strategy for primary care

April 2003 - March 2006

NHS Grampian
Historically, Primary Care has been fragmented, made up of many different clans who frequently do not communicate with each other and who work in isolation. The advent of Local Health Care Co-operatives started a process of bringing together General Practice, Pharmacy, Dentistry, Allied Health Professionals, Nurses and the other independent contractors in geographic groupings where they could start to relate to their communities more effectively and to other partners such as the Ambulance Service.

This process of developing a shared view and vision will be helped by the new GMS Contract, now practice rather than individual doctor based. It is, in fact, an opportunity for health care redesign across Grampian.

Many may question the need for a Primary Care Strategy in our new collaborative world. Why emphasise the difference between Primary and Secondary Care by having a separate document?

The Strategy is the demonstration of a growing confidence that the components of Primary Care can communicate and work together and then in turn relate more effectively with their colleagues in Secondary Care and in other areas. It is a building block for the strategic development of the Grampian health care system.

The patient’s journey starts and ends in Primary Care. We believe this strategy is an essential pre-requisite to building a strong Grampian health care system.

Dr Gordon S. D. Peterkin
Medical Director
Grampian Primary Care NHS Trust

Dr A. Lesley Stewart
Chairman, GP Sub Committee
• Primary Care ‘gate-keeps’ the entire health care system

‘For most people contact with the NHS begins and ends in primary care’

  Partnership for Care, 2003

• 90% of NHS care is delivered in Primary Care (Valuing General Practice in Grampian, 2002)

• 25-30% of General Practice appointments have a mental health component (Making the Connections, 2002)

• ‘Today in the UK patients are discharged earlier from hospital than ever before, while many conditions that used to mean a stay in hospital are now treated by the Primary Care team’ (NHS Alliance, 2001)

• Reducing the number of deaths in hospital by 5000 per year has been correlated with an increase of either 9000 hospital doctors or 2300 GPs (Jarman et al, 1999)

• Increasing the Primary Care orientation within a healthcare system:
  • Increases patient satisfaction
  • Reduces the total expenditure on healthcare
  • Reduces the number of prescribed drugs per head of population
  • Provides better population health outcome indicators

  (cf. Starfield, as cited in Valuing General Practice in Grampian, 2002)

• Providing more health care within Primary Care satisfies public/political desire for local access, reduces waiting times for patients, reduces DNA rates, and is demonstrably good value for money

• Investment in Primary Care is essential to redesign more effective healthcare in Grampian
EXECUTIVE SUMMARY

Primary Care stands in a unique position within the health care system: in its role as ‘gate-keeper’ to specialist services; in its direct access to local populations; and in its capacity to influence and lead redesign initiatives in order to bring about real change within an overloaded and pressurised system.

This document lays out the strategic direction for Primary Care in Grampian, acknowledging the key influences from national and local policy (the recommendations of the Primary Care Modernisation Group’s report, Making the Connections: Developing Best Practice into Common Practice, are fully adopted). Selected quotes from Partnership for Care – Scotland’s Health White Paper (Scottish Executive, 2003) are used throughout the document to support the context of the Strategy. Opportunities for development and redesign are highlighted, and links to established and developing initiatives are emphasised (section 1). Annex A explores the policy environment in more detail.

The clinical strategy (section 2) has six key strands:

- To support good quality core GMS activity and other frontline Primary Care services
- To develop (in partnership where appropriate): intermediate care services; the redesign of NHS Grampian; and the modernisation of Primary Care
- To work collaboratively with Local Authorities on key service areas
- To continue, and develop further, local health needs assessments involving patients and local communities
- To further develop Primary Care-based mental health services
- To support and develop the provision of dental services in Primary Care

Primary Care has prioritised some clinical services within the clinical strategy according to agreed principles. These will be reviewed in light of the new and developing NHS Grampian system-wide prioritisation process as it evolves.

The use of Managed Clinical Networks as a tool to deliver upon the priorities is explored. A discussion paper is appended at Annex C.

Section 3 outlines an implementation plan and the links to the Performance Assessment Framework.

The Primary Care Strategy is enhanced and enabled by clinical and non-clinical support strategies as outlined in section 4.

It is clear that significant investment in Primary Care is required in order to progress meaningful and imaginative whole system redesign. To that end value for money is emphasised.

Whilst it is acknowledged that this document precedes clear information regarding the new GMS contract, the general emphasis is unlikely to alter significantly. However, Primary Care must demonstrate its capacity to adapt to changing environments – local, political and legal – a flexibility which Primary Care has ably demonstrated in the past.

This strategy looks out over the next 3 years, but will be revised annually on a rolling basis.

This strategy was prepared by the Grampian LHCCs Group on behalf of the Grampian Primary Care NHS Trust/ NHS Grampian Board Management Group.
SECTION 1: BACKGROUND/CONTEXT

1.1 INTRODUCTION

This NHS Grampian strategy for Primary Care is an attempt to set the direction for Primary Care within a turbulent and constantly changing NHS environment.

In its efforts to be recognised as a Public Health Organisation the NHS Grampian system is focusing more directly on health in its widest sense as illustrated by Box 1.

Box 1: NHS Grampian Board Management Group, Statement of Strategic Intent for the Organisational Change Process

NHS Grampian believes that people in Grampian deserve the best health possible. To make our contribution to this, we need to realise our vision of an:

- integrated
- connected
- collaborative
- and corporate health system, working together to ensure that we:
  - develop health systems to maximise opportunities for health gain
  - sponsor and support the promotion of health
  - influence and work effectively with our partners to improve the wider determinants of health

‘Only by putting health improvement onto everyone’s agenda can we join together the various initiatives and achieve an impact which will be more than the sum of its parts’

*Partnership for Care, 2003*

Within this overall strategic direction Primary Care must continue to have the opportunity to develop services for patients as close to their homes as is feasible – this requires investment.

This strategy highlights key priority areas for investment within the overall redesign and modernisation agenda, giving cognisance to the ‘changing goalposts’, that is to say, the new GMS Contract, Consultant Contract and *Agenda for Change*, and the outcome of the high level *Management and Decision Making Review* within the NHS in Scotland, all of which are awaited.
1.2 **AIMS**

The aims of the Primary Care Strategy are:

1.2.1 To outline the general strategic direction for Primary Care within Grampian.

1.2.2 To work in partnership to influence the modernisation agenda in NHS Grampian, linking with all relevant projects in other parts of the NHS Grampian system. (Partnership with Secondary Care colleagues, Local Authorities, education providers, other professional staff, our patients, and the public.)

1.2.3 To make key links to national and local policy.

1.2.4 To provide the framework through which prioritisation and investment decisions about clinical services can be undertaken.

1.2.5 To emphasise the central role of Primary Care within the health system.

1.2.6 To ensure that clinical services are provided as close to the patient as is feasible.

[In line with the Grampian Primary Care vision (Box 2) and the vision of *Making the Connections: Developing Best Practice into Common Practice – Report of the Primary Care Modernisation Group* (Box 3).]

> ‘If it can be done in primary care it should be done in primary care’

*Partnership for Care, 2003*

1.2.7 To demonstrate health gain/health improvement through investment within Primary Care.

### Box 2: Grampian Primary Care: Our vision

- To make Grampian a healthy community in European terms.
- To provide high quality, responsive and flexible care which continues through the life of the patient.
- To provide care closer to the patient with all appropriate services being delivered within Primary Care.

### Box 3: *Making the Connections* vision

People live in communities, primary care has its roots in the community. People want to be supported to help stay well and if ill, cared for in, or near, their home.
1.3 PRINCIPLES

1.3.1 Primary Care clinical leaders and managers are committed to the system wide principles laid down within HealthFit (Box 4).

Box 4: HealthFit Principles

1. Re-modelling traditional forms of care to increase system capacity
2. Involving the public to improve understanding and gain under ownership to enable the HealthFit changes to happen
3. Developing local care and service centres to provide a wide range of services that improve fair access for all Grampian people
4. Re-shaping the configuration and activity of the acute and tertiary centres to get the most out of specialist skills within the health system
5. Developing partnerships to engage with the private and voluntary sectors
6. Developing appropriate new technologies to assist reconfiguration, e.g. telemedicine, mobile diagnostic facilities, ECCI
7. Strengthening managed clinical networks at three levels – across Grampian, regionally and nationally
8. Balancing the needs of communities with the requirement to provide safe and sustainable specialist services
9. Building on existing partnership working and collaboration within the NHS and between health and social care providers
10. Focusing on long-term workforce development and integrated workforce planning

1.3.2 In addition to the HealthFit principles this strategy is built upon available evidence which supports the development of Primary Care services. This evidence base includes research, audit and quality measures (for example, SIGN, SPICE, CSBS, HTBS, and SHAS).

1.3.3 The strategic direction involves major investment in Primary Care, therefore value for money will be demonstrated.

1.3.4 Investment in Primary Care, at a time of limited resource, will have an effect across the whole system, therefore opportunity cost, cost benefit analysis and risk analysis are essential features within the implementation plan.

