PRIMARY CARE PLANNING FRAMEWORK

1. INTRODUCTION

1.1 The delivery and development of primary care is fundamental to progressing the five strategic priorities identified in the Corporate Plan. It builds on our Greater Glasgow and Clyde Primary Care Strategy established in 2010 which has been driving a range of local work to develop primary care based services and work. In addition, we are working with the Scottish Government to play our full part in shaping changes to the general medical services and other national primary care contracts. Our review of clinical services beyond 2015 (Fit for the Future) looks at developing clinical services across primary, community and acute care, including mental health. This framework will inform this emerging work.

1.2 The Primary Care Planning Framework describes how primary care (general medical services, community pharmacy, optometry and dental services) will develop to respond to the five priorities. It also describes the changes required in primary care to support the delivery of other frameworks eg Long Term Conditions, Older People and Acute Services.

2. NATIONAL CONTEXT

2.1 The Corporate Plan notes that the biggest drivers of demand for primary care services are age and deprivation. Demographic changes are one of the biggest challenges currently facing Scotland. The response to this challenge has been set out in "Reshaping Care: A programme for Change 2011-2021". The aspiration that people will live longer, healthier lives at home will have significant implications for primary care. In 2012, the Scottish Government published an Intermediate Care Framework for Scotland: Maximising Recovery, Promoting Independence. Intermediate care aims to enable individuals to live independent lives with meaning and purpose, within their own community and to avoid dependency on health and social care. Primary care has a key role, with hospital services, Council Social Work and housing services and the voluntary sector in leading the development of intermediate care.

2.2 Other national policy and context which directly impacts on primary care includes:

- Delivering Quality in Primary Care.
- Quality and Outcomes Framework development.
- Plans to develop a Scottish GP contract to focus on patients, strengthen links between hospital and community and improve integration.
- General practice in Scotland: They Way Ahead (February 2010) (progress report March 2012).
- National Oral Health Improvement Strategy for Priority Groups (July 2012).
- Plans to improve patient pathways between General Optometry Services (GOS) and secondary care.

2.3 The Primary Care Framework covers our responses to primary care policy and our response in primary care to other policy areas.

2.4 Primary care services impact both directly and indirectly on the following HEAT targets:

- At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.

- To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% by 2014/15 (NHSGGC target 20%).

- At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breastfeeding rates and other important health behaviours.

- Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1000 population by at least 12% between 2009/10 and 2014/15 (5,630 in NHSGGC).

- No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting once treatment is complete from April 2013.

2.5 Primary care also has a signposting role in supporting the HEAT targets for smoking cessation and child healthy weight intervention.

3. LOCAL CONTEXT AND PROGRESS

3.1 The existing primary care framework has driven forward a number of changes and development in the last three years, particularly in general medical services. CH(C)Ps have developed locality groups to bring practitioners together to develop local solutions to problems and deliver service improvements. We have also invested in developing primary care premises. New Heath Centres have been opened in Renfrew and Barrhead and a wide programme of improvements of other GP premises has been implemented.

3.2 Targets for achieving cardiovascular health checks have been achieved, and the lessons learned from Keep Well are now being widely applied across Greater Glasgow and Clyde. The OPR process has driven a focus on primary care prescribing which will impact on how resources are managed and used Access to GP services has been a priority for CH(C)Ps and systems to improve and measure access are being implemented across Greater Glasgow and Clyde.

3.3 The Primary Care Deprivation Group, building on the work of the “Deep End” GPs, has brought together a range of professionals, practitioners and patients to address the needs of our most deprived populations. We will use this work to inform our thinking on the Scottish GP contract.

3.4 The QOF process is now beginning to address demand management. We have focused on orthopaedics, geriatrics, gastroenterology and neurology and the disaggregation of referral data in these areas.

3.5 Progress at the interface between primary and secondary care has been slower ,but change fund work and the QOF programme in 2011 and 2012 work have focused attention on the key areas and a number of improvement actions are now progressing.

