East Lothian
Health & Social Care Partnership

Primary Care Improvement Plan

July 2018

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1. Background to the New GP Contract

1.1 Following discussion between the Scottish Government and the British Medical Association a new General Medical Services (GMS) contract was implemented on 1st April 2018[1]. The new contract was preceded by the gradual withdrawal of some of the reporting and data-gathering requirements of the former 2004 contract.

1.2 The new contract is supported by a Memorandum of Understanding (MOU)[2] which anticipates that the work required between NHS Boards, Health and Social Care Partnerships (HSCPs) General Practitioners and their representatives and others to introduce the contract will be developed in the spirit of partnership. There is an expectation that the various elements of the new contract will all be introduced by the end of the contract transition period in 2021.

1.3 The provision of General Medical Services in evenings, overnight and at weekends is not included in the new contract. However, it is essential for in-hours services that out-of-hours services run efficiently and effectively, therefore specific actions to improve continuity of patient care which will reduce pressure on the local out of hours service will be incorporated into the implementation of the PCIP in consultation with Lothian Unscheduled Care Service (LUCS) and others. Consideration will also be given when developing any new services as to what impact they may have on current out-of-hours services.

1.4 The new contract seeks to develop the multidisciplinary practice team of practice nurses, advanced nurse practitioners (ANPs), advanced physiotherapy practitioners (APPs), pharmacists and others, to provide certain services at Health and Social Care Partnership level. These colleagues will support the transfer of workload from general practitioners as part of ensuring general practice is fit for the future.

1.5 Workload transfer is intended to allow GPs to develop their role as an *'Expert Medical Generalist'* and will allow for the development and modernisation of services by Health and Social Care Partnerships which are tailored to patient need and delivered through innovative approaches.

1.6 The new GMS contract places a duty on each Health and Social Care Partnership to develop a local Primary Care Improvement Plan (PCIP) to deliver all commitments and to develop *"...priority areas of service redesign..."* within the contract. The contract requires that the PCIP is agreed with the local GP Subcommittee of the Area Medical Committee and the Local Medical Committee.

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[1] http://www.gov.scot/Resource/0052/00527530.pdf
[2] http://www.gov.scot/Resource/0053/00534343.pdf

1.7 Nationally, implementation by NHS Boards of the new contract and implementation by the HSCPs of their PCIPs will be overseen by a GMS Oversight Group.

1.8 This document is East Lothian Health and Social Care Partnership's Primary Care Improvement Plan, developed in collaboration with primary care professionals, primary care representatives, stakeholders, service managers, the third sector and planners.

1.9 This plan aims to enhance the capacity of the whole system to address the current and future challenges in primary care and to improve outcomes. To do this, there is a need to develop a model of care which focuses on:

- Development of the multidisciplinary team approach to identifying and meeting patient needs
- Establishment of new ways of working and new ways to deliver primary care services across the county in suitable premises
- Improved, accessible information and education
- Greater provision of supported self-care and self-management
- Enhanced third sector services and community support.

1.10 In its development, the plan was consulted on with GPs across all of East Lothian's practices. It was considered and approved by the Lothian GP sub-committee and was discussed at the Strategic Planning Group before being taken to the East Lothian Integration Joint Board for approval on 28th June 2018.

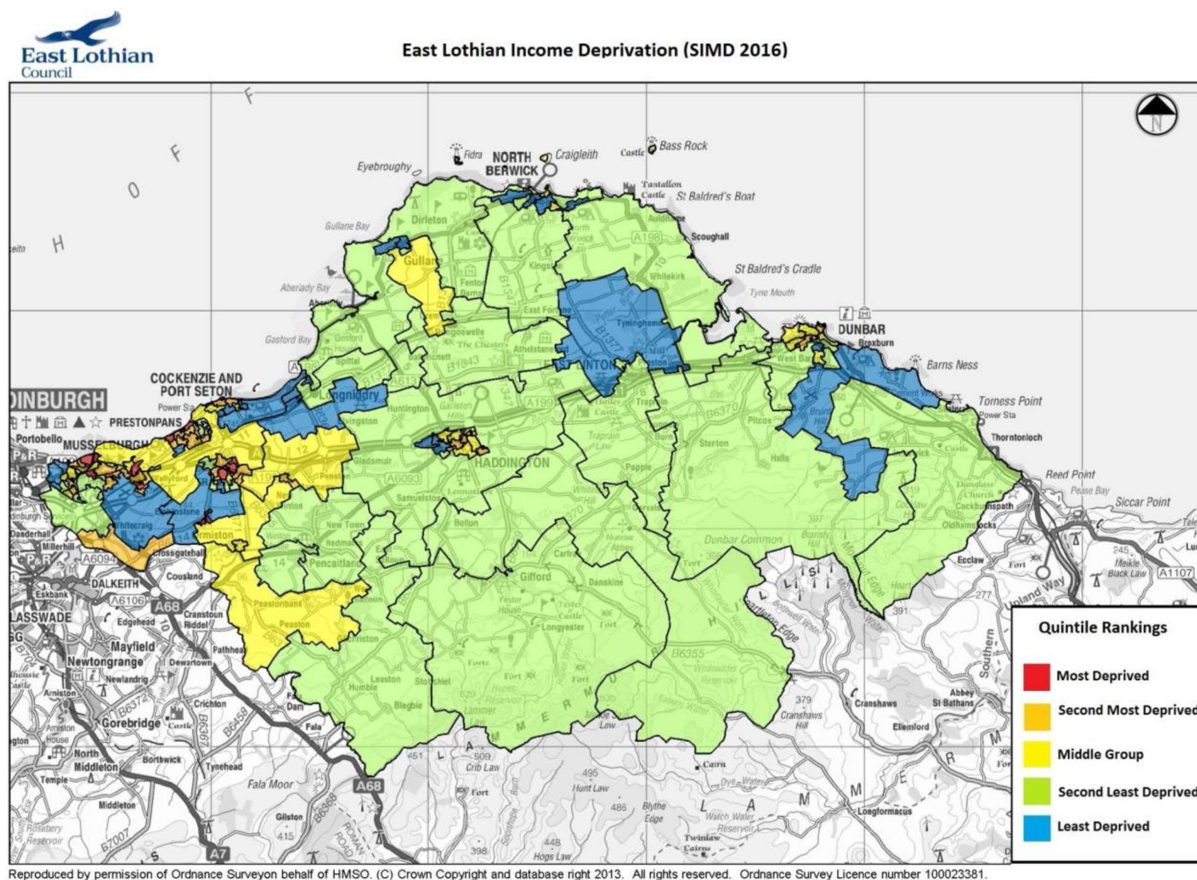
1.11 The final agreed Improvement Plan for East Lothian was issued to the Scottish Government on 2nd July 2018.

2. Primary Care in East Lothian - Meeting the Communities' Needs

2.1 East Lothian's 15 GP practices serve a population of 104,000. The practices range in size from 2,700 to nearly 19,000 and cover populous and rural areas. In recent years, both internal population growth and inward 'migration' driven by house building, particularly in the west of the county and associated increased demand for primary care services has placed pressures on practice teams.

2.2 East Lothian Health and Social Care Partnership has provided interim support to individual practices to cope with staffing and other difficulties. For a period the HSCP also directly managed a practice whose business had failed. This practice was subsequently taken over by another practice securing continuity of care to patients.

2.3 According to East Lothian Council estimates[3], the county's population faces growth of 23.3% up to 2037. This is one of the fastest rates of the 32 local authorities in Scotland. The highest growth in the East Lothian population is predicted to be among the over 65 age group (increasing by 72.2%, with many of them in single occupant households). The 0-15 year old population is expected to increase by 27.5% over the same period.



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2.4 The county's growing and ageing population will increase demand for health and social care services. In addition, the prevalence of long term conditions and, in particular, people living with multiple health conditions (multimorbidity) is projected to rise as the population ages.

2.5 East Lothian has marked variations in deprivation levels across the county, with most areas of deprivation located in the more densely populated west, in the area comprising Musselburgh, Tranent and Prestonpans (see map above[3]).

2.6 Accompanying deprivation are health inequalities, which are unjust and avoidable differences in people's health and wellbeing across social groups and between different population groups. The fundamental causes of health inequalities

[3] East Lothian by Numbers - A Statistical Profile of East Lothian. December 2016

are an unequal distribution of income, power and wealth. In turn, these are associated with the unequal distribution of work, education and good quality housing. This environment shapes individual experiences and leads to inequalities in health outcomes[4]. Hence many of the wider determinants of health inequalities lie outside primary care services. However, in keeping with the ambitions of the HSCP, this plan recognises the opportunities for primary care in East Lothian to strengthen its role in mitigating inequalities.

2.7 In keeping with best practice, this plan will be subject to an integrated impact assessment[5], to ensure it takes into account the needs of different groups in the population.

2.8 Link workers have an important role to play in assisting people to access supportive services. Section 13 outlines plans in East Lothian to continue to develop this programme of work.

2.9 The developing quality improvement role for general practice in the west and east clusters allows an opportunity to tailor interventions to address inequalities and to improve equity of access to meet the needs of the particular communities. This may require the development of different service delivery arrangements across the county to ensure that people who are socially disadvantaged and have higher health needs receive a level of service provision that reflects their needs.