1.3.5 An underlying principle of taking full advantage of opportunistic funding and ‘ring fenced’ revenue streams within the NHS system is supported.

1.3.6 Already within Grampian innovative practices/LHCCs have developed excellent systems of care using PMS funding (see annex A). These pioneering pilots, once evaluated, will form the basis for developing best practice into common practice across NHS Grampian thus ensuring adherence to the principle of equity.
1.4 THE POLICY ENVIRONMENT

The Primary Care Strategy is guided by and should be viewed within the wider policy context, at both national and local levels. Annex A outlines this in greater detail. Current areas of crucial significance to Primary Care include:

- The new GMS Contract
- The Primary Care Modernisation Group’s recommendations as outlined in the Making the Connections report (see Annex B)
- A Joint Future
- The public health/health improvement agenda
- The Grampian Health Plan (2002a; 2002b)

### Action 1

All practices within NHS Grampian will be supported to prepare for and implement the new GMS contract (assuming there is a national vote in favour).

### Action 2

The redesign and modernisation potential of the new GMS Contract, PMS contracting, the new Consultant Contract and Agenda for Change, will be utilised fully to support the implementation of the Primary Care Strategy.

### Action 3

All LHCCs will work towards the implementation of the recommendations within Making the Connections: Developing Best Practice into Common Practice. It is anticipated that NHS Grampian will support this action by fulfilling the NHS Board responsibilities highlighted within that report.

### Action 4

Primary Care, through LHCCs, will support the implementation of the objectives as laid out in the Local Health Plan of NHS Grampian.

1.5 WHOLE SYSTEM INTEGRATION

Whole system integration has been guided by such strategic drivers as the ‘whole-system change’ approach of HealthFit, and the concept of ‘a single local health system’ envisioned in Our National Health: A Plan for Action, A Plan for Change (Scottish Executive, 2000). It is reinforced by developments such as Managed Clinical Networks, enabling clinical interface and integration between primary, secondary and tertiary sectors.

‘… primary care is uniquely placed to influence and promote system-wide seamless care’

*Partnership for Care, 2003*

Many organisational change projects are ongoing within NHS Grampian under the banner of ‘whole system integration’. A particular challenge for Primary Care is to ensure that the primary and secondary sectors link in the most meaningful manner for robust patient care. The following four key change projects have a significant impact upon Primary Care and require Primary Care personnel input.
1.5.1 Development of Collectives

This area of organisational change is developing to address LHCC/Secondary Care/Local Authority co-working around joint provision of key service areas:

- Older people
- Mental health
- Learning difficulties
- Children
- Substance misuse
- Health improvement
- Palliative care

Primary Care is supportive of the collective working agenda in this way where clear patient benefit can be demonstrated.

“We want to see a more consistent and strengthened role for LHCCs at the heart of a decentralised but integrated healthcare system. We therefore expect to see LHCCs evolve into Community Health Partnerships to reflect their new and enhanced role in service planning and delivery’

‘Community Health Partnerships and Local Authority social work services need to evolve around distinct local communities’

Partnership for Care, 2003

1.5.2 Modernisation of Acute Services Programme

The five key elements of the Programme are:

- Emergency admissions
- Bed redistribution (including development of intermediate care)
- Junior doctors’ hours
- Critical care
- Interface with diagnostic services

In all five areas the benefits of a joint NHS Grampian system approach is evident. Primary Care is represented on each of the elements of the Programme and also on the Programme steering committee. Thus the interests of, and pressures within, the Primary Care sector are factored into the overall systems redesign.

1.5.3 Diagnostic and Treatment Services Project

Following on from the need to rebalance service provision between local communities and acute centres as identified through HealthFit, work is ongoing across NHS Grampian to identify a range of services (specialty areas and diagnostic) which could be designed differently to meet this need. Primary Care is supportive of the work of the project team and views it as complementary to the aims of the Primary Care Strategy.

‘… more acute services will be delivered in hospitals on a day-case basis, in ambulatory care and diagnostic centres’

Partnership for Care, 2003
1.5.4 Managed Clinical Networks

Managed Clinical Networks as a concept were introduced within the *Acute Services Review* (Scottish Office Department of Health, 1998). Since then guidance has come from the Scottish Executive as to how to develop Managed Clinical Networks (1999a; 2002a) and this is now supported by resource.

‘… Managed Clinical Networks will support primary care practitioners to work with others to provide the best possible integrated care to their patients’

*Partnership for Care, 2003*

Currently Primary Care, with the co-operation of the relevant Secondary Care clinicians, is leading the development of Managed Clinical Networks in NHS Grampian in the areas of:

- Diabetes
- Secondary prevention of Coronary Heart Disease
- Palliative Care
- Minor surgery

Although these are being progressed across Grampian, some LHCCs (Banff and Buchan, Deeside, Moray) have already developed managed clinical networks in these areas.

NHS Grampian has an established Managed Clinical Network in the field of cancer care (NESCCAG), and further work is developing within CHD, ENT and others. Primary Care roles within these networks are evolving.

A key challenge for Primary Care is to establish meaningful and representative links with all relevant emerging Managed Clinical Networks. The conflict between specialisms and the generalist and holistic nature of Primary Care work is accentuated in this respect. Opportunities exist to develop the Managed Clinical Network approach across intermediate care, chronic disease management and other Primary Care-based initiatives.

*Further discussion/debate in relation to Managed Clinical Networks and Primary Care is provided in Annex C.*

**Action 5**

Primary Care has a crucial role in most Managed Clinical Networks. For each Managed Clinical Network that evolves the role for Primary Care should be clearly defined via the Grampian LHCCs Group and the necessary resources identified.

**Action 6**

Work to progress the redesigned NHS Grampian is underway. Primary Care must be fully engaged within this process. The needs of, and pressures on, Primary Care must be fed into the redesign thinking, alongside other parts of the NHS Grampian system, to achieve the right services at the right place at the right time.

1.5.5 Capacity within Primary Care

It must be acknowledged that in order to fulfil the objectives integral to each of the ‘whole system integration’ change projects, the capacity within Primary Care requires to be expanded. This has an inevitable requirement for additional financial and human resources; both of which are limited within NHS Grampian. However, there is a strong research base developing which demonstrates the health gain advantages in Primary Care-based interventions (c.f. Campbell *et al* (1998) and Murchie *et al*’s (2003) work on secondary prevention of coronary heart disease in general practice).
SECTION 2: CLINICAL STRATEGY

This section outlines the key facets of the clinical strategy; the core work; the areas for development; the key services highlighted for working in partnership with Secondary Care; and indicates priority for investment.

The Clinical Strategy for Primary Care has six key themes:

- To support good quality core GMS activity and other frontline Primary Care services
- To develop (in partnership where appropriate): intermediate care services; the redesign of NHS Grampian; and the modernisation of Primary Care
- To work collaboratively with Local Authorities on key service areas
- To continue, and develop further, local health needs assessments involving patients and local communities
- To further develop Primary Care-based mental health services
- To support and develop the provision of dental services in Primary Care

2.1 GMS – PRIMARY CARE

The first key challenge for Primary Care is to meet the needs and manage the expectations of patients who present either ill or suspecting themselves to be ill. This is and will remain the core business.

2.1.1 Workforce planning for doctors, nurses, Allied Health Professionals, optometrists, dentists, pharmacists, and administrative staff requires to be robust to ensure the delivery of the core services and key policy targets. Allied to this, appropriate infrastructure (premises/IM & T training and education) is required to underpin this work (see section 4).

2.1.2 There is a political imperative to implement a system within all GP practices which will guarantee 48-hour access for patients to the practice professionals. This will entail significant investment and, in some cases, redesign within the practices and their extended teams.

2.1.3 The national pressure on resources for prescribing in Primary Care continues. Support for medicines management will help to ensure cost effective and appropriate prescribing. Continuing education around disease management and medicines is important to achieving good clinical outcomes and health gain. The NHS Grampian action plan arising from The Right Medicine strategy (Scottish Executive, 2002b) is fully endorsed.

2.2 INTERMEDIATE CARE

The second key challenge is to contain demand on Secondary Care; care should be delivered by Primary Care whenever possible. This will require significant investment in Primary Care services, and close working with Secondary Care colleagues1.

2.2.1 Some intermediate care services are best delivered at practice level, others at LHCC level.

2.2.2 It is anticipated that competent chronic disease management will be delivered for all relevant patients at practice level.

1 ‘Intermediate Care can be described as those services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team. This includes: intermediate care which substitutes for elements of hospital care (substitutional); and intermediate care which integrates a variety of services for people whose health needs are complex and in transition (complex care)’ (Anglia and Oxford Intermediate Care Project Steering Group, 1997).
2.2.3 LHCCs support the delivery of complex and substitutional intermediate care across geographical areas to an agreed high standard, in a manner influenced by local need, therefore more specialised intermediate care will be delivered comprehensively within LHCCs on that basis.

