NHS Tayside

Primary Care Strategy

Modernising Primary Care in Tayside

2003 - 2008

*"Our goals will be challenging but realistic ...
we need to have an appropriate balance
between national and local priorities
to ensure that the local voice
is heard and responded to"*

Planning Directorate
NHS Tayside Headquarters
Kings Cross Hospital
Clepington Road
Dundee

Telephone: 01382 424157
Facsimile: 01382 424003

© 2003 NHS Tayside

Section 1

Developing the Strategy 5

Introduction – Setting the Context 5

- Good planning 5
- Society 5
- The need 5
- Contractual Issues/Implications 6
- Technology 6

NHS Tayside – The Commitment 7
What do we mean by Primary Care? 7

How we have developed the Strategy 8

Setting our sights 9

A Strategic Framework 10

Do we need more money? Can we do things differently? 11

Where Primary and Secondary Care meet 11

Section 2

The Four Building Blocks of the Strategy 12

2.1 Capacity Building 12

- Model Practice Template 12

2.2 Service Design & Development 15

- NHS 24 16
- Community Hospitals 17
- Nursing Services 18
- The Policy Context 18
- Joint Futures 18
- Facing the Future 19
- Strengths and Weaknesses 19
- The current situation in Tayside 19
- Education and Training 20
- Pharmacy Services 20
- Optometry Services 22
- Dental Services 22
- Transport 23

2.3 Health Improvement 25

2.4 Public Participation 31

Section 3

Completing the primary care picture 33

Making connections with other strategies 33/34

- Caring for Older People 34
- Caring for people with Learning Disability 34
- Caring for Children and Young People 34
- Caring for People with Mental Health Problems 34

Developing support for Primary Care 34

- Moving towards a Strategic Financial Framework 34
- Developing our workforce 34
- Rethinking a primary care workforce 35
- Integrated approach to manpower planning 35
- Recruiting the right people 35
- Developing our people 36
- A fair deal for all staff 36
- Making premises fit for purpose 37
- Making the technology work for patients 38
- Promoting a culture of Research and Development 38

The Tayside Wide Picture 39

What Next? 41

Appendices

1. The process of Strategy development 43

2. Primary Care Executive group membership 44

3. Population statistics 45/47

4. Glossary 48

Section 1 - Developing the Strategy

Introduction - Setting the Context

NHS Tayside brings together the three organisations which are responsible for providing health care services in Tayside. We are the Board of Tayside NHS, Tayside Primary Care and Tayside University Hospitals. The creation of NHS Tayside in 2001 was an important step in modernising health care and making sure that treatment given to patients is quicker, more effective and less complicated.

We want patients to be at the centre of all that we do.

Why do we need a plan for Primary Care services?

Good planning helps us to address issues such as:

- major changes in national policy
- ambitious targets, such as Waiting Times
- the allocation of resources
- financial pressures
- demand on services.

The health service is constantly changing to reflect advances in medicine, clinical best practice and technology as well as changes in our population. Society is constantly changing and it is fair to expect the health service to change to meet differing needs. Some of the factors we need to take into account include:

Society:

- an overall decrease in the Tayside population and the impact of an ageing population
- changing public expectation and involving the public in the planning and delivery of health care
- the growth of consumerism and the 24-hour society
- a Government committed to improving the health and well-being of the population
- growing concerns that simply giving more money to the NHS is not the answer to improving health and health care.

The need for new service provision:

- lack of continuity in patient care
- the recognition that health and social care need to work together to improve patient care
- waiting times for access to services
- the emergence of different routes to health care, for example, drop-in centres, NHS 24 and nurse-led services
- the modernisation of acute services

- big increases in the workloads of primary care staff
- the expansion of the primary care team to include practice nurses, pharmicists, physiotherapists, dietitians, speech and language therapists, podiatrists and occupational therapists
- to reduce the gap between those who enjoy good health and those with poor health.

Contractual:

- the new GP contract
- different ways of contracting and awareness of other options, for example, Personal Medical Services (PMS)
- the development of Performance Assessment Frameworks (PAF)
- the difficulty in maintaining the professional workforce, attracting staff, keeping staff and being able to offer the right training.

Technology:

- developments in information management and technology
- improving clinical standards.

We have a clear choice. By taking account of these and other factors, we can picture how we want the future of the health system to be different from the present. We can strive to achieve that vision - or we can continue to be at the mercy of conflicting pressures with the inevitable consequences for our NHS. We are in no doubt what is needed.

Whilst the pressures will always be there, we must set out a clear view of where we want to be in five years' time and how we are going to get there.

Our goals will be challenging but realistic. NHS Tayside will need to support health professionals and teams, as they will be the ones who deliver this different future. We need to make sure that change is achieved and that the momentum for change is maintained. We must achieve change within existing resources. We need to strike a balance between national and local priorities to make sure that local needs and views are taken into account.

A major feature of this 5-year plan is NHS Tayside's commitment to the needs of different communities in Tayside.

This primary care strategy will form the basis of how we develop and improve health care locally. The strategy will support change which responds to local needs, in the interests of the health and well-being of our citizens.

NHS Tayside - The Commitment

The Board of Tayside NHS is committed to the following aims:

- Nurture with partners a health improvement culture within Tayside to promote the highest possible quality of life for the people of Tayside
- Achieve a measurable improvement in the overall health of Tayside's population and a reduction in health inequalities
- Create meaningful patient, public and staff involvement in planning and delivery of services
- Deliver effective integrated services/care for people in natural communities through integrated planning and performance
- Develop a 2-year action plan to regain public confidence
- Achieve the governance standards required by NHS Tayside.

The key themes are clearly set out. They have been reinforced during local involvement events and discussions, which have shaped and influenced this strategy. The change and development recommended in primary care over the next five years must make progress on these six major goals.

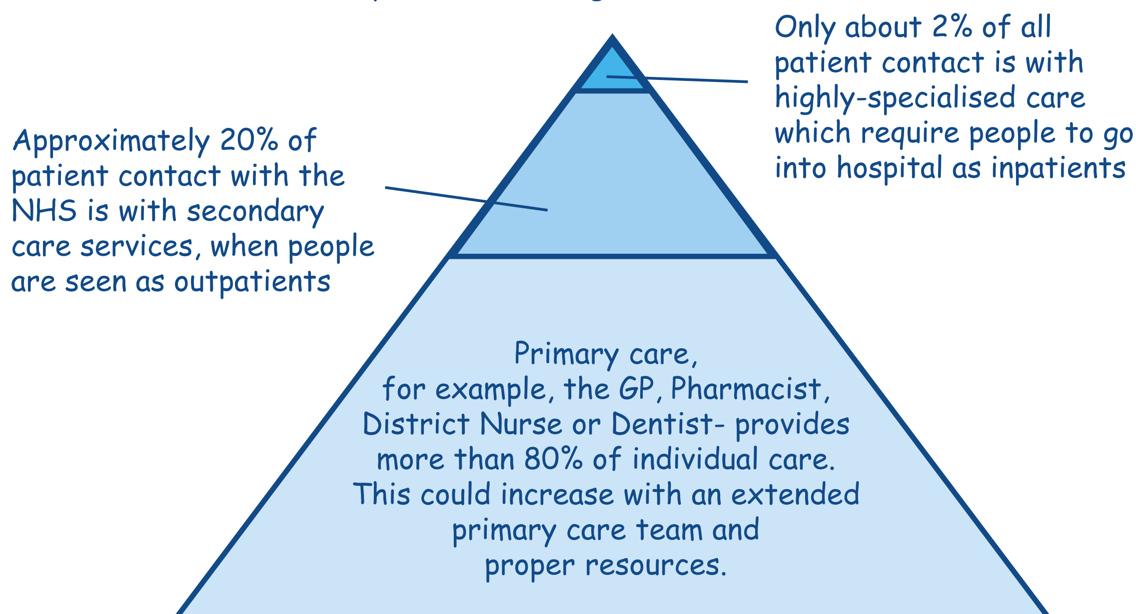
What do we mean by Primary Care?

For some individuals, primary care simply means their general practitioner; but a wide range of health care professionals now work together in teams to offer a comprehensive package of care.

This diverse range of health professionals includes doctors, practice nurses, health visitors, district nurses, pharmacists, dentists, opticians and optometrists as well as a range of therapists, such as physiotherapists, speech and language therapists, podiatrists, dietitians and occupational therapists. They also work with other professionals and agencies, such as social care and voluntary organisations, with a common aim to look after patients.

Primary care provides approximately 80% of health care in our communities. It embraces a broad range of services from health promotion and the early detection of health problems through to medical and surgical treatments and community care. Increasingly, the emphasis is on joining up acute and primary care and the development of Tayside-wide Managed Clinical Networks. **A Managed Clinical Network is a group of clinical people working together to agree and manage patient care across all professions.**

Think of the health care system as a triangle:



This means that primary care has an increasing role in developing and delivering services closer to patients and must therefore have a greater say in how resources are used. Traditionally, the GP has been regarded as the sole gatekeeper to the health care system. This strategy recognises the continuation of the GP as the sole gatekeeper is not desirable. This is clear from the increasing workload of many GPs and their teams. It is also clear, from the development of drop-in centres, healthy living centres, one-stop shops and NHS 24, that making it easier for people to use the service they need directly cuts out unnecessary appointments for the patient and GP alike.

We need to recognise and support the development of other, more appropriate routes to health advice, information, diagnosis, treatment and care.

How we have developed the Strategy

In Tayside, we strive to provide excellent health care services. We want to make them better for our patients and for the people who work to provide our services. From the outset, NHS Tayside has made a strong commitment to being open and genuinely involving the public and professional communities in how those services develop.

As we have developed the Strategy, we have tried to make sure that we have involved health and social care professionals, local authorities, patients, the public, carers and voluntary organisations, who make such a valuable contribution to care. We wanted to make sure that the content truly reflects what people think about our health care services and about what they would like to see happen in the future to make them even better.

Since October 2001, we have been talking to people involved in services and in the communities throughout Tayside. We have held stakeholder events, in Angus, Dundee and Perth & Kinross, as well as work within the Local Health Care Co-operatives (LHCCs) themselves. The stakeholder events in particular have been a

source of new thinking. The events have allowed us to join in a thorough exploration of the possibilities for service change and development. These sessions have helped us to take stock of the current issues for many primary care workers.

This Strategy is the result of those fruitful discussions. The detail of the process is shown at Appendix 1.

