



Aberdeen City Health & Social Care Partnership

Primary Care Improvement Plan

This Primary Care Improvement Plan sets out at a high level, the intentions of Aberdeen City Health and Social Care Partnership (ACHSCP) around modernising primary and community care in Aberdeen, specifically in relation to releasing capacity for General Practitioners to allow them to focus on their Expert Medical Generalist roles. When “Partnership” is referred to in this document, it refers to the Aberdeen City Health and Social Care Partnership in its widest sense including staff working for the Partnership employed by NHS Grampian and Aberdeen City Council; Independent practitioners and organisation, the third sector including community organisations and the citizens who live in communities in Aberdeen.



A

Local context: *profile of primary care in the HSCP, including any specific local challenge and opportunities*

Aberdeen is a significant regional and national business centre and is a popular place for people to live, work and socialise. However, there are also significant challenges which impact on the provision of primary care in the city.

There are 29 individual General Practitioner (GP) Practices in Aberdeen, spread across four locality/ cluster areas. In addition, there are other primary care services including optometry, community pharmacy, and dentistry.

Population

There are significant health inequalities in the city. Due to a recent economic decline in the area, there has been an increase in individuals presenting with mental health conditions.

There are several new and planned housing developments in various communities in Aberdeen which will result in significant demographic change over the next few years and decades.

In line with the rest of Scotland, Aberdeen's population will include an increasing proportion of older people, living longer with multiple co-morbidities.

Workforce

A recent sustainability questionnaire sent to all city GP Practices confirmed some of the challenges around workforce, the major one being an ageing GP and nursing population. The majority of practices who completed the questionnaire stated that they had a high number of GP's and nurses approaching retirement age or choosing to retire at 55.

The ability to recruit GPs is an ongoing challenge – the numbers entering and remaining in the profession are lower than required and an increasing number of GPs are choosing not to enter partnership for a variety of reasons (workload/ prohibitive cost of taking a share in practice owned premises etc.) The nursing workforce faces similar challenges and there are concerns about the future availability of suitably trained and experienced replacements for those nurses who are retiring.

There are also challenges with filling vacant posts for pharmacists, pharmacy technicians, health visitors and other Allied Health Professionals (AHPs). This could impact on our ability to recruit to the multi-disciplinary practice teams as outlined in the new General Medical Services (GMS contract).

The impacts of these challenges, particularly in respect of GPs, have led to a number of general practices in Aberdeen struggling to recruit which is impacting on sustainability and workload and creating wider system issues. While this has been challenging, these



“crises” have also provided opportunities for new models to be developed and tested, such as New Dyce Practice which has tested a range of new and innovative ways of working.

In addition, with the introduction and development of practice pharmacy and proposals for pharmacotherapy teams, finding a suitable workforce may be challenging.

Liaison and links between primary and secondary care in the city are good. Silver City multi-disciplinary teams and the Diabetic Outreach Programme are examples of a range of current positive working relationships and it is intended to build on these through the activities within this plan.

Wider Resources

There are infrastructure and other resources challenges, and it is anticipated that the new contract will assist in reducing workload, creating capacity and resolving some of these challenges. This Primary Care Improvement Plan sets out some of the activities that will release pressure on General Practitioners providing the capacity for them to fulfil their roles as Expert Medical Generalists.

There are several new infrastructure developments which will dovetail with the development of this plan, including the development of Community Diagnostic and Treatment Centres.

General Practices, working collaboratively together (and with the wider primary care sector) will create opportunities for realising maximum value from available resources.

Our increasingly digital society is creating opportunities for people to use technology to maintain their well-being and self-manage their conditions. However this increasingly smart technology is also leading to the identification of more conditions, which as well as supporting earlier diagnosis and intervention, is also increasing demand for primary care services. Opportunities for utilising digital solutions and shifting channels for engagement and service provision will be a core consideration across all our workstreams.



