

National Health and Social Care Workforce Plan

**Part 3 – Improving workforce planning
for primary care in Scotland**

CONTENTS

FOREWORD	3
INTRODUCTION	7
CHAPTER ONE: SETTING THE CONTEXT	10
CHAPTER TWO: THE SHAPE OF THE PRIMARY CARE WORKFORCE	15
CHAPTER THREE: THE CHANGING SHAPE OF PRIMARY CARE	27
CHAPTER FOUR: PLANNING AND DEVELOPING THE MULTIDISCIPLINARY WORKFORCE – NURSING AND MIDWIFERY	43
CHAPTER FIVE: PLANNING AND DEVELOPING THE MULTIDISCIPLINARY WORKFORCE – GENERAL PRACTITIONERS	51
CHAPTER SIX: PLANNING AND DEVELOPING THE MULTIDISCIPLINARY WORKFORCE - WIDER CLINICAL AND NON-CLINICAL WORKFORCE	61
CHAPTER SEVEN: A DATA AND INTELLIGENCE LED PRIMARY CARE	74
CONCLUSION AND NEXT STEPS	80
ANNEX A: OUTCOMES FRAMEWORK FOR WORKFORCE	86

FOREWORD

I am delighted to publish the *National Health and Social Care Workforce Plan: Part 3 – Improving workforce planning for primary care in Scotland*, which sits alongside the workforce plan parts one and two published last year. We are embarked on a long-term journey to reform primary care in Scotland to better serve the needs of our people, promote prevention and self-management, and put services on a sustainable footing. This plan is an important further step on that journey.

The plan focusses on developing, building and expanding Multidisciplinary Teams (MDTs), made up of professionals each contributing their unique skills to managing care and improving outcomes. This government has previously set out a series of ambitious commitments to significantly expand and strengthen the primary care workforce, backed by a historic increase in investment in primary care. The plan outlines how we intend to deliver these pledges. What is clear however, is that we are already seeing considerable benefits from enhanced MDT working and new models of care across Scotland, and I am confident this will gather pace in the coming years through the initiatives we and our partners are taking forward.

The Chief Nursing Officer, together with Scottish Executive Nurse Directors and partners, is leading an important piece of work to maximise the contribution of the nursing, midwifery and health professionals (NMaHP) workforce. The *Transforming Roles* programme is ensuring nationally consistent, sustainable and progressive roles, education and career pathways to meet the current and future needs of our population, and will inform and support local workforce planning. We will invest £6.9 million over three years for the training and education of General Practice Nurses and District Nurses to help support a sustainable 24/7 community nursing workforce.

In addition, recognising the importance of the District Nursing workforce in shifting the balance of care from hospitals to community settings, we will work alongside partners, including the Royal College of Nursing, to understand the requirements for sustaining and expanding this workforce. We are committed to undertaking this work at pace and will be in a position by September 2018 to better understand the requirements and investment necessary to grow the workforce. Integration Authorities and NHS Boards retain responsibility for planning and funding District Nurse vacancies and projected retirements from existing budgets.

The new GP contract, which I was delighted to see strongly endorsed by Scotland's GPs in January, will be crucial in making general practice a more attractive career choice. I recently announced our commitment to increase the number of GPs in Scotland by at least 800 over the next 10 years. This is challenging, requiring action across a number of fronts and with the input and support of many individuals and organisations. We can deliver, and the initiatives we set out in this plan move us along that road.

However, I fully recognise the considerable pressure our health services are under to meet the increasing demands of our ageing population. I hear the concerns expressed around our ageing primary care workforce and the need for bold action to address current vacancies across professions. The actions set out in this plan, alongside our wider programme of reform of primary care, will accelerate the pace of

change but I acknowledge we will continue to face significant challenges and tough decisions along the way.

Finally, I'd like to take this opportunity to thank the Royal College of Nursing, the British Medical Association, the Royal College of General Practitioners, Chief Officers, Allied Health Professions Federation Scotland, Optometry Scotland, Community Pharmacy Scotland, British Dental Association and other stakeholders who have helped shape the plan. I am aware the plan doesn't address all concerns raised by our partners but it is an important starting point. It sets a marker for further developments needed to improve workforce planning in Scotland, and we will continue to work closely with partners in developing an integrated workforce plan to be published by the end of this year.

Looking ahead, there is still much to be done but we have already come far in realising our ambition of a modernised primary care service. That is down to the skill and dedication of the many individuals – both clinical and non-clinical – that make up our workforce.



SHONA ROBISON
Cabinet Secretary for Health and Sport



SUMMARY OF KEY RECOMMENDATIONS AND NEXT STEPS

This Plan sets out recommendations and the next steps that will improve primary care workforce planning in Scotland. These complement the recommendations in parts one and two and, taken together, will form the basis of the integrated workforce plan in 2018. The recommendations below set out how we will enable the expansion and up-skilling of our primary care workforce, the national facilitators to enable this, and how this will complement local workforce planning.

Facilitating primary care reform

Recommendations and commitments:

1. Reform of primary care is driven by developing multidisciplinary capacity across Scotland. Workforce planners including NHS Boards, Integration Authorities and General Practices will need to consider the configuration of local multidisciplinary teams that offer high quality, person-centred care.
2. In recognition of an ageing workforce, local planners have responsibility for workforce planning and managing anticipated levels of staff turnover.
3. The implementation of the new GP contract will require services to be reconfigured to maximise workforce competencies and capabilities, and ensure people see the right person, at the right time and in the right place.
4. The National Workforce Planning Group will play a strategic role in implementing the recommendations of part three of the plan, and strengthen the development of approaches for the primary care workforce.
5. An integrated workforce plan to be published later in 2018 will move towards a better articulated joint vision for health and social care workforce planning.

Building primary care workforce capacity

Recommendations and commitments:

6. Significant investment will be made available over the next 3-5 years, as part of the First Minister's commitment to an additional £500 million for community health services, to plan for, recruit and support a workforce in general practice, primary care and wider community health, including community nursing.
7. Scotland's multidisciplinary primary care workforce will become more fully developed and equipped, building capacity and extending roles for a range of professionals, enabling those professionals to address communities' primary healthcare needs.
8. As part of national, regional and local activity to support leadership and talent management development, planners will need to continuously consider staff training needs in their workforce planning exercises; invest appropriately so that leaders in primary care are fully equipped to drive change; and enhance

opportunities for the primary care workforce to further develop rewarding and attractive careers.

Improving data, intelligence and infrastructure in primary care

Recommendations and commitments:

9. More integrated workforce data for primary care is required, in the context of the workforce data platform being developed by NHS Education for Scotland.
10. Local planners should consider workforce planning tools (such as the six step methodology) in developing their workforce strategies to address local population needs.
11. Planning for future staffing in primary care should identify and make use of available guidance and intelligence on local recruitment and retention issues, and of wider developments in workforce data and scenario planning.
12. The Scottish Government will publish the Primary Care Monitoring and Evaluation Strategy 2018-2028 by summer 2018.

INTRODUCTION

As set out in the *Health and Social Care Delivery Plan*¹, the Scottish Government's vision for the future of primary care is for enhanced and expanded multi-disciplinary community care teams, made up of a variety of professionals each contributing their unique skills towards delivering person-centred care and improving outcomes for individuals and local communities. This vision closely reflects the 21 underpinning principles on the future of primary care set out by Scotland's health professional groups in 2016².

We have established six long-term outcomes that support the delivery of our vision:

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

Delivering these outcomes, and the wider aspirations set out in the *Delivery Plan*, will take time and will involve significant challenges. Nevertheless, we are committed to investing in primary care and focusing on new models of prevention and self-management. Getting primary and community care right is an essential component of ensuring the whole healthcare system is sustainable. It will deliver the best outcomes for patients, in line with our vision of care being provided at home or in a homely setting, and help ensure rewarding, well-supported careers for our community healthcare workforce.

Committing to the future of primary care

With our local and national partners we have already embarked on an ambitious programme to support and build primary and community care. The First Minister announced in October 2016 an increase in funding in primary care of £500 million by the end of this Parliament. This investment will see at least half of frontline NHS spending going to community health services, and will enable us to significantly expand the primary care multidisciplinary workforce. This includes training an additional 500 advanced nurse practitioners across acute and primary care, 250 more community links workers in practices by the end of the parliamentary period to address patients' wider needs, training an additional 1,000 paramedics to work in

¹ Scottish Government (2016), *Health and Social Care Delivery Plan*
<http://www.gov.scot/Resource/0051/00511950.pdf>

² *The Future of Primary Care: a view from the professions* (2017), <https://www.rcn.org.uk/about-us/policy-briefings/sco-pol-future-of-primary-care-1-sept>

support of general practice, the expansion of mental health workforce, and enhanced roles for Allied Health Professionals (AHPs) in delivering person-centred care. General Practice will further be supported by ensuring all practices are given access to a pharmacist by the end of this parliamentary period.

The new General Medical Services (GMS) contract, jointly negotiated by the BMA and the Scottish Government, sets out a refocused role for GPs as Expert Medical Generalists (EMGs) and recognises the GP as the senior clinical decision maker in the community. This role for all GPs will be supported through service redesign and the expansion of the multi-disciplinary workforce. The Cabinet Secretary for Health and Sport recently committed to increasing the number of GPs by at least 800 (headcount) in the next 10 years through an ambitious training, recruitment and retention programme.

NHS Boards are responsible for allocating resources to ensure that people are able to access quality healthcare services both in and out of hours. We recognise the particular challenges faced by out of hours services and remain committed to having a high-quality service which fully meets patient needs. That is why we invested £10 million in 2016-7 and provided further investment as part of the £23 million Primary Care Transformation Fund (PCTF) in 2017-8, to deliver the recommendations in Sir Lewis Ritchie's report *Pulling together*³. Going forward, we expect Boards to maintain and develop a resilient out of hours service that builds on the recommendations in Sir Lewis's report, ensuring effective links and interface between in and out of hours GP services. This is also reflected in further work undertaken by Sir Lewis through *Improving Health and Social Care Service Resilience over Public Holidays*, published in December 2017⁴.

Alongside the expansion of the multidisciplinary workforce, we are currently implementing significant changes in how primary care will be organised. Our historic *Memorandum of Understanding (MoU)*⁵ with Integration Authorities, the British Medical Association, NHS Boards and the Scottish Government sets out the principles underpinning primary care in Scotland, including respective roles and responsibilities. It provides the basis for the development by Integration Authorities (IAs), as part of their statutory strategic planning responsibilities, of Primary Care Improvement Plans (PCIPs), clearly setting out how additional funding will be used and the timescales for the reconfiguration of services currently delivered under GMS contracts.

Workforce planning

The publication of *National Health and Social Care Workforce Plan: Part 1 – a framework for improving workforce planning across NHS Scotland*⁶ last June signalled the beginning of a process to further improve workforce planning across health and social care. It set out new approaches to workforce planning across Scotland, within a framework for wider reform of our health and care systems. Part 2

³ <http://www.gov.scot/Resource/0048/00489938.pdf>

⁴ <http://www.gov.scot/Publications/2017/12/2391>

⁵ *Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards* <http://www.gov.scot/Resource/0052/00527517.pdf>

⁶ <http://www.gov.scot/Resource/0052/00521803.pdf>

of the Workforce Plan – *A framework for improving workforce planning for social care in Scotland*⁷ – published jointly by the Scottish Government and COSLA – sets out a whole system, complementary approach to local and national social care workforce planning, recognising our new integrated landscape. The publication of this primary care workforce plan marks an important further step in that journey.

Part 3 does not restate the range of actions already underway to improve workforce planning as set out in parts 1 and 2, but focuses on how we will support the primary care workforce deliver improved outcomes for Scotland's people. It is recognised however, that to deliver integrated services and continuity of care for patients across community-based health and social care services and acute services, good interfaces based on shared understanding and trust, and supported by robust data and intelligence, are essential. Effective workforce planning needs to acknowledge interdependencies across the different parts of the system and take an iterative approach to planning across the wide range of skilled professionals involved in its delivery. The next stage in this process therefore builds on the actions taken to deliver the recommendations across the three parts of the workforce plan, with publication of a single, integrated national Workforce Plan later in 2018.

This plan is split into seven chapters. Chapter one sets out the role of primary care services in effectively responding to the changing and growing needs of our population, alongside the evidence of the significant benefits that will be delivered through focusing our workforce on prevention and supporting self-management. We set out the shape of the existing primary care workforce, including recent trends in workforce numbers, in Chapter two, before describing the anticipated changes in the way services will be developed to meet population need in Chapter three. Chapters four to six set out how the MDT will be strengthened to deliver an enhanced and sustainable workforce to improve patient outcomes. Chapter seven outlines how we will work with partners to ensure that better quality and more timely data is developed to drive effective local and national workforce planning.

⁷ <http://www.gov.scot/Resource/0052/00529319.pdf>

CHAPTER ONE: SETTING THE CONTEXT

Introduction

Primary Care in Scotland: A definition from the professionals⁸

Most of the time, people use their own personal and community assets to manage their health and wellbeing and achieve the outcomes that matter to them. Primary care professionals enhance this by providing accessible health care and support to individuals and families in the community, when it is needed, at whatever stage of life.

Primary care is provided by generalist health professionals, working together in multidisciplinary and multiagency networks across sectors, with access to the expertise of specialist colleagues. All primary care professionals work flexibly using local knowledge, clinical expertise and a continuously supportive and enabling relationship with the person to make shared decisions about their care and help them to manage their own health and wellbeing. Primary care is delivered 24 hours a day, 7 days a week. When people need urgent care out of core service hours, generalist primary care professionals provide support and advice which connects people to the services they need, in a crisis, in a timely way.

Scotland's health is improving, driven by the skill and dedication of the NHS workforce and the bold measures taken on public health since the establishment of the Scottish Parliament in 1999. We are now living longer, healthier lives with a marked reduction (by over a third) in premature mortality between 1994 and 2015 (including significant falls in premature deaths caused by cancer, coronary heart disease, and cerebrovascular disease)⁹.

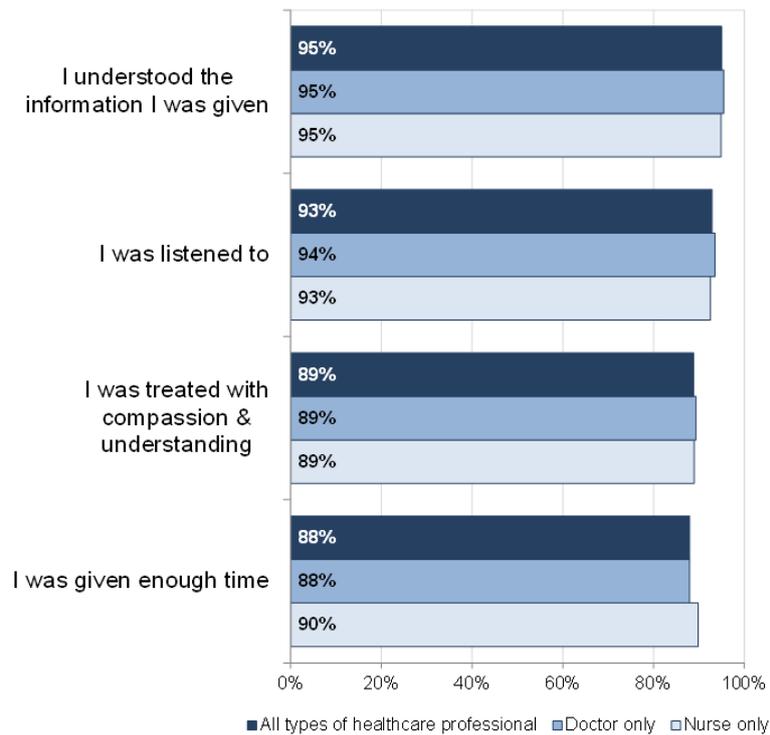
Despite pressure on services, patients are highly positive of their experience of the health service, with 83% of people rating the overall care provided by their GP practice as good or excellent in 2017-18¹⁰. Of those who needed an urgent appointment, 93% were offered one within 48 hours, an increase from 91% in 2015-16. As figure 1 shows, people were also highly positive about their experiences of person-centred care at their GP practice, with positive ratings typically around or over 90%. Overall ratings for care from out of hours services were similar to those for the GP practice at 83%. These are achievements of which the primary care workforce should be rightly proud.

⁸ *The Future of Primary Care: a view from the professions* (2017), <https://www.rcn.org.uk/about-us/policy-briefings/sco-pol-future-of-primary-care-1-sept>

⁹ Scottish Government (2017), *Realising Realistic Medicine*
<http://www.gov.scot/Resource/0051/00514513.pdf>

¹⁰ Scottish Government (2018), *Health and Care Experience Survey 2017/18 - National Results*
<http://www.gov.scot/Publications/2018/04/2112>

Figure 1: Patient experience, 2017-8



Challenges facing primary care

We are aware however, that as across the UK and internationally, demand on our primary care and social care services is steadily increasing due to a combination of an ageing population and rising levels of multi-morbidity¹¹. The number of people aged 65 and over is estimated to increase by around 60% from 0.93 million to 1.48 million by 2039¹², leading to substantial rises in a range of long-term conditions¹³. Patients are also demanding more from their healthcare professionals: they rightly expect higher standards of care, more information about their treatment, more involvement in decisions about their care and improved access to the latest treatments¹⁴.

People with long-term conditions already account for about 50% of GP appointments¹⁵, placing significant and increasing strain on services. Evidence also demonstrates that people with co-existing physical and mental health problems often have longer hospitalisations, treatment failure, poor quality of life and premature mortality. As we said in the *Mental Health Strategy for 2017-2027*¹⁶, our guiding ambition is that we must prevent and treat mental health problems with the same commitment, passion and drive as we do with physical health problems.

¹¹ Multi-morbidity is commonly defined as the presence of two or more chronic medical conditions in an individual.

¹² <https://www.nrscotland.gov.uk/files//statistics/population-projections/2014-based/pp14-fig4.xlsx>

¹³ Information Services Division (ISD) estimate an additional 243,000 individuals living with hypertension, diabetes, heart failure or COPD by 2029.

¹⁴ Baird, B. et al (2016), *Understanding pressures in general practice*, The Kings Fund

¹⁵ Department of Health (2012), *Long Term Conditions Compendium of Information: Third Edition* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

¹⁶ Scottish Government (2017), *Mental Health Strategy 2017-2027* <http://www.gov.scot/Publications/2017/03/1750>

The benefits of a strong and integrated primary care system

Whilst our workforce has continually adapted and innovated to meet an increasing and more complex workload, maintaining consistently high standards of care and treatment has become more difficult to sustain. There is growing consensus that the NHS needs to focus more on the development of preventative models of care (including self-management), rather than reactive management of patients with long term conditions to be financially sustainable, tackle persistent health inequalities, improve long-term outcomes and to reduce pressure on the workforce. This calls for a modernised healthcare system as set out in the Chief Medical Officer's ground-breaking reports *Realistic Medicine* and *Realising Realistic Medicine*¹⁷. Realistic Medicine puts the person at the centre of decision-making and creates a personalised approach to their care.

Primary care is at the heart of this vision. The primary care workforce is uniquely placed to influence the level of demand for other care settings, acting as a 'navigator' or 'gatekeeper' to secondary care, developing anticipatory care plans, and co-ordinating care, screening and health promotion. It is best placed to support self-management by helping patients to fully understand and manage their own conditions, as well as promoting a focus on both primary and secondary prevention.

This is supported by greater integration of health and social care services to develop stronger care pathways between primary and social care focused on the need of the individual. The ambition set out in Part 2 of the National Workforce Plan¹⁸ that social care supports people at all stages of their lives to live as independently as possible closely aligns with and supports the vision for a strengthened primary care system. The potential benefits in further strengthening primary care system, built on enhanced and expanded multi-disciplinary teams, are set out below.

Figure 2: Strengthening primary care: the benefits



¹⁷ Scottish Government (2016), *Realistic Medicine* <http://www.gov.scot/Resource/0049/00492520.pdf>; Scottish Government (2017), *Realising Realistic Medicine*

<http://www.gov.scot/Publications/2017/02/3336/downloads#res-1>
¹⁸ <http://www.gov.scot/Resource/0052/00529319.pdf>

The key benefits of a strong and integrated primary care system

- Half of cancers, three-quarters of cardiovascular disease and 80% of strokes are preventable. More systematic primary prevention in primary care therefore has the potential to improve population health outcomes and has been shown to be cost effective¹⁹.
- Lifestyle behaviours (such as smoking, diet, obesity and alcohol consumption) are driving non-communicable disease clusters, particularly in our most deprived communities, contributing to a legacy of health inequalities.
- Systematic and scaled-up secondary prevention – for example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure – has been found to be cost-effective, clinically significant and an important way to tackle inequalities in health²⁰.
- Improved access to primary and social care services could lead to a reduction in ‘social admissions’ – admissions based not on the severity of a patient’s clinical condition but on their inability to cope without appropriate support unless admitted, or if discharged. Social admissions and delayed discharges pose significant issues for hospitals, with up to 40% of admissions of elderly patients who have attended A&E shown to be avoidable²¹.
- Improved access to in and out of hours primary care has the potential to reduce demand for A&E attendances and unnecessary ambulance call outs.
- In the medium term, an enhanced primary care workforce could support patients to take a more pro-active approach to managing their conditions, leading to an estimated 8% to 11% reduction in avoidable admissions (that is, admissions for ambulatory care sensitive conditions)²².

Citizen engagement

It is vital that we engage our citizens at every step of the journey to successfully reform primary care services. They must play a key role in helping to shape the services they need now and in the future. In 2015 the Scottish Government launched a National Conversation *Creating a Healthier Scotland*²³ and through this and the subsequent engagement via the Scottish Health Council’s *Our Voice Framework*²⁴, we heard that people want more flexible primary care services, with appointments that fit in with their lives, including work and caring commitments. Engagement via *Our Voice* has produced a range of innovative suggestions on how to develop services, including highlighting ways to take the pressure off primary care, reduce physical access issues and support self-management.

¹⁹ Health England (2009). *Intervention Reports: Report no 5*.

²⁰ *Ibid*

²¹ Deloitte (2014) *Spend to save: The economic case for improving access to general practice* http://www.rcgp.org.uk/~/_media/Files/PPF/2014-RCGP-Spend-to-Save-Deloitte-report.ashx, Royal College of General Practitioners

²² *Ibid*

²³ Scottish Government (2016) *Creating a healthier Scotland - What matters to you* <http://www.gov.scot/Publications/2016/03/9693>

²⁴ <https://www.ourvoice.scot/>

In addition, the Scottish Government has recently commissioned a series of workshops across Scotland inviting people to give their views on changes to primary care, to hear how general practice teams are changing, and how the development of these teams might impact on them and how they can work for them. The findings from this engagement exercise will help inform the implementation of the new GP contract and the reform of primary care more generally.

As set out in Chapter seven, we are developing a 10 year monitoring and evaluation strategy to capture learning from the reform of primary care. We will ensure that people's views help inform that work as it is taken forward.

Conclusion

We are aware of the significant challenges currently facing the primary care workforce as demand on services continues to increase. Our commitment to reform and invest in primary care services – continuing to shift the balance of care from hospital settings to community health and social care services – is founded on robust evidence that demonstrates that health systems based on strong primary care infrastructure have better outcomes in terms of population health, access, co-ordination experiences and a lower and more appropriate use of resources²⁵.

²⁵ See, for example, Starfield B, Shi L, Macinko J. *Contribution of primary care to health systems and health*. *Milbank Q.* 2005;83(3):457–502.