Setting Our Sights

This Strategy is about **WHAT** and the document will define the objectives and tasks that will show how Tayside's health goals can be achieved.[1]

Increasingly, in an environment where the health service is striving to meet clinical and financial targets, it is easy to lose sight of the long-term vision. It helps to know that this strategy is focused very clearly on a primary health care system that will: -

- deliver more than 80% of a person's health care
- provide locally-based services wherever possible
- join up primary, community, social care and the voluntary sector
- improve the patients' access to primary care professionals and appropriate services within the wider health system
- work seamlessly with secondary care
- engage patients and the public in the planning and delivery of health care services
- empower people to take a more active role in their own health
- make a measurable impact on the health of local communities, particularly deprived communities and disadvantaged groups
- provide a focus for the work of a wide range of health professions and other stakeholders.

From a patient perspective, these clear aims will provide greater access to a whole range of different professionals and quicker referral to secondary care services when needed. Doctors, nurses and others will work more closely together to provide a service in partnership with patients, which is appropriate to their assessed needs. The vision sees the individual as central to the health care system. People will be able to access care through a number of options - for example:

1. The health centre where the reception staff can offer a range of options to the patients seeking attention:

    - same day assessment by nurse practitioner, with triage to GP if appropriate
    - rapid access to appointment systems
    - chronic disease management from practice nurses - for example, asthma care
    - direct access to therapists operating their own triage arrangements - for example, physiotherapy within 48 hours
    - advice from the practice pharmacist.

1. Draft Tayside Health Plan 2002 – 2007 Version 1

2. Joint Futures, providing seamless integration of health and social care needs to the community

3. the role of the community pharmacist, not just as a source of medication but also for advice on managing self limiting illness

4. NHS 24 which can provide advice and refer where appropriate to emergency services.

With nurse practitioners dealing with most minor illnesses, the GPs are able to use the time to develop intermediate specialist skills. This would allow longer appointments and more treatments within primary care. Direct access to ambulatory day care investigations allow GPs to investigate more fully patient problems - for example, Magnetic Resonance Imaging. Shared care arrangements with other community practitioners sees optometrists and GPs jointly managing diabetic care in the community.

This is the vision that underpins all of the objectives and tasks set out in this strategy.

A Strategic Framework

The strategy has two perspectives and four building blocks.

The first perspective is a Tayside-wide view that embraces issues that, for both consistency and equity, need to be addressed across the Tayside communities.

The second is a cornerstone of Tayside policy - the localities and Local Health Care Co-operatives (LHCCs). The three LHCCs (Angus, Dundee and Perth & Kinross) will provide the focus for local planning and implementation that is sensitive to local need and priorities.

We identified four strategic building blocks during an early workshop held in November 2000 and during subsequent discussions with primary care professionals.

These four building blocks are:

- **Capacity Building** - making sure that primary care is 'fit for purpose' and able to deliver a different and more patient-focused model of care
- **Service design & development** - which acknowledges the need to rethink the way in which care is provided to communities and identifies more cost effective service delivery
- **Improving health of communities** - which gives weight to the wider impact of primary care on the health status of local people
- **Public participation** - to genuinely shape the planning and delivery of local services.

Our extensive discussions, including the stakeholder events, have reinforced the view that these four cornerstones of the Primary Care Strategy are appropriate. Indeed, all of the issues raised fall within one or other of these categories.

We need to strike a careful balance here. People are concerned that national priorities may overwhelm local needs. This Strategy takes forward both. Indeed, we agree that the national priorities are right and appropriate. Our success will be measured in terms of the reduction of health inequalities at community level. For this reason, the locality focus must remain a major feature of this strategy.

Do we need more money? Can we do things differently?

The stakeholder event coincided with a national debate about how appropriate it is to simply invest in more of the same services with no noticeable impact on the health of the individual and communities or on service effectiveness. Research is beginning to question whether the UK is getting the best return on investment compared with other countries.[2] The validity of such comparisons will be hotly debated and there are important issues for policy makers, the public and health care professionals alike.

We take the view that we need investment to bring about change and to develop services in line with the modernisation agenda. We also believe that the case for redesigning clinical care is a robust one that will help us to achieve best practice and the kind of integrated and seamless care for Tayside that is at the heart of national policy. We need to make sure that primary care services are weighted towards meeting the needs of disadvantaged groups.

This strategy will help to place equal emphasis on the need for new investment as well as service design and development. We believe that core services should be supported and maintained whilst recognising that the shape of these services will look different in future.

Where Primary and Secondary Care meet

It is important for us across NHS Tayside to look at the whole health care system. **The relationship between primary and secondary care is a crucial one.** For some people, even the development of a separate Primary Care Strategy inhibits creative thinking about the future shape of our health service. We know and understand there is a mutual dependence and we were careful not to develop a strategy in isolation from the wider health system. **In addition, we anticipated that this first phase of the work should be regarded as a 'positioning' document for primary care and one which would enhance our contribution to the debate.**

As part of developing integrated care, we know that the emerging role of primary care must join up properly with the modernisation and development of acute services locally. We recognise that pressures in one part of the system will have an inevitable consequence upon other areas. Looking at the whole picture helps us to identify gaps, which lead to frustrations, not only for patients, but also for our professional staff.

We hope also that the development of the Tayside Acute Services Clinical Strategy will consider the issues raised **within this context.** Local discussions will need to take place in the near future on the integration of both approaches, allowing us to develop a joint Clinical Services Strategy.

The time is now right for this to happen.

2. Getting more for their dollar-a comparison of the NHS with California's Kaiser Permanente Richard G A Feachem, Neelam K Sekhri, Karen L White, BMJ 2002; 324:135-143

Section 2.1 - Capacity Building

The Four Building Blocks of the Strategy

Capacity building means looking at what clinical and development services we currently provide, what we can safely provide in the future and how we provide what's needed to achieve delivering the volume of services required.

For example, some GPs may wish to undertake more minor surgery or chronic disease management, extending the range of services they can offer to patients. They may need support in helping them to manage their day-to-day consultations to allow this specialisation. Likewise, a physiotherapist may wish to offer a back pain clinic, but needs resources to achieve this.

> ***Tom is a 43-year-old plumber in Blairgowrie, who hurt his back whilst removing an old cast iron bath a few years ago. He received physiotherapy treatment at the time but whenever it flared up again, he had to go back to his GP for a referral. Now, however, Tom can make an appointment directly with a physiotherapist at his local practice, without first having to take up a consultation with his doctor.***
>
> ***This gives Tom more control over his own health and treatment, recognising that the physiotherapist is an appropriate healthcare professional who is clinically able to deal with Tom's problem – and frees up the GP to deal with another patient.***

The group-work held during the stakeholder events generated very important and timely high level discussions. There was agreement among those taking part that capacity building must be a major priority.

The work that we have done during the development of the strategy has shown us there has been **significant increase** in the range of clinical services offered within primary care over recent years.

Much of this work has been taken on board gradually by primary care without, in many instances, appropriate funding being identified in the longer term. We have reached the stage where there is little or no capacity in the system to do this.

Model Practice Template

The concept of the Model Practice Template was first suggested in Tayside during the development of this Primary Care Strategy. This idea would help us to identify what makes an effective primary care practice. The concept is in line with the development of the new national GP contract, which is currently in draft form and out for consultation.

Part of each of the local events focused on the value of adopting **a model practice template**. This would act as both a benchmarking exercise and as a catalyst for practice development. Practices would be asked to complete a template, detailing the number of staff, administrative and clinical, the range of services offered and any specialities undertaken.

We acknowledge there are many examples of good practice throughout Tayside. However, we need to nurture an environment where **best practice is routine and innovation is promoted and encouraged.**

Equity is an important issue and the Primary Care Strategy needs to make sure that people have **guaranteed access to a range of core services wherever they live in Tayside, particularly addressing the needs of disadvantaged communities.** Furthermore, the development of a **minimum range of core services** within each practice will support the development of more specialist services within some individual practices, which could then be offered to communities across locality/ LHCC areas.

We believe that **finding out the current level of activity, resource and staff is a priority**. We would then be able to identify strengths and weaknesses, provide the focus for early investment to support under-resourced practices and help to develop practice development plans.

The notion of **'incremental access'** to services should be explored through the application of the template. This means that the appropriate skills of the primary care team members are matched with patient need. For example, patients requesting to be seen on the same day would be first seen (and treated if appropriate) by a nurse practitioner, and only those whose condition warranted it would then be seen by a GP.

The opportunity for patients to have **'direct access'** to other healthcare professionals needs to be developed further. This allows patients to self-refer to other primary care professionals without using the GP as the first point of contact. An example would be for patients to self-refer to physiotherapy or dietetics. This will require investment in these services and will also highlight the need for these services to develop their own skill mix and 'incremental access'.

There are other important initiatives that will support capacity building and have an impact on the shape of local services as well as the adoption of best practice:

- **Demonstration practices** could be used to highlight things that we do particularly well. This would help other practices to strive for improving the quality of care they provide and developing innovative, patient-centred services

- **Practice Accreditation** is a quality assurance process that practices can undertake on a voluntary basis. This already has professional approval and provides a validated quality standard for practice development. It has the disadvantage that accreditation is currently a voluntary process and practices can only be encouraged to achieve accreditation. However, practices will be expected to demonstrate a standard in line with accreditation in the future and through this strategy we will seek to identify the support required in order to achieve this

- The introduction of a **Service Design and Development Facilitator** for primary care, a new post within NHS Tayside, is recognised as an important first step in helping us to achieve some of the changes required. However, the agenda is growing and capacity is limited.

This strategy needs to determine a clear way forward. We are sensitive to concerns expressed about compulsion, enforcement and heavy-handed performance management. We can assure primary care practitioners that this is not a preferred way of working. Nevertheless, improving our clinical practice, our services and the care we provide to people remain high priorities.

These are our recommended strategic priorities for Capacity Building: -

Year 1

- To work with LHCC representatives and other stakeholders to do further exploratory work beginning in May 2002 on developing a Model Practice Template, making use of the resource within the finalised GP contract
- Use the template to audit current provision, identify investment and staffing priorities and develop practice plans
- Invest in the highest priorities determined by each LHCC, particularly those services currently not funded
- Encourage practices to seek accreditation – identifying required support
- Develop processes which would enable the targeting of resources towards disadvantaged communities
- Take forward the National Strategy for Pharmaceutical Care in order to expand the range of services available to patients and the public from local pharmacies.

Year 2

- Further implementation of the new GP contract and Model Practice Template work
- Encourage practices to create Practice Development Plans and prioritise investment
- Identify urban/rural demonstration practices and develop Tayside-wide quality improvement processes
- Review strategy and identify Year 3 and 4 priorities.

