Item 5.2

Report

Edinburgh Primary Care Improvement Plan (PCIP)
Edinburgh Integration Joint Board

15 June 2018

Executive Summary

1. The Edinburgh H&SCP is required to submit a Primary Care Improvement Plan (PCIP) to the Scottish Government by 1st July 2018, outlining our plans to implement the new Scottish GMS contract proposals. The Strategic Planning Group considered the PCIP at its May meeting and approved the document. The IJB is asked to approve this PCIP.

Recommendations

2. The Integrated Joint Board is asked to:

   i. Approve the proposed submission version of the plan (Appendix 1)

   ii. Note the next steps action plan (appendix 2)

   iii. Note the process required to reach final agreement of the plan (Appendix 4)

   iv. Note that this plan builds on the work carried out by the HSCP over the last 5 years and links to the Primary Care Strategic Commissioning Plan which will be taken forward under the auspices of the Primary Care Reference Board.

   v. Note the approval of the IJB Strategic Planning Group (11.05.18) and the GP Sub-Committee (anticipated as at 11.06.18) and the support of the pan-Lothian GMS Implementation Group.

Background

3. Contractual arrangements for general practitioners are negotiated centrally between the Scottish Government and GP representatives, almost universally the British Medical Association (BMA). These arrangements are extremely

detailed and govern all aspects of remuneration of GPs and funding of general practices, including key issues such as premises, rents, pay rates for staff, etc.

4. General practice in Scotland has been under increasing pressure over the last ten years due to a combination of changes in demography, technology and treatment regimens, and workforce availability.

5. In January 2018 GPs across Scotland voted in favour of a new General Medical Services (GMS) contract which was developed by the BMA and Scottish Government. The contract undertakes to shift work from GPs and GP practices and provide funds which allow services to be developed to enable this transition to happen. At the heart of the new contract is the GP as 'expert medical generalist' giving less care directly to patients and emphasising their roles as clinical leaders and their close working relationships with a wider multidisciplinary team delivering more direct care.

6. All NHS Boards are expected to develop a range of services which allow this to happen, initially over the three year 'Phase 1' of the plan, and this is expressed through the NHS components of HSCPs. The proposed plan for Edinburgh is provided at appendix 1.

7. The date for submission to the Scottish Government is July 2018.

8. The PCIP is subject to approval through a 'tripartite' arrangement between the GP Sub Committee of NHS Lothian, NHS Lothian and the Edinburgh Integration Joint Board. NHS Lothian will exercise its governance responsibilities through the tripartite 'Oversight Group' for all Lothian H&SCP's and GP Sub considered at its meeting on the 11th June, although at the date of writing the outcome is not known.

Main report

9. Since mid 2014, a series of once-stable independent GP practices were no longer able to function without additional support. Around 20 of the city's 72 practices have required additional support and attention to ensure continuity of GMS to all registered patients across the City, and there are currently over 40 practices which have restrictions on their lists.

10. The experience of supporting practices, often facing dissolution, resulted in a series of 'tests of change' in inserting new capacity into these teams. In late 2016 NHS Lothian pledged recurring funding to help with what was widely perceived as a growing crisis. The experience of helping stabilise practices as a reactive measure was fused into a proactive programme of 'Transformation and Stability' and consulted with across the City in early 2017. GPs were supportive, and in

June 2017 the Edinburgh IJB supported five recommendations for the use of the available funds.

11. The success of the Edinburgh Transformation and Stability Programme will be reported separately, but provides the expertise and experience required to implement the local sections of the new contract.

12. The Edinburgh IJB received the Primary Care "outline strategic commissioning plan" at its February meeting, which flagged the forthcoming activities required and issues to be tackled. The Primary Care Strategy is being developed by the Primary Care Reference Board, chaired by Councillor Melanie Main.

13. During March and April in particular, extensive consultation has taken place with primary care colleagues throughout the City about the options for the funding available under the PCIP, and this is outlined at Appendix 4. A small 'Writing Group' benefitted from the considerable input and influence of our two GP Sub appointed colleagues.

14. During May opportunities were taken to raise the awareness of the PCIP across the H&SCP and dedicated meetings were arranged through EVOC with Third sector partners and with Carer representatives.

15. Appendix 4 summarises the main activities undertaken to develop the PCIP.

16. Whilst the formulation of the PCIP is necessarily tightly focussed on augmenting GP workload, the implementation of the new capacity from late summer 2018, will be a much more collaborative exercise. The awareness raising and engagement events have illustrated the advantages of linkages with existing work on HUBs, in mental health and older peoples services, and in ensuring that preventative approaches are enhanced wherever possible.

17. The differential impact of this investment on inequalities remains a contentious issue across the GP community. Practices serving populations with high levels of deprivation or affluent populations with high numbers of elderly people being successfully sustained in the community, may both feel under great pressure. Practices with mixed inner city populations with high turnover, increasing mental health related presentations and divergent ethnicity, can feel their pressure are poorly understood, as can those with high student populations.

18. The importance of investment which alleviates the pressure across all types of practice is vital, and the concept of a 'floor' of common relevant services has been welcomed during the development of the plan.

Key risks

19. Without the clear support of City GPs through the GP Sub reps, the PCIP would not be supported by the Edinburgh GP community and the Scottish Government would require amendments to be made before the funding could be released.

20. Without access to additional New Contract funding into front line primary care capacity, the momentum which has begun to build could be lost and practices could be destabilised again. The consequences of destabilised practices are well understood in terms of patient safety, additional financial support, increased pressure on supporting services and adverse media attention heightening public and patient concern.

21. There is a risk that the shift in workload from medical staff and indeed from nursing is undertaken without due consideration and that patients and staff could be put at risk. The clinical governance structures and support for a programme of challenging change need to be sufficiently robust to manage this effectively. With the T&S (Transformation & Stability) Programme, 'small tests of change' the risk has effectively been internalised by the individual practices. The creation of separately managed services covering several practices requires careful progression.

Financial implications

22. An outline costing of the full implementation of the New Contract quickly builds to a figure of £12-15M for the city. Our current understanding is that about £1.6M will be available (recurring figure) for discretionary investment by EIJB.

23. This new funding adds to the New Contract funding already received and invested in pharmacy and a Linkworker network.

24. The new funding will be applied distinctly from the NHS Lothian funded Transformation and Stability (T&S) Programme. The T&S programme will continue to fund the development of individual practice capacity 'injections' which have 50% contribution to salary costs from the GP practice. The new contract funding will be used for capacity development across clusters and localities. Any underspend will be applied as agreed by the governance structures and reported both to EIJB and to the GPs across the City.

25. The Edinburgh Primary Care Support Team structures allow for this new funding to be applied as agreed across the City, as with the Transformation and Stability Programme funds. It is proposed that these arrangements continue to provide the required governance.

Implications for Directions

26. The IJB will issue a Direction to the effect that NHSL will support, through the HSCP and through central NHSL functions, the further development and implementation of the PCIP in Edinburgh.

Equalities Implications for Directions

27. Equalities implication Equalities Impact Assessment on the main report was undertaken on 22nd May 2018.

Sustainability implications

28. There are no direct environmental considerations arising from this report

Involving people

29. Appendix 4 outlines the efforts which were made to engage and communicate with stakeholders in the timeframe available. The report itself recommends a structured programme of public engagement to explain the adjustments being made to the delivery of Primary Care.

Impact on plans of other parties

30. There is wide recognition that the formation and deployment of a new primary care workforce of c200wte over the next 3 years is challenging to existing H&SCP services already struggling with recruiting sufficient staff to maintain existing levels of service. District Nursing is perhaps the most obvious example. The Chief Nurse is engaged in these discussions.

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Appendices

1 – Full draft Primary Care Improvement Plan
2 – Next steps action plan
3 – Glossary of terms
4 – Development Action Plan

Edinburgh Primary Care Improvement Plan

June 2018

Edinburgh Primary Care Improvement Plan

Executive Summary

This plan has been created collaboratively by GP Sub-Committee representatives and the Edinburgh Primary Care Support Team, including Locality Clinical Leads. Every GP and Practice manager has had the opportunity to see and input to the early draft, as have representatives of pharmacy, nursing and the link worker network.

The Plan is a key document which allows the Health and Social Care Partnership to set out for scrutiny, its plans for the implementation of the New GMS (General Medical Services) Contract.

The Health and Social Care Partnership (HSCP) Primary Care Improvement Plan (PCIP) will enable the development of the 'expert medical generalist' role, through a reduction in current GP and practice workload. By the end of the 3 year plan, every practice should be supported by expanded teams of NHS Lothian employed health professionals providing care and support to patients. Edinburgh HSCP will employ or fund 30-40 more staff in 2018/18, who will provide additional capacity and continue the transformation of primary care.

The focus on primary care development and resourcing through the new Scottish GP contract is as welcome as it is overdue. The aspirations of the contract are challenging to current practice, and in Edinburgh we believe we are already underway with important aspects of this work.

Equality and equity are fundamental principles, but the playing field is uneven. We must try not to make things worse, but primary care can't afford to wait until there is consensus over a perfect playing surface before we make a start. We need to be pragmatic in the short term and come back to this complex question with an approach which can manage our different perspectives.

The New Contract funding available in 2018/19 for discretionary investment across Edinburgh is understood to be around £1.7M. This quickly builds to £2.2M in 2019/20 and £6.6M the following year. This comes on top of the investments made directly to (most) practices through GMS uplift (c£1.5M) and investments into pharmacy support (c£1.0M). In addition, NHS Lothian has committed £2.85M, building over three years, and used to support our complementary 'Transformation & Stability Programme'.

The cost of fully implementing the new contract has been estimated at £12-14M across the City. By combining the New Contract income and the Transformation and Stability funds we will have a substantial portion of this available over the first three years. We believe we have established a reasonable consensus from our GP community, about where we should **first** focus both attention and resources to have the greatest impact. Our first task is to accelerate and lengthen our first steps and to bring forward the next generation of improvements, which will allow us to provide excellence and stability in Primary Care to Edinburgh's citizens.

Edinburgh Primary Care Improvement Plan

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PART ONE: BACKGROUND AND OVERVIEW

1. Introduction

The Edinburgh Primary Care Improvement Plan is focused on how to stabilise and transform General Medical Services (GMS) over the next three years. The plan therefore has a relatively narrow focus on the workforce and arrangements required to both relieve the current and future pressure on GMS and to accommodate significant population growth. A more inclusive approach to the wider constituents of primary care will be addressed by the first Edinburgh Primary Care Strategic Plan.

2. National Context

Proposals for a new GP contract were published in November 2017 and agreed in January 2018. The new contract aims to support the development of the Expert Medical Generalist role for GPs, with a shift over time of workload and responsibilities to enable this. A key enabler for this is investment in a wider multi-disciplinary team (MDT) in support of general practice. The new contract offer is supported by a Memorandum of Understanding (MoU) which requires:

> *"The development of a HSCP Primary Care Improvement Plan, in partnership with GPs and collaborating with other key stakeholders including NHS Boards that is supported by an appropriate and effective MDT model at both practice and Cluster level, and that reflects local population health care needs".*

Briefly, the major factors contributing to the current instability are:

- Increasing gap between capacity (access) and demographic pressures (rising Edinburgh population, patient demand, increasing numbers of frail elderly and complexity);
- Aging primary care medical and nursing workforce;
- General Practice is currently a comparatively unattractive option for qualifying doctors, and GPs are retiring early;
- Workload, premises and financial risk are significant barriers to GP partnership;
- Poor IT and technology investment and support relevant to primary care;
- Increasing demand on a relatively stable potential locum pool, further undermining the attractiveness of the permanent commitment to a GP Partnership, fundamental for primary care to function effectively.

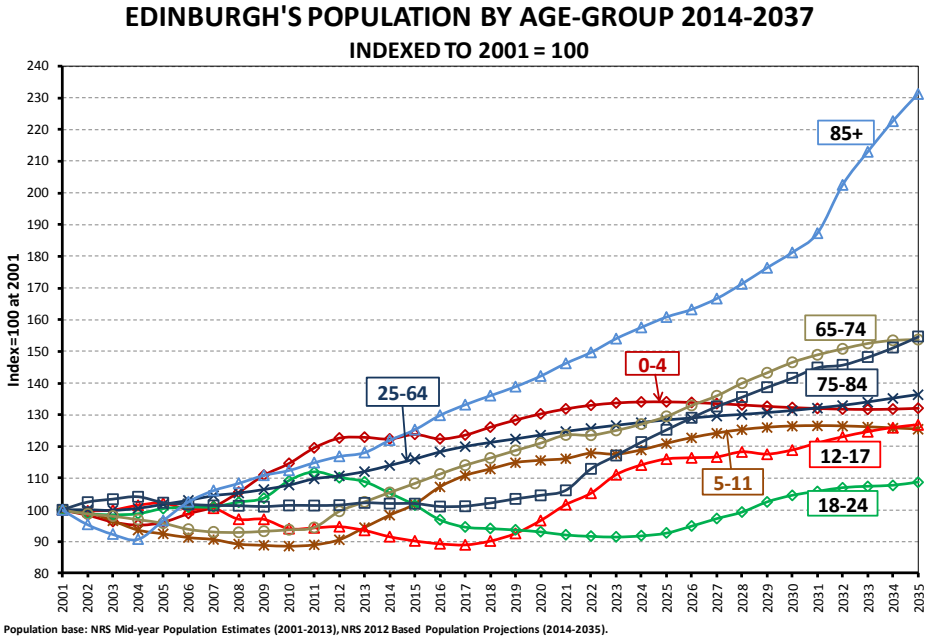
The new Scottish GMS contract has been specifically designed to address these factors and herald a new era for primary care in Scotland. The limitations of the available workforce to fuel the proposed changes are obvious and widely acknowledged. The recent publication of the National Health and Social Care Workforce Plan – Primary Care is

helpful context. Despite this limitation we believe much can be done to shift workload on a short and medium timescale.

3. Local Context

3.1 Needs Assessment

The Shadow HSCP undertook a Strategic Needs Assessment in 2015[1]: It outlines the wider setting but also delineates some of the Primary Care health challenges which will in part be met by the Improvement Plan. The population has already expanded rapidly and further significant increases are anticipated, particularly in older age groups:



Localities differ in their makeup, and the needs assessment highlights the heterogeneity of Edinburgh's population. The challenges include:

- Poverty and low income rates similar to the Scottish average, despite the City's affluence, with a fifth of children living in low income households. Health is poorest in the North East locality: boys born in Greendykes and Niddrie Mains between 2005 and 2009 had a life expectancy more than 25 years less than girls born in Barnton and Cammo.
- Minority and ethnic health and LBGT communities are also at risk of disproportionate ill health and the inverse care law
- The number of older people is increasing, and over a third live alone

[1] Edinburgh Shadow HSCP Joint Strategic Needs Assessment (2015)

- There are just over 400,000 adults aged over 18 in Edinburgh. Of these, the numbers who are supported by the Health and Social Care Department are:

    - 14,056 older people
    - 1,380 people with learning disabilities
    - 1,991 people with physical disabilities
    - 1,300 people with mental health issues
    - 816 people with addictions
    - 1, 153 other vulnerable people

    There are others with complex needs, who are marginalised and find it difficult to access appropriate care.

