Integration Joint Board
21st June 2018

Subject:	**PRIMARY CARE IMPROVEMENT PLAN IMPLEMENTATION OF NEW 2018 GMS CONTRACT**
Purpose:	The purpose of this report is to: • Seek approval from members on the requirements set out in the Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Board for implementing the new General Medical Services (GMS) Contract. • Present the draft Primary Care Improvement Plan and seek approval on the actions, timescales and investment that demonstrate how the new GMS contract will be implemented between 2018 and 2021.
Recommendation:	It is recommended that the Integration Joint Board: (i) Agree the requirements and responsibilities set out in the MoU. (ii) Approve the content, actions and financial spend set out in PCIP for implementing the new GMS contract before 2021.

GP	General Practitioner
GMS	General Medical Services
HSCP	Health and Social Care Partnership
IJB	Integrated Joint Board
LMC	Local Medical Committee
MoU	Memorandum of Understanding

1.	**EXECUTIVE SUMMARY**
1.1	Following the approval on 18 January 2018 to introduce a new GMS Contract in Scotland, Ayrshire and Arran has taken a three stage approach to advise the IJBs and the NHS Board of the requirements in the contract, as well as update on the development of the PCIP seeking approval from the Boards at each stage. This is the third of the three papers presenting the draft PCIP for approval.
1.2	The aim of the plan is to set out a clear direction of travel and act as a core framework for the HSCPs and NHS Board to reform primary care services. The PCIP describes the discussions and actions to date that have been approved through the previously agreed governance and programme arrangements.

1.3	Board areas were advised that the PCIPs should be developed jointly with the GP Sub Committee and signed off by the LMC. The PCIP was co-produced with the GP Sub Committee and approved by the LMC on 12 June 2018.
1.4	The PCIP will be presented to each of the IJBs between the 13 and 27 June 2018 for approval.

2. BACKGROUND

2.1 The first paper presented in February 2018 shared the content of the contract and the key actions set out within the MoU which included that each IJB was required to develop a three year PCIP by 1 July 2018.

2.2 The second paper was presented in March 2018 advising there had been agreement that there should be one coordinated PCIP produced for Ayrshire and Arran, with a focus on local priorities and delivery based on population need

2.3 The paper in March also described the governance arrangements (structures and reporting processes) that had been designed to provide a programme approach to the development of the PCIP. This approach ensured collaborative working across the three HSCPs and NHS Board to produce a joint PCIP in collaboration with the GP Sub Committee, aligned to the MoU priorities.

2.4 East Ayrshire Integration Joint Board is the lead partnership for Primary Care Services in Ayrshire and Arran. The Primary Care Transformation Programme – 'Ambitious for Ayrshire' which was previously co-produced with local Primary Care Professionals, the other HSCPs and the NHS Board.

2.5 The workstreams within the current programme have been aligned to the priorities set out in the MoU to be achieved by 2021. The national priorities include:

- Vaccination Services
- Pharmacotherapy Services
- Community Treatment and Care Services
- Urgent Care
- Additional Professionals for Multidisciplinary Team
- Community Link Workers

The PCIP sets out the remit of each of the Implementation Groups in detail along with the membership on each Group.

3. MEMORANDUM OF UNDERSTANDING

3.1 This MoU, attached as Annex 1, is an agreement between the Scottish Government, the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards, and represents a landmark statement of intent, recognising the statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) ("the Act") of Integration Authorities in commissioning primary care services and service redesign to support the role of the GP as an expert medical generalist. The MoU also recognises the role of NHS Boards in service delivery and as NHS staff employers and parties to General Medical Services ("GMS") contracts.

3.2 The MoU provides the basis for HSCPs to develop the PCIP as part of their statutory Strategic Planning responsibilities, setting how additional funding will be used and the timescales for the reconfiguration of services currently delivered under GMS contracts. It is stated that PCIPs should have a specific focus on the key priority areas listed at paragraph 7 of the MoU, with the aim of transitioning their delivery by the wider MDT between 2018 and 2021.

3.3 The respective responsibilities of the Integration Authority (typically delivered through the Health and Social Care Partnership delivery organisations) are:

- Planning, design and commissioning of the primary care functions (including general medical services) delegated to them under the 2014 Act based on an assessment of local population needs, in line with the HSCP Strategic Plan.
- The development of a HSCP Primary Care Improvement Plan, in partnership with GPs and collaborating with other key stakeholders including NHS Boards that is supported by an appropriate and effective MDT model at both practice and Cluster level, and that reflects local population health care needs.
- Collaboration with NHS Boards on the local arrangements for delivery of the new Scottish GMS contract.
- Section 2c of the National Health Service (Scotland) Act 1978 places a duty on NHS Boards to secure primary medical services to meet the reasonable needs of their NHS Board area. To achieve this, NHS Boards can enter into GMS contracts. HSCPs will give clear direction to NHS Boards under sections 26 and 28 of the 2014 Act in relation to the NHS Board's function to secure primary medical services for their area and directions will have specific reference to both the available workforce and financial resources.
- Where there is one or more HSCP covering one NHS Board area, the HSCPs will collaborate under section 22 of the 2014 Act in relation to the effective and efficient use of resources (e.g. buildings, staff and equipment) to achieve coherence and equity across service planning, design and commissioning, ensuring that patient needs identified in care plans are met

4. THE PRIMARY CARE IMPROVEMENT PLAN

4.1 The PCIP, attached as Annex 2, sets out how Ayrshire and Arran plans to implement the new GMS Contract by 31 March 2021. This is an introductory plan that meets both the national and pan Ayrshire requirements as set out in the MoU.

4.2 The aim of the plan is to set out a clear direction of travel and act as a core framework for the HSCPs and NHS Board to reform primary care services. The plan describes the discussions and actions to date that have been approved through the previously agreed governance and programme arrangements. It is noted that further discussion with General Practice, service providers and the public is required as implementation arrangements evolve and mature, this will fall within the Strategic Planning function of the IJBs.

4.3 The new contract introduces greater responsibilities for GP Sub-committees to engage in the implementation of the new contract at a local level and to provide a leadership role in organising and collating the views of GP Quality clusters across their Health Board area, and working with Medical Directors and Cluster Quality Leads to promote a cohesive general practice view on how the IJBs

commission services. This approach has been encouraged throughout the development of the PCIP and as implementation progresses, it is expected that the plans will become more detailed with local ownership.

4.4 Each requirement within the MoU has been addressed through the implementation action plans along with associated workforce and funding plans. The implementation and recruitment plans have been developed on the basis that initial funding will be available across 2018/19 and 2019/20.

4.5 The PCIP is being presented to each of the IJBs, NHS Board and Local Medical Committee in June for approval before submission to Scottish Government no later than 1 July 2018.

5 PRIMARY CARE IMPROVEMENT FUND

5.1 The Integration Joint Boards and NHS Board have received confirmation from Scottish Government of the allocated Primary Care Improvement Fund (PCIF) for 2018/19 which will be used by IJBs to commission primary care services, and is allocated on an NRAC basis through Health Boards to IJBs.

5.2 To assist with preparation of the PCIP, Scottish Government has announced its commitment to increase the overall funding to £250 million by 2021-22. Strictly as a planning assumption, and subject to amendment by Ministers, the IJBs have been advised that it is expected that the Primary Care Improvement Fund (PCIF) will increase to approximately £55 million in 2019-20, £110 million in 2020-21, and £155 million in 2021-22. This will, as this year, be distributed on an NRAC basis. As described earlier in the paper, this has allowed early planning assumptions for investment to be made for 2018-2020.

5.3 Scottish Government have advised that all PCIF in-year allocations should be considered as earmarked recurring funding, therefore staff may be recruited on a permanent basis to meet the requirements set out in the MoU.

5.4 On 29 May 2018 the Cabinet Secretary for Health and Sport issued a letter to Chairs/Vice Chairs of IJBs and Chairs of NHS Boards emphasising a “commitment to seeing the full sums invested and spent on the priorities identified” and “a guarantee that any funds covered by these allocation letters retained centrally due to slippage in delivery in 2018/19 or any other reason will be made available in full to Integration Authorities in subsequent years”. This has given us the reassurance in this initial plan to budget over a two year period.

5.5 Through each of the Implementation Groups initial work has been carried out to understand the investment required from now until 2022. This has also taken into account previous projects and tests of change that were invested in via the Primary Care Transformation Fund 2016-2018.

5.6 For the purpose of the plan, the required investment detailed in the financial summary, plans has been divided into IJB area based on that IJB’s NRAC share of the funding. This summary is supported by detailed investment plan for each Implementation Group. It should be noted that investment has been requested as pan Ayrshire service model funding, with each IJB being able to track investment and spend against their share of the PCIF.

6. GOVERNANCE AND OVERSIGHT ARRANGEMENTS

6.1 The Primary Care Programme Board will be the accountable Committee for overseeing the delivery of the PCIP, which is co-chaired by the Director of Health and Social Care (East) and the Chair of the GP Sub Committee.

6.2 The Director of the East Health and Social Care Partnership is the lead Director for Primary Care and also the Senior Responsible Officer for the Primary Care Programme – Ambitious for Ayrshire.

6.3 The Primary Care Programme Board meets every eight weeks with full details of the governance and reporting structure outlined within the PCIP.

6.4 The Strategic Programme Manager will be responsible for the management and oversight of the PCIP implementation, with each Implementation Group being assigned a Project Manager.

6.5 The Implementation Groups will meet on a regular basis and work to detailed project plans, including the workforce/recruitment plan, and the associated budget attached to that particular Group

6.6 Regular progress will be reported through the NHS Programme Office and Transformational Leadership Group. Formal update reports will be submitted to the IJBs and NHS Board every six months on progress and spend.

6.7 A detailed update will also be submitted to the Local Medical Committee every eight weeks.

7. CARER/ PEOPLE WHO USE SERVICE IMPLICATIONS

7.1 The benefits of the proposals in the new contract for patients are to help people access the right person, at the right place, at the right time in line with the Scottish Government Primary Care Vision and Outcomes.

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

8. STRATGIC CONTEXT

8.1 The strategy and programme outlined in this report will assist the IJB to deliver the following Strategic Objectives from its Strategic Plan to:

- Support people to live independently and healthily in local communities.
- Develop local responses to local needs.
- Operate sound strategic and operational management systems and processes.
- Communicate in a clear, open and transparent way.

The development and delivery of sustainable Primary Care and Community Health and Care Services supports the ambitions of the National Health and Care Delivery Plan.

9. Implications

Financial :	The implementation of the 2018 General Medical Services Contract for Scotland will see additional investment of £250m per annum in support of General Practice by the end of this Parliament. This is part of an overall commitment of £500million per annum investment in Primary and Community Health and Care services by the end of this Parliament
Human Resources :	The new Contract will support the development of new roles within multi-disciplinary teams working in and alongside GP Practices. The Contract also plans the transition of the GP role into an Expert Medical Generalist. These changes will require local and national workforce planning and development. Additional capacity as outlined within the PCIP will be deployed over the period of the plan to ensure effective delivery.
Legal :	The central purpose of the 2018 GMS contract is to provide better service to patients by providing stability and sustainability to General Practice. In so doing it also provides an environment that supports the wider policy aim of delivering care and support close to home when possible.
Equality :	Our aim through reformed primary care services is not just to extend life, but also reduce the time spent in poor health. Implementing the new GMS contract is an opportunity to mitigate health inequalities where possible. In support of the national 'Every Child, Every Chance, particular consideration will be given to: • Lone Parents • Families with 3 or more children • Families where the youngest child is under 1 • Mothers aged under 25 • Children and families whose lives have been impacted by Adverse Event Childhood Experiences (ACEs)
Environmental & Sustainability :	None.
Key Priorities :	None.
Risk Implications :	A key risk will be the availability of the identified additional professional staff to fill the new roles. By working in partnership within the professional groups we will seek to make the posts attractive and that Ayrshire and Arran becomes a workplace of choice.
Community Benefits :	The Wellbeing of people and communities is core to the aims and successes of Community Planning. Primary Care Improvement Plan, delivered as an integral part of the Wellbeing Delivery Plan, Integration Authorities Strategic Commissioning Plans and the Transformation Plan of both the NHS and Council, will contribute to support this wellbeing agenda.

Direction Required to Council, Health Board or Both	Direction to :-	
	1. No Direction Required	x
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

5.	**CONSULTATION**
5.1	Consultation has taken place across Ayrshire and Arran with IJB Chief Officers, GP Sub Committee representatives, strategic planning partners, and colleagues involved in Primary Care services delivery across Ayrshire and Arran. The PCIP was endorsed through the LMC on 12 June 2018.
6.	**CONCLUSION**
6.1	It is recommended that the Integration Joint Board: (iii) Agree the requirements and responsibilities set out in the MoU. (iv) Approve the content, actions and financial spend set out in PCIP for implementing the new GMS contract before 2021.

For more information please contact Vicki Campbell, Programme Manager for Primary Care Transformation at vickicampbell1@nhs.net

Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards

GMS Contract Implementation in the context of Primary Care Service Redesign

Introduction and Context

The principles underpinning the approach to general practice in Scotland were set out in a document *General Practice: Contract and Context – Principles of the Scottish Approach* published by the Scottish General Practitioners Committee ("SGPC") of the British Medical Association (BMA) and the Scottish Government in October 2016, noting that the Scottish Government and the SGPC are the two negotiating parties on commercial general practitioner (GP) contractual matters in Scotland. This Memorandum of Understanding ("MOU") between **The Scottish Government**, **the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards** builds on these arrangements and represents a landmark statement of intent, recognising the statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) ("the Act") of Integration Authorities in commissioning primary care services and service redesign to support the role of the GP as an expert medical generalist. The MOU also recognises the role of NHS Boards in service delivery and as NHS staff employers and parties to General Medical Services ("GMS") contracts.

For the purposes of this MOU, we refer to Health and Social Care Partnerships (HSCPs) responsible for the planning and commissioning of primary care services.

As an Expert Medical Generalist (as defined in the Scottish GMS contract offer document for 2018 the "Scottish Blue Book"), the GP will focus on:

- undifferentiated presentations,
- complex care,
- local and whole system quality improvement, and
- local clinical leadership for the delivery of general medical services under GMS contracts.

Expert Medical Generalists will strive to ensure robust interface arrangements, connection to and coherence with other parts of the wider primary care team (e.g. nurses physiotherapists), health and social care community based services and with acute services where required. The EMG will be supported by a multi-disciplinary team (MDT); maximising the contribution of both clinical and non-clinical staff in medicine, nursing, allied health professions, links workers, practice management, administration and others.