CHAPTER TWO: THE SHAPE OF THE PRIMARY CARE WORKFORCE

Introduction

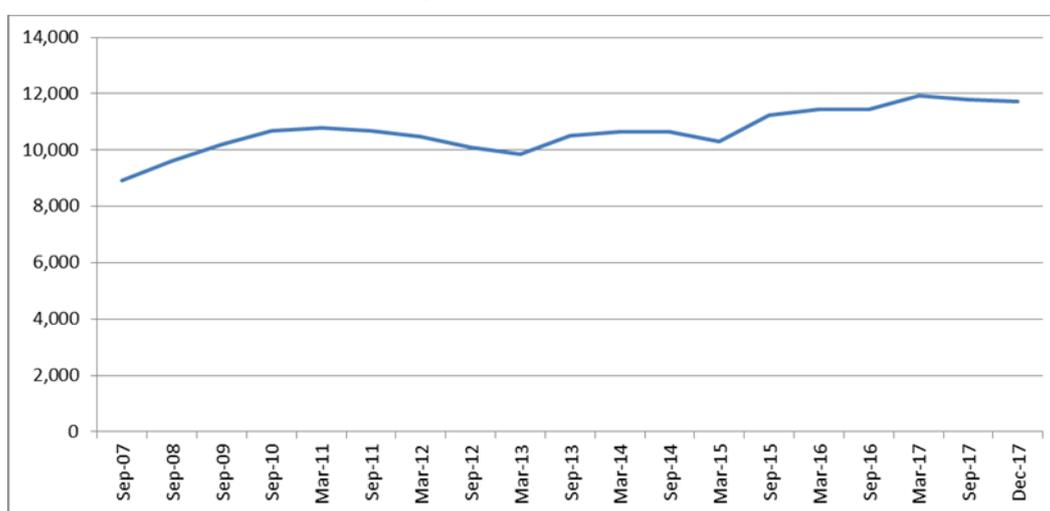
The first step in good workforce planning is to have good quality, consistent data on the shape of the current workforce, including recent and predicted future trends in workforce numbers. For the primary care workforce, much has still to be done to improve existing data to provide a more comprehensive and robust evidence base to inform workforce planning. Our approaches to enhancing the data available to planners and clinicians are set out in Chapter seven.

While current workforce data requires further development, it provides useful context on the profile of the existing workforce and potential effects of future pressures. Our understanding of trends will improve as fuller and more integrated data becomes available, informing subsequent iterations of the health and social care workforce plan.

Community and primary care nursing

There are approximately 60,000 nursing and midwifery staff (WTE) currently employed within NHS Scotland. Of those, around 12,000 (WTE) work in community settings, almost 3,000 more than in 2007. The increase in nurses working in the community reflects our strategic goal of moving care out of hospital settings to home or a homely setting wherever possible.

Figure 3: Nursing and midwifery (qualified and support) in community settings, WTE, 2007-2017²⁶



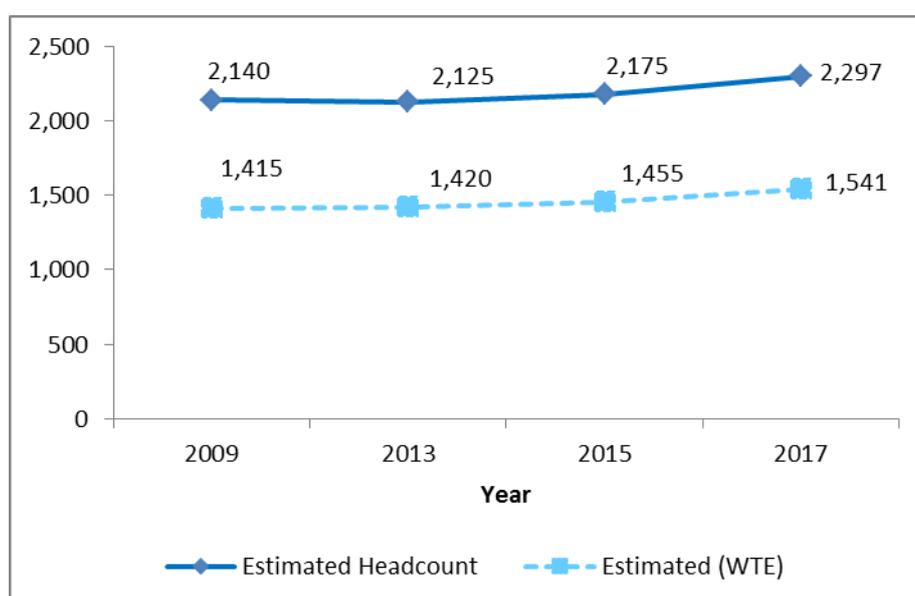
Note: Excludes nurses working in general practice.

²⁶ The graph shows the number of nursing and midwifery staff working in community settings; these data are consistent over time. Data on community nurses are not comparable prior to 2015 due to changes in coding following the review of nursing and midwifery 'job families'. Source: https://www.isdscotland.org/Health-Topics/Workforce/Publications/2018-03-06/Nursing_and_Midwifery_SIP_D2017.xls

General Practice Nursing

At present data on the number of nurses working in general practice (and not employed by NHS Boards) relies on biennial surveys of practices. As set out in Chapter seven our knowledge about the workforce will improve significantly as part of the workforce data that will be collected as part of the new GMS contract. The *Primary Care Workforce Survey 2017* suggested that there were around 2,300 General Practice Nurses (GPNs) working in general practice; approximately 1,540 WTE. These numbers have increased by approximately 160 (headcount) and 125 (WTE) since 2009.

Figure 4: Estimated registered nurse headcount and WTE, Scotland; 2009 - 2017²⁷



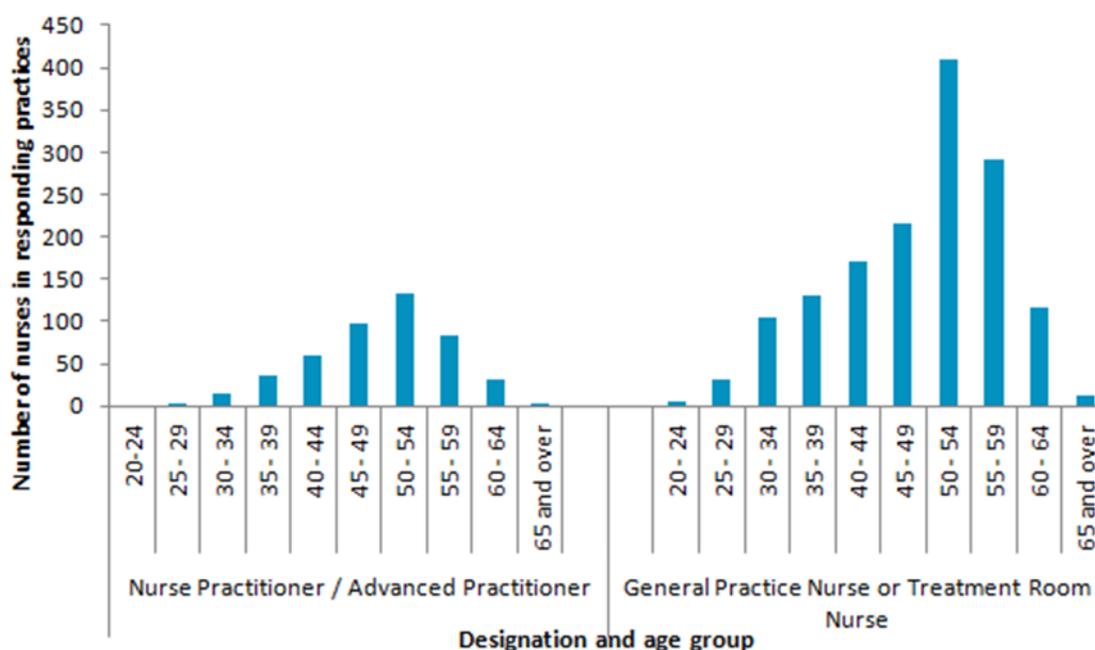
Of the 2,300 registered nurses (headcount) working in general practice, a quarter (544) are Nurse Practitioners or Advanced Nurse Practitioners (i.e. have acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice). The estimated headcount for General Practice/Treatment Room nurses was 1,754. We have seen a rise of 5% (from 520 to 544) in the number of Nurse Practitioners/Advanced Nurse Practitioners between 2013 and 2017, a positive indication of the enhanced role nurses are playing in general practice across Scotland²⁸.

The majority (98%) of registered nurses working in general practice are female. Over half (55%) of all nurses are aged 50 years and over, and this needs to be considered in planning for the workforce of the future.

²⁷ NHS National Services Scotland (2018), *National Primary Care Workforce Survey 2017*
<http://www.isdscotland.org/Health-Topics/General-Practice/Publications/2018-03-06/2018-03-06-PCWS2017-Report.pdf>

²⁸ *Ibid*

Figure 5: Age profile of General Practice Nurses, 2017²⁹



District Nursing and Health Visitors

Due to changes in classifications, longer term time series data on District Nursing and Health Visitors is unavailable. In December 2017 there were approximately 3,400 (WTE) staff working in District Nursing in Scotland (a slight fall from December 2015), and almost 1,450 (WTE) Health Visitors (an increase of approximately 270 since December 2015)³⁰. Of the 3,400 working in District Nursing, around 1,000 are band 6 and 7 District Nurses (WTE)³¹. The number of District Nurses has fallen by about 50 since December 2015.

Table 1: District Nursing and Health Visitors³² (WTE), Dec 2015 – Dec 2017

	Dec-15	Dec-16	Dec-17
District nursing	3,504	3,514	3,443
- of which District Nurses	1,056	1,055	1,002
Health visitors	1,180	1,292	1,448

The age profile of District Nurses (band 6 and 7) are shown below. Approximately 60% are aged 50 years and over. This is likely to partly reflect career pathways, with District Nurses tending to be experienced practitioners. Planning for routine staff turnover in light of local workforce data is the responsibility of NHS boards, but

²⁹ *Ibid*

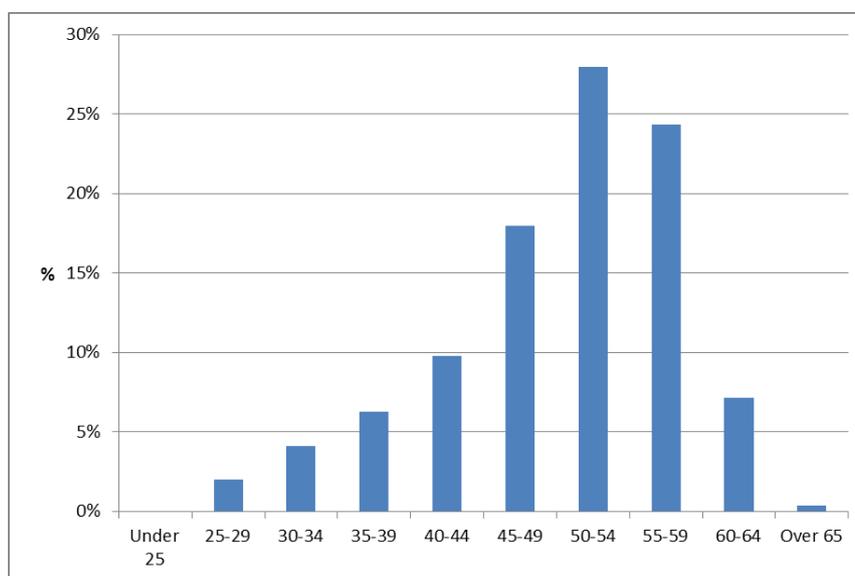
³⁰ Qualified Health Visitors classed as Agenda for Change (AfC) Band 6 and above; qualified District Nurses are Band 6; with Band 7 usually either DN Team leaders, DN ANPs or DN Practice

³¹ Qualified District Nurses are Band 6; with Band 7 are usually either DN Team leaders, DN ANPs or DN Practice Teachers.

³² *ISD Workforce Statistics*: <http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables2017.asp?id=2115#2115>

clearly such a sizeable proportion of the workforce being aged over 50 also has important implications for workforce planning in ensuring a sustainable service.

Figure 6: Age profile of District Nurses (band 6 and 7), 2017³³



Care Home Nursing

There are approximately 4,600 nurses (headcount) working in care homes, the vast majority (around 4,250) in private care homes³⁴. Further information on the numbers and trends in numbers of nurses in the social care sector is contained in Part 2 of the National Workforce Plan³⁵.

Health Care Assistants³⁶ (HCAs)

Health Care Assistants are a vital part of the community team, working across healthcare disciplines under the direction and professional accountability of registered practitioners, such as nurses, physiotherapists and pharmacists. For example, the *Transforming Roles*³⁷ review of district nursing roles in integrated nursing teams set out how support workers can work most effectively in a range of settings and activities.

Data on the number of HCAs working in general practice is available from the biennial *Primary Care Workforce Survey*. In 2017 it was estimated that there were

³³ Data from ISD Workforce statistics; analysis by Scottish Government

³⁴ Scottish Social Services Council (2017) *Scottish Social Service Sector: Report on 2016 Workforce Data* <http://data.sssc.uk.com/images/WDR/WDR2016.pdf>

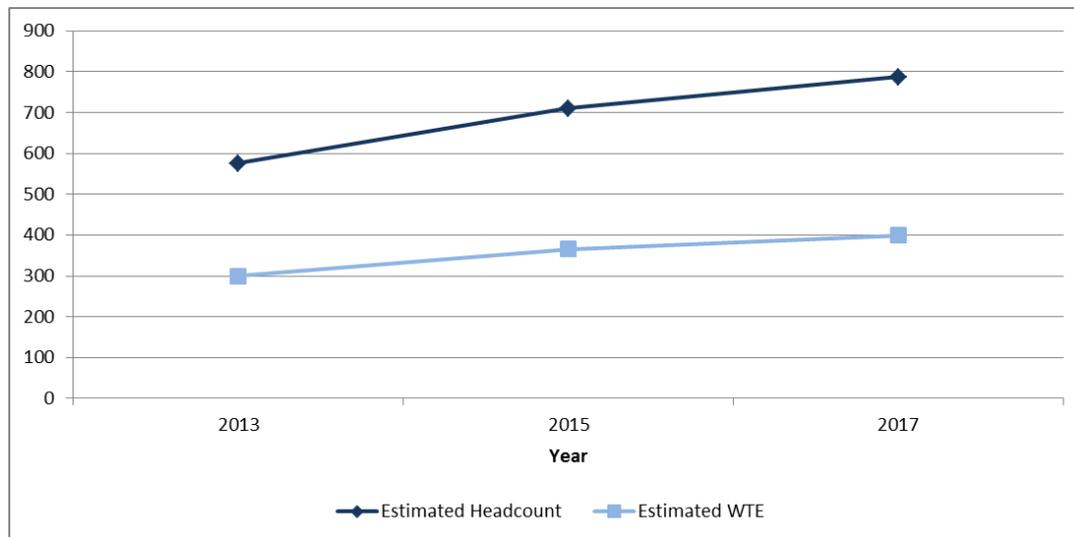
³⁵ <http://www.gov.scot/Publications/2017/12/2984>

³⁶ Also referred to as 'Health Care Support Workers'.

³⁷ Scottish Government (2017), *Transforming Nursing, Midwifery and Health Professionals Roles - The district nursing role in integrated community nursing teams* <http://www.gov.scot/Publications/2017/12/6658>

around 787 (399 WTE) HCAs, an increase of approximately 210 headcount and 100 WTE from 2013³⁸.

Figure 7: Health Care Assistants (estimated headcount and WTE), 2013-17³⁹



Allied Health Professions

Allied Health Professionals are a distinct group of health professionals⁴⁰ who apply their expertise to prevent illness, diagnose, treat and rehabilitate people of all ages. They deliver direct patient care, rehabilitation, treatment, diagnostics and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive and social functions. There are many developing AHP roles where practitioners are taking on extended generic skills and functions.

As shown in figure 8, the number of physiotherapists, occupational therapists, dieticians, and paramedics employed by NHS Scotland has increased since 2007, although there has been a slight fall in staff employed in podiatry. More comprehensive data on the AHP workforce is available at:

<http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables2017.asp?id=2115#2115>

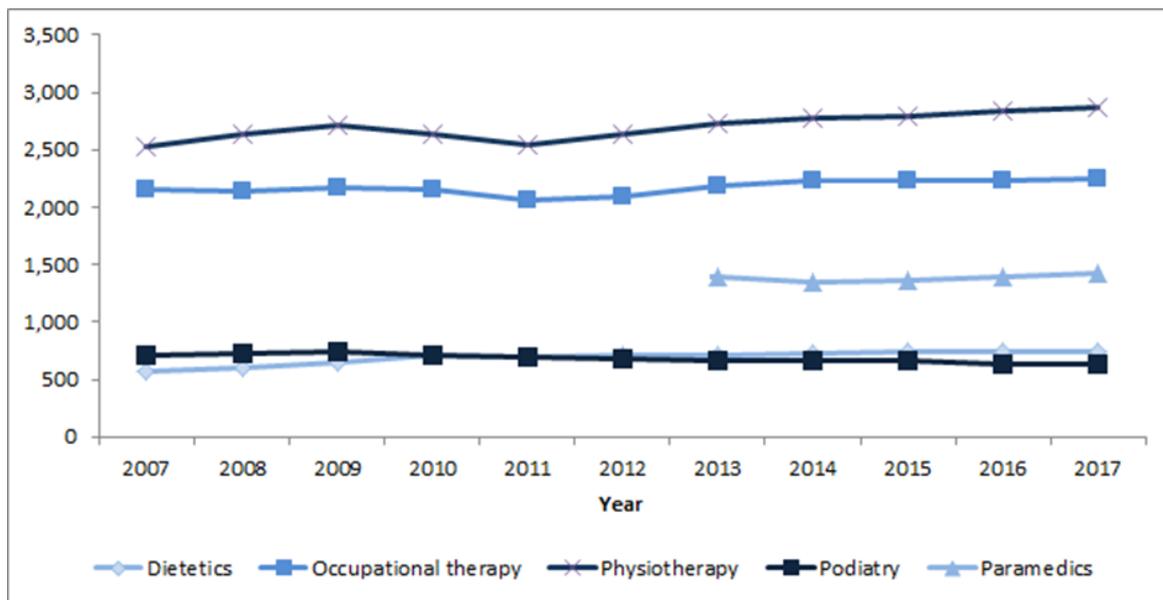
We know the number of AHPs working in the community is substantial but data is currently not available at a national level on location of practice. We are aware of the significant gaps in AHP workforce data and outline approaches to improving these data in Chapter seven.

³⁸ NHS National Services Scotland (2018), *Primary Care Workforce Survey 2017*
<http://www.isdscotland.org/Health-Topics/General-Practice/Publications/2018-03-06/2018-03-06-PCWS2017-Report.pdf>

³⁹ Data from ISD Workforce statistics; analysis by Scottish Government

⁴⁰ Art Therapists; Dietitians; Drama Therapists; Music Therapists; Occupational Therapists; Orthoptists; Orthotists; Paramedics; Physiotherapists; Podiatrists; Prosthetists; Radiographers (diagnostics) Radiographers (therapeutic); Speech and Language Therapists

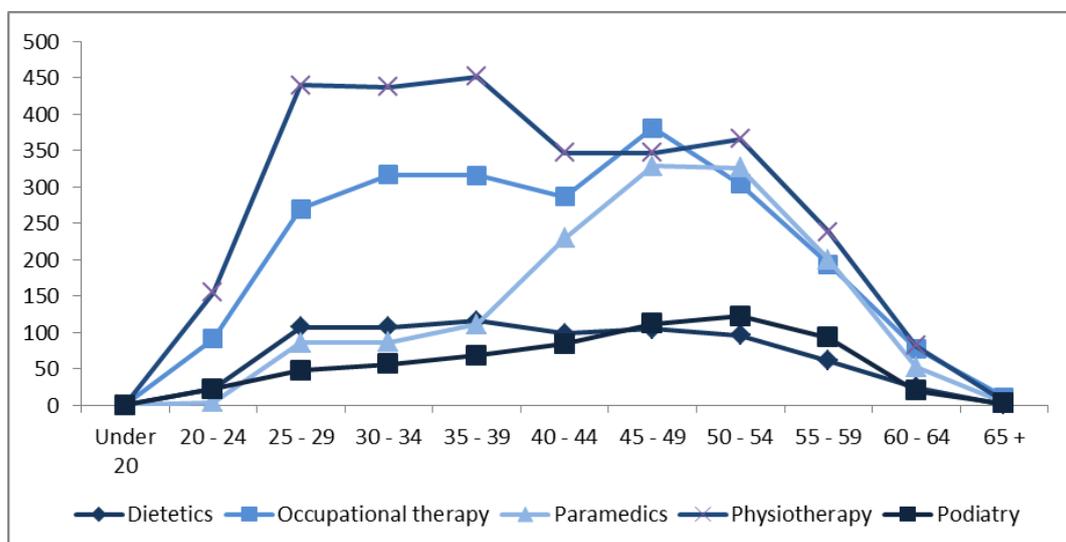
Figure 8: Selected Allied Health Professions groupings (WTE), 2007-2017⁴¹



Note: Paramedics were reclassified as allied health professions from 1st April 2013.

The age profile of the AHP workforce is provided below. The physiotherapist workforce is notable for having a relatively young age profile, with a significant proportion below the age of 40.

Figure 9: Selected AHP groupings, age profile, December 2017⁴²



General Practitioners

The number of patients registered with GP practices continues to rise slowly year on year and has increased by 5% since 2007, however the number of patients aged 65+

⁴¹ ISD Workforce Statistics: <http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables2017.asp?id=2115#2115>

⁴² *Ibid*

has increased by 20% since 2007. The number of practices in Scotland decreased by 7% since 2007, reflecting a trend towards larger practices⁴³.

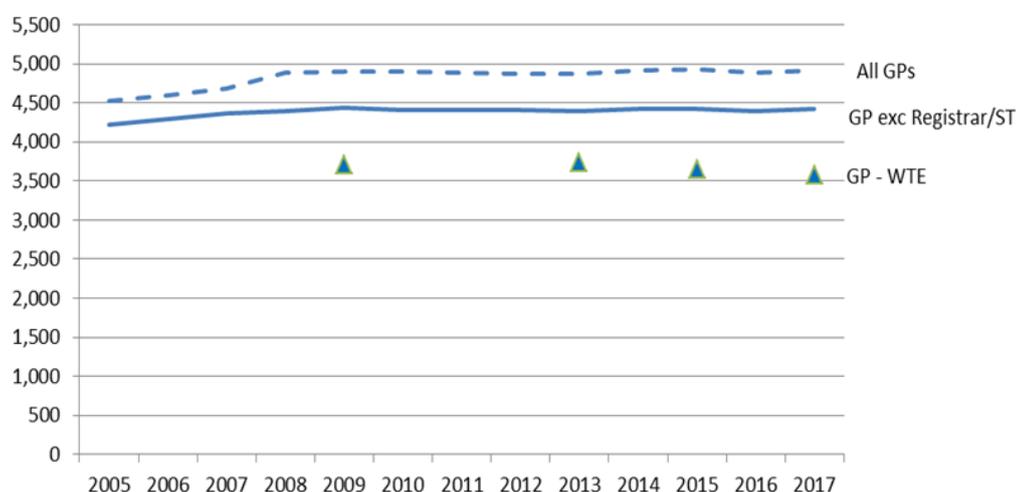
There were approximately 4,900 GPs working in around 960 practices in Scotland as of end of September 2017. The majority (3,500) of GPs are GP partners, with about 850 salaried GPs, 100 retainees⁴⁴ and 500 GP Registrars / specialist trainees. The number of salaried GPs (Board-employed and GP partner employed) has doubled over the last decade with falling numbers of GP partners and GP retainees. Around 60% of the GP workforce is female, up from half a decade ago.

