AGENDA ITEM NO: 15

Report To:	**Inverclyde Joint Integration Board**	**Date:**	**9 September 2024**
Report By:	**Kate Rocks Chief Officer Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/38/2024/AB**
Contact Officer:	**Alan Best Interim Head of Health and Community Care Inverclyde Health & Social Care Partnership**	**Contact No:**	**01475 715212**
Subject:	**NHSGGC Primary Care Strategy and Implementation**		

1.0 PURPOSE AND SUMMARY

1.1 ☐For Decision ☒For Information/Noting

1.2 The purpose of the report is to update the Integration Joint Board on the development and implementation of the NHSGGC Primary Care Strategy and share the Strategy and Implementation plan for noting.

2.0 RECOMMENDATIONS

2.1 The IJB is asked to:

a) Note the contents of this report and its appendices:
- Appendix A: NHSGGC Primary Care Strategy 2024-29
- Appendix B: NHSGGC Primary Care Strategy 2024-29 – Summary Implementation Plan
- Appendix C: NHSGGC Primary Care Strategy 2024-29 - EQIA

b) Receive an annual update on delivery of the programme.

Kate Rocks
Chief Officer
Inverclyde Health and Social Care Partnership

3.0 BACKGROUND AND CONTEXT

3.1 This is NHSGGC's first Primary Care Strategy, which was approved by NHSGGC Board on 30 April 2024. It spans five years to 2029 and aligns to NHSGGC's Delivery Plan and long term transformation programme (*Moving Forward Together*).

3.2 The Strategy defines primary care as all those services and staff working within the four independent contractor settings (dentistry, general practice, optometry, and pharmacy) as well as a range of NHSGGC / HSCP provided services. Together, these include:

- Advanced Practitioner Physiotherapists
- Dental and Oral Health, including Dental Out of Hours
- Chronic Disease Management
- Community Optometry
- Community Pharmacy
- Community Treatment and Care
- General practice and GP Out of Hours including Urgent care
- Community Link Workers (Social Prescribing)
- Mental Health in Primary Care
- Pharmacy Service
- Vaccination

3.3 The Strategy sets out a vision for 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 will deliver care in communities and be involved in the strategic planning of our services.

3.4 Long term primary care outcomes are aligned to NHSGGC's transformation programme Moving Forward Together, and the associated transfer of the balance of care, based on a tiered model of provision.

3.5 The long term outcomes for primary care are as follows:

- 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.

4.0 PROPOSALS

4.1 The attached Primary Care Strategy 2024-2029 (PCS/'the Strategy') sets out NHSGGC's strategic ambitions for primary care over the next five years, alongside a high level work plan which (once approved), will support Inverclyde Integration Joint Board's (IJB) Strategy 2019-24 (refreshed 2023/24), and the Primary Care Service Statement.

4.2 The ambition is that Strategy delivery will enable, in the short term:

- A sustainable workforce that is sufficiently staffed and skilled, and shares a common purpose;
- A step-change in data and digital technology innovations to improve patient health and care outcomes;

- Integrated care and well-connected services, supported by effective teams, improved system-wide working, leadership and planning; and
- Patients to have an improved understanding of available services and a better ability to navigate between primary care services.

4.3 In the medium to long term, the Strategy aims to enable:

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

4.4 The summary implementation plan (appendix B) sets out the activities planned to deliver on the above outcomes, over the period of the Strategy.

5.0 IMPLICATIONS

5.1 The table below shows whether risks and implications apply if the recommendation(s) is(are) agreed:

SUBJECT	YES	NO
Financial		X
Legal/Risk		X
Human Resources	X	
Strategic Plan Priorities	X	
Equalities, Fairer Scotland Duty & Children and Young People	X	
Clinical or Care Governance	X	
National Wellbeing Outcomes	X	
Environmental & Sustainability		X
Data Protection		X

5.2 **Finance**

The Strategy sets out the funding arrangements for primary care services in NHSGGC. Supporting delivery, as set out in the summary implementation plan, will be delivered within the agreed financial allocations which are set nationally for contractor groups.

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report	Virement From	Other Comments
N/A					

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact	Virement From (If Applicable)	Other Comments
N/A					

5.3 **Legal/Risk**

Not applicable.

5.4 **Human Resources**

There are staffing implications in terms of future workforce planning, composition and enhancement that will be further defined as the Primary Care Workforce Strategy is developed in 2024-25. Such changes will be identified and managed in partnership with NHS Staff Side Partnership representatives and professional bodies, and in accordance with Health and Care (Staffing) (Scotland) Act 2019 and organisational change policies.

5.5 **Strategic Plan Priorities**

The Primary Care Strategy aligns well with Inverclyde's Strategic Plan priorities, in particular:

- Big Action 1 - To reduce inequalities by building stronger communities and improving physical and mental health
- Big Action 4 - We will support more people to fulfil their right to live at home or within a homely setting and promote independent living
- Big Action 6 - We will build on the strengths of our people and our community.

5.6 **Equalities**

(a) Equalities

This report has been considered under the Corporate Equalities Impact Assessment (EqIA) process with the following outcome:

X	YES – Assessed as relevant and an EqIA is required.
	NO – This report does not introduce a new policy, function or strategy or recommend a substantive change to an existing policy, function or strategy. Therefore, assessed as not relevant and no EqIA is required. Provide any other relevant reasons why an EqIA is not necessary/screening statement.

An equality impact assessment (EQIA) has been completed for the Strategy. This can be found at appendix C and will be finalised on approval of the Strategy by NHSGGC Board. It commits to continued patient engagement, incorporation and review of equalities learning in implementation, aligned to our Public Sector Equality Duties, 2010 (Scottish Government, 2016).

(b) Equality Outcomes

How does this report address our Equality Outcomes?

The Strategy sets out dedicated action to improve equity and reduce inequalities in the design and delivery of primary care services, as well as targeted action in each of the Strategy priorities and wider areas for development (pages 42-43). These set out the ambition to deliver targeted and tailored action across our priorities and wider areas of development:

Equalities Outcome	**Implications**
People, including individuals from the above protected characteristic groups, can access HSCP services.	Strategy delivery will seek to increase workforce knowledge to

	support a system wide shift to prevention and early intervention, supported by effective and targeted action to reduce inequalities in access, improving access to trusted and needs-led health advice, and embedding patient voice in strategic planning and delivery.
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	As above.
People with protected characteristics feel safe within their communities.	None.
People with protected characteristics feel included in the planning and developing of services.	As above.
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	As above.
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None.
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None.

(c) Fairer Scotland Duty

If this report affects or proposes any major strategic decision:-

Has there been active consideration of how this report's recommendations reduce inequalities of outcome?

	YES – A written statement showing how this report's recommendations reduce inequalities of outcome caused by socio-economic disadvantage has been completed.
X	NO – Assessed as not relevant under the Fairer Scotland Duty for the following reasons: Provide reasons why the report has been assessed as not relevant.

(d) **Children and Young People**

Has a Children's Rights and Wellbeing Impact Assessment been carried out?

	YES – Assessed as relevant and a CRWIA is required.
X	NO – Assessed as not relevant as this report does not involve a new policy, function or strategy or recommends a substantive change to an existing policy, function or strategy which will have an impact on children's rights.

5.7 **Clinical or Care Governance**

There are no clinical or care governance implications arising from this report.

5.8 **National Wellbeing Outcomes**

How does this report support delivery of the National Wellbeing Outcomes?

The Strategy is relevant to all national health and wellbeing outcomes and is explicitly relevant to those outcomes highlighted below.

National Wellbeing Outcome	Implications
People are able to look after and improve their own health and wellbeing and live in good health for longer.	✓
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	
People who use health and social care services have positive experiences of those services, and have their dignity respected.	✓
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	✓
Health and social care services contribute to reducing health inequalities.	✓
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	
People using health and social care services are safe from harm.	✓
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	✓
Resources are used effectively in the provision of health and social care services.	✓

5.9 **Environmental/Sustainability**

Summarise any environmental / climate change impacts which relate to this report.

Has a Strategic Environmental Assessment been carried out?

	YES – assessed as relevant and a Strategic Environmental Assessment is required.
X	NO – This report does not propose or seek approval for a plan, policy, programme, strategy or document which is like to have significant environmental effects, if implemented.

5.10 **Data Protection**

Has a Data Protection Impact Assessment been carried out?

	YES – This report involves data processing which may result in a high risk to the rights and freedoms of individuals.
X	NO – Assessed as not relevant as this report does not involve data processing which may result in a high risk to the rights and freedoms of individuals.

6.0 DIRECTIONS

6.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	X
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

7.0 CONSULTATION

7.1 As the strategy applies to Greater Glasgow and Clyde there has been extensive engagement with Inverclyde and other HSCPs. The engagement with people accessing our services and with people providing them has driven Strategy development. Over two development phases, there were almost 2,000 contacts with patients/public partners and professionals, with engagement across both sectors broadly balanced.

7.2 The Strategy has been developed following wide consultation with strategic and operational health and care staff in NHSGGC, as well as with members of the public, and this has enabled its ambitions and priorities to be collaboratively defined, validated and refined.

