DEVELOPING PERSON-CENTRED PRIMARY AND COMMUNITY SERVICES
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1. INTRODUCTION AND BACKGROUND

Primary Care and Community Services provide the first point of contact between an individual and a healthcare professional in approximately 90% of contacts with health care services.

Within primary care there are 4 practitioner services; medical, dental, pharmaceutical and optical. These practitioners are usually independent of the NHS and are contracted by local NHS Boards to provide their particular service. Contracts are negotiated on a national basis, however NHS Boards have some scope to negotiate local contracts or employ practitioners directly as salaried NHS employees.

The key role of primary care services is to:

- Provide a first point of contact with healthcare services
- Offer continuity of care (diagnosis, prescribing and care management)
- Provide a universal service
- Co-ordination of care 24 hours a day, 7 days per week across primary, secondary and social care systems
- Improve the health of the population through health promotion and primary prevention

Each year, there are over 5 million contacts with general practices, 1.5 million contacts with community services and 136,000 contacts with the Lothian Unscheduled Care Service (Out of Hours General Medical Service).

1.1 General Practice

There are 127 GP practices in Lothian (excluding the challenging behaviour GP practice) supported by a total of 1,601 general practitioners. Around 10% of the practice population access their general practice each week in Lothian.

The Primary Care and Community Services healthcare team consists of general medical practitioners, practice nurses, managers and reception staff working together with Health Visitors, District Nurses and Health Care Assistants, Community Midwives, Phlebotomists, Community Psychiatric Nurses and Allied Health Care Professionals.

General practitioners and community teams are central to lifelong patient care and therefore there is a need to recognise this primary healthcare team needs to be accessible and adequately resourced to deliver a vast majority of NHS interventions and ensure their specialist role in co-production.
1.2 Dental Services

NHS General Dental Services are provided by dental practitioners under a national contract between themselves and NHS Boards with the aim to improve oral health.

There are 172 dental practices in Lothian, both independent contractors and salaried dentists working in the Public Dental Service, supported by 532 dentists. As of 30 September 2013, 83% of children and 75% of adults of the Lothian population are registered with a dentist\(^1\).

1.3 Optometry Services

The general ophthalmic services contract ensures a comprehensive eye examination, appropriate to individual need, symptoms and general health.

There are 114 optician premises in Lothian supported by 665 optometrists. In the year ending March 2013, 299,014 primary NHS eye examinations were undertaken in Lothian (34.5% of the Lothian population)\(^2\).

1.4 Pharmacy Services

There are 182 pharmacy premises in Lothian supported by circa 400 community pharmacists who dispense 11.7 million prescriptions every year, the cost of prescribing in primary care is in the region of £132 million per year.

It is estimated 94% of the population in Lothian access a pharmacy each year and 67% of the population visit a community pharmacy each month.

2. CHALLENGES FOR PRIMARY AND COMMUNITY SERVICES 2014 – 2024

2.1 As outlined within the NHS Lothian Strategic Plan 2014 – 2024 there are a number of recognised key challenges facing primary and community services.

- The population growth, extended life expectancy and the consequent increase in multi-morbidities that have contributed to the increased demand for access to primary care and community services without commensurate increases in capacity
- The need to address the existing and future capacity short-fall to meet the above increased, and increasing, demand upon Primary and Community services through the review of premises capacity and suitability, the need for additional GP Practices and work-force planning issues associated with GPs and community health teams particularly health visitors and district nurses

\(^1\) ISD, MIDAS 30 September 2013
\(^2\) ISD, OPTIX, August 2013
Access and the need to consider different models to support access to appointments within general practice, and alternatives to direct GP access to ensure our population wait no longer than 48 hours for a non-urgent appointment to see a GP or appropriate alternate healthcare professional.

Demand, Capacity and Access – An Overview (Appendix 1) summarises the current position across Lothian and provides comment on the future impact associated with the population growth.

Meet public expectations by ensuring timely consultation with an appropriate health care professional, patient and/or carer involvement in decision making about their healthcare choices, access to safe and effective treatment, clear and accessible information and experience of an efficient, approachable and responsive service.

Ensuring co-ordination of the care and support needed by patients across primary care, community health and social care and hospital based services which may all have a part to play in meeting individual’s health needs.

Support the shift in the balance of care from secondary to primary and community care services and ensure this transfer of care is appropriately resourced.

The need for further development of information technology to support timely communication and transfer of information between primary care contractors, hospital and social care services.

Increasing demands and issues associated with recruitment and retention of the out of hours workforce which is impacting significantly on delivery of the Lothian Unscheduled Care Service (LUCS).

3. DELIVERING THE PRIMARY AND COMMUNITY SERVICES PROPOSITIONS

There are a number of propositions outlined within NHS Lothian’s Strategic Plan 2014-2024 which require be further developed and implemented over lifetime of the plan.

The sections below provide additional information on the propositions and include details of how delivery of these propositions will be taken forward.

3.1 Engage with Individuals in Making Decisions about Their Care

There is a need to develop a new relationship between the NHS and the Lothian population to ensure individuals are clear on the limitations of medicine and to ensure individuals are supported to take responsibility for self care and self management (such as via long term conditions education programmes and self management plans e.g. diabetes, COPD and asthma).

There is also a need for our patient population to recognise not all treatments are possible and there is a need for NHS Lothian to cease treatments for which there is no clinical evidence.

This engagement programme could be supported through development of an NHS Lothian’s Patient Charter which should outline not only the rights of our patients but also to set out the limitations of our services.
3.2 **Develop Lothian’s Multimorbidity Action Plan**

A national programme is being developed to support NHS Boards in developing a multimorbidity action plan. This will ensure healthcare is designed around the needs of people.

The development of plans will be driven through the pathway developments outlined within the strategic plan, the managed clinical networks in supporting individuals to self manage their care via promotion of the use of self management plans, and co-production to ensure co-ordination of care around the needs of individuals.

