Appendix

Tayside Primary Care Improvement Plan

2018 to 2021

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Foreword

We are delighted to present our Primary Care Improvement Plan. This plan has been developed collaboratively between by Angus, Dundee and Perth and Kinross Health and Social Care Partnerships, NHS Tayside Board and GP Subcommittee.

The plan describes our commitment to support and deliver primary care services which meet the needs of the communities we serve both now and for the future. It represents an ambitious programme of change which places people at the heart of service delivery.

The Primary Care Improvement Plan does not sit in isolation. It is a living document that is a critical element of to the rich clinical context of strategic and transformative change taking place across Tayside and is integral to the delivery of the Integrated Clinical Strategy.

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Clinical Director
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June 2018

Dr Andrew Thomson
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Introduction

An effective primary care system is critical to sustaining high quality universal healthcare and is vital if we are to realise Scotland's ambition of improving the health of our population and reducing the burden of health inequalities that rests upon it. As a nation we require a strong and thriving general practice at the heart of our primary care system if we are to succeed in these goals.

The vast majority of healthcare interactions for our population start and end within primary care, with General Practices acting as a necessary and efficient gateway to decisions about referral, admission and prescribing. These decisions have a direct impact on the entire health and social care system with immense consequential resource implications.

This document describes a three year investment programme of unprecedented scale that aims to support the moving of patient care and resources into the community, the improving of quality and efficiency of healthcare delivery and the addressing of the Realistic Medicine agenda. This will ensure that we have a general practice and a primary care system that delivers high quality, effective and responsive care for our patients in the communities in which they live.

This Plan is a commitment to provide better care for our population. An effective, vibrant and fully functional primary care is essential for NHS Tayside and for the Health and Social Care Partnerships, who commission that care. It is also essential for the professions and services that deliver it. The spirit of collaboration and co-production runs through this plan and are essential to ensure its effective implementation.

National Background and Context

General practice has experienced a prolonged and unprecedented level of challenge across the UK. A sustained period of real terms decline in resource coupled with a negative portrayal of General Practice has resulted in a recruitment crisis with GP Practices; unable to match recruitment to the service with departures from it.

This challenge is set against a background of increasing demand for access through changes in societal values, an ageing demography and an increasing disease burden. Practices have not only struggled to attract sufficient doctors but also to recruit other healthcare professionals to deliver the service at the level to which they aspire. The result of this 'perfect storm' across Scotland is a wave of practices restricting their lists through closure, tightening boundaries and increasingly having to surrender their contracts due to insurmountable difficulties.

Development of the 2018 Scottish GMS contract

Recognising the severity of the situation, the Scottish Government in close collaboration with the Scottish General Practitioners Committee, developed the 2018 Scottish General Medical Services (GMS) contract. This contract seeks to both re-invigorate general practice and through fundamental service re-design create positive effects throughout Primary Care as a whole.

The 2018 GMS contract builds on re-energised core values, developing the GP as the expert medical generalist at the heart of the community multidisciplinary team. The aims of the contract are to create a dynamic and positive career for GPs; a resilient and responsive wider primary care with opportunities for all healthcare professionals to flourish; and an assurance that patients will continue to have accessible, high quality general medical services.

Scope of the Contract and supporting documents

The new contract is supported by a Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards. This MoU requires every area in Scotland to develop a Primary Care Improvement Plan (PCIP) as a collaborative process between the NHS Board, Health and Social Care Partnerships (HSCPs) and GP Subcommittee of the Area Medical Committee (GP Sub). Specific agreement is also required by the Local Medical Committee in relation to contract implementation.

The MoU identifies six key priority areas which must be included in the PCIP:

- Vaccination Transformation Programme
- Pharmacotherapy Services
- Community Treatment and Care Services
- Urgent Care Services (advanced practitioners)
- Community Link Workers
- Additional Professional Clinical and Non-clinical services including
    - Acute musculoskeletal physiotherapy services
    - Community Mental Health Services

The MoU represents a statement of intent recognising the roles of the Integration Authorities and NHS Boards in commissioning and delivering primary care services. Primary care service redesign and development will be in the context of delivery of the new GMS contract and accord with seven key principles:

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

Further key enablers for change identified are:

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

The MoU covers the 3 year period, from 1 April 2018 to 31 March 2021 to which this implementation plan relates.

Aims of the Tayside Primary Care Improvement Plan

The Tayside Primary Care Improvement Plan takes the principles detailed within the GMS contract and MoU; describing how they will be embraced and implemented by creating a better functioning, patient centred primary care that allows other healthcare professions to grow and develop while easing pressure within General Practice. This is not just to increase the sustainability of the profession, but also to release the time required for GPs to take a full part in shaping a reinvigorated primary healthcare system.

The changes that our Improvement Plan describes are the single greatest alteration to the shape of primary care in a generation. Each of the workstreams that lie within the plan is a major project in its own right. The improvements within the plan represent an opportunity for the whole of the Primary health and social care team to reshape itself; becoming more rewarding, attractive and sustainable. This will act as a catalyst for change which will reshape, refresh and re-invigorate the entire healthcare system so that our population will have timely access to the right person within their community delivering the highest quality achievable.

The PCIP will be interwoven within the Strategic Plan for each Health and Social Care Partnership (HSCP) and, to ensure the continued delivery of high quality, safe, person centred care, the transition to full implementation will happen over a period of three years.

A regional plan, locally owned

The three Tayside HSCPs (Dundee, Perth & Kinross and Angus), NHS Tayside and the GP Sub agreed to formulate a joint plan for Tayside. A single shared plan allows services to be planned at scale; to be integrated with the other major strategic changes occurring across the region's health and social care services; and assists in the aspiration of an equal standard of service across the population.

A single plan does not prevent or restrict but facilitates individual HSCPs in finding differing solutions that address the local needs of Tayside's disparate population. We strongly support an equality of outcome across Tayside that is supported by locally owned and designed solutions with regional support.

A description of how the PCIP was developed, how it will be implemented and how it will be monitored is included in the Governance section of this paper.

A Plan for General Practice

General Practice within Tayside is experiencing the same difficulties as elsewhere in Scotland. Three practices are already operated by NHS Tayside, as they were unable to sustain themselves as independent practices. Many others are struggling, particularly due to problems with recruiting new GPs. As a result many practices have, closed their lists, reduced their boundaries or reduced the scale of the services that they offer.

The PCIP aims to improve the resilience of our Tayside practices. It will do so in part by moving work and services more appropriately provided by others away from the responsibility of General Practitioners and in some cases practices.

The PCIP also aims to attract more doctors to the profession by creating a more fulfilling role for those working in it. The proposed new role for the profession is described below in the following extract from the 2018 GP Contract offer document:

"GPs are expert medical generalists who provide the first point of contact with the NHS for most people in their communities. They may deal with any medical problem, 'from cradle to grave', and by providing continuity of care to their patients, families, and communities, they contribute hugely to keeping the nation healthy.

General practice is a unique discipline. Rigorous scientific and clinical medical training and the ability to apply the evidence appropriately in community settings, places general practice at the centre of the NHS. This knowledge and skill set – when combined with the discipline's holistic, relationship based philosophy and broad generalist practice, distinguish the discipline in large measure from other medical disciplines."

The aspiration of this change in focus is that it makes General Practice a more attractive specialty to work in. The effect of this change should be to offer greater opportunities for the development of additional skills for other healthcare professions; and to make the care of patients central to an entire healthcare team working together.

The document goes on to outline the following aspiration for the new contract:

To enable and empower GPs to function as expert medical generalists, non-expert medical generalist workload needs to be redistributed to the wider primary care multi-disciplinary team, ensuring that patients have the benefit of the range of expert advice needed for high quality care.

Through delivery of this Primary Care Improvement Plan, which is interwoven with HSCP Strategic Plans, future service will be protected. This will ensure the delivery of sustainable services required to ensure our population's health and social care needs continue to be delivered.

A Plan for Our Patients - designed with our population

Throughout the development of the PCIP it has been critical to ensure that our Plan is suitable for the needs of our local populations and that the improvements it brings address the challenges our population face.

The most obvious of the many challenges that we face are those created by the shifting demographics of the population. An ever greater proportion of our community are living longer, resulting in an aging population. This brings with it an inevitable and growing burden of chronic disease accompanied by a relative decrease in the working age population. Addressing these pressures through the mobilisation of community assets and infrastructure is a priority.

Health inequality is, and will remain, a priority for NHS Tayside. We have pockets of both significant deprivation and geographic isolation within Tayside and the delivery of services to help tackle these will have to be sensitive to local needs that will vary between local populations.

Some of the priority workstreams such as Link Workers offer a vital tool in helping to address and mitigate these societal challenges that directly impact on wellbeing and the use of health resource. Delivery of enhanced and proactive care will be facilitated by freeing up GP time and through enhanced delivery within the community such as in Care and Treatment Centres.

Stakeholder Engagement

The successful delivery of the PCIP relies on it being seen as clinically necessary, clinically led and good for patients.

In implementing this plan, we place those responsible for delivering the services and the patients that they care for at its heart. Those services which are key to the implementation of the plan, along with each HSCP and GP locality clusters, are charged with ensuring that the needs and views of patients are integrated with the delivery and further evolution of the plan; and that our workforce is informed, supported and consulted in the necessary changes that must be made.

There has already been a broad focus on engagement seen throughout Tayside, both in terms of gathering and developing the views of professionals, and also facilitating local dialogue about principals and priorities for implementation. Each HSCP has undertaken surveys to help inform them of GP practice priorities for implementation of the contractual elements and this has been reflected within the priorities set within the following chapters. Implementation will be guided by local priorities with new services being made available to patients of every practice and locality at a roughly even rate with an expectation of full and universal provision by 2021.

Ongoing stakeholder engagement will be critical to successful delivery and we intend to expand further on our engagement with the public around service development as the route-map to implementation becomes clearer. Their views and experiences will guide our conversations and decisions, informing our choices for the development and prioritisation of services. We have a good track record of successful co-production which we envisage expanding upon during the implementation of the PCIP.

Tayside's population – Understanding Health Inequalities

Introduction

Understanding our population's demography is important if we are to provide for their current and predicted health and social care demands. Many illnesses, conditions and health related behaviours are associated with age, gender or other demographic characteristics. An awareness of population distributions and attributes can help identify those likely to experience health inequalities. This will enable us to plan the most efficient and effective services for the future.

Tayside currently has 64 GP practices providing care to a population of approximately 416,000 registered patients. Over a third of our population have been diagnosed with at least one chronic disease and for a growing number they suffer from multi-morbidity. These patients often require significant numbers of clinical attendances, are on multiple medications and may require significant social care support.

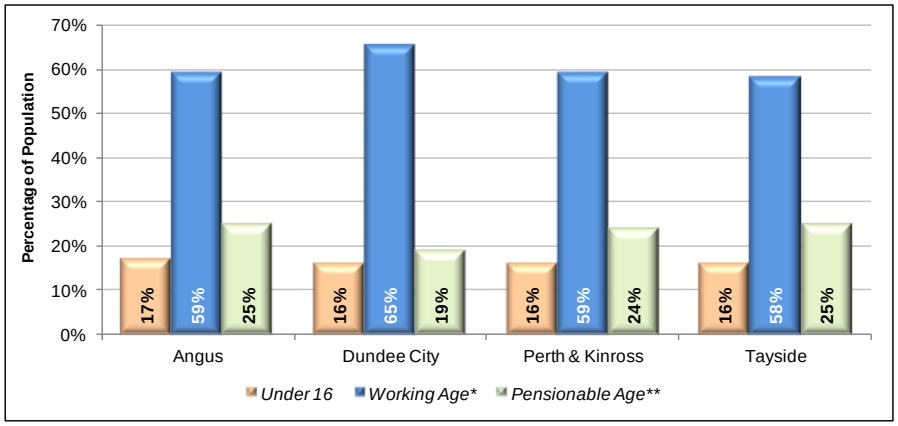
With an aging population (Fig: 1), health and social care demand is set to continue to increase and, without change, would outstrip our current capacity. This improvement plan uses the information we know about our population in developing and prioritising new approaches to the provision of health and social care to ensure our ability to continue the high quality provision for our population now and in the future.

Population Structure

The estimated population of Tayside on 30th June 2016 was 415,470, an increase of 430 (0.1%) from 2015. The gender distribution was similar to previous years, with males comprising 48.6% of the population and females 51.4%

Tayside's population is distributed across three local authority areas, in 2016 there were 116,520 residents [28.0% of the Tayside population] in Angus, 148,270 in Dundee [35.7%] and 150,680 in Perth & Kinross [36.3%]. Figure 1 displays the age structure of the Tayside population and its three local authority areas for 2016.

Figure 1. Age Structure of the Tayside Resident Population, as at 30th June 2016



The proportions in each age category across the three local authority areas are relatively similar. However, Dundee City has a higher proportion of the population who are of working age and a lower proportion of those who are pensionable in comparison to its Tayside counterparts.

Minority Ethnic Population

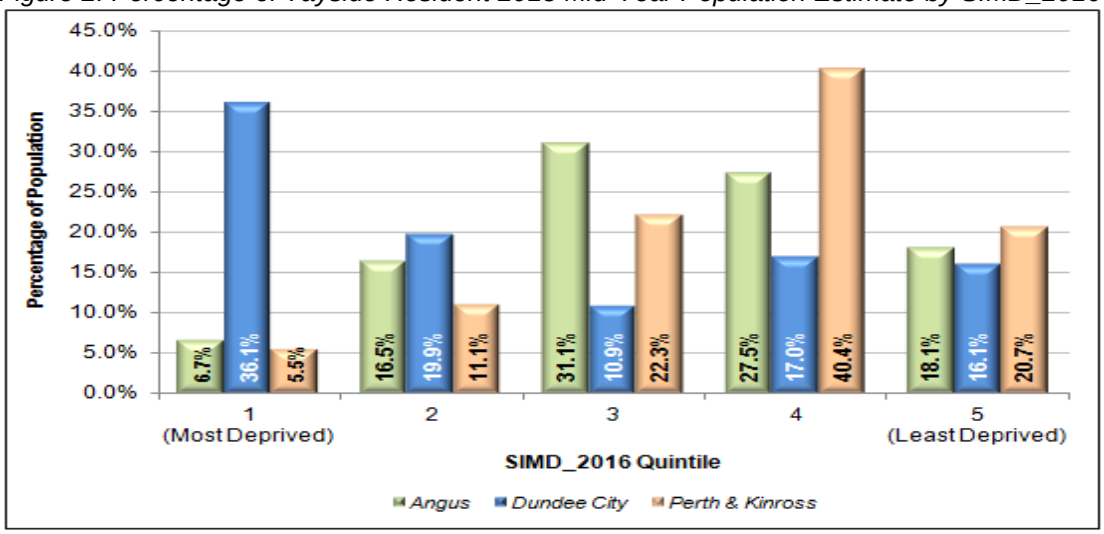
The 2011 Census reported that 3.2% (13,111 individuals) of the Tayside population were of non-white ethnicity. This varied across the region with the corresponding proportions in Angus, Dundee City and Perth & Kinross being 1.3%, 6.0% and 2.1% respectively.

Deprivation

The Scottish Index of Multiple Deprivation (SIMD1) is an area-based measure of deprivation, identifying small area concentrations of multiple deprivation in a comparative manner. It combines the domains of income, employment, health, education, skills and training, housing, geographic access and crime based on a ranking system from most to least deprived. These ranks can be grouped into categories, most commonly quintiles.

While in a standard population, 20% of the population would be expected to live within each quintile, across Tayside there are large variations between the differing levels of deprivation. Figure 2 displays the population proportions residing in each deprivation quintile for all three of Tayside's local authority areas.