Table 2: GP Designation by gender, Scotland, September 2017 (headcount)⁴⁵

Designation	Females	Males	All
GP Partners	1,868	1,631	3,499
Salaried GPs	625	221	846
GP Retainee	91	0	91
GP Registrar/ST	360	140	500
All GPs	2,935	1,985	4,920

The headcount number of qualified GPs working in NHS Scotland has increased by around 200 since 2005 to around 4,400. There has been a larger increase (of 400 to 4,900) in all GPs, including registrars and those in speciality training. However there has been a fall in the estimated whole time equivalent⁴⁶ in recent years (figure 10).

Figure 10: GP headcount and whole time equivalent, 2005-2017⁴⁷



⁴³ All figures in this section from ISD *GP Workforce and Practice Populations*:

<http://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-Populations/>

⁴⁴ The GP Retainer Scheme enables qualified GPs who are unable to commit to a full-time post to continue working in general practice in order to maintain and develop their skills. Up to four sessions per week are available for a period not exceeding five years.

⁴⁵ NHS National Services Scotland (2017), *GP Workforce and practice list sizes 2007–2017*

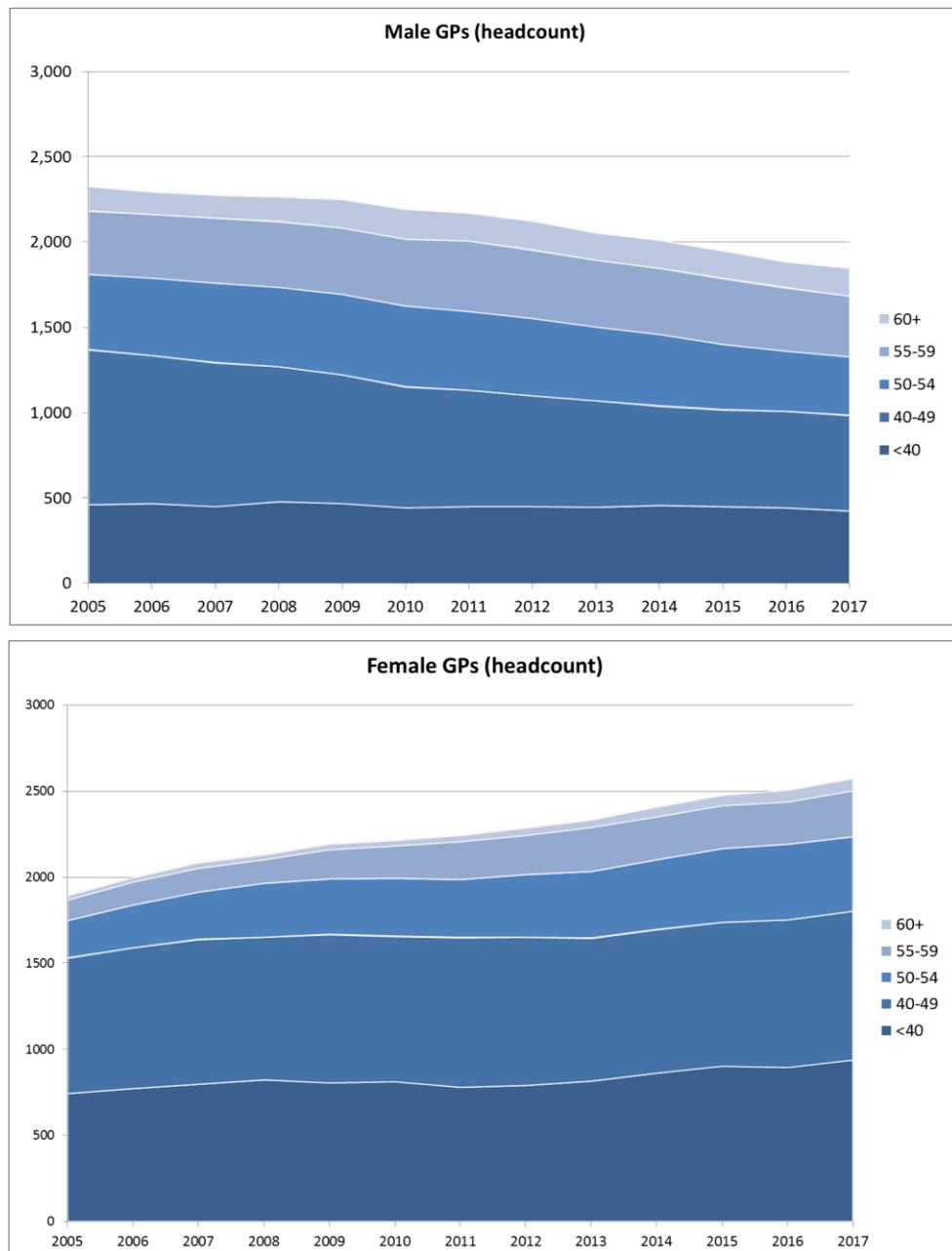
<https://www.isdscotland.org/Health-Topics/General-Practice/Publications/2017-12-12/2017-12-12-GPWorkforce2017-Report.pdf>

⁴⁶ The GP whole time equivalent figures are estimated based on data from the biennial *Primary Care Workforce Survey* and therefore are indicative.

⁴⁷ Data from *GP Workforce and practice list sizes 2007–2017*; *Primary Care Workforce Survey 2017*

The fall in WTE shown in figure 10 is largely driven by falling numbers of male GPs (particularly those in middle-age), who have traditionally worked more sessions than their female colleagues. The number of female GPs (headcount) has increased by almost a third since 2005 (Figure 11) and this trend is expected to continue.

Figure 11: GPs (headcount) by gender and age, Scotland 2005-2017⁴⁸

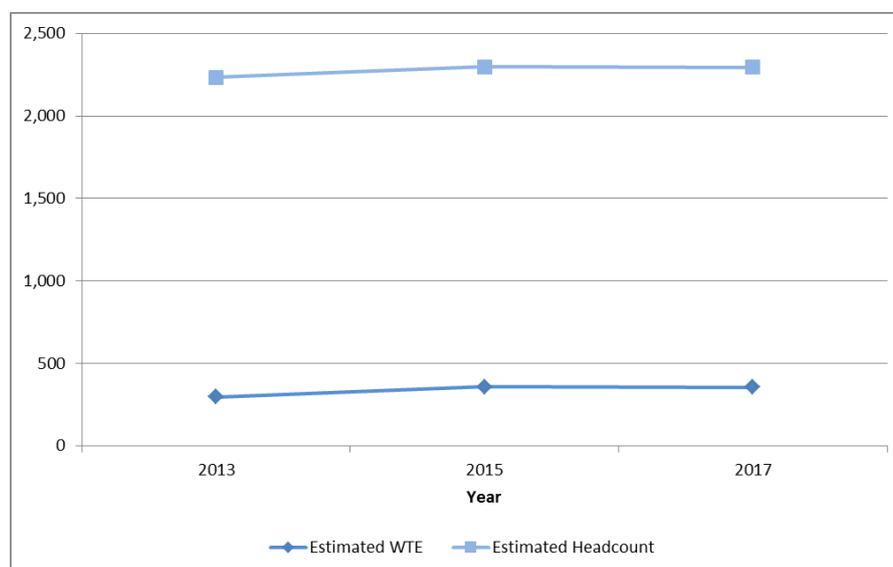


Out of hours services are vital in ensuring people with urgent care needs get the right advice at the right time. The number of GPs working out of hours has increased

⁴⁸ Data from General Practice Central Database (GPCD); analysis Scottish Government.

slightly since 2013⁴⁹. There approximately 2,300 GPs (including registrars/ST) providing Out of Hours in the year ending 31 August 2017.

Figure 12: Number of GPs (headcount and WTE) working Out of Hours, 2013-2017



Locums constitute an important part of our workforce offering flexibility and temporary support. Over four fifths of practices (83%) reported requiring to recruit locums for planned events, and approximately half (47%) for unplanned absences. There has been a slight fall in the use of locum sessions (per 10,000 patients) between 2013 and 2017⁵⁰.

While general practice workforce data currently relies on a biennial survey, submission of workforce and other practice data will become a requirement under the new GP contract (Chapter seven). This will improve the completeness and scope of the data available to planners.

Pharmacists

Pharmacists are located throughout our hospitals, GP practices and communities, from rural areas to deprived inner-city areas, providing pharmaceutical care on behalf of NHS Scotland. As well as dispensing around 100 million prescription items annually⁵¹, NHS pharmaceutical care services delivered in our community pharmacies include minor ailment, public health, and acute and chronic medication services. These services involve pharmacists in the community providing direct person-centred care as part of the wider primary care team.

⁴⁹ The OoH element of the survey was introduced as a pilot in 2013 and the survey coverage between then and 2017 has varied. Conclusions drawn from trend analysis should be treated with caution.

⁵⁰ NHS National Services Scotland (2017), *GP Workforce and practice list sizes 2007–2017* <https://www.isdscotland.org/Health-Topics/General-Practice/Publications/2017-12-12/2017-12-12-GPWorkforce2017-Report.pdf>

⁵¹ Information Services Division (2017), *Prescribing & Medicines: Dispenser Payments and Prescription Cost Analysis*

Pharmacy workforce data is one of the areas that we are working to strengthen, particularly in community pharmacies where, as independent contractors, pharmacy owners and managers determine staffing levels needed to provide safe and effective services in line with the General Pharmaceutical Council standards and guidelines.

As a proxy measure of overall pharmacy workforce numbers, figure 13 below shows the number of registered pharmacists and technicians in Scotland by age as at January 2018. In total, there are currently approximately 4,800 registrant pharmacists and 2,100 pharmacy technicians in Scotland.

Figure 13: Age profile of Registrant Pharmacists and Pharmacist Technicians, Scotland, January 2018⁵²

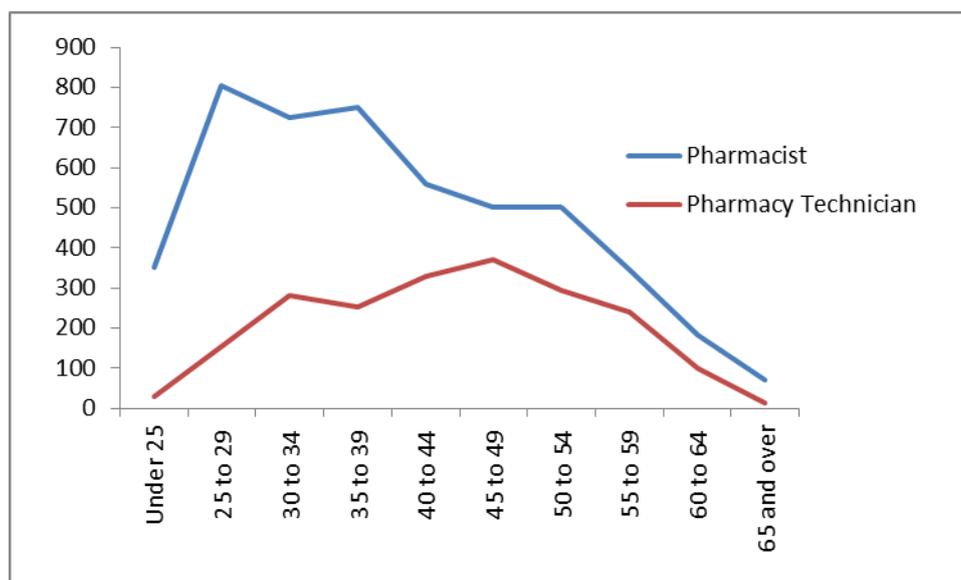


Table 3 represents the total number of pharmacy staff directly employed by NHS Scotland. As indicated above, it does not include those employed in community pharmacy as this is the responsibility of individual community pharmacy contractors.

Table 3: Age profile of Pharmacy Staff (WTE) directly employed by NHS Scotland, December 2017⁵³

WTE 31 st December 2017	Age Group (years)										TOTAL
	Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	≥ 65	
Pharmacy Staff	198.9	375.2	372.8	385.7	349.9	347.0	341.9	260.5	86.7	4.1	2,722.6

⁵² General Pharmaceutical Council of Great Britain. Data is based on registrants with a registered home address in Scotland. Data on registrants place of work or working in Scotland is not captured.

⁵³ Information Services Division workforce statistics

NHS Boards across Scotland directly employ approximately 2,700 whole time equivalent pharmacy staff working in hospital and providing support to community health services working within or with GP practices.

These figures are made up of pharmacists, pharmacy technicians, trainee pharmacy technicians, pharmacy assistants and pharmacy administration and clerical staff. In broad terms over half (approximately 55%) are registered pharmacists, with the remainder employed in increasingly important roles such as pharmacy technicians and assistants.

While the current age profile at a national level suggests a steady supply of pharmacists and pharmacy technicians aged under 50, it is acknowledged that there are greater challenges in some areas around recruitment and retention for both hospital and community sectors.

Dentists

In relation to oral health the dental workforce consists of dentists working alongside dental care professionals, i.e. dental nurses, hygienists, therapists, dental technicians, clinical dental technicians and orthodontic therapists. As oral health improves particularly amongst the younger generation, the dental needs of patients will change, focussing more on prevention. This will take several generations to work through and the dental workforce will require to be sufficiently flexible to meet the differing requirements. At the other end of the age spectrum with an increase in the number of frail, elderly patients retaining their natural teeth other challenges are emerging for clinicians in providing care for frail people, often in the patient's place of residence.

The number of dentists in primary care continues to increase. The majority of Primary Care dental services are provided by independent General Dental Practitioners (GDPs) with the remainder being provided by Public Dental Service dentists.

Table 4: Primary Care Dentists (headcount), Scotland, 2014-17⁵⁴

2014	2015	2016	2017	% change
3,332	3,348	3,397	3,407	2.3%

The increase in the independent GDP workforce (from 2,261 in 2007 to 3,004 in 2017) means that there are 55.6 dentists per 100,000 of the population providing NHS dental care and treatment, compared to 44.0 in 2007⁵⁵.

Optometrists

Community eyecare is a contractor service provided by optometrists and ophthalmic medical practitioners (OMPs). This has developed since the introduction of free eye

⁵⁴ Source: Combined non-GDS dentists and Public Dental Service dentists as at September 2017 (ISD Workforce Statistics)".

⁵⁵ ISD Scotland, *NHS Scotland Workforce Statistics* <http://www.isdscotland.org/Health-Topics/workforce/> 2017 figure uses 2016 population estimates.

examinations in 2006, to the service being the first port of call for people with eye problems, helping to detect eye diseases early.

Based on the most recent workforce data available, in 2016 there were approximately 1,453 optometrists and three OMPs (headcount) providing a community eyecare service in Scotland. In addition, there were approximately 410 dispensing opticians who advise and help with the supply of spectacles and contact lenses, as well as dispensing low vision aids and fitting spectacles for children⁵⁶. Historically, the number of optometrists in Scotland has increased on average by approximately three per cent per annum. This is due to more optometrists qualifying than retiring, with only a small number entering Scotland from elsewhere.

Optometrists can become independent prescribers on completion of an additional professional qualification, which is part funded by NHS Education Scotland (NES). Independent prescribing optometrists are able to prescribe licensed medicine for conditions affecting the eye, and the tissues surrounding the eye, within their recognised area of expertise and competence. To date, 214 community optometrists have qualified to become independent prescribers in Scotland – a third of the total UK figure.

Local variation

We have presented data at a national level to provide broad context on the shape of the current primary care workforce. We are aware that there is considerable variation across Scotland both in the size of the workforce and the pressures being experienced in retaining and recruiting staff. Data at Health Board level is available from Information Services Division: <http://www.isdscotland.org/Health-Topics/Workforce/> and is used to inform local workforce planning. However, as noted, we fully recognise the need to improve the information available to both local and national planners.

Conclusion

This overview of the primary care workforce in Scotland is a starting point. We recognise that some gaps remain in the data currently available and Chapter seven outlines the improvements underway to data quality and completeness that will aid national, regional and local understanding and planning of the workforce.

We have already acknowledged in Parts 1 and 2 the need over the longer-term to develop more sophisticated workforce modelling, including the design of a 'pipeline' approach indicating how supply via training and recruitment numbers will meet estimated demand for services and take account of, for example, the changing demographic profile of the workforce. NHS Education for Scotland is currently developing a workforce data platform which will help drive more informed, comprehensive and integrated workforce planning. We recognise that it is important for this work to extend in order to encompass the primary care workforce, and good progress is already being taken to ensure this.

⁵⁶ Data provided by National Services Scotland.

CHAPTER THREE: THE CHANGING SHAPE OF PRIMARY CARE

- We have a vision of a primary care workforce that supports everyone to live longer healthier lives at home, or in a homely setting.
- Developing multidisciplinary capacity at the heart of transformed and sustainable primary care services. Multidisciplinary teams will deliver care in communities and be involved in the strategic planning of services.
- The *Transforming Roles* Programme is ensuring nationally consistent, sustainable and progressive roles, education and career pathways for nurses, supported by investment in additional training and continuous professional development.
- Transformed Nursing, Midwifery and Allied Health Professional community roles, will inform and support local workforce planning.
- Reform of primary care gathering pace through the transformation programme and significant investment in new models of care.
- We have made a commitment to increase funding in direct support of general practice by £250 million by 2021.
- A new GP contract has been agreed, and a co-produced Memorandum of Understanding between the Scottish Government, the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards will support its delivery.
- Priorities areas are being taken forward to enable service change in general practice over the next three years, to ensure that patients receive the right service at the right time from the right profession.
- The six step methodology offers an evidence based approach to workforce planning which takes into account local need.
- Reconfiguring services will bring challenges – there is a need for local flexibility in how this is done.

Introduction

The previous chapter broadly set out the shape and size of our primary care workforce, acknowledging that there are gaps in the available data. This chapter describes the shared principles underpinning our approaches to developing a sustainable and safe primary care service for Scotland's people. Improving MDT capacity in primary care, with enhanced pathways to wider health and social care services including third sector service provision, is crucial for the development of new ways of delivering continued high quality services to patients. This is in the wider context of health and social care integration and the role of Integration Authorities in planning and commissioning primary care services.

Primary care is provided by generalist health professionals, working together in multidisciplinary and multiagency networks across sectors, with access to the

expertise of specialist colleagues. All primary care professionals work flexibly using local knowledge, clinical expertise and a continuously supportive and enabling relationship with the person receiving care, to make shared decisions about their care and help them to manage their own health and wellbeing every day, seven days a week.

Enabling change

The context for the reform of primary care in Scotland is Health and Social Care Integration. Integration is the most significant change to health and social care services in Scotland since the creation of the NHS in 1948. With a greater emphasis on joining up services and focussing on anticipatory and preventative care, integration aims to improve care and support for people who use services, their carers and their families. Since April 2016, Integration Authorities have been responsible for the commissioning, planning and delivery of all community and primary care services in their localities – including general practice.

The *2020 Vision*⁵⁷ for health emphasised the drive to provide more care at home or in a homely setting, and this was further underlined in *A National Clinical Strategy for Scotland*⁵⁸ and the *Health and Social Care Delivery Plan*⁵⁹, which embeds primary care at the heart of reform.

The vision for primary care is for enhanced and expanded multi-disciplinary community care teams delivering person-centred care and improving outcomes for individuals and local communities. The principles that underline this vision closely align with those set out by Scotland's health professional groups in *The Future of Primary Care: a view from the professions*⁶⁰.

The principles underpinning the approach to general practice in Scotland were set out in *General Practice: Contract and Context – Principles of the Scottish Approach*⁶¹ published by the Scottish General Practitioners Committee of the British Medical Association and the Scottish Government in October 2016. These provide a vision for general practice where:

- General practice and primary care at the heart of the healthcare system;
- People who need care are more informed and empowered than ever, with access to the right person at the right time, and remaining at or near home wherever possible;
- Multi-disciplinary teams in every locality, both in and out of hours, are involved in the strategic planning and delivery of services.

⁵⁷ Scottish Government (2011), *2020 Vision* <http://www.gov.scot/Topics/Health/Policy/2020-Vision>

⁵⁸ Scottish Government (2016), *A National Clinical Strategy for Scotland* <http://www.gov.scot/Publications/2016/02/8699>

⁵⁹ Scottish Government (2016), *Health and Social Care Delivery Plan* <http://www.gov.scot/Resource/0051/00511950.pdf>

⁶⁰ *The Future of Primary Care: a view from the professions* (2017), <https://www.rcn.org.uk/about-us/policy-briefings/sco-pol-future-of-primary-care-1-sept>

⁶¹ <http://www.gov.scot/Publications/2016/11/7258>

Following the agreement by GPs to the new contract, and as set out in the landmark Letter of Intent published in November 2017⁶², Chief Officers and Chief Executives are recommending to their respective Boards the approach set out in the co-produced Memorandum of Understanding.

The Memorandum of Understanding⁶³ between the Scottish Government, Integration Authorities, the British Medical Association, and NHS Boards, sets out respective roles and responsibilities including the development of Primary Care Improvement Plans. The Plans will set out how additional funding will be used and the timescales for the reconfiguration of the services set out in the MOU and the new GMS contract (see below). Health and Social Care Partnerships will ensure that local stakeholders are appropriately informed and involved in the process and in the development (and where appropriate, the approval) of the plans.

Leadership

The need for good collaborative leadership is essential in promoting and driving change, with leadership in primary care being the responsibility of all professions. The continued development of the skills and attributes of leadership should be supported and visible across all organisations. The Scottish Government recently funded the *Leadership for Integration* development programme delivered in partnership by NHS Education for Scotland, RCGP and the Scottish Social Services Council (SSSC). The aim of the programme was to build capacity and capabilities of primary care and social care professionals to work effectively at locality level and within integrated partnerships to deliver integrated models of care. The principal target audience was those with leadership roles in health and social care contexts, including GPs and other health professionals, and social care leaders from local authority, third sector and independent care organisations.

Leadership capability and capacity amongst our workforce needs to be developed and grown in tandem with service development. As part of the development of the primary care multidisciplinary workforce, NES will support GP practices to provide the necessary clinical leadership and supervision to the wider team of professionals as required. NES will work with Integration Authorities to align this support with the priority areas as set out in the GMS contract.

Investment

As part of its commitment to increase funding in direct support of general practice by £250 million by 2021, the Scottish Government is investing £110 million in 2018-19 to support implementation of the new GP contract and wider primary care development, in line with the priorities set out in *The 2018 General Medical Services Contract in Scotland* (“the Contract offer”)⁶⁴. There will be new investment in expanded teams of health professionals in practices and communities, which may include pharmacists, nurses, physiotherapists, paramedics, community mental health workers and non-clinical support workers such as community links workers.

⁶² <http://www.gov.scot/Resource/0052/00527515.pdf>

⁶³ *Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards* <http://www.gov.scot/Resource/0052/00527517.pdf>

⁶⁴ <http://www.gov.scot/Topics/Health/Services/Primary-Care/GP-Contract>

We outline our approaches to developing MDT capacity across primary care in Chapters four to six. Shifting the balance of care will require investment to grow the community nursing workforce, which includes District Nurses, General Practice Nurses, ANPs and others over the next three to five year period. A total investment of £6.9 million over three years will be allocated between general practice nurses and district nurses to help meet the training and education needs of a sustainable 24/7 community nursing workforce.

A modernised General Practice

General Practice has a long history of innovation to meet the changing need of its patient population. The new Scottish GMS contract will help accelerate the pace of change, with an enhanced opportunity for GPs to work as Expert Medical Generalists and senior clinical decision makers within multidisciplinary teams (described in Chapter five). To enable GPs to more fully deliver this role, strong and well-connected multidisciplinary teams are needed with workload appropriately redistributed to ensure that patients have the benefit of the range of expert advice needed and available for the delivery of high quality care.