- The number of people needing palliative care in the community continues to rise and there are needs for service development, including of community nursing teams
- Other key areas include sexual health, BBV prevention and care, and management of long term conditions.
- There are estimated to be over 65,000 carers in Edinburgh, one in five providing over 50 hours of care a week
- The role of the third sector is crucial
- There are variations across the City in unemployment, but some deficits in specific, needed skill sets
- Housing is a key determinant of health and there are significant, and growing, shortages, and extensive requirements for adaptation and support

The HSCP has to consider national health and wellbeing outcomes which include reducing health inequalities: the Improvement Plan must be sensitive to these directives. In its opening sentence the new Scottish GMS contract outlines that "*general practice is critical to sustaining high quality universal healthcare and realising Scotland's ambition to improve our population's health and reduce health inequalities".* We will consider models and proposals for resource to address these specific issues in a separate paper.

3.2 Workload

The new contract is being introduced at a time of significant pressures in General Practice related to increasing volume and complexity of workload, and challenging workforce availability. While the new contract and Government Memorandum of Understanding (MoU) is explicitly intended to address these issues, short term sustainability challenges remain. The PCIP takes account of action required to address these immediate pressures, as well as developing the longer term strategic direction.

Diagram 1 Indicative Primary Care Workload Increase Edinburgh 2010 – 2018 - 2026

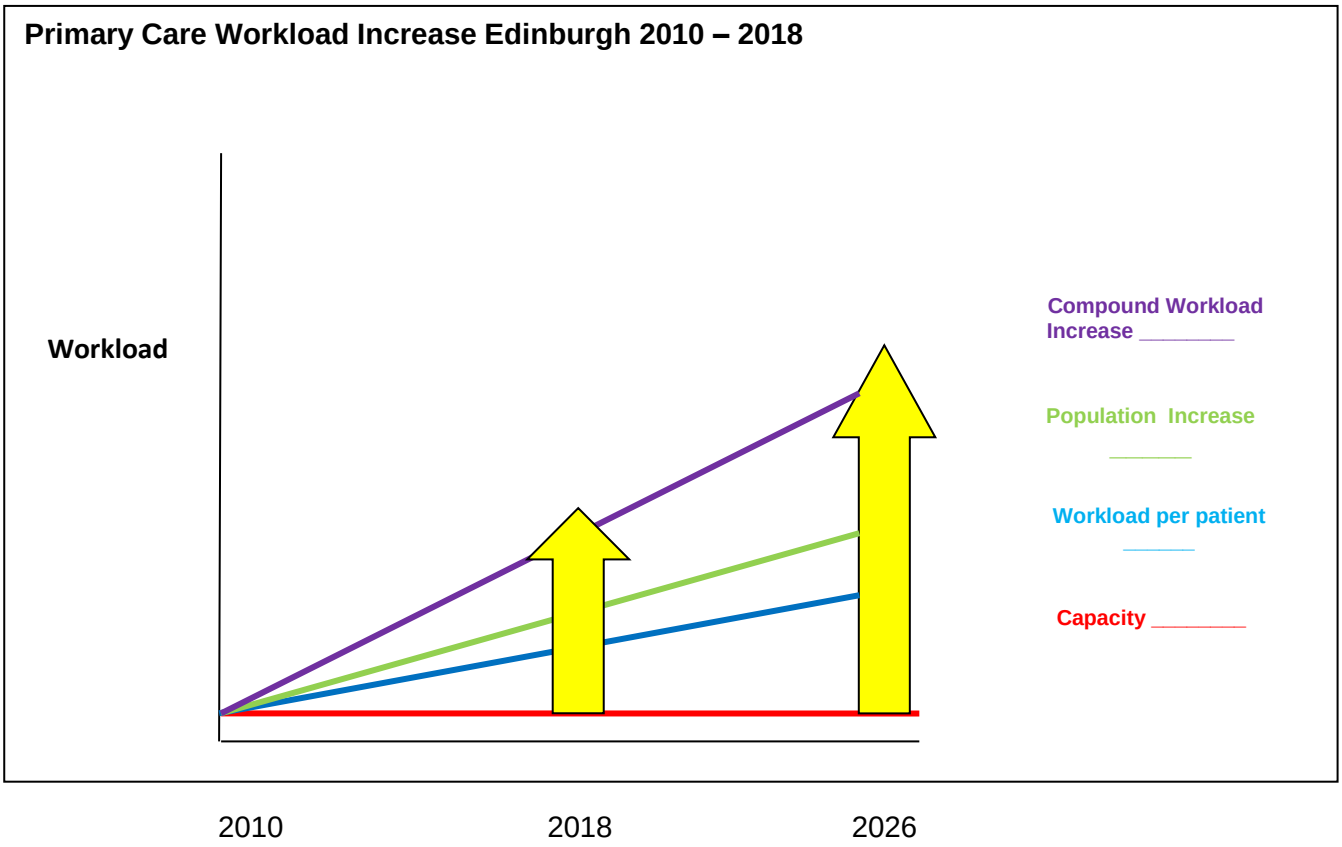


Diagram 1 suggests a representation of capacity and workload over time.

Since then, the average workload per annum per patient has increased (ageing and complexity influence) although slightly offset by a relatively younger incoming population.

The population size has steadily increased by 1% p.a. since 2007 and by 8,000 new additional patients in 2017 alone. The effect is simply projected forward to 2026, to align with the Edinburgh Local Development (Housing) Plan.

Capacity has not strictly flat lined since 2010 as shown in the diagram, but there has been a lack of practice expansion despite significant population increases. Of 72 Edinburgh practices, 9 are now 2c, 5 of which moved recently from GMS as they were unsustainable.

3.3 Other Significant local factors

a) Since 2014 many established Edinburgh practices have become operationally / financially unstable and required additional support. Approximately 20 of out 72 practices are receiving additional support at any given time.

b) A series of ad hoc arrangements were put in place to support unstable practices, initially on an individual basis. The experience of effective intervention was then fused into '**The Edinburgh Primary Care Transformation & Stability Programme'** agreed by Edinburgh Integration Joint Board (IJB) in June 2017. This set out to inject more clinical capacity into primary care in Edinburgh using £2.85m NHS Lothian recurring funds, building over 3 years. The approach aimed to adjust reliance on the medical workforce required to respond to an increased population.

c) As outlined above, the national pressures are magnified in Edinburgh by list growth. In 2007, 500,000 patients were registered and by 2017 this had grown by a further **57,000.** Each year 5-6,000 more people move to Edinburgh and register with a local GP practice. The rate of city growth is established as consistent with the Edinburgh Local Development Plan. This runs to 2026 when the anticipated GP registered population will have risen to 600,000.

d) The most obvious symptom of population pressure across Edinburgh is 'restricted' lists. Many practices now restrict their lists to a number of patients able to join their lists which equals the number of people leaving each week. This limitation on access has been able to be managed locally to ensure there is at least one practice per cluster group with unrestricted access, but after a decade of sustained population growth there are very few practices in the City with the physical capacity and Partner agreement to grow much beyond their current list size.

e) Edinburgh has a buoyant economy with considerable choice for the low – medium skilled workforce.

f) A **'Primary Care Support Team'** has been created by the Edinburgh Health and Social Care Partnership (EH&SCP), bringing together responsibility for strategic development, quality performance, operational support, premises development and prescribing. This coherence gives a good platform of understanding and engagement to develop capacity to implement the new contract.

g) At the inception of the EH&SCP a population needs assessment was undertaken designed to highlight variation in service demand both between and within the newly formed localities. This is underpinned by the categorisation of Edinburgh's 72 general practices into **5 'demand groupings'** based on a combination of the percentage of the practice list +75 years old, and the percentage deemed to be in the lowest quartile of economic deprivation. There is the potential to use this to help direct different types of additional support depending on a practices grouping.

3.4 Local Foundations

Edinburgh H&SCP Primary Care Support team has already undertaken extensive work, which will help with the infrastructure for future change:

- Appraisal of premises to individual practice level, with a realistic and cost-effective approach to support. Practices have engaged in that process and the targeting of over 30 small improvement grants to optimise existing buildings over the last 3 years to cope

with population increase. This has helped practices to be able to growth their list sizes from previously stable bases.

- An assessment of Edinburgh Population and Premises was completed in 2016 with considerable engagement with all GP practices across the City. The paper was presented to the Edinburgh IJB in September 2017 and highlighted the **requirement to invest c£57M** over the current planning period to avoid capacity in several parts of the City being exhausted (see appendices)
- The City Transformation and Stability approach was based on ascertainment of practices' views of what they felt they required, ensuring that GPs are familiar with process and 'bidding' on basis of perceived need, and the options available, much of which appears in the new contract. Of Edinburgh's 72 practices, over 50 have taken up the offer of workforce or technical support through this route.
- The combination of infrastructure augmentation and support to strengthen or 'transform' practice teams has been able to keep limited access to registration for patients. These solutions have been very much 'stop-gap' and a more ambitious response to the growing population is required to ensure access to Primary Care can continue to be available to Edinburgh's new citizens.

All these initiatives give a feel for practice priorities, some mechanisms for implementation (particularly of the new workforce) and a good starting point for engagement.

3.5 Locality Clusters

EHSCP formed four localities as the basis of its operating structure. GP practices aligned themselves with localities as part of the preparation for integration. Each locality then created two GP Quality Clusters made up of geographically contiguous practices. The constituent GP practice clusters defined the population served by the integration cluster teams, thus facilitating common focus and working relationships in the 'engine rooms' of the EH&SCP. The GP clusters, have, and will continue to influence the development of this Plan and provide the local platforms for implementation.

3.6 Local Intentions

In addition to the requirements set out in the national documents, a set of **local** intentions has been developed:

- Plans required by1st July 2018 will outline the relevant areas of change

- Priority in year 1 should be given to tested approaches where impact on GP workload can be evidenced, with reference to the impact of tests of change already established.

- Approaches across Lothian and Scotland should share consistent grading and generic job descriptions for common roles in the new MDTs. Re-design of existing roles within a common framework should allow design to be responsive to local practice circumstances and encourage innovation.

- Recruitment should be co-ordinated across EH&SCP where appropriate. Where it is agreed that services are best provided Lothian wide, then recruitment can be organised on this basis.

- Commitment to working in a collaborative way across HSCPs and with advisory structures.

- Plans should aspire to demonstrate how **all** practices will benefit from additional support recognising that practices will benefit differentially from investments, depending on their population and demand structure.

- Active support should be given for the development of the GP role as expert medical generalist and clinical leader alongside refocusing of activity within practices, as workload shifts.

- Extended multi-disciplinary teams will be developed with all contractual models; 17c, 17j & 2C practices.

- 'Divided We Fall' is a recent Nuffield Trust report offering thoughtful perspective on the potential for increasing fragmentation of Primary Care. In implementing the new contract we will be mindful that the deconstruction of general practice arguably risks losing some of the benefits of our existing system. *Do no harm!*

4. Roles and Responsibilities

4.1 The Memorandum of Understanding (MoU)

The MoU states that:

> *"HSCPs will agree these Plans locally. These plans will be developed in collaboration with local GPs and others and should be developed with GP Subcommittee (or representatives of by agreement locally) as the formally agreed advisors on general medical service matters. However, the arrangements for delivering the new GMS contract will be agreed with the Local Medical Committee. Integration Authorities will hold their officers to account for delivery of the milestones set out in the Plan, in line with their responsibility to ensure delivery of Strategic Plans, and through regular reporting to the Authority"*

4.2 The Tripartite Partnership

Development of the Edinburgh Primary Care Improvement Plan will build on established collaborative arrangements with the Lothian Local Medical Committee (LMC) and GP Sub Committee of the Area Medical Committee. The Edinburgh Health and Social Care Partnership HSCP plan will actively involve the nominated GP Sub Committee representatives to enable local agreement, their being seen as key contributors to the Primary Care Support Team. Representation from Edinburgh's 8 GP Quality Clusters on the core PCIP group has also been sought.

Specific contractual changes will be taken forward through the Lothian-wide GMS Oversight Group and associated sub groups. This includes the new Premises Code of Practice and any revised Premises Directions, enhanced services, practice IM&T and implementation of the new regulations, as well as any contractual changes resulting from the transfer of responsibility to the extended multi-disciplinary team. Final changes and implementation arrangements will be agreed with the LMC.

4.3 Other Health and Social Care Partnership (HSCP) Strategic and Improvement Plans

Whilst general medical primary care services are the essential foundation of Localities, they are also supported by an Edinburgh Primary Care Support Team because of the need for strong consistency and links across NHS Lothian and because of the turbulence of the primary care environment identified at sections 2 and 3 above.

This Edinburgh Primary Care Improvement Plan will link to wider HSCP responsibilities for strategic planning and will specifically be reflected in local workforce planning, financial planning and property strategy.

There are significant opportunities for collaboration with older peoples', mental health, Third Sector and acute services which have been raised and noted throughout the development of the Plan, but not yet fully explored. This is a clear intention for the implementation phase.

In addition, the new GMS Contract and the H&SCP share the objective of reducing inequalities in health.

4.4 Multi-disciplinary teams.

The MoU sets out clearly that:

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

Plans for developing the multi-disciplinary team will require new and expanded roles and change to existing roles. Staff Partnership involvement in the development of the plans is therefore essential. In addition to engagement on the development of the plans, consideration should be given to engagement on the implementation and development of multi-disciplinary teams to ensure that these work effectively at practice and cluster level.

This should include the full range of practice staff including practice managers who have significant existing skills and knowledge in enabling effective working practices for multi-disciplinary teams.

4.5 GP Quality Clusters

The new GMS contract outlines that GP practices will engage in clusters' quality improvement activities, including providing comparative data and sharing best practice. GP clusters will work with the wider system, in particular HSCPs, to achieve whole system quality improvement for patients.

A learning point from the Inverclyde pilot was that *"the pressure to get projects started and gather results quickly meant that the pre-project stage of design of data collection method was omitted, compromising the QI process".* It is crucial that data collection is designed in advance for every workstream.

GPs have emphasised the important role of some specialist staff with QI training to support the evaluation of the impact of the New Contract workforce, its benefits and its shortcomings, both intended and unintended. In particular, having analytical capacity and expertise, married with knowledge of the available primary care data sources, would accelerate the development of the potential of clusters to effectively guide change at scale which involves local GPs directly.

Through the use of Transformation and Stability funds, started in 2017/18, practices are already obliged to share their experiences with Cluster colleagues. This is designed to develop the role of the clusters in supporting and evaluating the development of the MDT and making links with wider network of support.

5. Development of the Improvement Plan

The requirement for engagement in the development of the plans is clearly set out in the MoU:

> *"The HSCP Primary Care Improvement Plan should be agreed with the local GP subcommittee of the Area Medical Committee HSCPs have a statutory duty via the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 to consult a wide range of local stakeholders and professional groups on their Strategic Plans and take decisions on the size and shape of local health and social care services on a collective basis based on dialogue with the local communities and service users."*

5.1 Our Key Values

A. That the new GMS contract implementation will brings benefit to all practices and all patients and their communities

B. Transparency over all additional resources available to individual practices/clusters/localities through all sources of non-GMS / enhanced service funding

C. Ongoing meaningful engagement, debate & development of primary care increasingly using the GP Cluster framework.

D. Recognition that addressing health inequalities is a core part of the work of Primary Care, and that inequalities present in many forms. As always changes to the delivery or availability of primary care may have a magnified effect on groups of the population who are less obviously vocal. We will continue to listen closely to our practices about any unintended consequences to vulnerable people as implementation proceeds.

5.2 Involving People

There have been a number of policy initiatives since 1997, which emphasise the importance of Public Involvement and how to apply this[2]. The guidance from the Scottish Government states that involving patients, carers and the public in the planning of services helps to ensure that services are appropriate and relevant to the people who use them.