B

Aims and priorities: *To reflect the agreed aims and principles as set out in the guidance*

Our aim is to ensure that primary care in its widest sense is safe and sustainable into the future, fostering opportunities created through collaboration within and across localities, working to allow effective integration of a wide range of multi-disciplinary professionals. This in turn will reduce pressure on general practice, by creating a system where tasks currently undertaken by GPs are realigned to more appropriate professionals with the correct skills and qualifications to undertake this work, allowing GPs to fulfil their role as Expert Medical Generalists.

Our priorities for delivering this are set out in this plan and reflect detailed input and feedback from General Practice and a wider range of stakeholders.

C

Engagement process: *How the plan has been developed and who has been involved*

A city GMS Implementation Leadership Group (GMS Implementation Group) has been established to oversee the development and delivery of the Primary Care Improvement Plan (PCIP) and associated GMS Contract implementation. The group is led by one of the Partnership's Clinical Leads, and includes representation from General Practice Management, Locality Management, Organisational Development, Finance and Transformation. Other key stakeholders have been and will continue to be invited to participate as required and to reflect the priorities over the coming years.

The plan has been developed through an iterative process, including workshops and feedback from General Practices in the city:

- 2/5/18 Workshop to which all GPs were invited. Presentations on six priority areas, and attendees worked in locality groups to discuss their key priorities.
- 2/5/18 All General Practices invited to provide individual feedback on priorities
- 21/5/18 First draft of PCIP circulated for consultation to: GPs, Primary Care Leads, Locality Leadership Groups
- May 2018 (various dates) First draft of PCIP circulated for consultation to the four Locality Leadership Groups (LLGs) in the city and discussed at regular meetings where these were happening during the consultation period. LLGs comprise of a range of local stakeholders, including members of community, third sector, independent care sector, housing, and health and social care service providers.
- 5/6/18 Refined Draft Plan discussed at ACHSCP Transforming Communities Programme Board, which includes a range of stakeholders from primary and community care, acute sector, independent sector and third sector.
- 12/6/18 Final Draft Plan discussed with GP Contract Oversight Group for



Grampian

- 13/6/18 Final Draft Plan discussed at PCIMG (Primary Care Integrated Management Group)
- 18/6/18 Final Draft Plan discussed with LMC and GP Sub Committee.
- Further and ongoing consultation with Patient Engagement Forums, General Practice and Patient Participation Groups is planned.

A detailed Implementation Plan and Communications and Engagement Plan is being developed and will ensure that the plan is implemented in an agile and inclusive manner.

D

Delivery of MOU commitments: *For each of the six priority areas, set out how new or extended teams will work with practices, with reference to section 6 of the guidance*

Please see Appendix 1 which sets out the expected progress against year's 1, 2 and 3.

(1) **The Vaccination Transformation Programme (VTP)**

This will align with the Grampian Wide Vaccination Plan which will see the responsibility for delivery of vaccinations transfer away from general practices over the next three years on the establishment of safe and sustainable alternative provision.

(2) **Pharmacotherapy Services**

All practices are currently receiving weekly pharmacist input, with allocation of resources according to practice list size. The role of the core team remains the promotion of safe, cost-effective prescribing and supporting national strategies including the implementation of the new GMS Contract. It is anticipated that as the pharmacy role develops within the GP practice team this will increase clinical capacity with patient-facing roles for both the pharmacist and/or pharmacy technician.

The PCIP will support the team to grow and develop (subject to the constraints of availability of resource and of workforce), allowing increased pharmaceutical care into:

- GP practice teams
- Care at Home (supporting patients living in their own home, who receive local authority commissioned care)
- Acute Care at Home (a short-term service supporting patients to avoid unnecessary admission to hospital or to facilitate early discharge from hospital)
- Intermediate Care (providing care for patients requiring additional support/enablement following hospital admission or crisis in the community, with the aim of facilitating a return to independent living)

This will allow consolidation of roles and responsibilities within the team and improve continuity of care for patients. This may involve using the current health and social



care employed pharmacists in a more patient facing role, while continuing to balance other priorities. This may also include them being more involved in acute and repeat prescribing.