7.3 Within Inverclyde there has been engagement with the Chief Officer, Strategic Planning Groups, NHS Staff Side Partnership representatives, senior clinicians, managers and practitioners in health and social care, as well as with members of the public. Staff groups and contractor representatives have been routinely consulted and briefed on the strategy, including its key priorities.

7.4 Priorities and wider areas for development were identified and agreed with the Primary Care Programme Board Strategic Group, whose membership includes independent contractor and provider member bodies (e.g. Local Medical Committee (LMC) and GP Sub Committee) and representatives from NHSGGC Area Partnership Forum (APF).

8.0 BACKGROUND PAPERS

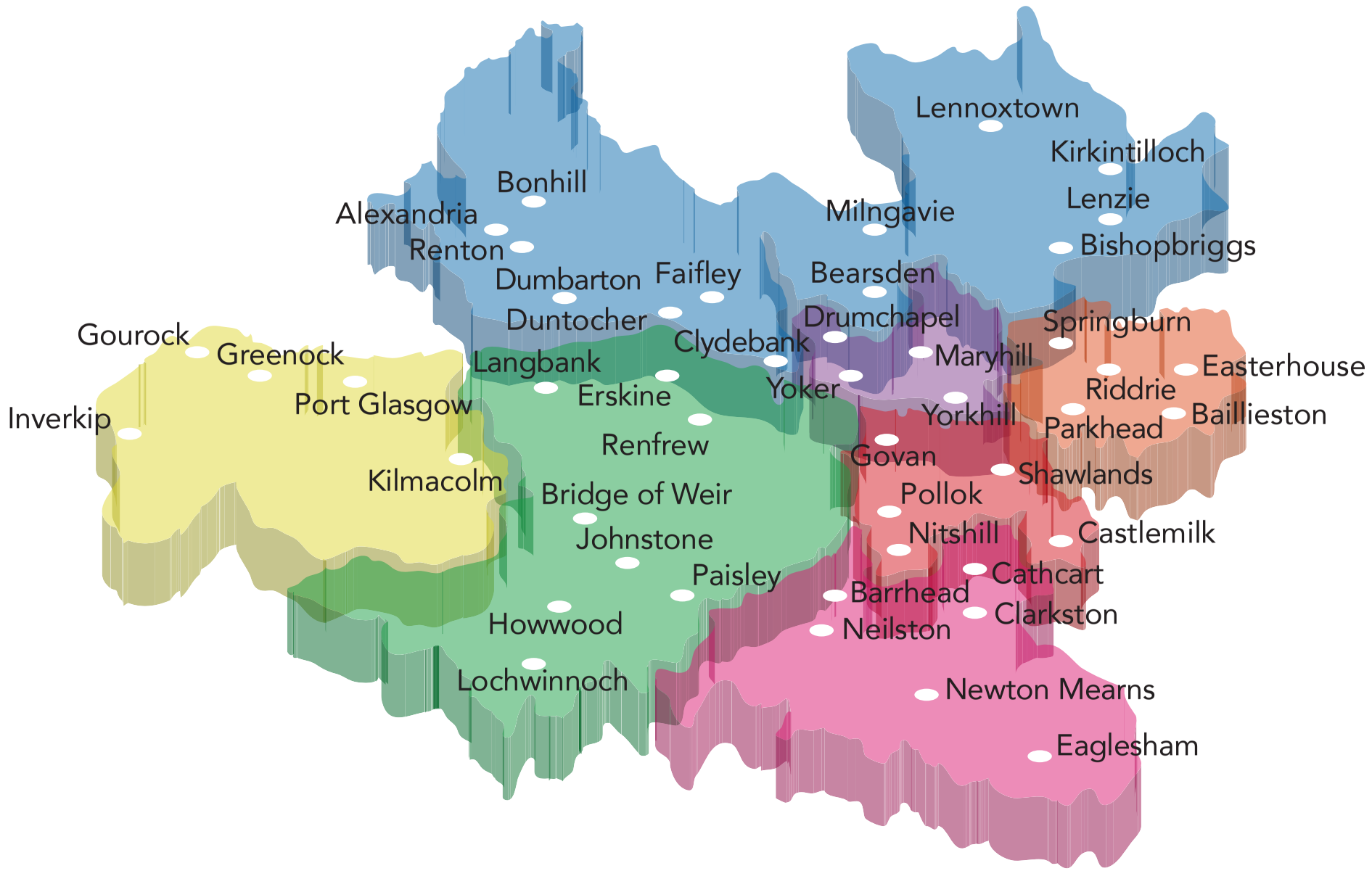
8.1 Not applicable.

NHS Greater Glasgow and Clyde

Primary Care Strategy 2024 - 2029

NHS Greater Glasgow and Clyde

Appendix A



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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			Improved access to the right advice, from the right professional, at the right time		Our experience as patients in primary care is enhanced	
Funding	Patient pathway review and development	Guidance on new patient pathways		More adaptable estate	Enhanced journeys into and through PC	Improved knowledge, skills and awareness (patients and workforce)	Our primary care services better contribute to improving population health	
Workstream delivery groups	System and process improvements	Process and system improvements	Increased understanding of local health needs through data	Patients are more informed and empowered	Increased workforce access to resource necessary to holistic, person-centred care (IT/ Digital/clinical/ wider)	Prevention is strengthened across primary care	Primary care better addresses health inequalities	
Infrastructure – digital and estate	Communications and engagement plan design and delivery	Enhanced accommodation				Increased general practice capacity		
Strategy, data and evidence	Consultation and engagement with professionals and patients	Communications and engagement plan		Improved pt & professional awareness of services/supports	Resources are more targeted at those who need them most	Improved leadership, culture and practice	Our primary care infrastructure, physical and digital, is improved	
Patient and Public Involvement	Quality improvement	Communications campaign		Multidisciplinary teams, partners & patients better involved in planning and delivery of services	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	
Workforce (independent and GGC/HSCP)	Partnership working	Patient information				Reduced unnecessary use of urgent and secondary care		
	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

My health & wellbeing

I usually go to my GP first for help with my health and wellbeing

Sign-posting & communication

I don't know what supports are available to me or how to access them

Easier access

I often have to travel to appointments near or further from home

I sometimes struggle to get an appointment and wait what feels like a long time

Digitally enabled care

My health professionals don't always have the information they need to provide my care

Better care quality, experience and outcomes

I sometimes see a lot of specialists before speaking to the right service

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

Figure 4 - Current and Future Pathways

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.

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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.

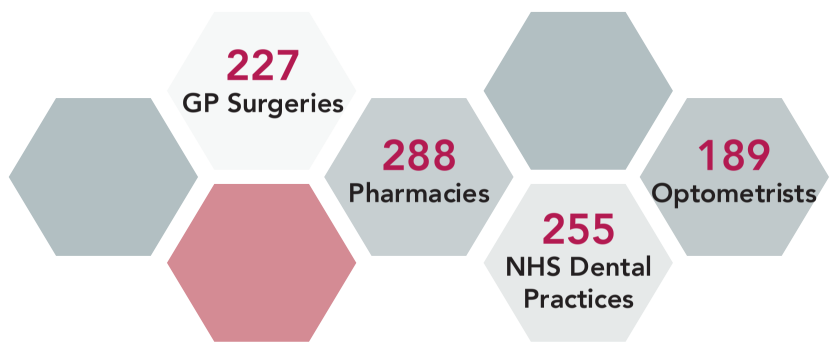
We continue to develop the 'first port of call' initiative across primary care, where patients can attend directly without needing to see a GP. Direct access is increasing for local pharmacies, opticians and dentists for advice, support and treatment. The new community glaucoma service, introduced in 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.

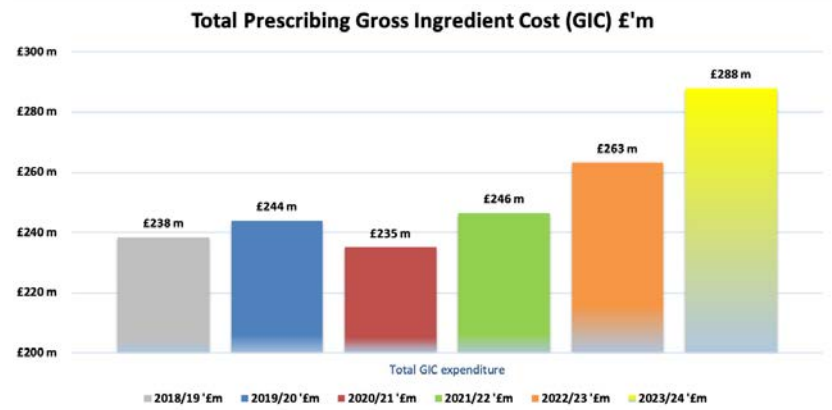


Figure 5: NHSGGC primary care prescribed drugs 2018/19-2023/24: total items and per item cost per annum

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.

