East Lothian
Health & Social Care Partnership

Primary Care Improvement Plan

Update April 2019

Contents

1. Background and Scope

1.1 The new General Medical Services (GMS) contract places a duty on each Health and Social Care Partnership to develop a local Primary Care Improvement Plan (PCIP) to deliver all commitments and to develop *"...priority areas of service redesign..."* within the contract[1]. .

1.2 East Lothian Health and Social Care Partnership's Primary Care Improvement Plan was developed in collaboration with primary care professionals, primary care representatives, patients, carer representatives, stakeholders, service managers, the third sector and planners. The PCIP was considered and approved by the Lothian GP sub-committee and the East Lothian IJB in June 2018.

1.3 The Primary Care Improvement Plan 2018 provided a detailed overview of the national and local policy and strategic context. The scope included a range of plans to enhance the delivery of primary care services and set out a broad programme of service development with a defined implementation period from 2018 until 2021.

1.4 This document provides an update on progress of work outlined in East Lothian's 2018 PCIP, including any adaptations to the PCIP and outlines plans for 2019-2020.

2. Local Strategy and Policy Context

2.1 The East Lothian Integration Joint Board has agreed a Strategic Plan for 2019-2022. The East Lothian Plan has identified Primary Care as one of its six main priorities to support the continued development of Primary Care. A Primary Care Change Board reports directly into the East Lothian Strategic Planning Group which in turn makes recommendations on strategic direction to the Integration Joint Board.

2.2 The Primary Care Change Board has four working groups delivering key elements of the Primary Care Improvement Plan. These groups cover Access and Service Delivery, Link Workers, Pharmacotherapy and Community Treatment and Care Services (CTACS). A GP Sub-Committee representative is a standing member of the Primary Care Change Board and ensures that GP and practice team perspectives are included.

[1] http://www.gov.scot/Resource/0052/00527530.pdf

2.3 In addition, ELHSCP has collaborative links with GP practices both directly and through the two local GP Clusters in the east and the west and through ensuring GP representation on the Primary Care Change Board.

3. Our Progress

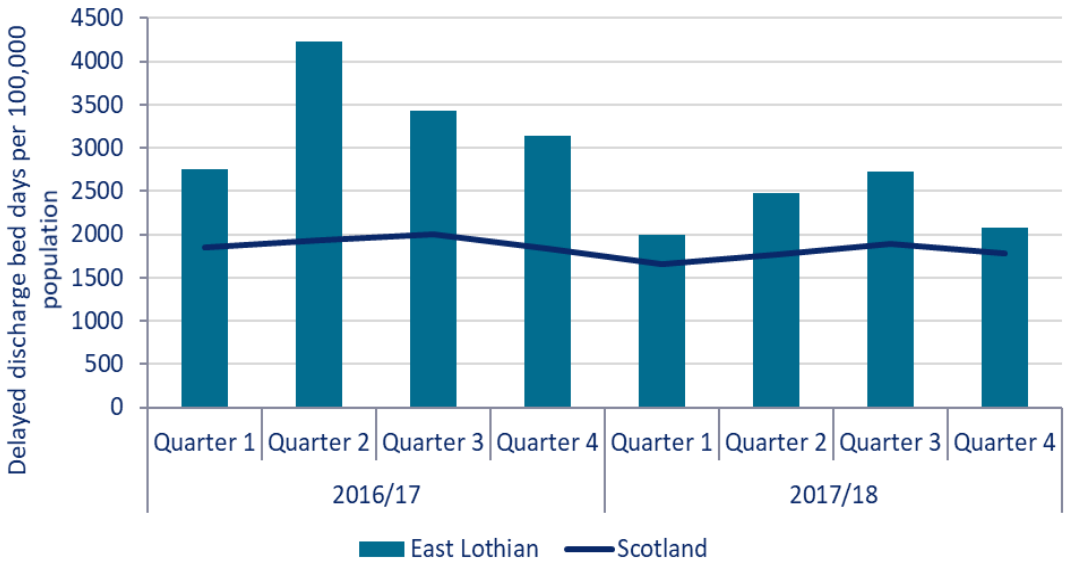
3.1 ELHSCP has made considerable progress against several national indicators. When compared with national averages in 2017-18, East Lothian's rates for premature mortality, emergency admission, emergency bed day, falls and the percentage of health and care resource spent on hospital stays for patients admitted in emergency are below Scottish rates (table 1).

