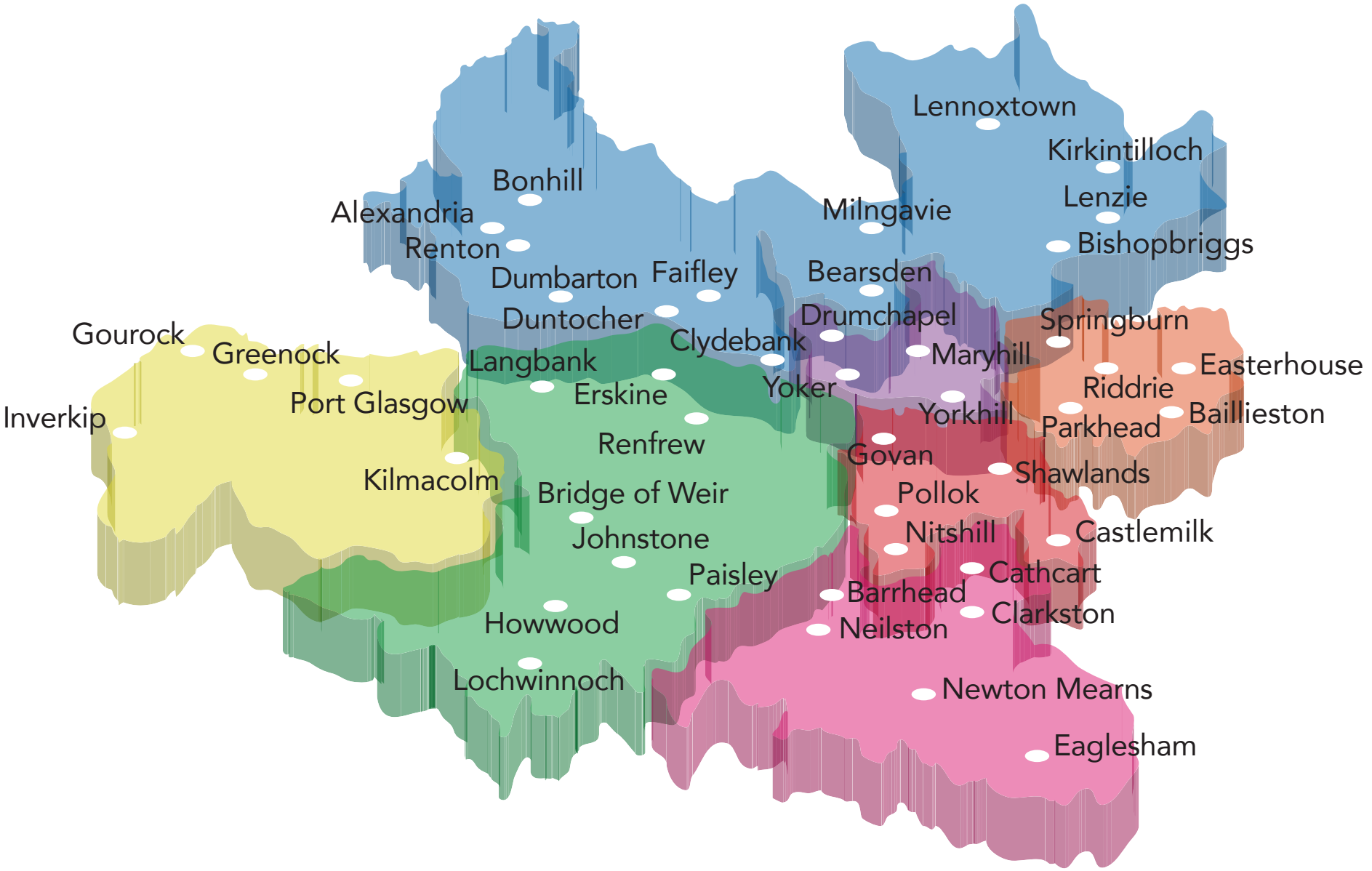
Primary Care Strategy 2024 - 2029

NHS Greater Glasgow and Clyde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Barrhead
Clarkston
Howwood
Neilston
Lochwinnoch
Newton Mearns
Eaglesham

Foreword

We are pleased to set out primary care's shared contribution to the health and wellbeing of people in NHS Greater Glasgow and Clyde (NHSGGC) over the next five years.

For the first time, primary care services in NHSGGC have come together to define shared ambitions and make a joint strategic commitment to achieve them.

We have developed this strategy collaboratively, bringing together representatives from the full range of primary care services to grow our shared vision and purpose. We have also engaged with the wider network of health and social care, community and specialist services to incorporate their perspectives around the best improvements to make. Perhaps most importantly, we have spoken with a substantial number and range of patients to understand what is most important in a 'good' primary care.

The Strategy launches at a time of significant challenge, which is a fundamental driver for combined action to sustain and improve our impact. Focussing on our shared opportunities to improve will allow us to make best use of available resource and real advances across our services.

Our vision is of a sustainable primary care, at the heart of the health system. People who need care will be more informed and empowered, able to access the right professional at the right time, and remain at or near home where possible. Multi-disciplinary teams will deliver care in communities and be involved in the strategic planning of our services.

We commit to improving patient care, our workforce, and our system of care. We will work together to ensure that we improve services, with patients at the centre. Realising our ambitions in the current context requires a sharp focus on where we can best bring benefit. We will do this through a whole system approach across primary care, plus collaboration with the wider system, data and evidence-informed approaches, and national advocacy. This approach will ensure that our strategic ambitions align with broader NHSGGC transformational change.

We would like to thank everyone for their support and contributions through the process.

Jane Grant
Chief Executive, NHSGGC

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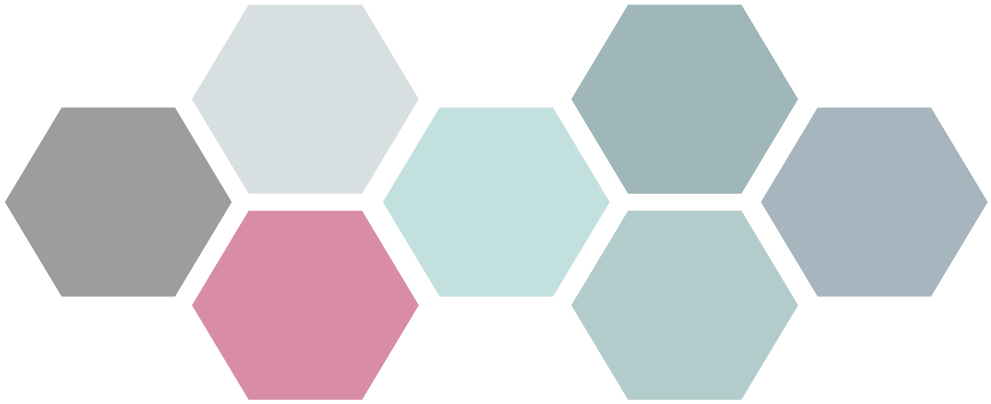


Executive Summary

Primary care is the first point of contact in the healthcare system – a front door to the wider NHS. It is critical to our health and wellbeing and to sustaining wider health and care resilience by intervening early to protect health and prevent ill-health, as far as possible.

Our five year strategy for primary care sets out our long term vision and approach to primary care transformation in NHS Greater Glasgow and Clyde (NHSGGC).

Our priorities and areas for action are set within a strategic framework that builds on the significant work already underway to improve our communities' health and wellbeing.

We know that the pandemic changed the conditions that we operate within. It rapidly accelerated how services are planned and delivered and opened up new ways for people to access them. As our population needs grow, primary care must evolve to be able to continue to respond. We need to do this in a way that makes best use of current resource and aligns well with wider system change.

This Strategy provides a high-level overview of our contribution, the context that we operate within, and the changes we want to make. It also defines our contribution to plans for wider system transformation across all-NHSGGC.

This Strategy is an opportunity for all of primary care to take a whole system approach to transformation, through new ways of working and by scaling up good practice.

Our ambition is that, by 2029, we will enable:

In the short term:

1. A sustainable workforce that is sufficiently staffed and skilled, and shares a common purpose;
2. A step-change in data and digital technology innovations to improve patient health and care outcomes;
3. Integrated care and well-connected services, supported by effective teams, improved system-wide working, leadership and planning; and
4. Patients to have an improved understanding of available services and a better ability to navigate between primary care services.

In the medium to long term:

5. People to access the right service at right time, more flexibly and in ways that suit them;
6. Strengthened prevention, early intervention and wellness;
7. Better access to trusted information on health and care; and
8. Strengthened contribution to reducing health inequalities.

Scope of the Strategy

We use the term 'primary care' to describe those services that people often use as the first NHS point of contact for their health needs. These are usually provided by general practice, pharmacy, dentistry, optometry (the four main independent contractor and practitioner groups) in our local communities.

Primary care also includes a range of professionals working in wider multi-disciplinary teams e.g., community link workers, pharmacy professionals, allied health professionals e.g. physiotherapists, occupational therapists, dieticians, podiatrists, advance nurse practitioners (ANPs), health support workers, practice managers, care co-ordinators, and social prescribers.