EH&SCP has an established record of engagement beyond traditional communication and consultation which reflects its commitment to involving people and underpins a wide raft of legislation for Public Involvement. EH&SCP is therefore mindful of its legal duties of involvement and how the outputs from informing, engaging and consulting are evidenced. As the proposed changes are progressed, appropriate and timeous Public Involvement shall be sought. The team shall be guided, advised and supported by the Public Involvement Coordinator.

Dialogue with GPs during the development of the PCIP has highlighted the pressing requirement for alignment of key messages to the public, of the opportunities of creating capacity for regular constructive local interaction and of harnessing 'Realistic Medicine' for the benefit of all.

The EH&SCP will take account of a wide range of opportunities to harvest the benefits of patient experience. We need to consider new ways of gleaning feedback which allows constructive dialogue between Primary Care and the Edinburgh public. A validated survey, would allow comparisons and help ensure representative feedback and inclusion of all groups. The intention would be to develop methods of feedback about the direction of travel, rather than just individual clinicians and practices.

A further dimension of this is the promotion of more effective **self management,** whether through signposting, encouraging awareness of NHS Inform, enhanced patient education and support programmes or improved technology.

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[2] Patient Focus and Public Involvement - December 2001
Consultation and Public Involvement in Service Change – HDL 42 (2002)
Scotland's Health White Paper – Partnership for Care - March 2003
A New Public Involvement Structure for NHS Scotland – March 2003
Informing, Engaging and Consulting the Public in developing Health and Community care Policies and Services CEL ((4) 2010)

Next Steps

- The establishment of a group tasked with the engagement and involvement of people and communities across Edinburgh, about how we reach a better balance between patient demand and our capacity to respond over the next decade.

5.3 Practice Management Leadership Development

The new contract acknowledges the growing role of the Practice Manager and practice management in the effective implementation of new arrangements. Edinburgh has a long standing locality-based network of PMs and contributes to both regional and national networks: that PMs have to be somehow lifted from administrators and reception managers, to embrace a new and more pivotal role, is both outdated and simplistic. The role of PM has been developing rapidly in Edinburgh over the last decade, with antecedents going back much further. Whilst more traditional roles still exist, PMs across the City have been instrumental in the development of their practice clinical teams, in advising the partners on investments in infrastructure (including IT development), in maintaining and enhancing a wide range of relationships and partnership outside the practice, and supporting the performance management and quality dialogue which underpins the development of healthy practice cultures.

Some practices have recognised these changes with the appointment of Business Managers, or supporting Assistant Managers, or inclusion of the PM as an 'associate partner'. There is no doubt that as MDTs develop, PMs will need to ensure that the practice team is co-ordinated and are well supported in managing the inevitable tensions and misunderstandings around the introduction of new roles. Practice managers have already responded enthusiastically to the suggestion of testing new Primary care roles. As practices begin to share resources as clusters/sub-clusters/localities, the practice manager networks should complement the GP Quality Cluster network, and be able to help assess and ensure both workload impact and value for money. The offer of a PM rep to routinely be included in GP Quality Cluster meetings would be a welcome first step.

Practice managers have commented in particular on the difficulties of releasing staff for training. There is increasing recognition of the potential of the traditional receptionist role to undertake a more diverse range of duties including routine clinical tasks eg weighing and BP monitoring to signposting patients to appropriate local resources.

Next Steps

- To engage with PMs to see what additional training or external support might be provided to complement the NES programme (end of 2018)
- To ask PMs whether they consider an increase in time funded to engage in relevant networks would be both feasible and worthwhile. The obvious parallel is to build on the existing PM network to create something like the GP Cluster arrangements to be able to more actively exchange the learning from each practice.
- To consider whether additional training support for practices could be offered to accelerate change.

5.4 GP Leadership Development

Edinburgh Health and Social Care Partnership has an established, effective system of Clinical Leadership of General Practices. Locality Clinical Leads, have leadership responsibility for all Primary Care activity in their respective geographical area.

Each of our four localities is divided into two GP Clusters. Edinburgh GP Cluster groups are deliberately designed around shared, or significantly overlapping populations.

Each GP Cluster has a Cluster Quality Lead, with responsibility for GP cluster quality improvement work as defined in the GP contract.

Cluster Quality Lead roles are new with some variance locally of role and responsibility: some CQLs are invited to sit on H &SCP Locality Management Teams, other CQLs report to Locality Management Teams or Locality Quality Improvement Teams.

The development of clinical leadership across Primary Care should not be confined to CQLs/PQLs. That said, these are important constituents and we need to support encouraging early beginnings to reach their potential. GPs across the City don't yet have the capacity to support their aspirations to learn from their own results and other's experience. Furthermore, there needs to be choice and recognition that a willingness to facilitate a peer focus on clinical quality is not necessarily synonymous with an interest in influencing the management of the locality. The immediate barriers are less a lack of attraction to these roles, but the practical implications of this sacrifice of time away from busy practices.

Next Steps

- A review of the realistic time commitment required from the CQL group – including the opportunity to adjust expectations or perhaps vary expectations between clusters
- Agree what admin support is required to ensure that all clusters are able to function without CQL capacity being used inappropriately.'

5.5 Improvement Plan - summary timetable

Below is a timeline of the development of the PCIP. The summary of development actions taken is at Appendix 3

The nature of General Practice across Edinburgh is diverse and the early part of the development of this plan(March/April) focussed almost exclusively on engagement with Primary Care. In May there were several opportunities for discussion with our closest Partners; including an event for the Third Sector, whilst Carers expressed a preference for engagement at a later stage. May and June have seen the PCIP developed further through our governance processes before submission to Scottish Government.

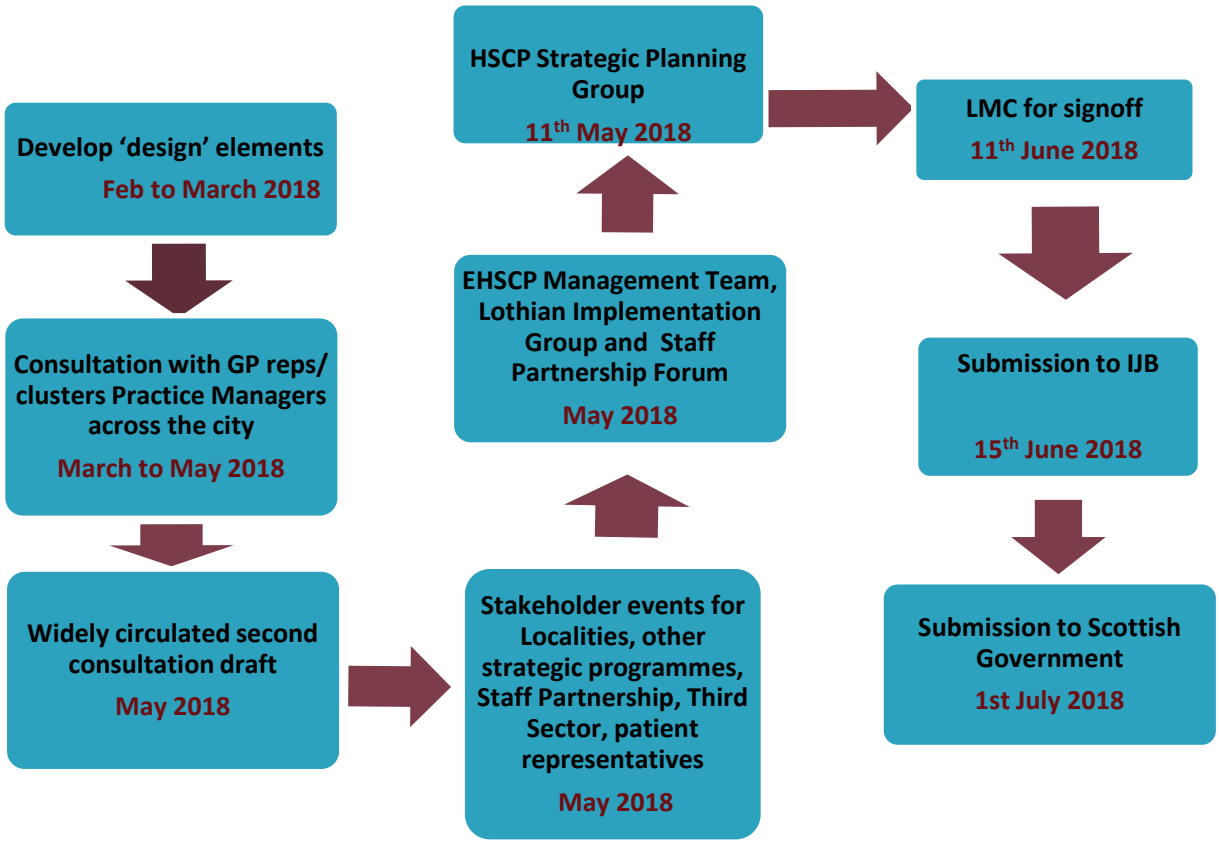


Diagram 2 Timeline for Development, Consultation and Approval of PCIP

PART TWO – IMPLEMENTATION OF SPECIFIC PROGRAMMES

Diagram 3: Proposed Approach

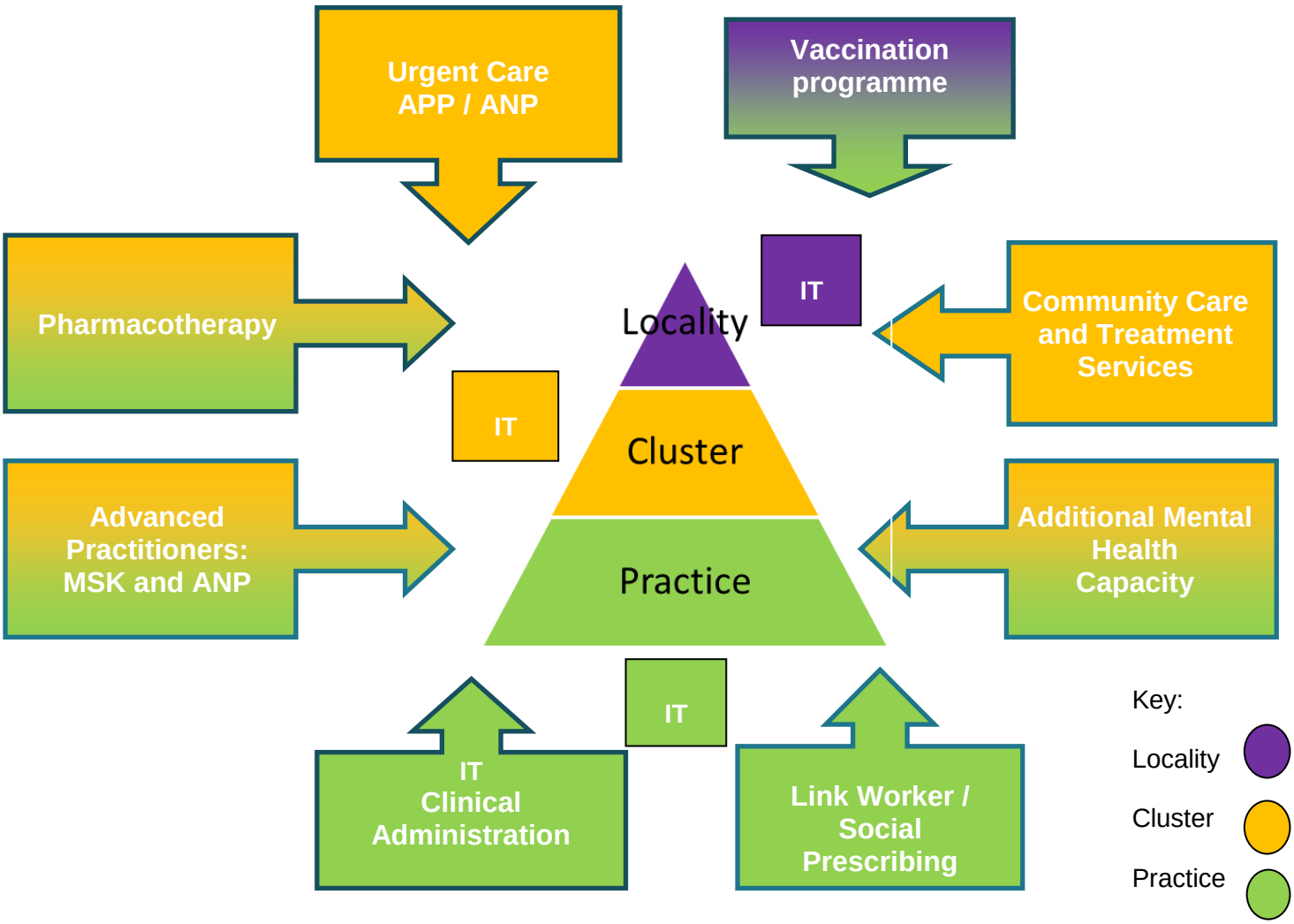


Diagram 3 summarises the overall proposed approach. Work will not be moved in a blanket process but in segments, which will vary according to resource availability and local circumstances. Clinical risk will be carefully assessed and managed in each case.

The Diagram shows those elements of activity which are best delivered on a Locality (or larger population) (purple)cluster or sub-cluster basis.(yellow) Much of the new capacity can be directly embedded in augmented practice teams;(green)practices with small list size may need to share workforce resource, or have less than full time appointments.

Work has already been undertaken in Edinburgh to classify all 72 practices into 5 groupings which reflect the different populations served ***(Supporting Info).***

6. Key Elements of the Plan

The main focus of the plan is how the new contract outline model can best be implemented at locality/cluster/practice level to stabilise and transform the primary care workforce. The development of new services to underpin this was defined by the national Primary Care MoU:

- *To detail and plan the implementation of services and functions listed as key priorities below with reference to agreed milestones over a 3 year time period;*
- *To give projected timescales and arrangements for delivering the commitments and outcomes in the priority areas and in particular to include intended timescales for the transfer of existing contractual responsibility for service delivery from GPs.*
- *To provide detail on available resources and spending plans (including workforce and infrastructure);*
- *To outline how the MDT will be developed at practice and cluster level to deliver primary care services in the context of the GMS contract.*

The Primary Care Improvement Fund Annual letter anticipates initial priorities of vaccinations, pharmacotherapy and CTACS. Work has already started and should continue to define models and approaches in areas where this is not yet fully developed. This is summarised below for each of the priority areas. There is a clear intention to have a **FLOOR** to services, such that all practices achieve a minimum provision for good practice – for those new contract services that are 'universal,' such as childhood vaccinations. Each area will have an associated implementation workstream. (Supporting info)

6.1 The Vaccination Transformation Programme (VTP)

6.1.1 Childhood Vaccinations

Early discussions have taken place about a Lothian wide co-ordinated approach to the design of the Vaccination Programme led by Public Health. Two Edinburgh test of change pilots for the childhood programme are due to start (Craigmillar and Muirhouse).

It is currently anticipated that Edinburgh will expand existing vaccination teams to gradually remove this workload from all practices. The favoured model would reflect that which has worked well in West Lothian and would involve the extended Community Vaccination Team visiting practices on a rotational basis, and retaining a connection with the Health Visiting (HV) team. The HV team has a crucial public health role, and should be the point of contact for additional information on vulnerable children or those defaulting. This also supports some recurrent themes of the Improvement Plan: maintaining continuity and local team cohesion as far as possible, and optimising local access. The role of the HV in developing knowledge of, and contact with, families over time is also crucial to this. The Scottish Government's national HV programme specifically highlights the unique contribution HVs can make to the Public Health agenda, and specifically their role in the immunisation

programme[3]. Having vaccinations given in practices also means that the Practice IT can be used, avoiding the need for duplicate data entry.