2.10 Specific action may be needed to ensure that the workload of GPs in the most deprived areas is made manageable.

2.11 Inequalities in health outcomes between the most affluent and more disadvantaged members of East Lothian's communities are longstanding, deep-seated and have proved difficult to change. Overall, 5% of the East Lothian population live in the most deprived Scottish quintile whilst 18% live in the least deprived quintile. Across East Lothian people living in the poorest neighbourhoods can, on average, expect to die 5 years earlier than those in richer areas and will spend more of their lives in ill health.

2.12 Such inequalities are due to a complex mix of social, economic, cultural and political reasons. Population health and wellbeing is not just a matter for the health and social care system but requires joint action and greater partnership working. A more sustainable model of health care delivery needs to place greater emphasis on maintaining people's independence and resilience and to recognise the wide range of non-medical factors which can impact on good health and wellbeing.

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[4] http://www.healthscotland.scot/health-inequalities/what-are-health-inequalities

[5] www.nhslothian.scot.nhs.uk/YourRights/EqualityDiversity/ImpactAssessment/Documents/IntegratedImpactAssessmentGuidance.pdf

2.13 Evidence suggests that deprivation influences the number and types of health conditions that people experience and that multimorbidity occurs 10-15 years earlier in deprived areas compared to affluent ones. Also, a greater mix of mental and physical health problems is seen as deprivation increases with a strong association between health inequalities and negative outcomes for individuals and families. Hospital admissions, A&E attendances and prescribing costs are all rising as a result of these pressures.

2.14 East Lothian HSCP recognises that the existing model of primary care needs to change to meet current and future challenges. The case for change outlined in this plan is built on a number of drivers set out below.

2.15 Over the last 3 years or so, most practice list sizes have grown, with thirteen practices increasing their list by between 1.7% to 9.8%. The remaining two practices experienced negative growth of -0.9% to -2.0%.[6]

2.16 Over recent months list size growth across all practices appears to be slowing up, but current and planned house building will inevitably drive up populations. Economic growth and market forces in the building sector will influence the speed of delivery of housing and therefore how fast populations grow across the various established and planned developments.

3. Population Growth and GP Premises Development

3.1 The East Lothian Local Development Plan[7] sets out how the county will accommodate up to 13,347 new homes (6,062 of which are committed to so far) in the period from 2016 up to 2037. Many homes will be located in the west of the county, with the bulk of building expected over the period 2015 to 2024. This will be a large increase on the current estimated 43,682 households in the county. The Blindwells development located between Tranent and Cockenzie will deliver its housing over 2021 to 2037.

3.2 Blindwells will create a significant expansion in primary care demand in the west of East Lothian. The development is in an area not currently covered by any existing GP practices, so will require a new build GP practice. The possible forthcoming investment in buildings associated with the new GP contract should be taken as an opportunity to define a strategy for this locality in the west cluster.

3.3 One option is to replicate the ’seed practice’ model seen elsewhere. Under this arrangement a small GP practice would be established within an existing

[6] Figures from ISD Primary Care Team at April 2018.
[7] Figures from 20th April 2017 draft of East Lothian LDP.

practice, moving to independent premises once the practice list is sufficient to support a full GP practice service.

3.4 A second option has arisen since a local GP practice is now expressing an interest in taking on patients from Blindwells. This may have cost advantages, but an options appraisal, taking into account providing stability of the neighbouring practices needs and tendering requirements will need to be carried out by the Primary Care Improvement Plan Group.

3.5 East Lothian HSCP should continue to provide support to population growth within existing practice boundaries. Currently, limited LEGup (List Extension Growth Uplift) funding is available to help practices expecting a large growth in patient numbers within a defined period. The potential downside of this as an investment is that the money has to be repaid if the growth does not meet the expected level. This may result in the money being 'saved' by a practice and only invested in necessary service delivery improvements after the event'.

3.6 Even more fundamental though, is the acceptance that the planning for and investing in growth is inextricably linked to exploring joint working and new ways of working to streamline resource and to ensure best possible patient care.

3.7 East Lothian has seen investment in new and refurbished/extended practices in recent years. The planning for further practice improvement is focussing on Harbours Practice in Cockenzie, the three practice facility in Haddington and North Berwick Practice.

3.8 Planning for future practice developments and utilisation of existing premises needs to take into account the accommodation needs of those new and expanded staff groups providing services to practices to deliver the GMS contract commitments.

4. The Local and National Policy Context

4.1 East Lothian Integration Joint Board's Strategic Plan 2016-2019[8] acknowledges the key role played by the primary care team in monitoring, responding to and supporting the health and well-being of the population at all life stages. It recognises the pressures placed on primary care by the increasing demands associated with a growing and ageing population, those arising from GP recruitment and retention difficulties and those associated with reducing practice income.

4.2 With a refresh of the Strategic Plan due towards the end of 2018-19 the opportunity will be taken to include in it the developments required to introduce all of the obligatory elements within the new General Medical Services contract and the commitments within the East Lothian Primary Care Improvement Plan. The Strategic Plan will also include commitments to reflect the particular needs of practices and their local communities in work planned across East Lothian.

4.3 Work in support of primary care must also play its part in contributing to the delivery of Scotland's public health priorities agreed between the Scottish Government and COSLA[9]. These priorities aim to move towards a Scotland where:

1. We live in safe and healthy places
2. We flourish in our early years
3. We have good mental wellbeing
4. We reduce the use and harm from tobacco, alcohol and other drugs
5. We have an inclusive economy with fair share, of what we have, for all
6. We eat well and are active.

4.4 East Lothian's Carers Strategy is currently under development[10]. This will consider the support needs of carers of all ages in all settings in which they present, including in primary care. Addressing carers needs will also be integral to enhancing support to specific client groups, some of which are described later in this plan. As part of the Carers strategy development, consultation will be carried out with the primary care teams across East Lothian.

4.5 During the transition phase for delivery of the new GMS contract and in the process of introducing the primary care improvement plan all relevant local and national policies and strategies will be taken into account.

[8] https://www.eastlothian.gov.uk/downloads/file/27195/ijb_strategic_plan
[9] Executive Delivery Group for Public Health Reform
[10] https://eastlothianconsultations.co.uk/adult-wellbeing/draft-east-lothian-carers-strategy/

5. Reflecting East Lothian's Strategic Priorities in the Improvement Plan

5.1 In preparation for the delivery of the new GP contract, and in recognition of the opportunity given to evaluate and re-model the delivery of Primary Care at all its interfaces, East Lothian Health and Social Care Partnership has developed this Improvement Plan. This is intended to be a template for change and will build on those principles already laid out by the partnership within its Strategic Plan to:

- Deliver more care closer to home - actively tackling the rise in unplanned or avoidable hospital admissions and significantly reducing delayed discharges from hospitals to home or a homely setting
- Address the variation in the use and delivery of health and social care services across the county and tackling inequality
- Develop a strong focus on prevention and 'low level' support
- Ensure best value for the public purse through more effective partnership working.

5.2 The vision in East Lothian's Strategic Plan is that people *"live the lives they want as well as possible, achieving their potential to live independently and exercising choice over the services they use".* Improving the health and care of people through provision of greater access to services which address health and social care needs and non-medical factors which impact on health and wellbeing are at the heart of delivering this vision.

5.3 This improvement plan incorporates the key priorities of the new GMS contract, the overarching principles of the Strategic Plan, as well as the information available regarding local priorities from the GP Cluster groups.

5.4 East Lothian HSCP recognises the ambition to consult all relevant stakeholders in the formation of this plan and that the new GMS Contract is an important context to the Primary Care Improvement Plan, but that the Plan should aspire to deliver change beyond the contract itself. The membership of the Improvement Plan Reference Group was selected with this in mind.

6. Developing the Primary Care Improvement Plan in East Lothian

6.1 East Lothian took an inclusive approach to development of the Primary Care Improvement Plan, engaging all stakeholders at the earliest stage in the process to include their views from the outset. It was felt that this approach would prove invaluable as plans progress through to the implementation stage of the new GP contract.

6.2 A Reference Group, chaired by Dr Jon Turvill, Clinical Director, East Lothian HSCP, oversaw the Improvement Plan's development, with representation from:

- ELHSCP Management
- Chief Nurse
- Primary Care Nursing
- AHP Lead
- Pharmacy
- Mental Health
- Care Home Team
- Public Health
- LIST
- Finance
- Communications
- GP Sub-Committee
- GP Cluster Leads
- Third Sector
- Community Pharmacy
- GP Practice Managers
- Service Users

6.3 The group was tasked with:

- Identifying clear milestones for the redistribution of GP workload and the development of effective primary care multidisciplinary team working
- Consideration of new service arrangements (collaborating with other HSCPs as necessary) for local delivery of the services identified in the new GP contract:
  - vaccinations services
  - pharmacotherapy services
  - community treatment and care services
  - urgent care services
  - additional professional clinical and non clinical services, including acute musculoskeletal physiotherapy services, community mental health services and community link worker services
- Producing the final East Lothian Primary Care Improvement Plan by July 2018, in line with the requirements of the new Scottish GMS GP contract and local agreements
- Developing clear local arrangements to deliver the commitments in respect of the new Scottish GMS GP contract.

6.4 The Reference Group met on a monthly basis, reporting to the East Lothian Strategic Planning Group and the Integration Joint Board.