Delivering improved levels of local care in the community will have a clear benefit for patients and must rely on effective collaboration between GPs, HSCPs, NHS Boards and other partners, both in and out of hours, valuing the respective contributions of those who deliver these services. This will require clear articulation of the respective roles and responsibilities of GPs and other members of

the primary care team both generally and in respect of each of the services set out in a HSCP Primary Care Improvement Plan (see Sections F and G of this MOU).

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

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

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

Equitable – fair and accessible to all.

Outcome focused – making the best decisions for safe and high quality patient care and wellbeing.

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

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

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

An important determinant of success will be how the planned changes are implemented, seek to influence and depend on wider services.

This change has already started with the move away from the Quality and Outcomes Framework introduced in the 2004 GMS contract. The new approach introduced by the GMS Statement of Financial Entitlements for 2016-17, sees GP practices working together in local Clusters with their HSCP and NHS Boards to identify priorities and improve the quality of services and outcomes for people.

<u>Further key enablers for change include:</u>

(1) Premises: The National Code of Practice for GP Premises sets out how the Scottish Government will support a shift, over 25 years, to a new model for GP premises in which GPs will no longer be expected to provide their own premises. The measures outlined in the Code represent a significant

transfer in the risk of owning premises away from individual GPs to the Scottish Government. Premises and location of the workforce will be a key consideration in delivering the multi-disciplinary arrangements envisaged in the HSCP Primary Care Improvement Plan. Details on the criteria for lease transfer and for accessing interest free loans will be set out in the premises Code of Practice and summarised in the GMS contract offer document which sets out the terms of the proposed new Scottish GMS contract.

*(2) Information Sharing Arrangements***:** The Information Commissioner's Office (ICO) has issued a statement that whilst they had previously considered GPs to be sole data controllers of their patient records; they now accept that GPs and their contracting Health Boards have joint data controller processing responsibilities towards the GP patient record.

The new GMS contractual provisions in Scotland will reduce the risk to GPs of being data controllers by clarifying respective responsibilities within this joint controller arrangement. These contractual changes will support ICO's position that GPs are not the sole data controllers of the GP patient records but are joint data controllers along with their contracting NHS Board. The contract will clarify the limits of GPs' responsibilities and GPs will not be exposed to liabilities relating to data outwith their meaningful control.

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

*(3) Workforce***:** The national health and social care workforce plan published on 28 June 2017 noted that Part 3 of the Plan, which would determine the Scottish Government's thinking on the primary care workforce, would be published in early 2018 following the conclusion of the Scottish GMS contract negotiations. The Plan will set out a range of options at national, regional and local level for the recruitment and retention of GPs and the expansion of the capacity and capability of the multi-disciplinary team. This will include plans for recruitment, training and development of specific professional groups and roles.

A. Purpose and aim of the MOU

This MOU will cover an initial 3 year period 1 April 2018 to 31 March 2021 and is structured to set out the key aspects relevant to facilitating the statement of intent the document represents:

Section A – Purpose and aim
Section B - Parties and their responsibilities
Section C - Key stakeholders
Section D - Resources
Section E - Oversight
Section F – Primary Care Improvement Plans
Section G – Key Priorities

It provides the basis for the development by HSCPs, as part of their statutory Strategic Planning responsibilities, of clear HSCP Primary Care Improvement Plans, setting how additional funding will be used and the timescales for the reconfiguration of services currently delivered under GMS contracts. Plans will have a specific focus on the key priority areas listed at Section G of this MOU with the aim of transitioning their delivery by the wider MDT between 2018 and 2021.

Taken together with the Scottish GMS contract offer document, the National Code of Practice for GP premises, and the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018, this MOU underpins the new Scottish GMS contract; and enables the move towards a new model for primary care that is consistent with the principles, aims and direction set by the Scottish Government's National Clinical Strategy (NCS) and the Health and Social Care Delivery Plan.

In addition, The *National Health and Social Care Workforce Plan: Part 3 Primary Care,* to be published following agreement on the new Scottish GMS contract, will set out the context and arrangements for increasing the Scottish GP and related primary care workforce and both the capacity and capability of the multi-disciplinary team.

This MOU will be reviewed and updated by the parties before 31 March 2021 through arrangements that will be agreed by March 2018.

B. Responsibilities (of parties to the MOU)

The respective responsibilities of the parties to this MOU are:

Integration Authority responsibilities (typically delivered through the Health and Social Care Partnership delivery organisations):

- Planning, design and commissioning of the primary care functions (including general medical services) delegated to them under the 2014 Act based on an assessment of local population needs, in line with the HSCP Strategic Plan.
- The development of a HSCP Primary Care Improvement Plan, in partnership with GPs and collaborating with other key stakeholders including NHS Boards that is supported by an appropriate and effective MDT model at both practice and Cluster level, and that reflects local population health care needs.
- Collaboration with NHS Boards on the local arrangements for delivery of the new Scottish GMS contract.
- Section 2c of the National Health Service (Scotland) Act 1978 places a duty on NHS Boards to secure primary medical services to meet the reasonable needs of their NHS Board area. To achieve this, NHS Boards can enter into GMS contracts. HSCPs will give clear direction to NHS Boards under sections 26 and 28 of the 2014 Act in relation to the NHS Board's function to secure primary medical services for their area and directions will have specific reference to both the available workforce and financial resources.

- Where there is one or more HSCP covering one NHS Board area, the HSCPs will collaborate under section 22 of the 2014 Act in relation to the effective and efficient use of resources (e.g. buildings, staff and equipment) to achieve coherence and equity across service planning, design and commissioning.
- Ensuring that patient needs identified in care plans are met

Scottish General Practice Committee responsibilities:

- Negotiating, with the Scottish Government, the terms of the GMS contract in Scotland as the negotiating committee of the BMA in Scotland.
- Conducting the poll (and any future poll) of its members on the terms of the GMS contract in Scotland.
- Representing the national view of the GP profession.
- Explaining the new Scottish GMS contract to the profession (including communication with Local Medical Committees (LMC) and GP practices).
- Ensuring that GP practices are supported encouraged and enabled to deliver any obligations placed on them as part of the GMS contract; and, through LMCs and clusters, to contribute effectively to the development of the HSCP Primary Care Improvement Plan.

NHS Territorial Boards responsibilities:

- Contracting for the provision of primary medical services for their respective NHS Board areas
- Ensure that primary medical services meet the reasonable needs of their Board area as required under Section 2C of the NHS (Scotland) Act 1978.
- Delivering primary medical services as directed by HSCP as service commissioners.
- Arrangements for local delivery of the new Scottish GMS contract via HSCPs
- As employers, NHS Boards will be responsible for the pay, benefits, terms and conditions for those employees engaged in the delivery of the priority areas set out in Section G.

Scottish Government responsibilities:

- Setting the legislative framework underpinning the commissioning of primary medical services by HSCPs and delivery by NHS Boards.
- In collaboration with NHS Boards and with HSCPs, shaping the strategic direction and the development of commissioning guidance in respect of primary care that is in line with the aims and objectives set out in National Clinical Strategy and the Health and Social Care Delivery Plan.
- Providing financial resources in support of the new Scottish GMS contract and primary care transformation (including the transfer of services) in line with the Scottish Government spending review process.

- Making arrangements with stakeholders to meet the future GP workforce requirements both in terms of numbers and education and training.
- Agreeing the metrics and milestones against which progress will be measured; with regular progress reporting as part of the existing statutory arrangements for reporting performance against Strategic Plans.

C. Key Stakeholders

HSCPs must collaborate with NHS Boards as partners in the development and delivery of their Strategic Plan (and the associated Primary Care Improvement Plan). Local and Regional Planning arrangements will need to recognise the statutory role of the HSCP as service commissioners; and the partnership role of NHS Boards as NHS employers and parties to the GMS contracts for the delivery of primary medical services in their Board area.

In addition to this, HSCPs have a statutory duty via the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 to consult a wide range of local stakeholders and professional groups on their Strategic Plans and take decisions on the size and shape of local health and social care services on a collective basis based on dialogue with the local communities and service users. In relation to the development of the Primary Care Improvement Plan that would include (but not be limited to):

- Patients, their families and carers
- Local communities
- SAS and NHS 24
- Primary care professionals (through, for example, GP subcommittees of the Area Medical Committee and Local Medical Committees)
- Primary care providers
- Primary care staff who are not healthcare professionals
- Third sector bodies carrying out activities related to the provision of primary care

In order to ensure that the provision of any new or reconfigured service has a patient-centred approach to care based on an understanding of patient's needs, life circumstances and experiences it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. HSCPs should ensure that patient engagement is a key part of their Primary Care Improvement Plans.

Good communications and understanding across the wider health and social care interfaces with both services and professional groups (e.g. primary/secondary, community health and social care services, district nursing, out of hours services, mental health services) will also be required to address direct patient care issues, such as prescribing, referrals, discharges, follow up of results and signposting. An important principle here is that each part of the system respects the time and resources of the other parts. There should not be an assumption that patient needs or work identified in one part of the service must be met by another without due discussion and agreement. This should ensure that patients do not fall through gaps in the health and care system.

D. Resources

General Practice funding – through the GMS contract funding allocated to NHS Boards, general practice funding represents a significant element of the public investment in community and primary care. The published draft Primary Medical Services budget was £821 million in 2017-18 – funding the remuneration of 4,460 General Practitioners; the c.3000 practice staff they employ, both nursing and non-clinical, and the non-staff expenses of running practices. This investment enables over 23 million healthcare interactions every year. The Primary Medical Services investment funds the part of the system that is the first port of call for most people's healthcare needs most of the time. In addition to the direct care enabled by this investment, the clinical decisions GPs make – whether to treat; how to treat; whether to refer to further specialist treatment – have a much wider impact on the health and social care system. The "GP footprint" is estimated to be as much as four times the direct investment in Primary Medical Services. This investment through the contract is, therefore, critical to the sustainability of the whole health and care system.

In March 2017 the Cabinet Secretary for Health and Sport announced that in addition to the funding for the provision of general medical services, funding in direct support of general practice will increase annually by £250 million by the end 2021-22. In 2017-18 £71.6 million was invested through the Primary Care Fund in direct support of general practice. Further investment will see this increase over the 3 financial years from 1 April 2018 to £250 million 2021-22.

<u>Process</u>

Specific levels of resource will be agreed as part of the Scottish Government's Spending Review and budget processes and allocated in line with the arrangements set out in this MOU.

Where appropriate these resources will be allocated to HSCPs through their NHS Board partners in line with the Scottish Government's National Resource Allocation formula (based on population need and taking account of geography and of life circumstances, including deprivation). Resources will be spent for the purposes set out in this Memorandum and in line with each HSCP Primary Care Improvement Plan to enable the transition to be managed and implemented effectively. The HSCP Plans must demonstrate how the funding will flow/be used to enable the redistribution of work from GPs to others and to optimise the role and functionality of the wider MDT. HSCPs will agree these Plans locally. These plans will be developed in collaboration with local GPs and others and should be developed with GP Subcommittee (or representatives of by agreement locally) as the formally agreed advisors on general medical service matters. However, the arrangements for delivering the new GMS contract will be agreed with the Local Medical Committee. Integration Authorities will hold their officers to account for delivery of the milestones set out in the Plan, in line with their responsibility to ensure delivery of Strategic Plans, and through regular reporting to the Authority. Key partners and stakeholders should be fully engaged in the preparation, publication and review of the plans.

The resources and any associated outcomes and deliverables (aligned to the Scottish Government's National Performance Framework and the six Primary Care Outcomes) will be set out in an annual funding letter as part of the Scottish Government's budget setting process.

The extent and pace of change to deliver the changes to ways of working over the three years (2018-21) will be determined largely by workforce availability, training, competency and capability, the availability of resources through the Primary Care Fund, and will feature as a key element of the National Health and Social Care Workforce Plan: Part 3 Primary Care.

E. Oversight

New oversight arrangements for the implementation of the GMS contract in the context of wider primary care transformation in Scotland will be developed including:

A *National GMS Oversight Group* ("*the national oversight group*") with representatives from the Scottish Government, the SGPC, HSCPs and NHS Boards will be formed to oversee implementation by NHS Boards of the GMS contract in Scotland and the HSCP Primary Care Improvement Plans, including clear milestones for the redistribution of GP workload and the development of effective MDT working.

National issue specific groups – A range of national issue specific groups with members drawn from a range of stakeholders, including NHS Boards, HSCPs and SGPC where appropriate will support and provide policy and professional advice to the national oversight group on a range of national policy areas relevant to the delivery of primary care transformation. These may include: GP Contract Implementation Group; GP premises; GP IT, e-Health; Data and Information; Remote and Rural; Nursing; GPN Group; Vaccination Transformation Programme; Patient Groups.

As well as the requirements on the HSCP to develop a Primary Care Improvement Plan as set out in Section D, NHS Boards with HSCPs will develop clear arrangements to deliver the commitments in respect of the new Scottish GMS contract as set out in the Scottish GMS contract offer document. These arrangements will include the priority areas set out in Section G of this MOU and must be agreed with the LMCs.

HSCPs should establish local arrangements to provide them with advice and professional views on the development and delivery of the Primary Care Improvement Plan. Arrangements will be determined locally and will take account of the requirement to engage stakeholders as set out above. The HSCP Primary Care Improvement Plan should be agreed with the local GP subcommittee of the Area Medical Committee with the arrangements for delivering the new GMS contract being agreed with the Local Medical Committee as set out above. HSCPs and NHS Boards will discuss and agree locally the arrangements for providing appropriate levels of support to enable this advice to be provided.

Within HSCPs, GP clusters have a critical role in improving the quality of care in general practice and influencing HSCPs both regarding how services work and service quality. Improving Together: a new quality framework for GP Clusters in Scotland[i] provides a framework for how that learning, developing and improving may be achieved. As GP Clusters mature, they will be expected to have a key role in proactively engaging with HSCPs, advising on the development of HSCP Primary Care Improvement Plans and working with their MDT and wider professional networks to ensure highly

effective health and social care provision within and across the HSCP area and where relevant across HSCPs.

HSCPs will support and facilitate GP Clusters to ensure their involvement in quality improvement planning and quality improvement activity as part of whole system improvement. *Healthcare Improvement Scotland* will work in support of HSCPs where required to ensure that GP clusters have the support they need to engage effectively in quality improvement activity.

The *Local Intelligence Support Team* (LIST) already provides support to HSCPs and has been commissioned to provide support through HSCPs to GP clusters. This support involves on-site expert analytical advice to provide local decision-makers with meaningful and actionable intelligence, leading to improved outcomes for service users.

F. Primary Care Improvement Plan

The collaborative implementation of the new GMS contract in Scotland should be set in the context of the HSCP Primary Care Improvement Plan. Plans must determine the priorities based on population healthcare needs, taking account of existing service delivery, available workforce and available resources. To support that aim HSCPs will collaborate on the planning, recruitment and deployment of staff.