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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:

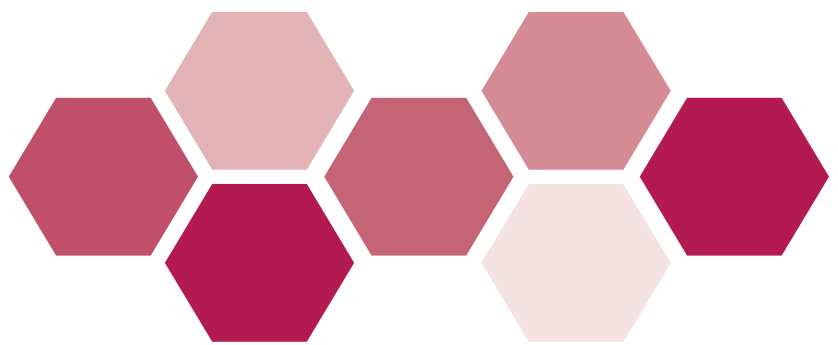
This will include work to increase direct access into and across primary care services, in-person and digitally. We will also work to improve access to high quality information and advice, and support patients to make decisions about their health and care that are right for them, based on what matters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

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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:

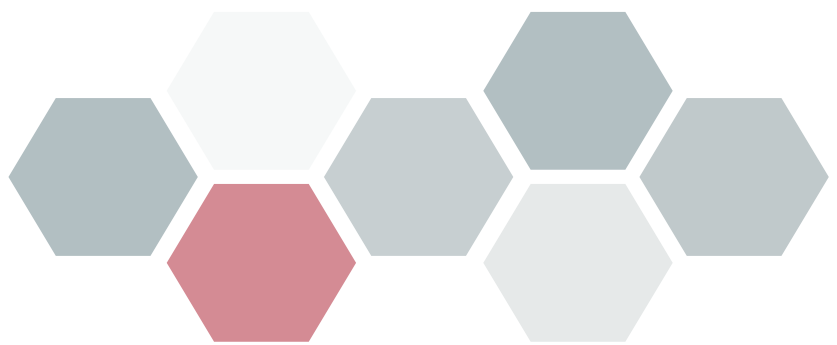
7. Meaningfully identifying and acting upon the barriers to equal and equitable access to care; and
8. Focussing improvements on improving access to information on health advice and services that will be most beneficial to people.

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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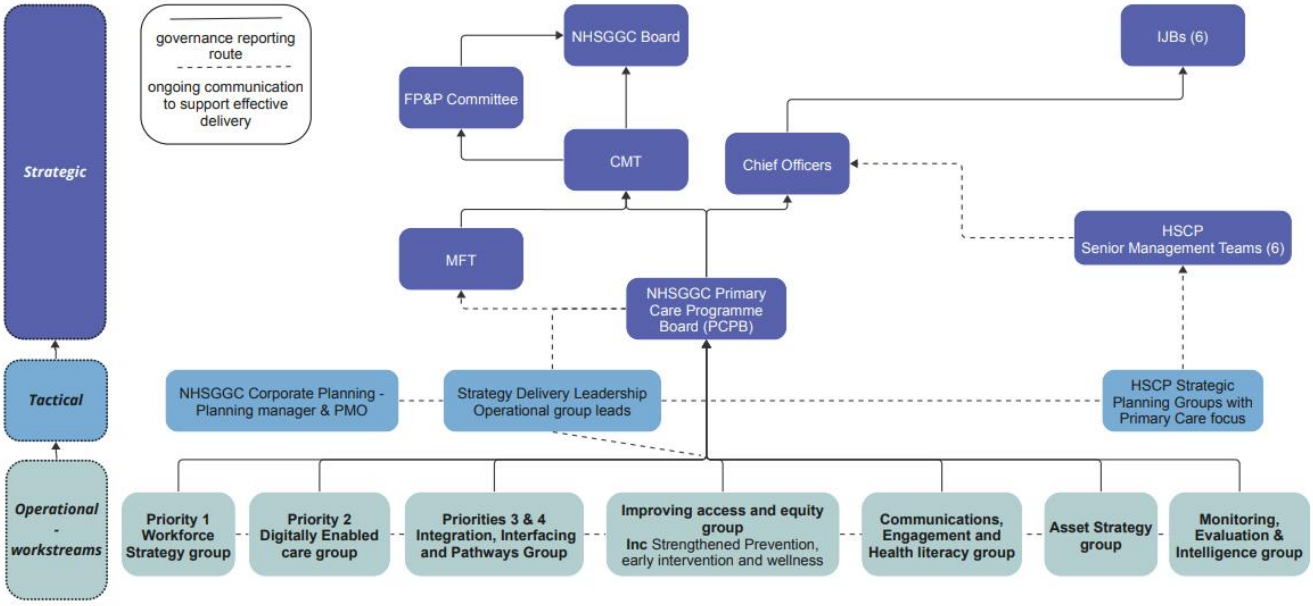
Appendix B

Primary Care Strategy 2024-29
Summary Implementation Plan

Overview

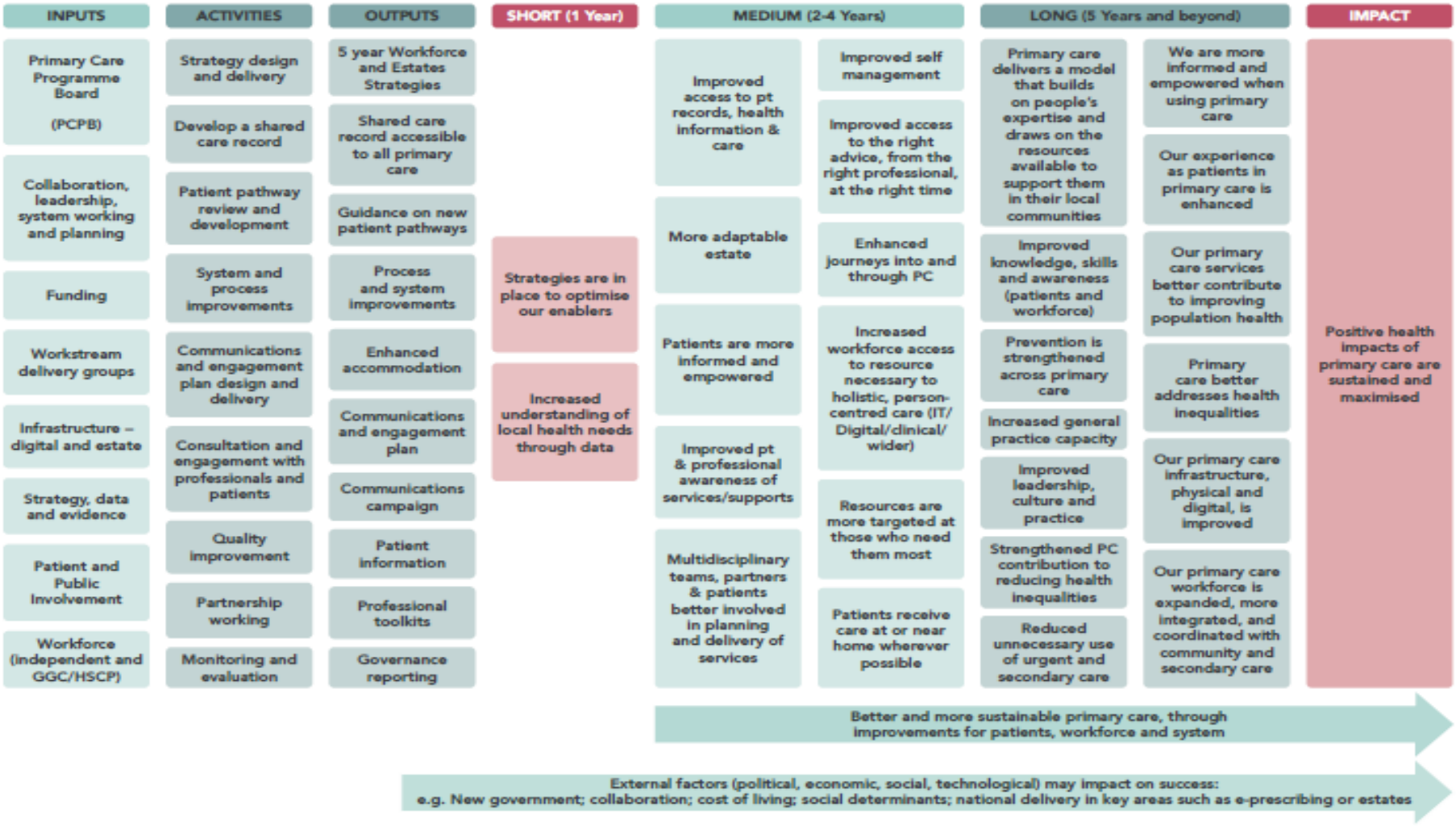
- The high level implementation Plan sets out arrangements to deliver NHSGGC's Primary Care Strategy 2024-2029.
- The term 'primary care' describes services that people often use as the first NHS point of contact and that are usually provided by general practice, pharmacy, dentistry, optometry (the four main independent contractor and practitioner groups) in our local communities.
- The Plan will be reviewed annually and refreshed as required (including as directed by our strategic oversight group, the Primary Care Programme Board).
- The Plan builds on the collaborative approach taken with partners to develop the Strategy, and we will update the remit and membership of existing work groups to ensure alignment of our deliverables and to effectively adopt whole system approaches at operational, tactical and strategic levels.
- Below is the Primary Care Strategy governance structure, followed by our logic model. The model illustrates the changes we want to achieve through our priorities in the short, medium and longer term.

