AGENDA ITEM No.8

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board
Agenda Item	8
Title	East Renfrewshire HSCP Primary Care Improvement Plan

Summary

This report outlines the ambitions to be delivered via the East Renfrewshire HSCP Primary Care Improvement Plan, in line with the Memorandum of Understanding.

Presented by	Kim Campbell, Localities Improvement Manager

Action Required

The Integration Joint Board is asked to note the content and ambitions in line with the Memorandum of Understanding and approve the plan to allow this to progress to implementation.

Implications checklist – check box if applicable and include detail in report

☒ Financial	☐ Policy	☐ Legal	☐ Equalities
☐ Risk	☒ Staffing	☒ Property/Capital	☐ IT

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

15 AUGUST 2018

Report by Chief Officer

EAST RENFREWSHIRE HSCP PRIMARY CARE IMPROVEMENT PLAN

PURPOSE OF REPORT

1. This report provides the Integration Joint Board the ambitions outlined in the East Renfrewshire Primary Care Improvement Plan.

RECOMMENDATION

2. The Integration Joint Board is asked to note the content and ambitions in line with the Memorandum of Understanding and approve the plan to allow this to progress to implementation.

BACKGROUND

3. The 2018 Scottish GMS contract is intended to allow GPs to deliver the four Cs in a sustainable and consistent manner in the future.
   - Contact – accessible care for individuals and communities
   - Comprehensiveness – holistic care of people - physical and mental health
   - Continuity – long term continuity of care enabling an effective therapeutic relationship
   - Co-ordination – overseeing care from a range of service providers

4. Refocus of the GP role as expert medical generalists building on the core strengths and values of general practice:
   - expertise in holistic, person-centred care
   - focus on undifferentiated presentation
   - complex care
   - whole system quality improvement and leadership

5. This means some tasks currently carried out by GPs will carried out by members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care.

6. To help ensure sufficient, visible change in the context of a new contract, it was agreed to focus on a number of specific services to be reconfigured at scale across the country. These priorities outlined in the MOU include:
   1) *The Vaccination Transformation Programme (VTP)*
   2) *Pharmacotherapy Services*
   3) *Community Treatment and Care Services*
   4) *Urgent Care (advanced practitioners)*
   5) *Additional professional clinical and non clinical services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services*

REPORT

7. Following on from our local engagement process, our local GPs have agreed and signed off the Primary Care Improvement plan

8. The NHSGG&C GP Sub-Committee supported the development of this plan.

9. It has been agreed that over the next 3 years we will endeavour to extend the primary care multi-disciplinary team employing a number of Advanced Nurse Practitioners, Pharmacists, Link Workers, and Community Phlebotomists and to create locality Treatment Rooms.

10. Support to deliver the ambitions of the PCIP and measure the impact of changes locally has been recognised. A proposal to share the cost of an 'Improvement Officer Post has been agreed, with a 50:50 split.

11. Some of these primary care multi-disciplinary team members will be attached to individual practices but inevitably, in some cases, resources may have to be shared between different practices. GP clusters will have an important role in facilitating cross practice working including developing common working practices and pathways.

12. There is enormous potential for improving local population health, including mental health, through GP clusters, better data on population health needs and better intelligence and facilitation through LIST analysts and links with the Adult Health & Care Localities Improvement function.

FINANCE AND EFFICIENCY

Funding

13. The confirmed funding for year 1 is £714k and we have made assumptions about years 2 & 3 based upon a proportionate share of the indicated future years. The full year effect of a year 1 plan would cost £932k and this would be £218k over the available funding. However given the timing of year 1 our part year effect will cost £595k and this will result in a minimum level of slippage of £119k to carry forward. Our year 2 plans exceed the assumed funding by £82k and this will be funded in full from year 1 monies brought forward.
14. Our year 3 plans are estimated at £1599k which is £285k over the assumed funding. Once we are clearer about year end funding from year 2 likely funding we can review and scale our plans accordingly.

15. Appendix 1 outlines the funding profile

IMPLICATIONS OF THE PROPOSALS

Risk

16. A significant risk in delivering the ambitions outlined in the PCIP is the lack availability of skilled staff to meet the phased level of recruitment, given demand for these staff groups across Scotland.

Policy

17. None

Staffing
18. Line Management of the extended Primary Care Team needs to be agreed.

Legal
19. None

Property/Capital
20. Space to provide services within GP practice space and within our HSCP premises will need to be considered.

Equalities
21. None

IT
22. Some enabling costs may arise to equip staff to access appropriate equipment and software programmes.

CONCLUSIONS

23. East Renfrewshire Primary Care Improvement Plan has been co-produced in line with the guidance and MOU priorities. The phased implementation of the resources outlined should facilitate the creation of a wider multi-disciplinary team allowing demand for GP services to shift.

24. Recruiting to posts may be challenging due to skills shortage and demand across Scotland for similar staff groups.

RECOMMENDATIONS

25. The Integration Joint Board is asked to note the content and ambitions in line with the Memorandum of Understanding and approve the plan to allow this to progress to implementation.

REPORT AUTHOR AND PERSON TO CONTACT

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June 2018

Chief Officer, HSCP: Julie Murray

BACKGROUND PAPERS

General Medial Service Contract
https://www.gov.scot/Resource/0052/00527530.pdf

IJB Paper: 14.02.2018, Item 9: 2018 GMS Contract
http://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=21802&p=0

Appendix 1

Primary Care Improvement Plan	Year 1			Year 2		Year 3	
	Full Year 2018/19		Part Year 2018/19	Full Year 2019/20		Full Year 2020/12	
Services	**WTE**	**£'000**	**£'000**	**WTE**	**£'000**	**WTE**	**£'000**
Pharmacist (Band 7)	6.0	287	241	8.5	406	19.0	908
Pharmacy First	1.0	20	20	1.0	20	1.0	20
Advanced Nurse Practitioners (Band 7)	3.0	164	41	3.0	164	3.0	164
Advanced Practice Physiotherapists	1.0	56	28	1.0	56	1.0	56
Community Link Workers	1.0	20	10	4.0	80	4.0	80
Healthcare Assistants (Band 3)	3.0	73	18	3.0	73	3.0	73
Treatment Room Nurses (Band 5)	3.0	99	25	3.0	99	3.0	99
Treatment Rooms Equipment Set Up			20				
Vaccine Transformation Programme	0.0	156	156	0.0	156	0.0	156
CQL Sessions		15	15				
PCIP Project Support Officer	1.0	42	21	1.0	42	1.0	42
Total Cost	**19.0**	**932**	**595**	**24.5**	**1,096**	**35.0**	**1,599**
Total Funding Available*		714	714		1,014		1,314
Surplus / (Shortfall)		(218)	119		(82)		(285)

*Year 1 confirmed, Years 2 & 3 assumed
Part Year Effect and one off investments in Year 1 result in slippage to offset year 2
Table shows cumulative cost of services

EAST RENFREWSHIRE
HEALTH AND SOCIAL CARE
PARTNERSHIP

Implementation of 2018 General Medical Services (GMS) Contract 2018 – 2021

East Renfrewshire Primary Care Improvement Plan (PCIP)

July 2018

Contents

A Local context

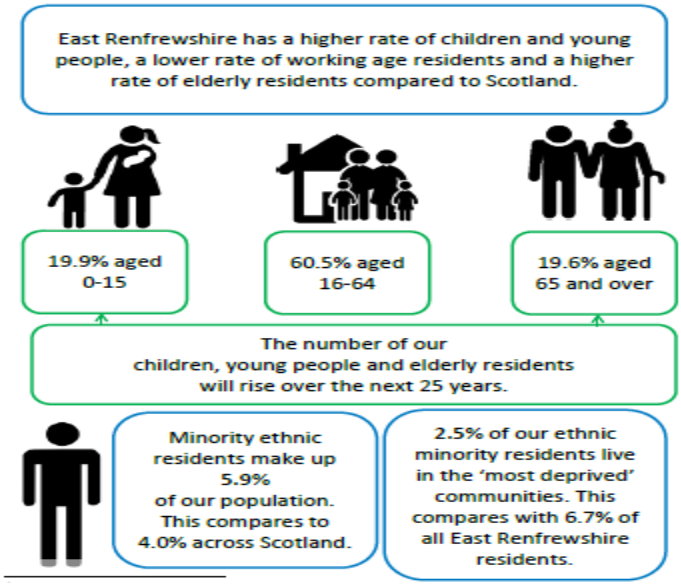
As a longstanding integrated partnership East Renfrewshire HSCP has developed strong relationships with many different partner organisations. Engagement and relationships with GPs across the HSCP is well established.