Table 1. East Lothian MSG Indicators as compared with Scottish rates in 2017/18

	Scotland	East Lothian
Premature mortality rate for people aged under 75 (per 100,000 population).	425	372
Emergency admission rate for adults (per 100,000 population).	12,183	10,325
Emergency bed day rate for adults (per 100,000 population).	123,035	120,782
Emergency readmissions to hospital within 28 days of discharge(per 1,000 discharges).	102	105
Proportion of last 6 months of life spent at home or in a community setting.	88%	86%
Falls rate per 1,000 population aged 65+.	22	19
Proportion of care services graded "good"(4) or better in Care Inspectorate inspections.	85%	85%
Percentage of adults with long term care needs receiving care at home.	61%	64%
Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population).	762	775
Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.	25%	24%

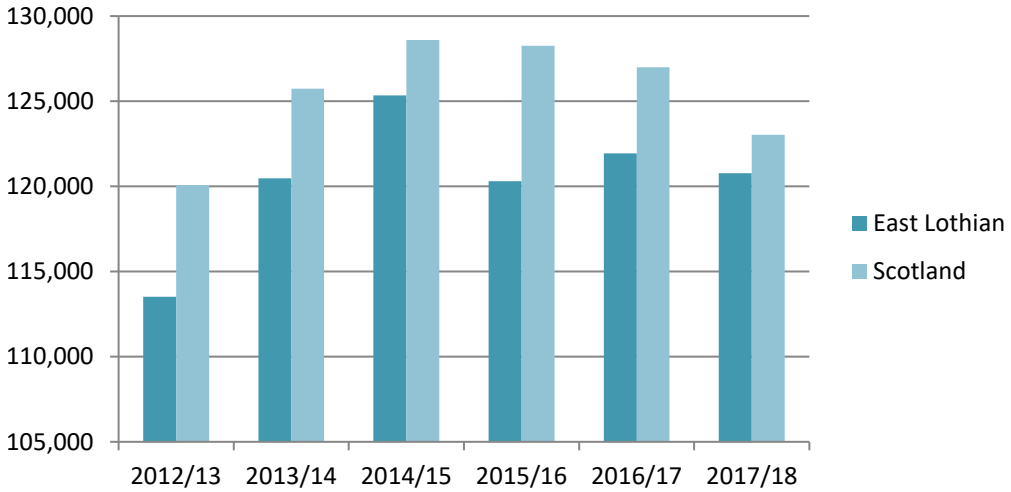
3.2 Over time there has also been a clear reduction of delayed discharge bed days for East Lothian patients who are ready to be discharged from acute hospitals (chart 1) dropping from an average of 3,389 in 2016-17 to 2,317 in 2017-18.

Chart 1 - Delayed discharge bed days per 100,000 population



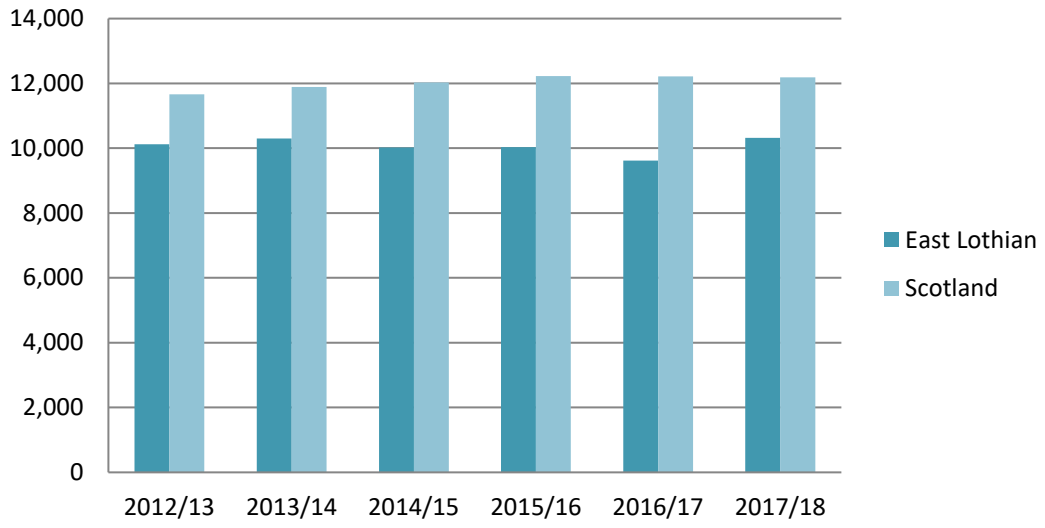
3.3 Over the past six years, despite an initial increase in emergency bed day rates for adults admitted into acute hospitals in 2013-14 our emergency bed day rates have reduced from 125,346 in 2014-15 to 120,782 in 2017-18 (Chart 2). East Lothian rates have remained below Scottish rates during this time period.

Chart 2 - Emergency bed day rate for adults (per 100,000 population)



3.4 During the period of 2012-13 to 2017-18, East Lothian's emergency admissions rate for adults (Chart 3) has also consistently fallen below Scottish annual rates.

Chart 3 – Emergency admissions rate for adults (per 100,000 population)



3.5 Much of this improvement has been achieved through multi-disciplinary team working across primary care and other services and the co-ordination of support between the Hospital at Home, Hospital to Home, Care Home and Social Care teams, working together to prevent unnecessary admissions and to reduce length of stay for patients.

4. Understanding the Needs of East Lothian's Communities

4.1 There is a need to continue developing collaborative, innovative approaches to meet the specific needs of the communities across East Lothian.

4.2 Primary care services must meet the needs of a diverse and growing population estimated at 104,070 (2017). East Lothian is currently served by 15 GP Practices ranging in size from 2,700 to nearly 19,000 across a wide geographical area.

