Report

Primary Care Funding and Investment

Edinburgh Integration Joint Board

16 June 2017

Executive Summary

1. The purpose of this report is to detail how NHS Lothian sourced funds can be utilised to ensure the stability of primary care in Edinburgh from 2017/18 .

Recommendations

It is recommended that the EIJB:

2. agrees a programme of 'Stability and Transformation' injections into individual GP Practices during 2017/2018;

3. supports the establishment of an Edinburgh primary care Linkworker network. This is a Partnership led project which aims to support more social prescribing;

4. supports investment in additional management capacity to ensure effective implementation and robust evaluation;

5. supports the management of these investments being made through the Edinburgh Health and Social Care Partnership (EHSCP) Primary Care Support Programme; and

6. supports the use of any non recurring flexibility into an agreed group of technological investments (50/50 funding with practices) and to support development work by cluster groups.

Background

7. A full background and rationale to the above recommendations is given in Appendix 1: 'Transforming the Primary Care Workforce in Edinburgh: Working to the Top of Everyone's Licence'.

8. The proposals are aimed firmly at the expansion of 'core' primary care capacity, in recognition of the challenges of instability in individual practices over the last three years.

9. The proposals envisage a cohort of primary care professionals; nurses, pharmacists, linkworkers, allied health professionals and others, being 'injected' into c30 practices which has reduced the reliance on medical sessions by up to 10% in most cases and around 15% in more 'transformational' practices.

10. The injections of funding will be made without cost to the practice for six months, then at 50% of the total cost thereafter.

11. The staff will be employees of the EHSCP and current line management arrangements for the respective professions will be used. The relationship with the practice will be set out in a Service Level Agreement which stipulates these arrangements, associated expectations and risk sharing. The members of staff engaged will be expected to become members of the core practice clinical teams and to be directed by the practice on a day to day basis.

12. Discussions will take place with the cluster managers within the four Localities and they are aware of the new workforce detail. As the implementation phase is complete, some may consider taking a stronger role in supporting the management and development of this workforce. If individuals work in more than one practice, every effort will be made to ensure their practices are in the same cluster.

Key risks

The following evaluation and review mechanisms are in place to ensure that the risks and issues are managed that may result from the proposals:

13. The governance framework for implementation comes under the EHSCP Primary Care Support Programme. A project group will be established to guide implementation which will report to the Edinburgh Primary Care Management Team. The key decisions about prioritisation of practices to access funding in the first year will be proposed by the Clinical Leads Group, under the chairmanship of the Clinical Director.

14. The approach will be subject to ongoing practice and city wide assessment of impact.

15. The expectations are clear at the outset; that a practice receiving an injection or associated support will be able to reduce the number of medical consultations by c10% and that this will accumulate, practice by practice, to c 4.6% (FYE) across the city by the end of the first year.

16. Furthermore, and critically, that no further practices are forced into a situation where a crisis intervention is required to maintain General Medical Services provision to their list

17. Ideally, practices which receive stability and transformation injections would be able to un-restrict their lists. This expectation needs to be carefully exercised to ensure that instability is not increased.

Financial implications

18. The funding associated with the proposals is in place and set out in Table 4 of page 15 of Appendix 1

Table 4	2017/18	2018/19	2019/20	2020/21
Transformation Fund	£0.66M	-	-	-
LHB	£1.1M	£2.2M	£2.75M	£2.75M
SG additional Allocation	-	?	√	√
GP Income	£0.2M	£0.4M	£0.8M	£1.1M
Lothian-wide investments	(£0.5M)	(£0.5M)	(£0.5M)	(£0.5M)
Total Income Available for flexible pool	**£1.46M**	**£2.1M**	**£3.05M**	**£3.35M**
Additional Capacity created in Consultations	150,000	200,000	225,000	250,000
Associated Cost	£1.5M (4.6%)	£2.1M (6.2%)	£2.4M (7.2%)	£2.7M (8.1%)
Balance available for investment in wider system	£0	£0M	£0.95M	£0.95M

19. In Year 1, the funding will come from the final year of the Scottish Government Transformation and Stability Funds (£0.66M) and the first year of NHS Lothian funding. (£1.14M)

20. Further funding available for direct application to core Primary Care is expected but not presumed. No recurring commitment is made in Year1 which does not come well within the total funding envelope (less GP contributions) available from the beginning of Year 2

21. Furthermore, individual practice investments and contracts will be able to be absorbed into wider service capacity if not continued.