Good things happening already:

- ✶ Practice Accreditation Scheme has been introduced across Tayside enabling the setting of good practice initiatives
- ✶ Quality Practice Award in several practices demonstrating a "gold standard" provision of service
- ✶ Practice Development plans are continuing to be supported in all practices
- ✶ Combined Care at Home schemes have been introduced in conjunction with Local Authority colleagues to enable support to patients living at home
- ✶ Early Supported Discharge schemes across Tayside for patients requiring support following discharge from hospital
- ✶ Protected Time Initiative in Dundee and Perth & Kinross, which gives time to primary care health teams to develop improved clinical practice.

Section 2.2

Service Design & Development

This important building block is reflected across the entire healthcare system as we explore ways of making the delivery of care smoother and quicker for patients. We need faster access to investigative services and to develop better access to alternative self-referral gateways such as NHS 24. We also need to tackle chronic service bottlenecks and to deal with the challenges of staffing shortages, which are particularly significant.

The pressure to review the patient experience is an issue in **both primary and secondary care and, importantly, where those services link up**. The work currently being undertaken in Dundee looking at 'alternatives to admission' for acute medical emergencies is an example of the design work in one area that will impact on and influence practice in another.

Mr and Mrs Macdonald are in their 80s, living in Menzieshill, Dundee. Mr Macdonald, whilst frail, keeps in reasonably good health. However, his wife is suffering from the early stages of dementia. During the winter, Mrs Macdonald comes down with a chest infection. In the past, she would have been admitted to Ninewells. Her husband is not able to look after her during her illness and she needs some nursing care, but doesn't need to be in an acute bed in Ninewells. As an alternative to admission, her GP assesses Mrs Macdonald as well enough to stay at home, as long as a suitable care package can be arranged for her.

As this is a busy time of year for medical admissions in Ninewells, this also means that a bed is now available for someone who requires more specialist care or investigation.

The GP arranges for Mrs Macdonald to be looked after by a range of professionals through the Combined Care at Home scheme until her chest infection clears up. Her GP and District Nurse contribute to her care, along with a home care assistant and social care officer, from the local authority's social work department. Together, they make sure Mrs Macdonald – and her husband – get enough good nourishment, whilst Mrs Macdonald gets help with bathing and toileting, medication and keeping on the move.

As well as Combined Care at Home, Early Supported Discharge and Intensive Care at Home schemes, there are other examples of best practice design and development initiatives across Tayside, which indicate that this approach is already beginning to support the anticipated significant changes in healthcare service delivery locally. Jointly-managed health and social care community mental health teams in Angus provide an integrated approach to patients with mental health problems.

The design of services needs to have a patient focus. This means engaging the public and patients in the process. Whilst care pathways and managed clinical networks will have a clinical focus to secure best practice and cost-effective care, the patient 'journey' is central to how we deliver care.

The stakeholder workshops highlighted the need for us to take the entire healthcare system into account during the **planning and delivery of services across**

primary and secondary care. We will need to make sure that every patient has a clear understanding of the care they will receive during each stage of their journey through the health system. This helps us to iron out bottlenecks and unnecessary duplication, particularly for the patient.

A Tayside-wide approach to service design and development will make sure there is co-ordination and 'joined up' thinking and action.

The NHS Tayside Health Plan should be the main focus for identifying key priorities for design and development and associated resource planning.

Locally, we have given much time to considering the **Primary Care Collaborative** models emerging in England. Primary Care Collaboratives are working groups of practices, which are set up to achieve rapid and sustainable improvement in clinical practice. Each of the practices involved is provided with protected time and significant management and administrative support to allow them to make change happen.

Clearly there are differences in the way primary care is organised north and south of the border and this would require to be taken into account, in particular the central role of the LHCCs within Scotland.

The management of patients with chronic disease such as diabetes and being able to go straight to the health professional they require are two of the important areas that we could support locally.

In fact, Tayside already has an excellent record in the management of diabetes and coronary heart disease, making effective use of computer technology to support seamless care between primary and secondary services. Continuing these developments and building on best practice are pivotal to this strategy.

Elizabeth, from Forfar, is a 56-year-old woman with Type 2 Diabetes Mellitus. Elizabeth has had to take time off work to attend the Ninewells Diabetes Clinic. She needs to have regular eye checks, as diabetes can cause blindness. However, Elizabeth also missed the eye van when it last visited Forfar due to her work commitments.

In future, as an improvement to the service, she may be able to get all her regular checks at her own GP's surgery and have a digital eye check at a Forfar optician on a day that suits her best.

NHS 24

The development of **NHS 24**, the new 24-hour nurse-led telephone health information and advice service, will also have an impact on service provision and patient access. Whilst there will be those who feel threatened by the development of alternative gateways to service, this is only one of the increasing number of ways in which the access problem will be tackled. For many patients, NHS 24 will be a more convenient and appropriate means to access clinical advice. The reality of patient choice is very much part of our thinking about service development.

Importantly, the emergence of NHS 24 adds to the debate about the role of the **GP as the sole NHS gatekeeper**. What we have found locally is that there is a willingness to challenge this role, particularly amongst GPs.

Barbara lives in Dundee and is woken late at night by her four-year-old son, Ewan, crying. He's flushed and says his head is sore. Barbara calls NHS 24, which is also the number for her GP's Out-of-Hours service. She speaks to a highly-trained nurse, who assesses what's wrong with Ewan, using a clinically-sound set of questions and guidelines – this is called nurse triage. The nurse reassures Barbara and suggests that she gives Ewan some paracetamol syrup and, if the problem persists, to make an appointment with her GP the following day. Barbara has no paracetamol suitable for Ewan in the house, but is able to ask her neighbour to visit their local 24-hour supermarket. Her local chemist has a shop within the supermarket and has recently developed a rota of local chemists to staff the shop.

This means that the public have 24-hour access to highly-trained and knowledgeable chemists, who can assess a condition and provide quality professional advice to patients, as well as offer a wide range of over-the-counter medicines.

By the following morning, Ewan was up and running about as normal – and his mum was reassured that he was fine and she didn't feel the need to contact their GP.

Community Hospitals

Community Hospitals are an important focal point for our communities, particularly in Perth, Kinross & Angus. Their future role **will have a major impact on modernising local care.**

NHS Tayside recognises that:

- care for patients should be appropriate to their needs
- care should take place as close to the patient's home as possible
- care should strive to look after the patient in their home and their community
- care should be carried out by the appropriate professional - whether this is a doctor, nurse, occupational therapist, social care worker or voluntary worker
- care should be holistic, involving health, social care and the voluntary sector and should also support the carer by also meeting their needs.

These concepts require the development of real integration of the extended primary care team including social work. The joint working or 'Joint Future' approach to the delivery of community care services, has arisen as a result of the new Health and Community Care (Scotland) Act. This provided new powers which allow NHS boards and local authorities to work more closely together with other agencies, making sure that patients and their carers have easier access to appropriate services, avoid duplication of assessment, and help people move through the system more quickly.

Integral to this kind of care is the development and maintenance of community beds for patients who require a level of care, which is generally not possible to provide at home but does not require the services of a specialist hospital. Community beds, in our view, are an essential part of the health service. Without them, specialist hospitals would be more heavily congested and unable to cope with demand.

We now have an opportunity, **consistent with the Tayside Acute Services Strategy**, to develop alternative models of care both in community hospitals and the wider community. We can develop more integrated care which includes a range of services, such as step-down care, rehabilitation, Early Supported Discharge and Prevention of Admission schemes which make sure that people receive the right care, in the right place at the right time.

Nursing services

This is an exciting time to be a nurse in Scotland. Since devolution there has been an increased awareness of health issues and the important role nurses play in promoting health and treating ill health.

This dynamic role for nurses will ensure:

- the promotion and delivery of evidence based clinical care
- the improvement of patients health
- equity of access to appropriate healthcare services
- an increased focus on the patient's journey
- a change in NHS culture from one of illness and treatment to one of health and illness prevention
- effective teamwork across different professional groups and agencies
- the on-going development and improvement of nursing practice.

The policy context

Caring for Scotland - The Strategy for Nursing and Midwifery in Scotland (2001)[3] outlines how nurses will respond to the challenges in the 21st Century and reinforces the commitment to the values and practice of caring. The Strategy outlines a range of initiatives to further enhance the capabilities of nurses to provide the flexible, responsive, needs-driven services the public demands. It highlights the personal and professional challenges, which face nurses and demonstrates the exciting variety of career and educational opportunities available to nurses.

Nursing for Health: A review of the contribution of nurses to improving the public's health[4]

The recommendations in Nursing for Health set out a radical and challenging agenda for nursing in public health. These will maximize the potential contribution of nurses, midwives and health visitors to improving the health of Scotland's people.

Joint Futures

Joint resourcing and management of health and social care is a reality in Scotland. Re-balancing care for older people is a priority and there is a drive for nurses and others to deliver care at home in creative ways.

Joint working across the health and social care setting is now the norm and the provision of integrated care is now a reality.

3. The strategy for Nursing and Midwifery in Scotland (2001)
4. Nursing for Health

Facing the Future (2001)

Following the launch of Scotland's response to recruitment and retention difficulties within nursing, an action team evolved which had a clear focus on solutions.

The plan is based on eight key issues, which are:

- the further development of nurse consultant posts
- an investment in developing nurse leaders
- working conditions and tools for the job
- education and training
- flexible working
- careers
- research and evaluation
- employment packages.

Strengths and Weaknesses of Current Public Health Nursing Practice

This was achieved through a widespread consultation process, whereby professionals across Scotland were invited to contribute opinions and to present evidence to the Review. Many examples of good practice were identified, including work undertaken in Tayside, but also concluded that in general terms:

- nurses', midwives' and health visitors' public health contributions were often ad hoc and uncoordinated
- there was a lack of clear leadership and direction
- nurses, midwives and health visitors were not contributing significantly to strategy
- little or no use was being made of information or evidence to support and inform practice
- professionals often worked in isolation, with little sharing of good practice or opportunity to be challenged on their own practice
- most practice involved work with individuals and families rather than communities
- education was not adequately preparing nurses, midwives and health visitors to address the new health agenda.

The Current Situation in Tayside

Public health professionals in Tayside were supported to take an active role in contributing to the Chief Nursing Officer's Review in all its stages. This included a series of local workshops across Tayside, gathering views on the consultation document for the review.

However, specific action to develop the contribution of nurses to improving the public's health has been underway in Tayside for several years now. Key initiatives are described in outline in the following paragraphs. These initiatives have been facilitated through the funding that has recently become available through the Health Improvement Fund.