The plan will support the continuation of the Pharmacy First Service which allows patients access to treatment for uncomplicated Urinary Tract Infections and Impetigo from a Community Pharmacy.

The plan could also support an increased role in the management of repeat and acute prescribing in general practice. In addition, with the introduction of "Workflow Optimisation" incoming clinical mail could be directed appropriately to pharmaceutical staff for processing. Workflow Optimisation is a training programme for practice administration staff which has been trialled and implemented across England and has proved effective in reducing the flow of mail to GPs on a daily basis by up to 80% (saving an average of 40 minutes per GP per day). Many of the clinical letters received daily in GP practices relate to medication issues, polypharmacy, medication reviews and medicine reconciliation and could, with appropriate staff training, be directed to and actioned by pharmaceutical staff leading to a significant reduction in GP workload.

(3) Community Treatment and Care Services

Self-management and Collaborative Care including the use of technology to support this, with an aim of ensuring that patients are better informed to manage their long-term conditions, have less requirement for review and hold more informed and productive consultations. Patients will benefit from quicker and more accurate clinical decision making, while having less travel to GP surgeries, therefore releasing capacity to the wider GP practice population.

Examples of such models may include – Florence and House of Care, both of which are already identified as priorities through the Technology Enabled Care (T.E.C.) framework and the Partnership's Transformation Plan.

Elective Care Project/ Locality Diagnostic Hubs – NHS Grampian are currently undertaking a review of their Elective Care work. One of the outcomes of this project has been to scope out Community Diagnostic and Treatment Centres, dovetailing with the theme of Community Treatment and Care Services.

Phlebotomy

It is recognised that there are opportunities for efficiencies and improved patient experience through new models of phlebotomy delivery and it is intended early on in this plan to develop an enhanced phlebotomy service. Opportunities exist to review existing services provided by a range of primary and community care practitioners and test alternative person-centred models, for example: potentially including exploring opportunities for self-collection kits.



Integrated Community Health and Care Hubs – For example, Healthy Hoose - a local nurse-led community drop in health care facility has been operating in a city community for several years. A range of services are offered and many of the patients' health queries and concerns can be dealt with there – saving an unnecessary journey to the GP surgery. This type of service can be of particular benefit to communities where citizens have lower car ownership and greater health inequalities, through allowing other practitioners to work to the top of their licence, patients see the correct person at the correct time thereby freeing up GP appointments for more complex cases. These hubs may also help with current pressure points in GP practices especially in relation to chronic leg dressings and the flushing of PICC (peripherally inserted central catheter) lines which are impacting significantly on general practice nursing capacity.

(4) Urgent Care (advanced practitioners)

Afternoon Visiting Service – The Afternoon Visiting Service has recently been rolled out in one locality supporting several GP Practices. This service uses an Advanced Nurse Practitioner supported by a driver, to visit patients who require home visits, and the support to patients is monitored through the patient's GP. Through this plan, this service would be rapidly scaled up.

Integrated Triage – This new way of working, involving individual GP practices working collaboratively to enable more efficient and effective triage, linking into relevant professionals including MSK (musculoskeletal), Advanced Nurse Practitioners and GPs, and utilising technology where appropriate.

(5) Additional Professional Roles

There is a commitment to develop a Health and Social Care Partnership Workforce Plan in the context of provision of future health and social care and the needs identified through this plan will be taken into consideration. This will align with our developing plans in relation to the commitment to deliver 800 additional Mental Health Workers across Scotland. Amongst others these could include:

Community Mental Health - Primary Care Psychological Therapists in primary care have been tested through our transformation programme and there is emerging evidence of the benefits of this community resource.

These posts will also contribute to the implementation of Action 15 of the National Mental Health Strategy in terms of recruiting additional mental health workers.

Chaplaincy Listening Service – This service has been supported through our transformation programme and there is developing evidence of the benefits of this resource to the community. The service is provided by volunteers, with clinical supervision.



These posts will contribute to the implementation of Action 15 in terms of recruiting additional mental health workers.