3.3 **Enhanced Palliative Care Community Based Model**

A Lothian Palliative Care Redesign Programme Board was established in February 2013. Representation is in place from carers/families, NHS Lothian services, City of Edinburgh Council, Midlothian Council, Independent Care Home providers, Edinburgh University, St. Columba’s Hospice and West Lothian partnership; arrangements are being finalised with the other three partnerships.

The programme aims to improve the community-based model of end-of-life care across Lothian. This would allow people to spend more time in their preferred place of care, minimise emergency admissions where avoidable, and support choice in place of death. Specifically, the programme objectives are to:

- increase capabilities to identify patients and to plan care in anticipation, and in advance, of needs;
- improve coordination of care, within and across settings, to support patients and families with complex and unstable palliative and end-of-life care needs;
- increase community-based care service provision, and accelerate progress in shifting the balance of end-of-life care towards greater community-based care; and
- increase public awareness of, and community involvement in, the issues related to death, dying and bereavement.

During 2013 palliative care services in West Lothian have been reviewed, with consideration in particular of the service model required for the future. NHS Lothian, Marie Cure Cancer Care and Macmillan Cancer Support will jointly provide specialist palliative care community services in West Lothian, in all care settings. Overseen by a steering group with membership from senior service and clinical management, the ‘West Lothian Palliative Care Service’ will have 3 stages of implementation in the first half of the 2014: community specialist palliative care service (March); start date for Consultant in palliative medicine (April); and palliative care day and outpatient services (June). West Lothian is also participating in the redesign work, which will help to chart a
course for the longer-term development on West Lothian palliative care services.

Throughout 2013, the redesign programme has conducted a review of the current evidence base and a series of workshops with a wide range of stakeholders, including patient and carer representatives, to identify options for transformational change of palliative care and support services in all settings. This has produced in excess of 800 ideas which have been distilled through two stages of options assessment to around 20 potential ‘capabilities’ including: a range of Health Promoting Palliative Care events and resources; a care home centre of excellence; a 24/7 rapid response service; and a community volunteer support service. By summer 2014, a business case and programme plan for the delivery of the preferred configuration of services and initiatives will be signed off by the Programme Board.

3.4 Scottish Government Modernisation Programme

The Scottish Government have outlined four key elements necessary for the transformation of primary care in order to achieve the 2020 Vision. These are:

- Development of new models of integrated care that better meets the needs of the changing population and that engages with and meets the needs of local people

NHS Lothian’s review and redesign of pathways of care around the needs of high users of our health and social care services (Callum, Hannah, Scott and Sophie) will support the development and resource shifts required to deliver the future models of integrated care.

- Involve General Practitioners to develop a ‘more Scottish’ GP contract as part of continuing effort in Scotland to deliver excellence in primary care and to ensure a clear focus of health and social care integration

General Practitioners are seen as a key to the delivery of the integration of health and social care services, this key contribution is recognised in the 2014-15 Scottish GP Contract in that:

- Each GP practice will nominate a practice-based liaison GP to link to a specified liaison person from the Health and Social Care Partnership
- Engagement with the evolving local Health and Social Care partnerships, and input to developments/decision-making will be led through these GPs as appropriate. Any additional consequential workload will be agreed

NHS Lothian and its partners will be taking these actions forward within our wider primary care actions aligned with our strategic and integration plans.

- Improve the quality and usefulness of primary care data as a tool for improvement
NHS Lothian’s Primary Care Data Group has a role to co-ordinate support to primary care services to make informed decisions on strategic and operational issues through collating existing data and information; analysing the data, reviewing the evidence; writing reports; and conducting ad hoc surveys where appropriate.

Strategic priorities have been identified as:

- Support the NHS Lothian’s Strategic Plan which is inextricably linked to the integration of health and social care
- Ensure co-ordination of information supporting primary and secondary care initiatives relevant to the strategic plan, in particular those which affect the interface between primary and secondary care

The operational priority is considered to be:

- Primary care benchmarking to ensure a Lothian wide approach to sharing and benchmarking of primary care information at general practice and partnership level
- NHS Boards are required to make medium term assessments of the strengths and weaknesses in delivering the 2020 vision for primary care. This assessment should include detail of the shift in resource to support the transformation of primary care

The resource shift required to support the transformation of primary care will be assessed as work progresses across a number of work streams such as the redesign of pathways of care, provision of local ‘step up’ and ‘step down’ beds, expansion of primary care premises and development of primary care and community care workforce plans.

NHS Lothian will continue to contribute to this Scottish Government primary care modernisation agenda through active participation at the Scottish Government Primary Care Strategic Forum.

3.5 New GP Contract 2014/15

Development of the Scottish GP contract in 2014/15 will contribute to delivery of the key priority areas outlined in the 2020 vision route map in terms of further reducing bureaucracy and creating a stable funding environment for general practice over the coming years. A further 264 Quality & Outcome Framework (QOF) points are being transferred into the global sum under core standard arrangements leaving a balance of 659 points for 2014/15. The main area of innovation in QOF is in relation to the quality and safety indicators:
Integration:

- A requirement for a designated practice-based liaison GP to link to a specified liaison person from the Health and Social Care Partnership and fully engage with the evolving integration agenda.

Quality Improvement:

- A new continuous quality improvement indicator requiring a quality report reflecting relevant activity in the previous year, plus participation in a 3 year rolling programme of formative and supportive peer review visits. The practice visits are intended to allow constructive discussion, identify areas of priority and support the sharing of best practice.

Patient Access:

- An annual review (involving patients) of current patient demand, focusing on both met and unmet needs; ‘Patient Access Action Report’ to be submitted to the Board for discussion at a formative and supportive quality review visit. This data will be key to our understanding of the current pressures on GP practices and improving the response times for patient appointments by the sharing of best practice.

Anticipatory Care / Key Information Summaries:

- Continuing the current work on developing anticipatory care plans / Key Information Summary (KIS) (including a polypharmacy review) for those patients predicted (from SPARRA data) to be most at risk of emergency admission or unscheduled care; requirement for quarterly multidisciplinary practice meetings focusing on this cohort of patients. There is a good evidence base for this work in primary care and over 10,000 KIS records were created in Lothian this year.