Our Population

The 2017 Mid Year Population Estimates have been published by the National Records of Scotland and show that East Renfrewshire continues to grow. The NRS estimates that the Authority now has a population of 94,760 (as at June 30th 2017), a rise of 950 (+1.01%) from the 2016 estimate. Only Midlothian (+1.7%) and City of Edinburgh (+1.2%) experienced higher increases in the past year.

The population is projected to rise by 17% over the next 25 years; this is significantly higher than the Scotland-wide projection of 5%. Our over-75 population is projected to grow by 34% over the next 10 years (7% higher than Scottish projections) and by 85% over the next 25 years (6% higher than Scotland) based on *NRS 2016 Mid Year* projections.

We expect to see a decline in death rates and to have an increase in the number of households, as more people live alone. East Renfrewshire is already one of the most ethnically and culturally diverse communities in the country and we expect this trend to continue.



Migration, has had a marked effect on the change of East Renfrewshire's population. For the past year, the NRS shows a total in-migration of 4,021, with an out-migration of 3,063, resulting in a net population gain through migration of 958. A further analysis of the origins of the migrants shows East Renfrewshire has the largest proportion of migrants moving to the area from elsewhere in Scotland. Of the 4,021 people estimated to have arrived in East Renfrewshire, about 86% were from elsewhere in Scotland, about 11% were from the rest of the UK and about 3% were from overseas.

The implications are that:

- Unlike some areas within Greater Glasgow and Clyde, East Renfrewshire's population is increasing
- Both our youngest and oldest populations are increasing. These are the groups which are the greatest users of universal health care services
- People over 80 are the greatest users of hospital and community health services and social care. East Renfrewshire is attracting people of this age because more retirement and care homes are choosing to open in our area. This puts significant pressure on GPs due to new patient registrations and growing complex list size.
- People with complex health conditions and profound and multiple disabilities are living longer and require intensive health and social care supports
- Growth in population is increasing demand for GP registrations within the G77 6 post code area. The projections for further growth in this area may result in the need for a new GP premises to meet the demand. Capital funding stream is unknown. (see section H & L)

Localities

East Renfrewshire HSCP Strategic Plan 2015-18 we divided the area into three localities based around our GP clusters. Since the last plan our GP clusters for the Eastwood area have changed with the GPs in the Eastwood Health and Care campus forming one cluster and the other Practices in Newton Mearns and Clarkston forming the other cluster. As GP practice populations do not reflect natural communities we have found it difficult to coordinate this approach so moving forward we propose to move away from a cluster-based locality model. We will develop two localities one for Eastwood and one for Barrhead. The population split is Eastwood 74% and Barrhead 26%. The new localities also reflect our hospital flows with the Eastwood Locality linking to South Glasgow hospitals and the Barrhead Locality to the RAH, which is part of Clyde.

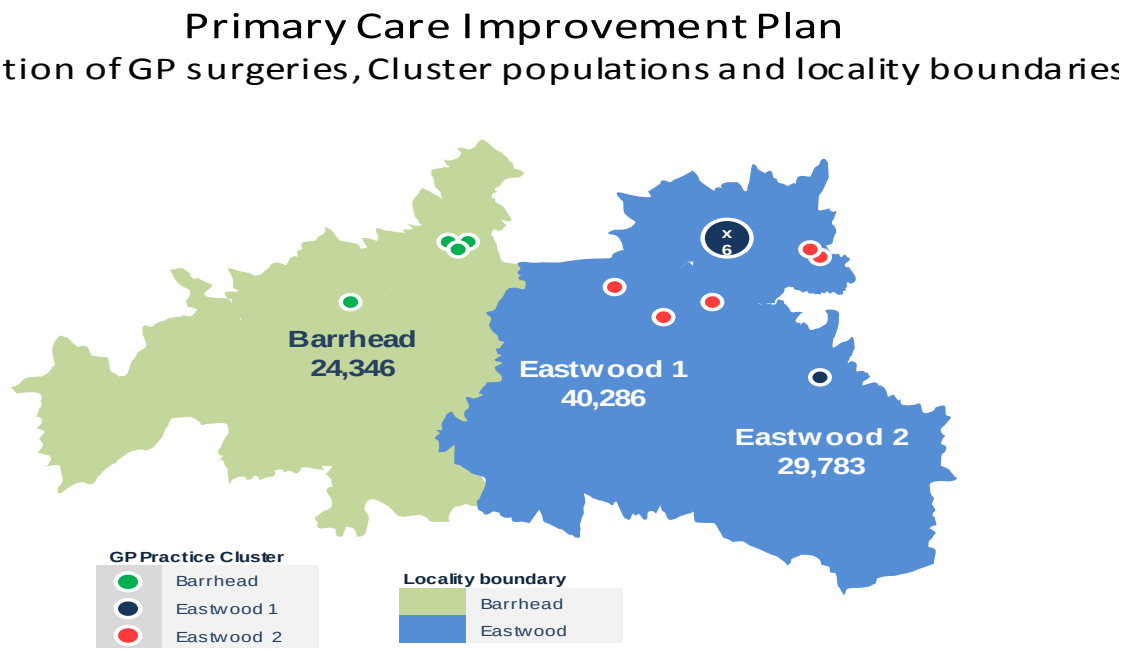
General Practitioner Provision

Across East Renfrewshire there are in total 15 GP practices serving a patient population of 94,874, as at July 2018. Practice list sizes range from our smallest practice with 2,031 patients to our largest practice hosting 12,719 patients. The average list size is 6,325; higher that the Scottish average of 6000 patients.

GP Clusters

GP Clusters were implemented in East Renfrewshire CHCP in 2014 as part of our Rehabilitation and Enablement Service (RES) redesign. Consultation with RES staff highlighted the benefits of alignment with District Nursing services to GP practices, with key benefits being improved relationships and communication. In response, 3 GP Clusters were developed with named GP leads in each practice. This meant that in 2016 when GP clusters were introduced in Scotland with the 2016/17 GMS agreement between the Scottish GP Committee and the Scottish Government, the change had a smaller impact. However, the stronger focus on bringing together individual practices to collaborate on quality improvement projects with PQLs and CQLs in place has been beneficial in strengthening relationships with the HSCP, GP peer group and Practice Manager peer group.

East Renfrewshire GP Clusters



The practices are listed below by cluster with the list size as at July 2018 in parentheses.

Eastwood 1 Practices	Eastwood 2 Practices	Barrhead Practices
Drs Morrice, Masson, Geddes & Andrews (7213)	Sheddens Medical Practice (2031)	Levern Medical Group (8626)
Drs Boardman, King, Earl & Boyd (6659)	Mearns Medical Centre (12719)	Glennifer Medical Group (8468)
Eastwoodmains Medical Practice (4688)	Broomburn Medical Centre (2835)	Oaks Medical Practice (3687)
Elmwood Medical Practice (3080)	Greenlaw Medical Practice (4413)	Neilston Medical Practice (3653)
MacLean Medical Practice (8753)	Carolside Medical Centre (8178)	
Williamwood Practice (9871)		

Primary Care Activity

Across the HSCP there is on-going improvement activity. Our Quality Clusters are developing well with really positive engagement with GP, Practice Managers and the HSCP evidenced across the 3 clusters. East Renfrewshire HSCP provides support to the clusters including administration support, LIST analysts and Improvement & Performance Management support. Sharing of best practice around managing patient demand and practice capacity, flu vaccination uptake rates and safe prescribing are some examples of quality improvement topics to date.

As a result of a presentation from our LIST analyst focussing on High Health Gain Individuals a test of change was developed and is underway. Below is a comment from a local GP:

Our experience of doing "High level ACP's" has so far been positive. We wanted to spend up to an hour with patients looking at relevant medical, social or mental health problems to see if there opportunities to improve their health or involve other support agencies where appropriate. We utilised the Anticipatory Care Plan as a way of recording the outcome.
Patients have been highlighted for a higher level ACP by being on the High Health gain list. Activities undertaken during a high level ACP include meeting with the patient to family and talk through their expectations and their desired ceiling of care. It is also a chance to update the KIS and discuss VOD and DNACPR and put the forms in place.
I think this is something that ANPs would be excellent at doing and would thereby contribute to a reduction in Emergency admissions by having these conversations with patients and their families at a point where their health starts to deteriorate and they start on the downward spiral of increasing frailty. As soon as a patient becomes infirm enough to have a house visit then an ACP should be considered to determine future wishes and support needs should their health continue to deteriorate.

