Improving General Practice Sustainability Working Group:

Progress Report

February 2019

Primary Care Division

Scottish Government
Riaghaltas na h-Alba
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CONTENTS

1. INTRODUCTION

PURPOSE

This report, produced for the Improving General Practice Sustainability Working Group (Working Group), provides an update on the programme of work undertaken during 2017/18 to implement the Improving Practice Sustainability: Recommendations of the Short Life Working Group(SLWG) Report, published November 2016.

BACKGROUND TO THE SUSTAINABILITY REPORT 2016

It is widely acknowledged that the sustainability of the GP Practice model has been challenged over time by a number of complex societal and operational pressures[1]. The Cabinet Secretary for Health and Sport requested in March 2016 that Scottish Government officials establish a SLWG with key stakeholders to better understand the pressures facing general practice. The main objectives of the multi-partner Working Group were to develop an understanding of the underlying issues contributing to practices getting into difficulty and to make recommendations on how general practices in Scotland could be supported to improve their sustainability over the short, medium and longer term. Membership included representation from SGPC[2], RCGP[3] and both territorial and national NHS Boards, including NHS24.

The SLWG produced a report indicating 4 key recommendations:

- Enact a Sustainability Action Plan for managing sustainable General Practice workload that contains short, medium and long term actions.
- Develop a Practice Sustainability Network that both shares and supports current and future learning on practice sustainability across Scotland.
- Promote the use of, and share learning from, a Practice Sustainability Assessment Tool.
- Create a longer term General Practice Sustainability Group.

Both the learning and Report recommendations have been instrumental in shaping the scope and content of contract negotiations between the Scottish Government and the BMA[4], the final content of the new GMS[5] contract and associated enablers of change e.g. the National Code of Practice for GP Premises.

[1] http://www.gov.scot/Resource/0052/00527530.pdf
[2] Scottish General Practitioner Committee
[3] Royal College of General Practitioners
[4] British Medical Association
[5] General Medical Services

2. CONTEXT

As many elements of the recommendations, particularly relating to the Action Plan, are covered within the new GMS contract developments, it may help to outline the key developments that have taken place since the 2017 Report was published. They include:

- Publication of the 2018 Scottish General Medical Services Contract Offer sets out the distinctive new direction for general practice in Scotland which will improve access for patients, improve population health including mental health, provide financial stability for GPs, and reduce GP workload through the expansion of the primary care multidisciplinary team.

- Publication of a co-produced Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards[6], in November 2017, which sets out agreed principles of service redesign, key partner roles and responsibilities, the establishment of Primary Care Improvement Plans (PCIPs) and the new national and local oversight arrangements for the contract and PCIPs.

- The 2017 National Code of Practice for GP Premises sets out the Scottish Government's plan to facilitate the shift to a model which does not entail GPs providing their practice premises. Amongst other things, this included the introduction of new interest free sustainability loans for GP owned premises supported by additional £30 million investment over the next three years.

- The Information Commissioner's Office now advises that GPs and their contacting Health Boards have joint data controller processing responsibilities towards any shared elements of the GP patient record. The new contract recognises that GPs are joint data controllers along with their contracting NHS Board. In this way, GP contractors will not be exposed to liabilities beyond their control. Further detail on premises and infrastructure initiatives can be found in the good working practice and general sustainability sections of the sustainability action plan.

- The third section of the National Workforce Plan: National Health and Social Care Workforce Plan: part 3, was published on 30 April 2018, sets out the Scottish Government's approach to recruiting 800 more doctors to general practice over the next decade and supporting and retaining the existing workforce. This is supported by an additional £7.5 million investment in 2018-19 to improve GP recruitment and retention, £2 million of that will be specifically to support remote and rural initiatives to attract and retain GPs in rural communities. Improved workforce planning which considers demand on services and an ageing population as well as a workforce is key to our national approach to workforce planning.