We describe a whole system approach being taken by all our primary care services and workforce working together, as set out above. We also want to work with the wider health and care system – that is, specialist and hospital services, as well as social care and third sector partners.

How we will deliver

Implementation of the Strategy will be directed and overseen by NHSGGC Primary Care Programme Board whose members include all primary care sectors and leads, as well as professional representatives for all independent contractor and provider bodies.

Progress with implementation will be reported primarily to the NHSGGC Corporate Management Team and HSCP Chief Officers, which will ensure that delivery of the Strategy aligns with wider NHSGGC strategic change and HSCP Strategic Plans.

We will set out our work to deliver the Strategy in a five-year implementation plan, which will include key areas of delivery: what will be done, when, and how we will know we have been successful.

It will also set out arrangements to progress wider primary care commitments from existing NHSGGC strategies. We will refresh this annually to ensure it remains up to date.

We will undertake regular monitoring and evaluation of our work to deliver the Strategy to ensure that we can understand and improve the impact of our work. That will focus on the positive results for our patients, as well as to our workforce and healthcare system. Learning will shape future service planning and delivery, including our next strategy for primary care.

Introduction

This Strategy sets out how we will maximise our contribution to the health and wellbeing of the people of NHSGGC, through collaborative action. It is for everyone in NHSGGC: people who need primary care services and those who are working in primary care. Our Strategy launches at a time of significant strategic and operational challenge. Ensuring we continue our crucial work is the first and fundamental focus of this Strategy.

Primary Care is understood to support the majority of all healthcare contacts across NHSGGC, undertaking a wide diversity of treatment and support through dentistry, general practice, optometry, pharmacy, and services provided by Health and Social Care Partnerships.

As a very broad guide during 2022/23, approximately 83% of all NHSGGC activity took place in general practice, dentistry, optometry, and community pharmacy services alone (see Appendix 2). Our services are delivered by Health and Social Care Partnership (HSCP) and Health Board employees, as well as by independent contractors and providers and their employees within dentistry, general practice, optometry and pharmacy, plus commissioned services. Primary care is generally accessible close to home, in local communities and HSCP areas.

Figure 1: NHSGGC Primary care services

The following sections set out our vision for future primary care and the outcomes we want to achieve - for patients, our workforce, and our health and care services. We describe key aspects of the context that we operate within, and our current contribution, and then set out our areas for action.

Our vision and outcomes

As we launch our first primary care strategy for NHSGGC, we want to maintain our ambition while appreciating the constraints that we work within. In doing so we aim to maximise our contribution to protecting and improving health, and to the success of all our health and care.

Our future primary care

Our vision is of a sustainable primary care, at the heart of the health system. People who need care will be more informed and empowered, will access the right professional at the right time, and will remain at or near home whenever possible. Multi-disciplinary teams (MDTs) will deliver care in communities and be involved in the strategic planning of our services.

Primary and community care services are core to the success of this vision, and we recognise that we will need to grow our resource to support the increased demand and volume of care.

We want to see a sustainable primary care at the centre of our healthcare system. This means a tiered model of care available to everyone, with different levels of advice, treatment and support tailored to what we need. It means a model responsive to changing levels of demand and resource, designed and resourced to deliver on our goals, and with people at the centre of all that we do. This will increase locally available care, with the best professional to provide it. More direct access to MDTs will reduce the need for routing through general practice, and free up GP and other professionals' time for patients needing their specific expertise.

In the long term, we aim to continue and expand local care, with less dependency on hospital treatment.

The tiers can be visualised as follows:

Figure 2: Tiered model of healthcare (NHSGGC, 2019: 75)

These tiers of care range from:

- good advice that helps us look after our health daily to the best of our ability - ('supported self-management'); to
- the first point of contact for health needs (primary, community services); to
- wider supports and specialist outreach teams - all close to home (specialist community and acute outreach); to
- more specialised care delivered in dedicated centres, where the complexity or seriousness of our health concerns demand it (hospital care).

The outcomes we want to achieve

Figure 2 sets out our primary care outcomes in NHSGGC. These include improvements to our patients' health and wellbeing, to our workforce, and across our primary care system. We want to better contribute to population health, and to action on health inequalities. We want to support patients to be more confident and knowledgeable when using primary care, and to have a better experience in the process. People will be able to access the right professional when they need it, at home or as near to home as possible. MDTs will become increasingly important in the delivery of local care in our communities, and be involved, alongside patients and partners, in the strategic planning of our services.

Primary Care Outcomes

We are more informed and empowered when using primary care	Our primary care services better contribute to improving population health	Our experience as patients in primary care is enhanced
Our primary care workforce is expanded, more integrated and co-ordinated with community and secondary care	Our primary care infrastructure – physical and digital – is improved	Primary care better addresses health inequalities

Figure 3: NHSGGC primary care outcomes

These outcomes will support NHSGGC's strategic aims of better health and better care. Shared action will support local HSCP strategic plans, which align to NHSGGC's ambitions and cover all health and social care activities.

We have set out our aims in the context of significant wider transformational change, as set out in NHSGGC's Moving Forward Together (MFT) programme, which aspires to modernise all NHS care and spans the next 20-30 years.

Our three horizons

The following model sets out the changes that we aim to achieve in the short, medium and long term. These reflect our early attention to putting in place long term plans to improve key enablers, such as our workforce and estate. The changes that we expect to see in the medium term, and their longer term impacts are also described.

We will undertake a range of activities to achieve our ambitions and these are summarised below. Perhaps the most crucial of these is whole system action across primary care.

The complexities of primary care arrangements mean that we need to collaborate with and across independent contractor and provider groups, through local and national negotiation. We recognise that we must deliver together to achieve our aims.

We will develop this model further throughout Strategy delivery. It will inform our onward approach to monitoring and evaluating the impact of our actions.

The actions in this Strategy align with and compliment the global ambitions of **MFT**, which include:

Our action across primary care will also support our national ambitions, as set out in our **national health and wellbeing outcomes** (Scottish Government, online).

Our model for change

INPUTS	ACTIVITIES	OUTPUTS	SHORT (1 Year)	MEDIUM (2-4 Years)		LONG (5 Years and beyond)		IMPACT
Primary Care Programme Board (PCPB)	Strategy design and delivery	5 year Workforce and Estates Strategies	Strategies are in place to optimise our enablers	Improved access to pt records, health information & care	Improved self management	Primary care delivers a model that builds on people's expertise and draws on the resources available to support them in their local communities	We are more informed and empowered when using primary care	Positive health impacts of primary care are sustained and maximised
Collaboration, leadership, system working and planning	Develop a shared care record	Shared care record accessible to all primary care	Increased understanding of local health needs through data	More adaptable estate	Improved access to the right advice, from the right professional, at the right time	Improved knowledge, skills and awareness (patients and workforce)	Our experience as patients in primary care is enhanced	
Funding	Patient pathway review and development	Guidance on new patient pathways		Patients are more informed and empowered	Enhanced journeys into and through PC	Prevention is strengthened across primary care	Our primary care services better contribute to improving population health	
Workstream delivery groups	System and process improvements	Process and system improvements		Improved pt & professional awareness of services/supports	Increased workforce access to resource necessary to holistic, person-centred care (IT/ Digital/clinical/ wider)	Increased general practice capacity	Primary care better addresses health inequalities	
Infrastructure – digital and estate	Communications and engagement plan design and delivery	Enhanced accommodation		Multidisciplinary teams, partners & patients better involved in planning and delivery of services	Resources are more targeted at those who need them most	Improved leadership, culture and practice	Our primary care infrastructure, physical and digital, is improved	
Strategy, data and evidence	Consultation and engagement with professionals and patients	Communications and engagement plan			Patients receive care at or near home wherever possible	Strengthened PC contribution to reducing health inequalities	Our primary care workforce is expanded, more integrated, and coordinated with community and secondary care	
Patient and Public Involvement	Quality improvement	Communications campaign				Reduced unnecessary use of urgent and secondary care		
Workforce (independent and GGC/HSCP)	Partnership working	Patient information						
	Monitoring and evaluation	Professional toolkits						
		Governance reporting						

Better and more sustainable primary care, through improvements for patients, workforce and system

External factors (political, economic, social, technological) may impact on success:
e.g. New government; collaboration; cost of living; social determinants; national delivery in key areas such as e-prescribing or estates