Some services which are currently provided under general medical services contracts will be reconfigured in the future. Services or functions which are key priorities for the first 3 years from 2018 - 2021 are listed in Section G below. The expectation should be that, where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices.

Additional investment is intended to provide additional MDT staff, which should, where appropriate, be aligned to GP practices to provide direct support to these practices under the oversight of GPs as senior clinicians. It will be important that GPs continue to work to their responsibility to ensure that their premises remain fit for purpose, services remain accessible to patients, that they are responsive to local needs and can maintain continuity of care; all of which will allow GPs to deliver an effective, integrated service as part of the MDT.

The HSCP Primary Care Improvement Plans will be considered alongside the NHS Board arrangements for the delivery of the GMS contract in Scotland in line with the requirements of the Scottish contract offer document.

The Plan should also consider how the new MDT model will align and work with community based and where relevant acute services, subject to wider stakeholder engagement to be determined by the HSCP in line with their statutory duty to consult.

<u>Key Requirements of the Primary Care Improvement Plan:</u>

- To be developed collaboratively with HSCPs, GPs, NHS Boards and the stakeholders detailed in Section C;

- To detail and plan the implementation of services and functions listed as key priorities under Section G, with reference to agreed milestones over a 3 year time period;

- To give projected timescales and arrangements for delivering the commitments and outcomes in the priority areas under Section G and in particular to include intended timescales for the transfer of existing contractual responsibility for service delivery from GPs.

- To provide detail on available resources and spending plans (including workforce and infrastructure);

- To outline how the MDT will be developed at practice and cluster level to deliver primary care services in the context of the GMS contract.

- Initial agreement for the Primary Care Improvement Plan secured by 1 July 2018

G. Key Priorities

Existing work to develop and test new models of care has shown benefits from the effective deployment of other professional staff working within a wider MDT aligned to general practice. The priority between 2018 and 2021 will be on the wider development of the services detailed below. Changes to services will only take place when it is safe to do so. The service descriptions and delivery timescales given here are provided for the purposes of this MOU.

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

In the period to 2021, HSCPs will deliver phased service change based on a locally agreed plan as part of the HSCP Primary Care Improvement Plan to meet a number of nationally determined outcomes including shifting of work to other appropriate professionals and away from GPs. This has already happened in many parts of the NHS system across Scotland for Childhood Immunisations and Vaccinations. This change needs to be managed, ensuring a safe and sustainable model and delivering the highest levels of immunisation and vaccination take up. As indicated above, there may be geographical and other limitations to the extent of any service redesign.

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

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

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

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

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

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

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

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

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

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

Workforce As part of their role as EMGs, GPs will act as senior clinical leaders within the extended MDT as described in this MOU. Many of the MDT staff deployed in the priority areas under (1) to (6) of Section G in the MOU will be employed by the NHS Board and work with local models and systems of care agreed between the HSCP, local GPs and others. Staff will work as an integral part of local MDTs. NHS Boards, as employers, will be responsible for the pay, benefits, terms and conditions for these staff. Some MDT members will be aligned exclusively to a single GP practice while others may be required to work across a group of practices (e.g. Clusters). Workforce arrangements will be determined locally and agreed as part of the HSCP Primary Care Improvement Plans.

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

Signatories

Signed on behalf of the Scottish General Practice Committee

Name: Alan McDevitt, Chair, Scottish GP Committee of the British Medical Association
Date: 10 November 2017

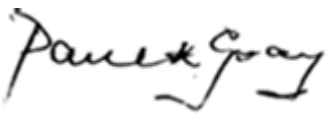
Signed on behalf of Health and Social Care Partnership Chief Officers

Name: David Williams, Chief Officer, Glasgow HSCP and Chair, Chief Officers, Health and Social Care Scotland
Date: 10 November 2017

Signed on behalf of NHS Boards

Name: Jeff Ace, Chief Executive, NHS Dumfries & Galloway and Chair, Chief Executives, NHS Scotland
Date: 10 November 2017

Signed on behalf of the Scottish Government



Name: Paul Gray, Chief Executive, NHS Scotland
Date: 10 November 2017

Annex 2

EAST AYRSHIRE
Health & Social Care
Partnership

North Ayrshire
Health and Social Care Partnership

south ayrshire
health & social care
partnership

NHS
Ayrshire
& Arran

AYRSHIRE ARRAN
GENERAL PRACTICE

Ambitious for Ayrshire

Implementation of 2018 General Medical Services Contract

2018-2021

DOCUMENT CONTROL SHEET: Key Information:

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South Ayrshire Integration Joint Board	27 June 2018	

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Contents

Foreword

Eddie Fraser
Director of East Health and Social Care Partnership
Lead Partnership for Primary Care
Ayrshire & Arran

Hugh Brown
Chair of the GP Sub Committee
Ayrshire & Arran

We are delighted to present Ayrshire & Arran's, once for Ayrshire, Primary Care Improvement Plan that sets out a new vision for General Practice and an overview of the considerations required to achieve it.

Following the agreement of the new General Medical Services contract, developing the Improvement Plan quickly gained momentum with the teams locally. It was seen as an opportunity to sustain general practice, whilst improving the coordination of care, access to services and taking a more proactive approach to supporting our population's health and wellbeing. Management and GP colleagues across the three Health and Social Care Partnerships have worked jointly throughout the development process and have established good working relationships to ensure a smooth transition to implementation over the next three years and beyond.

The plan represents the collaborative working between our clinicians, Integration Authorities, NHS Board, and other stakeholders to build on the work to date to find solutions to the current challenges within primary care, supporting the healthcare within our communities. As we work to build our devolved Health and Social Care System in Ayrshire and Arran, the critical role of primary care has been emphasised throughout the plan, and is viewed as a core component of an integrated community based care system.

Our joint vision focuses on the place and the people who live in it rather than the needs of an organisation or specific group. Throughout the implementation of our plan we are fully committed to working closely with our patients, communities, service users, and our staff across General Practice and wider services to achieve fully integrated services.

Mr Eddie Fraser
Director of East Health and Social Care Partnership

Dr Hugh Brown
Chair of the GP Sub Committee

Executive Summary

The Ayrshire & Arran Primary Care Improvement Plan is the initial plan setting out how we aim, as three Integration Joint Boards and NHS Board, to deliver the implementation of the new 2018 General Medical Services (GMS) Contract. It describes the discussions and actions agreed to date with the understanding that further discussion with General Practice, service providers and the public is required as implementation arrangements evolve and mature.

The new model for General Practice and primary care describes how clinical pathways, the role of the General Practitioner (GP), and other health and care professional roles and their workload will be redesigned to enable consultation and treatment by the right professional.

Primary care in Ayrshire and Arran has been under significant strain over the last few years due to the increase in demand and changing health needs of our population. The Primary Care Improvement Plan will function as a framework that sets out an ambitious and attractive vision for how services will be delivered in General Practice and primary care that operate in partnership with the wider health and care system.

The new 2018 GMS Contract includes clear underlying principles and requirements for each NHS Board area to introduce the new contract by 2021.

Each requirement has been addressed throughout the implementation actions plans, as well as the associated funding required from the fund committed to the implementation of the contract.

It is anticipated that alongside the core framework for delivery that has been developed, different areas across Ayrshire and Arran will deliver at different times, and at a different pace depending on their starting point, with local populations and professionals being involved in developing detailed plans based on what works best for that community.

The changes and pace required to reform Primary Care will not be possible without significant investment in workforce, estate, and infrastructure. Although the plans indicate initial funding required, further work is required in 2018/19 to assess the overall costs of new services.

The implementation plans have been developed on the basis that the full funds will be made available, including fully spending the allocation for financial year 2018-19. In this initial year of funding, the funding will issue in two tranches starting with allocation of 70% of the funding in June 2018. A high level report on how spending has been profiled must be submitted to SG by the start of September and, subject to confirmation via this report, that we will be able to spend the full 100% allocation in-year, the remaining 30% of funding will be allocated in November 2018.

Chapter 1: National Policy **The Scottish Government Strategic Primary Care Vision and Outcomes focuses on the modernisation of primary care to deliver a safe, effective and person-centred healthcare service in line with the 2020 vision, the National Clinical Strategy and Health and Social Care Delivery Plan 2016.**

The new 2018 Scottish GMS Contract came into effect from 1 April 2018. The contract facilitates a refocusing of the GP role as Expert Medical Generalist (EMG). This role builds on the core strengths and values of General Practice. The national aim is to enable GPs to use other skills and expertise to do the job they train to do.

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

The funding of general practice in Scotland has been reformed and a phased approach has been agreed to implement the contract fully. In Phase one, from April 2018, a new funding formula that better reflects practice workload has been introduced. A new practice income guarantee is also in operation to ensure practice income stability. The new funding formula will be accompanied by an additional £23 million investment in GMS to improve services for patients where workload is highest.

In addition, the contract offer proposes to introduce a new minimum earnings expectation to ensure no GP partner earns less than £80,430 (including pension contributions) NHS income for a whole-time equivalent post from April 2019. Evidence indicates this will benefit approximately one fifth of GP partners in Scotland.

The Memorandum of Understanding (MoU) with the new contract requires NHS Boards and local Integration Joint Boards to develop a Primary Care Improvement Plan (PCIP) to set how they will deliver the priorities over a three year period (April 2018-March 2021).

Chapter 2: Introduction **Sets out the plan and direction of travel to implement the 2018 Scottish General Medical Services (GMS) Contract that has been developed to re-invigorate and re-energise the core values of General Practice**.

There was agreement that there should be one coordinated PCIP produced for Ayrshire and Arran, with a focus on local priorities and delivery where services are commissioned within the Health and Social Care Partnerships(HSCPs) based on population need. This is an introductory plan that meets both the national and pan Ayrshire requirements. The PCIP describes how Ayrshire and Arran plan to implement the new GMS contract by 31 March 2021.

The aim of the implementation plan is to set out a clear direction of travel, and outline the key characteristics of successful, high quality General Practice. As implementation progresses, it is expected that the plans will become more detailed with local ownership,

Throughout the plan collaborative working is demonstrated between General Practice, the three HSCPs, NHS Ayrshire and Arran, the wider Primary Care services, voluntary and third sector organisations, as well as other national Boards across Scotland.

Our plan details:

- Our vision of what General Practice will look like in Ayrshire and Arran
- How we will achieve the requirements set out in the MoU, ensuring that General Practice are empowered to own and drive the changes needed along with their HSCP.
- How we will invest the Primary Care Improvement Fund into General Practice

In delivering the implementation of the new GMS contract by 2021, we strive to drive continuous improvement in quality of access to health services across Ayrshire and Arran. By improving access in General Practice we aim to reduce health inequalities, improve access to practices, improving pathways, improve overall health, and support the reduction of inappropriate attendances at our Emergency Departments.

Chapter 3: Our Vision **Sets out a vision which sees GPs and GP-led multi-disciplinary teams manage a wide range of health problems, providing both systemic and opportunistic health promotion, diagnoses and risk assessments, dealing with multi-morbidity, coordinating long term care, and addressing the physical, social and psychological aspects of patients' well-being throughout their lives.**

Ambitious for Ayrshire – Our Aim

To deliver safe, effective, person centred, sustainable Primary Care Services at the heart of the healthcare system for the people of Ayrshire and Arran

General Practice is at the core of primary care and through the implementation of the new contract, General Practice in Ayrshire and Arran will be supported to deliver, in a sustained way, the 4C guiding principles outlined to ensure patients access the right person, at the right place, at the right time. These are described in the Scottish Government Primary Care Vision and Outcomes as:

- **Contact** – maintain and improve access
- **Comprehensiveness** – introducing a wider range of health professionals to support the expert medical generalist
- **Continuity** - enabling more time with the GP for patients when it is really needed
- **Co-ordination** – providing more information and support for patients

To achieve this to a high standard General Practice will require to be fully integrated within a network of health and social care providers in the local communities. This includes an expanded multidisciplinary team within or attached to Practices, as well as links to community health and social care teams, and voluntary sector organisations.

Over the next three years a combination of additional investment, service redesign and increased capacity will allow for workload to evolve, increasing the time available for GPs to focus on the most complex patients with sufficient time to meet their care needs, as well as increase the time for professional development.

Using the additional investment through that Primary Care Improvement Fund, the HSCPs will invest in and support General Practice to:

1. Transform how practices work to allow them to manage workload, improve access, and provide high quality services
2. Improve population health, particularly amongst those at greatest risk of illness or injury
3. Manage and coordinate the health and care of those with long-term conditions
4. Manage urgent episodes of illness or injury
5. Manage and coordinate care for those who are at the end of their lives
6. Support practices to work together in their clusters and share resource, developing more resilient services to their locality based population
7. Fully integrate with community and healthcare service providers in the communities, wrapping services around patients in the community

Chapter 4: The Case for Change **General Practice is the first and most commonly used point of access to health care in Scotland. A combination of pressures including demographic changes, increasing complex health care needs, workforce shortages, financial demands and public expectations has resulted in the continued delivery of primary and community services no longer being tenable.**

More people in Ayrshire and Arran are living longer and as we grow older we tend to accumulate more long term conditions which results in requiring access our health and social care services more frequently. We know that 90% of patient activity occurs within primary care. As stated by the King's Fund & Nuffield Trust, Primary care is the "bedrock of NHS care" which, through GPs and primary care teams, provides the population with access to general medical care and onward referral to specialist care.

Activity data demonstrates that demand has now reached a critical point where if General Practice is to continue to meet this demand, whilst not being able to recruit GPs, there is a requirement to significantly redesign the way in which primary care services are delivered.

Whilst we know that the patients with the most complex chronic conditions will consume over 50% of health resources, we do not routinely and systematically identify and support those patients with the most complex needs. This can often lead to avoidable admissions to Acute Services where patients can remain until their condition or multiple conditions stabilise due to the limited resource available in community services.

As well as the increasing demand on Acute Services, the pressure on primary care services increases each year and GP practices have been absorbing this growth. Recent local data shows that GP Consultation rates have gone up 7% since 2015 and telephone consultations have gone up 37%.

Many GP Practices are absorbing this growth whilst losing experienced GPs from their practice and there have been difficulties attracting replacement GP partners. Many other Boards in the West of Scotland are also having difficulties attracting GP replacements. It has also been noted that many GPs will now work on a part time basis have other professional interests, therefore one GP leaving could result in two vacancies requiring to be filled.

