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Integration Authority Chief Officers
NHS Board Chief Executives

23 May 2018

Dear Colleagues,

PRIMARY CARE IMPROVEMENT FUND: ANNUAL FUNDING LETTER 2018-19

I am writing to confirm the 2018-19 funding allocations for the Primary Care Improvement Fund element of the wider Primary Care Fund, which will be used by Integration Authorities to commission primary care services, and allocated on an NRAC basis through Health Boards to Integration Authorities (IAs).

This letter should be read in close conjunction with two other letters due to issue, which will set out additional ring-fenced resources being made available to IAs in 2018-19:

- A second letter from my Division covering the allocation and use of an additional £5 million for Out of Hours primary care; and
- A letter from Penny Curtis, Deputy Director Mental Health Division, regarding funding of 'Action 15' of the Mental Health Strategy. Action 15 is a four-year commitment to deliver 800 more mental health workers in a range of settings, including primary care, and £11 million is being made available to IAs for this in the first year[1].

Background

Last year we brought together the Out of Hours, Primary Care Transformation Fund and Mental Health Funds into a single funding allocation, referred to as the Primary Care Transformation Fund (PCTF). My colleagues Penny Curtis and Linda Gregson wrote to you on 9 August 2017 to set out the 2017-18 allocation in your area and associated deliverables. An End of Year template for your completion is at Annex F.

[1] Note: for the avoidance of doubt, SG is also continuing to fund the development of primary care mental health services, in a similar way to previous years. This funding for primary care mental health now forms part of the Primary Care Improvement Fund. The £11m Action 15 funding referenced in the section above is additional to it.

Several key developments have taken place since then. These include:

- Scottish Government and BMA agreement to proceed with the 2018 General Medical Services contact following a poll of the GP profession – January 2018[2].
- Publication of the Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards – draft published November 2017 and finalised 19 April 2018[3]. This determines the priorities of Integration Authorities over the next period and should be read in conjunction with this funding letter.
- Primary Care National Workforce Plan – published 30 April 2018[4].
- Passing of Scottish Government Budget Bill in February 2018 confirming increase in Primary Care Fund from £72m in 2017-18 to £110m in 2018-19.
- Wider contextual developments (e.g. the new Oral Health Action Plan and ongoing work by the Health and Justice Collaboration Improvement Board to further develop 'Action 15' of the Mental Health Strategy, which committed to 800 new mental health workers in health and justice settings).

Taken together, these set the terms of the main deliverables we expect in 2018-19 and beyond. Further information on them is at Annex C.

2018-19 approach

The Scottish Government is investing a total of £115.5 million in the Primary Care Fund (PCF) in 2018-19. There are a number of elements to the overall Primary Care Fund:

- Primary Care Improvement Fund (the subject of this letter);
- General Medical Services;
- National Boards; and
- Wider Primary Care Support including Out of Hours Fund.

These are described in more detail in Annex B.

Primary Care Improvement Fund (PCIF)

An in-year NRAC allocation to IAs (via Heath Boards) will comprise £45.750 million of the £115.5 million Primary Care Fund. This in-year allocation is hereafter referred to as the *Primary Care Improvement Fund*.

[2] British Medical Association and Scottish Government (2017), *The 2018 GMS Contract in Scotland* http://www.gov.scot/Resource/0052/00527530.pdf

[3] *Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards - GMS Contract Implementation in the context of Primary Care Service Redesign*, published in draft 13 November 2017 and published as final 19 April 2018: http://www.gov.scot/Resource/0053/00534343.pdf

[4] http://www.gov.scot/Publications/2018/04/3662

Primary Care Improvement Plans should set out how this additional funding will be used and the timescale for the reconfiguration of services. Further information is at Annexes D and E.

Total PCIF allocation by Board area

The 2018-19 funding allocation for the PCIF is £45.750 million.

Allocation of the fund, by Health Board and IA, is shown in Annex A. All figures are calculated using NRAC. The money must be used by IAs for the purposes described in this letter. The PCIF (including £7.800 million baselined GP pharmacy funding being treated as PCIF) is not subject to any general savings requirements and must not be used to address any wider funding pressures.

