

13. PRIMARY CARE PLANNING FRAMEWORK

13.1 Analysis of Local Position

- 13.1.1 Renfrewshire's 30 GP practices are located across the more densely populated part of the Local Authority area – Paisley, Johnstone, Renfrew and Erskine. There are also practices in the rural areas of Houston, Bishop ton, Kilbarchan, Bridge of Weir and Lochwinnoch. 176,467 people were registered with Renfrewshire GPs on 1st April 2009, 4% greater than the resident population. List sizes vary from 1,949 to 10,209 with the average being approximately 6,000. There are only two single handed practices in Renfrewshire.
- 13.1.2 The town of Paisley has no NHS Health Centre. There are Health Centres in Glenburn, Linwood, Johnstone, Bishopton and Renfrew. Accommodation remains challenging in Renfrewshire, and we work closely with Acute, Mental Health and Council colleagues to make the best use of our estate.
- 13.1.3 Our primary/secondary care interface work is led by the GP Forum which is attended regularly by most practices. Clinicians from the Royal Alexandra Hospital (RAH) attend to address specific interface issues e.g. Dexa scanning, ENT referrals. Most Renfrewshire residents receive secondary care in the RAH.
- 13.1.4 We have reviewed the uptake of Enhanced Services in Renfrewshire, and much of this is covered in other sections of the plan (e.g. sexual health, addictions). The Coronary Heart Disease (CHD) LES is not available in Renfrewshire.

13.2 Numeric Analysis

13.2.1 Medical

The CHP's 30 GP practices serve a registered population of 176,467. 22% of patients are children/adolescents (0-19), 62% are adults (20-64) and 16% are older adults (65 plus years).

13.2.2 Dental

There are 30 dental practices within Renfrewshire. 76% of the population, and 82% of children, are registered for dental treatment. The all age's percentage is higher than the Scottish average of 69%, but slightly lower than the Scottish average (83%) for children.

13.2.3 Optometry

There are 18 optometry practices within Renfrewshire.

13.2.4 Pharmacy

There are 43 community pharmacies in the Renfrewshire area, with a number of them offering additional services e.g., emergency hormonal contraception, Falls/Osteoporosis Services, Heart Failure Service.

13.3 Health Gap and Key Issues

- 13.3.1 All practices in Renfrewshire carried out a patient survey in 2009/10 and produced an action plan. We are reviewing the action plans for common themes. Patient experience of access is varied, for example, 3 practices achieving less than 50%

satisfaction for appointments obtained in 2 days.

Our PPF is keen to work more closely with patient forum groups in general practice, and they have written to all practices seeking early discussion with groups about priorities.

- 13.3.2 We perform above average for uptake of cervical screening but below target. It is important that practices work towards improving performance where possible.
- 13.3.3 Ensuring RCHP practices optimise take up of Enhanced Services. A key issue here is that not all LES are available in Renfrewshire. CHD LES is still to be introduced.
- 13.3.4 The development of the Primary Care Framework has given us the opportunity to begin to explore how to develop the wider primary care team. It has highlighted how difficult it is to engage with other primary care contractors and to demonstrate the advantages of working more closely. Some of our CHP services have been aligned to the three Social Work Area Teams (Paisley, Johnstone and Renfrew) and there are challenges to us in realising the benefits of this alignment.
- 13.3.5 A key issue is the need to reduce prescribing costs through targeted approaches. Over the next three years the prescribing team consisting of a mix of pharmacists and technicians will continue to deliver closer working links with GP practices and promote cost effective prescribing. The team will continue to support prescribing practice through delivering prescribing advice, undertaking medication reviews, supporting clinics for long term conditions i.e. hypertension, COPD, training of support staff and prescribing efficiencies.

The prescribing team will also be involved in supporting community pharmacists deliver the new chronic medication service from June 2010.

An aim we would like to develop with the prescribing team is to have better links with secondary care so that clinical and cost effective prescribing initiatives are the same in primary care as they are in secondary care.

The prescribing team are also involved in delivering a service to Care Homes in the CHP and over the next year it is hoped that the majority of Care Homes will have support from the prescribing team for advice, ordering of prescriptions and training on various aspects of pharmacy care.

- 13.3.6 Primary Mental Health services are being rolled out across Renfrewshire. The Doing Well Service is now operating in 25 of our 30 practices with the remaining 5 practices expected to implement the service by July 2010. Recognising the link between anxiety and depression and employability and financial inclusion, we have linked Doing Well with initiatives to provide financial advice and to support employment.
- 13.3.7 We will continue to explore how to make our accommodation in NHS Health Centres and Clinics fit for purpose, maximising accessibility. Building on the 2008 audit of NHS premises, we will participate in the system-wide work to survey all premises delivering NHS services (Autumn 2010).
- 13.3.8 We will contribute to the process to enable GPs to move from GPASS to the replacement IM+T system. The timeline is not finalised, but we will support practices during the transition period.