Education and Training

To support the implementation and development of the public health nursing role, academic institutions are refocusing the previous public health degree courses, the emphasis now being on the health of communities and preventive models of health care. Six students across Tayside received funding support allocated from the Scottish Executive to undertake this qualification in 2001/2002. Work is currently underway to consider how these new roles will be introduced to current service arrangements.

Good things happening already:

- Consultant in Public Health Nursing
- A Steering Group has been established to develop an action plan, which will address the local implementation of the recommendations of Nursing for Health in Tayside
- Public Health Practitioners
- Practice Nurse Advisors in post
- Changes to Health Visitors/School Nurses role
- Increased skill-mix in Community Nursing.

Pharmacy services

The Scottish Executive Strategy for Pharmaceutical Care was launched in February of this year.[5] The strategy is designed to "deliver improved services to the public and patients, using the skills of the pharmaceutical profession to deliver effective care" and sets out how that might be achieved.

The document, which contains 60 key actions, comprises five chapters:

- Improving health
- Improving access
- Helping patients to make better use of their medicines
- Service design and development
- Partnership with staff.

Locally, the LHCCs have agreed priorities for 2002/3 and have set targets which are in line with these recommendations, developing the enhanced role of the pharmacy profession across primary care localities.

For some patients, the problems with their medicines occur when they move from their own home to hospital. For primary care to improve, all parts of the system must be addressed. It has therefore been agreed that we will review current systems of medicine management on admission to hospital, within hospital and at discharge. Models to ensure the safer, more effective, use of medicines will be developed, thus ensuring that every patient has their medication reviewed and any problems addressed, prior to discharge from hospital.

Mrs McCabe is in her 60s and lives in Broughty Ferry. She suffers with heart disease and as a result receives a number of medicines on repeat prescriptions. She is now able to collect her medicine directly from her community pharmacist monthly for up to 18 months without having to visit

5. The Right Medicine: A Strategy for Pharmaceutical Care in Scotland 2002

her GP practice. At her six monthly medication review her community pharmacist makes sure that her treatment is in line with national clinical guidelines.

Recently she was started on warfarin. Her community pharmacist tests her blood and advises on dosage changes. By undertaking this work and helping Mrs McCabe to manage any minor ailments over the year, her community pharmacist takes some of the workload off her GP, who is then able to spend more time with other patients.

Barbara is a single mother who lives in Arbroath. She is very concerned when her four year old son, Ewan, comes home from nursery scratching his head constantly. Barbara calls NHS24. She speaks to a trained nurse who assesses what is wrong with Ewan, using a clinically sound set of questions and guidelines. This is called nurse triage.

The nurse reassures Barbara and explains that Ewan most probably has caught head lice. She refers Barbara to her local community pharmacist, who as part of a new initiative is able to prescribe a suitable treatment for Ewan, free of charge on the NHS.

Ewan was assessed, diagnosed and treated within a couple of hours without Barbara even needing to contact his GP.

Good things happening already:

- A network of community pharmicists across Tayside has been established to provide additional support to palliative care patients across the region
- In Arbroath and Friockheim patients can access medicines through community pharmacy prescriptions. This successful project will be rolled out across the rest of Tayside in 2002/3
- Over the past four years more than half the community pharmacies in Tayside have installed Advice Areas so that patients can ask for advice or information in privacy
- A community pharmacy in Albert Street, Dundee has bee refitted to provide health promotion and consultation facilities
- All GP practices in Dundee have access to practice based pharmacists who work with the pratice team and with patients to ensure that patients have their medicines reviewed and updated
- Pharmicists have provided smoking cessation services, including advice on the range of products and motivational support, to patients and the public.

Optometry Services

NHS Tayside demonstrates a 'mixed' view in relation to **Optometry Services**, which help us to look after our eyes. Evidence shows that we have the worst track record in Scotland for shared-care/co-managed schemes - we don't have any.

We have a strong network of optometrists with well-organised local facilities. We need to take advantage of this.

We suggest the following strategic recommendations to make sure we capitalise on the very real strengths of our optometrists:

- We support the introduction of a **direct referral** processes to acute services for patients suffering from cataracts
- We support the development of **clinical networks** to provide shared-care schemes. We need to do further work to identify which conditions could benefit from this approach, such as diabetes and glaucoma.

Dental Services

The current situation regarding **Dental Services in Tayside** shows that dental care is delivered locally by three sources:

- the general dental service (GDS) provides the bulk of dental care
- the community dental service (CDS) is complementary to the GDS. It provides a safety net giving access to dentistry to those groups who may find difficulty in accessing GDS - for example, special needs groups, anxious patients and children in remote rural areas. CDS staff also have an important role in providing anaesthetic services in hospital situations. A Public Health role is undertaken by CDS staff in providing statutory screening programmes for school
- the hospital dental service (HDS) is a specialist service provided at Dundee Dental Hospital, Ninewells Hospital and Perth Royal Infirmary. Patients are seen on referral, by their General Medical Practitioner or General Dental Practitioner in various specialities. In addition the University Department at Dundee Dental School provides undergraduate and postgraduate teaching.

Generally, Tayside is not experiencing many of the difficulties faced in other areas in relation to the recruitment and retention of General Dental Practitioners and the availability of NHS dental care, **and we are working hard to avoid those issues arising locally.**

One of the most significant challenges for the dental health service is the availability of the **Emergency Dental Service.** This issue was highlighted during debate and discussion at the local stakeholder events. Continuing efforts are being made to develop a comprehensive emergency dental service across Tayside.

Currently in Tayside, we have a strong commitment from the dental profession to the provision of NHS Dentistry, although there are communities within Tayside which do not have access to this care. This issue will need to be addressed during strategy implementation. Any future reorganisation needs to recognise the role of the General Dental Service in maintaining not only the oral health, but also the general well-being of the population, as outlined in Tayside Oral Health Strategy.[6] We need to accept that the dental professions are also an important part of the

6. Tayside Oral Health Strategy 2001

multi-professional health care team.

In the development of the LHCCs, the General Dental Service has not yet found a place. As we work towards our vision of more integrated care, particularly in relation to the design and development of services, it is imperative that our dental colleagues are fully involved.

Transport

Finally, one of the most frequently raised topics is one of transport. The Tayside population is spread over a wide geographical area, some of which is urban and a large part is remote and rural. Whilst NHS Tayside does not have a responsibility for the provision of transport, we need to bear in mind that people must be able to get to and from the services that we provide. NHS Tayside is working closely with transport providers and the local authorities to develop more effective and relevant transport links. In addition, it is important that services should be provided in the most accessible locations and, therefore, the preferred locations for new developments will be sites which are conveniently accessible by public transport, pedestrians and cyclists as well as by car.

These are our recommeded strategic priorities for Service Development:

Year 1

- Work with the Scottish Executive to resource and establish Primary Care Collaboratives in Tayside
- Identify suitable practices across Tayside to implement the Primary Care Collaborative model.
- Make sure the Primary Care Collaborative model is evaluated
- Carry out a review of the 'GP as sole NHS gatekeeper' principle
- Make sure key design-development priorities are supported and implemented locally to remove blocks in the system around staffing and resources
- Support further appointments of service design facilitators
- Support the Tayside-wide roll out of NHS 24
- Identify the training and development needs in service design and development
- Review the contribution of Community Hospitals to the developing Primary Care agenda
- Make sure that **all** primary care professionals – GPs, pharmacists, opticians and dentists - make a contribution to the service design and development process
- To support working towards all patients having access to NHS Dentistry
- Consider the transport needs of Tayside patients.

Year 2

- Evaluate Primary Care Collaborative Model outcomes August 2003
- Following evaluation, expand and resource the Primary Care Collaboratives
- Implement Year 2 of redesign programme.

Good things happening already:

- Protected Time Initiatives – these allow practice staff funded time out of the practice to further develop clinical skills or practice development. Locums (replacement clinicians) can provide cover to keep seeing patients so no care is lost
- Improved access to PAMs (currently in Dundee LHCC)
- Practice based chronic disease management programmes - for example diabetes and heart disease
- Chronic Obstructive Pulmonary Disease (COPD) initiatives in Dundee, which help to care for people with breathing disorders and lung disease
- Practice pharmacists within all practices
- Practice Nurse Advisers in post in Dundee and Perth and Kinross
- Community Liaison Team introduced in Care Together
- Occupational Therapy Functionality project, Perth & Kinross – this assessment tool will help primary, community and acute staff to assess a person's ability to cope particularly after an illness, stroke or fall. This helps the professional to find out how dependent someone is and to work out the amount of therapy required.

Section 2.3

Health Improvement

Tayside has a troubling record of ill health and health inequalities, which is about people who are living in poverty and socially deprived circumstances having poor access to health care and a greater chance of developing ill health. Tayside has high teenage pregnancy and abortion rates, high levels of mental health problems and lung and heart disease including stroke. Many of these health problems can be related to alcohol use, smoking, lack of exercise, inadequate diet, poor housing, education and poverty.

This powerful message more than justifies investment in health improvement as one of our strategic priorities.[7] Unless we genuinely tackle the serious issue of Tayside's health status, and the ill health of many of our citizens, much of our work will be merely running faster to stand still.

NHS Tayside is committed to improving the health and well-being of our population. This means improving the survival rate from disease, reducing the incidence of disease, tackling health inequalities and supporting people to play a greater part in their own health. Primary health care teams have a vital public health role in this respect, particularly in relation to deprived communities.

We want to make the Tayside population the healthiest in Scotland.
Whilst we develop Tayside-wide health strategies, there is agreement that the appropriate response should be local and focused on the differing needs of Tayside communities. The Joint Futures agenda again reinforces the importance of joint working with local authorities and other agencies.

Health status is a community issue, not solely a health service one. The health of any individual will be influenced by a significant number of factors, many of which will be outside the direct responsibility of the health service and health professionals. This is why joint working with our partners on improving joint care is so important to reducing health inequalities, particularly for a community care client grouping such as older people services. These factors include the type and quality of housing a person lives in, their access to education and information, whether or not they are employed or living in poverty.

Health and Homelessness Guidance was issued to NHS Boards in September 2001 as part of the drive to tackle health inequalities and promote social justice. The Health and Homelessness Guidance required Boards to:

- Develop a Health & Homelessness Action Plan as an integral part of the Local Health Plan in partnership with Local Authorities, the voluntary sector and homeless people.
- Ensure the Action Plan which commenced in 2002 is effective.
- Provide clear mechanisms for linking the Action Plan with Local Authorities' Homelessness Strategies in 2003, and with locality Community Plans.