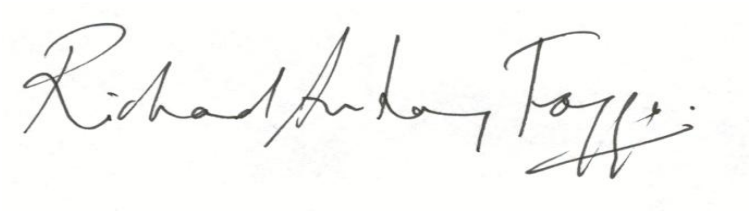
The fund must be delegated in its entirety to IAs. We do not anticipate any adjustment to these figures locally except in two circumstances:

- Marginal changes may be made with the agreement of the Health Board and Integration Authorities to reflect local arrangements, for example in relation to management arrangements within and between Integration Authorities.
- Health Boards and IAs may work collaboratively within their area to jointly resource pre-existing commitments which clearly fall within the scope of the MoU. An example of this would be early adopter link workers who are already in post in areas of higher socio-economic deprivation. This joint working to deliver the overall commitment to links workers (or other MoU related area(s)) can be appropriately reflected in PCIPs for all the IAs concerned. Such a joint approach should be considered especially where it is considered that continuation of such a service in an IA could disproportionately impact on funding available for other activities under the MoU.

Integration Authorities should set out their plans on the basis that the full funds will be made available and will be spent by them within financial year 2018-19. In this initial year of funding, the funding will issue in two tranches starting with allocation of 70% of the funding in June 2018. A high level report on how spending has been profiled must be submitted to SG by the start of September and, subject to confirmation via this report that IAs are able to spend their full 100% allocation in-year, the remaining 30% of funding will be allocated in November 2018. An outline template for making the start-September report is at Annex G. A final template will be issued before September.

I look forward to continuing to work with you in this pivotal year for primary care transformation.

Yours faithfully,



RICHARD FOGGO
Deputy Director and Head of Primary Care Division

Copy: Local Authority Chief Executives
COSLA Chief Executive
Integration Authority Chief Finance Officers
Health Board Directors of Finance
Health Board Directors of Pharmacy
Health Board Directors of Planning and Policy
Health Board Medical Directors
Primary Care Leads
Health Board Out of Hours Clinical Leads
Scottish Executive Nurse Directors (SEND)
Health Board AHP Directors
Health Board Directors of Public Health

ANNEX A

PRIMARY CARE IMPROVEMENT FUND: ALLOCATION BY BOARD AND INTEGRATION AUTHORITY

Allocation By Territorial Health Board

Allocations by Territorial Board 2018-19				
	2018-19 Target share	2018-19 NRAC Share	2017-18 Allocation now in 18-19 Baseline	2018-19 Allocation
NHS Ayrshire and Arran	7.41%	£3,389,685	£569,300	£2,820,385
NHS Borders	2.10%	£962,647	£161,300	£801,347
NHS Dumfries and Galloway	2.98%	£1,363,090	£229,100	£1,133,990
NHS Fife	6.81%	£3,113,646	£521,800	£2,591,846
NHS Forth Valley	5.42%	£2,479,354	£415,000	£2,064,354
NHS Grampian	9.87%	£4,516,701	£755,400	£3,761,301
NHS Greater Glasgow & Clyde	22.34%	£10,219,379	£1,718,200	£8,501,179
NHS Highland	6.44%	£2,947,380	£494,100	£2,453,280
NHS Lanarkshire	12.35%	£5,648,985	£947,700	£4,701,285
NHS Lothian	14.80%	£6,772,970	£1,132,000	£5,640,970
NHS Orkney	0.48%	£220,754	£75,000	£145,754
NHS Shetland	0.49%	£224,204	£76,200	£148,004
NHS Tayside	7.85%	£3,590,567	£601,900	£2,988,667
NHS Western Isles	0.66%	£300,639	£103,000	£197,639
Total	100.00%	£45,750,000	£7,800,000	£37,950,000

**Pharmacists in GP Practices funding was a recurring allocation in 2017-18 and will be included in Boards' 2018-19 baseline funding.*