To deliver the vision of primary care and shift the balance of care from hospital to community there needs to be a move to more proactive care to be delivered in the community. Through the implementation of a core MDT within General Practice at the heart of health and social care, as well as linking with the wider teams built around GP Surgeries in each locality, this will adopt system wide clinical care pathways and protocols, enabling teams to interface effectively with wider health and social care teams. This will support access to advice and expertise in order to manage patient care within primary care as well as the ability to facilitate the escalation of care needs when required, enabling patients to be stepped up and stepped down as appropriate and also ensuring appropriate access to specialist services and hospital based care. Ayrshire and Arran is also progressing a programme of Technology Enabled Care (TEC) interventions such as self-management in patients with COPD and Asthma, Tele-monitoring in heart-failure and assertive case management in mental health, comprehensive geriatric reviews and multidisciplinary interventions

Chapter 5: The Population of Ayrshire and Arran **Understanding our population and current demand to plan the most efficient and effective services for the future**

There are 56 General Medical Practices in Ayrshire and Arran with approximately 386,000 patients registered. 147,000 of these patients have been diagnosed with at least one lifelong chronic disease. In total there are 298,000 incidences of chronic disease with many patients suffering from multi-morbidity who require multiple clinical inputs and are on multiple medications requiring regular monitoring.

The projected increase in the number of patients who will be diagnosed with a chronic disease will further increase demand for services, and if nothing else were to change, would outstrip current service capacity. This projected growth and demand emphasises the need to prioritise different approaches to the delivery of health care services in Ayrshire and Arran, as well as supporting patients with chronic conditions more in the community.

A number of practices agreed to share data relating to a number of common activities from 2011 to 2015 to help understand demand (prescribing, co-morbidity, consultations and laboratory tests). This has shown:

- Acute “new” prescription – across 5 years 2010-2015 a 31% increase
- Increase in the rate of consultations per 1000 patients between January 2011 to November 2015 (almost 5 years) of 22%
- Increase in average annual rate of laboratory test results processed (main test types) between 2013 to 2015 of 13%.
- Increase in one practice of contacts (surgery consultations, home visits, phone consultations) per patient per year from 7.46 in 2014 to 8.17 in 2015 (9.5% increase) and scripts generated from 20.58 per patient in 2014 to 21.65 in 2015 (5%).

In summary, this gives an average rise in activity across 5 years of between 22% and 48%, with a median of 25%, this equates to 5% per annum.

There are areas where enhanced expertise in practices would enable more patients to be managed entirely within primary care without referral to secondary care or specialist services, along with providing more proactive and early intervention care. There are successful models in Ayrshire and Arran currently for the management of care within Primary Care for people with musculoskeletal and primary care mental health conditions. Although these have been at small scale as test sites, they have provided better outcomes for patients and more effective use of resources, which in turn has increased GP capacity to allow them to focus on the more complex patients. Through the PCIP these services will be scaled up across the wider population of Ayrshire and Arran.

Initial research work has been carried out by Public Health and Business Intelligence to review our population demographics including high deprivation, affluence, urban communities and rural areas. It is recognised that implementation plans must be flexible to meet diverse needs in relation to both geography and population. To achieve consistent quality it will not be possible to take a ‘one size’ fits all approach and this will be reflected in the detailed roll out plans going forward

Reducing Inequalities: Closing the Gap

The Health and Wellbeing outcomes within the HSCP Strategic Plans include a key outcome to reduce health inequalities.

The health and wellbeing gap is preventable and there are a range of factors that significantly contribute to premature mortality and people living in poor health. These factors include individual behaviours, poverty and deprivation, and poor housing. Closing the health and wellbeing gap requires us to take action in prevention, early intervention and mitigation of variation of service delivery. As well as national indicators, local indicators will also be used to address the inequalities across Ayrshire and Arran.

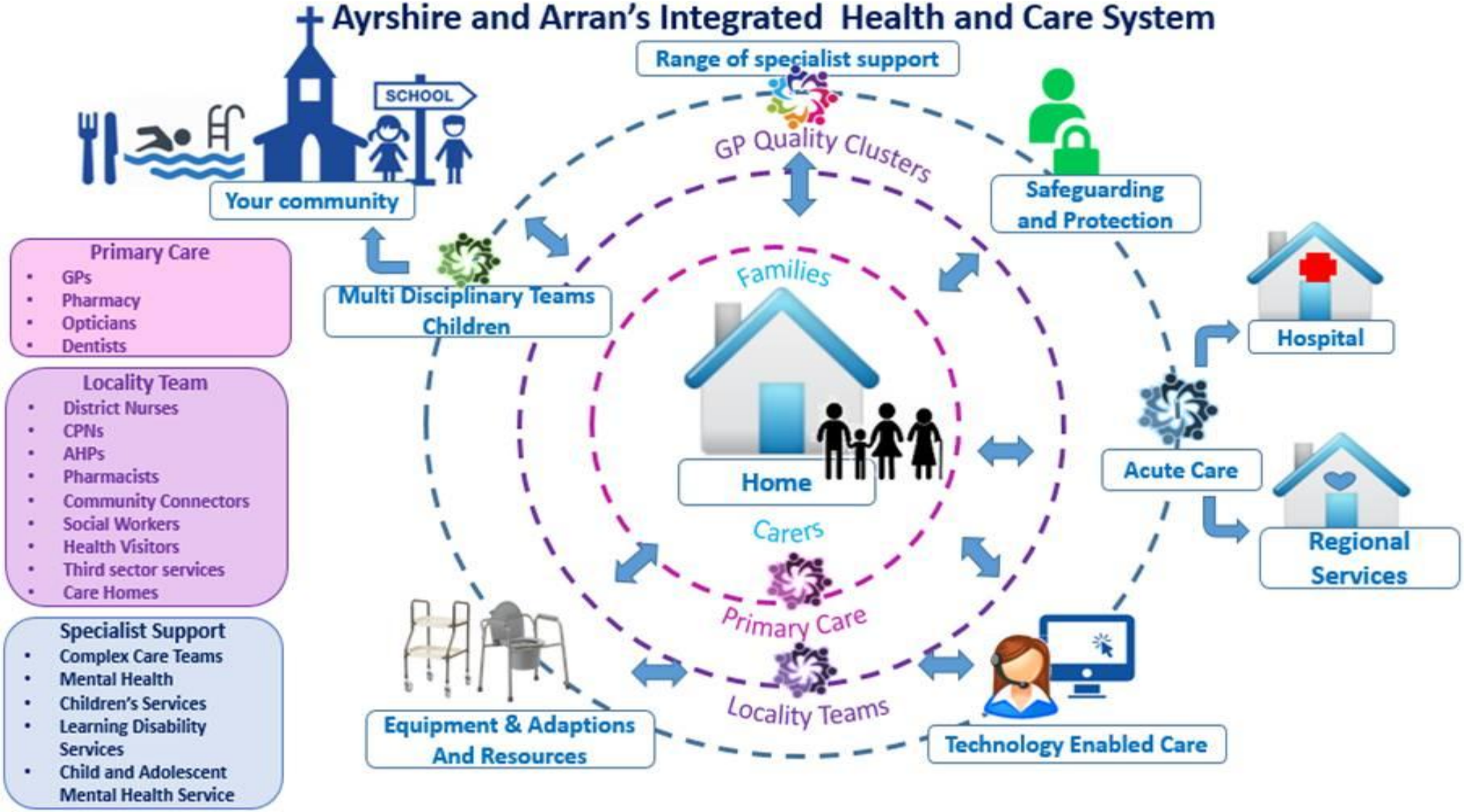
This will allow us to share good practice and address areas where there is significant variation affecting care and outcomes.

The publication 'The Role of the Health and Social Care Partnerships in Reducing Health Inequalities' was published in April 2018 to provide a framework to assist with preparing plans along with guidance and tools to be considered as plans are developed and implemented.

Ayrshire and Arran are committed to fully utilising the resources available within this publication to mitigate health inequalities where possible in the reform of primary care services.
To support the national 'Every Child, Every Chance, particular consideration will be given to:

- Lone Parents
- Families with 3 or more children
- Families where the youngest child is under 1
- Mothers aged under 25
- Children and families whose lives have been impacted by Adverse Event Childhood Experiences (ACEs)

Our aim through reformed Primary Care services is not just to extend life, but also reduce the time spent in poor health. Our integrated Health and Care System model to support all the population of Ayrshire and Arran is shown on Page 9.


Ayrshire and Arran's Integrated Health and Care System
Range of specialist support
GP Quality Clusters
Safeguarding and Protection
SCHOOL
Your community
Primary Care
GPs
Pharmacy
Opticians
Dentists
Multi Disciplinary Teams Children
Families
Hospital
Locality Team
District Nurses
CPNs
AHPs
Pharmacists
Community Connectors
Social Workers
Health Visitors
Third sector services
Care Homes
Home
Acute Care
Carers
Regional Services
Primary Care
Specialist Support
Complex Care Teams
Mental Health
Children's Services
Learning Disability Services
Child and Adolescent Mental Health Service
Locality Teams
Equipment & Adaptions And Resources
Technology Enabled Care

Chapter 6: Developing the Plan **Local Integration Authorities have been tasked by the Scottish Government to develop a Primary Care Improvement Plan in collaboration with the GP Sub Committee and the NHS Board.**

As the lead HSCP for Primary Care in Ayrshire and Arran, the development of the plan has been led by East Ayrshire HSCP. The Integration Authorities are responsible for the oversight and commissioning of services through the HSCPs with agreement from the Local Medical Committee (LMC). The NHS Board continues to hold and oversee the contract with GP Practices.

A programme approach with robust governance arrangements was designed to provide a structure to the process for development of the joint PCIP and overseeing the implementation. It was recognised locally that the GP Sub Committee had an integral advisory role in developing the plan and also all spend from the Primary Care Transformation Fund should be agreed with the LMC.

A core Writing Group was convened to develop the PCIP with four Implementation Groups were established to design and implement the required changes to meet the priorities set out in the MoU. These Implementation Groups are:

- Pharmacotherapy Service
- Primary Care Nursing Services (includes the delivery of Vaccinations and Community Treatment and Care services)
- Urgent Care
- Practice Based Multi-disciplinary Team (includes Community Link Workers)

The structures and reporting processes along with the membership details for each Implementation Group clearly articulate the roles and responsibilities of the Groups along with the pan Ayrshire membership of all key stakeholders. The programme governance structure is included in Appendix 1.

Remote and Rural Areas

In parallel to the Implementation Groups, discussions have taken place with GPs and service providers on the two Islands, Arran and Cumbrae, to align any new service developments with development work that is already taking place, and understanding the requirements and models will vary on the Islands.

It is recognised that alternative delivery models will also need to be considered on a population and practice basis for other remote and rural areas of Ayrshire.

Chapter 7: Key Benefits **Describes how the Primary Care Improvement Plan will improve the health needs of our population and support the implementation of the GMS Contract.**

The plan sets out a framework for integrating and expanding services in Primary Care and local communities that will deliver better outcomes for patients, ensuring services are delivered in the right place by the most appropriate person.

The implementation of the new contract provides an opportunity to develop a primary care workforce through additional recruitment and skill mix working towards changing the role of the GP by 2021. The plans set out how General Practice will operate within an integrated model with the focus on population outcomes.

A successful implementation will be achieved by creating the conditions for professionals to use their experience and judgement to maximum effect, improving the outcomes for all patients, empowering them to make effective evidence based decisions.

The Implementation Team will continue to engage with local GPs, Practice Managers and stakeholders, as well as work with the HSCPs and the public in the development of their local plans to ensure a joined up approach in designing the delivery of local services with a focus on specified populations.

The delivery of the new contract will see improved monitoring of demand in Primary Care and sharing of resource at scale. This will provide a greater level of sustainability to practices at a cluster and locality level providing more continuity of care to patient.

Key performance indicators will be developed through each of the detailed project plans to follow progress, share learning and evaluate if the aims within the plan are being achieved.

Implementing the new contract also provides opportunities to further engage with services and GPs across Ayrshire and Arran to deliver the most effective services for our population. As clinical leaders within Primary Care, GPs will actively contribute to the clinical governance and oversight of service design and delivery across health and social care as part of the GP cluster arrangements.

GP practices participate in cluster working and there will be a requirement for practices to provide agreed local and national data extractions to enable intelligence led quality planning, quality improvement and quality assurance.

Cluster working will contribute to the development of local population health needs assessments undertaken by public health and local information analysts. The Cluster and Practice Quality Leads will also provide professional clinical leadership on how those needs are best addressed. These arrangements will be enhanced by developing formal collaborative which will extend to practice and locality based GPs to ensure a bottom up approach to the development of service development.

Key principles

Regionally, the principles outlined in Regional Position and Discussion Document - Transforming Care Together for the West of Scotland, outlines the following principles to deliver the collective ambition of the West of Scotland Health and Care system:

1. Enable individuals and families to make informed decisions about their wellbeing and their care that are right for them within the context of their communities.
2. Encourage individuals, families and communities to enjoy healthy and independent lives.
3. Deliver high quality and safe care and support to people within or as close to their home as possible.
4. Emphasise prevention and early intervention across services.
5. Assure that staff and services work together and share information appropriately in a co-ordinated manner.
6. Promote equality of outcomes, experience and access to services across communities.
7. Recognise and support paid and unpaid carers
8. Engage, develop and motivate staff and teams.
9. Nurture a culture of continuous improvement and innovation.
10. Galvanise collective resources to ensure services are fair and sustainable.

Linking to the regional principles, locally within Ayrshire and Arran the key principles that underpin the transformation programme, and align to the IJB Strategic Plans, will ensure that through the implementation of the new contract and reform of primary care:

1. **We will encourage and empower our citizens and carers to take control of their own health and wellbeing by ensuring a 'do it with' and not 'do it to approach within our communities and services**
2. **We aim to deliver outcome-focused and responsive services for the population of Ayrshire and Arran**
3. **Service developments will aim to improve patient health and the patient journey aligned with the goal of supporting the continuous improvement and sustainability of Primary Care**
4. **Development of service delivery will, where practical, have clear alignment to the requirements stated within the Memorandum of Understanding and General Medical Services Contract (2018)**
5. **Service changes will, by default, be delivered to meet local needs and make best use of services available within localities and neighbourhoods recognising there will be times when, for good practical and clinical/financial governance sense, will remain pan Ayrshire.**
6. **Seek to ensure a balance between operating as a consistent, equitable service across Ayrshire and Arran alongside appropriate local flexibility to include the aspirations of local communities and professionals.**
7. **Within the context of a pan-Ayrshire improvement plan, we will support a reasonable, proportionate and consistent approach across each of the Health and Social Care Partnerships within Ayrshire and Arran**

Chapter 8: What will it look like and what will be the benefits? **Sets out the changes that will be visible to our patients, staff and communities.**

There are a number of key initiatives and design principles that the Implementation Groups have come up with to support our Primary and Community teams to work together.