Current State

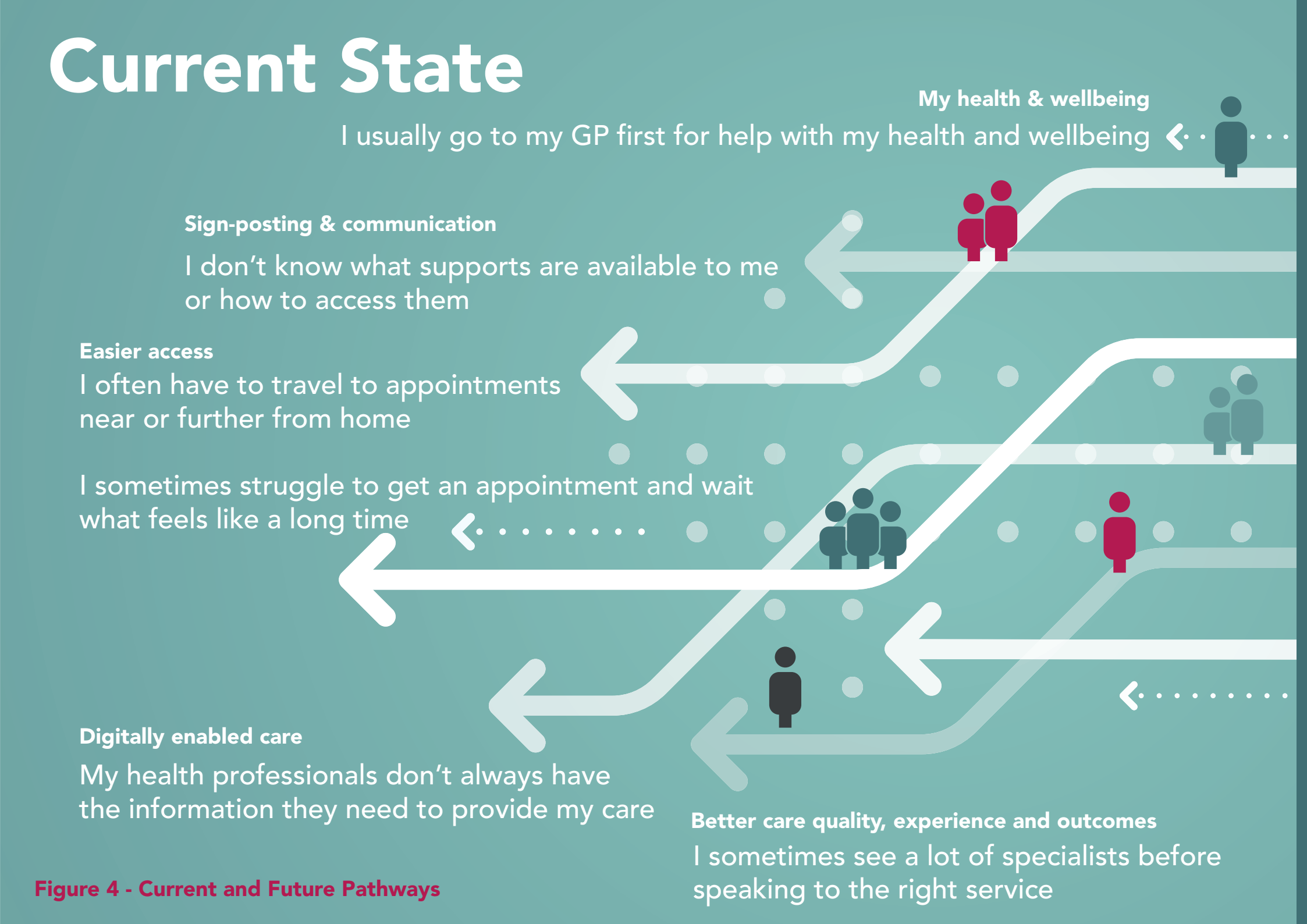


Figure 4 - Current and Future Pathways

Future State

My health & wellbeing

I know how to access a range of local primary care services directly

Sign-posting & communication

I can access the information I need to look after my health with confidence and as well as possible

Easier access

I can receive care closer to home wherever possible, virtually or in-person if I choose

I can make appointments more easily

Digitally enabled care

My care is better informed and coordinated and I don't have to repeat my health concerns

Better care quality, experience and outcomes

I receive the right care, at the right place, at the right time

Future patient experience

Figure 3 illustrates the future patient pathways and experience that we will work to achieve in the Strategy life course. These will involve being better able to manage our own health and care on a day to day basis, and to access care and support when needed. Many of the service developments will be guided by nationally-defined contract terms and resources. Figure 3 sets out our aspirations for the future patient experience, with the exact model being defined in line with the emerging national advice about our scope for change, e.g. through contract negotiations with independent contractors and providers.

These improvements will support longer term healthcare transformation over the next 20 to 30 years, our third horizon.

The MFT Primary and Community Care Target Operating Model (TOM) and supporting framework for implementation set out that vision.

Our context and contribution

Population health

NHS Greater Glasgow and Clyde serves some 1.3 million registered patients, around 25% of Scotland's population. It is the largest health board in the United Kingdom.

Thirty-four percent of our residents live in the 20% most deprived Scottish neighbourhoods and have significantly worse health outcomes, living shorter lives and suffering ill health for longer. A minority of people therefore need the most care, support and treatment to stay as well and independent as possible, for as long as possible.

Current and projected demographic change will increase the level and diversity of demand on services, property and premises.

Looking ahead, national forecasts predict more than 20% increases to the burden of disease in the next twenty years, despite a reducing population. Improvements to our healthy life expectancy have slowed and recently started to reverse. Joint with NHS Lanarkshire, improvements to life expectancy in NHSGGC are projected to be lowest in Scotland, an increase of just 0.2 years to 79.6 for women and 74.8 for men (National Records of Scotland, 2023). Infectious diseases, such as Covid-19 and influenza, will continue to be challenges for our health and care, including our ability to treat them effectively. We face real pressures to recover quickly from the pandemic, because of the high numbers of people waiting for care and presenting to us later, or with more complex concerns. Efforts to improve health are undermined by the current economic conditions, and these disproportionately disadvantage those of us with least power, money and resource (Walsh et al, 2022). We have also seen greater population diversity through our welcoming of asylum seekers, refugees, and displaced persons from war torn countries. These factors translate to greater and new asks of primary care.

We know that these changes can also create barriers to accessing care, and we have heard patients' frustrations around how quickly appointments can be arranged in primary care and more specialist services. Expectations have been heightened at a time when demand is greater than our available capacity. Primary care continues to support people prior to specialist appointments, while these services also work to recover their usual delivery. This means more frequent, ongoing and more complex patient support in primary care before people reach secondary care. More patients need help to **wait well** and for longer than before the pandemic (NHS Inform, online).

The following sections set out our contribution to health and wellbeing, our operating context and our ambitions for improvement.

Our contribution to health and wellbeing

NHS Greater Glasgow and Clyde's primary care has a significant role in protecting and improving our health. It prevents ill-health by supporting behaviour change, reducing health-harming activities, and encouraging healthy behaviours. It identifies disease as early as possible, supports us to manage our health as well as possible, and enables support with social stressors and specialist treatment. Continuing to grow our capacity in these areas will support people to stay well for longer, and our strategic focus on reducing reliance on hospital care.

Experimental data suggest that in an average month, we undertake around 540,000 patient encounters in general practice, more than 70,000 dental examinations, over 37,000 eye examinations and 116,690 Pharmacy First patient contacts (see Appendix 2).

Local access to health and care has already increased significantly. Newly rolled out community hubs for Pharmacotherapy, Vaccination and Community Treatment and Care (CTAC) now cover 80-100% of our GP practices. Our mental health and wellbeing services now cover 86% of GP practices. We continue to work to increase patient access to help with social stressors via Community Link Workers, with 73% of all GP practices having access to the service in 2022/23, although with reducing coverage for some. These improvements have been achieved through Primary Care Improvement Plan (PCIP) investment in general practice, and through rapid workforce development, including the growth of new roles e.g. Pharmacy support staff, Health Care Support Workers (HCSWs) and Advance Practitioners in primary care.

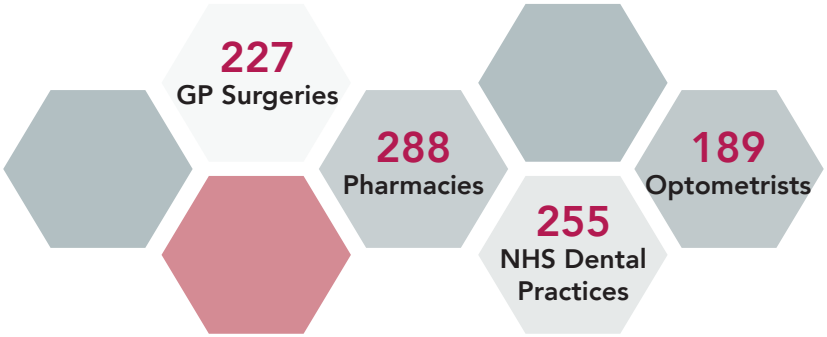
We continue to develop the 'first port of call' initiative across primary care, where patients can attend directly without needing to see a GP. Direct access is increasing for local pharmacies, opticians and dentists for advice, support and treatment. The new community glaucoma service, introduced in 2023, enables people with low risk glaucoma to be seen locally by accredited optometrists. This makes patient care more timely and efficient, and reduces the need for appointments in secondary care. Community pharmacy continues to extend access to clinical advice on common health conditions through Pharmacy First, without the need for an appointment. This creates capacity in general practice for more specialist patient care.

Primary care delivers a substantial and growing contribution to chronic disease management. We support people with long term conditions to have the best possible health and wellbeing for as long as possible. This includes living at home or in a homely setting, and often aided by prescriptions. Realistic Medicine means patient-centred care is based on shared decision making, and people can make treatment choices that take account of their individual needs and circumstances and better manage risk.

