Item No: 09

Meeting Date: **Wednesday 24th March 2021**

Glasgow City Integration Joint Board

Report By: **Gary Dover, Assistant Chief Officer, Primary Care and Early Intervention**

Contact: **Ann Forsyth, PCIP Programme Manager**

Phone: **0141 287 8705**

Primary Care Improvement Plan April 2021 onwards (PCIP 3)

Purpose of Report:	The purpose of this report is to seek approval from the Board for our primary care improvement plan for April 2021 onwards (PCIP 3).

Background/Engagement:	The original PCIP was approved by the IJB in September 2018. A number of subsequent progress reports have been presented to the IJB and to the Finance and Audit Scrutiny Committee. We published a PCIP 2 in May 2019 which covered the period 2019-2021. The attached PCIP 3 provides details of the programme for April 2021 onwards. We have engaged with GPs through the three locality groups and we held a session with all the Cluster Quality Leads//Practice Quality Leads in November 2020. The Local Medical Committee (LMC) representatives have been involved in the development of PCIP 3.

Recommendations:	The Integration Joint Board is asked to: a) note the contents of this report; and b) approve the attached PCIP 3.

Relevance to Integration Joint Board Strategic Plan:

Transforming primary care services is a vital element of the IJB's strategy, given that a significant volume of patient contacts take place within primary and community care each year, with the majority of patient contacts and episodes of care taking place entirely within this setting. Estimates suggest that up to 90% of health care episodes start and finish in primary and community care.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome:	All 9 health and wellbeing outcomes are relevant.
Personnel:	Recruitment of new staff.
Carers:	By extending care in the community carers should see benefits and increased levels of support for them in their caring role.
Provider Organisations:	A number of independent organisations have been contracted to provided services using funding from PCIP.
Equalities:	Sections 4 and 7 of the first PCIP provided details of the health inequalities and equality implications arising from the PCIP. We have completed a strategic equality impact assessment on the plan and the EQIA can be found at the following: https://glasgowcity.hscp.scot/publication/eqia-primary-care-improvement-plan
Fairer Scotland Compliance:	The socio-economic impact of decisions was included as part of the Equality Impact Assessment.
Financial:	The anticipated final allocation of funding from the Scottish Government of £18.792m will not be sufficient to fund all the commitments in the Memorandum of Understanding and the GP contract. This has been highlighted in our previous PCIPs and in our regular progress reports to the Scottish Government. In previous financial plans we estimated that to achieve all of the objectives of the MoU could cost in the region of £33.6m. To enable plans to progress, including discussions with Scottish Government about funding requirements, we had been working with a more conservative planning assumption of £22.313m

	and this was the basis of the previous update to the Scottish Government. No further funding has been forthcoming. Therefore the attached PCIP 3 presents a programme that will ensure that our final expenditure will be contained within the funding allocation of £18.792m set by the Scottish Government. PCIP 3 also includes our proposals for how to use the unutilised funding from the early years of the programme. This amounts to £4.5m and is non recurring funding.

Legal:	Not applicable.

Economic Impact:	Short term economic impact from the establishment of the new posts within community and primary care services and longer term outcomes related to health and well-being of our population and its contribution to economic development.

Sustainability:	Not applicable.

Sustainable Procurement and Article 19:	Not applicable

Risk Implications:	These are included in our risk register with details of mitigating actions where these are possible. The PCIP has been developed in partnership with the GP Subcommittee and the continuation of the positive working relationship between the HSCP and the GP Subcommittee will be vital to the success of the plan. Key risks are: • The pandemic has delayed implementation this year because of the pause in recruitment and the removal of staff from practices to work remotely. Some of the staff, whose posts have been funded by PCIP, were re-deployed from their work in practices to support the response to the pandemic. • Difficulties and delays in recruiting sufficient numbers of experienced practitioners. • Funding will not be sufficient to meet all the commitments in the new GP contract for all practices. • The future years' funding could be subject to amendment by the Scottish Government.

	• The cost implications for the Vaccination Transformation Programme are not fully known as the final models for adult flu and travel advice/vaccinations have not been finalised. • Key infrastructure challenges include the lack of suitable premises for the new/expanded services and the need for an integrated ICT system to support information sharing between members of the multi-disciplinary teams.

Implications for Glasgow City Council:	The implementation of the PCIP provides opportunities to improve joint working between primary care and wider council services for the benefit of those patients with multiple and/or complex needs.

Implications for NHS Greater Glasgow & Clyde:	The Health Board is responsible for the delivery of the GMS contract and as employer of the staff is responsible for the recruitment of the new workforce.

Direction Required to Council, Health Board or Both	
Direction to:	
1. No Direction Required	☐
2. Glasgow City Council	☐
3. NHS Greater Glasgow & Clyde	☒
4. Glasgow City Council and NHS Greater Glasgow & Clyde	☐

1. Purpose

1.1 The purpose of this report is to seek approval from the Board to our primary care improvement plan for April 2021 onwards (PCIP 3).

2. Background

2.1. The Scottish Government introduced a new contract with GPs in 2018 in response to growing pressures within primary care that are threatening sustainability, such as growing demands on the service and concerns about GP recruitment, early retirement and retention. The aim of the new contract is to enable GPs to operate as “expert medical generalists”. This will be achieved by diverting work that can best be done by others, leaving GPs with more capacity to care for people with complex needs and to operate as senior clinical leaders of extended multi-disciplinary teams. The principal elements of the 2018 contract are:

- To re-design primary care services to enable longer consultations by GPs with people with multiple morbidities requiring complex care.
- For health boards to take on responsibility for GP leased and owned premises.

- To reduce the risk to GPs from information sharing, improved use of new information technology.
- To give GP clusters a role in quality planning, quality improvement and quality assurance.
- To provide new opportunities for practice staff-nurses, managers and receptionists to contribute to patient care.

2.3 To support the introduction of the new contract a **Memorandum of Understanding (MoU),** covering the period 1st April 2018 to 31st March 2021 was signed by the Scottish Government, the British Medical Association, Integration Authorities and NHS Boards. The MoU covered 6 workstreams:

- Vaccination Transformation Programme
- Community Treatment and Care Services
- Pharmacotherapy
- Urgent Care
- Additional practitioners to expand multi-disciplinary teams in primary care, such as physiotherapists and mental health workers
- Community Links Workers

2.4 The MoU has been followed up by the Scottish Government with an annual funding letter, that outline how the additional investment is allocated to each IJB and the conditions attached to the funding. Based on the NRAC funding formula, it has been expected that Glasgow City's allocation would rise over the three year period to a final budget of £18.792m by 2021-22.[1]

2.5 The MoU committed integrated joint boards to develop for each HSCP a **Primary Care Improvement Plan (PCIP),** in collaboration with GPs and other stakeholders. The PCIP sets out how we will deliver on the MoU's priorities over the 3 year period and how we intend to use the additional funding from the Scottish Government. Glasgow's PCIP was approved by the IJB in September 2018, with a requirement to review our plans to bring expenditure within the final year's budget allocation. The PCIP has been updated each year since 2018/19 and the attached plan is our third update (PCIP 3), covering the period 2021/22 and beyond.

2.6 In December 2020 the Scottish Government and the BMA issued a "**Joint Letter - the GMS Contract Update for 2021/22 and Beyond**". A revised MoU is being drafted that will provide more detail on how these revised commitments will be implemented**.**

[1] Although described as "earmarked recurring funding" it is emphasised in the Scottish Government funding letter that we should treat these figures as planning assumptions and subject to amendment by Ministers without notice. Future funds will also be subject to the annual parliamentary budget process. The allocation of PCIF requires to be planned alongside separate funding allocated for out of hours primary care and for Action 15 of the national mental health strategy (a part of which is intended for primary care).

3. Summary of PCIP 3 for 2021-22 and beyond

3.1 Progress has been achieved (and continues to be achieved) towards meeting the requirements of the 2018 GP contract and MoU, despite the significant challenges posed by the pandemic during 2020/21. The PCIP 3 provides an update on progress for each of the workstreams as well as a snapshot of the priorities for 2021/22 and beyond.

3.2 We know that we will have insufficient funding to fully deliver all the commitments in the 2018 contract and the MoU. In previous financial plans we estimated that to achieve the objectives of the MoU could cost in the region of £33.6m, although up until now we have been working within a more conservative planning assumption of £22.313m to enable planning to progress and also to inform updates to the Scottish Government. No further funding has been made available from the Scottish Government, therefore final plans must be limited to the final funding which is available, which is £18.792m.

3.3 Over the past few months, therefore, we have been focusing on how we can make best use of the funding, without breeching the final allocation of expenditure from the Scottish Government. This has meant making difficult choices about where we will need to reduce our planned expenditure. We have consulted with GPs and representatives of the Local Medical Committee and the GP subcommittee on these proposed changes. Whilst there was a recognition by GPs that we need to make these changes, there was naturally a frustration that not all the commitments will be achieved for all 143 practices in Glasgow.

3.4 The main changes we are proposing to make to the final workstream budget and recruitment of staff are outlined in the following two tables (tables 1 and 2).

Table 1 PCIP 3 Budget forecast (Recurring funding only)

Workstream	Previous Planning Assumptions (£m)	Revised Estimate(£m)	Changes	% share of budget
Vaccination Transformation Programme	2.550	2.550	0.000	13.57
Pharmacotherapy	5.500	5.500	0.000	29.27
CTAC and Phlebotomy	5.674	5.500	-0.174	29.27
Urgent Care	1.136	0.660	-0.476	3.51
Community Links Workers	2.350	1.950	-0.400	10.38
Mental Health	2.000	2.000	0.000	10.64
Advanced Practice Physios	2.458	0.660	-1.798	3.51
Occupational Therapists	0.264	0.000	-0.264	0.00
Core support	0.381	0.381	0.000	2.03
Allowance for staff turnover		-0.409	-0.409	
Total	**22.313**	**18.792**	**-3.521**	**100.00**
Expected SG Funding	18.792	18.792		
Difference	**3.521**	**0.000**		

Table Workforce recruitment PCIP3

Workstream	PCIP 2	PCIP 3	Difference
Vaccination Transformation Programme	32	32	0
Pharmacotherapy	90	90	0
CTAC and Phlebotomy	193	180	-13
Urgent Care	21	10	-11
Community Links Workers	41	43	2
Mental Health	25	25	0
Advanced Practice Physios	51	11	-40
Occupational Therapists	2	0	-2
Core support	6	6	0
Total	461	397	-64

3.5 The expenditure table (table1) shows that we will, broadly, maintain existing expenditure plans for the Vaccination Transformation Plan, Community Treatment and Care Services, Pharmacotherapy Services, Community Links Workers and Mental Health. These reflect the "must dos" in the 2018 GP Contract/MoU and the priorities expressed by GPs during the consultation.

3.6 The main reductions in planned expenditure will be made on our Urgent Care, MSK Physiotherapy and Occupational Therapy Services.

3.7 We have retained expenditure in the project management costs but we will be reviewing these during 2021.

3.9 There remain a number of uncertainties in the final budget (for example, there is not an agreed model or costing for the final vaccination programme), therefore, we will need to revisit these expenditure estimates as we obtain more clarity.

4. Proposed Use of Unutilised PCIP Funding 2021-2023

4.1 Now we are in the final year we are planning on how to carry forward unspent funds from the earlier years of the programme. As this funding will not be recurrent we are proposing in PCIP 3 to use this funding for two main projects in 2021/22 and 2022/23. This funding amounts to £4.5m:

- Investment in upgrading of property of £3.0m reconfiguring the layouts of some of our health centres to provide additional treatment, consultation rooms and agile working space for services delivered by PCIP funding. This will address one of the main obstacles to the programme, which has been the lack of suitable accommodation. Discussions are underway within the HSCP and with NHS Greater Glasgow & Clyde Estates Team to supplement investment in these properties to provide an effective and efficient way of creating additional space, without the need to purchase and/or lease new premises. More detailed proposals are to be submitted to the Primary Care Implementation Leadership Group (ILG) and the NHS Capital Planning Group for approval.

- To provide funding of £1.5m in conjunction with the one-off additional expenditure of £0.600m from the Scottish Government to allow us to increase the number of practices supported by Community Links Workers by 81 for the next 18 months (66.4 whole time equivalent posts). At the end of the 18 month period the number of CLWs will decrease back to current 43 wte posts (covering 41 practices), unless additional recurring funding is made available by the Scottish Government.

5. Recommendations

5.1. The Integration Joint Board is asked to:

a) note the contents of this report;
b) Approve the attached PCIP 3.