22. If the approach is not able to achieve the impact sought across the system, the staff engaged will be readily deployed into other roles and the H&SCP will not be left with a workforce unable to be redeployed. Further protection is available where any 'unique' roles will be engaged on a fixed term or secondment basis, to protect both the individual and the H&SCP.

Involving people

23. This transformation plan has been discussed at various forums within the Partnership including GP cluster meetings, the Primary Care Joint Management group, and the GP Clinical lead meeting.

24. The plan has also been shared with Lothian Local Medical Committee.

Impact on plans of other parties

25. These investments are designed to stabilise General Practice and re establish a position where all city residents are able to register at a practice which is in their cluster. Where this cannot happen due to restricted lists the most vulnerable groups in society find it most difficult to access healthcare.

Background reading/references

Appendix 1, 'Transforming the Primary Care Workforce in Edinburgh: Working to the Top of Everyone's Licence'

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Appendix I

Transforming the Primary Care Workforce in Edinburgh: Working to the Top of Everyone's Licence (Draft April 17)

Transforming the Primary Care Workforce in Edinburgh

1. Purpose

The Edinburgh Primary Care Strategic Plan identifies key work streams which will take us out of the current deteriorating circumstances for Primary Care & re-establish a stable & effective sector. This paper approaches the immediate workforce capacity element of the challenge, on the basis of what is required and not what funding may be available. The quality of available premises, interface with support services & the increasing availability and reach of ambulatory care models is presumed. The paper notes however, that the available funding is potentially reconcilable with the size of the challenge, depending on decisions made over Transformation funds and LHB Primary Care Investment available from 2017/18. The paper anticipates but does not include assumptions about further Primary Care Funding.

The approach describes the first steps to 'eating the workload elephant' as new resources become available. It describes how we can approach the workforce design required to regain equilibrium across the system. The approach is founded on the conviction that a responsive, flexible and innovative Primary Care sector will prevent unnecessary hospital referrals and admissions, reduce potential 'hand offs', and allow Primary Care to use its influence with the public where it is most effective; at practice level and in the consultation process.

The proposal is firmly in line with the national/GP aspiration to operate 'at the top of the licence', & brings in a flexible range of professionals to help Primary Care become much more of a multi-disciplinary activity. The approach builds on a successful record of collaboration and involvement with GPs at Practice and local level, rather than attempting to solve workload challenges with more remote investments. The innovation and pragmatism of Primary Care is therefore enshrined in the design process.

2. Recommendations

a. The Scottish Government Transformation Funds available in 2017/18 and the LHB investment should be combined into a single funding pot to create a flexible workforce. The Transformation Fund can be replaced in 2018/19 by a combination of additional LHB funding and income from 50% GP contributions to the additional workforce costs.

b.

That the centrepiece of Primary Care workforce transformation is the development of a multi-professional flexible workforce for Edinburgh embedded in individual practices or potentially, by groups of practices & by Locality Clusters. This workforce will be initially developed to target

reducing reliance on GP medical sessions by shifting approximately 7% of the current medical consultation workload to a wider multi-disciplinary team over a three year period.

c. Individual practices (currently 7 & building to c30 in 2017) will benefit directly from a mixture of 'stability' & 'transformation' injections. These injections of workforce capacity will be funded 100% for 6 months and 50% by the practice if agreed as effective.

Practices not benefiting directly from these investments in the first two years will benefit indirectly from; less population / registration pressure – stable neighbours – improved access to available medical capacity. All practices will benefit from the establishment of Linkworker Network & Social Prescribing training for reception staff in particular. In addition, the Edinburgh Primary Care Support Team will benefit from a modest investment as we move from supporting a series of crisis situations, to a more preventative approach.

d. To recognise that a range of other key actions surrounding workload management need to be pursued to stabilise Primary Care. Key amongst these is a stronger dialogue with the public over appropriate use of public services and the development of our digital interface. Appendix 1 provides a dynamic summary of the key interventions currently proposed across the system to reduce the medical workload by more than 10% over a longer period.

e. This paper focuses on the replacement/augmentation of c7% of medical sessions across the City over 3-4 years. This additional capacity should be understood as c4.6% relief of current strain in the first year, a balance of relieving pressure & facilitating population growth in the second year & mainly facilitating population growth from year 3 onwards. 1

3. Background

- Since 2007, the City has added 50,000 new citizens to GP lists.

