1. Actions Recommended

The Scottish Government Primary Care Directorate visited NHS Grampian during January 2015 to consider the future of general practice and the development of the new GP contract which will be implemented in 2017. This has prompted a review of general practice issues in NHS Grampian given its pivotal role in primary care and in the transformation of the health and healthcare system as a whole.

Further work will be done to ensure that general practice and primary care is developed appropriately and primary care issues will feature in future Board seminars.

The Board is asked to:

- Note the summary of issues contained in this paper as the background to the further work in future seminars
- Endorse the actions being taken forward to deal with the workforce and infrastructure challenges
- Support the work underway to transform the approach to primary care in the future

2. Strategic Context

General Practice and primary care have long been regarded as the foundation of the NHS and is the first point of contact for the vast majority of people who are ill or require care. As well as being providers of healthcare the primary care team has also been the source of advice and support in relation to public health and health improvement for communities and individuals.

Primary care has experienced considerable pressure in recent years and general practice specifically has been under strain due to increasing workload and the challenges associated with the recruitment and retention of GPs. These pressures exist yet there is a consensus that primary care in its widest sense should be the focus for healthcare and a fundamental part of the developing health and social care integration agenda which aims to transform the approach to care in the community.

A greater emphasis on primary care is essential if NHS Grampian is to move towards the health system identified in the Healthfit 2020 vision. An enhanced approach to primary care will not only support people living in their own communities, but will also make a major contribution to people being treated and cared for in the right place, at the right time and by the right clinician.

A wide range of actions are underway to improve primary care locally but more needs to be done. Specific work is being taken forward to improve recruitment and retention, and investment in primary care premises continues. Ground breaking work is also being done as part of the Modernisation of Primary Care programme which
aims to transform the approach to team working, promote self management and engage the population in health and healthcare.

3. **Key matters relevant to recommendation**

**The Dimensions of General Practice**

It is important to define the scale of primary care and its contribution to the health and care system in the north east of Scotland. The following paragraphs provide an outline of its dimensions:

- There are more than 500 GPs working in 78 practices across the area ranging from single handed practices to the largest practice in Scotland in Inverurie with 16 partners, 2 salaried and 2 trainee GP, serving over 22,000 patient list. This contrasts to smaller practices such as Homeless practice with 401 patients and Braemar with 590 patients. There are 30 practices in Aberdeen City, 35 in Aberdeenshire and 13 in Moray.

- Primary care is organised into clusters or areas which bring together groups of practices with a total population of between 40,000 and 80,000. There are four clusters in Aberdeen, six in Aberdeenshire and one in Moray.

- Based on ISD information there are more than 2.5 million GP and practice nurse contacts in Grampian every year.

- Primary care practitioners make 152,000 referrals to acute care every year and deal the out of hours GMED service manages more than 16,000 contacts every year in the community at eight out of ours centres across Grampian.

- The GP workforce is ageing – General Practice Workforce Survey completed in 2013 indicates that in Aberdeen 32% of GPs are expected to retire in the next 10 years. In Aberdeenshire this figure is 39% rising to 47% in Moray.

- Total Hospital and Community Health Service spend for 2013/14 was £1.029 billion – within this Family Health Services Expenditure is outlined below:

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Medical Services</td>
<td>£84,369,000</td>
</tr>
<tr>
<td>Pharmaceutical Services</td>
<td>£108,913,000</td>
</tr>
<tr>
<td>General Dental Services</td>
<td>£34,205,000</td>
</tr>
<tr>
<td>General Ophthalmic Services</td>
<td>£9,806,000</td>
</tr>
</tbody>
</table>

Based on this primary care represents 23% of the total expenditure on hospital and community services with primary medical services being 8.2% of the total.

**Challenges and Opportunities**

There are a wide range of challenges and opportunities within primary care. The information below outlines a number of the overlapping issues relating to workforce, infrastructure and service delivery service:
Workforce

Challenges relating to recruitment, retention, training and gender balance within the Grampian primary care workforce are outlined in the annex 1 i.e. the summary of the output from the NHS Grampian General Practice Workforce Survey carried out in December 2013 and reported in early 2014. This report highlights an ageing workforce across the medical, nursing and administrative staff groups with a high proportion of all groups having staff aged 50 or over. The consequence of this is being felt in a number of practices in Grampian, and across the country as a whole, which are at risk of no longer being viable.