MSK – MSK services are well established across the City and are accessed through GP referral or patient self-referral via the NHS24 Musculoskeletal Advice and Triage Service (MATS). The plan will build on this work with a specific focus on developing a first contact practitioner MSK service to manage MSK demand at the front door of primary care to shift this demand away from the GP. This work will be informed by national MSK physiotherapy working group guidance and evidence from other established models across the UK.

Practice Aligned Care Management - The Health and Social Care Partnership already has a number of co-located Care Managers who deliver and support statutory social work and community care services within Primary Care settings. It is our intention to expand this joint working as resources and opportunities for colocation arise. The colocation and alignment of Care Management staff to GP Practices will yield workload dividends to primary care through easier communication, improved referral pathways, and the ability to integrate social work/social care into practice related activity (anticipatory care planning (ACP) work; palliative care management etc).

(6) **Community Links Practitioners**

The Community Link Working initiative aims to reduce the negative impact of social and economic circumstances on health. By introducing Link Practitioners into all practices within the city we aim to provide a person-centred service that is responsive to the needs and interests of the practice population. Their initial focus is on alleviating pressures in GP practices and mitigating health inequalities by supporting people to live well through strengthening connections between the third sector, independent sector, community resources and primary care. This will be achieved by supporting people to link more closely with opportunities in their community, enabling them to improve their health, wellbeing and personal resilience. It is our intention to embed the links approach into ways of working across Health and Social Care.

This approach will reduce GP workload and appropriately address many of the social/non-medical issues facing patients in the city.

Silver City and other outreach clinics - This way of person-focused multi-disciplinary team working is already paying dividends in a number of General Practices in the city. This plan would look to develop the successful elements of these activities further, increasing benefits for GPs by reducing the need for referrals, and improving links with community geriatric nursing team.



E **Existing transformation activity:** *Future plans for any existing pilots or transformation tests of change*

Aberdeen City Health and Social Care Partnership has a comprehensive programme of transformation, including several transformational activities which are in progress and directly relate to this PCIP. These are described in section D above.

F **Additional Content:** *Community Pharmacy, Optometry and Dentistry: linked developments and priorities*

Community Pharmacy:

Community Pharmacy services within Aberdeen City are wide-ranging with 51 contractors delivering prescription dispensing, Minor Ailments Service, Chronic Medication Service and Pharmaceutical Public Health services including Smoking Cessation, EHC (Emergency Hormonal Contraception) and Gluten Free Foods Service. These services have already removed pressure from GP services and are still developing. In particular, collaborative working on patient lists suitable for the Serial Prescribing element of the chronic medication service (CMS) will help release GP time.

The recent implementation of Pharmacy First triage for urinary tract infection (UTI) and Impetigo and potentially for other services fitting with this model will add to the multidisciplinary team healthcare approach and will provide vital leeway within GP practices. Collaborative working within the Primary Care Healthcare teams is important in planning for future patient-centred service delivery. The effective use of '**Know Who to Turn To**' within the ACHSCP is key.

The continuation of Pharmacy First service has been included in this PCIP plan.

Access by pharmacy teams to patient information is a key requirement for the continued improvement in patient safety and should be considered in all future planning initiatives.

Optometry:

The PCIP allows for linked developments and priorities to reflect collaborative working over the next 3 years, Optometry could look to work more closely with other Primary Care contractors e.g. GPs. Optometry already operates an unscheduled care ethic where an appropriate appointment is found for a patient. However, there is no contract (local or national), for this and finding a home for out of hours patients can often be challenging. The City PCIP could be an opportunity to collaborate more fully to solve this, organising local out of hours (OOH) Optometrist/s, possibly employed by the ACHSCP.



As Ophthalmology demand continues to grow and referral times get longer, more shared care in the community could evolve. Access to patient notes continues to act as a barrier for this initiative and so collaborating with General Practice may be a solution by using cluster Optometrists in Health Board Practices: A National Ophthalmology Electronic Patient Records (EPR) business case is being created by Scottish Government as a 'Once for Scotland Ophthalmology EPR' which could open up access for community-based optometrists to input and access notes. The new web front end system will be in place by end 2018 in Optometry Practices making shared care easier. This PCIP will take advantage of these changes to coordinate more collaboration with Optometry and Pharmacy.