- Since 2007 no commensurate investment has been made in infrastructure or the Primary Care workforce directly associated with older people and mental health. The Primary Care workload has therefore increased in the same way & for the same reasons as in the rest of the UK, but with the additional burden of increased population.

- The City population is highly likely to maintain or increase the rate of growth over the next 20 years. In common with other public services, Primary Care must establish mechanisms to facilitate this growth.

- GMS & prescribing funding streams are linked to population & adjusted to reflect demand, but other Primary Care resources are left to Health Board determination.

- The supply of doctors into Primary Care until approximately 2010/11 was adequate to accommodate any practice based disruption, and certainly to allow practices to recruit new doctors and where appropriate, new partners.

- By 2014 this had changed radically. Jobs advertised in successful Partnerships were no longer attracting suitable applicants & practices began to struggle with filling gaps in cover on a temporary basis due to shortages in available Locums.

- As a result, once stable practices became vulnerable, as established partners absorbed more & more work and responsibility.

- From the standpoint of a newly qualified GP; the prospect of Partnership is currently quite unattractive, despite the universal enthusiasm for the work & the interest in the role of GPs.

- The situation with GPs is mirrored in District Nursing & Health Visiting, key foundations of Primary Care which could otherwise have been augmented & adapted to help with the medical shortages.

- Similarly, Practice Nurses are attracted to Advanced Nurse Practitioner roles, but this can leave difficult to fill vacancies in the Practice Nurse Teams. Supporting the training programme will put further (temporary) pressure on GP capacity during a critical period.

- In contrast, there is a welcome supply of highly trained pharmacists and increasing recognition of the stronger role able to be played by pharmacy across Primary Care.

- The potential for effective linking between the Third Sector and Primary Care has been recognised for many years. Until recently, a coherent framework did not exist to allow the Third Sector to impact at a scale where Primary Care recognised (& funded) capacity in the Third Sector in preference to expansion of more traditional approaches.

- The availability of CPNs is limited although not as severely as GPs/DNs/PNs, and there may be a useful role for a 'Mental Health Worker' which could release capacity by supporting a mixture of frequently consulting patients and those with 'lower level' mental health issues. In addition, there may be an opportunity to test the introduction of psychological interventions at a practice level, making rapid assessments and preventing patients becoming 'frequent flyers'.

4. Problem Definition

4.1 GP consultations are proposed as the currency and starting point for Primary Care Transformation. GPs in Edinburgh will undertake c3, 250,000 consultations during 2017, or 6 visits per citizen per year to their local practice. The supply of doctors & medical sessions into the system is difficult to assess and & predict with confidence, but we are cautiously optimistic that the current compliment of medical sessions available to Edinburgh will remain constant, albeit with fewer GP Principles & more salaried doctors. The yield of clinical sessions per doctor is also declining & this needs to be carefully accounted for.

4.2 The growing imbalance between demand and supply of medical capacity is therefore a result of the additional population & lack of investment (beyond GMS & prescribing) together with aging population, patient expectations etc. It is important that we try to 'size' the gap & define a starting point, alongside the intended impact of our future actions.

4.3 An average demand population (i.e. not particularly deprived nor aged) of 5000 requires an additional 25 medical sessions & 10 Practice Nurse Sessions per week under a traditional approach, or 30 medical sessions & 12 Practice Nurse sessions when leave is factored in. The requirements of a young population, a highly deprived population or an affluent elderly population will be substantially different. There is a backlog of several years of this capacity being missing and the Edinburgh capacity gap can be guaranteed to increase at the equivalent of 30 medical sessions & associated nurse sessions per year.

4.4 At the beginning of 2017, we therefore propose that the problem is quantified as 4 years of 'backlog' together with this year's challenge;

6 consultations per patient per year x5years x 5,000 patients =150,000 consultations

150,000 consultations of capacity is immediately required in 2017/18 to begin to stabilise the system.

This addresses the 'core' Primary Care Team only, and not the shortfall in wider investment across the Health & Social Care system.

4.5 The immediate Edinburgh challenge in 2017 is therefore to create a workforce which will take approximately 150, 000 consultations out of the current GP workload & continue to do so at a rate of c30, 000 consultations per year for the next 5-10years. If the assumption about medical sessions available to the population proves to be optimistic due to an increased rate of Principle retirement, this target will need to be increased.