2.2.4 Key links within the NHS Grampian system exist with the Modernising Acute Services Project at GUHT and specifically with the Diagnostic and Treatment Services Project, and have been highlighted earlier.

2.2.5 Community hospitals in Grampian have a valuable role to play with respect to current and developing intermediate care services. The Grampian Association of Community Hospital Medical Directors provides an important Grampian-wide view of the capacity and capability of these resources. This committee links directly with relevant Secondary Care clinicians, advises the Diagnostic and Treatment Services Project, and liaises with the Scottish Association of Community Hospitals.

‘… we will need to sustain and develop our Community Hospitals’

Partnership for Care, 2003

2.3 HEALTH AND SOCIAL CARE

A third challenge for Primary Care is to work collaboratively across the wider health and social care systems in Grampian to provide integrated services in the following areas:

- Older people
- Mental health
- Learning difficulties
- Children
- Substance misuse
- Health improvement
- Palliative care

Primary Care, through LHCCs, will work collectively within Local Authority boundaries to assist the delivery of integrated health and social care services for patients.

2.4 ASSESSING HEALTH NEEDS/PLANNING AND DEVELOPING SERVICES

A core activity at all levels within the health system is to assess health needs and design and deliver services to meet them. LHCCs have this as one of their core objectives. Primary Care has access to rich sources of data; a practice has contact with 90% of its population in a twelve-month period.

Primary Care, through LHCCs, supported by Public Health Co-ordinators and the wider health improvement networks, will continuously assess local need for health care and provide services to meet that need. Local health needs assessments from LHCCs will feed directly into Community Plans.
2.5  MENTAL HEALTH

25-30% of all GP attendances have a mental health component. Making the Connections recommends that management of mild to moderate mental health conditions could be effectively managed within Primary Care.

Local needs assessments within LHCCs in Grampian have also highlighted a service gap for this group of patients. Multi-disciplinary, practice-based solutions require to be provided.

2.6  DENTAL HEALTH

Primary Care NHS dental provision comes from three main sources:

- General Dental Practitioners - Dentists who practice in the NHS General Dental Services (GDS) and receive payment depending on the treatment given and the number of patients registered. They are wholly independent contractors and work under specific regulations laid down by statute.
- Community Dental Services - Dentists who are salaried and work directly for the Primary Care Trust seeing specific priority groups of patients as per 1997 PCA (D) 10. These are principally priority groups within the community including children, disabled people, the elderly and the housebound.
- Salaried General Dental Practitioners - Salaried dentists who work on behalf of the Primary Care Trust under GDS regulations.

Whilst the whole population is eligible to register with a General Dental Practitioner for standard NHS dental treatment, many practitioners are limiting their NHS list size and/or ceasing to provide dental treatment under the NHS regulations. A significant proportion of General Dental Practitioners in Grampian carry out mainly private dental care. As a result, many patients are faced with a long journey to find the few practices willing to take on new NHS patients.

The Salaried General Dental Practitioners are few in number and are unable to cope with the demand for patients seeking NHS dental care. There are currently 40 vacancies within Grampian for General Dental Practitioners and five vacancies within the Salaried General Dental Services. The Community Dental Service continues to provide NHS dental care for those priority groups as identified above. Recruitment and retention of dentists remains a significant problem within Grampian.

Out of hours provision, principally for non-registered patients, is run through G-DENS (Grampian Dentists on Call). G-DENS, based in Aberdeen, effectively provides pain relief for patients throughout Grampian who cannot gain access to normal NHS dental provision during the day. This is a voluntary scheme. Although not all dentists take part, a number of dentists from all three sections of Primary Care dental services are involved.

All of Grampian’s dental services are severely stretched and cannot adequately cover the dental provision necessary. Primary Care dental services’ ability to provide a fully comprehensive service is further affected by diminished Secondary Care provision. Secondary Care dental services are also suffering from severe recruitment difficulties leading to long waiting lists. All of the dental services within Grampian are discussing a number of possible scenarios and options. These include developing outreach education facilities with the potential to help reduce the recruitment difficulties faced by Grampian in the longer term.
2.7 PRIORITISATION

In view of the financial constraints on the NHS Grampian system, along with other pressures, it is recognised that not all of the clinical strategy can be implemented at once. NHS Grampian has begun a system-wide process of prioritisation. Primary Care will feed in directly to this process and become part of it as it develops. In the interim Primary Care has prioritised clinical services on the basis of:

i. Local needs assessments
ii. National priorities
iii. Acknowledgement of pressure on Secondary Care provision from across the NHS Grampian system
iv. Identified gaps
v. A willingness from all parts of NHS Grampian to redesign services to improve patient care pathways/patient journeys.

Primary Care’s prioritised clinical services are:

- Diabetes
- Ischaemic heart disease/stroke
- Heart failure
- Hypertension
- Respiratory disease (asthma/COPD)
- Care of patients on repeat medications
- Inpatient and casualty care in community hospitals
- Sigmoidoscopy/endoscopy services
- Minor surgery
- Care of frail elderly patients in the community
- Palliative care
- Care of patients with special needs
- Chronic mental health problems (including schizophrenia)
- Adolescent health care
- Substance misuse
- Cardiac assessment services
- Ultrasound scanning
- Chemotherapy in community settings
- Dermatology
- Medical orthopaedics
- Homeopathy

Some of the services listed are priorities across the whole of Primary Care; others are specific to the locally identified needs of specific parts of the system.

2.8 MAKING IT HAPPEN

The implementation plan to achieve the objectives within the Primary Care Strategy is set out in section 3.

It is not possible for Primary Care to achieve the required outcomes alone. Section 4 acknowledges and highlights contributions from clinical and non-clinical support services. A key output from this strategy is to demonstrate that the combination of co-ordinated and structured Primary Care, working in partnership with Secondary Care and other colleagues with shared objectives, delivers better care for patients, closer to their homes and evidenced by improved health outcomes.
2.9 ACTIONS – CLINICAL STRATEGY

Action 7

Practices will be supported and enabled to provide core primary care services timeously, to a consistently high standard and to meet political imperatives (such as 48-hour access).

Action 8

All practices will be supported to provide, or arrange with another practice to provide on their behalf:

i. Chronic disease management; care of patients with:
   - Diabetes
   - Ischaemic heart disease/stroke
   - Heart failure
   - Hypertension
   - Respiratory disease (asthma/COPD)
   - Chronic mental health problems (including schizophrenia)

ii. Care of patients on repeat medications:
   - Warfarin
   - Lithium
   - Amiodarone
   - Thyroxine
   - Rheumatoid drugs
   - Other drugs which require monitoring

iii. Other specific services according to locally assessed needs.

Action 9

Intermediate care services to be developed (dependent on locally identified needs) will include:

- Inpatient and casualty care in community hospitals
- Care of patients with special needs, for example, homeless, asylum seekers, learning disabilities
- Adolescent health care
- Care of frail elderly patients in the community
- Substance misuse
- Cardiac assessment services
- Ultrasound scanning
- Sigmoidoscopy/endoscopy services
- Palliative care chemotherapy
- Dermatology
- Medical orthopaedics
- Minor surgery
- Homeopathy
Action 10

The Grampian Association of Community Hospital Medical Directors will advise on the capacity and capability of community hospitals in Grampian to develop intermediate care services.

Action 11

Recognised and robust systems at the levels of the practice, LHCC and Collective will be developed to support the delivery of integrated health and social care services to the appropriate patient groups/care areas.

Action 12

Primary Care data collection will be developed and supported to enhance local, Local Authority and regional needs assessment, planning and delivery of services (including community planning).

Action 13

Primary Care-based mental health worker models should be developed and evaluated in order to meet the identified need for services for the client group in Primary Care with mild to moderate mental health problems.