As a result of this feedback, the other clusters are keen to also target High Health Gain individuals for in-depth anticipatory care work and planning for future illness.

Family Wellbeing Service

The Family Wellbeing Service is a partnership between East Renfrewshire HSCP, local GP Practices, and Children 1st to provide a targeted service intervention to children and young people experiencing significant mental and emotional wellbeing concerns. Based within the Eastwood Health and Care Centre in Clarkston the programme has initially been commissioned as a one year pilot taking direct referrals from two predetermined GP practices.

The need to introduce the Family Wellbeing Service and test the effectiveness of its family centred approach was based on the recognition that many East Renfrewshire children and young people have presented at universal services particularly GP's with requests for support around anxiety, depression, distress, and associated behaviours which are symptomatic of relational disconnection and trauma. Many local professionals and parents have expressed worry about the wellbeing of children and young people and have called upon specialist and clinical services like CAMHS, or Educational Psychology to respond. Services have become overwhelmed often inappropriately which in turn has resulted in long delays before help is offered, if indeed it is offered at all.

The pressure on CAMHS is not unique to East Renfrewshire, in fact this is a national issue where Tier 3 services process large volumes of referrals and in particular referrals where restorative family support may be a much more effective approach. Over the last eight months the Family Wellbeing Service pilot has tested this assertion and as will be demonstrated has deployed a unique approach to supporting children as well as their families. Ensuring the needs of children within their family context, are identified quickly and early help is made available is key to eliminating distress in the child or family, reducing demand for clinical treatment services, and overall promoting resilience in the child and family

The Family Wellbeing Service approach can be summed up as follows:

- Ensure that children's presenting needs are held within the context of family and community.
- Effectively and honestly engage with parents, children and young people to fully understand the stories behind the presenting symptoms
- Ensure prompt early help is offered to improve the emotional wellbeing of children and families.
- Prevent unnecessary referrals to specialist clinical services
- Improve the connection, relationships and resilience of families.

In the eight months the service has been operating there have been 50 referrals, 42 of which met service criteria. Early indications would suggest that the service is having a positive impact and improving outcomes

for the users of the service. Evaluation mechanisms are in place to track and report on impact and an external evaluator has been appointed to assist with this task. Feedback from stakeholders is hugely positive especially GPs and schools.

The intention is to continue to fund the service for another year and extend the coverage to additional GP practices. This will test the effectiveness more robustly. However, funding as we go forward is unclear and further work is required to secure the resources required to ensure the service is more widely available.

Feedback from one of our GP Practices positively reviews this value of this service is outlined below:

> There has been a very positive response to use of the children's first service within Mearns medical practice with all clinicians reporting they found the service extremely valuable at a recent feedback meeting on the service on the 9th May with an external reporter. It provides a tier 2 service thus fulfilling a previously large unmet need amongst young people with mental health difficulties and their families who did not met the referral criteria for CAHMs. Clinicians anecdotally reported reduced further patient contact and need for follow up following initial referral.
> The service was well promoted initially with supplementary written information and good links were established after an initial meeting with representatives from children first. The service was easily accessible through telephone referral and all referrals were accepted and feedback from the service was that they were all appropriate. Children first would refer on to the CAHMs service if a progression of illness occurred reducing GP workload and GPs reported a reduced referral rate to CAHMs. Moreover, it provides a service when schools which would normally provide tier 1 services are closed during school holidays.
> In summary, the Children First service represents an excellent use of a non medical model fixing family issues. It helps improve care and outcomes for families halting progression of mental health issues prior to these becoming tier 3 issues. All GPs in the practice were very impressed with the service and there was a unanimous consensus that they would like this service to continue.
>
> - Local GP

Signposting

The need to have patients seen by the most appropriate healthcare professional, which may not be the GP, is acute; most practices are struggling to keep up with demand, and many GP appointments effectively end up with the GP signposting elsewhere. An audit conducted with practices across the HSCP demonstrated that 40-65 % of GP appointments did not need a GP at all and would have been best served by other allied health professionals. To reduce frustrations for both GP and patient, all clusters have been working on signposting activities. Know Who to Turn to materials are displayed as A1 posters and 6-foot high banner formats in both localities and have been made available to patients in the form of A6 leaflets (Eastwood) and business cards (Barrhead). Furthermore, a simple, user-friendly website at www.knowwhototurnto-eastren.co.uk has been created, for all GPs to add to their own practice websites and for patients to access directly. These resources tap into the already existent NHS Inform and NHSGG&C Know Who To Turn To websites. Practice staff in all the GP practices are receiving signposting training so that they know what to say to patients and how to direct them to the appropriate destination and/or information.

B Aims and priorities

HSCP Primary Care Improvement Plans will enable the development of the expert medical generalist role through a reduction in current GP and practice workload. By the end of the three-year plans, every practice in GGC should be supported by expanded teams of board employed health professionals providing care and support to patients.

East Renfrewshire Health and Social Care Partnership, supported by our GP Sub-committee representative will develop a three-year Primary Care Improvement Plan. This plan will enable the role of the GP moving forward to evolve in to the expert medical generalist. The new GP role will be achieved by embedding multi-disciplinary primary care staff to work alongside and support GPs and practice staff to reduce GP practice workload and improve patient care.

This model which will be extended to both 17C and 17J Practices, will allow the general practitioner to fulfil their new role of supporting a wide range of clinical professionals, working as an expert medical generalist and senior clinical decision maker within multi-disciplinary community teams. The key contribution of GPs in this role will be in:

- Undifferentiated presentations
- Complex care in the community
- Whole system quality improvement and clinical leadership

Additional staff, who will be Board-employed health professionals, will form part of a transformational service redesign over the next three years with the development of the multi-disciplinary team to support general practice. The HSCP will work with the Board and staff partnership in the co-ordination of recruitment of staff and potential re-design of existing roles. Staffing appointments will be consistent across NHSGG&C in terms of grading, and role descriptors.

The 2018 Scottish GMS contract is intended to allow GPs to deliver the four Cs in a sustainable and consistent manner in the future.

- Contact – accessible care for individuals and communities
- Comprehensiveness – holistic care of people - physical and mental health
- Continuity – long term continuity of care enabling an effective therapeutic relationship
- Co-ordination – overseeing care from a range of service providers

Principles we wish to adhere with this PCIP are:

- Equality of care regardless of age, gender or physical and cognitive ability
- Patients being treated as close to home as possible
- All HSCP professionals working to the top of their licence
- All patients/clients seeing the most appropriate professional for their health and wellbeing needs
- Reducing the unscheduled care burden

Priorities

The initial plan will be available by July 2018 with priority for year 1 focusing on locally tested approaches and evidence where there has been a positive impact on GP workload. This includes:

- The Vaccination Transformation Programme (VTP)
- Pharmacotherapy services
- Community Treatment and Care Services (Health Care Assistants and Treatment Room Nurses)
- Urgent Care (Advanced Nurse Practitioners, ANP)
- Additional Professional Roles (Advanced Physiotherapy Practitioners, APP)
- Community Mental Link Worker (CLW)

Years 2 and 3 will be used to continue to define models and approaches in areas where this is not yet fully developed and include:

- Community Treatment and Care Services (Community Treatment Rooms)
- Additional Professional Roles Community (Clinical Mental Health Professionals)

The extent and pace of change to deliver the changes to ways of working over the three years (2018/21) will be determined largely by workforce availability, training, competency and capability and the availability of resources through the Primary Care Fund.

Delivery of the Primary Care Improvement Plan will be supported by the HSCP Improvement & Performance Manager, Clinical Director, Quality Clusters and the Directorate Management Team. The GP Subcommittee must approve the plan before it can be submitted.

C Engagement process

East Renfrewshire Health and Social Care Partnership's three-year Primary Care Improvement Plan has been developed through learning from our local improvement activity including our Safe and Supported Programme. The individuals involved in the draft of this Implementation Plan include our Clinical Director, Improvement & Performance Manager who has a lead role within Primary Care, Cluster Quality Leads and our LIST Data Analysts.