4.6 Various studies have indicated that it should be possible to reassign around 25% of the current GP workload. The initial proposed 2017 target of 150,000 redirected appointments represents an initial 4.6% shift & the equivalent workload of c20 full time GPs.

5. Solutions

So how do we grow the capacity to replace 150,000 GP appointments in 2017?

There are 2 broad approaches to this;

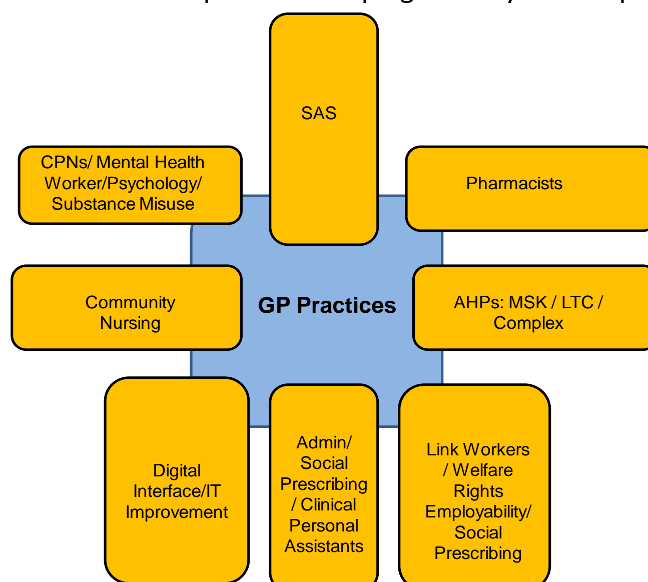
5.1 Firstly, we need to do everything possible to maintain the rate at which GPs, District Nurses & Practices Nurses (& ANPs) are brought into & retained by the system, i.e. 'Recruitment & Retention'. Some of the basic building blocks have already been put into place across Lothian; payment of Golden Hellos in certain practices, Maternity & Paternity leave payments have now been brought into line with other parts of Scotland. Nationally, the Returner & Retainer schemes have been enhanced and a Lothian training course for Practice Nurses has been established.

In addition, other measures have recently been taken to attract doctors; i.e. presence at national recruitment events and the Lothian 'Wisedocs' initiative to retain some sessional commitment from Partners who would otherwise retire. Some practices have been slow to adjust working patterns which are 'family friendly' and this could have an important marginal effect on capacity.

It should be acknowledged that recruitment within Edinburgh will impact on Primary Care stability around Scotland. There is an argument therefore, not to attempt to approach this as a single City.

5.2 Secondly, we have the opportunity to grow a Primary Care Workforce which replaces or augments the requirement for medical sessions per head of population. Diagram 1 (below) illustrates the concept of a growing & flexible workforce which practices can adapt to their own needs, whilst not taking on associated management responsibilities, nor the full financial burden. These staff have traditionally sat out with practice teams, whereas this new workforce will be firmly embedded within practices.

Workforce Fit For Purpose: Developing Primary Care Capacity



5.3 Table 1 (below) gives a subjective impression of which elements of the wider Primary Care Team may be available to help over the next 5 years. 'Sessional yield' is the number of medical sessions which investment in a full time post should be able to reduce per week, e.g. a full time pharmacist should be able to replace 4 medical sessions per week (depending on population type & practice size). To add a further level of understanding, it is likely that a full time experienced pharmacist would release 5 rather than 4 clinical sessions, but a fifth medical session would need to be reinvested to cover supervision, complex patients requiring joint assessment & liaison.

Table 1: Availability of Additional Primary Care Capacity

	2017	2018	2019	2020	2021	2022	Sessional Yield *
GPs	x	x	x	x	x	x	-
Pharmacists	√√	√√	√	√	√	√	4
Practice Nurses	√	√	√	√	√	√	4
Advanced PN	x	x	√	√	√	√	6
District Nurses	x	x	x	√	√	√	?
AHPs e.g. Advanced Scope Physio	√	√	√	√	√	√	4
Mental Health Workers	√	√		√	√	√	2
CPNs	√?	√?	√?	√?	√?	√?	5
Linkworker	√√	√√	√√	√√	√√	√√	2
Paramedics	√?	√?	√?	√?	√?	√?	?

* - Medical sessions released per 1 wte investment

5.4 It is important to note that the list in Table 1 is not designed to be either prescriptive or restrictive. Different professions and professional roles can offer different kinds of capacity, depending on list size, demography and existing investments. If a practice wishes to test a new role the same expectation should apply; if agreed, we will give 6 months of funding & then expect 50% contribution thereafter.