[6] Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards - GMS Contract Implementation in the context of Primary Care Service Redesign, published 13 November 2018
http://www.gov.scot/Resource/0052/00527517.pdf

- Scottish Ministers have also committed to a significant expansion of the multidisciplinary team, including the training of 500 advanced nurse practitioners,[7] 250 Community Link Workers to be in place by 2021, and 1000 paramedics to work in the community. General practice will further be supported by ensuring all practices are given access to a pharmacist by the end of this parliamentary period. An additional investment of £6.9 million will be made in nursing in primary care, particularly general practice nursing, district nursing and community nursing.
- The passing of Scottish Government Budget Bill in February 2018, confirming an increase in the Primary Care Fund from £72 million in 2017-18 to £110 million in 2018-19. This includes £100 million to support implementation of the new GP contract and wider primary care reform including a new Primary Care Improvement Fund, totalling £45.750 million, allocated to Integration Authorities in 2018-19 to fund delivery of the MOU service redesign priorities set out in local Primary Care Improvement Plans.

[7] **Education and development opportunities for nurses working in General Practice teams can be found** at: http://www.nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/careers-and-recruitment/transforming-nmahp-roles/general-practice-nursing.aspx

3. SUSTAINABILITY REPORT: 2018 UPDATE

Following on from the Report's publication, the reformed Working Group took time to consider how to deliver the recommendations, drawing on the considerable collective skill, knowledge, experience and resources of its members.

The following sections provide an overview of the work carried out to achieve the four key recommendations.

RECOMMENDATION 1: Enact a Sustainability Action Plan for managing sustainable General Practice workload that contains short, medium and long term actions

National Feedback
In addressing the list of actions outlined in the SLWG's Report, consideration was given by the Working Group to how this work should be approached and prioritised. The action plan consists of 55 actions which were broken down into eight broad themes based on priorities identified by the Scottish General Practitioners Committee(SGPC) and Health Boards. The new GMS contract together with the contract related developments, listed in the context section above, addresses more than 30 of the 55 recommendations in the action plan.[8]

Local Feedback
In addition, it was agreed that members of the longer term Working Group would provide feedback on work being carried out locally using the listing of the 55 point action plan (Recommendation 1) as a prompt, together with details of any work generated by the three other recommendations[9].

A total of five health boards, NHS Forth Valley, NHS Grampian, NHS Highland, NHS Lanarkshire and NHS Tayside provided local feedback on the work they have undertaken in support of the action plan.

The national and local data fed back to the Scottish Government will allow collective progress to be shared with members of the Working Group and more widely with the sector via the i-hub or within Scottish Government. This will aid knowledge-sharing, best practice and understanding. The following paragraphs highlight both local and national feedback:

1. *Partnership Working with External Organisations* – There is good progress on all actions, with initiatives being undertaken by the Scottish Government and other key organisations. Colleagues in Creating Health policy team are considering the introduction of an electronic referral system for fit notes that would remove the onus for GPs altogether. They are awaiting an indication from Westminster[10] that they can begin progressing a pilot. Meanwhile, to offset their sustainability issues, health boards report measures such as embedding welfare advisers in some of their

[8] See Annex C, which illustrates the 55 recommendations in the action plan
[9] R2: Develop a Practice Sustainability Network, R3: Create a longer term Practice Sustainability Group, R4: Promoting the use of a Practice Sustainability Assessment Tool
[10] The Joint Department for Health and Social Care and Department for Work and Pensions Health Unit recently announced that occupational therapists working in employment and vocation could sign off on the Fit Note, usually completed by GPs.

practices, to redirect the workload created by non-contractual requests e.g. welfare letters, or other examples of early adoption of the multi-disciplinary team(MDT) model.

2. *Supporting patients to self-care* – The Scottish Government is partnering with HIS[11] and four HSCPs to deliver on the Practice Administrative Staff Collaborative, which will support the MDT by looking at the development and training need of practice receptionists for signposting patients to the most appropriate professional. Other recent developments include the '*3 before GP'* campaign by the RCGP, involving a three-step approach of self-care, on-line advice such as NHS Inform and advice from a pharmacist for minor ailments before booking an appointment with your GP. Locally, the '*Know Who to Turn to'*[12] campaign is cited by most boards.

