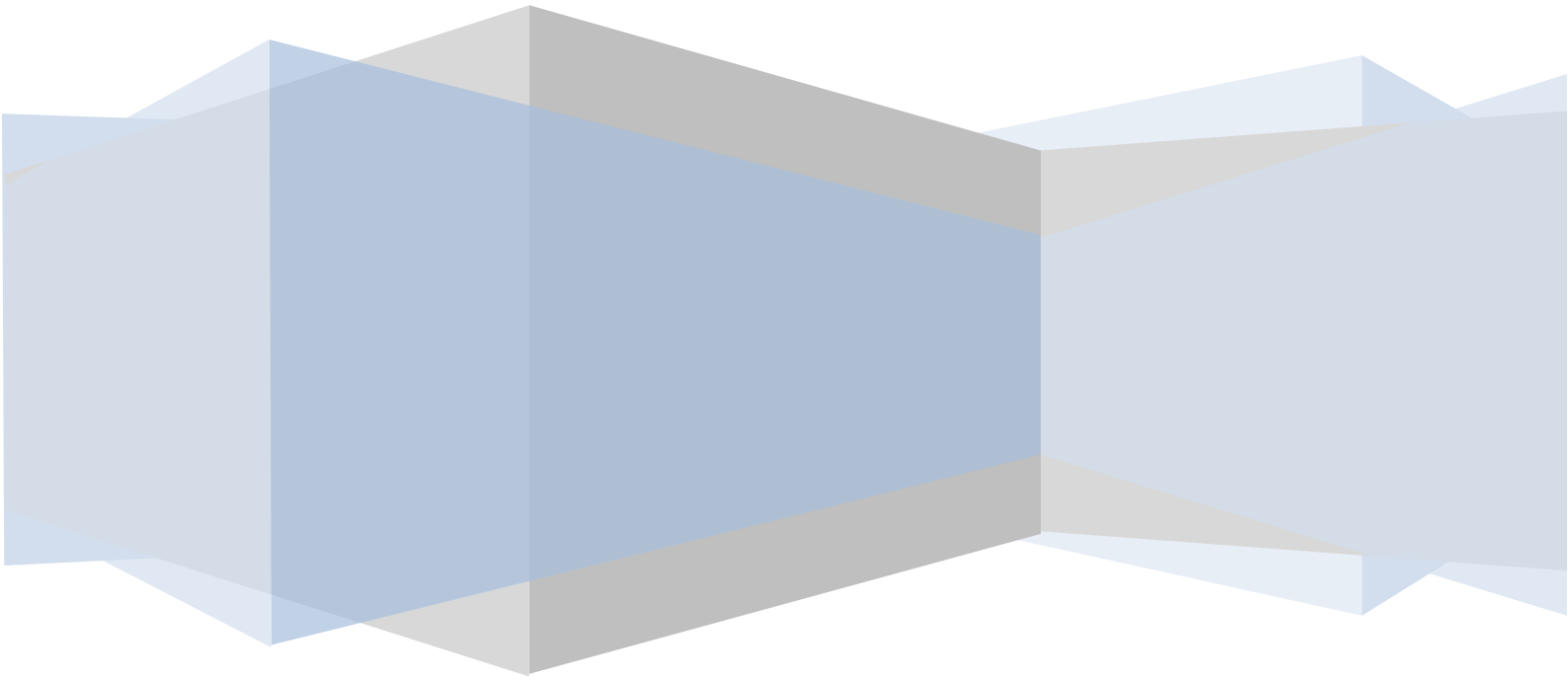
Glasgow City

Primary Care Improvement Plan 2018-21

July 2018



Contents

Section

Foreword

1 Introduction

2 Our Vision for Health and Social Care in Glasgow City

3 Profile of General Practice in Glasgow City

4 Local Population Health and Health Inequalities

5 Developing the Plan

6 Improving Primary Care Services

- Introduction
- Vaccination
- Pharmacotherapy
- Community treatment and care
- Urgent care
- Additional professionals for MDT
  - Physiotherapists
  - Mental health workers
  - Occupational therapy
- Community Links Workers

7 Tackling Health Inequalities

8 Implications for the Health and Social Care Partnership's services and staff

9 Developing the roles of the other primary care contractors

10 Related policies and strategies

11 Funding the Plan

12 Delivering the Plan

13 Summary implementation Plan 2018-21

Appendices Governance and Accountability Arrangements

- Glasgow City
- Greater Glasgow and Clyde

Glossary of Terms

Foreword

We welcome the new GP contract as it aims to guarantee a long term future for general practice and to substantially improve patient care, by maintaining and developing the role of primary care as the 'cornerstone of the NHS system'. It provides a welcome spotlight on primary care as a foundation on which to deliver more integrated care to patients throughout the city.

Given its unenviable health record the outcome of the contract's implementation is of crucial importance to the future prospects of the city's population. We see the Primary Care Improvement Plan (PCIP) as providing the framework whereby these commitments can be delivered.

While the new contract is intended to primarily benefit patients - by reducing and re-focussing GP and GP practice workload to support the development of the GP role as an expert medical generalist and to act as senior clinical leaders within wider multi-disciplinary teams - its implications are much wider; There is an expectation that many HSCP services will need to be reconfigured and, crucially, there are clear expectations of gains for patients in the city, in terms of easier access to effective integrated assessment, treatment, advice and support as well as improvements in how they are directed to local support networks and - for more complex patients - more time with their GPs.

This first PCIP is very much an initial plan. We see the PCIP as the start of a three year process to support primary care. This first plan maps some of the main directions for the future. Where we can we have identified firm actions for implementation in 2018-19 but at this stage there is much we do not know or are not yet certain of. This will require further investigatory work to be undertaken in the first year to establish assurance of a clear, confident and agreed path of action.

The requirements set out in the related Memorandum of Understanding - to meet the commitments made to GPs as part of the first phase of the contract negotiations - represent a significant programme of transformational change that will affect all practices. While this is a unique opportunity to shape primary care alongside community care services, there can be no doubt that this represents a major undertaking and it will be a challenge to deliver the agreed changes within the timelines.

At the heart of this PCIP lies shared leadership based on close cooperation and collaboration between HSCP services and GPs as well as with a host of other important stakeholders in its planning and implementation. The health of this relationship will be vital in determining the success of this plan. While there is much for us to do locally, and we positively embrace this responsibility, an important element of collaboration will be with the Scottish Government in terms of issues such as funding, workforce planning, policy alignment and flexibility.

We welcome the new monies that the Scottish Government has allocated to support the change over the next four years. We are mindful, though, that they may not be sufficient to meet the costs of such an extensive programme of change across so many practices, especially in Glasgow where the extensive health inequalities experienced by our population place additional burdens on health care. We recognise that this will leave us with choices to make and decisions on how we spend the available funding wisely to achieve the most impact.

While there are likely to be many hurdles to overcome, we believe that properly applied the PCIP can make a real difference for the people of Glasgow. We are committed to working together to fashion affordable and effective solutions to ensure the sustainability of General Practice and which will consequently benefit people in the city.

David Williams
Chief Officer
Glasgow HSCP

Alistair Taylor
Chair GP Subcommittee and LMC

Section 1: Introduction and Background

The new GP contract aims to guarantee a long term future for general practice and to substantially improve patient care by maintaining and developing the role of primary care as the 'cornerstone of the NHS system'.

The emergence of the PCIP is part of a wider programme of change, that includes the Moving Forward Together, and which sets a future framework for the development of health and social care services across Greater Glasgow and Clyde.

The essence of the new GP contract is to create the conditions that enable GPs to operate as expert medical generalists by releasing them from work that is capable of being carried out by others, thereby allowing GPs more time to spend on the complex care for vulnerable patients, undifferentiated illness and to operate as senior clinical leaders of extended primary care teams.

In this respect the HSCP values highly the GP practice teams who are providing safe, effective and person-centred care for the many patients they care for in Glasgow.

The new contract began in April 2018 and outlines a range of changes that will take place between 2018 and 2021. It is intended that this three year period will be phase 1 of the process and the Government and profession have agreed to develop plans for a second phase, which will be subject to another poll of GPs in 2020. The contract for 2018-21 is supported by a Memorandum of Understanding which requires:

"The development of a HSCP Primary Care Improvement Plan (PCIP)[1], in partnership with GPs and collaborating with other key stakeholders including NHS Boards that is supported by an appropriate and effective MDT model at both practice and cluster level, and that reflects local population health care needs".

The Memorandum of Understanding (MoU) - agreed between the Scottish Government, the British Medical Association, Integration Authorities and NHS Boards - identifies six priorities for reducing the workload of GPs as part of the broader plan for sustaining primary care services. These priorities are

- Vaccination services,
- Pharmacotherapy services,
- Community treatment and care services,
- Urgent care services
- Additional professional services, including acute musculoskeletal physiotherapy services, community mental health services
- Community link worker services.

The PCIPs are intended to explain how this will happen in each HSCP area over the next three years and will be supported by additional funding for four years from the Scottish Government. The Memorandum of Understanding explains that the PCIPs:

[1] The expected content of the plan and the requirements for the multi-disciplinary team are set out in the Memorandum of Understanding http://www.gov.scot/Resource/0052/00527517.pdf and the new contract framework (section 4 pages 24-38) http://www.gov.scot/Resource/0052/00527530.pdf.

"..must determine the priorities based on population healthcare needs, taking account of existing service delivery, available workforce and available resources. To support that aim HSCPs will collaborate on the planning, recruitment and deployment of staff".

Overarching aim of this plan

Based on the agreement in the new GP contract and the supporting Memorandum of understanding our aim is to **enable the development of the expert medical generalist role through a reduction in current GP and practice workload. By the end of the three year plan, every practice in Glasgow will be supported by expanded teams of board employed health professionals providing care and support to patients.**

SECTION 2: Our Vision and Approach

The Health and Social Care Partnership's Strategic Plan for 2016 to 2019 set out our vision for the future of health and social care in the city:

"We believe that the City's people can flourish, with access to health and social care support when they need it. This will be done by transforming health and social care services for better lives. We believe that stronger communities make healthier lives".

We will do this by:

- Focussing on being responsive to Glasgow's population and where health is poorest
- Supporting vulnerable people and promoting social well being
- Working with others to improve health
- Designing and delivering services around the needs of individuals carers and communities
- Showing transparency, equity and fairness in the allocation of resources
- Developing a competent, confident and valued workforce
- Striving for innovation
- Developing a strong identity
- Focussing on continuous improvement

The new GP contract provides a unique opportunity to achieve our vision through a fundamental transformation of primary care services.

Our approach to primary care

Our approach to the delivery of the PCIP is guided by the guidance provided by the Memorandum of Understanding and takes account of local priorities, population needs and existing services and builds on engagement with our local partners and stakeholders.

We will engage with GPs to agree a transparent and equitable way to guarantee that all practices and their patients in Glasgow will benefit from the new investment that is being made available by the Scottish Government to provide direct support for general practice.

Through the implementation of our plan we will support the re-focusing of the GP as an expert medical generalist and to facilitate improved patient care delivered by practices.

We are committed to working in a collaborative way with the advisory structures and representative bodies. The GP Sub Committee is integral to the successful delivery of this plan and the proposals outlined in this plan have been jointly developed with them.

Through our plan we balance our need to achieve the ambitions for primary care that are set out in the new GP contract against the funding that will be available to us, the capacity of our workforce and the complexities of delivering the commitments within a city the size of Glasgow.

We are particularly cognisant of the considerable health inequalities experienced by many patients living in Glasgow City. In preparing our plan we have given considerable thought to how we will design our services to address both the underlying causes of inequality and how

we respond to the poor health outcomes, which these inequalities both create and exacerbate. This approach reflects the Scottish Government's requirements - outlined in the funding letter from the Cabinet Secretary - which states that "Whilst we recognise that the key determinants of health inequality lie outside general practice services and health care generally, there remain opportunities to strengthen the role of general practice and primary care in mitigating inequality. All PCIPs should include a section on how the services will contribute to tackling health inequalities".

This plan is our initial attempt based on the knowledge and evidence we have at the moment and sets out the process for how primary care will be developed in subsequent years. Our priority in year 1 will be to implement approaches which have been shown to work effectively and where impact on GP workload has been evidenced through tests of change in Glasgow and elsewhere in Scotland.

Glasgow City HSCP is working in collaboration with NHSGG&C Health Board and the other 5 HSCPs through the Primary Care Programme Board, to develop approaches that, where appropriate and practicable, are based on consistent

- Principles
- Patient pathways
- Role descriptors and grading for posts
- Ratios for recruitment to the multi-disciplinary teams (i.e. using similar ratios for staff per practice/ patient population).

We will work in partnership with GPs through our city wide and local structures to agree the detail of the deployment of the additional staff to individual practices, within the overarching framework outlined in this plan.

When we are testing out a new model of service we will work in partnership with GPs and the GP Subcommittee in considering the type of service required and to ensure that it maximises the reduction in their workload.

Where practicable and appropriate we will collaborate with the other 5 HSCPs in Greater Glasgow and Clyde area to co-ordinate recruitment activity. In doing this we will take account of existing professional leads and hosting arrangements for services.

In working with GPs to develop the multi-disciplinary teams and new patient pathways, we will consider the re-design of existing roles/services as well as the recruitment of new staff. Extended multi-disciplinary teams will be developed with both 17c and 17j practices.

We recognise and value the importance of practice team working and through the implementation of this plan we will aim to support practices to both enhance and further develop the ethos of team working in primary care.

We recognise the wide variations in practices across Glasgow, reflecting the different demography and health needs of their patient populations and communities which practices serve, the size of practice patient lists, the location of practices, ways of operating, the number of GP partners and the staffing complement of practices.

We value the complementary and supportive roles that the third sector and our other community planning partner's fulfil. The third sector and others already provide services that prevent poor health, support self-management of health conditions and support aspects of recovery.

Section 3: Profile of General Practice in Glasgow City [2]

A significant volume of 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. Over time there is an expectation that many aspects of patient care, which are currently provided in acute hospitals, will be undertaken in community and primary care settings.

Central to this system of care is the list based system of primary care, where people are registered with a GP practice and this provides a foundation for the delivery of a full range of preventative and treatment services, as well as a network of locations for the delivery of care. This offers also an opportunity for coordinated care within a defined geographical area and utilising a wide network of services.

In 2007 there were 156 practices in Glasgow City but these had reduced to 146 by October 2017. The 146 practices in Glasgow represent 15% of all practices in Scotland (956) and provide care for 13% of all patients.

65 (44%) out of the 146 practices in Glasgow City are based in health centres, whilst the remaining 56% are based in their own premises. There are 23 single handed practices in Glasgow.

We have obtained information on the profile of GPs and their practice staff from the most recent Scottish Government primary care workforce survey. Although not all GPs responded to the survey (there was an 82% return rate by GPs across Scotland), it does provide some useful information on the profile of GPs, their practice staff and their patient populations. The information below has been extracted from the survey to provide a summary for Glasgow City:

Estimated GP Workforce[3]

- The estimated total number of GPs is 513 (head count) and 417 (whole time equivalent).
- The majority of GPs are partners (433 headcount). The remainder are salaried, retainees and sessional GPs.[4]
- Overall, 23% of GPs are aged over 55 years and 52% are over 45 years.
- Around 60% of GPs are female.

[2] Some figures may not add up as a result of rounding averages.

[3] Data taken from the Primary Care section of the ISD website http://www.isdscotland.org/Health-Topics/General-Practice/. The survey response rate increased from 58% in 2015 to 82% in 2017. Despite this increase in response rate there remains a possibility that the survey may not represent the situation in all GP practices. With this increased response rate, direct comparisons between results for 2015 and 2017 should be made with caution. Analysis does however suggest that the responding practices in both 2015 and 2017 were broadly representative of all practices in terms of practice list size, deprivation and rurality. Estimated figures for whole areas have been extrapolated based on data from responding practices and scaled using practice list sizes.

[4] There are a large numbers of sessional GPs who make a contribution to providing care within practices, without whom general practice would struggle to operate..

- Female GPs are more likely to be in the younger age groups than male GPs.

Glasgow City Estimated Practice Staff

- There are approximately 347 clinical staff (practice nurses, health care support workers and phlebotomists) working in Glasgow City's practices. This equates to a whole time equivalent of 194, indicating the high rate of part time working.
- The majority of clinical staff are practice nurses (estimated at 146 whole time equivalents), with the remainder being health care support workers (estimated at 45) and phlebotomists <5).
- 78% of practices nurses are aged 45 and above, whilst only 22% are younger than 45 and 15% of all nurses are over 60 years old.

The demographic profile of patients registered with GPs[5]

- Between 2007 and 2017 the registered patient population for Glasgow City increased from 661,319 to 717,255 (8.5%). This was a higher rate of increase than for Scotland, which was 5% over the same period.
- The average practice size in Glasgow has approximately 1,000 fewer patients than the Scottish average (4,913 patients compared to 5,961 for Scotland).
- Glasgow has the smallest and largest GP list sizes in NHSGGG&C: ranging from about 1,400 to almost 40,000 patients.
- Compared to Scotland, older (65 years+) patients make up a smaller percentage of the overall patient population in Glasgow (13% compared to 18% for Scotland).
- Glasgow has a much larger percentage of patients who are of working age than Scotland as a whole (the 24 to 64 year olds represent 60% of Glasgow's patients compared to 55% for Scotland).
- The profiles for children and young people (0 to 24 year olds) are similar at 28% of the patient population in Glasgow and 27% for Scotland.

In addition to the GPs and their practice employed staff there is a wide range of practitioners working within primary and community care who are working in health and social care partnerships, such as district nurses, health visitors, podiatrists, physiotherapists and pharmacists. Many of these practitioner groups share similar workforce and demographic challenges as the workforce employed in general practice.