Allocation by Integration Authority: overview of full £45.750 breakdown

Total Bundle £45.750m			
NHS Board	**2018-19 NRAC Share**	**IA Name**	**IA Share**
Ayrshire & Arran	3,389,685	East Ayrshire	1,111,935
		North Ayrshire	1,245,806
		South Ayrshire	1,031,944
Borders	962,647	Scottish Borders	962,647
Dumfries & Galloway	1,363,090	Dumfries and Galloway	1,363,090
Fife	3,113,646	Fife	3,113,646
Forth Valley	2,479,354	Clackmannanshire and Sti	1,166,827
		Falkirk	1,312,527
Grampian	4,516,701	Aberdeen City	1,793,412
		Aberdeenshire	1,935,573
		Moray	787,716
Greater Glasgow	10,219,379	East Dunbartonshire	830,888
& Clyde		East Renfrewshire	713,977
		Glasgow City	5,529,498
		Inverclyde	754,813
		Renfrewshire	1,553,435
		West Dunbartonshire	836,768
Highland	2,947,380	Argyll and Bute	847,966
		Highland	2,099,414
Lanarkshire	5,648,985	North Lanarkshire	2,939,438
		South Lanarkshire	2,709,546
Lothian	6,772,970	East Lothian	839,311
		Edinburgh	3,806,420
		Midlothian	720,229
		West Lothian	1,407,010
Orkney	220,754	Orkney Islands	220,754
Shetland	224,204	Shetland Islands	224,204
Tayside	3,590,567	Angus	985,878
		Dundee City	1,355,476
		Perth and Kinross	1,249,213
Western Isles	300,639	Eilean Siar (Western Isles	300,639
Total	**45,750,000**		**45,750,000**

Allocation by Integration Authority: IA share of £7.8m baselined funding[5]

£7.8m from Boards' Baseline Funding			
NHS Board	**Baselined funding**	**IA Name**	**IA Share**
Ayrshire & Arran	569,300	East Ayrshire	186,750
		North Ayrshire	209,234
		South Ayrshire	173,316
Borders	161,300	Scottish Borders	161,300
Dumfries & Galloway	229,100	Dumfries and Galloway	229,100
Fife	521,800	Fife	521,800
Forth Valley	415,000	Clackmannanshire and S	195,306
		Falkirk	219,694
Grampian	755,400	Aberdeen City	299,941
		Aberdeenshire	323,717
		Moray	131,742
Greater Glasgow	1,718,200	East Dunbartonshire	139,698
& Clyde		East Renfrewshire	120,042
		Glasgow City	929,683
		Inverclyde	126,908
		Renfrewshire	261,181
		West Dunbartonshire	140,687
Highland	494,100	Argyll and Bute	142,153
		Highland	351,947
Lanarkshire	947,700	North Lanarkshire	493,134
		South Lanarkshire	454,566
Lothian	1,132,000	East Lothian	140,278
		Edinburgh	636,186
		Midlothian	120,376
		West Lothian	235,161
Orkney	75,000	Orkney Islands	75,000
Shetland	76,200	Shetland Islands	76,200
Tayside	601,900	Angus	165,266
		Dundee City	227,223
		Perth and Kinross	209,410
Western Isles	103,000	Eilean Siar (Western Isle	103,000
Total	**7,800,000**		**7,800,000**

[5] Being treated as part of the PCIF. Note that there is no difference between the use for PCIP purposes of the baselined £7.8 million and the remainder of the PCIF this year.

Allocation by Integration Authority: tranche 1 and tranche 2 of £37.950 million in-year allocation[6]

£37.95m split into Tranche 1 and Tranche 2							
NHS Board	**2018-19 Board Allocation**	**Tranche 1 (70%)**	**Tranche 2 (30%)**	**IA Name**	**IA Share**	**Tranche 1 (70%)**	**Tranche 2 (30%)**
Ayrshire & Arran	2,820,385	1,974,270	846,116	East Ayrshire	925,185	647,629	277,555
				North Ayrshire	1,036,572	725,600	310,972
				South Ayrshire	858,629	601,040	257,589
Borders	801,347	560,943	240,404	Scottish Borders	801,347	560,943	240,404
Dumfries & Galloway	1,133,990	793,793	340,197	Dumfries and Galloway	1,133,990	793,793	340,197
Fife	2,591,846	1,814,292	777,554	Fife	2,591,846	1,814,292	777,554
Forth Valley	2,064,354	1,445,048	619,306	Clackmannanshire and Stirling	971,521	680,065	291,456
				Falkirk	1,092,833	764,983	327,850
Grampian	3,761,301	2,632,910	1,128,390	Aberdeen City	1,493,471	1,045,429	448,041
				Aberdeenshire	1,611,857	1,128,300	483,557
				Moray	655,973	459,181	196,792
Greater Glasgow & Clyde	8,501,179	5,950,825	2,550,354	East Dunbartonshire	691,189	483,832	207,357
				East Renfrewshire	593,935	415,754	178,180
				Glasgow City	4,599,815	3,219,871	1,379,945
				Inverclyde	627,905	439,534	188,372
				Renfrewshire	1,292,253	904,577	387,676
				West Dunbartonshire	696,081	487,257	208,824
Highland	2,453,280	1,717,296	735,984	Argyll and Bute	705,813	494,069	211,744
				Highland	1,747,467	1,223,227	524,240
Lanarkshire	4,701,285	3,290,899	1,410,385	North Lanarkshire	2,446,305	1,712,413	733,891
				South Lanarkshire	2,254,980	1,578,486	676,494
Lothian	5,640,970	3,948,679	1,692,291	East Lothian	699,032	489,323	209,710
				Edinburgh	3,170,234	2,219,164	951,070
				Midlothian	599,854	419,898	179,956
				West Lothian	1,171,850	820,295	351,555
Orkney	145,754	102,028	43,726	Orkney Islands	145,754	102,028	43,726
Shetland	148,004	103,603	44,401	Shetland Islands	148,004	103,603	44,401
Tayside	2,988,667	2,092,067	896,600	Angus	820,612	574,428	246,184
				Dundee City	1,128,253	789,777	338,476
				Perth and Kinross	1,039,803	727,862	311,941
Western Isles	197,639	138,347	59,292	Eilean Siar (Western Isles)	197,639	138,347	59,292
Total	**37,950,000**	**26,565,000**	**11,385,000**		**37,950,000**	**26,565,000**	**11,385,000**