3. *Delivering Solutions: good working practice* – To support good working practice, the Primary Care Professional Advisers Team use their expertise to provide a hands on advisory service direct to Primary Care Leads and HSPCs. The MoU was published alongside the new contract to ensure that primary care funds are solely used for primary care work. The non-clinical role of the community link worker has been introduced as part of the MDT, with a focus on practices in areas of high socio-economic deprivation, to aid signposting of patients to the most appropriate services.[13] However, on a local level, there has been variable use of the sustainability assessment tool although the vast majority of HSCPs have used it in some form.[14]

4. *Workforce* – In addition to the national workforce developments listed in the context section above, the Protected Learning Time (PLT) short life working group, a subgroup of the Working Group is examining how to best deliver PLT in an expanded MDT context, including clinical and non-clinical membership to ensure learning is shared with the wider MDT. Although not contractually obliged, NHS 24 and Out Of Hours (OOH) have played a pivotal role in supporting practices to deliver PLT by providing much needed cover, In revising the terms on which this service can continue to be supplied, NHS 24 is keen to work with partners at Board level to explore options for PLT provision beyond 2018/19.

All five health boards responding indicated that they were proactively developing the MDT approach. They reported mixed feedback on PLT, with some struggling to deliver as a result of service pressures. However, Tayside have an established PLT programme in all 3 of their HSCPs, and Grampian and Tayside report good work being done on their returner programmes.

[11] Health Improvement Scotland
[12] Know Who to Turn To is being replaced by the national directory of services which will be available on the nhsinform.scot website.
[13] See Annex A, Case Study 1, page 13
[14] See Annex E, page 17

5. *GP Contract* – A number of actions listed in the sustainability action plan were covered by the contract negotiations in agreement with the BMA[15], including elements around registration, closing lists and changing boundaries. A formal process to vary practice areas has been introduced via regulations and work is already underway with external partners on the GP retainer scheme across Scotland. Locally, Tayside reported proactive groups, with governance processes in place that are supported by clusters and HSCP data in a review of practice boundaries. Most HSCPs are in the early stages of the Primary Care Improvement Plan process and remain positive about the intention to engage with local stakeholders and service users in their re-design.

6. *Effective Primary/Secondary Care Interface Working* – The primary/secondary care interface is a key issue and as parallel work was being carried out by the Scottish Government team managing the Modern Outpatient Programme, Scottish Government colleagues have led on this work. This has also been a priority area of work for RCGP Scotland for the last four years. As a result of collaborative working with the Scottish Government, a well-received interface programme, funded by Scottish Government is now being delivered by RCGP Scotland.[16]

Nearly all health boards that responded, stated that they either have an existing group that looks at interface issues or a specific dedicated interface group. Some also advised they have an interface review process in place. Some Boards have also advised that they had successfully moved to 'specialist to specialist' referrals within secondary care, removing GPs from unnecessary involvement in the process. More than one health board have advised they have processes in place to allow fit notes to be completed by secondary care professionals rather than GPs when appropriate.

The new RCGP Scotland clinical lead, recruited in May 2018, will work across all Scottish health boards, supporting each board to establish dedicated high-functioning primary-secondary care interface group. This work will run over a three year period.

7. *Effective Working Between GP & Pharmacy Services* – The majority of actions on pharmacy services are underway or completed. Of note is the interim solution to allow pharmacists independent prescribers to prescribe electronically using GP clinical systems which were rolled out nationally in April 2017. A full national solution will become available through the GP IT re-provisioning process. In most cases, clinical pharmacists can already prescribe on practice software systems (EMIS and Vision) when working in practices.

8. *Strategic Sustainability Issues* – This section is the largest of all eight themes and most closely reflects on-going Scottish Government primary care policy initiatives, such as to the workforce plan, the premises strategy and elements of the contract covered in the MoU. Notable work includes the GP IT work where NHS Boards have commissioned a procurement competition to provide the next generation of GP

[15] R21: Remove discretionary elements under the contract for maternity, paternity and adoptive leave & R22: Review the numbers of patients required for a practice to qualify for locum cover for sick leave as detailed in the SFE

[16] See Annex B, Case Study 2, page 14.

clinical IT systems for GPs in Scotland. This is being undertaken by NHS National Services Scotland.

Through the investment in GP recruitment and retention and working with NES, two schemes have been introduced that will help improve GP numbers in the form of a returner scheme and an enhanced induction scheme targeting international GPs. In addition, SG Policy continue to produce a standing report on spend for the Working Group on practice improvement projects such as the General Practice Improvement Programme - GPIP, which is applicable to the whole practice.