5.5 Table 2 (below) illustrates an example of how c30 medical sessions (required for each year if additional population increase) might be configured as a' supplementary workforce to augment practice capacity across the City for one year and then for 5 years.

Table 2 One Year / Five Years Additional Capacity - City Wide

Year 1		**Sessional Yield**	**Cost**
2.0 wte	Pharmacist x2	8	£90k
1.0 wte	PNx1	4	£45k
1.0 wte	APP (MKS)x1	4	£45k
2.0 wte	CPN x 2	10	£90k
1.0wte	Linkworker	2	£35k
Total		28	**£305k**
Year 5			
8.0 4.0 4.0 8.0 4.0 8.0	Pharmacist Advanced N PR AHP CPN MMW Linkworker	32 20 16 40 8 16	£360k £180 £180 £360 £140 £280
Total		**132**	**£1.5M**

5.6 Different configurations cost slightly differing amounts, but this example gives us a useful supplementary workforce investment figure of c£300k per annum to cover the workload of 5000 patients, once we have reached a stable state. This of course, is in addition to the increased GMS – some of which will be subsequently reinvested to fund this workforce. It also establishes an initial cost of £1.5M to provide the immediate capacity injection required to begin to stabilise Primary Care in Edinburgh.

5.7 It should be emphasised that we foresee the increasing application of technology in helping to manage the workload. This will form part of the 'offer' to practices wishing to access transformational/skill-mix support. We anticipate this element of workload management will feature more strongly for 2018/19. During 2017/18 we will divert some 'slippage' funding to testing further how digital investment could increase productivity. Surgical pods & patient appointment text messaging systems are two examples where we could look to fund 50% of the purchase cost of equipment.

5.8 Appendix1 shows the wider picture and the potential of making a longer term shift in GP workload by application of a range of interventions beyond skill-mix. It is recognised that a flexible practice aligned Primary Care workforce cannot provide this shift in isolation. We need to make progress on the behavioural change/public influence dimension as quickly as possible, to prevent further erosion of the required capacity & stabilise existing practices. It remains to be established whether 20% of GP workload can redirected to other PHCT members, but we are confident that 10% is realistic target over the next 5 years.

5.9 Over time, this transformational workforce could be used to form a bridge between Primary and Secondary care, potentially creating posts which have shared responsibility. At year three, in the outline funding table (table 4), the potential for this flexibility begins to appear. It should be noted that GP Practices cannot be expected to contribute 50% to any investments which do not have a direct impact on their practice workload.

6. Implementation & Management Support

6.1 A practice interested in accessing workforce capacity support would approach the Primary Care Support Team for advice. The team would assess the practice population (and if possible workload) & make a skill-mix proposal based on the practice's demand profile.

6.2 Depending on Practice wishes & assessment a 'stability injection' or 'transformation' proposal would be made. A stability injection would typically be where funding support was sought for a single discipline individual to join the team e.g. ANP / CPN / Pharmacist Both approaches may include the funding of 'headspace' for a session to allow the practice to consider its best options for balancing demand & capacity.

6.3 An example of a 'transformation' proposals provided in Table 3 below. This example is of an average demand practice of 8000 patients using 40 medical sessions per week, requesting support for the replacement of a 5 session partner or a salaried GP.

Table 3 Illustration of Practice Level Investment

Proposed Investment		Sessional Yield (i.e. medical replacement)	Full Cost	Practice Cost i.e. 50% after 6 months
6 sessions	Pharmacist	2	27k	13.5k
5 sessions	CPN	2	22.5k	11k
5 sessions	Linkworker	1	17k	8.5k
Total		5	66.5k	33k

6.4 In short, the proposal is that through the introduction of these three people, the Practice would be able to reduce the GP consultation workload by 5 medical sessions per week. Following local discussion & agreement, a 'Service Level Agreement' (SLA) would be drawn up which would give the Practice full funding for a 6 months 'bedding in' period. A review would take place after 3 months to gauge whether there was confidence in the arrangements working as planned. If agreed, the team would be confirmed and the Practice would start to pay 50% of the direct costs of the posts. The Practice would have the option to set aside elements of the team and retain others before moving to the 50% payment phase.

Note, it may be that only 3 (not 6) months of funding is given for an Advanced Nurse Practitioner where the implementation phase should be much shorter.