Figure 2. Percentage of Tayside Resident 2015 Mid-Year Population Estimate by SIMD_2016 Quintile

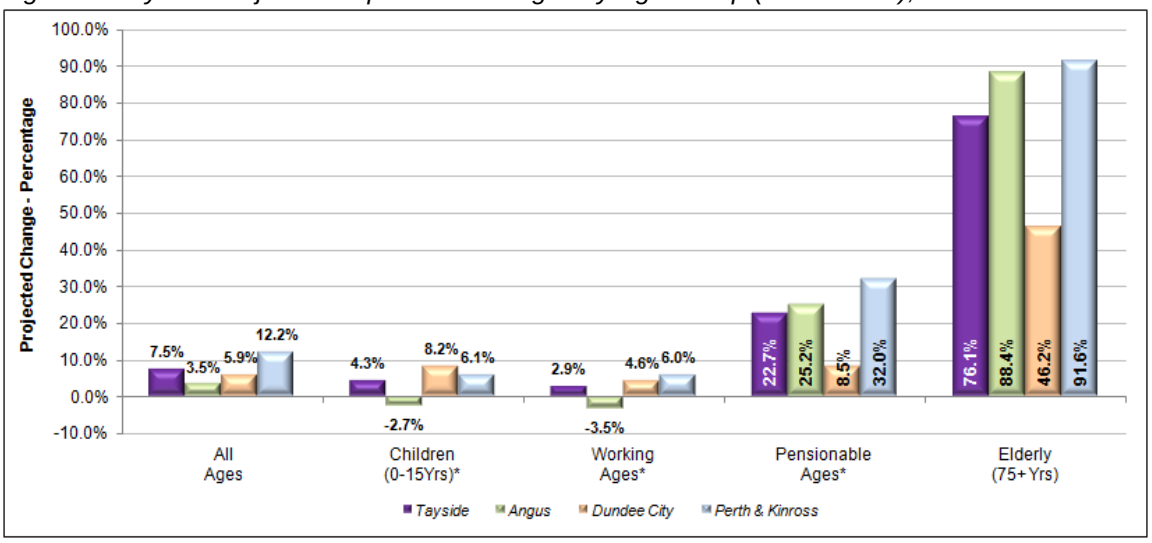


Dundee City has the greatest proportion of their residents living within the most deprived areas (SIMD Quintiles 1 and 2). 36.1% of the Dundee City population resided in the most deprived area, more than five times that compared to its Tayside counterparts.

Population Projections

The total Tayside population is projected to increase by 7.5% (N=444,763) by 2039 (2014 population estimate based). Displayed in figure 3 are the projected changes in the Tayside population, showing the variations in the differing age groups across the three local authority areas.

Figure 3. Tayside Projected Population Changes by Age Group (All Persons), 2014 and 2039



Perth & Kinross is expected to represent the largest projected population change by 2039, an increase of 12.2% (N=167,087) from the baseline estimate of 2014[2]. The other two areas are also projected to increase in total population by 2039, however by considerably less. (Angus - 3.5% (N=120,799), Dundee City - 5.9% (N=156,877)).

Of those age groups encompassed within the population of Tayside, those of pensionable age, and especially those aged 75+ years, are projected to display the greatest increase in population size by 2039 from the 2014 baseline estimate. Over the next twenty-five years, the most elderly age band, those aged 85+ years, are projected to increase by 128.7%. Of Tayside's three local authority areas, both Angus and Perth & Kinross are predicted to show the greatest increases in these elderly age groups.

Ill health

Many patterns of disease and conditions demonstrate inequalities between gender, age or geographical area. It is estimated that one in four adults (aged 16+ years) report some form of long term condition (LTC), health problem or disability and by the age of 65 nearly two thirds will have developed a LTC. Examples of common LTCs include diabetes mellitus, asthma and chronic obstructive pulmonary disease (COPD).

Understanding health inequality

Inequalities in health are a major challenge both for the NHS in Scotland and for Tayside. Despite improvements in many other health outcomes, there has been little improvement in relative inequalities with evidence of some areas where it is increasing.

Deprived socioeconomic groups suffer lower life expectancy, higher morbidity, and much lower healthy life expectancy than their more affluent peers. Male mortality exceeds that of women; those with physical or learning disability die earlier than those without; those with mental health issues have greater morbidity and mortality than those who don't. Some rural populations with limited access to patient service suffer greater ill health than more urban communities. The reduction of inequalities is a challenging priority at national, regional and local level. This is reflected in a number of strategies and plans in Tayside and is embedded in the Strategic and Commissioning Plan of each HSCP. NHS Tayside is committed the aim of achieving health equity within a generation.

Life Expectancy and Disease expectation

Life expectancy in Tayside overall is similar to the rest of Scotland. However there is significant variation. A baby boy in Dundee can expect to live to 75.1 years, while a baby girl in Perth and Kinross can look forward to surviving an additional 7.5 years. (Figure 4)

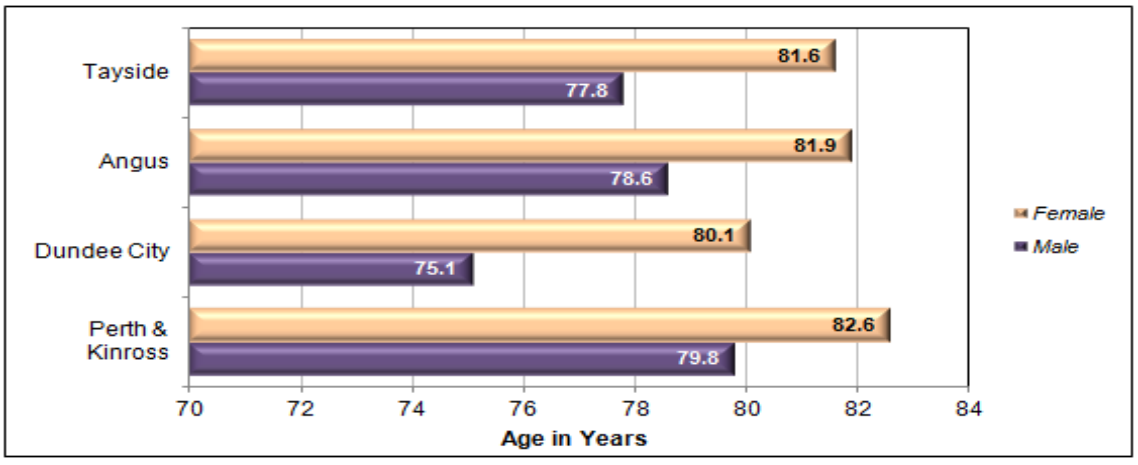


Figure 4. *Tayside Residents 'Life Expectancy at Birth' by Gender, 2013-2015*

These figures mask an even wider variation at locality level, with those in areas associated with higher levels of deprivation, having poorer outcomes across virtually all indicators of health. (Figure 5 and 6)

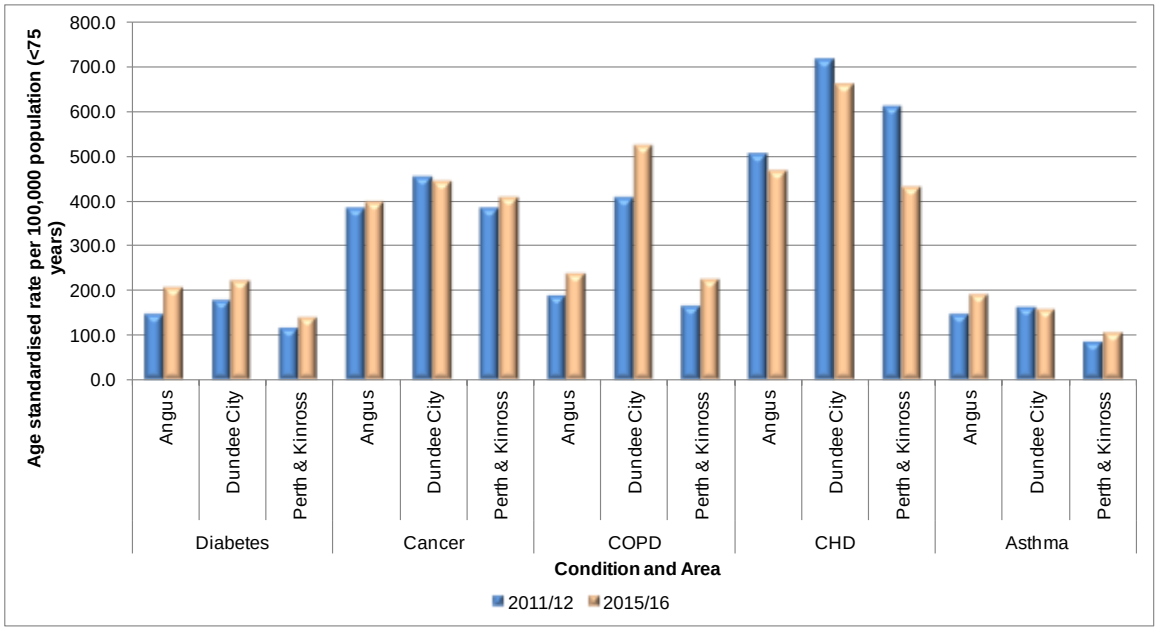


Figure 5. *Age standardised rates for those aged under 75 years for selected conditions across Tayside 2011/12 and 2015/16 (cancer registrations compare calendar years 2011 and 2015)*

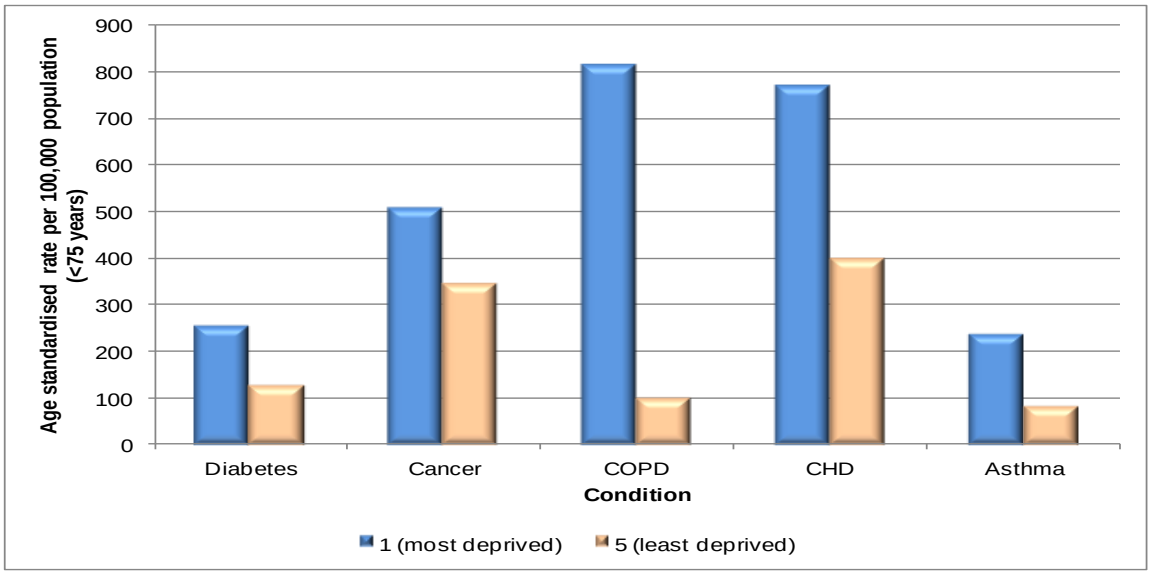


Figure 6. *Comparison of age standardised rates for the most and least deprived areas in Tayside for selected conditions 2015/16 (2015 for cancer registrations)*

Comprehensive evidence suggests that poverty causes harm through the chronic stress it causes. Unhealthy lifestyles, such as substance misuse, which help people cope with this stress, are passed on at very early ages. Teenage pregnancy is both a product of this cycle and an accelerant.

The lifestyle and socioeconomic factors which lead to ill health are interrelated. For example someone who has lost their job and income may have chronic stress and anxiety, with this impact on their mental wellbeing having a further negative impact on their physical health, and leading to longer term unemployment due to ill health. Breaking the cycle of deprivation leading to ill health early is therefore vital for future generations.

Having a sense of worth, aspiration and confidence can protect people from such harm and gives them resilience. We will build on existing confidence, promote resilience, and rebuild aspiration within communities. This is a very different goal than just aiming for faster or closer services.

Achieving Improvement

Through improving and innovating as detailed in this plan, there is an aim to reduce the avoidable differences dramatically; reducing the years of life lost annually to poverty in Tayside. This goal requires a fundamentally different approach to health and social care, starting with embedding improvements within Primary Care.

We will promote community resilience and support co-production; helping people to plan services and to take back elements of services which do not need to be delivered by health professionals. Engaged communities, with a caring and connected society will promote patient and community enablement, not more dependency on the NHS.

Our effort will need to be tailored to the needs of local populations within Tayside to reflect the problems and supports these communities possess. We will encourage cultural change to help communities become stronger and healthier. This will happen not just within our HSCPs but through inclusion of the voluntary and third sector.

Impact on and role of Primary Care teams

The impact on practices that have populations who predominantly reside in areas of higher deprivation is well documented including by the work of the “Deep End” practices. Socioeconomic deprivation has the greatest impact in Dundee where 33% live in the most deprived 20% of the population. The resulting workload impact on supporting those with multi-morbidity from a relatively early age is hugely demanding. There has been evidence for a number of years that practices in more deprived areas should have longer appointment times but this has not been achievable. Longer term as the workload in practices shifts as a result of the investment that the PCIP brings, it is anticipated that the duration of appointment times could be increased.

General practice and the wider primary care team, as described in the new contract, is core to achieving this ambition. As the key service which supports the whole population, General Practice has a critical role from pre-conception to palliative care. The aspiration of GPs as expert medical generalists at the core of a locality based

MDT within a local community will support identifying and planning for local health needs in a way that reflects the ambitions of the Health Equity Strategy.

Tayside already has a strong infrastructure to support this approach, with well established, GP led cluster groups, actively involved in considering quality improvement work for their local population. As capacity is released within general practice there will be the ability for GP teams to become more involved in the broader aspects of planning services around communities and community needs.

Inequality is also linked to rurality, with a number of contributory factors, particularly access to services, and low incomes. By its nature, the rural aspect of this issue makes it challenging but General practice is often unique in being part of the local community. An important aim of the contract is to ensure that services are provided as locally as possible. The role of technology to provide support is a key part of that solution, and with increasing rural connectivity, is more achievable now than it has been in the past.

Supporting Primary Care

A number of roles may support practices to interrupt the cycle of health inequality. The link worker role is one component of this, but wider social prescribing support can also add value. Where practitioners can easily refer to other agencies and groups, particularly where there is supported access when required, this can impact positively on all aspects of people's lives.

Examples of work undertaken in Tayside to develop this include:

- The use of **web based information systems** to support both self referral and professional referral based on ALISS infrastructure in Angus and Perth and Kinross.
- Dundee has funded the **co-location of welfare rights officers in practices** allowing clinicians to book patients directly to see the welfare rights officer. The officer has access to relevant medical information, with the person's consent, simplifying processes for a range of financial benefits, including PIP and DSA. This work has been evaluated very positively including a reduced impact on clinician time.
- The role of **link workers**, well evaluated nationally, with a well established model in Dundee. There is a social prescribing model that is currently operating in Angus practices with developing work within Perth & Kinross. These roles will be expanded across Tayside, using a range of models which fit local needs, as one of the priority areas of this improvement plan.

The positioning of care and treatment services locally within communities will also assist by providing better and more local access to care which can be augmented by embedding other community services such as social prescribing within the same location.

Tackling inequality

Through the improvements described within this plan, as well as NHS Tayside and HSCP strategic plans, we will:

- Encourage and support a more flexible appointment length for practice appointments for those with complex, socioeconomic or disability issues
- Increase the amount of social prescribing undertaken at practice level
- Continue to develop social prescribing support through a number of teams, including link worker models, wider social prescribing support, welfare rights and volunteering opportunities
- Continue to develop mental health resources within the community supported by the resources associated with Action 15, ensuring that it is tailored to meet the needs of our deprived and vulnerable populations to improve their resilience
- Develop the links established through local planning groups, ensure we work in a coordinated way to meet local health needs
- Build in Equality Impact Assessment in to all our developments
- Promote prevention at as early a stage
- Work with local people to promote a culture of proactive community support, to improve resilience and reduce social isolation.
- Encourage GP clusters to consider how they plan for, evaluate and address inequalities for their local population.
- Actively adopt technologies which increase accessibility and affordability of services. e.g. Florence or Attend Anywhere.
- Make better use of the information available at Tayside and HSCP levels to ensure that we are targeting our resources at those most in need.

