Appendix 1

Primary Care Transformation in Dumfries and Galloway Update

April 2023

Primary Care Transformation in Dumfries and Galloway
April 2023 Update
Table of Contents

SECTION 1 – INTRODUCTION

This update on the Primary Care Transformation Programme in Dumfries and Galloway aims to show the progress achieved to date by the Primary Care Transformation Programme in Dumfries and Galloway and sets out the expectation of the progress during the period January 2022 – April 2023.

The Primary Care Transformation Programme is the process by which the 2018 General Medical Services (GMS) Contract will be implemented in Dumfries and Galloway. The 2018 GMS Contract Framework[1] sets out the changes that are required to how GP services will be to ensure better care for our patients and the availability of sustainable healthcare services in our communities.

The Contract advocates the development of GPs as Expert Medical Generalists (EMGs), supported by a wider multi-disciplinary team (MDT) made up of a range of professionals including 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 issues such as premises, workforce and information sharing arrangements.

Across Dumfries and Galloway, the Health and Social Care Partnership is responsible for the strategic planning for the local population, including for primary care services. Within each of the four localities in Dumfries and Galloway (Wigtownshire, Stewartry, Dumfries and Nithsdale and Annandale and Eskdale), GP Cluster Groups have been established which bring together groups of GP practices with a focus on quality improvement and engagement with wider Health and Social Care Partnership structures with the aim of delivering service change and improvement. These four Cluster groups across Dumfries and Galloway have had a key role in the ongoing

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

development of the plan and will continue playing a key role as we move towards the full implementation of the GMS Contract.

This report will provide updates across all six current workstreams of the Primary Care Transformation Programme:

- Priority Area – Vaccination Transformation Programme
- Priority Area – Pharmacotherapy Services
- Priority Area – Community Treatment and Care Services
- Priority Area – Urgent Care
- Priority Area – Additional Professional Roles – Mental Health
- Priority Area – Additional Professional Roles – Physiotherapy
- Priority Area – Community Link Workers

The Dumfries and Galloway Health and Social Care Partnership view the Primary Care Transformation Programme as a fantastic opportunity to work collaboratively with the people of Dumfries and Galloway to shape the GP services of the future. This plan sets out a clear direction of travel for the period to December 2023.

SECTION 2 – AIMS AND PRIORITIES OF THE PRIMARY CARE TRANSFORMATION PROGRAMME IN DUMFRIES AND GALLOWAY

The local Primary Care Transformation Programme Board has agreed a Shared Vision for the Primary Care Transformation Programme for Dumfries and 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 and Galloway.

The Shared Vision for the Primary Care Transformation Programme also supports the shared vision of the Dumfries and Galloway Integration Joint Board within the IJB's Strategic Commissioning Plan:

> ***"People living happier, healthier lives in Dumfries and Galloway"***

It is acknowledged that 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 in Dumfries and Galloway 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 original Memorandum of Understanding[2] 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 and 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.

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

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

The 2018 General Medical Services Contract Framework[3] 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.

[3] 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 now and April 2023 will be on the wider development of the multi-disciplinary team services outlined in the priority areas for change set out in MOU2 – namely the Vaccination Transformation Programme, Pharmacotherapy and Community Treatment and Care. 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 first Memorandum of Understanding[4] outlined the priorities of the 2018 General Medical Services contract. The six workstreams defined are:

- **Vaccination Transformation Programme** - staged for types of vaccinations but fully in place by April 2023.

- **Pharmacotherapy Services** – made up, by April 2023, 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

- **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.

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

New staff will be employed predominantly by the NHS Board and work in models agreed between the Health and 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. However, noting specifically for the Community Treatment and Care Service some of those staff will be transferred across from Practices into the Board Managed Service.

SECTION 3 – DELIVERY OF COMMITMENTS IN THE MEMORANDUM OF UNDERSTANDING

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.

The development of Home Teams across Dumfries and Galloway also brings opportunities although it is recognised these require further significant conversation and development in order to maximise the benefits of these in relation to Primary Care working.