The output from the survey and the issues specifically related to general practice were considered at a GP workforce summit held in November 2014 which included wide participation from across the organisation. The key actions being taken forward from the summit include:

- Improved marketing of general practice in Grampian
- Exploring alternative models of partnership and identifying how to make partnership more attractive
- Improving the availability of locums
- Developing options for return to work
- Further promotion of Career Start
- Developing the advanced practitioner workforce

In relation to the development of advanced practitioners many practices have appointed and developed experienced nurses to undertake this role to deal with the GP recruitment challenge and to move towards an assurance that clinicians are working at “top of licence”. This term is gaining common currency and indicates a need to ensure that clinicians – GPs, nurses and others – are maximising the benefit to be gained from their education and training.

Infrastructure

There has been significant investment in primary care premises in Grampian over the past ten years but further significant investment is needed in the coming years to ensure that facilities are fit for purpose and support the development of the role of primary care.

NHS Grampian currently own 27 Health Centres, 22 clinics and 3 dental units. In addition, in Grampian, there are a number of privately owned and 3rd party healthcare provider properties – 71 GP premises, 70 dental premises, 131 pharmacies and 52 ophthalmic premises.

Annex 2 outlines the premises investment over the last ten years and the priorities proposed for future investment. Annex 2 also sets out the capital investment that is agreed and in the process of being implemented. Whilst there has been significant expenditure 27% of the remaining GP premises are classified as being inadequate in
terms of space. A NHS Grampian Premises Group has developed a prioritised plan for the next five years and the Scottish Government has made available £19m over the next 3-5 years to deal with the highest priorities. This funding will go some way towards addressing the space requirements and functional suitability issues.

Whilst there has been and will continue to be investment in the infrastructure the most significant current concern of general practitioners relates to the limitations of the IT infrastructure. This will be reviewed during 2015 with the aim of addressing the concerns and in recognition of the key role that a fully functioning IT infrastructure has in the provision of a modern health system. It is also clear that there needs to be a firm foundation for the wide range of digital health initiatives that are being developed which will improve the patient experience and improve efficiency.

Service Delivery and Transformation

As indicated above primary care is the first point of contact for the vast majority of patients and the focus for treatment, management and advice for a wide range of conditions. The need for change is acknowledged and this is reflected in the Royal College of General Practitioners publication “A Vision for General Practice in the future NHS – the 2022 GP” (2013). A local version of this has been developed and is included in annex 3.

The development and transformation of primary care will, in future, be closely linked to health and social care integration and the work of Integrated Joint Boards. Primary care is regarded as fundamental to integration and will be delegated to the IJBs when they are formally established during 2015/16. However, a range of actions are underway with the aim of moving in the direction of the vision. These actions include the following:

- **Modernisation of Primary Care:** This is a broad initiative which aims to test new ways of working within practices and methods of engaging the practice population. The initiative is sponsored by the Scottish Government and facilitates six “early adopter” practices to formulate practical solutions and develop a cultural shift towards empowering patients, prevention and using the assets available within communities to support better health and healthcare. The practice teams within the six practices have been exposed to new and innovative approaches and the “NUKA” model of health and healthcare which is delivered by the South central Foundation in Alaska.

  The NUKA model has some resonance with the NHS Grampian vision and with its focus on the engagement of the local community. A significant element of the Modernising Primary Care initiative locally is the Scottish Government funded deep community engagement programme being undertaken by the organisation Community Renewal which started in February 2015.

  Whilst there are a range of influences on the Modernisation of Primary Care Initiative, including NUKA, the aim is to develop a model for primary care which will meet the current and predicted challenges in innovative ways which will fits the health system locally.

- **GP Contract:** The joint visit by the BMA and Scottish Government in January 2015 illustrated the challenges and opportunities related to the new GP contract
which will be implemented in 2017. The new GP contract has the potential for encouraging more doctors into primary care and reinvigorating general practice. A considerable amount of common ground was demonstrated and there is a realisation given the limited GP resource that there is a need for all clinicians in primary care to work to the top of their licence.

During the meeting with BMA/Scottish Government representatives there was agreement that the Cluster/Area structure is important for clinical discussions, leadership and will be a focus moving forward. There was also a consensus that the independent contractor model remained appropriate but that the Quality Outcomes Framework needed to change as did the mechanisms for delivering chronic disease management.