6.5 To progress work in between meetings of this large group, a Steering Group was established. This:

- Supported the development of the East Lothian HSCP Improvement Plan for the new GP General Medical Services contract
- Produced, in consultation with the Primary Care Improvement Plan Steering Group, the draft improvement plan for East Lothian HSCP for approval by the East Lothian Integration Joint Board and finalisation by July 2018
- Worked with partners to develop the support arrangements needed to deliver the commitments in respect of the new GMS contract
- Assessed the steps necessary to roll out two current projects providing support to primary care teams. These are the CWIC (Collaborative Working for Immediate Care) service and the Care Home Team.

6.6 The Steering Group was also chaired by Dr Jon Turvill, Clinical Director. It had membership from:

- ELHSCP Management
- GP Cluster Leads
- GP Sub Committee
- Communications

6.7 Separate work streams were set up based on the services to be remodelled as identified in the new contract and working groups took forward discussions on the vision and broad principles for each service. As vaccination services are being taken forward on a pan-Lothian basis, through the Vaccination Transformation subgroup of the GMS Contract Implementation group, no local working group was established.

6.8 The working groups produced draft sections for submission to the Steering Group, and to feed into the draft plan. Demographic, demand, activity and outcome data was gathered for inclusion in the relevant parts of the improvement plan. All practices were asked to indicate their priority areas for development across the new contract domains. This information was taken into account in the improvement plan.

6.9 The draft plan was considered at an early May meeting of the steering group before being worked up for further discussion and input at the reference group.

6.10 On completion, the plan was consulted on with East Lothian practices, both directly and through the cluster groups. An engagement plan will guide how communication will be managed to inform patients of changes to primary care service delivery.

7. Quality Clusters

7.1 On the retirement of the Quality and Outcomes Framework in April 2016 Transitional Quality Arrangements were introduced. At this time, GP Quality Clusters were formed each based on a geographical group of about 6 to 8 practices. Each cluster has a GP acting as a Cluster Quality Lead (CQL) and each practice is represented by a GP as Practice Quality Lead (PQL).

7.2 In East Lothian two Quality Clusters were formed. The West Cluster comprises Prestonpans, Tranent, Ormiston, Harbours, Riverside (formerly also Eskbridge) and Inveresk practices. The East Cluster comprises the three Haddington practices, three Dunbar practices, Gullane, North Berwick and East Linton. Three Cluster Quality Leads were recruited who continue to support the groups.

7.3 East Lothian's Quality Clusters are well supported by the NHS Lothian Quality team, the NHS Lothian Quality Academy and the Local Intelligence Support Team (LIST) allowing development of a number of local Quality Improvement projects.

7.4 There are aspects of development of the CQL role which need to be addressed. Work is ongoing nationally and locally around this, including on time commitment to the role, training and education needs and support.

7.5 The clear intent that Quality Clusters should be involved in the development of the Primary Care Improvement Plans is demonstrated in East Lothian through the Cluster Quality Leads' input to the Improvement Plan Reference Group and Steering Group and the adoption of a co-production approach.

7.6 In March 2018, the Cluster Quality Leads carried out a mapping exercise to gather information from practices seeking views on priorities for the East Lothian Primary Care Improvement Plan and information on practice workforce. The survey was circulated to all East Lothian practices, achieving a 100% response rate. The data gathered has been analysed with the input of the LIST Team and will be used along with further survey data to aid planning and quality improvement work.

7.7 It is apparent from the survey that practice teams wish to see development of additional roles in primary care, for example advanced physiotherapy practitioners, community mental health nurses and community link workers. Among the aims of the new contract are: reduced GP workload, direction of activity to an expanded multidisciplinary primary care team and improving sustainability of primary care. East Lothian's practices take the view that new roles, such as those above, will support these ambitions.

7.8 As part of their future work the East Lothian Clusters are supporting the NHS Lothian plan for Primary Care Quality Improvement 2018-2021. Work on this will tie into and complement the implementation of the East Lothian Primary Care Improvement Plan.

7.9 The survey shows some understandable variety in local priorities which reflect existing local service availability. For example some practices have access to treatment room nursing and other practices employ their own staff to cover treatment room work.

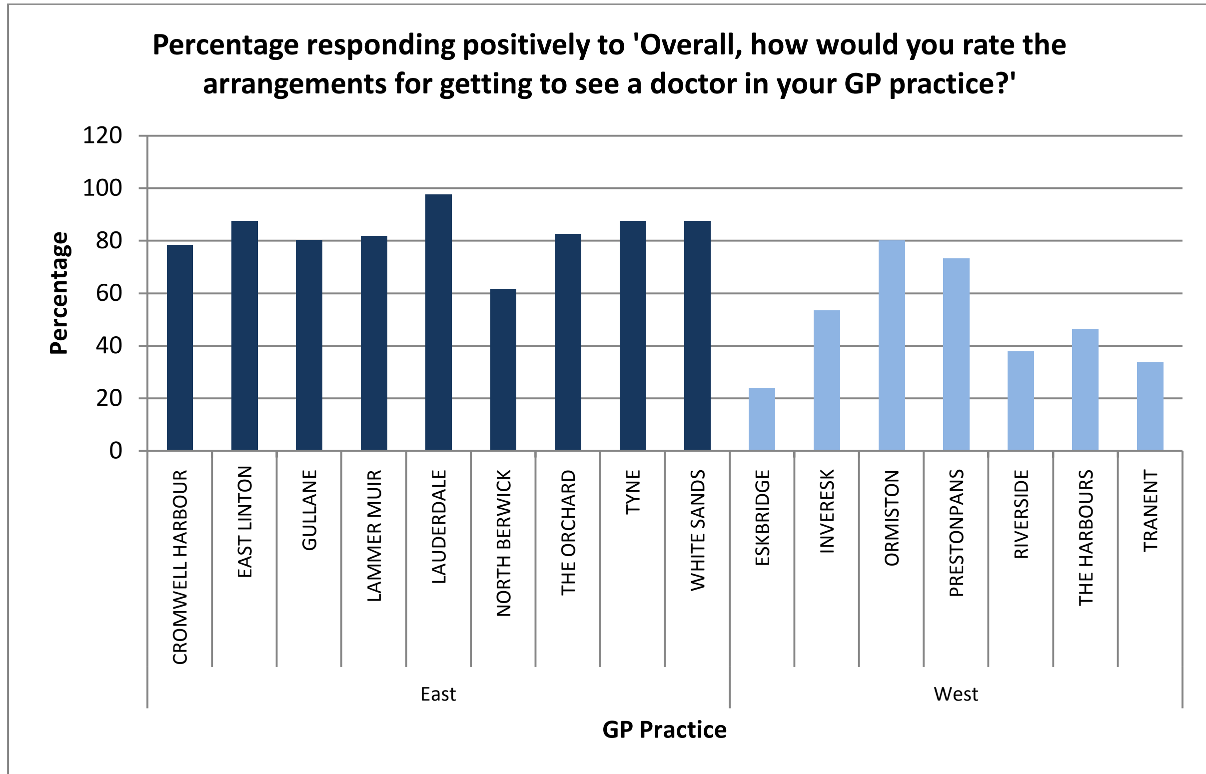
7.10 Practices feel that their top priority for service development in vaccination transformation is pre-school vaccinations. Again, the current model for delivery of this varies significantly between practices.

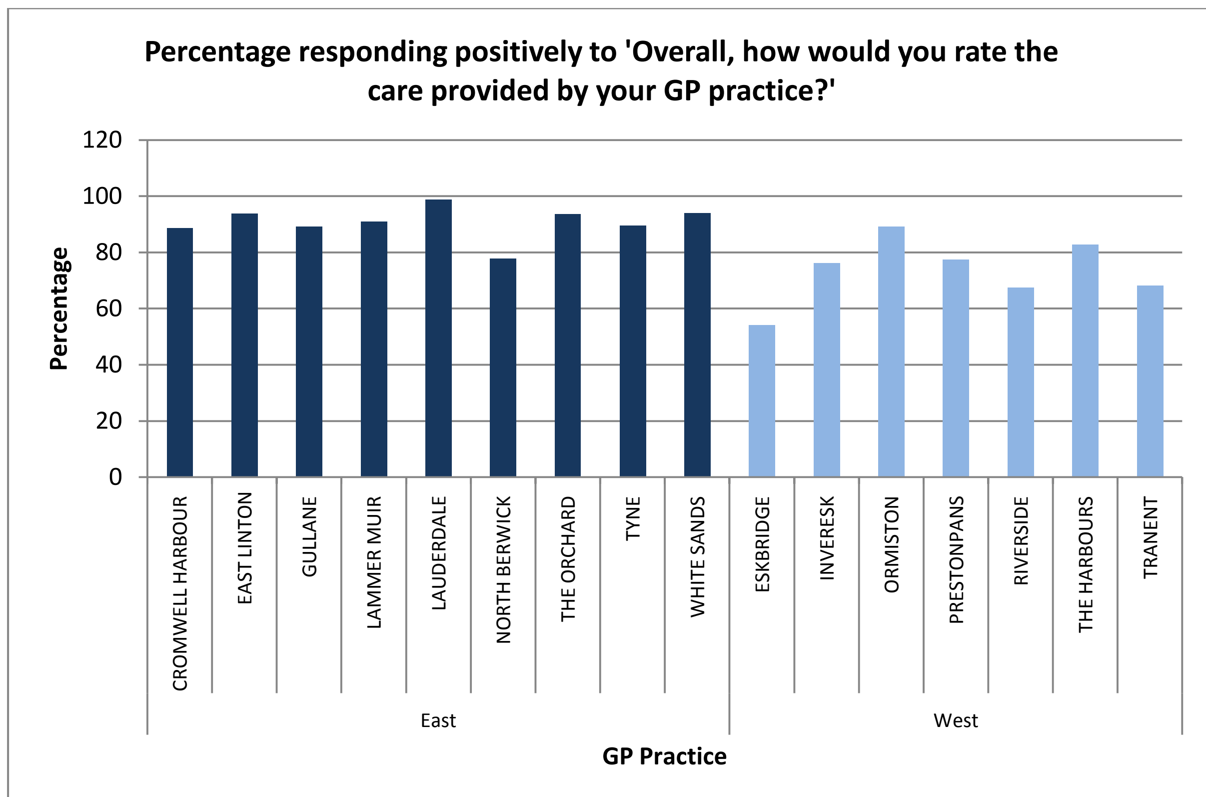
7.11 The Vaccination Transformation Subgroup of the GMS Contract Implementation Group has agreed that no decisions are made regarding the movement of Travel Health and Vaccinations from practices until forthcoming national guidance is available. This means current local arrangements at practice level will continue in the meantime.