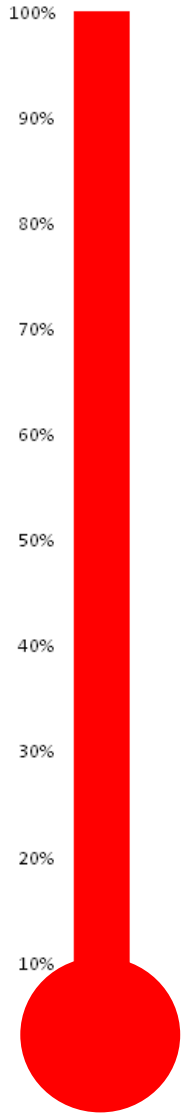
As outlined in the introduction to this Primary Care Improvement Plan, the Memorandum of Understanding defines 6 priority areas for change:

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

The following sections takes each of the six priority areas for change identified in the 2018 General Medical Services contract and sets out what has been achieved to date in the programme, current activity and what we hope to deliver by December 2023.

SERVICE 1
VACCINATION
TRANSFORMATION
PROGRAMME

100% Completed



Vaccination Transformation Programme - Introduction to Service Area

The Scottish Government announced a review of the delivery of vaccinations in Scotland in March 2017. The review has been prompted by a number of developments, including Primary Care Transformation and by the recent significant extension of the vaccination schedule. The Review will see a move away from the current practice of GP practice staff being the preferred provider of vaccinations towards these vaccinations being provided by NHS Board staff.

The Vaccination Transformation Programme (VTP) officially commenced on 1st April 2018. Between then and April 2021, there will be a phased process of service change in which models of delivery will be developed, tested and implemented based on a locally agreed plan.

Vaccination Transformation Programme - Service Specification

The Vaccination Transformation Programme is complex and involves the delivery of a range of vaccinations including:

- Routine infant and childhood vaccinations
- School-age vaccinations delivered in schools
- Adult vaccinations
- Vaccinations delivered to individuals on the basis of specific clinical need or identified risk factors (for example, people who are immunocompromised, Pertussis vaccination for pregnant women, at-risk influenza vaccinations).
- NHS funded travel vaccinations, diphtheria, polio and tetanus (combined booster), typhoid, hepatitis A and cholera, and those which are provided privately and from which the NHS may derive income.

Vaccination Transformation Programme - Service Aims

The main objectives of the Vaccination Transformation Programme have been defined as:

- To work with NHS Boards, Primary Care and others as necessary to develop and test proposals for future delivery of vaccination programmes, with a presumption that GPs / Primary Care will no longer be the default preferred provider

- To implement new models of delivery, based on local decision-making and leadership, and establish new operational arrangements as business as usual to successfully ensure any transformation in delivery is achieved without any adverse impact on safety or sustainability of existing vaccination programmes
- To ensure the necessary systems and infrastructure (e.g. IT, data and premises) are in place to support new models of delivery
- To ensure new models of delivery are sufficiently resourced

NHS Dumfries and Galloway will provide the full range of core immunisation programmes for all age groups. These will be provided in appropriate health care premises. NHS Dumfries and Galloway will become responsible for the call and recall of patients and the reporting of statistical information in relation to uptake to the Scottish Government.

Vaccination Transformation Programme - Summary of Activity to Date – NHS BOARD

All 32 practices have the following elements of the Vaccination Transformation Programme in place:

- Pre-school
- School age
- Out of Schedule
- Adult imms
- Adult flu
- Pregnancy

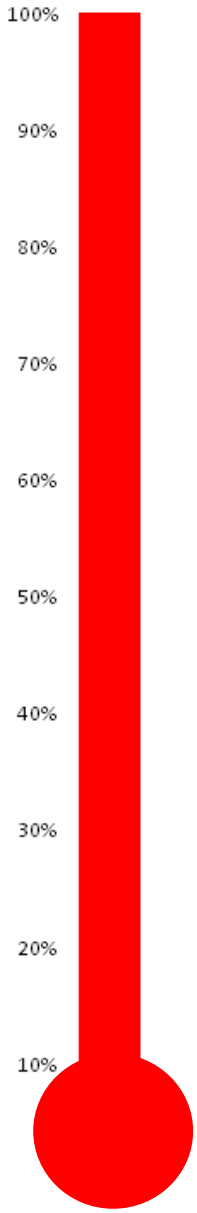
Vaccination Transformation Programme – Expected Progress for the Year Ahead

5 practices across Dumfries and Galloway will provide travel vaccination service by 1st February 2023. They are Glenluce, Dalbeattie, Greyfriars, Lochthorn and Lochmaben.

Vaccination Transformation Programme – Conclusion

All elements of the VTP has been implemented with the exception of the Travel Vaccination element. 5 practices across Dumfries and Galloway will provide travel vaccination service by 1st February 2023.