The 2015 list of practice arrangements is being updated and updated. This 2015 list indicates that for Edinburgh practices in terms of Childhood Immunisations:

- 46 are done by HV staff nurses
- 3 are done by a combination of practice staff and HV Staff nurses
- 4 are done by GPs
- 7 are done by Practice Nurses
- c. 12 are unknown

Next Steps – Childhood Vaccinations

- A spreadsheet of Edinburgh practices outlining what staff undertakes childhood vaccinations currently, numbers of children of relevant ages and sessions required for this work (end of May 2018). Outcome of pilots to be known (end of June 2018)
- Agreement of approach and costings on the basis of spreadsheet information (end of July 2018)
- A timetable for practices not currently receiving support to be agreed (July 2018)

6.1.2 Travel Vaccinations

Travel vaccinations potentially represent a more discrete piece of work, but also a significant burden to practices. The intention is to 'fast track' this work, and consider one or two not-for-profit centres, giving advice for a flat fee and all relevant vaccines (including NHS ones – those cannot be charged for).

[3] Universal Health Visiting Pathway in Scotland, Pre-Birth to Pre-School, Scottish Government October 2015.

Next Steps – Travel Vaccinations

- Ask all practices to indicate the average number of travel vaccines done per month, including how many of those are eg family groups where there are time savings (end of May 2018) and what clinical software system they use (Vision or EMIS).
- Liaise with the WGH existing travel clinic to ascertain capacity and potential for expansion
- Establish a new travel vaccine clinic in a central location (Lauriston Place?)
- Agree timetable of travel vaccination work by end of July 2018, aiming for full arrangements in place by the end of 2018. After this, when a patient requests a travel vaccination, the practice should print off the existing vaccination record (this can be readily done in either Vision or EMIS) and give this to the patient to take to the travel vaccination centres.
- The practice needs to be informed of vaccines given: the ideal would be that this is automatically entered by the Travel Clinic Centres into practice electronic records

Next steps - Other Vaccinations

- Flu / pneumococcal vaccinations for the housebound should be done by appropriately resourced District Nursing (DN) teams, accepting that practices will continue to give as many as possible opportunistically. Current arrangements with an external team undertaking these within a small number of programmed sessions does not work well for logistic reasons. DNs already have a strong presence in the community and could efficiently give domiciliary vaccines for those not on their caseload by geographically (and opportunistically) linking them to their existing work
- The remainder of the adult vaccination programme will be scoped in 2019-20 with some workload transfer during that year and fully by 2021.
- Midwives leads should be consulted on the feasibility and timetable for giving all required vaccines (currently flu and pertussis) to pregnant women (September 2018) .
- IT needs development so that recording vaccinations in the GP record is done electronically and automatically.

6.2 Pharmacotherapy Services

The new contract specifies that every practice should receive pharmacy support. This can be either from a Clinical Pharmacist or Pharmacy Technician, and be focussed on quality e.g. improved clinical outcomes, safe cost-effective prescribing and GP workload reduction. The latter should be intrinsic to the programme.

The new GMS contract (page 32) outlines the “core and additional pharmacotherapy services”: By April 2021, every practice will benefit from the Pharmacotherapy Service delivering the core elements described in Table 1.

Table 1 – Pharmacotherapy Services

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

15 Pharmacist Independent Prescribers can action (instigate and sign) prescriptions, non-prescriber pharmacists can action prescriptions but they still require to be signed by a prescriber.

There is an established programme of investment in Practice Support Pharmacists, and recurring funding for this will be included within the allocation to support the PCIP. Experience to date in Edinburgh strongly supports the pharmacists working as part of the practice team or across two smaller (or lower demand) practices – rather than a group of practices sharing a team. Holding an independent prescriber qualification has proven to be very advantageous in providing an effective contribution to a busy practice team. It will be necessary to ensure that sufficient numbers of GPs continue to be Designated Medical Practitioners (DMPs) to enable practice and community pharmacists to complete

independent prescriber training. This will also grow the team able to provide full level one pharmacotherapy services. It is envisioned that in the future regulations will allow non-medical prescribers to fulfil this function.

Edinburgh's prescribing performance is amongst the most cost effective in Scotland. The cost of medicines per patient per annum in Edinburgh is £147 (December 2017 figures). It is crucial to the financial stability of the H&SCP that the current arrangements and infrastructure to maintain and develop this record are sustained. Pharmacists are currently an integral part of the Edinburgh Primary Care Support Team and aligned to our four localities. The pharmacists contribute to the development of Primary Care alongside their 'technical specialist' role input on medicines governance, cost and quality.

Pharmacotherapy in Edinburgh practices already covers three aspects of care: cost and quality; undertaking long term conditions / polypharmacy clinics and for those with an independent prescribing qualification, an increasing focus on clinical care reducing GP workload. Current investment of the primary care transformation funding (circa ~ £1m) is as follows:

- 17 whole time equivalent clinical pharmacists have been employed by NHS Lothian and deployed across Edinburgh City GP Practices.

- 3.1 whole time equivalent integrated care pharmacy technicians have been employed by NHS Lothian and deployed across Edinburgh City GP Practices.

- Investments have been made in Education, Research and Development including an NHS Lothian wide leadership role to develop training plans and guide clinical pharmacists and technicians through NES general practice competency frameworks and advanced clinical skills training. Where appropriate, post graduate clinical qualifications are being supported including (with joint NES funding) the Independent Prescribing (IP) qualification for all pharmacists in this cohort.

- Pharmacist project management support to roll out Pharmacy First and other Community Pharmacy led initiatives which promote community pharmacy being used as a first port of call for patients with minor ailments/illness and self care advice. This has resulted in 1,000 consultations in NHS Lothian in the first 3 months of rollout, 900 patients were managed in community pharmacy with 10% requiring onward referral to GPs. This will have reduced workload for practices.

- Pharmacist led Quality Improvement work to evaluate clinical pharmacist led physical health monitoring clinics in GP practices, caring for patients under the care of Community Mental Health Teams.

- Pharmacists across Edinburgh are collectively spending up to one third of their GP practice time on specialist and advanced pharmaceutical care services including realistic medicine polypharmacy review and long term conditions management. The remaining time is spent supporting GP practice workload and clinically safe and cost effective prescribing.

The aim will be to widen and deepen provision, aiming for some universal provision at an early stage. A disadvantage of spreading resource equally but thinly is that pharmacy staff can be doing single sessions in a large number of practices, giving no continuity either for them or the practice. This is not professionally ideal or sustaining. The contract specifies that Level 1 work is to be prioritised, reducing GP workload. An early, universal provision also ensures that all practices adapt to this new way of working.

The management arrangements in Edinburgh , where pharmacists are an integral part of the Primary Care Support Team, allow us to ensure the two professions continue to collaborate closely in crafting arrangements for workload shift which are both realistic and sustainable. The success of Edinburgh's prescribing performance has been build on longstanding good relationships throughout the City, and we are well placed to move to an ambitious interpretation of the new opportunities.

The timeline set out in the GMS contract provides the opportunity to test the best way to utilise pharmacists and technicians to support reduced GP workload. Scottish Government have commissioned the University of Strathclyde and the Robert Gordon University to jointly undertake an evaluation of this work. Already underway, this work is expected to report in mid to late 2018. Locally, GP Practice pharmacy teams in Lothian have been contributing to this evaluation responding to qualitative and quantitative questionnaires, compiling workload data in a bespoke database and sharing this with researchers. The researchers are also expected to undertake evaluation with a number of GP practice teams and patients.

Early evaluations of the pharmacist and technician role were published following the pilot of a model of GMS in Inverclyde in 2017. This reassures us that the activity being undertaken will release GP time, but the applicability requires tested on local processes and against outcome measures.

Following this first wave of provision, there will be gradual increase towards the advanced and specialist levels of pharmacotherapy service provision. In Edinburgh, pharmacists and technicians in General Practice are already making use of all available information including SPARRA, the Scottish Therapeutics Utility (STU), and Tableau dashboards of prescribing information. Provision will be defined by levels of experience of employed and trained pharmacists with initial roll out relating to prescribing volume (patients with ≥4 prescriptions on repeat (a QOF indicator so readily searchable); number of hospital admissions and readmissions, care home or domiciliary status, high risk medicines, polypharmacy etc).

Next steps – Pharmacotherapy

- We will assess whether there is capacity to offer regular sessional commitment to every practice for level one work (April 2019), with a specified proportion relating to reduction in GP workload
- We will continue to provide Level 2 and Level 3 services where they currently exist
- We will ensure (and fund through New Contract funds) a network of Designated Medical Practitioners (DMPs) to support pharmacists to become Independent Prescribers
- Using the T&S Programme fund we will assess with a number of individual practices, the impact of augmenting the 'floor' of service provided through New Contract funds

6.3 Community Treatment and Care Services (CTACS).

The contract determines that:

> "Community treatment and care services include many non-GP services that patients may need, including (but not limited to): management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, chronic disease monitoring and related data collection". And: "It is expected that community care and treatment services will be available for use by primary and secondary care. For example, pre-hospital clinic bloods could be carried out for a requesting consultant without having to involve the GP practice staff. The consultant's name would be on the test result to avoid unnecessary GP involvement".

There are advantages to patients having services as close to home (practices) as possible: this is especially important for those who are vulnerable, find it difficult to travel and so on. The EHSCP will look for opportunities and there are obvious sites which might have space: Sighthill, Allermuir, Tollcross, Conan Doyle, Craigmillar and so on. Lauriston might also offer a site. It is recognised that the physical capacity to put this in place is severely limited as a result of Edinburgh's efforts to accommodate the additional population over the last decade, without matching premises investment. There may be individual practices which are able to develop this capacity shared with practice nurses and this should be explored as a helpful staging post. As with other workstreams, the aim should be for local provision and maintaining continuity and team cohesion, wherever possible.

The initial priorities are expected to be agreed as :

i. Hospital work currently 'delegated' to practices including hospital phlebotomy.

ii. Procedures which are time-consuming or require special equipment. These include suture removal, post-operative wound care, ABPI (using the Dopplex® machine these can be done in a few minutes rather than the best part of an hour), ear syringing (often requested by secondary care), spirometry and home BP monitoring.

iii. Chronic ulcer management with CTACS developing a 'hub' of specialism for that, including APBI measurement where appropriate, and involving the Tissue Viability and Lymphoedema teams. Such a service would help maintain quality and innovation, and could be fully integrated with the DN teams too. In the longer term this might also provide a cost-effective means for dermatology specialist outreach for problematic cases.

Initially practice bloods and simple measurements (BP, urinalysis) will continue to be done by practices: these are small, high volume tasks which require joined up IT (eg practices use GPOC-ICE to order tests and ensure results come straight back to the GP. This was achieved in Inverclyde by use of EMIS web).

There will need to be Lothian-wide interface work with secondary care to establish systems by which specialists order tests from CTACS. Those will be paid for by secondary care (agreed at Lothian level) and will require CTACS staff to access TRAK. There will need to be close monitoring of volume and workload transfer so that the services are not overwhelmed.

We propose that the task group considers the establishment of Clinical Administrator posts, funded by secondary care. These will be new staff, who can respond to all requests from patients for results or information generated by specialist services. Currently patients tend (or are encouraged) to ask GPs for these, or have to navigate the complexities of the hospital system. A discussion paper on CTACS development has already been developed.

Next steps - CTACS

- Establish a dedicated task group which will start by surveying possible sites in Edinburgh, both in practices and at Lauriston Place (end June 2018)
- Discuss potential sites through GP Quality Cluster Groups to ensure relevance to each area.
- Begin with hospital procedures currently delegated to GP or time-consuming GP procedures (end October 2018)
- Lothian-wide interface work round hospital procedures delegated to CTACS.
- Practice-ordered bloods and simple measurements (BPs, urinalysis) to remain with practices initially – for review 2019-2020- as require new IT arrangements to be efficient and safe and the new services need to be very cost-effective.
- Establish Clinical Administrator posts, so that patients no longer ask GPs for hospital-generated results. These new posts have the added benefit of helping patients 'navigate' the system.

6.4 Urgent Care (Advanced Practitioners)

Practice sensitive models and approaches are being developed and evidenced. The Lothian practice-based pilots engaged paramedics for first line house calls. These required significant 'start up' work to establish how best to deploy this resource, but then provided a very useful service, releasing GPs from house calls: both the paramedics and practices felt that they rapidly became integral members of the team. Home visits can take a disproportionate amount of GP time and early assessment of the very ill at home may also give more leeway for exploring alternatives to admission, or admitting promptly.
To undertake this work paramedics require additional specialist training and it is estimated that 15 have completed this and a further 15 will do so in 2018 (Notes from meeting with SAS paramedics and NHS Lothian staff, 20/7/17). There were issues which needed to be addressed and these included: that the evidence base for use is limited, that initial induction was time consuming, a vehicle was required, paramedics cannot prescribe (though this is changing on 1st April 2018 for some, but they can follow PGDs and overall this was not an issue on house calls), case load and mix. In the pilot the paramedics worked across more than one practice, and undertook non-house call work, too, including telephone triage and face-to-face consultations. Paramedics also need to spend some ongoing time in the acute sector to maintain those skills.

There is a requirement to maximise the effectiveness of this resource in terms of benefit to GPs (who are the only others able to do this work, and who often 'fit in' unscheduled house calls round scheduled care). Some house calls relate to lack of transport: providing that would also maximise cost-effectiveness.

Next steps – Urgent Care:

A SLWG (City or Lothian) should be quickly established (June 2018) to begin work on the development of this element of the contract. Further potential steps are outlined below as a basis for initial action;

- Establish paramedic availability and interest; administration and governance
- One option is for every practice which might have an interest in a delegated house call service to provide data on house call numbers - suitable for this service
- Practices be asked to indicate which of those house calls could have been potentially managed by bringing the patient to the practice, if appropriate transport was available.
- Paramedic staff to consider an early pilot to manage a defined proportion of afternoon house calls on a cluster-wide basis (end of August 2018). This might benefit those with severe GP timetabling pressures with populations liable to be more chaotic in requesting housecalls, allowing best use of a limited resource. Others may benefit from a specified morning input. The team could then also be available for early evening LUCS work, covering a time when it is difficult for working GPs to reach out-of-hours bases and may provide an incentive for more GPs to do that work.
- By April 2019, aim to cover all appropriate afternoon unscheduled house calls and complete scoping work for covering a proportion of morning calls. This is likely to be limited by practitioner availability as much as funding, so could not be universal. In order to cover this work, include a small number of ANPs would ideally be incorporated in any fledgling service, which will also enrich learning and development for both professional groups.
- (Until we have house call data, we do not yet know what capacity is needed, so this work will need an ongoing scoping and PDSA approach).
- Continue to encourage visiting efficiency by rationalising practice boundaries, particularly round outlying patients.
- Consider transport options to reduce housecall numbers

6.5 Additional Professional Roles

There is a balance to be made between the high impact of investment in a single practice and the more ‘diffused’ allocations to multiple practices. The initial proposal is to keep ‘injecting’ individual practices, keeping the additional resource as close to those as possible, and gradually moving to some collective arrangements where it is clear they are more effective.

Resource allocation will be difficult, when so many practices are in need, and the EHSCP is developing a separate paper and the dedicated 'resources' workstream to address this.