As set out in the MoU, we have agreed to focus on a number of specific priorities for service change at scale over a three year period. Table 5 briefly describes these services and the associated workforce.

Table 5: Workforce needed to deliver service reconfiguration in Primary Care

Service	Description of service	Workforce
Pharmacotherapy	By April 2021, every practice will benefit from the pharmacotherapy service delivering the core elements of the service including acute and repeat prescribing, medicines reconciliation and monitoring of high risk medicines. Additional elements of the service include medication and poly pharmacy reviews and specialist clinics. This will form part of a three-tiered approach to developing pharmacy services to support GP practices.	Pharmacists and pharmacy technicians
Vaccinations	Responsibility for vaccination and immunisation services will move from general practices to IAs and NHS Boards through the transforming vaccination programme.	Nurses, other appropriate clinical professionals and healthcare assistants

Urgent care services (advance practitioner)	Providing sustainable advanced practitioner support for unscheduled care, based on appropriate local service design. Advance practitioners such as a nurse or paramedic for GP clusters and practices as first response for home visits, and responding to urgent call outs for patients, working with practices to provide appropriate care to patients.	Paramedics, nurses where appropriate
Community Treatment and Care Service	These services include, but are not limited to: <ul style="list-style-type: none"> - basic disease data collection and biometrics (such as blood pressure) - chronic disease monitoring - the management of minor injuries and dressings - phlebotomy - ear syringing - suture removal; and some types of minor surgery as locally determined as being appropriate. Phlebotomy will be delivered as a priority	Nurses, and healthcare assistants
Additional Professional Roles	Additional professional roles will provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting. For example, but not limited to: <ul style="list-style-type: none"> - Musculoskeletal focused physiotherapy services - Community clinical mental health professionals (e.g. nurses, occupational therapists psychologists) directly working in general practice 	Musculoskeletal Physiotherapists and community mental health practitioners.

Community workers	links A generalist practitioner based in or aligned to a GP practice or cluster who works directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of (for example) the complexity of their conditions or rurality. As part of the Primary Care Improvement Plans, IAs will develop CLW roles in line with the Scottish Government's manifesto commitment to deliver 250 CLWs over the life of the Parliament. The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models/systems of care and support.	Non-clinical staff providing support and connection, based in practices or groups of practices
-------------------	---	--

Further detail on the new GP contract and reconfiguration of services can be found at: <http://www.gov.scot/Topics/Health/Services/Primary-Care/GP-Contract>

Safe and Effective Staffing in Health and Social Care

Taking a rigorous, evidence based approach to workload and workforce planning is important to ensure safe and effective staffing in primary care that reflects patients' care needs and promotes a safe environment for service users and staff. The Scottish Government's *Programme for Government 2017-18*⁶⁵ includes a commitment to introduce a Safe Staffing Bill to enshrine NHS staffing in law, starting with nursing and midwifery.

The Nursing and Midwifery Workload and Workforce Planning Programme has been in use since 2004. In October 2012 the application of the tools was mandated by the Scottish Government to be used as part of NHS Boards' annual nursing and midwifery workforce projections from April 2013. This is referenced in Local Delivery Plans and Workforce plans⁶⁶. There is now a suite of 12 tools covering 98% of all service areas, including a Community Nursing Tool.

In summary, the overarching intention is for the legislation to:

- Be a further enabler of high quality care and improved outcomes for individuals by helping ensure appropriate staffing for high quality care.

⁶⁵ Scottish Government (2017), *A Nation With Ambition: The Government's Programme for Scotland 2017-18* <http://www.gov.scot/Publications/2017/09/8468>

⁶⁶ http://www.isdscotland.org/Health-Topics/Workforce/Nursing-and-Midwifery/NMWWP/_docs/CEL2011_32.pdf

- Strengthen and enhance arrangements already in place to support continuous improvements and transparency in workforce planning and employment practice across Scotland.
- Support consideration of service delivery models and service redesign.
- Actively foster an open and honest culture where all staff feel safe to raise concerns regarding safe and effective staffing.
- Provide assurance – including for service users and staff – that appropriate staffing is in place to enable the provision of high quality care.

Given the importance of ensuring the right people, in the right place at the right time to deliver sustainable and high quality services with improved outcomes for service users, irrespective of setting, and of enabling integrated workforce planning, the intention is that the legislation will – in an appropriate and proportionate way – span the health and social care landscape. However, in taking this broader approach, the legislation will not be restrictive or prescriptive. Rather it will seek to be appropriate and enabling for the social care sector, and in particular support the recommendations in the co-produced Part 2 of the National Health and Social Care Workforce Plan to develop multidisciplinary workload and workforce planning tools where this is considered appropriate.

We consulted on initial proposals for safe staffing in 2017, and published a discussion document in January 2018 setting out refreshed legislative proposals, taking account of further engagement with stakeholders. Currently, the intention is that this legislation will:

- place a duty on Health Boards and care service providers to ensure appropriate numbers of suitably qualified staff, similar to and learning from the current requirement for care service providers set out in existing regulations
- enshrine overarching principles which will apply to NHS Boards and care service providers who will be required to take them into account in carrying out their general duty
- include more specific requirements where a validated workload planning tool and methodology exists – in the first instance this will only be applicable to nursing and midwifery services and to medical services in emergency medicine settings.

We continue to work closely with stakeholders to refine proposals and will introduce legislation later this year.

National Oversight Group

New oversight arrangements for the implementation of the GMS contract in the context of wider primary care transformation in Scotland have been developed including:

- A national oversight group with representatives from the Scottish Government, the SGPC, IAs and NHS Boards which will oversee implementation of the GMS contract in Scotland and the Integration Authorities' Primary Care Improvement Plans, including clear milestones for

the redistribution of GP workload and the development of effective MDT working.

- National issue specific groups – a range of national issue specific groups with members drawn from a range of stakeholders will support and provide policy and professional advice to the national oversight group on a range of national policy areas relevant to the delivery of primary care transformation.

Implementing the changes described in Table 5 relies on robust workforce planning, appropriate utilisation of the workforce, expansion where necessary or appropriate of MDTs and effective MDT working. This will be determined locally and set out in local improvement plans but in practice this will include a mix of the nursing, pharmacy, mental health, allied health professional, paramedic and non-clinical workforces. Delivering this change will require investment at national level to ensure workforce supply in future years. This is discussed further below.

The extent and pace of change over the next three years will be determined locally but will be affected by a number of factors including workforce availability, degree of skills enhancement and the needs of individual practices or practice clusters. In a small number of cases it may be locally determined that GPs and their staff continue to provide some of these services, for example in some very small remote and rural practices. Patient safety will also be a determining factor in local implementation in that the changes will only be made when it is safe to do so. These changes will require investment in the skills of the workforce so that these match the service needs.

Planning Multidisciplinary Teams

A clear and consistent approach to effective workforce planning at national, regional and local levels that involves appropriate engagement between service commissioners and employers is key to high quality service provision.

There is recognition that the multidisciplinary approach needs to grow. To develop an understanding of future requirements and how this approach should be taken forward, Scottish Executive Nurse Directors are leading work, together with the Chief Nursing Officer and partners, with the aim of profiling what an integrated Nursing, Midwifery and Allied Health Professional (NMaHP) community team for adults would look like in a cluster context. This will support local workforce planning and inform the need for national undergraduate and postgraduate education provision to support a growing workforce.

To manage and plan the workforce effectively, local workforce planning agencies need up to date information on:

- The healthcare needs of the population both now and in the future
- The number of people employed and what they do
- Current deployment of staff, past trends and anticipated changes
- What skills the workforce has and where there are gaps
- What skills and staff will be needed to deliver future services and priorities.

In the future, primary care services will increasingly be delivered through multidisciplinary teams including General Practitioners (partners and salaried), other health professionals and social care partners working across clusters of practices, integrated into Health and Social Care Partnerships.

MDTs can be organised at different levels – typically at practice level, but potentially also at cluster or wider primary care level depending on local circumstances. They can therefore be small or large in size and can vary in the composition of their membership. There is no fixed or defined structure for an MDT but instead a significant degree of flexibility to ensure that the services provided meet local needs.

Integration Authorities working with NHS Boards have, over the course of the last two years, identified priorities for local improvement. In 2015 a £20.5 million Primary Care Transformation Fund was announced aimed at supporting the redesign of primary care services across Scotland. A further £10 million was invested in primary care mental health services to encourage the development of new models of care. With investment from the fund, 24 tests of change in 10 NHS Boards focussed on the expansion of the multidisciplinary clinical team and these tests of change have supported the direction of travel set out in the GP contract. As an example, in Inverclyde, Advanced Practice Physiotherapists (APP) have been embedded in three general practices resulting in over 1,000 consultations being provided by APPs which would have otherwise been GP appointments.

Already we are seeing significant change happening through the primary care transformation programme. In particular, there is growing evidence to demonstrate that a sizeable proportion of current GP consultations can be safely and appropriately delivered by other professionals, freeing up GP time for the more focused Expert Medical Generalist (EMG) role. The Scottish School of Primary Care has been commissioned by the Scottish Government to capture key learning from the transformation fund tests of change and we anticipate a final report in late 2018.

GP Clusters

In January 2017, the Scottish Government published *Improving Together, a National Framework for Quality and GP Clusters in Scotland*⁶⁷. GP clusters are typically groups of between 5 to 8 GP practices in a close geographical location. The purpose of clusters is to encourage GPs to engage in quality improvement activity with their peers, and to contribute to the oversight and development of their local healthcare system. Each GP practice has a nominated Practice Quality Lead (PQL) and each cluster will have a Cluster Quality Lead (CQL). Healthcare Improvement Scotland (HIS) is developing the required educational and quality improvement support to embed continuous quality improvement in primary care. The aim of this work is to:

- Support GPs to care for their patients and to better address the health needs of their local communities;
- Reduce primary care health inequalities and contribute to improving people's health;

⁶⁷ <http://www.gov.scot/Resource/0051/00512739.pdf>

- Improve patient experience of primary care through the local delivery of care by a range of health professionals (e.g. GPs, nurses, AHPs, pharmacists, dentists);
- To develop a network of Quality Improvement leads to support and embed continuous quality improvement in primary care.

Where appropriate it is expected that integrated multidisciplinary teams will support and be shared across GP clusters, depending on priorities identified by local planners including cluster leads. The role of Local Intelligence Support Team (LIST) analysts has been expanded to support GP Clusters with the data, evidence and intelligence required to drive quality improvement (more detail on LIST is provided in Chapter seven). Public health professionals also have a clear role to play in advising on approaches to addressing local need and providing evidence on effective population health initiatives.

Approaches to planning the primary care workforce

There are a variety of approaches to identifying local population need and planning the primary care workforce to best address local circumstances. This requires good communication between planners and health and social care professionals. Employers across different sectors frequently use a variety of approaches in undertaking their workforce planning, including case management tools, *Indicator of Relative Need (IORN)*, and the NHS Scotland 6-step workforce planning methodology⁶⁸.

Applying the six step methodology provides the opportunity to take into account local population needs and assess potential impact on other services. Using the guide across workforce planning will assist in ensuring that decisions made around service design and recruitment of staff and MDTs are sustainable, realistic and support the delivery of high quality patient care.

⁶⁸ http://www.sehd.scot.nhs.uk/mels/CEL2011_32.pdf

The six steps in this tool are briefly outlined:

- 1. Defining the plan** – This could include measures to improve practice sustainability, improve integration of health and social care services, develop MDT capacity and strengthen workforce planning.
- 2. Mapping service change** – This step is about being clear on what services need re-configured to meet the aim(s) of the workforce plan. A strong vision of what an expanded and / or enhanced service can look like sets the appropriate parameters for workforce planning.
- 3. Establishing workforce needed to meet service demand** – Population needs analysis, as well as additional information on the current number and types of services provided is an important first step here. When assessing population need, consideration should be given the specific circumstances in terms of rural, remote or island communities (further detailed below), an increasing elderly population in many areas and/or the needs of areas of high socio-economic deprivation. The expansion of LIST analysts into primary care is an important facilitator in this respect, as is the role of Public Health professionals.
- 4. Mapping workforce skills and competencies** – Competency-based planning to help distribute work more efficiently, and skill mix initiatives should be utilised to determine the most appropriate use and redeployment of available workforce. Determining what type of skill mix is needed to meet future demand will help support succession planning. In order to support enhanced MDT roles in primary care it is critical that there are agreed roles supported by defined competencies and a robust career / educational and support framework irrespective of employer.
- 5. Understanding workforce availability** – The next step is to profile the existing primary care workforce, including vacancies, and the demographic profile of the workforce. Workforce demographics for certain staff groups may pose particular challenges which should be considered and addressed. We have already highlighted, for example, the older profile of our General Practice and District Nurses. These demographics may of course vary across local areas. This enables an understanding on whether current resources are in the right place, are being utilised effectively and whether the workforce has the right skills to deliver safe and effective patient care. Regional as well as local planning will help in the appropriate distribution of the workforce across Scotland.
- 6. Implementing, monitoring and refreshing** –It is essential to measure the impact of any change including outcomes for patients, services and the wider organisation or local community. Scotland is fortunate to have a range of national organisations whose role it is to provide data, improvement support and evaluation advice to local partners. We set our approaches to monitoring and evaluation in Chapter seven.

Additional factors that should be considered when planning MDTs, include:

The employment of staff will be an important consideration when redesigning services. The expectation is that there will be a mixed model of employment, with Practice Managers, administrative staff and General Practice Nurses generally remaining directly employed by the practice as independent contractors, and the new expanded workforce typically being employed outwith the practice by the Health Board or Scottish Ambulance Service but embedded within practice teams. This provides continuity of care to people, whilst supporting practice sustainability and professional governance.

One area which faces particular challenges is the sustainability of GP Out of Hours (OoH) services. Sir Lewis Ritchie's report – *Pulling together – transforming urgent care for the people of Scotland*⁶⁹ identified a number of key recommendations for service redesign, including workforce planning focussing on the development of MDTs, and the need for robust inter-relationships between daytime and OoH care to ensure a sustainable service for the future. Whilst OoH and in-hours will remain GP-led services, it may increasingly be the case that some patients' needs are best met by another member of the MDT, whether that be an advanced nurse practitioner, a pharmacist or a paramedical practitioner. *Improving Health and Social Care Service Resilience over Public Holidays*⁷⁰ focused on what can be done to ensure that good working practices and processes are rapidly put in place to ensure that appropriate levels of service are available throughout public holiday periods.

Where patients have high levels of non-clinical need, this may lead to consideration of whether provision of non-clinical support such as community links workers or welfare rights advisers would be a suitable intervention.

Local Examples of MDT approaches

Govan 'SHIP' was launched in 2015 by four practices working in Govan Health Centre who are within the top 100 most deprived practices in Scotland ('Deep End'). The practices are increasingly working with expanded and integrated network of partners from statutory and third sector agencies, which includes attached physiotherapy, pharmacy, housing, link workers, social work, education and are currently developing teamwork with secondary care. In a short period of time for a project of this complexity, it has managed to innovate, change patient behaviour and reduce use of health services across all patient groups⁷¹.

In Ayrshire and Arran some physiotherapists have been redeployed from acute into community settings to offer a better 'first point of contact' service for patients and fewer avoidable referrals into secondary care.

The *Headroom* initiative involved 23 GP practices across South East Edinburgh in areas with concentrated economic disadvantage. It recognised

⁶⁹ <http://www.gov.scot/Resource/0048/00489938.pdf>

⁷⁰ Scottish Government (2017), *Improving Health and Social Care Service Resilience over Public Holidays* <http://www.gov.scot/Publications/2017/12/2391/0>

⁷¹ Further information on Govan SHIP is included within the Deep End website:

<https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/reports/>

the distinct challenge and opportunities for more effective intervention by primary care through working in partnership, including with the local authority, voluntary and other community organisations. In particular *Headroom* delivered improvements aimed at the critical `life-wrecking` dimensions of inequality; mental health, alcohol, drugs, severe parenting problems, housing, employability, chronic disease and social isolation. While *Headroom* came to an end March 2017, a number of strands of learning have gone on to inform and/or support general practice including the implementation of a Community Link Worker Network across Edinburgh and the continuation of small `Total Place` groups delivering responsive, local outcomes through collaborative working.

Remote and Rural

There can be particular challenges in recruiting and retaining GPs, nurses, pharmacists, AHPs (particularly paramedics) and other clinical staff in remote and rural areas. Working in rural areas, especially very remote areas or islands, can be significantly different from working in more urban areas – e.g. relatively limited options to develop careers, access to updating professional skills, difficulty in meeting employment needs of spouses and partners, etc. This is coupled with the often dispersed nature of the practice population, the potential difficulty in recruiting locum cover, wider expectations of the role of health and social care professionals, and the (lack of) availability of other support services such as Care Homes, palliative care, etc.

Clinical staff working in these remote areas often need to have a wider or different range of skills to meet the needs of the local population. We must therefore ensure that we develop a workforce that has the appropriate skills and experience to work in our remote and rural areas. This includes supporting professionals working in these areas and ensuring such roles are attractive and rewarding.

These recruitment and retention challenges should be reflected in the Primary Care Improvement Plans of rural Health Boards/ Integration Authorities, as the role of the MDT and the skills required of the team will be different in each area depending on local need.

In addition, the Scottish Government and BMA have committed to setting up a Rural Short Life Working Group which will support the implementation of the new GP Contract in rural areas, both in the short and longer term, and support the sustainability of remote and rural practices, in particular for very small practices in remote areas.

This will work alongside a Dispensing Short Life Working Group which will look at the needs of dispensing practices in Scotland, including workforce development and training needs especially for non-clinical dispensing staff, and the role of Pharmacists to support dispensing practices.

The Scottish Government will also continue to fund the Scottish Rural Medical Collaborative to take forward work looking at the recruitment, retention and training

needs of primary care staff working in rural Scotland (further details are provided in Chapter five).

The Chief Nursing Officer's *Commission on Widening Participation in Nursing and Midwifery, Education and Careers*⁷², published in December 2017, sets out a number of recommendations and will provide a platform for further targeted work to attract and retain individuals into careers in nursing and midwifery, including remote and rural areas.

Health Inequalities

Health inequalities are linked to a range of factors that are complex and interrelated. For example, genetic factors and poor housing can have a major effect on an individual's health over time, and issues can be exacerbated by behaviours such as poor diet, smoking, sedentary behaviour and alcohol misuse. Public services in Scotland can address some of these factors, for example by improving social housing or access to sports and community facilities. Broader UK and global factors, such as levels of economic growth also play a significant role.

Better addressing health inequalities therefore requires continued action beyond primary care but, as set out in Chapter one, the primary care workforce also has a significant role in focusing activity on prevention, anticipatory care planning, and managing complex care to improve patient outcomes. A key aim of the new GMS contract is to focus GP time on complex care as an Expert Medical Generalist, whilst we continue to build capacity in the wider MDT. As patients living in our most deprived areas experience higher levels of ill health earlier in their lives, enabling GPs to address complex care will benefit those patients with greatest clinical need. All Integration Authorities will develop Primary Care Improvement Plans which will show how they intend to address inequalities locally.

The new Scottish Allocation Formula (SAF) is a methodological improvement on the previous formula. It more accurately captures the determinants of the workload of GPs, giving greater weight to older patients and to deprivation. It uses smaller geographies than the previous formula, ensuring that both deprivation in urban areas and isolated pockets of rural deprivation are better addressed by the new formula. The formula provides about 25% more funding to support the care of patients living in the most deprived areas compared to the least deprived. With the introduction of the new formula, all GP practices in Scotland will be protected from any potential funding losses. To this end, the Scottish Government has committed to invest an additional £23 million to fund the additional care needs recognised by the new formula. This additional investment has been provided to practices to improve services for patients in areas where workload is highest.

A significant proportion of consultations with GPs in areas of very high deprivation are due to experiences of social adversity, especially poverty and financial problems. This can place additional pressures on practices, whose primary aim is to address the clinical needs of their patient population. We have therefore committed to recruiting 250 community links workers by the end of this Parliament. CLWs are one

⁷² <http://www.gov.scot/Publications/2017/12/5568>

of six key services that, in future, will be provided to patients in GP practices by Health Boards under the new GP contract. The roles of the CLWs will be consistent with assessed local need and priorities. CLWs are one of the ways in which local systems can tackle health inequalities, and therefore our expectation is that the first priority for CLWs will be more deprived areas.

Promoting workforce health and wellbeing

The health and social care workforce is our greatest asset, they have a vital role in delivering *Everyone Matters - the 2020 vision*⁷³, to drive improvements in health, patient care and reducing inequalities. It has been recognised that improvements to staff health and wellbeing have major benefits to the economy, society as a whole, and to reducing disease and illness⁷⁴, with staff themselves benefiting from improved morale, job satisfaction and improved health and wellbeing⁷⁵. Crucially, a workforce that is healthy, valued and treated well improves patient care and overall performance⁷⁶. The Boorman Review found that over 85% of staff reported their health and wellbeing impacts upon patient care, while a recent influential study found a direct relationship between staff health and wellbeing and staff reported performance⁷⁷.

There are key challenges in this area. The workforce is ageing; some staff require support with management of their weight; musculoskeletal disorders and mental health problems can lead to staff absences; and issues with working cultures and shift patterns can also cause staff ill-health. Some of the issues are already being addressed through current policies and programmes including: *Workforce 2020 Vision, Healthy Working Lives, iMatters, Partnership Information Network (PIN)* policies, and our public health policies. The *Nursing Vision 2030: Promoting Confident, Competent and Collaborative Nursing for Scotland's Future* recognises the need to put in place measures to protect and promote nurses' physical and mental health and wellbeing. *The Nursing Vision 2030* recognises that all environments in which nurses work, whether in communities, hospitals, care homes or elsewhere, are hugely influential in fostering – or inhibiting – professional practice and behaviours. A positive culture can help support the workforce to feel valued, and share their experiences and insights honestly and openly, leading to a healthier workforce that feels more valued.

In addition, in October 2016, the Scottish Government and the BMA launched the General Practice Occupational Health Service to provide a range of occupational

⁷³ Scottish Government (2013), *Everyone Matters: 2020 workforce vision*
<http://www.gov.scot/resource/0042/00424225.pdf>

⁷⁴ Waddell, G., and Burton, A. K. (2006). *Is work good for your health and wellbeing?*
<https://www.nice.org.uk/guidance/ng13/evidence/evidence-review-1-workplace-policy-and-management-practices-to-improve-the-health-of-employees-pdf-75821149>

⁷⁵ The Point of Care Foundation (2014), *Staff care how to engage staff in the NHS and why it matters*
https://16682-presscdn-0-1-pagely.netdna-ssl.com/wp-content/uploads/2014/01/POCF_FINAL-inc-references.pdf

⁷⁶ Scottish Government (2013), *Everyone Matters, 2020 vision*
<http://www.gov.scot/Resource/0042/00424225.pdf>

⁷⁷ Boorman, S (2009) *NHS Health and Well-being: Final Report*
[http://webarchive.nationalarchives.gov.uk/20130103004910/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108799_NA\(M\)](http://webarchive.nationalarchives.gov.uk/20130103004910/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108799_NA(M))

health services to GP's, GP Locums, Administration, nursing and other practice staff. This service can be accessed through local NHS Board Occupational Health Services, which is available to all NHS staff. The Occupational Health Service for General Practice provides a range of services including pre-placement assessments, management and self-referrals, Immunisation and BBV exposure follow up, Health Surveillance, Physiotherapy and Mental Health advice and support.