Specific and focussed engagement has, and will continue to be through:

- HSCP Management Team
- Chief Nurse
- Prescribing Lead
- GP Forum
- GP Subcommittee of the LMC
- PQL/CQL meetings
- Practice Nurse Forum
- Profession and care group specific management and leadership structures (nursing, AHP, Mental Health service etc) at both local and board level
- Local Community Pharmacy, Optometry and Dentistry forums
- NHSGG&C Primary Care Programme Board

We will engage with the public, staff and local partners around the content of plan and changes they may notice in Primary Care at events planned during Spring and early Summer. The first of these events will focus on Moving Forward Together programme, with GP Contract and Locality developments soon after.

A communication and implementation plan will be developed and shared.

D Delivery of MOU commitments

There are 6 priority areas:

(1) The Vaccination Transformation Programme (VTP)
(2) Pharmacotherapy Services
(3) Community Treatment and Care Services
(4) Urgent Care (advanced practitioners)
(5) Additional Professional Roles
(6) *Community Links Worker* (CLW)

(1) The Vaccination Transformation Programme (VTP)

Scottish Government announced a three-year (2017-2020) Vaccination Transformation Programme (VTP) in early 2017, with the aim of ensuring the health of the Scottish public through the modernisation of the delivery of vaccinations, empowering local decision making and supporting the transformation of the role of the General Practitioner. There is an existing GGC wide co-ordinated approach for the Vaccination Transformation Programme (VTP) with phased implementation of the programme to be fully complete by April 2021.

Scope

The scope of the VTP includes all NHS vaccination programmes:

- Routine childhood immunisation programme delivered by GP practices both with and without support from NHS Board/HSCP employed staff
- School immunisation programmes, both in primary and secondary schools delivered by HSCP employed staff
- Adult immunisation programmes, primarily delivered by practices without NHS Board support
- Delivery of seasonal flu vaccines to the housebound population
- Travel immunisation and advice, primarily delivered by GP practices

East Renfrewshire HSCP along with many other partnerships in Glasgow has already moved to a new model of delivering childhood immunisations and school immunisation teams hosted by Glasgow are in place. At the time of writing, 12 of 15 practices are having their childhood vaccines delivered by the new model and firm plans are in place to extend this to the remaining 3 practices.

The VTP Board shared indicative figures in May 2018 showing the cost for each HSCP for the under 5s portion of the VTP, the principal commitment in Year 1:

HSCP	Total Project Funds Required	Contribution from existing HSCP Budgets	Funding required as part of HSCPs' Primary Care Transformation Programme budget
East Dun	215,230	66,800	148,430
East Ren	201,715	60,100	141,615
Glas– NE	449,140	230,500	218,640
Glas – NW	401,240	207,100	194,140
Glas– S	583,120	273,900	309,220
Inverclyde	172,700	76,800	95,900
Ren	295,060	160,300	134,760
West Dun	178,300	100,200	78,100
TOTAL	**£2,496,505**	**£1,175,700**	**£1,320,805**

These figures form the basis of our budget estimates in the PCIP. These figures are subject to change as the VTP is developed over the three years.

The future delivery of adult immunisations, including housebound adult immunisations, and travel immunisations and advice will be developed by the Vaccine Transformation Programme Board, it is anticipated that the delivery of this will be in year 2 and 3 of the plan.

(2) Pharmacotherapy Services

Level 1 (core): acute prescribing, repeats, discharge letters, medication compliance reviews
Level 2 (additional advanced): medication review, resolving high risk medication problems
Level 3 (additional specialist): polypharmacy reviews, specialist clinics

All 15 practices in East Renfrewshire have access to prescribing support delivered by a team of 16 Prescribing Support Pharmacists and Prescribing Support Technicians. This local team is supported by a Central Prescribing team at health board level who provide data, data analysis, support materials and co-ordinate with other parts of NHSGGC providing links to acute care and community pharmacy for example.

In 2015 the Scottish Government announced details of Primary Care Investment Funding (PCIF) to support the primary care workforce. This included £16m phased over 3 years to March 2018 for pharmacists to work directly with practices. This funding in round one in 2015-16 provided 1.2WTE pharmacists and 0.4WTE technician resource to East Renfrewshire HSCP. 6 practices received additional pharmacy support from this resource which was deployed to undertake tasks such as hypertension and antidepressant clinics, medicines reconciliation post-discharge, processing acute prescriptions and outpatient letters. The Cabinet Secretary announced on 10 March 2017, that the Primary Care Funding for Pharmacists in GP Practices for year three would be increased from £7.8m to £12m. PCA (P) (2017) 4 provides the detail for this. This has provided an additional 2.2WTE pharmacists which will allow additional support at an effective level to be provided to 10 of the 15 practices during 18/19.

Local discussions highlighted the fact that there was discord relating to the allocations as described above. We therefore created a new methodology for the allocation of pharmacotherapy services, based on how far away each practice is at June 2018 from where we all want to be at March 2020 - namely 0.4WTE/5000 patient list size, with a minimum input of 0.4WTE. Using this ranking system, the 5 practices with no input are first, followed by the 6 practices which need 'topped up', followed by the 4 practices that already have 0.4WTE/5000 patients. This methodology was unanimously agreed as fair and workable at the GP Forum in June 2018 and will be used to allocate the pharmacists as they are employed by the HSCP.

To bring all the practices up to the minimum 0.4WTE/5000 patients will require the employment of 5 WTE pharmacists. Costings are shown in the table at the end of this plan.

In November 2017 the government released for consultation the '2018 General Medical Services Contract in Scotland' which was later voted in favour of by Scottish GPs. This includes a Scottish Government commitment to roll out a 'pharmacotherapy' service, increasing the number of GP practice-based pharmacists further over a three-year period. Workforce planning, and pilot evaluation is currently being undertaken by Scottish Government to calculate the resource allocation model, and therefore funding that will be required to deliver this. Until this is completed in the summer of 2018 the detail of the service model, skill mix of pharmacists and technicians and timescale to fully implement is unknown. Once the workforce level required to deliver the service at a feasible level based on staff availability, the rising population in East Renfrewshire will also require to be considered when determining the level of workforce required to implement this new service. A surplus will also require to be factored in to the resource allocation model to cover periods of staff absence due to annual leave, maternity leave and sickness. Business Support will also be required to manage rotas, leave cover and to support the expanding team with general administration tasks going forward.

In recognition that there will be a need for increased pharmacy workforce, the Scottish Government have made a commitment as part of the GP contract to increase the number of undergraduate training places from 170 to 200 per intake to help increase the available workforce.

(3) Community Treatment and Care Services

Recommendations from the review of Community Treatment Room service in Inverclyde suggested a separate phlebotomy service within the Treatment Room, better management of appointments (avoidance of "on the day" walk-in appointments) and standardising hours to GP practice opening where these do not already exist. East Renfrewshire are keen to utilise this learning to shape the creation of a Treatment Room service over the next 3 years. East Renfrewshire HSCP has never operated a Treatment Room model of service delivery, so we will be creating this service from scratch, using best practice learning from across GG&C.

In Year 1: Development of Treatment Rooms employing Band 3 Health Care Assistants and Band 5 Treatment Room Nurses. Band 3 HCAs are preferred to Band 2 Phlebotomists as they can undertake a broader variety of tasks to support scheduled chronic disease management. Band 3 workers can work in a Treatment Room setting or out in the community. A proportion of the Treatment Room service, expected largely to consist of phlebotomy services, may be delivered at home through agreement with practices and subject to ongoing review by GP Clusters who will be provided with regular updates on services provided in patients homes and of referrals to the service. These patients currently have their Long Term Conditions monitoring undertaken by GPs. This new service will be available only to reduce current GP workload and will be accessible only by referral from GPs or delegated GP practice staff.

Band 5 Nurses will also be employed to undertake more complex activities including dressings. It may be useful to have some Band 5 oversight if we undertake centralised Near Patient Testing for DMARDs e.g. call and recall activities and flagging of abnormal blood results.

Year 1-3: Development of a Treatment room model with 2 treatment rooms; 1 per locality. Each of these will be hosted within the Health & Care Centres, 1 in each locality.