Patient Safety:

- Two patient safety indicators are retained in QOF requiring practices to conduct a safety climate survey and two case note reviews using validated tools to detect safety incidents, discuss the results as a team and share a reflective report with the Board. This work will be complemented by a comprehensive enhanced service (ES) which will focus on improving outpatient communication in 2014/15. Previous work by practices in relation to Warfarin monitoring and medicines reconciliation has already produced excellent results and contributed to a material culture change in general practice as part of the Scottish Patient Safety Programme in Primary Care.
3.6 **Anticipatory Care and Polypharmacy**

A local enhanced service has been established which aims to facilitate a joint polypharmacy review between the pharmacist and the patient’s general practitioner. These reviews link with Anticipatory Care Plans (ACPs).

- Year 1 (2012-13) – reviews were offered to all GP practices with patients in care homes in addition to frail elderly patients identified at high risk (over 75 years and on 10 or more medicines)
- Year 2 (2013-14) – co-horts of patients were identified for review using the SPARRA risk prediction tool
- Year 3 (2014-15) – continue to invite all practices with patients in care homes to be offered review and practices will be invited to identify patients who are at risk of readmission. Community pharmacists will continue to jointly lead reviews with general practitioners.

3.7 **Review of General Practitioner Numbers and Practices**

Population growth in Lothian, as predicted by National Records of Scotland (NRS) will be an average of circa 9,000 per annum between 2010 and 2020, or circa 8,000 per annum between 2015 and 2020. It should be noted however that, historically, there is a significant disparity between the NRS predicted population estimates and the GP lists size, across Lothian and within each locality.

Graph 1 – Population Trends in Lothian 2010 - 2024
Demographics in Lothian are predicted (NRS) to change significantly with the number of people over the age of 65 increasing by circa 25% between 2010 and 2020, as demonstrated in the table below.

**Table 1 : National Records Scotland Population Predictions (1,000's) 2010 based**

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</thead>
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<tr>
<td>All NRS</td>
<td>836.70</td>
<td>843.73</td>
<td>883.70</td>
<td>925.20</td>
<td>88.50 10.58% 41.50 4.70%</td>
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<td>0-15</td>
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<td>143.36</td>
<td>147.40</td>
<td>157.10</td>
<td>15.70 11.10% 9.70 6.58%</td>
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<tr>
<td>16-64</td>
<td>571.40</td>
<td>571.00</td>
<td>595.50</td>
<td>613.00</td>
<td>41.60 7.28% 17.50 2.94%</td>
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<tr>
<td>65+</td>
<td>124.00</td>
<td>129.37</td>
<td>140.80</td>
<td>155.30</td>
<td>31.30 25.24% 14.50 10.30%</td>
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* 2012 NRS estimate based on 2011 Census data

It is difficult to predict the growth of the elderly population, at a locality or practice level, which is where this will impact on GP Practices capacity.

There are 127 GP Practices across NHS Lothian. Although the number of practices has grown this has been the result of existing practices sub-dividing using existing premises capacity and with their relevant practice populations. The last new and additional practice was created over a decade ago.

Mapping of General Practice, General Dental Practice and Pharmacy locations has been completed and shared with each Community Health Partnership (CHP). Work is underway to identify the localities and individual practices experiencing, or predicted to experience, specific population pressures and map these to the relevant current General Practice boundaries.

Each CHP will then develop general practice capacity plans within their locality, and in partnership across CHP boundaries where appropriate, to address these capacity issues, including the development of existing practice premises and the identification of where new and additional practices will be required. (See Appendix 2)

As well as facilities, these capacity plans should also address practice manpower planning, Community Services resource levels, new ways of working and the potentials provided through advances in information technology.

Work is underway to consider a replacement mechanism for the former Initial Practice Allowance (part of the previous General Medical Services Contract) to facilitate the creation of new and additional General Practices in Lothian.

### 3.8 Shifting the Balance of Care

We continue to evaluate the GP enhanced services programme (circa £13 million GMS investment) on an annual basis to ensure best strategic fit, effectiveness and value for money.

Recent examples of enhanced service developments include:
• **Domiciliary Phlebotomy**

Primary care services have seen an increased demand for domiciliary phlebotomy services (carried out in a patient’s home) as a result of 3 broad drivers:

- increased requirements associated with remuneration frameworks such as QOF;
- population growth
- clinical change, where requirements for disease monitoring or treatment have been altered and the resource has not necessarily been provided to reflect this change in clinical practice

To meet future demand, a domiciliary phlebotomy service has been established supported by recurring investment of £350,000.

• **General Practice Support to Care Homes**

The current local enhanced service (LES) which allows practice teams to provide additional care to patients in care homes for older people is under review. The anticipatory care LES provides for a single practice to take ‘lead practice’ responsibilities for each care home in Lothian. This has proved a successful model although there are currently four care homes where we continue to seek a practice to take on lead status and this requires further development and investment in the region of £300,000.

• **Models of Care for Frail Elderly**

There is a clear identified need to better support integrated pathways of care for frail, older people living at home. Development work on a new model of care focusing on service redesign to cover complex frail elderly patients in the community is underway. This will cover patients in care homes and also those living in their own homes. Information transfer between primary care and acute services will be improved, together with a consistent approach to polypharmacy medication reviews.

A number of initiatives have already been developed to support the shift the balance of care from hospital based to community services.

• **Near Patient Testing (Warfarin)**

A recent example of this shift is the provision of Near Patent Testing for warfarin in East and Midlothian which allows general practices to provide safe, effective and convenient access to testing with immediate results and thus avoids patients having to wait for results and for changes to medications. This initiative is supported through local investment of circa £60,000.
Looking forward, NHS Lothian will continue to regularly review existing local enhanced services, have identified current local enhances services which require further development and will consider new local enhanced service proposals.

3.9 Services for People at Risk and Suffering from Diabetes

Diabetes represents a rapidly expanding workload with circa 2,200 individuals in Lothian diagnosed with type 2 diabetes each year, a prevalence of (at least) 4.7% in the Lothian population (35,288 in 2012) and (at least) a 9% share of the NHS Lothian prescribing budget.