SERVICE 2
PHARMACOTHERAPY
SERVICES
100% Completed



Pharmacotherapy Services - Introduction to Service Area

The 2018 General Medical Services Contract states:

"***From April 2018, there will be a three-year trajectory to establish a sustainable pharmacotherapy service which includes pharmacist and pharmacy technician support to the patients of every practice. This timeline will provide an opportunity to test and refine the best way to do this, and to allow for new pharmacists and pharmacy technicians to be recruited and trained***."

This timeline was impacted by the pandemic. The contract also states that this new pharmacotherapy service will:

"***allow GPs to focus on their role as Expert Medical Generalists, improve clinical outcomes, more appropriately distribute workload, address practice sustainability and support prescribing improvement work."***

In each territorial Health Board, Directors of Pharmacy are expected to lead the implementation of this new service. Within the contract, three different levels of pharmacotherapy are defined with level 1 activities being regarded as the core service to be delivered by April 2023 (according to MOU2) with levels 2 and 3 being regarded as additional services. These are shown on the table below.

Figure 2: Core and additional pharmacotherapy services

CORE AND ADDITIONAL PHARMACOTHERAPY SERVICES		
	Pharmacists	**Pharmacy Technicians**
Level one (core)	• Authorising/actioning[15] all acute prescribing requests • Authorising/actioning all repeat prescribing requests • Authorising/actioning hospital Immediate Discharge Letters • Medicines reconciliation • Medicine safety reviews/recalls • Monitoring high risk medicines • Non-clinical medication review Acute and repeat prescribing requests includes/ authorising/actioning: • hospital outpatient requests • non-medicine prescriptions • installment requests • serial prescriptions • Pharmaceutical queries • Medicine shortages • Review of use of 'specials' and 'off-licence' requests	• Monitoring clinics • Medication compliance reviews (patient's own home) • Medication management advice and reviews (care homes) • Formulary adherence • Prescribing indicators and audits
Level two (additional - advanced)	• Medication review (more than 5 medicines) • Resolving high risk medicine problems	• Non-clinical medication review • Medicines shortages • Pharmaceutical queries
Level three (additional - specialist)	• Polypharmacy reviews: pharmacy contribution to complex care • Specialist clinics (e.g. chronic pain, heart failure)	• Medicines reconciliation • Telephone triage

A planned and transitional approach to service change is underway with a gradual increase in the capacity of the pharmacy team to deliver the new service as competence grows and new job roles develop. These new job roles must be made rewarding for individuals otherwise the sustainability of the service will be at risk. All of this is underpinned by a strong commitment to educational support from within the pharmacy profession as well as GP clinical supervision and an overarching commitment from practices to adapt their systems and processes to allow each member of the pharmacy team to work to the maximum level that their competence allows.

This approach allows the development of the safe, sustainable, effective, person-centred, outcome focussed, equitable and value for money service that both Memoranda of Understanding demand.

Pharmacotherapy Services – Service Specification

A Level 1 pharmacotherapy service is being delivered in every practice, ahead of the deadline of April 2023. Patients across all 32 practices will benefit from this service with improved patient outcomes as a key focus. The service creates capacity in the GP workload to allow GPs are able to become Expert Medical Generalists. The service must also provide for a rewarding career for pharmacists, pharmacy technicians and pharmacy support workers for it to be sustainable. In addition, this robust and sustainable pharmacotherapy service will seek to incorporate the skills and services offered by community pharmacists and their colleagues.

The implementation of Pharmacotherapy Services will result in a transformation in the way that the Level 1 services are carried out in GP practices. Each Cluster area in the region has now implemented a Hub Model to support the delivery of Level 1 work across the region. The hub model brings together the skills and knowledge of the Cluster Pharmacy Technicians and Support Workers, enabling them to work collaboratively through the level 1 workflow from each practice in their cluster. This gives pharmacy team support to every practice every day (Monday-Friday, regardless of annual leave and sickness) and a more time efficient model remotely accessing the workflow instead of travel all-round the Cluster. The Hubs are Technician led, with support from GPCP's where required for more complex cases. The Hub model enables GPCP's to continue their allocated practice time, focusing on scheduled clinics

to hold medication reviews and specialist clinics, thus developing and implementing the Level 3 element of the GP Contract.