Treatment room workers are not as scarce a resource as the Band 7 AHPs within pharmacotherapy, physiotherapy and advanced nurse practitioner fields; it is likely, therefore, that workforce limitations amongst Band 7s will free up funds to expand the treatment rooms at a more accelerated pace than cautiously outlined in our financial modelling.

(4) Urgent Care (Advanced Nurse Practitioners)

In 2011, East Renfrewshire Community Health and Care Partnership employed three Advanced Nurse Practitioners (ANP's), to work alongside multi agency teams aligned to our recently formed GP Cluster model. This was funded via Change Fund. The main function was to prevent admission to hospital of patients who have Long Term Conditions and are on the Scottish Patients at Risk of Readmission and Admission (SPARRA) to hospital. In 2011 this staff group was unique to NHS GG&C. As at 2017, we have 1 ANP currently employed.

Findings from our early adoption highlighted areas for improvement. The level of engagement and utilisation of the ANPs varied, across clusters and practices within clusters. The largest GP practice in the HSCP utilised the ANP service far greater than others, this practice praised the resource and the added value it brought to the practice, patients and reduction in hospital admissions. It has been agreed by all practices that the ANPs can be a highly valuable resource, if used appropriately. Key learning from our local test of change is the requirement for ANPs to be mentored by a GP and that they need to feel part of a team. At this time, we have 1FTE Advanced Nurse Practitioner.

We are keen to test models of service delivery provided by this highly skilled workforce to ascertain where the biggest impact can be provided. We propose using our ANPs recruited in Year 1 to:

- Provide house visit and care home visits with a focus on preventing hospital admission using an anticipatory care planning approach supporting KIS completion.
- Provide minor illness/acute presentation consultation adult +/- paediatric minor illnesses
- Provide support to those patients with COPD requiring community support to prevent admission.

In Year 1: Recruit 3-6 ANPs to be allocated across the 3 GP Clusters as per local agreements with practices. We acknowledge that there may be workforce limitations on filling a total of 6 posts.

Year 2 & 3: Aim to increase the number of ANPs according to affordability. Learning from Year 1 will shape how this resource is utilised.

The impact of ANPs on GP workload and improving outcomes should be relatively easy to measure; there should be a quantifiable number of patients seen for minor illness instead of seeing GPs, a quantifiable number of house visits/care home visits carried out by ANPs and a quantifiable reduction in unplanned admissions from care homes as a result of good quality Anticipatory Care Planning.

ANPs will be employed by NHSGG&C on the agreed ANP Job Description and managed by East Renfrewshire HSCP Community Nursing Service. Each ANP will be supported by practices/clusters.

(5) Additional Professional Roles

MSK

Inverclyde New Ways of Working provided an opportunity to develop and test a model to use an Advanced Practice Physiotherapist (APP) within the GP practice as first point of contact for patients presenting with MSK conditions. The APP role has been shown to offer a safe, cost effective alternative to the GP and brings additional patient and organisational benefits including improved self- management, and a reduction in prescribing, imaging and orthopaedic referrals.

The model tested is the attachment of the APP to no more than 15,000 patients or 3 practices. They should be used as part of the practice team and have bookable appointments – they do NOT need referrals from the GP. Practices with access see a benefit of 14-16 appointments per day; some have just seen these as added capacity, others have removed 14-16 GP appointments or used them for other tasks.

At this time, the hosting HSCP (West Dunbartonshire) has written a proposal regarding resource allocation. Within this proposal East Renfrewshire HSCP will be allocated 1 x APP in Year 1, a further one in Year 2 and a further one in Year 3.

The appropriateness of the current model of service delivery for Physiotherapy services in East Renfrewshire has been discussed at Cluster Quality meetings. It is agreed that this resource could be shaped to support our local population demands more effectively if the service could be shaped locally in conjunction with the MSK Management team. Discussions with the local MSK physiotherapists reveal a desire to change current working practices, including the clearing of long waiting lists by using group treatment sessions and a willingness to see acute sore backs as soon as possible – early intervention reduces return appointments to both MSK and GPs, and improves quality of life for the patients.

Year 1: small test of change utilising 1 x APP within 1 GP Cluster. The utilisation of this skill set will be monitored along with the impact on GP appointments and patient satisfaction.

Year 2 and 3: Realistically, we will have no more than 3 APPs across the HSCP, meaning that they will have to be operated on a locality-based model and shared by the practices. Negotiations are underway between HSCPs and the hosted service regarding changing the model of delivery from practice-based to cluster/locality based, to address the fact that no HSCP will get enough APPs to replicate the Inverclyde model.

NHSGG&C Primary Care Programme Board agreed that East Renfrewshire HSCP will lead a review of the current hosted physiotherapy service within the local area. Impact of the small test of change implemented will be shared with the Primary Care Programme Board to inform any wider changes to the current delivery model.

(6) *Community Links Worker* (CLW)

Our pilot for Community Link Worker Programme commenced December 2016, an output following our Safe & Supported Programme. This was a co-produced improvement programme seeking to identify new ways of working to safely support people in their local community. The development is a partnership primarily between RAMH and East Renfrewshire HSCP as a consequence of shared awareness between the partners, of the impact on Primary Care specifically General Practice, of a significant cohort of 'patients' who sought recurring and regular support from GPs, for what were often issues associated with loneliness, social isolation, lack of community connectedness and associated 'social' issues (housing, physical inactivity and financial issues).

GPs find the service very beneficial as the Community Link Workers are often working with individuals with complex issues; many of these are non-medical. There is evidence of excellent integrated working and outcomes for these individuals. Significant signposting to the correct agency is an important outcome for this service, and any gaps identified in community services to meet the needs and outcomes of service users are discussed with the partner agencies and the wider community to ascertain whether a new development is feasible. Anecdotally, GPs feel that the number of appointments with GPs for many of this cohort has reduced. To this end, the GPs are keen to continue with and increase the Community Link Workers across the HSCP.

Currently a total of 70 hours each week is provided (4 staff members x 17.5 hours) deployed between 9 GP practices. Each practice has a dedicated, named worker who spends time in the practice seeing patients (3 x 1-hour sessions allocated to each individual, if required) with the remaining hours supporting service users to engage, signpost or for admin tasks.

Year 1: we intend to increase the number of Link Workers by 2 staff x 17.5 hours. This will provide 6 Link Workers providing 105 hours, this resource will be split across the 2 Localities.
Year 2: review service, individual outcomes and reduction in GP appointments. This will influence any increase in capacity. The funding section demonstrates the effect of doubling the CLW cover in Year 2 and maintaining that level of cover.

Community Link Workers are not as scarce a resource as the Band 7 AHPs within pharmacotherapy, physiotherapy and advanced nurse practitioner fields; it is likely, therefore, that workforce limitations amongst Band 7s will free up funds to expand the CLW at a more accelerated pace than cautiously outlined in our financial modelling.

Community Clinical Mental Health Professionals

Our local GPs recognise that there is high demand for Primary Care Mental Health services across East Renfrewshire. The local team recently moved to 'self-referral' system in response to GPs raising issues around people they were referring have significantly long waits. We are keen to review how this service manages demand and utilises its current capacity and have agreed that a review will be undertaken in Year 1. This will be supported by the launch of the new NHSGG&C 5-year Adult Mental Health Strategy which has a clear focus on Primary Care and recovery.

Year 1: Service review of Primary Care Mental Health service

E Existing transformation activity

Primary Care Improvement and implementing the new GP Contract is just one element of developing health and care services in East Renfrewshire HSCP. These include improving access to services and in particular improving digital access and online self- assessment for services. The HSCP is also developing digital signposting.

We recognise that in order to deliver on the outcomes of the new GP contract, a culture change in how primary care services are used is required. Building on the theme of every health professional working to the top of their licence, this led to our 'Know Who to Turn to' campaign, which has been widely publicised using a variety of printed and social media.

Crucial to this is investing time in training the reception staff in General Practice on appropriate care navigation to provide them with the confidence and tools to signpost patients appropriately.

F Additional Content

Community Pharmacy, Optometry and Dentistry

While the new GP contract offers potential and opportunity it also brings challenges associated to other professions e.g. the community pharmacy network, optometry and dentistry.