For all patients

- Greater opportunity and support to self care
- More consistent care
- Signposting and triage to the most appropriate person to support/treat

For patients with less complexity/predominantly needing episodic care

- Quicker assessment to the right person
- More opportunity to self care with greater use of technology
- Better triage and assessment to specialist advice to reduce any unnecessary interventions

For patients with greater complexity/predominantly needing continuous care

- Wrap around care from an integrated multi-disciplinary team
- More time with and easier access to a GP
- A greater range of services provided through the GP Practice
- Pro-active support, empowering people to plan their own health

Local care delivered by local teams

- GP Practices providing clinical leadership within a wider multi-disciplinary team, offering integrated care for patients within increased capacity.
- Practices working together at a bigger scale
- Opportunities to link with other multi-disciplinary teams as the model progresses

Access and advice when needed

- Patients are assessed and streamlined in a consistent way
- The system is simplified with fewer and more accessible access points
- More triage, more self care, more skill mix

Grow our workforce

- Grow and keep our own workforce across all professions
- Offer attractive packages for portfolio careers
- Diversity skill mix
- Support practices on an individual basis, to improve their workload
- Manage and shape demand
- Establish opportunities for new roles such as mentoring and supervision

← ← ← ← ← ← ← ← **Infrastructure** → → → → → → → →

Integrated Care Records | **Digital solutions** | **Improved facilities**

Chapter 9: Interdependencies with other Plans **Ensuring joined up working across all transformation programmes within Ayrshire and Arran to maximise the benefits and outcomes for patients.**

In addition to implementing the new GP contract and transforming the role of the GP, there are a number of transformational programmes underway across the HSCPs and NHS Board that currently have an impact on GP workload and capacity, and will require to link closely with the implementation groups due to interdependencies and capabilities across all programmes. These programmes are currently linked and monitored via the NHS Programme Management Office and rely on close working between the identified Programme Managers. A high level summary of each Programme is detailed below.

Unscheduled Care

Unscheduled care demand continues to increase within the Ayrshire Health and Social Care system. This results in increased demand for community services and hospital care beyond current resources. Unscheduled care is a key element of the Health and Social Care system in Ayrshire and Arran. Services require to be responsive to need, whilst at the same time transforming in a way that, where appropriate, moves contact from reactive to planned engagement and from hospital based care to community. The aim of the Unscheduled Care Programme is to

- reduce emergency admissions by providing accessible community alternatives;
- reduce occupancy and length of stay by improving systems and processes within the Acute Hospital and reduce delays in discharge by providing appropriate community capacity.
- reducing delays in discharge by providing appropriate community capacity.

Intermediate Care and Rehabilitation Model

East, North and South Ayrshire Health and Social Care Partnerships are working with partners in NHS Ayrshire and Arran to deliver the agreed Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation over 2018/2019. This new investment over and above the fund provided for primary care focuses on providing high quality care and support through pro-active early intervention and preventative action to stop older people and people with complex needs becoming unwell in the first place or supporting them to manage their conditions more effectively. In addition, Technology Enabled Care (TEC) such as telehealth, telecare, video conferencing and self-care and digital apps and web based platforms have the potential to transform the way people engage in and control their own healthcare, empowering them to manage it in a way and a place that is right for them. When deterioration is unavoidable, the model aims to create integrated, multi-disciplinary services delivered in the home and in the community through health, social services, third and independent sectors to prevent unnecessary hospital admissions and get people home from hospital quickly.

This is the first steps towards achieving the New Model of Care for Older People and People with Complex Needs by focussing on providing an alternative to acute hospital admission or supporting early discharge from acute hospital through a four tier Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation that supports people at different stages of their journey.

End of Life Care

A considerable number of people within Ayrshire and Arran die in hospital when they prefer to be supported to die at home or in a homely setting. In order to support more people to die where they choose, we need to improve how we identify people with palliative and end of life support needs. We need to start these conversations much earlier in the course of their chronic conditions so that we discuss and plan for their future care through Advanced Care Planning conversations, share these plans with all professionals, and make it easy for professionals from all settings to access the Key Information Summary of the plan. Developing a new model for Palliative and End of Life Care will require effective co-ordination of care, excellent communication skills and up skilling of a range of community professionals including, district nurses, GPs, Ayr Hospice staff, care at home staff, care home staff, pharmacists, social workers and allied health professionals to ensure end of life care and support meets the needs of individuals, their families and carers. In addition, a small number of dedicated palliative and end of life care beds in each partnership to provide medical support, where necessary.

Transformation of Out-patients

The Modern Out-Patient (previously known as TOPS and then Delivering Outpatient Integration Together, or DOIT), is a national programme which supports NHS Boards and Health and Social Care Partnerships to deliver more integrated and accessible outpatient services to provide better outcomes for people who need to use these services. The Modern Out-Patient aims to ensure that all patients are seen at the right time, by the right person, and that the right information is available.

In Ayrshire we want to use our outpatient resources appropriately and improve the patient experience by reviewing and streamlining administrative procedures so that they support the patient pathway and make effective use of resources. This includes implementing initiatives such as; advice only referrals, implementing e-Internal referrals, develop the workforce to support the delivery of effective and efficient patient centred care, along with considering non-doctor staffing and skill mix in outpatient departments.

Infant, Children and Young People's Transformational Change Programme

Supporting children and young people's wellbeing is key to achieving the most positive outcomes for them. It develops their potential to grow up ready to succeed and play their part in society. GIRFEC is the national approach to how services aim to promote, support and safeguard the wellbeing of children and young people in Scotland. Promoting children's and young people's rights, it supports them and their parents to work in partnership with the services that can help them.

Most children get all the support and help they need from their parents, wider family and local community, in partnership with universal services like healthcare services. Where extra support is needed, the GIRFEC approach aims to ensure that support is easy to access, and seamless with the child always being at the centre. This approach has been tested and developed across Scotland over a period of more than ten years, during which time children's services have become more integrated and child-centred.

Developing a common understanding of the Getting It Right for Every Child (GIRFEC) is critical within primary care services in Ayrshire.

Key Messages

- Getting it right for every child (GIRFEC) is the Ayrshire approach to improving outcomes and supporting the wellbeing of our children and young people.
- It puts the rights and wellbeing of children and young people at the heart of all our services, and helps ensure that we all work together to get things right.
- It is built on the good practice already used by services across Ayrshire to improve outcomes for children and families.

Mental Health and Wellbeing

As part of the Mental Health Strategy 2017-2027, Scottish Government Ministers made a commitment to provide funding to support the employment of 800 additional mental health workers to improve access in key settings such as Accident and Emergency departments, GP practices, police station custody suites and prisons.

In 2017 Ministers established the *Health & Justice Collaboration Improvement Board* (HJCIB). Ministers asked the Board to consider how our commitment to additional mental health workers might best be delivered. The Board has also adopted some broad principles (helpfully informed by a Short Life Working Group with membership from Integration Authorities, Health Boards, justice and local government) that it believes are likely to inform credible local improvements. These include recognition that:

- the application of additional resources should result in additional services commensurate with the commitment in the Mental Health Strategy to provide 800 additional mental health workers by 2021-22
- the nature of the additional capacity will be very broad ranging – including roles such as peer and support workers;
- prospective improvements may include the provision of services through digital platforms or telephone support;
- improvement may include development for staff who are not currently working in the field of mental health

The PCIF includes recurring funding for mental health services, building on the funding for primary care mental health previously provided.

Although it is separate to the primary care funding line, it is recognised there will cross-over between the services, particularly in general practice settings, and in some cases the staff may be the same individuals.

Scottish Government have written to all IJBs on 23 May asking them to each develop a plan by 31 July that sets out goals for improving capacity in the settings outlined in Action 15 of the Mental Health Strategy. To ensure IJBs are able to utilise the additional resources for 800 mental health workers and the PCIF flexibly to support sustainable mental health and primary care service redesign, the IJBs and NHS Board are being encouraged to align planning, governance and evaluation processes.

Each IJB is being asked to set out:

- How it contributes to the broad principles
- How it takes account of the views of local Justice and other Health partners in the area about what improvements should be introduced
- How it fits with other local plans currently in development.
- Initial scoping of potential staffing changes over the next four years as a result of this additional funding, towards the committed 800.

As set out in the letter, PCIPs should also demonstrate how this allocation of funding is being used to re-design primary care services through a multi-disciplinary approach, including mental health services.

Scottish Government have also advised that the PCIP should also show how wider services, including the mental health services which are the subject of this letter, integrate with the new primary care services. This section will be further developed in conjunction with the development of the plan to address Action 15 of the Mental Health Strategy.

Chapter 10: Workforce – what do we already know? **Describes our workforce and training needs within General Practice and the proposed wider multi-disciplinary team members to identify development opportunities and grow a sustainable workforce and service models.**

The PCIP is a step change in the level of investment and support to General Practice. The HSCPs and NHS Board are fully committed to supporting the development of our local workforce to reform Primary Care and develop multi-disciplinary capacity across Ayrshire and Arran.

The first step to ensuring we achieve the right staffing and service models is to scope and fully understand our current workforce and skill mix. Through the implementation groups, consistent data on the shape of the current workforce, including recent and predicted future trends in workforce numbers, will be collated to assist with the service model proposals, detailed implementation and roll out plans. Some of this data is already available pan Ayrshire or in each HSCP area, but having this collated across every service to form an overarching view will provide a more comprehensive and robust evidence base to inform workforce planning going forward.

The recruitment and retention project continues in Ayrshire and Arran to attract and retain GPs where possible. The GP with Special Interest (GPwSI) posts that were tested 2016-18 are now being developed in conjunction with Acute Services to provide support and sustainability to secondary care services that are experiencing workforce challenges. This approach sees the GP working a mix of sessions within a GP Practice and also sessions within an Acute speciality.

General Practice

Initial data returns from General Practices in Ayrshire and Arran from May 2017 demonstrates:

- The GP age profile is increasing and as doctors retire they are becoming increasingly difficult to replace. Currently 35% of local GP workforce is aged over 50 years (21% are 55 years and over) of which the majority will be eligible to retire over the next 5 years.
- There are 30 Advanced Nursing Practitioners (ANP) (27.60 wte) and 115 Nurses (80.09 wte), which includes all other nurses, are all female. 79% of these posts are part time. The age profile reflects that of NHS community nursing with 53% aged 50 years or more (8% are 60 years plus). Only 3% are under 30 years old.
- Other practice employees - staff 98% of these employees are female, over two thirds are part time and almost half (47%) are aged 50 years and over (9% are 60 years plus). The majority are administration roles (58%) although role breakdown varies greatly by practice.

Overall the workforce profile for Ayrshire and Arran GP Practices reflects national position of:

- an ageing GP workforce
- more GPs wishing to work more part time hours within practice
- an ageing nursing workforce, all female, majority part time
- a growing resource of ANPs

Community Nursing

The Chief Nursing Officer Transforming Roles to accommodate the need to look at the wide MDT/AHPS Group is responsible for directing and coordinating the future work in relation to role development within nursing and midwifery across Scotland.

The first practice areas being reviewed and transformed are:

1. Children and Young People
2. Community (adult) Nursing (including General Practice Nursing)
3. Advanced Practice

Planning for the future of the nursing workforce in Ayrshire and Arran is also set in context of both the national and local strategic imperatives as set out in The National Clinical Strategy for Scotland (2016), NHS Ayrshire & Arran's People Strategy – People Matter, NHS Ayrshire and Arran Transformational Change & Improvement Plan and East, North and South Ayrshire HSCP Strategic Plans.

NHS Ayrshire and Arran with the three HSCPs have established local Transforming Nursing Roles (TNR) Implementation arrangements for all three work streams in a manner which is integrated and connected to the wider board transformational change programmes.

Within the Community (adult) Nursing work stream and specifically related to primary care, there is national work underway to identify areas for developing a refreshed General Practice Nursing role which includes the need to

- Identify requirements for contemporary General Practice Nurse (GPN) educational provision with Chief Nursing Officer/ Primary Care provision to support proposed refreshed role.
- Utilise best available evidence to support decision making and current models of good practice within General Practice / NHS Boards/ HSCPs
- Have cognisance of the new Scottish General Medical Services Contract and the potential for the GPN role to evolve.
- Scope and agree the future interface with wider community nursing services

It is also recognised that within TNR programme the role of the District Nurse (DN) should be transformed to ensure successful implementation of both the Unscheduled Care and Intermediate Care and Rehabilitation Programmes. In order to deliver this the relationship between DN and GPN, and the professional opportunities need to be explored, understood and maximised.

With the demographic changes in our communities leading to significant increases in demand for community health and care services, there is evidence that a growing number of nursing interventions are required to be delivered across the primary care / community service interface. This is occurring at a time when the workforce itself is demographically changing with over two thirds of both GPN and DN staff over 40 years of age.

Advanced Practitioners

As the deployment of Advanced Practitioners is becoming an increasingly popular and preferred option in the provision of new models of frontline health care delivery within the NHS and HSCPs in Scotland. Through the leadership of the Associate Nurse Directors, these roles should be developed within a framework which promotes safe, effective and efficient delivery of clinical care.

Due to the ongoing recruitment difficulties to GP vacancies and review of reasons for GP appointments, it is anticipated that an Advanced Nurse Practitioners (ANPs) could see a large percentage of patients requesting an appointment with a GP with undifferentiated and urgent care needs, manage long terms conditions as well as support the Practice triage system.

An ANP is a highly educated and skilled registered nurse who can manage the complete clinical care for patients, not solely any specific condition. As a clinical leader they have the freedom and authority to act and accept responsibility for their actions. Their level of practice is characterised by high level autonomous decision making, including assessment, diagnosis and treatment, including prescribing for patients with complex health needs. An ANP will make decisions using high level expert knowledge and skills and this includes the authority to refer, admit and discharge, or refer to secondary care.

NHS Ayrshire & Arran, in collaboration with NHS Lanarkshire and Dumfries and Galloway, have developed a robust advanced practice training and development programme (ANP Academy) for Primary Care ANPs to meet the challenges of family medicine. Practitioners will be developed with generic primary care experience similar to that of a GP Trainee in order that they can provide clinical sessions, make referrals, do house calls, visit care homes, and undertake reviews of those with the long terms conditions.

There are 14 Ayrshire and Arran practice nurses included within ANP Academy Cohort 1 training places funded through the Primary Care Transformation Fund which commenced in September 2017 with a view to commencing Cohort 2 in September 2018. It is recognised that formal ANP training takes around 18 months to complete and can be a significant pressure on GP Practices whilst the training ANP is mentored and supervised until they feel confident acting in the role fully. In some cases this can take up to 36 months.

Following an educational needs assessment and audit of ANPs in Primary Care, it was projected in 2017 that Ayrshire and Arran required to be developing a minimum of 10-15 ANPs each year between 2017-2022 to address workforce challenges and meet the requirements of the GP contract. This has been projected through the ANP Academy costs until 2022 to meet this commitment.

Pharmacotherapy Service

From April 2018 there is a three year trajectory to establish a sustainable Pharmacotherapy Service where every GP Practice will receive pharmacy and prescribing support. This timeline has been established within the MoU to provide opportunity to test and refine the best way to deliver this service and to allow for new pharmacists and technicians to be recruited and trained.