7.12 Local demands on services will need to be better understood as part of the process of reshaping services. Engagement and consultation with practices will continue throughout the 3 year period of the implementation of this plan.

7.13 The 2017-18 Health and Social Care Survey[11] carried out across Scotland considered many aspects of satisfaction with services. The two charts below, show responses to two questions: *'Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?'* and *'Overall, how would you rate the care provided by your GP practice?'* The charts show contrasting results between the west and east clusters, in terms of satisfaction with access to a GP. The difference is less marked regarding satisfaction with care.

[11] www.gov.scot/Resource/0053/00534419.pdf


Percentage responding positively to 'Overall, how would you rate the arrangements for getting to see a doctor in your GP practice?'
Percentage
120
100
80
60
40
20
0
CROMWELL HARBOUR
EAST LINTON
GULLANE
LAMMER MUIR
LAUDERDALE
NORTH BERWICK
THE ORCHARD
TYNE
WHITE SANDS
ESKBRIDGE
INVERESK
ORMISTON
PRESTONPANS
RIVERSIDE
THE HARBOURS
TRANENT
East
West
GP Practice


Percentage responding positively to 'Overall, how would you rate the care provided by your GP practice?'
Percentage
120
100
80
60
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20
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CROMWELL HARBOUR
EAST LINTON
GULLANE
LAMMER MUIR
LAUDERDALE
NORTH BERWICK
THE ORCHARD
TYNE
WHITE SANDS
ESKBRIDGE
INVERESK
ORMISTON
PRESTONPANS
RIVERSIDE
THE HARBOURS
TRANENT
East
West
GP Practice

7.13 The East Lothian Clusters are involved in a project funded by the iHub branch of Healthcare Improvement Scotland entitled the ‘Practice Administrative Staff Collaborative’ (PASC). Funding for this work runs until March 2019 but there should be ongoing benefits of the initial work.

7.14 There are three workstreams involved in this project:

> **1 - Quality Improvement Training** for all primary care staff in East Lothian, delivered with the help of a seconded part time Associate Improvement Advisor
>
> **2 - Document Management**, aiming to increase GP capacity by improving systems around document management in practices
>
> **3 - Care Navigation or Signposting**.

7.15 Work related to these areas will be shared nationally. The signposting workstream will assess current demand on practices. The intention is then to develop robust processes to ensure patients are seen by the right person, in the right place and at the right time. Engagement with patients will be an important element of this, in order to change perceptions around how and where care is delivered in primary care and fostering better supported self-management.

8. The Scope of the East Lothian Improvement Plan

8.1 There remains a degree of uncertainty at this stage regarding the details of the finance available to implement the aims of this plan. As a result, the Primary Care Improvement Plan as it stands is an ambitious document with much of the content requiring working up of further detail and confirmation of an appropriate budget to deliver its desired outcomes.

8.2 It is also recognised that a reduction in the health inequalities across the county is necessary to achieve, particularly with reference to access to primary care services. Nationally commissioned surveys have shown a marked difference between the high satisfaction with access in the east of the county and the low satisfaction in the west. This is mirrored by differences in satisfaction with services, with the east having higher satisfaction scores than the west.

8.3 One of the foremost principles in the delivery of this plan is the intention to direct resource to need. Once the PCIP is finalised it is reasonable to expect further discussion regarding where and how services should be prioritised. This will require suitable data gathering exercises to quantify current levels of need and service delivery.

8.4 Rather than simply using the key priorities as defined in the Memorandum of Understanding to direct all work, we have identified those areas of primary care that matter most in East Lothian (for example frailty and substance misuse services) which merit specific reference and detailed work.

8.5 To develop thinking regarding the priorities, each of the main areas of primary care services had a working group established to help design and progress change and to liaise with the PCIP Steering Group. Although the PCIP has to be submitted by beginning July 2018, the East Lothian Steering Group consider it to be a work in progress, which will adapt over the next three transitional years of the contract. Inevitably amendments will be required as needs are identified and new contexts emerge.

8.6 By early agreement of the PCIP, East Lothian HSCP can progress with the significant changes required over the next three years to deliver the new GP Contract. Aside from budgetary planning and service re-design, there is a need to expand recruitment, training and education of the new and varied workforce required to help deliver against the modernising primary care landscape. While this creates an exciting opportunity for development of existing and new roles across primary care, the scale of this project is not to be under-estimated. The support of the whole primary care team and the wider, NHS Lothian resources available to establish the contract are needed to ensure success.

9. Implementing Improvements over Time

9.1 Following agreement of the Primary Care Improvement Plan in July 2018, the PCIP Reference Group will continue to oversee the implementation of the plan

9.2 The PCIP Steering Group will lead the ongoing operational delivery in partnership with individual practices, groups of practices and the multidisciplinary primary care team. Some areas of service delivery will require further analysis and planning and the Steering Group will continue to feedback findings and proposed developments to the PCIP Reference Group.

9.3 The reference group will consult with practices, with clusters and with professional groups throughout the period of transition to deliver all elements of the new GMS contract.

10. Supporting Specific Client Groups – Frailty and Dementia

10.1 Though not in itself a ‘clinical’ diagnosis, the recognition of frailty as a condition that requires a coordinated approach to management is helpful. The high impact of frailty on both health and social care resources and its common association with dementia cannot be ignored and action through the Improvement Plan should strive to deliver high quality management of patients with frailty and support to their carers.

10.2 The identification of patients with frailty within General Practice is not currently carried out routinely or recorded specifically within a patient’s records. It is subjective, but early identification may help with issues including social care, anticipatory care planning and unnecessary prescribing and polypharmacy avoidance.

10.3 Diagnosis of and support to people with dementia is important in ensuring they receive health and social care post-diagnostic and ongoing support tailored to their needs and in ensuring the support needs of carers are identified and acted on.

10.4 Clearer identification of patients with frailty and/or dementia as early as possible may also help to link existing GP services with those delivered by East Lothian HSCP, such as Hospital at Home, Medicine for the Elderly, Psychiatry of Old Age and Lothian Unscheduled Care Service. Delivery of long term conditions management approaches and the resulting admission avoidance can be more difficult in patients with reduced mobility and other factors which limit their ability to access planned and practice-based primary care services.

10.5 East Lothian HSCP will work with partners at LIST (Local Intelligence Support Team) to better understand how we can capture and record data on patients with frailty and with dementia and how we can use that data to direct and improve services and care. The intentions in working with this patient group are to:

- Deliver the principles of 'Realistic Medicine'
- Avoid unnecessary hospital admission, through preventative and reactive community interventions
- Reduce harmful poly-pharmacy
- Ensure seamless transition between different branches of East Lothian HSCP led care services
- Improve support for carers.

11. Supporting Specific Client Groups - People Misusing Substances

11.1 East Lothian has seen a continued rise in the numbers of drug-related deaths throughout the county. Whilst this is a national trend, it is recognised that more local engagement and visibility of services, such as assertive outreach (offering treatment in peoples' homes/communities) would improve our ability to reach out to and support individuals with substance misuse issues and their carers.

11.2 The plan is for new investment to be identified to establish locality based services supporting primary care, with teams in Dunbar, Haddington, North Berwick and Tranent/Prestonpans.

11.3 These locality teams would be affiliated with the respective GP cluster. This would establish new pathways for client flow from the main Substance Misuse Services (SMS) team back to the respective locality for the individual, supported through their GP and the locality team. This would ensure robust management of the capacity of the core SMS team and improve access to services within the Local Delivery Plan target of 21 days.

11.4 Partnership work with Community Justice colleagues will be increased to better address and reduce re-offending through integration of the support to individuals in custody.

12. Supporting Specific Client Groups - People with Mental Health Support Needs

12.1 It is intended to explore extension of the current CWIC model to provide mental health support to practices across East Lothian. This would be achieved through deployment of mental health nurses (who are qualified non-medical prescribers) and mental health occupational therapists (OTs) in order to provide enhanced support to adults seeking unscheduled primary care support for a mental health problem.

12.2 In the process of assessing the needs of people presenting with mental health problems the needs of carers will also be considered through the application of appropriate joint working approaches.