Sustainability of primary care services

The PCIP's role is to demonstrate how we support the sustainability of the GP role by transferring workload from GPs to a range of other practitioners and services. Some of the factors included in the profile above which are threatening the longer term sustainability of general practice in Glasgow include:

- The older age profile of GP partners as over 50% of GP partners are aged 50 years.
- Changing working patterns as newer GPs are choosing a different work/life balance arrangement (they are working an average of fewer than 7 sessions per week rather than the previous 9-10), therefore just to retain the existing level of service, more GPs need to be recruited to replace those who leave the profession[6].

[5] http://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-Populations/
[6] We note that some GPs may have reduced their sessional commitments as a means to manage their workload and the ability to offer these work-life balance arrangements may aid retention of the GP in the workforce.

- The demands and complexity of working in areas with high levels of multiple deprivation and the changing demography of the general population and its overall growth.
- The older age profile of practice staff and HSCP community staff.

Examples of the approaches we would wish to take forward, both at the national and local level, include how we can retain the existing GPs; supporting the recruitment of new GPs through encouraging young people from all backgrounds to choose general practice; working with the universities to demonstrate to medical students the positive aspects of becoming GPs; and working with the GPs across a range of settings and the Scottish Government, to consider how pilot projects and tests of change in different approaches to retaining and recruiting GPs could be mainstreamed across all practices.

Actions

As part of our existing support for primary care through our Clinical Directors we will work with a number of GP practices across Glasgow, to gather intelligence through utilising the practice sustainability assessment tool that is provided by the Scottish Government.

SECTION 4: Local Population Health[7] and Health Inequalities

Demographic change

The population of Glasgow City is generally younger and much more socio-economically deprived than that of Scotland and the other NHS GG&C partnership areas. The population will begin to age over the period to 2025, but as a result of lower life expectancy and migration of younger working age people into the city, this will take place much more slowly than across other areas of NHS GG&C.

Health inequalities

The population experiences lower life expectancy and lower healthy life expectancy for men and women, and higher deaths rates from heart disease, deaths in young adults and cancer deaths than the Scottish average.

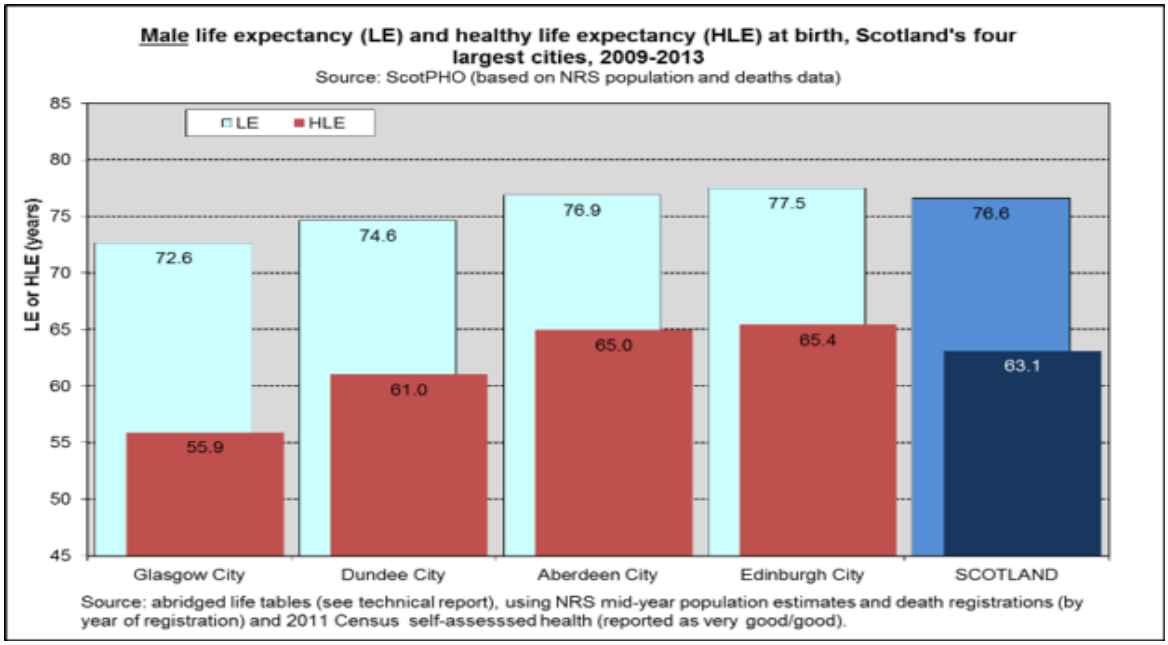
The graph below shows male life expectancy (LE) and healthy life expectancy (HLE) at birth in Scotland's four largest cities in the period 2009-2013. Edinburgh had the highest male LE at birth (77.5 years) and Glasgow City the lowest male LE at birth (72.6 years), a life expectancy gap of approximately 5 years.

HLE at birth broadly follows the same pattern, with Edinburgh having the highest male HLE (65.4 years) and Glasgow City the lowest (55.9 years). This means that a boy born during 2009-2013, subject to the self-assessed health and mortality patterns for Glasgow City during that period, would be expected to live in a healthy state for **9.5 years less** than a similar baby experiencing the patterns for Edinburgh.

A boy from Glasgow would be expected to have the longest period spent not in good health (16.7 years) - the difference between the estimates of overall life expectancy and healthy life expectancy.[8] This is a crucial factor for the workload of GPs who work in communities with more deprived populations and where these trends are intensified.

[7] Glasgow City HSCP Primary Care Improvement Plan Intelligence Chapter, Public Health, NHSGG&C (May 2018)

[8] http://www.understandingglasgow.com/indicators/health/trends/male_healthy_life_expectancy/scottish_cities/males

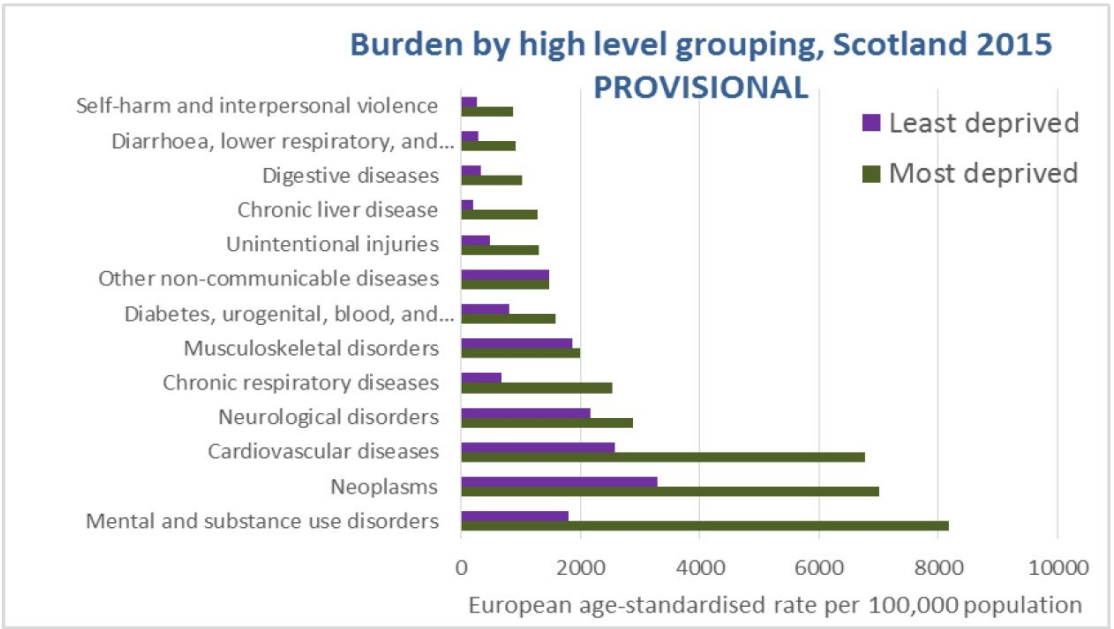


Residents in Glasgow are more likely to be diagnosed with cancer, heart disease or respiratory disease. The population of Glasgow has lower mental wellbeing and life satisfaction scores than its Scottish counterparts.

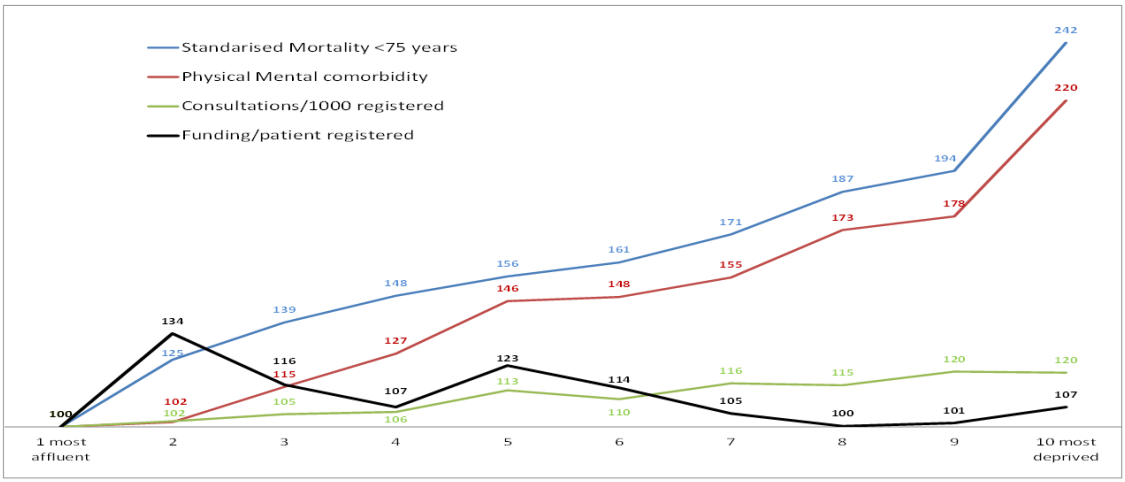
Poverty is the underlying issue that influences the health and wellbeing of Glaswegians and this in turn creates circumstances which result in challenges around health behaviours and in the way citizens access services.

A key proxy indicator of 'health inequalities' is the level of child poverty in a population. The Institute of Fiscal Studies recently published predictions for child poverty rates, which suggest child poverty will rise from 34.3% (2017) of all children in Glasgow to 42% by 2021. Such a stark rise in child poverty suggests that the 'burden of poverty,' already experienced in the city, will rise during the period of this plan and could exacerbate current pressures on primary care and wider health care systems.

The recent 'burden of disease' work led by Health Scotland (years of life, and years or living with a disability) shows very clearly the nature and extent of the impact of poverty on primary care and other health services.



The graph below illustrates how premature death and multiple and complex illness increases with deprivation while rates of consultation and levels of funding remain relatively flat.



% Differences from least deprived decile for mortality, co-morbidity, consultations and funding

Mental health is worse for residents who live in the more deprived communities as a result of factors such as poverty, unemployment and exclusion and this can create a vicious cycle of poor physical health and co-morbidity related to substance misuse.[9]

Alcohol and drug problems and their impact on health outcomes for residents of Glasgow are more prevalent in Glasgow City than for Scotland as whole.[10] In 2017 in Glasgow City there were 192 drug-related deaths - an increase of 12.9% since 2016.

Glasgow City accounted for 17% of the total number of alcohol related deaths in Scotland in 2017.[11] In 2013 over a third of individuals presented to their GP with alcohol related problems in the first instance[12].

Patterns of service uptake

Glasgow City residents are less likely to use primary care out of hours services and more likely to use emergency departments than elsewhere in NHS GG&C; this could be explained by the younger and more deprived population living in the city.

Long Term Conditions (LTCs) are no more common in the city than elsewhere - reflecting the younger population - although this is not true in the most deprived communities, where the prevalence of multiple LTCs is higher and occurs earlier in a person's life.

Immunisation rates are slightly lower in Glasgow than for NHS GG&C as a whole. It will be important to maintain immunisation rates and improve them across the population and subgroups of it, such as the more deprived, through the period of the vaccine transformation programme.

[9] Healthy Minds: The report on the health of the population of NHSGG&C, Director of Public Health, November 2017
[10] The "Drug related deaths in Scotland in 2017" report published by the National Records of Scotland (NRS) on 3rd July 2017
[11] Alcohol related death data from the National Records of Scotland.
[12] An ADP report which explored the journey of a cohort of patients who had died from alcohol related death causes.

Screening uptake for bowel, cervical and breast cancer and for diabetic retinopathy and for abdominal aortic aneurysm are lower than elsewhere in NHSGG&C and deprivation is the main determinant of these disparities.

Patients in Glasgow have a higher rate of unscheduled care and relatively lower rate of scheduled care than the rest of NHSGG&C. There is very limited information available on patient contacts in primary care[13].

The challenge of unscheduled care is not restricted to the acute hospital system. We have a challenge in ensuring that people either present to the correct part of the health and care system or are directed there as efficiently as possible. Our aspiration is that significantly fewer people with non-medical needs such as loneliness, present to their GPs but are instead connected into the community supports we are seeking to build across the city.

District nursing, physiotherapy, outpatients' referrals, day cases and in-patients' activity are all projected to see a modest increase by 2025 but these increases will be less marked than elsewhere in NHS GG&C.

In 2016 85% of inpatient activity was non-elective, and 85% of unscheduled care was driven by self-referral to emergency departments.

Equalities

In addition to poverty we know that health outcomes and health inequalities can be related to a number of other factors, such as a person's protected characteristics. These are some of the key equality statistics about Glasgow's population[14]:

- Over 20,000 adults in Glasgow have a learning disability.
- Almost one in every four residents lives with a disability (substantially higher than any other city in Scotland).
- For the period 2013-17, the suicide rate was more than two-and-a-half times higher in the most deprived tenth of the population compared to the least deprived (21.9 deaths per 100,000 population compared to 7.6). In 2017, the suicide rate for males was more than three times that for females.
- Our minority ethnic population more than doubled between 2001 and 2011, with growth across most ethnic groups, significantly amongst African, Polish and Roma communities. Interpreting services are used for over 80 different languages.
- Glasgow formally receives people seeking asylum and in this capacity we welcome and support around 3000 people seeking asylum a year.
- We understand that around one in every fourteen residents is Lesbian, Gay, Bisexual or Transgender (LGBT).

There is now clear international evidence that strong primary care systems are positively associated with better health and better equity.[15] As the gateway to health care, the design and accessibility of primary care services for people with protected characteristics is critical. Discrimination, stigma and prejudice increase the likelihood of illness and exclusion for these groups.

[13] This will be addressed in the data requirements for the 2018 General Medical Services Contract

[14] Statistics taken from Glasgow City HSCP's Equality Scheme and http://www.scotpho.org.uk/health-wellbeing-and-disease/suicide/key-points

[15] Andrew Scott , Gregor Smith, Richard Foggo Scottish Government, 2017).

A Fairer NHS Greater Glasgow & Clyde (2016-2020) and the Integrated Joint Board's Equalities Plan set out the ambitions and actions of the NHS in relation to the Equality Act (2010) in relation to.

- Eliminating unlawful discrimination, harassment and victimisation;
- Advancing equality of opportunity between groups of people with different 'protected characteristics';
- Fostering good relations between these different groups.

This plan will ensure primary care developments are accessible and meet the needs of all patients in compliance with the Act and be guided by the actions that will be identified as a result of an equality impact assessment.

Section 5: Developing the Plan

For Glasgow City the production of the initial PCIP has been co-ordinated by the HSCP's Primary Care Strategy Group (PCSG), which comprises a range of senior clinicians and managers as well as GP subcommittee and LMC representatives and other independent contractors. The PCSG is responsible for linking with the NHSGG&C-wide Primary Care Programme Board (PCPB) and for assimilating and synthesising national information and directions with local intelligence on needs, resources, circumstances and performance. The PCSG also connects across the principal functions of the HSCP to provide a profile and cohesion of primary care with other HSCP plans. The governance structures in Appendix 2 demonstrate the scale and complexity of this task within Glasgow City.

We have used workshops with members of the PCSG to comprehend the task, define our starting position and develop ideas for the pilot initiatives that are included in the implementation plan Section 13

In Glasgow we undertook a communication and engagement process to inform the preparation of this plan. We used our existing city wide and local planning structures as well as well as running additional workshops and meetings. We received also a number of written comments. The communication and engagement process involved the following stakeholders:

- GPs and their staff, such as practice managers and practice nurses
- Patients, their families, carers and local communities, primarily though our local engagement forums.
- Primary care providers: pharmacists and optometrists
- HSCP staff, such as district nurses, physiotherapists, prescribing support pharmacists
- Third sector bodies carrying out activities related to the provision of primary care

This plan has been written in partnership with GPs in Glasgow over the past few months and we have made every attempt to respond to their views and suggestions. Likewise, this plan has benefited from the many perspectives that we have received from the other stakeholders who we have spoken to during this period. We would like to thank everyone who has given their time to think through the many issues and to contribute to the proposals for action.

We recognise that, given the short timescale to undertake the engagement, we still need to meet with a number of stakeholders, including the Scottish Ambulance Service, NHS 24 and our oral health colleagues. We gave a commitment also to all the people we talked to that we will continue to involve them in the further development of the proposals outlined in this plan.

Where possible we have tried to weave the feedback from the engagement into this plan, especially where there were specific proposals for service developments or where there were practical suggestions for how the plan should be implemented.

A summary of the key themes from the engagement is provided below:

- A clear communication strategy across both Scotland and locally will be critical to the success of the plan. The communication strategy should explain to patients how they access and use services in primary care, support people to self-mange, how

primary care will change over the next few years and the improvements that they should expect to see.

- High quality multi-disciplinary team working will provide an opportunity for practitioners to collaborate to provide holistic and continuity of care for patients and will free up time for GPs to provide longer consultations with more complex/ vulnerable patients.

- A focus on the need for robust co-ordination of treatment and care and the sharing of information between practitioners and services will be critical to the success of the multi-disciplinary teams, especially for those patients who are vulnerable and/or have complex health problems. This will be a critical area of work as the current practice teams are extended to include a larger and wider range of members, many of whom will be employed within the HSCP rather than the practices.