- **CONNECT Initiative:** This GP sponsored initiative seeks to develop closer links between primary care and hospital based clinicians to ensure that there is a high level of continuity of care for patients and shared learning and development. CONNECT has been successful in developing a range of joint workstreams and work shadowing with more than 100 shadowing pairs being organised.

  The current CONNECT priorities considered at a seminar on 25 March included:

  Direct access to diagnostic services

  Innovation

  Teamworking

  Professional behaviours

  Decision support

  Constructive feedback mechanisms

  Excellent training environment

- **Prescription for Excellence:** Pharmaceutical care is a key component of safe and effective healthcare. It involves a model of pharmacy practice which requires pharmacists to work in partnership with patients and other health and social care professionals to obtain optimal outcomes with medicines and eliminate adverse events whenever possible. Patients regardless of their setting should receive high quality pharmaceutical care. This is particularly important for patients with complex health issues including multi-morbidities and those in care homes. The key Prescription for Excellence recommendations are outlined below:

  - All patients will have access to NHS pharmaceutical care by NHS accredited clinical pharmacist independent prescribers in all settings

  - Pharmacists in secondary care and in primary care work together in an integrated way which would be supported by a common clinical pharmacy career structure
- Patients have a close relationship with an individual pharmacist, ensuring greater continuity and consistency of care for patients, introducing the concept of the named pharmacist and patient registration with NHS Board listed pharmacists

- Pharmacists work closely with GPs, primary care, community teams and secondary care, sharing information for the benefit of the patient. These pharmacists would be known as general practice pharmacists

- Pharmacists work in groups to deliver NHS pharmaceutical care to patients in all care settings, especially those with complex or long term conditions, with allocation of case loads

- Pharmaceutical care for specific patient groups is provided under a national framework and to nationally determined standards. A national framework and NHS standards for the pharmaceutical care of residents of care homes and people receiving care and support at home would be prioritised

- NHS Board Pharmaceutical Care Services Plans with needs assessments to enhance local healthcare planning which would include equitable access to services in deprived areas, as well as specific public health needs driving a new contractual framework for premises and pharmaceutical care, removing any perverse incentives

- The Scottish Government will work with patients, dispensing doctors and appropriate stakeholders to explore how rural communities can be further supported in terms of pharmaceutical care

- Pharmacists undertake an enhanced role in preventing ill-health, co-production and minimising health inequalities

- NHS Boards would provide professional and clinical leadership for all pharmacists providing NHS pharmaceutical care services

Prescription for Excellence is a Scottish Government sponsored initiative aimed at building pharmacy capacity to support general practice and the wider healthcare team in the delivery of care locally. This provides further opportunities for joint working across the system by different professionals working to create the best access to the right professional including the Pharmacist as a health care professional within a community.

- **Pathway Ownership**: Significant work will be taken forward via the strategic planning process of the shadow Integrated Joint Boards to review emergency pathways in the context of shifting the balance of care and developing the primary/secondary care interface. There are already significant examples of good practice within planned care pathways where diagnostics are delivered locally through general practice and the opportunity exists to scale this up across Grampian achieving the aims of local access.

- **Primary Care Out of Hours Service – GMED**: GMED is the NHS Grampian out-of-hours primary care service which started with the 2004 when the new GP
contract of that time removed the requirement of GPs to provide 24 hour cover for registered patients. GMED operates over 118 hours of each week and also covers public holidays, protected learning times and festive breaks with daytime cover. The workforce has been modified over the last ten years as fewer GPs elect to work out of hours. At present 168 GPs contribute sessions to the service out of the total cohort of 503 GPs in Grampian. The core of the service is maintained by 4.65 WTE salaried GPs, 2.10 WTE emergency general practitioners and 15.58 WTE advanced nurse practitioners with 1.74 WTE paramedic practitioners. The 2013 primary care survey confirmed that older GPs tend to contribute a higher proportion of shifts than those in the first ten years of practice.

Over the last two years the roster has come under pressure because of a combination of factors which discouraged many sessional GPs from contributing. A redesign plan was developed to address these issues and since January 2015 the roster has improved.

The significant changes at present can be summarised as engagement with the advisory structures and GPs to improve pay rates, introduce better working conditions including flexible shift patterns, working from home and improved induction and clinical feedback systems.