4. FINANCE AND WORKFORCE

4.1 Most of our expenditure on primary care is set by national contract and our key areas of influence for 2013-16 are:

- Prescribing budgets.
- Local enhanced services.
- Local contract variations eg 17(c) contracts.

Activity in primary care also drives costs throughout the NHS system and our focus on appropriate secondary care referrals and patient pathways will reduce costs in the acute sector.

4.2 We will continue to develop the primary care team, working in localities with community services and, where appropriate, social care and voluntary services.

EARLY INTERVENTION AND PREVENTING ILL HEALTH

Early intervention and preventing ill health in primary care are critical to reducing the demand for acute care. We will focus on anticipatory care (including Keep Well) and chronic disease management in the next three years.

<table>
<tr><th>Outcomes</th><th>Change/Development Required</th><th>Measures</th></tr>
<tr><td>There will be consistency and a systematic approach to anticipatory care planning across Greater Glasgow and Clyde

→ The learning from the first phases of Keep Well will be rolled out across GGC</td><td>Keep Well to be implemented across the Board area.

Learning from Community oriented primary care pilot in Drumchapel to be disseminated

Anticipatory care plans to be developed

A new approach to enhanced services is developed to support comprehensive chronic disease management</td><td rowspan="3">Increasing breastfeeding rates

No. of FAST screens and ABIs

% 11 year olds with no DMFT

% 3-5 year olds registered with a dentist

No. of Keep Well checks v target

% of people ready to change who are referred

Increased use of social prescribing

Sustaining/improving levels of immunisation rates

Number of carers' assessments

Reduced COPD bed days and morbidity</td></tr>
<tr><td>There will be increased identification and a reduction of key risk factors (smoking, obesity, alcohol use)

→ Primary care practitioners will be aware of key risk factors and onward referral routes</td><td>Alcohol Screening and Brief Interventions to be promoted in primary care

CHPs to maximise existing effort and resource to reduce the COPD burden</td></tr>
<tr><td>Disadvantaged groups will be enabled to use services in a way which reflects their needs

→ Health improvement for vulnerable groups will be prioritised</td><td>The work and findings of the deprivation group will inform practice in primary care and will influence practice in other services

A range of early interventions (including oral health) for priority groups will be progressed

Routine systems established to identify carers in primary care and refer on for assessment</td></tr>
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SHIFTING THE BALANCE OF CARE

Primary Care has a key role to play in supporting the shift in the balance of care. We will use the opportunities offered by the proposed health and social care integration, joint service planning and by ongoing service review and redesigns to ensure that people are cared for in a setting appropriate for their needs.

Outcomes	Change/Development Required	Measures
The interface between acute and primary care is much better, with the acute sector only dealing with acute issues → Clear referral pathways into secondary care will be established → Patient pathways will be streamlined → Better understanding of variations in primary care referral behaviour → Diagnostics pathways will be improved for patients	Jointly agreed implementation plan to be developed to transfer radiology services to secondary care Referral guidance for high volume conditions will be developed and implemented Explore direct referral from primary care to endoscopy Establish clarity around access to CT scans Secondary care onward referrals are not returned to primary care Key areas identified through the QOF process will be targeted (orthopaedics, gastroenterology and neurology) by ensuring only electronic referrals, using demand profiles and QOF reports and developing/improving referral guidelines Explore opportunities for direct access to a wider range of diagnostic services	Rollout of Liverpool Care Pathway LARC provision Development of locality level indicators Implement planned new referral guidance across all NHSGGC
Care will be provided in the most appropriate place by the most appropriate professional → Service redesigns will focus on workforce and interface issues	Audit/review if better access to emergency outpatient appointments could reduce admissions ATOS work will be developed into a comprehensive plan to reduce A&E	