4.3 East Lothian continues to face pressures both in relation to population growth as well as challenges regarding an older population and health inequalities across the county. By 2037, the East Lothian population is projected to grow by 23%[2]. The highest growth is predicted to be among the over 65 age group (increasing by 72%, with many of them in single occupant households).

[2] East Lothian by Numbers - A Statistical Profile of East Lothian. December 2016

4.4 East Lothian also has marked variations in deprivation levels across the county, with most concentrated areas of deprivation located in the more densely populated west (Chart 4). The Scottish Index of Multiple Deprivation allows us to identify people who live in the 20% most deprived areas of Scotland. Overall, 5% of the East Lothian population live in such area (Chart 5).

Chart 4 – Map of East Lothian showing areas of concentrated deprivation (SIMD 2016)

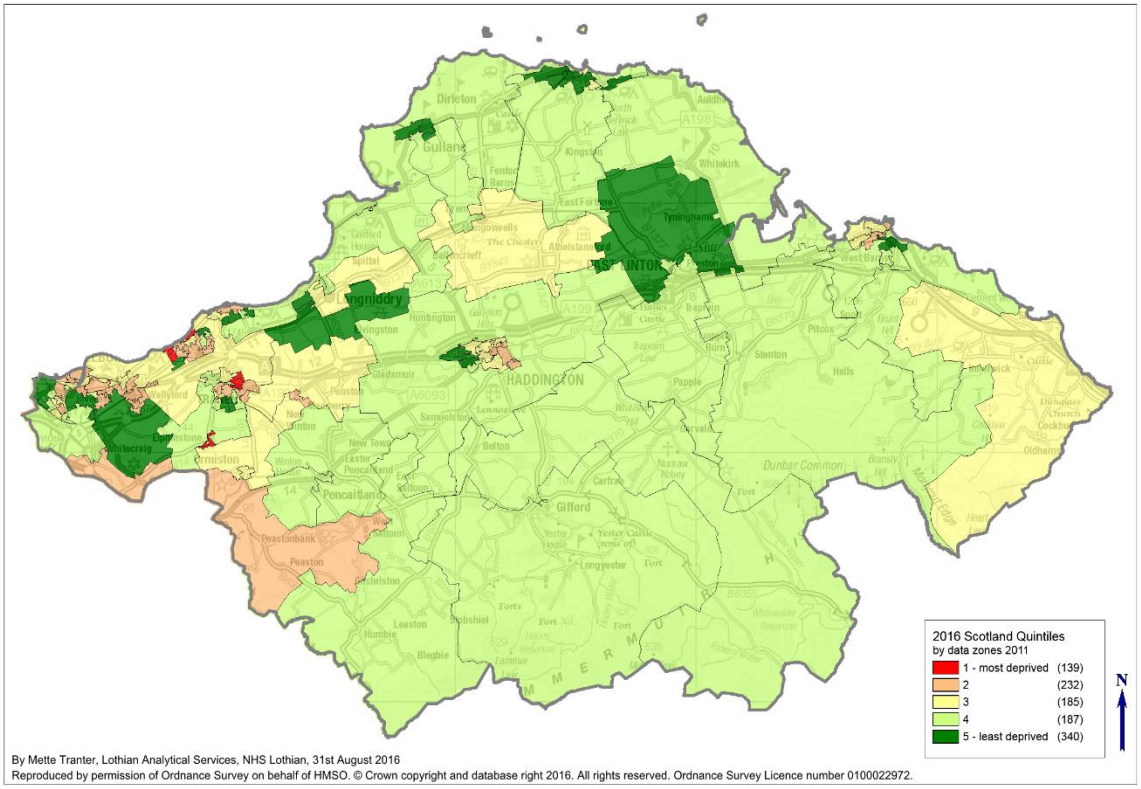
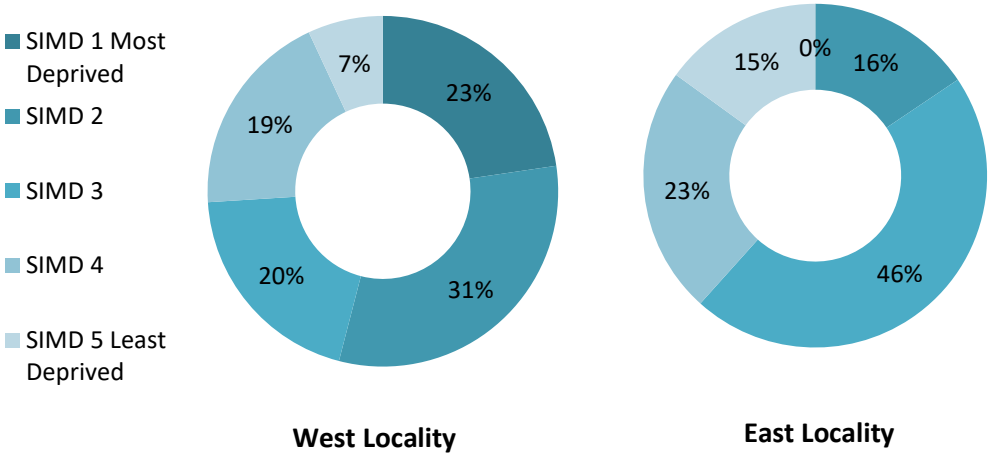


Chart 5 – Proportion of patients experiencing different levels of multiple deprivation by list size and locality (SIMD 2016)



4.5 Social and economic circumstances have a significant impact on health outcomes, with higher deprivation being associated with poorer outcomes and reduced access to care[3].