13.4 Outcomes Table

Primary Care

Outcomes	Actions/Activity Required 2010/11	Change/Progress/Performance Indicator
A - Access and Engagement with Services		
A1 Patients can access primary care at the place and time they need it, including out of hours.	Agree robust systems to test and measure the access available for patients across primary care, including variation and gaps in access, particularly in relation to specific groups who may experience difficulties in accessing services due to disability, race or gender.	Systems in place to monitor patient satisfaction, complaints, waiting times, referral rates, DNAs etc.
A2 Primary care services seek and are responsive to patient views.	Test different models of patient engagement, building on existing PPF structures, to determine the most effective means of generating robust information: at practice level; - in planning; - in individual consultations; - with specific communities of interest.	Experience from practices' patient groups being shared with GP Forum Evaluation of Single Point of Access (SPOA) Feedback from Patient Experience Group OACMHT – carers' views sought through Talking Points approach. Podiatry – patients' views sought through Patient Experience Group.
A3 Primary care provides a range of services to meet patient needs in different settings and with appropriate entry arrangements.	Review potential for directories of services at locality level as a means of improving referral and access by patients.	Directory of services developed with Renfrewshire Council that supports SPOA
A6 Primary care services understand and respond to the inequalities which affect patients in accessing primary care and onward referral to secondary care.	Develop a 3 year trajectory to ensure disaggregated patient data is available at practice level to ensure that we understand: - the diversity and different characteristics	Disaggregated data collated through review and redesign of community services and EQIA action plans

Primary Care

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	<p>of our population;</p> <ul style="list-style-type: none"> - their diverse needs; - their access and utilisation of services; <p>and ensure that this information is communicated to Acute via SCI to enable planning for effective service delivery and to test potential discrimination at each part of the patient journey</p> <p>Develop and pilot models of clinical practice, and practice organisation, which identify and address complex health and social circumstances, including:</p> <ul style="list-style-type: none"> - develop descriptors of effective practice; - clarify the link between inequalities and individual patient characteristics; - work with small teams to develop and implement the model; - models of professional leadership and behaviour change; - CHP development programme on routine enquiry/social history taking; - clear pathways into employability and financial inclusion support in the community; - collection of appropriate data; - different experience and needs of specific communities due to, e.g. disability, race, gender. 	<p>One care group identified e.g. Diabetes and journey tested from an equalities perspective</p> <p>Opportunities identified to link this to Rehabilitation and Enablement service model for Older People/Physical Disability</p> <p>Early discussions with Social Work and CHP, referring to the model being developed in East Renfrewshire.</p>
B - Resources		
B1 Primary care services are resourced to	CHP planning should take full account of the	Considered within ePEG work plan

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meet the demands they face and to meet the needs of patients.	impact on primary care demand and type of service required due to demographics and patterns of illness, specifically: <ul style="list-style-type: none"> - long term conditions - mental health, including depression - alcohol - ageing population 	Lead geriatrician attending May meeting of GP Forum to discuss LTC 4 priorities: diabetes; CHD; asthma; and COPD - current and future prevalence of disease considered and service models to address these. Doing Well rolled out to all practices. Cross ref. Joint Addictions Plan. Joint commissioning plan for Older People. Contribution to NHSGGC approach to Reshaping Services for Older People
B2 The distribution of resources for primary care reflects articulated priorities and relative need so that services are resourced to reflect the workload they face.	Process through new General Medical Services (nGMS) <ul style="list-style-type: none"> - enhanced services - Resource Allocation Model for community services 	Services are resourced to reflect their workload
B3 Gaps and challenges to services are fully considered in reviewing and changing the distribution of resources.	Identify through local service reviews and redesigns	Resources are distributed to best effect
B5 Premises for primary care services are planned and resourced to reflect service requirements.	CHP accommodation strategy to include clear plans for independent contractor premises including consideration of the potential for joint working and effective use of premises within localities across the 4 independent contractors groups. This should include: <ul style="list-style-type: none"> - plans to address accessibility issues including DDA compliance 	Incorporated into RCHP Premises and Capital Plan (within existing resources).
C - Primary Care in NHSGGC		
C1 Primary care has a clear place at the centre of NHSGGC planning, decision	Develop a model of locality groups which create structured engagement and joint	RCHP to fully participate in the review of current Professional Executive Group