GMED will be delegated to the new Integrated Joint Boards when they are formally established by the end of 2015/16 and the transition will commence during the year.

Conclusion

This paper provides a very high level summary of the current challenges facing general practice, the actions being taken to address the challenges, and the work being done to develop a model for primary care which will be sustainable in the future. The information and initiatives outlined above will be developed at future Board seminars and contribute to the formulation of a clearer strategy and profile for primary care which will contribute to the IJB and NHS Grampian planning processes.

4. Risk Mitigation

The issues identified relate to the undernoted risks in the NHS Grampian Strategic Risk Register.

859: Sustaining access to professional clinical staff
1134: Sustainable work force
1784: Integration of Health and Social Care
610: Involvement and engagement
851: Delivery strategies to meet the future health of the population
855: Infrastructure
The development of the approach to primary care identified above will mitigate these risks and support the development of strategies to support integration and the development of robust strategic plans.

5. **Responsible Executive Director and contact for further information**

If you require any further information in advance of the Board meeting please contact:

**Responsible Executive Director**  
Graeme Smith  
Director of Modernisation  
graemesmith@nhs.net

**Contributers**  
Dr C Provan  
Clinical Lead, Aberdeen City  

Dr M McCrone  
Clinical Lead and Chair of PCIMG

20 March 2015

Pam Gowans  
Chief Officer, Moray and Lead Manager for Primary Care

Caroline Howarth  
Vice Chair, GP Subcommittee

Mark McEwan, Service Planning Manager
Annex:

**NHS Grampian General Practice Workforce Survey 2013**

**Executive Summary**

**Introduction**

An NHS Grampian General Practice Workforce Survey was undertaken across the three CHPs during winter 2013. A questionnaire was forwarded to the practice manager for every General Practice in NHS Grampian. This was developed in partnership with the LMC.

The aim was to develop a comprehensive General Practice Workforce profile for NHS Grampian. This will include all staff that are currently employed by General Practice.

The information collated includes headcount, age, gender, full-time/part-time for the following professional groups: medical, nursing, administrative, other clinical staff and other staff. Data was also collected on vacancies and recruitment, with free quantitative data questions at the end of the survey.

**Data Robustness**

The completion rates were 100% for Aberdeen City CHP (30 out of 30 practices), 100% for Aberdeenshire CHP (36 out of 36 practices) and 100% for Moray CHP (14 out of 14 practices). 71 of the 80 practices that completed the questionnaire submitted a full data set.

According to the General Medical Services Surgery List (January 2014) there are 503 GPs in NHS Grampian and the General Practice 2013 Workforce Survey captured 471 GPs. This is a 94% data capture, so therefore data quality is robust.

**Medical Staff**

28% of the medical workforce are aged 50 or over in Aberdeen City CHP, 35% of the medical staff are aged 50 or over in Aberdeenshire CHP and 44% of the medical staff are aged 50 or over in Moray CHP.

62% of the medical staff are working part-time in Aberdeen City CHP, 60% of the medical staff are working part-time in Aberdeenshire CHP and 61% of the medical staff are working part-time in Moray CHP. When compared to the 2009 General Practice workforce surveys, part-time working has increased by 5% for Aberdeen City CHP and by 9% for Aberdeenshire CHP. No comparison could be undertaken for Moray CHP due to a 56% completion rate of the General Practice workforce survey in 2009.

Of the medical workforce who are working part-time; 23% are male in Aberdeen City CHP, 21% are male in Aberdeenshire CHP and 39% are male in Moray CHP.
Nursing Staff

53% of the nursing staff are aged 50 or over in Aberdeen City CHP, 43% of the nursing staff are aged 50 or over in Aberdeenshire CHP and 35% of the nursing staff are aged 50 or over in Moray CHP.

In Aberdeen City CHP, 80% of the nursing staff are working part-time, in Aberdeenshire CHP, 93% of the nursing staff are working part-time and in Moray CHP, 82% of the nursing staff are working part-time.

Across the three CHPs, thirteen of the advanced nursing practitioners are over the age of 55. This is out of a total headcount of 40 advanced nursing practitioners.

Administration Staff

51% of the administration staff are aged 50 or over in Aberdeen City CHP, 45% of the administration staff are aged 50 or over in Aberdeenshire CHP and 35% of the administration staff are aged 50 or over in Moray CHP.