7. NHS Tayside Health Improvement Plan 2001 – 2006

Within Tayside, a Health and Homelessness Plan was developed during 2001/02 in partnership with the Local Authorities and was submitted to the Scottish Executive in June 2002. The aim of the plan was to provide an outline for addressing service improvements, together with a suggested implementation programme. This included:

- A profile of homelessness in Tayside and within each Local Authority area.
- An assessment of homeless people's health and health care needs.
- An understanding of the network of health services within primary and secondary care currently supporting homeless people, including services used and their accessibility.
- An evaluation of strengths, weaknesses and gaps in current provision.
- An action plan addressing issues and key areas of concern.
- Links with other strategies which encompass social inclusion.

Main findings

The main overarching key issues highlighted within the action plan included:

- Limited core funding and therefore limited ability to meet the needs of this client group.
- Problems associated with accessing services.
- Issues around staff attitudes.
- The need for interagency training on the health needs of homeless people and their children.
- The need for increased joint working, joint care planning and single assessment processes.
- Service issues, particularly issues around mental health and substance misuse services.
- The need for advocacy and befriending services.
- The need for more detailed health needs assessment and therefore priorities for investment.
- The need to plan and engage with prison services.
- Involving service users.
- Particular issues around physical health care and health promotion.
- The need to collectively look at the prevention of homelessness.

In terms of service development, five key areas were consistently highlighted:

- The need for a dedicated health co-ordinator in each locality for health and homelessness.
- The need for a locality "one stop shop" type facility for homeless people.
- The need for an inter-agency/inter-disciplinary rapid response team in each locality.
- The need to refocus on outreach services, particularly General Practitioner services, as well as clinic provision
- The need for specially geared services to suit the needs of individual client groups, in terms of suitable accommodation and housing provision.

Following on from submission of the action plan, a Tayside wide Steering Group has now been formed to provide a strategic forum to oversee and plan health services in relation to homeless people, detailing priorities and to oversee and support the implementation, monitoring and evaluation of both the Tayside and local action plans.

Elaine is fourteen years old and lives in Dundee. She had an abortion six months ago, which caused her mother to throw her out of the family's home. She went to live with her gran and refused to go to school. She recently ran away from her gran's home and was missing for more than two weeks. Eventually, the police brought her back – she had been living in Edinburgh in a vulnerable situation, and being sexually exploited. A support group in Edinburgh, which works with prostitutes, had spotted her on the streets and alerted Tayside Police Family Support Team. She is now living back with her mother, but both are receiving a lot of support from the local Social Work Department.

Her GP told her about The Corner in Dundee, which offers health information, advice and healthcare services to young people and where no one judges her. Elaine now regularly goes there - she has become involved with an art project and drama group there and her confidence is improving. She is also more aware of how to look after

her own health, particularly in relation to her sexual health. Her Social Worker has helped her to go to a new school, where no one knows her and she feels she is making a fresh start.

Assessing the health needs of the local communities should be an important ongoing process, which informs and directs activity within LHCCs, local health plans and the community planning process.

Aspects outwith the traditional health remit, such as life circumstances, should be considered - for example, poor housing, unemployment and low-income. The NHS in Tayside with its partners will plan how they can address these issues through joint working and shared resources.

However, we need to explore the **public's perception of the GP as the fount of all knowledge and information.** Undoubtedly, many people go to surgeries for information rather than treatment. **Should GP practices be developed as information centres**, without adding to the burden on practices? Self-care can only become a reality when our patients are well-informed about the choices available to them.

Effective health improvement programmes with measurable benefits are already available in places throughout Tayside - helping people to stop smoking for example, or to lose weight. We know that maintaining a sustainable service over a long period is part of improving health and shaping services. We need to build on those examples of good practice and make more of them available to more people.

We agree that any health improvement/inequalities strategy needs to focus on **education, information and empowerment.** The relationship between health inequalities and these issues are evident.

Primary care professionals have the most significant role to play, given the level of patient and public contact. Again the message is clear - those who **work in the community are best placed to focus health improvement initiatives** and work with vulnerable and disadvantaged groups.

Health improvement will be a common thread running through Tayside's strategic objectives.

All of this means reviewing the contribution of a wide range of health professionals to the health improvement agenda. Particular emphasis has been given to the input of health visitors, dietitians and community pharmacists - in reality, all health professionals are able to make an impact on improving the health of their local population.

Jack has worked on a light engineering production line for over twenty years. He was made redundant last year. He has been drinking quite heavily for some time now and this has caused the family considerable distress. His wife, Cath, and two children Brian (aged 13) and Debbie (aged 11) are also terrified of his anger when he's drunk – although he has never been violent.

Cath and the children have now moved out, which has worsened Jack's drinking. Cath has been to her GP – she doesn't want the children to stop seeing their father, but she's worried that something happens when he's not in control. She's very agitated and nervous and has lost a lot of weight in the last few months. Also, both Brian and Debbie are becoming withdrawn and their schoolwork is suffering. It seems as if their whole lives are now being dominated by Jack's alcohol problem.

The GP asked Cath to persuade Jack to make an appointment with him – it is clear that Jack is suffering a lot of anxiety and depression, which is made worse by the amount of alcohol he's going through in a week. Also, his finances are worsening due to the amount he spends on drink.

The doctor refers Jack to the Community Mental Health Team, which is made up of both psychiatric nurses and social workers. Together they help Jack deal with his depression and anxiety. In addition, Jack takes up the suggestion to contact Tayside Council on Alcohol, which is a voluntary organisation. TCA has counsellors to support people with alcohol problems – it is a confidential service and they also can support young people who are affected by alcohol, whether it is their own drinking or a family member's.

Cath is now considering moving back home and the children's schoolwork has improved. They seem much happier – they have made a number of new friends through the Basement at Tayside Council on Alcohol and can share their worries and thoughts with people who understand.

The growth of the public health role in primary care in Tayside has been gathering momentum recently and further developments are planned in the coming year.[8]

We will:

- build on existing achievements
- maintain the enthusiasm and commitment of those engaged in the process to date
- extend the multidisciplinary nature of the public health function in primary care and the links to other initiatives - for example, local Health Alliances and the public health activities which take place in the NHS acute sector
- make sure that the development of public health makes full and appropriate use of current evidence.

Investment should be focused on what works already, or that the intervention is shown to be likely to deliver real health improvement as a return on investment.

Arbroath couple, Steve and Beth have a six-month-old baby called Rosie. Steve, 23, is currently looking for work as a mechanic. Beth, 18, is finding being a new mum quite stressful and both she and Steve smoke. Now, Rosie seems to be developing asthma. Their local health visitor has been very helpful – she visits regularly and offers good advice about looking after baby and explains how careful budgeting and a healthy diet will help all of them flourish. Also, she runs a stop smoking support group in the town's Abbey Health Centre. With some careful planning, both Steve and Beth can attend groups at different times, so that they can help each other to quit. The family doctor is optimistic that Rosie's breathing difficulties will soon clear up, now that her living environment has improved.

The health visitor has also helped Steve by encouraging him to do some computer training at Angus College to extend his skills. Beth has joined a parenting skills group at the community flat, run by local health and social care staff, and she feels more able to cope with a demanding family life, supported by friends, family and local professionals.

These are our recommended strategic priorities for Health Improvement: -

Year 1

- Update local needs assessment carried out by LHCCs with the local authorities
- Assess the contribution of primary health care teams, including mental health professionals, Professions Allied to Medicine (PAMs) such as physiotherapists, dietitians, podiatrists, occupational therapists, speech and language therapists and the other independent contractors to the health improvement agenda
- Practices and localities should contribute to shaping the local health plans
- Make sure that LHCC health improvement budgets are identified
- Expand investment in evidence-based good practice – what we know works

8. The Report of the Director of Public Health 2001

- Make sure that an evaluation framework is established for all investment
- Develop a local health inequalities strategy in partnership with other key agencies
- ensure issues raised within the Health and Homelessness Guide (2001) are addressed.

Year 2

- Integrate the health improvement agenda into the work of the emerging Primary Care Collaboratives
- Sustain investment in what works
- Any member of the primary health care team will be able to refer patients for exercise or fitness regime
- Evaluate ongoing interventions.

Good things happening already:

- Smoking cessation clinics introduced in the community using Health Visitor/ Public Health Nurses and on an individual basis by Practice Nurses
- Schools Public Private Partnership initiative (Dundee LHCC)
- The Corner, which is a young people's health information and advice centre in Dundee
- Angus under 21's health project.
- Scottish Health at Work (SHAW) introduced in areas throughout Tayside, which aims to maintain the good health of employees working in the health service
- A risk management policy was introduced in Perth & Kinross. Systems are put in place to ensure risk is minimised within a service.

Section 2.4

Public Participation

NHS Tayside is committed to involving the public in the development of services and in their own health. We have already taken innovative steps to secure involvement at the highest level in policy making and strategy development. We will demonstrate our commitment **at every level of the health system**.

There are already **established mechanisms** for engaging the public at locality level. This includes the involvement of a member of Tayside Health Council or a patient representative group joining in at LHCC Board level. Tayside Health Council has already played a significant part in NHS Tayside's public involvement efforts and they are to be thanked for their commitment and support.

Patients, service users or carers are often involved in planning a particular service – this already happens in the care of elderly people, maternity, mental health, palliative care and stroke services. Some GP practices run patient user groups and many of the community hospitals are supported by local people.

Recent experience has shown that NHS Tayside must listen and people must be involved in the development of local services. **Arrangements that have been shown to work well need to be further extended and supported.**

One of the difficulties with genuine public participation is that most of us tend to be influenced by life events such as having children, coping with dementia in an elderly relative or coming to terms with chronic illness. Most of our experience shows that **where public involvement is relevant to a person's experience and interest, participation can be very successful.**

How do we know if it is working? From the public perspective, we must gauge the success of participation **by the extent to which care planning and delivery have been** shaped by their views and experiences.

During the development of this strategy, it has become clear that, as we modernise our health care in Tayside, our citizens must be involved in the process. People who use our health care services bring a unique perspective to the table and we greatly value their contributions. We need to make sure that we use the most effective ways of involving people at a local level.

To this end, the Board of Tayside NHS has given its support to four major projects, which show a tangible commitment to genuine public engagement. The projects are:

- The creation of a **Citizens Panel** to give their views on planning and service provision
- A **comprehensive** audit of the level of public engagement and involvement
- A **Citizens Jury** to enhance Projects 1 and 2 and provide insights into how people might be more effectively involved
- **A National Health Partnership** - a long term project involving a major cultural shift and the development of a 'people's contract' between the NHS and the people of Tayside.