Primary Care Strategy Governance Structure



Primary Care Strategy Logic Model

The model below sets out the changes we want to achieve short, medium and longer term, alongside the resource and activities required to achieve them. Our focus is on achieving our aspirations within the five year period of the Strategy and we will continue to work to align with NHSGGC transformation ambitions in the much longer term.



Primary Care Strategy deliverables and milestones 2024 – 2029: Our priorities

We aim to 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 of greatest impact on our sustainability, capacity and efficiency – and therefore patient care. We will progress activity set out under our wider areas for development in line with available resource. As set out under Deliverable 9, we will develop a monitoring and evaluation framework by summer 2024, including agreed measures.

Deliverable	Actions	Dependencies	Impact	Delivery milestone
Primary Care Strategy priorities				
1. **Develop and deliver an NHSGGC primary care workforce strategy**	1. Establish Workforce Strategy development group 2. Ongoing national advocacy/influence to optimise trainees 3. Inform NHSGGC Workforce strategy 2025-30 with primary care requirements	✓ Support by HR SMT ✓ Primary care representation at workforce supply group ✓ Engagement and collaboration with independent contractors and providers; higher education	✓ A sustainable, sufficiently staffed and skilled workforce ✓ Aligned workforce strategy across NHSGGC ✓ NHSGGC primary care as a vibrant and progressive place to work	1. 2025: Strategy draft completed 2. 2025-26: Workplan development and initiation
2. A shared care record accessible to all primary care	1. Roll out read access to Electronic Patient Record (EPR) 2. Deliver information sharing (IS) agreement(s) 3. GPIT re-provisioning 4. Procurement of and access to Clinical Systems	✓ Independent contractor and provider support, adoption and compliance with developments	✓ Health professionals have improved ability to work together to improve patient outcomes: ✓ Improved real time information sharing to support patient flow ✓ Increased flexibility in patient and general practice time ✓ Further ability for patient dialogue, self-referrals and signposting	1. 2026/27: shared care record accessible to all primary care 2. 2026: complete IS agreements 3. 2026: 100% general practices adopt GP IT reprovisioning 4. 2025/26: Documentation management system adopted by general practices

Deliverable	Actions	Dependencies	Impact	Delivery milestone
3a. Improving care pathways into and from wider health and social care – *developing our system*	1. Review and update patient pathways 2. Develop key principles for streamlined, effective and efficient pathways; link with wider system to agree, embed and improve delivery 3. Develop and deliver NHSGGC-specific content on the national Right Decision resource – providing support to referrers and patients	✓ Whole system agreement of overarching principles to ensure strong risk management ✓ Support for Prof-to-Prof ✓ Whole system support e.g. acute, planning, change management and eHealth ✓ National and local developments (e.g. Centre for Sustainable Delivery) ✓ PEPI/Public engagement ✓ Monitoring, evaluation and intelligence group	✓ Patients get the right treatment from the right professional quicker and have a better experience and outcomes ✓ Increased workforce and system capacity ✓ Strengthened primary care contribution to health and wellbeing ✓ Improved health literacy across patients and professionals ✓ Improved culture, relationship and trust across patients and professionals	1. 2024/25: workstream/ workplan development and initiation 2. 2024/25: principles developed and agreed 3. TBC via workplan
3b. Improving care pathways into and from wider health and social care – *developing workforce capacity*	1. Mainstream and standardise primary care clinician access to professional-to-professional decision making *('Prof-to-Prof')* with acute services 2. Prioritise improvements to pathways identified in deliverable 3a. Extend primary care Prof-to-Prof access to include wider multi-disciplinary teams	✓ Collaboration with partners	✓ Improved access to specialist advice will improve our ability to provide local care reduce specialist service intervention ✓ Patients at risk of/with serious health conditions are better supported by primary care ✓ Improvements to culture, relationship and trust in primary care and wider health and care	1. By 2029: Professional to professional decision making is normalised across agreed primary care professions

Deliverable	Actions	Dependencies	Impact	Delivery milestone
Wider Areas for Development				
4. **Improve access to primary care**	1. Collaborative action to scope and agree our vision for change, identifying how we will maximise our efficiency and effectiveness through an evidence and value-based approach 2. Engage with patients on digital improvements to health information access (Digital Front Door) 3. Support patients to make decisions about care that is right for them	✓ Independent contractors support ✓ Improvements in line with general practice access principles ✓ Practitioner and patient support to change ✓ National developments/ directions ✓ Digital Strategy delivery	✓ Better understanding and improve our impact with patients and professionals ✓ Strengthen equity/better contribute to health inequalities ✓ Ensure compliance with public sector equality duties	1. 2024/25: Agree workplan and priorty areas for change 2. TBC via workplan; aligned to Digital Strategy delivery c2026-9
5. **Strengthen prevention and early intervention**	1. Promote uptake of routine vaccination and screening 2. With key NHSGGC strategies, map existing activity underway, identify gaps and agree priority areas 3. Increase use of strength-based approaches to empower people to look after their own health as well as possible	✓ Collaboration with stakeholders ✓ System capacity to develop and deliver ✓ Resource for new treatments ✓ National programmes (including vaccination records)	✓ Vaccination is one of the most successful and cost-effective interventions to save lives and improve health (WHO) ✓ Reduced variation in uptake strengthens our contribution to health inequalities ✓ Compliance with legal duties outlined in Carers (Scotland) Act 2016	1. 2024/25: Undertake collaborate planning sessions with key leads 2. 2024/25: Update implementation plan 3. By 2024/25: recommendations on for approval

Deliverable	Actions	Dependencies	Impact	Delivery milestone
6. Improve equity and reduce inequality	1. Cross-cutting action across PCS workstream delivery to strengthen prevention and better target action in areas of greatest need, to include: a. Engagement with providers b. Ongoing: support to strategy delivery in line with wider workplan c. Ongoing: translation of learning throughout implementation	✓ Sustainable and sufficient resource in place ✓ Establishment of strategy workstreams ✓ Collaboration with contractors and providers	✓ Better avoid ill-health, protect wellbeing, and improve supported self-management ✓ Targeted activities to protect and improve the health and wellbeing of those needing these most ✓ More person centred, effective and equitable information supports (self-management and primary care access)	1. Autumn 2024/25: principles and proposal for areas for action agreed
7. Support self management and improved primary care navigation/use	1. Develop and deliver a primary care communications and engagement plan 2. Grow our offer of accessible health information for supported self-management 3. Embed patient voice in our strategic planning and delivery	✓ Communications and engagement plan approval ✓ Required resources in place ✓ Right decision resource ✓ Collaboration with independent contractors and providers	✓ Increase patient & professional awareness of primary care offer and how to access ✓ People are more able to look after their health to the best of their ability ✓ Person-centred, effective and equitable information supports (for patients & professionals) ✓ Improved patient flow and increases to primary care capacity	1. 2024: Membership of PCPB expanded to include Communicaitons 2. 2024-6: Communications and engagement plan developed and initiated

Deliverable	Actions	Dependencies	Impact	Delivery milestone
8. Optimising primary care accommodation and property	1. Asset Strategy development and delivery 2. Grow the use of good quality data on population need in our property planning	✓ Independent contractor and provider collaboration ✓ Reconciliation of medium-long term delivery ambitions with contract terms (e.g. GP Contract changes) ✓ HSCP support ✓ Updated GMS Premises Directions ✓ Support nationally and locally for capital investment and on-going revenue investment to primary care buildings ✓ Business Intelligence capacity	✓ People get the right care in the right place at the right time, close to/at home when possible, and supported by MDTs and digital improvements. ✓ Increased capacity to shift care from secondary to primary and community ✓ NHSGGC-wide approach to primary care estate optimisation, with HSCPs ✓ Greater levels of integrated care in multi-use buildings including hub and spoke ✓ Primary care contributes to achieving our wider sustainability and climate change targets	1. 2024/25: Target to commence Asset Strategy (Commence on conclusion of MFT Implementation Strategy, aligned to Sustainability strategy and Strategic Delivery Plan) 2. Align to NHSGGC transforamitonal programme
9. Monitor and evaluate our Strategy	1. Develop and implement a monitoring and evaluation framework with work stream leads 2. Define relevant primary care intelligence population health indicators to inform ongoing strategic planning and delivery, and local quality improvement	✓ Agreement of oversight and delivery responsibilities ✓ Public Health capacity ✓ Availability of relevant / appropriate primary care data ✓ Business Intelligence capacity	✓ We know and improve upon the impact of our work on for our patients, workforce and system ✓ Our future strategy development and implementation is informed by improved data and evidence	1. By summer 2024: approval of Strategy monitoring and evaluation framework 2. 2024/25: Development of Primary Care Monitoring, Intelligence, and Evaluation Group annual work plan 3. 2024-2029: regular monitoring reports

NHS Greater Glasgow and Clyde
Equality Impact Assessment Tool

Equality Impact Assessment is a legal requirement as set out in the Equality Act (2010) and the Equality Act 2010 (Specific Duties) (Scotland) regulations 2012 and may be used as evidence for cases referred for further investigation for compliance issues. Evidence returned should also align to Specific Outcomes as stated in your local Equality Outcomes Report. Please note that prior to starting an EQIA all Lead Reviewers are required to attend a Lead Reviewer training session or arrange to meet with a member of the Equality and Human Rights Team to discuss the process. Please contact Equality@ggc.scot.nhs.uk for further details or call 0141 2014560.