Action 14

Primary Care will continue to explore options to help reduce the recruitment difficulties faced by dental services in Grampian in the longer term.
### 3.1 IMPLEMENTATION PLAN

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   • Chronic mental health problems (including schizophrenia)  
   2. Care of patients on repeat medications:  
   • Warfarin  
   • Lithium  
   • Amiodarone  
   • Thyroxine  
   • Rheumatoid drugs  
   • Other drugs which require monitoring  
   3. Other specific services according to locally assessed needs.                      | LHCCs Advisory structures                    | Variable over 3 years |
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|     |      | • Medical orthopaedics  
|     |      | • Minor surgery  
|     |      | • Homeopathy  | LHCCs  
|     |      | GUHT  
|     |      | Advisory structures  | Variable over 3 years |
| 10. | 2.2  | The Grampian Association of Community Hospital Medical Directors will advise on the capacity and capability of community hospitals in Grampian to develop intermediate care services.  | Grampian Association of Community Hospital Medical Directors  | Ongoing |
| 11. | 2.3  | Recognised and robust systems at the levels of the practice, LHCC and Collective will be developed to support the delivery of integrated health and social care services to the appropriate patient groups/care areas.  | LHCCs Collectives Local Authorities  | Annual review |
| 12. | 2.4  | Primary Care data collection will be developed and supported to enhance local, Local Authority and regional needs assessment, planning and delivery of services (including community planning).  | LHCCs  | March 2005 |
| 13. | 2.5  | Primary Care-based mental health worker models should be developed and evaluated in order to meet the identified need for services for the client group in Primary Care with mild to moderate mental health problems.  | LHCCs Mental Health Services Advisory structures  | March 2005 |
| 14. | 2.6  | Primary Care will continue to explore options to help reduce the recruitment difficulties faced by dental services in Grampian in the long term.  | Dental Services NHS Grampian NHS Education Scotland Advisory structures  | Annual review |
3.2 PERFORMANCE ASSESSMENT FRAMEWORK

Performance measurement is the essential foundation upon which performance management can be built. The Performance and Accountability Framework (PAF) will allow NHS Grampian to account for local performance and to draw comparisons with other NHS Boards in Scotland.

An annual Accountability Review takes place with the NHS Grampian Board and the Scottish Executive Health Department, using the results from the PAF to discuss good and weak performance, including necessary recovery action. The actions in this plan are reviewed on a quarterly basis.

The Framework consists of a set of measures, indicators and assessments designed to provide a balanced picture of performance, using the following categories:

- Health improvement and reducing inequalities
- Fair access to health care services
- Clinical governance, quality and effectiveness of health care
- The patient’s experience
- Involving the public and communities
- Staff governance
- Organisational and financial performance and efficiency

Within these fields are high-level indicators which are used to compare performance across Scotland.

In Grampian there has been a tendency to view these as being the responsibility of either Secondary or Primary Care to address. In setting the future for Performance Management we within Primary Care see the focus as becoming system wide, to include all health and Local Authority partners. The involvement of Secondary and Primary Care clinicians in this process will ensure appropriate direction and help to target resources across the system.

The implementation plan of the Primary Care Strategy will be reported to NHS Grampian through the Grampian LHCCs Group on an annual basis, in addition to specific PAF actions (for example, indicator 7.02.01 regarding the Primary Care Modernisation Group report recommendations), which will form the basis of NHS Grampian’s response to the PAF.

Primary Care will continue to support NHS Grampian’s aim to improve services and accountability by ensuring clarity of purpose and that systems are aligned with objective setting and performance review processes.
The achievement of the Primary Care Strategy is a combined and co-ordinated effort across disciplines, sectors and agencies. This section concentrates on the contribution from a variety of key professional groups.

**SECTION 4: SUPPORT STRATEGIES**

**4.1 CLINICAL SUPPORT STRATEGIES**

**4.1.1 Nursing and Midwifery**

*Caring for Scotland* (Scottish Executive, 2001a) set the national policy for Nursing and Midwifery in Scotland. Locally within NHS Grampian a Nursing and Midwifery Strategy (2002c) has been developed which describes a broad direction of travel and is designed to encompass all nurses working in NHS Grampian. The vision is ‘... to enable nurses and midwives in collaboration with other disciplines, to fulfil a pivotal role in addressing the health and wellbeing needs of the people of Grampian’. This vision is underpinned by three main themes:

- Delivering quality care
- Shaping the multi-disciplinary future
- Developing the capability and capacity of staff

These themes are central to the success of delivering the objectives laid out within the Primary Care Strategy. Flexibility of staff and their ability to take forward the challenges of a redesigned/modernised NHS Grampian cannot be underestimated.

**4.1.2 Allied Health Professions**

*Building on Success – Future Directions for the Allied Health Professions in Scotland* (Scottish Executive, 2002c) sets the agenda and strategic direction for AHPs. In Grampian it is anticipated that the AHPs will develop a locally based strategy with individual professions taking forward their own plans. The summary of actions for AHPs as outlined in *Building on Success* are supported by the AHPs in NHS Grampian.

The valuable and unique contribution of this diverse group of professionals to patient care is widely acknowledged and it is recognised that they have an integral role in the delivery of future healthcare services. In their day-to-day work the AHPs collaborate with a range of other professions (including medical and nursing) to deliver evidence based patient care. There are 13 professions grouped under the heading of AHPs, each with a different remit:

- Arts Therapists
- Dietitians
- Drama Therapists
- Music Therapists
- Occupational Therapists
- Orthoptists
- Orthotists
- Physiotherapists
- Prosthetists
- Podiatrists
- Diagnostic Radiographers
- Therapeutic Radiographers
- Speech and Language Therapists
AHPs, in addition to their clinical duties, have a role in improving health and can contribute significantly to the public health agenda. In order to fulfil their potential AHPs need to be involved in planning, service redesign and education. It is important that AHPs have access to effective IT systems to support communication and clinical decision making, for example, through the use of image links/teleradiology between community and acute hospitals.

AHPs in Grampian support the aims and objectives of the Primary Care Strategy as laid out in this document. As this overview has demonstrated, along with the acknowledged multi-disciplinary nature of Primary Care, we require to work collectively to achieve the desired outcomes for patients.

4.1.3 Pharmacy

_The Right Medicine_ strategy (2002b) is an agenda for the modernisation of pharmacy services, with the aim of working in partnership with other health care professionals and with patients to ensure the best and safest use of medicines. In doing so pharmacy can play a key role in supporting chronic disease management. Pharmaceutical care forms an important part of integrated services and collaborative working, particularly for older people at home as well as those in intermediate and long term care.

Hospital, LHCC-based, practice-based and community pharmacists are all integral to the success of realising the Primary Care Strategy in NHS Grampian. The support of this group of professionals is essential in working together to meet the objectives as described.

4.1.4 Optometry

Optometrists are the major providers of eye care in the community. They test sight and examine the eyes for signs of abnormality, injury or disease. They prescribe corrective appliances for defects of vision and will refer patients for medical care where appropriate. Optometrists are able to manage patients’ conditions themselves until or unless referral becomes necessary.

Optometrists are also a valuable source of skills for enhanced eye care services in the community, working with GPs and ophthalmologists to provide more effective primary eye care and support for the secondary sector. There is an opportunity in Grampian for optometry to play an even greater role within the NHS than at present. Some of the longest waiting lists in the NHS are in hospital eye departments. Through the involvement of optometrists in co-managed care schemes waiting lists can be reduced and more effective use made of ophthalmologists’ specialist skills.

In optometry, the NHS has a well trained, under-utilised profession capable of playing a far greater role within the primary health care sector. Optometrists are a cost-efficient way of providing high quality eye care in the community. Every co-managed scheme to date has demonstrated both the profession’s ability and the public’s preference for greater optometry involvement. Optometry input to the Primary Care Strategy is welcomed.
4.2 ORGANISATION DEVELOPMENT

A number of organisational issues arise within this strategy and it is important to ensure that the overall approach remains connected and co-ordinated both within and beyond Primary Care (for example to Secondary Care and to Local Authority functions) in order to deliver on the outcomes described. An organisation development approach will be used and supported by the available organisation development resource.

The organisational issues of key importance are:

- The maintenance of a balance between local service provision and taking a Grampian wide perspective.
- The effective integration of Primary and Secondary Care services ensuring that there are appropriate links between the generic and the specialty service provision, respectively, of the two types of service.
- The redesign of working practices which may be initiated at practice level but may have LHCC, Collective or whole system knock-on effects.
- The ongoing need to ensure that the process for delivering the Primary Care agenda as outlined reflects any changes in the wider organisational arrangements, for example, as a result of the high level review.

Primary Care managers and clinicians will be supported in their leadership of this strategy with an organisation development resource which will:

- Help them to create opportunities to stand back, reflect on the whole system and develop a planned approach to bringing about the changes outlined in the strategy.
- Assist them in gathering and interpreting data from the organisation which will then inform the plan for change.
- Challenge systems and thinking from an outside perspective in order to ensure that there is a rigorous foundation to plans.
- Facilitate change processes by working with individuals and teams to reduce resistance to change and increase the contributions to the change process.

4.3 FINANCE

4.3.1 Background

Making the Connections identifies improving access, chronic disease management and mental health problems as its early priorities together with a range of organisational support issues. The Scottish Executive has released additional funding (£0.85 million in 2002/03) in support of these principles to tackle existing inequalities in service provision.

Recent guidance on Personal Medical Services (PMS) as an alternative method of contracting for Primary Care services links the development and future investment in PMS to the achievement of the above priorities. The Scottish Executive has released further additional funding (£0.75 million in 2002/03) to be accessed exclusively by approved PMS practices in pursuit of these objectives.

NHS Grampian has previously agreed diabetes services to be the priority for development in Primary Care. £0.25 million additional recurring funding was made available in 2000/01 financial year in order to support diabetic services. This has been used to support partially the direct costs within one LHCC and to set up a Grampian-wide retinal screening service.