Urgent and unscheduled care enables patients with time sensitive issues to be triaged by pharmacy and general practice, and often have their needs addressed on the day. Triage and signposting systems enable patients to be directly supported or reviewed by an appropriate health professional in practice MDTs without first needing to see a GP. This enables patients to see the right health professional more quickly, and also creates capacity for GPs to focus on more complex medical presentations. Through continued strengthening of links between primary and secondary care, patients are signposted or referred directly to the right service and specialism when needed. This ensures the best possible outcomes and experiences and effective patient flow, including reduced time in hospital.

In NHSGGC, we offer in the region of 1,000 'front doors' to the NHS, where people can present for healthcare treatment and support

This translates as:



Case study - Improving the primary-secondary care interface to help people get home sooner

Delays at the point of hospital discharge are often caused by the need for patients to wait for their medications to be dispensed. A recent quality improvement project in NHSGGC looked at whether the discharge process could be improved for patients and services by using community pharmacy staff and medicines, rather than those in the hospital. Evaluation showed that the new community pharmacy model resulted in a median time saving of 142 minutes per patient. Researchers concluded that this model has the potential to deliver transformational change in patient flow, and to free up hospital pharmacy staff capacity for other clinical interventions, if delivered more widely.

General Practice Out of Hours (OOH) provides people with urgent advice and treatment during evenings and weekends, when they are referred to the service by NHS24. Staff undertake telephone/video consultations and home visits with patients, and support access to hospital care where necessary. The service is delivered by both employed and sessional staff. Dental Out of Hours' patients are referred in after triage by NHS24 and the service is staffed on a sessional basis. Both Out of Hours services support patients to receive the right care at or close to home, as far as possible. This means that fewer people need to go to secondary care, which increases hospitals' capacity to focus on patients with greater clinical need.

Together, these areas contribute significantly to NHSGGC's Corporate Objectives of improving our health and our care, and using our resource to the best possible value. We work to support people to get the care they need locally, and hospitals' capacity to be optimised.

Our resources

Our people

Our workforce is diverse, and a significant proportion is made up of independent contractors and providers which employ their own staff. Together they deliver services in general practice, community optometry, dental and pharmacy. Given the independence of this part of our workforce, health boards hold limited information about its totality, meaning that we are currently unable to definitively measure and profile the sector. National activity continues to improve workforce data.

We are proud to have achieved real improvements to primary care provision in the last 5 years.

We have increased coordination of PCIP delivery across HSCPs, and developed a new general practice MDT workforce with more diverse mix of professionals and skills. This workforce has increased the provision of direct treatment and care, removing the need for patients to first see a GP, and has grown to include an additional 750 whole time equivalent (WTE) staff. Roles include nursing, pharmacy staff, physiotherapy and community link worker (CLW) staff. In the GP Out of Hours' service, we have promoted the role of employed (rather than sessional) GPs. Looking ahead, we will further extend our MDTs to include advance practitioners as well as a continually expanding skillset. These changes will support all our professionals to work to the top of their license, and increase GPs' capacity to focus on complex medical care adding system capacity to provide suitable care, on a 24/7 basis.

Consistent with the national trend, it is a challenge to attract, retain and grow an appropriately skilled workforce. This is made more difficult by the large proportion of our workforce not directly employed, whose terms are decided within their own practices. Our

independent provider workforce is also reducing, which creates additional pressure on our ability to provide enough care. We have recently seen a decrease in the number of general practice surgeries due to mergers, and an increase in dental providers delivering private care.

Within services directly delivered by NHSGGC/HSCPs, our recruitment and retention requirements remain significant, with pressure on a range of sectors and professions where demand is high.

Our systems, digital and data resources

Given the independent nature of current primary care provision, our services use a range of IT systems. Many are individual to particular services and hold service specific patient health information. All general practice and relevant community pharmacy, optometrists and dentist have access to the NHSGGC digital health record. General practice have a comprehensive clinical record, and other contractors have read-only access to a summary of this, via the digital health record.

This means that primary care professionals' ability to read and update full health records is variable, and the lack of communication between systems often requires a duplication of work. Patients' own access to their health records is also limited.

Local and national investments have allowed us to make significant progress in this area.

Improvements include the Electronic Patient Record (EPR) Portal systems, which link with primary, community and secondary care.

Further developments are underway to improve shared data access and system efficiency. These will support better and timelier patient care, particularly within general practice.

Developments also aim to increase data consistency and capacity to better inform our planning, and we recognise that it will be important to grow primary care's familiarity and use of the portal. NHSGGC have also invested significantly in infrastructure with investment in PCs, servers and Wi-Fi upgrades for general practice.

The potential of more significant system improvements is recognised, however as the majority of primary care budget is allocated to specific activities, this type of long term investment is challenging.

Our accommodation and property

Our primary care estate is substantial, and accessible locally to most people living in the NHSGGC area. It includes around 230 GP practices, almost 290 community pharmacies, 189 optometry places, 255 dental practices, at least three Out of Hours sites during evenings and weekends, plus a range of HSCP multi-use buildings. While large, the majority of our estate is not NHS owned or managed. It is made up

of a mix of health board, privately owned and leased accommodation.

While a huge resource, there are significant challenges around achieving an estate that supports our ambitions. These impact on our ability to expand to meet local health need through, for example, growing local hubs. We want to be able to better support greater need in certain geographic areas. For example, where new communities develop quickly as a result of housing developments. We want also to expand our growing primary care offer.

While there is an established need and desire to develop our estate, funding to upgrade and maintain our properties remains a challenge.

We continue to work with the Scottish Government to obtain a clearly defined position on general practice lease assignation and property standards. Clarity in these areas, including what support – if any – will be available to fund this additional pressure on NHS Boards, will help us to sustain general practice for the future, and better support **2018 General Medical Services (GMS) contract** implementation. Progress in this area is crucial; its absence undermines our ability to make long term improvements to the NHSGGC estate in the ways that we know are needed. Our ability to provide sufficient and suitable space is limited and short term, interim solutions can be costly.

Our funding

The importance of primary care in contributing to NHS recovery is **set out nationally** and supported by a Scottish Government commitment to increase primary care spending by at least 25%, by the end of the current parliament (Scottish Government, 2021: 9).

Within NHSGGC, the 2022/23 financial envelope for primary care (workforce and wider costs) was approximately 20% of the health board's annual budget.

Primary care funding is complex and made up of two broad budgets. Family Health Services (FHS) finances independent contractors and providers and is managed by NHSGGC HSCPs, under nationally agreed terms around the care that is provided. The Primary Care Improvement Fund (PCIF) covers a range of services under the 2018 GMS Contract. One is Community Treatment and Care (CTAC), which includes the Phlebotomy and Vaccination programmes and is allocated to HSCPs on a non-recurring basis.

The 2023/24 year has seen real time reductions in national funding to NHSGGC for HSCPs at a time of increased expenditure, through pay uplifts and utilities for example, and the amount to spend on care delivery is expected to reduce further in 2024/25. In addition, these allocations are currently subject to annual adjustments that reflect changes to the national funding

formula ('NRAC'), which in turn impacts on delivery of agreed programmes, for example through a reduction in whole time equivalent staff, to reflect the revised budget. National communications on our short term funding have outlined a reduction in the Board budget of £71.1M in 2023/24, then £79.8m and £54.5m for subsequent years, assuming savings targets are met (NHSGGC, 2023). Current funding levels are insufficient to fully deliver the Memorandum of Understanding (MOU), and scoping has found funding uplifts of 30-50% to be necessary to deliver and benefit all practices equitably (NHSGGC, 2022). As a result, our plans need to be restricted to what is deliverable with the available finance. The most recent financial constraints create uncertainty around national commitments to increase primary care spend.

Wider finance allocations generally remain the same year on year, making it difficult to respond to growing demand. This also creates additional pressure when other costs increase, such as inflation, salaries, capital investment, Covid-19 and energy costs, with funding confirmation often received part-way or late in the financial year. Pressures also include a lack of investment in some GMS budgets (such as pension contributions, out of hours, IT and estates), which have not had any inflationary uplifts over the last several years. To spend funds during the award period risks reactive delivery within a reduced timeframe.

The majority of our funding is committed to specific activities, and acknowledged to be insufficient to meet current patient need. Both of these factors acutely limit our ability to make local decisions about where we should best focus our efforts.

The challenges that we share with wider health and care around increased demand and stretched resources make shared improvement harder - and all the more important. Aligned resources, particularly our estate and workforce, will be key enablers to successful transformation of all our health and care.

Prescribing cost pressures

The greatest risk to delivery is the cost of prescribing,

which arises from local demand and is the responsibility of HSCPs to meet. In 2022/23, community pharmacy contractors dispensed 25.5 million prescriptions, mainly from general practice. This is an average of 2.13 million items per month, and a 3.5% increase from the previous year. Just over 70% of the NHSGGC population had at least one prescription item dispensed to them. The total cost for these was £263m compared with £246m the previous year (for 24.6m items).