Secondary care diabetes services need to focus specialist skills on individuals with type 1 diabetes and those with type 2 who are complex or developing complications.

Historically, most patients with diabetes were referred to hospital at the time of diagnosis, though many are subsequently discharged back to the care of the General Practitioner once their initial assessment and management plans are in place and their condition stabilised.

An enhanced service would provide the resource for this initial assessment and ongoing care to be undertaken in general practice and would reflect the well established rise in prevalence and complexity. In order to support this proposal, investment of circa £300,000 is required.

Whilst the proposal service outlined above will provide support for those newly diagnosed with type 2 diabetes, a number of gaps and areas for improvement have been identified:

- discharge planning
- earlier supported discharge
- follow up of type 1 diabetes who do not attend hospital appointments
- GP practice support
- review of late stage type 2 diabetes with polypharmacy
- community support for those with long term stable type 2 diabetes on insulin.

In order to further enhance and bridge the gap between primary and community services, there is a need to develop a community diabetes specialist nurse (CDSN) service across Lothian. The benefits of provision of these posts will support the gaps / service improvements which have been outlined, has the potential to reduce readmissions and diabetic ketoacidosis (DKA) admissions, relieve pressure on secondary care clinic capacity, support the avoidance of travel for some stable, elderly patients to hospital services, provide support in the implementation of the national and local diabetes prescribing strategies and support the cross pollination of good practice and a more patient centred pathway of care.
3.10 **Dementia Link Workers**

Scotland’s National Dementia Strategy 2013-16\(^3\) outlines the importance of increasing the availability, consistency and quality of post-diagnostic support to people with dementia. It is expected that everyone diagnosed from April 2013 should be offered post diagnostic support.

- **Provision of Link Workers**

NHS Lothian, Local Authorities in City of Edinburgh, West Lothian and Midlothian have secured change fund monies to establish Alzheimer’s Scotland Post Diagnostic link workers. The link worker service will complement existing post diagnostic support (PDS) services currently available through community mental health teams and are aligned to local geographical areas. Discussions are underway in East Lothian for a proposed PDS service.

- **Developing the 8 Pillars Model**

The 8 Pillars Model will build the resilience of people with dementia and their carers to enable them to live in the community for as long as possible. It builds on the one year post-diagnostic support guarantee, to ensure the impact of the investment in early intervention is not lost. Midlothian is a Scottish Government test site for the 8 pillars model.

North West Edinburgh Integrated model is working with NW Section 17c GPs in partnership improve the outcomes and experience for people diagnosed with dementia, their families and carers by providing a continuum of integrated support throughout their dementia journey.

- **Dementia Awareness**

A joint dementia awareness campaign was launched in Edinburgh in January 2014, providing information and encouraging people to seek help for a diagnosis if they were worried about their memory. This is being developed into making Edinburgh a dementia friendly city; a local example is Barnton and Cramond dementia friendly community and the work is being led in this area by a local pharmacist.

3.11 **Patients with Neurological Conditions and Sensory Impairment**

3.11.1 **Lothian Neurological Care Improvement Plan**

It is estimated that round 17% of general practice consultations in Lothian (918,000 consultations each year) are for neurological symptoms such as dizziness, seizures, paralysis, headache and sensory symptoms\(^4\).

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\(^3\) Scotland’s National Dementia Strategy 2013 – 2016, Scottish Government, 30 May 2013

\(^4\) Functional and dissociative neurological symptoms : a patient’s guide J Stone

www.neurosymptoms.org
Neurological conditions include epilepsy, seizures, chronic headache and migraine, Parkinson’s disease, multiple sclerosis, acquired brain injury, Huntington’s disease, dystonia, functional neurological symptoms, cerebral palsy, motor neurone disease and muscular dystrophy.

In Lothian, there is an estimated 53,480 people living with a neurological condition, of whom 5,348 will be disabled by the condition and 1,872 will require assistance with tasks of daily living.

Each year, there is circa 8,489 individuals in Lothian who receive a new diagnosis of a neurological condition. Having a neurological condition is the most likely reason for experiencing complex and physical disability for people aged under 65 years.

NHS Lothian and partners, through the Neurological Care Improvement Group are developing a Lothian Neurological Care Improvement Plan 2014 - 2017 which will set out a vision for and actions to deliver improvements in care and support for people with neurological conditions. High level themes and issues outlined within the draft plan include:

- Seek to build shared patient records and a single point of contact to support an infrastructure to deliver co-ordination of care
- Review of neurological pathways to ensure these are fully integrated across all tiers of health, social care and the voluntary sector
- Clear designated clinical leadership for each neurological pathway
- Development of a neurological care eHealth strategy which supports effective use of existing systems to support the co-ordination of clinical care and to support engagement with patients

3.11.2 National Sensory Impairment Strategy

The Scottish Government have indicated a national sensory impairment strategy, ‘See Hear’, will be published by the end of April 2014. NHS Lothian and our partners will take forward work to support implementation of the strategy recommendations. It is anticipated the themes of the national strategy recommendations will relate to audit of spend, basic sensory screening, sensory awareness training, local partnership work, local information and the Equality Act.

The work streams outlined above will be taken forward under the guidance of the Lothian Physical and Complex Disability Programme Board.

3.12 Improvements in Dental and Oral Health

The key strategic priorities relating to dental care for the next 10 years have been identified as:

- Increase registration for those aged up to 2 years
As at 30 September 2013, 41% of 0 to 2 year olds were registered with an NHS dentist compared to 47% registration rate across Scotland. NHS Boards in the West of Scotland that began Childsmile Practice earlier than the East of Scotland NHS Boards, show better registration. NHS Greater Glasgow and Clyde have 52% of 0 – 2 year olds registered. By 2024, NHS Lothian should aim for 70% of 0 to 2 year olds registered.

- Improve access to specialist dental services by integrating and aligning the Public Dental Service (PDS) with the Edinburgh Dental Institute (EDI)

By redesigning services provided by the PDS and EDI agree a single point of referral for suitable services. This will mean that referrers have an easy route to access specialist services, and that patients will be seen by the most appropriate clinician in a location as close to their home as is practicable in as timely a way as possible.