In Aberdeen City CHP, 71% of the administration staff are working part-time, in Aberdeenshire CHP, 76% of the administration staff are working part-time and in Moray CHP, 71% of the administration staff are working part-time.

Vacancies and recruitment

GP positions are on average are taking 3-6 months to recruit in Aberdeen City CHP. This is for 6-7 GP positions in Aberdeen City CHP.

At the time of the survey, Aberdeenshire CHP had 4 GP vacancies which had been vacant for more than 6 months and each post had been advertised three times. Aberdeenshire CHP is experiencing medical staff recruitment issues as vacancies tend to be advertised more than once and take greater than 6 months to fill.

There are issues with the recruitment of GPs in Moray CHP. Three of the five GP vacancies have been advertised more than once and the same three posts have been vacant for 3-6 months.

Initial Workforce Supply and Mapping Analysis

Figures from NES indicate that 67 GPs in training (GPST) are about to qualify in 2015 and 2016. 56 of these GPSTs are from General Practices in Aberdeen or Aberdeenshire South.

Only 8 GPSTs are about to qualify from GP Practices in Aberdeenshire North from 2014 to 2016 and only 13 GPSTs are about to qualify from GP Practices in Moray CHP from 2014 to 2016.
Qualitative data

GP locum availability was a constant theme across all three CHPs, as was difficulty recruiting into GP partnerships. There is significant interest in hearing about advanced clinical practitioners from General Practices across all three CHPs.

Career start

Career start is a programme initiated in 2005 to aid local GP recruitment and retention. The evidence from this programme suggests that 28 out of 51 GPs that have gone through this programme have entered a GP partnership.
Annex 2:

Infrastructure

The 2004 – 2014 Primary Care Premises Plan set out a range of priorities for General Medical Services and dentistry, the majority of which have been successfully completed.

Third Party Developments – Operational Dates

<table>
<thead>
<tr>
<th>New Medical Centre</th>
<th>Operational Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Old Aberdeen Medical Centre, Aberdeen</td>
<td>26.12.03</td>
</tr>
<tr>
<td>Garthdee Medical Centre, Aberdeen</td>
<td>17.08.04</td>
</tr>
<tr>
<td>Calsayseat Medical Centre, Aberdeen</td>
<td>20.12.04</td>
</tr>
<tr>
<td>Pitmedden Medical Centre, Pitmedden</td>
<td>17.01.05</td>
</tr>
<tr>
<td>Skene Healthcare Centre, Westhill</td>
<td>01.07.05</td>
</tr>
<tr>
<td>Oldmachar Medical Centre (Jesmond Surgery), Aberdeen</td>
<td>12.06.06</td>
</tr>
<tr>
<td>Oldmeldrum Medical Centre, Oldmeldrum</td>
<td>09.10.06</td>
</tr>
<tr>
<td>Carden Medical Centre, Aberdeen</td>
<td>30.10.06</td>
</tr>
<tr>
<td>Great Western Medical Centre, Aberdeen</td>
<td>05.02.07</td>
</tr>
<tr>
<td>Cove Medical Centre, Cove, Aberdeen</td>
<td>21.05.07</td>
</tr>
<tr>
<td>Moray Coast Medical Centre, Lossiemouth</td>
<td>28.01.08</td>
</tr>
<tr>
<td>The Glassgreen Medical Centre, Elgin</td>
<td>14.09.09</td>
</tr>
</tbody>
</table>

NHSG Capital Schemes – Operational Dates

<table>
<thead>
<tr>
<th>New Health Centre</th>
<th>Operational Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marywell Health Centre, Aberdeen</td>
<td>13.03.06</td>
</tr>
<tr>
<td>Maud Community Resource Centre, Maud (cap. cont)</td>
<td>17.03.09</td>
</tr>
<tr>
<td>Laurencekirk Health Centre, Laurencekirk</td>
<td>14.04.09</td>
</tr>
<tr>
<td>Banff Health Centre</td>
<td>01.03.10</td>
</tr>
<tr>
<td>Whinhill Health Centre</td>
<td>07.12.10</td>
</tr>
</tbody>
</table>

NHSG hubCo

The following 4 projects were priorities within the 2004 – 14 Plan, 2 of which will be achieved shortly after the plan’s expiry and 2 of which are being developed.