The Pharmacotherapy Service will build on the investment over the last few years from the Primary Care Fund to allow more pharmacists and pharmacy technicians to work with GP practices, reducing GP workload and improving patient care through achieving better outcomes with medicines.. The Pharmacotherapy service vision will be to effectively manage the medicine-related issues and tasks that arise in GP practices on a day-to-day basis and to support people in the management of their long term conditions. As well as reducing GP workload the Pharmacotherapy Team will have responsibility for improving the cost effective use of medicines in primary care.

Combining the prescribing support team and the Primary Care Funding, NHS Ayrshire & Arran has a total of 37.9 pharmacy and prescribing support staff within Primary Care supporting General Practice and testing new ways of working. More detail is included within the Pharmacotherapy Service Implementation Plan on how this service will be expanded and rolled out across Ayrshire and Arran at scale.

Primary Care Mental Health and Wellbeing

There have been tests of change carried out throughout 2017/18 and early evidence suggests that many patients attending with low level mental health conditions are better supported through their GP Practice whilst linking with the Community Connectors/Community Link workers where patients present for non clinical support and advice on a wide range of issues that assist them with their health and wellbeing. The aim of the Primary Care Mental Health Practitioners attached to the GP Practices is to:

1. Reduce the number of GP clinical appointments for people seeking advice about their mental health
2. Reduce the number of referrals into specialist mental health services
3. Direct and support more people in their localities to access and use alternative self-management tools, community resources and other services.
4. Develop more comprehensive local networks of mental health support between GP practices, mental health services and community organisations

It is proposed Mental Health Practitioners are employed on a cluster basis to deliver sessions with GP Practices. The Practitioner would be able to assess patients, make a diagnosis, and triage patients for onward referral to the specialist Primary Care Mental Team where appropriate. The pathways and service models for Primary Care Mental Health will be scoped further in 2018/19 with three HSCP teams to address the requirements set out in the MoU and as part of the Mental Health Strategy to provide 800 additional mental health workers by 2021-22. Further detail on actions and timescales can be found within the MDT Implementation Plan in Appendix E

Community Link Workers

Initial scoping work has confirmed that all HSCPs have the correct number of community link worker posts to provide a basic level service to all GP Practices, with the exception of South Ayrshire who require an additional 1.5 wte workers to ensure full coverage. A more detailed scoping exercise on the tasks carried out, along with patient outcomes is underway through the sub group reviewing this element of the MDT.

Musculoskeletal (MSK) Physiotherapist

Due to the increasing number of GP appointments relating to an MSK complaint and the high number of onward referrals or self referrals to secondary care MSK service it was recognised that having and Advanced Practice Physiotherapists in post to deliver 1st point of contact roles in GP practices would impact significantly on GP workload and time, as well as ensure patients were seen in an appropriate timeframe by the most experienced clinician, providing the best outcome medium and longer term.

From December 2016 three Advanced Practice Physiotherapists were funded through the PCTF, one in each HSCP area working across identified GP Practices. Each WTE has 0.8 direct clinical time, currently delivering approximately 15 new patient appointments each day. Clinical leadership is provided by an identified lead GP for each practice and peer support provided by MSK/Orthopaedic Advanced Practice Physiotherapy Team. Day to day management continues to be delivered by Team Lead Physiotherapist for each partnership area.

Data collection commenced in February 2017.Over the first year the following activity was captured:

- **6013** patients presenting with an MSK condition in primary care have been assessed by the Advanced Practice Physiotherapist
- **66.19%** were seen as a first point of contact
- Only **1.32%** required GP involvement

Chapter 11: NHS Scotland Special Board Support **Describes the wider support available from other NHS Scotland Health Boards to achieve the aims set out within our action plans.**

The NHSScotland national boards provide services where improved quality, value and efficiency are best achieved through a national approach. They share a common purpose, enabling improvements in the health and wellbeing of the people of Scotland. Working more closely together and with our key partners in the Scottish Government, territorial boards, regions and Integration Joint Board will enable the transformational change required to improve services and strengthen leadership to protect and improve Scotland's health and reduce demand on services. These Boards include, NHS Scottish Ambulance Service, NHS 24, Health Improvement Scotland, and NHS Education for Scotland.

Collaborative Principles

To help key partners redesign services to meet technological, demographic and societal changes. Underpinning the National Boards overarching plan are the following principles, the special boards will:

- use existing capacity and capability
- focus on the potential benefits
- focus on where we can achieve most by working differently together
- be ambitious
- work in partnership across health and social care
- involve the public and staff in defining and implementing change

Primary and Unscheduled Care

The national boards will work with regions, health and social care partnerships and improvement, transformation and evaluation support to develop alternative routes into services which will help reduce the pressure on primary and unscheduled care. This will require new models of care and advanced clinical support which ensures the safe and seamless flow of people from one service to another.

In particular we will continue to work closely with the Scottish Ambulance Service in lead up to the roll out of the Advanced Paramedics in 2020, identifying opportunities to be involved in any test sites. The cluster support team in Ayrshire and Arran will also seek to learn from the Healthcare Improvement Scotland Collaborative Programme on Signposting as well as developing and testing improvements locally through establishing a collaborative with our cluster and quality lead GPs.

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

At the national level, the Scottish Government plans to publish a 10-year Primary Care Monitoring and Evaluation Strategy in June 2018, setting out our overarching approach to evaluating primary care reform. A Primary Care Outcomes Framework will also be published which maps out planned actions and priorities against the changes we are working towards. The Framework was co-produced by the Primary Care Evidence Collaborative, which includes NHS Health Scotland, the Scottish School of Primary Care, Healthcare Improvement Scotland, NHS Education for Scotland, National Services Scotland, the Alliance, and the Scottish Government

Chapter 12: Engagement and Communication **Our approach to communicating with our public and staff, as well as engaging widely in the design of services and pathways.**

For our plans to succeed all providers and users of our Primary Care services need to be fully engaged as we work towards our aim of achieving a fully integrated health and care system.

There will be one Engagement and Communication Group, with wide representation from across the Implementation Groups and stakeholders that underpins the whole programme of implementation to ensure our communication messages to staff, patients and the public are consistent and clearly show the benefits of transforming our services. We will continue to develop meaningful dialogue with all our stakeholders as we develop our plans and services.

It is the aim to have one engagement and communication plan attached to the PCIP with sub sections to each Implementation Group.

Our communication and engagement plans will include:

Engagement:

- Continuous engagement, including mapping all our stakeholders
- Regular stakeholder engagement events with specific services as well as overall informative sessions

Communications

- internal and external communications
- an online and social media presence
- opportunities to share best practice, news and invite feedback

The engagement and communication plan will also link to each of the HSCP communication plans as well as the NHS Ayrshire & Arran communication plan.

Chapter 13: Delivering the Plan **Provides an overview of the actions and oversight arrangements that have agreed through the Implementation Groups and overarching Writing Group. Each area of the contract has been discussed and explored in detail with key stakeholders and representatives on each Group.**

Leadership

It is recognised that the changes set out in the implementation action plans will require significant leadership. The Director of the East Health and Social Care Partnership will be the lead Director and Senior Responsible Officer for the Programme and will co-Chair the Programme Board along with the Chair of the GP Sub Committee.

The Ayrshire wide model will have joint pan Ayrshire management clinical leads and GP Sub Committee representatives leading each Implementation Group for the duration of the programme. Through the Writing Group, these Groups will report to the IJBs, the LMC and NHS Board. There will also be formal reporting from and to the Cluster and Practice Quality Lead arrangements within localities to ensure wider engagement with the GPs in each locality. The full governance and reporting structures are included within Appendix 1.

The Implementation Groups and Writing Group have met on at least two occasions. The outcomes from these discussions to date are summarised below with more detailed actions and timescales captured in the Implementation Action Plans within the Appendices

Due to the pace and size of change, effective leadership is essential for the delivery of the programme of implementation, ensuring alignment to the wider objectives and initiatives across the four organisations. As stated within the the Kings Fund 'Centre for Creative Leadership' (2014), the key components to successful collective leadership are:

- a partnership approach between staff and management
- strong components of leadership through engagement
- communication of information on engagement levels and linked improvements in service delivery throughout the organisations
- quick action after listening to bring change
- timely feedback to staff and stakeholders on achievements using simple methods.

The approach in the development of the PCIP has focussed on collective leadership across the system, striving to ensure that all leaders have a responsibility to ensure delivery of the programme of implementation as a whole. It is the aim to embed this culture throughout delivery also.

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Pharmacotherapy Service Implementation

The GP contract includes an agreement that every GP practice will have access to a pharmacotherapy service. The combined skill mix of these pharmacists and technicians are supporting over one third of GP practices across Scotland.

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

Pharmacists and pharmacy technicians will take on responsibility for:

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

During the three year trajectory to establish a sustainable pharmacotherapy service, the service will be front loaded in terms of recruitment and training of the eventual required workforce. This will ensure that capacity is in place by year three, the final implementation stage. This approach allows a contingency for adjustment and refinement to the provision of level one, two and three pharmacotherapy services across all practices by the last half of 2020/2021. A three month pilot will test the staffing level assumptions and involve four practices in providing level 1 and level 2 pharmacotherapy services (excluding serial prescribing and dispensing). It is noted that National investment in additional training posts (up from 170 to 200) will support a sustainable pool of staff.

The list sizes and resource required that is detailed below has been made on best evidence available from the current test sites. It is recognised that individual conversations will take place with individual practices where this number requires to be explored further.

A critical success factor to the provision of pharmacotherapy services is the take up of serial prescribing and dispensing which is the subject of national enabling work as well as a local three month pilot and roll out plan to be at least in step with the pharmacotherapy pilot and implementation plan

List size	Number of Practices	Assumed Clinical Pharmacist resource	Assumed Technician resource
>5000	34	1.0WTE	0.4WTE
<5000	21	0.5WTE	0.2WTE

Primary Care Nurse Service Implementation

It was identified in the early planning of the PCIP that there were many synergies with scoping and developing the Community Treatment and Care services and Vaccination Transformation Programme, therefore these priorities within the MoU are included within this implementation group.

Community Treatment and Care

As stated within the MoU, these services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate. IJBs have been advised that phlebotomy should be delivered as a priority in the first stage of the PCIP.

As with all the services, there will be a three year transition period to allow the responsibility for providing these services to pass from GP practices by April 2021. These services are currently delivered by NHS staff, practice staff and HSCP staff and the implementation plan details the timeframes attached to reviewing and understanding the current workforce and skill mix across Ayrshire and Arran to deliver the services listed within the MoU, and propose service models that span across General Practice to community. The Health and Social Care Delivery Plan (2016) states that District nurses, along with General Practice nurses and mental health nurses, play a pivotal role within our integrated community teams.

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

To develop and grow a sustainable primary care nursing workforce, and taking into consideration the age profile of the current nursing teams, it has been suggested that 2018/19 would be an ideal time to trial and test what the Primary Care Nurse role would like. This can be achieved through developing a training programme for newly qualified nurses who have trained in Ayrshire and Arran, offering them the opportunity to gain further skills and experience on a rotational learning programme within General Practice and Community. This would be with the aim to include this cohort of staff in the first roll out of the developed service in 2019/20. It is anticipated that 3 training posts in each HSCP would allow different models to be fully tested with the different teams, as well as provide immediate support to General Practices.

Vaccination Transformation Programme

Vaccination programmes in Ayrshire & Arran have been embedded within General Practice over many years and this model of delivery has proved highly successful, however changes have to be made in light of the increasing levels of complexity of vaccination programmes and pressures across Primary Care. The MoU states that by 2021, vaccinations will have moved away from a model based on GP delivery, to one based on NHS Board delivery through dedicated teams. We have been empowered to develop local solutions to meet local needs in a planned way, progressing at a pace that ensures safe and sustainable delivery continues.

The Vaccination Transformation Programme has been divided into different work streams:

1. pre-school programme
2. school based programme
3. travel vaccinations and travel health advice
4. influenza programme
5. at risk and age group programmes (shingles, pneumococcal,
6. hepatitis B and other groups associated with increased risk such as pregnant women)

It is expected that each Board area will have all five of these programmes in place by April 2021. The order and rate when the transition occurs may vary but progress is expected to be delivered against locally agreed milestones in each of the 3 years, including significant early developments in financial year 2018-19.As plans are developed the Primary Care Programme Board will have oversight of these plans.
The Public Health Department of NHS Ayrshire & Arran remains responsible for the effective co-ordination and monitoring of all immunisation programmes to the local population in line with national policy and guidance. The responsibility for this within the department resides with the named Immunisation Coordinator (IC) – this is a nationally recognised post, is normally at Consultant level and is found in all territorial Health Boards.
The IC Chairs and leads the Vaccination Implementation Group, reviewing each of the workstreams advising on the requirements and practicalities to ensure a safe transfer of each of the vaccine groups to a new service model.
To date it has been agreed in Ayrshire that scoping work is required to understand some of the more complex vaccination programmes, with a view to prioritise the following areas in 2018/19:

- Pre-school programme
- At risk group – pregnant women
- Travel vaccination is also an early priority and initial scoping has been completed. A national group has been convened which will provide specialist advice to all Health Boards in Scotland about a ‘national model/approach’ for Travel Vaccination.

Urgent Care Service Implementation

When people seek urgent care about their physical, mental health and wellbeing this can be a stressful and our vision is to enable the population of Ayrshire and Arran to get the right care they need in the right place, at the right time. This will be delivered, in partnership with the HSCPs, third sector and partners such as NHS24 and NHS Inform, by enabling informed self-care, self-management and supportive and connected communities.

As we implement our new multi-disciplinary teams in practices this will mean that professionals such as Advanced Practitioners (Nursing, Paramedics and AHPs), Pharmacists and Community Link Workers or Connectors, and Mental Health workers will often be the first point of care assessing and treating individuals presenting with urgent care needs. This will enable GPs to have the time to develop their role as Expert Medical Generalists, focusing on caring for individuals who present with undifferentiated, chronic and complex illness.

People often know what care they need and in future more people will be able to seek this directly, so that for example a person with shoulder pain may see a Physiotherapist as a first point of contact, while individuals with minor ailments will increasingly find that Community Pharmacists can provide a range of treatment. Key to achieving efficient joint working between professionals will be the implementation of Joint Data Controller agreements in 2018/19 and improved information technology infrastructure.

To achieve individuals receiving the right care quickly we will develop clear pathways between services as well as share good practice in relation to triage in 2018-2020. The role of administrative staff in GP practices will be key in directing patients and supporting them to navigate care and we have commenced extensive training on this for staff. We will work collaboratively across the three Ayrshire and Arran HSCPs, NHS Inform and the Alliance to communicate and inform the public about where they can access support for self-care, third sector and professional input from the range of primary and community services. We will work to support the roll out of NHS24 Practice Websites to practices, where desired, during 2019/20.