The volatile and very variable nature of drug costs also creates significant challenges. For example, Omeprazole (20mg) is a drug that reduces stomach acid and was prescribed 900,000 times last year. Its price increased almost four times from £0.89 to £3.20 and then to £2.90, per pack of 28. The volume prescribed translates

to increased costs of £1.8m for this drug alone. To continue to meet these rising costs in practice, HSCPs must use service budgets or make savings from elsewhere in health and social care services, for example by reducing whole time equivalent staff headcount.

Pressure on prescribing costs is expected to continue in 2023/24 as a result of drug price inflation across all therapeutic areas and a growth in the volume of items prescribed. It is estimated that NHSGGC will dispense over 26 million prescription items in 2023/24. In addition, Scottish Government national funding allocations for 2024/25 do not include any inflationary uplift for prescribing budgets, which is adding to the already significantly high pressure within this area. Figure 4 illustrates the continued increase in prescribed items' number and cost since 2018/19.

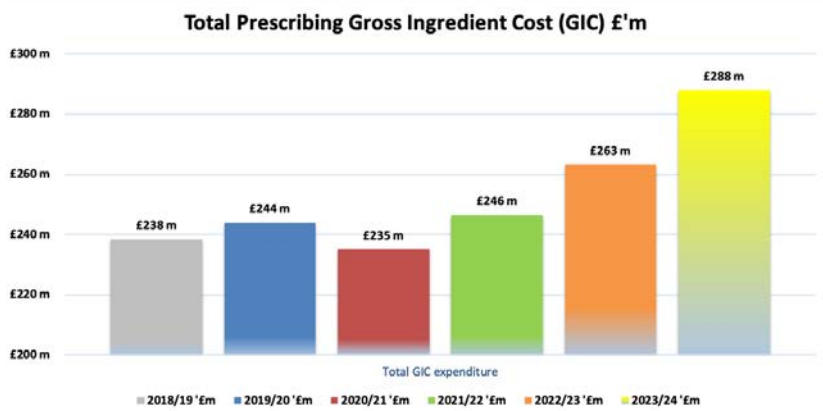


Figure 5: NHSGGC primary care prescribed drugs 2018/19-2023/24: total items and per item cost per annum

Our approach to developing the Strategy

Our Strategy has been developed in collaboration with patients, primary care, health and social care and the wider network of community services to identify our priorities for the next 5 years. From the outset, our aim has been to reach consensus on our ambition and purpose across primary care as well as wider health and care. We aim to continue that to successfully implement change.

We developed our Strategy through:

- Phased, extensive engagement with our strategic partners, including independent contractors and providers and PCIP services, the public; secondary care, HSCP strategic planning groups and our staff
- Working to identify and agree areas of shared focus
- Making best use of our existing engagement and communication structures, networks and groups.

Our key stakeholders

Our key stakeholder groups are as follows:

Those accessing our services	Those delivering our services
• Patients, carers and family members • Local communities • People in protected characteristic groups and/or marginalised groups (dedicated engagement to support effective action to reduce health inequalities)	• Primary care service staff • Independent contractors and providers and representative bodies e.g. Local Medical Committee (LMC) • Partners across all sectors of health and social care support

Table 1: Key NHSGGC primary care stakeholder groups

In the first phase, we sought to raise awareness of the primary care strategy and understand priority issues common to all parts of primary care, alongside the opportunities and strengths that we could draw upon to respond to them. To do so we engaged with both the public and professionals and, for the latter, focussed on engaging with primary care service staff. We achieved over a thousand contacts, mostly through focussed workshops.

Stakeholder feedback was organised into strategic change areas, with proposed actions under each. These were shortlisted then prioritised by senior primary care leaders on the basis of their feasibility to deliver and their impact on our strategic ambitions. They were further refined in the following stage.

In the second phase, we repeated and grew our engagement to test and refine proposals and identify any gaps. Sessions were held with HSCP leadership, strategic planning groups, and frontline staff as well as stakeholders from phase one. Over 912 staff and service representatives, strategic partners and members of the public attended sessions (some staff attended more than one session). Our engagement with professionals and patients over both phases was fairly equally balanced between both groups.

The table below sets out our engagement with professionals and members of the public in Phases one and two.

	Phase one	Phase two
Professionals	388	623
Public	624	324
Total	1012	947

Table 2: Engagement with professionals and the public to support primary care strategy development

This process of engagement has helped us to understand, shape and refine our priorities over the next five years.

Our primary care ambitions

We will focus on eight areas of improvement across primary care.

We will deliver this Strategy within our existing budget, working together to greatest effect. Given our constraints and challenges, we will prioritise action in a small number of key areas that will have most impact in promoting primary care sustainability, working to improve and innovate to increase our capacity and efficiency. We will progress wider developments in line with the available resource.

Our ambition is that, by 2029, our primary care strategy will enable:

In the short term:

1. A sustainable workforce that is sufficiently staffed and skilled, and shares a common purpose;
2. A step-change in data and digital technology innovations to improve patient health and care outcomes;
3. Integrated care and well-connected services, supported by effective teams, improved system-wide working, leadership and planning; and
4. Patients to have an improved understanding of available services and a better ability to navigate between primary care services.

Focussing on the above ambitions first will support achievement of our medium to long term goals:

5. Access to the right service at right time, more flexibly and in ways that suit patients;
6. Strengthened prevention, early intervention and wellness;
7. Better access to trusted information on health and care; and
8. A strengthened contribution to reducing health inequalities, including through increased equity.

We will continually look at how we make best use of our resources, for example, our professionals, our time, and our premises. This will enable us to review whether there are things that we should do less of, or stop, so that we can continue to improve our effectiveness and efficiency and to reduce waste.

This Strategy is the parent document setting out the shared strategic ambition across all NHSGGC primary care. Our goals align to a range of existing expectations of NHSGGC primary care in local strategies and plans, and we will ensure that our implementation plans and structures support coordinated delivery.

The existing key NHSGGC and HSCP plans relevant to primary care include:

Key local strategies and plans	
NHSGGC	**HSCPs**
• Moving Forward Together • Delivery Plan • Public Health – Turning the Tide through Prevention Strategy • Adult Mental Health Strategy • eHealth Digital Strategy • Unscheduled Care Commissioning Plan • Moving Pharmacy Forward	• Strategic Plans • Medium Term Financial Plans • Primary Care Improvement Plans • Local Transformation Plans • Primary Care Premises Strategies

Table 3: Key NHSGGC and HSCP strategies and plans relevant to primary care

The following sections set out our priorities and the actions we will take to achieve them, before setting out wider areas of development.

Our priorities are:

1. Optimising our workforce – through development and delivery of a five-year workforce strategy;
2. Digitally enabled care – through development of a shared care record for all primary care, in- and out of hours;
3. Improving our patient pathways – by making them clearer, more consistent and effective; and
4. Improving primary care access to the right advice at the right time – by mainstreaming professional to professional decision making.

Our priorities

The following pages set out our four priorities in more detail, explaining what we want to achieve and why, and the actions we will take.

Optimising our workforce

Our professionals - current and future - are our greatest strength as they provide the services for our patients. It is our top priority to optimise our workforce to support long term sustainability of primary care.

Benefits of our action

By optimising the primary care workforce, we can better achieve our current commitments as well as our ambitions in this Strategy and longer term. We can support staff to be more effective in all that they do, through improved trust, communication and information sharing across professionals, as well as better job satisfaction and staff morale. Increased staff retention, alongside a fuller staff complement, will reduce the need to rely on sessional, locum and bank staff and retain organisational memory, improving efficiency and resilience. Strong primary care leadership will support a whole system transformation within primary care.

Supporting all our professionals to work confidently to the top of their license will increase our capacity and effectiveness across primary care and beyond.

We will develop a five-year NHSGGC primary care workforce strategy in year one, focussed on primary care sustainability and security, and setting out how we will:

1. Embed strong primary care leadership and influence in primary care and NHSGGC;
2. Focus on improving workforce attraction, retention, and progression;
3. Develop workforce knowledge and skills;
4. Improve staff health and wellbeing; and
5. Promote NHSGGC area as a vibrant and progressive place to work.

This will align with the four pillars of the NHSGGC Workforce Strategy 2021-2025: health and wellbeing, attraction & retention, learning and support and leadership and set out how we will 'grow our own' staff locally, and offer training and development in key areas. We will take action to improve working conditions through collaborative working, and improve our understanding of NHSGGC and independent contractor capacity to flex to changing service demands. We will continue to engage nationally, e.g. with the new National Centre for Workforce Supply.

We will work to protect, develop and retain our current workforce, and improve our ability to attract new, high quality professionals. Through successful action across both areas we will increase our capacity to respond to emerging need and models of care. We will collaborate locally and nationally to progress this. Not doing so risks our ability to maintain service continuity, deliver improvements, and meet our ambition of increasing our primary care offer.

We will draw on national developments to deliver our growing ambitions around MDTs, independent prescribers and supporting staff to work within the full scope and range of their competency, to ensure effective delivery of the NHS Recovery Plan 2021-26. For example, all pharmacists should be able to prescribe from the point of qualification from 2026.

We will align with emerging national workforce developments, including implementation of the Health and Care (Staffing) (Scotland) Act 2019, to ensure safe, high-quality services that meet patient needs. This will enable us to meet our statutory duties around appropriate staffing in health, and to manage any related risks.