Name of Policy/Service Review/Service Development/Service Redesign/New Service:

NHSGGC Primary Care Strategy

Is this a: Current Service ☐ Service Development ☒ Service Redesign ☐ New Service ☐ New Policy ☐ Policy Review ☐

Description of the service & rationale for selection for EQIA: (Please state if this is part of a Board-wide service or is locally driven).

What does the service or policy do/aim to achieve? Please give as much information as you can, remembering that this document will be published in the public domain and should promote transparency.

042

NHSGGC's Primary Care Strategy: 2024/25 -2029/30 sets out our long term vision and approach to primary care transformation across NHSGGC.

The Strategy provides a set of principles and commitments which will support the long term future of primary care services to maintain and improve patient care. It will inform the Primary care delivery/ implementation plan which will detail the actions to maintain and develop the role of primary care as part of the patient's journey of care within the wider health & social care system. It will also provide a spotlight on primary care as a foundation on which to deliver more integrated care to patients throughout NHSGGC. Primary care services provide the first point of contact in the healthcare system, estimates suggest that around 90% of health care episodes start and finish in primary community care.

In addition to our principles and commitments, this strategy includes a set of initiatives that cover the NHSGCC wider responsibilities in relation to primary care, including responsibilities for managing the primary care prescribing budget, the interdependencies between NHSGGC, HSCPs in working with primary contractors i.e. GPs, optometrists, dentists and community pharmacists and support for promoting improvement and the sustainability of primary care in NHSGGC.

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Appendix C

The Core principles are:

1. Within our overall Scottish Government funding implement the requirements of primary care contracted services in line with emerging guidance
2. Promoting the sustainability of primary care services
3. Making sure we have a high quality of engagement with primary care contractors, third sector networks, our locality engagement forums and equality groups
4. Progress our support for quality improvement (QI) in primary care
5. Ensuring that our primary care strategy is connected to the NHSGGC MFT programme, the 6 HSCP's strategic plans for other transformation programmes and to the policy developments by the health board and Scottish Government
6. Improving our performance management framework for those primary care functions where we have a responsibility

Why was this service or policy selected for EQIA? Where does it link to organisational priorities? (If no link, please provide evidence of proportionality, relevance, potential legal risk etc.). Consider any locally identified Specific Outcomes noted in your Equality Outcomes Report.

The Primary Care Strategy is a key strategic document for NHSGGC and the 6 HSCPs which sets out how primary care service ambitions will be met in order to deliver the best possible care to our communities in the most efficient way.

The Strategy is a guide to how we will approach the development of primary care which has many work streams and covers a large number of primary care services and contractors. For context, NHSGGC hosts 189 optometrist practices; 228 general practices (GPs); 255 general dental practices (GDS) and 288 community pharmacies (CP) delivering primary care services to around 1.3 million GP registered patients.

The 2023-2028 strategy will set out how those care ambitions will be underpinned with due regard to meeting the legal requirements of the Public Sector Equality Duty (or general duty) of the Equality Act 2010 and the 2018 Fairer Scotland Duty (the duty). In the past a number of primary care programmes & services have conducted EQIAs to support the 3 parts of the General Duty. For example, the Mental Health Strategy & PCIP, HSCP PCIPs and travel health vaccination provision. Additional EQIAs will therefore be undertaken by individual services in the future as part of primary care implementation plan. These will be captured and tracked centrally to ensure coordination of assessments and identify any recurring or related risks to protected characteristic groups.

Our ambitions contained within the strategy are:

In the short term:

1. Shared purpose across a sustainable, sufficiently staffed and skilled workforce

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2. Step-change innovations in data and digital technology to improve patient health and care outcomes
3. Integrated care and well-connected services, supported by effective teams, system working, leadership and planning
4. Improved understanding and navigation across our primary care

In the medium to long term:

5. People can 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
8. Strengthened contribution to reducing health inequalities.

The priorities to help realise the ambitions are:

Our priorities are:

1. Development and delivery of a five-year primary care workforce strategy
2. Development of a shared care record accessible to all primary care, both in- and out of hours
3. Improvements to the clarity, consistency and effectiveness of patient pathways
4. Improvements to primary care's access to the right advice at the right time

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We will also work to deliver:

1. A five-year communications and engagement plan
2. A range of process and system improvements to enhance journeys into and through primary care
3. Public engagement around digital options to better access information and services
4. Strengthened prevention to better avoid ill-health, protect wellbeing, and improve supported self-management
5. Enhancements to our accommodation and property
6. A strengthen contribution to reducing health inequalities, including through targeted and tailored action.

We will proportionately increase activity around these areas in the event additional resource becomes available.

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Who is the lead reviewer and when did they attend Lead reviewer Training? (Please note the lead reviewer must be someone in a position to authorise any actions identified as a result of the EQIA)

Name: Ann Forsyth, Head of Primary Care Support	**Date of Lead Reviewer Training:** Updated 2019

Please list the staff involved in carrying out this EQIA
(Where non-NHS staff are involved e.g. third sector reps or patients, please record their organisation or reason for inclusion):

PC Strategy Communications & engagement group:
Daniel Connelly, Deputy Director Public Engagement, Public Experience and Public Involvement (PEPI)
Lisa Martin, Manager, PEPI Team
Calum Lynch, Project Manager PEPI Team
Josh Kane, Senior Communications Officer, Communications Department
Alastair Low, Planning Manager, Equality and Human Rights
Helen Cadden, Public Partner Primary Care
Ronnie Nicol, Public Partners Primary Care
Gaynor Darling, Family Health Service Advisor, Primary Care Support
Debra Allen, Senior Planning & Policy Development Officer, Renfrewshire HSCP

Consultation with members of the: Primary Care Programme Board – Strategic group

Christine Laverty, Chief Officer Renfrewshire Health & Social Care Partnership
Gary Dover, Assistant Chief Officer, Primary Care and Early Intervention (Glasgow City HSCP)
Allen Stevenson, Director Primary Care
Ann Forsyth, Head of Primary Care Support
Dr Kerri Neylon, Deputy Medical Director Primary Care
Claire McArthur, Director of Planning

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		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
1.	**What equalities information is routinely collected from people currently using the service or affected by the policy? If this is a new service proposal what data do you have on proposed service user groups. Please note any barriers to collecting this data in your submitted evidence and an explanation for any protected characteristic data omitted.**	***A sexual health service collects service user data covering all 9 protected characteristics to enable them to monitor patterns of use.***	Equalities data is collected to varying degrees by the primary care services. Where information is not routinely available, equalities data can be collected where necessary to inform the design of a service and the overall demographic trends in NHSGGC will also be taken into account. These are outlined in the NHSGGC Glasgow City Health and Social Care Partnership Demographic and Needs Profile June 2022. Primary care contractors do not routinely collect data on the nine protected characteristics. However, each pathway/service (either direct, public sector or contracted) has a duty to comply with any legislation relating to the nine protected characteristics and to ensure provision of goods and services complies with the Equality Act and Public Sector Equality Duty. As many primary care services are independent contractors in different services, data completeness and sharing practice and systems varies, and data is not owned by NHSGGC. The complexity of service pathways within the Primary Care (and their respective patient information systems) means it is not possible to create a single data repository that captures equality monitoring data across all nine protected characteristics.	We recognise the limitations of the data currently being collected by the varying services and contractors but continue to work on improving this in line with the recommendations made by the Scottish Government's Equalities Data Improvement Programme. Opportunities will be identified to encourage both primary care contractors and HSCP to gather data related to the nine protected characteristics. This will include incorporating the requirement for equalities data to be collected when commissioning services from other organisations.

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		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
2.	**Please provide details of how data captured has been/will be used to inform policy content or service design.** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ■ **4) Not applicable** □	***A physical activity programme for people with long term conditions reviewed service user data and found very low uptake by BME (Black and Minority Ethnic) people. Engagement activity found promotional material for the interventions was not representative. As a result an adapted range of materials were introduced with ongoing monitoring of uptake. (Due regard promoting equality of opportunity)*** √	Services are required to ensure consideration of equalities in all areas of service planning, development and implementation, with evidence that some services have adapted their model of service design and delivery to ensure effective access for protected characteristic groups who may experience related barriers. A recent example of where service uptake data has been used to inform practice is the **Vaccination Transformation Programme (VTP).** Innovative ways of engaging with disadvantaged communities and to increase uptake amongst underrepresented groups (Black, Asian and minority ethnic) providing various targeted provisions now includes; • Mass drop-in clinics across local community venues including the Central Mosque • Vaccination mobile bus • Older people & adult residential care homes • Patient home visiting service. Translated materials, NHS Inform, use of interpreting services and sign language are provided to support inclusive practice.	As described above, there is no single shared mainstream data collection system across all primary care service providers. While this hampers the ability to aggregate all service use data and understand access patterning by protected characteristic, each system can be interrogated independently where data fields allow. We recognise that that collection of quantitative data is not uniform across all services but within primary care there are a number of opportunities to share good practice, case studies and reporting mechanisms in place through operational & strategic groups.