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<p>making, resource allocation, communication and public engagement.</p>	<p>working between independent contractors, community staff and CHP management. These will:</p> <ul style="list-style-type: none"> - enable shared decision making on service delivery and use of resources; - provide an opportunity for independent contractors and frontline community staff to bring about change; - strengthen and encourage innovation and development including the testing of new ideas; - focus on effective primary care team working, including exploring different models of attachment and alignment; - be structured around natural communities and local circumstances within the CHP area; - be an integral part of the CHP structure with contractor engagement supported and funded by the CHP; - contribute to strengthening engagement with patients; - provide a primary care perspective to inform the CH(C)P interface with secondary care; - support independent contractors to work together including professional development. 	<p>arrangements within CH(C)Ps. Implementation of the Primary Care Framework. Initial planning meeting May 2010; short-life working group (multi-professional/agency) will be established to develop and implement locality model. Locality model implemented and evaluation framework progressed by Dec 2010.</p>
<p>C5 The independence of primary care practices is balanced with cooperation where that is in the interests of patients.</p>	<p>Develop further models of community service provision which are based around the practice structure. To achieve this we will need to:</p> <ul style="list-style-type: none"> - explore opportunities for working with 	<p>Build on the local “buddying” agreements that exist for pandemic flu.</p> <p>Considered through Children and Families</p>

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	groups or 'clusters' of practices; - consider the implications for small or single handed practices to ensure they benefit from changing arrangements.	Teams. Considered through District Nursing redesigned Teams.
D - Workforce		
D4 The primary care workforce is appropriately trained and professionally developed.	Ensure protected learning time (PLT) is used effectively to delivery primary care priorities, across all contractor groups. Establish effective development programmes for key staff groups including practice managers and practice nurses.	Renfrewshire PLT programme is designed around the needs of local primary care professionals. Practice Nurses have accessed Board wide training programmes e.g. Advanced COPD module
D6 There is a robust and clear plan to ensure the future workforce for primary care.	Reach collective agreement with the LMC (and other contractor representative bodies) to collect comprehensive workforce information to support effective workforce planning arrangements.	RCHP will participate in agreed LMC approach.
F - Secondary Care Interface		
F1 Primary care can access the full range of supporting secondary services it requires in the timeline and model required.	Explore changes to processes and systems needed to ensure that there is clear joint ownership of service challenges across acute services and CH(C)Ps including:	Secondary care engaged through GP Forum (ePEG to look at these). To be agreed by RCHP Director and Acute Services Division Chief Operating Officer.
F2 Where patients require referral or intervention from secondary services there are clear routes and criteria agreed with primary care.	<ul style="list-style-type: none"> - managing demand; - population health; - quality of care; - levers and incentives for change; - using evidence of effective models and lessons from other systems. 	Progress through care group specific JPPIGs – Older People's; Mental Health; Addictions; Learning Disabilities etc.
F3 Care pathways between primary and secondary services are planned and designed in partnership including the resources required and there are agreed	Develop effective information flows and relationships between secondary and primary care including:	

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feedback arrangements about utilisation and appropriateness.	<ul style="list-style-type: none"> - Develop the Renfrewshire CHP/RAH interface, to identify system changes required to support engagement on day to day activity and pathway redesign. <p>Ensure short term delivery of specific improvements to the acute/primary care interface, specifically:</p> <ul style="list-style-type: none"> - discharge information; - medicines management and hospital prescribing; - access to investigations; - CH(C)Ps to develop stronger response within primary care on issues placing significant demand on secondary care, e.g., alcohol; <p>Communicate change effectively through regular reporting on progress with actions on interface and redesign.</p>	<p>RCHP Director and Chief Operating Officer for Acute Services to agree and pilot a local approach in Renfrewshire. Cross ref. Short-life Working Group responsible for Action 19/C1.</p> <p>Agree set of improvement measures:</p> <ul style="list-style-type: none"> - baseline data collated - improvement measures agreed - gaps identified - issues addressed - process reviewed 		
F4 There are agreed, effective and timely information flows between primary and secondary care in the most appropriate format.				
F5 The mutual interdependence between primary care and other services is recognised and planned for.				
F6 The shared responsibilities of primary and secondary care are identified.				

13.5 Finance and Workforce

- 13.5.1 A discrete budget exists within the CHP to allow independent contractors to attend meetings, such as the PEG and GP Forum.

While expenditure on independent contractor premises has up until now been granted on a case by case basis on its individual merits, it is acknowledged that future allocations will have to recognise available resources.