- Whilst the six priority commitments included in the new contract are of equal importance, GPs advised that the most effective ways of reducing their workload would be to invest in additional pharmacy and mental health support within their practices.

- Many potential opportunities were identified for developing collaborative and partnership working with the wide range of public and third sector organisations in Glasgow.

- The GP Subcommittee gave a clear message that the new resources to support the implementation of the PCIP should be focused on the primary aim of the new contract which is to free up the time of GPs.

- Challenges were identified around the lack of capacity in the existing workforce in Scotland to provide enough experienced practitioners to take on the new roles and in the ability of the educational system to provide sufficient numbers of graduates quickly enough.

- Both GPs and HSCP staff highlighted the importance of having enough space in practices' buildings and health centres to provide accommodation for the multi-disciplinary teams and to support the transformation of community treatment and care services.

- The challenges around IT and electronic health systems, that do not always join up to facilitate information sharing, were highlighted throughout the discussions.

A more detailed report on our communication and engagement work is available.

Section 6: Improving Primary Care Services

Introduction

The Memorandum of Understanding (MoU) includes a list of the services or functions which are priorities for re-design between 2018 and 2021 and these are as follows:

- Vaccination services
- Pharmacotherapy services
- Community treatment and care services
- Urgent care
- Additional professionals for multi-disciplinary team dependent on local geography, demographics and demand (e.g. physiotherapists focusing on musculoskeletal conditions and mental health services)
- Community Links Workers

The MoU explains that there is an expectation that, where feasible, the re-configured general medical services should continue to be delivered in or near GP practices.

The Scottish Government is providing additional investment to allow HSCPs to recruit staff for the multi-disciplinary teams and, where appropriate, these teams should be aligned to GP practices; the teams will be clinically led by GPs as senior clinical leaders.

Where we have evidence that a certain approach or model of service will result in a reduction in a GPs workload, we have included this approach in our implementation plan for the next three years. Where we believe that that there is little or no evidence or where the outcomes of an approach are unclear, then we are proposing to do further investigations and evaluative analyses during 2018/19.

The following sections follow a standard structure covering:

- Background and context
- Requirements of the MoU
- Evidence from the work so far and implications for Glasgow. This will refer to experience of work within Glasgow as well as elsewhere, particularly Inverclyde which has been the site of the New Ways demonstration projects that have tested some of the initiatives proposed in the MoU.
- Messages from engagement
- Initial modelling based on the available intelligence to indicate what is likely to be required to support all practices. In some cases this is based on broad assumptions
- Actions split between those actions to be started in 2018/19 and those for subsequent years

Vaccination Services

Background and context

There are five broad programmes of vaccination delivered by GPs and HSCP staff and the new GP contract envisages that, over the next three years, the GPs' responsibilities for these programmes will be transferred to the HSCP. These programmes are:

- **Pre 5 routine immunisations are** delivered by GP practices, both with and without support from the HSCP's health visiting staff. A review group is overseeing the change programme for all six HSCPs in Greater Glasgow and Clyde.

- **2 to 5 year old flu vaccination programme** are delivered solely by practices without any support from staff within the HSCP.

- **School immunisation programmes** are delivered by HSCP staff. A team dedicated to providing immunisations for the whole health board area was established in 2016 and is hosted by the North West Locality.

- **Adult** vaccinations are primarily delivered by practices without support from HSCP staff. These are quite extensive programmes (both age and risk based) covering flu vaccine, shingles vaccine and the pertussis vaccine for all pregnant women.

- **Travel vaccination and health advice** are currently delivered by GP practices and 56 Yellow Fever Centres across NHSGG&C. Consultation with patients includes advice on avoidance of food borne diseases, mosquito borne diseases and staying safe. Only a small number of vaccines are free of charge in the NHS (DTP booster, Hep A and Typhoid), with the other vaccinations available as a private service.

Requirements

In 2017, as part of the commitment to reduce GP workload, the Scottish Government and Scottish General Practitioners Committee agreed that vaccinations would progressively move away from a model based on GPs having responsibility for delivery to one based on NHS Boards having responsibility through dedicated teams by 2021. The national Vaccination Transformation Programme is reviewing and transforming how we deliver vaccinations in Scotland. Delivery will move away from the current position of GP practices being the preferred provider of vaccinations on the basis of national agreements.

Evidence from work so far and implications for Glasgow

Improving uptake rates for specific groups, such as people living in the most deprived neighbourhoods and pregnant women, will be an important area for development.

Furthermore, we will want to ensure that we continue to at least maintain (if not improve on) the high level of uptake of childhood immunisations through the future delivery model as these are one of the most effective preventative measures that we have in the health system.

The childhood immunisations' sub group for the Health Board is well established and terms of reference, project plan, options' appraisal are all complete and a standard operating procedure has been agreed. Work is underway to create a "corporate clinic" approach in

Glasgow during 2018/19 for pre-5 immunisations that will be delivered through our children and families' services.

Messages from engagement

We will need to ensure a consistency in how we plan and deliver vaccinations and provide clear communication to GPs and our own staff about the vaccination transformation programme and about how it will be phased during the 3 years.

We will need to have sufficient staff capacity with the appropriate skills and knowledge. There will be a need for a training programme for those staff who will be delivering the vaccinations in the future, particularly travel vaccinations, as the service specification includes giving health-related travel advice to patients.

There may be potential for community pharmacists to deliver those travel vaccinations that are currently delivered in the GP practices.

It will be important to have an effective system for sharing with their GPs the details of immunisations carried out for patients and, where possible, reduce the need for duplicate entries into electronic records.

Successful delivery of the vaccination transformation programme will rely on us being able to offer sufficient clinical space.

Some GPs expressed concern that they would lose opportunities to engage with patients, especially the most vulnerable about other health issues, when vaccines are moved away from their practice staff. We will need to think through carefully how we will maintain the access to other services when we are re-designing the vaccination delivery programme.

Initial modelling

An NHS GG&C Vaccination Transformation Programme Board (VTPB) has been established to oversee the programme and will be exploring new models of delivery; these models could include providing vaccinations in HSCP-led clinics, by community pharmacy, through midwifery service, setting up yellow fever clinics and running clinics in the evenings and weekends. The timetable for implementing the vaccination transformation programme in Glasgow City will be dependent on the outcome of the work of the VTPB in scoping out how the new arrangements will work in practice.

Actions

Pre-School Immunisations

By end 2018/19 we will implement the recommendations from the review of pre-school immunisation delivery across Glasgow City.

School age vaccinations

School age vaccinations will continue to be delivered by the current HSCP team hosted in North West Locality.

Influenza programme for 2 to 5 year olds, pregnant women and adults (65 years +, <65 at risk groups)

By July 2018 the VTPB will complete the initial scoping of service demand for the pre-school and pregnant women vaccinations. By November 2018 the scoping will be completed for adults and at risk groups. Recommendations will be made on potential alternative delivery models, including identifying challenges and enablers of implementation and the indicative costs for each model.

The LMC GP subcommittee has expressed a view that the delivery of the flu and pertussis vaccinations for pregnant women could be delivered by maternity services at the antenatal clinic and, as part of our participation in the Board-wide programme; we will investigate the feasibility of this with midwifery.

As an interim measure during 2018/19 we will provide funding to enable District Nurses to provide vaccinations for people aged over 65 years, who are housebound but not on a district nurses' case load.

Pregnant women – pertussis (whooping cough)

By the end of June 2018 the VTPB will complete the initial scoping of service demand for each HSCP and make recommendations on potential alternative delivery models, including identifying challenges and enablers of implementation and the indicative costs for each model.

Travel vaccinations and travel health advice

We are awaiting the completion of the national options' appraisal exercise that is being led by Health Protection Scotland to provide clarification of the scope of the programme.

Pharmacotherapy Services

Background and context

The Scottish Government is committed to establishing a sustainable pharmacotherapy service by 2021, which will include pharmacist and pharmacy technician support for the patients of every practice. The Scottish Government's expectation is that this timeframe will provide an opportunity to test and refine the best models of service, and to allow for new pharmacists and pharmacy technicians to be recruited and trained.

Alongside the development of the pharmacotherapy service envisaged by the new GP contract, there are the wider commitments outlined in 'Achieving Excellence in Pharmaceutical Care' (AEiPC); this aims to transform the role of pharmacy across all areas of pharmacy practice, to increase capacity, and offer the best person-centred care. It sets out the priorities, commitments and actions for improving and integrating pharmacy services in Scotland. The 9 commitments and complementary actions provide direction for what needs to be done over the next five years.

The HSCP has a "Prescribing Support Service" for Glasgow of 34 WTE staff that helps to ensure financial balance in the prescribing budget, through optimising the safety, effectiveness and efficiency in the use of medicines. These activities reflect level 2 and 3 of the pharmacotherapy service model described in the GP contract document. The service provides an average allocation of a half to one day per week per practice and has evolved collaboratively with GPs over nearly two decades.

In recognition that there will be a requirement to increase the pool of qualified pharmacists, the Scottish Government has provided additional funding to increase the number of training posts for pharmacists from 170 to 200 per year from September 2018. We recognise that this may need to be reviewed by the Scottish Government once the implications of the investment in new pharmacy support is clearer and the possible future size of the workforce across Scotland is better understood. In addition, work is required nationally to review the number of pharmacy technicians and their training requirements.

Requirements

It is required that, by April 2021, every GP practice will benefit from the pharmacotherapy service, delivering the "core" elements as described in the table below that were agreed as part of the new GP contract. Some areas will also benefit from a service which delivers some or all of the "additional" elements described in the table. 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

Messages from engagement

Embedding pharmacotherapy services within practices was strongly supported by GPs as it will offer considerable potential to reduce their workloads and provide improved patient care. Additionally, some described their positive experience of working collaboratively with pharmacists in Glasgow.

Community pharmacy has an important contribution to make to the pharmacotherapy service. Pharmacy First[16] and serial dispensing were given as examples of existing services that can reduce GP workload. The GP Subcommittee has expressed concern that the Pharmacy First may not necessarily be a priority for GP practices and may not be work that GPs would see as being delivered by the pharmacotherapy service. Prior to extending this type of service in Glasgow City we would seek the views of GPs to see if this type of service reflects their priorities and would result in a reduction in their workload.

Evidence

Since 2016/17, Glasgow HSCP has used the Primary Care Transformation Fund to employ an additional 23 whole time equivalent (WTE) pharmacy staff. The current cost of these staff at top of the pay scale is £1.256m. The allocation model used to date has involved ranking

[16] Funding for Pharmacy First is included in this PCIP. However, the GP Subcommittee has advised that they are making representations to the Scottish Government that this should not be funded through the PCIP. At this stage we have decided to keep the funding commitment within the budget for the PCIP, pending confirmation from the Scottish Government about how this service should be accounted for.

practices based on demographics and medicines usage data, and allocating 0.4-0.5 WTE of pharmacy time per average (weighted) list size. 36 of the146 (25%) practices in Glasgow are receiving around this level of input, which is additional to the existing - separately funded - Prescribing Support Team. This does not allow for the full service as described in the GP contract but should be considered a starting point for facilitating a reduction in GP workload. These pilot practices have not included certain elements of the pharmacotherapy service; for example, the authorising and actioning of all repeat prescribing remain untested.

To date, decisions about how the additional pharmacy staff are used is based on agreement at practice level. Learning from the Inverclyde New Ways programme has been adopted to inform where pharmacy staff are best utilised to improve safe, effective and efficient prescribing whilst also helping to release GP time. This includes ensuring a balanced role profile for promoting multi-disciplinary team working and to support new staff learning and development in the setting.

We know from the initial evaluation of the pilot in Glasgow City and Inverclyde that a significant enhancement of the resource will be needed to provide the full pharmacotherapy service described in the table on the previous page for all practices. To deliver the specifics of the contract, workforce planning must be undertaken to define the resource allocation model, and the infrastructure that will be needed to support service delivery. It is anticipated that this work will be undertaken collectively across all HSCPs in Greater Glasgow and Clyde to agree a common service model that optimizes productivity and efficiency.

The memorandum of understanding states that each practice should be provided with the level of pharmacotherapy service that they require to at least fulfil the 'core' work by April 2021. It may be that different practices will require different levels of service commitment to achieve this objective but the 'range of services' will be equitable across practices**.**. We will consider also innovative ways to deliver the pharmacotherapy services, such as using new technology.

Initial Modelling

We have completed some initial modelling which has assessed three options based on different assumptions to estimate the size of the workforce that we would require.

- **Model 1 – Scaling up for Glasgow from Inverclyde HSCP to deliver levels 1 to 3**

- **Model 2 – Scaling up for Glasgow from Inverclyde activity volumes to deliver level 1 (core) -** This does not reflect the full requirements of the core service model and importantly does not include repeat prescribing or the prescribing support elements.

- **Model 3 - Continuation of current Glasgow City approach -** This model presents an enhancement of the current provision that has been used in pilot test sites from 2016-2018. Elements of the contract (e.g. repeat prescribing) were not included in any pilots and therefore operational detail and the resources that will be needed are unknown.

The table below summarises how the three models would look in terms of the number of whole time equivalent staff required to provide the service and the funding for the workforce over three years. Depending on the model adopted, between 90 and 229 whole time equivalent staff would be required, with total costs within a range of £4.5m to £12m by the end of the three year planning period.[17] [18]

[17] The ranges are used to reflect different combinations of staff

	2018/19 (£)	2019/20 (£)	2020/21 (£)	WTE
Model 1 – full provision	£3,720,049-£4,080,048	£6,183,896-£8,160,096	£8,647,745-£12,240,144	178.5-229.5
Model 2 –core level 1 provision (ex repeat presc)	£2,852,440-£3,428,402	£5,704,880-£6,856,804	£8,557,320-£10,285,206	193.36
Model 3 – current model	£1,477,166-£2,014,464	£2,954,333-£4,028,928	£4,431,500-£6,043,392	90

To be able to deliver a sustainable pharmacotherapy service by 2021 will need a pragmatic approach which balances the funding that will be available through the new contract with our ability to recruit the necessary staff.

The addition of 0.5 WTE post to an average practice (model3) has been shown in the pilot sites to meet the contract aims of reducing GP workload and improving patient care. This represents a level of staffing that our existing teams can commit to train safely and effectively. Adding this to the existing prescribing support service means that to guarantee better communication and co-ordination of care there should be no more than three staff aligned to the one practice. It makes also the requirements for accommodating the staff more workable, would limit the use of remote access, and would enable the full embedding of practitioners within the multi-disciplinary teams.

Actions

The memorandum of understanding provides a commitment that by 2020/21 HSCPs will deliver the pharmacotherapy commitments of the new GP contract. Glasgow City HSCP will take forward the following actions to deliver on this commitment:

- We aim to recruit an additional 67 new Whole Time Equivalent (WTE) pharmacy posts by 2021 - subject to agreement on the chosen model - and this would increase to 90 WTE posts the total support to GPs.

- We will involve GPs in the implementation of the pharmacotherapy work stream and, where needed, support them to develop collaborative based working arrangements with the new pharmacy staff as part of the multi-disciplinary teams.

- We will collaborate with the other HSCPs and NHS GG&C to develop a workforce and recruitment plan to set out how we will enhance the pharmacy workforce by 2020/21.

- We will work with national stakeholders including NHS Education for Scotland (NES) and the Scottish Government Pharmacotherapy Service Implementation Group.

- We will collaborate with GPs, the other HSCPs, NHS GG&C and the wider pharmacy system to develop the new service models and service improvements.

- We will develop the partnership working across the wider pharmacy system in Glasgow City, including community and hospital pharmacy, to consider innovative

[18] Calculations include 23% uplift to cover for staff sickness and holidays

ways of working which will reduce GP workload and improve services for patients. For example, by building on the Pharmacy First approach.

- We will continue to maintain a strong focus on working within our prescribing budget as set by the HSCP's financial plan by influencing prescribing practice.

- We will undertake engagement and communication with pharmacists, GPs and our staff on the future changes.

Community Treatment and Care Services

Background and context

Community treatment and care services include many 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

Requirements

The new GP contract explicitly 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. 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 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.

Evidence

A review was commissioned by Glasgow City HSCP to develop proposals that will enable patients from all GPs across Glasgow City to access both phlebotomy and mainstream treatment room services. Currently approximately 60% of GPs have access to treatment rooms based in health centres across the city. An element of phlebotomy is currently undertaken within treatment rooms for these GPs, but a significant level of this activity occurs within GP practices. It is clear that there will be an increase in workload for HSCP treatment rooms as a consequence of implementing the new GP contract.

Changes to the GP contract anticipate a shift in both phlebotomy and treatment room activity as described above. Additionally both phlebotomy and treatment room activity, not currently available in non-health centre practices, will need to be undertaken through services managed by the HSCP. A small amount of this activity is already putting pressure on the available capacity and resources and it could not be sustained in the longer term.

Further increases in service activity for both phlebotomy and treatment room services are also anticipated as a consequence of people living longer and a continuing upward trend in activity from acute hospitals - including demand from out-patients and the requirement to facilitate the earlier discharge of patients. We are collecting data to understand demand for services, activity and capacity in order that we can plan services to meet these increasing and changing needs.

Messages from engagement

Some GPs highlighted the importance to their ability to care for patients of retaining access to information on chronic disease monitoring (patient test results) and the potential for ICT solutions to help with this. Furthermore, for those GPs operating from premises that are located at a distance from health centres, there was a concern that their patients may be unwilling or unable to travel to health centres to receive treatment.

Initial modelling

We will develop a community phlebotomy service during 2018/19 as stage 1 of the change process. In stage 1 we will recruit 11 WTE phlebotomists to support the provision of services in both health centres and other locations, including community provision (such as the patient's home). Stage 1 will include the recruitment of a band 7 Team Leader (Treatment Room), to support the management of the service.