All responding health boards are actively involved in the Working Group with 'action learning set' meetings in the first half of 2018 being held in Tayside and Highland Board areas. All responding Board areas also have proactive local practice sustainability groups.

Conclusion

Although the sustainability action plan may have initially been seen as aspirational, at a national and local level more than 50 of the 55 action points have already been addressed. On-going review of the action plan remains central to the Working Group. The Working Group continues to discuss and address these issues alongside new issues as they arise.[17]

The vast majority of recommendations in the action plan have already been or are being actioned as part of the implementation of the 2018 GMS contract, or are an integral part of the service redesign. There are, however, one or two pieces of work that are still under discussion e.g. two elements relating to care homes.[18] Some local work has been undertaken to address requests for care home GP visits[19] and at a national level an outline plan is in place for a test of change working together with the Care Inspectorate. Further detail is expected to be provided at the next Working Group meeting in September 2018. Although translation services[20] are listed on the national action plan, resolution is thought to best take place at a local level and again progress on this is reflected in local feedback.[21]

The new GMS contract rightly focuses on undifferentiated presentations, complex care in the community and whole system quality improvement and clinical leadership as key elements of the GP role as an expert medical generalist supported by an enhanced, wider MDT. The sustainability action plan closely reflects this shift. As new actions come into play as the GMS contract is implemented and benefits of the contract related developments are realised, this may be an opportune moment to revisit how we use the action plan. It is proposed however that not further work is done on the plan in its current format at this time.

[17] Best use of the MDT skills mix will become apparent over time.
[18] Recommendations 4 & 5;
[19] More than 60% of visit are being undertaken by physiotherapists and that could quickly become 80% if they are to become prescribers.
[20] R10
[21] Forth Valley, Tayside and Highland

RECOMMENDATION 2: Develop a Practice Sustainability Network that both shares and supports current and future learning on practice sustainability across Scotland.

Following initial discussions on networking, the Working Group identified that it would be difficult to progress the recommendations set out in the Report unless there was increased visibility and awareness of their work. Members agreed that the Knowledge Hub pages[22] offered an opportunity as a repository and to create an Improving General Practice Sustainability Network profile. Using the already established pages for primary care, two new sections were created: one an open practice sustainability page for anyone to join and share and the other a private group for members of Primary Care (PC) Leads. However, uptake to date has been limited and members of the Working Group are assessing how they can refresh this in the short term.

In an effort to improve utilisation and value of shared sustainability learning, the Working Group are also considering whether the management of the communications and networking processes should be devolved to Healthcare Improvement Scotland (HIS). HIS are members of the Working Group, who are already working collaboratively with healthcare providers and Scottish Government. They also operate an i-hub and in developing and extending this resource, HIS will be able to provide a one-stop-shop for primary care improvement, including GP practice sustainability.

RECOMMENDATION 3: Promote the use of, and share learning from a Practice Sustainability Assessment Tool (SAT).

The Report suggests that Boards will be supported to identify vulnerable practices, including any with premises issues, by developing and promoting the use of a SAT and a practice risk register. There is at present no one single, assessment tool to provide comprehensive feedback on all the possible sustainability issues. However, the Working Group developed a Scottish version of the Sustainability Assessment Framework Tool, adapted from an earlier NHS Wales version, which takes into account pressures being experienced in NHS Scotland.

The Tool was initially tested across Scotland by three Health Boards - NHS Tayside, NHS Forth Valley and NHS Lanarkshire. This test and subsequent roll out to all health boards, allowed Boards and practices to adapt this tool for local use.

On behalf of the Working Group, colleagues from NHS Forth Valley Health Board led on a country-wide assessment of usage of the tool, which generated responses from six of the 14 Health Boards. Findings indicate that if used, the tool *could* aid greater collaboration between individual practices and Health Boards in dealing with sustainability issues and was a helpful indicator for forward planning.