In summary:

- 30 of Edinburgh's 72 practices have benefited (or are set to benefit) from additional staffing capacity 'injections' through the T&S monies which were available to all on a 'bidding' basis;

- Practices have to pay for 50% of ongoing costs after a trial period, which was effective at distinguishing 'need' from 'want', and supporting 'tests of change' across the city.

- The 50% contributions were agreed on the basis they would be 'recycled' to reach a further tranche of practices as confidence in this method of augmentation grows.

- Maximising the use of the new workforce often necessitates new ways of practice working (diverting MSK cases without unnecessarily involving GPs needs good receptionist signposting for instance);

- Factors which need to be taken into consideration with application of new contract funding will include: pressures due to age, multimorbidity or other local circumstances; levels of previous investment; additional funding available to practices through the SAF; that the new workforce available is funding limited and has extensive training needs; the contractual requirements to address health inequalities and admissions avoidance; locally-identified priorities; supporting individual practice resilience (some practices needing urgent help to remain viable)

- To ensure that the GP view particularly round equity and fairness is fully considered, both the GP Sub-Committee representatives and the Cluster Groups will be part of the resources workstream.

- The Clusters will have shared responsibility for quality improvement and assurance support for ALL the workstreams: data round outcomes will need to be considered as part of that process, and also agreed with Cluster leads.

- The Inverclyde pilot indicates that extensive time is needed for planning, data collection, and developing integrated models and relationships: this needs to be factored into workstreams too.

- There will be initial practice survey work for many workstreams as this is the only way to establish what capacity is required.

6.6 Advanced Nurse Practitioners (ANPs)

That Lothian has already established and funded an ANP training programme is very welcome: essentially that lack in Inverclyde meant that only one ANP post was established and is still in the early pilot stage. Edinburgh HSCP will therefore continue to pay its share for this and find additional ways to incentive and support practices as they take on training roles.

ANPs and Advanced Physiotherapy Practitioners (APPs) have both successfully undertaken Care Home work in Lothian. APPs are independent practitioners, accustomed to full case management including diagnosis, and they have proved valuable in Boroughloch Practice. We need to understand how much this reduces GP Care Home workload, which largely relates to frailty, palliative care, withdrawing treatment, multi-morbidity and so on: EHSCP will ascertain from East Lothian the cost-effectiveness of its extensive programme for ANPs to undertake such work. There is an alternative view that Care Home residents are complex patients, many requiring palliative care, and are best served by the GP as expert medical generalist. As an example, a single GP- with adequate generalist DN support - can look after a 75-bedded Care Home in 2 sessions per week. This complex work is crucial to 'Realistic Medicine' and keeping ill and end-of-life patients at home. eFrailty approaches may also provide ways of targeting ANP and other resource: Midlothian is piloting this model.

ANPs also have a crucial role to play in practices, managing patients alongside GPs in the surgery. This represents a very direct way of increasing front line capacity and needs to be expanded. They can also take on complex chronic condition care, traditionally done by GPs eg diabetes management. The Edinburgh T&S investment has already funded several of these posts.

PNs can take on more work traditionally done by GPs, without achieving full ANP status and complementing their role in chronic disease management and health promotion. Examples include minor illness management, triage roles, anticipatory care planning, management of respiratory exacerbations and so on. Releasing time for PNs to take on this work is an important part of our approach to workload management.

Next steps – ANPs:

- Continue to support ANP training in Lothian
- Include some ANP presence in the Urgent Care service
- Further assess cost-effectiveness in Care Home settings
- Further deployment in practices and assessment of impact with existing investments.
- Support new ways of working (with the associated training) for PNs
- Explore new ways of targeting care – eFrailty models.
- Consider funding interested GPs to attend hospital at home training

6.7 Musculoskeletal-focused physiotherapy services

APPs have adopted very successful roles in Edinburgh in other settings (eg Community Respiratory Team) so account will need to be taken of these approaches when considering MSK capacity.

Useful work has already been done in this area: the Inverclyde baseline audit identified that 10-20% of consultations *could* be dealt with by APPs: barriers to this included that both practitioners and practices had to change how they worked. The APPs underwent several months of training in General Practice. Inverclyde reported "a savings in costs associated with 8-10% of GP appointments time" and improvements in GP morale and approach to treating joint problems, though the robustness of the data was questioned.

'Think Physio for Primary Care'[4] outlines that MSK conditions accounts for around a fifth of GP consultations, are the single biggest requirement for repeat GP appointments and that APPs as autonomous practitioners can readily take on this workload. The outcomes are good, and generally orthopaedic referral rates drop. There are established approaches to implementation[5], produced with BMA and RCGP involvement, and which gives detail round both pathways and governance. The work done in Forth Valley for 'first contact' APP involvement was that the service was safe, efficient, accessible and cost-effective, and welcomed by staff and patients. In the 6 month pilot, only 4% were referred on to the GP and the vast majority did not need GP- generated prescriptions.

The full potential for saving of GP time with an APP can only happen with receptionist signposting: there are training and redesign implications for those practices not already doing this. Telephone advice is not considered in these documents but many presentations are repeat consultations due to chronicity or very recent-onset presentations where advice is adequate: an audit in one Edinburgh practice has shown that some MSK consultations can be managed with phone advice only. Therefore APP telephone advice as an option should be assessed as that may further improve cost-effectiveness.

In Edinburgh, tests of changes have been agreed for two particular practices, but it may be that enhancing direct access as a cluster based approach may be preferred, as APP availability will be limited.

[4] Think Physio for Primary Care; Chartered Society of Physiotherapy; Policy Briefing Scotland 2017.
[5] General Practice Physiotherapy posts: A guide for implementation and evaluation. Chartered Society for Physiotherapy; RCGP; British Medical Association.

Next steps –MSK focussed Physiotherapy Services

- Some localities have already asked practices if they wish to have access to an APP. Ask all practices if they are interested, a pre-requisite for involvement being 'front door' signposting (end of May2018).

- Initial telephone management is key, and may be by receptionists (sign-posting) or GPs or APPS (triage and management). Consider piloting telephone advice as part of the service – this would be a means of managing consultations rather than an alternative to the non-specialist led NHS24 MSK line.

- Establish means of referral to others: the Forth Valley pilot indicated that APPs not only referred to orthopaedics but also to falls' services, podiatry, and weight and pain management services too (by September 2018).

- Two practices will run pilots using T&S money for in-house programmes as a test of change, and others to be based at Cluster or Sub-Cluster level (see Diagram 2): one FTE APP per locality by Sept 2018; and adding a FTE per cluster p.a. for the next 3 years, with full review of model each year.

- Take account of academic work on APP implementation in Primary Care (WJ)

- Agree data collection and outcomes – readily available from existing programmes and guidance but would include 'containment' (self-management, no onward or GP referral); patient satisfaction; accessibility; prescribing etc.

6.8 Community Clinical Mental Health Professionals

The experience of embedding Mental Health Professionals in practice teams in Edinburgh has been very encouraging, and more have been recruited through the Transformation and Stability (T&S) fund to join practices. Senior Mental Health Nurses can manage drug misuse patients, and those with mild-moderate anxiety and depression as well as other mental health issues presenting to GPs. Standard disease register coding will not be an adequate marker of workload: many patients present with recurrent symptoms over years, or have psychological or emotional difficulties which are not necessarily coded. The emphasis now is on non-pharmacological approaches for mild or moderate illness, so prescribing patterns will not adequately reflect practice workload either, but will give an indication, as will demographic factors.

Further development of supportive local networks and use of the 'Link Worker network' to inform future development is envisaged. Both Mid- and West Lothian have developed locality hubs where patients can be referred (or self-refer) and these can provide useful links to both third sector resources and secondary care. This model originated in the Fountainbridge area of the City with the development of the Rivers Centre and EHSCP will explore these models further as part of the Mental Health Workstream.

Some GPs report poor provision of standard secondary care mental health services and this context needs to be taken into account, too.

Next Steps - Community Clinical Mental Health Professionals

- Explore ways of ascertaining practice workload which can be undertaken by a Mental Health Professional
- Assess the relative merits of the available models of delivery (August 2018).
- Continue to embed Mental Health Professionals in high need practices (ongoing).
- Establish appropriate model for local networks – and whether those are appropriate for Edinburgh (Nov 2018) - with a view to beginning to establish those by April 2019.
- Consider the potential for extra capacity to be provided through the Third Sector.

6.9 Community Link Worker (CLW) (& including 'care navigation')

Edinburgh has a group of 20 practices with ≥20% deprivation who already have established Link Workers through the Scottish Government (SG) Primary Care Fund. This national investment was accelerated by local investment in a management structure which will focus strongly on supporting these new professionals to be as effective as possible in impacting on practice workload as well as the lives of vulnerable people. The initial ratio of one day per 1000 people on the practice list in quartile four of Scottish Index of Multiple Deprivation (SIMD) will be tested for its efficacy.

The Link Workers in Edinburgh also have responsibilities to support practice staff to effectively 'socially prescribe'. This involves training and enabling the practice team and particularly reception staff to recommend local resources to support patients; a version of 'care navigation'. In addition, further tests of change are taking place with 17C and T&S funding to assess the impact Link Workers can have working with non-deprived populations.

The network has built on the already strong relationships with the Third Sector, particularly in tackling inequalities. The existing network is strengthened through joint delivery with both Welfare Rights and Employability Support where this is already funded by the H&SCP. Over time, a proportion of the available funding may be used to develop relevant capacity as Primary Care develops better understanding and closer links with wider community resources.

A survey of 400 appointment requests at St Triduana's indicated that fully training reception staff in sign posting can remove up to 6% of demand for appointments (against a baseline estimated to be 1-2%). The Linkworker Network capacity (top sliced from LHB funds) has a programme of receptionist signposting training for ALL Edinburgh practices. It is expected that Link Workers will also inform and train reception and other staff in the 20 City practices where they are embedded.

There is much scope for the strengthening of signposting and this would be part of the purpose of the public engagement initiative.

Next Steps – Link Workers

- Establish outcomes – numbers of patients referred, numbers seen, success of onward referral
- Identify a small number of practices for more in depth assessment of success looking at more detailed data and qualitative work too (GP consultation rate before and after intervention, patient engagement and 6 and 12 months; accessibility and so on). (April 2019)
- Access outcomes of the Link Worker in the elderly non-deprived pilot practice (Dec 2018)
- Develop signposting throughout Edinburgh through dialogue with public and dissemination of supporting materials.

6.10 Clinical Administration

Several Edinburgh practices are already testing how clinical administrative work can be shifted from GPs to appropriately-trained and supported A&C staff (Clinical Administration Workers). A particular focus has been on Docman management, and initial feedback is positive. We need to explore the level of competency and associated training which is most effective. Examples of work needing different skill levels include: management of normal results; management of certain groups of low risk abnormal results (particularly for chronic disease management) through simple algorithms; identifying actions and coding from clinical letters; reduction in letters requiring GP attention, management of patients who DNA appointments (some of whom may be high risk).

Under QOF, patients with chronic disease were recalled automatically on the basis of their condition. The new approaches round multi-morbidity, frailty, Realistic Medicine and better stratification of patients with chronic disease (eg complexity, clinical need, disability and vulnerability) bring opportunities for much more tailored work. With this underpinning Practice Nurse teams can bring more appropriate levels of input for patients – more for some, less for others. It also better places teams to get the patient seen by the ‘right person at the right time’, increasingly important as our teams become ever-more multi-disciplinary. These approaches particularly suit House of Care, and the new models of frailty and multi-morbidity working.

One of the tests of change being supported through T&S funding, is the potential for increased automation of the registration and de-registration process. This would potentially free up administrative capacity across all practices, and be of particular benefit to those with high list turnover.

The support of an IT systems manager has proved very effective at one particular practice, allowing practices to maximise the use of their software systems, round recall work, data collection, and everyday activities. This has proved a very efficient and popular development. It could be that this model might be applicable at the Cluster or locality level with local resource provided through the application of New Contract funds. One cluster area has already made this proposal.

Next Steps – Clinical Administration

- Review of pilots and develop a coherent work stream (modelling) for Clinical Administration Workers. There is much room for rationalisation of processes and staff working.
- Review registration and deregistration automation pilots and roll out to all practices.
- Ensure capacity for training staff on IT application
- Ensure adequate IT systems management support to maximise potential and capacity of current IT system

6.11 Supporting Role of GP Quality Clusters

GP Quality Clusters play an essential role in designing and implementing local arrangements and providing a feedback forum for the effective and safe redesign of clinical pathways and associated workload distribution

The SSPC report on quality[6] highlights that:

> *"If the external role [of Quality Clusters] is not quickly developed, there is a risk of new arrangements with IJBs moving forward without GP involvement, worsening the engagement of general practice with the rest of the NHS. This would be detrimental to NHS working across systems, the 2020 vision and to integration of health and social care".*

(Under the Leadership section the need to support Cluster Quality leads in their 'extrinsic' roles was identified as a required action).

[6] Quality after QOF. The Scottish School of Primary Care. 23 March 2016

Next Steps - Development of cluster involvement

- A Cluster Quality Lead (CQL) have been invited and participated in the writing of, and review, of the Implementation Plan.
- Each Cluster was asked to review the PCIP in its Cluster Groups and to seek individual feedback with all constituent practices through PQLs;
- Clusters will be key in co-producing documentation on outcomes, quality improvement and assurance

7. Premises

EHSCP has already undertaken extensive assessment of practice premises suitability and capacity and outlined its proposals for support[7]. There is to be a national survey of all GMS premises in 2018-19, by a Scottish Government-approved surveyor and this will also further inform the Partnership.

The assessment presented to the EIJB in Sept. 2017 highlighted the requirement for an estimated £57M premises investment over the course of Edinburgh's Local Development (Housing) Plan. This would see the replacement of premises for 14 practices and in addition the development of 3 new practices in new premises.

EHSCP will discuss with the Board the additional staff needed for premises management.

The contract specifies that:

- There is initial prioritisation of practices requesting GP Sustainability Loans (p40)
- *"NHS Boards will ensure that GP contractors are provided with fit-for-purpose accommodation which complies with the standards set by the Premises Directions"* (p41). EHSCP will need to support any practices who assert that these standards are not being met.

[7] Population Growth & Primary Care Premises Edinburgh 2017 – 2026. A Strategic Plan for Growth (March 2017)

- GPs with private leases which expire prior to 2023 should have the option of Boards taking these over if requested (or finding them alternative accommodation (p41). Again the EHSCP will work with NHS Lothian to support practices in this process

Next Steps – Premises:

- Continue to keep a register of practice premises and perceived needs. Formally review the SG-led premises survey results
- Jointly HSCPs discuss with the Board the additional staff needed for premises management.
- Establish the priorities for the GP Sustainability Loans (p40)
- *"NHS Boards will ensure that GP contractors are provided with fit-for-purpose accommodation which complies with the standards set by the Premises Directions"* (p41): support any practices who assert that these standards are not being met.
- GPs with private leases which expire prior to 2023 should have the option of Boards taking these over if requested (or finding them alternative accommodation (p41). The EHSCP may need to support practices in this process.
- Continue to develop the Edinburgh Primary Care Support Team Premises work stream to manage and monitor all the above.

8. District Nursing Services

District Nursing is a pivotal part of Primary Care, and although the New Contract does not address District Nursing directly, it is important that District Nurses are understood as integral to the transformation of Primary Care. There is considerable scope for differently organising current services and this work is already embraced within the profession. Some of the elements of the new contract could bring new opportunities if we approach the potential thoughtfully. District Nursing has a long established focus on skill mix, building stronger clinical leadership within teams, better integration and so on. This work could be enhanced and accelerated through the new contract emphasis on ANPs (Urgent care) and CTACS in particular. The design of these new elements should be taken forward with the full and earliest involvement of DN colleagues.