In stage 2 (from 2018 to 2021) we will develop the new model of treatment and care service and manage the transition the treatment room activity that is currently delivered in GP practices into the HSCP Treatment and Care Service. Stage 2 will increase treatment room activity because the removal of the phlebotomy service will free up capacity within existing treatment room locations. We will undertake a review of how we deliver services in treatment rooms to investigate ways of meeting the increasing demand. The review will include the use of extended hours, generating efficiencies by reducing "Did Not Attend" rates, providing access to alternative locations, the creation of additional capacity through new developments and negotiation with partner organisations, including GPs.

As part of stage 2 we will scope out also the range of interventions that will be delivered by a Treatment and Care Service and investigate the different options for the service model. These options will consist of providing wider access to hubs in our health centres and peripatetic Community Treatment and Care Services that can deliver services from a range of sites. A range of tests and checks could be completed within the community pharmacy network for a number of specific conditions, such as blood pressure checks to manage blood and management of contraception, inhaler techniques to manage asthma and COPD conditions, blood checks to manage warfarin levels and thyroid treatment.

The current annual cost for treatment room services in health centres is £1.475m. If approximately 60% of practices currently have access to these services then, notwithstanding the outcome of the different efficiency initiatives, an initial planning assumption to expand the services to provide access to all GPs might be based on a 40% uplift in the budget to £2.458m. Although we can use these figures for forward planning purposes, the scoping exercise needs to be undertaken to reflect the impact of the introduction of additional phlebotomists and, consequently, the actual uplift and total cost may be different from these estimates.

It is vital that Treatment and Care Services are effectively co-ordinated in partnership with GP practices. We need to work with GPs to consider their future role in prescribing medicines and in providing emergency treatment. Other practical issues which will need to be addressed include how staff will be distributed across localities, referral pathways, referral criteria, management arrangements and IT and associated issues.

Actions

- During 2018/19 we will recruit the 11 WTE phlebotomists.
- From 2018/19 to 2020/21 we will develop the new model of treatment and care service and manage the transition of the treatment room activity that is currently delivered in GP practices into the HSCP Treatment and Care Service.
- We will undertake engagement with GPs and patients as we develop the new model.

Urgent Care

Background and context

The new GP contract advises that we should re-design services to focus on urgent and unscheduled care, and to develop the roles of other clinical and non-clinical professions, working in the practice, to support physical and mental health of patients.

Requirements

The memorandum of understanding sets out the benefits of utilising advanced practitioners to respond to urgent unscheduled care within primary care, including being the first response to a home visit or responding to urgent call outs, thereby freeing up GPs to focus on their role as expert medical generalists. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care. Where service models are sufficiently developed, advanced practitioners may also directly support the work of GPs by carrying out routine assessments and monitoring of chronic conditions for vulnerable patients at living in their own homes or in care homes. These advanced practitioners may be advanced paramedics or advanced nurse practitioners. It is for the health and social care partnership in collaboration with GP clusters to determine the best provision for their locality. By 2021, there should be a sustainable advanced practitioner provision in all HSCP areas based on appropriate local service design.

Evidence

The Inverclyde New Ways programme tested out using both Advanced Nurse Practitioners (ANP) and Paramedics to provide the urgent care home visits.

Inverclyde HSCP recruited 1.4 WTE ANPs for around 23,000 patients across 6 practices with the objective of covering 40% of home visits and to increase this to cover 50% of home visits across the Inverclyde area by 2021. The findings from the pilot so far are that an ANP carrying out home visits can reduce GP workload/ time spent on visits with positive feedback from GPs and their patients. Inverclyde GPs expressed a view that the roll out of the ANPs should be implemented fully.

The Inverclyde New Ways programme tested also the use of paramedics to carry out urgent home visits in partnership with the Scottish Ambulance Service. 4 WTE paramedics were introduced, although only 2 were in place at any one time for 17,000 patients across 2 practices in 2 GP clusters. The paramedics covered 47% of visits in the 2 hosting practices. Inverclyde HSCP is continuing to test the approach because the findings of the pilot remain unclear in relation to the model being used, the skill mix for the posts, the most appropriate employment arrangements for the staff and the governance structure.

Messages from engagement

Amongst some Glasgow GPs there was uncertainty about the level and nature of need for urgent care and what should be done to reduce GP workload and that further work is required to scope this out.

However GPs valued retaining home visits in view of the level of patient need. GPs were particularly keen for us to develop new approaches to dealing with urgent care in care homes. The GPs we spoke to were not particularly supportive of using paramedics to cover their home visits. Furthermore, the importance of effective triage to identify the appropriate response to urgent care calls was identified as a priority during the engagement period. GPs

asked us to look at how we can improve the approach to urgent care particularly for HSCP residential homes (the present care home liaison service covers purchased care only).

Initial modelling

We have given considerable thought to how we implement this priority in Glasgow, given that the context for Inverclyde is different from Glasgow and that there may be challenges with scaling up the Inverclyde approach in the city. Based on the Inverclyde experience and recognising that the most appropriate response for Glasgow has yet to be formulated our initial modelling would suggest the following:

Advanced Nurse Practitioners**:** If we apply the Inverclyde HSCP model to Glasgow for 50% of home visits we would need to recruit somewhere between 44 and 55 full time practitioners at estimated costs of between £2.2m and £2.75m per year.

Paramedics[19]**:** We can apply the model in Glasgow based on two different assumptions: 4 WTE paramedics for 2 practices or 4 WTE paramedics for each group of 17,000 patients. These two options would result in the recruit of 292 or 164 paramedics and would need funding of £14.6m or £8.2m per year.

Actions:

During the first year of our plan for Glasgow we will work with GPs to agree a definition for "urgent care" so that we can design services based on mutually agreed requirements; in addition, we will investigate the scale of the need and the types of interventions that are more likely to reduce the time spent by GPs in providing urgent care services. We need more intelligence and data around activity (such as home visits and contacts) to inform our future service model.

During 2018/19 we will consider the different options for delivering urgent care services, identify the evidence of what works and test out a number of methods. We will involve GPs in the assessment of the different options. There are some lessons from Inverclyde HSCP which we can utilise to shape our approach, particularly around the importance of triage. We will investigate in more detail the type and number of new posts which may be required for Glasgow, to develop a suitable recruitment strategy, to measure the impact on the existing district nurse and practice nurse workforces, to gather the views and experiences of patients and assess whether or not there are likely to be increases in referrals to secondary care.

We will progress a test of change in one of our residential homes, using ANPs (or nurse prescribers) and Care Home Liaison Nurses to be available in the unit throughout the week to provide an input to frail residents and avoid the need for GP call outs. We know that one of the city's residential homes (8x15 bed units) is serviced by 26 different practices and many different GPs and associated district nursing teams. A week of care audit is planned to allow some analysis of the call outs and to gather the feedback from GPs on whether these calls required a GP or if they could have been managed by other practitioners. This test of

[19] In the National Health and Social Care Workforce Plan Part 3 - improving workforce planning for primary care in Scotland the Scottish Government indicated that there will be an increase in paramedics and advanced paramedics in the coming years. The Scottish Government has committed to training 1,000 additional paramedics during this Parliament to work in Scotland's communities to deliver more care at home. This is also in alignment with the Scottish Ambulance Service's strategy *Towards 2020: Taking Care to the Patient*[108] – focusing on increasing the Service's capacity for care at home or in the community. This role could be further enhanced as plans are now underway to allow paramedics to become independent prescribers. http://www.gov.scot/Publications/2018/04/3662

change will help us set out a model to follow for a new home that is due to open early 2019 and, if successful, would be something that could be replicated in other residential and care homes. (Given the level of need this is a development that should be met from the 'set aside' budget from Acute Services).

Further actions include:

- We will consider the potential for up skilling existing staff, such as practice nurses and care home liaison nurses.

- Undertake some development work on the interface with care homes where we feel that there could be some early gains – possibly by extending the care home liaison role to cover residential care.

- Investigating e-health solutions to increase the efficiency and effectiveness of urgent care.

- Connecting this work to other developments, such as the out of hours review and initiatives to improve anticipatory care planning.

- We will work with GPs to identify ways of improving how patients are triaged for urgent care.

Additional Professionals for Multi-Disciplinary Teams

Multi-Disciplinary Teams (MDTs)

Background and context

The new 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.

Requirements

By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and 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 level 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.

Evidence

In Glasgow, we would like to build upon and further develop the experience of the partnership working that already takes place between HSCP staff, such as health visiting and district nursing teams, and GP practice teams.

The Govan SHIP project, for instance, has been piloting MDT working for the past few years, with GPs time freed up to work with a team of practitioners (district nurse, health visitor, social care worker, physiotherapists and mental health practitioner) to agree and monitor care plans for vulnerable patients. The MDT working in the Govan practices has facilitated anticipatory care and preventative approaches, improved communication and information sharing between practitioners, the identification and management of risk as well as more effective targeting of resources. An evaluation of the SHIP project has found that the MDT working has reduced the frequency and level of attendance by patients at the practice, the need for crisis/emergency activity within primary care, the number of home visits and has allowed more focussed use of diagnostics. We will need to monitor the impact of this approach as we scale it up across Glasgow to see if it remains effective for a much larger population of patients.

Through our integrated working in Glasgow we have been developing neighbourhood based health and social care teams across our services. We would expect that these teams will collaborate with the MDT teams to co-ordinate care for patients and will be the building blocks for the further improvement in multi-disciplinary and multi-agency team working across the city.

Moreover, we have GP clusters, primary care implementation groups and GP forums in each of our three localities that facilitate shared learning, quality improvement and collaborative approaches to service planning between GPs, HSCP services and the other primary care contractors.

Message form our engagement

The value of MDT working was widely recognised by many of the people who we engaged with, though there was an acknowledgment that a number of different approaches had been used across the city.

Actions

We will use the learning from the different approaches that have been used across the city and develop a model that can be used to deliver the MDT requirements of the new GP contract in the most effective way.

Physiotherapy (focused on musculoskeletal conditions)

Background and context

Musculoskeletal (MSK) conditions are the most common cause of disability in the UK, and MSK Physiotherapists are experts in assessment, diagnosis and management of these conditions. MSK conditions account for up to 30% of the GP caseloads. MSK problems frequently cause repeat appointments and are a significant cause of sickness absence in Scotland. The majority of a GP's patients with MSK problems can be seen safely and effectively by an advanced practice physiotherapist (APP). MSK Physiotherapy Services are hosted by West Dunbartonshire HSCP and operate across NHS GG&C.

Evidence

A pilot project by Inverclyde HSCP provided an APP across 3 GP practices and this approach was extended to the Govan Health Centre (as part of the Govan SHIP project) in November 2017. The pilot projects have utilised experienced physiotherapists who are on secondment from the MSK Physiotherapy Service. The model of service offers the patient:

- A 20 minute appointment with the physiotherapist.
- Screening for non-MSK conditions and serious pathologies.
- A brief specialist assessment, MSK diagnosis and management plan.
- A management plan which can include tailored exercise programmes, lifestyle, wellbeing and physical activity advice and signposting to community services.
- The APP liaises with the pharmacist and GP regarding medication and fit-notes where these are required for patients[20].
- Referral as appropriate to physiotherapy (for a course of rehabilitation), orthopaedics, A&E or other investigations.
- An open review where the patient could come back to the APP at any time.

Messages from our engagement

There were two issues highlighted during the engagement process: the first was that the current waiting times for the MSK Physiotherapy Service are too long for both routine and urgent appointments and that any proposals should address this as a matter of priority. [21]; the second was the potential to draw away experienced practitioners from the existing service, if we scale up the recruitment for APPs too quickly and as a consequence reduce the capability of the physiotherapy service to improve its waiting times.

Initial modelling

The pilot project has been positively evaluated and, therefore, the MSK Physiotherapy Service has proposed to extend this approach during 2018/19 by another 10 wte posts across NHSGG&C - 5 of these posts would be be based in GP practices in Glasgow. In

[20] Including looking at APPs being possibly being able to issue fit notes would be helpful though it is recognised that this would need legislative change

[21] At the end of March 2018 44% of patients referred to MSK Physiotherapy were seen with 90 days of referral. However, improvement work is in progress to reduce waiting times and the service now has an average wait of 51 days for a routine appointment and all urgent referrals are still seen within 4 weeks.

addition, the Service has estimated that a further 10 posts could be recruited for Glasgow between 2019/20 and 2020/21.

For planning purposes the full implementation of the pilot model would require between 44 to 51 WTE posts at a total estimated cost of between £2.2m and £2.55m per year. These planning assumptions are based on a ratio of 1 WTE physiotherapist for up to a maximum of 3 practices (patient population of 14,000 to 16,000 per WTE post) with an average activity of 14 to 16 consultations per day.

Our expectation is that the new APP posts will be established by HSCPs across Scotland so there is likely to be high demand for all grades of staff. The Physiotherapy Service does not normally have problems recruiting in Glasgow but there are indications that fewer newly qualified staff are available at the moment. The Service has advised that not every practice will need to utilise a full time APP as a practice needs to have a large enough patient list to generate enough MSK Physiotherapy consultations and, furthermore, some practices may not have sufficient room space to provide accommodation. The Service anticipates that there may be a need to share APPs amongst a number of smaller practices and it is possible that the actual number of physiotherapists needed for Glasgow will be lower than these planning assumptions.

Actions

In view of the challenges explained in this section we will progress the roll out of MSK Physiotherapists in a phased way. During 2018/19 we will increase the number of Advanced Practice Physiotherapists by 5 and embed them in GP practices as part of multi-disciplinary teams

At the same time we will give more consideration to the specification for the role and whether or not we want to include treatment as well as assessment in the APP's role, given the concerns expressed by GPs in Glasgow about the long waiting times for appointments for the MSK physiotherapy services. This will give us time to evaluate the impact of the physiotherapist role in the Govan SHIP and to take account of any further outcomes from the Inverclyde approach. Further role out of recruitment would then take place from 2019/20 based on the agreed service specification.

There may be other options for providing advice and support to patients with muscular skeletal problems, such as up skilling practitioners from sectors related to sports and physical activity, and the phased approach described above will give us time to investigate these different approaches.

Mental Health

Background and context

Mental Health is an area of considerable concern for primary care and others within Glasgow. Last year Glasgow City Council set up a Health Inequalities Commission on mental health[22]. The Commission brought together councillors, 'Deep End' GP's, public health experts, representatives from community groups and citizens with lived experience of poverty and poor health. Citizens and others repeatedly reflected on the important role of primary care (GPs) *'cause where else do you go when you are feeling that low'***.** The commission found that, although primary care was where people were most likely to go, GPs and specialist mental health services were not always what people needed.

Mental health services in Glasgow (PCMHTs, CMHTs[23] and third sector organisations) offer high quality evidence based treatment for a range of mental health difficulties from mild and moderate through to serious mental illness and highly complex conditions. However there is a group of people presenting to primary care, with a range of less well-defined difficulties, who are less well served. With the new GP contract, the new national mental health strategy, the recently published strategy - "A Connected Scotland: Tackling social isolation and loneliness and building stronger communities"[24] - and the new investment from Scottish Government in primary care, there is a real opportunity for change within the scope of this plan. Particularly we will work with primary care to consider how to better meet the needs of this large group and to build community support systems that enable people to get support without necessarily needing to access primary care services.

Within the national Mental Health Strategy 2017-27[25] there are a number of commitments that are linked to the transformation programme for primary care. These include

- Action 23 – the Scottish Government will "test and evaluate the most effective and sustainable models of supporting mental health in primary care, by 2019".

- Action 15 - to increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and prisons. Over 5 years the Government has committed additional investment to recruit 800 additional mental health workers in these key settings.

In our response to the mental health strategy we will improve the service response by taking forward a number of mental health service improvements from 2018/19. Examples of these include enhancing the Psychiatric Liaison Service, a project to strengthen the pathways from primary care to mental health services, the roll out of the Primary Care Computerised CBT service, a recovery orientated system of care, learning from best practice in England to shape a police custody service and services for older people. Given the inter-relationship between the mental health fund and the Primary Care Improvement Fund we will ensure that there is a joined up and transparent decision making process for agreeing how each programmes of work is financed.

Requirements

The new contract proposes that "Community clinical mental health professionals (e.g. nurses, occupational therapists), based in general practice, will work with individuals and

[22] https://glasgow.gov.uk/index.aspx?articleid=21703
[23] Primary and Community Mental Health Teams
[24] http://www.gov.scot/Publications/2018/01/2761
[25] http://www.gov.scot/Publications/2017/03/1750

families assessing their mental health needs, providing support for conditions such as low mood, anxiety and depression. The outcome sought is improved patient care through rapidly accessible, appropriate and timely mental health input". The focus of the new service developments should be on both adults and older people.

There is meant to be a "close cross over" with the primary care component of the Action 15 mental health monies. The Action 15 allocation letter advocates taking a flexible and broad ranging approach to providing additional mental health capacity and PCIPs should show how mainstream mental health services will improve integration with primary care.

Evidence

Mental health problems are the largest single cause of disability, representing a quarter of the national burden of ill-health, and are the leading cause of sickness absence in the UK. Roughly one third of presentations to primary care relate to "mental health" problems, which typically occur in the context of psychosocial stress and distress[26]. Deprivation is strongly associated with poor mental health.

Research evidence and clinical experience suggests that histories of childhood trauma and adversity are closely correlated with mental health and addiction problems. Adverse childhood experiences make it harder for people to make and sustain relationships and to manage distress, especially in "care-seeking" situations. Those difficulties are experienced by practitioners as non-engagement, non-compliance, non-attendance at services and ineffective clinical interventions.

Practitioners can be unaware of the extent to which trauma and adversity underlies many of the relational, emotional and mental health problems which present to NHS and social care services. The failure to frame emotional and psychological problems in the context of trauma and adversity means that the nature and extent of these difficulties is routinely misunderstood. Patients are commonly referred to services that are oriented towards their presenting symptoms (low mood, harmful use of substances) but clinical responses are often ineffective because the underlying causes of those symptoms have not been fully identified or responded to.