However, many felt that, in isolation, the tool provided only part of the picture and that it needed to be used in collaboration with other local intelligence measures. As

[22] A global public sector community that enables people to connect digitally and share knowledge, best practice, learn from experiences and inspire innovation and new ways of working.

it was used in a different way in different areas the tool could also not support an accurate assessment of sustainability challenges across different HSCP/Board areas. For those practices already experiencing difficultly the tool was perceived as offering too little or no new information. Some local experiences with the tool were;

- **NHS Tayside** - while providing an objective measure, the SAT is only considered to be one piece of the jigsaw that requires marrying up with local knowledge, circumstances and context.
- **NHS Lanarkshire** - need for tool to highlight practices in early stages of difficulty and SAT on its own may not provide that sensitivity. The score can change rapidly over 48 hours with a change in one or two inter-dependent factors.
- **NHS Orkney** - some qualitative areas like adaptability, innovation and flexibility are hard to score and the SAT does not always take practice culture into account. There is limited recognition of rural issues and health inequalities.
- **NHS Highland** - the tool did not shed any additional light on practices in difficulty or about to be so.
- **NHS Dumfries and Galloway** – that the information gathered allowed the Health Board to quantify local need.
- **NHS Forth Valley** - **c**ompletion was best carried out as a joint process by the Practice and Board

Anecdotally, HSCPs and Boards have indicated that they see the tool as best used in combination with other local intelligence/measures of practice sustainability.

Since the tool was reviewed, the 2018 GMS contract will ensure that local systems receive a standard dataset (details as yet to be agreed) on practice activity and demand that should complement use of the tool locally. (**See Annex E, page 17**)

RECOMMENDATION 4: Creating a long term Sustainability Working Group

The reformed multi-partner Working Group has focussed on delivering the four key Report recommendations. The Working Group has met several times over the past 18 months and has effectively engaged on a range of perspectives, largely drawn from its member organisations. This has included sustainability challenges associated with delivering safe and sustainable OOH services across Scotland, improving primary/secondary care interface working, proposals to free up GP time and extend the multidisciplinary team through the development of pharmacotherapy and other MDT services.

The initial phase of work was highly successful; however, in response to feedback from Primary Care Leads, a new ‘action learning set’ format was successfully tested at the Working Group meeting in Dundee, February 2018. This meeting gave members the opportunity to present and ‘troubleshoot’ live sustainability issues and to consider innovative ways of working, using workshop and feedback sessions. It is intended, subject to regular review that this format continue for the short to medium term until changes under the new contract start to be felt.

At the first meeting using the new format, presentations were made by Tayside and Forth Valley Health Boards, on Protected Learning Time (PLT) by NES and on NHS 24 support to practices in difficulty. Key issues included workforce, working hours, premises & infrastructure and 2C practices. Follow up actions included establishing a PLT sub-group.

This change was accompanied by a review of the Working Group's attendance and a broadening out of their membership together with greater engagement from health boards and supporting organisations. This reflects changes to the Working Group's terms of reference and a desire to locate and hold meetings outside the central belt (e.g., Tayside and Highland Health Board areas) to encourage the increased attendance of those representing rural and remote locations.

The Working Group last met in May 2018, when live sustainability issues were presented by Highland and Grampian. Meeting the desire to innovate and importantly addressing the rural theme, presentations were given on the work of the Scottish Rural Medicine Collaborate and on rural aspects of the Community Link Workers programme. The next meeting will be held in Glasgow in September 2018 and will include consideration of live sustainability challenges in Greater Glasgow and Clyde and the Islands (Orkneys, Shetland and the Western Isles).
(**See Annex F, pages 18&19**)

4. CONCLUSION

The learning from the Improving General Practice Sustainability SLWG, the implementation of the new 2018 GMS Contract together the actions taken to address the Report recommendations have taken us a long way in addressing the sustainability issues facing general practice in Scotland. Significant progress has been made in delivering all four of the recommendations.

The vast majority of recommendations captured within the Action Plan (recommendation one) have or are being actioned with any outstanding recommendations being considered by the Working Group during 2018-19. It is proposed that, beyond these actions that no further work is done on the action plan in its current format.

HIS have taken the lead on developing a one stop shop for primary care improvement and are investigating extending the i-hub resource to include GP practice sustainability. The Scottish Government will continue to work with them to deliver and promote the use of this product.

The SAT has aided greater collaboration between individual practices and health boards in dealing with sustainability issues. The 2018 GMS contract will ensure that local systems receive a standard dataset (details yet to be agreed) on practice activity and demand that should complement use of the tool locally. It is recommended therefore that the tool continues to be made available as a resource for health boards but that no further development is necessary.