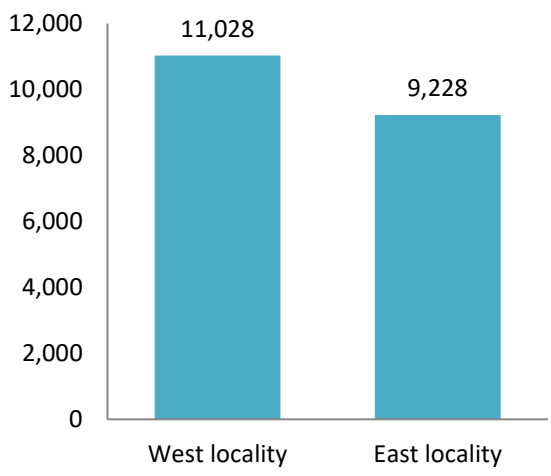
4.6 Across East Lothian people living in the most deprived areas have a life expectancy 5 years lower than those in the least deprived areas. People experiencing higher levels of deprivation will also spend more of their lives in ill health.

4.7 Evidence suggests that multi-morbidity tends to occur 10-15 years earlier for people living in the most deprived areas compared to the least.

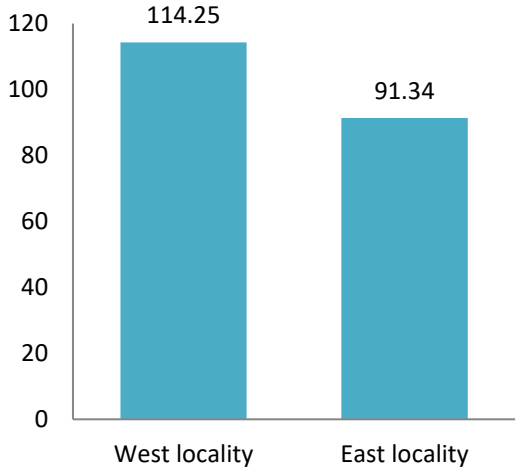
4.8 Such inequalities are due to a complex mix of social, economic, cultural and political reasons. Population health and wellbeing is not just a matter for the health and social care system but requires joint action and greater partnership working.

4.9 Performance against national indicators is also variable across localities (Chart 6). In the west of East Lothian emergency admissions rates are 11,028 admissions per 100,000 and 9,228 in the eastern part of the county. There is a similar disparity when comparing emergency readmission rates to hospitals within 28 days of discharge.

Chart 6 – Emergency admissions and readmissions rates 2017/18



Emergency admission rate for adults (per 100,000 population)



Emergency readmission rates for adults (per 1,000 population)

[3] Marmot M. *Fair Society, Health Lives: The Marmot Review*. The Marmot Review, 2010.

5. Developing Primary Care

5.1 The East Lothian Primary Care Improvement Plan is intended to support significant changes in how patients access Primary Care services as well as social care services, specialist services and third sector and other supports and how these services are delivered. ELHSCP is committed to the 'Right Care, Right Place, Right Time' approach to health and social care delivery, recognising that individuals may require different pathways to care[4].

5.2 During consultation on the 2018 Primary Care Improvement Plan and discussion on the reasoning for the ambitions within there was a great degree of debate and a number of communications from practices to the HSCP expressing concerns. These came in particular from practices in the east of the county and Prestonpans, which did not see the need for, or relevance of, the 'Musselburgh Model in their areas.

5.3 These responses appeared to reflect a number of factors, including the differences between communities and levels of demand in different parts of the county.

5.4 All opinions expressed during the original consultation were listened to and have been and will continue to be used to shape alternative support services according to individual practice need and demand and to reflect the GP contract requirements. In the next few months we plan a series of monthly meetings with GPs to hear their views, ideas and suggestions for implementation of the PCIP and the new GMS contract over the next two years.

5.5 The Primary Care Team at ELHSCP continues to support GP practices across the county in a variety of ways, including building infrastructure and capacity across all practices and providing support to individual practices in times of need. It also works with practices in testing, implementing and evaluating new models of service delivery to transfer demand from GPs and practices.

5.6 In March 2018, Cluster Quality Leads carried out a mapping exercise to gather information from East Lothian practices on priorities for the Primary Care Improvement Plan and information on practice workforce.

5.7 The survey achieved a 100% response rate. It is apparent from the survey that practice teams wish to see development of additional roles in primary care, for example advanced physiotherapy practitioners, community mental health nurses and community link workers. The roll-out of these and other supports to primary care

[4] https://www2.gov.scot/resource/doc/311667/0098354.pdf

across the country will be phased to reflect available staff and funding and the requirements of individual practices and areas.

5.8 By supporting partnership and collaborative working, developing a highly skilled multi-disciplinary primary care workforce and identifying models that meet the needs of our communities, the HSCP will deliver service improvement, reduce GP workload, provide greater capacity to respond to increased demand on services and ensure better outcomes for patients.