Dentistry

Over the next few years, it is expected that the Public Dental Service (PDS) will reduce general dental services provision and will, in future, be complementary to the independent sector. PDS will provide a more specialised service, caring for priority group patients who may find difficulty in accessing high street services, including provision of services requiring extended skills or access to secondary care facilities.

All care homes within Aberdeen City have a linked PDS practice, to ensure residents can access dental care routinely or if required, in an emergency, and dental staff are in contact with GMS colleagues should medical expertise be required.

Whilst dental registration has steadily improved in Aberdeen City, the older age cohort registration level of 57-66% remains well below national and local targets. Health and social care integration presents an opportunity for dental teams to interface with patient-contact services to help identify barriers to dental attendance for the over 65-year age group, and to better understand how care pathways may be simplified and expedited from all referral sources.

Community Services:

The implementation of the PCIP will dovetail with our approach to developing locality working including new ways of working such as Integrated Neighbourhood Community Aberdeen (INCA) teams which bring together care at home workers and nurses in small community-based teams, wrapped around people and their connections and linking into other primary care supports in the community.

Our locality structures are being developed and will complement the activities within this PCIP.

Interface with Acute Services – primary care will continue to interface with Acute Services to reduce unnecessary admissions. For example, Silver City, if used successfully would reduce the number of avoidable admissions.



Other linked local priorities (e.g. practice sustainability)

The implementation of the PCIP will make the role of a General Practitioner as an Expert Medical Generalist more attractive, helping to reduce recruitment and retention challenges which currently impact on practice sustainability. It is acknowledged that collaboration across the GP and wider primary care community will be essential for achieving the ambitions of this plan,

G

Inequalities: *How plans, including allocation of resource, will address locally identified need and inequalities*

Our plans take cognisance of health and other inequalities, for example:

- Our Link Working approach will support practices across the city, however the allocation of this resource will be weighted in favour of practices with populations with greater socio economic and health inequalities.
- Developments of Integrated Community and Care Hubs and new ways of working supporting mental health will be focussed around those areas experiencing greatest need.
- Where appropriate, new ways of working will be developed in a manner that allows for the services to shift and flex dependent on need and demand as this changes over time.
- We will be cognisant that while reducing inequalities is a key aim of the plan, it is intended to achieve this by increasing health and wellbeing levels overall in the city, therefore not destabilising areas with existing good health

H

Enablers: *Workforce planning: how HSCP workforce plans will support the PCIP requirements*
Accommodation: how accommodation strategies will support PCIP requirements

This plan aligns with the Partnership's Re-imagining Primary and Community Care vision which was approved by IJB in January 2018. This vision starts to articulate our future workforce requirements, which includes the development and implementation of new roles, increased multi-disciplinary and collaborative working and using technology where appropriate.

Our Primary Care Premises Plan has recently been approved across Grampian, this identifies several strategic capital priorities. Along with this, the PCIP will require accommodation strategies to support closer integrated working.



I

Implementation: *Process for engaging with clusters and practices| Leadership and change management capacity and support |Multi-disciplinary team development: how practices, clusters and the wider MDT will be supported to develop new ways of working*

Our initial process for engaging with clusters and practices has been through workshops, targeted communications and consultation on this plan during its development process.

The detailed feedback received from individual practices has highlighted individual preferences in relation to the implementation and prioritisation of various workstreams. This will inform the detailed implementation plans that will be developed following the endorsement of this plan.

Along with this detailed implementation plan, the GMS Implementation Group has identified several key stakeholders including (not exhaustive or in any particular order):

- Operational teams (locality MDT teams and service teams)
- Professional leads
- Locality Leadership Groups
- GP clusters
- GP Practices
- ACHSCP Senior Management Team
- Corporate Stakeholders
- Integration Joint Board
- Patients and members of community
- Politicians (local and national)
- Patient Participation Groups
- Local Medical Committee (LMC)
- GP Sub Committee

These key stakeholders will be mapped on an interest/ influence matrix to assist in the development of a detailed communications and engagement plan.