In response to stakeholder feedback, and recognising that it will take time to realise some of the benefits of the new contract, the Working Group will continue to play a key role in supporting local partners to understand and address live sustainability issues. To meet this need the Working Group will continue to focus on delivering a programme of action learning meetings in various locations throughout Scotland in the short to medium term.

Annex A CASE STUDY: 1 - Community Link Workers (CLW)

The Scottish Government has made a commitment to deliver 250 Community Link Workers[23] over the life of the Parliament, building on the existing 53 SG-funded post holders who are already working in areas of socio-economic deprivation. Early adopter sites include Dundee, Glasgow, North Ayrshire, Inverclyde and Edinburgh. CLWs will be provided to patients in GP practices or clusters of GP practices by health boards under the new GP contract. Their roles will be designed and planned by Health and Social Care Partnerships, based on assessment of local need, collaborating with local GPs, patients and the third sector, the latter being a valued part of the mix.

Impact on GP Sustainability
Evidence provided by one study where analysis of data for 148 patients over a 6 month period showed a reduction of 0.63 appointments per patient (93 less appointments), and reduction in the number of prescriptions issued for anti-depressants (22%) and hypnotic/anxiolytics (42%). Early adopters are continuing to test and refine the evaluation framework being developed by Health Scotland.[24]

One GP working closely with their WRO[25] advised that in one case, a 35 year old homeless patient with a history of mental health and drug problems, was found fit to work by the DWP, despite presenting with a number of chronic co-morbidities requiring multiple prescriptions. The patient felt unable to comply and expressed feelings of hopelessness and suicide. Within 2 days of meeting with the WRO, a mandatory reconsideration letter was submitted, along with supplementary medical evidence detailing his physical and mental health problems. The hospital letters were printed from the medical records by the WRO. The patients mental health improved significantly and he no longer required crisis or emergency services.[26]

Another prominent GP has opined that "*The GP workforce is in crisis at the current time, and the 10-minute appointment is no longer fit for purpose for patients with the most complex health and social care needs. Having access to a CLW allows me to practice more "realistic medicine.*"'[27]

Further anecdotal evidence suggests that "*Over the last 25 years a body of evidence has emerged illustrating the effectiveness of collaborative working between the advice sector and general practice. The outcomes for patients include income maximisation, being re-housed, repeal of sanctions, increased literacy skills, new social networks, increased confidence and self-esteem, and better self-management. The outcomes for GP's are that they feel more productive, able to provide an alternative to prescribing, and see a reduction in patient need for clinical intervention*."[28]

Contact: Kate Burton, Public Health Practitioner, ScotPHN Kate.Burton@nhslothian.scot.nhs.uk

[23] A CLW is a non-clinical role ideally integrated or embedded in the primary care MDT. Their purpose is to improve patient health and well-being and tackle health inequalities and by doing so reduce pressure on general practice.
[24] Evaluation of the impact on GP surgeries of the Citizens Advice Bureau Health Outreach Service (2010)
[25] A Welfare Rights Officer (WRO) is a specialist CLW providing bespoke welfare rights advice.
[26] Case note from John Budd, GP at Edinburgh Access Practice (EAP)
[27] Comment from Carey Lunan, GP at Craigmillar Practice
[28] Comment from Kate Burton, Scottish Public Health Network

Annex B CASE STUDY: 2 - Primary/Secondary Care Interface

Around 50% of medical errors can occur at interfaces with up to one-third of this occurring at the primary secondary care interface. A poorly functioning interface can adversely impact patient safety and the patients experience of the healthcare system, leading to increased patient complaints, damaged inter-professional relationships and morale. It can also lead to poorer clinical outcomes for patients.

RCGP have been funded by the Scottish Government to lead on the interface programme, with a newly appointed clinical lead working within each Health Board in Scotland to establish a dedicated interface group. The objectives of these groups are to rebuild inter-professional relationships, act as a professional advisory forum on issues relating to interface, and undertake pieces of work to improve systems and learning across the primary-secondary care interface. E.g. Significant Event Analysis (SEAs) from both primary and secondary care to help identify issues and work together to improve procedures.