12.3 The team would support 'MAXOUT' a Scottish Government funded academic practice partnership focused on mental health and wellbeing and CLEAR (Community Living, Enablement and Resilience). This would specifically aim to build on individual and community resilience to engage individuals in a meaningful life and reduce service utilisation. The approach would provide effective, evidence-based service pathways and promote and enable resilience skills in individuals who are socially isolated and repeatedly present at services within primary care.

12.4 Those patients directed to the nurse/OT-led mental health service will be an acute presentation, with a relapse of a known condition, or difficulty managing social stressors. Conditions suitable for inclusion to the service include expression of suicidal thoughts, hallucinatory experiences, low mood, anxiety/panic, eating disorders, problems with sleep, medication reviews, review of mental health in terms of fitness to work, drug and alcohol misuse, social isolation and issues relating to work-related stress. The key role of the mental health OT would be to support primary care to alleviate pressure for return to work assessments and fit note sign off.

12.5 Patients under the age of 18 will referred to Child and Adolescent Mental Health Services (CAMHS) via the GP. Older patients presenting with acute confusional states will be directed to the dedicated CWIC GP. Patients with a diagnosed learning disability will be directed to the appropriate service. The intention is that appointment slots for patients visiting the CWIC mental health arm will be 30 minutes.

12.6 As people living with mental health problems are also likely to make unhealthy lifestyle choices, to have physical health conditions and to have social care needs the services will adopt a holistic approach to address these issues, encouraging and empowering patients to take action to enhance their physical health and well-being.

13. Pharmacotherapy

13.1 The new GP contract states that *"...every practice will benefit from the pharmacotherapy service"*. East Lothian already has 5 Practice Pharmacists in 9 of its 15 GP Practices. There are also four pharmacy technician providing support. This means across East Lothian all practices receive support from either a pharmacy technician or a pharmacist. These colleagues carry out a range of tasks including:

- Medicines reconciliation and hospital outpatient letters
- Monitoring of high risk medications
- Medication reviews
- Polypharmacy reviews
- Responding to medication queries from patients and staff
- Implementation of cost-effective prescribing
- Review of use of 'specials' and 'off-licence' prescription requests
- Responding to medicines shortages (requiring identification of suitable alternatives)
- Pharmaceutical queries.

13.2 This support has been well received in Primary Care. Feedback from the two GP Clusters however suggest that the role varies between practices. Further evaluation of the support required across clusters and individual practices is needed to create tailored practice pharmacy support that consistently meets the needs of individual practices and East Lothian HSCP and that reflects any special characteristics of practice populations.

13.3 Some aspects of existing variation may reflect the current management structure under which Practice Pharmacists are managed by NHS Lothian. This is in contrast to other clinical groups who are directly managed within East Lothian HSCP. While the PCIP recognise the aspirations for the role of pharmacists in primary care, this may not reach its potential, or better suit local needs without an amendment to the organisational structure, to devolve management to the HSCP.

13.4 A working group is being created to oversee development of pharmacotherapy. This will evaluate the currently delivered service to identify the most effective areas of intervention, in terms of: clinical benefit to patients; reduction in GP workload; and service efficiency. This information will be coupled with the service needs identified through the Cluster Groups to help plan responsive pharmacy support for practices.

13.5 Any variation in demand for pharmacotherapy services across practices will need to be assessed to ensure cost-effective deployment of resource including through use of remote support where indicated and technically feasible. There is a particular need to plan for the matching of pharmacist expertise or technician support to specific work requirements and to meet pharmacy support requirements across the range of practice list sizes in East Lothian (varying as they do from 2,700 to nearly 19,000 patients). Support arrangements in all cases will be agreed with practices, ensuring none is left without support if requested.

13.6 It is also recognised that the processes behind prescribing are a significant part of the patient experience and the workload of GP practices. Similarly the interface between GP practices and community pharmacy requires evaluation, particularly with reference to avoidance of medicines wastage (and where there is a risk of medication related harm). At present, each prescription ordering process evolves from individual practice need. Involving the practice pharmacist team, as well as practice administration representatives in an exercise to improve the cost and time efficiency of prescribing across East Lothian has the potential to improve the experience for both primary care colleagues and service users.

13.7 Community Pharmacy

13.7.1 Community pharmacies are open at times when many other services are closed and are based in accessible, high street locations. Improved signposting and collaboration between GP practices and community pharmacy has the potential to improve access for patients to pharmacy-provided care, so reducing demand for GP appointments. The current range of services and the opportunities for development are described below. An important requirement for the development of community pharmacy support to primary care will be the establishment of systems to securely share between community pharmacy and the primary care team relevant electronic information and data.

13.8 Minor Ailment Service

13.8.1 The Minor Ailment Service (MAS) allows specific groups of people to access community pharmacy treatment for self-limiting illnesses without the need for an appointment with a GP.

13.8.2 East Lothian HSCP will take into account the learning from current work looking at benefits of extending MAS eligibility to more people and expanding the range of conditions covered. Expansion has the potential to improve access to treatment for a range of uncomplicated illnesses normally requiring a prescription and should reduce demand on GP practices, out-of-hours services and A&E.

13.9 Chronic Medication Service

13.9.1 The Chronic Medication Service (CMS) has two elements; pharmaceutical care and serial prescribing. CMS will develop further with a proposed shared agreement between individual GP practices, the relevant primary care pharmacist and community pharmacists.

13.10 Pharmaceutical Care in Community Pharmacy

13.10.1 Plans are underway for the introduction in late 2018 of a scheme to establish annual pharmacist-led medication reviews. Such reviews are usually carried out by GPs, so this initiative will further transfer workload from practices. To succeed, this work will require collaborative working between community pharmacy, GP practices and the primary care pharmacy team.

13.10.2 In addition, a number of community pharmacists are providing additional initiatives such as condition specific clinics to support people with long term conditions. For example, Tranent is supported by a community pharmacist to run a cardiovascular risk clinic. Evaluation of such approaches is needed and the availability of local resourcing to further develop such clinics in community pharmacies or GP surgeries across East Lothian will need to be assessed.

13.10.3 Over time, community pharmacists will be enabled to play a greater role in managing people with long term conditions, by prescribing, monitoring and adjusting medicines, working alongside all members of the multidisciplinary primary care team.

13.10.4 Nationally, there is a commitment to funding training of more community pharmacist independent prescribers and training in advanced clinical skills. This should be reflected in an increased community-based workforce able to provide such services in the next few years. East Lothian will assess how best to introduce this development locally.

13.11 Serial Prescribing

13.11.1 National work has shown the serial prescribing and dispensing element of the Chronic Medication Service can potentially reduce workload for GP practices and community pharmacies.

13.11.2 Serial prescribing also provides opportunities to align with aspects of the Realistic Medicine agenda, to reduce harm, variation and waste, supporting person-centred care and shared decision making.

13.12 Additional Services and Future Potential

13.12.1 Community pharmacy offers additional services to remove the need for a GP appointment. All services are delivered under Patient Group Directions (PGD) with clear inclusion and exclusion criteria for treatment.

13.12.2 It is recognised that GP cluster groups provide an opportunity to further define local public health priorities. There is the potential locally to add further services based on local needs assessment.

13.13 Urgent and Unscheduled Pharmaceutical Care

13.13.1 Although urgent provision of medication on PGD without a prescription has been in place for many years, previously only items on repeat prescription could be supplied at the pharmacist's discretion. Recent changes provide additional situations where patients who have run out of their medication can have this supplied through community pharmacy.

13.14 Signposting by Community Pharmacies

13.14.1 Community pharmacies are conveniently placed within communities and provide an opportunity to improve signposting and access to information and services, including for those who may have difficulty in accessing mainstream healthcare. Consideration will be given to assessing the outcomes of community pharmacy signposting pilots to assess the merits of replicating these in East Lothian.

14. Link Workers; Changing Conversations, Changing Relationships

14.1 There is good evidence to support the development of new relationships between patients and professionals in the consulting room as a means of improving health and other outcomes. Third sector partners suggest patients want healthcare professionals to do more to support self-care.

14.2 It is known that patients who are active participants in managing their health and healthcare have better outcomes than patients who are passive recipients of care. This is especially true for the growing number of patients living with one or more long term conditions. These individuals account for more than 50% of all general practice appointments, 65% of all outpatient appointments and over 70% of all inpatient bed days, as well as 70% of the total health and social care spend[12].

14.3 It is recognised that traditional primary care clinical options might have only a limited impact if, for example, poor housing or finance or employment concerns are significant factors in a person's presentation. It has been estimated that around 20% of patients still consult their GP for what are primarily social problems.[13] This alone has a significant impact on GP workload which could be diverted to more appropriate professionals with likely better outcomes for patients.

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[12] http://www.gov.scot/Topics/Health/Services/Long-Term-Conditions

[13] Low Commission. (2015) The role of advice services in health outcomes: evidence review and mapping study.

14.4 Evidence as to whether alternative models of care delivery such as social prescribing reduce demand on health services, though inconclusive at this stage, indicate that for those patients referred to a link worker, there was a 28% reduction in subsequent GP attendance (range 2% - 70%) and an average reduction in subsequent A&E attendance of 24% (range 8% - 27%). The evidence that social prescribing delivers cost savings, whilst encouraging, is not fully quantified. [14]

14.5 Link worker input provides an opportunity to change to how a person moves between statutory and third sector or wider support services and in so doing supports development of greater resilience and wellbeing.

