review process requires to take place as soon as possible so there can be clarity around accommodating an extended primary care team in a way that fosters good team working and positive development.

Information Sharing Agreements

The Information Commissioner's Office (ICO) has issued a statement which states that whilst they had previously considered GPs to be sole data controllers of their patient records, they accept that from 1st April 2018 that GPs and their contracting Health Boards have joint data controller responsibilities towards the GP patient record. The contract will clarify the limits of GPs responsibilities and GPs will not be exposed to liabilities relating to data out with their meaningful control.

The new contractual provisions will lay the foundations for increased lawful, proactive and appropriate sharing of information amongst professionals working within the health and social care system for the purposes of patient care.

The E-Health strategy is currently being revised nationally. There requires to be some local reflection on the outcomes of this review locally once this has been made available. There are multiple challenges around the integrated working of these new multi-disciplinary teams (for example data sharing consent systems and security) and the practicalities of mobile working which are critical for the provision of a community based service.

Work is already underway to support practices with new General Data Protection Regulation effective from 25 May 2018 and further collaborative work with Practice Managers is planned.

Workforce

The National Health and Social Care Workforce Plan, Part 3 Primary Care was published in May 2018. It sets out the context and arrangements for increasing the Scottish GP and related primary care workforce. This includes plans for recruitment, training and development of specific professional groups and roles with the MDTs to be developed.

The First Minister announced in October 2016 an increase in funding in primary care of £500 million by the end of this Parliament. This investment will see at least half of frontline NHS spending going to community health services and will allow for the expansion of the primary care multi-disciplinary workforce. Across Scotland, This includes training an additional 500 advanced nurse practitioners across acute and primary care, 250 more community link workers in practices by the end of the parliamentary period to address patients' wider needs, training an additional 1,000 paramedics to work in support of general practice, the expansion of the mental health workforce, and enhanced roles for Allied Health Professionals (AHPs) in delivering person-centred care. General practice will further be supported by ensuring all practices are given access to a pharmacist by the end of this parliamentary period.

As part of their role as EMGs, GPs will act as senior clinical leaders within the extended MDT. Many of the MDT staff 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 within a cluster area. Workforce arrangements will be determined locally and agreed as part of the ongoing developing of the Primary Care Improvement Plan for Dumfries & Galloway.

Existing practice staff will continue to be employed by practices. Practice Managers, receptionists and other practice staff will continue to have important roles in

supporting the development and delivery of local services. Practice 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.

Our staff teams and our communities are the most important resources in this Primary Care Transformation programme. We need to support a localised approach to engaging with them to help them understand what the changes will mean, what their role is in delivering change and what ideas they have about making the service successful and sustainable. While a high level regional strategy will help set the direction, there is no substitute for this direct engagement with teams which we have endeavoured to do in the locality over the last 2 years. The resource to support this work has been very limited and thus the impact and level of engagement has been similarly limited as a result. However it is hoped that with a new Programme Manager now in post and with the initial Primary Care Improvement Plan being submitted in early July, there will be increased scope going forward for a significantly increased level of engagement as the updated plan is developed for the next iteration which will be available in early 2019.

The model of integrated working that is being developed is all about people and behaviours. There are significant challenges with the acute sector feeling increasingly remote to primary care. In many ways, primary care is closer to social work. It will be necessary to grow the alternative community based care before patients can be passed there from an acute hospital setting. This change will require a long term commitment and the planning and sustaining of community based care and support.

It will become increasingly necessary to support a culture of improvement around the Primary Care Transformation Programme. Quality and safety must be underpinned by clinical and care governance and this must be at the heart of everything we do. This kind of culture change only grows upwards from the teams on the ground. Trying to impose this risks attracting significant resistance. The message from our localities is that this must be supported as close to the front line as possible.

Initiatives to support practices with recruitment difficulties also requires to be a key focus. As an area, we need to be increasingly creative about how we attract people to live and work in Dumfries and Galloway. We know that some practices will be able to do this well whilst others will have significant difficulties with this. Across the region, we need to explore further how co-operation between practices can be encouraged.