NHS Scotland has transformed its approach to measuring staff experience⁷⁸. The national staff survey has been replaced by the *iMatter Continuous Improvement Model* complemented by a short additional *Dignity at Work Survey* to provide a full overview of national staff experience. The *iMatter Continuous Improvement Model*⁷⁹ was developed by NHSScotland staff for staff and provides a team-based tool offering individual teams and managers the facility to measure, understand, improve and evidence staff experience. The Dignity at Work Survey addresses questions about discrimination, bullying and harassment, violence and abuse from patients and members of the public, resourcing and whistleblowing.

These new arrangements have been developed in full partnership and through focussed engagement with the HR community and local and national staff side representatives. It comes with the full support of these communities and has been endorsed by the Scottish Workforce and Staff Governance Committee (SWAG), and approved by the Cabinet Secretary for Health and Sport. This has enabled NHS Scotland to obtain a comprehensive picture of staff experience indicating areas of success and those which require improvement both nationally and locally. A number of Integration Authorities have been involved in this new transformational approach, and more staff than ever before have used their employee voice to engage in the new approach across health and social care.

Conclusion

Primary care is embarked on a process of reform to place it on a more sustainable and resilient footing and to address the increasing and changing needs of Scotland's population. The Memorandum of Understanding sets out the principles underpinning primary care in Scotland, including respective roles and responsibilities going forward. We are investing significantly (including £250 million in direct support of general practice by 2021) to enable the reshaping of primary care to be delivered.

Shifting the balance of care from hospitals to community and primary care settings presents significant challenges and will require collaborative working across many partners. What is clear though is that to deliver our vision of a modernised and reformed primary care, we must develop multidisciplinary capacity across Scotland and the following chapters begin to set our approaches to increasing workforce capacity.

⁷⁸ *iMatters* covers staff employed in NHS Scotland and social care. It does not survey staff employed directly by GP practices.

⁷⁹ Scottish Government (2018), *Health and Social Care Staff Experience Report 2017*
<http://www.gov.scot/Publications/2018/03/5142>

CHAPTER FOUR: PLANNING AND DEVELOPING THE MULTIDISCIPLINARY WORKFORCE – NURSING AND MIDWIFERY

- Integrated community nursing teams will play a key role in planning, providing, managing, monitoring and reviewing care, building on current roles and best practice to meet the requirements of people with more complex health and care needs in a range of community settings.
- Nationally consistent approaches to roles and educational preparation for advanced nursing practice, district nurses, general practice nurses, health visitors and school nurses are supporting the development of these integrated teams.
- Programme for Government 2016-17 commits to invest £3 million to train an additional 500 advanced nurse practitioners across primary and secondary care. This will enable nurses across Scotland to maximise their leading role in integrated health and social care of the future.
- We have committed to an investment of £3 million over three years into training and education needs of general practice nursing.
- We will invest an additional £3.9 million over three years into training and education needs of district nurses to help sustain a 24/7 community nursing workforce.
- By September 2018, we will work alongside partners, including the Royal College of Nursing, to understand the requirements and investment necessary to grow the District Nursing workforce.
- An additional 2,600 additional nurse and midwife training places will be created over the life of this Parliament, with a 10.8% increase (sixth increase in a row) in nursing and midwifery student intake places for academic year 2018/19, as a further step to ensure we can recruit and train the next generation of staff.
- We will increase the number of health visitors by 500. This is being supported by funding which has increased over four years to £20 million annually (recurring).
- A marketing campaign will be developed to attract individuals into nursing and midwifery careers and ensure a sustainable workforce is available to meet Scotland's future requirements.

Introduction

Nursing is the largest occupational group in community care, with approximately 12,000 nurses working in community settings (see Chapter two). As more people with increased complex needs receive care in their own homes and other community settings, the vital role of community nursing as expert nursing generalists is reinforced. Shifting the balance of care from hospital to community and primary care settings at or near people's homes aims to improve population health, increase quality and safety, and secure best value from health and social care services.

More Advanced Nurse Practitioners (ANPs), District Nurses, Community Pharmacists and AHPs will be required to meet the evolving needs of individual communities and localities. This is in keeping with the *National Clinical Strategy*⁸⁰ and national health and social care workforce planning. The recent *Improving health and social care service resilience over public holidays* report⁸¹ showed that workforce planning and development of extended professional roles within primary care recommended by the *Primary Care OoH Review*⁸² is underway.

All those responsible for workforce planning should consider the full range of options at their disposal to deal with recruitment and retention issues within their nursing workforce to ensure sustainable 24/7 services. This Chapter sets out the national activity taking place to strengthen the nursing workforce in primary and community care settings, whilst recognising local challenges. Chapters five and six cover general practitioners and the wider clinical and non-clinical workforce.

Maximising the contribution of the nursing and midwifery workforce

The nursing and midwifery workforce will be enabled to work to its maximum capability; to do more or to work differently, reflecting changing population needs or service models irrespective of whether these staff are GP or Health Board employees. Part 1 of the *National Health and Social Care Workforce Plan* outlined the steps that the Scottish Government is undertaking to ensure that our supply of nurses and midwives meets anticipated future demands.

An additional 2,600 nursing and midwifery training places will be created over the lifetime of this Parliament. These will include a further expansion of training places to provide an additional 1,600 places, to build on the 1,000 extra places already committed to as part of the *Programme for Government 2016/17*⁸³. This is expected to bring the total number of training places to over 12,000, an historic high which will strengthen the supply of qualified nurses and midwives across health and social care settings.

A further package of measures will extend and increase funding for *Return to Practice* programmes, enhance access programmes for support workers; improve recruitment, retention and completion rates particularly targeted at remote and rural areas; and support measures to retain and attract nurses and midwives to work in Scotland. These enhanced initiatives are expected to result in a further 1,300 nurses and midwives working in Scotland.

The package of measures will be targeted towards those practice and geographical areas where particular needs are identified, including primary care, mental health, midwifery, maternal and child health, and more remote and rural areas, particularly the North of Scotland. It will be closely aligned to the Chief Nursing Officer's

⁸⁰ Scottish Government (2016), *A National Clinical Strategy for Scotland*
<http://www.gov.scot/Resource/0049/00494144.pdf>

⁸¹ <https://beta.gov.scot/publications/improving-health-social-care-service-resilience-over-public-holidays-9781788514965/>

⁸² <http://www.gov.scot/Publications/2015/11/9014>

⁸³ Scottish Government (2017), *A Plan For Scotland: The Scottish Government's Programme For Scotland 2016-17* <http://www.gov.scot/Publications/2016/09/2860>

*Commission into Widening Participation in Nursing and Midwifery Education and Careers*⁸⁴ and will help deliver its recommendations. The report – published in December 2017 – identified best practice and current barriers to nursing and midwifery careers, both in terms of ambition and access, and made recommendations to support and enhance access across the education and employment sectors.

The Commission report also concluded that further action is needed to celebrate the impact and opportunities of nursing and midwifery education and careers and recommended a national campaign to promote career opportunities. We will take forward a campaign later this year with the aims of:

- emphasising the professions' flexibility and extensive opportunities for personal and professional development;
- recognising nursing and midwifery career opportunities beyond the traditional boundaries of NHS Scotland, with a particular focus on care home nursing given increased workforce challenges in those settings;
- tackling stereotypical images of nurses and midwives, creating a more positive professional role model.

As noted in Chapter six, we anticipate that the campaign will be broadened to cover health care careers notably in Allied Health Professions and Health Care Science, given on-going recruitment challenges in these professions.

Good quality primary care workforce data is vital in planning for the future nursing and midwifery workforce. We are aware of the need to strengthen the data we currently collect and our approaches to developing more robust, integrated workforce data are set out in Chapter seven.

Integrated Community Nursing teams

Community nursing can be broadly described as any nursing care provided outside of an acute hospital. This includes healthcare provided in the home or other homely settings, and also in other settings, for example, General Practice, a community hospital, the custody suite of a police station, a school or care home and we acknowledge that not all roles have been covered in this chapter but all make a valuable contribution to improving the health and wellbeing of the people of Scotland.

Integrated community nursing teams will play a key role in planning, providing, managing, monitoring and reviewing care, building on current roles and best practice to meet the requirements of people with more complex health and care needs in a range of community settings. Delivering our aim of shifting the balance of care from hospital to primary and community care settings requires a different approach that enables community nursing staff to develop new and innovative ways of working to provide safe, effective, person-centred care and clinical interventions tailored to meet the needs of the individual.

⁸⁴ <http://www.gov.scot/Publications/2017/12/5568>

District nurses, general practice nurses, ANPs and their wider teams working as an integrated community nursing team will provide a seamless interface and reduce any boundaries between their practice and place of care.

Integrated nursing teams are at the heart of the *Buurtzorg* model of neighbourhood care which has been so successful in the Netherlands. The model involves unhurried visits by community nurses who provide continuity of care and have freedom to work autonomously in small, self-organising teams to develop a flexible range of solutions to meet people's needs. A number of integrated community nursing and home care teams in Scotland are testing the Buurtzorg principles, using the learning to accelerate progress with integration as well as the development of the community health and social care workforce.

District nursing

Sir Lewis Ritchie's independent review of Out Of Hours emphasised the essential role of district nurses to support 24/7 community healthcare. The review sought to underpin a consistent district nursing role, where nurses have the capacity, capability, infrastructural support and access to resources, enabling them to meet patient need.

In response, the Chief Nursing Officer's *Transforming Roles* programme has outlined a nationally consistent role for district nurses within integrated community nursing teams⁸⁵. This emphasises district nurses' leadership role in areas such as anticipatory, palliative and end-of-life care; balancing their role in managing complexity alongside promoting self-care, independence, prevention and community engagement.

District nurses will play a pivotal role in integrated community teams. They will be at senior practitioner level within the career pathway and will be supported by the wider community team, including healthcare support workers, registered nurses and advanced nurse practitioners, to promote health and wellness, enable self-care and deliver personalised health outcomes in people's own homes or communities. Services will be integrated appropriately with social care and other partners and properly signposted to ensure a full range of locally led, co-ordinated, high quality, accessible and well-understood services are in place.

Refocused and nationally consistent core education provision has been developed to support a future-facing district nursing role, with guidance on caseload and resource-allocation agreed to complement the triangulated approach within the nursing and midwifery workload and workforce planning tools.

NHS Education for Scotland is managing a range of activities on behalf of the Scottish Government to support the implementation of the refocused District Nursing role. For example, NHS Boards are being funded to train District Nurses in nonmedical prescribing and Advanced Clinical Assessment modules with 95 training

⁸⁵ Scottish Government (2017), *Transforming Nursing, Midwifery and Health Professionals Roles - The district nursing role in integrated community nursing teams*
<http://www.gov.scot/Resource/0052/00529738.pdf>

places in 2017/18. A Continuous Professional Development (CPD) digital resource has also been developed which focuses on the skill required for the refreshed role. The resource has been developed in partnership with District Nurses to ensure the key areas for role development are addressed. In addition local projects within NHS Boards have been funded to support the implementation of the refocused role. For example, NHS Western Isles is testing implementation of the role in a remote and rural setting, and NHS Lothian has developed peer support groups to support roll out of the District Nursing CPD digital resource.

In total over £158,000 has been invested in District Nurse education and CPD in 2017/18. District Nurse education will continue to be a national priority and this is reflected in our investment of an additional £3.9 million over three years into training and education needs of district nurses to help sustain a 24/7 community nursing workforce.

In addition, recognising the importance of the District Nursing workforce in shifting the balance of care from hospitals to community settings, we will work alongside partners, including the Royal College of Nursing, to understand the requirements for sustaining and expanding this workforce. We are committed to undertaking this work at pace and will be in a position by September 2018 to better understand the requirements and investment necessary to grow the workforce. Integration Authorities and NHS Boards retain responsibility for planning and funding District Nurse vacancies and projected retirements from existing budgets.

General Practice Nursing

General Practice Nurses are essential to the future of general practice and are an integral part of the core practice team. They provide primary care services, mainly through direct employment by GPs, with general nursing skills and extended roles in health protection, urgent care and supporting people with long term conditions.

The numbers of consultations for GPNs relative to GPs increased from 28% in 2003/4 to 33% in 2013, illustrating the continued shift of chronic disease management from GPs to nurses⁸⁶. With the growth in chronic disease prevalence, significant focus on the role of GPN is needed to reduce demand through more effective disease prevention and management including self-management and anticipatory care. The benefits of such an approach are set out in Chapter one.

With a dedicated Community Treatment and Care Service delivered through Integration Authorities, the 2018 GMS contract will support GPNs to focus on a refreshed role in general practice as expert nursing generalists providing acute and chronic disease management, enabling people to live safely and confidently at home and in their communities, supporting them and their carers to manage their own conditions whenever possible.

Over half (53%) of all nurses in general practice are aged 50 years and over. In order to support an enhanced role safely integrated into general practice and to grow the GPN workforce, making general practice an attractive career choice for nurses,

⁸⁶ Information Services Division (2013), *Practice Team Information (PTI) Annual Update*.

under the Chief Nursing Officer's *Transforming Roles* programme, a short life working group was established in 2017 to refresh the role and educational requirements of GPNs. The overall aim of the General Practice Nursing Group is to scope the current GPN role across NHSScotland Boards and identify areas for developing a refreshed GPN role.

We are investing a further £3 million over a three year period for additional training to enhance the skills of GPNs so that they are better equipped to meet the needs of patients with multiple health conditions, making it easier for patients to access the right person at the right time.

Advanced Nurse Practitioners

ANPs are qualified to Masters level and are competent to work at advanced level as part of multidisciplinary teams across all clinical settings, dependent on their area of expertise. They are clinical leaders with the freedom and authority to act, and accept responsibility and accountability for those actions. The role is characterised by high-level autonomous decision-making, including assessing, diagnosing and treating (including prescribing for) patients with complex multidimensional problems. ANPs have the authority to refer, admit and discharge within defined clinical areas.

To ensure consistency and sustainability ANP roles need to be developed in a systematic way. The Chief Nursing Officer's *Transforming Roles*⁸⁷ programme has set out a nationally consistent approach to advanced nursing practice. To underpin this, NHS Education for Scotland has produced a *Service and Education Needs Analysis Tool*⁸⁸ to support NHS Boards/employers to plan, and evaluate the implementation of ANP roles and the education required to support them. NHS Boards/employers have been requested to complete an ANP Education Needs Analysis annually.

ANPs in primary care provide a high quality, responsive service within the MDT context, whilst encouraging career development within the nursing profession. Many of the Primary Care Transformation Fund projects have developed the role of ANPs; an evaluation report from the PCTF will be published later in 2018 setting out key learning from the programme.

The Scottish Government has commitment to investing £3 million to train an additional 500 advanced nurse practitioners across primary and secondary care. This will equip nurses across Scotland to maximise their leading role in integrated health care of the future.

We are also improving data on the availability on the size and profile of the ANP workforce. Statistics on the number of ANPs employed by NHS Boards were published by NHS National Services Scotland for the first time in September 2017⁸⁹.

⁸⁷ Scottish Government (2017), *Details for the Transforming nursing, midwifery and health professionals roles: advanced nurse practitioner roles*: <https://beta.gov.scot/publications/transforming-nursing-midwifery-health-professions-roles-advanced-nursing-practice/>

⁸⁸ See: http://www.nes.scot.nhs.uk/media/4031459/final_anp_sna-ena_tool.docx

⁸⁹ Available at: <http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables2017.asp>

These data will be published annually, providing a more comprehensive picture of this crucial workforce.

Case Study: Primary Care Advanced Nurse Practitioners

East Ayrshire HSCP is testing a process of development and implementation of Primary Care ANPs in four GP practices. All have completed a post graduate certificate in advanced clinical practice and are working towards completion of a Masters' degree. They have received positive feedback from GP partners and service users. Running in parallel, NHS Ayrshire and Arran have identified and supported a cohort of primary care practice nurses to develop their knowledge and skill set to advanced clinical practitioner, through academic study, supervision, competence frameworks and clinical practice.

ANPs will be developed with generic primary care expertise similar to that of a GP so that they can provide clinical sessions responding to undifferentiated conditions, make referrals, house calls and visit those in care homes, undertake reviews and care for those with long term conditions. Mentoring is provided by GPs in a similar way to that provided to trainee doctors. Competency frameworks and the processes for support and mentoring have been implemented for Primary Care ANPs in conjunction with The West of Scotland Advanced Practice Academy and in line with national guidance.

Children and Early Years

Health Visitors

As part of the *Transforming Roles* programme, work has been completed to refocus the role and visiting pathway for Health Visitors. Focusing on family and child health, prevention, early identification and intervention, Health Visitors play a central role within early years services. They particularly focus on families with children under five years of age and offer universal services to all families whilst offering more targeted support to those families and children in greatest need.

To support and maximise the role and impact of Health Visitors within early years the Scottish Government has made a significant investment of £40 million (including over £3.4 million in health visitor training) over four years since 2014 to enable the number of Health Visitors in Scotland to increase by 500 by the end of 2018. When delivered, this will represent an unprecedented 50% increase in the number of Health Visitors. The Scottish Government will continue to support, develop and invest in career pathways for community nursing.

School Nurses

With a similar focus on prevention, early intervention and support for the most vulnerable, work has just completed to refocus the role of school nurses, increasing their capacity and competency and maximising their contribution as part of multiagency/multidisciplinary teams supporting health and wellbeing and raising

attainment of the school age population. This future facing role centres around children, young people and families with additional needs, alongside a number of priority areas (looked after children, mental health and well-being, substance misuse, domestic abuse, youth justice, young carers, homeless families and children, transition periods and child protection).

The Transforming nursing, midwifery and health professionals roles paper on the refocused school nurse role is available at: <https://beta.gov.scot/publications/school-nursing-role-integrated-community-nursing-teams/>

Supporting the best start in life

The *Best Start* review⁹⁰ was published in January 2017 and sets out a vision for the future planning, design and safe delivery of high quality maternity and neonatal services in Scotland. It puts the family at the centre of decisions so that all women, babies and their families get the highest quality of care according to their needs. It signals a shift towards relationship based care, with a move towards a continuity of carer model and local delivery of care within community hubs. This will have implications for the midwifery workforce that we will consider carefully.

Conclusion

The role of the nursing and midwifery workforce in supporting and driving the reform of primary care in Scotland is vital. Through significant investment in expanding the workforce and enhanced support for education and training, we will support integrated community nursing teams address the needs of people across a range of community settings.

We are clear that shifting the balance of care will require growth and additional investment in district nurses as key members of integrated community nursing teams. The Scottish Government will lead work alongside partners to understand the on-going requirements and investment necessary to deliver the required expansion of this workforce. There is a need for robust evidence and reliable data on supply needs to support both current delivery and emerging models of care to ensure effective targeting of investment.

⁹⁰ Scottish Government (2017), *The Best Start: A Five Year Forward Plan For Maternity And Neonatal Care in Scotland*, <http://www.gov.scot/Publications/2017/01/7728>

CHAPTER FIVE: PLANNING AND DEVELOPING THE MULTIDISCIPLINARY WORKFORCE – GENERAL PRACTITIONERS

- The new GP contract will deliver an enhanced role for the GP focused on complex care, undifferentiated illness and clinical leadership.
- There will be a reduction in GP workload pressures and responsibilities through service redesign.
- At least 800 (headcount) additional GPs will be added to the workforce over the next 10 years to meet increasing patient demand.
- A comprehensive package of retention measures will be put in place to support GPs, including during the first five years and towards the end of their careers.
- There will be enhanced support for GPs working in remote and rural areas.
- There will be enhanced support and encouragement for GPs working in the OoHs period
- On-going expansion of medical school and training places will help grow the GP workforce.
- The establishment of an *Increasing Undergraduate Education in Primary Care Working Group* to consider ways of increasing undergraduate education in primary care settings, which will help facilitate future careers in general practice.
- A marketing and recruitment campaign will promote Scotland as a great place to work as a GP.

Introduction

The GP has been at the heart of the health care system since the establishment of the NHS in 1948. Working within MDTs and wider community services, GPs manage the widest range of health problems, addressing multimorbidity, coordinating long-term care and addressing the physical, social and psychological aspects of patients' wellbeing.

The context under which GPs operate has changed significantly in recent years, with an ever more important role as clinical leaders in deciding how health services should be organised to deliver safe, effective and accessible care to patients in their communities within an increasingly integrated health and care system.

This evolving role formed the basis of the recent negotiation of the new GP contract between the Scottish Government and the BMA. The negotiations were guided by Barbara Starfield's "four Cs" of primary care⁹¹, namely that GPs are uniquely able to deliver:

⁹¹ Starfield, B. (1992) *Primary Care: Concept Evaluation and Policy*. OUP, New York

- Contact – accessible care for individuals and communities;
- Comprehensiveness – holistic care of people – physical and mental health;
- Continuity – long term continuity of care enabling an effective therapeutic relationship;
- Co-ordination – overseeing care from a range of service providers.

These four pillars of primary care are also evident in the landmark Royal College of General Practitioners (RCGP) report on *Medical Generalism*⁹². The ethos of generalism described in this report includes comprehensiveness, co-ordination and continuity. Generalism, by definition, is a form of care that is person - not disease - centred. It is precisely the type of medicine needed to meet the challenge of shifting the balance of care, realising *Realistic Medicine*⁹³, and enabling people to remain at or near home wherever possible.

The new GMS Contract articulates a refocused role for GPs as Expert Medical Generalists (EMGs). This recognises the GP as the senior clinical decision maker in the community, who will focus on:

- undifferentiated presentations;
- complex care in the community;
- whole system quality improvement and clinical leadership.

Expert Medical Generalists will ensure strong connections to, and coordination with, the enhanced primary care team, health and social care community based services and with acute services where required. Better coordination of patient care, including greater access to the right professional at the right time, will deliver improved patient outcomes and a more proportionate use of resources.

The role of the GP as an EMG can only be achieved if they have the capacity to develop this leadership role. We have set out in Chapters three and four how we will deliver enhanced MDTs to support comprehensive service reconfiguration in primary care. This chapter describes how we will support and retain our current GP workforce through a comprehensive package of support measures, while expanding the number of GPs working in Scotland by at least 800 (headcount) over the next decade.

Supporting and retaining the existing workforce

We recognise the pressures GPs are under due to changing demographics and the expectations of patients. The Cabinet Secretary for Health and Sport announced in December 2017 a comprehensive package of measures to retain and support the GP workforce:

- **Mentoring** – embarking on any career can be challenging and stressful and we know that young GPs want more portfolio type careers and a better work/life balance. GPs within their first five years will be offered mentoring

⁹² Royal College of General Practitioners (2012) *Medical Generalism: Why expertise in whole person medicine matters*

⁹³ Scottish Government (2016), *Realistic Medicine* <http://www.gov.scot/Resource/0049/00492520.pdf>

support from experienced GPs as growing evidence suggests this may be an effective component to retaining GPs in workforce⁹⁴.

- **Continued Professional Development (CPD)** – heavy workloads can mean opportunities for CPD are limited. The new GMS Contract recognises this and will provide practices with resources to support 1 session per month for Professional Time Activities. Further support is being offered to GPs in first five years of their career.
- **Coaching** – Research demonstrated that professional coaching can be successful in turning around intention to leave the profession.

Table 6: Pre- and post- coaching 'likelihood of leaving the profession' ratings⁹⁵

	Pre-coaching (base 51)	Post-coaching (base 28)
Average 'leave' rating	7.2	4.9
7 or above	74.5%	32%
4 to 6	23.5%	21%
3 or below	2%	46%

Note: where 1 = highly unlikely to 10 = highly likely

The aim of the coaching programme is to help GPs develop their resilience and develop ways of self-management to combat burnout. Such a scheme is already operating successfully in NHS Lanarkshire. We intend to build on this success and offer a national coaching service across Scotland with an initial aim of providing four sessions of professional coaching to 100 self-identified GPs.