Direction from the Glasgow City Integration Joint Board

1	**Reference number**	240321-09
2	**Report Title**	Primary Care Improvement Plan April 2021 onwards (PCIP 3)
3	**Date direction issued by Integration Joint Board**	24 March 2021
4	**Date from which direction takes effect**	24 March 2021
5	**Direction to:**	NHS Greater Glasgow and Clyde only
6	**Does this direction supersede, revise or revoke a previous direction – if yes, include the reference number(s)**	Yes (reference number: 080519-7-a) Supersedes
7	**Functions covered by direction**	Staff recruitment in support of priority workstreams as outlined in PCIP 3
8	**Full text of direction**	NHS Greater Glasgow and Clyde is directed to allocate the funding to take forward the priorities of the PCIP 3 as outlined in this report.
9	**Budget allocated by Integration Joint Board to carry out direction**	Budget allocation to carry out this direction is £18.792m as indicated in Table 1 of this report and in Section 5 of PCIP 3 (recruitment) and £4.5m (property upgrades and community links workers) as per section 4.
10	**Performance monitoring arrangements**	Performance to be monitored every 6 months aligned to reporting of Local Implementation Tracker to Scottish Government.
11	**Date direction will be reviewed**	September/October 2021

Glasgow City

Primary Care Improvement Plan (PCIP 3) 2021-2022 and beyond

March 2021

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6.0 Programme Summary

7.0 Appendices

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- Full text of the joint letter from the Scottish Government and the BMA

Section 1: Background

In 2017/18 agreement was reached by the Scottish Government and the Profession on the new GP contract. The **Primary Care Implementation Plans (PCIPs)** were intended to explain how this will happen in each HSCP area over a three years period until full delivery in 2021/22.

The new contract was introduced in April 2018 in response to the growing pressures within primary care that are threatening sustainability, such as growing demands on the service and concerns about GP recruitment, early retirement and retention. The aim of the contract is to enable GPs to operate as "expert medical generalists". This will be achieved by diverting work that can best be done by others, leaving GPs with more capacity to care for people with complex needs and to operate as senior clinical leaders of extended multi-disciplinary teams. The principal elements of the 2018 contract are:

- To re-design primary care services to enable longer consultations by GPs with people with multiple morbidities requiring complex care.
- For health boards to take on responsibility for GP leased and owned premises.
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- To provide new opportunities for practice staff-nurses, managers and receptionists to contribute to patient care.

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- Vaccination Transformation Programme
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- Pharmacotherapy
- Urgent Care
- Additional practitioners to expand multi-disciplinary teams in primary care, such as acute musculoskeletal physiotherapy services, community mental health services
- Community Links Workers

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The Scottish Government has requested completion by partnerships of a tracker every six months summarising progress since July 2018 and setting out scheduled spend and recruitment. The latest tracker is included as Appendix 1.

In December 2020 the Scottish Government and the BMA issued a "**Joint Letter - the GMS Contract Update for 2021/22 and Beyond**" (see Appendix 2)**.** A revised MoU is being drafted that will provide more detail on how these revised commitments will be implemented.

each health board/IJB is based on the use of the methodology developed by the National Resource Allocation Committee (NRAC).

Section 2: Stakeholder involvement

2.1 Stakeholder involvement with developing PCIP 3

In previous years we have undertaken a range of stakeholder engagement activities to report back on progress and to seek input to our future plans. For example, in September 2019 we held a number of events with primary care staff at Hampden Park as part of the mid-year review process. We have met with individual groups of practitioners, such as practice managers, practice nurses and GPs on a regular basis as part of our on-going participation and engagement programme. Individual workstreams have undertaken engagement activity on specific elements of their work.

As a consequence of the pandemic our opportunities for engagement have become more constrained, since we moved to on-line meetings and staff became very busy in responding to the Coronavirus. However, throughout the past year we made every attempt to keep stakeholders involved in the implementation of the programme and in developing different aspects of the programme. For example, we have representation by GPs and practice managers in our workstream groups.

As part of the preparation for PCIP 3 we held a development session with Cluster Quality Leads (CQLs) and Practice Quality Leads (PQLs)[2] in November 2020, that allowed us to explore their priorities for the investment and how we could reduce our estimated expenditure to ensure we do not exceed our final years' budget allocation. We followed this up with meetings with CQLs in each of the localities during January and February 2020 and asked them to seek the views of GPs in their clusters.

The PCIP Implementation Leadership Group (ILG) has continued to meet regularly over the past year and has allowed the HSCP to ensure that the Local Medical Committee and the GP subcommittee to be a core part of the decision making process. The ILG has overall leadership for planning, financial management and co-ordination of implementation at a city level and – combined with our locality engagement - ensures that the deployment of investment fits best with GP preferences as well as increasing effectiveness and matching local needs and circumstances. In 2020/21 this collaborative working at locality and city level has increased all stakeholder understanding of the challenges to deliver fully on the MoU commitments and to make best use of limited resources.

[2] NHS Circular
PCA(M)(2016)(7)
GP clusters – Scotland – A One Page Guide for GP Practices for 2016/17
GP clusters were introduced in Scotland with the 2016/17 GMS agreement between the Scottish GP Committee and the Scottish Government. The agreement specifies that each GP practice will have a Practice Quality Lead that will engage in a local GP cluster. Each GP cluster will have a GP designated as a Cluster Quality Lead who will have a coordinating role within the cluster. It is expected that GP clusters will have direct involvement and influence in improving the quality of all health and social care services provided to patients registered within their locality. This will include services that are not provided by GP practices in the community including those provided by secondary care.

2.2 Priorities identified by GPs

The following key messages were made by CQLs and PQLs when we discussed with them the future years' budgets for PCIP:

- A concern that the budget allocation for Glasgow City will not be sufficient to meet all the commitments in the 2018 contract and the MoU.
- Concern that some practices will have more support from PCIP than others and a strong view of the importance of equity in the share of resources across practices because the 2018 contract is for all GPs.
- Support for the priority to being given to the pharmacotherapy workstream.
- Strong emphasis on strengthening our approach to mental health with a preference that support should be based, wherever possible, by having mental health practitioners based in practices as per the MoU commitment.
- No consensus on whether or not reducing GP home visits as part of the Urgent Care workstream should be a priority for investment.
- A continued stress from GPs that the PCIP investment should be focused primarily on those interventions which have been shown to reduce GP workload and to free up their time so that they can operate fully as "expert medical generalists".

SECTION 3: Workstreams Progress and Plans

3.1 Vaccination Transformation Programme (VTP)

Background

The objectives of the Vaccination Transformation Programme is to transfer responsibility for delivering a range of vaccinations from GPs to NHS Boards/HSCPs. There are five 5 vaccinations included in the PCIP programme.

The overall Vaccination Transformation Programme (VPT) is coordinated at a NHSGG&C Board level, although we have a Glasgow group that oversees implementation in the city

Progress so far

Progress has varied across the different programmes. One of the main limiting factors for the adult flu programme has been the lack of a bespoke IT system for call and recall and data sharing arrangements between practices and the wider system. Detailed below is an update on progress and the future direction for the vaccination programmes;

Childhood Immunisation Programme

The Children's programme has been transferred fully to the HSCP and includes;

- Pre 5 Routine and School Immunisation Programmes, including flu is being delivered by HSCP staff by a dedicated team hosted by the North West Locality that covers the whole of the Board area.
- The HSCP delivered 2 to 5 year old Flu Vaccination Programme in 2020/21 using temporary staff contracted on a fixed term basis.

Adult Immunisation (Pneumococcal, Flu and Shingles)

Adult vaccinations is an extensive programme which is both age and risk based covering flu, shingles, pneumococcal, and the pertussis vaccine for all pregnant women. With progress being made at variable rates across the VTP programme as follows:

- From 2020/21 all the immunisations for pregnant women for pertussis are being delivered by Maternity Services.
- Adult Shingles and Pneumococcal remains with general practice and planning is underway for Pneumococcal to transfer to the HSCP in 2021/22. Shingles will only transfer when a non-live vaccination becomes available.
- Adult Flu – in 2020/21 a hybrid model was implemented because of the difficulty of providing mass vaccinations within the constraints imposed by the high levels of infection control that is now required because of the

Coronavirus, such as requirements related to social distancing. This hybrid model was comprised of:

- HSCP delivered vaccination to all over 65 years.
- Housebound patients – vaccination was delivered by HSCP teams with 141 practices opting into the programme for 2020/21. This cohort included carers of housebound patients eligible for vaccine
- For patients aged between 18 and 64 years who are "at risk" responsibility remained with general practices.
- 42 practices were unable to provide the vaccinations in their surgeries because of insufficient space to meet social distancing guidelines and these practices provided "vaccinator time" instead at HSCP clinics.
- A new cohort of patients aged 55 to 64 years was defined last year but the funding for these was not included in the MoU commitments or the original PCIP and in future will be dependent on funding and vaccinations being available.
- Community pharmacists were commissioned to provide a "mop-up" of patients who did not receive a vaccination in the first 3 months of the programme.

In 2020/21 staff were redirected from our Community Treatment and Care service to support the adult flu vaccinations and, therefore, we will need to consider how we recruit additional staff to deliver the programme for 2021/22 as it is unlikely that we will be able to re-deploy them for future years, without major disruptions to the delivery of CTAC services.

Travel Vaccination and Health Advice

A three tier model for travel health advice and travel vaccinations has been proposed nationally. Whilst planning continues, there is limited information available on the delivery of travel vaccinations and, therefore, no details of projected costs for this part of the programme to assess the implications for the final budget. The travel health advice will not be delivered by 2021/22

Looking ahead – 2021 and beyond

The "**Joint Letter - the GMS Contract Update for 2021/22 and Beyond**" issued by the Scottish Government and the BMA stated that:

"Vaccinations that are still in the core GMS contract under the Additional Services Schedule, such as childhood vaccinations and immunisations and travel immunisations, will be removed from GMS Contract and PMS Agreement regulations by 1 October 2021. All historic income from vaccinations will transfer to the Global Sum 2022-23 including that from the five vaccination Directed Enhanced Services[1]. Whilst our joint policy position remains that general practice should not be the default provider of vaccinations, we understand that practices may still be involved in the delivery of some vaccinations in 2022-23 arrangements. Where this is necessary, it will be covered on a new Transitionary Service basis to be negotiated by SGPC and the Scottish Government in 2021 and payments will be made to practices providing these services from 2022-23".

This presents the HSCP with a number of challenges and risks this year with delivering of this commitment:

- The main task in 2021/22 will be to manage the transfer of the Adult Flu Vaccination Programme from general practice to the HSCP.
- The delivery of the Adult Flu Vaccination Programme may need to be delivered in conjunction with the next roll out of the COVID vaccination programme. Delivering both programmes together could place pressures on our vaccination workforce.
- At this stage because we do not have an agreed model for delivery of the adult programme we are not able to quantify the delivery costs. Our current costs are estimates and any increases in the cost of delivery will need to be funded from the other workstream budgets.
- In 2020/21 some aspects of the programme were delivered by our CTAC service but the costs were not included in the VTP budget.
- We do not know what the transitional arrangements will be for those practices that will still be delivering this year, including arrangements for the funding.

3.2 Pharmacotherapy

Background

The MoU provides a commitment that by 2020/21 HSCPs will deliver the pharmacotherapy commitments of the new GP contract, with a pharmacotherapy service being established in every GP Practice. Every GP practice will be supported to deliver the “core” elements as described in the table below. Some areas will also benefit from a service which delivers some or all of the “additional” elements. The pharmacotherapy service will evolve over the three year transition period, with pharmacists and pharmacy technicians becoming an embedded member of the practice clinical teams.

CORE AND ADDITIONAL PHARMACOTHERAPY SERVICES		
	Pharmacists	**Pharmacy Technicians**
Level one (core)	• Authorising/actioning[15] all acute prescribing requests • Authorising/actioning all repeat prescribing requests • Authorising/actioning hospital Immediate Discharge Letters • Medicines reconciliation • Medicine safety reviews/recalls • Monitoring high risk medicines • Non-clinical medication review Acute and repeat prescribing requests includes/ authorising/actioning: • hospital outpatient requests • non-medicine prescriptions • installment requests • serial prescriptions • Pharmaceutical queries • Medicine shortages • Review of use of 'specials' and 'off-licence' requests	• Monitoring clinics • Medication compliance reviews (patient's own home) • Medication management advice and reviews (care homes) • Formulary adherence • Prescribing indicators and audits
Level two (additional - advanced)	• Medication review (more than 5 medicines) • Resolving high risk medicine problems	• Non-clinical medication review • Medicines shortages • Pharmaceutical queries
Level three (additional - specialist)	• Polypharmacy reviews: pharmacy contribution to complex care • Specialist clinics (e.g. chronic pain, heart failure)	• Medicines reconciliation • Telephone triage

PCIP 1 explained that to deliver the full requirements would be unachievable because of the insufficient funding and the difficulties in recruiting qualified staff within the 3 year timescale. Therefore, in PCIP 2 a number of developments were introduced with the objective to generate efficiencies in the service model:

- Adjusting the skill mix of the pharmacy workforce by increasing the proportion of technicians from 12% to closer to the national average of 28%.
- Developing a training programme for student pharmacy technicians.
- Recruitment of junior pharmacists.
- Introducing digital and remote working solutions to reduce duplication and increase efficiency by a more integrated approach to tasks, such as with medicines' reconciliation.