Early suggestions for exploration include: involvement in delivery of flu vacs programme; structure of ulcer care; better locality-based provision with defined competencies in every team (including a nurse prescriber, someone who can verify death, someone who can assess for and sign DNACPR forms); skill mix; committed specified reduction in paperwork; deployment of specialist nurses eg IMPACT nurses, increase anticipatory and complex care expertise; all housebound to be 'automatically' on the DN caseload; every team to have access to practice-based software for prescribing and updating ACPs in GP records, referrals to podiatry, dieticians, physiotherapy, CRT, to be made by DN using practice system. Many of these aspirations are already shared by District Nurses and a matching set of suggestions from DNs is welcomed.

In the longer term, such reorganisation would allow transformative change to a fully integrated nursing team, based round - and very closely associated with local practices, - but with Hubs, CTACS and other cluster and sub-cluster services being integral. This would also allow for much closer working and joint collaboration between PN and DNs. The aspiration is a unified locality provision, with District Nursing and associated services as part of a fully-integrated adult community nursing team.

Next Steps – District Nurses

- Seek advice on how best to approach the potential for long term constructive and dynamic relationship with District Nursing services to complement arrangements already developing within clusters.
- Establish SLWG

9. Generic NHS Lothian Services

9.1 Corporate services

NHS Lothian Corporate services will provide essential support to H&SCPs in the delivery of the New Contract. There needs to be consideration of NHS Lothian corporate function staff with responsibilities now covered by HSCP functions. The HSCPs request that the Oversight Group reviews the support which needs to be responsive to the new HSCP landscape and may include services and functions such as: epidemiology, medical statistics, health care planning, impact assessments, Primary Care data management.

IT support to General Practice in Lothian is a longstanding source of frustration: many report a very poor service, significantly reducing working efficiency and wasting precious clinician hours. Provision in line with other Health Boards would greatly increase GP capacity – we suggest achieving the Scottish norm. We request that the development of national Service levels and performance management agreements be fast-tracked to allow adequate provision for what is currently a hugely under-resourced for the size of the current and future challenge. Our current systems undermine safety and quality.

The new contract places continuity of care as one of the key features of primary care. It is hoped that with greater support from the new workforce, that GPs will have the capacity to focus more on the frail multi-morbid patients with high levels of complexity that benefit most from high levels of continuity of care. There is the risk however, that an increased number of different practitioners delivering care could result in increased fragmentation of the service. (*Divided we fall - The Nuffield Trust by R Rosen*). To minimise these risks it is vital that communication between different health professionals is as effective and efficient as possible. It is therefore imperative that the GP clinical system is the record for all primary care activity, whether this occurs in the practice, CTACs or at any other site in the locality.

For this to happen, there will need to be careful planning of the IT systems for CTACs and other locality based professionals. Information being provided in letter form to be managed through Docman will only add to workload.

HR provision can be slow in response to the often immediate requirements of relatively small teams to maintain vital clinical services. We would like the Lothian Contract Oversight Group to consider an SLA with minimum standards and turnaround times for all processes, and that the emphasis should be on flexible, timely support. An array of standard templates reflecting the roles of the 'new workforce' should be made available for ready adaptation. Many of these already exist.

9.2 Interface Group

The new contract highlights the importance of interface working as a core aspect of managing workload:

> *"We know that workload is currently one of the most challenging aspects of being a GP. We are introducing measures to address this by:*
>
> - *continuing to reduce contractual complexity*
> - *improving efficiency of primary/secondary care interface working*
> - *building a wider primary care multi-disciplinary team" (p24)*

The contract goes on to outline that:

> *"To ensure effective working between primary and secondary care, we will continue to implement the recommendations of the Improving General Practice Sustainability Advisory Group as set out in its report on November 2016.*
>
> *Within the recommendations there are a number of broad themes including effective primary and secondary care interface working. Interface working will be better achieved through well-functioning primary and secondary care interface groups. These groups will support NHS Boards and HSCPs to reduce GP workload and provide a better patient experience by removing the need for GP involvement when it is not clinically necessary".*

NHS Lothian has been pioneering in this area, having established a Lothian Interface Group with a small number of GPs and Consultants who are aware of the issues and keen to find solutions. However the group has no operational capability, and is resourced for a small number of meetings but not other substantive work.

There is so much to gain in interface working: improved quality, safety, relationships and the possibility of reducing waste and harm. We wish to see closer working between AMC and LIG. We also need to see closer working between LIG and operational boards to implement change

Next Steps – Generic Services

- HR provision reviewed with a new SLA
- Review of other managerial, advisory and data support services
- Adequate IT support to ensure safe and efficient clinical working with the added capacity necessary for New Contract implementation defined
- New Contract implementation becomes a standing item for the Interface Group
- Premises support capacity was highlighted in the premises section.

10. Quality Improvement

There is now an extensive NHS literature and experience on Quality Improvement (QI), and the lessons are clear: quality improvement requires systematic tools, shown to bring benefit, and a coherent organisation-wide approach, embedded in the organisations culture. QI should not be a series of projects or 'add ons' but instead a long-term commitment to change and 'reform from within'[8] The new contract and Improvement Plan provides an opportunity to a systems-wide approach, and we would hope a systems wide commitment to incorporating QI methodology in all the new programmes. Quality of healthcare is traditionally defined as being safe, effective, efficient, patient-centred, timely and equitable and these themes lend themselves well to all the new programmes being envisaged. QI work, done properly, can reduce waste, improve cost-effectiveness and provide encouragement and involvement for teams: it can work as well in the "clinical microsystems which make up the NHS" as bigger organisations.

. We have a unique opportunity to 'get it right first time' and that should be reflected in the initial programme design.

NHS Lothian has developed a welcome infrastructure to QI in Primary Care, outlined in its 3 year plan for Primary Care Quality Improvement Programme[9] (and see: https://qilothian.scot.nhs.uk/primary-care-network-1/) for further detail). We would want to see that work expanded and developed to encompass all clinical changes implemented. This will require additional use of NHS Lothian expertise: data analysts, QI specialists and the use of the Primary Care Data group to specifically consider new contract needs. Other supporting programmes and documents are the sentinel publications from the RCGP[10] and Scottish Government[11] and we would anticipate these being used extensively by Cluster, strategic and operational groups.

The GMS Contract rightly emphasises the 'four pillars' of General Practice: contact (access), comprehensiveness (holistic care), continuity (therapeutic relationship) and co-

[8] 'Embedding a Culture of Quality Improvement' The King's Fund; Joni JABAL, 2017.
[9] 'Making Healthy Change Happen'. Lothian Quality; Better Health, Better Care, Better Value; April 2018
[10] 'Quality Improvement for General Practice. A guide for GPs and the whole practice team. RCGP 2015
[11] 'Improving Together. A national framework for quality in GP in clusters in Scotland.

ordination (overseeing care). These have made British General Practice supremely effective and cost-effective. 'Divided We Fall', mentioned earlier, distinguishes between fragmentation and segmentation, the latter representing different levels of care depending on need, where that is managed differently or by other teams. The risk is that the new models of wider multidisciplinary team involvement and novel roles compromises generalist care. There are approaches developed in Lothian which should help (House of Care, 'archetypal' patients) which may help, but it is crucial that Cluster work round quality encompasses these aspects of care too.

The new contract specifies that:

> *"GP clusters and quality improvement GP practices will engage, as agreed in GP clusters, in quality improvement activities, including providing comparative data and sharing best practice. GP clusters will work with the wider system, in particular HSCPs, to achieve whole system quality improvement for patients" (p55).*

EHSCP recommends establishing a working group, with Public Health and Cluster input, to develop and maintain a framework for Quality improvement and assurance. This year the Lothian Safety SESP requires participating practices to complete a project using the Quality Improvement workbook and that should also feed into this work. Some of this work might be best done at a Lothian-wide level.

Next Steps – Quality

- The 'four pillars' of General Practice need to be maintained: contact (access), comprehensiveness (holistic care), continuity (therapeutic relationship) and co-ordination (overseeing care). These needs to be considered as part of quality assurance processes.
- GP Clusters need to be integral to quality improvement in the Primary Care Improvement Plan: early identification of necessary data collection is crucial
- The Partnership will continue to support Edinburgh CQLs in undertaking the Quality Academy programme, and extend that to PQLs.
- Further develop Public Health and Cluster input, to develop and clarify the role of clusters and develop a framework for Quality improvement and assurance including the required development of capacity.

11. Funding

The resources and any associated outcomes and deliverables (aligned to the Scottish Government's National Performance Framework and the six Primary Care Outcomes) have been set out in the Primary Care Improvement Fund: Annual Funding Letter 2018-19. This has been based on the following principles set out in the MoU:

> *"Where appropriate these resources will be allocated to HSCPs through their NHS Board partners in line with the Scottish Government's National Resource Allocation formula (based on population need and taking account of geography and of life circumstances, including deprivation). Resources will be spent for the purposes set out in this Memorandum and in line with each HSCP Primary Care Improvement Plan to enable the transition to be managed and implemented effectively. The HSCP Plans must demonstrate how the funding will flow/be used to enable the redistribution of work from GPs to others and to optimise the role and functionality of the wider MDT"*

The Plan takes account of existing commitments notably Transformation & Stability (T&S) capacity injections and over a longer time period should also develop (post submission) to include funding from previous allocations, notably 17C and 'Next Steps'. We also note the Mental Health Strategy Funding which will deliver 800 more mental health workers (Scotland-wide) in a range of settings, including Primary Care.

The Edinburgh GMS base funding of c£80m has been uplifted by c£1.5m through application of a national formula. Practices have already been informed whether their income has remained stable or has been uplifted. The H&SCP does not have any discretion over these allocations.

Table 2 (below) sets out the anticipated funds available for application over the course of the PCIP.

In 2017/18 the Edinburgh IJB agreed that the NHS Lothian (£1.1m recurring) and the Scottish Government Transformation Funding (£0.66m non-recurring) should be combined to create the Edinburgh Transformation and Stability Fund. £0.5m was top sliced for agreed Lothian wide investments and £0.2M for City management investments required for the T&S Fund itself and the separately funded Link Working Network (leaving an in year balance of £1.1M for City investments directly used to create primary care capacity)

In 2018/19 the Scottish Government Transformation Funding disappeared, but was replaced by an additional £1.1m allocation from NHS Lothian, again top sliced by £0.7m. (Giving a balance of £1.5m available for direct primary care investments).

Recent Government correspondence confirms that **£45.75m will be released to HSCPs nationally** in 2018/19. The anticipated **Edinburgh** (recurring) resource resulting from this is **£3.8m**.

It is presumed that the (c£1m) existing investment in pharmacy support will come from this resource, as will the Link Worker network funding (£0.7M). Vaccination investments require further local clarity, but are presumed to be reserved for additional local capacity.

The GP income line is the income attached to the 50% contributions made when practices have (LHB funded) Transformation and Stability injections dedicated to their teams.

The £2.2m LHB funds for 2018/19 are already committed on T&S investments (& top slices) for 2018/19. A further c£1.7M is expected to be available for flexible investment on City priorities from the new contract funding. **This £1.7M is the initial focus of this Plan** and will allow us to begin work on a range of capacity creating improvements and have confidence in the effective investment of the increasing funds anticipated in subsequent years.

Table 2 Summary of Available Funding & Commitments

	2017/18	2018/19	2019/20	2020/21
SG Transformation Fund	**£0.66M**	**-**	**-**	**-**
LHB Stability Funds (T&S)	**£1.1M**	**£2.2M**	**£2.75M**	**£2.75M**
Lothian-wide investments **ANP training/Diabetes/Phlebotomy**	**(£0.5M)**	**(£0.5M)**	**(£0.5M)**	**(£0.5M)**
H&SCP Capacity **Link Worker Network** **Transformation Project Manager**	 **(£0.1M)** **(£0.1M)**	 **(£0.1M)** **(£0.1M)**	 **(£0.1M)** **(£0.1M)**	 **(£0.1M)** **(£0.1M)**
Sub Total	**£1.1M**	**£1.5M**	**£2.05**	**£2.05**
GP Income from T&S Programme		**£0.4M**	**£0.8M**	**£1.1M**
SG New Contract Funding (TBC) **Pharmacy (in place)** **Link Worker Network (in place)** **Vac Team??** **LHB Management Support** **New Contract income for Local Investment**	**-**	**£3.8M** **(-£1.0M)** **(-£0.7M)** **(-£0.2M)** **(-£0.2M)** **£1.7M**	**£4.5M** **(-£1.0M)** **(-£0.7M)** **(-£0.4M)** **(-£0.2M)** **£2.2M**	**£9.1M** **(-£1.0M)** **(-£0.7M)** **(-£0.6M)** **(-£0.2M)** **£6.6M**
Total Investment Income	**£1 .1M**	**£3.6M**	**£5.05M**	**£9.75M**

In summary, the two principle sources of funding are the New Scottish GMS Contract and the LHB funded Transformation and Stability (T&S) Programme. The T&S Programme will continue to fund practice specific dedicated injections of capacity, whilst the New Contract funding will be used for cluster or sub-cluster (or wider) collective investments during 2018/19. The T&S Programme investments are usually subject to a 50% salary contribution after 6 months if they have successfully replaced or augmented capacity. The collective investments made with the New Contract funds will not require any contributions from practices. This demarcation is anticipated to continue until at least the end of Phase 1 in March 2021. If sufficient funding for the implementation of the new contract is made available, reducing or eliminating these contributions in Phase 2 may be possible. Currently, they are widely regarded as a reasonable mechanism to guide access to limited resources.