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		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
3.	**How have you applied learning from research evidence about the experience of equality groups to the service or Policy?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics** ■ **4) Not applicable** □	***Looked after and accommodated care services reviewed a range of research evidence to help promote a more inclusive care environment. Research suggested that young LGBT+ people had a disproportionately difficult time through exposure to bullying and harassment. As a result staff were trained in LGBT+ issues and were more confident in asking related questions to young people.*** ***(Due regard to removing discrimination, harassment and victimisation and fostering good relations).***	Related recent research has been reviewed to learn and understand what matters to people from equality groups as detailed in section 4 below. Research recommendations for Primary Care are currently being considered. Some of our PCIP programmes and services have been developed as the result of applied research learning. The original need for the community link worker programme came from GPs working in Glasgow's most deprived neighbourhoods (Deep End GPs). The research evidence clearly recognised the additional health needs and barriers to engagement with services among those living in areas of high deprivation. The CLW was therefore developed as a deprivation based targeted service to remove discrimination and promote equality of opportunity. The Glasgow Disability Alliance published a Disabled People's Mental Health Matters report in October 2022. The findings from this paper align with some of the feedback from public engagement sessions held across Glasgow during development of this strategy.	Nationally, public research has been carried out on public views and experiences of primary care services to learn and monitor trends. For example, the Health and Care Experience survey (2022) is conducted every 2 years. The Public understanding and expectations of primary care in Scotland: Survey Analysis Report was published in November 2022. We recognise that these surveys do not provide local data on protected characteristics. To inform future direction of local Primary Care service the Patient Engagement & Public Involvement team (PEPI) have conducted local engagement (detailed below) and is also currently leading board wide engagement as part of the strategy development. We are actively monitoring and reviewing emerging

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			This strategy (and in its alignment to the NHSGGC Mental Health and Public Health strategies) will begin to address some specific barriers experienced by those facing discrimination, exclusion and hardship.	equalities learning to ensure this can be incorporated into the Primary Care Strategy development. Protected characteristic data is not collected as part of the National Health & Social Care survey therefore unable to extract NHSGGC data.
		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
4.	**Can you give details of how you have engaged with equality groups with regard to the service review or policy development? What did this engagement tell you about user experience and how was this information used? The Patient Experience and Public Involvement team (PEPI) support NHSGGC to listen and understand what matters to people and can offer support.** **Your evidence should show which of the 3 parts of the General Duty have been**	***A money advice service spoke to lone parents (predominantly women) to better understand barriers to accessing the service. Feedback included concerns about waiting times at the drop in service, made more difficult due to child care issues. As a result the service introduced a home visit and telephone service which significantly increased uptake.*** ***(Due regard to promoting equality of opportunity)***	In 2022/23, the strategy project team, supported by the Patient Engagement and Public Involvement (PEPI) Team undertook a wide variety of in-person and virtual events to understand the experiences of primary care contractors, HSCP staff and service users on primary care services. There was no exclusion criteria and the team engaged with a broad spectrum of community groups, across Greater Glasgow, many of which represented people with protected characteristics with a total of 324 members of the public engaging in the sessions. Specific protected characteristics were represented by some of the groups listed below: BME people; new Scots; asylum seekers; refugees; older people; carers; disabled people; men and women.	We recognise that due to the scale and scope of primary care services and for the reasons outlined, we were unable to capture all staff & service users' experiences. The findings will be proactively taken into consideration to shape the direction for primary care services. We will take into account all aspects of the General Duty i.e.: remove discrimination, harassment and victimisation, promote equality of opportunity and foster good relations between protected characteristics.

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	considered (tick relevant boxes). **1) Remove discrimination, harassment and victimisation** ☒ **2) Promote equality of opportunity** ☒ **3) Foster good relations between protected characteristics** ☒ **4) Not applicable** ☐	**** The Child Poverty (Scotland) Act 2017 requires organisations to take actions to reduce poverty for children in households at risk of low incomes.***	**Primary Care Strategy Public Engagement Sessions**: 27/04/23 Inverclyde Your Voice Community Forum 22/05/23 Renfrewshire In-Ren Network 25/05/23 East Dunbartonshire Senior Carers Forum 30/05/23 Public virtual/online open session 01/06/23 Public virtual/online session 07/06/23 Glasgow The Life I Want Group 08/06/23 HSCP Locality Engagement Forum 09/06/23 East Renfrewshire Big Lunch Event 13/06/23 West Dunbartonshire Clydebank Pop-up Session 19/06/23 West Dunbartonshire Locality Group, Community Representatives 19/06/23 Glasgow, Chance2change Expert Reference Group 22/06/23 Inverclyde Your Voice Community Forum 29/06/23 West Dunbartonshire Pop-up Session 16/08/23 Public virtual/online session 18/08/23 Public Online/virtual session To ensure the engagement sessions and meetings were easily accessible, several methods were used to engage including presentations and discussions via Microsoft Teams, open discussions during some HSCP meetings, a social media survey and face to face discussions with local community groups. In summary, engagement findings with the stakeholders and staff suggest the NHSGGC should address the sustainability of primary care, quality improvement, communication and engagement, collaborative working and property. The patient and service user findings suggest improvements in	

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			access to primary care services, in particular GPs and dentists, and effective communication from and between primary care services. Patients also identified a clear need for improved mental health services.	
		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
5.	**Is your service physically accessible to everyone? If this is a policy that impacts on movement of service users through areas are there potential barriers that need to be addressed? Your evidence should show which of the 3 parts of the General Duty have been considered.** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ■ **4) Not applicable** □	***An access audit of an outpatient physiotherapy department found that users were required to negotiate 2 sets of heavy manual pull doors to access the service. A request was placed to have the doors retained by magnets that could deactivate in the event of a fire.*** ***(Due regard to remove discrimination, harassment and victimisation).***	Primary care services are universal services delivered from community-based premises and are compliant with the Public Sector Duty in terms of physical accessibility, understanding the need to make any reasonable adjustments where barriers may exist. Where services are delivered from premises belonging to primary care contractors, all premises must be DDA Compliant. The location and accessibility of community based premises is a key component of the design of services. For example, with the new integrated social and primary care, mental health and community hub at Parkhead, inequalities have been considered as part of the design. The building will meet the accessibility requirements, be DDA compliant and have a dementia friendly design. Engagement will continue with a wide range of people to ensure that people with protected characteristics can participate in the consultation activities. Work will take place with equalities groups to seek their input in the proposed development and	

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			the community facilities within the hub will be designed and managed to support access by all groups, inclusive of those with protected characteristics. In addition to ensuring physical accessibility, the continued investment in patient-facing digital access solutions needs to ensure it does not inadvertently contribute to widening the health gap. Primary care services will ensure that where a digital solution is identified, developed and integrated into access pathways, it will not be to the detriment of those who experience digital exclusion and are unable to benefit from the investment. Access will be underpinned with the principle that no one will be left behind and that digital access to appointments as the first option will not be the default position.	
		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
6.	**How will the service change or policy development ensure it does not discriminate in the way it communicates with service users and staff?** **Your evidence should show which of the 3 parts of the General Duty have been**	***Following a service review, an information video to explain new procedures was hosted on the organisation's YouTube site. This was accompanied by a BSL signer to explain service changes to Deaf service users.***	Primary care services that are delivered to NHSGGC patients/service users are supported by mainstream interpreting and translation resources. This means that where a communication support is identified for an individual, provision can be made, either in spoken language, BSL or alternative format. All NHSGGC Service in the development of communications should utilise the NHSGGC Clear to All guide. The guide has been developed to support	We will continue to engage with patients around access to services and how we can improve this equally and equitably

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	considered (tick relevant boxes). **1) Remove discrimination, harassment and victimisation** ☒ **2) Promote equality of opportunity** ☒ **3) Foster good relations between protected characteristics** ☒ **4) Not applicable** ☐	***Written materials were offered in other languages and formats.*** ***(Due regard to remove discrimination, harassment and victimisation and promote equality of opportunity).***	creation of simple, clear and concise information that allows us to meet our legislative requirements and the needs of our patients. In this context, patient information refers to written information such as leaflets, flyers and posters, as well as video and audio recordings. Many patient information systems will highlight communication support to allow for pro-active planning. Where patients who require communication support access a service where additional needs are unknown, telephone interpreting can be accessed immediately.	
7	**Protected Characteristic**		**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(a)	**Age** **Could the service design or policy content have a disproportionate impact on people due to differences in age? (Consider any age cut-offs that exist in the service design or policy content. You will need to objectively justify in the evidence section any segregation on the grounds of age promoted by the policy or included in the service design).** **Your evidence should show which of the 3 parts of the General Duty have been considered.**		The Primary Care Strategy Team and PEPI team engaged with groups of primary care contractors, HSCP staff and members of the public. Primary care services are universal, so open to all members of the population regardless of age. Feedback from engagement with the East Dunbartonshire Seniors and Carers Forum (31 attendees) showed that people were concerned about the equity of services and a need for improvement to the consistency and variations across the Greater Glasgow & Clyde area.	NHSGGC acknowledge that funding challenges have led to some inconsistencies in service availability across the 6 HSCP areas. This strategy seeks to take a proportionate approach to delivering services where it is needed most, tackling