J

Funding profile *How new earmarked funding and any residual PCTF funding will be used in support of the plan |How any other additional sources of funding will be used in support of the plan | Other resources or realignment of funding*

The costs associated with the implementation of this plan and the ACHSCP's wider primary and community care aspirations will be supported by transformation and change funding including residual Primary Care Transformation Funding, the Primary Care Improvement Fund and Action 15 Fund.



A detailed 4-year financial profile has been developed to cover all the projects within this plan and is aligned with the confirmed and projected funding available for this purpose.

As projects progress, the financial profile will be refined and monitored, utilising the transformation governance process approved by the ACHSCP IJB and as utilised for our wider Transformation Programme.

The development of each project within the programme will be supported through a robust business case process, and changes supported through the partnerships Change Control Framework process.

Progress of the plan including monitoring of overall expenditure is reported through the partnership's Programme Board governance structure, including regular reporting to the ACHSCP's Audit and Performance Committee.

Summary of indicative overall funding available:

	2018/19	2019/20	2020/21	2021/22
Funding Source				
PCIF	£1,793,412	£2,065,710	£4,131,420	£5,821,547
Action 15	£431,203	£666,404	£940,806	£1,254,408
GP Out of Hours Fund	£196,001	£196,001	£196,001	£196,001
Total	£2,420,616	£2,928,115	£5,268,227	£7,271,956

K

Evaluation and outcomes: *Key success indicators over the life of the plan and how these will be assessed*

One of the focal drivers of this plan is reducing current GP workload to allow a refocus of the GP role as Expert Medical Generalist, focusing on undifferentiated presentations, complex care, and quality and leadership. Therefore, primary success indicators will involve assessing changes in GP workload over time. At a practice-level, these indicators may be measured by ascertaining frequency and volume of GP tasks across implementation (including administrative and consultations) and comparing this to historical data. It is acknowledged that this indicator may be masked by existing unmet demand. In addition, strategies will require to be developed to identify and manage any excess capacity.



This will be supplemented by qualitative data to understand from GPs' perspective the impact that the plan has had on their daily working.

Evaluation at this high level will be composed of complementary synergies derived across the span of individual services, therefore evaluation activity will be necessary for each project to unpick these synergies. This will facilitate an understanding of which projects affect different elements of GP workload. For example, Advanced Nurse Practitioners undertaking a visiting service on behalf of GPs will save not just GP time on the consultation itself, but also on travel time to and from the visit.

The detail within each service-specific evaluation framework will be developed individually, however several elements will remain consistent across the overall framework to derive overall impact. Consideration will be given to the barriers / facilitators of implementation, in addition to understanding benefit at numerous levels, including patient/citizens, unpaid carers, staff and resources/services. These will be assessed through a combination of quantitative and qualitative methods to develop robust and pragmatic evaluation frameworks.