NHSGGC recognises the significance of partnership working with independent contractors and providers. We will work to strengthen our collaboration to achieve our shared ambitions together.

Achieving a digitally enabled primary care

We aim to develop systems so that patients no longer need to repeat their health concerns and can directly share their information.

We will develop a shared care record across primary care, accessible to all primary care professionals, both in- and out of hours.

We will deliver this by procuring and implementing new systems which meet the needs of services, are integrated and contribute to the electronic patient record (EPR) to broaden professional access to systems through data sharing agreements.

We will increase patients' digital access to information, treatment and care through opportunities to submit health information for remote monitoring, digital triage and signposting solutions and putting in place the foundations for future Digital Front Door initiatives. Following the growth in popularity of telephone appointments as an option for patients, we will also look to increase video appointments where appropriate and where patients choose.

We will continue to dedicate support to the national progression of a step change in digital improvements in primary care. Through the NHS Recovery Plan 2021-2026 we will work with Scottish Government to protect investment in digital solutions, e.g. to GP IT re-provisioning, digital solutions for ePrescribing and eDispensing, which will enable us to better manage demand and effectively use our workforce.

The Digital Prescribing and Dispensing Pathways (DPDP) programme aims to radically improve prescribing and dispensing by digitising the full process, making ordering and receiving of prescriptions easier, faster and more efficient. Due to begin during the life course of the Strategy, the programme will increasingly interface with other NHS eHealth clinical systems over time.

We want to improve patients' experience of primary care, supported by digital improvements for both patients and professionals.

Benefits of our action

With the necessary investment, digital primary care improvements carry enormous promise for improving patient access and experience, automating routine tasks and reducing duplication of effort, better organising care, and freeing up time for patient facing care.

Shared records can bring improvements to both patients and staff, in reducing the need for repeat conversations, and time spent sending and retrieving information between partners (such as hospital discharge records, changes to care plans).

Optimising e-prescribing and e-dispensing will increase efficiency, safety and speed. Multi-professional and multi-location digital prescribing will enable new service models to be developed and delivered. It will also contribute to wider climate sustainability by reducing the use, transport, scanning and destruction of paper.

Case study: Using digital tools to better support patients to look after their own health and create new primary care capacity

Since December 2022 around 4,400 Connect Me blood pressure monitors have become available to NHSGGC patients, via their general practice. NHSGGC's primary care support and digital (ehealth) teams have continued to promote the monitors to GP practices.

Connect Me is a remote monitoring tool that patients use independently at home. It collects clinical readings and the data is automatically sent to their general practice for GP or nurse review. It is offered to patients with high blood pressure and aims to improve early detection and intervention around their condition, as well as to support them to look after their own conditions well, with personalised support where needed. This means that patients whose condition is well managed do not need to attend regular appointments, and GPs' capacity is increased to support those whose condition is more complex. People's risks of developing cardiovascular disease (CVD) are reduced through improved detection and control of elevated blood pressure, in turn reducing their risk of heart attack and stroke.

Patients receive prompts (e.g. by text or phone) to take blood pressure recordings at daily, weekly or monthly intervals. The data is automatically sent to their general practice for review by the GP or nurse.

At February 2024, fourteen months after the launch, 106 GP practices across NHSGGC had taken up Connect Me, 4,046 patients have registered to use it so far. Looking ahead, NHSGGC will continue to support its adoption. While blood pressure is the first clinical area where remote monitoring has been offered to general practice, it is hoped that more may be supported in future, for example long term conditions.

Improving our patient pathways

We aim to put in place more consistent, timely and effective patient pathways in primary care and to onward health and care.

We need to strengthen our connections with other services in primary and community care, and our ability to refer patients to the right professional directly. We want to connect better with secondary care, for the necessary specialist advice to support people locally. We also want to grow our integration with wider social care, and the third sector. This will require a joined up and person-centred approach across professional and geographical boundaries.

We will improve the clarity, consistency and effectiveness of patient pathways into and out of primary care

We will do this in collaboration with secondary and specialist care, structured quality improvement activity, evidence based review and update of our patient pathways, increasing awareness and adoption of updates, and monitoring and evaluating the impact of our actions for patients, workforce and the system.

Case study: how local, specialist MDTs improve the ease, efficiency and quality of care for patients, primary and secondary care services

General Practice Advanced Practice Physiotherapists (GP APPs) act as the first point of contact in primary care for patients with suspected musculoskeletal (MSK) problems. The team provide expert care and diagnosis without patients needing to first see a GP, and are currently based in 89 of NHSGGC's general practices and accessible to 44% of NHSGGC's population. Our GP APPs saw just under 60,000 patients with suspected musculoskeletal (MSK) complaints in 2022/23 with anticipated increase of 10% patients to be supported in 2023/24.

Advanced Practice Physiotherapists are part of our MDTs and provide care closer to home, help people to look after their own health as well as possible while living independently in the community, and support any onward referrals to be more direct and timely. The vast majority of patients seen are supported within primary care, reducing referrals into secondary care. The advanced triage skills of the team are enabling

people to see the right service, first time – resulting in earlier, quicker, and higher quality care for patients, alongside reduced inefficiency and better value for our healthcare system.

In 2022/23, our advanced practice physiotherapists:

- Provided support to enable ~80% of patients to self-manage (e.g. with advice and guidance, exercise prescription, corticosteroid injection, signposting to third sector support);
- Enabled patients to access care closer to home, with only ~20% of patients needing onward referral to secondary care;
- Demonstrated the value of our Multi-Disciplinary Teams with, on average, 15.7% lower referral rates to orthopaedics than practices without a GP APP; and
- Undertook skilled triage and effective diagnosis, with Rheumatology confirming that 95% of referrals to them were correctly made and treated, compared to wider general referral rates being as low as 33% confirmed as appropriate.

Improving primary care access to the right advice at the right time

We will work with wider health and care to mainstream and standardise professional-to-professional decision making, broadening its access across primary care professionals, including MDTs.

Our aim is to ensure we can give patients the very best care informed by the right advice, support better patient retention in primary care, and reduce the need for specialist service intervention.

Benefits of our action

Improved care pathways will mean patients can see the right professional more directly. They will get the right treatment quicker, and achieve more favourable outcomes, including satisfaction. Clearer, and more consistently effective pathways will reduce referrals requiring redirection and create capacity for our workforce and wider system.

Better advice, interfacing and pathways will strengthen our contribution to health and wellbeing through improvements to culture, relationship and trust – in primary care and with wider health and care, based on the principle of civility saves lives.

Together, both of these priorities will support better primary care integration and interfacing within primary care and across the wider health system. The next section sets out the combined benefits that we anticipate seeing, as a result of our work.

Wider areas for development

This section sets out a number of wider areas where will seek to make meaningful improvements over the next five years. As with our priorities, these are themed around the changes we want to make, and set out high level plans for how we will achieve them.

Improving our communications and engagement

Effective communication and information will support people to use primary care confidently when they need to, in ways that suit them, and with fewer unnecessary contacts.

We will take a strategic and structured approach to growing public and professional awareness of what primary care delivers, and how access is changing. We will work to ensure that, when people don't need to see a professional, they can obtain reliable information and advice that enables them to manage their health as well as possible.

We want to ensure that our primary care improvements include patient perspectives, and recognise that one size does not fit all. We will grow patient involvement in our strategic and operational work to strengthen our person centred design and delivery.

In year one, we will develop a five-year primary care communications and engagement plan, setting out how we will:

1. Develop and grow a single, agreed NHSGGC 'primary care offer';
2. Strengthen shared action to support primary care sustainability;
3. Promote primary care as the first point of contact in most care journeys;
4. Improve health literacy, particularly around system navigation and supported self-management; and
5. Embed patient voice in our strategic planning and delivery.

We will consult with patients and professionals to develop our plan. We will improve information access and grow a culture of listening and learning with patients, the public and our workforce. We will continue to advocate for national communications that raise awareness of current healthcare challenges, what people can expect and how we can all support primary care recovery.

Benefits of our action

A joint approach to primary care communications and engagement can contribute to measurable improvements in the proportion of patients accessing the right care. Improvements should reduce the number of interactions required per completed episode of care. This will increase efficiency, reduce reliance on services for signposting, create capacity to help those who need it most, and improve patient care.

People will be able to access the care and information they need in a way that suits them, when they need it. They will be better informed and empowered to act to improve their health and wellbeing and to better understand their health needs.

By ensuring we understand how to tailor information and support equitably, we will better contribute to action on health inequalities.

Improving access to care

We aim to support patients to access care when and how it suits them.

Alongside making it easier for people to see the right professional on first contact, we want to increase choice around how people make and have appointments when they need them, to better suit their needs and preferences, whether they need care during the week or out of hours.