As a result of the first phase of the pandemic, the practice based pharmacy service was moved to a mainly remote working model. This remote working brought a number of benefits to working practices which will be useful to retain, although there are benefits also of practitioners having a physical presence in the practices to maximise contribution to effective patient care. The focus of work changed during the pandemic period, with fewer IDLs[3] and outpatient requests to action, and a focus on supporting the most important medicine related activities for practices and the population, e.g. anticipatory prescribing for palliative care and care homes patients.

[3] Initial Discharge Letters sent out by the hospital when a patient is sent home.

Progress so far

124 out of 143 practices now have additional input from PCIP-funded pharmacotherapy services. The implementation so far has been developed in collaboration with individual practices to reflect their specific priorities and, consequently the scale and nature of delivery may vary between practices.

By March 2021 most practices will receive some other aspects of level 1 work, the specifics of which will be agreed with the individual practice. Level 2 and 3 work is on-going in a proportion of practices. More practices will receive input from pharmacy teams during 2021/22.

Pharmacotherapy teams have developed a revised staffing model to include greater use of technicians and assistants and have commenced the implementation of **Pharmacotherapy Hubs** in each of the localities to make best use of limited resources and to make sure that all practices will receive some level of access to the service. An evaluation of the hub based at Stobhill Hospital which provides services for the practices in Springburn cluster, received positive feedback from GPs and made a number of recommendation that will help with further improvements. Other hubs have been developed in the North West Locality for Drumchapel practices and additional hubs are being developed for the South Locality (based in Clutha House) and North East (to be based at the social work training centre in Brook Street). The timescale for progressing these hubs will depend on the procurement of additional ICT equipment and, in the case of North East, the property being brought back into use.

All 143 GCHSCP practices have prescribing support input as part of NHSGG&C's pre-existing Prescribing Support Pharmacy[4] service. Existing PSP activities are at a level 3 (see table above), therefore, all practices benefit from partial level 3 activity. PSP activity is not funded by PCIP.

Looking ahead – 2021 and beyond

The "**Joint Letter - the GMS Contract Update for 2021/22 and Beyond**" issued by the Scottish Government and the BMA stated that:

"Regulations will be amended so that NHS Boards are responsible for providing a Level One Pharmacotherapy service to every general practice for 2022-23. Payments for those practices that still do not benefit from a Level One Pharmacotherapy service by 2022-23 will be made via a Transitionary Service until such time as the service is provided".

Based on the modelling we completed for PCIP 1 to achieve full delivery of the pharmacotherapy commitments in the MoU, would require approx. 2.5 wte[5] per 5000

[4] Prescribing Support Service – provides expertise in relation to efficient and effective prescribing practice

[5] Wte – whole time equivalent employee

registered patients and delivery of level 1, excluding repeat prescribing, would require 1.4 wte per 5000 registered patients. To scale this up across all GP practices in Glasgow would result in the need to recruit 229.5 wte pharmacy staff at a cost of £12.2m and the allocation of 65% of our PCIP funding to just one of the six workstreams. Furthermore, we have known since we consulted on our PCIP 1 that there are not enough pharmacists in the national labour market to meet this demand.

Glasgow City HSCP continues to work to revised skill mix based on a ratio of 2 Pharmacists to 1 Technician at a total cost of £5.5m for that will see us delivering approximately 50% of the commitments by the beginning of 2022/23. Ongoing review of the model and skills mix is taking place with possibility of working towards 1 Pharmacy to 1 Technician to provide further efficiencies

The constraints on full delivery (costs pressures, adequate cover for leave, available space and GP capacity for mentoring and staff turnover) have been highlighted in our first two PCIPs and these remain as challenges to meeting the commitment given in the original MoU and the joint letter.

Consequently, despite our on-going work to revise the staffing mix and delivery model, we will remain some way from delivering the full commitments by the end of 2021/22. By the end of 2021/21 we will need additional funding of around £6.7m, if we are to deliver on the full 2018 contract commitments.

3.3 Community Treatment and Care (CTAC)Services

Background

Community Treatment and Care services include non-GP services that patients may need, including (but not limited to):

- Management of minor injuries and dressings
- Routine phlebotomy
- Ear care
- Suture removal
- Chronic disease monitoring and related data collection

The 2018 GP contract notes a shift of workload into Community Treatment and Care services. The new contract states that there will be a three year transition period to allow the services that are currently delivered by GP practice staff to transfer to HSCPs. It was expected that by April 2021, these services will be commissioned by HSCPs and delivered in collaboration with NHS Boards as they will employ and manage appropriate nursing and healthcare assistant staff. Phlebotomy services will be delivered as a priority in the first stage of the primary care improvement plans. The second stage will be to transfer other aspects of work currently delivered by GPs to the community treatment and care services.

At the time of publishing our first PCIP there was insufficient detail on what the final model of CTAC services would look like and PCIP 1 explained that the service would be developed in stages as the detailed requirements became clearer. At that stage

we made a rough estimate that the final cost would be in the region of £2.5m per year.

By the publication of PCIP 2 an NHSGG&C model for phlebotomy services had been developed which would require us to recruit phlebotomist on a ratio of 1 phlebotomist for every 8,000 registered patients. This revised modelling resulted in a significant growth in the size of the projected workforce to 90wte posts and, consequently a need to shift additional funding to the CTAC workstream.

In PCIP 2 we gave a commitment to review the leadership, management and administration structure that would be needed to support a substantially larger CTAC service than we had planned at the beginning of the PCIP programme. This review has resulted in a revised skill mix for the service.

Progress so far

In spring 2020 phlebotomy support was opened out to all practices and accessed via a Single Point of Access telephone line and SCI Gateway referral System with around 2,300 patients being seen per week in clinic and domiciliary service in January 2021; demand has often outweighed supply for the service. The use of the phlebotomists is dependent on practices accessing this service and is often better utilised by those practices based within the health centre setting who had previously used the service.

Current staffing of phlebotomy is with 63.4wte staff and since April 2020 all practices have accessed CTAC service i.e. phlebotomy and / or treatment rooms albeit at varying levels. From April 2020 to end January 2021, 65,570 patients have been seen either in clinic or at home by phlebotomy with developments largely dependent on the availability of accommodation and revised ways of working due to responding to Covid 19. We are scoping the feasibility of delivering phlebotomy services from other (non-health centre) settings. This could include a hybrid model which means that as well as operating the preferred hub model in health centres, some practices could have access to dedicated phlebotomy sessions within their surgeries.

As with phlebotomy, the care and treatment service model continues to be developed and is projected to double in size by the end of the PCIP programme. There were 69,816 treatment room appointments between April 2020 and the end of January 2021. The availability of accommodation remains one of the main issues to be addressed with business cases being prepared for some locations in the city as part of a work programme to reconfigure the room layouts in our health centres.

During the pandemic CTAC staff have been deployed across the board area to support the provision of mainstream community nursing and vaccinations (i.e. Adult Flu & Covid 19 vaccinations) with a reduced CTAC service continuing to be maintained wherever possible, within the constraints imposed by social distancing requirements. A domiciliary service (including phlebotomy) was delivered to care for patients who could not leave their homes.

Looking ahead – 2021 and beyond

The "**Joint Letter - the GMS Contract Update for 2021/22 and Beyond**" issued by the Scottish Government and the BMA stated that:

"Regulations will be amended so that Boards are responsible for providing a community treatment and care service for 2022-23. Where practices do not benefit from this service, payment will be made via a Transitionary Service basis until such time the service is provided".

The enhancement in the phlebotomy workforce and the revised skill mix in the overall CTAC service has resulted in a higher cost model of service that will need to be financed from the PCIP budget. During 2020/21 we temporarily suspended further recruitment because of the growing costs and this has provided time to evaluate the model, to revisit the demand and to further refine the final service and staffing model.

As part of the pandemic remobilisation plans NHSGG&C is planning that bloods required for patients receiving care from the acute hospitals as outpatients, should be taken in community settings. Close collaboration between the acute and HSCPs will be required to ensure that both programmes of change are delivered efficiently and effectively.

Despite our plans to recruit around 193wte staff work revision to staffing skill mix will result in possible reduction to 180wte at a cost of £5.5m we are predicting that, whilst all practices in Glasgow will have access to CTAC services by the end of the programme this is unlikely to meet the expectations of all practices.

3.4 Urgent Care

Background

The MoU set out the benefits of utilising advanced practitioners (such as advanced nurses – ANPs - and advanced paramedics) to respond to urgent unscheduled care within primary care, including being the first response to a home visit or responding to urgent call outs. The MoU explained that the health and social care partnership should collaborate with GPs to determine the best provision for their locality. By 2021, the plan was that here should be a sustainable advanced practitioner provision in all HSCP areas based on an appropriate local service design.

In PCIP 1 we noted that the feedback from the consultation with GPs in Glasgow was that they were not particularly attracted to the urgent care model adopted in the test of change in Inverclyde, which used paramedics or ANPs for urgent home visits. Glasgow City GPs did recognise, though, the on-going shift in the provision of urgent care towards community and primary care, with an increase in the complexity of care for those patients who are managed at home and in residential and nursing home settings. In respect of residential and nursing home settings, GP's indicated that there could be potential to reduce their workload by providing support in these settings.

Progress so far

During 2018-19 we recruited Band 7 ANPs to work alongside existing district nurses to reduce the need for unscheduled GP visits to patients in our five provided residential care homes.

At the moment 72 out of the 143 practices with registered patients in GCHSCP residential care homes have access to this new ANP service. We know that these ANPs have made a significant impact on reducing the time that GPs need to spend on call outs to our care homes as well as improving the quality of care for patients. Between Sep to Dec 2020 the ANPs provided 2054 nursing interventions resulting in GP time saved of 454.85 hours during this period. The impact for individual GP workloads will however depend on the number of care home patients that are registered with a specific practice.

The ANPs made a significant contribution to the care of residents during the pandemic because of the complex and end of life needs and ANPs supported residents, families, care home staff and other health professionals.

In response to the difficulty in recruiting fully qualified ANPs we have recruited nurses who are part qualified, on the basis that they will progress to complete the full course once employed.

As part of the urgent care workstream we worked with practices to raise awareness of the 'Knowing Who To Turn To' publicity materials and supported practices to improve the management of unscheduled care through adopting work flow efficiency and care navigation approaches.

Looking ahead – 2021 and beyond

Recruitment has taken place as planned for 2020/21 for trainee ANPs**.** Trainee ANPs have commenced the ANP Education Pathway September 2020 and we expect them to graduate between September and December 2021. Work is underway to agree how these additional nurses will be utilized by practices and we are recruiting a band 8a to provide the clinical leadership for the team.

The "**Joint Letter - the GMS Contract Update for 2021/22 and Beyond**" issued by the Scottish Government and the BMA stated that:

"Legislation will be amended so that Boards are responsible for providing an Urgent Care service to practices for 2023-24. Consideration will need to be given about how this commitment fits into the wider Redesigning of Urgent Care work currently in progress".

In our PCIP 1 we estimated that, to provide ANP/paramedic practitioners to cover the urgent home calls for all practices in Glasgow we would need to recruit 55 wte ANPs at an estimated cost of £2.8m per year We will need to consider what the implications of this proposed amendment to the legislation may be, given the potentially substantial cost of providing an ANP/paramedic service to all practices in the city and the difficulties in recruiting fully qualified and experienced practitioners.

3.5 Additional Professionals for Multi-Disciplinary Teams (MDTs)

Background

The 2018 GP contract represents the start of a transformation of general practice, with the development of multi-disciplinary teams working as part of practices to ensure that patients can access the right professional at the right time. Teams will be based in or near to GP practices and working with either individual practices or groups of practices. By 2021 specialist professionals will work within the local MDTs to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs within an agreed model or system of care. The specific working arrangement and profile of each team will depend on local geography, the demographic profile of the practice population and levels of demand for services. The new GP contract includes MSK physiotherapist and mental health workers as examples of the practitioners who could be part of the teams.

Progress so far

We have so far recruited MSK physiotherapy practitioners and contracted with voluntary sector organisations to provide the Community Links Workers for practices. At this stage we have not agreed a model for the mental health workstream. More detail on progress and our future plans for the individual professional roles are outlined in the following sections. We have been working also as part of the Primary Care Programme Board to develop a package of support for general practice to help them develop further their MDT working.