- Continue with Scottish Government funded prevention programmes - Childsmile and Caring for Smiles aimed at improving oral health for young and older people

Childsmile is a national dental prevention programme delivered locally by each NHS Board. All children in nursery provision are offered the opportunity to participate in a tooth brushing programme. Children attending nursery located in the SIMD most deprived quintile are offered the opportunity to participate in the Childsmile Fluoride Varnish Programme. The proportion of Primary One children with no obvious dental decay in Lothian has risen from 50% to 70% since the Childsmile Programmes began. By 2024, we should aim for 80% of Primary One children in Lothian with no obvious decay.

Caring for Smiles resource was launched in 2010 in partnership with NHS Health Scotland and the National Older People’s Oral Health Improvement Group. This resource provides a guide for oral health professionals to deliver training for staff in care homes and enable carers to provide a high standard of oral care for dependent older people. The training highlights to care staff that good oral health is important for overall general health and it also encourages carers to consider that oral care should be an integral part of personal care.

3.13 Pharmacy Services

The key priority for pharmaceutical services is to implement the recommendations outlined in Prescription for Excellence\(^5\) published in 2013 which outlines a vision and action plan for the delivery of pharmacy services across Scotland to support people living in the community, receiving care at home, living in care homes and those receiving hospital / specialist hospital care at home.

\(^5\) Prescription for Excellence, A Vision and Action Plan for the right pharmaceutical care through integrated partnerships and innovation, Scottish Government Health Department, September 2013.
The recommendations will be implemented through establishing a framework for joint working and information sharing between primary and secondary care pharmacist and other members of the multidisciplinary team.

### 3.14 Optometry Services

Optometry services should be recognised as the first point of contact for individuals who are experiencing eye problems. Since 2006 the General Ophthalmic Services contract has been in place to allow community optometrists to provide a comprehensive patient-specific examination and any necessary follow-up appointments for accurate diagnosis or monitoring of conditions.

There are a number of optometry legislative and pathway changes which support improved joint working and a shift in the balance of care, these will be the focus for development over the coming years.

- **Independent Prescribing Rights to Optometrists**

  In 2013, new legislation was introduced to extend NHS prescribing to optometrists who are recognised by the General Ophthalmic Council (GOC) as appropriately qualified. All optometrists in Scotland, who have completed a GOC approved training course and are entered on the GOC Register as an Independent Prescriber, to provide NHS prescriptions for conditions affecting the eye and tissues surrounding the eye. This legislation will assist to shift demand from general practice as individuals do not have to visit their general practitioner to request eye prescriptions and can access specialist eye services in the community.

- **Optometrist Direct Referral to Hospital Ophthalmology Services**

  In 2014 all community optometry practices will have access to SCI Gateway for referrals to the Hospital Eye Service. This will provide more detailed information (particularly retinal photographs) to the hospital allowing them to triage accurately. Referral guidance is available on the Lothian Referral Guideline website and there are plans to develop guidelines for additional ophthalmic and systemic conditions.

### 3.15 Services for Frail Older People

There are a number of health and social care integrated teams providing assessment and rehabilitation services for frail older people available across Lothian. The continuation of these services and resources to support further development of this type of model of care is essential when supporting the shift in the balance of care. Examples of integrated teams for frail older people are described below.

- **Edinburgh – COMPrehansive Assessment (COMPASS)**
This model supports a new way of working which aims to provide more integrated care for frail older people in Edinburgh. A key component of the COMPASS model is regular multidisciplinary team meetings whose role is to identify older people at risk of hospital admission. The aim of the meetings is to deliver better outcomes for older people and their carers through improved understanding and communication across teams and professionals.

The COMPASS pilot began in South East Edinburgh in April 2012 and rollout out further to North West Edinburgh in April 2013. There are plans to roll out the COMPASS model across all areas in Edinburgh.

- East Lothian - Integrated Service for the Elderly (ELSIE) and Midlothian MIDCare

These services are integrated co-located services which provide urgent assessment, rapid response (health and social care), rehabilitation and re-ablement for frail older people at time of crisis. Both services benefit from medical and nursing input (medicine of elderly consultant and advanced nurse practitioners) with access to Allied Health Professionals, social care and crisis care services.

East and Mid Lothian partnerships plan to further develop ‘frailty models’ and further enhance local rapid response services.

- West Lothian - Rapid Elderly Assessment and Care Team (REACT)

The REACT service provides better care for elderly patients at home by providing alternatives to hospital admission.

- Phase 1 – Hospital at Home

Currently comprising a team of nurse practitioners, consultant geriatricians, specialty doctors, a community pharmacist and an administrator, the Hospital at Home service accepts daily acute referrals for urgent assessment of older patients to prevent unnecessary admissions to hospital and to maintain individuals in their own homes where possible. The team work closely with the physiotherapists and occupational therapists to provide rapid intervention as required.

- Phase 2 – Intermediate Care Team

The Intermediate Care Team comprises physiotherapists, occupational therapists and speech therapist. They provide rehabilitation within the patient’s own home and accept referrals from the hospital wards facilitating an early supported discharge, direct from the community or from the hospital at home team. They also support Phase 1 Hospital at Home patients providing rapid assessment and intervention as required.

- Future Development of REACT In-Reach Team
The appointment of Specialist Nurses to assess frail elderly at the front door and downstream wards will facilitate the most appropriate pathway including accessing relevant community services. These nurses will work closely with the duty Consultant Geriatrician who will also be the single point of contact available to GPs and other clinicians. The team will also include senior physiotherapist and occupational therapist pulling patients back out into the community for assessments and interventions in their own home.

3.16 Reduction and Elimination of Delayed Discharge

In April 2008, a National Standard was introduced, that no patient should wait more than 6 weeks for discharge from hospital after being declared medical fit to do so. This standard was strengthened by the Scottish Government to be 4 weeks in April 2013 and 2 weeks in April 2015.