Vaccinations – There are in the region of 60-70% of Community Pharmacies currently offering a private flu service out with the National Health service provision. Although under current legislation they would be unable to provide an NHS service they could under a private PGD deliver a flu service in line with National Guidelines. This skill set could and would be easily transferable to being able to deliver travel vaccinations that currently go through the GP practices.

Pharmacy First services – due to ease of access and a no appointment system Community Pharmacy is well placed to deliver a range of addition services that can help and benefit the healthcare needs of patients in the community e.g. An extension of National Pharmacy First to treat a range of minor conditions e.g. UTI, impetigo, shingles etc. under PGD as well as maximising the use of the minor ailments service to ensure patients are managing their own conditions. So far, there have been over 15,000 contacts made since the inception of the Pharmacy First service. East Renfrewshire's share of the cost of Pharmacy First is £19,950, in its current guise. Evaluation will need to be undertaken locally as to whether this represents good value for money and takes sufficient work away from GPs to be extended as part of the PCIP.
Our tripartite meetings with GPs, Optometrists and Community Pharmacists have been extremely successful. Our Optometry Lead attends our GP Forum and has worked very closely and successfully with the HSCP and Clinical Director to improve signposting to optometry services.

Interface with Acute Services

Every 4-6 weeks there is a Primary Care Interface meeting at the QEUH, chaired by the Medical Director and usually also attended by the QEUH Chief Executive. This is attended by our Clinical Director, and the CDs for all HSCPs referring into the QEUH. There is no equivalent meeting for the RAH (serving the Barrhead Locality), but the CQL for Barrhead interacts with acute services in relation to referral pathways. This interface will help mould other developments, such as Moving Forward Together, which will include Tier 4 services being delivered from Eastwood Health & Care Centre (EHCC) and Barrhead Health & Care Centre (BHCC) e.g. outreach clinics from secondary care. It is the responsibility of secondary to set up, run and

finance these clinics.

Community Services

Our integrated Rehabilitation and Enablement Service teams have been aligned to GP Cluster model for a number of years. The rationale behind this redesign was to improve the communication and engagement with GPs building on the positive relationship with District Nurses and our local GP practices. Our Locality Adult Health & Social Care structure is being reviewed with an implementation date for the new structure by the end of 2018.

This new structure will aim to:

- strengthen our preventative approach through a highly skilled initial contact team and Talking Points
- safely support people to remain at home or other community setting
- supporting people to return home as soon as possible following hospital admission
- preventing hospital admissions/readmissions

GPs will be involved in developing pathways to each team.

Mental Health

Health and Social Care Partnerships across Greater Glasgow and Clyde are committed to working together to develop a whole system five-year strategy for adult mental health. Implementing the strategy will involve a whole series of actions and service changes.

Our local services in partnership with third sector organisations like RAMH will move to recovery-oriented care supporting people with the tools to manage their own health. A recovery-based approach has the potential to improve quality of care, reduce admissions to hospital, shorten lengths of stay and improve quality of life. While service users will always have access to the clinical and therapeutic services they need, a recover approach will require services to embrace a new way of thinking about illness, and innovative ways of working. Those changes include,

• A change in the role of Mental Health professionals and professional expertise, moving from being 'on top' to being 'on tap': not defining problems and prescribing treatments, but rather making their expertise and understandings available to those who may find them useful

• A recognition of the equal importance of both 'professional expertise' and 'lived experience' and a breaking down of the barriers that divide 'them' from 'us'. This must be reflected in a different kind of workforce (one that includes peer workers), and different working practices founded on co-production and shared decision making at all levels.

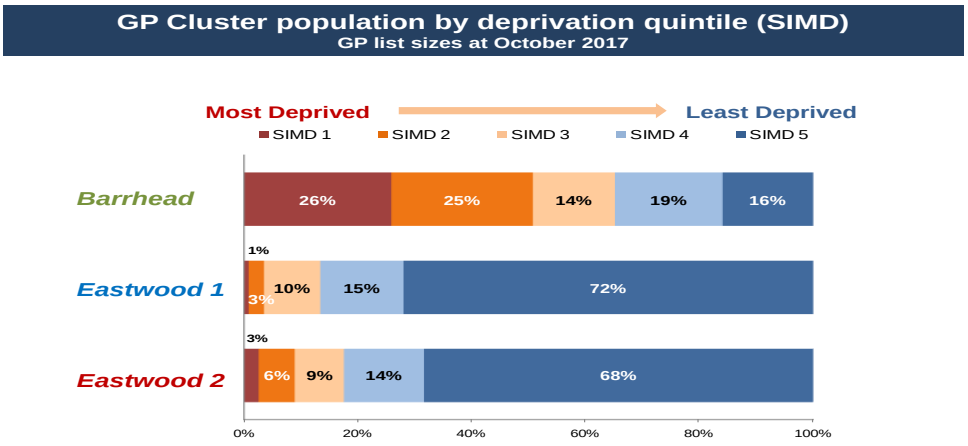
We will work together across Greater Glasgow and Clyde to improve responses to crisis and distress, and unscheduled care. Integrating crisis, home treatment and OOH models so that they are provided consistently as a comprehensive Crisis Resolution and Home Treatment (CRHT) service, available for community care 8am to 11pm, 7 days a week.

This strategy signals a further shift in our balance of care moving away from hospital wards to community alternatives for people requiring longer term, 24/7 care, with mental health rehabilitation hospital beds working to a consistent, recovery-focussed model.

G Inequalities

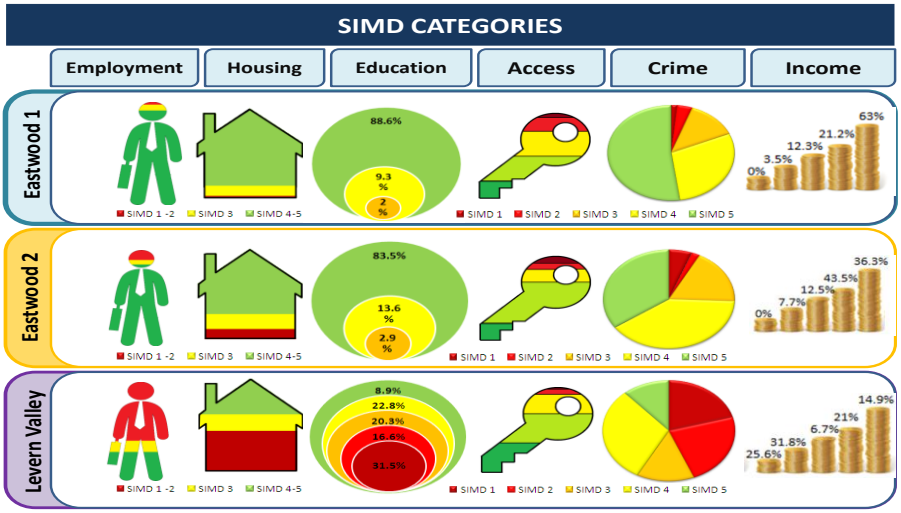
Half of the population in Barrhead fall among the 40% most deprived in Scotland. In contrast the significant majority of the population in Eastwood are among the least deprived in Scotland.

The chart below demonstrates the significant variation in deprivation for all 5 quintiles across the clusters:



Evidence suggests that poor socio-economic circumstances affect opportunities for good health and access to services. As highlighted in Section A, East Renfrewshire's Barrhead locality has significant pockets of deprivation, (Arthurlie, Dunterlie & Dovecothall and Auchenback) that have areas within the 20% most deprived areas in Scotland, with significantly poorer outcomes in health, education, housing and employment. The Oaks practice in Barrhead is the only practice with over a third of registered patients living in the most deprived Quintile (and 23% in the most 15% of deprived areas).

SIMD ranks deprivation in data zones by a number of factors, including employment, income, health, education and others. The graphic overleaf illustrates the variance across the factors by GP Cluster.



The relationships built across the wider multi-disciplinary team including health, social care, housing, third sector and others will be the lever with which to address the health inequalities of local populations. Cluster working is one aspect of this, improving local population health through an emphasis on better intelligence supported by LIST Analysts. Agreed quality improvement projects will focus on improving outcomes for individuals and subsequently communities.

H Enablers

Eastwood Health & Care Centre & Barrhead Health & Care Centre

It's recognised that having access to modern health and care centres located in each locality is advantageous. The flexibility of the space provides opportunities to develop services within the local community to meet the need of the community; this could include treatment rooms, acute hubs, and diagnostics and outreach clinics from secondary care. The space can also be used to facilitate 3rd sector/community activities and support groups.