5.9 Developments in service delivery in primary care across the county will continue to be evaluated, taking into account the needs of local communities and local community opinion. Outcomes of this work will be shared across the East Lothian practices and to other partnerships.

6. Multi-Disciplinary Approaches

6.1 The Access and Service Delivery Working Group supports development of pathways for patients seeking access to Primary Care services, with a particular focus on the benefits of multi-disciplinary approaches. The working group is focused on ensuring that patients are given a tailored access journey, and importantly, that they see the right professional for their presenting problem at the outset.

6.2 A choice of multi-disciplinary approaches are being developed across the county, taking into account the particular needs of each locality.

6.3 A multi-disciplinary approach has already been piloted to improve access for patients seeking same day access to care. In partnership with Riverside Medical Practice and NHS 24, the 'Musselburgh Model' was tested and developed to serve nearly 20% of the East Lothian population. NHS24 support is funded from their own resources at no cost to our Primary Care Improvement Fund.

6.4 The Musselburgh Model demonstrates a collaborative approach drawing on expertise from Nurse Practitioners, Advanced Physiotherapy Practitioners, Mental Health Nurses, Mental Health Occupational Therapists, and Advanced Nurse Practitioners to ensure patients access the right type of support for their needs.

6.5 The Musselburgh Model has been established with clear clinical governance arrangements to ensure patient safety. It also provides a training hub for professionals from across Lothian to develop further skills and expertise within their enhanced role as well as gain experience working within a multi-disciplinary team.

6.6 Robust evaluation of the Musselburgh Model has demonstrated reductions in outpatient referral numbers and prescribing, including significant reductions in

antibiotic prescribing. Monitoring of a range of outcomes continues, across the NHS24 and Musselburgh Model services and Riverside practice, and externally with the help of an independent East Lothian third sector body.

6.7 ELHSCP is committed to expanding access to multi-disciplinary healthcare teams for patients across the county. NHS 24 have committed to expanding their input via extra investment from Scottish Government.

6.8 The Musselburgh Model pilot is now being adopted across three additional neighbouring practices to form a multi-disciplinary same day service benefiting over 53,000 patients. This will serve over half of the East Lothian population. This new expanded service (the Community Health Hub) will, as set out in the first PCIP agreed by the IJB and the GP subcommittee in 2018, offer a same day primary care response to patients in all participating practices as well as being the training and development hub for the multi-disciplinary primary care workforce.

6.9 A second service is in development to serve the East of the country, taking into account the different needs of each locality, the preferences of individual practices and varying levels of demand on Primary Care. Early needs assessments in the east have highlighted a requirement to support patients in accessing musculoskeletal services and in getting help with Mental Health issues.

6.10 This pathway will establish a second Community Health Hub and possible locations are being explored in the East Lothian Community Hospital in Haddington. GP practices will be supported to establish local care navigation pathways and the service will offer improved same day access for mental health and musculoskeletal Support, allowing GPs to spend more time on routine care. The possibility of satellite hubs will also be explored.

7. Support to Care Homes

7.1 A nurse practitioner team has been working directly with Care Homes and GP Practices to deliver prompt and continuous care to residents of care homes by being the first point of contact for the homes when medical support is required. Nursing expertise, augmented with clinical decision-making capabilities and prescribing, has led to a more seamless level of ongoing and acute care to residents and has supported the Care Homes and GP Practices.

7.2 Feedback from involved practices has been positive and GP workload significantly reduced. Advanced Care Planning and continuity of care have been supported and enhanced and GPs enabled to spend more time on other work.

7.3 Currently the Care Home Team covers Musselburgh, Wallyford, Gullane, and Haddington (49,500 of the East Lothian population). In recognition of the success of this service and the need to ensure we provide the best possible care for one of the most frail populations, ELHSCP intends to grow this team to ensure all care home residents in the county can benefit.

7.4 Care Homes in North Berwick and then Tranent will be the next to have this support (an additional 23,000 patients are covered by these practices, meaning CHT will be covering practices caring for 72,500 patients, or 66% of the county's patients). We have three practices without care homes in their area (East Linton, Harbours and Prestonpans, totalling 21,500 patients). The final phase of CHT rollout will be to add Ormiston and Dunbar practices, which care for 18,300 patients.

7.5 The Care Home service is currently being evaluated by Healthcare Improvement Scotland (HIS) with a focus on the impact in Tranent, capturing data before and after deployment. A working group is developing this using Quality Improvement methodology with representation from the practices and the partnership.

8. Pharmacotherapy

8.1 Practice Pharmacists continue to provide services for patients of several practices in East Lothian. Three additional Pharmacists are currently being recruited, ensuring that every practice will have access to a pharmacist by the end of 2019-20.

8.2 Pharmacotherapy services are managed at board level and delivery models are being explored across Lothian. ELHSCP will continue to evaluate pharmacy-led models locally, and innovative ways of working to ensure delivery of improved pharmacotherapy services for patients across the county.