One activity specifically excluded from the service is the signing of regular repeat prescriptions as per the National Pharmacotherapy Service specification which states... ***"Pharmacist Independent Prescribers should not sign repeat prescriptions where they are not directly involved in the patient's care or where there is no requirement for medication review at the time of issuing the prescription i.e. prescriptions being routinely issued for medications already authorised until the next review".***

Additionally, GP practices will also continue to be responsible for the following activities:

- Processing routine repeat prescription requests
- Managing recalls and appointments
- Clinical read coding
- Follow up review or investigations except where an advanced pharmacist independent prescriber has assumed management of patient care under a Level 3 activity or agreed local procedures

GP practices will also continue to support the Cash Releasing Efficiency Savings (CRES) and prescribing improvement work that it is incumbent on the Community Health and Social Care (CHSC) pharmacy team to carry out. The pre-existing core resource within the team to promote cost-effective, clinically effective and safe prescribing, i.e. the traditional prescribing support work, needs to be recognised and respected.

This is a Monday to Friday service that operates during normal GP practice opening hours.

Pharmacotherapy Services – Service Aims

The following vision for Pharmacotherapy Services in Dumfries and Galloway has been developed:

> *"To achieve a pharmacy-led service delivering realistic person-centred care, ensuring safe, effective and appropriate use of medicines within an integrated multidisciplinary team".*

The aims of the Pharmacotherapy Services programme are as follows:

- To establish a Pharmacotherapy model to support the operation of a service from which patients in every general practice in Dumfries and Galloway will benefit
- To ensure that this service provides patients access to the 'right person at the right place at the right time' through an effective multidisciplinary model of care
- To develop the most appropriate skill mix in order to staff the pharmacotherapy model effectively and deliver this within the defined timescales of the 2018 General Medical Services Contract
- To have a technician led level one service established by 2023

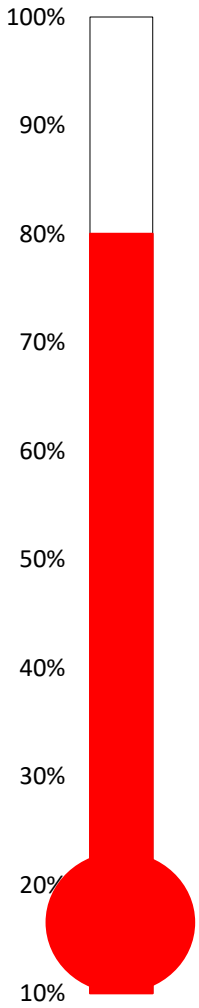
Pharmacotherapy Services – Summary of Activity to Date – NHS Board Feedback

All 32 practices have Pharmacotherapy Level 1 service in place.
All 32 practices have partial Pharmacotherapy Levels 2 and 3 services in place.

Pharmacotherapy Services – Expected Progress for the Year Ahead

Transformation work to continue past April 2023.

SERVICE 3
COMMUNITY TREATMENT
AND CARE SERVICES
80 - 90% Completed



Community Treatment and Care Services (CTAC) – Introduction to Service Area

The 2018 General Medical Services Contract states that the Community Treatment and Care Services priority area includes many services that patients may need, including (but not limited to):

- Management of minor injuries and dressings
- Phlebotomy
- Ear syringing
- Suture removal
- Chronic disease monitoring and related data collection
- B12 Injections
- ECG

These interventions are defined as Level 1 - CTAC Service where a Health Care Support has the competencies to delivery on these.

There will be a transition period to allow the responsibility for providing these services to pass from GP practice staff to NHS Boards that will employ and manage appropriate nursing and healthcare assistant staff.

Local circumstances and demand will determine where it is most appropriate to safely situate these services. It is expected that many of these functions will be provided in the GP practice premises for patient convenience and the benefits of having these services carried out with the close support of the wider practice team. This would also enable easier sharing of necessary data and the patient records.

Community Treatment and Care Services – Service Specification

The CTAC service specification will cover the basic services listed above but not the further services listed below. The service must be in place by April 2023.

Community Treatment and Care Services – Service Aims

The priority area will deliver the services outlined in the introduction above. Further services may also include:

- minor surgery
- travel health
- family planning

Community Treatment and Care Services – Summary of Activity to Date – NHS Update

- 32 practices currently have full access to all CTAC services where all Health Care Support Works are fully signed off to provide Phlebotomy.
- 24 practices currently have access to chronic disease monitoring such as BP / Heights / Weights this work continues to ensure all 32 Practices have this in place.

There is a training programme in place for Ear Syringing / B12 Injections .

Over the last few months, a number of existing practice staff have been TUPE'd over to the Health Board. Other posts have gone out to recruitment.

It is planned that the total compliment of staff required to deliver this service will be in place for 1st April 2023.