An element of the investment supporting these goals will come through existing work planned by HSCPs, local authorities and NHS Tayside. A further element will come through the investment in community link workers associated with this PCIP and the additional funds linked to the Action 15 funding stream for mental health services described in the finance section below.

However, if we are to see the greatest impact on reducing the health and social care burdens associated with inequality we need to embed the cultural changes referred to above throughout all the workstreams described within this document.

Barriers and Opportunities

This PCIP describes a radically different future for primary care from the present in which we now live. It describes an expanded workforce that does not currently exist, with competencies that we have not yet fully described, working in part from premises that have not yet been built or developed, with an IT infrastructure that is not yet readily available. Funding information is relatively limited in extent and is being released at a time that NHS Tayside is encountering significant financial strain and requirements for contraction of spend. Funding sources for the PCIP will need clearly defined with appropriate staff and resources moved across the health and social care system as services are delivered within the community in new and innovative ways. There is an opportunity for greater efficiency of resource usage through innovation and close working between clinicians and managers in a clinically led and directed service.

An additional external pressure within Tayside relates to the early adoption of the link worker scheme within Dundee. This scheme was initially funded separately by Scottish Government but is now expected to come from the resources allocated to the implementing the PCIP. The Government recognised when they made that choice that this might disproportionately impact on HSCPs that had successfully applied to this scheme and therefore gave authority to HSCPs to work jointly to manage this.

The Government have directed that HSCPs and Boards should take note that the continuation of the early adoption of the link worker scheme should be considered to be a priority, whilst leaving it up to HSCPs to decide whether there is a need to change the scope, oversight, employer or lead responsibility for these posts. Discussions regarding how this scheme will develop are ongoing.

This PCIP seeks to coordinate the activities of our 3 HSCPs, the Health Board and an array of services hosted, managed and reporting to a variety of locations across NHS Tayside in a complex reshaping of care clinically led by 13 different GP clusters with a requirement to take into account the needs and views of the 416,000 patients we all serve. The scale of the challenges we face should not be underestimated and the efficiency and speed of decision making and progress should not be fettered by blunt instruments designed for a previous era of healthcare delivery.

We have an opportunity to develop systems of care that enable patients to have access to services close to their home and to be flexible to deal with patients that may live across either Board or HSCP boundaries in a way that ensures the patient is the focus.

The HSCPs and NHS Tayside have a responsibility to monitor, evaluate and report on the impact of the plan to Scottish Government whilst the Government's reporting requirements continue to evolve.

It is almost inevitable that the outcome we will see in 2021 at the culmination of Improvement Plan will differ in part from that which we are seeking to describe in 2018.

The key opportunity this PCIP brings is a massive catalyst for change and development. Whilst envisaged as a means to improve the sustainability of General Practice, it also offers a tremendous chance for other professions to develop into new, enhanced, and more rewarding roles. It allows those in existing roles to be facilitated to develop further having their skills recognised and utilised appropriately.

The changes, and possible redeployment opportunities, arising as part of NHS Tayside's financial recovery, offers the prospect of the release of an already highly skilled workforce, largely based within Secondary Care, into the new services described within this plan. This has potential to provide us with some of the capacity to meet our new and emergent needs.

The release of General Practitioner time to develop into the role of expert medical generalist allows both health and social care services to tap into an additional clinical resource that can support our evolving multidisciplinary teams to provide better care for patients. The GP Clusters will have increasing opportunity and responsibility to shape the quality of service delivered in their locality and will be facilitated by accurate, timely and relevant information delivered through comprehensive IT and data service support, both locally and nationally.

The improvements in IT infrastructure which this plan describes represent an opportunity to ensure better, safer and more efficient communication between primary and secondary care; more local care for patients; and for more coherent specialist clinical management of complex patients by those who have the expert knowledge to do so.

There will be an opportunity to focus on ensuring the principal of 'single entry' delivering appropriate sharing for clinical and care recording reducing and eliminating the risks identified through data transcription that exists currently.

Finance and Resourcing Principles

The changes described in this Primary Care Improvement Plan offer an opportunity to reshape our local healthcare system. The development of Care and Treatment Services; enabling an efficient and safe local IT infrastructure; and the augmentation to the nursing, pharmacy, physiotherapy and other healthcare services described are a catalyst to further improve services not covered directly within the Plan but reflected in the Strategic Plans of each IJB. There is a real opportunity, over time, to move services currently delivered in hospital settings closer to where people live; and to augment social care services by linking them more intimately with healthcare provision.

While the Primary Care Improvement Fund is designed as a facilitator to enable and accelerate change with the intention to provide direct support to General Practice. This funding stream can be, and may need to be, broadened by extended local re-modelling of other services to deliver the broader strategic plan for Primary Care.

The programme of investment and improvement outlined in the Primary Care Improvement Plan will be supported by funding made available by the Scottish Government as part of the Scottish Government's overall commitment to increase Primary Care Funding by £250m by 2021/22. The General Medical Services contract document is clear in stating that the funding streams agreed with the profession are for the direct support of general practice.

Primary Care Improvement Funding has been made available at an IJB level and, while funding has only been confirmed for 2018/19, overall national funding is planned to increase from c£46m in 2018/19 to £155m in 2021/22. The funding available locally is assumed to be as follows:-

	2018/19	2019/20	2020/21	2021/22
	£k	£k	£k	£k
Angus	986	1185	2370	3340
Dundee	1355	1630	3259	4592
Perth	1249	1502	3004	4232
Tayside	3591	4317	8633	12165
Scotland	45750	55000	110000	155000

While funding has been made available at an IJB level based on NRAC weightings, locally it is acknowledged that much of the investment will provide direct support to General Practices and therefore differential weightings may be required. It is also recognised that IJB's have the ability to collaborate where appropriate at a regional level and examples of this would naturally include areas where it is acknowledged that regional development is both necessary and an efficient use of funding (e.g. development of a core process for use of Care and Treatment services or engagement of appropriate levels of professional advisory and project management support).

At this stage in the development of local plans, allocations to specific outcomes have not yet been agreed and this will remain under development and subject to local prioritisation and approval. Scottish Government have stipulated that they require a progress report, including financial details, which must be submitted by September 2018. These will include Local Medical Committee approval in relation to monies provided for direct support of general practice and the implementation of the GMS 2018 contract provisions. Costings mentioned within the workstreams should therefore be regarded as indicative rather than as confirmed.

Within overall plans issues such as impact on premises, IT and other support will be considered along with the impact of existing local commitments (e.g. “early adopter” link workers) and the cumulative impact of inflation. Specific requirements of this funding stream including it not being subject to savings measures or being used to address wider funding pressures will be adhered too.

While in the first year of the Primary Care Improvement Plan overall investment will be dependent on early clarification of plans and ability to quickly recruit to any new posts, in the longer term it will remain challenging to deliver the overall plan within available funding.

However, there is also recognition within the Primary Care Improvement Plan that additional sources of funding may also be available to provide further support including:-

- Mental Health Strategy : Action 15 funding , to improve access in settings such as Accident & Emergency, General Practice, Police custody settings and Prisons.
- GP Out of Hours Funding
- GP Recruitment and Retention Funding.

Tayside	2018/19	2019/20	2020/21	2021/22
	£k	£k	£k	£k
Mental Health (Action 15)	863	1334	1884	2511
GP OOH Funding	392	392	392	392
Recruitment & Retention	TBC	TBC	TBC	TBC

Governance

The ethos behind the Primary Care Improvement Plan (PCIP) is that it should be locally owned, reviewed and implemented whilst being regionally approved and nationally monitored.

Integrated Joint Boards are responsible for commissioning the PCIP and must be confident that it is fit for their local population and that it is being implemented equitably and effectively. All three Tayside HSCPs are committed to working together to deliver the best PCIP for the people living within NHS Tayside. The GP Sub is similarly committed to ensuring that the PCIP fosters a stronger, more sustainable primary care system for our patients.

The delivery of the PCIP will be embedded within the strategic development and improvement plans of the HSCPs and of NHS Tayside. This is essential to maximise the whole system improvement that the 2018 GMS contract offers.

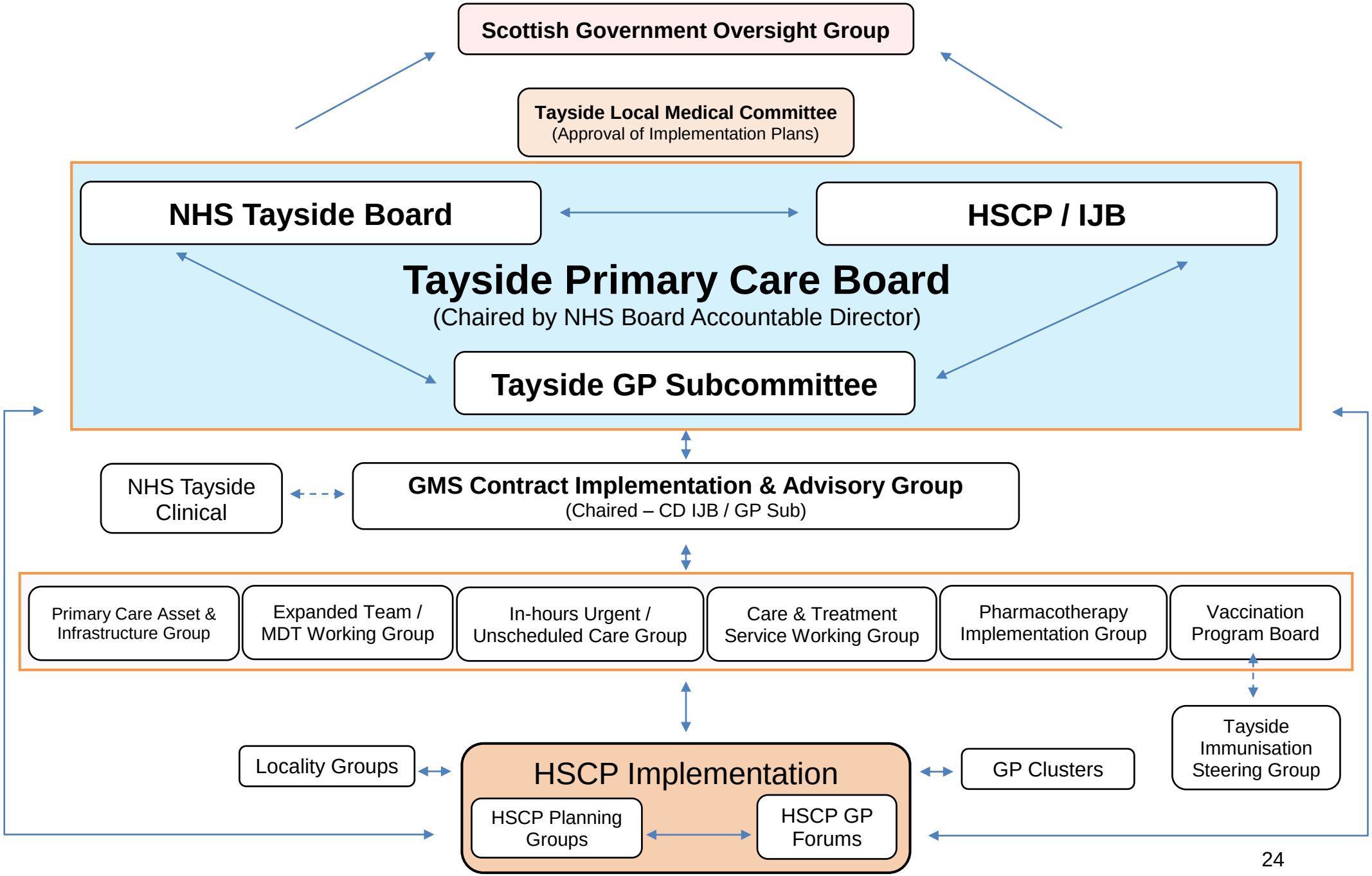
Development of the Plan

Each of the different work streams outlined in the following sections was developed on a regional basis with inputs from each HSCP, NHS Tayside and with Clinical Expert support and GP Sub collaboration. A group entitled the GMS Contract Implementation & Advisory Group (GMS CIAG) was set up for this purpose. This ensured efficient use of resource and an improved ability to generate common understanding of challenges and achieve expeditious solutions.

Ongoing national and regional monitoring of the PCIP

GMS CIAG's role is not confined to the generation of the PCIP. It has an ongoing role in monitoring and evaluating the outputs of the PCIP. Each regional work stream will continue to report to GMS CIAG. GMS CIAG's membership comprises healthcare professionals and service leads; representatives of the GP subcommittee; managers and clinical directors from the Health and Social Care Partnerships; and the Associate Medical Director for Primary Care and Primary Care Department Managers. GMS CIAG should act to facilitate communication between multidisciplinary teams, ensuring that all are supporting each other through the challenge of implementing the PCIP. GMS CIAG reports on progress and barriers to progress to the Tayside Primary Care Board. Quarterly funding status reports must be brought to the Primary Care Board with funding approved also by the LMC. The Governance flow diagram below presents this structure graphically.

Updates on the PCIP's progress must be sent in periodically to the National Oversight Group. This national group is comprised of representatives from the Scottish Government; the SGPC; Integration Authorities (HSCPs) and NHS Boards. It is responsible for overseeing implementation of both the GMS 2018 Contract by NHS Boards and Primary Care Improvement Plans by HSCPs. This will include focus on delivery of clear milestones for the redistribution of GP workload and the development of effective MDT working, including with non-clinical staff.


Scottish Government Oversight Group
Tayside Local Medical Committee
(Approval of Implementation Plans)
NHS Tayside Board
HSCP / IJB
Tayside Primary Care Board
(Chaired by NHS Board Accountable Director)
Tayside GP Subcommittee
NHS Tayside Clinical
GMS Contract Implementation & Advisory Group
(Chaired – CD IJB / GP Sub)
Primary Care Asset & Infrastructure Group
Expanded Team / MDT Working Group
In-hours Urgent / Unscheduled Care Group
Care & Treatment Service Working Group
Pharmacotherapy Implementation Group
Vaccination Program Board
Tayside Immunisation Steering Group
Locality Groups
HSCP Implementation
HSCP Planning Groups
HSCP GP Forums
GP Clusters

Local implementation and monitoring of the PCIP

Each Health and Social Care Partnership owns its own Improvement Plan and monitors it locally, reporting back to its Integrated Joint Board, and holding councils and health board to account in ensuring the timely implementation.

Professional and Care Governance is critical to the protection and improvement of high quality service delivery. Local and regional governance structures will be refreshed to ensure that they are clinically focussed providing guidance to the emergent new landscape of primary Care Delivery.

As workstreams are delivered at local level many of them will have and develop interdependencies with other services that will vary according to local circumstances. It will therefore be necessary to work with GP clusters, patients and other stakeholders in ensuring that robust, locally owned plans are developed, approved and implemented.

Cluster role in implementing and guiding the PCIP

Each HSCP has aligned its structures into locality units. Each of these has a grouping of General Practices forming a 'Cluster'. GP clusters, with identified quality leads from each GP practice (PQLs), have a clear role in quality planning, quality improvement and quality assurance. Their core functions include an intrinsic focus to improve clinical care quality for their practice populations through peer led review whilst also providing meaningful influence the local system on service function and quality. Quarterly service provision reports will be made available for review by clusters to ensure quality and consistency and reassure of service development across all areas.

Each Cluster has an identified lead GP. These Cluster quality leads are an integral part of locality improvement groups which, in turn, feed into HSCP Strategic Planning Groups responsible for service commissioning. GP clusters also feed into the local Clinical, Care and Professional Governance Forums which report to both the Integrated Joint Boards, and through the Clinical Quality Forum to NHS Tayside Board.

This model of engaging GPs within clusters, and cluster leads within HSCP structures is consistent with the contract's call for GPs to become expert clinical generalists playing a clinical leadership role in the design of services along with other professional colleagues.