Clinicians in a primary care environment are well placed to understand the familial and social context in which difficulties arise and foster good engagement with the patient through the development of consistent therapeutic relationships. Evidence supports the idea that services offered within a GP practice provide both accessibility and a high level of acceptability for patients because there is not the same stigma attached to attending a local health centre as there is to attending a mental health service.

A further issue that must be addressed by both primary care and mental health services is the poor physical health outcomes for people with severe and enduring mental illness. Capacity needs to be developed within services to respond to the often complex physical health care needs of patients with mental health issues.

Our approach has to reflect the diverse needs of the people who present with mental health problems at GP practices.

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[26] http://www.parliament.scot/ResearchBriefingsAndFactsheets/S4/SB_14-36.pdf Information about GP consultations is available via the Practice Team Information programme4. This programme uses data from a subsample (about 6%) of GP practices across Scotland to inform on the number of consultations between patients and either a GP or a practice-employed nurse.

Recently, we have initiated two pilot projects where approaches to helping patients with mental health problems are being tested (the Jigsaw project in Drumchapel and the Govan SHIP) and we can use the learning from these to shape our future approaches. Given the influence of poverty on mental health, the financial inclusion services described later in the section on health inequalities provide evidence for the types of services we could roll out as part of this plan.

A landmark paper, published in 2010, which reviewed 148 studies, discovered that those with strong social relationships had a 50% lower chance of death across the average study period (7.5 years) than those with weak connections[27]. The magnitude of this effect is of profound clinical concern. Within this plan we outline the expansion of the Community Links Worker programme, which is designed to support the GP practice team to become better equipped to match social support services to the needs of patients who attend for health care. The Community Links Worker programme has already evidenced an impact on feelings of isolation, and this evidence base will be further investigated as we expand the programme. The interplay between mental health services and Community Links Workers will be critical to create different opportunities to reduce, and respond to, the distress patients present with in primary care.

Messages from engagement

During the development of this plan Cluster Quality Lead GPs (CQLs) emphasised that actions to improve access to mental health services should be a priority. In particular, they underlined the need to shorten waiting times for CAMHS and PCMHT, the need to establish a one door approach to mental health services and that improvements are required in the interface between GPs and PCMHT. Their preference was for rapid same day access. GPs highlighted that a large number of people present at their practices with a range of less well-defined difficulties (such as stress and distress) and are less well served. There is an opportunity to re-design current service provision to better meet their needs; and since this group are typically facing socio-economic pressures and often have experience of childhood trauma and adversity, a conventional “medical” model based on a diagnosis of “mental illness” may not be appropriate. When developing our new model (s) we need to take into account all ages, from young people through to older people. In general there was no consensus on the role of mental health worker in a MDT and further work would be required to scope this out.

Initial modelling

We are not at the point where we have conclusively framed the problem that we are trying to solve or in a position to establish proposals for new models of service for Glasgow. What we do know is that amongst GPs there is a preference for such services to be embedded within individual GP practices, rather than being shared amongst a group or cluster of practices. Based on parallel experiences of the other priorities outlined in this plan, however, this could amount to a considerable resource requirement to meet this aspiration. In planning the future investment we have used - as a rough guide - the estimate that one in three patient presentations at GP practices relate to mental health problems; this results in a provisional assessment that by the third year of this plan around £6m would need to be allocated to mental health provision in GP practices. This broadly equals the cost of providing a service in each city practice.

[27] Social Relationships and Mortality Risk: A Meta-analytic Review Julianne Holt-Lunstad, Timothy B. Smith, J. Bradley Layton Published: July 27, 2010 https://doi.org/10.1371/journal.pmed.1000316

Actions

- We will undertake an information gathering, process mapping and scoping exercise in collaboration with GPs that will provide the knowledge and understanding necessary to plan and develop effective and efficient service responses to divert workload from GPs. The scoping exercise will incorporate perspectives from GPs, practice staff, patients, third sector, primary care practitioners and mental health service providers.

- We will review the outcomes achieved by the initiatives supported by the existing primary care mental health fund as well as use the lessons from COPE, the Govan SHIP and other projects to inform future developments.

- We will use any outcomes from Action 23 of the national mental health strategy to inform our future approach.

- Using the scoping exercise and the reviews of existing initiatives we will design tests of change in collaboration with three or four GP clusters by late 2018-19; these will be used to obtain evidence of what works in providing mental health support in a primary and/or community setting. We will be looking to frame our responses around the three themes of 1) supporting the wider social and community based infrastructure that lies beyond formal services, 2) early intervention in primary care to respond to the stress and distress experienced by patients and 3) improving access to treatment and care.

- We will Involve GPs and the LMC GP Subcommittee in this work to ensure that they are supportive of the eventual proposals and that they are satisfied that GP workload (in terms of appointments and referrals) will be reduced as a result of the investment.

- Continue to invest in all current mental health training programs. In addition we will undertake a training needs analysis among primary care staff to ascertain level of knowledge about mental health issues and confidence in responding to them. The results of the analysis will inform the development of a mental health training package for non mental health staff. We will develop a training package for mental health staff that provides education on recovery oriented, strengths based and trauma informed models.

- We will make the connections with our response to the national mental health strategy (Actions 15 and 23) and identify opportunities for joint work and joint funding between the two streams of activity that meet the requirements outlined in the MoU.

Occupational Therapy

Background and Context

A test of change in primary care is being progressed in Lanarkshire where an Occupational Therapist has worked in a GP Practice and has received referrals directly from GPs. The objectives of the project were to improve the health and wellbeing of patients by offering proactive interventions, enabling them to manage their health and wellbeing and continue with their daily lives; and to reduce patient reliance on the GP and primary care team. Funding for the initiative is available until April 2019.

Requirements

By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment as agreed with GPs and within an agreed model or system of care.

Evidence

The initial evaluation indicates that patients who complete OT intervention are achieving positive outcomes in terms of quality of life and functional performance.

Messages from engagement

This proposal was highlighted during the engagement on this plan.

Modelling

We have not undertaken any modelling on this proposal as it was identified only recently as an option.

Actions

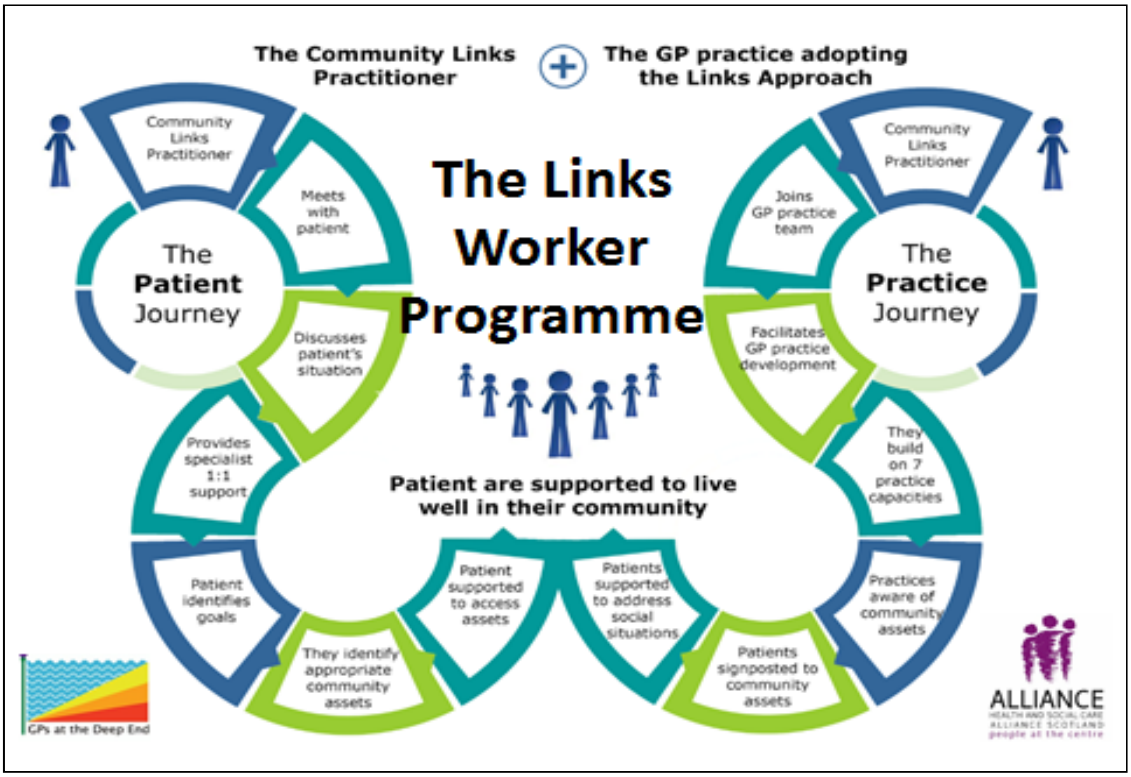
We will learn from the experience from Lanarkshire of embedding an occupational therapist in a GP practice and where this is shown to be effective in reducing GP workload - and subject to agreement with the GP Subcommittee - we will give consideration to how this role could be developed in Glasgow City.

Community Links Workers

Background and context

The Community Links Worker programme was piloted in Glasgow city and has operated with a selection of practices since 2015. Community Links Workers support people to live well through strengthening connections between community resources and primary care. Individuals are assisted to identify issues and personal outcomes then supported to overcome any barriers to addressing these by linking with local and national support services and activities. In addition, Community Links Workers support the GP practice team to become better equipped to match these local and national support services to the needs of individuals who attend for health care and to work with them to support their well-being,

Diagram: Community Link Workers



Requirements

The Scottish Government's manifesto commitment was to fund 250 Community Links Workers across Scotland over the lifetime of the current parliament, focused on GP practices with the most deprived patient populations. The roles of the Community Links Workers should be consistent with local needs and priorities and function as part of the local models of care and support. The roles should be flexible and we anticipate that there will be differences between individual practices and clusters of GPs in how the workers will be used. We will align the further implementation of the Community Links Workers programme with the other similar roles in the City, such as the Community Connectors, Local Area Co-ordinators and the approach used by Community orientated primary care.

Evidence

The Community Links Worker evaluation[28] concluded that impacts varied between practices and were reliant on how well the Community Links Worker had managed to integrate into the practice team, and how well the 'practice' components of the model had been adopted. There were a number of improvements observed in patient well-being for those who benefited from the Community Links Worker input compared with patients drawn from comparator practices; these improvements included more patients who were less likely to be anxious, to feel depressed, to feel socially isolated, to smoke, experience "social morbidity' and who visited their GP less frequently. Although these results are promising the evaluation relates to only a few practices and further evaluation is required to be confident that such benefits can be replicated at a larger scale.

Glasgow has 18 Community Links Workers based in practices and we propose to build on the existing programme using the learning from the programme so far. Initially, our priority will be to centre the recruitment of Community Links Workers on practices operating in the most deprived neighbourhoods. We anticipate refining the model depicted in the diagram above with Community Links Workers concentrating primarily on the social reasons that bring patients into general practice, alongside the community responsiveness of the practice team. The programme will be developed with third sector partners.

Messages from engagement process

There is support for the roll out of the Community Links Workers because of their potential to address the social needs of patients presenting in primary care as well as reducing patient reliance on their GP. There was concern expressed that, given the scale of Glasgow's deprivation, only around half of the most deprived practices in the city may eventually be able to access this programme, representing less than a fifth of the 250 Community Links Worker posts that will be funded across Scotland.

The people we spoke to highlighted the potential for Community Links Workers to improve the mental health and wellbeing of patients as those patients suffering from stress and distress could be supported by local third sector and community organisations. Community Links Workers have the time available to listen to patients and to find out what would best help them connect to services provided in the local community.

Moreover, those GPs who have experience of the Community Links Worker role stressed that they need to be embedded in practices and must be recognised by the wider practice team as having a vital role in improving the quality of life for patients.

Initial Modelling

Various modelling options have been considered and are shown in the table below:

	Option	WTE posts	Full year costs
1	NRAC formulation of GHSCP resource	35	1,593,473
2	Existing + next 25 most deprived practices,	43	2,201,732

[28] http://www.healthscotland.scot/publications/evaluation-of-the-links-worker-programme-in-deep-end-general-practices-in-glasgow

Option		WTE posts	Full year costs
3	Practices with more than 50% of patient list in poorest 15% SIMD	63	3,223,150
4	Glasgow's Deep End Practices	80	3,776,291
5	All Practices	146	7,408,746

This rough modelling is based on a post per practice but as the role develops there is scope to consider shared roles between practices and, potentially, clusters. The financial modelling includes salary and management costs for host organisations, practice development funds and infrastructure costs, including the evaluation required to evidence the impact of the overall programme.

Using the NRAC formula for allocating funding across health boards we will be able to fund up to 35 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 above the 35.[29] Our ability to do this would depend, though, on additional resources being made available by the Scottish Government and would require the adjustment of the NRAC formula.

Actions

- We will involve GPs in developing the methodology for allocating Community Links Workers to practices.
- During 2018/19 we will continue to develop the Community Links Worker Steering Group through extending membership to key third sector organisations and partners.
- During 2018/19 we will undertake a public procurement process to invite potential third sector suppliers to tender to be on a "Glasgow City Links Worker procurement framework". This will enable us to increase the number of Community Links Workers over the lifespan of the Primary Care Improvement Plan.
- During 2018/19 we will increase the number of Community Links Workers to 27 from the current 18. We plan to increase this to a total of 35 in 2019/20.[30]
- We will continue to liaise with the Scottish Government to establish a funding allocation for Community Links Workers that reflects the substantial health inequalities of Glasgow's population.
- We will work with other stakeholders – for example from the employability sector - on workforce planning and training.
- We will work to establish the routine data reporting and the evaluation programme for Glasgow City's Community Links Worker programme.
- We will work to strengthen the connectivity between the primary care mental health programme and the Community Links worker programme.

[29] 63 of the 146 practices have more than half of their practice list living in the poorest 15% SIMD postcodes and have populations that require additional input, such as some of our black and minority ethnic communities.

[30] In our planning assumptions we have increased the number to 43 posts as an example of the implications of increasing the funding.

- We will test the ‘links worker’ role for a protected characteristic group to ensure non-geographical community networks and resilience are developed as part of the model.

Section 7: Tackling Health Inequalities

Background and context

Section 4 gave a stark description of the health and social inequalities faced by many of Glasgow's residents and the burden of disease that they suffer as a result of living in poverty. It also highlighted the diversity of Glasgow's population and the need to design and deliver services which best meet the needs of the different communities and groups living in the city.

Requirement

In the Primary Care Improvement Fund letter the Scottish Government makes clear that, whilst the Government recognises that the key determinants of health inequality lie outside general practice and health care generally, there remain opportunities to strengthen the role of general practice and primary care in mitigating inequality. All PCIPs should, therefore, address how the services will contribute to tackling health inequalities. The funding letter refers to the Community Links Workers and the quality improvement role of GP Clusters as two examples where inequalities could be tackled and asks us to consider what more can be done to ensure there is parity of access for all groups, and that the workload of GPs in the most deprived areas is manageable.

Integration Joint Boards are also subject to the new Fairer Scotland duty. The duty aims to ensure that public bodies, when making strategic decisions, take every opportunity to reduce inequalities of outcome caused by socio-economic disadvantage, We must also complete an equalities impact assessment of this plan and as part of the assessment process we will include socio-economic disadvantage alongside the other protected characteristics.

Evidence from work so far and implications for Glasgow

Glasgow City Council's Health Inequalities Commission in 2017 recommended that initiatives to reduce health inequalities should deal with the following issues:

- Addressing poverty and injustice e.g. financial inclusion
- A good start – childhood (including mitigating adverse childhood experiences)
- Reducing alcohol and drug misuse
- Reducing death by suicide e.g. responding to distress
- Reducing loneliness & building/strengthening social connections and quality relationships.

The "GPs at the Deep End" Group" has used the Govan SHIP Project, the Pioneer Scheme and the Attached Alcohol Nurse Pilot to demonstrate approaches that enhance the primary care team. The HSCP is committed to working in partnership with the "GPs at the Deep End" group to consider how the learning from these projects can be used to shape the implementation of the Primary Care Improvement Plan over the next three years. [31]

[31] If all GP practices in Scotland are ranked by deprivation (approximately 1,000 practices), the most deprived 100 practices are termed to be "GPs at The Deep End". This is an internationally recognised brand, with Glasgow GPs at the forefront of developing initiatives to tackle the "Inverse Care Law" and to reduce health inequalities. This is the principle that the availability of good medical or social care tends to vary inversely with the need of the population served. Of the 100 Deep End practices in Scotland, 85 are located in Greater Glasgow and Clyde, and 80 in Glasgow City (37 in

The Deep End GP Pioneer Scheme was created to support the recruitment and retention of both early career and experienced general practitioners. The scheme is developing a change model for general practices serving very deprived areas, involving the recruitment of younger GPs, the retention of experienced GPs, and their joint engagement in strengthening the role of general practice as the natural hub of local health systems. The Pioneer Scheme aims to strengthen the generalist role of a GP by providing unconditional, personalised continuity of care for all patients, whatever condition or combination of conditions they have.

The Govan SHIP Project commenced in April 2015 and was established to find new ways of working within primary care which better address the complex needs of patients in a predominantly deprived community. The project did this by offering additional and protected GP time, operating through structured multi-disciplinary team (MDT) working and aligning professionals from community and social work services with the GP practices. The evaluation of the SHIP has found that it developed a new way of working that has addressed and overcome challenges involved in creating a multi-disciplinary team; demonstrated a reduction in GP demand; a shift in demand to appropriate professionals; a breaking down of silos between practitioners and has made better use of the multi-disciplinary team to release GP capacity.

The Attached Alcohol Nurse Deep End Pilot (July 2015/16) tested a service model that brought specialist community services into Deep End general practice settings. The aim of this model is to address the needs of people with problem alcohol use who are in contact with their general practices but who have not previously engaged well with alcohol and drug services or who are not known to alcohol and drug services. The outcomes from the pilot demonstrated that 82% of those who accepted a referral went on to receive specialist alcohol assessment and treatment.