It is acknowledged that further development work on the service will be required in the period following April 2023.

Community Treatment and Care Services – Expected Progress for the Year Ahead

CTAC service must be in place for April 2023. This means

- 32 practices with full access to phlebotomy service by 1st April 2023 – complete
- 32 practices with full access to management of minor injuries and dressings service by 1st April 2023 – planned to finalise May 2023
- 32 practices with full access to ear syringing service by 1st April 2023 - planned to finalise May 2023
- 32 practices with full access to suture removal service by 1st April 2023 - planned to finalise May 2023
- 32 practices with full access to chronic disease monitoring and related data collection by 1st April 2023 – scoping exercise being undertaken by the nurse management team for CTAC

Community Treatment and Care Services – Conclusion

There is still much work to do to ensure the CTAC service is in place by April 2023.

A new task force group has been convened to take forward the implementation of this service and ensure that the staff and services are in place for 1st April 2023.

SERVICE 4
URGENT CARE
SERVICES
30% Completed

Urgent Care Services – Introduction to Service Area

Urgent and unscheduled care is any clinical work that is in addition to the pre-booked and predictable work within a practice. It is very hard to plan and allocate resources within a traditional primary care model to respond in a timely and efficient way. The consequence of urgent and unscheduled work is that it directly impacts on the pre-booked and predictable as well as the capacity within the primary care system. As the staffing crisis within primary care deepens the capacity for urgent and unscheduled care falls and the impact on practices worsens.

The Urgent Care Services workstream has initially focused on three core pieces of work which will be explored in more detail below. These are:

- Wigtownshire Paramedic Pilot
- ANP Support in Stewartry Care Homes
- Vital Signs Training in Stewartry Care Homes

Proposals for Urgent Care Services in other localities are currently under development with a mixed model of paramedics and ANPs being developed for the immediate short term.

Urgent Care Services – Service Specification

Wigtownshire Paramedic Pilot

A small team of paramedics or specialist paramedics are attached to a group of practices within two areas of Wigtownshire, with a single paramedic each day working in each area on a rota basis to ensure 52 week cover. Individual practices receive home visit requests and the GPs despatch the paramedic to attend appropriate visits. The paramedics are making a full assessment and where appropriate initiating a management plan for the patient. The paramedics can also discuss the case with an appropriate GP to agree the management plan and outcome. Where required, the paramedic will initiate treatment and have admitting rights to hospital. Individual practices are able to determine any exclusion criteria for this service. For example, currently palliative care and severe mental health will remain a GP responsibility. Peer support and mentoring is a key feature of the model.

Urgent Care Services – Service Aims

The aim of the Urgent Care service is to reduce the impact of urgent and unscheduled care on GP workload and to provide a comprehensive model for unscheduled care using paramedics, specialist paramedics and ANPs. GPs will continue to be involved in unscheduled care but only in the cases which specifically require their skills as the Expert Medical Generalist. This reduction in urgent and unscheduled care workload will directly impact on capacity within practices allowing GPs to fulfil their potential as Expert Medical Generalists at the centre of the new extended multi-disciplinary primary care team. For patients, this will improve health and wellbeing outcomes for individuals and help to improve person centred approaches.

Urgent Care Services – Summary of Activity to Date

- 9 Practices with full access to Urgent Care Services
- 17 Practices with partial access to Urgent Care Services
- 6 Practices with no access to Urgent Care Services

Urgent Care Services – Expected Progress for the Year Ahead

The Scottish Government will bring forward secondary legislation so that Boards are responsible for providing an Urgent Care service from 2023-24.

An ANP model is being developed currently.

A further paramedic pilot is in place to support two further localities whilst ANP training to support the new model continues as follows:

- 20th March 2023 – Charlotte Street practice and Gretna practice
- 27th March 2023 – Lochthorn practice and Canonbie practice
- 3rd April 2023 – Greyfriars practice and Langholm practice
- 10th April 2023 – Dunscore practice and Ecclefechan practice
- 17th April 2023 – Thornhill practice and Lockerbie practice
- 24th April 2023 – Sanquhar practice and Lochmaben practice One paramedic per locality (Nithsdale and Annandale & Eskdale) will provide support on a weekly basis.