8.3 Work has already begun to improve medicines ordering and reconciliation processes to reduce the administrative burden on practices. This will include evaluation of teams which utilise pharmacy technicians and administrative support alongside pharmacists as well as assessing remote models of working.

9. Link Workers

9.1 A Link Worker service has been developed in collaboration with a third sector provider and is currently serving four GP practices in East Lothian. The Link Worker service provides additional capacity for Primary Care to respond to patients with more complex social needs, who are socially isolated, or who would benefit from engagement with community supports.

9.2 Each individual receives an initial assessment and is provided with support and signposting tailored for their particular needs. During the first three quarters of 2018 the top two reasons for referral included support for mental health and financial/benefits help. A local database of community resources was also developed to improve signposting.

9.3 A full review of this service is currently underway to identify the impact of the service for patients as well as GP practices. The Link Worker sub-group has been initiated to help ensure continuity of service delivery for 2019-20.

9.4 Recently the working group has had input from the National Lead for Community Link Worker models and will consider models for the intended expansion of the Link Worker service. It is anticipated that the Link Worker service will be available to all our practices as of April 2020.

10. Community Treatment and Care Services (CTACS)

10.1 Delivery of services via Community Treatment and Care Services will ensure a more equitable service for patients, agreed treatment protocols and improved clinical outcomes.

10.2 It is recognised that some nursing services may lend themselves better to a CTACS model and discussions with Primary Care Providers regarding local development of CTACS are ongoing.

10.3 An evaluation of current Primary Care Nursing services (including Practice Nursing, treatment room services, and Health Care Assistants and Phlebotomy) within existing GP Practices has also been completed. These services are currently provided by a workforce of mainly GP-employed and some ELHSCP-employed staff.

10.4 Partners in the Local Intelligence Support Team (LIST) provided support to carry out detailed data analysis over a 2 week period of all GP practices in East Lothian to identify the top reasons for interaction with nursing and the time spent per interaction.

10.5 Further development and implementation of CTACS will be based around activity and need. These new centres, as envisaged by the new GMS contract, will deliver nursing services for Primary Care and will be developed in partnership with GP Practices and run by ELHSCP staff.

10.6 An evaluation of current secondary care phlebotomy provided by general practice staff is currently being undertaken. This will help us identify workload and future secondary care phlebotomy requirements within CTAC services.

10.7 Premises for our first implementation of new CTAC services has been identified in the East Lothian Community Hospital. A pilot is expected to begin in August 2019. ELHSCP will continue to test and refine the CTACS model to evaluate outcomes of service development and the impact on local GP practices. All practices will have support from a CTAC service by March 2021and it is envisaged that these will be based in at least two centres.

11. Home Visiting

11.1 New models of Home Visiting, including the input of Paramedic Practitioners, and Allied Health Professionals are being developed which will allow ELHSCP to create different models of response for situations of acute illness, as well as complex issues of frailty, and improve pathways into secondary care and social services.
11.2 In collaboration with Scottish Ambulance Service (SAS) a model of home visiting involving anticipatory care planning and triage against core competencies has been embedded within one practice locally. This service allows specialist paramedics to assess patients in their homes as an alternative to acute admission.

11.3 Funding for the SAS model is secured for the coming year and the model is currently being evaluated. Early feedback from GP and SAS staff is positive.

11.4 A further test of change involving nurse-led home visiting is also now being considered. This East Lothian Home Visiting Service (ELHViS) would focus on unscheduled care including frailty and acute illness, and would link seamlessly with other ELHSCP services, including District Nursing, Hospital @ Home, and Practice Pharmacists. The service will also link with Social Care services, especially in the context of admission avoidance, via our well-developed ELCH Hub.

11.5 Depending on successful evaluation, all East Lothian practices who choose to access this additional support will be able to access a home visiting service by March 2021.

12. Mental Health

12.1 The creation of different pathways for people in East Lothian experiencing mental health issues is essential to ensure they have access to the right information and support at the right time. Investing in a pathway that ensures earlier access to support is a priority.

12.2 The Musselburgh Model will continue to expand a Mental Health Occupational Therapist (OT) model for offering same day access for people presenting to primary care. This expansion will offer services to practices opting into this model of primary care.

12.3 In addition, a Nurse-led model of Mental Health is being developed which will include intensive in-reach of Community Mental Health Nurses managed by the Community Mental Health Team. Initially this model will be developed collaboratively with practices in Dunbar, Prestonpans, North Berwick, Haddington, and East Linton.

12.4 There are ongoing discussions with practices to develop criteria and pathways for the service. It is envisaged that this model would offer face-to-face support for patients as well as brief interventions.

12.5 Pathways and criteria for enhanced provision of out of hours mental health support are currently in development as part of work by the Unscheduled Care Board in conjunction with Lothian Unscheduled Care Services. This will include a 3 month pilot of a primary care mental health assessment and referral pathway to local resources including the East Lothian Intensive Home Treatment Team (IHTT) where appropriate.

13. Substance Misuse

13.1 East Lothian has seen a continued rise in the numbers of drug-related deaths throughout the county. The Substance Misuse Service (SMS) was created in collaboration with the local Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP) and is funded through the Scottish Drugs Strategy. It aims to ensure greater specialist local provision in primary care settings and improve access to treatment for patients.