As a partnership, we need to look very creatively at how we support practices knowing that recruitment into GP is very challenging. We know that some will be able to do this without any trouble when others will never manage. We have to explore how we encourage co-operation between practices and make the incentives palpable.

The National Health and Social Care Workforce Plan proposes the following recommendations and next steps that will improve primary care workforce planning in Scotland. These complement the recommendations in Part One and Part Two of the National Health and Social Care Workforce Plan and, taken together, will form the basis of the integrated workforce plan in 2018. The recommendations set out below explain how the expansion and up-skilling of the primary care workforce will be enabled, the national facilitators to enable this, and how this will complement local workforce planning.

Facilitating Primary Care Reform

1. Reform of primary care is driven by developing multidisciplinary capacity across Scotland. Workforce planners including NHS Boards, Integration Authorities and General Practices will need to consider the configuration of local MDTs that offer high quality, person-centred care.
2. In recognition of an ageing workforce, local planners have responsibility for workforce planning and managing anticipated levels of staff turnover
3. The implementation of the new GP contract will require services to be reconfigured to maximise workforce competencies and capabilities, and ensure people see the right person, at the right time and in the right place.
4. The National Workforce Planning Group will play a strategic role in implementing the recommendations of part three of the plan, and strengthen the development of approaches for the primary care workforce.
5. An integrated workforce plan to be published later in 2018 will move towards a better articulated joint vision for health and social care workforce planning.

Building Primary Care Workforce Capability

Recommendations and commitments

6. Significant investment will be made available over the next 3-5 years, as part of the First Minister's commitment to an additional £500 million for community health service, to plan for, recruit and support a workforce in general practice, primary care and wider community health, including community nursing.
7. Scotland's multidisciplinary primary care workforce will become more fully developed and equipped, building capacity and extending roles for a range of professionals, enabling those professionals to address communities' primary healthcare needs.

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

Improving data, intelligence and infrastructure in primary care

Recommendations and commitments

9. More integrated workforce data for primary care is required, in the context of the workforce data platform being developed by NHS Education for Scotland.
10. Local planners should consider workforce planning tools (such as the six step methodology) in developing their workforce strategies to address local population needs.
11. Planning for future staffing in primary care should identify and make use of available guidance and intelligence on local recruitment and retention issues, and of wider developments in workforce data and scenario planning.
12. The Scottish Government will publish the Primary Care Monitoring and Evaluation Strategy 2018-2028 by summer 2018.

Part Three of the Workforce Plan also sets out the diverse nature of the workforce needed to deliver service reconfiguration in primary care. This is clearly illustrated in the table overleaf:

Service	Description of Service	Workforce
Pharmacotherapy	By April 2021, every practice will benefit from the pharmacotherapy service delivering the core elements of the service including acute and repeat prescribing, medicines reconciliation and monitoring of high risk medicines. Additional elements of this service include medication and poly pharmacy reviews and specialist clinics. This will form part of a three-tier approach to developing pharmacy services to support GP practices.	Pharmacists and pharmacy technicians
Vaccination Transformation Programme	Responsibility for vaccination and immunisation services will move from general practices to IAs and NHS Boards through the Transforming Vaccination Programme.	Nurses, other appropriate clinical professionals and healthcare assistants.
Urgent Care Services (advanced practitioner)	Providing sustainable advanced practitioner support for unscheduled care, based on appropriate local service design. Advance practitioners 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.	Paramedics, nurses where appropriate
Community Treatment and Care Services	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	Nurses and healthcare assistants

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. For example, but not limited to: • Musculoskeletal focused physiotherapy services • Community clinical mental health professionals (e.g. nurses, occupational therapists, psychologists) directly working in general practice	Musculoskeletal Physiotherapists and Community Mental Health Practitioners
Community Link Workers	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 PCIP, IAs will develop CLW roles in line with the Scottish Government 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.	Non-clinical staff providing support and connection, based in practices or groups or practices.

The next section of the Primary Care Improvement Plan for Dumfries & Galloway focuses on the plans for implementation, the process for engaging with clusters and practices, leadership and change management capacity and support for the multi-disciplinary team development.