In Glasgow financial inclusion services have been based in some health centres and embedded in GP practices. At the moment we have 15 practices benefiting from these services that are funded by the Scottish Legal Aid Board, Clyde Gateway and the HSCP until March 2019. The cost of providing the service does vary but when averaged it is £6550 per annum per practice for 1 or 2 sessions a week. From the services in place to date the average financial gain per client is £2,600 but can be as high as £4,900 for those services that are embedded in primary care, with an uptake rate ranging from 45-65% of referrals. Our experience has been that the longer the service has been working with a practice the more referrals they receive. To provide this service to all GPs in the Deep End would cost around £564,000 (total referrals of approximately 8,300) and for all practices in Glasgow around £982,500 (referrals of approximately 14,400).

Community Oriented Primary Care (COPC) is an approach to primary health care, which combines epidemiological and health improvement interventions with clinical care. A pilot project was initiated in Drumchapel as part of the Keep Well programme in 2011. It aimed to strengthen links between strategic planning, front line clinical staff and community/third sector organisations and to realise the assets available in local communities to shape coherent and responsive change for local health improvement (Scoular et al 2013) Since then a further three sites were developed in Possilpark, East PollokShields and Govanhill.[32].

North East, 24 in North West, and 19 in South). These 80 practices cover a population of approximately 357,000 patients.

[32]Identifying the contribution of Community Oriented Primary Care to local public health programmes, Suzanne Whiteford, Primary Care, Health Service, Public Health, June 2018

Messages from engagement process

Feedback from our engagement was strongly of the view that through this plan we need to meet the needs of our patients who have multiple health and socio-economic problems (including issues of addiction, poor mental health and poverty, financial inclusion and disability).

Improving communications with patients was highlighted by many of the people we talked to as critical; good communication will make sure that they know how services will be changing in the future, how they can access the service that is best for them and what they should expect from primary and community services. This was highlighted during discussions as a key issue for ethnic minority patients who do not speak English but also applies to the wider population.

In order to make a decisive shift towards self-care and prevention, we must work to support health literacy and inequality-sensitive care across all of our staff groups and services. Approaches based on care and support planning and inequality sensitive practice were noted as providing a starting point for the development of skills and for planning approaches that could be used by multi-disciplinary teams as they are developed. We must work collectively with acute services and other partners, such as the third sector and professional educational organisations, to deliver strong, person-centred self-care approaches, which will explicitly take account of inequalities and differences in health literacy. This approach will support new models of care and ensure that these tackle inequalities and the over-reliance on reactive care.

Furthermore, the additional investment will make possible an increase in the capacity of primary care to adopt more holistic forms of care that can incorporate the multi-faceted aspects of health inequality. This would be based on providing more time for patient consultations and in doing so allow GPs to properly explore and find solutions to complex health and social problems and will support prevention and early interventions strategies that are embedded in GP provision.

Initial Modelling

We recognise that the fundamental objective of the PCIP is to reduce GP workload across all GPs but that, as part of this work, we believe that there should be a focus on reducing inequalities (as these inequalities create additional burdens on practice workloads). Using a variety of funding mechanisms and initiatives (such as the funding for mental health services and funding from the Alcohol and Drugs partnership), in conjunction with the new investment for primary care, we would propose to progress a range of initiatives which will result in reductions in the workloads of GPs and in a narrowing of the health inequality gap.

Actions

Examples of some of the work we will take forward during the period of the plan include:

- We will complete an equality impact assessment on this overall plan.
.
- Improving access to primary care for those people who normally find it difficult to engage with current systems. As part of the further roll out of the Community Links Worker programme we will test the ‘link worker’ role for a protected characteristic

group to ensure non-geographical community networks and resilience are developed as part of the model.

- We will engage with the work that the Deep End practices and Dundee University are undertaking to analyse in more depth the impact that the co-located financial advice services are making to reducing demand for GP time. The findings of this work could be used to inform our development of the Community Links Worker model and for assessing the potential for rolling out the approach to a wider range of GP practices.

- We will build on the learning from the youth health provision to develop a preventative and clinical service that will work with more vulnerable adolescents and be based in some of our poorest neighbourhoods.

- We will use the learning from Community Orientated Primary Care to shape future ways of working.

- Our approach in this PCIP will build on and complement a range of developments funded by the Alcohol and Drugs Partnership (such as the roll out of the Attached Alcohol Nurse Deep End project and the prevention and recovery programme) and the funding from the Mental Health Strategy (such as funding in mental health training).

- The Mental Health Strategy aims to reduce social isolation and the City Council has allocated £2 m to invest in projects which support its campaign to end loneliness. We will support general practice to know what is being taken forward locally and to ensure that their patients are able to benefit from these projects.

Section 8: Implications for the Health and Social Care Partnership's Services and Staff

The new GP contract has wide ranging and significant implications for the HSCP across all our workforce and services. The proposal to further roll out multi-disciplinary team working and the additional funding to recruit new practitioners to take on more of the practice workload will require us to reshape how we provide services. The following are examples of some of the challenges and opportunities which we may face as we progress the plan:

- The **district nursing workforce** is crucial to the emerging models of community care and the provision of high quality care at home. However, our workforce is being depleted as a result of both increasing retirements and (despite initiatives to recruit and train new nurses over the past few years) continuing difficulties in recruiting enough new nurses into the service to fill the vacancies. In 2017 the average age of the Band 6 nursing workforce was 53 years with 70% of the workforce over the age of 50 years. District nurses over 55 years of age can opt to leave the service at any time and the numbers of staff that have the option to leave in the next 24 months represent 13% of the current workforce (2017). There is a risk that the recruitment of Advanced Nurse Practitioners to deliver on the Urgent Care priorities could attract experienced district nurses, thereby, diminishing our existing cohort of nurses.

- One of the successes in reducing GP workload has been our **community respiratory service**. However, demand is now exceeding the available resources and is resulting in longer service response times as well as reducing the capacity of the service to undertake preventative work with patients. There is a requirement also to develop a 7 day service response to meet patients' needs. The community respiratory service might be one of the elements we include as our response to urgent care.

- For our **rehabilitation teams** the shorter length of stay in hospital, our introduction of intermediate care and the requirement for more support in the community is lengthening our response times and resulting in patients with less urgent needs being placed on a waiting list.

- The development of **large residential homes**[33] presents an opportunity to review patient registrations with GPs and the clinical input required for patients. These facilities also provide the option of residents receiving treatment and care interventions through the use of Advanced Nurse Practitioners and Care Home Liaison Nurses.

- The increasing prevalence of people with dementia and the need for early diagnosis and support may require us to review how GPs and our practitioners in **Older People's Mental Health Services** work together to provide patient care.

- Our **Palliative and End of Life Care Plan 2018-2023** includes a number of actions that are about working to enhance the quality of **Anticipatory Care Plans,** through enhanced use of multi-disciplinary team working and increased completion of eKIS[1].

[33] Three are operational and another two are under construction.

[1] eKIS is an online care plan completed by practice staff in Primary Care that can be viewed during unscheduled/ emergency care episodes.

- Implementation of the **"Neighbourhood"** delivery model of community older people health and social care services - with service managers covering specific geographies within a locality and with teams which are more closely aligned to GP clusters, to housing providers, to third sector organisations, community planning arrangements and health improvement teams - provides a framework for the development of MDT working across a wide spectrum of services.

The implementation of the PCIP will provide opportunities for GPs to shape these developments and to improve connections with (and make better use of) a wider range of NHS, Council and third sector services for the benefit of patients (examples, include improving the rate of referrals to money advice services and the MacMillan Cancer Journey Service).

Section 9: Developing the Roles of Other Primary Care Contractors

The new GP contract offers opportunities for re-defining over time the roles of the other primary care contractors to improve access and a to create a seamless care pathway for patients so that they can see the right practitioner at the right time.

Optometry - since 2005 there has been a major shift in optical workload from GPs to optometrists from 34% to 90% and the aim is that all acute eye problems should go to optometrists. Where funding is available optometrists are willing to take on new types of work. Prevention and early intervention to identify eye conditions and to reduce the likelihood of them becoming worse are important areas for further development, especially for people with learning disabilities and black and minority ethnic communities. Health promotion and activities that aim to increase the awareness of eye problems were recommended by optometrists involved in the discussion on this plan.

Action

We will improve communication between GPs and optometrists identifying an optometry contact for each GP cluster.

Community Pharmacy - while the new GP contract offers potential and opportunity, it brings challenges for the community pharmacy network. Pharmacy has challenges with the availability of locum cover and recruitment at a time when the pharmacist and pharmacist technician roles are required across all aspects of healthcare provision. This should not, however, prevent the identification of developments in community pharmacist that could support other aspects of primary care to promote the well-being and on-going management of patients care in the community.

As a consequence of the ease of access to services and a “no appointment” system, community pharmacy has the potential to deliver a range of additional services that could benefit the healthcare needs of patients in the community. One example is an extension of the Pharmacy First service to treat a range of minor conditions under PGD[34] as well as maximising the use of the minor ailments service to ensure patients are managing their own conditions. Community pharmacy may have a role in the provision of vaccinations. Funding and developments in IT and information sharing would be required to support further extensions to the role of community pharmacies.

Action
We will proactively engage with community pharmacists to explore the nature and extent of their potential contributions.

We will pay close attention to the shaping of the new pharmacist contract.

[34] Patient group directions (PGDs) - GOV.UK, https://**www.gov.uk**/government/publications/patient-group... Who can supply and or administer specific medicines to patients without a doctor under a PGD and which medicines can be administered

Dental and oral health - The Oral Health Improvement Plan published in January 2018 sets out the direction of travel for oral health services which will be taken forward across Greater Glasgow and Clyde, with health and social care partnerships working collaboratively with General Dental Practitioners and the hospital and community dental services. There are over 250 General Dental Practices across Greater Glasgow and Clyde. As recorded in September 2016, 91% of the Scottish adult population were registered with a dentist and almost three quarters had attended their dentist in the previous two years.

Actions

- We will engage with community pharmacists to explore the nature and extent of their potential contributions and pay close attention to the shaping of the new pharmacist contract.

Section 10: Related Policies and Strategies

Adult Services' Transformation Programme

Adult Services in Glasgow City HSCP incorporates Community Justice Services, Sexual Health Services, Alcohol and Drug Services, Mental Health Services, Homelessness Services and Learning Disability Services. The vision for Adult Services sets out the need to deliver high quality and effective services for adults with a complex range of needs. Service users and patients should receive the right services at the right time and service users and their families should be supported to live as independently as possible within their communities. Our focus for transformation will be on approaches which promote prevention, early intervention and recovery.

Older People's Transformation Programme

It is envisaged that by 2021 the HSCP's older people's service provision will be characterised by achieving the best possible outcomes and quality of life for all older people and on supporting more and frailer older people to remain living in the community for as long as possible. Only those older people with genuinely acute medical needs should be occupying hospital beds. Where no such needs are present, older people will be diverted from admission at the front door or discharged speedily when their acute medical needs have been attended to. Where older people are being supported in the community they will experience a more joined up and co-ordinated input from the HSCP and more effective co-ordination between the HSCP and the Acute.

Children's Transformation Programme

The priority areas are:

- Keep children safe – Glasgow's children and young people are safe, free from harm, physical and sexual emotional abuse.
- Healthy and resilient children – Glasgow's children and young people are healthy, nurtured and happy, have places to play and have fun and have an adult who they can trust to talk to.
- Family support and early intervention – we will work with families and third sector organisations to build positive relationships, and to ensure the right measures are put in place to improve the families' circumstances and the wellbeing and development of the child.
- Raise attainment and achievement for all – Glasgow's children
- Care experienced children and young people – our care experienced children and young people will be given every opportunity to improve their life experiences and chances.

Unscheduled Care

In March 2017 the IJB approved the HSCP's three year unscheduled care strategic commissioning plan. That plan and the subsequent action plan described significant change programmes to improve outcomes for patients and closer working between primary and secondary care. The plan was based on feedback from GPs, community services and secondary care clinicians. The plan focused on three main areas:

- Programmes that better support manage patient care in primary care and community settings e.g. roll out of the Glasgow respiratory service, introduction of neighbourhood teams, anticipatory are plans for specific patient groups etc.;
- Programmes that improve discharge and support people after a hospital episode e.g. development of intermediate care, introduction of the Home is Best Team etc.; and,
- A joint programme of work with acute clinicians to improve the primary / secondary care interface e.g. the development of primary / secondary care interface arrangements, improved access to consultant geriatricians, exploring the potential for "hot clinics" and access to diagnostics / investigations.

Unscheduled care is a strategic priority for the HSCP and a key part of the HSCP's wider strategic intention to shift the balance of care and resources towards a more primary care and community focus, since that is where the majority of patient contact takes places. This strategic direction is supported by NHSGG&C's Moving Forward Together programme. GPs and clusters clearly have a vital role to play in improving unscheduled care for patients, and the HSCP is committed to supporting GPs in taking this agenda forward. Key areas for discussion with GPs include:

- Appropriate arrangements for access to consultant advice to inform clinical decision making in primary care.
- Information on waiting times.
- Closer working with consultant geriatricians to manage patients in care homes.
- Supporting the completion eKIS.
- Supporting the implementation of anticipatory care plans for agreed patient groups.
- Developing a model to better manage frailty in the community.

Moving Forward Together and working in collaboration with acute hospital services

The Moving Forward Together programme for Greater Glasgow and Clyde sets out a future vision for health and social care. This describes a whole system approach in which services are delivered by a network of integrated teams across primary, community and specialist and hospital based care. The MFT programme has been developed in parallel with the primary care improvement plans and builds on the direction of travel for the new GP contract, including the expert medical generalist role and the development of the multi disciplinary team. MFT envisages the development of an enhanced community network, which goes well beyond the changes identified in PCIPs and describes some of the enablers and infrastructure required to support this. While there will be an opportunity to build on the foundation of the MDT established through the PCIPs, the further detail and investment required for the enhanced community network will be developed as part of the next phase of MFT.

Review of Out of Hours' Services

The provision of General Medical Service in evenings, overnight and at weekends is not included in the new GP contract. We are acutely aware of the significant challenges facing the GP out of hours service in providing a sustainable service and it is essential for in-hours services that out of hours services run efficiently and effectively, therefore specific actions to improve continuity of patient care, which will reduce pressure on the local out of hours service, should be incorporated into the implementation of the PCIP.

A review of health and social care Out of Hours (OOH) services has commenced across the Greater Glasgow and Clyde area and includes GP OOHs; District Nursing; Rehabilitation; Homelessness; Mental Health; Home Care; Glasgow and Partners Emergency Social Work Services; Emergency Dental Services and Out of Hours Children's Social Work Residential

Services. The local review is intended to consider 28 recommendations from the national review and to determine if there are new ways of working that can implemented locally. The review of the Out of Hours services will have an impact on in-hours work for GPs and their practices.

The key issues which we need to consider as we progress the PCIP are as follows:

- To develop a more streamlined, integrated and efficient provision of HSCP Out of Hours Services in line with the Strategic priorities as outlined in the National Review of Primary Care Out of Hours Services
- Developing Public Awareness which will Support and make Best Use of Services during the OOHs period by ensuring that access is for Urgent care only, that is, any symptom or request that can't wait for daytime services
- Establish and agree the interface and inter-linkages between daytime and OOHs, with the patient / client at the centre, which will ensure that when urgent care is needed in the OOHs period it is coordinated
- Developing More Effective Use of Technology to support information sharing across the service, which will facilitate decision making during the OOHs period
- Scoping the Future Role of the Third and Independent Sectors to support the OOH period

Ensuring the development of an integrated and rotational (between daytime and OOHs and across HSCP services as appropriate) multi-disciplinary workforce and creating a supportive environment where staff are attracted to and want to keep working in the OOHs.

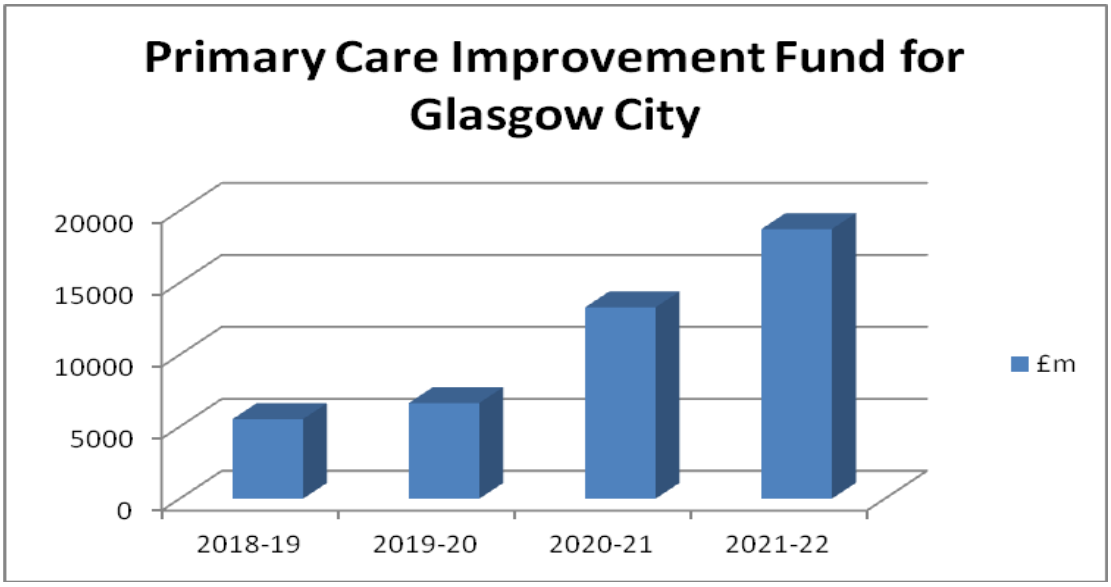
Section 11: Funding the Plan

The Scottish Government has recognised the increasing demand and expectations that are placed upon our frontline services within primary care and is clear that the status quo is not an option. In support of this and to ensure that the new GP contract can be fully implemented, the Cabinet Secretary for Health and Sport has announced that, in addition to the funding for General Medical Services, funding in direct support of general practice will increase annually by £250 million by the end of 2021-22, and forms part of the Scottish Government's commitment to an extra investment of £500 million per year for primary care funding.