RCGP Scotland have also established a Cross-College Interface group which has created a SOAR[29] template for work-shadowing which will be formally launched during 2018. Other areas of work-in-progress include improving the IT infrastructure by introducing generic email addresses for all specialities for clinical advice, improved functionality for SciGateway for email advice and dedicated professional to professional phone lines in both primary and secondary care. A quality improvement module, "Effective Interface" has also been designed and piloted by RCGP. (case study below)

Barns Medical Practice, Ayr volunteered during May 2017 to use the RCGP Scotland Effective Interface learning module and were asked to look at their interface with psychiatry. They already had a good relationship with the local Consultant Psychiatrist and some excellent systems in place at the interface. The Module prompted a dialogue about unresolved quality issues. The priorities chosen were communication between CPNs and the GP practice, monitoring of physical health issues in patients with chronic mental health problems and ECG monitoring during initiation and on-going administration of antipsychotics. Both parties had collected relevant data to aid the process.

The Effective Interface Module had a beneficial impact on the interface between this particular GP Practice and their local Psychiatry service. Alterations to processes and changes in current practice, which will improve patient care, have been agreed. These include improved communication from CPNs to the practice and agreement as to who does what part of the monitoring required when a patient is receiving antipsychotic drugs. Mutual respect was confirmed and enhanced. The likelihood of further collaborative communication and opportunities for future beneficial change was increased.

"The Effective Interface process is an excellent way to stimulate dialogue and bring about improvements in patient care by encouraging ownership of the primary care secondary care interface by both parties. It does require a willingness to get involved from both parties, however."[30]

Contact: Leanne Brown, RCGP Projects & Initiatives - Leanne.Brown@rcgp.org.uk

[29] Scottish Online Appraisal Resource template
[30] Comment from Dr Tommy Hunter, senior GP partner at Barns

Annex C CASE STUDY: 3 - The Advanced Care Academy, Grampian

The creation of an Advanced Care Academy (ACA) and associated fellowship programme in collaboration with higher education organisations will enable NHS Grampian to provide a replicable model that will support robust initial preparation for ACP/ANP[31] roles and subsequent career pathways and skills consolidation. It will also potentially enable increased use of NMAHP-led[32] practice within all aspects of care provision, allowing patients to participate as equal partners in the delivery of their care and provide best value for public funds. The ACA, run by a multi-professional faculty of expert clinicians with teaching expertise, will provide CPD and clinical supervision opportunity to qualified ACPs and support ACPs transitioning to different roles with skills refreshers/additional competencies as well as recruitment of quality candidates for advanced practice roles. "Fellows" will be the Faculty of the future.

Expected benefits:

- Consistent alignment of standards of clinical practice with specific role titles
- Well governed, safe and effective workforce
- Supported workforce: clarity of expectations/role development/career progression.

Achievements to date

The ACA went live mid-April 2018 under the leadership of NHS Grampian's two Nurse Consultants for advanced practice. In order to launch, "Fellows" (experienced, ANPs) have been recruited - in the first instance to an ACA bank, pending a more formal programme of development. It is anticipated that future Fellows will have a wider range of healthcare backgrounds, but work within the same triangulated approach to capability: theoretical knowledge; robust clinical competency assessment; effective clinical supervision.

Recruited Fellows have been actively sustaining the 2C provision of general medical services at An Caorann practice (Aberchirder & Portsoy sites) through expert clinical supervision to the ANP trainees which enables continuity of service and robust competency assessment. Fellows and trainees benefit from the guidance and support of the Nurse Consultant for Advanced Clinical Practice in Primary Care, to rationalise provision of service across the two sites.