Across Lothian achieving these standards has been a challenge. The Partnerships of West Lothian and Midlothian have managed to keep pace with the National standards and are on a path that will see them achieve the impending April 2015 target. City of Edinburgh and East Lothian are experiencing challenges associated with the availability and affordability of Care Homes, and increasingly workforce shortages in the care at home market. Whilst both have achieved the 6 week standard, the 4 week standard is more challenging.

The partnerships across Lothian have identified short and long term actions to support the reduction and eventual elimination of delayed discharge.

City of Edinburgh

The City of Edinburgh partnership have already undertaken a number of actions to support a reduction in delayed discharge in Edinburgh. This includes:

- an increase in domiciliary care capacity
- development of 42 'step down' beds.

A draft project plan has been developed to further reduce the demand for hospital admission, make the discharge process more efficient, increase capacity in existing services and enhance community capacity.

In the short term, this plan includes:

- an additional 2,500 domiciliary care hours to be provided by April 2014
- the roll out of COMPASS to all quadrants of the city
- investment in re-ablement to clear the current backlog
In the long term, this plan includes:

- the re-tender of the care at home contract which expires in October 2014
- commissioning additional ‘step-down’ beds
- establishing a discharge hub on each hospital site to increase the efficiency of the discharge process.

**East Lothian**

The East Lothian partnership will reduce the total number of delayed discharges and meet the 4 week and 2 week targets through:

- establishment of step down capacity
- the introduction of new contracts for care at home
- supporting a social enterprise model to provide care to specific cohorts of patients and service users
- implementation of a ‘frailty model’
- enhancement of the emergency care service

**Midlothian**

The Midlothian partnership have identified a number of key actions to address delayed discharge which will be to:

- explore ways of strengthening the Midlothian In-Reach service which involves Midlothian staff working in the acute hospital settings)
- implement the ‘Frailty Model’ through an enhanced Rapid Response Service
- extend the provision of assessment and intermediate care beds the Highbank care facility
- review care home provision in Midlothian and further develop extra-care housing
- refresh the workforce development strategy in Primary Care to support ‘Shifting the Balance of Care’
- Continue to strengthen working links between Midlothian Partnership and the Acute sector
- From April 2014 begin to shadow the two week target for delayed discharge (this approach was adopted for when the 4 week target was introduced)

**West Lothian**

The West Lothian Partnership has a diverse range of initiatives in place to support the reduction and elimination of delayed discharges through:

- Reducing demand for hospital admission:
  - REACT,
  - Crisis Care,
- Integrated Care Pathways development supported through Interface Group and Primary Care Work Plan
- Additional capacity for falls coordination and further development of robust falls pathway
- Currently over 4000 households benefit from telecare services with access to 24 hour Careline

• Making the discharge process more efficient.

- Integrated Discharge Planning Pathway
- Multidisciplinary and multiagency involvement in early identification of patients needs and discharge requirements
- Increased capacity to facilitate early supported discharge through REACT intermediate care team, re-ablement service and mental health Older People Acute Care Team

• Increasing capacity in existing services.

- The development of step up and step down model in St Michaels Hospital
- Universal re-ablement services
- Redesign of domiciliary physiotherapy service
- Development of integrated workforce plan
- Continuing development and delivery of care home education programme
- Expansion of inpatient physiotherapy and occupational therapy services to 7 day working
- Working with independent sector on their demand and capacity plans to support care at home and care home provision

• Enhancing community capacity.

- Development of an additional housing with care complex In Bathgate
- Further investment in telecare
- Telehealth research with focus on providing care at home
- Ensuring capacity in health and social care services to support 7 day discharge model

3.17 Review of Role and Function of NHS Inpatient Continuing Care

The NHS Lothian Strategic Plan and the requirement to rebalance care from hospital and community settings require the Board to have a strategic plan for the future model and provision of inpatient complex care (IPCC) beds across Lothian. NHS Continuing Care is a package of healthcare provided and solely funded by the NHS. Patients normally receive NHS Continuing Healthcare in a hospital ward, hospice or a contracted inpatient bed within an independent sector provided e.g. Care Home.

The purpose of the review is to identify the factors that will affect future demand and need for inpatient continuing care and to propose a strategy to
meet the care needs of the ageing population. The main factors are; increasing demand from an ageing population, reducing demand because community services can increasingly provide for people with higher care needs, and evolving national eligibility guidance for IPCC.

The first stage of the review will conclude by end of February 2014 and will describe an emerging strategic plan for future IPCC provision. This will be incorporated into the NHS Lothian Strategic Plan for consultation.

3.18 **Assess the Potential for a new ‘Care Village’ Concept**

The Edinburgh partnership will host a workshop in April 2014 to begin initial discussions and assess the potential for this concept.

3.19 **Redevelopment of the Royal Edinburgh Hospital**

NHS Lothian and its partners, through the current mental health strategy: A Sense of Belonging 2011 - 2016; sets out plans for the redevelopment of the Royal Edinburgh Hospital and the required investments and developments in community services.

For the past 8 years, mental health services have had clear agreed strategic direction and clear plans are outlined for the remainder of the current strategy. These plans have delivered significant bed reductions compensated by investments in community services such as the intensive treatment teams and crisis intervention services.

Similarly, the number of sites from which acute mental health inpatient services are delivered has reduced from 4 to 2 sites during this period. This has resulted in significant shifts in the balance of care from hospital to community and clinical service functions providing safe, supportive assessments and treatments to patients at home who were previously admitted to hospital.

NHS Lothian’s mental health strategies and resulting community developments have been agreed and developed in partnership with local authorities and Third Sector organisations and this continued partnership will be key to the success of the plans for the redevelopment of the Royal Edinburgh Hospital. A Sense of Belonging outlines how the redevelopment will be delivered including service redesign, investments in community services and associated improvements in reduced inpatient services to provide a better quality of inpatient care for individuals who cannot be safely or appropriately supported at home.