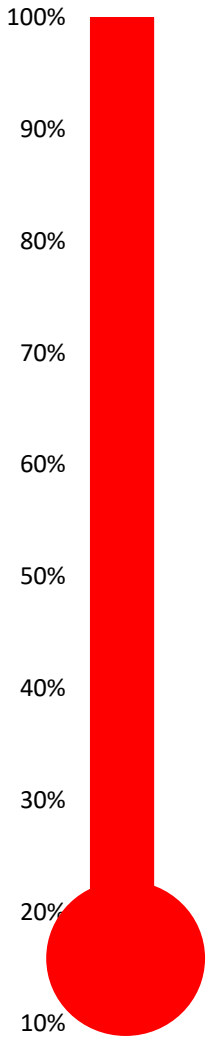
Bases have been agreed as Charlotte Street practice and Gretna practice. Five paramedics per locality will support this model on a rota basis. Funding will be required to roll out to other areas.

Paramedics will be given remote EMIS access to record their own consultations without returning to the practice. Paramedics in the West return to the practice to upload their consultation notes. Sandhead and Glenluce practices have agreed paramedics can email consultation notes for upload for effective time management due to rurality of the practices. Remote EMIS access for paramedics in the West would be beneficial. BP is pursuing laptop/tablets for each locality.

Urgent Care Services – Conclusion

Although not an immediate priority according to MOU2, work around Urgent Care Services requires urgent further development to ensure equity of service across all localities.

SERVICE 5a
ADDITIONAL
PROFESSIONAL ROLES –
MENTAL HEALTH
88% Completed (Previously 66% Completed)



Mental Health – Introduction to Service Area

Mental health issues are a common feature of primary care consultations, with around a third of GP consultations having a mental health element.

The 2018 General Medical Services Contract sets out the development of new multidisciplinary models for supporting people with mental health difficulties in primary care.

The model rolled out across NHS Dumfries and Galloway sees Mental Health Nurses based in GP practices. 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 focus 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.

This approach aligns itself to the Scottish Governments 2017- 2027 Mental Health Strategy which advocates primary care mental health services being easily accessed, efficient and safe. It emphasises services focusing on prevention, early intervention, and self-management.

Anecdotal feedback to date indicates a reduction in GP workload, and improved patient experience, safety and equity of access to a range of mental health expertise in Primary Care.

Mental Health – Service Specification

Individuals cannot directly self-refer to the service. People can access the service via the individual triage system within each practice and appointments are booked via the electronic GP system. There is no requirement for people to see a GP face to face prior to seeing the PCMHN. Some practices operate a PCMHN triage system whereby people are booked in following a mental health screening.

Individuals are invited to attend an initial mental health assessment Initial assessments follow an SBARR format; exploring the main issues, obtaining some brief personal history, gaining an overview of daily functioning and mental health assessment, and considering risk.

If it has been identified from the initial assessment that follow up appointments are appropriate, a plan of care will be devised in partnership with the individual.

Follow up appointments are arranged directly with the PCMHN, and a joint discussion with the patient will decide whether this needs to be a 15 or 30 minute appointment. The service offers short term follow up sessions focused on brief psycho-social interventions. Interventions include psycho-education, lifestyle management, problem solving, stress management/reduction, coping strategy enhancement, medication advice/review, and signposting to other services/agencies where appropriate.

Mental Health – Service Aims

The Primary Care Mental Health Service uses a multi-disciplinary, multi-agency approach that aims to provide accessible, safe, effective, person-centred care and treatment to all patients. This includes ensuring that every patient receiving care and treatment from Mental Health Services has an identified lead professional, an agreed plan of care, and arrangements for further review or onward referral.

Primary Care Mental Health Nurses (PCMHNs) aim to provide early intervention and work with individuals on a self management approach, empowering people to enhance resilience and prevent worsening of symptoms.

The service encourages active participation with family and Carers, recognising the contribution Carers make to an individuals' care.

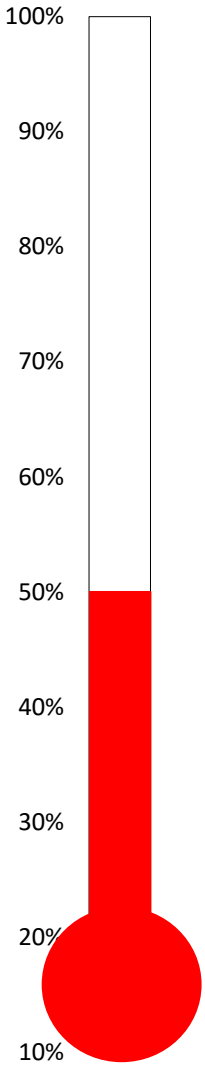
Mental Health – Summary of Activity to Date

32 practices with full access to mental health worker

Mental Health – Expected Progress for the Year Ahead

Transformation work to continue.