SECTION H - IMPLEMENTATION

GP Clusters and Practices

In January 2017, the Scottish Government published Improving Together, a National Framework for Quality and GP Cluster in Scotland[20]. GP clusters are typically groups of between 5 to 8 GP practices in a close geographical location. The purpose of clusters is to encourage GPs to engage in quality improvement activity with their peers, and to contribute to the oversight and development of their local healthcare system. Each GP practice has a nominated Practice Quality Lead (PQL) and each cluster has a Cluster Quality Lead (CQL). Healthcare Improvement Scotland (HIS) is developing the required educational and quality improvement support to embed continuous quality improvement in primary care. The aim of the work is to:

- Support GPs to care for their patients and to better address the health needs of their local communities
- Reduce primary care health inequalities and contribute to improving people's health
- Improve patient experience of primary care through the local delivery of care by a range of health professionals (e.g. GPs, nurses, AHPs, pharmacists, dentists);
- To develop a network of Quality Improvement leads to support and embed continuous quality improvement in primary care

When appropriate, it is expected that integrated MDTs will support and be shared across clusters depending on priorities identified by local planners including cluster leads. The role of Local Intelligence Support Team (LIST) analysts has been expanded to support GP Clusters with the data, evidence and intelligence required to drive quality improvement. Public health professionals also have a clear role to play in advising on approaches to addressing local need and providing evidence on effective population health initiatives.

Locally the four cluster teams in Dumfries & Galloway are currently working together to regularly discuss the implementation of the 2018 GMS contract. The focus is around how clusters or small groups of practice can work together and share additional staff resource and considering how best these individuals can be deployed and accommodated. Local Regional Cluster events continue to allow for further shared discussion across cluster groups.

[20] Available here: http://www.gov.scot/Publications/2017/01/7911

Leadership & Change Management Capacity & Support

The locality based support for this significant transformation programme has been identified by the locality managers as insufficient at present. This clearly requires further development. Cluster teams feel that this facilitation needs to be embedded in the locality team and be able to feel very much part of the cluster/locality entity. This will allow for the building of credibility and a sensitivity to local issues and politics which may require delicate handling. This is a longitudinal programme which needs leadership and development expertise over the entire 3-4 year period of phase one. An early commitment is required on this level of local support.

Multi-disciplinary Team Development

Individual practices and GP Cluster group are currently spending time considering how together they might be able to support the development of a more integrated and extended primary care team.

There is already a great deal of work currently underway in the localities that support the primary care transformation agenda. Practices are being supported by the One Teams, rapid response services which are now available in some localities. There is also ongoing work with Community Link Workers across the localities. Struggling practices are being given additional pharmacist support.

Some localities have begun to develop a locality based plan for the Primary Care Transformation Programme. This reflects a need to try and support all practices were possible and at the same time optimise the opportunity to train and support a new workforce within the environment where they will ultimately be placed and integrate with their ongoing clinical support. It is clear with clusters of smaller practices that many of the additional resource in terms of people will be shared between them and this will require some discussion about how that service may be provided. In the future we need to continue to build on the current work and positive discussions around priority identification to ensure that GP practices and clusters link with locality team staff more closely along with the work taking place as part of the Primary Care Transformation Programme.

There is also a need to explore more sensitively how practices can support each other, particularly where those that are failing struggle with the need to transform their services and business model.

Non Clinical Staff

Primary care transformation presents an opportunity to consider how non-clinical staff (practice managers and receptionists) can be up-skilled to help coordinate care as part of a wider MDT.

Practice Managers have a key role in ensuring the smooth and efficient day to day running of General Practices and the long term strategic management and co-ordination of primary care, including supporting the development of the MDT as set out in the new contract.

With the introduction of the 2018 contract, the need for practice managers with wide ranging, adaptable and versatile skills is going to increase as general practice and primary care becomes a more complex landscape. In addition to continuing to manage the practice employed practice team and dealing with other practice based issues, their role working with external stakeholders including GP clusters, health boards and HSCPs is going to develop and expand. Working closely with the developing services such as Vaccinations and Community Care and Treatment Services and other members of the MDT that will be working in the practice or with the practice team will be vital. Co-ordination and communication with these new services will be crucially important across a range of issues including access to IT systems and supporting patients to access services.