6.5 This proposal is designed to ensure close engagement of the Practice in the development of the additional capacity posts as part of their team. Only those Practices who need the additional capacity, & are able & willing to support the development process will be attracted to apply in the first couple of years.

6.6 Once the investment is made, the management of the additional capacity will be through professional management lines, but with oversight of the use of the resource by the Local Integration Cluster. The intention is that each investment will be discrete to a cluster area i.e. a Linkworker who works 3 sessions per week in three different Practices would work for Practices in the same cluster. The Practices, CQL & Cluster Manager would therefore have an overview of how effectively their additional workforce was developing and to ensure learning was quickly shared amongst the Cluster practices.

6.7 The Primary Care Support Team would prioritise competing investment proposals where necessary, with due consideration for the need to balance supports, innovation, ensuring

stability & geographical equity. Appendix II describes a set of criteria against which these decisions can be made.

6.8 All staff would be employed by the EH&SCP (with exceptions as agreed) which would retain lead responsibility for formal management responsibilities using established professional lines. The Practice Manager (or lead GP within the Practice) would have responsibilities for work allocation & development of the role with the clinical team.

6.9 When a staff member leaves there is potential for the funding to be reallocated, or for the arrangement to continue. The SLA (Service Level Agreement) between the EH&SCP & Practice will define responsibilities & expectations, i.e. training, absence management etc.

6.10 This is an important opportunity for the new Quality & Integration Clusters network to play a vital role in empowering & supporting the transformation process. If replacing medical sessions in Primary Care, were either less costly or easy, Practices would have done this already. Although there are encouraging early signs, this will be a delicate and testing process of trial and error and a supportive culture is essential.

7. Funding

7.1 Availability of funding is currently limited to a combination of Transformation Fund & LHB allocation in 2017/18 & LHB funding, as set out in Table 4.

Table 4	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Transformation Fund	£0.66M	-	-	-
LHB	£1.1M	£2.2M	£2.75M	£2.75M
SG additional Allocation	-	?	√	√
GP Income	£0.2M	£0.4M	£0.8M	£1.1M
Lothian-wide investments	(£0.5M)	(£0.5M)	(£0.5M)	(£0.5M)
Total Income Available for flexible pool	**£1.46M**	**£2.1M**	**£3.05M**	**£3.35M**
Additional Capacity created in Consultations	150,000	200,000	225,000	250,000
Associated Cost	£1.5M (4.6%)	£2.1M (6.2%)	£2.4M (7.2%)	£2.7M (8.1%)
Balance available for investment in wider system	£0	£0M	£0.95M	£0.95M

7.2 Table 4 shows our best current understanding of the available funding streams. 'Lothian wide investments' shows the presumed contribution of these funds & investments already agreed by all IJBs; phlebotomy, practice nurse training and others to be confirmed. In addition, there is no quantification of the additional funding anticipated from Scottish Government from mid 2018/19 (£500M nationally). It may be that this investment comes ear-marked, rather than an element being subject to local discretion.

7.3 As can be extrapolated from the example in section 5, an additional (to GMS / prescribing) annual investment of £300K is required to replace the equivalent of c30 medical sessions per week for 5000 additional patients each year. As the proposed arrangements mature, it would be expected that 50% of this would be recovered from Practices. The reality is that a modest proportion of the investment will be returned in 2017/18, building to 40% in 2018/19. The principle reasons for this are that some of these investments may 'fail' i.e. GPs do not wish to proceed after 3 months, and some practices will need to be compensated (or not charged) during periods where the agreed service cannot be delivered according to the SLA e.g. absence beyond agreed parameters.

7.4 Table 4 illustrates that after the first two years, the model would start to produce a surplus for investment in the wider system. This is based on the assumption that an initial capacity injection of £1.5M or 4.6% in 2017/18 followed by 2% increase in 2018/19 would be adequate to stabilise the system. This can be accelerated by c1% through additional tranches of £300k being made available as confidence & understanding of workforce augmentation grows with experience.

7.5 At the individual practice level, concern has been expressed over the sustainability of the funding over a longer period. If a practice commits to 50% will they then find that the contribution level is increased to the point where the investment becomes a financial burden? The undertaking is that if the individual leaves their post within the first two years & the practice is willing to continue, then another appointment will be made on the same terms (but not 6 months free).

7.6 This proposal is being developed in line with our understanding of the **likely** shape of the new GP contract. It may be that significant adaptation is required as this becomes more visible later this year.