SERVICE 5b
ADDITIONAL
PROFESSIONAL ROLES –
Musculoskeletal (MSK) Services
70% Completed



MSK – Introduction to Service Area

Musculoskeletal problems frequently cause repeat appointments and are a significant cause of sickness absence in Scotland. The majority of a GP's musculoskeletal caseload can be seen safely and effectively by a physiotherapist without a GP referral. However the existing patient pathway often includes an unnecessary delay while initial non-physiotherapeutic solutions are attempted prior to access to a musculoskeletal physiotherapy service. There are variable waiting times across the country for access to face-to-face physiotherapy.

MSK – Service Specification

Physiotherapists are already well situated to work collaboratively with primary care multi-disciplinary teams and support the GP role as Expert Medical Generalist. Physiotherapists are an expert professional group. They have a high safety record and are trained to spot serious pathologies and act on them. Physiotherapists utilise their wider knowledge and skills as part of their assessment. A first point of contact service could also be seen in the context of the wider musculoskeletal pathway.

There is a requirement to develop models to embed a musculoskeletal service within practice teams to support practice workload. In order to provide a realistic alternative for patients, access times must be comparable to those of general practice.

All other NHS Boards in Scotland have First Contact Practitioners embedded within GP practices. These practitioners undertake assessment and management of the patient's condition instead of and behalf of the General Practitioner and are not whilst in their FCP role offering mainstream physiotherapy musculoskeletal services.

Initially, national work indicated a ratio of 1 FCP to a population of 20,000 but most recent work has calculated this to 1:16,000. Job evaluation has indicated that these posts are at a Band 7 Level Practitioner.

The FCP has a job profile of 70% First Contract sessions with the remaining 30% contributing to the other Pillars of Practice and triaging, report writing, liaising with other professionals and clinical supervision.

Based upon information from across Scotland, the work profile for 1 WTE FCP is modelled as below:

- Approximately 15 new patients per day/ 20 minutes per appointment
- 70% First Contact Time = 5.25 hours per day
- 75 Appointments per Week
- Over 42 weeks = 3150 Appointments

Clinical leadership is provided by an identified Lead GP for each Practice. In other Board areas, it has proved beneficial to have an identified Band 8a as Clinical Lead for this group of staff.

MSK – Service Aims

The aims of the new MSK service would include:

- Quicker access to expert MSK assessment, diagnosis, treatment and advice
- Reduced number of MSK referrals to secondary care thus reducing demand and waiting times for Orthopaedics, Pain Services, Rheumatology and Physiotherapy
- Improved use of Imaging
- The release GP time for more complex patients
- A reduction in prescription costs

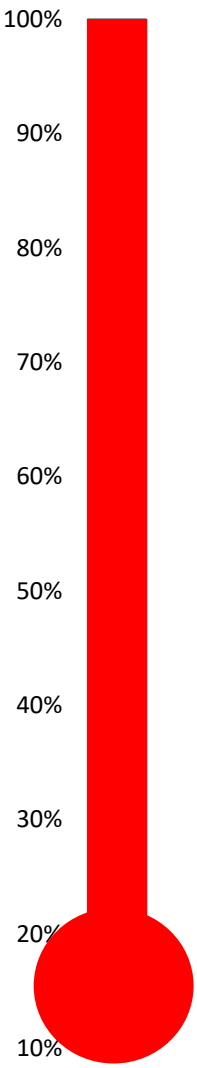
MSK – Summary of Activity to Date – NHS Update

15 practices have full access to the MSK service

MSK – Expected Progress for the Year Ahead

Transformation work to continue.

SERVICE 6
COMMUNITY
LINK WORKERS
100% Completed



Community Link Workers – Introduction to Service Area

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

As part of the Primary Care Improvement Plan, Health and Social Care Partnerships across Scotland will develop CLW roles in line with the Scottish Government's manifesto commitments 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 will function as art of the local models/systems of care and support.

Community Link focuses on allowing people the time to talk, be listened to and to explore their current situation and begin to make plans for the future. It recognises that every individual is different and the flexibility of the service means people may choose to come in and out, as and when they need support.

There are now a range of projects across Dumfries and Galloway that utilise social prescribing approaches, and whilst the projects share a commonality in aims, there is variance in practice and operational delivery. All projects use a similar model to Community Link Workers although the workforce may be referred to differently, for example 'health facilitator or navigator'.