Looking ahead – 2021 and beyond

The "**Joint Letter - the GMS Contract Update for 2021/22 and Beyond**" issued by the Scottish Government and the BMA stated that:

"Additional Professional Roles (e.g. Mental Health Workers, Physiotherapists, Community Link Workers) – The pandemic has highlighted the need for early local intervention to tackle the rising levels of mental health problems across all practices as well as the challenges in areas of high health inequalities. Working with Health & Social Care Partnerships and NHS Boards, we will consider how best to develop these services at practice level, and establish more clearly the 'endpoint' for the additional professional roles commitment in the Contract Offer by the end of 2021".

We will await the outcome of these discussions with the Scottish Government. In our previous PCIPs and in our regular updates we have highlighted that the main challenges with delivering on this commitment are the insufficient resources to enhance MDT provision for all 143 practices in the city, the lack of qualified and experienced practitioners that are available in the labour market and insufficient space with some surgeries.

Additional Professionals for Multi-Disciplinary Teams - Community Link Workers

Background

PCIP 1 outlined how we would deliver the national programme to increase the number of Community Link Workers (CLWs) within those practices serving some of the most deprived patient populations.

Using the NRAC formula for allocating funding across health boards we have been able to fund 43 Community Links Workers. Given the magnitude of the health inequalities and health problems experienced by Glasgow's residents, we would prefer to see an increase in the number of Community Links Workers to cover all GPs, especially those serving patients living in the most deprived neighbourhoods**.** Our ability to do this will depend, though, on additional recurring resources being made available by the Scottish Government.

Progress so far

We have exceeded our original target of providing 35 CLWs. We now have 43 CLWs providing support to 41 practices and 2 thematic themes based i.e. youth health, and asylum seeker and refugee communities.

In Q1 and Q2 of 2020/2021, CLWs received 2,414 referrals with 12,233 appointments to support 2,913 patients i.e. new and existing patients. In quarter 2 of 2020/21, 77% of individuals had a statistically significant improved wellbeing score at exit from support, whilst the remainder showed no improvement or a decline. A decline in score is recognised as a potential outcome for people who are experiencing health difficulties and embarking on change. Where a decline is detected for an individual, the Link Worker makes sure the individual has a clear plan of action in place, including onward referral and signposts.

Patient Feedback:

Patients continue to provide feedback on their experience of being supported by Community Link Workers, some quotes from patients include:

'There really are no words that could be used to explain my appreciation, wonderment at you professionally helping me from below ground zero until today'

'Y was a great help to me during a very stressful time in my life, there were times I didn't think I could get through the day but Y was always at the other end of the phone to talk to me and help me realise I wasn't along. Y is the reason I am here today'

'W is amazing and has always the best interest of the person she is dealing with. Very approachable and very professional'

'I am still experiencing the same anxiety symptoms, but X has been helping me with these issues going forward'

'V helped push my comfort zone and come up with alternatives I hadn't thought of. I'm a work in progress but at least now a bit further down the line'.

Looking ahead – 2021 and beyond

In PCIP 2 we said that we would continue progressing negotiations with the Scottish Government to seek additional investment in CLWs in Glasgow, given the large scale of deprivation and inequality in the city. Based on the original national modelling, there was an expectation that Glasgow city would require 70 CLWs for the 80 practices serving the most deprived areas.

The Scottish Government recently allocated additional non-recurring funding of £0.600m to finance CLWs for the period 2021/22 to 2022/23. During February 2021 we agreed to provide additional PCIP funding to enhance this two year extension by using funding that was not used in the early years of the programme. We will continue also to bid for additional recurring funding, so that we can make a longer term commitment to GPs.

The CLW extension programme continues to have a deprivation focus and practices will be identified using a ranked score (combination of % of practice population living in 20% most deprived data zones and number of patients living in the 20% most deprived data zones).

A revised allocation of CLW has been developed for the programme extension. Practices who are part of the programme will receive an allocation of a whole time equivalent CLW resource based on total practice list size – ranging from 0.5 to 1.0 WTE. This will allow us to recruit an additional 23.4 CLWs to provide coverage across a further 6 clusters (40 additional practices). For the next two years only, the total programme cost will rise from £1.950m in 2020/21 to £2.845m in 2021/22 and £3.150m in 2022/23. After this two year period the funding will revert to £1.950m unless additional recurring funding is received from the Scottish Government. A summary of the funding is shown in the table below:

Funding source	Current	2021/22 (£m)	2022/23 (£m)	Recurring (£m)
Existing PCIP	1.950	1.950	1.950	1.950
Unutilised PCIP from previous years		0.595	0.900	
Scottish Government additional funding		0.300	0.300	
Total funding	**1.950**	**2.845**	**3.150**	**1.958**
Practices provided with support	**41**		**81**	**41**

Additional Professionals for Multi-Disciplinary Teams
- Mental Health and Wellbeing

Background

The 2018 GP contract proposed that “Community clinical mental health professionals (e.g. nurses, occupational therapists), based in general practice, will work with

individuals and families assessing their mental health needs, providing support for conditions such as low mood, anxiety and depression. The outcome sought would be improved patient care through rapidly accessible, appropriate and timely mental health input".

The intention was for a "close cross over" with the primary care component of the Action 15 mental health funding. The Action 15 allocation letter advocated taking a flexible and broad ranging approach to providing additional mental health capacity and that PCIPs should show how mainstream mental health services will improve integration with primary care.

Responding to the mental ill health and distress of their patients is a significant component of GP workload, in which patients presenting with low mood, anxiety and depression would often be unable to have their issues fully resolved by the GP, thus resulting in an outcome whereby patients keep returning for help. The demand on GPs to care for patients with mental and emotional health problems has increased as result of the pandemic and there has been a consistent message from GPs that they need more help.

Progress so far

Our approach was to develop a mental health and wellbeing model which would:

- Provide a more comprehensive response to patients presenting with low mood/anxiety and depression through the development and implementation of a mental well-being programme.
- Respond to unplanned emotional distress presentations in primary care.
- Improve patient care pathways components between primary care and specialist mental health services.

We have not used the funding from PCIP to embed mental health workers in practices as it would not be achievable within the existing PCIP resources to provide every practice with a dedicated worker. Instead additional services have been funded to provide practices with access to mental health and wellbeing help for their patients. This has included Lifelink services, expansion of the Youth Health Service for young people and the in-hours Compassionate Response Distress Service (CRDS) for primary care.

While our approach may not deliver the type of "in-house" practitioner support that some practices aspire to, it has contributed to the reduction in waiting times for patients to access support. More detail on the services is outlined below:

- Lifelink received 2,590 referrals from April-September 2020**.** These referrals comprised 70% of self-referrals, 25% from other services and 5% from GPs. 65% of self-referrals were made after the patients heard about the service from their GP. 5943 appointments were offered. The remaining 35% referrals come from other services.
- The CDRS service launched in September and in the first 2 months 54 practices have accessed the service for their patients. The service contract is to receive and deal with 1000 referrals a year, therefore the activity by

January 2021 of 1613 patient referrals was already in excess of the contract limit. Additional funding was agreed to February 2021 to extend the contract to enable a service for the additional patients.

- Youth Health Service – PCIP funding provides a contribution to the overall cost of expanding the YHS from the North West Locality to sites in North East and South. In February 2020, the provision of the Youth Health Service was increased to 2 additional sites (Gorbals and Shettleston) to create a total of 5 service locations in Glasgow (Maryhill, Possilpark and Drumchapel). We have plans that by this summer there will be a further extension to 2 further sites by the early summer (Springburn and Govan). Whilst referral numbers fell initially during COVID, they have increased to approximately 20-25 consultations per evening.

Lifelink Patient Feedback:

"I am very happy with the service. You have helped me so much. I feel that a weight has been lifted from my heart. I am feeling happy and positive about my life. It made a big difference speaking to a deaf counsellor. I felt I could be myself and you were so easy to understand (your signing). Thank you so much."

"Lifelink has changed my life. I cannot thank you enough to have been given the opportunity to have counselling with another deaf person who can communicate with me and understand."

"Therapy has been really helpful. I felt a real trust with the therapist, and he provided really tangible ways of perceiving things in a fresh way for myself. I feel like the pieces of the puzzle are coming together for me now, and I feel very inspired."

"I'm really grateful for the quick response, it meant I got the help when I needed it. I'm also really grateful for how you helped me rethink my thought process, it was good to know there was someone I could speak to about things in confidence".

CDRS Patient feedback;

'*Before this happened I would probably slag off people who said talking helps, but it has really helped me. If it wasn't for you I don't know where I'd be, maybe six feet under*'

'I feel like I can see a glimpse of light now. I feel very relaxed and able to talk to you about things I have never spoken about, you just make me feel comfy and safe…without you I wouldn't be here, I couldn't cope. I'd be dead.'

'Compassionate Distress Response Team was an absolute life-saving service for me. For months, I had CPNs, psychologists, psychiatrists, doctors, and hospital staff brush off and not take seriously the level of distress I was in….(CDRS worker) has honestly been an angel sent from the sky and has saved my life in more words than I can express'

Furthermore, a number of other initiatives were agreed as part of PCIP 2. A summary of the current position is shown below:

- Support for practices and clusters of practices to develop their local pathways into mental health and wellbeing supports – delayed because staff were re-deployed as part of the pandemic response.
- Training for staff in how to respond to patients suffering from bereavement (being delivered digitally) and resources distributed to all practices.
- Learning on prescription – the test of change was delayed because of lockdown.
- Completion of research into the needs of people presenting to primary care in distress and trauma-informed practices.
- Live Active pilot – the test of change was delayed because of lockdown
- Employability – not agreed for PCIP funding but alternative sources of finance being investigated.
- Embedded Financial Advice in practices – not agreed for PCIP funding but alternative source of finance was identified to continue service on a temporary basis.

Looking ahead – 2021 and beyond

Responding to the mental ill health and wellbeing of patients attending primary care services has been highlighted as one of the priorities by GPs because of the increasing number of patients who are presenting with these problems, and the expectation that this number will increase as we move towards recovery. Our priorities are, therefore:

- Collaborate with adult and children's mental health services to develop a new model of working between primary care, specialist mental health and the voluntary and community sectors in line with the recommendations of the Scottish Governments Short Life Working Group for Mental Health in Primary Care. Our ambition is to create multi-agency teams at neighbourhood level to provide advice, support and some levels of treatment for people who have mental health, distress or wellbeing problems.
- As part of the Mental Health and Primary Care Oversight group ensure that we establish a joined up approach to improving mental health and wellbeing services in primary care.
- Continue investment in the existing commissioned services until the completion of the current contracts. We will continue to review the longer term need to fund these contracted services as part of our development of neighbourhood mental health teams.

Additional Professionals for Multi-Disciplinary Teams - Physiotherapy

Background

PCIP 1 explained that in order to meet the requirements of the contract in Glasgow, we estimated that we would need to fund 51 wte advanced physiotherapy practitioner (APP) posts. In anticipation that we would struggle to recruit this number of APPs, we planned a more conservative plan that would see us increasing the number practitioners to 22 by March 2022.

Progress so far

By 31st December 2020, 30 practices had additional resource from 10.2 wte advanced practitioners. On average 1,370 patient were being seen per month with 61% of patients having been redirected from the GP reception. 86% of patients were supported to self-manage their condition and 14% were offered an onward referral (11% for MSK Physiotherapy treatment)

In response to the constraints on resources (both money and staff) and the lack of clinical space in some smaller practices, a pilot project to run an APP hub in the North West Locality was established in late 2020.

Looking ahead – 2021 and beyond

As part of the review of funding we have placed a halt to further recruitment and funding will be made available only to finance existing posts.

The hub in the North West will be evaluated and, if it proves successful we will give consideration to how this approach could be scaled up to cover additional practices.

Additional Professionals for Multi-Disciplinary Teams - Occupational Therapy

In PCIP 2 we planned to undertake a test of change by funding the embedding of OTs in general practice, initially within 2 practices in the one area for a 12 month period. If successful this would be extended to further practices during 2020/21. However funding for OTs was not supported by the Implementation Leadership Group because there was a view that we should be focusing resources on the other elements of the MoU. We agreed to continue to consider evidence from other parts about the impact of OTs in primary care.

Section 4: Infrastructure and Support for Implementing PCIP

4.1 Sustainability

In PCIP 2 we gave a commitment to establish a systematic approach to gathering and analysing intelligence on practice sustainability and to use this evidence to provide targeted and bespoke support for practices which were shown to need help. Given the impact of the pandemic these actions were not progressed, although they are likely to feature in our longer term plans for supporting practices in Glasgow.