14.6 A link worker service was established in four East Lothian practices in late 2015/early 2016 (Tranent, Prestonpans, Inveresk and Riverside practices). The service has been well received by practice staff and patients.

14.7 It is recognised that the existing link worker provision cannot meet demand for service in the practices they are currently working in. The majority of practices in the county as yet have no access to the service.

14.8 Work is ongoing locally to further evaluate the impact of the service in general practice. This evaluation, supported by the LIST team, will utilise both primary care data and third sector data to provide a better understanding of service impact and demand and provide greater clarity around service gaps in the community setting.

14.9 In further developing the link worker model in East Lothian there is the potential to learn from other local and national schemes and to consider how best to incorporate learning from alternative models which foster patient resilience and supported self-management.

14.10 It is intended to continue the existing level of link worker input to East Lothian practices with a view to evaluating how best to extend it across the county in recognition of Scottish Government's commitment to expansion of this service.[15] In doing this the service, as with all other commissioned services in East Lothian, will need to be assessed for best value and strategic fit.

14.11 A sub-group of the PCIP Reference Group will be established to consider issues relating to ongoing evaluation, governance, training, education and service improvement across a range of services, including link workers.

14.12 East Lothian's Primary Care Improvement Plan provides a timely opportunity to review how link workers are best deployed as a resource for patients and practices locally, building connections with the assets in our communities and recognising and appropriately resourcing, developing and supporting the contribution of the voluntary and third sector and of volunteers.

[14] http://westminsterresearch.wmin.ac.uk/19223/1/review-of-evidence-assessing-impact-of-social-prescribing.pdf
[15] http://www.gov.scot/Publications/2016/09/2860

15. Communications and Engagement Plan

15.1 The key messages to be developed in engaging with patients, the public, professional groups, other stakeholders in health, East Lothian Council, the third and private sectors regarding changes to service delivery arrangements arising from the new GP contract are that:

- It is positive for staff - building on and developing skills and careers across the primary care family
- Many services will be directly delivered by the Health and Social Care Partnership
- It will relieve existing pressures on GPs and the practice teams
- It will help patients and communities to get the most out of their local health centres.

15.2 Communication methods will include:

- Newsletters
- Briefings
- Time lines
- Web information
- Internal communications
- Awareness raising posters/campaign
- Public Information – video, slides etc about how to get the most your of your practice.

15.3 Engagement activities will include

- Meetings with existing Patient Participation Groups (PPGs) in GP practices and support to develop new PPGs
- Events
- Surveys
- Workshops
- Online consultation
- Questionnaires in practices enabling staff to be consulted.

16. Optometry and Dentistry

16.1 The PCIP group recognise the contribution these two large groups of independent contractors make to Primary Care delivery. At the early stages of the Improvement Plan development neither group has been able to attend the PCIP group.

16.2 East Lothian HSCP plans to work with these groups to ensure that the skills they have are recognised and incorporated into relevant patient management pathways and signposting. Both these specialities have the perhaps untapped potential to independently manage patients with symptoms that often present first to GP surgeries.

16.3 There is a clear opportunity to reduce demand on GP surgeries for eye and dental problems by ensuring timely access to the relevant community-based expertise in order to remove the GP surgery from the patient journey, or at least to minimise this to appropriate care navigation for patients presenting at the 'front desk.'

16.4 Further exploration of the opportunities in this area will be carried out once an active engagement process with relevant stakeholders has commenced.

17. The Role of Nursing in Primary Care and Community Settings

17.1 The role of nurses has evolved significantly over the last few decades and is continuing to do so. There are many differing roles within community nursing in East Lothian all of which are adapting to meet the needs of the changing population.

17.2 Most users of primary care are familiar with the role of the practice nurse, though this in itself remains a title without a clear definition, or consistency between practices. Although practice nurses are employed by independent GP contractors, there are many aspects of long term conditions management which are managed wholly by practice nurses and the supporting practice administrative teams.

17.3 The development of disease registers and structured management of long term conditions under the former QOF (quality outcomes framework) arrangement enabled the development of the practice nurse role including the more widespread use of independent non-medical prescribing.

17.4 District nurses have worked closely with general practice over many years, providing a holistic and comprehensive community nursing service to patients who are housebound. The service continues to provide reactive and proactive skilled nursing care to patients with long term conditions and palliative care diagnoses. Wound management, holistic continence assessment and management and support to hospital discharge are all integral to the role of the district nurse.

17.5 The new district nursing course will enable district nurses to provide a wider and more highly skilled service including assessment, diagnosis and treatment to housebound patients. The inclusion of non-medical independent prescribing and a clinical decision making component to the course will support this expanded role. The modular format of the course provides flexibility to district nurses in availing themselves of this development opportunity.

17.6 Any expansion of the East Lothian district nursing service provision will be constrained by the numbers of fully qualified staff currently within the service and the investment available to appoint to further posts.

17.7 With the development of integration will come opportunities for district nursing to establish closer working with social care colleagues to provide holistic care to patients needing support.

17.8 Specialist palliative care nurses in East Lothian work in partnership with GPs, the district nursing service and hospices to provide a specialist resource within. The team are currently all non-medical independent prescribers and will develop this aspect of their practice to support transfer of GP workload. With the introduction of a new Band 4 role, this will enable the specialist practitioners to concentrate on the more complex patients and provide further education and support to the wider community nursing teams.

17.9 The nurse-led Hospital at Home team, which has consultant support, continues to expand. It provides a reactive service to prevent hospital admission and to facilitate earlier discharge to patients over 16. The service currently employs Advanced Nurse Practitioners (ANPs) Nurse Practitioners (NPs) and Band 5 nurses but is expanding to appoint to further ANP and NP. Development opportunities within the team are ongoing with mentorship being built in. The service covers the East Lothian 'step-down' unit, relieving some workload pressure from GPs. Clinical cover arrangements for the smaller community hospitals are currently under review.

17.10 Discussions so far at the Improvement Plan Reference Group would suggest that some of the principles laid out in the new GP contract and the related MOU, regarding nursing services are not completely reflected by local primary care service providers. General practitioner representatives at the Reference Group feel that the preferred model of delivery of community treatment and care services is to maintain these at a very local level and for the most part to have them remain under the operational control of independent contractors. This is with particular reference to most aspects of long term conditions management (including monitoring) currently carried out mainly by practice nurses.

17.11 As already noted, the GP Clusters carried out a survey of GPs practices to establish service delivery priorities. The survey has provided some helpful pointers to GP priorities but further statistical analysis of the results is being carried out. At this early stage, it seems likely that ELHSCP will be asked to prioritise a change in arrangements for certain task-orientated services including:

- Ear care
- Suture removal
- Phlebotomy carried out for secondary care services
- Spirometry.

17.12 Included in the above list will be a range of treatment room services, such as wound care and continence services. The likely method of delivery of treatment room services is via two or three local centres with tasks carried out by Band 5 nurses and healthcare assistants. Removing these services from more senior nursing staff will allow those with a higher level of training to concentrate on more detailed and autonomous chronic disease reviews, including prescribing.

17.12 As far as long term conditions management goes, the view is that this is mostly delivered well at present within GP Practices. This arrangement has the advantage of direct access to GP records and detailed and personalised information regarding the patient's medical history and acute-on-chronic episodes accessible to a team than knows the patient. While the quality of care at this level does seem to be mostly excellent, there is variance which would lend itself to action at GP Cluster

level. The Steering Group believes that the organisation of care for patients with long term conditions management needs should be left to GP Practices to deliver, but that ELHSCP should provide support to the practices to:

- Identify and take action to include patients with long term conditions who are currently not attending, or who are unable to attend scheduled healthcare encounters
- Ensure nursing staff who are delivering long term conditions management are appropriately qualified and attending relevant updates to training
- Maintain practice nurse employment by independent contractors, but involving them at a local level in service design and development
- Standardise methods and templates and data gathering for long term conditions reviews
- Create pathways for practice nurses to seek advice from secondary care services directly to avoid referral and to expedite changes to patient management
- Use all of the above to ensure equitable and high quality management for all patients in East Lothian.

17.14 In order to progress this area, the suggested next steps are:

- Set up a working group to lead activity incorporating representation from practice nursing, cluster groups, LIST and ELHSCP
- Establish and agree local priorities
- Evaluate current service delivery
- Quantify workload
- Create and agree a plan for primary care disease prevention and long term conditions management
- Prioritise and implement over the period 2018-2021.

18. Home Visiting

18.1 The Primary Care Improvement Plan Group will need to consider the complex area of home visiting. This is another form of access subject to some of the same inequalities that patients experience accessing Primary Care Services for other reasons. As such, variability and inequality is present in patients seeking a home visit and these may be of greater significance due to the nature of the patients involved and the greater likelihood of frailty.

18.2 Although GPs are the usual members of the practice team carrying out home visits, alternative models of home visiting have been tested in other areas. These have either been centred upon paramedic practitioners (briefly tested in East Lothian with favourable outcomes) or a GP home visiting service (similar to out-of-hours arrangements). These services have the advantage of prompt assessment of the acutely unwell, which can prevent escalation to hospital admission and can improve time and resource management for GP Practices, as provision of home visits requires a disproportionate allocation of GP time, especially when serving rural areas.

18.3 Advanced Nurse Practitioners, if available, could be trained to carry out assessment of patients at home on behalf of a practice or practices. Training for this role could be delivered via the CWIC (Collaborative Working for Immediate Care) service in conjunction with other partners.