- **Staying in practice scheme (SIPS)** – we are revising and extending the current retainer scheme (which is currently limited to those with caring responsibilities). The aim is to widen access to scheme to those who are considering leaving general practice early due to workload pressures.
- **Support for GP appraisal** – GPs undertake appraisal annually, and this is an important part of staying up to date, ensuring high quality patient care and is a route to GMC revalidation. However, some GPs report that they find the preparatory work for appraisal burdensome and bureaucratic. Working with NES, we will provide funding for tailored appraisal support to GPs who wish it through a series of workshops. The workshops will support the individual needs of the GP, for example, the challenges some GPs experience navigating the appraisal website or the articulating reflective component of CPD and Quality Improvement activities.

⁹⁴ For a description of mentoring, including the benefits, see:

<https://www.bma.org.uk/advice/career/progress-your-career/mentoring>

⁹⁵ Faculty of Medical Leadership and Management (2017), *NHS England GP Coaching Pilot: Evaluation Report* <https://www.fmlm.ac.uk/news-opinion/nhs-england-gp-coaching-pilot-evaluation-report>

Support for rural GPs

We recognise that there are particular challenges in attracting and retaining GPs and other health professionals to Scotland's remote and rural communities. Along with the BMA we have committed to setting up a *Rural Short Life Working Group* which will support the implementation of the new GP Contract in rural areas. This will support the sustainability of remote and rural practices in particular for very small practices in remote areas.

An additional package of measures to support rural GPs includes:

- **Scottish Rural Medical Collaborative** – we will build on the current work of the collaborative to help target and tailor support to primary care services in remote and rural areas. It is anticipated that this may include a mentoring scheme for rural GPs, recruitment policies tailored for rural and remote areas, development of an overarching recruitment strategy, rural deprivation preference bursary to coach rural students prior to medical school application, including work experience.
- **GP for GP** – many very remote and rural GPs and their families have difficulty accessing routine general medical services, due to geography, remoteness or distance from registered GP. The NHS Highland GPs for GPs scheme, which has been running since 2003, provides a confidential service to rural GPs and their families at times of stress or illness, when they may have difficulty going to their own GP. In the past it has supported Highland GP's with problems such as stress, depression, inability to cope, and bereavement. We will extend this scheme to provide support for a greater number of remote and rural GPs across Scotland. This service is provided in addition to the GP Occupational Health Service which is available to all GPs and practice staff. The GP for GP scheme may refer or suggest self-referrals to the GP Occupational Health Service.
- **Relocation package** – we will encourage GPs to come and work in rural practices by offering an enhanced relocation package. The current scheme will be extended from a maximum of £2,000 to £5,000 to cover expenses such as removal costs, rent, etc. and we will widen the eligibility criteria from 44 Island practices to 160 remote and rural practices across Scotland.
- **Golden Hello** – to reflect the need to support sustainable rural services we will substantially expand the existing Golden Hello scheme from 44 to 160 practices in rural and remote areas, offering £10,000 for GPs taking up post in their first eligible rural practice.

Expanding the GP workforce

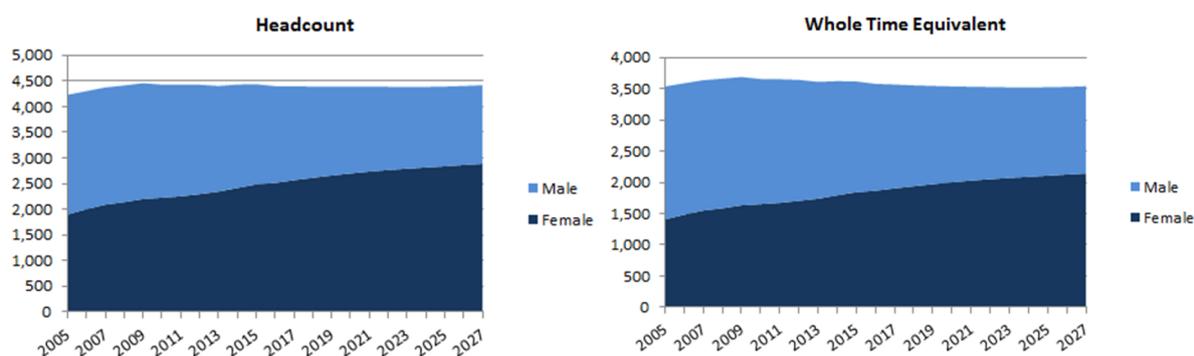
We know demand on primary care services will inevitably rise given increasing levels of multimorbidity from an ageing population and our strategic goal of shifting care from hospitals to community and home or homely settings. This requires a GP workforce that is both sufficient to meet demand but also flexible enough to address changing needs. As set out above, the new GMS contract is an important step in beginning to address workload issues by eliminating unnecessary bureaucracy,

reducing and streamlining the number of services that GP practices provide, and expanding and reconfiguring the primary care MDT.

But we recognise the need to go much further. We are able to estimate the number of GPs likely to be in the workforce over the next 10 years by modelling the age and gender of the current workforce, the number that typically leave and join the profession on an annual basis (whether new GPs completing training, flows in and out of Scotland, retirement, etc.) and taking account of increased part-time working.

Using data from the past five years we estimate that the number of GPs will remain broadly stable up to 2027. There is currently limited evidence that the GP workforce will contract significantly in the next decade, although this is difficult to assess with any degree of certainty and is based on a number of assumptions (e.g. that current rates of part-time working will remain unchanged). What does appear clear however is that the current workload issues are being driven by ever increasing demand of an ageing population rather than a significant reduction in GP capacity.

Figure 14: Forecast GP numbers to 2027⁹⁶



The anticipated stability in the size of the GP workforce is not sufficient to meet increasing demand, estimated to increase at around 1% annually. We are therefore committed to a package of measures to ease the pressure on GPs, both in terms of support to retain those that may be considering leaving the profession and in promoting general practice as an excellent career choice, both for those considering a career in medicine and those currently training to be a doctor.

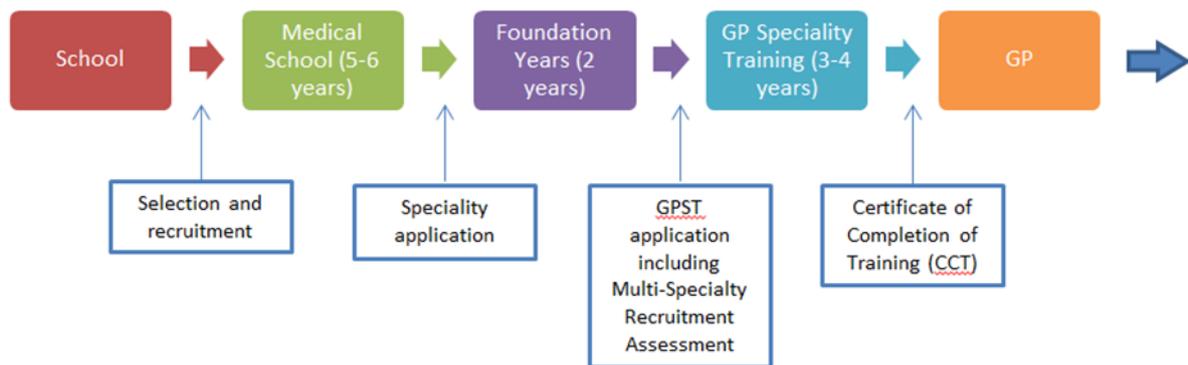
In December 2017 the Cabinet Secretary for Health and Sport committed to expanding the GP workforce by at least 800 GPs (headcount) over the next 10 years. We recognise the need for both short and longer-term initiatives to address current GP shortages and that there are no simple solutions to expanding the workforce. We need to be realistic on what can be achieved, and by when, but our commitment to increase GP capacity within primary care is clear. This commitment will require constant monitoring and review, based on better quality data (see Chapter seven).

⁹⁶ Analysis undertaken by Scottish Government. The WTE analysis was undertaken prior to the publication of the *Primary care Workforce Survey* that provides updated WTE data. The analysis will be re-run prior to the publication of the integrated workforce plan later this year.

Medical education and training

The Scottish Government is implementing and developing a range of medical education and training initiatives to increase the sustainability of the current and future workforce in Scotland. A number of strands of work are being taken forward and will address each stage of the GP career pathway set out below.

Figure 15: Medical education and training pipeline



(i) The Medical Education Package

The medical education package is a £23 million investment in undergraduate medical education. As part of that investment the Scottish Government increased the number of medical undergraduate places by 50 in 2016, and this increase was sustained for 2017 and will be again for 2018.

In addition, Scotland's first Graduate Entry Medical programme (ScotGEM) will commence in autumn 2018 adding a further 55 medical school places. The programme will be delivered by the medical schools in Dundee and St. Andrews in collaboration with the University of Highlands and Islands. This exciting new course focuses on primary care and remote and rural working offering immersive experience and aiming to attract students into these career paths.

The Scottish Government will pay the tuition fees of Scots domiciled and EU students who are accepted onto ScotGEM in order to offer as attractive a financial package as possible. Through ScotGEM we are also testing innovative retention methods. The Programme will also offer a 'return of service' bursary to all ScotGEM students. The scheme, to be administered by NHS Education for Scotland, will offer ScotGEM students a bursary of £4,000 per student per annum in return for a year of service up to a maximum of four bursaries and four equivalent years of service. We will evaluate ScotGEM over the short and long term, paying particular attention to the effectiveness of the return of service bursary and the numbers of ScotGEM graduates choosing a GP career.

(ii) Widening Access

As well as increasing capacity within medical schools, we are widening participation in medicine by promoting applications from talented young people from socially and

geographically disadvantaged situations. The 50 places added in 2016, for instance, are targeted at students from the most deprived 20% of Scotland's, as measured by the Scottish Index of Multiple Deprivation (SIMD).

The Scottish Government funded two new pre-medical entry courses at Glasgow and Aberdeen Universities, which commenced in autumn 2017. These courses support 40 places for pupils from less socially advantaged backgrounds to better prepare to undertake undergraduate medicine. This initiative supports key recommendations set out in the Report of *The Commission for Widening Access*, including a target that by 2030 students from the 20% most deprived backgrounds should represent 20% of entrants to higher education in Scotland. The programmes are also identifying school pupils from rural backgrounds who because of the size of their schools may experience disadvantage; this is an important part of the rural pipeline.

(iii) Proposed further action on medical school places

Part 1 of the National Workforce Plan committed to adding a further 50-100 undergraduate medical school places over the course of this Parliamentary term. These places will be awarded on a commissioning basis in line with strategic objectives which include significantly increasing the GP workforce. In order to attract as many young doctors into general practice as possible the Scottish Government has asked in particular for proposals which increase the percentage of clinical teaching that takes place in general practice to at least 25% of the clinical curriculum. It has also asked for proposals which ensure that all students are regularly selected, taught and/or assessed by GPs from the beginning of first year. The successful bids will be announced shortly.

Wider measures to increase exposure to primary care at undergraduate level

There is a clear need to address negative perceptions of careers in general practice. The RCGP's *Destination GP* report found a majority of students (91%) believe their peers hold negative views about general practice, and that they are most likely to associate the profession with being "boring", "lower status than other medical professions" and "less intellectually challenging"⁹⁷. Research from the UK and abroad shows that exposure to general practice has a positive influence on students considering general practice as a career⁹⁸. The RCGP has also found clinical placements in other specialities are particularly likely to expose students to negative views of general practice⁹⁹. Equally, evidence demonstrates that medical students' perception of their GP teachers' job satisfaction positively affects their wish to become GPs¹⁰⁰.

⁹⁷ Royal College of General Practitioners (2017), *Destination GP: Medical students' experiences and perceptions of general practice* <http://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2017/RCGP-destination-GP-nov-2017.ashx?la=en>

⁹⁸ Howe A., and Ives, G. (2001) *Does community-based experience alter career preference? New evidence from a prospective longitudinal cohort study of undergraduate medical students*. *Med Educ* 35(4):391–397

⁹⁹ Royal College of General Practitioners (2017), *Destination GP: Medical students' experiences and perceptions of general practice*

¹⁰⁰ Harding A, McKinley R, Rosenthal J, Al-Seaidy M (2015) *Funding the teaching of medical students in general practice: a formula for the future?* *Educ Prim Care* 26(4):215–219

Currently some Scottish Universities teach as little as approximately a tenth of their clinical curriculum in primary care. Despite GPs comprising around 27% of the medical workforce, the UK's academic GPs account for only about 6% of all clinical academics¹⁰¹. We recognise that increasing clinical teaching in primary care and by primary care practitioners brings with it a number of complex challenges for medical schools and the Service and we do not underestimate these. As noted, these include the need to increase the number of GP educators and issues around competing demands on GP practice's time and around ACT funding and infrastructure. Under the joint auspices of the Scottish Government and the Board for Academic Medicine, we have established an *Increasing Undergraduate Education in Primary Care Working Group*, chaired by Professor John Gillies. It will consider ways of increasing undergraduate education in primary care settings, within a challenging but realistic timescale.

Post Graduate Medical Training

In 2016, as part of our programme to grow the numbers of graduates entering General Practice Specialist Training (GPST), 100 additional posts were introduced in Scotland, coupled with a further round of recruitment to maximise the number of posts filled. In recognition of yearly recruitment data and trainee feedback indicating persistent problems in filling unpopular four-year GPST posts where the 4th year of training is spent in hospital based posts, the Scottish Government asked NHS Education Scotland to reconfigure the balance of 3 and 4 year training programmes to prioritise 3 year rotations which maximised educational quality and ensured these posts met the curricular requirements. These measures will contribute towards making unpopular GPST posts more attractive options for potential trainees and help improve overall fill rates. Work to phase out educationally poor posts in favour of high quality 3 year rotations will continue in 2018 and 2019.

In tandem, to promote General Practice as an attractive career choice, a one-off bursary of £20,000 is available to trainees in posts that historically have found it more difficult to recruit including the Scottish National Rural Track Programme posts. The bursary payment is made to trainees as a lump sum on taking up the post and in return they agree to complete the three year placement in that location. If the trainees leave before completing three years they then have to repay the bursary.

Preliminary assessment of this initiative has shown there is a more even distribution of trainees, away from central areas and towards some harder to fill posts in rural areas.

To assist with increasing the number of doctors choosing a career in general practice we intend to offer additional support to foundation level doctors keen to undertake GPST. Where candidates have been unsuccessful in the GPST selection process, we would like to offer a 1 year development post with tailored support to equip individuals for re-application for subsequent GPST recruitment. A financial incentive would be offered to GP Trainers for supporting these candidates during their

¹⁰¹ Centre for Workforce Intelligence (2014) *In-depth review of the general practitioner workforce: Final report*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/507493/CfWI_GP_in-depth_review.pdf

development post. We are in the process of gauging interest from previously unsuccessful GPST candidates in such a scheme.

Shape of Training

The Scottish Government is also committed to implementation of recommendations arising from Professor Sir David Greenaway's *Shape of Training: Securing the future of Excellent Patient Care review*¹⁰² as outlined within the report of the UK-wide Shape of Training Review Steering Group published in August 2017. Many of these recommendations align with the transformational plans already set out by the Scottish Government. In relation to GP training, the commitment is to develop an enhanced training model in which qualified GPs are offered a further year of training to furnish them with additional skills. It is clear that the development of additional skills must be responsive to local provider and patient needs and complement the Expert Medical Generalist role, particularly the increasing delivery of complex care in the community. It is also evident that there is a clear desire by many GPs to enhance their skills and experience complementary to their Expert Medical Generalist role, which facilitates a portfolio career. Against that background there are a number of formats which a further optional year of post CCT training or development could take and in conjunction with key stakeholders, including the BMA and RCGP, we will continue to develop and test a variety of options.

Additional measures to increase GP numbers

(i) Marketing and recruitment campaign

Scotland has a lot to offer its GPs – no bureaucratic Quality Outcomes Framework (QOF), no clinical commissioning and a new GMS Contract that refines and focuses the role of the GP as an Expert Medical Generalist and clinical leader of an expanded MDT. Patient satisfaction is consistently high with 87% rating the overall care provided by their GP practice as good or excellent in 2015-6¹⁰³. Scotland is also blessed with natural beauty and a vibrant and tolerant culture, and is an excellent place to bring up a family.

We must do more to make the best use of these assets and promote Scotland as a great destination for GPs to relocate. We will therefore launch a GP marketing and recruitment campaign during 2018 to increase the number of GPs who wish to work in Scotland from the rest of UK and overseas. The aim of the campaign will be to improve the way we market abroad the opportunities to work in NHS Scotland, improved the use of SHOW website, and to build better targeted and more effective advertisement of Scottish jobs in England and elsewhere.

We will look at opportunities to employ a recruitment agency to work run alongside the marketing campaign. Scottish recruitment agencies are already working with individual health boards to attract GPs to Scotland; working at scale will offer additional advantages and better value for money. This could include access to databases, recruitment events, headhunting, support and pastoral care during and

¹⁰² <https://www.shapeoftraining.co.uk/reviewssofar/1788.asp>

¹⁰³ Scottish Government (2016), *Health and Care Experience Survey 2015/16 - National Results*
<http://www.gov.scot/Publications/2016/05/9045>

after recruitment. We will ensure consistency and coordination with the planned marketing campaign to attract nurses to work in NHS Scotland.

(ii) Exploring ways to enable doctors to switch specialities

At present most registrars / consultants who wish to become GPs are required to undertake the full three year GP training. This is perceived as a barrier to moving into general practice. We propose working with NES and others to consider ways in which this route to general practice could be better supported. This can be achieved but needs a substantial amount of work to be put in place by 2019.

Conclusion

We recognise the workload challenges currently facing our GPs and the need to expand both GP numbers and the wider MDT that will help deliver the aspirations set out in the new GMS Contract. Our intention to increase GP numbers by at least 800 (headcount) over ten years is ambitious, but our assessment is that it is achievable through a range of measures targeted at every stage from medical school through to late career. It is an essential component of building a strong and sustainable primary care system which will continue to serve as the bedrock of the NHS in the years ahead.

CHAPTER SIX: PLANNING AND DEVELOPING THE MULTIDISCIPLINARY WORKFORCE - WIDER CLINICAL AND NON-CLINICAL WORKFORCE

- We will build a sustainable pharmacotherapy service in Scotland that includes access to pharmacist and pharmacy technician support for every GP practice.
- Faster and more efficient whole system pathways will support patients with musculoskeletal conditions, led by physiotherapists.
- There will be a significantly enhanced paramedic provision in all Integration Authorities, aligned to clusters, based on local service design, and delivered via the commitment to train an additional 1,000 paramedics to work in the community.
- We will see a developed and enhanced role for allied health professionals in supporting patients' needs, including promoting prevention and self-management with improved access.
- We are committed to increasing the mental health workforce in A&Es, GP practices, police station custody suites and prisons by 800. Supported by investment of £12 million in 2018-19, with annual investment rising to £35 million by 2021-22.
- There will be 250 community links workers in place by 2021, reducing practice workload and supporting patients' holistic needs.
- We will support enhanced training and support for practice managers and practice receptionists to develop their roles, supported by continued investment.
- There will be increasing use of community pharmacy for improving population health, managing self-limiting illnesses and supporting self-management of stable long term conditions in- and out-of-hours, and an expanded workforce.
- We will work with stakeholders to consider the need for a proposed marketing campaign to attract individuals into allied health professions to ensure a sustainable workforce is available to meet Scotland's future requirements.

Introduction

The previous two chapters set out our approaches to enhancing and expanding the nursing and GP workforces. In this chapter we focus on how we will develop the wider clinical and non-clinical workforce to ensure enhanced MDT models of care will provide patients with the most appropriate treatment, as quickly as possible, by the most appropriate practitioner in the most appropriate setting. This includes models being developed for pharmacy, musculoskeletal physiotherapists, mental health workers, community links workers and paramedics as first point of contact. To ensure effective MDT working that delivers high quality person-centred care, local planners will need to give consideration to the collective mix of generalist and

specialist skills within each team and service. This will be facilitated by the development of more comprehensive workforce data, as set out in the final chapter.

Physiotherapists

Neck and lower back pain generates the second highest burden of disease in Scotland¹⁰⁴. Early intervention and self-management can have a significant impact in preventing chronicity of these conditions. Musculoskeletal (MSK) health issues are a common cause of GP appointments but the majority of a GP's MSK caseload can be seen safely and effectively by a physiotherapist without a GP referral. However the existing patient pathway often includes an unnecessary delay while initial non-physiotherapeutic solutions are attempted prior to access to an MSK Physiotherapy service. While there is no waiting time to access advice via the Musculoskeletal Assessment and Treatment Service (MATS), there are variable waiting times across the country for access to face to face physiotherapy. Under a new model, physiotherapist's could provide first point of contact appointments providing assessment, diagnosis (including access to diagnostics), advice and onward referral to secondary care services if appropriate. Where they have appropriate training and skill mix, MSK physiotherapists should carry out prescribing as well as treatments such as injections. This will enable a faster and more efficient whole system pathway for patients with MSK conditions.

A sustainable Physiotherapy / Advanced Practice Physiotherapy provision should be considered by all Integration Authorities in developing their Primary Care Improvement Plans, potentially aligned to GP clusters. A significant proportion of the current workforce either already has the skills required, or could be quickly up-skilled to take on these roles. However, the training of new physiotherapists will take time, with undergraduate training currently lasting two to four years, therefore a transitional phase would be required to enable a sustainable model to be achieved.

New models of MSK physiotherapy provision have been tested across Scotland as part of the Primary Care Transformation Fund. The Scottish School of Primary Care is evaluating selected models on behalf of the Scottish Government. The study will help us understand the context in which the new models of MSK physiotherapy were tested, and examine the barriers and facilitators to deployment and uptake that were met by the test sites. It will also consider how well, in early sites, the changes have been embedded as part of routine practice, and consider sustainability issues. A report setting out key findings will be published by the end of 2018.

Future AHP workforce

NHS Boards across Scotland have indicated challenges around recruitment across all of the AHP workforce, but particularly affecting physiotherapy. The numbers entering the Allied Health Professions are not currently controlled, and are largely determined by supply and demand factors. The potential for a more managed approach to workforce planning for those training to become AHPs is being explored.

¹⁰⁴ Scottish Public Health Observatory (2017), *The Scottish Burden of Disease Study, 2015*
<http://www.scotpho.org.uk/media/1474/sbod2015-overview-report-july17.pdf>

Consideration is also being given to the potential for other, faster, routes into the professions such as return to practice and post graduate training.

In addition, we will work with a range of stakeholders to consider how best to attract and retain people into AHP careers – particularly for those professions where it is already difficult to recruit to such as physiotherapy. As part of this wider work, we will consider the potential need for a marketing and recruitment campaign.

Pharmacists and pharmacy technicians

A three-tiered pharmacotherapy service is to be implemented in a phased approach with the aim of introducing a sustainable service that includes access to pharmacist and pharmacy technician support in every GP practice by 2021 as set out in the Memorandum of Understanding. Level one is a core service that will be made available to all GP practices, with activities at a generalist level of pharmacy practice focused on acute, repeat and serial prescribing, medication management and prescribing efficiencies (technical and basic clinical roles). Levels two (intermediate) and level three (advanced) are additional services and describe a progressively evolving stage of clinical pharmacy practice and experience which includes medication and polypharmacy reviews. The levels of support will take into account the needs of individual practices and practice clusters by planners at local level.

The Inverclyde *New Ways of Working* pilot provided an average of 0.5 WTE pharmacist per practice alongside some pharmacy technician involvement. Another model, which better accommodates the needs of remote and rural practices is 1 pharmacist per 10,000 list size.