Community Led Support East Renfrewshire Talking Points

These are places where you individuals and their families can come along and find out about health and social care information, and activities that are going on within their local community. East Renfrewshire is an early adopter of the CLS approach in Scotland. By adopting the approach we aim to:

- make sure that information about health, care, support and social activities is available in local communities and that it is easy to access
- make it easier for individuals to be in contact with the HSCP
- work together with people to improve lives and build capacity with individuals and communities.

By having more effective conversations with people from their first contact with the HSCP the organisation believes that they will reach more people before their health or social care needs become really urgent, or they reach a crisis. We envisage our Talking Points to play a vital support role for GPs in signposting individuals to further information regarding community support.

Fit for the Future Programme

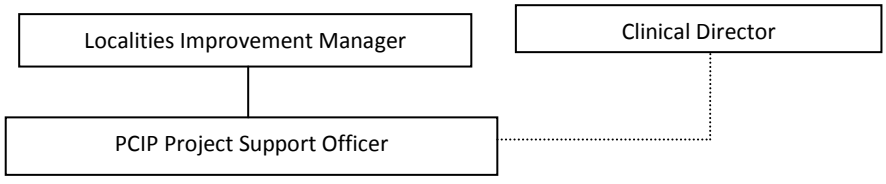
Our Fit for the Future programme has been established to develop an approach to complete a suite of end to end operational service reviews in conjunction with a review of our organisational structure. Our HSCP adult health and social care management arrangements will change to mirror this new structure and strengthen our ability to support and engage meaningfully in locality planning. In redesigning our HSCP services we will look to:

- Understand and refresh our pathways
- Redesign our Locality Services around our key pathways
- Ensure we have right person, doing the right thing at the right time
- Build on community led support and talking points
- Strengthen and build on our relationships with General Practitioners and the opportunities arising from the new GP contract

As the PCIP is implemented its key that this links with the Fit for the Future developments. With this in mind the PCIP has formed a work stream within the programme along with Unscheduled Care.

Primary Care Innovation Support

Learning from Inverclyde New Ways indicates that a dedicated primary care innovation team is a critical success factor. This mirrors reflection from local learning. Moving forward it is essential that a role to support and facilitate the implementation of the PCIP and the evolving multidisciplinary team and to monitor their impact. The new PCIP Project Support Officer's (Band 7) role will be overseen by the Clusters and in terms of management the post is shown in the structure below:



I Implementation

The HSCP Localities Change Manager and Primary Care Business Improvement Officer will lead the primary care teams through the management of change and re-design. The team will seek to embed the ethos of quality improvement through the use of recognised QI tools to develop a workforce at the forefront in delivering improvements in the safety, effectiveness and quality of care and treatment.

T**his team will:**

- Support the development of a clearer role of the General Practitioner and the progression of the GP role as expert medical generalist ensuring a refocus of activity is applied within practices, after workload shifts.
- Support the delivery of improved patient care by achieving the principles of contact, comprehensiveness, continuity and co-ordination of care.
- Support the re-design of services and embedding of multi-disciplinary primary care teams to create a manageable GP workload and release GP capacity for those patients with more complex needs.
- Support the process of measuring impact of new roles and new ways of working to support informed decision making
- Provide data at locality and cluster level to increase knowledge and support decision making processes.
- Identify opportunities to improve individual outcomes through actively encouraging and involving all key individuals in patient flow and pathway sessions with HSCP, acute and other partners.
- Identify, evaluate and share the learning of 'non-traditional' multi-disciplinary team members such as Community Links Workers, and support these to become embedded within the extended MDT.
- Engage with NHS GG&C Board in the financial aspects of the contract to support the introduction of the new funding model and investment.
- Engage with NHS GG&C Board to improve the infrastructure and reduce risk for General Practice.
- Encourage peer led discussions and value driven approach to quality improvement to create better health in our communities and improve access for our patients.
- Horizon scan to encourage innovative thinking
- Ensure that all local Practices will benefit from additional support and no exclusions are made.

Whilst delivering the above, it is essential that the 'team' continue to:

- Engage with our established Clusters through attendance at Cluster meetings attended by CQL, PQLs and Practice Managers. A key role is the administrative support provided by the HSCP.
- Support Practice Managers in expanding their role into leading and co-ordinating the developing multi-disciplinary team.
- Work with Chief Nurse and Practice Nursing colleagues in the development and enhancement of their roles within General Practice.
- Support the reception workforce in the new care navigation role to help with the re-direction of patients and the changing role of front line staff in Practice.
- Continue to develop and enhance a primary care multi-disciplinary workforce in delivery of the new contract.
- Commit to working collaboratively with neighbouring Health and Social Care Partnerships and with our advisory structures and representative bodies in sharing learning, experiences and gain feedback.
- Work collaboratively with the LMC who have responsibility to monitor delivery of the MOU commitments via the PCIP.

J Funding profile

The share for East Renfrewshire Health & Social Care Partnership in Year 1 is £0.714m which is an NRAC share of around £50 million to the HSCPs that are co-terminus with NHSGG&C. The future years funding increases by 0.3m per annum proportionately.

There is also £0.172m coming to Eat Renfrewshire HSCP as part of Mental Health Strategy Action 15. These funds must be used for mental health related activities, but this may include the CLWs.

It is assumed that existing services which are deemed fit to continue, will continue to be funded by the HSCP e.g. the existing ANP salaries, the existing CLW salaries. Please note that the existing pharmacotherapy pharmacists (not PSPs – they will be continue to be funded centrally by GG&C) do NOT count as their funding has always been through PCIF and they will therefore have to be adopted by the new contract funds.

The summary table below indicates the total cost of providing services at the indicated levels. It shows cumulative totals. The three subsequent tables detail the year on year workforce improvements.
For ANPs and Pharmacists, the levels are based on tested models of change (1 ANP per 15-20k population and 1WTE Pharmacist per 5000 population).
For APPs the levels are based on projected allocations over 3 years from GG&C.
The levels for HCAs and TR nurses are indicative to demonstrate the total cost of provision.
The levels for CLWs are based simply on upscaling the current service to all practices.
The cost of the Vaccine Transformation Programme is an estimate and is unavoidable. It must be accounted for.

	Year 1		Year 1 Part Year			Year 2		Year 3	
	2018/19		Apr to Sep	Sep to Mar	Total	2019/20		2020/12	
Services	**WTE**	**£'000**				**WTE**	**£'000**	**WTE**	**£'000**
Pharmacist (Band 7)	6.0	287	88	153	241	8.5	406	19.0	908
Pharmacy First	1.0	20	10	10	20	1.0	20	1.0	20
Advanced Nurse Practitioners (Band	3.0	164		41	41	3.0	164	3.0	164
Advanced Practice Physiotherapists	1.0	56		28	28	1.0	56	1.0	56
Community Link Workers	1.0	20		10	10	4.0	80	4.0	80
Healthcare Assistants (Band 3)	3.0	73		18	18	3.0	73	3.0	73
Treatment Room Nurses (Band 5)	3.0	99		25	25	3.0	99	3.0	99
Treatment Rooms Equipment Set Up				20	20				
Vaccine Transformation Programme	0.0	142	71	71	142	0.0	142	0.0	142
CQL Sessions		15	8	7	15				
PCIP Project Support Officer	1.0	47		24	24	1.0	47	1.0	47
Total Cost	**19.0**	**923**	**177**	**406**	**583**	**24.5**	**1,087**	**35.0**	**1,590**
Total Funding Available*		714			714		1,014		1,314
Surplus / (Shortfall)		(209)			131		(73)		(276)

*Year 1 confirmed, Years 2 & 3 assumed

Part Year Effect and one off investments in Year 1 under review

Table shows cumulative cost of services

Year 1 (2018-19) developments (ranked by importance/ability to shift demand):

Service	Suggested development	Estimated cost per 6 months
Pharmacotherapy Services	Additional 2.2WTE to make up to 0.4WTE/practice (total of 6 WTE)	£154k
Pharmacy First	Maintain current service	£20k
Advanced Nurse Practitioners	3 FTE posts added to existing 3 FTEs capacity	£82k
Advanced Practice Physiotherapists	1x Full Time APP	£28k
Community Links Workers	1 WTE to equalise cover to all practices	£10k
Health Care Assistant Band 3	Employ 3.0 WTE Band 3 Treatment Room HCAs	£37k
Treatment Room facility in both Health & Care Centres	3 WTE Band 5 posts	£49k
Vaccine Transformation Programme	Pre-school programme + whole system planning/ coordination	£78k