Practice managers therefore require a wide range of skills including financial management, IT management, HR management, contract management, leadership and facilitation, Quality Improvement skills, change management, communication and patient engagement skills. Following the announcement in May 2017 of £500,000 investment in the development of practice managers and practice receptionists, work is on-going with NES to work with Practice Managers to identify their training needs for the future, and make sure those needs are met over the next few years. Career development and succession planning is also going to be important for the profession going forward and is also being considered.

Alongside the changing role of Practice Mangers, the role of receptionists and other non-clinical staff in the practice has also changed and developed and will continue to do so.

Practice receptionists have a challenging role, managing patients' requests and expectations, often in difficult circumstances. They play a vital role both now and in the future which needs to be recognised, valued and supported and developed. In some practices the title of Practice Receptionist is now considered to be outdated and does not fully reflect their role and there should be consideration of a revised job title in future. Opportunities such as developing and up skilling practice receptionists to carry out care navigation of patients in this increasingly complex primary care landscape or to increase their role in the management of practice documentation, is currently being developed with NHS Healthcare Improvement Scotland who will be

working with GP Clusters to develop training and resources to support this group of staff.

There is also a wide range of other practice administrative staff who carry out a variety of tasks depending on the needs of the practice from prescription management, medical secretarial skills, IT management including call and recall, documentation management, health and safety, finance management and healthcare assistant roles. These staff are a highly skilled and adaptable workforce who will continue to have an important role in the delivery of care by general practices. Strong leadership by Practice Managers supported by their teams and by the practice GPs is vital.

Future Opportunities with NHS 24

NHS 24's 111 service is at the forefront of delivering sage and effective urgent care and support to the public when GP practices are closed. As a national organisation, NHS 24 has a unique opportunity through its infrastructure to align itself more closely with primary care, social care and voluntary and independent sectors, in response to key drivers including Health and Social Care Integration, primary care transformation and national strategies such as the National Clinical Strategy. It is anticipated that over the next 5 years, to support the programme of development, an additional 371 WTE staff will require to be recruited. This represents an increase of approximately 40% of NHS 24's existing workforce. The majority of the resource requirements, approximately 65%, are for non clinical staff, call handlers in particular; however there will also be a requirement for NHS 24 to grow its requirement for clinical staff, including more nurse practitioners and allied health professionals. With these additional staff in place, we would expect NHS 24 to work with HSCPs to set out what support NHS 24 can offer at a local level, including the triage of patients to general practice or to self management pathways as part of the primary care improvement plans.

The next section of the Primary Care Improvement Plan for Dumfries & Galloway looks at the Funding Profile for the Primary Care Transformation.

SECTION I – FUNDING PROFILE

KATY LEWIS CURRENTLY FINALISISING THE FUNDING PROFILE SECTION – IT WILL BE CIRCULATED AS SOON AS IT IS COMPLETED.

SECTION J - EVALUATION AND OUTCOMES

The importance of good quality and timely data and the capacity to use it to drive the reform of primary care and quality improvement cannot be under-estimated. Across primary care, there is a need to strengthen the primary care data collected, and it will be important to ensure that the right healthcare professionals have the right access to the right data at the right time in order to improve patient outcomes. A significant programme of work is currently being rolled-out nationally ensuring there is sufficient investment to enable consistent, high quality and reliable data to be sourced, managed and utilised appropriately.

The continuing reform of primary care is challenging and will take time. Expectations will require to be managed around the changes we expect to see and when. An ability to be responsive to changing circumstances also requires to evolve. The Scottish Government will publish a 10 year National Monitoring and Evaluating Strategy for Primary Care, which has been developed in partnership with NHS Health Scotland, by summer 2018. The Scottish Government are also working with partners to develop a set of national indicators to track progress.

This piece of work will clearly inform the local plans for the development of Key Success Indicators over the Primary Care Transformation Programme's 3 year development.