A further £0.16 million of recurring funding was made available to compensate practices for additional staffing costs in support of INR testing.
4.3.2 Costs of increasing capacity in Primary Care

Banff and Buchan, Moray and Aberdeen West LHCCs have each prepared a case for the development of Primary Care services as part of the work necessary to complete their LHCC wide PMS applications. The cases identified the direct practice costs of implementing this strategy across each LHCC.

Together the three LHCCs cover 46% of the population of Grampian and, in the absence of robust costs for other LHCCs, a simple extrapolation would indicate that a total investment of £5.3 million, at 2002 pay and price levels, is required to roll this approach out across Grampian (£3.7 million after allowing for existing PMS and Primary Care modernisation development funding).

The above costs, however, represent only direct costs within General Practice and do not include any infrastructure costs, such as premises improvements, or any necessary developments in mainstream community nursing, paramedical services or increases in GP prescribing.

4.3.3 Financial strategy

It is estimated that additional targeted investment of £4 million to £5 million, plus costs of premises, will be required on a recurring basis over a 5-year period to create the necessary capacity, delivering on the current expectations around the development of chronic disease management and other quality improvements in Primary Care. This investment should be viewed as a fundamental part of the strategy to reduce NHS waiting lists and alleviate the pressures on Secondary Care.

A new GMS contract is currently under negotiation which, if accepted, is likely to include some additional funding provision for enhanced Chronic Disease Management services and will meet part of the required investment. It is recognised however that NHS Grampian are presently undertaking an exercise to review service provision on a whole system basis and that some service reprioritisation may result depending on overall resource availability.

The following financial principles are an integral part of the strategy for Primary Care development:

1. Future investment in Primary Care must be driven by the required service outcomes in terms of improved quality, value for money and efficiency.
2. The approach will be ‘whole system’, reflecting national and local priorities with an agreed service and infrastructure investment plan covering the next 5 years.
3. The service investment plan will maximise all sources of available funding including the opportunities for redesign within Secondary Care which arise from the improvements in intermediate care and chronic disease.
4. Only those services in line with the priorities identified in this strategy will be authorised to proceed, subject to overall affordability.
5. LHCCs at a more advanced stage of their service planning will be allowed to proceed and ‘draw down’ (subject to approval and availability of overall funding levels) a disproportionate share of available funding.
6. Other LHCCs will have priority access to future funding streams as part of the Primary Care investment plan.
4.4 WORKFORCE

The Primary Care Strategy emphasises the need for Primary Care to adapt to changing environments and promote a whole systems approach to service planning and delivery. The success of the strategy is clearly dependent on the capability and capacity of the Primary Care workforce to influence and deliver such changes and will therefore be underpinned by the Staff Governance principles of ensuring that staff are:

- Well informed
- Appropriately trained
- Treated fairly and consistently
- Involved in decisions that affect them
- Provided with an improved and safe working environment

The capacity and capability of the current workforce will be developed to respond to the increased activity levels and the service redesign proposals, for example, intermediate care, chronic disease management, the development of PMS projects, Managed Clinical Networks and Diagnostic and Treatment Services. This will be achieved through aligning workforce plans and learning and development plans with the service plans at individual, team, service area and organisational levels, in line with the Workforce Development principles included within HealthFit.

An integrated team approach to workforce planning will be developed, taking account of changing roles across professional and organisational boundaries and embracing independent contractor staff as associate employees. This will aim to facilitate the movement of skills and expertise across traditional organisational boundaries, for example, health and social care, and Primary and Secondary Care, to ensure a more whole system, seamless approach to patient care.

Making the Connections emphasises the need to actively support multi-disciplinary working and learning, the recruitment and retention of Primary Care staff through the promotion of Family Friendly Policies, flexible opportunities and equal access to training and development to support both individual and team training. These processes will be developed through the Staff Partnerships networks both within the Trust and across NHS Grampian.

In addition, Staff Partnership networks have now been established with Local Authority partners through the Joint Future agenda and these will provide a framework to jointly support service redesign across organisational boundaries. The strategy will be further underpinned by the development of the new Consultant and GP Contracts and the frameworks developed by the Agenda for Change initiative.

This section will be further developed when service planning processes are further developed across NHS Grampian, new contractual arrangements are agreed for consultants and general practitioners, and when decisions are made regarding the Agenda for Change proposals.
4.5 PREMISES

4.5.1 Context

Without adequate premises the aims of the strategy cannot be fully met. At present, premises are provided in a number of ways, and there is only a minor degree of joint planning. The Capital Planning Group examines all directly NHS-funded developments, but GP practices have the opportunity to plan and build their own premises through the GMS Cash Limited and Non-Cash Limited funding streams, with little opportunity for joint planning across these different routes in a more strategic way.

To an extent this has been overcome by cross-representation between the Capital Planning Group and the GMS Premises Group. However, there is still room for premises to be developed piecemeal by practices according to their local vision. This is enhanced by the different rates at which planning is usually completed in the two sectors; GP developments are much quicker to build, largely because they are less complex, and the building standards can be somewhat less stringent.

Improvements to premises, and the development of new premises, will be essential under the new GMS Contract (see Annex A). This presents us with a problem in managing this process, but also an opportunity to integrate premises developments to improve care delivery.

4.5.2 Premises Strategy actions

- All GP premises (re)development requests will be examined and prioritised against explicit criteria, including 3PD (Third Party Development) proposals.
- GP premises (re)development requests will be considered against local priorities and in conjunction with other known developments.
- LHCCs and practices will work together to consider the implications of developments on neighbouring services and organisations.
- Capital projects will, where appropriate, include a review of their potential effects on Primary Care, including the possibility of joint developments.
- In future (date to be agreed) the planning of premises will be by a single method, whatever the funding source.

4.5.3 Community hospitals

Primary Care provides 20 community hospitals throughout Grampian. The services available in each hospital differ, reflecting local needs and historical development. However, core services based around these facilities include:

- GP acute care, assessment, treatment and rehabilitation
- Maternity services
- Long stay inpatient care for frail elderly groups
- Continuing care in old age psychiatry and dementia services
- Day hospital care
- Casualty services
- Radiology
- Consultant led outpatient clinics
- Paramedical services
- Telemedicine
The aims and functions of these services include:

- Improving access to services.
- Enhancing the range and quality of primary and community health services, providing a base for minor surgical procedures and ‘one stop’ diagnostic and therapeutic facilities to the local population.
- Improving recruitment and retention through improved working conditions.
- Enabling community and public participation in service design and provision.
- The provision of integrated services in partnership with Local Authorities and other organisations.

The positive outcomes of these services include:

- Local, accessible and equitable health care services for the populations they serve.
- Enhanced quality of life indicators for patients through faster access to health services and facilitation of appropriate discharge planning for the catchment population.
- Better, fairer access to a range of services and improved journey of patient care.
- Co-location with Local Authority departments such as Social Services, Housing and Education. This will enable better joint planning and co-ordination of local communities’ health needs in order to pursue a common sense of purpose and direction. Furthermore community confidence in local health services has indirect health benefits through a sense of security and stress reduction which leads to better social cohesion.
- Scope to provide a ‘one stop’ facility for patients with complex needs.
- Smoother transition of services from the acute sector to Primary Care.

Community hospitals will continue to feature as assets to the overall health system in NHS Grampian. Work is continuing around the business case in support of Diagnostic and Treatment Services which is viewed as a positive and complementary development.

**4.6 IM & T**

The *Strategy for IM & T and Health Informatics 2001-2005* outlines the vision for IM & T within NHS Grampian. This document reaffirms the Directorate’s commitment to improving information support to the patient’s journey. Key aspects of the strategy include:

- Electronic Clinical Communications Implementation in Grampian (ECCI-G)
- Electronic Patient Record (EPR)
- Joint working (Health and Social Care)
- CSAGS/Security

The speed at which the vision can be realised is dependent upon the level of investment available. The current position within Primary Care is one of pressure and the need to renew equipment (especially relevant to server capacity). Significant investment is required to maintain the current position; further investment is required to deliver upon the Primary Care Strategy as outlined in this paper.

This section will be further developed when the future of the new GMS contract is decided.
4.7 EDUCATION AND LEARNING

The successful implementation of the Primary Care Strategy will depend on the skills of staff and their ability to adapt, to cope with change, to take on new roles and ways of working, and to continually learn and develop to meet the demands of the patient and organisation.

The Primary Care Strategy therefore needs to be supported by an Education and Learning Strategy which embraces the key principles set out in Learning Together – A strategy for education, training and lifelong learning for all staff in the National Health Service in Scotland (Scottish Executive, 1999b):

- **Fitness for purpose** – ensuring all our staff are equipped with the skills, knowledge and attitudes to deliver the services patients and their families expect.
- **Improved access and opportunity** – ensuring all our staff are supported and encouraged to develop and maintain their skills.
- **A flexible workforce** – where all staff accept responsibility for their own learning and are capable of responding efficiently to changing clinical practice and new models of service delivery.
- **Effective team working** – encouraging methods of working and learning which promote an integrated approach to patient care.
- **Recruitment and retention** – career progression and job satisfaction, fulfilling the needs and aspirations of our staff regardless of their social, academic or ethnic backgrounds.
- **Staff development as an investment in quality** – raising awareness among all managers, supervisors and service planners of the value of education, training and lifelong learning in delivering quality services.