Year 2:

Service	Suggested / Possible development	Estimated total cost per annum
Pharmacotherapy Services	Increase with 2.5WTE (8.5WTE)	£406k
Pharmacy First	Maintain current service	£20k
ANP	Maintain (3+3WTE)	£164k
APP	Maintain 1WTE	£56k
Community Mental Health Links Workers	Double total (2+4WTE)	£80k
Health Care Assistants Band 3	Maintain 3WTE	£73k
Treatment Room in both Health & Care Centres	Maintain 3WTE Band 5	£99k
VTP		£156k

Year 3 onwards:

Service	Suggested / Possible development	Estimated total cost per annum
Pharmacotherapy Services	Increase with 10.5WTE (19WTE)	£908k
Pharmacy First	Maintain current service	£20k
ANP	Maintain (3+3WTE)	£164k
APP	Maintain 1WTE	£56k
Community Mental Health Links Workers	Maintain (2+4WTE)	£80k
Health Care Assistants Band 3	Maintain 3WTE	£73k
Treatment Room in both Health & Care Centres	Maintain 3WTE Band 5	£99k
VTP		£156k

Whilst we will endeavour to fulfil this aspiration, the ability to do so will depend largely on the ability to recruit and retain appropriately qualified staff or to support the training and mentorship of staff to reach the required level of practice.

There may be other sources of funding which become available across the lifetime of this plan such as that associated with strategy implementation or tests of change.

We need to be careful to spend the money where we believe it will make the most difference to GP workload in the most sustainable way long term.

K Evaluation and outcomes

Key success indicators over the life of the plan will be agreed with primary care. Measurement of that success will rely in part on the supply of the necessary information. The LIST Analyst Support will be pivotal in developing systems to collect appropriate data to measure the impact of local tests of change. A key challenge will be to ensure that the all data can be collected electronically which is not currently possible and limits what can be collected and can affect quality.

A. **Workload shift for GPs**
   Workload shift for other practice staff
   Continual measurement over the life of the plan using week of care data and SPIRE in comparison with activity data from other professionals (ANP, Pharmacy etc.)
   Increased appointment length for GPs

B. **Primary care is an attractive area of work for all healthcare professionals**
   Wellbeing scores/survey responses throughout the period of the plan. Track if there are any changes across the 3 year implementation.

C. **Effective integration of additional healthcare professionals into practices is achieved.** ***How will we know they are working effectively?***
   Activity Data.
   Locality MDT meetings and minutes.
   Multi-disciplinary quality improvement projects – cluster/locality based or pan HSCP with project

outlines and success measures monitored
Examples and case studies of positive multi-disciplinary working
Complaint reviews/ incident recording.

D. Patients have access to the right professional, in the right place at the right time
Self- reporting/ questionnaire.
Waiting times for appointments/ assessment/ review.
Impact of re-direction/ culture change 'East Renfrewshire Know Who to Turn To', potential decrease of A&E attendance for minor illness/ injury
Complaint reviews
Monitor population growth and impact on GP practice list sizes

E. The vaccination transformation plan will result in the majority of vaccinations being removed from practice workload
Will need evidence of shift that will rely on activity data.
Track progress in years 1,2 and 3.

F. Community Mental Health links workers are successfully embedded in practices, providing an alternative point of contact for patients who are frequent GP attendees who are socially isolated, have low level anxiety or wider social issues and helping them to engage with organisations that can help them
Evaluation based on current measures in partnership with RAMH using both qualitative and quantitative data
Reduction in GP appointments for cohort

G. MSK Physiotherapy
Continue to monitor activity, workload shift and progress of current tests of change.
Percentage of MSK cases seen by APP rather than GP.

H. Urgent care
Target of ANPs seeing of home visits/care home visits.
Reduction in PPAs for top 4 outlined across localities
Reduction ion PPAs for top 4 Care Home admissions
Continue to monitor activity, workload shift and progress of current tests of change and also additional members of staff when they roll-out.

I. Community Treatment and Care Services
Community Health Care Assistants
Measuring of chronic disease parameters in patients who were housebound
Treatment Rooms
Measurement of agreed parameters (still to be agreed)

J. Improving Health and Inequalities
Population and practice data- disease prevalence, use of secondary care, key health outcome indicators.

L Risk

Increasing population

Unlike some areas within Greater Glasgow and Clyde, East Renfrewshire's population is increasing. Both our youngest and oldest populations are increasing. These are the groups which are the greatest users of universal health care services. East Renfrewshire is attracting people over 80 years of age because more retirement and care homes are choosing to open in the area. This puts significant pressure on GPs due to new patient registrations and growing complex list size.

The majority of East Renfrewshire GP practice list sizes continue to see net growth, the challenges around

this for the GP, wider practice team and premises is captured below by a local GP:

> The influx of new patients into the Eastwood area has a significant impact on all General Practices in the area. There is an effect on all members of the practice team with an increased administrative workload while members of the clinical team have to take time to summarise and reconcile medication. Building new therapeutic relationships with these patients is also time consuming. All of these issues are magnified when dealing with more frail elderly patients. Due to the heathy lifestyles of many patients in the Eastwood area, there is an increasing ageing population which inevitably leads to more complex health problems within this age group. There have been two new nursing homes opened within the last 2 years and the relatively small numbers of patients in these facilities carry a disproportionate workload.
> The increasing workload is stressful for the whole team and it can have a detrimental effect on morale, leading to higher sickness absence which then puts further strain on the whole practice team. The practices need to expand to cope with the rising population but employing high quality staff can be difficult and many practices across Scotland have unfilled posts due to the shortage of GP's.
> A major challenge is limited space within the General Practices hosted in GP own premises in the Eastwood area which means there is a finite capacity for expansion.
> - Local GP

East Renfrewshire Council Local Development Plan

The local development plan outlines that East Renfrewshire has a diverse, growing population, with significant changes expected in future years. The Strategic Housing Need and Demand Assessment estimates that East Renfrewshire will continue to see new household formation, which could mean a reduction in the average household size. The Strategic Housing Need and Demand Assessment highlight the increasing trend for people living on their own, and in part reflect the increasing ageing population. The requirements of households for housing and support to meet their needs can be wide ranging, especially when considering those who have particular needs. Those which are significant in East Renfrewshire include older people, those with a disability, young people with complex needs and ethnic minorities.

The Council has identified sufficient land for a minimum of 4100 homes and associated infrastructure to be delivered in East Renfrewshire by 2025 to comply with the Strategic Development Plan requirements with significant growth post 2025 also planned. The growth will be predominantly delivered in 3 main areas:

Urban expansion at:

A:

- Malletsheugh/Maidenhill/Newton Mearns. Approximately 1060 homes to be phased. 450 homes by 2025 and 610 homes post 2025.
- Barrhead South/Springhill/Springfied/LyonCross. Approximately 1050 homes to be phased 470 homes by 2025 and 580 homes post 2025.

B:

- A major regeneration proposal Glasgow Road/Shanks Park, Barrhead. Shanks Road, approximately 400 housing units by 2015. Glasgow Road, approximately 45 housing units by 2025 and 60 beyond 2025.
- Elsewhere in the rural settlements further limited growth has been identified for the village of Neilston. Crofthead Mill, 200 units post 2025. Brig o Lea football ground, 35 housing units by 2025. Other residential redevelopment 60 houses by 2025 and 233 post 2025.

C:

- Proposed retirement residential community for over 55, care home, multi-purpose village centre in Newton Mearns.

The rising population and the level of housing and residential redevelopment outlined above is a significant risk for East Renfrewshire Health & Social Care Partnership. This will increase demand for managed services and our local GP practices. A significant amount of the regeneration work is within the Newton Mearns and Neilston areas; both of which are served by a limited number of GPs housed in sites where expansion opportunities have been maximised. This will pose a challenge over the coming years as access to capital and revenue funding becomes increasingly limited.

GDPR

East Renfrewshire HSCP, as other HSCPs do, await guidance from the Health Board regarding our position as joint data controllers in line with the new GDPR guidance.