We will make a range of process and system improvements to enhance journeys into and through primary care:

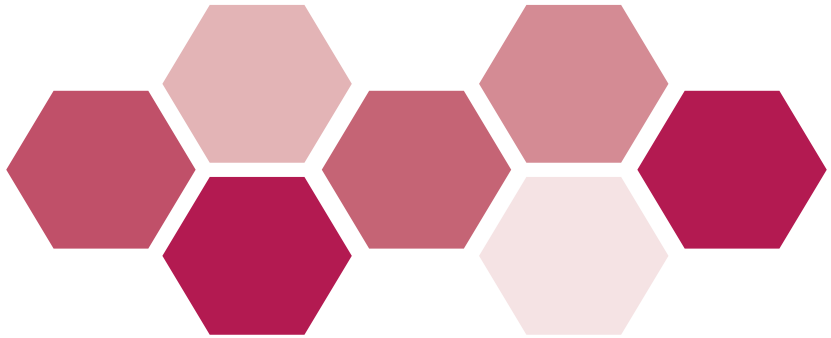
This will include work to increase direct access into and across primary care services, in-person and digitally. We will also work to improve access to high quality information and advice, and support patients to make decisions about their health and care that are right for them, based on what matters to them, aligned to the principles of Realistic Medicine.

Benefits of our action

We will make it simpler for everyone to access the right care with as few appointments as possible. That will improve the quality of patient care, by increasing its person-centredness and timeliness. Improved efficiency and effectiveness will increase our patient facing capacity, and our ability to focus on complex care, including better continuity of care for those needing it most.

By using evidence to inform what we do, and working with patients to support them to make the best decisions about their care, we will maximise the value added by our work and focus on where we can make the biggest impact.

We will work to prioritise improved access for those who need it most to avoid any negative impact on inequalities.



Strengthening prevention, early intervention and wellness

As part of a wider system, primary care plays a significant role preventing ill-health and mitigating health inequalities, through primary, secondary and tertiary approaches.

As the first point of NHS contact for most patients, primary care takes direct action to:

- promote physical and mental wellbeing, including through community leadership, connection and empowerment;
- prevent illness and protect health;
- support early diagnosis of key conditions to better manage chronic conditions and reduce long-term complications; and
- with partners, advocate for better health in marginalised groups, and support improvements in life circumstances that impact on health.

Given the huge projected worsening of our burden of disease, preventing illness, promoting wellbeing, early diagnosis and reducing health inequalities will be more crucial than ever. Investing our time and resource in these areas hold promise of a substantial health return on investment, leading to longer, healthier lives for the people of NHSGGC. However, prevention is all the more

challenging when increased demand creates additional pressures on non-statutory provisions.

We will continue to grow our capacity to provide continuity of care for patients with the most complex needs, keeping them as well and as independent as possible, for as long as possible. We will also grow our collaboration with wider parts of health and care to ensure our work is as impactful as possible.

We will work to strengthen prevention to better avoid ill-health, protect wellbeing, and improve supported self-management

Areas for development include increases to strengths-based approaches and a move away from more traditional models of care, growing our offer around accessible health information for supported self-management, and promoting uptake of routine vaccination and screening programmes across primary care.

Benefits of our action

Continuing to support prevention allows us to invest in keeping the people of NHSGGC healthier for longer. These approaches contribute to much lower-cost improvements in life-expectancy, including healthy life expectancy. For example to:

- Encourage and support people to live healthier lives will improve mental wellbeing, and mean that fewer people suffer with chronic conditions;
- Through early diagnosis and treatment of cancers, we can effect lasting cures.

Tackling the underlying causes of ill health can lead to healthcare cost-savings. For example, resolving causes of stress, anxiety, and depression could lead to a reduction in physical ailments, chronic disease severity, medication use and harmful behaviours.

Case study – Community Link Worker model

The Community Link Worker (CLW) programme enables general practices to directly support people experiencing issues impacting their health and wellbeing. People can be linked with appropriate supports to stressors such as isolation or financial difficulty, and empowered to engage in their community.

Emma was almost 16 and due to leave school

to start college. She rarely socialised and her mother was concerned that this affected her mood. Emma previously attended attended Child and Adolescent Mental Health Services (CAMHS) for depression and panic attacks. Emma's GP referred her to the practice CLW. Emma received 1:1 support; a referral for a gym pass and a shadowing opportunity at local nursery.

Outcome: A local nursery offered Emma volunteering and Emma advised that she was finding it enjoyable and rewarding. Emma enjoyed using her gym pass and found that exercise helped her mental health and was keen to continue using the gym. Emma's mum stated that her daughter's confidence had improved substantially and is very grateful to the CLW for the support she provided. Emma recently had a CAMHS appointment and they were happy with her progress. She was looking forward to starting college and felt a lot more confident and well-prepared than three months ago.

Wider patient experience of CLW programme:

'I didn't know that there was any help out there, now after talking to you I can't believe how much there is'

A range of existing actions, outlined in wider NHSGGC strategies[1], will also support this commitment. These actions include:

- Continuing to work to embed a sustainable community link worker model;
- Supporting people to improve their health and reduce health harms, through social prescribing and health improvement programmes;
- Targeted action to identify and intervene early in key health conditions;
- Aligning primary care with mental health and wellbeing resources and promoting good mental health;
- Supporting children to have the best start in life, with a focus on the early years; and
- Providing effective support to people with multi-morbidities and / or complex health needs.

1 See for example, our NHSGGC Delivery Plan, Moving Forward Together Implementation Strategy, Public Health and Mental Health strategies.

Enhancing our primary care accommodation and property

Where possible and clinically appropriate, we want people to be able to access care in our local communities. We also want our existing property to support our longer term ambitions of moving more care into community settings.

We aim to enhance the primary care estate so that it is fit for the future, by making sure it can both deliver existing care, be a better workplace and be adaptable to future models of care.

Work is underway in NHSGGC to develop a Primary Care Asset Strategy (PCAS) focussed on optimising our estate. This will be supported by through an improved understanding of current strengths and weaknesses, and anticipated future demands, for example through new housing developments or population changes. We will deliver the PCAS within five years. We recognise that deprivation is likely to translate into more space being needed per head of population in certain areas, reflecting the fact that greater health need requires greater space for relevant services to support it.

The PCAS will provide the vehicle for HSCPs to take a shared and strategic approach to estate transformation, in line with future population need and local authority plans. HSCP property strategies and supporting work will form the foundation for effective PCAS links with the Board's wider **Moving Forward Together (MFT) Implementation Strategy**. All will recognise the crucial need for a whole system approach to clinically-led NHS estate transformation.

We will develop and deliver a Primary Care Asset Strategy that aims to:

1. Maximise the patient facing estate and support HSCPs' new accommodation plans;
2. Prioritise the HSCP estate and general practice leased accommodation;
3. Ensure the transformation of our primary care estate aligned to long term plans for all NHSGGC as set out in Moving Forward Together;
4. Create accommodation that supports greater levels of integrated care in our own and other multi-use buildings over the life of the strategy, including via hub and spoke models; and to
5. Take an equitable approach, supported by increased use of good quality population data in planning.

Benefits of our action

People will get the right care in the right place at the right time, in local communities close to or at home whenever possible, and supported by multi-disciplinary teams and digital improvements. In parallel, we will grow whole system capacity to shift the balance of care from secondary to primary and community settings, reducing reliance on hospital services.

Case study – Increasing local health and care availability

NHSGGC is the first health board in Scotland to move glaucoma services out of specialist services and into primary care. Launched in April 2023, the new service model offers patients with glaucoma the opportunity to now see accredited optometrists on the high street, rather than as a hospital outpatient.

Early patient feedback has been positive, with a reduction in long waits and the removal of parking challenges often experienced in acute sites. The new model allows follow up appointments more flexibly, in line with patient needs/preferences, and is intended to reduce waiting times for outpatient appointments and bring care closer to where people live.

Clinicians have reported that the widening Optometry role and response in primary care is enabling care reviews to happen more quickly, in patients' local area and reducing clinic time.

In the remainder of 2023/24 we aim to transfer care of 1,000 glaucoma patients to primary care. Over the next 3-5 years, we will continually increase our primary care capacity to be able to support 3,000 people, and who are currently seen as outpatients.

Improving equity and reducing inequality

Health inequalities in NHSGGC are the deepest and worst in Scotland, and our Strategy launches at a time of considerable economic uncertainty, including a cost of living crisis. While primary care is just one of a number of services taking action to mitigate against inequalities, the current climate means that this is all the more crucial.

We will strengthen system-wide action to increase equity and reduce health inequalities in re-designing and delivering primary care services by:

1. Giving particular attention to improving the health and wellbeing of those worst off in this Strategy's delivery;
2. Focussing on inequalities most affecting health and wellbeing, including gender, socioeconomic status and ethnicity; and
3. Targeting activities to protect and improve the health and wellbeing of those who need them most, including identifying and resourcing measurable improvements to key service areas (such as screening and immunisation), and reducing inequalities in those areas.

Benefits of our action

Because of difficulties in accessing appropriate care, people who most need care are often those who are least able to access it. By being deliberate in ensuring that care is accessible in accordance with the level of need, we can better contribute to reducing health inequalities.

We will deliver targeted and tailored action across our priorities and wider areas of development:

Optimising our workforce - training and development that includes:

1. Improving population health knowledge to support a system-wide shift to prevention and early intervention; and
2. Effective action to reduce inequalities in access and supported self-management.

Achieving a digitally enabled primary care:

3. Paying particular attention to the needs of equality and inequality groups in digital developments, to avoid widening inequalities in health.