13.2 The Substance Misuse Service provides additional capacity to support patients to improve all aspects of health, including managing and reducing substance misuse as well as addressing other physical and mental health needs.

13.3 This collaboration offers new pathways for client flow from the main SMS team back to the respective locality for the individual and aims to improve access to services within the Local Delivery Plan target of 21 days. Central management of these assertive in-reach teams will ensure appropriate supervision and clinical care governance.

13.4 The SMS team will be affiliated with primary care locations across the county, with teams being rolled out in Dunbar, North Berwick, Musselburgh, Tranent and Haddington by September 2019.

14. Vaccinations

14.1 ELHSCP is participating in the pan-Lothian Vaccination Transformation Programme (VTP). The VTP in Lothian is on course to deliver the priorities agreed by the VTP Strategic Group. Current options appraisals are being undertaken with consideration of mixed models of delivery to meet practice population needs.

14.2 One priority for year one is piloting of 0-5 year routine childhood vaccination delivery for any GP practice where there was delivery by GPs or practice staff, or dual delivery with Health Visiting.

14.3 Transfer of vaccinations to the Community Vaccination Team (CVT) for ages 0-5 has already benefited 6 practices in East Lothian, 2 of which previously had Health Visitor delivered support.

14.4 Plans for year 2 include the continued rollout of childhood vaccinations following the options appraisal, scoping of pilots for adult vaccinations and the continuation of the rollout of pregnancy vaccinations across Lothian.

14.5 Further national guidance is awaited to direct the rollout of future travel vaccinations. The Lothian VTP group has agreed to establish a travel vaccines group to begin development of an agreed, Lothian-wide specification for delivery of the service.

14.6 Tackling health inequalities by ensuring vaccinations continue to be accessible is a major consideration. ELHSCP will continue to support opportunistic flu vaccinations within other areas of primary care services to increase uptake.

15. Evaluation and Monitoring

15.1 Locally infrastructure and capacity across ELHSCP is being developed to support data-sharing and the monitoring and improvement of services.

15.2 To better support data-sharing and analysis across primary care, SPIRE (Scottish Primary Care Information Resource) training is also being rolled out to practices across East Lothian for the remainder of 2019.

15.3 ELHSCP has now established a Data Group with the aim of supporting better use of data and resources across the Partnership, including test projects within primary care.

15.4 Developments in primary care across East Lothian continue to be monitored and evaluated to inform future service design and improvement. For example an evaluation of the Musselburgh Model has already identified significant reductions in antibiotic prescribing as well as significant reductions in mental health and orthopaedic referrals to secondary care.

15.5 East Lothian HSCP understands that work is underway in the Scottish Government on evaluation of primary care. The partnership will adopt any agreed national and Lothian approaches to evaluation of its primary care services.

15.6 The Primary Care Change Board will also work in conjunction with the Local Intelligence Support Team (LIST) to identify key local indicators for primary care to capture the impact of local service developments.

15.7 Patient involvement will continue to be a critical part of monitoring and evaluation to ensure patient's insights, experiences and priorities are taken into account in assessing the impact of local service developments.

15.8 LIST also continues to support GP Clusters in data analysis to inform quality improvement initiatives. A recent example includes the successful piloting of community pain management clinics led by the GP Clusters. This has led to a proposal for a tiered community pain management service, which has been submitted to the Shifting the Balance of Care Change Board for consideration. If implemented, this service has great potential to support GPs in managing the large numbers of people with long term pain, and in offering alternatives other than medication.

16 Workforce Planning and Development

16.1 In East Lothian, our objective is to work in collaboration with all our partners and stakeholders to ensure we have a knowledgeable and skilled workforce able to respond to current challenges to delivery primary care services.

16.2 National workforce shortages continue to present challenges locally. GP shortages are increasing, and the reduced number of medical graduates selecting general practice as a career has severely limited the number of GPs available to maintain a stable workforce. Many practices locally continue to be dependent on locum GPs.

16.3 The development of Advanced Nurse Practitioner and Nurse Practitioner roles also require ongoing investment in post-registration training and in providing relevant experience. There is a risk that growth of ANP and NP posts in non-hospital settings will cause shortages of nursing staff in other settings.

16.4 Advanced Physiotherapy Practitioner posts also need to be developed to provide musculoskeletal services in primary care, similarly primary care based pharmacy posts need to be developed to extend this role. Work is needed to attract and develop staff with these enhanced roles.

16.5 For Pharmacotherapy services, there is a need to explore the role of pharmacy technicians and how implementation of alternative models of working could support pharmacists to deliver across wider geographical areas.

16.6 Across all grades of staff we need to ensure colleagues are working safely at the top of their licence and within their experience.

16.7 East Lothian IJB has supported a workforce plan which outlines future actions to create a sustainable workforce in both clinical and non-clinical roles, and includes plans for primary care services directly managed by ELHSCP.

16.8 Local workforce projections have been provided to the Lothian Primary Care Workforce Planning Group. Current recruitment challenges and the difficulty recruiting advanced practitioners have also been highlighted.