As part of this funding package, the Scottish Government is investing a total of £115.5 million in the Primary Care Fund in 2018-19 and the details of this are shown below.

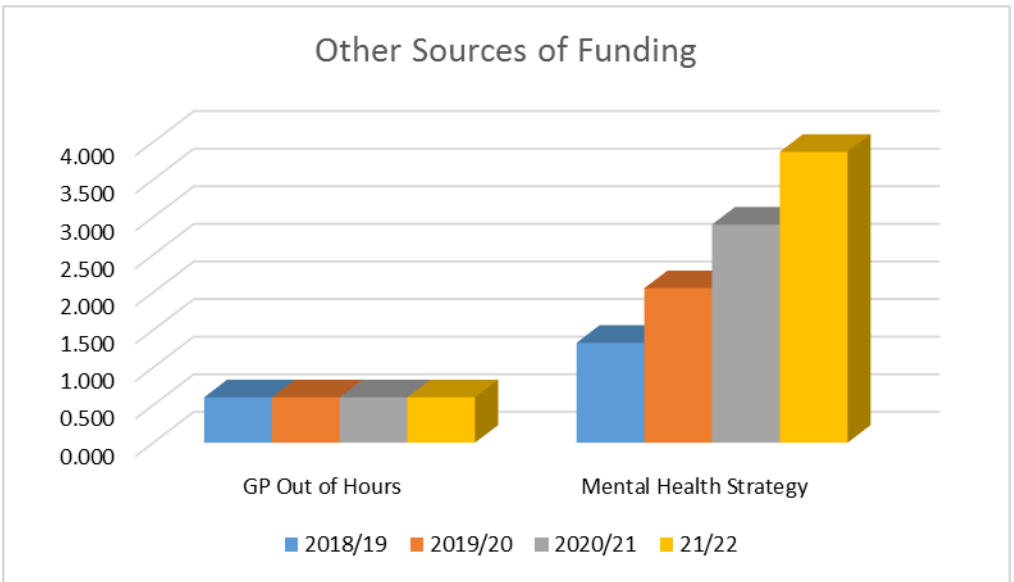
Primary Care Fund	**2018-19 £millions**
Primary Care Improvement Fund :	
GMS:	
National Boards	**16.569**
Wider Primary Care Support:	
National Support	5.606
Primary Care Infrastructure	2.000
Out of Hours	5.000
GP Recruitment and Retention	5.000
Wider Primary Care Support Total	**17.606**
Total	**115.500**

This allocation includes £45.750m to support the implementation of the Primary Care Improvement Fund, of which Glasgow City IJB/HSCP has been allocated £5.529m. This is forecast to increase to £155m by 2021-22, of which £18.732m will be for Glasgow City.



Integrated Joint Boards (IJBs)/HSCPs have been asked to plan on the basis that full funds will be available and will be spent in 2018-19. Funding for 2018-19 will be issued in two tranches, with 70% paid in June and the remaining 30% in November 2018. However, given the timing of the approval of the plan and the lead in time required to secure the right resources to support GP's, it is possible that full spend will not be achieved in 2018-19. In light of the challenge to fully fund the investment required it is helpful that the Scottish Government has given a commitment to ring fence any unspent allocation from 2018-19 for use in 2019-20.

In addition, IJBs have been provided with funding to support delivery of GP Out of Hour Services and funding to support the employment of 800 additional mental health workers to improve access in key settings including GP practices. Glasgow City IJB has been allocated additional funding in support of these priorities and some of this will be accessed in support of the delivery of the PCIP. Details of this total funding are shown below. Detailed plans are still under development and as these are refined we will map out how these will be used to support the objectives of the PCIP.



(Mental health Strategy refers to Action 15 of the national mental health strategy)

The Regional Plans being developed for the NHS also include a commitment to prioritise funds for primary care and once these are further developed can be used to supplement delivery of the plan.

Glasgow City's PCIP has identified a number of areas of investment which are required to support the commitments which have been made under the new GP Contract. The table A below reflects the current high level planning assumptions and broad costs for the plans which have been developed to date.

Table A

Primary Care Improvement Plan	2018/19	2019/20	2020/21	2021/22
	£000's	£000's	£000's	£000's
Existing Commitments				
Mental Health	792	-	-	-
Govan SHIP	80	-	-	-
Urgent Care - Out of Hours Service	481	495	510	526
CQL Cluster Support	218	300	309	318
Community Treatment and Care Services - Phase 1	221	375	386	398
Cluster Tests of Change	200	-	-	-
Out of Hours (GP)	252	-	-	-
PC Support	94	-	-	-
Community Link Workers	415	896	923	951
Pharmacy First	172	177	182	188
Pharmacotherapy (Legacy)	1,425	1,468	1,512	1,557
Sub Total	**4,350**	**3,711**	**3,823**	**3,937**
New Commitments				
Vaccination Services				
Vaccination Transformation Programme - Pre -School	372	766	789	813
Vaccination Transformation Programme - School	tbd	tbd	tbd	tbd
Vaccination Transformation Programme - Adults	tbd	tbd	tbd	tbd
Vaccination Transformation Programme - Housebound	85	88	90	93
Vaccination Transformation Programme - Travel	tbd	tbd	tbd	tbd
Pharmacotherapy Services				
Pharmacotherapy Service	178	1,697	3,071	3,504
Community Treatment and Care				
IP Clinic Contraception	7	-	-	-
Community Treatment and Care Services - Phase 2	200	500	750	1,000
Urgent Care				
Urgent Care - Advanced Nurse Practioners or Paramedics	-	2,833	2,917	3,005
Out of Hours Services - balance of spend to be programmed	123	109	94	78
Multi Disciplinary Team Working				
MDT - MSK Physioterapists	218	635	932	960
Mental Health	-	2,216	4,431	6,244
Community Link Workers				
Community Link Workers	221	746	1,413	1,456
Infastructure and Project Management and Evaluation				
Project Team	75	155	159	164
Primary Care Plan Implementation - PCDO Posts	170	175	180	186
Programme Evaluation	tbd	tbd	tbd	tbd
Back Scanning	tbd	tbd	tbd	tbd
Sub Total	**1,649**	**9,918**	**14,827**	**17,502**
Total	**5,999**	**13,629**	**18,650**	**21,440**

Funding Sources	2018/19	2019/20	2020/21	2021/22
	£000's	£000's	£000's	£000's
Primary Care Improvement Fund	5,529	6,647	13,294	18,732
GP Out of Hours (OOH) Fund	604	604	604	604
Primary Care Transformation Fund - Carry Forward	1,857	-	-	-
Funding Available	**7,990**	**7,251**	**13,898**	**19,336**

+Balance Remaining/-Shortfall	**1,991**	**- 6,378**	**- 4,752**	**- 2,103**

Table A highlights proposed investments in support of GP practices of £21.440m by 2021/22. However as can be seen from this table, this is still a work in progress, with a number of investment proposals still to be costed. This represents a risk to the PCIP in terms of the need to make decisions on expenditure in 2018-19 before all plans are known and the risk that the overall plan may be not be affordable once full costs are available. This is already evident in the current estimates which will be in excess of the funding available from 2019/20 onwards.

However emphasis will remain firmly on managing within the allocated budget, ensuring affective and affordable models and approaches which will direct workload from GPs and advance patient care.

The pace at which plans can or need to be delivered is also an issue. The funding identified to date to support this plan is identified in table A. This includes the use of funding which has been carried forward from previous financial years for the purposes of supporting primary care investment and is now being used to support the plan. This table highlights the need for us to slow down our proposed investment to match the funding profile and highlights the importance of any unused funding from 2018-19 being ring-fenced for Glasgow City IJB to support of the acceleration of investment in future years. We welcome the Scottish Government's commitment that any under spend that is occurred during this year will be retained for use in 2019/20.

Section 12: Delivering the Plan

Leadership and Engagement

Shared leadership will be critical to the success of this plan. This will be necessary at different levels- clusters, localities, city and GG&C (see appendix 1 and 2).

In Glasgow City HSCP the Primary Care Strategy Group (PCSG) will retain overall responsibility for developing the initial PCIP over future years, taking forward its implementation, managing the available resources in ways that fulfil the requirements of the memorandum of understanding for the benefit of patients, practices and services and reporting regularly to the Integration Joint Board. The HSCP is committed to working in partnership with the GP Subcommittee to oversee the implementation of the PCIP.

However in recognition of the scale, pace and complexity involved in taking forward the PCIP in Glasgow it is proposed to establish a PCIP Implementation Leadership Group co-chaired by an Assistant Chief Officer (ACO) from the HSCP and a member of the GP Sub Committee. This will oversee and guide the work of the individual work streams to ensure delivery of the actions within the timescales and within the constraints of the available budget. The implementation work stream groups will comprise a nucleus of Clinical Director, senior manager, GP Subcommittee representative and support staff.

Our engagement with GPs principally with CQLs ,[35] at city level and with GPs within our 3 localities has been significant and has made a notable difference in shaping the plan. We will ensure that this engagement remains an integral part of future development and implementation of the plan.

We recognise there is scope to go further and that having different layers of engagement with GPs is vital. CQLs have played a valuable role in influencing the plan by providing advice on those actions that would make the most impact for them in shifting workload from individual practices. We see value in this type of engagement continuing but recognise that it may require greater support in recognition of the rising pressures and expectations on the role of CQLs.

We think that the present arrangements for GP engagement could be usefully supplemented by a twice yearly session directed primarily at PQLs[36] but open to all GPs working in the city. This would help improve understanding of the present initial plan, its background and design, allow us to appreciate the challenges and prospects for implementation over the next three years, enable contributions to ways in which implementation could be tailored and accelerated, confirm local priorities for action, promote effective engagement with GP clusters, ensure that we achieve best value and advise on deployment of staff. We plan that the first of these sessions will take place in September 2018.

The memorandum of understanding makes references to acute care services and to the potential importance for them of the changes in primary care and of the value of them being more aware of the implications and of being more closely involved. In 2108-19 we will take this forward within the city and at NHSGG&C level and/or regionally through the Primary Care Programme Board.

[35] GP Cluster Quality Leads
[36] GP Practice Quality Leads

Programme Support and Infrastructure

To be a success a plan of this scale, complexity and public profile will require robust programme and project management provision. To support implementation a programme management team will be established consisting of a programme management and project support, administrative support plus capacity for evaluation (see below). Programme and project management support will be essential not only to progress and firm up the initial proposals but to sequence, prioritise and forward plan, integrate with other services, ensure on-going engagement and communications and support the implementation work streams Other infrastructure costs will be incurred to support the cluster model of GP working, to fund the tests of change and to evaluate the existing legacy projects. We appreciate that the PCIP fund is to be used to provide additional support for GPs and, therefore, we will ensure that the programme support costs will be kept to the minimum necessary to ensure the effective implementation of the six workstreams.

Monitoring and Evaluation

The PCIP maps out the beginnings of an ambitions and implementation programme and while many benefits are assumed and planned for it is vital to ensure best value and that workload is being efficiently diverted away from GPs. This will require a proper evaluation plan from the outset which can demonstrate what this additional investment and services are achieving. We aim to work with public health and possibly Glasgow Centre for Population Health (GCPH) building on their guidance and expertise and also to utilise the LIST resource.

Nationally we will take account of the forthcoming national Primary Care Monitoring and Evaluation Strategy and Primary Care Outcome Framework. The monitoring and evaluation activity will be led by the Primary Care Strategy Group in partnership with the GP Subcommittee. We will agree with the GP Subcommittee how this M & E process will take place to ensure that they are fully informed on the impact of the workstreams.

The following areas will be priorities for our evaluation:

- Collaborating with GPs to get a better understanding of patient activity in primary care and the role of cluster working in improving the quality of care.
- Measuring the impact of the plan on reducing GP workload, improving patient care and reducing inequalities in health.

Employability and workforce

We will need to develop a robust workforce plan to outline how we intend to recruit and train the new staff, to up skill existing staff to take on some of the roles, to explain how we will manage the impact of the programme on our existing workforce. The proposed staffing numbers identified in this plan will have a significant impact on health board-wide staffing but also potentially at a regional and even national basis. Colleagues in HSCPs across NHS Scotland will be modelling similar plans and seeking to recruit from a limited pool of existing trained staff. Importantly, details of the requirements proposed must be reflected within regional planning arrangements at a minimum, but the HSCP will engage with NHS Professional Leads from across the health board to discuss current and future training requirements, to see what opportunities can be developed regionally and to address competing requirements for clinical expertise across the whole health system.

We know that for some of the new posts there are insufficient numbers of experienced practitioners currently in the employment market to take on these roles and that it can take many years to train people up to become proficient. This is the case for pharmacists, for

instance, as there will be a time lag of several years before enough experienced pharmacists will be available for the primary care posts, without a large recruitment drive having adverse affects on the wider pharmacy workforce.

The Chief Nursing Officer for Scotland has confirmed her commitment to maximising the contribution of the nursing, midwifery and health professions workforce to push the 'traditional' boundaries of professional roles. This is described as the 'Transforming Roles' programme, which aims to provide strategic oversight to develop and transform these roles to meet the current and future needs of the health and social care system and to ensure nationally consistent, sustainable and progressive roles with education and career pathways.

Work has already begun to look at the district nursing role in integrated community nursing teams, with a key leadership role in public health, anticipatory care, assessment, care/case management, complexity and frailty, intermediate care and palliative/ end of life care. This detail will be represented as part of our on-going workforce planning arrangements for the HSCP and wider district nursing workforce.

The new working arrangements will allow us to explore new roles within job families, and review the capabilities and requirements of existing roles. For example, within our nursing workforce we have the established cohort of health care support worker staff and there may be an opportunity to review their roles and responsibilities appropriately to support the work to be delivered.

We will work closely with GPs through the GP Subcommittee to ensure that the proposed roles are appropriate for the work that they will be expected to carry out in practices.

Equally we need to review the delivery and numbers of emerging professionals and to take the opportunity to review any areas of untapped opportunity with highly qualified graduates, who may be able to undertake a range of the work to be delivered with the relevant support and training.

Glasgow City HSCP will work with colleges and training providers to put in place employability pathways so that people in the City, who would not normally consider employment within the health and care service, can be supported to access these job opportunities.

New GP Clinical IT and Information sharing

NHS Boards have commissioned a procurement competition to provide the next generation of GP clinical IT systems for GPs in Scotland. All GP practices will transition to the new systems by 2020. GPs will continue to have the right to choose a clinical IT system from those which have been approved by the Scottish Government.

The contract sets out the roles and responsibilities of GP contractors and NHS Boards in relation to information held in GP patient records. The contract will support adherence to the Data Protection Act 1998 and help prepare GP contractors and NHS Boards for the new General Data Protection Regulations.

The new contractual provisions reduce the risk to GP contractors of being data controllers. The contract recognises that contractors are not the sole data controllers of the GP patient record but are joint data controllers along with their contracting NHS Board. The contract clarifies the limits of GP contractors' responsibilities. GP contractors will not be exposed to liabilities beyond their effective control and there will be data sharing agreements in place to support MDT working.

The Moving Forward Together Programme sees digital technology (DT) as "central to achieving the transformational change necessary to support integrated health and social care teams in delivery of new models of care". The harnessing of DT will alter possibilities and enhance prospects for the implementation of the new GP contract, improving patient outcomes and better MDT working. Examples already exist, such as the Clinical Portal, which show the progress that is being made. MFT foresees scope in the future for improved communications and decision-making support enabled by DT, facilitated by shared care with access for the patient and multi-professional team to the available information to decide on and co-ordinate patient care, and ultimately the development a single integrated electronic comprehensive care plan comprising relevant health and social care information. Embracing DT will usher in many innovations, such as home health monitoring, virtual consultation and technology enabled early warning alerts of patient deterioration.

Premises and space planning

In Glasgow 56% of GP premises are either owned by GPs or leased by them from third parties. GPs receive financial assistance from the Health Board towards the cost of these premises. The National Code of Practice for GP Premises (November 2017) was agreed between the BMA and Scottish Government in recognition that there is pressure on the sustainability of general practice, which is linked to liabilities arising from GP contractors' premises. The Code of Practice sets out the Scottish Government's plan to transfer to a model that does not entail GPs providing their practice premises. The Code advises that

- The Scottish Government and Health Boards will enable the transition over a 25 year period to a model where GP contractors no longer own their premises;

- The Scottish Government and Health Boards will support GPs who own their premises during the transition to the new model by offering interest-free secured loans.

- The Scottish Government will set up a "GP Premises Sustainability Fund" and will commit £30 million of additional support to this fund to be spent by the end of this Parliament. Allocation of the funding to individual practices will be based on criteria developed nationally.

The Code also sets out the actions that those GP contractors who no longer wish to lease their premises from private landlords must undertake to enable Health Boards to assume that responsibility.

The HSCP published a Property Strategy in 2017 that outlines the key priorities for health and social work capital investment. The Property Strategy will be reviewed to take account of the Code. The aim of the strategy is to ensure that our buildings allow the delivery of high quality health and social care services. In considering the Code the following issues need to be taken into account:

- Whilst Glasgow has benefited from investment to develop new health and social care hubs over the past few years, we still own and lease a substantial portfolio of older buildings, which will require significant investment to enable them to provide sufficient, good quality accommodation.
- The opportunities from mobile/agile working to free up space within our existing properties that could be used to provide additional clinical accommodation.
- The requirements for additional and/or flexible space in health and social care hubs to provide space for GPs practices that relocate from their current properties.
- The requirement to provide space in health centres/GPs' own buildings to provide accommodation for the multi-disciplinary teams.