4.2 Collaborative Leadership and Learning

Background

Over the 2018/19 we considered the collaborative thinking and leadership approaches that are needed to develop the relationship skills to develop trust and respect to deliver on new ways of working. A leadership group was set up to share learning approaches to the changing issues arising from the PCIP, to coordinate learning activity and to identify stakeholder engagement that will be necessary to support changes in values, attitudes and behaviours.

In PCIP 2 we recognised the need to consider the readiness for change and how embedding additional staff in the practice processes leads to success. This is supported by the recruitment of a workforce with the relevant value set and skills, matching them appropriately with practices, taking an integrated MDT approach, while being able to support an evolving process and at each step sharing the learning, with a need to understand the roles and relevance of what each profession brings to the expanded MDT. This requires risk sharing and delegation within practice teams by creating time and space to have discussion, collaborative thinking and support in order to implement transparency and honesty, while developing effective and efficient working tools and embedding them into practice.

Progress so far

A draft programme of support was initially proposed in 2019/20 and further developed in an Organisational Development (OD) Plan in 2020/21 with options for practices, clusters and other stakeholders, covering both individual and team development needs. Unfortunately, the pandemic resulted in delays to some aspects of this programme but it will be included in our new PCIP Organisational Development Programme which we intend to launch in 2021/22.

We continue to provide organisational development advice, interventions and 121 coaching, which have been focused on stakeholder and staff engagement, stakeholder management, team development, managing change, leadership behaviours and approaches, difficult conversations, influencing techniques and coaching approaches.

Development programmes have been delivered. The ‘You As a Collaborative Leader’ (YACL) Programme ran 3 cohorts and was offered to all practices and 47

staff from practice MDTs[1] took part in the programme, which we now intend to deliver future cohorts.

We ran an online "Strategic Influencing for Change and Engagement" programme with a mix of GPs and senior HSCP managers. This was the first cohort to take part in the course and our intention is to offer this to course to further cohorts early in 2021/22.

As part of the board-wide programme we have been developing a framework to support general practices with MDT working.

Early in 2020-21 PASC[2] Programme was offered to all practices in Glasgow with 27 taking up the opportunity in cohort 1 and a further 21 practices in cohort 2. COVID 19 did however impact adversely on the progress of both "Care Navigation" and "Workflow Optimisation" as patient attendances at practices reduced significantly; there was a national relaunch of the "care navigation" element of the programme in October 2020 and the Glasgow City PCIP team will support this initiative.

Looking ahead – 2021 and beyond

Key actions will be:

- Implementation of our Collaborative Leadership and Learning Programme and OD plan.
- Delivery of support for practices to help develop and sustain multi-disciplinary team working.
- Support for the relaunched PASC programme.

4.3 Premises and Space Planning

Background

The NHSGGC Property and Asset Management Strategy includes independent contractor -owned and -leased premises. Oversight of GP premises developments is provided through the board's GMS Premises Group which reports to the overarching Primary Care Programme Board.

In Glasgow there are 143 practices located in a combination of health centres and GP owned/leased premises. However, the amount of capital funding available to provide and or improve accommodation for the additional staff has been a major constraint on our ability to embed PCIP funded staff within or near GP practices.

Consequently, since PCIP 1 we have indicated that we would need to invest to improve and expand accommodation and the Scottish Government has awarded additional expenditure in previous years to fund work to upgrade both GP owned/leased premises and HSCP health centres. However, we anticipate that

[1] Multi-disciplinary Teams

[2] Practice Administrative Staff Collaborative in Primary Care

significant additional investment will be required in 2021/22 and possibly in the longer term to implement fully our premises' improvement plan.

Progress so far

A comprehensive programme of backscanning has been undertaken to free up space within practices for more clinical and administrative space to be provided, as well as supporting digital infrastructure through the removal of paper records.

All 143 practices will have had their patient records backscanned completion by end March 2021 and by early to mid-April 2021 all NHSGG&C practices will no longer receive paper records from Practitioner Services as patient records are being digitised at the point of transfer. We will commence a "mop-up" exercise to collect any records accumulated by practices since they have been backscanned and will collect any remaining paper records and have these digitised, thereby eliminating paper records being held in the practices.

Progress on issuing improvement grants was delayed as a result of the pandemic and a review of initial requests from practices has been reviewed. 7 practices received full improvement grants for PCIP-related work in 2019/20 at a cost of £83,419 and in 2020/21 3 practices are being reviewed at a potential total cost of £47,195.

Given the requirement for additional clinical space for services and staff funded by PCIP, we commissioned a feasibility study into the potential to make better use of the spaces in health centres. We have identified work in 6 health centres as a priority to support the expanding programme, especially to facilitate the extension of Community Treatment and Care Services and the vaccination programmes.

Other aspects of the 2018 GP contract include the Scottish Government's commitment to provide sustainability loans for option for NHS Boards to take on the leases for practice accommodation. At the time of writing this plan:

- 23 sustainability loan agreements for practices in Glasgow were agreed by the Scottish Government and work is in progress to conclude the loans imminently with central legal office and the practices' legal representatives.
- 5 expressions of interest from practices seeking assignation of leases and NHSGGC are in the process of developed to ensure meets HSCP strategic direction

Looking ahead – 2021 and beyond

Our priority will be to progress the work to re-model the internal room layouts in a number of health centres to create additional consulting, treatment room and agile working space to provide additional clinical and office space for staff and services that have been developed using the PCIP funding. Our priorities will be Shettleston, Bridgeton, Baillieston, Govanhill, Govan/Elderpark and Thornliebank Health Centres. We will then investigate options for health centres in the North West. Capital funding from the PCIP budget will be required to fund this work along with match funding from the HSCP and/or NHSGG&C.

A property strategy survey to include all health centres, social work services and independent GP premises in Glasgow will be developed over 2021 and, for all capital developments (as we did with north east hub in Parkhead) we will contact local GPs to offer them space in our future developments.

4.4 Patient Engagement

Background

During 2018-19 we used the public participation and engagement infrastructure in each of the three HSCP localities to seek views on the priorities in the PCIP. One of the key areas for improvement will be to engage with patients and carers about the changes they will see over the next few years in their GP practices.

Progress so far

In PCIP 2 we committed to use the Locality Engagement Forums as a means to continue this dialogue and further work with clusters to consider ways in which we can support GP practices to engage with their patients. We worked with the locality forums initially to consider new ways of engagement and we received valuable contributions to how we should present PCIP public information literature; unfortunately, this activity had to be suspended at outset of the pandemic.

Looking ahead – 2021 and beyond

We require to further engage patients and carers in primary care as part of the wider participation and engagement activity of the HSCP (for example as part of the development work on Maximising Independence), the health board and the Scottish Government.

We are keen to hear to the views of people with complex and chronic conditions as their care needs can be the most challenging to manage and will provide the greatest test for joint working of GPs and the extended multi-disciplinary teams.

4.5 Digital Infrastructure

Background

Within NHSGGC, the eHealth team works in conjunction with HSCPs in the introduction of new services and processes within practices. This ensures where possible the standardisation of approach, provides a fit to the Digital Strategy, promotes the use of core systems and minimises cost overheads. Since the initial consultation on our PCIP 1, GPs have told us that a joined up IT system is vital for the success of the programme.

The Scottish Government has made available additional funding for ICT for general practice. NHSGG&C will use the funding to upgrade desktop computers, increase

the number of webcams and extend Microsoft support. These investments will support practices to undertake remote consultations and facilitate virtual multi-disciplinary team meetings.

The 2018 GP contract introduced a joint data controller arrangement between Health Boards and GP Contractors. The PCIP plans highlighted the need to develop MDTs supported by robust information sharing agreements with all practices for the delivery of clinical care, for audit and review purposes and for service, workforce and public health planning.

Progress so far

In 2019-20 the Scottish Government allocated £0.684m to invest in GP ehealth initiatives in NHSGG&C and this was used to enhance WIFI provision and to facilitate the use of Attend Anywhere/Near Me for remote patient consultations.

Many of the practitioners recruited from PCIP have worked from home remotely during the pandemic and this was facilitated via investment in additional equipment. However, there are indications that delays in procuring laptop equipment because of the global demand is hindering our ability to support remote working for our new PCIP funded staff.

An information sharing agreement that sets out the rules to be applied by a Health Board and a GP Contractor when sharing information has been progressed since PCIP 2, with data controller posts created by NHSGG&C to support HSCPs and general practice understand and sign up to the data sharing agreement.

Looking ahead – 2021 and beyond

A further investment of £2.107m is being made across practices in NHSGG&C that will further increase WIFI provision in practices, provide further support for online consultations, upgrade personal computers and extend software support.

Some of the key on-going developments that will support the transformation in primary care will be the implementation of the new GP IT system and further advances in the collation and use of data on primary care activity to support service improvements.

4.6 Evaluation

Background

During 2018/19 work was undertaken across NHSGG&C on behalf of all six partnerships to develop a proposal to evaluate the implementation of our PCIPs. The work in GCC is structured around six questions, using quantitative and qualitative methods, aimed at measuring the impact on GP workload, patient and professional satisfaction, better patient outcomes and navigation of new systems, improved equality and wider effect on health and social care.

In addition, there has been on-going monitoring and evaluation activity in each of the 6 MoU priority workstreams.

Progress so far

A detailed brief for the evaluation work was prepared by Public Health colleagues but was put on hold as a consequence of the pandemic. A short life working group was established in December 2020 to progress the evaluation work and is reviewing which aspects of the original brief could be undertaken during 2021. It is likely that this will be an interim evaluation as the pandemic

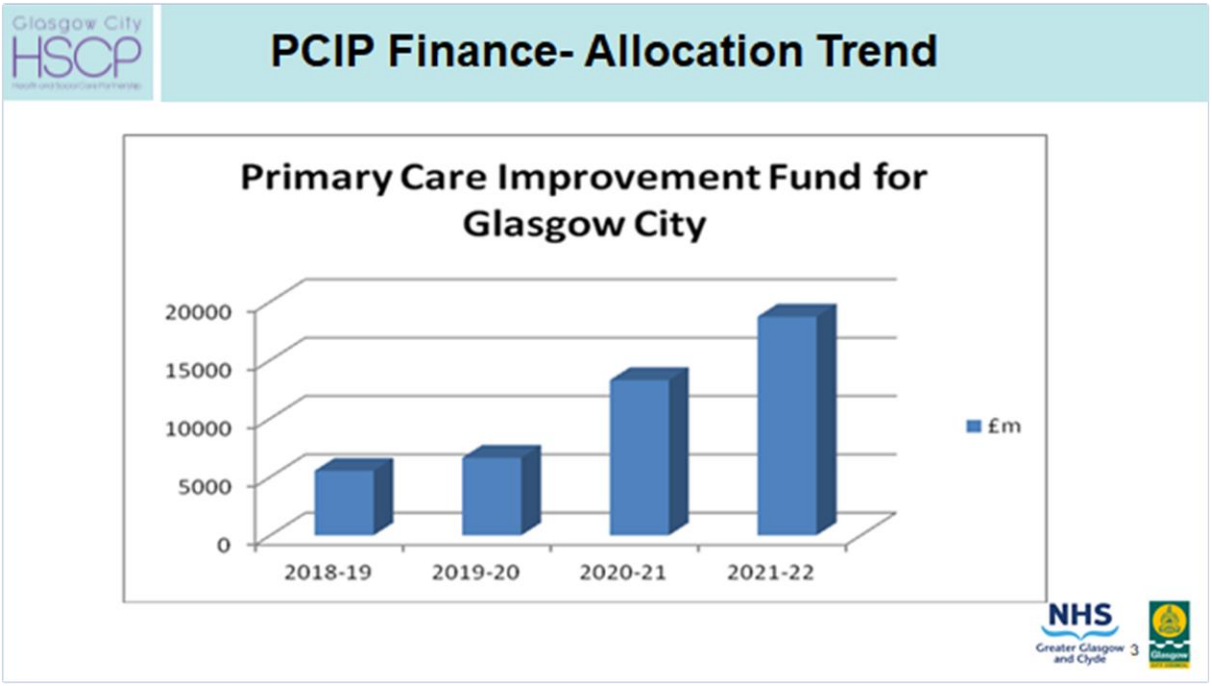
Looking ahead – 2021 and beyond

We will progress an interim evaluation during 2021/22 to consider practitioner and patient experience of the impact of the PCIP investment.

SECTION 5: Financial Plan and Workforce Plan

Financial Plan

The graph below shows the original estimated allocation of PCIP funding per year since 2018/19. The funding was shown to increase year on year from approximately £5m in 2018/19 to £18.792m in 2021/22 and our expectation is that the future recurring annual funding from April 2022 onwards will continue at £18.792m.