<table>
<thead>
<tr>
<th>New Health Centre</th>
<th>Provisional Operational Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woodside Health Centre</td>
<td>30.6.14</td>
</tr>
<tr>
<td>Forres Health Centre</td>
<td>21.7.14</td>
</tr>
<tr>
<td>Inverurie Health Centre (Initial Agreement approved)</td>
<td>2017/18</td>
</tr>
<tr>
<td>Denburn Health Centre (NHSG approved)</td>
<td>2017/18</td>
</tr>
</tbody>
</table>

Priorities within 2014 – 2024 Property and Asset Management Plan

The plan covers the period 2014 to 2024 and will be updated annually. Priorities agreed by the Primary Care Premises Group for 2014/15 are as follows –

- Complete work to existing planned priorities carried forward from the 2004 to 2014 plan
- Continue to allocate premises improvement grants against annual allocation to offset the need for significant capital works
- Support the need for condition surveys across all contractor services
- Plan primary care responses in new settlements
- Support CH&SCPs to seek funding sources for progression of 10 priority new builds listed below (currently under review).
1. **Bucksburn** – 1 new building to host Gilbert Road Medical Group (Bucksburn), Brimmond Medical Group (Bucksburn) & Bucksburn Medical Practice

2. **Banchory** Medical Group

3. **Ellon** Group Practice

4. **Dyce** – 1 new building to host Gilbert Road Medical Group (Dyce), Brimmond Medical Group (Dyce)

5. **Northfield/Mastrick** Medical Practice to encompass Main & Second sites

6. **Keith** Medical Group

7. **Danestone** Medical Practice

8. **Kincorth** Medical Centre

9. **Fochabers** Medical Centre

10. **Torry** – Torry Medical Practice & Holburn Medical Practice (Torry)

**Capital Investment**

- The following table summarises our investment plans for primary and community premises:

<table>
<thead>
<tr>
<th>Planned spend - Period to 2017/18</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary and Community Care</strong></td>
<td></td>
</tr>
<tr>
<td>Inverurie Health Centre (CMU and x-ray facilities)</td>
<td>13.1</td>
</tr>
<tr>
<td>GP premises (Hub projects) New and emerging communities</td>
<td>20.0</td>
</tr>
<tr>
<td>Foresterhill Health Centre relocation (Hub project)</td>
<td>7.5</td>
</tr>
<tr>
<td>Denburn Health Centre</td>
<td>5.0</td>
</tr>
<tr>
<td>Capital contribution for minor works and improvement grants</td>
<td>1.5</td>
</tr>
<tr>
<td>Other unallocated funding</td>
<td>4.0</td>
</tr>
<tr>
<td><strong>Total - Primary and Community Care</strong></td>
<td><strong>51.1</strong></td>
</tr>
<tr>
<td><strong>Total – NHS Grampian capital programme</strong></td>
<td><strong>125.0</strong></td>
</tr>
</tbody>
</table>
Annex 3:

General Practice 2020 vision

The NHS Grampian 2020 – A Possible Future for General Practice

In 2020....................

1. The General Practice and extended Primary Care Team continues to provide: “universal access to first contact care; deals with undifferentiated symptoms and provide patients with holistic care; ensures co-ordinated access to specialist care whilst containing healthcare costs; integrates with other health and social care services to the benefit of patients and carers; provides continuity of relationship between patient and doctor over time, leading to better health outcomes and increased patient satisfaction”.

2. General Practice has changed and moved forward dramatically in the last 8-10 years, reconfigured effectively to meet the challenges of demographic change, multiple morbidity and financial constraints. The shift to practices organised around natural communities, in clusters, created greater opportunities for valuable resources to be leveraged much more effectively across these area populations. Clusters of practices emerged in 2010 and a year later, 11 were formally recognised by the NHSG Board each with their own GP-led leadership teams.

3. Clusters have facilitated the much needed higher levels of integration with Health, local authority, 3rd and private sectors. The position of GP practices as the hub of the communities they serve has been enhanced further and a ‘nexus’ of integrated agencies has been created with the GP practice retaining a pivotal role in diagnosis and treatment while also improving disease prevention and health promotion.