The key to successful local engagement is to make sure that public engagement is built into all our planning and service initiatives. **Where we require funding to support projects, involvement will be a routine requirement. The extent and effectiveness of public engagement will need to be demonstrated.**

These are our recommended strategic priorities for Public Participation: -

Year 1

- We need to make sure that our communities are involved in service redesign and capacity building
- Make sure that the primary care strategy is discussed by the Citizens Jury and Panel to explore the potential for enhanced public involvement
- Ensure that there is an effective evaluation of public engagement on all primary care development initiatives
- Support LHCCs in the production of their public involvement strategies
- Review Tayside-wide information for patients and public.

Year 2

- Improve the availability of patient and public information about services and care
- Make sure the developing Primary Care Collaboratives have appropriate public involvement.

Good things happening already:

- ✶ Patient/Client involvement (Perth & Kinross LHCC/Care Together): through patient/client satisfaction surveys in general practice, community nursing, health visiting and PAMs out-patinet services
- ✶ A number of GP practices have developed user groups
- ✶ User involvement in mental health services
- ✶ Patient/public involvement in modernising health services in Angus and in local maternity services.

SECTION 3 - Completing the Primary Care Picture

Making connection with other Strategies

We are reassured to note from the similarity of issues arising from local debate and discussion that this Primary Care framework cannot be developed in isolation from other strategy development work. Indeed, as we spoke with 'major players' in health and social care, we heard loud and clear that the Primary Care Strategy must reflect the wider context within which services are being planned and developed. The following is a summary of the perceived challenges within specific care groups:

PRIMARY CARE SERVICES

Caring for Older People

Issues

- Health and social care are developing greater joint working to look after our older people - primary care currently provides a generic service for the population
- Resourcing of the joint training and development agenda
- Communication and information sharing, including the development of a single shared assessment for patients
- Models of locality single management
- Culture/change fatigue/leadership

Recommendations

- **We must make sure that we enable and support the LHCCs to meet the challenges of caring for older people**
- **We will continue to strengthen our partnership working arrangements with Local Authorities and other health partners to implement the actions contained within the Local Partnership Agreements**

Caring for Children and Young People

Issues

Each LHCC must incorporate action from NHS Tayside's Child Health Strategy into its local health action plans by December 2002. These will focus on:

- Food and Nutrition, including breastfeeding, healthy eating and dental health
- Smoking (including cessation) for children, young people and pregnant women
- Physical activity
- Mental wellbeing to include promotion of positive mental health and action related to mental illness, including depression in teenage girls
- Immunisation – for example, Measles, Mumps and Rubella (MMR)

Recommendations

There are also specific additional targets for Dundee. Finally, the Child Health Strategy Group has agreed six joint priorities between health and local authorities. This will be relevant to local plans.

The six priorities are:

- **Child and Adolescent Mental Health Services**
- **Children with Complex Needs**
- **Sexual Health**
- **Substance Misuse**
- **Child Protection**
- **Looked after Children**

Caring for People with Learning Disabilities

Issues

- 'Same As You' is the national strategy which aims to look after people with learning disabilities in small, home-like environments, away from unsuitable, old-fashioned instituitions. To help NHS Tayside to achieve this, we need to appoint local area co-ordinators and practice based registers, which include personal life planning for each individual
- Taking into account the shift in balance of care and the increasing numbers of people with learning disabilities, including Autistic Spectrum Disorder, multiple and profound disability, we must recognise that the individuals needs are becoming increasingly complex

Recommendations

- We must increase capacity and expand the role of primary care to implement the 'Same As You' requirements, joining up Community Learning Disability Teams and primary care within localities

We must enhance our core primary care services to support people in the community more effectively. This means developing the skills and expertise of care professionals, developing health promotion for people with a learning disability and being aware of the needs of individuals, families and carers

Caring for People with Mental Health Problems

Issues

- The balance of care is moving away from large institutions and towards local, more person-centred care. Resettlement means there will be an impact on prescribing budgets, out-of-hour services and the level of care provided by GPs
- The increase in mild to moderate mental illness in the practice population, which includes mental health, well being and health promotion)

Recommendations

- As we strive to support resettlement and care in the community developments, we must incorporate additional resources for primary care
- We must develop a more effective transfer of care between secondary and primary care
- We must enhance primary care skills and expertise

As we develop models of care for people with less severe mental health problems, we should make sure that the emphasis is on mental health and well-being and health promotion, including psychological interventions, counselling and stress management.

Moving towards a strategic financial framework

We know that we need a robust **investment plan** to support the strategic proposals contained within this Primary Care Strategy. During the course of the development work, a number of issues were raised which will help us to develop a sound financial framework:

- there is a desire within primary care to allocate resources where they are most required
- looking at the whole health care picture will help us to 'do things differently' within existing resources
- too much money is lost through **drug wastage** – for example, by people not completing courses of treatment, lack of communication between hospitals and primary care over medication and unnecessary repeat prescriptions. Significant savings could be made by tackling this problem
- **a more flexible approach to the allocation of resources will make it easier to deliver a more responsive service**
- there is a need to identify a better way of handling financial risk - for example, how much financial risk can we take and who will manage the financial risks?
- One-off, non-recurring money could be used to bring about change
- we may need to identify 'change funds' cash for new work
- there is a desire to **move away** from **time-limited funding** for short-term projects
- new investment should be targeted towards care and service **design and development priorities** and the formulation of **joint clinical strategies.**

Developing our workforce

There are a number of workforce issues, which will impact on the delivery of the primary care strategy. These are inextricably linked to a number of issues:

- the modernisation of health services resulting from the Tayside Acute Services Strategy
- the design of clinical and non-clinical services so that the aspirations of the Health Plan can be met
- European directives such as Working Time Regulations.

Unlike clinicians working in the secondary care sector, primary care practitioners are self-employed and therefore independent contractors. This means that the NHS has a contract with many primary care practitioners to deliver NHS health care services.

Despite the creation of Primary Care Trusts and within them, the establishment of LHCCs, primary care practitioners are governed by different regulations, which require us to think laterally about how primary care should be organised in future.

While a good deal has been achieved in establishing a corporate approach through the LHCCs, little has been done to address issues around the shape of the future workforce. There are no Trust-wide mechanisms that take account of all independent contractors.

This difference will have an impact on our ability to recruit, retain and develop the right people to deliver the right services in the right environment.

Rethinking a primary care workforce

We recognise there are overlaps between community staff, who are Trust-employed, and practice staff, who are generally employed by the GP, dentist, optician or pharmacist themselves. We need to review the situation in each locality area, taking into account the size and type of practice, community and other hospital infrastructure.

We will need to review the levelling out of conditions of service for practice and Trust staff. We are therefore planning for a workforce that will be shaped and skilled differently from current arrangements and this will no doubt have an impact on resources.

At the moment, practice staff are not often viewed as part of the NHS as the GP or other independent practitioner employs them. They therefore feel neglected and there are often blocks in the system around practice staffing issues. Differential pay systems mean that someone working in a GP practice doing exactly the same kind of work as someone in a hospital, who is employed by a Trust, can receive less pay and have poorer terms and conditions of service.

There should also be a more integrated approach to manpower planning.

We need to consider all practice-based staff, including Administration and Clerical, Professions Allied to Medicine, nurses and community staff as part of NHS Tayside. Therefore, we need to take a corporate approach to addressing these issues.

In addition, there are a number of challenges facing Boards in relation to LHCC development.[9] These include:

- **the role of the LHCC in improving the health of their local communities, through multi-disciplinary and multi-agency working**
- **developing the capacity in LHCCs to manage an evolving organisation**
- **taking action where LHCCs are not progressing the health agenda in their locality**
- The development of transitional training – for example, for Practice Nurses.

We have been aware for some time that we will need to address this to provide a stable and sustainable service in the community and to support the shift of care from secondary to primary care.

Recruiting the right people for the right job

We recognise that the planning assumptions of the past will need to change. Increasingly, the next generation of qualified practitioners across all disciplines will have different expectations in term of their career and life balance. An increasing number of GPs desire to work part time or to job-share, perhaps to fit in with the needs of their families. Others resist the financial commitment of an investment in a partnership. The issue of salaried practitioners has been piloted and other innovative Personal Medical Services (PMS) schemes are being looked at to address these challenges.

9. Making The Connections 2002

Tayside has its lowest-ever number of GPs under 30 and the highest number of those over 50. Over the next few years, we will find ourselves with a significant shortfall due to retirements unless we take action now to address this.

The impact of Working Time legislation affects us all. Historically, GPs have been expected to be available to their patients, 24 hours a day, 7 days a week, providing a call-out service when required. Legally, this is no longer possible – nor is it clinically safe for either the doctor or the patient. Tired and over-stretched people make mistakes.

European Working Time Regulations are a significant employment issue for Primary Care practitioners, both as employers and employees. There are also a number of national shortages in other professional groups such as the Professions Allied to Medicine (PAMs). We have already experienced some difficulties in recruiting the right people because there is significant competition for a relatively small supply of suitably qualified and experienced people.

We are working with colleagues in the Scottish Executive Health Department nationally and regionally to look forward and plan for our future workforce. This work will inform the number and type of future workers required, making sure that our colleagues in education are able to train sufficient numbers. We have to balance this with professional registration, revalidation requirements and higher staffing levels.

Work is already starting in Tayside to address the challenges of 'Facing the Future', which is the national recruitment strategy for nursing and the development of a strategic approach to the recruitment and career development of PAMs [10]

Developing our people

It is vital for staff – whether they are clinical or not – to keep their skills up-to-date. We will need to establish the skills required in relation to any changes associated with the primary care strategy. We may need to retain and re-skill existing staff as a consequence of the development of their role. We will also need to transfer staff into new areas of work. This is a more complex issue in primary care due to the nature of multiple employers needing to work together to achieve this.

Resources need to be identified to help us to address this, although important early steps such as protected time initiatives have already been established in some areas.

A fair deal for all staff

We recognise that primary care contractors are independent employers but the foundations are being laid to make sure that staff, regardless of employer, are treated fairly and consistently and supported to provide the best possible care for patients and clients.

We want to make sure that all employers in the 'primary care family' can demonstrate good practice as far as staff governance (quality employment) is concerned. All staff should expect:

- to be well informed
- to be appropriately trained
- to be involved in decisions which affect them

10. Facing the Future 2001

- to be provided with a safe and improving working environment
- to be treated fairly and consistently
- to have equal pay and conditions for the same jobs.