There are some real opportunities here but we just need to be clear what questions we want answered. Questions around what success might look like in our local communities should be part of the ongoing engagement process across all staff, service users, partners and stakeholders.

For example, Part Three of the Workforce Plan outlines some of the benefits of the Primary Care Transformation Programme as follows:

- Half of cancers, three-quarters of cardiovascular disease and 80% of strokes are preventable. More systematic primary prevention in primary care therefore has the potential to improve health outcomes and has been shown to be cost effective[21].

- Lifestyle behaviours (such as smoking, diet, obesity and alcohol consumption) are driving non-communicable disease clusters, particularly in our most deprived communities, contributing to a legacy of health inequalities.

[21] Health England (2009). Intervention Reports: Report no 5.

- Systematic and scaled-up secondary prevention – for example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure – has been found to be cost-effective, clinically significant and an important way to tackle inequalities in health[22].

- Improved access to primary and social care services could lead to a reduction in 'social admissions' – admissions based not on the severity of a patient's clinical condition but on their ability to cope without appropriate support unless admitted, or if discharged. Social admissions and delayed discharges pose significant issues for hospitals, with up to 40% of admissions of elderly patients who have attended A&E shown to be avoidable[23].

- Improved access to in and out of hours primary care has the potential to reduce demand for A&E attendances and unnecessary ambulance call outs.

- In the medium term, an enhanced primary care workforce could support patients to take a more pro-active approach to managing their conditions, leading to an estimated 8% to 11% reduction in avoidable admissions[24].

The challenge will be in measuring these outcomes in a sensible and meaningful way.

In terms of local data collection and monitoring and evaluation, there is a large amount of work ongoing locally across Dumfries & Galloway. The following section provides further information.

Current Work around Data Monitoring & Evaluation

Discovery

Data available through the Discovery system is being reviewed and shared across primary care.

[22] Health England (2009). Intervention Reports. Report no 5.
[23] Deloitte (2014) Spend to save: The Economic Case for Improving Access to General Practice http://www.rcgp.org.uk/~/media/Files/PPF/2014-RCGP-Spend-to-Save-Deloitte-report.ashx, Royal College of General Practitioners
[24] Ibid

Scottish Primary Care Information Resource (SPIRE)

SPIRE is an integral part of the reform of primary care and is a crucial tool in enabling the emerging model of more collaborative multi-disciplinary primary care. By improving the management and usability of existing data within general practice records the introduction of SPIRE is an essential component of making GP clusters effective.

SPIRE is currently being rolled out across Scotland and will help practices provide patients with better care and services and help with the following:

- Analysing and streamlining practice workload, getting information on patient encounters , and analysing practice demographics
- Analysing the number of patients that have certain illnesses or looking at the medicines they are prescribed
- Monitoring and improving data quality
- Enabling GP clusters to work together to improve the quality of care
- Improve the provision of health and care to vulnerable or disadvantaged groups

SPIRE is seeking to fulfil GP contract data requirements from April 2018. In Dumfries & Galloway, visits have taken place to various GP practices to support them in the use of SPIRE for Government returns and audit purposes. This work is still under development.

Other data evaluation work

In Dumfries & Galloway work is on-going to support DGC Social Services to ensure data being submitted to SOURCE is fit for purpose. High Health Gain patient data is currently being issued quarterly to all GP practices by e-mail, with the intention that, later in 2018, this will be available online via the primary care information dashboard which is currently being developed. Work is also underway to agree a new AHP national data-set. Efforts are continuing to ensure that the data around GP Practice Sustainability is easily updateable and kept current. Finally, there is some work underway to develop a set of easily updatable Out of Hours activity indicators.

Workforce Data

The Primary Care Workforce Survey is designed to capture aggregate workforce information from Scottish GPs and NHS Board-run GP Out of Hours services. The survey provides information on GPs, registered nurses (including nurse practitioners) and other clinical staff employed by Scottish General Practices. It also collates data on vacancies, temporary cover for sessions/hours and out of hours commitments. The 2017 workforce survey was published in March 2018.