This strategy needs to be part of a whole system strategy for Education and Learning which is clearly linked to key principles of improving patient health and care through planning for education and learning at an individual, team, organisational and inter-organisational level where appropriate.

There is also a requirement to promote cross-organisational working to ensure that staff are ‘fit for purpose’, have improved access and opportunity, and to allow the development of a more flexible workforce.

Partnerships with education and training providers and other key stakeholders need to be further developed. This will ensure the necessary links are made for pre and post registration training with workforce development and the modernisation of services. Within NHS Grampian, REAL (Research, Evidence, Audit and Learning) goes some way towards making the right links. In addition the universities can offer support to develop a reflective learning environment in Primary Care, and through traditional courses and mentoring support.

In order to meet the requirements of the Primary Care Strategy and the Education and Learning Strategy, good leadership and people management skills will be essential. In addition, a wide range of educational and learning methods will be required to support a flexible approach and the recognition of different styles of learning (for example, protected learning, E-learning). These methods will support individual learning, team learning and continuous professional development.

To ensure the training and development of all appropriate professionals to the required levels, dedicated time for education and learning is also essential. ‘Protected learning time’ within general practice and associated Primary Care teams should be supported. LHCCs can provide support for this approach.
KEY REFERENCES


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ANNEX A

THE POLICY ENVIRONMENT

1. KEY NATIONAL POLICY DRIVERS


This White Paper sets out the direction for health in Scotland, with the emphasis on: health improvement; the creation of a health service fit for the 21st century; patient involvement; partnerships; whole system integration and redesign – with a central role for Primary Care; and organisational support to achieve its aims.

1.2 The new GMS Contract

The modernised GMS Contract proposed has the potential to encourage additional resources to Primary Care, improve services to patients and revitalise general practice.

If approved, this contract offers the opportunity to redesign and modernise traditional GMS and other Primary Care services, and move more responsibility for chronic diseases and intermediate care into practices/LHCCs.

Box 5: The New GMS Contract - Key Components

- Fundamental redesign
- Practice based contract
- Categorisation of medical services
- Out of hours changes
- Funding flows follow patients/activity
- Rewards for Quality
- Career structure for GPs
- Modernisation of premises
- Benefits for patients assured

1.3 Personal Medical Services

The Primary Care Act of 1997 introduced the term ‘Personal Medical Services’ (PMS). PMS is a description of the type of services provided by Primary Care teams for all patients living in their local communities. PMS is an opportunity for Primary Care teams and Trusts to test out different flexibilities for the delivery of existing services, focused on local service problems and bringing about demonstrable health improvement.

The PMS model of quality based collaborative contracting has been proven to empower clinical teams, and the completion of the audit cycle has contributed towards creating a culture of continuous improvement. This model can support the evolution of LHCCs in Grampian and is dedicated to the attainment of our core local and national objective to improve the health of our local communities.
There are a number of robust organisational models available under the PMS umbrella that enable Primary Care to undertake the following:

- Test out the contractual switch from national to locally targeted arrangements that deliver high quality Primary Care to patients, while at the same time rewarding health professionals for good clinical performance, improving clinical outcomes and adding value.
- Tackle specific problems stifling the delivery of Primary Care services through salaried contract options, thereby addressing recruitment and retention issues.
- Address specific local health problems, for example, targeting specific diseases including coronary heart disease, diabetes, mental health problems or other areas of chronic disease management and developing better services for vulnerable people of specific groups including homeless, substance misuse and learning disability.
- Develop LHCC wide or locality based services to explore the opportunities for a more consistent approach to service delivery and to redress inequalities across the health care system.

1.4 The new Consultant Contract

It is important, as we develop the new GMS Contract – which will redesign Primary Care – that we align the Consultant Contract also within the overall redesign in NHS Grampian.

Consultants’ job plans, under the new contract, will be seen as an integral part of service planning and thereby contributing to the NHS Grampian service planning processes. The job plans include direct clinical care, education, audit, research, and additional and external duties.

For example, an overall objective of developing integrated Managed Clinical Networks for chronic disease is to look after people where possible in Primary Care, thus attracting quality payments for practices. It is important that at a high level an appropriate Secondary Care Specialist shares the vision. Work with Consultants’ Job Plans is required to reflect objectives around the education of people in Primary Care, team working between Primary and Secondary Care, and the development of quality measurements of the services as they evolve.

1.5 Agenda for Change

*Agenda for Change* (2003) is the proposed new pay and service modernisation system for all staff employed by NHS organisations other than those covered by the doctors’ and dentists’ pay review. It is a workforce and service modernisation tool. The proposals revolutionise the remuneration systems and allow far greater flexibility. This will ensure staff are fairly paid for the jobs they undertake and are rewarded for doing things differently to improve patient care, improving the ability to recruit and retain quality staff and hopefully positively impacting upon staff morale.

The proposals will be implemented nationally from October 2004, although ‘early implementers’ (which do not include any Scottish implementers) will test out the systems in advance of this date.

1.6 *Making the Connections: Developing Best Practice into Common Practice* – Report of the Primary Care Modernisation Group (2002)

This report states that its recommendations should be implemented in order to strengthen Primary Care and to improve the working of the whole NHS and social care system. The complete list of recommendations is appended at Annex B. Box 6 lists the key components.
Box 6: *Making the Connections* - Key Recommendations

- Improve access to Primary Care Services incorporating service redesign approaches and tackling inappropriate use of clinical time
- Provision of chronic disease management – a locally supported systematic approach – at LHCC level
- Manage mild to moderate mental health problems at LHCC level
- Provision of robust organisational support to:
  - Develop LHCCs (including movement towards health and social care co-operatives)
  - Plan and develop primary care workforce
  - Redesign services to provide integrated care
  - Develop primary and community care premises fit for purpose
  - Develop clear IM & T strategies relevant to primary care

Monitoring the implementation of *Making the Connections* is part of the overall Performance Assessment Framework within NHS in Scotland.

1.7 Nursing for Health: A Review of the Contribution of Nurses, Midwives and Health Visitors to Improving the Public’s Health (2001b)

This document outlines the key role played by LHCCs in moving forward the public health agenda in Scotland. One of the most significant developments arising from this document has been the appointment of Public Health Co-ordinators in each LHCC. These individuals have been tasked with leading public health work across the LHCC team, and having an influencing role across the system, both vertically and horizontally.

The role of Primary Care in improving public health is an integral aspect of the NHS Grampian Primary Care Strategy. This will be reinforced by the next report of the Primary Care Modernisation Group which will focus on promoting health and wellbeing and preventing ill health.

1.8 A Joint Future

*A Joint Future* (2000) represents a ‘rebalancing’ of care for older people, and laid out a plan to develop combined health and social care services for older people.

The components of this report include:

- Joint resourcing and joint service management
- Information sharing
- Shared single assessments
- Combined occupational therapy services
- Rapid response teams
- A variety of other measures to maintain older people at home
Primary Care services will have to engage with these changes to the ways of supporting older people and to the developments towards joint teams. This service area is the first of many to develop a joined health and social care provision and provides the template for these other service areas to follow:

- Mental health
- Learning difficulties
- Children
- Substance misuse
- Health improvement
- Palliative care

2. LOCAL POLICY DRIVERS

2.1 Public Health/Health Improvement

“National policy guidance highlights the need for the NHS system to take a ‘corporate approach’ to its health improvement work, supported by a strategic framework and values which are shared across the organisation.” (Dr E Baijal, Director of Public Health, May 2002)

As NHS Grampian develops as a Public Health Organisation, Primary Care and LHCCs must embrace the ethos and behaviours that ensure health improvement is at the centre of planning and activity to enable sustained contribution by NHS Grampian to meeting national targets.

Opportunistic and early interventions by all Primary Care professionals around the key target risk factors:

- Tobacco
- Alcohol
- Low fruit and vegetable intake
- Physical activity
- Obesity

and within the following target areas:

- Early years
- Teenage transition
- Workplace
- Communities

will make long term improvements in tackling the national clinical priorities and reducing health inequalities. Central to achieving this will be internal partnership working with other NHS sectors as well as external partners in the statutory, voluntary and private sectors.