Interface Issues

The PCIP is being implemented at a time when there is a wider set of changes to flows of work across Primary and Secondary systems. Inevitably without good communication across these systems we will not be able to achieve the best outcomes for our patients. A new Primary : Secondary Care interface group is being developed to address these issues.

This is supported at NHS Tayside level with the appropriate recognition and authority to influence pathways of care for patients across the Generalist / Specialist and Community / Hospital interfaces. This will assist in turn the realisation of the Primary Care Improvement Plan's core aim of maintaining and improving the quality, efficiency and effectiveness of the care delivered to our population.

Future of the PCIP

The Improvement Plan is a living document. As services develop, new staff are employed, new premises and new ways of working are developed, it is inevitable that the Plan will change. At each stage of this development, further engagement will be required, including sharing ideas and working in partnership with various staff side and professional bodies. Although this Improvement Plan is for a three year time period, it will be reviewed many times over that period, ensuring it is on track and adapting as necessary. In keeping with that ethos, the Scottish Government has mandated that there will be at least annual formal review of the Plan. Within Tayside HSCPs, NHS Tayside and the Local Medical Committee are committed to ensuring that our PCIP is current, effective and responsive to the changing needs that will emerge over this time.

Evaluation & Monitoring

We will require a robust evaluation of the implementation of the PCIP across its three year lifespan. This is partly to identify the benefits that it will bring; partly to identify where a change in priority or direction is required and partly to identify where investment needs to be focused differently.

There will need to be tests of change and pilots as part of scoping for new services. These will require review and evaluation to ensure that they are capable of being scaled up, and that adequate information is available to ensure efficient and effective development and delivery of services.

Each priority area will identify a set of 'SMART' measures and hard objectives with which to monitor progress towards implementation and drive further improvement and development.

Evaluation will involve community and staff consultation in addition to quantitative and qualitative analyses.

There is a need to provide a suitable, timely and robust project and programme management resource to each HSCP area with the allocation of adequate business development and change management resource to allow for the initiation, monitoring and evaluation of local projects.

There will need to be a fundamental bolstering of resource to support HSCPs, primary care managers, and other workstream teams through this period of implementation to allow them to adequately support the clinically led delivery of the Plan.

As identified in the MoU and further clarified in the Funding Allocation letter, there must be a commitment to adequately resource this support as well as the required professional advice and support of the GP Sub and work of the Cluster GP leads in driving forward quality improvement at local level.

Workforce

Introduction

The PCIP describes fundamental change in Primary Care. It describes change in how healthcare is delivered, who delivers it, where it is delivered and how that care is organised, communicated and contracted for.

This change in how Primary Care is provided means that there will be a necessary requirement to change the primary care workforce that we currently have into the one that we will need for the future. Our future workforce will require new and differing competencies and skills to do the new and interesting tasks that are new to how we have worked before within Tayside.

Requirement for a comprehensive workforce plan

We need a Tayside wide workforce plan that takes us from where we are to where we need to be. This necessary transition requires the development of a robust workforce development programme. This programme must ensure that we possess within our workforce the competencies, skills and scale of workforce to deliver our new future.

There is a need to develop and enhance the existing skill sets of almost all staff involved in the care of our community, from Advanced Nurse Practitioners to Paramedics, Physiotherapists to Administration team. New skills and job descriptions that have yet to be defined will undoubtedly emerge as we implement this challenging but achievable Implementation Agenda.

To support this development there is commitment to break down barriers in recruitment, facilitate the streamlining and efficiency of grading processes and develop and invest in the necessary training resources required to develop our future workforce.

Employment arrangements of our workforce

There is a separate challenge as tasks previously performed by GP contractor employed staff become the responsibility of Board and HSCP employed staff, while aspects of necessary day to day clinical direction of the workforce remains with the GP. While this presents a new operational challenge, it is nonetheless critical to the risk reduction promises within the new GMS contract for independent contractor GPs.

Development of the wider workforce

The workforce development plan, as it develops, will outline a set of developments over a wide set of professional groupings. The Improvement Plan describes fundamental changes in scale, skills, and competencies within the nursing, pharmacy, physiotherapy and paramedic professions. If that is to be delivered within the ambitious time targets we have set ourselves, then we must not only describe how we address recruitment and training; but also address the contractual, trade

union and other employment issues that will inevitably follow from the new roles, new means of employment and new skills needed from our workforce.

Developing the workforce plan: identifying the existing workforce

Recruiting, developing and retaining our workforce against a backdrop of vacancies across Tayside, retraction occurring within secondary care, demographic pressure within the workforce itself and pre-existing pressure within the healthcare environment to develop new skills and roles is challenging. This is even before we consider the new roles and needs that the PCIP will bring.

We have at present only partial knowledge of our total current workforce, with only limited information about those employed by GP practices. At present we do not have central clear current knowledge of the head count, whole time equivalents, grades or competencies of those employed within practices across Tayside
In order to plan the transformation of this workforce it is essential that we possess baseline information on the current state position. This needs to cover:

- Current roles and numbers.
- Current skills and skill gaps.
- Required staffing models for primary care based on population differences and need.

One of the first actions in planning our future workforce therefore must be finding out the attributes and disposition of our current one. This should then allow us to identify where gaps are likely to exist, and allow us to plan how to recruit and train so that we can progress towards the workforce we require. In order to do this, we plan to survey both GP practices and existing primary care services over the 2018-19 period to establish a comprehensive picture of our current state.

Developing the workforce: identifying the future need

The needs of our future workforce are necessarily dependent on the following factors:

- the scale of the services that we plan to offer
- the locations at which are staff are employed
- the models chosen of how we employ our staff
- the models chosen of how we operate our services
- the models chosen of how our services will work together
- the availability of staff
- the new needs and skills our staff require to perform their roles
- the need to recruit and retain staff
- the opportunities to use staff more flexibly across services
- the financial envelope available

In recognition of the scale of the challenge we face, GMS CIAG has set up an expert led, professionally supported working group to collate and review these factors to produce early recommendations of where change or investment is required. There will be direct input into this group from the service areas impacted upon by the PCIG. Recommendations from this group will be sent to the Primary Care Board, the HSCPs and NHS Tayside for review, consideration and necessary action and approval.

Premises

Introduction

The work performed under the new Improvement Plan will require workplaces suited to the needs of patients and staff, with IT links that support the delivery of that care, and which operate within structures that provide for the safe communication of the results of that care into the patient record and back to those who have requested that care be performed.

While there are existing premises that are owned or managed by NHS Tayside and our local councils, there will be an increasing need to provide workplaces within local communities to perform work previously done within practices. With limited capital funding we will need to make the best use of those premises we have, consider where it is practical to use space within practices, and consider where new buildings are needed.

The PCIP recognises that the provision of appropriately located and designed premises linked by an effective IT infrastructure is critical to the development and delivery of improvement of Primary Care within our communities.

GP practice estate

The new GP contract recognises that asking GPs to own their own premises or to hold a lease that may commit the practice to paying rent for decades into the future places significant risks on General Practitioners and may discourage new partners from joining the practice when older GPs approach retirement. The contract therefore states that the ownership of leases and of premises should move from GPs to Health Boards. The effect of this change will be a substantial reduction in risk for GP partners in Scotland, which should lead to a substantial increase in practice sustainability and hence result in better care for patients.

GP Owned Premises

New interest-free sustainability loans will be made available, supported by £30 million investment over the next three years. GP contractors have been informed of the priority categories for applications and requested to provide notes of interest by 25 May. The District Valuer has provided refreshed estimates of the existing-use value of GP owned premises and the intention is that these will be provided to GP contractors before the scheme opens.

The GP Premises Implementation Group have met and agreed broad principles for the loan documents. There will be discussions with BMA and NHS representatives on the detail of the loan documents with a view to all parties reaching agreement. The plan is to open the scheme once the detail of the loan documents has been agreed.

GP Premises Survey

Health Facilities Scotland has prepared the High Level Information Pack for bidders for the survey contract and an assessment panel is being identified. Health Boards have been asked to confirm that the list of properties to be surveyed is correct.

GP Leased Premises

The Scottish Government's long term strategy is that no GP contractor will need to enter a lease with a private landlord for GP practice premises. NHS Boards will gradually take on the responsibility from GP contractors for negotiating and entering into leases with private landlords and the subsequent obligations for maintaining the premises. NHS Boards will ensure that GP contractors are provided with fit-for-purpose accommodation which complies with the standards set by the Premises Directions.

There are three ways in which NHS Boards can take on the responsibility of providing a GP contractor with practice premises. These are:

- negotiating a new lease for the GP contractor's current premises, with the NHS Board as the tenant
- accepting assignation of the GP contractor's current lease
- providing alternative accommodation for the GP contractor when its current lease expires

If a lease expires before 1 April 2023, the most likely course of action is for the NHS Board to negotiate a new lease or provide alternative accommodation.
If the lease expires after 1 April 2023, NHS Boards will take on the existing lease from GPs where:

- The practice has ensured that its premises are suitable for the delivery of primary care services and are sufficient to meet the reasonable needs of its patients
- The practice has met its statutory obligations regarding the premises
- The practice has provided all relevant information to its NHS Board
- The practice has given sufficient notice to its NHS Board of its need for assistance
- The practice has registered the lease with the NHS Board
- The practice has the agreement of the landlord to the assignation of the lease (and the other necessary conditions)
- The practice has complied with its obligations under its existing lease
- The rent represents value for money

Current GP Premises Portfolio for Service Provision

GP practices currently operate a range of premises models in Tayside. The models vary in form and include large teams operating from independently leased purpose built facilities using private sector funding, wholly owned premises or mortgaged by the independent contractor, through to Board owned / leased premises.

There are 64 GP practices operating their main surgeries from 54 sites across Angus, Dundee and Perth & Kinross. With respect to sites these sites:-

- 13 are Board owned / leased premises sites
- 24 are premises leased from third party developers (including PFI)/ private landlords
- 17 are owner occupied premises

In addition to this GP practice estate there are a number of Board owned or leased premises, such as community hospitals and community care centres, embedded in the community which may be able to support delivery of the new services, specifically where there location facilitates local access for patient.

At present NHS Tayside occupy space within 37 practices supporting the delivery of community nursing services and anticoagulation clinics.

Planning for the future non-GP Primary Care estate

This Improvement Plan also describes a shift of work from General Practitioners to other healthcare professionals, many of whom will be located outside of General Practices. The Plan describes new services that will be developed; and existing services that will be enhanced. This section therefore also describes how we will ensure that we have premises fit for these new services and these new workers.

Although the Improvement Plan comes with significant resource aimed at shifting work from GPs to other healthcare professionals, it does not come with a capital allocation for the development of new premises for our new workforce to work in.

NHS Tayside has established an Assets and Infrastructure Programme Board with the purpose of developing, implementing and reviewing the regional primary care strategy for assets and infrastructure. This will pull together both national and local strands to develop a coherent strategy that provides the necessary infrastructure and premises to meet the needs identified by each of the Health & Social Care Partnerships.

NHS Tayside and our local councils own or manage a range of existing premises. However, it is recognised that the current premises portfolio is not designed to meet the needs of GMS 2018 or those of the extended multidisciplinary teams that will be

developed both within GP Practices and their localities. Premises provision has to date developed individually at a local level to meet local needs and has not been seen as part of a strategic plan.

There will be an increasing need to provide workplaces within local communities to perform work previously done within practices. With limited capital funding we will need to make the best use of those premises we have, consider where it is practical to use space within practices, and consider where new buildings are needed. It is important to realise that premises will not be replaced on a like for like basis.

There is a need for additional premises to support delivery of the services within each HSCP's improvement plan, in particular to provide locality hubs and care and treatment centres. The strategy will recognise HSCP priorities arising as a result of each of the phases in their three year implementation plans with initial delivery likely to be from existing facilities. Premises milestones will be mapped out for each phase and element during implementation of the plan.

The implementation of NHS Tayside's premises strategy will be underpinned by the national perspective which recognises that that the general practice estate needs to be considered as an integral part of the local care estates and planned for and invested accordingly, recognising that it is unrealistic to expect GP practices to fund new primary care premises.

Actions

NHS Tayside will be required to:

- Implement a detailed work programme to inform their strategy.
- Quantify the premises requirement and seek to establish optimum locations to meet the needs of the service.
- Develop a complete register of the estate available both within Health and within Social Care
- Prioritise the development of existing premises and the development of new premises to meet the needs of the Health & Social Care Partnerships

There are significant funding challenges attached to the development and implementation of the premises strategy to support delivery of services including; the need for capital investment, revenue funding to support function, space and quality surveys across GP Practices and funding to support lease transfers.

IT Infrastructure

Introduction

This PCIP describes a future where work is moved from General Practitioners and from GP practices to other healthcare professionals who may be working in other locations. This cannot proceed safely without IT systems that capture that work into the patient's core GP record.

Our IT systems need to be able to connect and communicate across primary care, and into secondary care. We need systems that can allow both primary and secondary care clinicians to appoint patients where and when they need to be seen. We need IT processes that return necessary clinical information about test results and procedures to those who have requested them.

Most medical error takes place when communication fails, and the future we are constructing will only work if our communications structure is robust. It is essential therefore that we develop safe and effective communication links that operate within safe, effective and well understood processes that work for both primary and secondary care.

This section describes the work that we are doing and the work we need to undertake to make sure that our population receives the safe, efficient and high quality healthcare it requires in the future described within this Improvement Plan.

Tayside's eHealth Programme

Tayside's eHealth programme recognises the role that technology will have in enabling the changes required to support the implementation of the GMS Contract, the NHS Tayside Improvement Plans and assist in the deliver for Primary care Transformation.

This support will cover the 6 key service areas identified in the GMS Contract:

- vaccination services,
- pharmacotherapy services,
- community treatment and care services,
- urgent care in hours services
- additional professional roles (MSK, Mental Health)
- community link worker services

The strategic aims of the national eHealth strategy remain in support of this work and are to:-

- enhance the **availability of appropriate information** for healthcare workers and the tools to use and communicate that information effectively to improve quality
- support people to communicate with NHS Scotland, **manage their own health and wellbeing**, and to become more active participants in the care and services they receive
- contribute to care integration and to support people with long term conditions
- improve the **safety of people taking medicines** and their effective use.
- provide clinical and other local managers across the health and social care spectrum with the **timely management information** they need to inform their decisions on service quality, performance and delivery
- maximise **efficient working practices, minimise wasteful variation**, bring about measurable savings and ensure value for money
- contribute to innovation occurring through the Health innovation Partnerships, the research community and suppliers, including the small and medium enterprise (SME) Sector

Key Principles

The following key principles will be used to evaluate and support implementation for the services in scope. These guiding principles, while apparent, are worth stating and include:-

- The need to provide services with access to an appropriate electronic health record to ensure relevant information is available at the point of care to aid clinical decision making.
- The solutions and systems will be prioritised against those already invested in by NHS Tayside, the North of Scotland region and nationally.
- The intention is to capture data once, but make it available for viewing and use at multiple stages in the provision of 6 key service areas – providing efficiency
- The design and build of the services should be applied consistently for Tayside, where clinically safe to do so. Variation will cause complication and result in difficulties in implementing solutions/systems and ensuring continuous improvement.
- The ability to refer and commission the services in scope of GMS contract will be phase through Primary, Secondary and Community care and likely Local Authority MDT Personnel and contractors, with Primary Care being the priority. Implied in this is Secondary and Community care will maintain an as

is position for accessing these services during the delivery of the primary care phase.

- Solutions and systems need to be clear, easy to use and have a simple ability to ensure patients are safely referred into and transferred across services. Having a consistent model for the service delivery model across Tayside will be a determining factor for this.
  Already at this early stage it is apparent that the technology to support business process will need to be provided by multiple systems. All stakeholders and users will require to directly engage with these systems.
- The ability to remain agile and flexible to emerging requirements is essential during the period of implementation and will require assessment when considering any 3rd Party providing support.