Recruiting and deploying new staff into Primary Care with appropriate support needs to develop carefully to be effective. Over 40 new Primary Care staff were introduced in Edinburgh during 2017/18, and current support capacity needs to be increased if this rate is to be sustained. Effective use was able to be made of non-recurring underspends to quickly stabilise practices experiencing difficulties, to invest in new technology and to develop ‘tests of change’ where promising proposals for transformation were supported. Given the restrictions on available workforce in any given year, the H&SCP has already begun the conversation about use of non-recurring resources with City GPs. Some early suggestions have already attracted support for application of non recurring funding:

- Continuation of ‘technology fund’ e.g. acceleration of hypertension monitoring
- Additional CQL/PQL contract implementation capacity
- Additional QI capacity
- Public engagement and information programme
- Training at a variety of levels
- Flexible support for individual practices at risk
- Continuation of some tests of change begun in 2017/18

Diagram 4 Investment Summary – Edinburgh (2018/19)

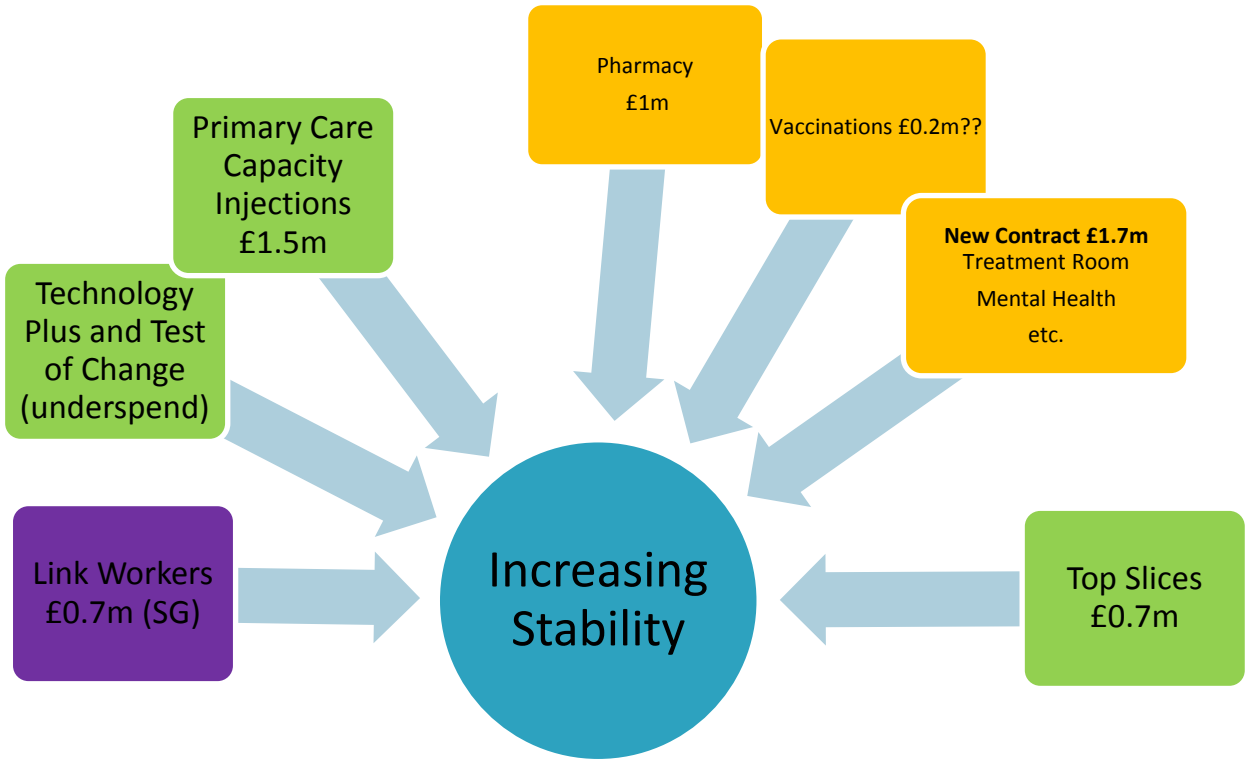


Diagram 4 illustrates how Transformation and Stability Programme funds and new contract funds combine.

12. Implementation

12.1 Progress to date/local background Transformation and Stability (T & S):

In June 2017 the IJB agreed that the Edinburgh Primary Care Support Team would establish the 'Edinburgh Primary Care Transformation and Stability Programme'

The June 2017 IJB paper anticipated the allocation of Edinburgh Link Workers from Scottish Government and the requirement for Programme Management capacity. The Link Worker Network has already been established as a constituent part of the T&S Programme

In the first six months of the Edinburgh Primary Care Transformation Programme, over 50 of the city's 72 practices were aided by either an 'injection' of new staff capacity, or additional workload related technology. Both staff and technology injections have been funded on a 50% basis (excepting Scottish Government Link Workers who are funded 100%, as specified nationally).

Available recurring funding has focused on additional staff, with in-year under spends supporting technology and associated investments to test new approaches as well as relieve particular pressures.

The recurring commitment of this program is £1.5m therefore utilising all of the available recurring funds for 2018/19 (after topslices). Further T&S investments for 2018/19 are therefore reliant on the anticipated income from the 50% contributions which were part of these agreements.

12.2 The New Contract.

The new contract funding will work well alongside the continuation of the 'Transformation and Stability' approach. The Edinburgh decision making and project support are already largely established.

It is proposed that any discretionary primary care funding made available to the HSCP by the Scottish Government in 2018/19 is passed to the Primary Care Support Team to be invested in individual practices, clusters and localities in accordance with the agreed Improvement Plan

Implementation progress will be reported to the NHS Lothian Oversight Group and to the HSCP Management Team on a quarterly basis, with progress report to the Edinburgh IJB in late 2018 / early 2019.

The 2017/18 funding has allowed investment in a Link Worker Network Manager and a Transformation Project Manager post. The Network Manager post was filled briefly on a temporary basis, but neither post has been able to be filled substantially pending a restructuring of the Primary Care Support Team which has been held up as part of the implementation of the EHSCP integration management structure. This capacity is urgently required to support the current and future effective investment of these funds.

In addition to project management capacity, strengthened clinical design capacity is required, both at medical leadership level and redesigning the supporting workforce. GP Sub-Committee representatives have been funded to facilitate proportionate involvement across Edinburgh during the formulation of the PCIP and additional capacity will be required throughout implementation. The capacity and time required for 'bedding in' new roles to practices and larger groupings should not be underestimated and needs to be supported effectively to have the workload impact sought.

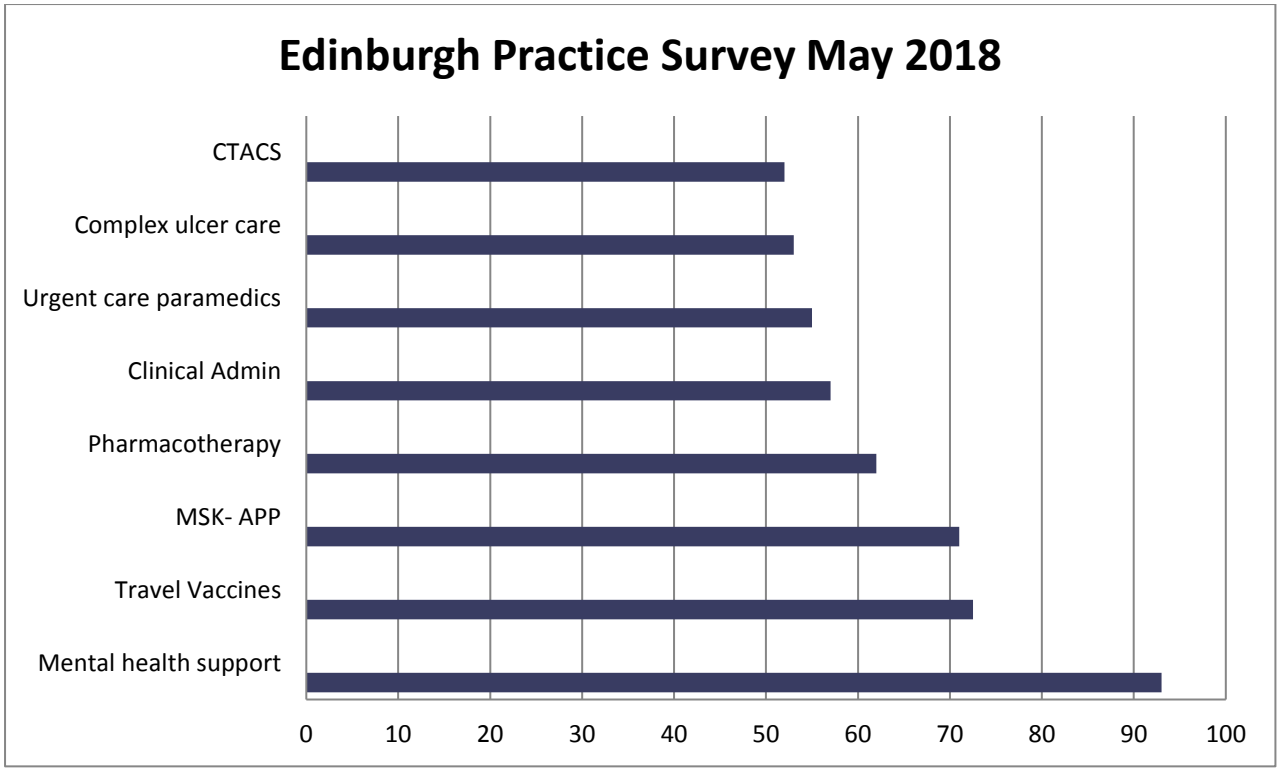
A governance structure has been proposed which would allow mutual support, exchange of ideas and helpful consistency across the four Lothian HSCPs

The obvious challenge is to combine the established T&S Fund support with the new contract resources in a way which strengthens and accelerates impact. An important understanding with practices which took the 50% T&S option was that they would not be disadvantaged in any sense by the roll out of the New Contract.

The availability of the new workforce is a widely held concern. The approach taken with T&S funding ie to utilise a wide range of capacity 'injections' has worked well in the initial stages. This should increasingly be matched with adjustments to national training programmes such as already made with pharmacy. Timescale for implementation will need to respond to the reality of new workforce availability as implementation proceeds.

Engagement with City GPs will continue after the EPCIP is submitted. The priorities for investment of the £1.7m have emerged through a series of meetings with GPs and a structured questionnaire. Funding and timescales will be allocated from the available £1.7M (TBC) against these areas as further work is undertaken to assess feasibility and impact**;**

The Edinburgh-wide practice survey gave the following preferences for the Improvement plan proposals:



Other areas (not covered in the survey) include premises & IT support and further tests of change/workstreams to ensure the other elements of the contract are developed for later implementation. The childhood vaccination programme is an urgent and immediate 2018/19 priority for the Practices who do not currently have this support, as is retention of the current provision for those who do.

It should be noted that the diversity of the City population is such, that a single consistent solution to alleviating workload is not going to be supported or effective or equitable. The application of the new resource will focus on improving or maintaining the floor of services for all practices (eg vaccinations) whilst encouraging local variation and testing the application of different elements of the contract. Again, the role of Cluster groups in helping to guide this investment is anticipated to become increasingly significant.

The national new contract priorities of vaccinations, pharmacotherapy and CTACS development have already been augmented by our early establishment of a Link Worker network. The message from Edinburgh GPs about additional capacity for mental health is

very clear and local work suggests very early benefits from improved clinical admin and signposting.

13. Outcomes, targets and indicators:

There is an urgent need to develop indicators to define how workload is transferred or reduced under the new contract. This is not straight forward when practices face widely varying pressures and have adopted many solutions to those over the years; when patterns of working vary widely, and when the alternative and new workforce is also diverse. We propose that many practices consider their in-house capacity in terms of GP sessions and want to consider that as a possible 'currency' for identifying successful workload transfer. This model also does not require analysis of current GP approaches, but rather sessions saved by the new developments. Using this proposition would promote debate with Lothian HSCP colleagues: the ideal would be co-development of a common model for use across Lothian. We would hope to liaise with Scottish Government and others who have already started examining outcome measures.

Some practices have undertaken internal audit work – for instance coding for reasons for attendance – and then looking at GP workload reduced by having a new advanced practitioner. This, and tally charts, involve additional work, but it may be that a selection of practices undertaking simple measures may provide some indicators for others. It is always difficult to get very busy clinicians to code – even for consultation type – which makes this work more difficult. The Primary Care Data management group is looking at other ways of capturing this information.
There are dangers, too, in generalising to other settings where GPs may work very differently. Outcomes – including workload reduction – are also very practitioner-dependent. Practitioners from specialist settings in particular need to work in very different ways in generalist settings where a different approach to patient care is needed. Some will require extensive training and coaching, and that time needs to be taken into account too.

Table 3 (below) begins to demonstrate the relationship between the injection of additional staff into the Edinburgh Primary Care system and how this relates to how pressure/ workload overload is expected to continue to develop. **At this stage we are not confident in the assumptions which underpin the figures – but have left in to illustrate our intentions**.

The first year (2017/18) describes a gap between medical sessions required (based on 1 session per 175 people) and medical sessions available based on Primary Care Contracting Organisation (PCCO) returns. All calculations should be treated with caution and will be revisited, since they can under-estimate or exaggerate the workload and capacity gap. For example, the average list size of 1800 is taken from a full time doctor working 9 clinical sessions to give 200 per doctor session. Furthermore, a ratio of 6.3 sessions per doctor on the Performers List is used from a census of Scottish doctors taken in 2013. The city figure may be materially different.

Table 3: Possible Model showing the Relationship between additional staff capacity and workload/ population increase (excludes SG Funded Linkworkers)

	2017/18	2018/19	2019/20	2020/21
Practice Population	550,000	555,000	560,000	565,000
Performer Medical Sessions Available (weekly est)	2250	2250	2250	2250
Medical Sessions Required[12]	2750	2775	2800	2825
Weekly Deficit Capacity in medical sessions	500	525	550	575
Funding Available see Table 2[13]	£1.1m	£3.6m	£5.05m	£9.75m
Additional WTE	25	84	117	227
Sessional Contribution[14]	75	252	351	681
Outstanding Sessional Deficit	- 425	- 273	- 199	+ 106

Note Linkworker investment (not shown) gives additional 15wte staff and c 15 sessions capacity.

Additional workload saved through technology investment and internal admin improvements also not yet assessed sufficiently robustly to be included.

[12] A planning assumption of 1 medical session per 200 patients has been used
[13] Includes GP income from T&S programme
[14] Average of 3 sessions per WTE has been used to relate impact of non-GP staff to GP workload based on current experience

14. Specific Outcomes (for further development)

The first expectation of the Edinburgh PCIP is to help support the city's practices to move away from what has been a period of unprecedented instability. There are;

Indicators of Stabilisation:

- Ensure no further practice faces situation where their contract needs to be returned (unless part of a planned change)
- Assess whether there is capacity to reduce the number of Edinburgh practices forced to declare their lists as 'restricted' (practices who restrict their lists report reaching a ceiling and must balance the number of registrations and de-registrations to keep the service safe and sustainable; others do not have the premises to expand - or insufficient clinicians - and so on).
- Prevent further practices transferring to 2c (currently 8) or needing 'intensive' support (c12 at any time)
- Increased number of GP partners (baseline 305)
- Reduced number of practices with GP vacancies (baseline to be established)
- Additional population absorbed onto GP lists
- GP wellbeing (use RCGP and other standard resources)

Indicators of capacity increase

- Number of additional staff engaged through either T&S or New Contract – the aim would be for 40 WTE, dependent on funding and personnel.
- Assessment of whether anticipated medical session injection average of 3 session's replacement/augmentation per additional wte is confirmed (range across new workforce).
- Agreement of the Specific outcome measures – delineating progress – and under each of the headlines of the new GMS contract *(with contract page numbers in brackets):*
- To include urgent Care services – number of practices covered per days of week for unscheduled home visits
- Vaccination services (28) – number of practice services transferred (for childhood programme and travel).
- Travel vaccine transfer to be complete by April 2019.
- Pharmacotherapy services (29) – number of new clinical pharmacists / technicians with sessions and number of practices benefitting.
- CTACS (32) – number established, services covered, secondary care workload transferred.
- Premises (39) – number of leases transferred, number of practices taking up GP sustainability loans; review of premises survey.
- GP Clinical IT services (42). There are to be national standards (p43):

- SLA delineating expectations of Lothian IT with implementation date of 30/9/18.
- Central server rollout (number of practices by….).
- Practice IT to receive Scottish average in terms of proportionate spend (primary / secondary care IT) - by Dec 2018
- Fast track of new IT for CTACS allowing staff to access TRAK.