DRAFT



Appendix 1 – Expected Progress on 6 priority areas in Years 1, 2 and 3

	Year 1	Year 2	Year 3
<i>The Vaccination Transformation Programme (VTP)</i>			
	Year 1 will include centralised co-ordination of travel vaccines, neonatal BCG, and pregnancy related vaccinations.	Year 2 will include centralised co-ordination of pre-school and shingles immunisations.	Year 3 will include centralised co-ordination of adult vaccinations such as flu and additional vaccinations for patients at high risk (e.g. coeliac patients, immunosuppressed, etc).
<i>Pharmacotherapy Services</i>			
	<p>During year 1, scoping, planning and implementation of the following will be undertaken:</p> <ul style="list-style-type: none"> - Consolidate and expand the number of pharmacists and technicians working in GP practices. - Explore and develop opportunities for pharmacists to continue to adopt a greater patient facing clinical role, and the planned “pharmacotherapy” service which will support prescribing improvement work, improve clinical outcomes and contribute to the multi-professional team approach to addressing sustainability issues within GP practices. - Expand the number of technicians working in Care Homes, Care at Home and Intermediate Care settings. This would truly support integration and multidisciplinary working equitably across primary care and social care services within the partnership, 	<p>Year 2 will involve the continued implementation and development of the pharmacotherapy teams in practices.</p> <p>Year 2 will also see potential changes to the existing model where more practice pharmacists & pharmacy technicians are recruited and employed through the partnership.</p> <p>Scoping work will be undertaken to determine the viability of geographical/locality-based service compared to pharmacotherapy teams based in individual practices.</p>	<p>Year 3 will see the full delivery of the new model with pharmaceutical support to every practice, where work force availability allows, and an interim model where there are workforce challenges.</p> <p>The new model will allow for all ACHSCP pharmacists to be able to undertake their new GMS role (<i>i.e. patient facing clinical role, polypharmacy reviews, supporting cost-effective prescribing, management of systems & processes relating to prescribing</i>). This would allow greater flexibility</p>



	<p>by supporting medicines management for patients/clients/service-users in their own home/homely setting and the provision of excellent person-centred care. A business case is currently being developed to support this.</p> <ul style="list-style-type: none"> - Identify opportunities for better use of community pharmacy including CMS (Chronic Medication Service), Pharmacy First and Minor Ailments Service. <p>Once the business case is approved, including allocating the appropriate resources and developing an implementation plan, work will commence on recruiting the required workforce.</p> <p>In addition, in Year 1, work would be undertaken to plan and commence the implementation of the Workflow Optimisation project.</p>	<p>In Year 2, implementation of the Workflow Optimisation project would be spread across all practices wanting to adopt this system. Work would commence to identify opportunities for shared working across practices, linked to Workflow Optimisation processes.</p>	<p>across the team and would support recruitment & retention across a range of roles, especially GPs and pharmacists.</p> <p>Benefits expected to be realised include positive impacts on the prescribing budget.</p> <p>It is anticipated that some city practices will be planning to work in a more integrated manner around Workflow Optimisation.</p>
<p>Community Treatment and Care Services</p>			
<p><u>Self-management and Collaborative Care</u></p>	<p>In Year 1, projects will continue to be scoped and planned, and full robust business cases developed. Some initiatives, such as House of Care will be implemented in a small number of practices.</p>	<p>In Year 2, the projects will continue to be scaled up as appropriate. Ongoing refinements and improvements will be made.</p>	<p>In Year 3, the projects will be fully operating as business as usual, with ongoing continuous improvement.</p>



<p><u>Elective care project/ Locality Diagnostic hubs</u></p>	<p>Work will be undertaken to scope this out in Year 1 in addition to ongoing work with the Elective Care Project Team. Several workshops have been held and more are planned to discuss this project. Work will also be done to scope out potential locations of these centres (separate work streams ongoing).</p>	<p>Continue to work alongside Elective Care Project to develop business case and commence implementation where appropriate.</p>	<p>Implementation stage.</p>
<p><u>Phlebotomy</u></p>	<p>Scope and develop a business plan for the implementation of a smart phlebotomy service and begin to roll out new service.</p>	<p>Implement new service, improve service processes.</p>	<p>Fully operational.</p>
<p><u>Integrated Community Health and Care Hubs</u></p>	<p>During Year 1, scoping work would be undertaken to plan the roll out of this and or other appropriate service(s) to other communities in the city. Specifically, there may be opportunities in relation to new capital community developments which may be planned in the city, both of which include citizens experiencing health inequalities.</p>	<p>Develop business case for roll out of these hubs if other suitable communities are identified. Commence implementation where appropriate.</p>	<p>Implementation stage. It is anticipated that an additional hub will be in place by 2020/21.</p>
<p><i>Urgent Care (advanced practitioners)</i></p>			
<p><u>Unscheduled Care Visiting Service</u></p>	<p>There is currently one visiting team in place consisting of an ANP and driver. During Year 1, the impact of the new service will be evaluated, and plans developed to scale up the service. Subject to the availability of resources, the initial scale up of this service will commence during this year.</p>	<p>Continue initial scale up of the afternoon visiting service to cover a greater number of GP practices. Plan to scale up the service to all GP practices that feel this would be of benefit to their patient population, reduce GP workload and improve sustainability of primary care. Scale up will include consideration of service increasing to cover a greater time period.</p>	<p>Full scale up of Afternoon visiting service to cover all GP practices which wish the service and greater time coverage.</p>