Home visits and on the day requests from patients were identified by the Urgent Care Implementation Group. The contract made particular reference to home vists within the contract as an area where other professionals and Advanced Practitioners, could provide input and release GP time to provide greater focus and continuity of care for individuals with complex health needs.

The Implementation Group agreed to review the existing pattern of home visit provision across Ayrshire and Arran, seeking to learn from good practice. We will test out new models of Advanced Practitioners undertaking home visits and this will include HSCP staff as well as working with the Scottish Ambulance Service. We will seek to be a test site for Advanced Paramedics undertaking home visits in 2019/20 and if this is not possible we will prepare for the national roll out from 2020 to 2023. The HSCPs are developing the use of Advanced Nurse Practitioners and other professionals supporting older people and those with complex at home and in care homes and primary care will work collaboratively with these initiatives.

We will scope our urgent care requirements for our island and rural populations in 2018/19 and will seek solutions including those involving technology. We will continue to test collaborative working with communities, partners and primary care independent contracts at a community level, with a test of change underway in Stewarton and other initiatives in development for 2018/19.

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Links to Other Urgent Care Services

The publication of 'Achieving *Excellence in Pharmaceutical Care – A Strategy for Scotland' in 2017* by the Chief Pharmaceutical Officer for Scotland, provides an opportunity to review and align community pharmacy services with the Ambitious for Ayrshire vision for multi-disciplinary team working in Primary Care. The Strategy makes a commitment to increase access to community pharmacy as the first port of call for self-limiting illnesses and supporting self-management of stable long term conditions, in and out of hours.

Through the Minor Ailment Service (MAS) community pharmacies are increasingly becoming the first port of call for eligible patients for a range of common clinical conditions and Ayrshire and Arran has added to the range of common clinical conditions treatable by community pharmacists under the Pharmacy First Ayrshire service. Women between 16 and 65 can now be treated for uncomplicated urinary tract infections and patients aged two years and over, can also be treated for impetigo. Both conditions previously required prescriptions through GP practices or Out of Hours services.
We are also expanding in 2018/19 the range of common clinical conditions that can be treated by community pharmacists for other skin infections and shingles, and intend to further expand the range of conditions that can be treated. Expanding the range of common clinical conditions treated will improve outcomes for patients and reduce the workload for GPs and other health and social care professionals.

A number of community pharmacists are qualified as Independent Pharmacist Prescribers, providing clinics from their community pharmacy, in conjunction with local GP practices. These clinics include respiratory clinics, as well as hypertension and sexual health clinics. Further training and development of this workforce will unlock a further resource that can play a role in the multi-disciplinary team and promote patient self-management of long term conditions, improving outcomes for people.

Community optometrists provide a comprehensive eye examination service model to care for an aging population. The eye examination is universally funded and therefore free of charge to all eligible patients. Geographical access to eye care at optometrist practices across Ayrshire and Arran is good.

The 'Modern Outpatient Programme' (2016) outlines the further need for a collaborative approach to health care. In Ayrshire and Arran accredited optometrists provide locally enhanced eye care services reducing the burden on secondary care. These include: Low Visual Aids (Visual Impairment); Bridge to Vision (Learning Disability); Post-Operative Cataract Surgery Assessment; Medical Contact Lenses and Diabetic Retinopathy Screening.

We will continue to promote 'Eyecare Ayrshire' which offers community optometrists as a first point of contact for eye problems with the provision of eye drops available free of charge dispensed from community pharmacists. This was launched in February 2017 and is a re-direction initiative which provides effective, swift and accessible care for eye problems in local optometry practices meaning that individuals no longer need to seek a GP appointment or attend Emergency Departments.

We will promote dentists as a first point for contact for individuals with oral health concerns and dental pain. As well as working in line with the Scottish Government published Oral Health Improvement Plan, 2018. The plan sets the direction of travel for oral health improvement for the next generation and has a strong focus on reducing oral health inequalities, moving to a preventive based approach for NHS dentistry and meeting the needs of the ageing population.

The aims of the new plan are to focus on prevention, encouraging a more preventive approach to oral health care for patients of all ages to ensure that everyone can have the best oral health possible and that education and information sharing is specifically targeted at individuals and groups most at risk such as those who do not attend regularly for check-ups, communities in low income areas and particularly those people who either smoked or drink heavily. New approaches will also be introduced to make it easier for dentists to treat older people who live in a care home or are cared for in their own home and to enable those dentists with enhanced skills to provide services that would otherwise be provided in a Hospital Dental Service i.e. oral surgery, treatment under intravenous sedation and complex restorative services. NHS Ayrshire and Arran's *Oral Health Strategy 2013-2023,* closely aligns with the new national Plan with the aim of ensuring the 'best oral health possible for the people of Ayrshire and Arran'.

Out of Hours services are key to delivering urgent care for our residents. East Ayrshire Health and Social Care Partnership launched in November 2017 a new pan Ayrshire out-of-hours service, 'Ayrshire Urgent Care Service'. This brings together the competencies, expertise and capacity of health and social care out of hours services to enable the citizens of Ayrshire to access the right person, with the right skills at the right time.

Ayrshire Urgent Care Service delivers services through an 'urgent care hub', operating from the Lister Centre at University Hospital Crosshouse, supported by local urgent care centres and the home visiting service.

In partnership with NHS24 there will be continued promotion of self-care and redirection to the most appropriate service, for example local pharmacists. Ayrshire Urgent Care Service includes

- Doctors and Advanced Nurse Practitioners
- Out-of-hours district nursing service
- Out-of-hours social work
- East Ayrshire overnight emergency response personal carers
- Service support staff

North HSCP is currently developing a pan Ayrshire Mental Health Crisis Resolution Team to deliver a community based, single point of contact service to GPs, Ayrshire Urgent Care Service, the Emergency Departments, and Police Scotland to enhance service provision to GPs, Ayrshire Urgent Care Service, the Emergency Departments, and Police Scotland. This service will also provide enhanced communication with day time GP services and reduce urgent next day appointments where patients have attended the Emergency Department with a mental health condition out of hours.

This redesign is in-line with national policy for urgent care services as set out in the report '*Pulling Together: transforming urgent care for the people of Scotland, 2016'*, which recognised the difficulty in sustaining GP involvement in out-of-hours services. The service will continue to test new ways of working to ensure a safe, high quality, effective and efficient out of hours service is delivered to the communities of Ayrshire.

We recognise that the above changes to in-hours and out of hours urgent primary care will require extensive engagement and communications with our residents to support them to access the right care, first time. We welcome working in conjunction with national or regional communication campaigns and will scope and plan local initiatives during 2018/19.

We will measure our improvements and performance through local patient and the national patient experience surveys; level of redirection and access to support for self-care; the level and appropriateness of home visits and the effective use of multi-disciplinary team professionals as first points of care, releasing GP capacity.

The detailed action plan for Urgent Care Services is included as Appendix D.

Multi-disciplinary Team in General Practice

The introduction of MDT working is complex and the scale of change required across professions is a unique opportunity to progress a longer-term strategy of transformational change to deliver the vision for Primary Care. The teams within General Practice will also link closely with the wider locality teams as shown in the Health and Social Care Diagram on Page 8. For the purposes of the implementation of the contract, the Implementation Group has focussed only on the GP Practice based team as outlined in the MoU.

The ambition of the MDT is to deliver care to the patient in a seamless way, reducing the number of visits and number of professionals working with a person and their family, as well as reducing the amount of times a person needs to repeat the same story to a range of professionals.

There is agreement that during the initial investment and recruitment, additional resource should be directed to the areas in most need, resource will be allocated using the local population data and intelligence from GP Practices, along with clusters, to ensure resource is fairly spread to the areas of need.

To ensure the most sustainable services are delivered to patients, arrangements should be developed between the GP Clinical Lead in the Practice and the service manager around the coordination of duties and roles and responsibilities.

Where there are already additional professionals within the GP Practice that form part of the MDT, discussions will take place regarding transfer of employment to the wider service where appropriate.

It is recognised within current core services that, as well as recruiting new staff members, there should be a skill mix of development and recruitment within the core team for succession planning. We are committed to working with teams to develop their skills and support development opportunities to grow and invest in our workforce during this transition towards more community based care models. In order to deliver the extended teams in the community, an increased level of training and development is required to attract, retain and support staff.

As the GP Clinical Pharmacist and MSK Physio roles have been tested, and the services models defined on evidenced based outcomes for patients and GP workload, there is agreement that these two services should be invested in within Year 1 of the programme. It is widely acknowledged that recruiting to large numbers of staff is going to be a challenge. Ayrshire and Arran are having ongoing discussions with the Universities across the country, along with NHS Education for Scotland to consider all options for training and developing staff from a basic competency level in their profession. Due to the success of the ANP Academy, this is an approach being considered for all professions within the MDT along with organising a pool of mentors and supervisors from current GPs to assist with ongoing trainee support.

Scoping work with the nursing services across our communities and mental health services team to understand current service models and staffing numbers/skill mix is required. This will be concluded within Year 1, also linked to the development plan and investment to address Action 15 of the Mental Health Strategy.

Full details of the roll out numbers within the MDT are included within Appendix E. It should be noted that the GP Clinical Pharmacist role is included as part of the Pharmacotherapy Service within Appendix B.

Chapter 14: Primary Care Infrastructure **Introduces a number of measures designed to manage the risks of GPs carrying the responsibility for premises and providing the infrastructure to support services to patients.**

One of the overarching aims of reforming General Practice is to improve infrastructure and reduce risk in areas such as ownership of premises, IT and information sharing. These areas are being taken forward and explored on a national basis with a view to transitioning new arrangements by 2020. A local Premises and Infrastructure Group will be established to oversee the national guidance and steps required locally to implement in line with the GMS Contract

The National Code of Practice for GP Premises was published on 13 November 2017. Following the acceptance of the GMS contract offer by SGPC, Scottish Government and Health Boards are working to implement the Code of Practice. The Code sets out plans to offer interest-free secured loans to GPs who own their premises. It sets out the steps that GP contractors who lease their premises privately must take if they wish their Health Board to take on the lease.

The Primary Care Premises and Infrastructure Workstream within the Programme Structure will oversee the local arrangements in relation to the sustainability loans, GP Premises Survey, GP Leased Premises and IT Systems.

This section includes an overview of the requirements set out in the contract for these areas with additional guidance expected from Scottish Government expected in the near future.

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

IT Infrastructure
NHS Boards have commissioned a procurement competition to provide the next generation of GP clinical IT systems for GPs in Scotland. This is being undertaken by NHS National Services Scotland.

The new systems will be more intuitive and user friendly. They will be quicker and more efficient, with increased functionality. They will be underpinned by strong service levels and performance management, with clear lines of responsibility and accountability, providing, overall, a more professional GP IT Service.

All GP practices will transition to the new systems by 2020. GPs will continue to have the right to choose a clinical IT system from those which have been approved by the Scottish Government.

Information Sharing
The new contractual provisions will reduce the risk to GP contractors of being data controllers. The contract recognises that contractors are not the sole data controllers of the GP patient record but are joint data controllers along with their contracting NHS Board. The contract will clarify the limits of GP contractors' responsibilities. GP contractors will not be exposed to liabilities beyond their effective control.
Further guidance is expected imminently from Scottish Government on how this is implemented locally. The actions within the guidance will be introduced through a Short Life Working in conjunction with the Head of Information Governance for the Board, reporting progress through the Urgent Care Service Implementation Group.

Chapter 15: Primary Care Improvement Fund **Provides a financial summary of the overall investment from each IJB against the funding required against of the implementation programmes.**

Funding Allocation

The Integration Joint Boards and NHS Board have received confirmation from Scottish Government of the allocated Primary Care Improvement Fund for 2018/19 which will be used by IJBs to commission primary care services, and is allocated on an NRAC basis through Health Boards to IJBs.

To assist with preparation of the PCIP, Scottish Government has announced its commitment to increase the overall funding to £250 million by 2021-22. Strictly as a planning assumption, and subject to amendment by Ministers without notice, the IJBs have been advised that it is expected that the Primary Care Improvement Fund (PCIF) will increase to approximately £55 million in 2019-20, £110 million in 2020-21, and £155 million in 2021-22. This will, as this year, be distributed on an NRAC basis. This has allowed early planning assumptions for investment to be made within the PCIP.

All PCIF in-year allocations should be considered as *earmarked recurring* funding. It should be assumed therefore that staff may be recruited on a permanent basis to meet the requirements set out in the MoU. Scottish Government will engage with the IJBs and NHS Boards over the three years on any plans to baseline these funds.

Investment Required

Through each of the Implementation Groups initial work has been carried out to understand the investment required from now until 2022. This has also taken into account previous projects and tests of change that were invested in via the Primary Care Transformation Fund 2016-2018.

As detailed in the summary of outcomes from the Implementation Groups, there is recognition of what projects have added value to General Practice, and where further scoping work is required to understand how we meet the requirements set out in the MoU. This is outlined in detail within the implementation action plans.

For the purpose of the plan, the required investment detailed in the implementation action plans has been divided into IJB area for each year, along with WTE share, based on that IJB's NRAC share of the funding. It should be noted that investment has been requested as pan Ayrshire service model funding, as outlined in the actions plans, but this approach to financial planning will be helpful for each IJB to track investment and spend against their share of the PCIF. As noted earlier in this document, the aim is to deliver a core pan Ayrshire service delivery model where possible in General Practice, with the recognition that there may be slight variation in delivery models based on the HSCP local delivery plans and population need. Any changes or adjustments to the PCIP as it develops and matures will require to be signed off by the LMC.

Any discussions on variation of service delivery models should take place through the Implementation Groups in the first instance and then escalated to the Writing Group or Oversight Group where required.