8. Starting Point

8.1 The proposal to grow a supplementary Primary Care Workforce has already begun, albeit in a fragmented way to date, using resources from the Scottish Government Transformation Fund in 2016/17.

Table 5 (below) shows where we are as at January 2017.

	WTE	Recharge dates (tbc)	Practices	Funding	Potential GP Recharge
GPs					
Pharmacists	94 sessions	? 1.10.17	Wide variety	£423/141k	£70K
AHPs	1.2	01.04.17	B'loch	£60k	£30K
Nurses	1.0		Links	£45k	£27.5K
CPNs	2.0		Mill L./B'loch	£90k	£45K
Linkworkers	6.0	? 01.10.17	Sighthill/ Wester Hailes/Slateford/ Crewe / Muirhouse	£140k	£70K
Nursing Home	2.0	-	Crewe	£30k	-
SAS	??		Crammond B'loch		
Total	104.2				£307.5K

8.2 Table 5 shows the current investments and where we could expect Practices to provide a 50% contribution after an agreed date. The position with pharmacists is that each of the 94 pharmacist sessions may be deployed in practices for a number of reasons; cost reduction, workload augmentation & professional development. GPs will only consider reimbursing 50% where they are confident the session is effectively augmenting their workload. The £423k invested is therefore only potentially partially rechargeable (estimated £141k of which 50% is £70K).

9. Next Steps

This City proposal is building on our experience in supporting practices who have found themselves in difficulty by using this as an opportunity to stabilise & then transform.
We will identify practices & clusters where stabilisation & transformation offers most.

The phases envisaged are;

- March/April - Consultations & draft development
- April - proposal formulated/discussion at LPCMG, PCIB & LMC
- 4th May Primary Care Summit

- Edinburgh Management Team 11th May or 8th June
- 16th June IJB

10. Evaluation

10.1 Appendix 1 sets out the overall evaluation framework. The investments need to establish proven effectiveness to enable confidence in wider application, beyond solutions which work only a in the context of a particular practice team.

10.2 Part of the investment in City wide structures is to ensure there is dedicated support to the group of 'Stabilisation' and 'Transformation' practices to make these changes. This will help us to understand the sessional yield, timescales & relationships with the five different 'demand profiles' which describe almost all city practices. Much of the work involved will initially focus on changing processes & relationships to reduce medical & practice nursing consultations per patient. It is recognised that one of the shifts which may be quickly delivered is creating capacity amongst Practice Nurses to allow more medical consultations to be moved to them.

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Appendix I:

Edinburgh GP Consultations: 3,250,000 PA – Target 10% shift (or reduction) of 325,000 over 5 years (not adjusted for anticipated population growth)

1. Direct	**Workload Reduction**	**Potential Consultation Reduction**	**Status**	**Resource required**	**Training required**	**£K**	**Lead**	**Anticipated first impact**
Intervention Description								
Eye referrals to Optometrists	1%	C32,500	pilot in NW	Capacity exists	Receptionists	£4K	AMCN	2016
NHS 24 Call handling	0%	0		none			EMcG	.
Pharmacy	7%	227,500					SMcB	
- Deflection of presentations to community pharmacy	2%	65,000	Increasingly routine		receptionists		SMcB	2016
-Consultations in practice deflected to practice pharmacist	2%	65,000			GPs		SMcB	2016
-Consultations offered as alternate by independent prescribers	2%	65,000			GPs		SMcB	2016
-Bundle of PGDs	1%	32,500	pilot	test of change underway with cystitis	receptionists		SMcB	
District nursing/home visits H @ H	1%	32,500			district nursing/care home staff		MW	
Advanced nurse practitioners	5%	162,500	training programme established	In place			PMcI	2016
Physio/MSK	2%	65,000			GPs/receptionists		RB/EB	
Link Workers & Social Prescribing	5%	162,500	report commissioned to describe roll out. Several pilots up and running	50WTE approx 25% existing, 50% SG investment & 25% GP investment	3 month training & induction	£2M	AC/DW	Pilots established
Population Education/Additional Carer Support	1%	32,500					MB	
Digital Interface Development	1%	32,500	Minor developments supported as part of Transformation					
Mental Health Consultation	5%	162,500	CPNs in 2 practices	32.0WTE		£1.5M	MR/EMcG	Pilots Established
TOTALS	28%	910,000						
2. Indirect	Minutes per day gained							
IT System Upgrade	30mins per GP							in 2nd year of 3 year programme