<p><u>Integrated Triage</u></p>	<p>During Year 1, work will be undertaken to scope out opportunities for GP practices to work together to share triage for urgent care. This will include scoping the potential use of other community resources for urgent care. Work will commence on the development of the business case.</p>	<p>Continue to develop the business case for implementation of this new way of integrated working, ensuring robust clinical and care governance and making appropriate use of all appropriate contractor groups.</p>	<p>Implement new ways of integrated working, ensuring robust clinical and care governance.</p>
<p><i>Additional Professional Roles</i></p>			
<p><u>Community Mental Health</u></p>	<p>During Year 1, working in conjunction with mental health services to continue existing GP aligned mental health hubs and determine the potential for scale up and sustainability of this service, alongside any other mental health services that provide early intervention and prevention and subsequently reduce GP workload. During Year 1, a plan will be submitted with regards to Action 15 of the Mental Health Strategy and aligned to this PCIP.</p>	<p>During Year 2 the business case will start to be delivered.</p>	<p>New model will be integrated into business as usual.</p>
<p><u>Chaplaincy Listening Service</u></p>	<p>The service is currently at capacity, and during Year 1, the existing service will continue, and plans will be drawn up to expand the service.</p>	<p>During Year 2 the plans for expanding the service will start to be delivered.</p>	<p>During Year 3 the plans for expanding the service will be delivered.</p>
<p><u>MSK</u></p>	<p>During Year 1, work will commence to scope out opportunities and develop the business case. This will include exploring different service delivery options and how they might be delivered e.g. practice level, across localities etc. The scoping will also include any workforce training and development requirements associated with each model e.g. non-medical prescribing, provision of Fit-notes, injection therapy, advanced clinical skills</p>	<p>During Year 2 the business case will start to be delivered.</p>	<p>During Year 3 the agreed model will be fully implemented across the city.</p>



	development etc.		
Practice Aligned Care Management	Develop and scope plans for implementation.	Implement Practice Aligned Care Management where appropriate.	Further roll out of Practice Aligned Care Management.
Community Links			
Link Practitioners	During Year 1, Link Workers will be recruited and aligned with General Practices on a phased basis. (20.8FTE across the 29 practices in Aberdeen.) Scoping work will be undertaken to plan how the wider GP Practice population can be supported to build the link working approach across all aspects of their practice working. This would reduce GP workload and appropriately address many of the social/non-medical issues facing patients in the city.	During Year 2, an iterative learning process will be used to improve the way that Link Practitioners work with General Practices and the local community. This will be carried out by developing strong mutually supportive relationships with local community and third sector organisations and where appropriate identifying gaps in provision. Utilisation of the National Service Directory will strengthen the links approach and aid long term self-management.	By Year 3, the link working approach and culture will be embedded into GP practices and their local communities.
Silver City	During Year 1, we will scope out and develop the business case which will agree the model to be rolled out across the city.	During Year 2 the plans to expand the model will start to be delivered	During Year 3 the agreed model will be fully implemented across the city.
Community Links Portal linked to GP website	During Year 1 we will continue to work with the Alliance and NHS24 to develop A Local Information System for Scotland (ALISS) and National Service Directory respectively. This digital platform will provide a mechanism to support signposting and be used as a tool to identify duplication and gaps in provision across the city.	During Year 2 we will continue to refine and make improvements to the quality of the information held within the system.	During Year 3 the platform should be fully developed, and we will continue to update and maintain the information.



Aberdeen City Health & Social Care Partnership

A caring partnership

DRAFT