The importance of a ‘bottom-up’ approach to health planning is increasingly being recognised. Primary Care, with its local networks and knowledge, has a huge role to play in influencing partners, supporting public health activity, and ensuring that appropriate local information is fed into the planning process. Public health should be seen as integral, not additional, to the work of all LHCCs and practices. The development of the role of the LHCC Public Health Co-ordinators and the Public Health Lead posts within Collectives will ensure that public health maintains a high profile within Primary Care.
2.2 Local Health Plan

The Grampian Health Plan for 2003-2004 is the strategic resource document for NHS Grampian which influences the development of the Primary Care Strategy. This strategy provides further detail on the contribution of Primary Care in Grampian to the key categories as laid out in the Local Health Plan:

- **Improving Health and Tackling Health Inequalities: Building Healthy Communities**
  
  Primary Care and LHCCs play crucial roles in community planning processes and in the assessment of, and delivery of services to address, the health needs of local populations. In order to build internal and external public health capacity, active, local engagement with established partnerships (for example, Community Planning, Joint Health Improvement Plans, Joint Futures, New Community Schools) is required. This investment will assist Primary Care and LHCCs in meeting health challenges around improving lifestyle and life circumstances that will positively impact on both life quality and expectancy.

- **Improving Health: The priorities**
  
  - **Children and Families**
    
    Health visitors, school nurses and Public Health Co-ordinators have a significant role to play in improving the health and wellbeing of children and families as a priority for Primary Care and its partners in building the foundation of a healthy society. School health services should be supported to be fully integrated within LHCCs as part of the redesign of nursing. The New Community Schools agenda has huge potential for developing new health improvement strategies for children and their families.

  - **Older People**
    
    Ageing with Confidence and Joint Futures are key strategic initiatives influencing the health of older people. Primary Care will be integral to how this guides the planning and delivery of services.

  - **Lifestyles and Behaviour**
    
    The contribution of Primary Care to the health lifestyles and behaviours of local populations is evidenced by the role of Public Health Co-ordinators within LHCCs, and the current redesign of public health and its movement into LHCCs. Members of the Primary Health Care team have a crucial role in advising and supporting the strategic direction of health topic related planning in Grampian, for example, through membership of Grampian Tobacco Alliance, the Physical Activity Steering Group, and in Drug and Alcohol Services.

- **Clinical Priorities**

  - **Cancer**
    
    There is an established Managed Clinical Network for cancer care in Grampian, and an active role for Primary Care in related Focus Groups. A Primary Care reference group has been developed at the levels of NESCCAG and NOSCAN to ensure a consistent and organised Primary Care interface with these networks.

  - **CHD and stroke**
    
    Primary Care will be involved in developing the managed clinical network approach for CHD and stroke in partnership with other sectors of the health system in Grampian.

  - **Mental health**
    
    Mental health promotion will be influenced by the integration of public health into Primary Care. Mental health represents a key component of the Making the Connections recommendations, and the delivery of services for mental health should also be supported at practice level. The Mental Health Promotion Strategy will help to orientate Primary Care in relation to the importance of mental health and wellbeing.
• **Chronic conditions**
  Primary Care priorities for chronic conditions are detailed further in the Clinical Strategy. Objectives in relation to diabetes are already being met.

The Primary Care Strategy has been approved as an underpinning document to the Local Health Plan.

### 2.3 PMS in Grampian

At present Grampian has 22 practice based/salaried PMS projects in development or operation. Two LHCC wide proposals are currently operational with a further two in the process of development (Aberdeen West and Deeside LHCCs). Grampian is leading the development of PMS in Scotland and hosts the North of Scotland PMS Network. In addition to the LHCC wide pilots currently in operation or being developed, a number of other PMS initiatives are being considered that will seek to address system-wide issues across Grampian that disadvantage local communities. It is envisaged that the PMS model will continue to be utilised as a catalyst for redesign across all sectors, firmly focused on enhancing the quality of patient care while fulfilling the aspirations of the wider Primary Care and community team.

### 2.4 HealthFit: Creating the vision for Grampian’s health (2002)

HealthFit was designed to examine a process through which to create a vision for the future shape of health services in Grampian. The process which began at HealthFit, and is evolving, suggested the need to rebalance service provision between local communities and acute centres.

Key projects emerging from this event include an examination of the feasibility of developing ‘Diagnostic and Treatment Services’ across Grampian. Emphasis was also placed on the development of ‘intermediate care’. The success of both of these developmental initiatives is dependent upon the capacity within Primary Care.
FULL RECOMMENDATIONS FROM MAKING THE CONNECTIONS: DEVELOPING BEST PRACTICE INTO COMMON PRACTICE (Primary Care Modernisation Group, 2002)

Summary of Recommendations

The Primary Care Modernisation Group (PCMG) identified improving access, chronic disease management and mental health problems in the initial priorities to be addressed, together with a range of organisational support issues.

Listed below is a summary of the recommendations of the PCMG; these are discussed in more detail in the main part of the report.

Improving Access to Primary Care Services

- Overall access to primary care services in each locality should be systematically audited and action plans developed to move towards the target of accessing a relevant member of the primary care team within 48 hours. In doing so, the specific needs of particular disadvantaged groups should be addressed.

- As part of local property strategies, an audit of primary care premises in each locality should be undertaken, identifying suitability for current and future use, including the standard of accommodation and location. This audit should cover the whole of primary care including dental, optical, pharmaceutical, and professions allied to medicine (PAM) services;

- The broader local community needs, as demonstrated through the community planning process, and the outcome of the premises audit should be used to develop a premises strategy which makes the most effective use of existing facilities and the various sources of funding available for primary and community care developments;

- To help people have access to the right member of primary care staff to meet their needs, there should be locally planned programmes which could include:
  - telephone triage systems
  - Development and more effective use of the skills of all primary care staff
  - direct access to the full range of primary care staff
  - local protocols for inter-disciplinary referrals within primary care
  - information to local people about how to access and make the best use of services
  - use of NHS 24

Service redesign approaches should be supported which:

- Improve access to primary care (in particular, the Primary Care Collaborative approach should be adapted for, and tested out, in Scotland).

- Improve referrals to, and discharges from, Secondary Care (this needs to include direct access from a wider range of primary care staff and be supported by improved information and communication technology).
Inappropriate use of clinical time should be tackled:
- locally by better use of support staff (clerical and technical)
- nationally by getting rid of unnecessary paperwork (e.g. form filling of various kinds).

Chronic Disease Management
To ensure high quality care and effective utilisation of the skills of the full range of staff (GPs, nurses, pharmacists, PAMs, etc.) there should be:

- a locally supported, systematic approach at LHCC level to
  - identify local needs
  - agree the contribution which each profession can make towards meeting those needs
  - use the nationally agreed standards and guidelines to agree the structure, process and organisation of care
  - monitor and review of the outcome of services delivered
  - ensure appropriate training, development, support and supervision to safely deliver services
  - a process for involving Primary and Secondary Care professionals in designing services which are resourced to have an increasing focus within primary care.

Managing Mild to Moderate Mental Health Problems

- NHS Boards together with LHCCs and other local providers of mental health services should develop proposals to utilise the specific resources available to promote mental health and wellbeing;
- PCTs should support LHCCs in developing processes and structures to deliver national and local standards in mental health in primary care;
- to support integrated care, PCTs should strengthen the relationship between primary care services and specialist mental health services, with Community Mental Health Teams clearly focused at LHCC/locality level;
- in order to improve access to a full range of services, NHS Boards should support LHCC participation in the development of multi-agency, high quality, locally-based mental health services.

Organisational Support

LHCC Development

- NHS Boards should review with PCTs and LHCCs the organisational support needed for LHCCs to assume the growing responsibilities within the NHS and in partnership working. This should include developing and supporting the leadership needed within LHCCs;
- within NHS Board-wide plans, clear objectives should be agreed with each LHCC and performance monitored against these. This framework should clarify LHCCs’ responsibilities and accountability for the services managed or delivered together with responsibilities in relation to joint planning of services with Secondary Care and local authorities;
• LHCCs should support the development of health and social care “co-operatives”, moving partnership working from pilots and projects to mainstream community care;

• NHS Board should work with local authorities to develop joint plans to support staff and organisational development which will underpin joint service development at locality level.

**Workforce**

• The new Special Health Board for NHS Education in Scotland should ensure that there is an appropriate emphasis on the needs of primary care and on multidisciplinary working and learning;

• local HR Departments should actively support primary care, including independent contractor employers, in the recruitment and retention of staff, including family-friendly, flexible employment opportunities;

• within NHS Boards each area should develop local policies to ensure that all staff receive equal opportunities to access training and development, and that this supports both individual and team training.

**Service Redesign**

• In order to provide integrated care for patients, it must be a core responsibility of NHS Boards to establish local mechanisms which bring together LHCCs and the specialist sector to develop strong collaborative arrangements to tackle issues of joint interest.

**Premises**

• The specific needs of primary and community care are recognised in the national and local premises investment plans;

• SEHD should review the funding arrangements for the provision of pharmacy and dental premises;

• with the involvement of the local community in the planning process, NHS Boards and LHCCs should investigate all possible partnership opportunities for funding where upgrading or new premises are required;

• SEHD should act as a resource to facilitate sharing of good practice in this area of service development.