The pharmacotherapy service will be led by the Directors of Pharmacy for the three year trajectory period to allow workforce planning to be supported, appropriate governance arrangements embedded and the successful initial momentum to be maintained. This will also allow the service to reach a level of maturity before being reviewed with the view to a handover to Integrated Authorities. A national implementation group has been established to support the delivery of the service.

Approximately one third of GP practices currently have pharmacy input supported by Primary Care Funding. Boards have adopted a number of different delivery models, including sessional input from hospital and community pharmacists, and split posts between practices and locality approaches. We will continue to work closely with NHS Boards to monitor progress against the Programme for Government commitment and to ensure that recruitment to the new pharmacotherapy service is delivered in a sustainable way so as to minimise any risk of destabilising other parts of the system. That is why a phased approach to the recruitment of pharmacists and pharmacy technicians into general practice has been essential.

The commitment that every GP practice will receive pharmacist and pharmacy technician support by 2021, through the Pharmacotherapy Service, is being supported through the Primary Care Fund. The funding available in 2017-18 for general practice pharmacy support was increased by a further £4.2 million. Based on this additional funding over and above the original three year figure of £16.2 million, by the end of March 2018, NHS Boards planned to have appointed over 200 whole

time equivalent pharmacists and over 50 whole time equivalent pharmacy technicians working with or within GP practices. Outturn figures up to the end of March 2018 are currently being gathered.

As part of their Primary Care Improvement Plans (PCIPs) Integration Authorities and Health Boards will be updating their plans for 2018-19 up to the end of 2021 and this will be reflected in future iterations of the workforce plan.

An evaluation of the workforce aspects of the GP practice-based pharmacists and pharmacy technicians should be available by the end of 2018 and the early findings, alongside the Inverclyde evaluation, will be used to inform detailed workforce planning work to identify how many additional pharmacists will be required to deliver full roll-out of the pharmacotherapy service.

Developing the future pharmacist workforce

Community Pharmacy

Community pharmacy already plays an important role in the provision of NHS pharmaceutical care, providing highly accessible services for people both in-hours and out-of-hours. We want more people to use their community pharmacy as a first port of call, not only for the treatment of self-limiting illnesses and medicine-related matters, but for the on-going self-management support for people with long term conditions. Enhancing these services also expands the clinical role of community pharmacists.

*Achieving Excellence in Pharmaceutical Care*¹⁰⁵ committed to working in collaboration with NHS Education for Scotland and other key stakeholders to understand and address future pharmacy workforce requirements. It describes the need to further build the clinical capacity within community pharmacy and our commitment to target resources to expand the number of community pharmacists undertaking independent prescribing and advanced clinical skills training. This includes exploring how resources to cover back-fill for the residential training and period of learning in practice can be provided in order to build clinical capacity to deliver an extended Minor Ailment Service and enhanced Chronic Medication Service.

Given the importance of community pharmacy in helping transform our primary care services, in Chapter 7 we describe how for the first time we have undertaken a national community pharmacy workforce survey to provide the necessary insights into staff numbers and skill mix to meet the challenges of delivering new models of primary care. Crucially this will inform national workforce planning and the educational needs of the profession in this sector.

¹⁰⁵ Scottish Government (2017), *Achieving Excellence in Pharmaceutical Care: A Strategy for Scotland* <http://www.gov.scot/Publications/2017/08/4589>

The Pharmacotherapy Service

With regard to the pharmacotherapy service in GP practices, there are a number of additional implementation factors that need to be considered alongside the number of pharmacists and pharmacy technicians required to deliver it. This includes their education and development and importantly securing the pipeline of new pharmacists.

Depending on the experience of the pharmacists and pharmacy technicians working in GP practices there can be a need for additional training, this includes advanced clinical and independent prescribing skills. This will also require appropriate levels of clinical mentorship. Resources have been identified and allocated to Boards to support this. Additionally, the new NES vocational training programme for pharmacists in primary care and community pharmacy will contribute towards ensuring early career pharmacists build skills and capability. A *General Practice Clinical Pharmacist Competency and Capability Framework*¹⁰⁶ has been developed to underpin the education and training needs of pharmacists supporting GPs going forward.

As a first step, and in order to increase the pool of qualified pharmacists available to provide the pharmacotherapy service, additional funding has been secured to increase the number of NES pre-registration pharmacist training posts from 170 to 200 per year from 2018/19 onwards.

Paramedics

A number of tests of change in Scotland over the last two years have focused on the role of paramedics in primary care. Evidence from pilots in Inverclyde, Hawick and Kelso shows that support (such as responding to urgent call out to patients) allows GPs to provide more appropriate patient care. The Inverclyde Pilot, for example, found that in the first three months following paramedic support to practices being put in place, the percentages of home visits carried out by GPs reduced by over 60%¹⁰⁷. Paramedics are equipped to consult with unscheduled urgent care presentations, making them an ideal fit to work with primary care colleagues. This model will free up GPs' time to focus on their EMG role by reducing appointments and home visit requests for unscheduled and urgent care presentations.

This model also supports paramedics to practice their skills at the highest level of their professional competence, consolidate their learning, gain exposure to and experience of patients with acute illness and injury and develop closer relationships with primary care colleagues, becoming part of a wider multi-disciplinary team. It helps support the *Memorandum of Understanding*, which specifies that advanced practitioners, such as paramedics, should be used to respond to urgent care appointments, such as home visits, in place of the GP. These practitioners will be aligned to clusters as appropriate and be based on local service design and working

¹⁰⁶ The Framework is available to the Pharmacists funded via the Primary Care Fund, who access an electronic version via Portfolio on the NES TURAS platform. Additional information is available at: <http://www.nes.scot.nhs.uk/education-and-training/by-discipline/pharmacy/pharmacists/prescribing-and-clinical-skills/pharmacists-working-in-gp-practices.aspx>

¹⁰⁷ <http://www.gov.scot/Resource/0052/00527530.pdf>

during core general practice hours, as well as out of hours. These paramedics will assess and treat patients in a range of settings, including urgent and emergency care presentations, home visits and Health Centre attendees.

As autonomous practitioners, paramedics will not require regular supervision by the GP within a cluster, but will need access to support when issues outwith their scope of practice arise. While this will be provided by a clinician, this may not necessarily be the GP. Supervision for paramedics working within a practice will always be agreed under the GPs clinical oversight. Peer supervision with clinical oversight and leadership from the GP will be encouraged under this new model.

Paramedics and advanced paramedics will continue to be employed by the Scottish Ambulance Service (SAS). As part of the Primary Care Improvement Plans, we expect the SAS to work with Integration Authorities to set out what support is required at a local level, using evidence gathered from current tests of change, such as in Inverclyde. This will include developing robust clinical governance frameworks and evaluating practice data.

SAS will integrate all existing pilot activity, such as the work being carried out in Inverclyde, into a single national programme of work to transform primary care in a 'Once for Scotland' approach. This will include developing robust clinical governance frameworks and evaluating practice data. As part of the Primary Care Improvement Plans, we expect the Scottish Ambulance Service to work with local Health and Social Care Partnerships to set out what support is required at a local level.

Patient safety will be fundamental in delivering this workforce at scale. At all stages of the roll-out, we will ensure the available workforce is appropriate to ensure the safety of patients requiring urgent unscheduled care is assured, and core ambulance services are not negatively impacted. This will require consistent and reliable provision of paramedic staff working in primary care teams, appropriate training and education, supervision and support arrangements, and, crucially, positive relationships between colleagues in the MDT.

Future paramedics workforce

There will be an increase in paramedics and advanced paramedics in the coming years. The Scottish Government has committed to training 1,000 additional paramedics during this Parliament to work in Scotland's communities to deliver more care at home. This is also in alignment with the Scottish Ambulance Service's strategy *Towards 2020: Taking Care to the Patient*¹⁰⁸ – focusing on increasing the Service's capacity for care at home or in the community. This role could be further enhanced as plans are now underway to allow paramedics to become independent prescribers.

Current paramedic training is carried out through a two year diploma in higher education and Scotland's first undergraduate BSc in Paramedic Science commenced in September 2017. Following publication of the *Paramedic Evidence*

¹⁰⁸ Scottish Ambulance Service [Towards 2020: Taking Care to the Patient](#)

Based Education Report (PEEP)¹⁰⁹ in 2013, a consultation is now underway to explore changing the training to be undertaken as a degree. This may impact on the availability of workforce due to longer training times and we will work with SAS and other stakeholders to ensure suitable transitional arrangements are in place.

Mental health workers

Mental health issues are a common feature of primary care consultations. For instance, Scottish research in primary care showed that depression is associated with a wide range of physical health conditions and is a significant burden on primary care¹¹⁰. Across a range of conditions, each patient with co-morbid depression costs health services between 30% and 140% more than equivalent patients without depression¹¹¹.

Appropriately skilling our primary care workforce to ensure they are confident in dealing with mental health problems is crucial. Mental health expertise therefore needs to be embedded in multi-disciplinary primary care teams through a mixture of specialist mental health workers and by ensuring that other professionals are mental health trained / aware.

A £10 million Primary Care Mental Health Fund (PCMHF) has allowed different services to try different approaches to improving mental health provision. The Scottish School of Primary Care is undertaking an evaluation of a range of projects funded by the Primary Care Transformation Fund and the PCMHF. The evaluation will comprise case studies with a geographic and thematic focus and will be published in Autumn 2018.

Future mental health workforce

The *Mental Health Strategy for 2017-2027*¹¹² recognises the importance of primary care transformation and sees it as an opportunity to improve services for people with mental health problems with parity of esteem between physical and mental health. This includes Action 23 which is a commitment to test and evaluate the most effective and sustainable models of supporting mental health in primary care, by 2019.

In addition, Action 15 states that we will increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. It commits to increasing additional investment to £35 million per annum by 2021-22 (including £12 million in 2018-19) for 800 additional mental health workers in those key settings.

¹⁰⁹ <https://www.collegeofparamedics.co.uk/downloads/PEEP-Report.pdf>

¹¹⁰ Smith, D. et al (2014) *Depression and multimorbidity: a cross-sectional study of 1,751,841 patients in primary care*, J Clin Psychiatry. 2014 Nov;75(11):1202-8

¹¹¹ Melek S. Norris D. (2008), *Chronic Conditions and Comorbid Psychological Disorders*. Seattle: Milliman Research Report

¹¹² Scottish Government (2017), *Mental Health Strategy 2017-2027*
<http://www.gov.scot/Publications/2017/03/1750>

There are a number of implementation factors which need to be considered in respect of the delivery of this commitment. These include the commissioning arrangements of each Integration Authority and how to align the roles of services from both a national and local perspective in order to balance the skills and capacity for this additional workforce.

The Scottish Government has asked the Health and Justice Collaboration Improvement Board (which includes senior public sector leaders who, amongst other responsibilities, identify and address organisational and systemic barriers to working collaboratively) to develop recommendations on how to achieve Action 15 from 2018-19.

Wider Clinical Roles

There are a range of other roles as part of the MDT that can offer high quality care as part of a comprehensive and person-centred service.

Healthcare Scientists are the fourth largest clinical group, who collectively are responsible for over 80% of all clinical diagnoses¹¹³. This workforce covers over 50 different scientific specialities and is the specialist workforce in the health system that responds directly and uniquely to advancing scientific and technological changes.

A more holistic approach to treatment pathways could see scientists integrated into patient pathways, and working in multi-disciplinary teams as part of a whole systems approach. The ability to support patients with complex needs at home will increasingly rely on the use of networked medical technology supported by Medical Physics and Clinical Engineering services in collaboration with eHealth. Clinical Engineering services are already experienced in supporting equipment, such as portable ventilators and assistive technology, in the community and this expertise can be utilised to allow the roll out of other medical equipment for use in the non-hospital settings in a safe, controlled manner.

Healthcare Scientists can contribute to reducing out-patient attendance such as for Audiology, Cardiac Physiology and Respiratory Physiology where what are typically “routine” out-patient attendances for investigations and rehabilitation can be delivered in local setting e.g. community hospital type setting. Pharmacists and healthcare scientists are working together to develop models of point of care testing in community treatment centres.

Dieticians can now train as supplementary prescribers and have the skills and knowledge to help manage conditions such as irritable bowel syndrome, reducing referral to secondary care and improving symptoms for 70% of people, type 2 diabetes and food intolerance conditions¹¹⁴.

113

<http://www.nhsemployers.org/~media/Employers/Publications/Healthcare%20scientists%20in%20the%20NHS%202013%20April%20final.pdf>

¹¹⁴ Williams M. (2013), *The importance and practical implementation of the LOW FODMAP Diet*. Complete Nutrition Focus; 5(1): 9-11

Mental health problems and presentations of distress are common in primary care. Early intervention can prevent later mental ill health and improves outcomes for the person. The prevalence of mental illness also has a profound effect upon our success in treating physical illness. Mental health presentations can be seen in the first instance by a primary care mental health practitioner (PCMHP). Occupational Therapists (OTs), working as a first point of contact practitioners in general practice, are providing quick access to early assessment and intervention for people with emerging mental health problems. When required the therapist can signpost and refer to third sector and other healthcare professionals as appropriate.

OTs have particular expertise in helping people who are frail or have long term conditions. The benefits of this role include enabling independence and social inclusion; preventing deterioration; and minimising crisis situations, thus reducing demand on GP practices and acute admissions.

A fully integrated primary care podiatry service can safely diagnose, manage, rehabilitate and prevent disease related complications of the feet, ankles and lower limbs, particularly around MSK, diabetes, rheumatoid conditions and peripheral arterial disease. They also have a significant role in the public health and prevention agenda specifically around falls prevention, cardiovascular risk reduction, medicines management and reconciliation, antibiotic stewardship and keeping people mobile and active.

Podiatrists have the ability to utilise advanced diagnostic techniques including imaging and can prescribe independently, for a range of lower limb conditions. As the experts in lower limb health and disease, podiatrists have the requisite knowledge, skills and training to work as first point of contact practitioners in primary care

Speech and language therapists have the specialist knowledge and skills to diagnose, directly assess and support problems in relation to communication, safe eating, drinking and swallowing. The assessment and management of eating, drinking and swallowing problems has an important role in to prevent malnutrition and dehydration, reduction the risk of repeated chest infections, urinary tract infections and falls.

Dentists

The 2016 dental workforce report¹¹⁵ is the latest in a series of biennial dental workforce reports that aim to inform workforce planning for dental services in Scotland. The report examines supply and demand for services based on several contributory factors including uptake of services, population projections, changes in demography, country of qualification of the dentists and the years spent in the service post qualification.

On the current trajectory our dentist workforce will exceed the needs of the projected Scottish population by 2026. To help counter this potential future over-supply of

¹¹⁵ NHS Education for Scotland (2016), *The Dental Workforce in Scotland 2016*
<http://www.nes.scot.nhs.uk/dental-workforce1.html>

dentists we have reduced the dental school in-take of Scottish, Rest of the UK and EU dental students to 135 per year. The impact of this reduction will begin from June 2018 onwards.

However, when planning the dentist workforce it is necessary to consider the make-up of the workforce going forward, in particular the number of EU dentists and the possible impact Brexit may have. Primary Care dental services in remote and rural areas have a higher non-UK dentist workforce, made up of EU and international dentists, and would potentially feel the effects of any Brexit impact more acutely than other parts of the country.

Dentists wishing to provide NHS General Dental Services in Scotland, unless otherwise exempt, have to complete a vocational training (VT) period of one year duration. Three-quarters of dentists who started working in Scotland after finishing VT in the UK were still in NHS Scotland six years later. If, however, they entered NHS Scotland from the EEA only 46% remained after six years. After 10 years more than half of vocational dental practitioners stayed in NHS Scotland. Currently approximately 10% of GDCs in Scotland qualified in the EEA but in recent years there is the beginning of a trend of these numbers reducing. Since the distribution of EEA dentists is skewed towards remote and rural areas, this is a concern for the future. We will continue to monitor trends in the profile of dentists via the biennial workforce plans.

Dental Care Professionals

The role of dental care professionals (DCPs), also has to be taken into account when planning the dental workforce. Approximately 40 new dental therapists qualify every year. As the emphasis on care moves towards prevention and there is an increasing need to consider the on-going care of older people the more potential there is for greater involvement of DCPs particularly therapists. Direct Access to DCPs (instead of patients visiting a dentist first) may enable them to contribute significantly more than at present but legal challenges to introduce this arrangement will first have to be overcome.

Optometry

Optometry plays a key role in the provision of community care. This has developed since the introduction of free NHS funded eye examinations in 2006, to the service being the first port of call for people with eye problems, helping to detect eye diseases early. More integrated care is being provided in local practices, with community optometry supporting pharmacy, GP, nursing, social care and third sector colleagues to help patients remain within primary care. The development of General Ophthalmic Services (GOS) to support community eye care has reduced the burden on GPs and has allowed more patients to be discharged from the hospital eye service. Age is the greatest risk factor for developing eye conditions, and training is being developed to enable safe and high quality community care for patients with long-term ophthalmic conditions.

The *Community Eyecare Services Review*¹¹⁶ was commissioned by the Cabinet Secretary for Health and Sport in 2016 to consider and evaluate community eyecare services currently provided across Scotland, and identify examples of good practice that could be replicated on a national basis. The Review also forms part of the *Health and Social Care Delivery Plan*. The Review made a number of recommendations, including schemes to reduce geographical differences in services, more tailored arrangements for patients with specific complex needs to support care closer to home, and suggested that some eye services traditionally offered in hospitals (such as post-cataract surgery appointments and managing stable glaucoma patients) should be made available locally. The Scottish Government is in the process of implementing the recommendations of the Review, including the development of new GOS regulations, and is engaging with a range of stakeholders, including health professionals and patients.

Non-clinical staff

Community Links Workers (CLW)

Community links workers (CLW) have a specialist or generic non-clinical role in the primary care workforce. Their purpose is to improve patient health and well-being, reduce pressure on general practice and tackle health inequalities. To be most effective a CLW should be integrated or embedded in general practice, provide a non-clinical intervention which meets the needs and demands of the practice and practice population and is employed by a local authority or third sector organisation.

They provide an essential role in tackling deprivation, and the needs of those who have complex conditions, are socially isolated, or live far from other support. Following successful piloting in areas of high socio-economic deprivation, there are now CLWs in place in several areas. There are also numerous staff fulfilling comparable roles across the country with a range of job titles. Many CLWs are generalists, but staff providing specialist non-clinical support specifically with, for example, welfare issues or supporting mental health are providing equally valid services to patients who need it, and form part of our overall approach to CLWs.

CLWs are one of the six key services that, in future, will be provided to patients in GP practices or clusters of GP practices by Health Boards under the new GP contract. Their roles will be designed, commissioned and planned by Health and Social Care Partnerships, based on assessment of local need, working hand in hand with local GPs, patients and the third sector. This will be a locally-determined and delivered service, built up across the country to deliver our overall national commitment to at least 250 staff as per the Scottish Government's commitment. The new GMS contract National Oversight Group will ensure that the service is being rolled out at pace nationwide over the next three years.

¹¹⁶ Scottish Government (2017), *Community Eyecare Services Review*
<http://www.gov.scot/Resource/0051/00516810.pdf>

Practice manager and receptionists

Primary care transformation presents an opportunity to consider how non-clinical staff (practice managers and receptionists) can be up-skilled to help coordinate care as part of a wider MDT.

Practice Managers have a key role in ensuring the smooth and efficient day to day running of General Practices and the long term strategic management and co-ordination of primary care, including supporting the development of the multi-disciplinary team as set out in the new 2018 GP Contract.

With the introduction of the 2018 contract the need for Practice Managers with wide ranging, adaptable and versatile skills is going to increase as General Practice and Primary Care becomes a more complex landscape. In addition to continuing to manage the practice employed practice team and dealing with other practice based issues, their role working with external stakeholders including GP Clusters, Health Boards and HSCPs is going to develop and expand. Working closely with the developing services such as Vaccinations and Community Care and Treatment Services and other members of the multi-disciplinary teams that will be working in the practice or with the practice team will be vital. Coordination and communication with these new services will be crucially important across a range of issues including access to IT systems and supporting patients to access services.

Practice Managers therefore require a wide range of skills including financial management, IT management, HR management, contract management, leadership and facilitation, Quality Improvement skills, change management, communication and patient engagement skills. Following the announcement in May 2017 of £500,000 investment in the development of Practice Managers and Practice Receptionists, work is on-going with NES to work with Practice Managers to identify their training needs for the future, and make sure those needs are met over the next few years. Career development and succession planning is also going to be important for the profession going forward and is also being considered.

Alongside the changing role of Practice Managers, the role of receptionists and other non-clinical staff in the practice has also changed and developed and will continue to do so.

Practice Receptionists have a challenging role, managing patients' requests and expectations, often in difficult circumstances. They play a vital role both now and in the future which needs to be recognised, valued, supported and developed. In some practices the title of Practice Receptionist is now considered to be outdated and does not fully reflect their role and there should be consideration of a revised job title in future. Opportunities such as developing and up skilling practice receptionists to carry out care navigation of patients in this increasingly complex primary care landscape or to increase their role in the management of practice documentation , is currently being developed with NHS Healthcare Improvement Scotland who will be working with GP Clusters to develop training and resources to support this group of staff.

There is also a wide range of other practice administrative staff who carry out a variety of tasks depending on the needs of the practice from prescription management, medical secretarial skills, IT management including call and recall, documentation management, health and safety, finance management, and healthcare assistant roles. These staff are a highly skilled and adaptable workforce, who will continue to have an important role in the delivery of care by general practices. Strong leadership by Practice Managers supported by their teams and by the practice GPs is vital.

NHS 24

NHS 24's 111 service is at the forefront of delivering safe and effective urgent care and support to the public when GP practices are closed. As a national organisation NHS 24 has a unique opportunity through its infrastructure to align itself more closely with primary care, social care, and voluntary and independent sectors, in response to key drivers including Health and Social Care Integration, Primary Care Transformation, and national strategies such as the National Clinical Strategy. It is anticipated that over the next five years, to support the programme of development, an additional 371 WTE staff will require to be recruited. This represents an increase of approximately 40% of NHS 24's existing workforce. The majority of the resource requirements, approximately 65%, are for non-clinical staff, call handlers in particular, however, there will also be a requirement for NHS 24 to grow its requirement for clinical staff, including more nurse practitioners, advanced nurse practitioners, mental health nurses, general practitioners, and allied health professionals. With these additional staff in place, we would expect NHS 24 to work with Health and Social Care Partnerships to set out what support NHS 24 can offer at a local level, including the triage of patients to general practice or to self-management pathways as part of the Primary Care Improvement Plans

Conclusion

This chapter set out new models of care that will ensure quality service provision and build MDT capacity in local communities. To service these models we are re-configuring services both at a national and local level with associated investment. Nationally we are beginning to ensure through better workforce planning across all primary care professions the education and supply pipeline is adequately resourced and planned to ensure a sustainable workforce that takes account of changing trends.

CHAPTER SEVEN: A DATA AND INTELLIGENCE LED PRIMARY CARE

- Enhanced workforce data across 3 broad GMS contract areas: workforce, GP income and expenses, and quality improvement and sustainability/clinical activity.
- Improvements underway in collection of AHP, pharmacy and optometry workforce and activity data.
- Roll out of the Scottish Primary Care Information Resource (SPIRE), enabling health professionals and GP clusters to work more effectively together to improve the quality of care.
- Expansion of the successful Local Intelligence Support Team (LIST) programme into primary care to support GP Clusters deliver quality improvement.
- Development of the NES workforce data platform and supply modelling.
- The Primary Care Digital Services Development Fund, 2016-2018 delivering a wide range of systems enhancements, infrastructure improvements and innovative trials of new tools and technologies.
- Development of a 10 year Primary Care Monitoring and Evaluation Strategy to understand and share learning, including progress in delivering the commitments set out in this plan.