Improving patient pathways and primary care access to specialist advice:

4. Focussing quality improvement approaches firstly on those conditions and pathways that will bring greatest population health benefit.

Improving communications and engagement:

5. Embedding patient voice in our strategic planning and delivery; and
6. Ensuring equality impact assessments meaningfully inform our public engagement, so that we understand and tailor responses to their needs.

Improving access:

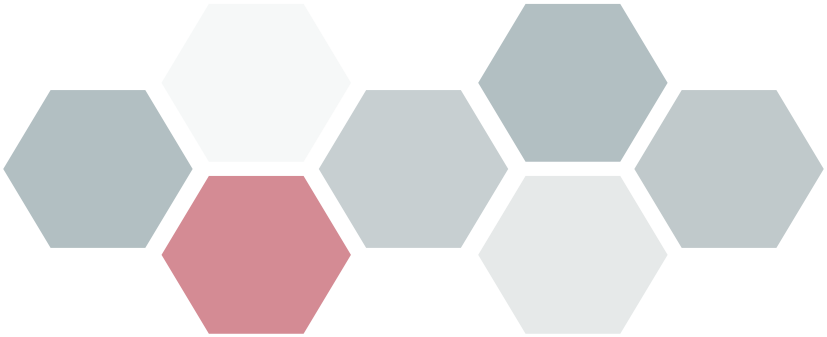
7. Meaningfully identifying and acting upon the barriers to equal and equitable access to care; and
8. Focussing improvements on improving access to information on health advice and services that will be most beneficial to people.

Strengthening prevention, early intervention and wellness:

9. Ensuring health information and support is accessible, known and used by patients, supported by needs-led approaches to content development and dissemination; and
10. Actively improving pathways to early diagnosis of serious health conditions like cancer, diabetes and heart disease.

Enhancing our primary care accommodation and property:

11. Growing the use of good quality data on population need in our property planning.



How we will implement this Strategy

Implementation of the Strategy will be directed and overseen by NHSGGC's Primary Care Programme Board (PCPB), whose members include all primary care sectors and leads, as well as professional representatives for Dental, General Practitioner, Pharmacy, and Optometry contractor/provider bodies and staff side representatives.

The Programme Board will report into NHSGGC Corporate Management Team, linking with HSCP Chief Officers, then into Finance Performance and Planning (FP&P) and Integrated Joint Boards (IJBs). This ensures that delivery of the Primary Care Strategy will align with wider NHSGGC Board Strategies (including remobilisation and MFT's transformational change) and with individual HSCPs' Strategic Plans.

We will actively work with and to the six IJBs within NHSGGC on their local strategies and commissioning of individual contractor services. We will do this through the continued work of PCPB and respective HSCP primary care support teams.

We will set out the detail of how we will implement the strategy in a five-year action plan, which will set out all board wide primary care commitments, the benefits we expect each to bring and their contribution to our strategic outcomes.

It will set out our key areas of delivery, what will be done, by whom, when, and how we will know we have been successful, alongside any dependencies.

We will undertake regular monitoring and evaluation of our Strategy and its implementation to ensure that we can understand, measure and continually seek to improve the impact of our work. We will focus on those actions that will maximise the positive outcomes for our patients, as well as our workforce and healthcare system. Learning will shape future service planning and public health interventions.

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Appendix 2 – Primary care data

The following tables set out experimental primary care data that are drawn from a range of published sources.

While substantial amounts of activity across primary and secondary care are included below, they are not complete. Activities listed are not meant to be exhaustive, there are services where data are not collected nationally (or are not readily available at NHS Board level). The most recently available datasets have been used.

The Primary care In-hours general practice activity figures are based on experimental statistics, so it is important that users understand that limitations may apply to the data.

Sector	Activity	Measure	Value	Time period	Source	Link
Primary Care	In-hours general practice (GP)	Number of encounters	4,647,498	2022/23	ESCRO data extraction tool, PHS	Link
	In-hours general practice (other clinicians)	Number of encounters	1,883,471	2022/23		
	Dental services	Number of claims	884,504	2022/23	MIDAS, PHS	Link
	Ophthalmic services	Number of eye examinations	447,921	2022/23	Ophthalmic Data Warehouse, PHS	Link
	Out of hours primary care services	Number of consultations	190,320	2021/22	GP OOHs datamart	Link

Sector	Activity	Measure	Value	Time period	Source	Link
Secondary Care	Accident and Emergency	Number of attendances	400,666	2022/23	A&E datamart, PHS	Link
	Inpatient and daycase	Continuous inpatient stays	314,773	2022/23	SMR01, PHS	Link
	Mental health inpatient	Continuous inpatient stays	3,700	2021/22	SMR04, PHS	Link
	Outpatient	Number of attendances	965,965	2022/23	SMR00, PHS	Link

Notes

General	• The activities listed here are not meant to be exhaustive, there are services that exist where data is not collected nationally or is not readily available at NHS Board level (e.g. Community Services, Pharmacy Services etc.).
In-hours general practice	• These are experimental statistics published to involve users and stakeholders in their development and as a means to build in quality at an early stage. It is important that users understand that limitations may apply to the interpretation of this data. • Mappings between raw data and groupings remain provisional, figures quoted exclude a significant number of encounters classified as 'Unmapped'. • Includes direct encounters only: Surgery consultation, Telephone consultation, Home Visit, Clinic, Video consultation & eConsultation. **Refer to 'Methdology and Metadata' for more information - https://www.publichealthscotland.scot/media/21991/methodology-and-metadata-v11.pdf**
Dental	• Each claim may cover a single appointment or multiple appointments depending on the treatment provided.
Ophthalmic	• Includes primary and supplementary eye examinations.
OOH primary care	• Includes consultations that took place attending a Primary Care Emergency Centre/Primary Care Centre (PCEC/PCC), a Home Visit or an OOH GP/Nurse Advice Telephone Call.
A&E activity	• All attendances at Emergency Departments and Minor Injury Units. Includes new and unplanned return attendances only.
Inpatient and daycase	• Figures are based on NHS Board of Treatment so include all activity at NHSGGC hospitals.
Mental health inpatient	• SMR01 returns are approximately 98% complete in NHSScotland for financial year 2022/23. • Excludes Genito-Urinary Medicine (GUM) and Geriatric Long Stay specialties.
Outpatient	• Figures are based on NHS Board of Treatment so include all activity at NHSGGC hospitals. • Consultant led new and return attendances. • SMR00 new attendances are approximately 98% complete in NHSScotland for financial year 2022/23.

Appendix 3 – Glossary of acronyms and terms

Below, we list the key acronyms used in the Strategy set out in full. We include a brief explanation for a small number of these, where they are likely less familiar to all readers.

AHPs	Allied Health Professionals – a range of regulated and specialised professions in areas of health and care, such as physiotherapy, occupational therapy, and dietetics and podiatry
APP	Advanced Physiotherapy Practitioner
CAMHS	Child and Adolescent Mental Health Services
Community Link Worker (CLW)	There are many recognised Community Link Worker (CLW) models, most frequently including the principles of working as a core member of a GP Practice Team while helping patients find the right support with any social issues affecting health and wellbeing. CLWs provide non-medical support, and they work to address health inequalities created by socio-economic issues while enabling and empowering patients to identify and achieve their priorities and goals. They provide a bespoke service which connects patients to resources and/or services to meet their individual practical, social and emotional needs.
CTAC	Community Treatment and Care
GP	General Practice / General Practitioner
HWSW	Healthcare Support Worker
HSCP	Health and Social Care Partnership
IJB	Integrated Joint Board
LTCs	Long term conditions – these include both physical conditions such as diabetes or cardiovascular disease (CVD), as well as severe and enduring mental illnesses such as psychosis, schizophrenia, bipolar disorder, or personality disorders.
MFT	Moving Forward Together is NHSGGC's long term programme for the transformation of healthcare delivery
MDTs	Multi-disciplinary Teams
NHSGGC	NHS Greater Glasgow and Clyde
PCAS	Primary Care Asset Strategy
PCIP	Primary Care Improvement Programme

PCIF	Primary Care Improvement Fund
Pharmacy professionals	A range of pharmacy professionals including pharmacists, pharmacy technicians and pharmacy support workers
RM	Realistic Medicine puts the person at the centre of decisions about their care and encourages health and care professionals to find out what matters most to the patient and treat the patient as an equal partner. This, along with discussing the benefits and risks of treatment allows shared decisions and reduced chances of care not adding value to the patient. There are 6 principles: 1. Shared Decision Making 2. Personalised Approach to Care 3. Reduce Harm and Waste 4. Reduce Unwarranted Variation 5. Managing Risk Better 6. Becoming Innovators and Improvers The vision for Realistic Medicine is that by 2025 everyone providing healthcare in Scotland will demonstrate their professionalism through the approaches, behaviours and attitudes of Realistic Medicine.
VBH&C	Value Based Health and Care is the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person (University of Oxford, 2019). This is also the name of the initiative through which we will implement Realistic Medicine. By 2030 all health and care colleagues will be supported to deliver VBH&C. We will continue to practice Realistic Medicine and achieve the outcomes that matter to people.

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