**IM & T**

• As part of local IM & T strategies, NHS Boards should include all sectors of primary care in order to support electronic clinical communications within primary care and with other parts of the NHS and local authorities;

• relevant information is made available to primary care staff about those aspects of the national and local IM &T strategies which will impact on their work;

• to make the best use of the technology, NHS Boards should make available appropriate training and development support to all staff;

• clinical staff working from the same location should be encouraged to share technology as far as is practical.
MANAGED CLINICAL NETWORKS AND PRIMARY CARE

The managed clinical network concept is one which sits very comfortably with the philosophy and ways of working currently operating within Primary Care. As a tool and a discipline it also has much to offer in terms of organising and defining the Primary Care role within developing formal Managed Clinical Networks (MCNs).

‘Promoting the Development of Managed Clinical Networks in NHS Scotland’ (Scottish Executive (2002a), HDL (2002) 69) has provided a clear signal to the NHS system that this modus operandi is one which has been proven to bring benefit. This circular also announced ‘pump priming’ funding to develop the concept more widely. As a result many specialisms are considering travelling in this direction. In this paper, the MCN concept is reviewed and its actual current and potential impact on Primary Care explored.

1. Background to MCNs

Formal MCNs are defined as:

‘… linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and Health Board boundaries, to ensure equitable provision of high quality clinically effective services’ (Scottish Executive (1999a), MEL (1999) 10).

The ultimate aim of MCNs is to improve patient care with respect to quality, access and appropriateness. It is therefore based around the ‘patient’s journey’.

Key principles for MCNs are that they:

- Are managed (clinically led)
- Improve patient care
- Are evidence based
- Measure outcomes (audit)
- Are quality assured
- Produce annual reports
- Are multi-disciplinary and multi-professional
- Involve patients fully.

Formal MCNs are assessed and approved by the CSBS (to become part of Quality Scotland).

MCNs are promoted as being flexible and pragmatic (formal MCNs can be specific to disease type, function, or geographical area). The technique can be adapted to any situation.
2. **MCNs in Grampian**

2.1 **Context**

Within NHS Grampian, formal MCNs include:

- Cancer (NESCCAG)
- Diabetes (in development)
- CHD/stroke (in development)
- Public Health (North of Scotland)
- Paediatric specialisms (North of Scotland)
- ENT (in development with regard to West of Grampian specifically)

Local experience of using the MCN technique at an LHCC level includes:

**Banff and Buchan**

- Diabetes
- Minor Surgery
- Palliative Care
- CHD/Hypertension
- Substance Misuse

**Moray**

(In development)

- ENT
- Depression
- Cardiology
- Diabetes
- Ophthalmology
- Palliative Care

2.2 **Using the MCN methodology locally**

The process of setting up a local managed clinical network at LHCC level has been developed as follows.

This methodology was developed in Banff and Buchan LHCC and has been emulated in others across Grampian. It ensures full commitment to the network through: local involvement; thorough preparation; and good communication.
2.3 Advantages and disadvantages of using the MCN approach

Advantages of MCNs:

• A quality assured way of producing care in a decentralised manner.
• Concentration on a clinical area in this way will improve care.
• Ability to cross organisational boundaries.
• Co-ordination of care across a geographical area.

Potential disadvantages/challenges for Primary Care:

• Large numbers of service areas are considering this approach; Primary Care requires to be connected in some way to each.
• Dealing with multiple regional and supra-regional MCNs.
• Conditions not presently supported by a MCN.
• Balancing the specialist nature of some MCNs with the generic holistic nature of Primary Care.
• Ensuring Primary Care services are involved with the resource allocation process within the various networks.

3. Developing the MCN concept for Primary Care

The following examples of MCNs are used to highlight key issues.

3.1 Diabetes MCN (formal, developing)

Within the above network:

• Patients are involved at all levels
• Consultant staff are aligned to members of LHCC lead teams
• Individuals are identified within each practice to lead/deliver the service
• DICT support: 2 paid sessions per week for lead clinician
  2 paid sessions per week for lead GP
• SIGN dataset agreed as standard (evidence based)
• Grampian Guideline used as standard (evidence based)
• Audit becoming uniform (SDS and others)
• CSBS reviewed
• DICT/LDSAG produce annual report
• Multi-disciplinary, multi-professional service
• MCN managed through DICT.

This clearly demonstrates fulfilment of the eight MCN principles outlined earlier in this paper.

Primary Care key issues:

• Diabetes care (as with other chronic disease management services) is a service which, in MCN terms, has a high impact within Primary Care.

• The model builds from Practice level, through LHCC networks to a NHS Grampian level via the Lead Team.

• Acute care staff are involved at all levels, as are members of the public.

• This model may be useful to repeat for other CDM service areas which have high Primary Care impact.

3.2 Example: Cardiology MCN

This example is an attempt to demonstrate how a Primary Care-based intervention (secondary prevention of IHD) can be enhanced across NHS Grampian using the MCN concept; with the added advantage of being able to ‘plug in’ to related developing, specialist, formal MCNs.
Primary Care key issues:

- Working through the eight key principles for secondary prevention IHD (similar to diabetes) and using the LHCC approach to MCN development, this network could be easily established.

- This can then be a platform to progress to more system contentious development, for example, cardiac assessment.

- Establishing the Primary Care network/discipline in this way provides the vehicle through which co-ordinated (evidence based) bids against network targeted resources can be made, for example, £x invested in providing more CABGs with the number of lives saved versus £x invested in secondary prevention IHD with many lives saved.

3.3 Example: Proposed Minor Surgery MCN (has not adopted the MCN discipline)

This example is used to demonstrate the benefits potentially involved in using the MCN methodology to assist with redesigning services.

Primary Care key issues:

- The eight key principles cannot be demonstrated within the current redesign. It may be useful to review progress using the eight principles and engaging the local methodology described earlier.

- Again, this service area is relatively high impact for Primary Care, and would likely benefit from the networking approach.
3.4 Cancer (formal, established MCN)

Primary Care key issues:

- To date NESCCAG is the only formal MCN that Primary Care in NHS Grampian has experienced.
- The focus group structure does not fit comfortably with Primary Care, although cancer cannot be viewed as a 'low impact' range of services for Primary Care.
- There is no clearly demonstrated link to practices directly or through LHCCs within the formal structure.
- Primary Care representation is the subject of ongoing discussion and review. It is manpower intensive on Primary Care and difficult to achieve.
- All resources for cancer care developments are via this MCN route; to date Primary Care investment has been fairly low.
- A special group comprising: executives from NHS Grampian Board, GPCT, GUHT, and the NESCCAG executive team, meet to ‘link’ the MCN with NHS Grampian structures – this could be adopted by the GMT in the future.

N.B. Although this is set up as a MCN, formal MCNs are currently being developed within this structure for breast, colorectal, lung and gynaecology cancers, yet again emphasising complexity in engagement possibilities between these four emerging networks and Primary Care.
4. **MCN issues for consideration for Primary Care:**

- The Grampian LHCCs Group seems a natural locus to discuss developing/emerging networks from a co-ordinated Primary Care perspective.

- LHCC PMS+ projects within NHS Grampian can be used as models to develop across the LHCCs for funding/evidence base/outcomes as opportunity arises.

- Primary Care as a body requires to ascertain the most relevant level of engagement and involvement with emerging networks, for example, a tertiary level arrangement around CABG provision versus diabetes/chronic disease management models.

- Primary Care should use existing evidence/research to influence investment decisions within formal networks. For example, monies invested in increased numbers of CABG versus the same monies invested in secondary prevention of IHD in Primary Care including, most importantly, the health impact/outcome data.

- There should be recognition of the fact that not all LHCCs would target investment into the same priorities when examining health impact versus local needs.

- The absence of a formal MCN in a particular area should not preclude LHCCs/Primary Care using the concept to co-ordinate care within defined conditions, providing an organised Primary Care network to interface with more formal and/or more acute care driven MCNs at a later date.

- The concept of a ‘lead team’ within Primary Care or from across the whole system should be considered for high impact MCNs from a Primary Care perspective. This model makes best use of the natural networks via LHCCs.

- The potential of using the MCN concept to assist with redesign initiatives should not be underestimated, for example, Minor Surgery.

- Where problems emerge the GMT could have a key role to play.

5. **Conclusion**

The MCN concept is one worthy of developing within the organised Primary Care systems across NHS Grampian.
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Area Clinical Forum
Area Dental Committee*  Grampian Management Team
Area Medical Committee  GP Sub Committee
Area Pharmaceutical Committee  LHCC Professional Advisory Committee
Board Management Group  Local Health Council
Capital Planning Group  Psychiatric Medical Advisory Committee
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*At the time of printing these committees had been consulted with but the feedback process was incomplete.

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FOR AND ON BEHALF OF THE GRAMPIAN LHCCs GROUP
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