Out of Scope

Infrastructure Items – It is expected that the Primary Care Assets and Infrastructure group, will be responsible for the implementation of any infrastructure changes required to support the full GMS Implementation Programme. For the eHealth element this would be expected, where assessed necessary, items such as network capacity and coverage and End Point availability.

Current Priorities

There are five priorities for the eHealth Programme:

Priority 1 – to understand and document the business processes required to support the Tayside plan.
Priority 2 – consider the delivery model proposed by the different
Priority 3 – develop a joint mapping process to formally assess existing systems and solutions to map their ability (current and future) to support the implementation.
Priority 4 - carry out an assessment of capability or improvement necessary to support the implementation.
Priority 5 – carry out prioritised work-packages to realise changes to support delivery of solution/systems to the services in scope.

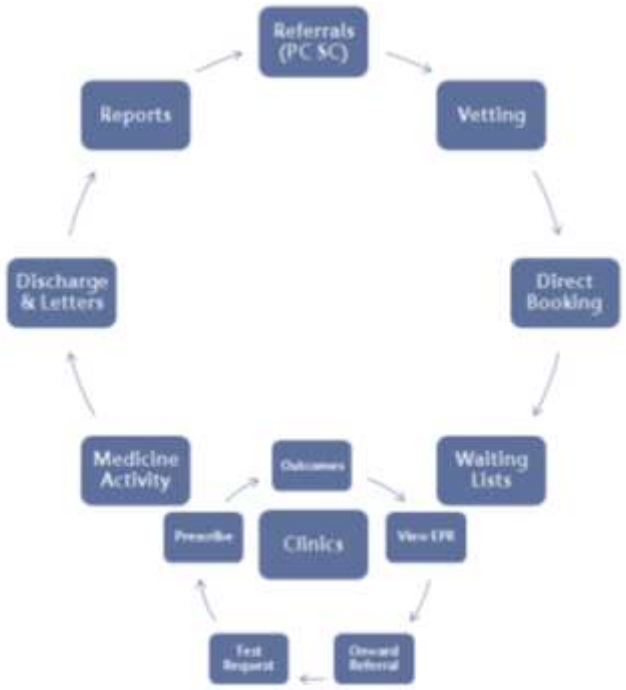
A proposed categorisation is as follows:-

Red	Supplier has no formal plan to provide this functionality in their product – i.e. not on a published roadmap
Amber	The supplier has a plan to provide this functionality or is running a test of change to help its development. Should also include functionality that is in use in other markets but has not been used in Scotland. That test of change could be in place in NHS Tayside/Scotland
Green	The supplier has the functionality in their current product set and this is working/functioning in live sites in NHS Scotland
Blue	NHS Tayside are currently using this functionality at present

Aims of Solutions and System

As well as their support of the guiding principles the solutions will be required to cover the range of high level processes detailed in *Figure 7 – High Level Business Processes*. These processes will be considered for every service level and require a significant investment in resource to understand the requirements. The processes need to be capable of being initiated by Primary Care (Phase 1) followed by Secondary and Community Care (Phase 2) and likely Local Authority MDT Personnel and contractors (Phase 3)

Figure 7 - High Level Business Processes



Current Projects and Early Milestones

Project Name	Project Description	Benefits	Current Status
Letham Federated Working	A solution was required to support a hub model agreed to provide MDT services to the population of Letham	• Ability to present patient details from multiple practices in a single view • Ability to record clinical updates in a system • Ability to provide these updates within the practice system in a timely manner • Presentation on the costs model associated with this working method • Information Governance model for sharing • Evaluation of benefits for this project	Test of Change **Closure**
Lochee Health Centre	The development of a 2c Practice and the merging of solutions and infrastructure to support a more modern delivery of hosted solutions, similar to a future GP IT Re-provisioning model	• Supports multi-agency working and health and social care agenda. • a blueprint for future primary care premises supporting GP IT Re-provisioning and new GP contract.	**Initiation**
Technology Care Fund	Through the national funding route for Primary Care Digital Funding. Practices are implementing, through choice, a range of technologies. These are:- **Clinical Coding** **Patient Text Reminder** **Mobile**	• assess the ability to reduce time spend coding and filing within the existing systems • Assess the impact on reducing waste through reduction in DNA's and releasing valuable clinical time. • Ability to provide offline working and update clinical records in a timely manner	**On Hold** **Execution** **Execution**

	WiFi **Patient Online Services** **Patient Portal**	• Provide a limited WiFi canopy in GP practices for use by MDT teams and for Patient Services • Provide ability to patient to make appointment and request repeat prescriptions, without the involvement of practice staff • Provide further access to self care management information	**Execution** **On Hold** **On Hold**
South West Angus	Test federated approach with 2 Angus practices in a virtual care and treatment centre	• Ability to present patient details from both practices in a single view • Ability to share appointments books • Ascertain solution suitability	Test of Change Request **Registration**
18/18 Care and Treatment	Requirements gathering and solution matching for Care And Treatment Services.	• Supporting access to and recording of relevant information within Care and Treatment Services in line with new GP Contract.	Test of Change **Initiation**

Other Active Projects that have dependencies

Project Name	Project Description	Benefits	Status
18/12 Extend Clinical Portal to all Pharmacies	17/92 community Pharmacies currently have pharmacists able to access clinical portal in them. This request is to roll this out fully and give access to clinical portal in the other 75 Community	• Ability to access Test results to support Pharmacy First and patients on drugs requiring monitoring eg. lithium • Ability to access Electronic discharge documentation (EDD): ▪ To support patients discharged from hospital	Initiation

	Pharmacy premises and their pharmacists.	who receive compliance devices from their pharmacy, ▪ In NHS crisis times where bed pressures exist to help with early supported discharge from hospital for medicines (required on discharge) to be dispensed through community pharmacy ▪ Support medication review of patients in care homes ▪ Emergency supply of medication required after hospital discharge as per community pharmacy unscheduled care PGD v 23 • Ability to Access to ECS – where necessary to facilitate an emergency supply of medication under community pharmacy unscheduled care PGD v 23	

18/06 Corporate CP Access to Staffnet	Provide access to staffnet in Community Pharmacy	To enable 18/12 Extend Clinical Portal to all Pharmacies	Initiation
17/40 Chronic Medication Service	Rollout of CMS to all Tayside GP/CP	The Chronic Medication Service aims to encourage joint working between GPs and community pharmacists to improve patient care by: • Identifying and Prioritising risk from medicines • Minimising adverse drug reactions • Address existing and prevent potential problems with medicines • Provide structured follow-up and interventions where necessary	Execution
18/67 Chronic Medication Service National Review Recommendations/Refresh	Refresh of CMS project		Request Registration
18/15 PCTP Assets and Infrastructure Dataset	Develop a comprehensive data set of information about all community based premises and their associated resources.	• Provide a solid base of comprehensive and accurate information on all aspects of GP premises and will underpin decision making process going forward.	Execution
17/139 AP Rollout (130 AP's) General Practice	Infrastructure Project to facilitate WiFI in General Practice	• To enable PC Digital WiFi Project	Execution

Enablers

The key enablers to support the implementation process mentioned below could be considered as deliverables for the Tayside Primary Care Board.

Information Governance – a data sharing arrangement needs to be put in place for the handling and control of patients' data currently retained by GPs but made available to NHS Tayside for use in clinical systems. The change required to enable this is defined in the following statement:-

"*Both General Practitioners and Tayside NHS Board ("the Board") are Data Controllers in their own rights. For data that has been agreed for share and viewable in Clinical Portal or other Board clinical IT systems, General Practitioners and the Board will be Data Controllers in Common. The responsibility for "legitimate access" to the shared data will therefore rest with the employer of staff."*

Primary Care Assets and Infrastructure Group - this group is collating a data set that could be used to confirm locality approaches to providing services and solutions from the locations identified. It is also consider that this group, following review of their data set, would be in a position to recommend and implement infrastructure improvements in order to enable the provision of services and solutions as required by the plans. Examples of this would include Network connectivity for provision of solutions, patient video conferencing, Unified Communication platforms.

GP IT Re-provisioning

The deliverables through the GP IT Re-provisioning should be considered prerequisites and need to be controlled to ensure they support the delivery of the overarching work-packages that are key to the programs objectives. The timeline for this delivery will require NHS Tayside to adopt the services offered through the GP IT Re-provisioning programme during the three year programme.

It is also critical to successful delivery that NHS Tayside seeks to adopt single system coverage within GP Practices. Any movement from the current model will impact on timescales and budgets and will require resources to be diverted to providing the solutions necessary for the GMS implementation and will put at risk the ability to deliver this agenda.

The requirement from the GP IT re-provision must therefore be set to minimise the work associated with adopting the new model and minimise the degree of re-work associated with the test of change/current implementations. The potential scale of this work, available to be implemented from 2019, could divert significant resource and is a significant risk to all programmes of work in the scope of the GMS Contract implementation group.

Early discussion with the Primary Care IT Group, has confirmed this as a risk. A move towards a single system should be the considered as the key enabler to support the GMS implementation and reduce the risk of patient data not being available to clinical staff via electronic means.

Potential Risks

Resources – there is a risk that competing organisational priorities will result in resources having to be utilised in other projects or programmes during the 3 year period of implementation. Given the size and scale of many national programmes due to impact systems and solutions during 2018 – 2021, the risk is currently a likely (4) and would have a major (4) impact on the programme. This gives an inherent risk quantification of 16 High.

The mitigation to this is for the programme to procure dedicated programme and project management resource ensuring these resources are ring fenced for the duration of the programme. It is expected that the resourcing requirements will reduce during the 3 year period as the solutions commissioned move into a Business as Usual support model.

Dependencies – given the complexity of this programme and the number of dependencies and enablers are significant in number. Some, but not all of the dependencies are detailed in this paper, while others will be discovered as the programme moves through initiation. Key items mentioned are Data Sharing arrangements, Infrastructure Requirements, GP IT Re-provisioning etc. Given the number the likelihood of this happening is likely (4) and the impact, depending on the dependency, is moderate to major (3 – 4). This gives and inherent risk quantification of 12–16 High.

The mitigation to this is for the programme to ensure active management of the dependencies, to be clear with the responsible officers the criticality of these and to seek support of the Primary Care Transformation Board when escalation is necessary.

Supplier Management and System Maturity – there is a risk that the systems provisioned in recent periods within NHS Tayside either directly or through National Frameworks, were not specified to the requirements to be detailed as part of the GMS Contract. In addition, the agility of suppliers in the Healthcare sector to adapt and change their software has been limited either through resource challenges internal to the 3rd Party or a result of the solution being managed nationally. That said they are Healthcare system and so the likelihood of some business functionality not being available is possible (3) and the consequence moderate (3). This gives an inherent risk quantification of (9) or Medium.

The mitigation to this is to build on existing supplier relationships, leverage active procurement activities nationally, regionally and locally and provide regional pressure to suppliers where appropriate to adapt and tailor their software to the requirements. With this in mind the business requirements gather has been focussed on areas where there is suspected business process gaps e.g. Pharmacotherapy.

Financial Risk – there is a risk that suitable funding for solutions/systems is not available to provide the needs of the services. The risk if further enhanced given that the requirements is still to be understood and translated into licencing, implementation and support costs. In addition many of the systems will go through contract re-negotiation during the period of implementation. The likelihood of this risk occurring is considered possible (3) and the consequence to provide efficient electronic working practice is major (4) – given a risk exposure of high (12)

The mitigation to this is to move through the requirement process as quickly as possible so funding can be profiled and secured.

Governance

The design, testing and implementation of solutions (systems) and infrastructure serviced by eHealth will require clear guidance and decision making from within the governance structure. This structure is set out in NHS Tayside's *Delivering Primary Care Transformation & GMS 2018 Implementation* document and is assisted by a number of specific sub groups working with operational personnel responsible for the service improvement plans.

Funding

Additional funding will need to be provided to support implementation, licensing, integration and resources to support implementation.

The detailed funding model will require refinement as the service plans are translated to a system delivery stages, so are likely to be phased over the 3 year period. An early estimate is detailed below but subject to change.

The expected funding requirements are:-

Funding Item	Nature One Off/Recurring	Description	Estimate
System Licences	One Off?	Provision of system licencing costs and use	Unable to estimate
System Implementation Costs	One Off	Provision of 3rd Party implementation services	Unable to estimate
System Integration Costs	One Off	Provision of interfacing of data item to multiple systems	Unable to estimate
Activity Reporting Development	One Off	1x Reporting Consultant	£55k
Implementation Resources	On Off	1x Programme Manager 2 x Project Manager/Business Analysts 1 x Project Administrator	£450k
System support costs	Recurring	Annual Support and Maintenance Costs	Unable to estimate

Vaccination Transformation Programme

As part of a commitment to reduce GP workload Scottish Government and SGPC agreed vaccinations will move in stages from a model based on GP delivery to one that is NHS Board delivered through the development of multi-disciplinary teams. By 2021 almost all vaccinations previously undertaken in General Practice will be delivered this way.

In NHS Tayside we have been delivering most childhood vaccinations since 2016. The changes introduced by the new GMS contract provide us with the opportunity to extend our vaccination programme, to work collaboratively with other parts of the system to design models that increase the opportunities available for our workforce by developing attractive roles and build sustainability.

Introduction

The Vaccination Transformation Programme (VTP) is a 3-year Scottish Government led programme running from April 2018 to April 2021. The VTP forms one of a number of priority work-streams within the Government's programmes for Primary Care transformation.

The VTP seeks to develop and transform vaccination administration throughout Scotland. The main drivers for the VTP include the increasing number of vaccinations and complexity of schedules, transformation of school nursing and health visiting roles, re-establishing the role of general practitioners as expert medical generalists, and re-configuration of health and social care services including the formation of Integrated Joint Boards (IJBs) and Health and Social Care Partnerships (HSCPs).

Current Position

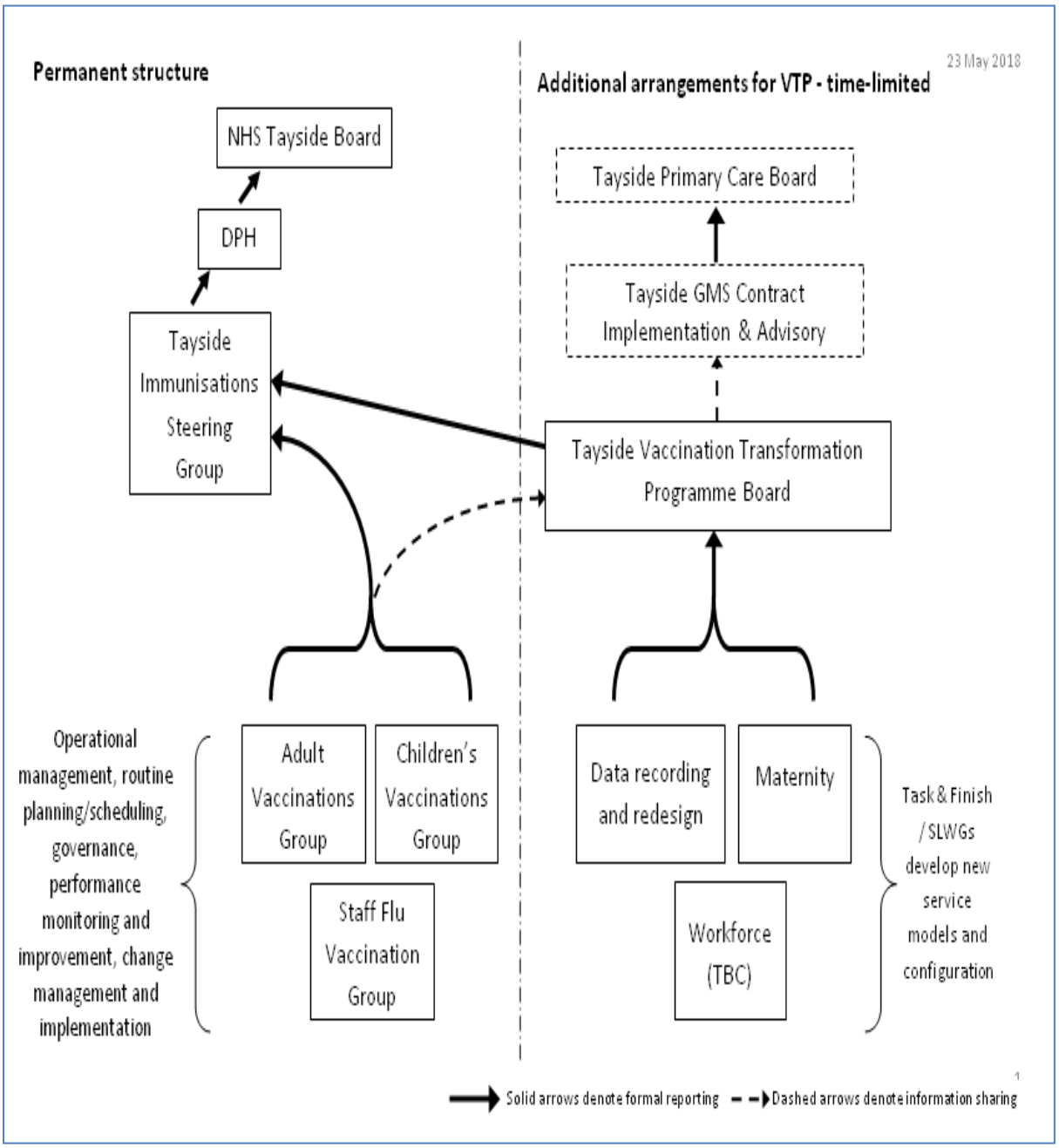
An NHS Tayside Children's Immunisation Service was formed in 2016, becoming operational in October 2016. The service delivers routine pre-school and school age primary immunisation programmes previously delivered by general practice, health visitors and school nurses. A recent review of the service and workforce identified positive benefits achieved and identified a number of challenges and areas for development. These include recommendations around workforce (staffing, cover, retention and career development); induction, CPD, supervision; clinical practice and travel/travel costs. Routine adult immunisations some catch up/mop up vaccines for children and selective children's and adult vaccinations are administered by a range of services in primary care, community pharmacy, specialist services and private providers.