There is a great deal more work to do and the Strategy will eventually be to identify the resource requirements to achieve this.

Making premises fit for purpose

As the range and development of primary care services expands, there will be significant implications for primary care premises – that is, the practices, health centres and surgeries where services are provided.

These changes will be driven by:

- the growth of new services delivered at the primary care level
- the integration of services
- the requirement to increase the quality of service provision - for example, the new GP contract
- the increasing influence and range of information technology (IT) developments and new ways of working
- issues around safety – for example, Health and Safety legislation and adapting premises to offer better protection for staff against violent incidents.

We have made significant investment in improving and new-build primary care premises in Tayside in the past 10 years. However, due to the development of the primary health care team in relation to the numbers of professionals involved and their clinical skills, there is further pressure on the space available within our premises.

Investment in premises continues at a high level in Tayside and, within the last two years, five new primary care centres have been completed, along with three major upgrades. A further fourteen new developments are being taken forward within the next two to three years.

Many of our new premises developments are much more complex. They involve not only primary care services, but Trust services such as podiatry, minor injuries, community psychiatry and rehabilitation to name but a few, with dentistry, social work and voluntary services all now being part of providing a quality primary care service to patients.

With the ever-increasing size and complexity of primary care centres, costs of new buildings are escalating into the several million pounds level. Traditional funding sources such as Cost Rent/Improvement Grant can no longer be the only method of providing capital.

Whilst development of primary care premises are well ahead in Tayside, our aim is to find better ways to identify capital for premises development. It is essential that we take account of all new developments and new ways of working in the NHS in Scotland. We must continue to consult with all stakeholders, when planning new buildings for primary care services, so that we give patients a comprehensive, well-integrated system of health care at a local level.

Making the technology work for patients

NHS Tayside is fortunate to have a wealth of clinicians and information technology (IT) staff who have a visionary and innovative approach to technology in improving patient care and communications. We are leading the way in initiatives which develop the exchange of clinical patient information between clinicians to speed up diagnosis and treatment.

Significant investment has already been made around Information Technology, particularly in relation to General Medical Practices. NHS Tayside is committed through our Area Wide Information Management and Technology (IM&T) Strategy to make sure our systems are modern, effective and accessible to the wider primary care team working from practice premises.

Key strategic IT issues impacting on primary care in 2002/03 onwards include:

- Electronic transfer of patient information and the continuation of Scottish Executive-funded Electronic Clinical Communications Initiative (ECCI) principles - for example, patient discharge summaries, electronic referrals from a GP to a hospital consultant, diagnostic test results
- Consolidation of electronically stored records such as the Unique Personal Identifier (UPI) and the Community Health Index (CHI) throughout the Tayside system. As health and social care have different patient/client identification methods, the UPI is a tool being developed to provide more effective joined-up record-keeping in line with the development of integrated care
- An on-going commitment to IT support arrangements for General Practice, particularly the need for additional staff to support the transfer of patient records from paper to computer-based systems, whilst maintaining the existing systems
- Further developments of Out-of-Hours commitments - for example, Taycare, which is a web-based system used to record a patient's out-of-hours health care, and the roll out of NHS 24
- Five year IT equipment replacement programme
- Investment in Tayside-wide communication bandwidth.

In addition to the above, General Dental Practice, Community Pharmaceutical and Ophthalmic Practices will require investment in line with the National IM&T Strategy. So far, no additional resources have been identified for these areas.

Promoting a culture of research and development

NHS Tayside has a strong profile in Primary Care Research and Development. We have one of the most successful Scottish networks in the Tayside Research Consortium, TayRen; six Chief Scientist's Office (CSO) research practices; and a department of General Practice with national and international strengths in informatics, lung health and other research methods. We also have strong links to other networks, particularly FresCo in Fife and academic departments throughout Scotland and beyond.

We intend to integrate service developments more fully with research expertise by making sure that clinical academics are located within practice settings, providing NHS colleagues with support for their research.

When NHS Tayside's £1.8M Centre for Health Informatics opens in 2003, Tayside Audit Research in Primary Care (TARPC) and the Royal College of General Practitioners (RCGP) will move into space vacated by Tayside Centre for General Practice's (TCGP) informatics researchers.

Research and development activities are currently resourced by funding from the Scottish Higher Education Funding Council, through the University of Dundee; NHS Education for Scotland; The Chief Scientist's Office and a number of other grant-awarding bodies.

We contribute to, and benefit from, the research governance framework established by the Tayside Research Consortium. Recent changes to this framework require that all primary care researchers be offered an honorary contract with Tayside Primary Care. The TayRen Executive must approve all research undertaken. Some additional resource for this increased workload will flow from the CSO because of our increasing success in research.

By funding the clinical sessions of clinical researchers, NHS Tayside will make sure that the demands to provide training and support are also met. In addition, primary care fully supports the encouragement of a culture of research and development during pre and post registration training placements.

These are our recommended strategic priorities for completing the Primary Care Picture:

Year 1 and ongoing

Making connections with other strategies

- Make sure that strategic priorities for Mental Health, Learning Disabilities, Older People and Children and Young People are fully integrated with the strategic implementation proposals for Primary Care.

Finance

- To devise a robust, flexible investment plan that will support the strategic proposals contained within the Primary Care Strategy
- Make sure that new investment is targeted towards design and development priorities as identified and agreed locally.

Developing our workforce

- To develop a comprehensive workforce plan which takes into account the needs of both Trust and practice staff
- To encourage the development of a learning culture within primary care through development planning
- To consider the harmonisation of Human Resource Policies for both Trust and independent contractor employees.

Making premises fit for purpose

- To find better ways to identify capital for premises development
- To update and integrate both Trust and Primary Care premises strategies.

Making the technology work for patients

- To implement the key priorities as contained within the Primary Care Strategy.

Promoting a culture of Research and Development

- To provide on-going support and commitment to research and development within Primary Care.

The Tayside-wide Picture

Our three LHCCs are an example of NHS Tayside in action.

Nevertheless, there are important policy issues and actions that must be developed on a Tayside-wide basis.

Approximately 80% of all health care takes place in a primary care setting – this must be recognised by NHS Tayside and reflected in the development of the region's acute services. We must make sure our approach reflects this balance of care.

In order to achieve the changes now proposed for primary care, NHS Tayside is determined to **maintain the momentum and the commitment** to achieving best possible standard primary care services across Tayside.

Although there are early initiatives that will enhance both capacity and capability, much of **what needs to be done to improve services over the next five years involves an enormous amount of change to how and where our health care is provided.**

Local discussions have given us clear and consistent messages. We must make sure that we have the money available to pay for services before we commit to delivering them. We may also need an injection of dedicated resources to kick-start the process. This could be either cash or additional skilled staff who can help us to achieve the change required.

In fact, it was clear through the stakeholder events that it may not be just money which makes the difference when trying to bring about change - identifying experienced people who can bring about new ways of working and thinking can be all that is needed.

Keeping patients and the public voice at the heart of our services will greatly assist in both primary and secondary care to provide and maintain very patient-focused care.

Whilst there is a Tayside-wide approach and support to public involvement, we are keen to maintain existing areas of good practice and encourage local initiatives to flourish.[11]

NHS Tayside is keen to maintain this kind of open and transparent environment and allow the exploration of new thinking and shared problem-solving.

The primary care strategy has set out challenging, yet achievable, goals. It will tackle the priorities at the grass roots level of the health system and dismantle the barriers to progress, such as attitude, culture and resistance to change, which have existed in the past.

The stakeholder events provided feedback to NHS Tayside suggesting the need to address a number of issues.[12]

Board-level strategic management and planning can do much to smooth the patient's progress through the health system and open up new possibilities. We must also make sure that the goals set for NHS Tayside itself reflect the tasks set out in the four building blocks.

11. Making the Connections 2002
12. Issues from the Stakeholder Events , Stuart Dickens – Dearden Consulting 2002

These are our recommended strategic priorities for Tayside:

Year 1

- Publish the Tayside vision of the primary care service to take us to 2007
- Provide funding to support our priority tasks
- Maintain existing initiatives around public engagement
- Promote practice accreditation
- Review the 'GP as sole NHS gatekeeper' principle
- Support and resource Tayside Primary Care Collaboratives as appropriate
- Review and develop leadership skills in key staff to support change
- Support the implementation of Performance Assessment Frameworks in Primary Care.

Year 2

- Interim evaluation of Primary Care Collaboratives
- Review any issues, which arise between primary and secondary care and produce an integrated Clinical Services Strategy.

What next?

During our development work on Tayside Primary Care Strategy, we have made a considerable effort to show a real commitment to being open, honest and transparent, engaging professionals, patients, other care agencies and the wider community and identifying their issues and concerns.

Jointly, we have explored and discussed creative solutions to our often shared problems.

Throughout the strategy, we have highlighted a number of achievable key objectives for the forthcoming years – for example:

- exploring new and different gateways to care
- challenging the role of GP as 'gatekeeper'
- introducing the Collaborative approach to service design and development
- developing ways which will make sure we deliver a core standard service.

We intend to ensure that this strategy is about action not words. The next steps in the process will include: -

- developing locally agreed action plans with our LHCCs around these achievable key objectives
- agreement on how these actions will be implemented
- identification of support required by our LHCCs in order to bring about the changes identified within the strategy.

We believe that the old ways of 'thinking' and 'doing' will not meet the challenges of a modernised primary health care service for Tayside in the 21st century.