Outcomes	Change/Development Required	Measures
→ People are supported to stay at home in their own community for as long as possible → Non urgent/avoidable use of emergency care services will be minimised	attendances. A&E staff will be supported to work with vulnerable frequent attenders. Optometry/2° interface improved Develop indicators of demand and activity in primary care to model the impact of service change	
There are agreed patient pathways across the system with roles and responsibilities clearly defined including new ways of working for primary and community care	Locality groups to continue to develop and provide evidence of added value Primary Care team toolkit to be tested in localities Develop a plan to match practice lists with geographical localities. Development of Scottish contract to address current limitations re vulnerable children and adults with complex needs	
More people are able to die at home or in their preferred place of care	CHPs to demonstrate through use of SPAR and LCP that more people can end their life at home	

RE-SHAPING CARE FOR OLDER PEOPLE

Primary Care is an important part of the complex system of care required for our growing older population. We will use the Change Fund and our work with Social Work departments to reduce dependency on hospital care for older people.

Outcomes	Change/Development Required	Measures
Older people will have their health and social care needs met in an integrated way → Older people will only receive secondary care services when they have a need for Acute care	Demonstrate the involvement of GPs and other primary care practitioners in Change Fund plan actions/improvements to services Develop plans to provide consistent GP support to care homes Review and enhance Out of Hours access to Community Services	Change Fund KPIs
Older people have improved experience of care in all our services	CHPs to develop improvement plans to address older people's experience of services	

IMPROVING QUALITY, EFFICIENCY AND EFFECTIVENESS

Improved access to primary care services and better communication and information sharing between primary care and other services are our priorities to improve quality, efficiency and effectiveness.

Outcomes	**Change/Development Required**	**Measures**
We can demonstrate that patients have improved access to general medical services	Robust access measures and reporting arrangements to be established in all CH(C)Ps	Evidence that advance booking and 48 hour access is available Accommodation/premises strategy deliver planned improvements Evidence of use of patient feedback at practice level and through other routes such as PPF, Locality Groups, Patient Opinion GP prescribing budgets and cost/population
Patients are engaged in developing primary care services	We have better understanding of patient experience in primary care, linking practice patient groups with local PPFs. Patients have influence in changing primary care services Independent contractors are fully involved in quality programmes Patient information/leaflets for endoscopy and knees to be reviewed	
Better communication and information sharing to improve patient care	Roll out of SPSP in primary care. Improved information flows between primary and secondary care, including information sharing.	
We make the best use of available resources	Primary care prescribing budgets are met and measures are put in place to reduce non-formulary prescribing in secondary care affecting primary care. Chronic Medication Service (CMS) is rolled out Each CH(C)P to develop an accommodation strategy for primary care services. Strategies	

Outcomes	**Change/Development Required**	**Measures**
	should address sustainability and environmental concerns	

TACKLING INEQUALITIES

Our primary care practitioners are well placed to identify and respond to the inequalities faced by patients. Recent work by the Deprivation Group has resulted in a series of proposals for primary care and other services to narrow the inequalities gap caused by deprivation.

Outcomes	Change/Development Required	Measures
We plan and deliver health services in a way which understands and responds better to individuals' wider social circumstances → Employment, financial inclusion and literacy pathways will be clear to primary care practitioners	Information sharing policies developed to respond to the gaps identified by the Deprivation Group Improve communication between GPs and Social Work Agree an approach for primary care practitioners to respond to Gender Based Violence Develop clear pathways for primary care practitioners into literacy, employment and financial inclusion services	Fluoride varnishing rate No. of Keep Well checks by SIMD DNA rates/SIMD Number of referrals into literacy, employment and financial inclusion services
We narrow the health inequalities gap through clearly defined programmes of action by our services → Improved concordance with treatment protocols as a result of communication needs being met	Keep Well targeting Reduce the inequalities gap in DNAs Childsmile programmes to be consistently supported. Further develop the GP Docman system to audit the outcomes of DNA letters sent to patients	