Redesign Work already underway

Members of the VT Programme met with stakeholders throughout November and March to map out and agree a potential model for future vaccine delivery in Tayside and to develop the VT programme governance structure.

Governance & Monitoring

A multi-disciplinary Steering Group oversees immunisation governance, development and service delivery. The diagram below sets out the suggested synergy between current working groups and governance structures, the newly established VTP Board, and additional new working groups that may be required.



Future Vision

Following consultation, the agreed Tayside vision, is for an integrated comprehensive locality-based adults and children's vaccination service, integrated within HSCPs, operating within a single Tayside management structure. In line with IJB transformational plans, by 2021 this service should be coordinated around existing GP clusters, but with NHS directly employed staff and integrated within HSCP Care & Treatment Services (locality hubs) as part of the new model for primary care delivery.

This model provides opportunity for flexible roles, integrated service provision across primary and community care, and facilitates career development within the locality and services. Within immunisation therefore, individual staff roles may be flexible and negotiable, from dedicated child or adult vaccinators, to vaccinators for all programmes, to staff who deliver vaccines as part of a wider role. Other services and providers, including maternity, paediatrics and community pharmacies, will also have roles in delivering and contributing to specific vaccines and programmes.

Successful integration and future delivery of the VTP is dependent upon a number of factors being in place. These include integrated workforce planning between nursing, AHPs, Pharmacy and HSCPs, sufficient funding, additional resource, robust and integrated IT systems and premises.

Milestones

Year one of this Programme seeks to build on existing work undertaken within children's service delivery (0-19), with Years two & three seeking to take an integrated approach to service and workforce development in partnership with all HSCPs, GP and practice nurse services, Pharmaceutical, AHP and Nursing workforce plans therefore ensuring integrated service delivery within locality, primary care and treatment services.

The table below sets out an initial transition programme for vaccines in Tayside.

Year 1 (2018/19)	• Build resilience of the current Children's Immunisation Team and ensure that routine pre-school and school vaccines are provided in a safe and timely fashion. • Expand the remit of the Children's Immunisation Service to cover all children's vaccinations, including catch-up and mop-up doses for children with incomplete or unknown immunisation status; missed school age vaccines; children new to the UK; and immunisations of children with underlying medical conditions not routinely provided by a specialist service. Provision of adolescent booster mop-ups through community pharmacy may be considered as an interim arrangement. Pre-school influenza, travel vaccines, and those provided routinely by specialist services are specifically excluded from transitioning in Year 1.

	• Operational management of Children's Immunisation Service to remain with Children, Young People & Families Directorate. Begin to develop plans for redesign and integration within locality models and structures. • Begin to shift the responsibility for delivery of individual adult immunisations programmes away from General Practice e.g. vaccinations in pregnancy. • Expand community pharmacy administration of vaccinations for residents in Care Homes (e.g. influenza, pneumococcal, shingles) • Provide additional strategic Consultant PH leadership and project management to lead and develop and oversee the three year VTP programme. Seek to clarify any additional workforce implications within PH vaccination team.

There is less certainty as to the priorities for Years 2 and 3, as this will be shaped by Tayside VTP Board discussions, resource allocation, and the implementation of the PCIP in Tayside, as well as national progress and direction for specific vaccination programmes (e.g. Travel vaccinations and travel health advice).

Year 2 (2019/20)	• Pre-school influenza • Build on adult's service e.g. selective immunisations for at risk groups and individuals with underlying medical conditions or immunosuppression.
Year 3 (2020/21)	• Age related adult programmes (e.g. pneumococcal, shingles and influenza) • Travel N.B During the 3 year programme when it is safe and appropriate to do so, responsibility for the delivery of the majority of immunisation programmes will be transferred to IJBs.

Resource Requirements & Finance

A detailed costing of Year one of the programme has been developed and is currently being prepared for wider consultation. The cost of the first year of the programme is projected at £411k, divided between additional resource to deliver immunisations; administrative and managerial support to co-ordinate and manage the programme; and clinical input to guide it.

Barriers and Opportunities

The changes proposed for the delivery of the vaccination programme offer the opportunity for us to deliver services differently. We have the opportunity to build new and exciting roles for the team, away from purely being vaccinators. This development and broadening of the roles should help us meet some of the current difficulties and challenges we have been experiencing in the recruitment and

retention of staff. We will also have the opportunity to build the service around the newly formed care and treatment centres, which again should help to alleviate some of the challenges around staff travel and attracting staff to the role. In order to manage the complexity of the programme and the scale of the work detailed within the workstream there needs to be significant investment in clinical leadership and programme management support.

Evaluation of the programme

The VTP board is developing a range of evaluation measures as part of the implementation phase. These will include:

- Vaccination roles for specific vaccination strands
- Measures for staff such as recruitment &retention progress
- Staff experience
- Patient and Carers satisfaction
- Prediction of vaccination wastage and error rates

Pharmacotherapy

Introduction

The GMS Contract describes how by 2021 every practice will receive support from a new sustainable pharmacotherapy service which includes pharmacist and pharmacy technician support to the patients of every practice. This will allow GPs to focus on their role as expert medical generalists, improve clinical outcomes and support prescribing improvement work. This is in line with the professional aspirations of the Achieving Excellence in Pharmaceutical Care Strategy to integrate pharmacists with advanced clinical skills and pharmacy technicians in GP Practices to improve pharmaceutical care and contribute to the multidisciplinary team.

From April 2018, the pharmacotherapy service will evolve over a three year period with the aim that at the end of year three pharmacy teams will be integral to the core practice clinical teams delivering a consistent sustainable service. 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.

Over the three year implementation period, pharmacy teams will take on responsibility for:

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

The table below set out in the new GMS Contract describes the service that NHS Tayside will have to develop by 2021.

Core And Additional Pharmacotherapy Services		
	Pharmacists	**Pharmacy Technicians**
Level one (core)	• Authorising/actioning 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	• Monitoring clinics • Medication compliance reviews (patient's own home) • Medication management advice and reviews (care homes) • Formulary adherence • Prescribing indicators and audits

	includes/authorising/actioning: • hospital outpatient requests • non-medicine prescriptions • instalment requests • serial prescriptions • Pharmaceutical queries • Medicine shortages • Review of use of 'specials' and 'off-licence' requests	
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

Current Position

Currently in Tayside medications are dealt with by a mixture of professionals within GP practices including GPs, practice admin staff and by dedicated pharmacy support. The existing locality pharmacy service is already delivering elements of the pharmacotherapy service, mainly in Levels 2 and 3 (see table below). These level 2 and 3 services will continue to be delivered over the three year implementation period.

Additional Advanced Level 2 Services

Role	**Activities**	**Pharmacy Team Member**		
		Senior Locality Pharmacist	**Locality Pharmacist**	**Senior Pharmacy Technician**
Level 2 (additional advanced)	Medication review (more than 5 medicines) Polypharmacy / medication reviews for specified groups of patients at both levels 2 and 3, either in their own home, care homes or in the practice, focusing on the priorities of NHS Tayside e.g. patients identified through DQIP2, chronic pain, older people, new patients registered to practice if complex. This may involve managing caseloads of patients on an	✓	✓	

	ongoing basis, developing referral pathways and using Independent Prescribing when appropriate			
	Resolving high risk medicine problems	✓	✓	
	Non-clinical medication review			✓
	Medicines shortages			✓
	Pharmaceutical queries			✓

Additional Specialist Level 3 Service

Role	**Activities**	**Pharmacy Team Member**		
		Senior Locality Pharmacist	**Locality Pharmacist**	**Senior Pharmacy Technician**
Level 3 (specialist advanced)	Polypharmacy reviews: pharmacy contribution to complex care	✓	✓	
	Specialist clinics (e.g. chronic pain, heart failure)	✓	✓	
	Medicines reconciliation			✓
	Telephone triage			✓

In addition pharmacy teams are delivering locally agreed activities as detailed below, depending on resourcing and skill mix within GP clusters. These services need to be maintained over the 3 year implementation phase to promote and maintain safe, efficacious and high quality prescribing.

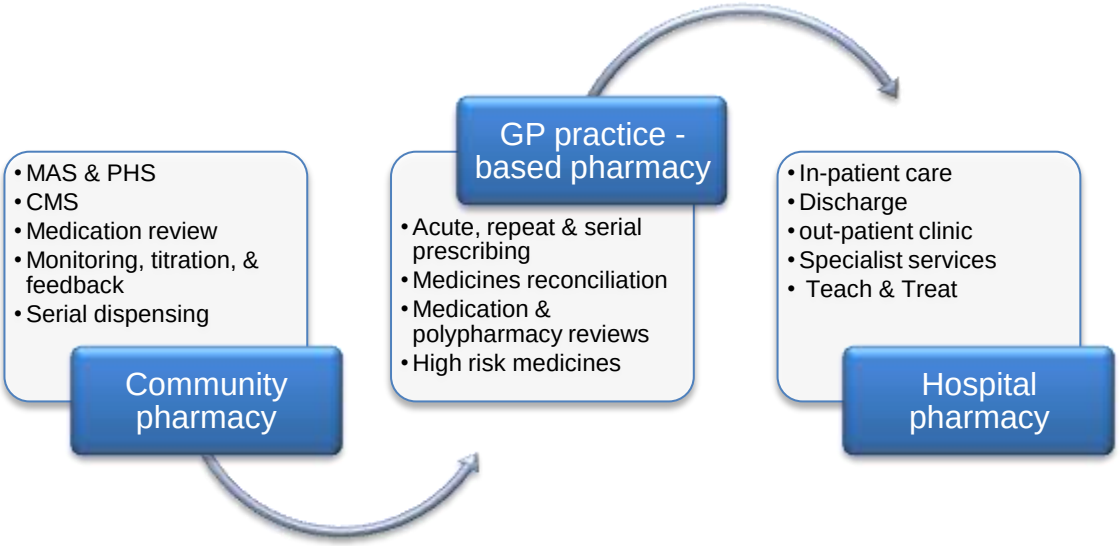
Tayside Locally agreed General Practice Pharmacy Services

Role	Activities	Pharmacy Team Member		
		Senior Locality Pharmacist	**Locality Pharmacist**	**Senior Pharmacy Technician**
Medicines Safety and Governance	Provide advice on local prescribing status of medicines e.g. shared care agreements/IPTRs	✓	✓	
	Advice on actioning MHRA warnings	✓	✓	✓
	Contribution to Significant Events, IR1s, Datix, Large Scale Investigations (Care Homes), Medication Complaints, Care at Home	✓	✓	✓
	Antimicrobial Stewardship	✓	✓	✓
	Controlled Drugs Governance	✓	✓	✓
Teaching and Training	Teaching of other pharmacists and pharmacy technicians in training and foundation posts	✓	✓	✓
	GP Education on Medicines related topics	✓	✓	✓
	Mentoring of others (nurses, pharmacists and AHPs) undertaking Independent Prescriber Training	✓	✓	
	Support and train practice staff to undertake non clinical medication reviews (NCMRs) as part of the repeat prescribing system			✓
	Job Shadowing for Medical Students in GP training practices	✓	✓	✓
Facilitating Prescribing Improvement	Prescribing Support Meetings with practices to discuss prescribing data and reports, and current prescribing priorities	✓	✓	✓
	Meetings with IJBs/clusters to discuss relevant prescribing data	✓		
	Supporting Organisational Prescribing Priorities	✓	✓	✓
	Facilitating and/or undertaking prescribing audits and quality prescribing projects	✓	✓	✓
	Simple PRISMS queries			✓
	Dealing with queries from projects e.g. from patients/carers		✓	✓
General	Clinical input into Practice Meetings	✓	✓	
	Service Development e.g. Teach and Treat, ECS and Care Homes	✓	✓	✓

The current service is delivered by 28 WTE Locality Pharmacists and 10 WTE Pharmacy Technicians in primary care across Tayside covering between 1-8 sessions per week (1x session= 0.5 day in line with GPs). There are an additional 10 WTE staff affiliated with the locality teams e.g. the ECS Pharmacy Technicians but they do not currently deliver sessions in GP practices.

Future Vision

In conjunction with the range of services to be delivered by 2021 (referenced in the introduction of this section), the GMS Contract describes the future Pharmacotherapy Service to be delivered in all regions by 2021:



This means that over the three year implementation period, all pharmacy staff, regardless of funding source will become part of an integrated team.

Milestones

In order to continue to progress the Pharmacotherapy service, the first priority will be to undertake a Test of Change (TOC) commencing in August 2018 to scope the workload resulting from level one service and estimate the resource and skill mix required to deliver the service consistently, taking into account other drivers in addition to list size such as deprivation and demographics. The results from the test of change will inform the three year implementation programme in terms of developing the level one activities that can be delivered consistently in year one. Other level one activities will be added in years 2 and 3 as staffing resource allows with full implementation of level one service required by year 3. Arrangements for this are now underway.

Work is also underway to make arrangements with community pharmacists to work directly with GPs to deliver patient facing care as per the requirements of PCA (P) (2017) 4. A successful pilot is currently in place in South Angus with the Monifieth, Carnoustie and Arbroath practices. The intention is to provide an arrangement of 2 days a week for each HSCP. This model has also been used in other Health Boards via Service Level Agreements. The capacity to deliver this approach at scale will need to be scoped further.

Good links will be established between the pharmacotherapy service and local community pharmacies to make full use of the clinical capacity within the chronic medication service (CMS). Community Pharmacists can carry out an annual medication review, as well regular monitoring and feedback to the GP practice for patients registered for this service. Making full use of the clinical capacity within community pharmacy can improve the pace and efficiency of delivery of the pharmacotherapy service in GP Practices.

GP Practice teams will also make full use of the other NHS Services available through local community pharmacies, such as self care advice, access to minor ailments service and Pharmacy First (currently restricted to UTI and impetigo). Further common conditions work is developing.

Resources and funding required

Funding of £922,100 was made available in 2017-18. This provided access to Pharmacists for all practices. It also provided an initial baseline of Pharmacists to support the delivery of the most appropriate skill mix, to enhance the service to the priority areas and provide pharmacists with advanced clinical skills. The funding has allowed an increase in pharmacy technicians, as well as of pharmacists within practices.