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	1) Remove discrimination, harassment and victimisation ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ■ **4) Not applicable** □	The impact of such inconsistencies mean that people's experience of care can differ depending on where they live. A large number of primary care users are over 65 or under 5 years of age. The number of people aged over 65 in the population is due to increase by nearly 32% over the next 20 years. A key focus when designing services will be availability and accessibility of services for this age group. Services will also be adapted for children under 5, where appropriate.	inequalities and promoting fairness across the system.
(b)	**Disability** **Could the service design or policy content have a disproportionate impact on people due to the protected characteristic of disability?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ■ **4) Not applicable** □	'The Life I Want Group' is a social partnership covering Greater Glasgow to create opportunities for people with learning difficulties. An engagement session with this group highlighted mixed views and experiences of primary care. Digital developments were generally viewed as potentially helpful for people with disabilities but assumptions regarding access should be avoided and alternatives offered. Other feedback related to gaps in staff awareness of equalities and patient rights in general, a higher susceptibility (for people with disabilities) towards misleading health information and signposting to services should be accessible to all. A questionnaire was also specifically sent to members of the Involving People Network (IPN). Primary care services are open to all members of the population and the engagement undertaken didn't highlight any specific areas to be addressed in	Through implementation of the strategy any redesign of service and /or policy redesign that impact on protected characteristics will be subject to EQIA process to identify potential and consequential impacts

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		relation to disability that weren't expressed by those who engaged as a whole. All of the above will be taken into account when designing the Primary Care Strategy and implementation / delivery Plan with focused attention during service related specific review.	
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(c)	**Gender Reassignment** **Could the service change or policy have a disproportionate impact on people with the protected characteristic of Gender Reassignment?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics** ■ **4) Not applicable** ☐	The Health needs assessment of lesbian, gay, bisexual, transgender and non-binary people (NHSGGC, NHS Lothian and Public Health Scotland, 2022) found that most participants were happy with their Primary Care experiences. Of those people using their GP in the previous year, 88% reported a positive experience. It is possible that where a service user is signposted to a health professional other than their own GP, that healthcare professional may not know the patient's trans history. Where any services are configured on a separate or single sex basis in a primary care setting, the EHRC document – Separate and Single Sex Service Providers – A Guide on the Equality Act Sex and Gender Reassignment Provisions will be referred to.	Staff training on gender re-assignment issues can support mitigation against any patient being discriminated against. Close links can be developed with the Sandyford Clinic to ensure that all aspects of the service take cognisance of gender re-assignment issues.
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(d)	**Marriage and Civil Partnership**	Not applicable to this strategy.	

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	Could the service change or policy have a disproportionate impact on the people with the protected characteristics of Marriage and Civil Partnership? **Your evidence should show which of the 3 parts of the General Duty have been considered** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ■		
(e)	**Pregnancy and Maternity** **Could the service change or policy have a disproportionate impact on the people with the protected characteristics of Pregnancy and Maternity?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■	The Strategy project team and the Patient Engagement and Public Involvement (PEPI) Team engaged with groups of primary care contractors, HSCP staff and members of the public which were representative of the overall population. Primary care services are open to all members of the population and the engagement undertaken didn't highlight any specific areas in relation to pregnancy or maternity which needed addressed. However, Primary care service design will continue to consider pregnant women and maternity services. For example, the Vaccination Transformation Programme facilitated ease of access for pregnant	

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	2) Promote equality of opportunity ■ **3) Foster good relations between protected characteristics.** ■ **4) Not applicable** □	women, by delivering vaccination within the maternity services which women were already attending.	
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(f)	**Race** **Could the service change or policy have a disproportionate impact on people with the protected characteristics of Race?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics** ■ **4) Not applicable** □	Feedback from the In-Ren (Renfrewshire) network highlighted that New Scots communities can experience limited information on how the healthcare system in Scotland works compared to other countries. This group also noted a need to consider communication methods for non-English speaking individuals and communities. Currently alternative language formats for health information is available to all on request from members of staff.	Overall, NHSGGC has a higher proportion of people from a BAME backgrounds compared to the overall national average. Service design in all areas will need to take the needs of this group into account. For example, when providing interpreting services at healthcare appointments and providing information in different languages. The primary contractors currently use the interpreting service when required to book an interpreter over the phone or in person.
(g)	**Religion and Belief**	The health records of individual patients may contain information on religion or belief which could affect the care they wish to receive.	

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	Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Religion and Belief? **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☒ **2) Promote equality of opportunity** ☒ **3) Foster good relations between protected characteristics.** ☒ **4) Not applicable** ☐	However, in terms of the population as a whole, the strategy project team and the PEPI team engaged with groups of primary care contractors, HSCP staff and members of the public which were representative of the overall population. Primary care services are universal to all members of the population and the engagement undertaken didn't highlight any specific areas in relation to religion or belief which needed addressed.	
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(h)	**Sex** **Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sex?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).**	Primary care services are open to all members of the population. Health records of individual patients may contain information on sex which could affect the care they wish to receive. This may because certain sex specific services are due to biology, rather than any exclusion of service user e.g. cervical screening. In terms of the population as a whole, the strategy project team and the PEPI team engaged with a broad range of primary care contractors, HSCP staff and members of the public which were	

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	1) Remove discrimination, harassment and victimisation ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ■ **4) Not applicable** ☐	representative of the overall population. The engagement undertaken didn't highlight any specific areas in relation to sex which needed addressed.	
(i)	**Sexual Orientation** **Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sexual Orientation?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ■ **4) Not applicable** ☐	In terms of the population as a whole, the strategy project team and the PEPI team engaged with a broad range of primary care contractors, HSCP staff and members of the public. Primary care services are open to all members of the population. Due to initial challenges identifying an appropriate LGBTQ group available to participate and subsequently securing suitable dates, we were unable to deliver this specific session within the agreed phase two engagement period. However, we have agreed to continue to engage with the identified group re further opportunities for participation as the strategy moves forward and in particular around any local or service-specific actions and improvements that arise from the implementation phase. Additionally, we will continue to develop our knowledge of and relationships with local LGBTQ groups and networks, to ensure that the programme of ongoing engagement provides accessible and	As part of implementation change require to consider engagement with LGB service users during implementation given limited engagement during strategy development

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		appropriate opportunities that reflect peoples' lived experience. Recent recommendations from NHSGGC, NHS Lothian and Public Health Scotland's LGBTQ+ report will also be considered.	
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(j)	**Socio – Economic Status & Social Class** **Could the proposed service change or policy have a disproportionate impact on people because of their social class or experience of poverty and what mitigating action have you taken/planned?** **The Fairer Scotland Duty (2018) places a duty on public bodies in Scotland to actively consider how they can reduce inequalities of outcome caused by socioeconomic disadvantage when making <u>strategic</u> decisions. If relevant, you should evidence here what steps have been taken to assess and mitigate risk of exacerbating inequality on the ground of socio-economic status. Additional information available here:** Fairer Scotland Duty: guidance for public bodies - gov.scot (www.gov.scot). 7 Qs? 1. What evidence has been considered in preparing for the decision, and are there any gaps in the evidence?	The strategy project team and the PEPI team engaged with many diverse groups of primary care contractors, HSCP staff and members of the public. The negative impact of health inequalities and poverty on health and wellbeing is immense. There is evidence that austerity measures and increases in the cost of living compound health inequality by affecting mental health, so as the cost of living increases, it is more important than ever to design services with this in mind. Furthermore, it is crucial to recognise this when designing services for Primary Care, as it has been recognised that strong primary care systems are positively associated with better health. Recent learning has highlighted digital exclusion as an issue to consider, particularly for people with less resource and/or older adults. With this in mind it is vital that an approach which prioritises investment in	We will further explore prevalence and patterning of digital exclusion in NHSGGC and ensure that we retain patient choice around ways to access information, care and treatment and support that include non-digital routes. Impact of commitments will be monitored through the evaluation framework which will be developed to support monitoring of the strategy

	2. What are the voices of people and communities telling us, and how has this been determined (particularly those with lived experience of socio-economic disadvantage) 3. What does the evidence suggest about the actual or likely impacts of different options or measures on inequalities of outcome that are associated with socio-economic disadvantage 4. Are some communities of interest or communities of place more affected by disadvantage in this case than others? 5. What does our Duty assessment tell us about socio-economic disadvantage experienced disproportionately according to sex, race, disability and other protected characteristics that we may need to factor into our decisions 6. How has the evidence been weighed up in reaching our final decision? 7. What plans are in place to monitor or evaluate the impact of the proposals on inequalities of outcome that are associated with socio-economic disadvantage?	developing a digital 'front door' to primary care services does not inadvertently compound barriers to access for people living in poverty. Poverty is often a common denominator for protected characteristic groups most marginalised in society. To this end, digital exclusion will have the greatest impact on the frail/elderly, those with disabilities, transgender people and those from Black, Asian and/or ethnic minority communities. Due to Primary Care Improvement Plan funding, the Community Link Worker (CLW) service was established in some GP practices located some HSCPs in the most deprived areas of NHSGGC. One of the services offered by CLW's is financial advice and they also link clients to the Welfare Advice Health Partnership project located within some GP surgeries or Third sector financial inclusion organisations.	
(k)	**Other marginalised groups** **How have you considered the specific impact on other groups including homeless people, prisoners and ex-offenders, ex-service personnel, people with addictions, people involved in prostitution, asylum seekers & refugees and travellers?**	The strategy project team and the Patient Engagement and Public Involvement (PEPI) Team engaged with many groups of primary care contractors, HSCP staff and members of the public. In addition to the feedback (as per section F) from public engagement which outlined the main concerns in relation to New scots and non-English speaking communities, the communication and engagement commitments and associated delivery plans will set	The strategy aligns with the NHSGGC mental health and public health strategies and all marginalised and/or underrepresented groups will be considered and included as part of development of this strategy and its associated implementation/delivery plans.