Appendix II

	Performer Locum	Performer Provider	Performer Retainer	Performer Salaried (Board)	Performer Salaried (Practice)	Total (2)	Clinical Sessions per week per post	Yield of Clinical Sessions (3)	Clinical Sessions required by Population (4)	Weekly Sessional Capacity gap	Capacity Gap in annual consults (000)
2012	15	316	31	23	57	443	6.5	2304	2600	296	222
2013	18	313	32	20	64	448	6.4	2294	2625	331	248
2014	14	315	26	22	66	444	6.3	2238	2650	412	309
2015	13	308	25	26	86	460	6.2	2282	2675	393	294
2016	16	310	22	34	93	476	6.1	2323	2700	377	283
?2020 ?	16	305	12	48	120	501	5.6	2244	2800	556	-

1. Average sessional commitment unknown but declining. (Estimated from 6.4 in 2013 – ISD Lothian Survey figures)
2. Availability of doctors
3. Total drs X est'd clinical sessions per post x 0.8 for AL/sick/study
4. Population list size / 200 as working assumption of actual clinical session requirement per week per patient.
5. Sessional capacity gap expressed as consultations ie gap times 15 per session x 50 weeks per year

Appendix III:

Criteria

1. Practice unable to recruit doctors & session / population ratio out of line with demand profile peers.

2. Practice willing to share information on available resources / workload assessment and replace up to 10% of medical sessions.

3. Practice in area of population build-up & willing to keep list unrestricted.

4. Practice has long term future in serving their population.

5. Practice willing to have investment ratified by Cluster & progress / effectiveness scrutinised.

6. Ensuring there is a level of investment in each cluster area to promote approach.

Appendix IV

Edinburgh Transformation Stability Funds (2017-18)										
	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Transformation Funding	£8,000	£8,000	£8,000	£8,000	£8,000	£8,000	£4,000	£4,000	£4,000	£4,000
Stability Funding	£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000	£2,000	£2,000	£2,000
Stability Funding	£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000	£2,000	£2,000	£2,000
Transformation Funding		£8,000	£8,000	£8,000	£8,000	£8,000	£8,000	£4,000	£4,000	£4,000
Stability Funding		£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000	£2,000	£2,000
Stability Funding		£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000	£2,000	£2,000
Transformation Funding			£8,000	£8,000	£8,000	£8,000	£8,000	£8,000	£4,000	£4,000
Stability Funding			£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000	£2,000
Stability Funding			£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000	£2,000
Transformation Funding				£8,000	£8,000	£8,000	£8,000	£8,000	£8,000	£4,000
Stability Funding				£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000
Stability Funding				£4,000	£4,000	£4,000	£4,000	£4,000	£4,000	£2,000
Transformation Funding					£8,000	£8,000	£8,000	£8,000	£8,000	£8,000
Stability Funding					£4,000	£4,000	£4,000	£4,000	£4,000	£4,000
Stability Funding					£4,000	£4,000	£4,000	£4,000	£4,000	£4,000
Transformation Funding						£8,000	£8,000	£8,000	£8,000	£8,000
Stability Funding						£4,000	£4,000	£4,000	£4,000	£4,000
Stability Funding						£4,000	£4,000	£4,000	£4,000	£4,000
Transformation Funding							£8,000	£8,000	£8,000	£8,000
Stability Funding							£4,000	£4,000	£4,000	£4,000
Stability Funding							£4,000	£4,000	£4,000	£4,000
Transformation Funding								£8,000	£8,000	£8,000
Stability Funding								£4,000	£4,000	£4,000
Stability Funding								£4,000	£4,000	£4,000
Transformation Funding									£8,000	£8,000
Stability Funding									£4,000	£4,000
Stability Funding									£4,000	£4,000
Transformation Funding										£8,000
Stability Funding										£4,000
Stability Funding										£4,000
Monthly Spend	**£16,000**	**£32,000**	**£48,000**	**£64,000**	**£80,000**	**£96,000**	**£104,000**	**£112,000**	**£120,000**	**£128,000**
Cumulative Spend		**£48,000**	**£96,000**	**£160,000**	**£240,000**	**£336,000**	**£440,000**	**£552,000**	**£672,000**	**£800,000**
Note; FYE of 10 Transformation /20 stability practices after 6 month trial period; £960K										