However, further funding is required to secure the required levels of staff to deliver the Pharmacotherapy Service. Guidance for pharmacy staffing in the National Health Service and Social Care Workforce Plan part 3 – Improving workforce planning for primary care in Scotland equates this to an additional 59 WTE pharmacy posts during the 3 year contract implementation period, to deliver a 52 week per year service, providing cover for annual leave and sickness.

For year 1 2018-19 this means we will be looking to recruit 11.6 WTE pharmacy posts at a cost ranging from £395-£697K depending on the preferred skill mix of post following the Test of Change evaluation (range between Band5 – Band 8a).

The table below breaks this down to individual HSCP

Total Year 1 Indicative Funding Required for additional Pharmacy Staff

HSCP	**Funding Required 2018-19** (dependent upon banding)
Angus	£92K-£161K
Dundee	£166K- £293K
Perth & Kinross	£136K- £239K

Currently the administration of medicines in General Practice is undertaken by practice employed admin staff. If the Tayside service were to employ all these administration staff to deliver appropriate roles with the pharmacotherapy service, this additional resource required would equate to an additional 104 WTE band 4 staff (based on 1WTE per 5000 patients). This would amount to a total cost of £2.9Million at the end of year 3, with year 1 costs of £574K. This reflects the true hidden costs of this work. However, it is recognised that further discussion and negotiation is required to ascertain how best this area is addressed.

Total Year 1 Indicative Funding Required for Administration Staff:

HSCP	**Funding Required**
Angus	£148k
Dundee	£230k
Perth & Kinross	£195K

Risks and Issues

The ability to fund and recruit additional pharmacy staff including administrative support is critical to the success of the programme. Recruitment for both pharmacists and pharmacy technicians is an increasing problem. The Scottish Government target of an additional 140 Pharmacists for Primary Care in the last 2 year period has resulted in vacancies and increasing challenges to recruit to this number of posts in such a short period of time. Consideration is also currently being given to recruiting to additional foundation pharmacist posts at Band 6 to build capacity for the future within Primary Care.

There is a real risk that there is not currently the specialised workforce available in order to carry out the roles as described within the new GMS Contract and that this will not be available by 2021. Other concerns are in relation to funding and having adequate funding to develop and implement a robust and efficient Pharmacotherapy Service in Tayside within the timescales allocated. There is a risk around availability of suitable and accessible premises, space and infrastructure to deliver a Pharmacotherapy service. Other practical concerns relate to IT infrastructure and that suitable IT systems will not be available to allow the communication required between the MDT, the Pharmacotherapy service and community pharmacy.

There is a risk that if a professionally satisfying pharmacotherapy service cannot be designed it will fail to attract and retain a suitable and motivated work force. We also need to be mindful of the fact that if highly skilled clinical pharmacists have to deliver Level 1 services routinely, staff may disengage. We need to think about these issues and how we make both the service and the roles within it professionally rewarding and satisfying. The market place for pharmacy staff will be competitive and we need to ensure that Tayside is an attractive place to work. There will be substantial requirements for training and mentorship, as well as for educational and clinical

supervision. We will need to ensure that sufficient staff are available to supervise education and training placements. We also need to explore what level of risk Pharmacists are willing/able to accept when issuing prescriptions, an area still to be explored.
Amongst some other potential unintended consequences that we must be mindful of is that if we use a greater proportion of the existing locality pharmacy resource to deliver the pharmacotherapy service, we may lose focus on prescribing efficiencies work. This may then place NHS Tayside at a potential financial risk. These practical issues will be worked through as we move through the implementation period, but it should be recognised that building a fully integrated Pharmacotherapy Service whilst providing many positive benefits to patients and staff, is not without significant challenges and difficulties which will have to be overcome in order to achieve the vision laid out by Scottish Government within the contract offer.

Engagement & Governance

A pharmacotherapy implementation group has already been established, with representation from all of the key stakeholders. This working group will feed into the GMS CIAG, which will report to the Primary Care Board.

Regular engagement with the GP Sub-committee will be essential throughout the implementation period. In view of this, they are represented on the Pharmacotherapy Implementation Group. Project support and improvement support has already been established. We also recognise that developing the Pharmacotherapy Service will require substantial staff engagement, across all sectors with workforce colleagues and staff side representatives. Patients and their interests are at the heart of everything we do. Patient engagement and public involvement both for this work stream and wider in terms of the plan overall will be a central feature of how we progress this work over the next three years.

Community Treatment and Care Services

Introduction

Community Treatment and Care Services provide an opportunity to deliver high quality care that is located within the community where patients live.

The types of services which may be provided include:

- management of minor injuries and dressings
- phlebotomy (suggested in the contract that this is a priority in year 1)
- ear syringing
- suture removal
- chronic disease monitoring

The responsibility for providing these services will move from General Practice to HSCPs over the next three years.

This is an ambitious programme of re-design representing one of the greatest opportunities to get things right for patients so that they are seen by the right person, at the right time and in the right location. It also presents an area where we can get it right for the professionals who work in primary care by creating rewarding and satisfying careers. The Scottish Government has committed HSCPs to developing care and treatment services for patients local to where they live. By necessity Partnerships are required to meet the distinct needs of their local populations whilst at the same time recognising that a number of core principles for the redesign of services require to be retained.

Community Treatment and Care services have been designed for use by primary care. They should also be available for secondary care referrals if they would otherwise have been work load for GPs. Where Care and Treatment Services are used by secondary care, they will require funding that is in addition to that which is outlined here in the PCIP.

Current Service Provision

These services are currently delivered in a number of different ways including:

- In Practice by GPs and Practice employed staff
- Partly funded by Local Enhanced Funding streams
- In community hospitals, treatment rooms and Minor Injury and Illness Units by HSCP staff
- Elements of care and treatment services work performed in secondary care

Future Vision

By 2021 these services will be commissioned by HSCPs and delivered in collaboration with NHS Boards who will employ and manage appropriate nursing and healthcare assistant staff.

Local circumstances and demand will determine where it is most appropriate to safely situate services. In some circumstances, services may still be carried out in the Practice environment, in others the NHS Board may decide to operate these services from separate facilities. Where a separate facility is developed, this offers an opportunity to co-locate other health, social and third sector services as part of a larger community hub delivering a broad range of complementary services to the entire community.

The key aim is to allow patients convenient and comprehensive access to community treatment and care services. Where it is agreed locally that practices will continue to deliver care and treatment services then support will be provided in the form of payment of staff expenses or in the direct provision of NHS employed staff.

These changes offer a radically different future for primary care from the one in which we now live. We cannot under estimate the scale and complexity of what is required, as we design services with a workforce that currently does not exist, with competencies that we have not yet fully worked out, working from differing premises.

Core Principles

In Tayside we have agreed upon a number of core principles that are required in the future redesign of and provision of care and treatment services:

Principle 1:

- A single system facing towards secondary care

Rationale:

Secondary care does not have the flexibility or resource to identify the specific delivery mechanism in each locality area. A single system that allows tests or procedures to be ordered in a set, common fashion will have a lower error rate and a higher adoption rate.

Principle 2:

- Room for differing local implementation in different HSCP areas depending on the available resource

Rationale:

There are three main ways in which a secondary care request might be satisfied:

- Delivery of the service in a locality centre or community hospital
- Delivery of the service by NHS employed staff in a local GP practice
- Delivery of the service by a local practice at an agreed tariff

The choice of which is the preferred route will be dependent on what resources the locality possesses. Some localities will already have staffed community hospitals or centres that can fulfil secondary requests. Some localities will not have any appropriate NHS owned resource near enough for the local community to be useful and will not have sufficient GP contractor capacity to deliver such a service from a GP practice. Local practices may however have sufficient room to embed an NHS employed staff member to deliver the service. The anticoagulant monitoring service has used this model in some practices with periodic clinics held in GP managed premises by NHS employed staff. In some localities where there is spare practice nursing capacity within practices it may be reasonable to consider either a bulk contract or item of service contract model of employing GP managed staff to deliver this service.

Principle 3:

- Diagnostic tests ordered by a clinician should return to that clinician regardless of whether they are based within primary or secondary care

Rationale:

The aim of the contract is to free up GP time in order to allow GPs to fulfil their role as "expert medical generalists". It is therefore necessary that secondary care requests are returned to secondary care for interpretation and action. The movement of work from nursing and HCA staff out of General Practice whilst retaining the responsibility of interpreting and managing the result does nothing to deliver on this objective and runs contrary to the GMC view that the ordering clinician should be responsible for interpreting the result of the test they have ordered.

Engagement and Consultation

Each HSCP has undertaken significant consultation with general practices given the need to consider local circumstances in development of services to ensure convenient and safe patient services. Results are summarised below.

Whilst scoring systems used varied considering all responses priority afforded was as follows. (1 being of highest priority and 7 being of lowest)

Task	Dundee	Perth & Kinross	Angus
Leg ulcer care	1	2	1
Wound care	2	1	2
Phlebotomy	3	5	4 =
Minor injuries	6	4	3
Ear Syringing	5	6	4 =
Suture removal	4	3	6
Chronic disease monitoring & related data collection	7	7	7

Significant planning work has taken place within each HSCPs in relation to contract delivery and the wider implementation of local strategic plans. Regional planning around IT requirements has started. Each HSCP has established a local working group to oversee the implementation of Community Care & Treatment Services.
Whilst we recognise that phlebotomy has been identified by Scottish Government as the priority area for 2018-19, we will also be reflecting the viewpoints of our local practices and clusters.

Progress to date in each HSCP is as follows:
Dundee:

1. Complex leg ulcer clinics in place for 2 clusters with further roll-out planned.
2. Job descriptions developed and submitted to AFC to support expansion of teams.
3. Planning initiated to develop Lochee HC as a care and treatment centre.

Perth & Kinross:

1. Currently scoping phlebotomy services, leg ulcer and catheter clinics
2. Proposed service developments Aug 2018-Feb 2019 include lithium/ECG, anticoagulation, phlebotomy service introduction and pre-operative surgical assessment

Angus:

1. Initial planning progressed within Angus Care Model conversation and planning.
2. MIIU service model approved and will be implemented in 2018/19
3. Proposed service developments for 2018/19 and the 2021 vision for Care & Treatment Services in Angus available in draft pending local approval

Barriers and Opportunities

There are a number of general and specific risks presented by this complex area of redesign. Many of these services are already managed well within general practice where care is already delivered close to the patient. HSCPs will have to make decisions on the number, locations and how services will be delivered in their areas. Perth & Kinross and Angus have community hospitals that may provide possible locations for these services, but this work will need to take place in conjunction with the other complex review and change programmes taking place. Dundee has no community hospitals. This makes finding specific locations more challenging. However, there is flexibility in how we provide this model with services being delivered in a variety of different ways. Along with the changes in premises introduced by the new GMS contract, there is opportunity to do things very differently. It will be for HSCPs to consider this in their planning and implement what best suits their specific needs and local populations.

The roles of staff in supporting this work, the capacity of staff to absorb the work and the various professional standards required and how they are contracted is still to be worked out. The changes to roles will result in additional training, supervision and development of standard operating procedures. The detail of this will require input from the Nursing Directorate and will need to be negotiated with HSCPs, NHS Boards and GPs.

The intent behind establishing the care and treatment service is to relieve pressure on primary care. The service also presents opportunities to move secondary care services closer to the communities where the people who need those services live. Care and treatment services might also act as care hubs around which other community and third sector services might be constructed. The PCIP does not bring funding for either of these desirable goals and they would therefore need to be resourced from outside of this plan.

IT is one of the greatest challenges to the care and treatment service. We require IT systems that are fit for purpose and which can communicate across services, primary and secondary care and with GP practices. Safe systems that can perform this function need to be developed and rolled out. If we cannot achieve this we will not meet the intended aim of these services in providing safe, seamless care for patients and it will not result in a shift in workload from GP practices.

Urgent Care Services (in hours)

Introduction

A significant amount of GP time is used in visiting patients at home who could have their needs effectively dealt with by other health professionals. The new GMS contract and MoU describe a future model with advanced practitioners providing support as first responders for certain urgent unscheduled care presentations and home visits. The aim of this model is to free up GP time so it can be reinvested in the model of GP as expert medical generalist.

Current model

Currently almost all home visits are made by GPs. In certain circumstances nurses and advanced nurse practitioners may visit as part of enhanced community support, nursing home support or other project teams but this is very much the minority. Paramedics employed by Scottish Ambulance Service (SAS) visit and assess patients who have accessed them directly through the 999 service and may deal with some of these presentations within the community without GP involvement. However, this presents a tiny fraction of the overall workload.

Future Model

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

Redesign already underway

There are two strands to our approach in Tayside for providing advanced practitioners as first responders undertaking home visits. The first is to develop and enhance the nursing teams that already have some input into visiting in the community and the second is to work with SAS to progress and grow the Specialist Paramedic Practitioner role.

Paramedics

There is real potential to further maximise the contribution paramedics and specialist paramedics make as a member of the community based multi disciplinary team. This approach is outlined in *Towards 2020: Taking Care to the Patient- A Strategic Framework for 2015-2020*. As part of the SAS national strategy, 21 specialist paramedics will be appointed to Tayside, with the first cohort already in training.
In line with this workstream, in 2018/19 it is proposed that SAS will appoint 2 wte paramedics to support tests of change to inform future modelling. This will allow the testing of service models to further develop the service. This will ensure that this test is ‘ringfenced’ and thus avoid any negative impact on core service provision.

Within Angus it is proposed that a paramedic will be included, as a test of change, within the enhanced community service of one Angus cluster. That will provide the potential for the paramedic to support both home visits and in practice patient reviews for patients, following an initial practice based triage. This will provide additional information regarding the effectiveness of this model of care.

Evaluation

A robust evaluation process will be detailed upon approval. This will include:

1. Qualitative data such as:
- Profile of patients seen by paramedics as part of the practice MDT response
- Place of care delivery (home/practice/clinic)
- Patient outcomes
- Impact of SAS rates of low acuity calls
- Emergency admission rates
2. Quantitative data such as:
- Patient satisfaction
- Staff satisfaction within MDT

A multidisciplinary, multiprofessional group will monitor the outcomes of these tests of change and report back to GMS CIAG, the Primary Care Board and the HSCPs.

Barriers and Opportunities

Recruitment of sufficient workforce may prove challenging. There is a concern that current paramedics may not wish to progress to these new specialist paramedic posts. GPs have expressed concern that the development of these roles may impact adversely on the current provision of SAS services.

Many practices have worked hard over a number of years to manage demand for house calls by actively supporting and encouraging attendance to the practice. Patients able to attend GP practices are seen in better conditions with better information than those at home. Introducing a responsive home visiting service may drive up demand as a more convenient option for some who could attend their practice but choose not to.

House calls are often made to the sickest and most vulnerable in society. As these patients may be medically very complex they may be better served by continuing to see the GP as the expert medical clinician who is more appropriate to deal with complex undifferentiated illness. An effective urgent visiting service needs to be able to recognise those cases that require GP input; it cannot be seen as a substitute for all GP visiting. It is vital that a GP who knows the patient is available for clinical direction and input to the visiting service if the service is to function safely.

We will require robust clinical IT systems that can provide appropriate access to the patient clinical record both to determine the clinical requirements of the patient and

to document and communicate back to practices what has been done. We also require administrative IT systems which can manage referral bookings from a range of sources.

Support is required from practices and specialist services to develop and implement new protocols and pathways. Without access to suitable training and in particular the commitment for the provision of mentorship support from the GP community whilst these staff are in training, they will not be able to progress in the competencies they will need to do their work with patients safely.

Next Steps

In addition to the national monies provided directly to SAS to support training of specialist paramedics and increase workforce for the long term, an initial short term funding of 2wte Band 6 paramedics, at a cost of £85k, will support a test of change within each HSCP area in 2018/19. This will enable models to be tested and developed with view to roll out in 2019/21.

Developing the nursing model

A further strand in providing advanced practitioners to support urgent unscheduled care presentation in hours is to augment the existing peripatetic nursing home service and the current enhanced community nursing model to visit housebound and care home patients who are not currently covered by these services.