16.9 ELHSCP Primary Care Management Team also supports GP practices to address local challenges in workforce planning and development where necessary, for example, supporting arrangements for locum transfers or practice management.

16.10 The development of multi-disciplinary models of working across East Lothian has created unique opportunities for workforce development. For example, within

the Musselburgh Model, an educational framework has been built into the service in order to attract and develop staff locally.

16.11 The Musselburgh Model offers clear training pathways from Nurse Practitioners to Advanced Nurse Practitioners within the service. In addition, the services hosts an NHS Lothian Education Coordinator who is able to offer guidance and support to team members and support students to see patients in a live environment.

16.12 With the establishment of the two Community Health Hubs across the county, there will continue to be opportunities for future development for staff to work across multi-disciplinary teams in innovative services with the expectation that this will help us grow our workforce locally.

17 Premises

17.1 ELHSCP is committed to developing sustainable premises which can continue to meet the need for primary care services for a growing population.

17.2 ELHSCP is linking with GP practices to plan for areas with significant development and growth. ELHSCP has already requested expression of interests for GPs to expand their boundaries to ensure primary care access in the new Blindwells housing development. Four GP practices have currently expressed an interest in doing so.

17.3 In terms of existing capital projects, the East Lothian Community Hospital is due for completion in October 2019 and Cockenzie Health Centre is due for completion in 2020.

17.4 East Lothian is committed to exploring the use of campus approaches and existing premises that may be available. Plans are being explored within the new Wallyford development and the new CTACs service will be based within the East Lothian Community Hospital campus.

17.5 During the 2018/19 cycle of capital prioritisation ELHSCP identified additional projects listed in Table 2 that are considered priorities where further Strategic Assessments are still to be completed.

Table 2: Service Priorities awaiting Strategic Assessments

	Project	Timescale required in (where known)	Date SA Planned
1.	Blindwells Health Centre	2022/23	Early 2019
2.	Haddington Health Centre	2020/21	Early 2019
3.	North Berwick Health Centre	2020/21	Early 2019
4.	East Linton	TBC	Early 2019

17.6 As premises are identified, ELHSCP is also linking with Council transport to identify possible models of collaboration to ensure that patients who currently experience difficulties due to transport practicalities are not disadvantaged, and to consider those who are at risk of becoming disadvantaged by any future service changes.

18 Funding

18.1 Primary Care Improvement Fund and Scottish Government investment is provided to support the implementation of the new GMS Contract and is planned to grow over the next three years. In addition investments have been made at NHS Lothian and ELHSCP level (for example the Care Home Team and Links Workers) to support the development of primary care and support services. A breakdown of projected primary care investments is shown in Table 3.

18.2 An anticipated underspend of £219,000 from 2018-2019 is being carried forward into 2019-2020 to increase the total investment from £1.76 million to £1.98 million.

18.3 The requirements of the GMS contract present delivery challenges. Decisions will need to be made on prioritisation of the Scottish Government, East Lothian HSCP and NHS Lothian funding to best meet practice and community needs and to most efficiently deliver support across practices.

18.4 Funding is available to deliver the 2019-2020 primary care development plans. However, financial pressures may arise in coming years as the HSCP strives to deliver all elements of the new GP contract and to develop and roll-out local support services for primary care in East Lothian. Combined with potential

difficulties in recruiting staff, this may influence the speed at which services can be introduced.

18.5 It is anticipated that further service developments in Mental Health and Substance Misuse, funded through Action 15 funding and the Scottish Drugs Strategy funding, will also benefit primary care services by providing access to specialist and community services.

Table 3: Funding to support the development of Primary Care services

Primary Care Investment in Future Years			
	PCIF	**Other NHSL**	**Combined**
	£000s	**£000s**	**£000s**
2019-20	1,009	746	1,755
2020-21	2,018	746	2,764
2021-22	2,844	746	3,590

19 Communications and Engagement

19.1 Successfully embedding new models of working requires innovative engagement with local communities.

19.2 The East Lothian Health and Social Care Partnership is committed to systematic engagement of all relevant stakeholders throughout the implementation of the Primary Care Improvement Plan. ELHSCP is also committed to carrying out engagement in line with the National Community Engagement Standards.

19.3 The Primary Care Change Board's four working groups provide an opportunity to ensure patient, carer and a range of professional views are taken into account in the implementation of the Primary Care Improvement Plan.

19.4 The ELHSCP has also developed a variety of tools to ensure ongoing communication regarding Primary Care updates, including a Primary Care newsletter as well as a blog which serves as a forum for discussion.

19.5 Patient Participation Groups (PPGs) have already been involved in carrying out an independent evaluation of the new Multi-Disciplinary Team approach in Riverside Practice.

19.6 ELHSCP is working with the Scottish Health Council to support the further development of Health and Well-being groups as well as the PPGs across East Lothian.

19.7 There are further plans to engage with these networks in order to ensure patient perspectives are taken into account in future service development.

19.8 ELHSCP is also working with NHS Lothian Communications to ensure patients receive up-to-date information regarding any service developments going forward.

19.9 Evaluations of specific service developments will also continue to draw on patient and professional expertise to inform future improvements.