APPENDIX 1 - The process of strategy development

THE STRATEGY DEVELOPMENT PROCESS

1. The Tayside Primary Care Strategy Project Plan/Specification identified 4 key building blocks. This was based upon prior local discussion with primary care professionals and other key stakeholders. These blocks were:

- Capacity Building
- Service Design/Development
- Improving the Health of Practice Population/Local Communities
- Public Participation

2. There was full LHCC involvement using a variety of approaches:

- in Angus and Dundee local representatives were identified to work with practices and staff
- in Perth & Kinross the Project Manager attended locality meetings in order to ascertain local views and opinions

3. Presentations were made by the Project Manager to:

- LHCC Boards
- Healthy Dundee
- The Area Pharmaceutical Committee
- The Partnership Forum
- The Practice Manager Group within Perth & Kinross. Invitations were also extended to Practice Manager groups in Angus and Dundee
- Tayside Health Council

4. Stakeholder Events were held in:

- Dundee
- Angus
- Perth & Kinross

Participants at these events included not only Primary Care Professionals but also patient/ Local Authority representatives

5. The Primary Care Strategy Executive Group held monthly meetings throughout the course of the project in order to provide support and guidance and undertook a two-day strategic analysis event which enabled the collation of data/information for the strategy

6. A meeting was held between Area Dental/Optometry representatives and key members of the Primary Care Executive group

Commenced 19th September 2001 - 31st March 2002 1st Phase

APPENDIX 2 - Group Membership

TAYSIDE PRIMARY CARE STRATEGY - EXECUTIVE GROUP MEMBERSHIP LIST

NAME	TITLE
DR JOYCE MEIKLE	Chair - GP Sub Committee/LMC
DR ANDREW BUIST	Secretary - GP Sub Committee/LMC
DR ANDREW RUSSELL	Associate Medical Director - Tayside Primary Care
DR CHARLES CARNEY	Chair Dundee LHCC
DR HARRY LEADBITTER	Director of Primary Care Tayside Primary Care
IAN McDONALD	Assistant Director of Finance Tayside Primary Care
BILL NICOLL	Associate Director of Planning NHS Tayside
SHEILA PHILLIPS	Project Manager Tayside Primary Care Strategy NHS Tayside
JOSIE JONES	Support Manager Tayside Primary Care Strategy NHS Tayside
CATRIONA NESS	Primary Care Design & Development Facilitator Tayside Primary Care
JOHN RANKIN (FROM JANUARY 2002)	Director of Strategic Planning & Development Tayside University Hospitals
JULIE BELL	Communications/Press Officer Tayside Primary Care
SHEILAGH MACFARLANE	Practice Nurse Dundee LHCC Board Member
MARIANNE MITCHELSON (UNTIL DECEMBER 2001)	Strategic Development Co-ordinator Tayside Primary Care

APPENDIX 3 - Population Statistics

The estimated population of Tayside at 30th June 2000 was 385,500 accounting for 7.5% of the total population of Scotland.

Changes in population between 1999 and 2000 and expected change by 2010

Between 1999 and 2000

- The population of Scotland fell by 0.1% (4,600 people) and is expected to drop by a further 0.5% (25,521 people) by 2010
- The population of Tayside dropped by 0.7% (2,800 people) and is expected to fall by a further 1.9% (7,180 people) by 2010
- The population of Angus dropped by 0.6% (660 people) and is expected to drop by 0.3% by 2010
- The population of Dundee City dropped by 1.2% (1,730 people) and is expected to fall by a further 8.1% by 2010
- The population of Perth & Kinross dropped by 0.3% (410 people) and is expected to rise by 3.6% by 2010

Population Distribution by Sex

The gender distribution in similar for Scotland, Tayside and its Council areas with generally just over 50% females and just under 50% males.

Analysis by age group shows that there tend to be more males than females in the youngest age group (0-14) and an equal gender split in the 15-44 and 45-64 age groups. In the 65-84 group almost 60% are female and in the 85+ group this increases to 73% females.

Tayside and Angus tend to reflect the gender distribution of Scotland within each age group. Dundee has higher proportions of females in the age groups from 45 onwards, whereas Perth & Kinross has lower proportions of females in older age groups (65 on).

Population Distribution by Age

Comparison of the distribution by age of the population of Scotland with the population of Tayside shows that

- Around 18% of the population of each of the areas are aged 0 to 14.
- In Scotland, almost 43% of the population are aged 15 to 44 while only 40% of Tayside residents fall into this age band. In Dundee 41% of the population are aged 15 to 44 and only 39% in Angus and 38% in Perth & Kinross fall into this age group.
- Tayside has slightly higher proportions of its residents in each of the age bands 45-64, 65-84 and 85+ than Scotland as a whole.

In Tayside,

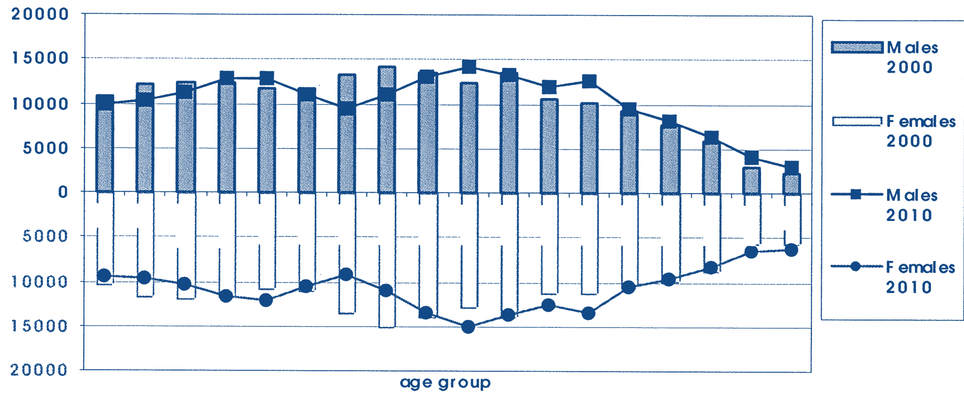
- Dundee City has a slightly lower proportion than the Tayside average in the 45-64 age group.
- Angus has slightly higher than average proportions in the 45-64 age group but is lower in the 15-44 and 65-84 groups.
- Perth & Kinross is lower than the Tayside average in the 15 to 44 age group and slightly higher in the 45-64 age group.

Expected change in Age Distribution of Population between 2000 and 2010

The population pyramid shown below describes the age/sex distribution of the population in 2000 (bars) and then again at 2010 (lines).

Of particular note in Tayside is the expected decrease in those aged between 30 and 39 and the expected increase in those aged 45 to 69.

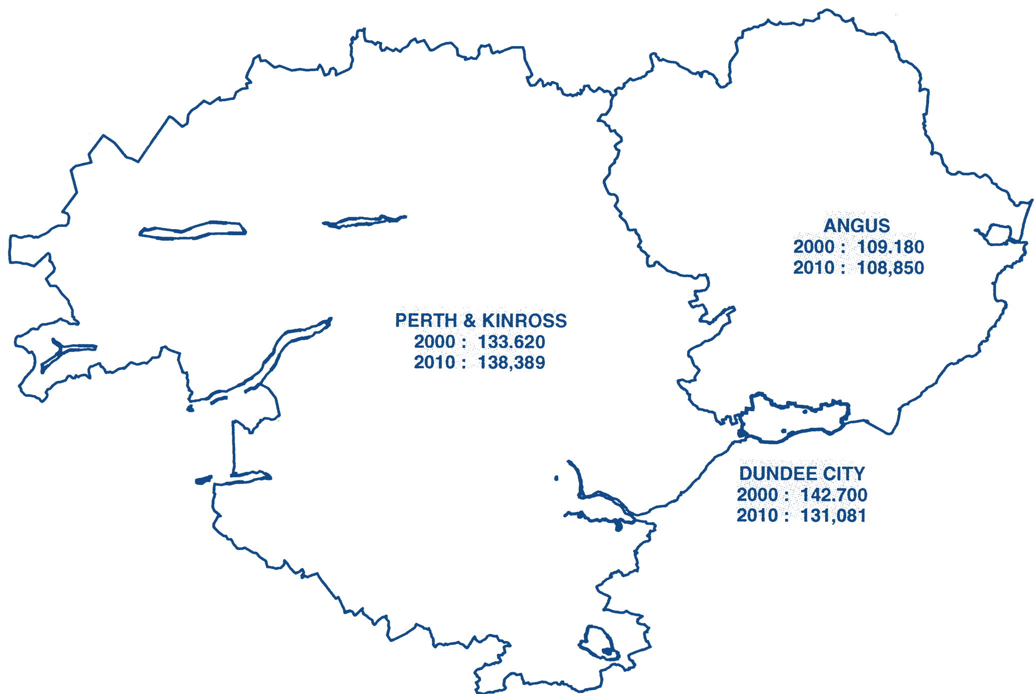
Population Pyramid for Tayside, 2000 & 2010



Population Distribution by Council Area

Of the population of Tayside, 37% live in Dundee City, 35% live in Perth & Kinross and 28% live in Angus.

Population projections for Tayside indicate that by 2010 Dundee City will account for just over 35% and Perth & Kinross for just under 37% of the Tayside population, with the remaining 29% being resident in Angus.



AREA OF RESIDENCE	SEX	AGE GROUP 0-14	15-44	45-64	65-84	85+	ALL AGES
SCOTLAND	MALES	479573	1096805	590183	295885	22241	2484687
	FEMALES	456574	1083026	621375	407504	61434	2629913
	BOTH SEXES	936147	2179831	1211558	703389	83675	5114600
TAYSIDE	MALES	35326	76493	46378	25720	2150	186067
	FEMALES	33766	75910	49223	34813	5721	199433
	BOTH SEXES	69092	152403	95601	60533	7871	385500
DUNDEE CITY	MALES	12987	29637	15501	9338	646	68109
	FEMALES	12473	29425	17356	13290	2047	74591
	BOTH SEXES	25460	59062	32857	22628	2693	142700
ANGUS	MALES	10260	21758	13821	6981	594	53414
	FEMALES	9787	20980	14109	9228	1662	55766
	BOTH SEXES	20047	42738	27930	16209	2256	109180
PERTH & KINROSS	MALES	12079	25098	17056	9401	910	64544
	FEMALES	11506	25505	17758	12295	2012	69076
	BOTH SEXES	23585	50603	34814	21696	2922	133620

Source: GRO mid-year population estimates 2000

For further information contact :

Information Services * NHS Tayside Board * Kings Cross

Tel : (01382) 818479 Fax : (01382) 424027

APPENDIX 4 - Glossary

BANDWIDTH	Technical term for the cabling specification that needs to be improved for those sites that have a requirement for increased levels of data communication
CDS	Community Dental Service
CHD	Coronary Heart Disease
CHI	Community Health Index – A database which holds information on patients
COPD	Chronic Obstructive Pulmonary Disease – A chest condition
ECCI	Electronic Clinical Communications Initiative
ENT	Ear, Nose and Throat
GDS	General Dental Service
GMS	General Medical Services
GP	General Practitioner
HDS	Hospital Dental Service
INDEPENDENT CONTRACTOR	GP, Community Pharmacist, Dentist and Optometrists
IT	Information Technology
IM & T	Information Management & Technology
LAs	Local Authoritys
LHCC	Local Health Care Co-operatives – A group of professionals coming together to manage our local health service
NHS 24	24-Hour Nurse Led Advisory Service
PAF	Performance Assessment Framework
PAMs	Professions Allied to Medicine
PMS	Personal Medical Services – An alternative way of funding primary health care
SE	Scottish Executive
SHAW	Scottish Health at Work
UPI	Unique Personal Identifier

Notes:

Notes:

NHS

Tayside