Redesign work already underway

Within Angus, Advanced Nurse Practitioners based within the Medicine for the Elderly service have supported community nursing teams and practices within Enhanced Community Services to support complex care coordination and same day assessment in the deteriorating patient. This model has also been tested supporting triage of same day demand, including house calls, within practices.
Dundee HSCP is developing their existing nursing teams with a view to undertaking house calls and have identified four types of patients requiring acute home visiting:

Type 1: Care Home residents

Type 2: Minor illness cases

Type: 3 Acute Undifferentiated illness and long term conditions

Type: 4 Palliative patients

In year 1 they will test and develop a model that supports and enhances the existing care home team to undertake dealing with urgent/acute care of care home residents across Dundee. At the same time the existing ECS team will be trained and supported to take on acute visiting of minor illness of conditions such as urine and chest infections and falls within the elderly. This will be tested in one cluster initially. As part of the testing, a framework for ANP/specialist nurse role in GP Practice settings will be developed along with models of good practice to support people with palliative care needs.

In Year 2 all Type 1 acute visiting will be directed to the Care Home team. There will be a roll out of Type 2 visits to all clusters and localities.

In year 3 an acute visiting team made up of advanced nurse and paramedic practitioners will start to review Type 3 presentations. This testing will be phased so to ensure that any roll out is performed safely.

Additional Professional Roles

The new GMS Contract sets out a vision that by 2021 additional specialist professionals will be working as part of an extended Multi-Disciplinary Team seeing patients as a first point of contact. Not only does this free up GP time and work load, it ensures that patients see the most appropriate professional for their needs in a timely manner. We support patients receiving the right care, at the right time in the right location and believe this provides the best care and most cost effective outcomes.

In Tayside the areas where we see potential for providing additional specialist roles as part of an extended multi-disciplinary team are MSK Physiotherapy and Mental Health.

MSK Physiotherapy

Introduction

Musculoskeletal problems frequently cause repeat appointments and are a significant cause of sickness absence in Scotland. An estimated 85% of GP's musculoskeletal caseload can be safely and effectively be seen by a physiotherapist without the need for a GP referral. Presentations perhaps better dealt by MSK physiotherapy account for up to 30% of GP consultations. Dealing with these entirely within the MSK service offers the potential to improve efficiency and productivity across the health and social care pathways and systems, improve outcomes for patients and have a positive impact upon the health economy.

Current Service

Across Tayside MSK services are provided via the Physiotherapy Service with specialist input from occupational therapy, orthotics and podiatry with access routes through the Musculoskeletal and Advice Triage Service (MATs), GPs, Consultants and other health care professionals. The musculoskeletal physiotherapy services are operated from mainstream outpatient departments across Tayside with small numbers of clinics on satellite sites.

Future Service

We propose in Tayside a future service which sees first contact clinics for MSK services provided on a cluster basis across the region. Patients will use MATs or be signposted by practice staff to an Advanced Physiotherapy Practitioner who will be working as an integral member of the primary care multi-disciplinary team, there will be no need for patients to see the GP first, if at all for MSK presentations.

Redesign work already underway

Angus Model

We have already made progress in looking at how we can deliver MSK differently and support General practice. In Angus a test of change is running in Brechin Health Centre. This model, started in response to a shortage of GPs, has an Advanced Physiotherapist Practitioner embedded in the health centre team, working directly in the practice.

A number of positives have been identified by this model. These include closer working with GPs and the primary care team; participation in the MDT huddle; opportunities for joint training and sharing good practice. In common with tests that have taken place in other parts of the country we have seen that earlier intervention avoids the development of chronicity of conditions and decreases referrals to secondary care.

Crieff Model

This model is similar to the Brechin model but differs slightly in that a nurse triages patients to physiotherapy and patients are then appointed into clinics set within the GP surgery. As with the Brechin model the benefits are broadly similar in that the model provides the opportunity for closer working with GPs and the other members of the primary care team. There are opportunities for joint training, sharing good practice and early intervention. It has evidenced a similar decrease in the development of chronicity which impacts positively on secondary care referrals.

Milestones

During year 1, we plan to build on the redesign work in place and roll out the MSK model to one cluster per Partnership across Tayside. This will be rolled out further to include all clusters within Tayside by the end of 2021.

Governance

A working group lead by the Director of AHP has been established and a detailed project plan is being developed to include how this programme will be taken forward over the next 3 years. This work stream reports to the GMS CIAG, Primary Care and HSCP Boards.

A number of evaluation measures have been identified:

- Numbers seen by physiotherapist
- Impact on GP capacity
- Numbers referred to MSK services for therapy
- Onward referrals to secondary care
- Re-referral or attendance for same condition
- Prescribing
- Patient satisfaction and PROM (patient reported outcome measures)

Finance and Resources Required

In year 1 additional funding will be needed for an initial 5.0 wte Band 7 physiotherapy posts, an approximate cost of £260k. We believe that this is achievable and realistic; we need to ensure that we attract external interest in these posts, as adopting a purely internal recruitment process would adversely affect our ability to sustain services in other areas.

Total Year 1 Staffing required for additional Physiotherapy Staff

HSCP	Staffing Required 2018-19
Angus	1.5wte
Dundee	2.0wte
Perth & Kinross	1.5wte

By 2021 we estimate that we will require approximately an additional 12 wte Physiotherapists at a cost of approximately £612k (subject to how the model continues to evolve throughout the 3 year period).

Barriers and Opportunities

By its very nature, this is an evolving programme of work. Year 1 will allow data gathering which can then inform what is required in subsequent years. It is recognised that service redesign requires us to think differently about how services are configured and that it is not simply a question of introducing additional staff to do the same. Equitable and sustainable models must be built whilst recognising the challenges around workforce and the national shortage of physiotherapists in Scotland.

In implementing the model we will have to address issues such as premises and accommodation and work these out with relevant parties and stakeholders recognising that one size may not fit all and that some of this requires to be tailored to the specific circumstances of a locality or cluster group. The ability to communicate effectively between IT systems in common with the redesign of other services related to this improvement plan will be a major issue to be addressed.

Mental Health

Introduction

Mental health and wellbeing affects and influences the lives of individuals, families, and communities. Mental health problems are managed mainly in primary care by general practitioners who have access to specialist expertise in a range of secondary care services.

The contract states that:
'*Community clinical mental health professionals (e.g. nurses, occupational therapists) based in general practice, will work with individuals and families assessing their mental health needs, providing support for conditions such as low mood, anxiety and depression. The outcome sought is improved patient care through rapidly accessible, appropriate and timely mental health input.*'

The Scottish Mental Health Strategy (2017) supports health and wellbeing in Primary Care:

Action 15 of this strategy commits the Government to increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years there will be an additional investment of £35 million for 800 additional mental health workers in those key settings. The funding for Action 15 comes from a separate funding pot, as described in the finance section.

Action 23: Test and evaluate describes the development of effective and sustainable models of **supporting mental health in primary care,** by 2019.

Current Service

In many cases those who have a mental health or wellbeing issue will present to their GP, and much GP time involves consultations with a mental health aspect, even if this is not the primary presentation. After assessment the GP will often refer to a wide range of services within the health and voluntary sector, and can also encourage self care or signpost to online resources. A number of practices in Tayside will use link workers or the listening service to provide additional support. Navigating the options in terms of onward referral can be complex for a range of reasons, including waiting times and charges for some services.

Future Service

The future aim would be for all NHS Tayside Practices to have access to a Mental Health and Well being Service, whether Practice based or located elsewhere (e.g. within a Care and Treatment Centre). The model should be able to support people at universal level with clear pathways or routes into targeted services and onwards into specialist services for those in greatest need.

Health and Wellbeing model

Angus HSCP has tested two Health and Wellbeing models in two separate burghs over the past 18 months. Each consists of 2 part time qualified band 6-7 experienced Registered Mental Health Nurses (RMN) seconded from Community Mental Health Teams in the same locality. This ensures a good interface, sharing of local knowledge and provides supervision and support for the workers.

The workers deal with all requests from adult patients connected with:

- Distress- A better response by services to individuals in distress is seen as a key component in supporting people at risk of non-fatal self-harm, future suicide prevention and mental health services.
- Substance misuse – Trained to deliver evidence based Alcohol Brief Interventions
- Mental illness

The Pilot pathway summary (subject to some variation across the two practices):

1. The worker identifies available patient's slots each day. Receptionist and/or clinical triage allocates consenting patients to the worker instead of a GP. Nurse accesses VISION notes as well as MIDIS.

2. Worker provides a timely connection with patient to identify of immediate presenting issues. Nurse carries out first level mental health assessment, and record findings on VISION.

3. Disposal: signpost to self help, including Beating the Blues, General Practitioner, Level 1/ social prescribing, examples include Talking Services in practice, Long Term Conditions Group, WRAP Groups, Insight Counselling, Adult Psychological Therapies Service, Substance Misuse Services, Adult Community Mental Health Team or Older Peoples Community Mental Health Team.

4. The worker does not deliver any ongoing interventions themselves but can offer one follow up appointment if patients needs time to consider options available which will also test patient's motivation to change. Patient should be equipped to make ongoing referral themselves although worker can refer into services, thus reducing need for further screening. Statutory services need to accept experienced nurse referral.

Worker will record outcome of assessment and follow up within VISION.
53% of GP practices have access to 'Do You Need To Talk' delivered by NHS Tayside Spiritual Care Department. Based in Health and Social Care contexts, the Do You Need to Talk service promotes wellbeing by offering an active listening service. The service helps people explore their deepest hurts and draw strength from their own inner resources and those of the communities of support around them.

The service is a short term, early intervention model of person-centred, assets based listening with the aim of promoting personal and communal wellbeing.

Primary Care transformation funding supported a staff wellbeing project for staff in general practice, aiming to improve wellbeing and increase resilience. The findings of this are positive.
The link worker role described in the next section is also an important aspect of supporting wider mental health and wellbeing.

Funding and Resources Required

Tayside's share of the Mental Health allocation is £863,306 in 2018/19 rising to just over £2.5 m by 2021/22.

Based on the findings of the Angus pilot work we estimate that to replicate the model across Tayside by 2021 will cost in the region of £1.9 m. However, there are variations in how each IJB sees this work progressing. Dundee propose to test a model with initial psychology assessment, rather than nursing. As learning develops the model and skill mix can be reviewed across Tayside. Depending on the findings of these tests the costs may vary quite significantly from the figure noted.

Do You Need to Talk is a key service in some but not all practices in Tayside. To support the integration of this across Tayside a further £65k would be required.

Wider redesign of services will be reviewed alongside these developments, recognising the evolving pathways and capacity issues this work both support and creates. Local planning infrastructures for mental health in each HSCP will incorporate this in to their planning processes.

Development of resources to support staff in GP Practices

Transformation funding was used to support the wellbeing of our own staff through developing the services offered through the Tayside Spiritual care Team. The funding tested the concept of and impact of a network of care for staff in the community supported by staff from the Well Being Centre. Over the test period, teams were introduced to and had access to support for resilience and wellbeing through the use of support and supervision, incorporating group Values Based Reflective Practice, Mindfulness concepts and practices, and one to one confidential support.

Workforce recruitment and retention is a key challenge for all practitioners and services delivering GP and primary care services; providing a sustainable resource to support staff would add to the attraction of Tayside as a place to work whilst supporting our existing workforce.

Based on the resource package for the test phase, this model could be supported across Tayside with £40k investment. The model implemented would enable growth and roll out of the current model and be sustainable across all 3 partnerships.

Barriers and Opportunities

Workforce availability is the main risk to this development. In Tayside particularly in its more rural areas there are significant challenges in attracting staff. Having the availability of appropriate staff with the necessary skills and attributes may take time to develop. Recruiting from within the current workforce could leave other areas depleted which could be detrimental to mental health services overall.

A major review of Mental Health Services is currently taking place within Tayside, this may provide an opportunity to meet some of the future staffing requirements for primary care mental health services.

Accommodation and IT requirements as described elsewhere in this plan apply equally to developing mental health primary care services that are integrated and part of the extended MDT.

Opportunities are available through working more closely and investing in the community based third sector and universal services as well as the digital options and choices. Governance arrangements would need to be embedded within the models and local structures.

Community Link Workers

Introduction

Social Prescribing is a term used to describe a spectrum of approaches to support clients, community members and service users to access services and activities that can help them to deal with their life circumstances. A non medical model that provides community solutions to life problems can empower patients who would otherwise have their problems medicalised with little benefit to them.

Community Link workers are non-medical practitioners aligned to practices within GP clusters. They work directly with patients to help them navigate and engage with a full range of health, social care and third sector services. They often serve socio-economically deprived communities or assist patients because of the complexity of their conditions, rurality or a need for assistance with welfare issues.

Current Service

Each locality in the region has its own specific model in place. All localities have link workers based within GP practices already and/or working closely with practice staff, albeit to different scales with Dundee being the most significant service for now.

All localities regard social prescribing as a strategic priority and work in partnership with the third sector. In Dundee, link workers are employed by NHS Tayside and are sited within the Health and Social Care Partnership whereas in P&K and Angus, staff are employed within either the local authority or Third Sector. Each service has referral mechanisms in place and is monitoring and evaluating outputs and outcomes.

Future Service

The Government is clear that each HSCP as part of their Improvement plan is required to assess the local need and develop link worker roles in every area, in line with the manifesto commitment of delivering 250 link worker roles in the life of this Parliament.

Issues and Risks

Each locality has a model that works for them. There is an opportunity to use the Primary Care Improvement Fund to scale up the work in each area, taking into consideration the HSCPs Strategic plans and own local based need assessments.

Dundee Health & Care Partnership was an early adopter for the national link worker programme and received significant resources to scale up the previous pilot. The initial pilot in 2011 ran in one practice, this was extended to a further three in 2014. Over time this has increased and following external evaluation in 2017 the service was extended further and is now available in 16 Practices.

The funding letter of 23 May spells out that the link workers already in post should be seen as a priority, however, it makes reference to HSCPs working jointly to resource early adopter link workers and that flexibility around the scope oversight, employer or

lead responsibility. Further clarification nationally is being sought and further local discussion will be required.

Angus

Community link workers, known locally as social prescribers, are sited within the third sector and embedded within general practices, working closely with the wider multi-agency team and supporting care models, such as enhanced community support. Whilst social prescribing has been available in a number of practices in Angus for some years, the model has had the opportunity to develop and undergo significant evaluation as part of the new models of care programme in two practices in Forfar since 2016. A development event is planned for August to finalise Angus service modelling for planned roll-out in 2019/21.

Perth

A partnership group has been formed to support the development of social prescribing led by the HSCP with representation from the third sector interface and the local authority. Mapping is underway at present to identify the nature and breadth or social prescribing activity in the locality

Conclusion

This PCIP describes a comprehensive reshaping of primary care that is ambitious in scope and transformative in scale. This will be delivered over a challenging three year time scale. It offers a future for our population of better quality, better co-ordinated health care, developed with the people receiving it and delivered closer to the communities in which they live.

The PCIP has been developed in partnership across the three HSCPs in Tayside and with NHS Tayside in collaboration with the services and professions that will deliver that healthcare.

The PCIP is a beginning. It represents a vision, and it is now necessary to implement that vision. The PCIP was written in collaboration and it shall be implemented in the same way. The PCIP has been designed to improve the health of our population and it must be co-produced with our population. The next phase of developing the outline plans into fully costed programmes that can be rolled out across our population has already begun.

This will require significant work from all of the partner organisations that have contributed to the PCIP. We are confident that they are fully committed to this in accordance with the MoU. It will require the evolution of new finance and accountability structures; and the rapid and effective evaluation of the new care models that are being developed and rolled out. IJBs have a key scrutiny role in discharging their role of managing the commissioning of the services described within the plan.

Inevitably there will be changes made to the plan. It is a living document, and as time goes on it will change from being an aspirational statement of the better services we aim to provide for our population to a fully realised description of a more ambitious, more resilient, more sustainable thriving primary care assisted by a vibrant general practice at its heart.

Appendix 1- Contributors

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