18.4 An alternative strategy, and one which may be more rapidly deployed, would be for ELHSCP to directly employ paramedic practitioners. There are already a number of suitably trained practitioners who could be attracted to a new primary care home-visiting service within East Lothian.

18.5 However, the role of the GP team in home visiting remains relevant, especially in the context of managing the frail and elderly and in palliative care management. When more detail regarding this area of the new GMS contract is available, the Primary Care Implementation Plan Reference Group should agree a test of change in the area of home visiting.

18.6 There are options to consider for the establishment of a starting model to provide home visits to an area covering the Prestonpans, Tranent and Harbours Practices:

- **Paramedic Practitioner** - could provide up to 11 visits per day, split proportionately across the practices. A car and equipment (including drugs to be given within Patient Group Directive limitations) would be required. The service would run between 8:00am and 6:00pm.

- **Advanced Nurse Practitioner Team** - would initially consist of an experienced Band 7 Advanced Nurse Practitioner (ANP) and a band 6

Nurse Practitioner (NP) both posts 1.00 WTE. In combination, this could reasonably be expected to provide up to 16 visits per day, depending on skill set. In recognition of the current pathway for District Nurse training including clinical decision making and prescribing, there is potential for the expansion of the home visiting team from this service. Although this is a wider aim of the District Nursing service, this will be dependent on the skill level of the team and the capacity to meet additional demand.

- **Advanced Physiotherapy Practitioners** - could focus on patients with long term conditions, frailty or mobility issues. To fulfil this role, these colleagues would need skills in clinical decision making, in assessing patients in their home setting and as independent prescribers. They would need to link directly with other local services, for example the Community Access Service, the Hospital at Home service and the Care Home Team.

18.7 As the service grows there may be training needs (possibly from some GP sessions) to meet specific mentoring requirements (e.g. ANP training or prescribing). The team would be based in and managed by the CWIC service, allowing flexibility of working roles and varied experience.

18.8 Communication with and referrals to the district nursing service for any appropriate home visits will need to be robust to avoid disruption to the wider district nursing managed service and to reflect the district nursing management arrangements.

18.9 Evaluation of the home visiting model selected for development will be designed to investigate the following outcomes:

- Admission rates
- Internal referrals to other East Lothian HSCP services, especially Hospital at Home
- External referrals to non-East Lothian services
- Patient experience
- Effect on GP practice services, especially access
- Response times.

19. CWIC (Collaborative Working for Immediate Care) Unscheduled Care Service

19.1 In recognition of the desire to provide unscheduled and rapid care (or to respond to 'same-day demand') the CWIC service is currently being tested and evaluated in Musselburgh Primary Care Centre (MPCC).

19.2 Early outcome measures, including patient satisfaction, suggest this approach to service delivery is effective, particularly working in parallel with GP practices under a General Medical Services contract. Structured signposting and, if necessary, face to face clinical assessment of patients seeking unscheduled care has not only improved access to care, but has ensured patients are directed to and managed by the most appropriately trained clinician for the presenting problem. CWIC also allows GPs to concentrate on managing complex care in extended appointments.

19.3 The CWIC service currently provides care to patients registered at Riverside Medical Practice (recently enlarged from 10,000 to circa 19,000 patients after taking on Eskbridge patients). The service is delivered from the modern Musselburgh Primary Care Centre premises.

19.4 The plan is to expand CWIC in stages to offer care to all patients registered within the west cluster of the East Lothian GP practices. The service will remain based at MPCC, with patients attending appointments there. Patients seeking planned GP services (e.g. GP appointments or practice nursing) would attend their registered practice as before.

19.5 The CWIC service will need to significantly develop IT functions and communication structures to ensure sufficient exchange of clinical information to deliver patient care. There could an option of a second CWIC 'base' as part of the new development at Blindwells. Given the projected levels of population growth in the west cluster, this may provide a welcome alternative strategy for CWIC expansion in the coming years.

19.6 The Primary Care Improvement Plan will take into account the challenges presented in growing CWIC including 'marketing' of the service to patients, IT, communications between CWIC and the practices it serves, data sharing, staff training and realignment of perceptions of current GP-led care.

19.7 The Primary Care Improvement Plan Reference Group will need to discuss the geographical priorities for CWIC expansion, making appropriate recommendations within the Improvement Plan. Current evidence would suggest that the expansion of services to the west cluster is a priority, as demand would seem to be higher there compared to the East Cluster. Also, the larger population in the west is served by a similar number of GPs to the east, so giving the west practices more patients per GP. However, there is currently very little data available to East Lothian HSCP regarding patient access and demand in the East Cluster. It is a priority to gather such data. In the meantime, differences in patient satisfaction

with access might be considered a useful reference. Evidence shows there is a marked difference between the west (with low patient satisfaction) and the east (with high patient satisfaction for this measure).

19.8 East Lothian HSCP's Strategic Plan aspires to ensure equity of service delivery. To this end, all patients across East Lothian should be able to access a consistently high level of primary care services which are independent of their location within the county. To do this would require a level of meaningful engagement with all practices across both clusters looking at the variation in patient experience, service delivery and patient outcomes and actions needed to address disparities.

19.9 The 'same day demand' needs of the east cluster are, at present at least, much harder to quantify. Whether a similar service e.g. based in Haddington would be appropriate, or perhaps a 'CWIC-lite' service delivering only musculoskeletal and mental health support, would require consultation with the teams in the east and evaluation.

19.10 Continued investment in the CWIC service is vital to allow development and evaluation of services including of travel requirements. Growth will be dependent on the availability of sufficient financial and staffing resources to implement the new GMS contract. This remains an uncertainty.

19.11 CWIC's approach to meeting same day demand, although in hours, will inform the development of Lothian's Urgent Care Resource Hub which is an outcome of the National Review of Primary Care Out of Hours Services. The review recommends that out of hours services (delivered by multidisciplinary health and social care teams, with third sector and other partners) are co-ordinated across the patient journey and:

- Are person-centred, sustainable, high quality, safe and effective
- Provide access to relevant urgent care when needed
- Deliver the right skill mix of professional support for patients during the out-of-hours period.

19.12 East Lothian HSCP is represented on the Programme Board for the Urgent Care Hub, which reports to the GMS Oversight Group which is also overseeing delivery of the PCIPs across Lothian.

20. East Lothian Care Home Team

20.1 In East Lothian, medical care within care homes has for many years been provided for by GP surgeries under the standard arrangements of the GMS contract. For the most part, this has provided funding to GP surgeries using essentially the same framework as members of the community living at home. It is not certain that these arrangements have adequately provided for the unique care needs of this vulnerable population.

20.2 Latterly, the GP contract offered additional funding to GP practices offering Anticipatory Care Planning (sharing of key information with NHS24, SAS and the Lothian Unscheduled Care Service). For a 60 bed care home this would increase resource by around £10,000 per annum. While any increased funding is welcome, it has been suggested this level of funding is insufficient to significantly enhance primary care delivery in the care home setting.

20.3 Several years ago, having identified a need, East Lothian set up a nurse-led Care Home Team. This was primarily to provide support, advice and some training to the staff of Care Homes to ensure the wellbeing and good nursing care of residents. Further to this, the team was available to liaise with and advise the GPs managing the same patients on various aspects of care.

20.4 This service was well received by GPs and by families and carers. It also helped to forge links between the HSCP and GP providers. The Care Home Team took another significant step forward, through necessity, following the acute medical need generated from the withdrawal of the Eskbridge Medical Centre GP Partnership from their contract in December 2015.

20.5 At this point, the opportunity to widen the role of the Care Home Team was taken. Comprised of Nurse Practitioners (NPs) the team took over all day to day medical management of patients. This included assessment, diagnosis and prescribing for acute presentations and long term conditions, as well as admissions, referrals and care planning.

20.6 The Care Home Team has continued to grow and covers patients in Musselburgh and Gullane and will soon extend its support to Haddington.

20.7 With a number of existing care homes in East Lothian that would benefit from the support as well as the new care home opening in early summer in Haddington and population growth in the county, further investment needs to be explored to expand this service.

21. Patient Access and Signposting and Patient Satisfaction

21.1 At present, patient access to primary care medical services remains variable across the county, relatively unstructured and probably exacerbates health inequalities.

21.2 High demand practices often try to manage access by brief assessment of perceived clinical urgency. In many practices, patients will still book appointments directly to see a GP, with no initial assessment of needs. From a patient's perspective, especially those who still view a GP appointment as the 'gold standard', this may be desirable. However, given that a significant proportion of patients attending GP appointments could be managed at least as well by another member of the primary care team or third sector services, or do not need a face to face appointment at all, this perception must be challenged. Furthermore, when resources are limited, demand high and GP numbers low, it is simply an unsustainable method of service delivery.

21.3 The implementation of robust and reproducible call handling access models can help in responding to high levels of demand. Building effective partnerships between primary care service providers (GP practices, CWIC, NHS 24, community pharmacy, etc) can only be done with structured access models fully utilising all elements of clinical expertise and support services. There is no place for 'luck of the draw'; first come first served appointment systems in a modern day healthcare system. It is preferable for patients to be directed to the correct professional or other support to best meet their assessed need. In addition, to properly support the development of new service delivery models, robust and scalable IT and telephony infrastructure needs to be developed.