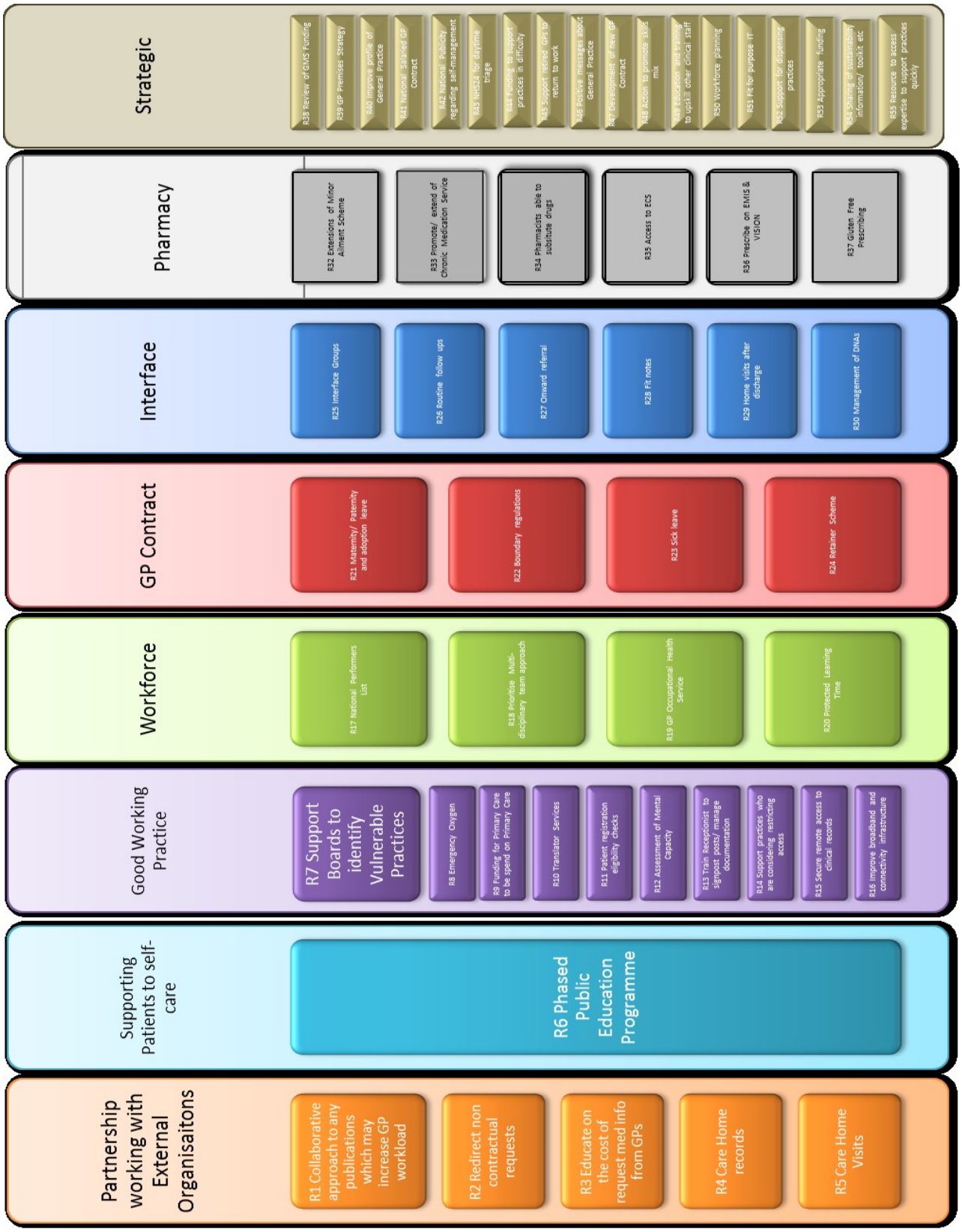
The ACA is working to provide sustainable workforce solutions to the current challenges faced at Dr. Gray's Hospital, Elgin, which may be alleviated with development of a more blended workforce including tiered ACP provision. Staff workload audit and a service needs analysis is in progress to inform the roles and skillsets required, co-ordinated by the Nurse Consultant for Acute.

The ACA has been supporting the development of enhanced District Nursing roles which map to advanced level practice, the development of custody care with newly developed educational resource and provision of face to face scenario-based training with both NHS and Police colleagues.

Contact: Alison Moggach, Advanced Nurse Practitioner, NHS Grampian a.moggach@nhs.net

[31] Advanced Care Providers/Advanced Nurse Practitioners
[32] Nursing, Midwifery and Allied Health Professionals

Annex D Overview Of The Sustainability Action Plan



Annex E Assessment Of The Practice Sustainability Framework Tool

The Working Group developed a Scottish version of the (SAT), adapted from an earlier NHS Wales version. An assessment of usage of the tool, involving 6 of the 14 Health Boards, making recommendations for how the tool should best be applied, is also downloadable with this document.

Annex F Improving GP Sustainability Working Group, Inverness, 16 May 2018

Inverness, May 2018/*contd.*

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