Previous Financial Planning Assumptions (PCIPs 1 and 2)

In the first PCIP our preliminary estimates identified that our projected level of spend to deliver the full programme could breach the end point funding allocation of £18.792m and this assessment was confirmed by the time we published PCIP 2. In PCIP 2 we recognised the need to review projected expenditure to bring in line with final year's funding allocation.

Early in 2020 we presented our financial planning assumptions to the Scottish Government and these showed that our planning assumptions would mean the expenditure in the final year of the programme (in 2021/22) would reach £22.313m, against an expected allocation from the Scottish Government of £18.792m.

Indeed, the funding of £22.313m would not allow us to fully implement the MoU but was considered a reasonable estimate at that time of what could be delivered within the initial three to four year timeframe. In previous financial plans we have estimated that to achieve the objectives of the MoU could cost in the region of £33.6m.

Our estimates included the costs of the 6% uplift to superannuation and highlighted the need for additional funds to cover both this and the annual pay uplifts.

Table 1 Revised Projected Spend for PCIP Programme

In view of the likelihood that we will over spend our allocation by the end of the 2021/22, we have re-prioritised the workstreams and reduced projected expenditure. These changes were discussed with CQLs at a number of meetings between November 2020 and February 2021. The outcome of this exercise is shown in table 1 below and demonstrates how we have reduced our estimated expenditure in 2021/22 from the previous planning figure of £22.313m to £18.792m.

Workstream	Previous Planning Assumptions (£m	Revised Estimate(£m)	Changes	% share of budget
Vaccination Transformation Programme	2.550	2.550	0.000	13.57
Pharmacotherapy	5.500	5.500	0.000	29.27
CTAC and Phlebotomy	5.674	5.500	-0.174	29.27
Urgent Care	1.136	0.660	-0.476	3.51
Community Links Workers	2.350	1.950	-0.400	10.38
Mental Health	2.000	2.000	0.000	10.64
Advanced Practice Physios	2.458	0.660	-1.798	3.51
Occupational Therapists	0.264	0.000	-0.264	0.00
Core support	0.381	0.381	0.000	2.03
Allowance for staff turnover		-0.409	-0.409	
Total	**22.313**	**18.792**	**-3.521**	**100.00**
Expected SG Funding	18.792	18.792		
Difference	**3.521**	**0.000**		

The assumptions underpinning the changes shown in table 1 are summarised below:

Vaccination Transformation Programme - No change in budget at the moment but it may need to be increased once the actual costs of delivering the adult flu programme are known.

Pharmacotherapy – Continue as per existing programme

CTAC and Phlebotomy - Recruitment paused to allow review of model and to ensure costs do not exceed budget.

Urgent Care - No further recruitment. Budget to cover existing approved posts only.

Community Links Workers – Additional non-recurring funding of £1.5m has been allocated in conjunction with the one-off additional expenditure of £0.600m from the Scottish Government to allow us to increase the number of practices supported by Community Links Workers to 81 for the next 18 months. This will increase the number of CLWs to 81. At the end of the 18 month period the number of CLWs will decrease back to current 43 unless additional recurring funding is made available by the Scottish Government.

Mental Health - Future model being explored. Approximately £1m per annum has been committed for next 2 years with existing contractors.

Advanced Practice Physiotherapists - No further recruitment. Budget to cover existing approved posts only.

Occupational Therapists - This workstream was not agreed for funding, therefore, no funding will be needed.

Project management support – Retain at current level on basis that the nature and cost of the core support will be reviewed during 2021/22

Proposed Use of Unutilised PCIP Funding 2021-2023

Now we are in the final year we are planning on how to use carry forward unspent funds from the earlier years of the programme. As this funding will not be recurrent we are proposing in PCIP 3 to use this funding for two main projects in 2021/22 and 2022/23. This funding amounts to £4.5:

- Investment in upgrading of property of £3.0m reconfiguring the layouts of some of our health centres to provide additional treatment, consultation rooms and agile working space for services delivered by PCIP funding. This will address one of the main obstacles to the programme, which has been the lack of suitable accommodation. Discussions are underway within the HSCP and with NHS Greater Glasgow & Clyde Estates Team to supplement investment in these properties to provide an effective and efficient way of creating additional space, without the need to purchase and/or lease new premises. More detailed proposals are to be submitted to the Primary Care Implementation Leadership Group (ILG) and the NHS Capital Planning Group for approval.

- To provide funding of £1.5m in conjunction with the one-off additional expenditure of £0.600m from the Scottish Government, to allow us to increase the number of practices supported by Community Links Workers by 81 for the next 18 months (66.4 whole time equivalent posts). At the end of the 18 month period the number of CLWs will decrease back to current 43wte posts (covering 41 practices), unless additional recurring funding is made available by the Scottish Government.

PCIP Workforce Plan

Workforce planning has been one of the most significant challenges highlighted in the Primary Care Improvement Plans, in terms of availability of workforce at a sufficient scale to support all practices across NHSGG&C and the change process required to support effective working for the new teams.

After a pause of a number of months at the start of the lockdown, recruitment continued during 2020/21, although the pace has been slower than previously because of the current constraints. Additional time has been required for induction of new employees due to reduced patient numbers in clinics, the impact of social distancing measures for training and the need for the signing-off of competencies to be done remotely.

Investment in primary care through the PCIP fund has provided development and career opportunities for the available workforce. We are beginning to experience the consequence of this as services compete for the same limited staff, resulting in higher levels of turnover as staff move around the system to promoted posts. This will require us to further review the workforce plan to support movement of staff and in some professions to cover for leave (e.g. maternity).

Work is underway to implement the agreed programme of pre-registration pharmacy technician training and the Phlebotomy Service has been reviewed and has led to the addition of more senior, qualified staff to triage referrals, support staff and scheduling, staff supervision and professional development.

Glasgow HSCP ran a national advertising and recruitment campaign (including prime time TV adverts) for key practitioner groups in February 2021 and this included opportunities for jobs funded by the PCIP programme.

The availability of key staff groups continues to require action at national level, particularly to ensure sufficient training places and development of skills for primary care.

The estimated recruitment targets for the HSCP derived from the PCIP investment are included in the HSCP workforce plan. In our previous PCIPs we estimated that we would need to recruit around 450 - 460 additional wte staff to deliver on our plans. These estimates have been subject to refinement as models develop.

The number of posts that will be funded by PCIP will reduce to reflect the reduction in estimated expenditure. In table 2 we show the likely reductions in the numbers of staff as a result of the changes to the final workstream budgets:

Table 2 Future Workforce Projections for 2021-22 (wte) to reflect revised workstream budgets

Workstream	PCIP 2	PCIP 3	Difference
Vaccination Transformation Programme	32	32	0
Pharmacotherapy	90	90	0
CTAC and Phlebotomy	193	180	-13
Urgent Care	21	10	-11
Community Links Workers	41	43	2
Mental Health	25	25	0
Advanced Practice Physios	51	11	-40
Occupational Therapists	2	0	-2
Core support	6	6	0
Total	461	397	-64

Section 6: Programme Summary

Workstream	MoU Commitment	GCHSCP Planning	Variance	Challenges	Next steps	Final Budget /Delivery
Vaccination Transformation Programme	*HSCP take on responsibility for NHS vaccinations*	Working with NHSGGC to develop model for all vaccinations i.e. childhood, flu, at risk, travel	Working to deliver programme Require detail of travel model for costs	• IT solution to support safe delivery. • Availability of workforce • Availability of accommodation • Confirm coat for Adult & Travel	• National group working to consider IT solutions • Implement National framework for HCSW delivery of vaccinations • Define model for Adult	£2.550m
Pharmacotherapy	*Pharmacist resource into all GP practices to for level 1-3*	Revised skills mix 2 pharmacy:1 tech with being further reviewed for 1 pharmacy:1 tech predicted of full delivery for 2022/23	Use of Technical staff and assistant at changed ratio Hub model to deliver Level 1 variable level 2-3 n practices	• IT solution to support safe delivery. • Availability of workforce • Workforce development • Ongoing review of model	• National solution to access to multiple practices e.g. single sign-on • Development of hub model for appropriate task	£5.500m
Community Treatment and Care Services	*HSCP take on provision of services for Phlebotomy, chronic disease monitoring and management of minor injuries/ dressings*	Revised model based on Renfrewshire learning lead to significant increase in costs than original plan	Increased staffing to implement current model Funding & Recruitment capped to undertake review of demand and service model	• Accommodation to support full transfer of service • Financial planning for city increased significantly form initial planning • Defining model with growing demands for service	• Require to evaluate the model and revisit demand to further define service and staffing model required. • Agree funding and allocation for refurbishment of accommodation	£5.500m

Workstream	MoU Commitment	GCHSCP Planning	Variance	Challenges	Next steps	Final Budget /Delivery
					• Set ciretira for CTAC to provide clarity on service delivered within funding allocaiton	
Urgent Care	*Urgent unscheduled care including the provision of advanced practitioner resource as first response for home visits*	Based on Residential care homes and notlHome Visits	Not planned for coverage of all home Visits	• IT solution to support safe delivery. • Availability of skilled workforce • Funding allocation to workstream reduced for GCHSCP programme	• Consideration for delivery of residential / Nursing care homes Workforce planning at national level required • National solution to access to multiple practices e.g. single sign-on	£0.660m
Additional Professional Roles – Advance Physiotherapy Practitioners (APP) MSK	*Alternative to GP as first point of contact in the practice setting as part of the wider MDT with examples i.e. MSK* *HSCPs will develop models to embed a musculoskeletal service within practice teams to support practice workload*	Based on 0.33wte per 14-16,000 population and Inverclyde new ways of working	Current model not deliverable within timescales due to limited workforce Developing Hub model and skills mix to maximize use of reseource	• IT solution to support safe delivery. • Availability of workforce skilled • Funding allocation to workstream reduced for GCHSCP programme	• National solution to access to multiple practices e.g. single sign-on • Consideration of hub model for some task • Consider skills mix • Link to future revewof MSK services	£0.660m

Workstream	MoU Commitment	GCHSCP Planning	Variance	Challenges	Next steps	Final Budget /Delivery
Additional Professional Roles – Mental Health	*Alternative to GP as first point of contact in the practice setting as part of the wider MDT with examples i.e. MH professionals based in practice, will assess MH, provide support for conditions such as low mood, anxiety and depression through rapidly accessible, appropriate and timely mental health input*	Early stages of planning with MH services and some small tests of change using mental wellbeing Model	The HSCP has not currently taken the approach to develop a Mental Health (MH) worker into practices	• Complex MH system and joint working • Shared understand of type of demand and appropriate response • Jined up system wide approach between MH & PC	• Test well-being model to inform future planning • Mapping of MH pathway lead by MH services • Development of additional element of commissioned contract i.e. lifelink and CDRS	£2.000m
Community Links Workers	*The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models of care and support*	Insufficient resources to meet commitments to all practices in deprived areas	Allocation for CLW on deprivation in ranked way top 38 practices	• Funding to meet SG manifesto commitment	• Ongoing discussion with SG re resources • Agree Model for the use of additional nonrecurring funding for the programme	£1.950m

Section 6: Appendices

6.1 National Local Implementation Tracker Covid PCIP 3

COVID PCIP 3

Health Board Area: Greater Glasgow & Clyde
Health & Social Care Partnership: Glasgow City HSCP
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MOU PRIORITIES

2.1 Pharmacotherapy	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices with PSP service in place	0	0	143	0	0	143
Practices with PSP level 1 service in place	19	124	0	0	143	0
Practices with PSP level 2 service in place	19	124	0	0	143	0
Practices with PSP level 3 service in place	19	124	0	0	143	0

Comment / supporting information
Please detail the impact of COVID on implementation and where you are in this process, including the impact of the COVID response on previous projected delivery

As a result of the first phase of the pandemic, the practice based pharmacy service was quickly moved to a mainly remote working model. This brought a number of benefits to working practice which will be useful to retain, although there are benefits to the ongoing physical presence in the practices to maximise contribution to effective patient care. The focus of work changed during the pandemic period with fewer IDLs and outpatient requests to action but a changed focus to support the most important medicine related activities for practices and the population, e.g. anticipatory prescribing for palliative care and care homes.
A number of priorities have been identified to be the focus of local pharmacy teams over the next few months to ensure that primary care access to medicines is suitably prepared for a potential second wave of the pandemic, e.g. rapid implementation of the Pandemic Annual Medication Service (PAMS) as a new way of delivering level 1 pharmacotherapy service (serial prescribing).
Recruitment has continued although has been slower than anticipated and pressures on accommodation which have been exacerbated by the need for social distancing has meant that some induction and training is being undertaken remotely. Work is currently underway to implement the agreed programme of pre-registration pharmacy technician training.