Summary of Investment by IJB Allocation of Primary Care Improvement Fund

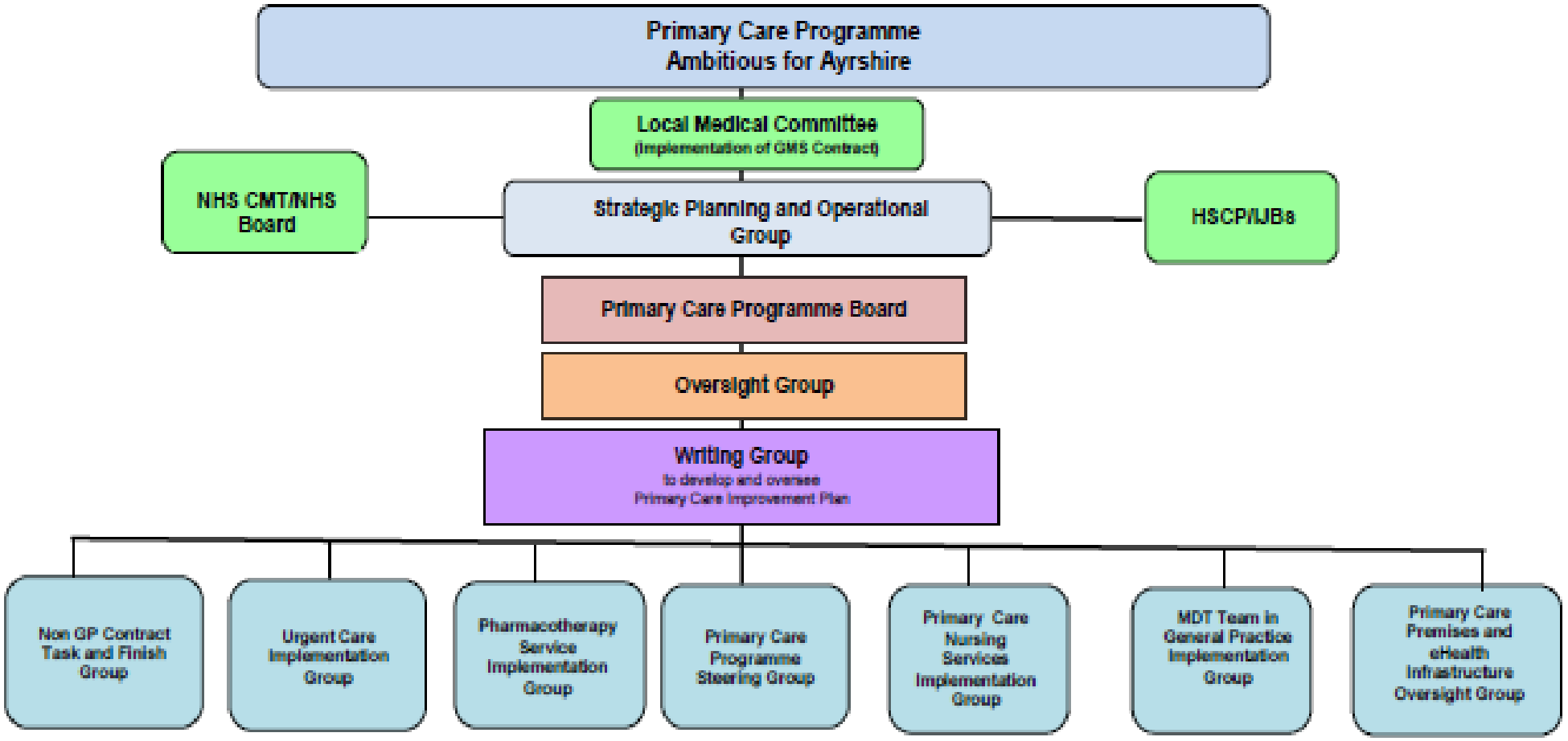
For the areas that have been identified as early priorities in 2018-2020, the tables below details the summary of investment required for the priority areas over a two year funding and recruitment period. This takes into account the £3,389,685 investment in 2018/19 and the £4,074,685 (£685,000 additional) in 2019/20. Resource for 2018/19 has been costed on part year costs in 2018/19 and recruitment will be phased accordingly through the workforce plans for each implementation group.

As stated within the funding allocation section, future additional allocations of a larger sum will be received in 2020/21 and 2021/22. The implementation plans detail the scoping and design work that will be carried out 2018-20 to understand how this resource will be invested. It is noted that some pan Ayrshire proposals will be an equal NRAC split across the IJBs, with other proposals specific to the relevant IJB.

Table 1 – Summary of Required Investment

Priority within MoU/ Implementation Group	Investment £	2018/19 to 2019/20 Total Allocation £7,464,370		
		32.80% EA £2,463,2421 £	36.70% NA £2,761,816 £	30.44% SA £2,239,311 £
Pharmacotherapy Service	3,880,163	1,347,802	1,327,763	1,204,598
Primary Care Nurse Service	575,996	195,929	204,004	176,033
Urgent Care Service	451,500	148,600	166,490	136,410
MDT in General Practice	2,202,939	660,589	936,346	666,004
Programme Delivery	296,875	97,385	109,110	90,380
TOTAL	**£7,407,473**	**£2,450,137**	**£2,743,713**	**£2,273,425**

Appendix A


Primary Care Programme
Ambitious for Ayrshire
Local Medical Committee
(Implementation of GMS Contract)
NHS CMT/NHS Board
Strategic Planning and Operational Group
HSCP/IJBs
Primary Care Programme Board
Oversight Group
Writing Group
to develop and oversee
Primary Care Improvement Plan
Non GP Contract Task and Finish Group
Urgent Care Implementation Group
Pharmacotherapy Service Implementation Group
Primary Care Programme Steering Group
Primary Care Nursing Services Implementation Group
MDT Team in General Practice Implementation Group
Primary Care Premises and eHealth Infrastructure Oversight Group

Membership Agreed for Implementation Structure to Date

Oversight Group	Writing Group
Director of East HSCP (Accountable Officer) Chair GP Sub Committee Secretary GP Sub Committee Associate Medical Director for Primary Care (Professional Lead)	The Head Primary Care and Out of Hours (co-chair) Secretary GP Sub Committee (co-chair) Associate Medical Director Primary Care Associate Nurse Director Primary Care Director of Pharmacy Director of Public Health (Children's Services Lead also) Three Representatives from GP Sub Committee North HSCP Representative – Clinical Director South HSCP Representative – Partnership Facilitator Programme Manager

Urgent Care Implementation Group	Pharmacotherapy Service Implementation Group	Primary Care Nurse Service Implementation Group	MDT Implementation Group
Associate Medical Director Primary Care – Co Chair GP Sub Exec Member – Co Chair The Head Primary Care and Out of Hours Clinical Director – Out of Hours SAHCP – Community Ward GP Practice Manager x 2 NAHSCP Senior Manager – Intermediate Care & Clinical Nurse Manager - Lead General Practice Nurse	Director of Pharmacy Co-Chair Chair GP Sub – Co-chair GP Stakeholder NAHSCP – Primary Care Mental Health Services Lead SAHSCP – Clinical Director Lead Pharmacists x 2 Lead Community Pharmacists Practice Manager x 2	Associate Nurse Director –Co-Chair Secretary GP Sub – Co-Chair Chair VTP Implementation Group Clinical Lead Phlebotomy Management Lead Phlebotomy Director of Public Health Lead General Practice Nurse – pan Ayrshire SAHSCP – Associate Nurse Director NAHSCP – Head of Service, Children and Families & Team Leader MHS Lead Community Pharmacist Practice Managers x 2	AHP Lead EAHSCP – Co-Chair GP Sub Exec Member – Co Chair NAHSCP Rep – Team Leader Mental Health & Senior Manager Locality Services SAHSCP – Partnership Facilitator Lead General Practice Nurse – pan Ayrshire Clinical Nurse Manager ANPs Clinical Lead MSK Physio Lead Pharmacist Practice Manager x 2

Priority:	**Pharmacotherapy Service**	**Appendix B**
Objective	**How do we get there**	**Timescale**
Establish a sustainable pharmacotherapy service by 2021	Establish project structure and governance arrangements	2018/19
	Create a Pharmacotherapy Planning and Innovation team to focus on meeting this objective in order that existing service provision and improvements continue and transition can be managed safely and efficiently	2018/19
	A three month pilot to test the staffing level assumptions and produce standard service processes and procedures	2018/19
Rollout serial prescribing and dispensing	Fill existing vacancy (existing funding, post re-focused on Pharmacotherapy roll out) within the Community Pharmacy Team – Band 8a – to lead enabling and rollout of serial prescribing and dispensing	2018/19
	Establish a systematic and standard approach for initial identification and take-up of suitable patients; documentation templates; phased implementation and roll out plan	2018/19
Leadership and Training Academy	Establish a Pharmacotherapy/Education and Training leadership structure	2018/19
	Establish a training academy to bring pharmacists and technicians through training based in primary care and develop towards providing full pharmacotherapy service role	2018-20
	Create a refreshed pharmacy management structure to reflect eventual model of pharmacotherapy services	2018-2020
Workforce Recruitment	Recruit one band 8b Pharmacist as Pharmacotherapy/Education & Training lead	2018/19
	Recruit one band 5 wte project support	2018/19
	Recruit one band 8a wte pharmacist (will become cluster lead in new structure)	2018/19
	Recruit one band 6 pharmacy technician (existing funding)	2018/19
	Recruit four band 6 pharmacists to test primary care training academy (plan to move to core establishment when primary care training academy tested and established)	2018/19
	Recruit up to 14 band 7 pharmacists	2018/19
	Recruit up to eight Band 5 pharmacy technicians	2019/20
	Recruit up to 14.4wte band 6/7 pharmacists (skill mix subject to pilot and year 1 experience, potentially reduce by 4 WTE if primary care training academy successful))	2019/20
	Recruit up to 4.5wte band 5 pharmacy technicians(subject to pilot and year 1 experience)	2019/20

Priority:	**Primary Care Nurse Service** **Community Treatment and Care Services & Vaccination Transformation Programme**	**Appendix C**
Key Action set out in Memorandum of Understanding	**How do we get there**	**Timescale**
• Management of minor injuries and dressings • Ear syringing • Suture removal • Chronic disease monitoring and related date collection	1. Group established to carry out full scoping exercise to understand the current workforce and requirements.	May -December 2018
	2. Test Primary Care Nurse model with new graduates – providing training and development in community and primary care nursing	2018/19
	3. Design proposed workforce models to share with services	March 2019
	4. Implementation and roll out of workforce	2019-21
Phlebotomy	Secondary Care Blood Requests	
	1. Phase 1 – test site renal and urology	June 2018– October 2018
	2. Phase 2 – Extend to other specialties	October 2018 – March 2019
	5. Phase 3 – Provide Phlebotomy Service for General Practice	2019/20
Vaccination Programme		
Pre-school Programme	1. Scope and cost a pan Ayrshire model	July 2018
	2. Implement new model (excluding flu)	March 2019
School based Programme	1. No changes	
Travel vaccinations and travel health advice	1. Scope current landscape	June 2018
	2. Criteria for assessment of the minimum requirements for the safe and effective delivery of potential options. Await national guidance.	March 2019
Influenza Programme	1. Scope planned programme approach to deliver via nurse bank/primary care nurse development roles	January 2019
At risk and age group programmes (pregnant women shingles, pneumococcal, hepatitis B	2. Pregnant Woman to be delivered by midwife at 20 week scan within Ayrshire Maternity Unit. A cost of 2.5 wte midwives to expand the service will be required.	October 2018

Priority:	**Urgent Care Service**	**Appendix D**
Key Action set out in Memorandum of Understanding	**How do we get there**	**Timescale**
Advanced Practitioner Resource to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care	**Access Multi-Disciplinary Team (MDT) Practitioner Resource to assess and treat urgent care presentations by:**	
	1. Link to MDT workstream to establish standardised pathways for Advance Practitioner Resource to assess and treat urgent or unscheduled care presentations	2018-20
	2. Develop policy on Joint Data Controller	2018/19
	3. Review IT infrastructure to maximise re-direction pathways	2018/19
	4. Develop signposting algorithms / pathways linked to clinical decision making 2018-20 in line with MDT development	2018-20
	5. Provide infrastructure /pathways for consistent signposting / navigation across A&A in line with MDT development (signposting training, NHS24 / H&SCP directories, Linkworkers / Community connectors)	2018-19
	6. Scope Remote and Rural specific requirements and solutions	2018-19
	7. Support implementation for NHS24 Practice Websites where add value	2019/20
	8. Maintain Eyecare Ayrshire and continue to promote	2018-21
	9. Maintain existing Pharmacy First and promote	2018-21
	10. Maximise the uptake of community pharmacy as a first port of call for common clinical conditions by utilisation of the Minor Ailment Service (MAS)	2018-21
	11. Support the development of Independent Pharmacist Prescribers (IPPs) for common clinical conditions	2018-21
	12. Undertake social media / communication campaign for right care, right person, linking to national work as appropriate – scoping and planning	2018-21
	13. Support implementation for NHS24 Practice Websites where add value	2019/20
	14. Develop Mental Health pathways for PC MDT and CMHT	2019/20
	Reduce GP Delivered Home Visits (including care homes) by:	
	1. Seek to become a test of change site with NHS24 advanced paramedics	2018/19
	2. Create a local collaborative with clusters to undertake quality improvement activity including minimising home visits	2018/19
	3. Scope home visit activity, demography, ANP involvement and practice protocols across practices, learning from good practice	2018/19
	4. Link to MDT workstream to enable continuing development of Community Nursing team and engagement of ANP for nursing home visits	2018-21

Build capacity and resilience in local community to pre-empt and avoid individual seeking urgent care services	1. Maximise digitally enabled support to reduce GP attendance (continued rollout of A&A Tec 2018/19; seek to be a test site for NHS24 MH digital service in 2019/20 with national rollout 2020-23)	2018-23
	2. Learn from test of change in Tam's Brig Practice for electronic case management planning for housebound patients 2018/19	2018/19
	3. Continue and learn from Stewarton pilot 2018/19 and work with H&SCP on approaches to community capacity and resilience 2019-21	2018-21

Priority:	**Multidisciplinary Team in General Practice**	**Appendix E**
Key Action set out in Memorandum of Understanding	**How do we get there**	**Timescale**
MSK Physio	1. 4 MSK physios currently in post across Ayrshire	Already Committed
	2. 6 x Band 7 MSK Physios to scale across Ayrshire	2018/19
	3. 1 x Band 8a to develop and manage the MSK Physio Service aligned to General Practice as well as provide clinical leadership and support for decision making. This post will also be half time clinical providing	2018/19
Primary Care Mental Health Services	1. 2016-18 £85k was invested in Community Mental Health Services in each HSCP area. This included a mix of MH practitioners and community link workers.	Already committed
	2. Further work required with operational community mental health teams to scope pathways and models before further investment could be agreed	2018/19
Community Link Workers	1. Group established with HSCP Leads to review number of Link Workers in post and scope current roles.	
	2. North Ayrshire allocated additional link workers from national programme – now incorporated into programme	Already committed
	3. Initial scoping identified South Ayrshire required 1.5wte to ensure full coverage across all practices in line with other HSCPS	2018/19
Development of ANPs	1. Development of 15 ANPs through ANP Academy – includes academic study and mentoring/supervision in their place of work. Cohort 1 of 14 commenced September 2017	Committed
	2. Cohort 2 – 10 students and spread across additional GP Practices. Reduced number due to evaluation taking place and learning to take place on cohort 1	September 2018
	3. Cohort 3 – 10 students	September 2019
	4. Cohort 4 – 15 students	September 2020