4. The emergence of strong, connected clinical leaders played a critical role in how services are organised and delivered in 2020. This leadership was instrumental in bringing general practitioners to the table early in 2011 and through 2014 when many factors converged (changes to GP contract, ECC, new models of decision support) to create the opportunity for transformational change. Powerful, collaborative relationships, formed nearly 10 years ago, remain a defining feature of our health and care system in 2020.

Patients

5. In 2020 self management is the norm with many minor ailments being dealt with via self medication, internet/telephone support or following consultations with their local pharmacist. It is known that the more informed patients are, the greater the reduction in their health care costs and greater reduction in variation of care. For more complex cases and where chronic disease and multiple morbidities are present, care planning is the norm.
6. Anticipatory Care Plans (ACP) identifying all appropriate resources for the provision of health and social care are routinely used to deliver high quality care nearest to the patient’s home. The General Practitioner and the Primary Care team are highly skilled at identifying risks and planning their reduction. These ACPs are co-produced and shared with each patient and between care providers. They are “owned” by the patient, or their carer, linking with personal care budgets via Direct Payments.

7. Home monitoring is routinely used in 2020 with patients monitoring their own blood pressures, weights, INR and other blood tests etc.. Their care is supported remotely by GP, Nurse and Pharmacist. Other routine tests are organised via the GP who monitors the results remotely. Patients, at first slow to adapt to these changes, have become advocates for these “virtual wards” and IT systems were to support these changes. No face to face consultation need take place as patient, GP, and team have trust in their care systems. Clinical accords detailing responsibilities of Health Care teams and patients, underpins the service.

Access

8. From 2016-17 marked uptake of Pharmacy services has delivered considerable improvements in patients being able to access timely and appropriate care, with patients registering with their local pharmacist. This has allowed formal relationships to be joined between medical and pharmacy practices enabling shared and holistic care of patients. Pharmacists provide minor ailment advice and management, and support chronic and multiple disease management in partnership with the GP. Patients clearly understand who to contact and when.

9. In 2020, local pharmacies have become much more than a retail or dispensing facility with patients, using their pharmacy as first point of contact, being managed in a structured way with quick and appropriate onward access to GP services if needed. This relationship is also seen in community Optometry services and combined with changes to the GP contract in 2013 helped unlock capacity within General Practice.

10. There still is a requirement for face to face consultation with a GP or member of the Primary Care team. The team however work much closer than in the past, sharing knowledge between themselves and other health service providers. The GP is the coordinator of these services, trusted by the patient. The single electronic patient record helps to facilitate this key “case manager” role. Delegation within the Primary Care team is the norm with the skill mix in these teams reflecting this previously well developed process. This has been helped with further development of independent prescriber status.

11. Continuity of care is maintained through the GP and the Primary Care team. Continuity of care is important clinically as well as financially and plays a major role in reducing hospital admission as well as improving quality of care.

Multiple Morbidity/Complex Care

12. Looking back from our current position in 2020 of wholly integrated care across community and hospital settings a significant turning point occurred late in 2014 when the considerable work that had been invested in improving hospital pathways began to merge with the activity developing in the clusters. This development saw patients, who previously would have gone in to hospital to see a specialist, having their care and treatment delivered in a community setting and in the case of certain outpatient activity, an elimination of the need for follow up/repeat hospital appointments altogether.

13. In Scotland in 2007 there were 2 million people with long-term conditions and as generally forecast this has risen to c2.6m. They accounted for 50% of GP
consultations, 64% of Out Patient appointments and 70% of all in patient bed days. Our ability to cope with this demand increase has been brought about by embracing a holistic approach to patient care as opposed to single system care planning. This holistic approach, centred on the GP, was essential in containing cost and maintaining quality of care.

14. Starting with Medicine for the Elderly in 2010 other specialist services began to reposition themselves to provide support for GPs to maintain patients with complex care as near to their homes as possible. This created opportunities for specialists to move out of the hospital environment and as we see currently they now work alongside GP/community teams.

15. Furthermore this also saw the enhancement of GPs with special interest working in key areas supporting the team e.g. diagnostics, clinical areas and management. These GPs, alongside their specialist colleagues, provide essential training for the community teams, to increase capacity and confidence in managing multiple morbidity and complex disease.