In the 143 GCHSCP practices all have prescribing support input as part NHSGGC original PSP service.
Existing PSP activities are at a level 3 so all practiced will have some partial level 3 activity but this has not been delivered through PCIP.
124 of the 143 have additional input through pharmacotherapy with implementation to date being developed in partnership at a local level to agree practice priorities for delivery and therefore partial delivery may vary from low activity to high for some tasks.
Full delivery of Pharmacotherapy would require approx. 2.5 wte/ 5000 population and delivery of level 1 excluding repeat prescribing requires 1.4 wte/5000 population.
Given the constraints on resources available for the full programme Pharmacotherapy have undertaken significant work to develop a revised staffing model to include greater use of Technicians and Assistants and have commenced the implementation of Pharmacotherapy Hubs to make best use of limited resources to provide all practices with some level of access to the service.
The revision of skill mix and developments of hub model differs from that outlined in the MoU.
All practices will have some level of Pharmacotherapy but not at all levels as outlined in the contract & MoU. However, we are on track to deliver the programme we outlined in our original PCIP.

2.2 Community Treatment and Care Services	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices with access to phlebotomy service	0	143	0	0	143	0
Practices with access to management of minor injuries and dressings service	0	143	0	0	143	0
Practices with access to ear syringing service	0	0	0	0	0	0
Practices with access to suture removal service	0	143	0	0	143	0
Practices with access to chronic disease monitoring and related data collection	0	143	0	0	143	0
Practices with access to other services	0	143	0	0	143	0

Comment / supporting information
Please detail the impact of COVID on implementation and where you are in this process, including the impact of the COVID response on previous projected delivery

CTAC staff have been deployed across the board area during the covid-19 pandemic to mainstream community nursing workforce with a reduced CTAC service continuing to be maintained wherever possible. The further recruitment of CTAC staff has been impacted by the pandemic thus some recruitment catch up is needed in most areas. The pandemic and resultant impact on use of space in our clinical settings has further impacted on accommodation pressures which were already a rate limiting factor to the roll out of CTACs, therefore our ability to delivery CTAC in line with plans developed pre-pandemic has been significantly affected. Our collective delivery of the seasonal flu vaccinations programme will also have an impact on the next three months of CTAC implementation as many of the same staff are required to support this corporate priority across NHSGGC.

In GCHSCP at the point of lockdown in March / April 2020 Phlebotomy and Treatment Room Services were required to close most of their clinic rooms and move to small hubs, reducing clinic capacity to around 15% of what it was previously and domiciliary services were immediately set up for both services.
Phlebotomy was rolled out quickly to all practices and accessed via a Single Point of Access telephone line which is still operational with over 7,000 calls per week and around 1,500 patients are seen per week by a team of 38 Phlebotomy staff with demand outweighing supply for the service. Access is dependant on practices accessing this service and is often better utilised by those practices based within the health centre setting who previously unitised the service.
SCI Gateway referral system was introduced to support referral into Phlebotomy and is still being piloted.
Phlebotomy continued to recruit and induct staff into to post during this period.
The staffing structure for Phlebotomy services has also been reviewed and has led to the addition of qualified staff to triage referrals, support staff and scheduling, staff supervision and professional development

Treatment Room interventions were reduced to those that could easily be performed either by the patient / carer with training or those that could be undertaken without the static equipment available in treatment rooms e.g. ear microsuction.
A pause was put on staff recruitment for Treatment Rooms due to social distancing and staff were encouraged to work agilely: this worked well for phlebotomy staff who have access to mobile phones and laptops (as part of the service delivery model) however this proved more difficult of treatment room staff with no access to mobile devices.

Alternative methods of accessing Phlebotomy and Treatment Room Services are being implemented e.g. appointing from reception desks within designated Health Centres. As premises begin to reopen slowly with social distancing determining the number of patients that can be seen in clinics. As space opens incrementally, accommodation is being sought within General Practice premises and an additional model for service delivery is being trialled: a hybrid model which means that as well as operating the preferred hub model, some practices will have access to dedicated phlebotomy sessions. This is still being scoped dependent on practice size.
Recruitment has recommenced with additional time required for induction due to reduced patient numbers in clinics and social distancing implications for training and signing off competencies. The staffing structure for Phlebotomy services has also been reviewed and has led to the addition of qualified staff to triage referrals, support staff and scheduling, staff supervision and professional development.

Currently it is predicted that, while all practices will have some level of access to CTAC services, this will not be at a level envisaged by some practices without redirection of the current funding from other workstreams and therefore GCHSCP will be unable to deliver services at the level outlined in the MoU given the predicted demand.

2.3 Vaccine Transformation Program	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Pre School - Practices covered by service	0	0	143	0	0	143
School age - Practices covered by service	0	0	143	0	0	143
Out of Schedule - Practices covered by service	??					
Adult imms - Practices covered by service	143	0	0	0	0	0
Adult flu - Practices covered by service	0	143	143	0	143	0
Pregnancy - Practices covered by service	0	0	143	0	0	143
Travel - Practices covered by service	143	0	0	143	0	0

Comment / supporting information
Please detail the impact of COVID on implementation and where you are in this process, including the impact of the COVID response on previous projected delivery

J Reid to Provide Board update

Children programme is fully transferred to HSCP who will deliver the Children Flu programme in 2020/21.
Adult - Shingles and Pneumococcal remains with practices and planning is underway for Pneumococcal to transfer to the HSCP. Shingles will only transfer when a non-live vaccination available
- HSCP delivering flu to all over 65 years.
- Housebound Flu - 141 practices have opted into the programme for 2020/21 includes carers of housebound patients eligible for vaccine.
- 18-64 years at risk will remain with practices. Given space challenges with COVID the HSCP has worked with practices to agree with those unable to deliver the programme in practice i.e. 42 practices will providing vaccinator time into the HSCP programme.
- The HSCP is also providing space for practices where requested given limitation to deliver in practice premises i.e. 5 practices

New flu cohort i.e. Flu 55-64 years will be dependant on funding and vaccinations being available and planning is underway to consider deliver in Jan 2021 and for unpaid carers & those living with shielding patients will access Flu through community Pharmacy
Travel - awaiting national work to progress

2.4 Urgent Care	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices supported with Urgent Care Service	71	72	0	71	72	0

Comment / supporting information
Please detail the impact of COVID on implementation and where you are in this process, including the impact of the COVID response on previous projected delivery.

ANPs provided vital support to GPs in management of residents in GCHSCP Care Homes who might otherwise have required GP input throughout the pandemic. 72 Practices with registered patients in GCHSCP residential care homes have access to this service. Access is variable to practices dependant on number of registered patients in the units and can vary from one to multiple patients.
There were more residents during the pandemic with complex and end of life needs. This impacted on the ANPs as they worked additional hours to provide care to residents over 7 days. Staff adapted well but did report the situation challenging due to the numbers of ill residents and the reduction of other healthcare professionals coming into the Care Homes. ANPs supported residents , families, care home staff and other health professionals.
Recruitment is impacted by the lack of fully qualified ANPs rather than by COVID and the 10 staff in place by Autumn 2020 comprise both qualified and trainee practitioners.
Trainee ANPs have commenced the ANP Education Pathway September 2020 with expected date of graduation is September - December 2021 and work is underway to agree how this additional resource will be utilized by practices and leadership required to support ANPs to reduce impact on GP support.

Given the current financial allocation across the programme it is envisaged that there will limited further development in this areas.

Additional professional services

2.5 Physiotherapy / MSK	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices accessing APP	121	0	22	108	0	35

Comment / supporting information
Please detail the impact of COVID on implementation and where you are in this process, including the impact of the COVID response on previous projected delivery

As part of COVID response and changes in practices the APPs were initially reassigned from GP practices in order to support COVID 19 response.
Recovery commenced and APPs back in all practice as per March 2020 and is dependant on practices being able to support through access to agile working and clinical space in practices .
Given the limited resources and availability of APPs discussion is underway to consider new way of working developed during the COVID response i.e. Remote working and consultations and the learning from other workstreams to develop a MSK APP Hub model to maximise efficient use of limited APP resource.
The target of 35 practices will be achieved through current staffing resource and moving to Hub access.

Given the current financial allocation across the programme it is envisaged that there will limited further development in this areas with around 25% of practices being able to unitise resource.

2.6 Mental health workers (ref to Action 15 where appropriate)	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices accessing MH workers / support	0	143		0	143	

Comment / supporting information
Please detail the impact of COVID on implementation and where you are in this process, including the impact of the COVID response on previous projected delivery.

In GCHSCP the approach to mental health has not been to fund the embedding of workers in practices and /or clusters as this would not be achievable within the existing resource allocation. Instead capacity has been increased to provide practices with access to commissioned services i.e. Lifelink and the Compassionate Response Distress Service (CRDS), including 1:1 and group support. While this model does not deliver the support that some practices may aspire to, it has supported the reduction in waiting time to access these services.
In hours component of CRDS launched end of August for patients presenting to primary care.
Lifelink service has delivered throughout providing telephone/online counselling and group programmes - both for adults and also through Youth Health Service for young people.
CLW are also contributing to supporting patients whose mental health is impacted by COVID and/or other social circumstances.
3 Health Improvement Senior (B6) staff were employed to develop Glasgow's mental wellbeing model with GP practices and clusters. Engagement with clusters had begun and pilot programmes (anti-depressant/physical activity and learning on prescription) were due to commence in March but have been delayed due to COVID. Discussions underway now to consider when these can recommence.
Bereavement training delivery for primary care staff is being delivered digitally (16 sessions scheduled) and resources distributed to all practices.
Research into people presenting to primary care in distress and trauma-informed practices complete.
Action 15 development for GCHSCP has been focused on increasing the capacity around specialist MH/ condition specifics which all practices can access.
As per of the Covid-19 response MH assessment hubs were set up and continue with consideration being given to these becoming part of the MH response and allowing GP access through referral.

Prior to the pandemic practices were requesting a more targeted response to well being and this has increased since March 2020. As a result work is planned to consider how we can develop the future model for mental health & well being within current commissioning arrangements of service and available funding resource.

2.7 Community Links Workers	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Practices accessing Link workers	102	3 (These practice have access to thematic CLW for Asylum Seekers)	38	101	3 (These practice have access to thematic CLW for Asylum Seekers)	41

Comment / supporting information
Please detail the impact of COVID on implementation and where you are in this process, including the impact of the COVID response on previous projected delivery.

Two Thematic posts were recruited during this time (Asylum Seekers / Youth Health Service) which practice can access.
All Community Links Workers moved to home working during COVID-19 to provide mainly telephone consultations to existing and new referrals from Practices. Some CLWs offered additional support to shielding patients in their practices. This was agreed locally based on practice need.
Up-to-date information was circulated to the wider cluster with regard to local support services.
Duration of engagement with CLWs increased, caused by both the impact of the pandemic on participants, and the restricted availability of services that CLW refer onto.
CLWs have begun to return to GP practices on a phased basis in line with Government guidelines.
The move to home working has impacted on process of embedding CLWs in practice, which is identified in research as being a key to component of programme success.

2.8 Other locally agreed services (insert details)	Practices with no access by 31/8/20	Practices with partial access by 31/8/20	Practices with full access by 31/8/20	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21
Back Scanning	31	12	100	0	0	143
OD - Advice	0	123	20	0	143	0
OD - YACL	0	47	0	0	47	143
PASC	0	48	0	0	0	143

Comment / supporting information
Please detail the impact of COVID on implementation and where you are in this process, including the impact of the COVID response on previous projected delivery

Back scanning - of 143 practices, 100 practices have been back scanned with remainder planned for completion by March 2021 i.e. 12 in progress , 10 planned for mid Nov and 21 still to commence.
Improvement grants - progress was significantly impacted on during the pandemic and review of practices initial requests has been reviewed.
OD advice - advice and intervention have been focused on stakeholder and staff engagement, stakeholder management, team development, approaches for change conversations and managing change, leadership behaviours and approaches, difficult conversations, influencing techniques and coaching approaches.
YACL Programme - You As a Collaborative Leader (YACL) Programme was offered to all practices and 47 staff from practice MDT took part in the programme which is now being reviewed to be delivered remotely.
PASC - Programme was offered to all practices in GCHSP with 27 taking up opportunity of PASC cohort 1 and a further 21 practices in cohort 2. COVID did however impact adversely on the progress of both Care navigation and workflow optimisation as patient flow in practices reduced significantly.
There will be a national relaunch of the care navigation element of the programme in October and the Glasgow City PCIP team will support this initiative.