Introduction

The importance of good quality and timely data and the capacity to use it to drive the reform of primary care and quality improvement cannot be under-estimated. We are aware of the need to strengthen the primary care data we collect, and ensure the right healthcare professional has the right access to the right data at the right time to improve patient outcomes. We are currently rolling out a significant programme of work and investment to enable consistent, high quality and reliable data to be sourced, managed and utilised appropriately.

Workforce data

The *Primary Care Workforce Survey* is designed to capture aggregate workforce information from Scottish general practices and NHS Board-run GP Out of Hours services. The survey provides information on GPs, registered nurses (including nurse practitioners) and other clinical staff employed by Scottish general practices. It also collates data on vacancies, temporary cover for sessions / hours and out of hours commitments. The 2017 workforce survey was published in March 2018¹¹⁷.

In recognition of the importance of reliable workforce data we have agreed with the BMA as part of the new GMS contract that, from 2018-2019, practices will return

¹¹⁷ NHS National Services Scotland (2018), *National Primary Care Workforce Survey 2017*
<http://www.isdscotland.org/Health-Topics/General-Practice/Publications/2018-03-06/2018-03-06-PCWS2017-Report.pdf>

data to NHS National Services Scotland. This will create a richer set of data to support local and national workforce planning and service improvement. Data is required across three broad areas:

- Workforce data for workforce planning and assessing practice sustainability. This is likely to be broadly in line with the information collected via the existing workforce survey but we will explore the potential of collecting these data on a quarterly basis;
- In order to prepare for Phase 2 of the GMS Contract we need to fully understand the current expenses of running a GP practice, the income of salaried GPs and the income of GP partners as well as the hours worked by individual GPs. The Scottish Government and the BMA have agreed that all GP practices will be required to provide this data (earnings, expenses, working hours/sessions) in a similar way to the data already provided for pension purposes;
- Clinical quality and activity data to support GP cluster quality improvement, planning and service re-design.

The need for robust data for ensuring continuity in high quality patient care applies equally to primary care services provided out-of-hours. This was acknowledged as one of the main recommendations in Sir Lewis Ritchie's *National Review of Out-of-Hours Services* report published in November 2015¹¹⁸. Since the Review's publication, work has been underway across all NHS Boards to improve the data collected and used within out-of-hours service, by upgrading the Adastra IT system. Once fully in place, this will ensure standardised use of the system across Scotland, allowing for consistent meaningful data to be collected.

The benefits of the system changes and the improved data collection are already being seen. NHS National Services Scotland is now reporting on primary care out-of-hours services data¹¹⁹. This data shows patient and workforce data for out-of-hours services, so allows Boards to plan and monitor how their service is delivered to ensure it is high quality and safe.

We are aware of the need to improve data on the AHP workforce. There is no national approach to the collection of all AHP activity data, or detailed information on where and how AHP services are delivered across all health and social care sectors (including in primary care). The *AHP Operational Measures*¹²⁰ project aims to address the activity data gap; paramedic data is collated separately. While ISD publish quarterly AHP workforce data¹²¹, more detail is needed to fully understand how AHP services are delivered across all health and social care sectors. The AHP Directors of Scotland Group (ADSG) recognise the importance of understanding more about the AHP workforce and have begun a process of reviewing existing

¹¹⁸ Scottish Government (2015), *National Review of Primary Care Out of Hours Services*
<http://www.gov.scot/Publications/2015/11/9014>

¹¹⁹ <http://www.isdscotland.org/Health-Topics/Emergency-Care/GP-Out-of-Hours-Services/>

¹²⁰ <http://www.isdscotland.org/Products-and-Services/Data-Definitions-and-References/Allied-Health-Professionals-National-Dataset/Operational-Measures.asp>

¹²¹ <http://www.isdscotland.org/Health-Topics/Workforce/Allied-Health-Professions/>

workforce and workload tools. This work is in its early stages but a report including recommendations will be produced in due course.

For optometry, the national listing of optometrists and dispensing opticians (a key recommendation of the *Community Eyecare Services Review* published in April 2017)¹²² on a single system will deliver improvements in the provision of optometry workforce data and in workforce planning.

In recognition of the gap in robust baseline data on the number of pharmacists and pharmacy technicians working in our network of community pharmacies, in February 2018 NES Pharmacy undertook the first national community pharmacy workforce survey to gain a better understanding of staff numbers and skill mix within community pharmacy in Scotland. The survey was carried out in partnership with Community Pharmacy Scotland, Community Pharmacy Champions and health board staff, and the Company Chemists' Association.

The survey was designed to capture a snapshot¹²³ of the community pharmacy workforce including pharmacists, pre-registration trainee pharmacists, pharmacy technicians including trainees, and pharmacy support staff. The information obtained is being analysed and will help to inform future iterations of workforce planning, to help ensure we have the right workforce in place and to take action to meet future service models and demands.

NES Data Platform and supply modelling

As set out in the *National Health and Social Care Workforce Plan: Part 1*, NES is working with stakeholders to bring together and align relevant workforce data under a data platform to better inform workforce planning. As an initial step NES has led a process to develop a minimum standardised data set with potential to use across different sectors. NES is currently engaging with regional and national planners with the aim of finalising the minimum dataset shortly. These engagement sessions will help inform further development of the platform over the course of this year.

The platform will assist the development of more sophisticated workforce modelling, including the design of a 'pipeline' approach demonstrating how supply via training and recruitment numbers will meet estimated demand. This work will be progressed during 2018 with full implementation expected in 2019. These are significant development that will lead to more informed and better integrated workforce planning decisions at local and national level.

Scottish Primary Care Information Resource (SPIRE)

SPIRE is an integral part of the reform of primary care and is a crucial tool in enabling the emerging model of more collaborative multi-disciplinary primary care¹²⁴. By improving the management and usability of existing data within general practice

¹²² Scottish Government (2017), *Community Eyecare Services Review*
<http://www.gov.scot/Publications/2017/04/7983>

¹²³ Survey was undertaken during the period Monday 19th to Sunday 25th February 2018

¹²⁴ More information on SPIRE can be found at: <http://spire.scot>.

records the introduction of SPIRE is an essential component of making GP clusters effective.

SPIRE is currently being rolled out across Scotland and will help practices provide patients with better care and services and help with the following:

- Analysing and streamlining practice workload, getting information on patient encounters, and analysing practice demographics;
- Analysing the number of patients that have certain illnesses or looking at the medicines they are prescribed;
- Monitoring and improving data quality;
- Enabling GP clusters to work together to improve the quality of care;
- Improve the provision of health and care to vulnerable or disadvantaged groups.

Local Intelligence Support Team (LIST)

LIST analysts have been successfully working locally with Health and Social Care Partnerships and others, to help drive forward integration. The Scottish Government has provided additional funding from 2017-18, to expand the LIST service to work with primary care. This will support GP Clusters and their focus on improvement, following *Improving Together: A National Framework for Quality and GP Clusters in Scotland*¹²⁵.

LIST, part of NHS National Services Scotland, mainly comprises information analysts with the aim of adding capacity and capability to local expertise. The increasingly multi-disciplinary nature of the LIST team, with its connection to the national level resources in ISD and the ability to use national and local data, will help deliver an intelligence-led service which is joined up across health and social care, including GP Clusters. As of April 2018, LIST has grown to around 65 whole time equivalent staff. The team supports cluster and partnership working across Scotland¹²⁶.

Information Systems

We recognise the need to improve IT to help enable efficient and effective working. NHS Boards have commissioned a procurement competition to provide the next generation of GP clinical IT systems in Scotland. This is being undertaken by NHS National Services Scotland. The new systems will be more intuitive and user friendly. They will be quicker and more efficient, with increased functionality. They will be underpinned by strong service levels and performance management, with clear lines of responsibility and accountability, providing, overall, a more professional GP IT Service. All GP practices will transition to the new systems by 2020.

¹²⁵ <http://www.gov.scot/Publications/2017/01/7911>.

¹²⁶ More information on LIST is available at: <http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Local-Intelligence-Support-Team/>

Increasing Digital Capacity

The *Primary Care Digital Services Development Fund, 2016-2018* has enabled general practices to benefit from a wide range of systems enhancements, infrastructure improvements and innovative trials of new tools and technologies.

A number of the opportunities selected serve to increase the availability of, and access to, timely data. For example, the practical benefits of remote working tools to enable real time access out with the practice, dual monitors in consulting rooms to facilitate ease of working between information systems in real time and ultimately to support shared decision making with patients. A range of infrastructure improvements, including server replacements to increase speed of backups and connectivity and practice wi-fi to support multidisciplinary team working. Trials of new technologies include online consultations, decision support, mobile working software solutions and devices.

The impact of the fund is being measured using an outcomes framework developed with stakeholders which is aligned to the wider Primary Care Outcomes Framework (see below). A specific study on the use, spread and experiences of Mobile Working is being undertaken which encompasses the wider community and primary care workforce.

Monitoring and Evaluation

The continuing reform of primary care is challenging and will take time. We need to be realistic about what changes we expect to see and when, and be responsive to changing circumstances. The Scottish Government will publish a 10 year national monitoring and evaluating strategy for primary care, which has been developed in partnership with NHS Health Scotland, by summer 2018. We are also working with partners to develop a set of national indicators to track progress.

A Primary Care Evidence Collaborative (PCEC) involving national organisations¹²⁷ has also been established to champion evidence-based practice and service delivery across the primary care sector and to identify and help to fill gaps in evidence through research. The collaborative helped to develop Primary Care Outcomes Framework which describes, at a high level, how the vision for primary care will be achieved¹²⁸. The outcomes pathway for workforce (see Annex A) sets out the short to longer term outcomes the actions set out in this plan, and as part of the wider reform of primary care, are expected to deliver. We will work with our partners to further develop this pathway and to ensure robust monitoring of these workforce outcomes is established.

¹²⁷ Primary Care Evidence Collaborative members: NHS Health Scotland, Scottish School of Primary Care, Healthcare Improvement Scotland, NHS Education for Scotland, National Services Scotland, The Alliance for Health and Social Care Scotland, Scottish Government (Primary Care Policy and Health and Social Care Analysis).

¹²⁸ <http://www.gov.scot/Topics/Health/Services/Primary-Care>

Conclusion

Local and national workforce planning needs to be informed by good quality and timely data on both the shape of the current workforce and intelligence on how the workforce needs to develop and expand to address a growing and increasing elderly population. We recognise that we are still some way off realising that ambition, but significant progress is now being made. Through the NES data platform and the enhanced general practice data that will be delivered via the GMS contract, supported by expanded local analytical support, we are moving towards our goal of evidence-led workforce planning. Further iterations of the National Health and Social Care Workforce Plan will set out how this work is developing.

CONCLUSION AND NEXT STEPS

We are rightly proud of the many achievements our primary and community workforce have delivered to improve Scotland's health, which is recognised in the continuing high levels of patient satisfaction with the care they receive. Whilst the workforce has continued to respond to increasing demand for services, we recognise that change is needed to ensure continued sustainability.

Getting primary and community care right is an essential element of ensuring the whole healthcare system delivers the highest quality care for its patients and promotes health and wellbeing among its staff. This plan therefore focuses on developing, building and expanding multidisciplinary teams, made up of professionals each contributing their unique skills to managing care and improving outcomes. The key principle underpinning the reform of primary care is that patients receive the most appropriate treatment in the most appropriate setting, when they need it.

To deliver this vision we have set out a series of ambitious commitments to significantly increase the primary care workforce, backed by a historic increase in investment in primary care. This is supported by the reshaping of roles and responsibilities as set out in our historic *Memorandum of Understanding with Integration Authorities*, the British Medical Association, NHS Boards and the Scottish Government. This plan begins to outline how we intend to deliver these pledges. What is clear however, is that we are already seeing considerable benefits from enhanced MDT working and new models of care across Scotland. This will gather pace in the coming years through the initiatives we and our partners are taking forward. Table 7 below summarises the commitments we have set out in this plan.

Leadership capability and capacity is fundamental to the effective organisation and nature of MDTs and the wider reshaping of primary care in Scotland. The re-focused role of the GPs as an Expert Medical Generalists will ensure strong connections to, and coordination with, the enhanced primary care team, health and social care community based services and with acute services where required.

We recognise the continuing need to improve the quality and breadth of data available to local and national planners. Going forward, the NES data platform will be crucial in supporting more integrated local, regional and national workforce planning in health and social care. This plan sets out a number of specific additional actions that will improve the data we have on the primary care workforce.

Integrated and collaborative workforce planning will become increasingly important in the period ahead. An integrated workforce plan will be developed later in 2018, bringing together progress on workforce planning, and allowing us to move towards a better articulated, holistic vision for the totality of the health and social care workforce. The establishment of the National Workforce Planning Group, involving representatives of health and social care workforce staff, employers and policy development, will provide a strategic focus for workforce planning. Ministers are clear that the Group has an important role in contributing to promoting change in workforce planning to ensure that the NHS and social care sectors in Scotland can continue to meet the needs of service users and provide rewarding careers for staff.

Table 7: Key recommendation and actions in reforming primary care services

	Recommendations	Supporting Actions
Facilitating primary care reform	<ol style="list-style-type: none"> 1. Reform of primary care is driven by developing multidisciplinary capacity across Scotland. Workforce planners including NHS Boards, Integration Authorities and General Practices will need to consider the configuration of local multidisciplinary teams that offer high quality, person-centred care. 2. In recognition of an ageing workforce, local planners have responsibility for workforce planning and managing anticipated levels of staff turnover. 3. The implementation of the new GP contract will require services to be reconfigured to maximise workforce competencies and capabilities, and ensure people see the right person, at the right time and in the right place. 4. The National Workforce Planning Group will play a strategic role in implementing the recommendations of part three of the plan, and strengthen the development of approaches for the primary care workforce. 5. An integrated workforce plan to be published later in 2018 will move towards a better articulated joint vision for health and social care workforce planning 	<ul style="list-style-type: none"> • Increasing in funding in primary care by £500 million by the end of 2021-2, including £250 million direct support of general practice. This investment will see at least half of frontline NHS spending going to community health services. • Implementing the terms of the MoU over the next three years through the development of local Primary Care Improvement Plans. • Establishing a National Oversight Group to support service change over the next three years to ensure that patients receive the right service at the right time from the right profession. First meeting of Group in Spring 2018. • Three year Primary Care Improvement Plans to be submitted by Health and Social Care Partnerships (HSCPs) by July 2018 setting out proposals to transform and improve local services. • Working with partners to support the health and wellbeing of the workforce. • Continuing to help local partners test new ways of delivering primary care services through the Primary Care Transformation Fund. Publication of evaluation report by end 2018.

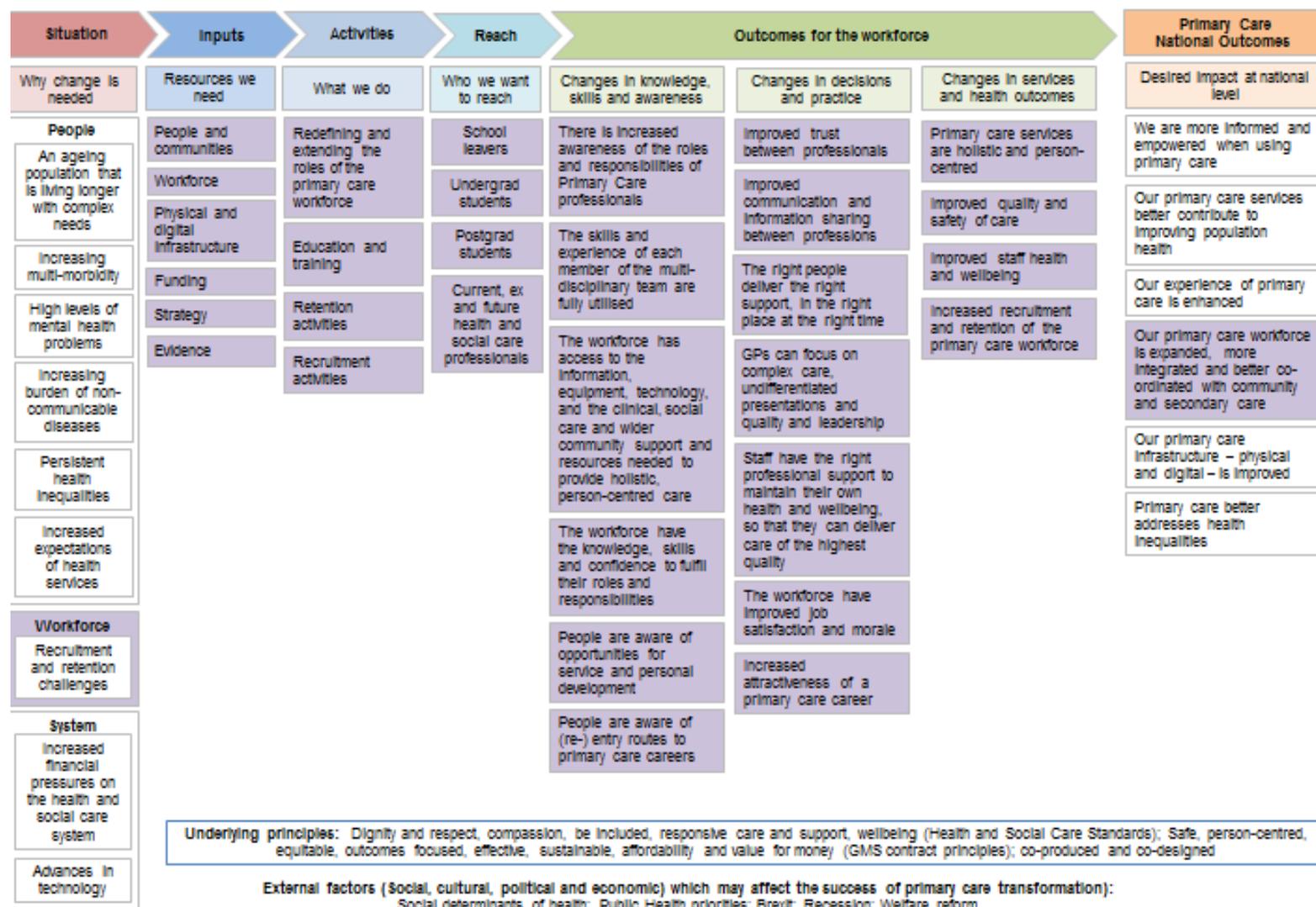
		<ul style="list-style-type: none"> • Publishing an integrated workforce plan later in 2018 bringing together progress on Parts 1-3, allowing us to move towards a better articulated, holistic vision for the health and social care workforce.
<p>Building primary care workforce capacity</p>	<p>6. Significant investment will be made available over the next 3-5 years, as part of the First Minister's commitment to an additional £500 million for community health services, to plan for, recruit and support a workforce in general practice, primary care and wider community health, including community nursing.</p> <p>7. Scotland's multidisciplinary primary care workforce will become more fully developed and equipped, building capacity and extending roles for a range of professionals, enabling those professionals to address communities' primary healthcare needs.</p> <p>8. As part of national, regional and local activity to support leadership and talent management development, planners will need to continuously consider staff training needs in their workforce planning exercises; invest appropriately so that leaders in primary care are fully equipped to drive change; and enhance opportunities for the primary care workforce to further develop rewarding and attractive careers.</p>	<ul style="list-style-type: none"> • Delivering an additional 2,600 nurse and midwife training places over the life of this Parliament, including a 10.8% increase in places for 2018/19, to ensure we can recruit and train the next generation of staff. • Investing £3 million to train an additional 500 advanced nurse practitioners by 2021. • An investment of £3 million over three years into training and education needs of general practice nursing. • An additional £3.9 million over three years into training and education needs of the wider community nursing team, including district nurses. • By September 2018, we will work alongside partners, including the Royal College of Nursing, to better understand the requirements and investment necessary to grow the District Nursing workforce. • Increasing the number of health visitors by 500, supported by funding which has increased over four years to £20 million annually, recurring.

		<ul style="list-style-type: none"> • Working with our partners to deliver our commitment to expand medical school and training places, helping deliver a commitment to recruit at least 800 (headcount) additional GPs over the next 10 years. • Investing in the Scottish Graduate Entry Medicine (ScotGEM) programme, a new four year course in medicine focused on general practice and remote and rural working commencing Autumn 2018. • Recognising the unique recruitment and retention challenges, offering a package of enhanced support for GPs working in remote and rural areas. • The establishment in Spring 2018 of an <i>Increasing Undergraduate Education in Primary Care Working Group</i> to consider ways of increasing undergraduate education in primary care settings. • Delivering a marketing and recruitment campaign in 2018-9 to promote Scotland as a great place to work as a GP, and to attract individuals into nursing and midwifery careers. • A marketing campaign to attract individuals into nursing and midwifery, allied health professional and other health and social care careers. • Delivering on our commitment that all GP practices to have access to pharmacist support
--	--	---

		<p>by the end of 2021.</p> <ul style="list-style-type: none"> • Increasing the mental health workforce in A&Es, GP practices, police station custody suites by 800 by investing £12 million in 2018-19, with annual investment thereafter rising to £35 million by 2021-22. • Developing an enhanced role for allied health professionals in supporting patients' needs, including promoting prevention and self-management with improved access. • Recruiting 250 Community Links Workers by 2021 to help address patients' holistic needs. • Training 1,000 paramedics to work in the community, helping to reduce pressure on A&E services. • Enhanced training and support for practice managers and practice receptionist to develop their roles, supported by continued investment.
<p>Improving data, intelligence and infrastructure in primary care</p>	<p>9. More integrated workforce data for primary care is required, in the context of the workforce data platform being developed by NHS Education for Scotland.</p> <p>10. Local planners should consider workforce planning tools (such as the six step methodology) in developing their workforce strategies to address local population needs.</p> <p>11. Planning for future staffing in primary care</p>	<ul style="list-style-type: none"> • Enhancing workforce data across three broad GMS contract areas: workforce, GP income and expenses, and quality improvement. Submission of enhanced data to commence by end of 2018. • Improvements underway in collection of AHP, pharmacy and optometry workforce and activity data. • Developing the NES workforce data platform and

	<p>should identify and make use of available guidance and intelligence on local recruitment and retention issues, and of wider developments in workforce data and scenario planning.</p> <p>12. The Scottish Government will publish the Primary Care Monitoring and Evaluation Strategy 2018-2028 by June 2018.</p>	<p>supply modelling during 2018 to drive more integrated workforce planning.</p> <ul style="list-style-type: none"> • Delivering the next generation of GP clinical IT systems in Scotland by 2020 to help enable facilitate efficient and effective working. • The Primary Care Digital Services Development Fund, 2016-2018 delivering a wide range of systems enhancements, infrastructure improvements and innovative trials of new tools and technologies. • Investing in local analytical (LIST) capacity to inform and drive service design; 65 analysts (WTE) in place by April 2018. • Continuing to support the roll out of the Scottish Primary Care Information Resource, with 85% of GP practices able to use SPIRE by the end of June 2018 with the remainder able to use it by December 2018. • Publishing a monitoring and evaluation strategy to capture and share learning from the reform of primary care in by summer 2018.
--	--	--

ANNEX A: OUTCOMES FRAMEWORK FOR WORKFORCE





Scottish Government
Riaghaltas na h-Alba
gov.scot

© Crown copyright 2018

OGL

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication is available at www.gov.scot

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-78851-703-4 (web only)

Published by The Scottish Government, April 2018

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS381646 (04/18)

W W W . G O V . S C O T