Hospital Specialist interface

16. We have seen that early access to specialist advice and diagnostics are essential for care to be optimized as near to the patient’s home as possible. While hospital admissions are of course still required both in community hospitals and specialist centres, we have seen them to be more focussed and for the shortest appropriate duration. The introduction of the Clinical Decision Support Hub 2016 transformed the way clinicians requested and received crucial information (24/7) ensuring their patients received the best pre-hospital (and emergency) preparation - most pre-operative assessment routinely take place in community settings linked closely to the GP’s risk assessment of the patient.

Clusters

17. The Practice as a unit has long been recognized as a successful component of our health service particularly in providing continuous care in a holistic way for a defined patient population. The formation of clusters of practices, typically 6-8 practices per cluster, c50,000 patients/cluster has allowed economies of scale to be leveraged and more importantly powerful, collaborative relationships between GPs and other stakeholders to emerge. From 2017 we saw a greater shift to flexible GP contracts with sub groups of 2-3 practices collaborating in more formal, contractual terms. This has proved a key ingredient in fulfilling our transformation. Small single-handed, independent practices are rare with remote, rural populations now served by a range of virtual and physical branch surgery services (including local pharmacies) using assistive technologies. These larger practices provide the majority of care and diagnostics for their populations. Where more complex services are required then aggregation of services around natural communities occurs.

18. Clusters have become an important organisational unit for the development and delivery of these services, for each cluster population; hospital and community resources are aligned accordingly together with local authority partners, 3rd and private sectors. With the aggregation of services around natural communities, this has allowed more complex services to be delivered locally. Old practice boundaries have become much more fluid as patients can effectively receive care from a range of appropriate community facilities within the cluster. From 2013-14, significant Public Health investment, channelled through the clusters, in health promotion and disease prevention is now beginning to bear fruit as we see reductions in risk associated lifestyle indicators.
**Infrastructure**

19. The emphasis on care at home, or as near to home as possible, has seen a significant change in provision and commissioning of hospital and community facilities. The provision of Specialist services within communities has seen a reduction in traditional hospital based outpatient services. Increasingly these are now provided in modern commissioned community facilities combining traditional Primary Care with Social care with diagnostics and Specialist facilities. These are greatly supported by assistive technologies. In-patient activity is centred on Community hospitals, where available, with ARI and Dr Gray’s providing highly specialist service.

20. Increasingly the Workforce is community based and works in a peripatetic fashion supporting local service providers based around practices and the wider cluster/area.

**Technology**

21. In our current Health & Care system of 2020 we enjoy a new relationship both with technology itself as a powerful enabler of service delivery and also with the IT providers who design and deliver our technology solutions. This in marked contrast to the very challenging period from 2000-2015 where technology developments were consistently mis-aligned with organisational requirements. Digital assistive solutions developed fast from 2015 with many micro solutions deployed in our clusters all through 2014-16. From 2014-15 solutions began to be delivered with a scale that tipped Grampian into real transformation with a bow wave of converging telehealth/telemedicine services, web based solutions, digital TV, multiple devices, etc. In all of these solutions the central role of the patient remains crucial.

22. Today interaction with patients has been fully supported by technology with web based appointment systems for community and hospital clinics, routine email communication between GP/Specialist-Patient, automatic reminders using email/SMS, post-surgical follow up using VC/Skype, specific consultations using high definition TV. Patients today can access personalised content relating to their condition through a range of devices including 3-way video consultations with patient-GP-Specialist. Dermatology was one of the first services to embrace this new way of working to its fullest extent and other services quickly followed, taking the opportunity to re-engineer their processes to make best use of the technology. Specialists have dedicated remote outpatient times.

23. Patients were sceptical at first considering the technology solutions were a poor replacement for a face to face interaction. This attitude diminished, at first slowly then rapidly as patients quickly embraced the richer (more personalised) experience and convenience many of the new interactions now offered. For professionals, the development of the Clinical Guidance Intranet and the Decision Support Hub finally gave recognition to the crucial role played by the proper provision of information to the point at which it is needed and also facilitated the integration of many key clinicians; GP, paramedic, ambulance driver, other first responder.

24. The GP now undergoes a longer period of training to fulfil the needs of their extended role to deliver a wide range of clinical, managerial, academic and leadership functions.

25. Relationships between community and hospital clinicians have improved immeasurably. New levels of trust have been achieved between patients and their health and care service providers, health professionals with each other and finally, strong resilience in our Health and Care systems has restored confidence in their ability to support our objectives.