21.4 As noted above, models of access, such as those being developed in Riverside Medical Practice (see section 17) in combination with CWIC and NHS 24, should be considered for replication or expansion across East Lothian's practices. Expansion could occur in isolated GP Practices, linking them to centralised expertise, or through shared resource and joint working within GP Clusters. These access models should be built around principles of patient choice and signposting, not necessarily on 'clinical' triage. Whatever approach is taken it should be tailored to the practice and should represent a balanced journey into the most clinically relevant patient pathway.

22. Training, Education, Workforce Planning and Workforce Development

22.1 Integral to the development of modernised access and service delivery arrangements is adequate clinical staff training and education and continuing staff development. At present, training and education of primary care staff, other than GPs, relies too heavily on input from independent contractors. The reality however, is that suitable training is hard to obtain and to schedule due to pressure of time for the practice teams.

22.2 East Lothian is already participating in advanced nurse training, at least in the context of acute care delivery by Nurse Practitioners and Advanced Nurse Practitioners. The Primary Care Improvement Plan Reference Group will consider how to develop nurse training for new developing roles and for long term conditions management

22.3 Training of advanced physiotherapy practitioners, primary care mental health nurses, occupational therapists and others needs resourced with the training structured specifically to community needs. Importantly, with shortages in certain staff groups and large numbers of some colleagues being eligible to retire in the next 5 years, East Lothian also needs to present itself as an attractive place for clinical staff to work in.

22.4 Fundamentally, training has to be led and designed by East Lothian HSCP, but with the support of independent contractors and training bodies, including higher education establishments to ensure it remains relevant to changing practice and changing patient needs and produces staff groups with the requisite skills to work in a modern, multi-disciplinary primary care team

22.5 Developments across the multidisciplinary primary care team in East Lothian need to link with the workforce workstream being developed under the auspices of the Lothian GMS Oversight Group. Local action also needs to take into account the requirements of the April 2018 Primary Care National Workforce Plan[16] and, when available, the Scottish Government's integrated workforce plan. East Lothian HSCP will need to ensure that practices are supported to in turn support and mentor advanced practitioners as they develop their skills.

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

23. Joint Working

23.1 The evolution of GP Practices and their structures, particularly in the context of responding appropriately to increased patient demand, has led to innovations in systems and means of service delivery. However, progress is too often isolated; perhaps limited to an individual practice and roll-out doesn't happen routinely.

23.2 Similar improvement projects can be happening in two or more practices at the same time, with no awareness of each other's existence. This situation has improved to an extent with the creation of the GP Clusters and the work of the Cluster Quality Leads. However, the HSCP needs to do more to facilitate this sharing of innovation and to look to other members of the practice teams such as practice managers and primary care nurses in taking forward collaborative development of services.

23.3 GP practices might also improve business stability by combining resources and reducing overheads. This could be as simple as sharing administrative processes, or as sophisticated as combining patient access pathways and centralising appointment systems. Currently, there are many practice processes that are duplicated unnecessarily across the county and between adjoining practices, with cost implications.

23.4 To address this in a meaningful way might require some very open and perhaps, challenging discussions on modernising the business models for primary care in East Lothian. The Primary Care Improvement Plan Reference Group will consider how it can facilitate this process and how it can support significant changes in GP practices, particularly those that are perceived to have a high degree of risk and uncertainty over sustainability.

24. Sources of Primary Care Improvement Funds

24.1 The Scottish Government is investing £115.5m nationally in 2018-19 as part of the implementation of the new GMS Contract and other Primary Care Investments. These funds will increase in 2019-20 and 2020-21.

24.2 Of the £115.5m in 2018-19, £45.8m has been allocated across the Integration Authorities (in East Lothian, the Integration Joint Board) to support the development of multi-disciplinary teams as part of the implementation of the new contact. This investment (now called the Primary Care Improvement Fund) is planned to grow over the next few years in line with the overall growth in investments as shown in table 1.

Table 1 - further development of the Primary Care Improvement Fund

Potential Primary Care Funding in Future Years			
	National	**Lothian**	**East Lothian**
	£000s	**£000s**	**£000s**
2018-19	45,750	6,773	839
2019-20	55,000	8,142	1,009
2020-21	110,000	16,285	2,018
2021-22	155,000	22,947	2,844

24.3 However, not all of this £45.7m of national investment in 2018-91 is 'new' monies, as it in part comprises a series of investments that have been made over the past two years. Table 2 shows what separate funding sources have made up primary care investment at Lothian level over a three year period from 2016-17 to 2018-19.

Table 2 - Scottish Government Primary Care investments 2016-17 to 2018-19

Lothian Funding Sources	**2016-17**	**2017-18**	**2018-19**
	£000s	**£000s**	**£000s**
Primary Care Transformation Fund	1,160	1,160	6,773
Mental Health	513	513	
GP Recruitment and Retention Fund	50	60	
Prescribing for Excellence	951	1,132	
Pharmacists in GP Practices	-	602	
Pharmacy First		155	
Total	**2,674**	**3,622**	**6,773**

24.4 The Scottish Government has also made an additional £740k available recurrently to Lothian (which is Lothian's share of £5m nationally) to support investments in Out of Hours services.

24.5 East Lothian, as with other HSCPs in the region, made investments in 2016-17 and 2017-18. The recurrent elements of these investments applying in 2018-19 will therefore have to be funded from the 2018-19 allocation.

24.6 The sums in table 2 are overall Lothian values. In 2018-19, the Scottish Government committed to all of this funding being provided to the Integration Authority and their respective partnerships. East Lothian's share of the Lothian resource is 12.4% which is based on its population.

24.7 In addition to the funds above, NHS Lothian, as part of its commitment to invest in primary care capacity made available £2.0m in 2017-18, £4.0m in 2018-19 with a proposed further £1.0m in 2019-20 making a recurrent investment of £5.0m. As before, all of these funds have been and will continue to be made available to the four Lothian IJBs.

24.8 Utilisation of Primary Care Funding

24.8.1 As discussed above, each partnership has already made investments in primary capacity and started to develop programmes to support the new GMS contract.

24.8.2 In East Lothian investments have been made in the Collaborative Working for Immediate Care service and the Care Home Team. Other investments were made on a pan-Lothian basis with East Lothian contributing its share. These support the Local Enhanced Service (LES) for Diabetes, the Local Enhanced Service for Phlebotomy, the training of Advanced Nurse Practitioners and (in 2018-19) resources to all GPs to engage with the Health and Social Care Partnerships in this work.

24.8.3 Development of pharmacy support to the practices has been undertaken on a pan-Lothian basis. It is clear from the guidance that these funds must also be used to support the vaccination transformation programme, community link workers and investments in further professional roles (such as mental health and physiotherapists).

24.8.4 The current primary care funding position for East Lothian Health and Social Care Partnership in 2018-19 is summarised in table 3.

24.8.5 The table is based on the known costs and an assumption that the total pharmacy costs to be funded from the Primary Care Improvement Fund are £1.9m. However, at the time of preparing this report (at end June 2018) the costs of the vaccination transformation programme are not known. Work continues to refine these costs.

Table 3 - Total Primary Care Funds for 2018-19 in East Lothian

Funding Sources	**£000s**
Share of Primary Care Transformation Fund	839
NHS Lothian Investment	480
Total Funding	**1,319**
Commitments	**£000s**
Pharmacists	234
Diabetes LES	43
Phlebotomy LES	43
Advanced Nurse Practitioner Training	31
GP Attendance	11
Care Home Team	240
Collaborative Working For Immediate Care	459
Additional Commitments	**£000s**
Vaccination Transformation	To be confirmed
Link Workers	Pilot project underway
Physiotherapy (MSK)	CWIC team includes MSK Physios
Mental Health Workers	To be confirmed
Remaining Sum	**258**

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25. Making Best Use of Data

25.1 The MOU commitment to change primary care data controller arrangements from GPs only to joint arrangements with health boards provides the opportunity to use primary care data, in agreement between partners, for service planning and delivery purposes in order to benefit patients. In doing this, all required steps will be taken to fully comply with all data protection legislation and health board and council policies.

25.2 To support data sharing between East Lothian HSCP, GP practices and third sector organisations and NHS Lothian, agreements need to be established and monitored to ensure all relevant data is securely shared.

25.3 The necessary technical infrastructure and equipment to support data sharing in East Lothian needs to be provided and supported by all relevant NHS Lothian corporate functions.

25.4 The expertise to develop and maintain data collection and to provide routine and on-request analysis to assess performance and outcomes needs to be embedded in the HSCP. This will require strengthened relationships with Lothian Analytical Services (LAS) Primary Care Team as well as the ongoing input of LIST (Local Intelligence Support Team) analysts.

25.5 East Lothian's two primary care clusters will be supported to utilise data to progress quality improvement work across the county at practice and cluster level. Opportunities will be taken to carry out activity surveys to better match support to demand.

25.6 Data sharing arrangements between health and social care services will be further developed to support integration and to monitor performance.

25.7 Data visualisation tools and dashboards for data reporting purposes will be developed with LAS and the Geographical Information Systems (GIS) teams and others to assist all partners in understanding clinical and other outcomes.

25.8 The data gathered in East Lothian should, where possible, reflect what is recorded in other HSCPs across Lothian to ensure consistency in data gathering and to allow analysis of and comparisons between locally gathered data.

25.9 The HSCP will, in agreement with practices, make full use of SPIRE (Scottish Primary Care Information Resource) reporting and research opportunities.