2.9 Overall assessment of progress against PCIP

Specific Risks

Insufficient funding to implement the MoU as requested using current funding model i.e. NRAC formula given breadth and depth of inequalities in Glasgow and higher registered than resident population.
Achieving projected workforce numbers at the end of the programme is only achievable with additional funding.
Managing GPs expectations as we will need to move to delivering alternative models as those outlined in the MoU are not achievable for all practices in Glasgow within the current funding allocation.
Adjusting to new way of working to support collaborative and MDT working along with engagement with GPs, patients and others balanced against speed of change and need for social distancing.
Delivering variance in service model to meet local need across 143 practices.
Responding adequately to effects of deprivation on GP workload.
Availability of skilled staff, ANPs, APPs and Pharmacists with competition in recruitment between HSCP and Practices.
Providing quantifiable evidence of the impact of additional services in reducing GP workload and benefiting patients.
Maintaining sustainability of GP practices.
Loss of GPs as a result of attrition and need for succession planning across tripartite arrangements
Availability of appropriate accommodation which has increased further due to requirement for social distancing and number of staff and patients on premises.
Project future pressures in community premises with move of acute bloods to community

adjusting to new way of working to support collaborative working and engagement with GPs, Patients and others balanced against speed of change and need for social distancing.

Practices are expecting their MDT to be enhanced which is not possible for all practices given CTAC and VTP will account for 50% of funding allocation
Availability of IT hardware to all MDT members not only for clinical consultations
Digital solutions to support PCIP has been support during COVID but is not yet developed at speed to provide all practice members with access to agile and remote working to enable engagement in new ways of working.
Organisational Development support to manage significant change alongside COVID response.
COVID has accelerated the use of remote consultation in practices and by the full MDT which for some practices and patient has been welcomed.
Require to be mindful of this impact on staff well-being and working remotely and benefits of peer support particularly when challenged by disclosures in non traditional work place i.e. staff members home
General practice and MoU areas have additional challenges in delivering face to face service with additional restrictions on space and footfall into practices and clinics

Issues FAO National Oversight Group

National workforce planning, recruitment and training.
Desire for local flexibility within the MoU parameter to provide GP input for local flexibility.
Candour in the above with SGPC that fulfilment of plans will at present rate overshoot plan period (2020/21)
No financial support to cover staff pay uplifts and superannuation costs
Accommodation availability and funding process for GP practices through improvement grants.
The expectations of the MoU are not affordable within the funding being made available given the large number of practices in Glasgow and the high levels of inequalities in the city.

Health Inequalities

COVID has highlighted existing health inequalities and without mitigation the response to COVID is likely to increase health inequalities. Ministers are keen to see all sectors renewing their efforts on this and will be encouraging all sectors to work together. HSCPs and GPs are already taking significant actions to close the gap. HSCPs are using their position to bring sectors together to help take a whole-system approach to big issues. GPs are playing their part - whether through referrals to services for weight management or smoking cessation, or through outreach to the communities which are hardest to reach and where most inequality is experienced.
Please provide any comments on the impact of COVID on health inequalities and any measures taken to mitigate this impact.

Pre pandemic GCHSP had the highest number of the most deprived 5%, 10% and 20% datazones in Scotland and holds the view that the NRAC formula does not reflect the scale and multi-dimensional nature of the social, economic and health inequalities experienced in the City. The pandemic has imposed fundamental challenges on people's lives, more so for some protected characteristic groups and those already living in poverty. The recovery phase will be crucial to ensure meaningful mitigation of poverty and inequality.

Research carried out by Glasgow Disability Alliance provides an extensive overview of the impact on disabled people, stating that 'Covid-19 has supercharged inequalities already faced by disabled people'. The full report and summary briefing- 'Supercharged: a human catastrophe' are available at gda.scot.

The HSCP will continue to contribute to the city's partnership effort to address the impact of the pandemic on those with protected characteristics and living in poverty.

Further Reflections

Please add any other reflections on the impact of the pandemic, for example:
New developments (e.g. IT, services) which were brought in during COVID which support contract delivery and aims.
Any other services / developments which are locally agreed.
Any other general comments.

Developed and established COVID Hub and Assessment Centre (CAC) as the primary care response to COVID within very short timescales and the service continues to operate to reduce GP workload and divert to e with symptomatic patients away from practices.
PCIP staff i.e. CTAC and APPs were reassigned to CAC initially but have returned to core services.
IT accelerated in practices to support attend anywhere / near me.
Increased engagement has taken place with practices which has strengthened cluster working through weekly virtual meetings

Workforce profile

Health Board Area: Greater Glasgow & Clyde
Health & Social Care Partnership: Glasgow City HSCP

Table 1: Workforce profile 2018 - 2022 (headcount)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL headcount staff in post as at 31 March 2018	15	3	1	11	0	0	0	0	2	0	0	0
INCREASE in staff headcount (1 April 2018 - 31 March 2019)	16	2	0	0	0	1	0	0	2	6	5	17
INCREASE in staff headcount (1 April 2019 - 31 March 2020)	24.1	2.4	72.0	55.0	12.0	4.0	0.0	0.0	n/a	9.2	6.0	22.0
PLANNED INCREASE in staff headcount (1 April 2020 - 31 March 2021) [b]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
PLANNED INCREASE staff headcount (1 April 2021 - 31 March 2022) [b]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
TOTAL headcount staff in post by 31 March 2022	55	8	73	66	12	5	0	0	4	15	11	39

[a] please specify workforce types in the comment field

[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Table 2: Workforce profile 2018 - 2022 (WTE)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL staff WTE in post as at 31 March 2018	15.3	3.4	1.0	11.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	15.6	2.2	0.0	0.0	0.0	1.0	0.0	0.0	2.0	5.8	5.0	17.0
INCREASE in staff WTE (1 April 2019 - 31 March 2020)	19.3	1.0	44.8	34.0	11.0	3.5	0.0	0.0	n/a	3.6	7.0	22.0
PLANNED INCREASE in staff WTE (1 April 2020 - 31 March 2021) [b]	9.0	15.0	32.0	42.0	7.0	5.0	0.0	0.0	n/a	1.0		4.0
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	0.0	7.2	0.0	42.4	0.0	11.5	0.0	0.0	n/a	11.7	0.0	0.0
TOTAL staff WTE in post by 31 March 2022	59.2	28.8	77.8	129.4	18.0	21.0	0.0	0.0	4.0	22.0	12.0	43.0

[a] please specify workforce types in the comment field

[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Comment:

Vaccinations/Community Treatment & Care services includes adult & housebound flu programs which are delivered through additional nursing & admin hours (including bank), planning work is ongoing and therefore addtional WTE cannot be accurately estimated at this time.

Please note that planned increase in WTE (1 April 2021- 31 March 2022) includes all workforce approved by ILG and reflects the WTE required to deliver PCIP program as indicated by MoU however, the current indicative endpoint funding allocation is not sufficient to fund this model and planned WTE will require to be reviewed, and potentially reduced, to achieve financial balance if addtional funds are not made available.

Joint Letter - GMS Contract Update for 2021/22 and Beyond

Prior to the Scottish LMC Conference, we want to take this opportunity to emphasise our continuing commitment to the 2018 General Medical Services Contract in Scotland document ("the Contract Offer" or "Blue Book") and to reconfirm the investment commitment into general practice and primary care. Our experiences and those of the wider system during the pandemic have confirmed to us that the principles and aims contained within the Contract Offer remain the right ones - collaborative multi-disciplinary teams working alongside GPs in their role as Expert Medical Generalists to manage patients in their own community.

We have achieved a great deal and it is important we do not lose sight of that. But we must recognise we still have some way to go. Nowhere is this clearer than in our efforts over the last two and a half years to deliver enhanced multi-disciplinary teams; a key commitment in the Contract Offer. This is why we intend to make the reforms we have made a permanent part of the support that you receive from NHS Boards and Health & Social Care Partnerships – by putting them on a contractual footing.

This presents a number of challenges as we will need to do it in such a way that continues the development of NHS Board-employed multi-disciplinary teams and the transfer of responsibility for services from practices to Health & Social Care Partnerships, as was originally intended in the Contract Offer. Patient safety will be paramount in our efforts to transform primary care and there can be no gap in service provision as a result of our proposed changes. On this basis, we have jointly agreed to the following approach for each of the multi-disciplinary team services committed to in the Contract Offer.

Vaccination Services – Vaccinations that are still in the core GMS contract under the Additional Services Schedule, such as childhood vaccinations and immunisations and travel immunisations, will be removed from GMS Contract and PMS Agreement regulations by 1 October 2021. All historic income from vaccinations will transfer to the Global Sum 2022-23 including that from the five vaccination Directed Enhanced Services[6].

Whilst our joint policy position remains that general practice should not be the default provider of vaccinations, we understand that practices may still be involved in the delivery of some vaccinations in 2022-23 arrangements. Where this is necessary, it will be covered on a new Transitionary Service basis to be negotiated by SGPC and the Scottish Government in 2021 and payments will be made to practices providing these services from 2022-23.

Pharmacotherapy – Regulations will be amended so that NHS Boards are responsible for providing a Level One Pharmacotherapy service to every general practice for 2022-23. Payments for those practices that still do not benefit from a Level One Pharmacotherapy service by 2022-23 will be made via a Transitionary Service until such time as the service is provided.

[6] The Childhood Immunisation Scheme, the Influenza & Pneumococcal Scheme, the Meningitis B Immunisation Scheme, the Pertussis immunisation programme for pregnant and post-natal women, and the Shingles (Herpes Zoster) Immunisation Scheme.

Community Treatment and Care Services – Regulations will be amended so that Boards are responsible for providing a community treatment and care service for 2022-23. Where practices do not benefit from this service, payment will be made via a Transitionary Service basis until such time the service is provided.

Urgent care Service – Legislation will be amended so that Boards are responsible for providing an Urgent Care service to practices for 2023-24. Consideration will need to be given about how this commitment fits into the wider Redesigning of Urgent Care work currently in progress.

Additional Professional Roles (e.g. Mental Health Workers, Physiotherapists, Community Link Workers) – The pandemic has highlighted the need for early local intervention to tackle the rising levels of mental health problems across all practices as well as the challenges in areas of high health inequalities. Working with Health & Social Care Partnerships and NHS Boards, we will consider how best to develop these services at practice level, and establish more clearly the 'endpoint' for the additional professional roles commitment in the Contract Offer by the end of 2021.

Let us both be clear that we are not proposing to make any changes to practices' responsibilities to provide essential services. There may be times where it is appropriate for a practice to provide a service opportunistically such as wound care, phlebotomy or repeat prescriptions. GPs will also still retain responsibility for providing travel advice to patients where their clinical condition requires individual consideration. But you will all have a contractual right to extended multi-disciplinary support in your communities as set out above. We also recognise that there will be by exception some practices in **remote and rural communities** where there are no alternatives to ongoing practice delivery identified through a satisfactory options appraisal. The Scottish Government and SGPC will negotiate a separate arrangement including funding for these practices.

We also want to be clear that transitionary services are not our preferred outcome nor something we see as a long-term solution. We are keen for NHS Boards, Health & Social Care Partnerships and Board-funded GP sub-committees to do everything they can at local level to accelerate service redesign in the next 18 months.
Regulation changes strongly signal our intent that GP practices will not be the default provider of these services in future and community multi-disciplinary teams will be a permanent part of the health and social care landscape. Throughout the process for making these changes, we will rely on your input, that of NHS Boards and Health & Social Care Partnerships as well as the public at large to ensure the changes proposed here are done in ways that remain true to the Contract Offer commitments. On this note, work will now begin between Scottish Government, the BMA, NHS Boards and Health & Social Care Partnerships on updating the Memorandum of Understanding under which these services will be delivered.

We are also aware that whilst the focus of this letter has been on recommitting to and charting a course for the delivery of multi-disciplinary teams, we will however not enhance the sustainability of general practice through these steps alone. The Scottish Government remains committed to investing an additional £500 million per year in Primary Care by the end of this Parliament, including £250 million in direct support of general practice. It is important that we continue to have an updated understanding of the general practice workforce in itself and to that end, we commit to jointly analysing the workforce data provided by practices as soon as practical in 2021 as well as issuing a voluntary workload survey shortly. This will be an important part of the groundwork for delivering the expansion of GP numbers by 2027 that Scottish Government is committed to. Finally, we remain committed to Phase Two of the GP Contract and will analyse the earnings and expenses data previously provided by practices in 2021.

Our shared aim is to create for Scotland a world class publicly funded health care system which starts with General Practice and all the support networks around it. We look forward to further sharing our vision with you on how we make that happen with you at the Scottish LMC Conference.

Jeane Freeman
Scottish Government

Andrew Buist
British Medical Association

02 December 2020