- There may be a need to provide additional Business Support resources for health centres.
- We will take an integrated approach to our property strategy which will include working with the City Council and other local partners as part of the community planning arrangements to maximise the use of the land and buildings.

Section 13
Summary Implementation Plan 2018-21

Vaccinations

Requirement of Memorandum of Understanding - Through the Vaccination Transformation Programme shift responsibility for delivering vaccinations away from GPs

Action	Estimated Timescale
We will implement the recommendations from the review of pre-school immunisation delivery across Glasgow City.	2018/19
Complete the initial scoping of service for influenza programme for 2 to 5 year olds. Recommendations will be made on potential alternative delivery models, including identifying challenges to implementation, what will facilitate implementation and the indicative costs for each model.	2018/19
Complete the initial scoping of service for influenza programme for pregnant women. Recommendations will be made on potential alternative delivery models, including identifying challenges to implementation, what will facilitate implementation and the indicative costs for each model.	2018/19
We will investigate the feasibility of midwifery delivery of the influenza and pertussis vaccinations with maternity services.	2018/19
Complete the initial scoping of service for adults (65 years +, <65 at risk groups). Recommendations will be made on potential alternative delivery models, including identifying challenges to implementation, what will facilitate implementation and the indicative costs for each model.	2018/19
We will provide funding to enable District Nurses to provide the influenza vaccine for people aged over 65 years, who are housebound but not on a district nurses' case load.	2018/19
Complete the initial scoping of service for Pregnant women – pertussis (whooping cough). Recommendations will be made on potential alternative delivery models, including identifying challenges to implementation, what will	2018/19

Action	Estimated Timescale
facilitate implementation and the indicative costs for each model.	
We are awaiting the completion of the national options appraisal exercise that is being led by Health Protection Scotland, to provide clarification of the scope of the Travel vaccinations and travel health advice programme.	To be agreed

Pharmacotherapy

Requirement of Memorandum of Understanding - Establish a sustainable pharmacotherapy service by 2021

Action	Estimated Timescale
To deliver on the national commitment to the core pharmacotherapy services as outlined in the new GP Contract we will recruit an additional 67 new whole time equivalent pharmacy posts to increase the total support to GPs to 90 wte posts.	By 2020/21
We will involve GPs in the implementation of the pharmacotherapy workstream and, where needed, support them to develop collaborative based working arrangements with the new pharmacy staff as part of the multi-disciplinary teams.	2018/19 to 2020/21
We will engage and communicate pharmacists, and our staff on the future changes.	2018/19 to 2020/21
We collaborate with GPs, the other HSCPs, NHSGG&C and the wider pharmacy system to develop the new service models and service improvements.	2018/19 to 2020/21
We will develop the partnership working across the wider pharmacy system in Glasgow City, including community and hospital pharmacy, to consider innovative ways of working which will reduce GP workload and improve services for patients.	2018/19 to 2020/21
We will maintain a strong focus on working within our prescribing budget as set by the HSCP financial plan.	2018/19 to 2020/21
We will Collaborate with national stakeholders including NES and the Scottish Government Pharmacotherapy Service Implementation Group.	2018/19 to 2020/21

Action	Estimated Timescale
We will explore with community pharmacy opportunities for further development of their services.	2018/19 to 2020/21

Community Treatment and Care Services

Requirement of Memorandum of Understanding - The responsibility for providing these services will move from GP practices to HSCPs

Action	Estimated Timescale
We will develop a community phlebotomy service and recruit 11 wte phlebotomists.	2018/19
We will develop the new model of treatment and care service and manage the transition of a range of treatment room activity that currently delivered in GP practices into the HSCP Treatment and Care Service.	2018/19 to 2020/21

Urgent care

Requirement of Memorandum of Understanding – The PCIP should set out how we will respond to urgent unscheduled care within primary care, including being the first response to a home visit or responding to urgent call outs, freeing up GPs to focus on their role as expert medical generalists

Action	Estimated Timescale
We will agree a definition for “urgent care” so that we can design services based on mutually agreed requirements.	2018/19
Will investigate the scale of the need and the types of interventions that are more likely to reduce the time spent by GPs in providing urgent care services.	2018/19
Jointly with individual practices, we will consider the potential for up skilling existing staff, such as practice nurses and care home liaison nurses.	2018/19 to 2019/20

Action	Estimated Timescale
We will undertake some development work on the interface with care homes possibly by extending care home liaison role to cover residential care.	2018/19
We will progress a test of change in one of our residential homes, using ANPs (or nurse prescribers) and Care Home Liaison Nurses.	2018/19 to 2019/20
We will investigate e-health solutions to increase the efficiency and effectiveness of urgent care.	2018/19
We will connect this work to other developments, such as the out of hours review and initiatives to improve anticipatory care planning.	2018/19
We will work with GPs to identify ways of improving how patients are triaged for urgent care.	2018/19 to 2019/20

Additional Professionals for Multi-Disciplinary Teams

Requirement of Memorandum of Understanding - By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care.

Action	Estimated Timescale
We will use the learning from the different approaches that have been used across the city and develop a model that can be used to deliver the MDT requirements of the new GP contract.	2018/19

Additional Professionals for Multi-Disciplinary Teams

Requirement of Memorandum of Understanding - By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care.

MSK Physiotherapists

Action	Estimated Timescale
We will increase the number of Advanced Practice Physiotherapists by 5 and embed them in GP practices as part of multi-disciplinary teams	2018/19
We will give more consideration to the specification for the role and whether or not we want to include treatment as well as assessment to the APPs role.	2018/19
We will evaluate the impact of the physiotherapist role in the Govan SHIP and to take account of any further outcomes from the Inverclyde approach.	2018/19
We will investigate other options for providing advice and support to patients with muscular skeletal problems.	2018/19
We will recruit another 10 wte posts Advanced Practice Physiotherapists and embed them in GP practices as part of multi-disciplinary teams	2019/20 to 2020/21

Additional Professionals for Multi-Disciplinary Teams

Requirement of Memorandum of Understanding - By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care.

Mental Health Workers

Action	Estimated Timescale
We will undertake an information gathering, process mapping and scoping exercise with GPs that will provide the knowledge and understanding necessary to plan and develop effective and efficient service responses that will divert workload from GPs.	2018/19
We will review the outcomes achieved by the initiatives supported by the existing primary care mental health fund as well as us the lessons from COPE, the Govan SHIP and other projects to inform future developments.	2018/19
We will use any outcomes from Action 23 of the national mental health strategy to inform our future approach.	2018/19
We will design tests of change in three or four GP clusters that can be taken forward to obtain evidence of what works in providing mental health support in a primary and/or community setting.	2018/19 to 2019/20
We will Involve GPs and the GP Subcommittee in this work to ensure that they are supportive of the eventual proposals and that they are satisfied that GP workload will be reduced as a result of the investment.	2018/19 to 2020/21
We will undertake a training needs analysis among primary care staff to ascertain level of knowledge about mental health issues and confidence in responding to them. Results would inform the development of a mental health training package for non mental health staff. We will develop a training package for mental health staff that provides education on recovery oriented, strengths based and trauma informed models.	2018/19 to 2019/20
We will make the connections with our response to the national mental health strategy (Action 15 and 23) and identify opportunities for joint work and joint funding between the two streams of activity that meet the requirements outlined in the MoU/PCIP.	2018/19

Additional Professionals for Multi-Disciplinary Teams

Requirement of Memorandum of Understanding - By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care.

Occupational Therapist

Action	Estimated Timescale
We will learn from the experience of Lanarkshire NHS Board in embedding an occupational therapist in a GP practice and, where this is shown to be effective in reducing GP workload, we will give consideration to how this role could be developed in Glasgow City.	2018/19

Community Links Workers

Requirement of Memorandum of Understanding - Recruit Community Links Workers (as part of the Scottish Government's commitment to deliver 250 CLWs across Scotland), focused on GP practices with the most deprived patient populations

Action	Estimated Timescale
We will involve GPs in developing the methodology for allocating CLWs to practices.	2018/19
We will continue to develop the Community Link Worker Steering Group through extending membership to key third sector organisations and partners.	2018/19
We will undertake a public procurement process to invite potential third sector suppliers to tender to be on a "Glasgow City Links Worker procurement framework". This will enable us to increase the number of Community Links Workers over the lifespan of the Primary Care Improvement Plan. We anticipate extending the number of practices with Community Links Workers from the current 18 to 27.	2018/19
We will test the 'link worker' role for a protected characteristic group to ensure non-geographical community networks and resilience are developed as part of the model.	2018/19

Action	Estimated Timescale
We will work to establish the routine data reporting and the evaluation programme for Glasgow City's Community Link Worker programme.	
Further extension of the Community Links Worker programme. The total number will depend on the available resources and we have provided a number of options.	2019/20
We will work to strengthen the connectivity between the primary care mental health programme and the community link worker programme.	2018/19 to 2020/21
We will continue to liaise with the Scottish Government to establish a funding allocation for CLWs that reflects the substantial health inequalities of Glasgow's population.	2018/19 to 2020/21
We will work with other stakeholders from the employability sector on workforce planning and training.	2018/19 to 2020/21

Tackling health inequalities

Action	Estimated Timescale
We will complete an equality impact assessment on this overall plan.	2018/19
We will test the 'link worker' role for a protected characteristic group to ensure non-geographical community networks and resilience are developed as part of the model.	2018/19
We will engage with the work that the Deep End practices and Dundee University are undertaking to analyse in more depth the impact that the co-located financial advice services are making to reducing demand for GP time.	To be agreed
We will build on the learning from the youth health provision to develop a preventative and clinical service that will work with more vulnerable adolescents and be based in some of our poorest neighbourhoods.	2018/19 to 2020/21
We will use the learning from Community Orientated Primary Care to shape future ways of working.	To be agreed

Action	Estimated Timescale
We will build on and complement a range of developments flowing from the Alcohol and Drugs Partnership and the funding from the Mental Health Strategy.	2018/19 to 2020/21
We will support general practice to know what is being taken forward by the City Council through its campaign to end loneliness and to ensure that their patients are able to benefit from these projects.	2018/19

Developing the Roles of Other Primary Care Contractors

Action	Estimated Timescale
We will improve communication between GPs and optometrists by identifying an optometry contact for each GP cluster.	2018/19
We will proactively engage with community pharmacists to explore the nature and extent of their potential contributions.	2018/19 to 2020/21
We will pay close attention to the shaping of the new pharmacist contract	2018/19 to 2019/20

Delivering the Primary Care Improvement Plan

Action	Estimated Timescale
We will further develop and then implement arrangements and structures for involving GPs in the delivery of the PCIP.	2018/19 to 2020/21
We will establish a PCIP Implementation Group	2018/19
We will set up a Programme/Project Team	2018/19
We will establish arrangements for monitoring and evaluation of PCIP.	2018/19
We will develop and implement a communication and engagement plan to ensure that all stakeholders continue to be	2018/19 to 2020/21

Action	Estimated Timescale
involved in the further development of the PCIP.	
We will incorporate the PCIP into our workforce plan	2018/19
We will work with employability agencies to identify the potential for offering pathways into the new posts.	2018/19 to 2019/20

Practice Sustainability

Action	Estimated Timescale
As part of our existing support for primary care through our Clinical Directors we will work with a number of GP practices across Glasgow to gather intelligence through utilising the practice sustainability assessment tool that is provided by the Scottish Government..	2018/19 to 2020/21
Work with the Deep End practices to learn from the projects that they have been progressing and, where possible, incorporate this learning into future initiatives supported by the PCIP.	2018/19 to 2019/20

Appendix 1

Glasgow City HSCP Primary Care Governance Map

PCIP Implementation

- Vaccination
- Pharmacotherapy
- Community
- Treatment & Care
- Urgent Care
- MDT
- Physiotherapy
- Mental Health
- Link Workers
- Premises
- workforce

Integration Joint Board

Senior Management Team

Primary Care Strategy Group

PCIP Implementation Leadership Group

Localities

- North East
- South
- North West

Core Leadership Groups

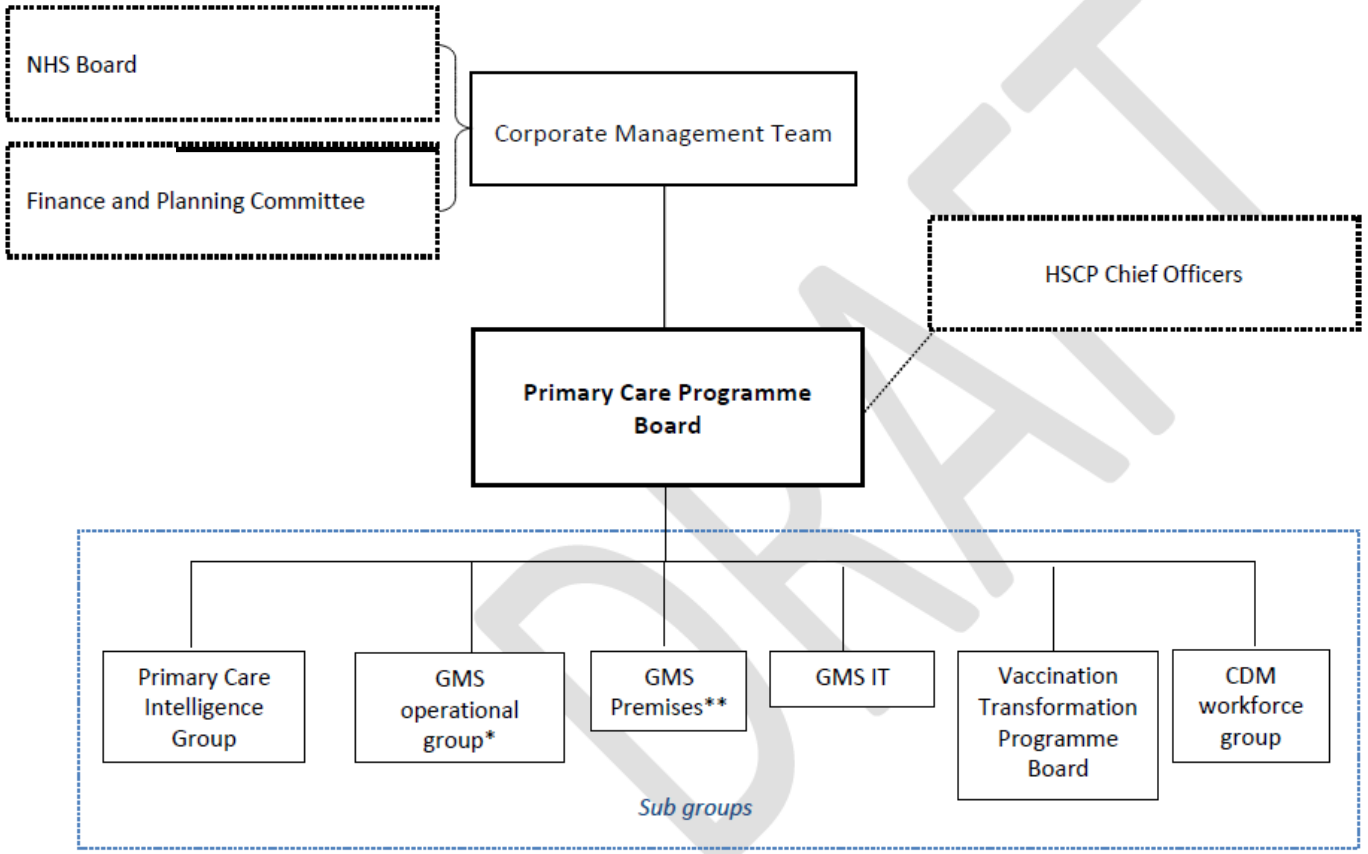
- Capital / Property
- Adults
- Children
- Older People

Associated Groups

- Chief Officers Network Meeting with Richard Foggo
- Oversight Group for New GMS Contract
- Primary Care Leads Group
- Chief Officers Special Interest Group on Primary Care
- NHS GG&C Corporate Management Team
- GG&C Primary Care Programme Board
- GG&C Chief Officer Group

Each with:
CQLs/PQLs/ Clusters
GP Forum/ Committee
Primary Care Implementation Groups

PRIMARY CARE PROGRAMME BOARD: SUB GROUPS AND GOVERNANCE



*to include Local Enhanced Services
** also links to Property Committee

Associated Groups and Forums

- Clinical Directors
- Acute / Primary Care Interface
- HSCP Strategic Planning Groups and Primary Care Strategy Groups
- Referral Management Group
- Out of Hours redesign
- Primary Care mental Health Interface Group
- GP Subcommittee
- ACF and professional advisory structures
- Prescribing Management Group

NHSGGC Primary Care Programme Board April 2018

Appendix 2

Glossary of Terms

HSCP	Health & Social Care Partnership
PCIP	Primary Care Improvement Plan
GG&C	Greater Glasgow & Clyde
LMC	Local Medical Committee
GP	General Practice
PCPB	Primary Care Programme Board
PCSG	Primary Care Strategy Group
MoU	Memorandum of understanding
COPD	Chronic Obstructive Pulmonary Disease
OOHs	Out of Hours
APP	Advanced Practice Physiotherapist
ANP	Advanced Nurse Practitioner
MSK	Musculoskeletal
CQLs	Cluster Quality Leads
PQLs	Practice Quality Leads
PCDOs	Primary Care Development Officers
SHIP	Social & Health Integration Partnership
COPE	COPE Scotland (community organisation based in Drumchapel)
CAMHS	Child & Adolescent Mental Health Services
CMHT	Community Mental Health Teams
PCMHT	Primary Care Mental Health Teams
CLWs	Community Link Workers
COPC	Community Oriented Primary Care
IJB	Integration Joint Board
SMT	Senior Management Team
GCPH	Glasgow Centre for Population Health
NHS GG&C	National Health Service Greater Glasgow & Clyde