In recognition of the importance of reliable workforce data, it has been agreed with the BMA as part of the new GMS contract that, from 2018-19, practices will return data to NHS National Services Scotland. This will create a richer set of data to support local and national workforce planning and service improvement. Data is required across three broad areas:

- Workforce data for workforce planning and assessing practice sustainability. This is likely to be broadly in line with the information collected via the existing workforce survey but we will explore the potential of collecting these data on a quarterly basis.

- In order to prepare for Phase 2 of the GMS contract we need to fully understand the current expenses of running a GP practice, the income of salaried GPs and the income of GP partners as well as the hours worked by individual GPs. The Scottish Government and the BMA have agreed that all GP practices will be required to provide this data (earnings, expenses, working hours/sessions) in a similar way to the data already provided for pension purposes.

- Clinical quality and activity data to support GP cluster quality improvement, planning and service re-design

The need for robust data for ensuring continuity in high quality care applies equally to primary care services provided out-of-hours. This was acknowledged as one of the main recommendations in Sir Lewis Ritchie's National Review of Out of Hours Services report published in November 2015. Since the review's publication, work has been underway across all NHS Boards to improve the data collected and used within out-of-hours service, by upgrading the Adastra IT system. Once fully in place, this will ensure standardised use of the system across Scotland, allowing for consistent meaningful data to be collected.

The benefits of the system changes and the improved data collection are already being seen. NHS National Services Scotland is now reporting on primary care out-of-hours data. This data shows patient and workforce data for out of hours services, so allows Boards to plan and monitor how their service is delivered to ensure it is high quality and safe.

Local Intelligence Support Team (LIST)

LIST analysts have been successfully working locally with Health & Social Care Partnerships and others to help drive forward integration. The Scottish Government has provided additional funding from 2017-18 to expand the LIST service to work with primary care. This will support GP clusters and their focus on improvement following Improving Together: A National Framework for Quality and GP Clusters in Scotland.

LIST, part of NHS National Services Scotland, mainly comprises information analysts with the aim of adding capacity and capability to local expertise. The increasingly multi-disciplinary nature of the LIST team, with its connection to the national level resources in ISD and the ability to use national and local data, will help deliver an intelligence led service which is joined up across health and social care, including GP clusters. As of April 2018, LIST has grown to around 65 whole time equivalent staff. The team supports cluster and partnership working across Scotland.

Information Systems

The need to improve IT to help enable efficient and effective working has been fully recognised. NHS Boards have commissioned a procurement competition to provide the next generation of GP clinical IT systems in Scotland. This is being undertaken by NHS National Services Scotland. The new systems will be more intuitive and user friendly. They will be quicker and more efficient, with increased functionality. They will be underpinned by strong service levels and performance management, with clear lines of responsibility and accountability, providing, overall, a more professional GP IT services. All GP practices will transition to the new systems by 2020. Improved systems will go a long way towards making it easier to achieve a robust monitoring and evaluation approach to the Primary Care Transformation Programme.

SECTION K – NEXT STEPS

The development of this initial Primary Care Improvement Plan for Dumfries & Galloway represents the first step in a long journey which will take us to the end of March 2021 and beyond.

Given the very short period of time between the final allocation letters being issued (24th May) and the initial Primary Care Improvement Plan for Dumfries & Galloway having to be submitted to the Scottish Government on 1st July, it has not been possible at this stage to provide the level of detail about Year 1 plans that would have been liked at this stage.

Now there is clarity on the available funding for Year 1, cluster teams are analysing their current workload to determine how much of the existing work being done by GPs could be done by someone else. This analysis will allow clusters to aggregate this information and start to develop MDT models that will work across all practices within a cluster. Work will then be completed to identify priorities for delivery across the six priority areas for change for Year 1 for each cluster. It is hoped much of this analysis will take place in June and July 2018 so work can be taken forward as soon as possible.

This work will be used to inform the September submission of the Financial Reporting Template.

The Primary Care Improvement Plan will continue to evolve as the programme develops. It will be revisited at the time of the Financial Reporting Template submission in September with further updates being produced at least on a six monthly basis.