Phase 1 of the Royal Edinburgh Hospital campus redevelopment will focus on providing inpatient mental health assessment, treatment and rehabilitation facilities and the re-provision of the national brain injury unit. The construction associated with the Phase 1 redevelopment is estimated to be completed in November 2016.
3.20 **Develop jointly with Local Authority partners a community and residential support service for people with learning disability**

A number of strategic developments and work streams are being progressed across Lothian to ensure that specialist learning disability services are of high quality, effective and fit for purpose. Key work streams relate to:

- Reprovision of Learning Disability Inpatient Service.

The final stage of benchmarking and service model development will be complete by April 2014. This will inform the clinical brief for the business case for Phase 2 of the Royal Edinburgh Hospital reprovision.

- Repatriation of Out of Scotland Patients.

The national learning disability strategy requires that repatriation of patients is concluded by 2018. This will be included in the work above.

- Support Discharge of Long Stay Patients

This work stream has the potential to deliver community based opportunities for 16 individuals.

- Development of a Joint Community Facility for Autism and Learning Disability

A project to support this development is planned for 2016/17. A revised Initial Agreement will be considered in April 2014.

- Develop a New Model of Care Fit for Future Learning Disability Inpatient Services

To support this new model of care, patient pathways will be revised across all levels of the health and social care system.

Development of a Model of Care and Delivery of Services for People with Profound and Multiple Disabilities

A working group will be set up to take forward this initiative.

- Development of a Health Inequality Strategy Building on the Interim Lothian Action Plan and National Strategy; The Keys To Life within the overarching framework of NHS Lothian’s Health Inequality Strategy, the learning disability programme will detail health promoting actions specific to the needs and wishes of people with learning disability and their families.

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6. **The Keys to Life – Improving Quality of Life for People with Learning Disability, Scottish Government Health Department, June 2013**
3.21 **Develop a new East Lothian Community Hospital**

We will develop a new East Lothian Community Hospital to replace Roodlands and Herdmanflat Hospitals with modern accommodation and increase capacity to treat more East Lothian residents locally, it is anticipated the new community hospital will open in late 2017.

The provision of this local community hospital will ensure that more patients can be admitted directly and more can be discharged quickly from Edinburgh hospitals for post acute care through increasing the capacity for step-up/step-down provision for older people.

The new hospital will also increase capacity for day surgery and outpatients so that more East Lothian residents can be treated locally in line with the Lothian wide scheduled care capacity plans.

3.22 **Redesign of Midlothian Community Hospital**

The Midlothian partnership is at an early stage of developing a project plan to support the redesign of Midlothian Community Hospital. The key actions at this stage will be to:

- strengthen the Midlothian in-reach service
- implement the ‘frailty’ model through an enhanced Rapid Response Service
- extend the provision of assessment and intermediate care beds at the Highbank care facility

The main challenge in Midlothian is the limited availability of care home beds, however in the interim, the partnership will continue with the development and provision of extra care housing.

3.23 **Lothian Unscheduled Care Service (LUCS)**

LUCS has a mixture of salaried and ad hoc General Practitioners working within it, the split of shifts covered is approximately 50/50 salaried and ad hoc. It also employs Emergency Nurse Practitioners and paramedics via a Memorandum of Understanding with the Scottish Ambulance Service.

The service is based across 5 bases within Lothian, 3 are open until midnight and the other 2 are open overnight. LUCS covers 118 hours per week, two thirds of the week.
Over the last eighteen months the national shortage of doctors has severely impacted on the ability of LUCS to cover its rotas. Out of hours (OOH) work is not popular among General Practitioners. This is due to a number of factors outlined below:

- European Working Time Directive
- Busier day time practice
- Busier out of hours shifts
- Recruitment and retention of salaried medical staff has been difficult and those that transferred into the new system in 2004 are now aging and the new doctors are looking for a work life balance that does not put Out of Hours in the forefront of roles they would be seeking to do

Since 2005/06 (first full year of operation) to 2012/2013 the demand on the service has increased by 18%. With the current move to maintain higher numbers of complex patients in the community and to manage flow through the hospital sector 7 days a week there are increasing demands on LUCS. The increase in LUCS activity from 2004 is outlined in the graph below.

**LUCS Activity 2004-05 to 2012-13**

In meeting this demand, a number of new initiatives and other ability of LUCS to maintain core work:

- The services are seeing an increase in the level of complex patients seen in OOHs (particularly the frail elderly, care homes and palliative patients).
- There was an increase in the direct access to OOHs through our professional to professional telephone line, a 25% increase since 2010/2011 and patients using LUCS as a walk in service
In addition to the current pressures of demand, there are a number of challenges facing LUCS such as new initiatives and other increasingly complex areas of work and this will impact on the ability for the service to maintain core work. Key challenges relate to:

- the increase in level of complex patients seen in OOH, particularly the frail elderly, care home and palliative patients
- the increase in direct access to OOH through our professional to professional telephone line, a 25% increase since 2010/11
- the additional demands on OOH over and above the normal core work e.g. public health
- information sharing through anticipatory care plans is leading to longer home visits (expected to increase further due to the Key Information Summary and QOF)

LUCS will undertake a service review as part of addressing these challenges.

4. **SUPPORTING DELIVERY OF OTHER NHS LOTHIAN STRATEGIC PLANS**

In addition to the reference in Section 3 above, outlining the key role primary care and community services play in supporting delivery of NHS Lothian’s mental health, older people, learning disability and palliative care strategies. NHS Lothian also has an existing sexual health strategy and is also refreshing the children and young people and cancer strategies for which primary care and community services play a key role.

4.1 **Better Cancer Outcomes in Lothian 2015 - 2020**

A number of areas have been outlined within the cancer strategy where primary care and community teams have a pivotal role. These have been identified as:

- Participation in the Detect Cancer Early (DCE) Programme at local and national level including developing and implementing specific Lothian initiatives
- Improving access to diagnostic services to support earlier detection, including scoping the potential for pathway redesign and working alongside national improvement programmes
- Assist practices in improving their screening programme uptake, in particular supporting the bowel screening Scottish Quality and Outcomes programme initiative in 2013/14 and 2014/15
- Supporting the improvement of cancer referral guidelines by working locally and nationally, and supporting their local implementation in liaison with referrals advisors and others
- Supporting the palliative care programme including supporting learning and development associated with the Palliative Care Directed Enhanced Service (DES), and supporting the Lothian Palliative Care Redesign Programme
• Assessment of redesign potential to improve follow-up, and participation in the Lothian Transforming Care After Treatment programme

Work has already begun to support the DCE programme which aims to achieve earlier diagnosis of cancer with an initial focus on breast, colorectal and lung cancers.