Across Dumfries and Galloway, the following list of services take a social prescribing approach to addressing population health and wellbeing:

- Healthy Connections Wigtownshire
- Healthy Connections Nithsdale
- Health Connections Stewartry
- Community Link Service (Annandale and Eskdale)
- CoH-Sync (Dumfries and Stranraer) European Union's INTERREG VA programme, which aims to implement a collaborative, community-based

approach to promoting healthier lifestyles which targets the risk factors associated with long term health conditions

- MPower (Wigtownshire) –European Union INTERREG VA cross-border funded programme that will create a service for the older population with long term conditions. It works with communities and services to enable people to live well, safely and independently in their own homes and focusing on self-management through social prescribing and digital health interventions identified through wellbeing plans.
- SPRING Social Prescribing is a partnership between the Healthy Living Centre Alliance and Scottish Communities for Health and Wellbeing based within the The Hub – Your Community Action Centre (Stewartry, Annandale and Eskdale, and parts of Nithsdale)

Community Link Workers – Service Specification

As outlined above, there are already Community Link Workers across all four localities in Dumfries and Galloway. The challenge for the Primary Care Transformation Programme is to ensure that there is consistent alignment to GP Clusters across all four localities within Dumfries and Galloway and to identify where additional community link resource is required to ensure an effective Community Link Service aligned to GP Clusters is in place.

The Community Link Worker role is primarily to work with individuals to help them to identify what is important to them and support them to find solutions and ways of improving their health and wellbeing. The approach is person centred, flexible and enables people to take control and responsibility for their own and/or their families' health and wellbeing. This 'flexibility' and outcome focused approach is quite different to our traditional service models. It allows the service to successfully work with more vulnerable people who may struggle to engage with, or who have chosen not to engage with, traditional health and social care or other support services. Through closer working with partners in Social Work, Community Services and Primary Care, the Community Link Worker service has created a real shift towards earlier intervention and crisis avoidance.

Although the Community Link Programme was initially developed in Annandale and Eskdale with a view to reducing social isolation and loneliness in the later years, the link workers are now supporting increasingly complex adults (16 years+), who would have once been supported by Social Services but who no longer fit the 'critical' criteria. They are also seeing a high number of referrals from General Practice and are working with a high number of adults who are experiencing low/medium mental health issues (approximately 80%).

The key to capacity is mobilising all of the available resources to be found within the community and help them to grow.

Community Link Workers – Service Aims

The Community Link Worker service aims to:

- Support independence and reduce reliance on acute and specialist services
- Address non-clinical demands on primary and acute services
- Make effective use of both individual and community assets and to strengthen relationships between local communities, voluntary sector organisations and traditional providers of health and social care
- Support changes to the way that health and social care is delivered through a model that focuses on individual assets and community resources
- Help to strengthen and transform the role of GP services as a community resource that connects people to appropriate support and activities
- Community Link also works with people, communities and partners to develop support and services that meet the needs identified

Community Link Workers – Summary of Activity to Date – NHS Board Feedback

32 Practices with full access to Community Link Workers.

Community Link Workers – Expected Progress for the Year Ahead

Further transformation work is clearly required around this priority area.

SECTION 4 – CONCLUSIONS AND NEXT STEPS

This report has focused on the 6 priority areas contained within the 2018 GMS Contract. The five previous cross-cutting workstreams listed below have not been considered as part of this update but should not be forgotten in the current discussions.

These are:

- Primary-Secondary Care Interface
- GP Premises
- GP Sustainability
- Technology
- Communication & Engagement

It is recognised that discussions are now also required to address the financial shortfall which has been highlighted in previous Primary Care Improvement Plans and how best to move forward to implement the best outcomes with the funding available in relation to the non-priority workstreams. This must include consideration of equality of services across the localities/practices.

Programme Management is now in place to support to support the planning and communication and engagement activities between the various workstreams and the various governance structures involved in this programme of work (including Contract Development Group, GP Sub, LMC, Clinical Leads, GP Clusters, GP Practice teams including practice manager networks). The support and knowledge of the Primary Care Practice Manager Advisor will also be a great benefit. Building on, and strengthening, the linkages between the various workstreams and these governance structures will be central to the success of the programme going forward.

The challenging timescales, cannot be underestimated but it is recognised that new structures have recently been put in place to support this vital work going forward into the new year. Progress in this area will require to be communicated effectively and regularly to all practices as will updates on all strands of work relating to the programme, including the cross-cutting workstreams identified above.