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		out how we will work with marginalised groups in the future.	All workstreams and change proposals will be subject to EQIA.
8.	**Does the service change or policy development include an element of cost savings? How have you managed this in a way that will not disproportionately impact on protected characteristic groups?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics.** ☐ **4) Not applicable** ☐	A draft budget for primary care services has been set which reflects the anticipated funding. We are following the Scottish Government guidance and anticipate delivery within current forecasted funds.	We recognise that if any service was removed due to financial constraints, consideration would need to be given to the impact and this would have on patients in terms of access and travel, for example. Planning would be put in place to minimise or mitigate any foreseen adverse consequences.
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
9.	**What investment in learning has been made to prevent discrimination, promote equality of opportunity and foster good relations between protected characteristic**	Equalities Training and staff development for primary care staff deliver are being further developed. Work is ongoing to progress this action, including a	

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	groups? As a minimum include recorded completion rates of statutory and mandatory learning programmes (or local equivalent) covering equality, diversity and human rights.	newsletter and updates provided to all staff on primary care initiatives with requirement for equalities training, including undertaking of EQIAs. Mechanisms are in place to record statutory & mandatory equalities training for HSCP staff and contractor groups as employer responsible for providing and maintaining training of their staff.	

10. In addition to understanding and responding to legal responsibilities set out in Equality Act (2010), services must pay due regard to ensure a person's human rights are protected in all aspects of health and social care provision. This may be more obvious in some areas than others. For instance, mental health inpatient care or older people's residential care may be considered higher risk in terms of potential human rights breach due to potential removal of liberty, seclusion or application of restraint. However risk may also involve fundamental gaps like not providing access to communication support, not involving patients/service users in decisions relating to their care, making decisions that infringe the rights of carers to participate in society or not respecting someone's right to dignity or privacy.

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The Human Rights Act sets out rights in a series of articles – right to Life, right to freedom from torture and inhumane and degrading treatment, freedom from slavery and forced labour, right to liberty and security, right to a fair trial, no punishment without law, right to respect for private and family life, right to freedom of thought, belief and religion, right to freedom of expression, right to freedom of assembly and association, right to marry, right to protection from discrimination.

Please explain in the field below if any risks in relation to the service design or policy were identified which could impact on the human rights of patients, service users or staff.

Through the delivery of a coordinated EQIA programme for aligned service developments, the Primary Care Strategy and Implementation plan will ensure the right to protection from discrimination is upheld.

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Please explain in the field below any human rights based approaches undertaken to better understand rights and responsibilities resulting from the service or policy development and what measures have been taken as a result e.g. applying the PANEL Principles to maximise Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality or FAIR* .

PANEL principles were used as part of this EQIA of the Primary Care Strategy 2023 – 2028 to ensure that services and programmes take a human rights-based approach with a focus on responding to and tackling inequality.

Participation- Primary care seeks active participation and engagement of patients and service users through direct engagement and evaluation. A comprehensive engagement exercise was undertaken from March - June 2023 with primary care contractors, HSCP staff and service users as detailed in Section 4.

Accountability- a dedicated equalities assessment of Primary Care Strategy 2023 – 2028 is now being undertaken and will be reviewed on a six monthly basis. Component programmes and services within the Primary Care have or will also produce EQIAs.

Non-discrimination - primary care services are universal services which are open to all.

Equality/Empowerment- The Primary Care Strategy seeks to promote equality and equity within NHSGGC and has continued to commission and utilise research reports to raise awareness, plan, resource and act on the significant health inequality challenges for the board. We have introduced and will embed patient and public involvement via the Communications and Engagement Sub-group.

Legality-The service is compliant with UK and Scottish Law.

- **F**acts: What is the experience of the individuals involved and what are the important facts to understand?
- **A**nalyse rights: Develop an analysis of the human rights at stake
- **I**dentify responsibilities: Identify what needs to be done and who is responsible for doing it
- **R**eview actions: Make recommendations for action and later recall and evaluate what has happened as a result.

Having completed the EQIA template, please tick which option you (Lead Reviewer) perceive best reflects the findings of the assessment. This can be cross-checked via the Quality Assurance process:

☐ Option 1: No major change (where no impact or potential for improvement is found, no action is required)

■ Option 2: Adjust (where a potential or actual negative impact or potential for a more positive impact is found, make changes to mitigate risks or make improvements

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☐ Option 3: Continue (where a potential or actual negative impact or potential for a more positive impact is found but a decision not to make a change can be objectively justified, continue without making changes)

☐ Option 4: Stop and remove (where a serious risk of negative impact is found, the plans, policies etc. being assessed should be halted until these issues can be addressed)

11. If you believe your service is doing something that 'stands out' as an example of good practice - for instance you are routinely collecting patient data on sexual orientation, faith etc. - please use the box below to describe the activity and the benefits this has brought to the service. This information will help others consider opportunities for developments in their own services.

As part of GP contract and HSCPs associated PCIP 2019-21, the Community Links Worker programme was developed. The programme is a service that is in most HSCPs deprivation focused and operates within the GP practices. The enhanced support to patients within universal GP practices provides non-stigmatising targeted action against health inequalities. NHSGGC recognises the particular need to reduce inequalities of outcome caused by socioeconomic disadvantage, so the programme continues to request additional financial investment and further expansion at national level.

Actions – from the additional mitigating action requirements boxes completed above, please summarise the actions this service will be taking forward.	**Date for completion/ Who is responsible? (initials)**
Progress developing access to LearnPro community for the non HSCP workforce to provide opportunity for staff to complete the Equality and Human Rights modules to ensure competence with regard to the protected characteristics.	TBC with Implementation
Provide or support access to awareness sessions in the NHSGGC and wider primary care workforce on issues affecting marginalised groups to ensure staff are able to understand and recognise the needs of marginalised groups.	TBC with Implementation
Provide or support access to more specialist training in NHSGGC and wider primary care workforce on issues affecting specific marginalised groups to ensure staff are knowable and skilled at responding to the needs of specific marginalised groups.	TBC with Implementation

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With an increasing BAME, asylum seeking and refugees population, 80 different languages are spoken within NHSGGC. We will: • Support the pathway for primary care contractors / practice requests for information in other languages and formats. • Provide information to practice staff with regard to the use of interpreters in primary care settings.	TBC with Implementation
Opportunities will be identified to encourage both primary care contractors and HSCP staff to gather standardised data related to the nine protected characteristics. This will also include incorporating the requirement for equalities data to be collected when commissioning services from other organisations.	TBC with Implementation
We will continue to look to other data sources in NHSGGC and nationally to benchmark and assess the equalities data as required.	TBC with Implementation
It is important that we understand the experience of equalities groups who access our service. We will build on our previous engagement events to gather the views of primary care contractors, HSCP staff and service users on primary care services. We will continue to progress our engagement work to seek to capture patient and service users experiences and perspectives across equalities groups. We will seek public health advice and support to ensure that Strategy actions do not negatively impact on equalities (and where possible, will positively impact on them).	TBC with Implementation
Throughout the duration of this Strategy and implementation phase, we have committed to build on and share learning from the PC services.	TBC with Implementation
We will continue to review and report on equalities performance to NHSGGC Primary Care programme Board – Strategic Group, on an as required basis.	TBC with Implementation

Ongoing 6 Monthly Review- please write your 6 monthly EQIA review date:

Oct 2024

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Lead Reviewer:	**Name:**	Ann Forsyth
EQIA Sign Off:	**Job Title:**	Head of Primary Care Support
	Signature:	
	Date:	**17/11/2023**
Quality Assurance Sign Off:	**Name**	**Alastair Low**
	Job Title	**Planning Manager**
	Signature	**Alastair Low**
	Date	**15/11/2023**

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NHS GREATER GLASGOW AND CLYDE EQUALITY IMPACT ASSESSMENT TOOL
MEETING THE NEEDS OF DIVERSE COMMUNITIES
6 MONTHLY REVIEW SHEET

Name of Policy/Current Service/Service Development/Service Redesign:

Please detail activity undertaken with regard to actions highlighted in the original EQIA for this Service/Policy

		Completed	
		Date	Initials
Action:			
Status:			
Action:			
Status:			
Action:			
Status:			
Action:			
Status:			

Please detail any outstanding activity with regard to required actions highlighted in the original EQIA process for this Service/Policy and reason for non-completion

		To be Completed by	
		Date	Initials
Action:			
Reason:			
Action:			
Reason:			

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Please detail any new actions required since completing the original EQIA and reasons:

		To be completed by	
		Date	Initials
Action:			
Reason:			
Action:			
Reason:			

Please detail any discontinued actions that were originally planned and reasons:

Action:	
Reason:	
Action:	
Reason:	

Please write your next 6-month review date

Name of completing officer:

Date submitted:

If you would like to have your 6 month report reviewed by a Quality Assuror please e-mail to: alastair.low@ggc.scot.nhs.uk

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