NHS Lothian has commenced a pilot with 10 practices to explore different models of improving GP engagement to improve breast and bowel screening rates supported by a £60,000 investment from local DCE programme funding.

To support roll out of the DCE programme; NHS Boards have been allocated ‘6 QOF points equivalent’ funding to support the development of a Local Enhanced Service. An enhanced service specification will be developed in conjunction with NHS Lothian’s Detect Cancer Early Programme Board.

Further development of the work streams outlined above will be supported via NHS Lothian and Macmillan Cancer Care support a GP Lead post and a Nurse Consultant post for Cancer and Palliative Care. This team will work with colleagues across the healthcare system to manage this programme of work. There is a need to establish an appropriate forum straddling both primary and secondary care to discuss the how best primary care services can support the redesign of pathways and services and identify resource requirements to meet the aspirations of the cancer strategy.

4.2 Strategy for Children and Young People 2013 – 2020

A recent consultation has been undertaken to refresh NHS Lothian’s Strategy for Children and Young People 2013-2020. The strategy focuses on achieving the following outcomes:

• Every child and young person will have access to high quality healthcare that is accessible and appropriate to all children and their families, delivered proportionately to need and at the earliest opportunity
• Disabled children and young people will have their additional needs met
• Children, young people and their families will be involved in decisions that affect their health and wellbeing
• NHS Lothian staff will have an increased understanding of the needs of the younger population and will use this understanding to inform the planning and delivery of services
• To improve health and resilience in those more vulnerable to poor health NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions (Article 24 UNCRC)
• The range and quality of healthcare services for children and young people will be improved through the reprovision of the Royal Hospital for Sick Children, the integration of children’s services, and the development of services at St John’s Hospital
• NHS Lothian will have an effective and efficient workforce that is fit to meet the demands of a growing population of children and young people (Article 42 UNCRC)

• Robust governance and performance improvement arrangements will be in place for overseeing implementation of this strategy (Articles 43-54 UNCRC)

In 2013, A Vision for General Practice in the Future NHS\textsuperscript{7} was published. This vision outlines the changing landscape in which an understanding of high-quality health care is changing. It recognises the move towards a twenty-first-century system of integrated care, where clinicians work closely together in flexible teams, formed around the needs of the patient and not driven by professional convenience or historic location. It is therefore crucial that GPs are involved in the development of plans for the integration of children’s services.

Furthermore, the report states that GPs in 2022 will need expert generalist clinical skills, particularly in the context of managing children with complex medical conditions and that, “They will be able to respond to both urgent and routine needs, providing first-contact services to the majority of children…..”. It is therefore important that GPs generally have opportunities to maintain their knowledge and skills.

NHS Lothian’s Strategic Plan 2014 - 2024 outlines the need to review GP numbers and workforce support in light of the population and demographic changes. In addition, to support GP training in the management of children and young people, GPs are encouraged to access programmes such as the Lothian Fellowship Programme for paediatrics and the National Education for Scotland Paediatric Scholarships, which are particularly aimed at GPs with a special interest or wanting to take a lead in the practice.

4.3 Sexual Health and HIV Strategy 2011 – 2016

Primary Care has a crucial role to support the delivery of this strategy as the majority individuals contact primary care services for matters relating to sexual health.

A number of key ambitions for primary care are outlined within the strategy as follows:

• Increase uptake of long acting reversible contraception (LARC) through the local enhanced service
• Increase testing for HIV for higher-risk populations
• Reduce demand for routine sexual health interventions in the specialist service by signposting patients to primary care and developing clear referral guidelines for primary care

\textsuperscript{7} The 2022 GP - A Vision for General Practice in the Future NHS, Royal College of General Practitioners, May 2013
The strategy for Blood Borne Virus (BBV) is outlined through the Hepatitis Managed Clinical Network (MCN) work plan and the Sexual Health and HIV Strategy.

Ambitions for primary care relate to:

- Provide sterile injecting equipment to people who inject drugs, and educate people who inject drugs to use sterile equipment on each occasion.
- Increase testing for HCV and HIV through primary care, particularly for the populations at higher risk (a Local Enhanced Service for BBVs supports this objective) and improve access into specialist services for antiviral treatment.
- Increase vaccination rate for Hepatitis B for higher risk populations.

4.4 Substance Misuse

There are strategies in the four Alcohol and Drug Partnership which emphasise prevention, access to treatment and support to recover. Primary care services, health and social care partnerships and the voluntary sector have a key function in the delivery of this work. The ambitions for primary care outlined within the partnership plans relate to:

- Increase number of Alcohol Brief Interventions (ABIs) in primary care, reduce current variation of uptake between practices and establish ABIs as routine.
- Support and increase the quality and effectiveness of the service provided through the National Enhanced Service (NES) for Drug Misuse (circa 4000 patients receive treatment from their GP for opiate dependency).
- Increase the opportunities for people receiving treatment through the NES to achieve recovery within a substitute prescription.

5. Delivering the Primary Care and Community Service Propositions

The four Lothian Health and Social Care Partnerships are to develop a Strategic Plan supported by a number of Joint Commissioning Plans such as those for older people, mental health, learning disability, addition and criminal justice services.

In order for the aspirations outlined in this plan to be met, these need to be reflected within the partnerships strategic plans to ensure local ownership.

There is a need to continue to support existing and establish new forums across primary, secondary and social care services to support the redesign of pathways and services outlined within NHS Lothian’s Strategic Plan. There is a need to agree a mechanism to ensure representation in these forums from primary care services.
The developments associated with the primary care contractors will be taken forward with support from the Primary Care Contractor Organisation (PCCO).