Resources and supporting information

Information on existing programmes and outcomes is available but not attached;

- Edinburgh Health Needs Analysis by Locality (from Strategic Plan 2015)
- Edinburgh Primary Care Transformation & Stability Plan (IJB June 2017)
- Edinburgh Primary Care Premises Assessment (IJB September 2017)
- Edinburgh Strategy for Pharmacy Support to General Practice 2017-19
- Edinburgh Link Worker Network Update
- Edinburgh Primary Care Technology Investment Summary
- Edinburgh Primary Care Government Structure.
- Edinburgh General Practice demand groupings based on 2016 information
-Edinburgh Poll of New Contract preferences for implementation priorities
-Edinburgh draft list of supporting local implementation workstreams

Documents relating to process, governance and current situation:

- Representation and leadership structures and processes
- Clinical governance and quality
- Both overview and granular detail round premises, workforce, practice situations (vulnerability, gaps)
- Publication of detail of values and guiding principles
- Publication of agreed outcomes and data collection
- Documentation of lessons learnt.

Edinburgh Primary Care Improvement Plan (EPCIP)
Summary of Next Steps (29.05.18) – Appendix 2

Next Steps

- The establishment of a group tasked with the engagement and involvement of people and communities across Edinburgh, about how we reach a better balance between patient demand and our capacity to respond over the next decade.

Next Steps

- To engage with PMs to see what additional training or external support might be provided to complement the NES programme (end of 2018)
- To ask PMs whether they consider an increase in time funded to engage in relevant networks would be both feasible and worthwhile. The obvious parallel is to build on the existing PM network to create something like the GP Cluster arrangements to be able to more actively exchange the learning from each practice.
- To consider whether additional training support for practices could be offered to accelerate change.

Next Steps

- A review of the realistic time commitment required from the CQL group – including the opportunity to adjust expectations or perhaps vary expectations between clusters
- Agree what admin support is required to ensure that all clusters are able to function without CQL capacity being used inappropriately.'

Next Steps – Childhood Vaccinations

- A spreadsheet of Edinburgh practices outlining what staff undertakes childhood vaccinations currently, numbers of children of relevant ages and sessions required for this work (end of May 2018). Outcome of pilots to be known (end of June 2018)

- Agreement of approach and costings on the basis of spreadsheet information (end of July 2018)

- A timetable for practices not currently receiving support to be agreed (July 2018)

Next Steps – Travel Vaccinations

- Ask all practices to indicate the average number of travel vaccines done per month, including how many of those are eg family groups where there are time savings (end of May 2018) and what clinical software system they use (Vision or EMIS).

- Liaise with the WGH existing travel clinic to ascertain capacity and potential for expansion

- Establish a new travel vaccine clinic in a central location (Lauriston Place?)

- Agree timetable of travel vaccination work by end of July 2018, aiming for full arrangements in place by the end of 2018. After this, when a patient requests a travel vaccination, the practice should print off the existing vaccination record (this can be readily done in either Vision or EMIS) and give this to the patient to take to the travel vaccination centres.

- The practice needs to be informed of vaccines given: the ideal would be that this is automatically entered by the Travel Clinic Centres into practice electronic records

Next steps - Other Vaccinations

- Flu / pneumococcal vaccinations for the housebound should be done by appropriately resourced District Nursing (DN) teams, accepting that practices will continue to give as many as possible opportunistically. Current arrangements with an external team undertaking these within a small number of programmed sessions does not work well for logistic reasons. DNs already have a strong presence in the community and could efficiently give domiciliary vaccines for those not on their caseload by geographically (and opportunistically) linking them to their existing work

- The remainder of the adult vaccination programme will be scoped in 2019-20 with some workload transfer during that year and fully by 2021.

- Midwives leads should be consulted on the feasibility and timetable for giving all required vaccines (currently flu and pertussis) to pregnant women (September 2018)

Next steps – Pharmacotherapy

- We will assess whether there is capacity to offer regular sessional commitment to every practice for level one work (April 2019), with a specified proportion relating to reduction in GP workload

- We will continue to provide Level 2 and Level 3 services where they currently exist

- We will ensure (and fund through New Contract funds) a network of Designated Medical Practitioners (DMPs) to support pharmacists to become Independent Prescribers

- Using the T&S Programme fund we will assess with a number of individual practices, the impact of augmenting the ‘floor’ of service provided through New Contract funds

Next steps - CTACS

- Establish a dedicated task group which will start by surveying possible sites in Edinburgh, both in practices and at Lauriston Place (end June 2018)
- Discuss potential sites through GP Quality Cluster Groups to ensure relevance to each area.
- Begin with hospital procedures currently delegated to GP or time-consuming GP procedures (end October 2018)

- Lothian-wide interface work round hospital procedures delegated to CTACS.

- Practice-ordered bloods and simple measurements (BPs, urinalysis) to remain with practices initially – for review 2019-2020- as require new IT arrangements to be efficient and safe and the new services need to be very cost-effective.

- Establish Clinical Administrator posts, so that patients no longer ask GPs for hospital-generated results. These new posts have the added benefit of helping patients ‘navigate’ the system.

Next steps – Urgent Care:

A SLWG (City or Lothian) should be quickly established (June 2018) to begin work on the development of this element of the contract. Further potential steps are outlined below as a basis for initial action;

- Establish paramedic availability and interest; administration and governance
- One option is for every practice which might have an interest in a delegated house call service to provide data on house call numbers - suitable for this service
- Practices be asked to indicate which of those house calls could have been potentially managed by bringing the patient to the practice, if appropriate transport was available.
- Paramedic staff to consider an early pilot to manage a defined proportion of afternoon house calls on a cluster-wide basis (end of August 2018). This might benefit those with severe GP timetabling pressures with populations liable to be more chaotic in requesting housecalls, allowing best use of a limited resource. Others may benefit from a specified morning input. The team could then also be available for early evening LUCS work, covering a time when it is difficult for working GPs to reach out-of-hours bases and may provide an incentive for more GPs to do that work.
- By April 2019, aim to cover all appropriate afternoon unscheduled house calls and complete scoping work for covering a proportion of morning calls. This is likely to be limited by practitioner availability as much as funding, so could not be universal. In order to cover this work, include a small number of ANPs would ideally be incorporated in any fledgling service, which will also enrich learning and development for both professional groups.
- (Until we have house call data, we do not yet know what capacity is needed, so this work will need an ongoing scoping and PDSA approach).

Next steps – ANPs:

- Continue to support ANP training in Lothian
- Include some ANP presence in the Urgent Care service
- Further assess cost-effectiveness in Care Home settings
- Further deployment in practices and assessment of impact with existing investments.
- Support new ways of working (with the associated training) for PNs
- Explore new ways of targeting care – eFrailty models.
- Consider funding interested GPs to attend hospital at home training

Next steps –MSK focussed Physiotherapy Services

- Some localities have already asked practices if they wish to have access to an APP. Ask all practices if they are interested, a pre-requisite for involvement being 'front door' signposting (end of May2018).
- Initial telephone management is key, and may be by receptionists (sign-posting) or GPs or APPS (triage and management). Consider piloting telephone advice as part of the service – this would be a means of managing consultations rather than an alternative to the non-specialist led NHS24 MSK line.
- Establish means of referral to others: the Forth Valley pilot indicated that APPs not only referred to orthopaedics but also to falls' services, podiatry, and weight and pain management services too (by September 2018).
- Two practices will run pilots using T&S money for in-house programmes as a test of change, and others to be based at Cluster or Sub-Cluster level (see Diagram 2): one FTE APP per locality by Sept 2018; and adding a FTE per cluster p.a. for the next 3 years, with full review of model each year.
- Take account of academic work on APP implementation in Primary Care (WJ)
- Agree data collection and outcomes – readily available from existing programmes and guidance but would include 'containment' (self-management, no onward or GP referral); patient satisfaction; accessibility; prescribing etc.

Next Steps - Community Clinical Mental Health Professionals

- Explore ways of ascertaining practice workload which can be undertaken by a Mental Health Professional
- Assess the relative merits of the available models of delivery (August 2018).
- Continue to embed Mental Health Professionals in high need practices (ongoing).
- Establish appropriate model for local networks – and whether those are appropriate for Edinburgh (Nov 2018) - with a view to beginning to establish those by April 2019.
- Consider the potential for extra capacity to be provided through the Third Sector.

Next Steps – Link Workers

- Establish outcomes – numbers of patients referred, numbers seen, success of onward referral
- Identify a small number of practices for more in depth assessment of success looking at more detailed data and qualitative work too (GP consultation rate before and after intervention, patient engagement and 6 and 12 months; accessibility and so on). (April 2019)
- Access outcomes of the Link Worker in the elderly non-deprived pilot practice (Dec 2018)
- Develop signposting throughout Edinburgh through dialogue with public and dissemination of supporting materials.

Next Steps – Clinical Administration

- Review of pilots and develop a coherent work stream (modelling) for Clinical Administration Workers. There is much room for rationalisation of processes and staff working.
- Review registration and deregistration automation pilots and roll out to all practices.
- Ensure capacity for training staff on IT application
- Ensure adequate IT systems management support to maximise potential and capacity of current IT system

Next Steps - Development of cluster involvement

- A Cluster Quality Lead (CQL) have been invited and participated in the writing of, and review, of the Implementation Plan.
- Each Cluster was asked to review the PCIP in its Cluster Groups and to seek individual feedback with all constituent practices through PQLs;
- Clusters will be key in co-producing documentation on outcomes, quality improvement and assurance

Next Steps – Premises:

- Continue to keep a register of practice premises and perceived needs. Formally review the SG-led premises survey results
- Jointly HSCPs discuss with the Board the additional staff needed for premises management.
- Establish the priorities for the GP Sustainability Loans (p40)
- *"NHS Boards will ensure that GP contractors are provided with fit-for-purpose accommodation which complies with the standards set by the Premises Directions"* (p41): support any practices who assert that these standards are not being met.
- GPs with private leases which expire prior to 2023 should have the option of Boards taking these over if requested (or finding them alternative accommodation (p41). The EHSCP may need to support practices in this process.
- Continue to develop the Edinburgh Primary Care Support Team Premises work stream to manage and monitor all the above.

Next Steps – District Nurses

- Seek advice on how best to approach the potential for long term constructive and dynamic relationship with District Nursing services to complement arrangements already developing within clusters.
- Establish SLWG

Next Steps – Generic Services

- HR provision reviewed with a new SLA
- Review of other managerial, advisory and data support services
- Adequate IT support to ensure safe and efficient clinical working with the added capacity necessary for New Contract implementation defined
- New Contract implementation becomes a standing item for the Interface Group
- Premises support capacity was highlighted in the premises section.

Next Steps – Quality

- The 'four pillars' of General Practice need to be maintained: contact (access), comprehensiveness (holistic care), continuity (therapeutic relationship) and co-ordination (overseeing care). These needs to be considered as part of quality assurance processes.
- GP Clusters need to be integral to quality improvement in the Primary Care Improvement Plan: early identification of necessary data collection is crucial
- The Partnership will continue to support Edinburgh CQLs in undertaking the Quality Academy programme, and extend that to PQLs.
- Further develop Public Health and Cluster input, to develop and clarify the role of clusters and develop a framework for Quality improvement and assurance including the required development of capacity.

Appendix 3 – Glossary of Abbreviations

ACPs	Anticipatory Care Plans
ANP	Advanced Nurse Practitioner
APP	Advanced Physiotherapy Practitioner
BP	Blood Pressure
CEC	City of Edinburgh Council
CQL	Cluster Quality Lead
CTACS	Community Treatment and Care Services
DMP	Designated Medical Practitioner
DN	District Nurse
EH&SCP	Edinburgh Health and Social Care Partnership
EMG	Expert Medical Generalist
GP	General Medical Practitioner
HV	Health Visitor
IJB	Integration Joint Board
IM&T	Information Management and Technology
LHB	Lothian Health Board
LMC	Local Medical Committee
LUCS	Lothian Unscheduled Care Service
MoU	Memorandum of Understanding
MSK	Musculoskeletal
NES	NHS Education for Scotland
PCCO	Primary Care Contracting Organisation
PCIP	Primary Care Improvement Plan
PDSA	Plan, Do, Study, Act
PM	Practice Manager

PQL	Practice Quality Lead
QUOF	Quality and Outcomes Framework
SLA	Service Level Agreement
SLWG	Short Life Working Group
STU	Scottish Therapeutics Utility
T&S	Transformation and Stability
WGH	Western General Hospital

Primary Care Improvement Plan (PCIP)
Plan Development Actions

	Action	Key Date(s)	Progress	Lead	Complete
1.	Development of the 'design' elements on 20.02.18 by the Edinburgh Primary Care Support Team incorporating GP Sub-Committee membership	20.2.18	Meeting held Dr M	DW/CLs/ E.McG	√
2.	Consultation with GP reps / clusters Practice Managers across the city	March – May 18	Meetings held/ongoing	DW/CLs	√ (12 presentations made to primary care groups as plan developed)
3.	GP 1st 'open meeting to discuss new GMS Contract and Primary Care Improvement Plan	20.3.18	Open meeting held	DW/CM	√
4.	Writing group meetings	29 March/10 April /others	Meetings held	DW/CM/ R.McD	√
5.	Widely circulated Primary Care consultation draft	13.4.18	Draft circulated for comments	DW/CM/ R.McD	√
6.	Second GP 'open meeting to discuss new GMS Contract and Primary Care Improvement Plan	17.4.18	Meeting held – follow up notes prepared	DW/CM/ R.McD/C Ls	√
7.	Advice sought over Patient Engagement / Carer Engagement	18.4.18	Anne-Marie-Comber/MM asked	DW	√
8.	Primary Care Management team session on PCIP Questionnaire sent to all GPs asking them to indicate preferences under the 'discretionary' contract elements. 55 (from 72) City practices responded with good representation	1 May 18 30/4/18 – sent 24/5/18 – results	Melanie M. attending	DW/MM	√

	from all 5 'demand groupings'.	complete and compiled.			
9.	Prof Advisory Group	08.05.18	Carl emailed 18.4	DW	√
10.	May 2018 draft finalised along with summary paper for governance & re-circulated to GPs & wider stakeholders	8.5.18		DW	√
11.	May 2018 draft available for public comments through CEC portal/NHSL Twitter account	8.5.18	NHS Coms emailed 19.4 & again 9th may	DW	Not actioned
12.	Stakeholder events to ensure that localities, other strategic programmes, Staff Partnership have opportunity to comment	9.5.18 23.5.18	Invite sent 20.4.18	DW/RN	√ (0 & 8 attended sessions)
13.	H&SCP Strategic Planning Group Paper submitted	11.05.18	Wendy asked to put on agenda	WD	√
14.	Submission to EH&SCP Senior Management Team/proxy of the APM on 28th may.	17.05.18	Paper submitted	DW	√
15.	Draft submitted to Lothian Primary Care Contract Implementation (oversight) Group And to second meet	27.4.18 24.5.18 (tbc)	Meeting on 3.5.18	DW	√
16.	3rd & final GP open meeting before submission	16.05.18	Book meeting room, circulate email, tea/coffee	RN	√ (strong GP and PM attendance)
17.	Potential dedicated Carers/Patient/Third Sector events	EVOC 24.5.18 Carers 31.5.18	MM/EVOC/AMC to advise		√
18.	Equality Assessment (EQA)	22.5.18	Sarah bryson /kate burton agreed to establish	NP	√
19.	Writing Group make final changes (invite all CLs)	(24.5.18) 31.05.18	Emailed on 18 April to establish	DW	√
20.	GP Sub for signoff (date for submission)	11.06.18 (4.6.18)		DW	
21.	Staff Partnership Forum (meeting too late for changes to	13.06.18	Noreen/Helen	DW	

	document)		emailed (18.4.18)		
22.	Submission for IJB(Agenda planning meet)	15.06.18 (28.5.18)		DW	
23.	Submission to Scottish Government	01.07.18			