[6] Total PCIF minus the £7.8 million baselined amount. Note that there is no difference between the use for PCIP purposes of the baselined £7.8 million and the remainder of the PCIF this year.

ANNEX B

OVERVIEW OF NATIONAL PRIMARY CARE FUNDING ARRANGEMENTS

Primary Care Fund 2018-19

The Scottish Government is investing a total of £115.5 million in the Primary Care Fund (PCF) in 2018-19. There are a number of elements to the overall Fund:

- Primary Care Improvement Fund;
- General Medical Services;
- National Boards; and
- Wider Primary Care Support including Out of Hours.

The full Primary Care Fund breakdown is below.

Primary Care Fund £m	2018-19	Notes
Primary Care Improvement Fund: Service redesign through Primary Care Improvement Plans	**45.750**	Wider MDT development across 6 priority areas in the GMS contract/ MoU, including Pharmacy, CLW, Vaccination Transformation Programme, primary care mental health and Pharmacy First.
GMS: Income & Expenses Guarantee Professional Time Activities Rural package GP Additional support GP clusters (PQLs) **GMS Total**	 23.000 2.500 2.000 3.075 5.000 **35.575**	Additional support includes oxygen, occ health, parental leave, sickness, appraisal and GP retainers scheme
National Boards	**16.569**	Cluster support (HIS and LIST), SAS Strategy/national board transformation, practice nurse training
Wider Primary Care Support: National Support Primary Care Infrastructure Out of Hours GP Recruitment and Retention **Wider Primary Care Support Total**	 5.606 2.000* 5.000 5.000 **17.642**	National support includes primary care development, GP sustainability reccs, community eyecare review, evaluation
Total: Primary Care Fund *£10m Premises Fund available in 2018-19 from a separate funding source	**115.500**	

The table above demonstrates the allocation of the entirety of the Primary Care Fund. A separate letter will be prepared and copied to IAs in due course providing a

breakdown of which elements of the Primary Care Fund are in direct support of General Practice, contributing to the Scottish Government's commitment to invest an additional £250 million in direct support of General Practice by the end of this Parliament.

Primary Care Improvement Fund

An in-year NRAC allocation to IAs (via Heath Boards) will comprise £45.750 million of that £115.5 million Primary Care Fund. This in-year allocation is hereby referred to as the Primary Care Improvement Fund (PCIF). Primary Care Improvement Plans should set out how this additional funding will be used and the timescale for the reconfiguration of services.

In 2018-19, for the PCIF, we are continuing the process of radical simplification we began last year. As agreed with the *Scottish Government – Chief Officer Advisory Group on Primary Care*, we are making a single broad allocation, to provide maximum flexibility to local systems to deliver key outcomes. This is a successor fund to activities previously funded including:

- Pharmacy teams in General Practice
- Vaccination Transformation Programme
- Primary Care Transformation Fund
- Community Links Workers
- Mental Health Primary Care Fund
- Pharmacy First

Primary Medical Services

A separate Primary Medical Services (PMS) revenue allocation letter will issue in due course, which will include the elements of the Primary Care Fund that relate to General Medical Services (GMS) such as the £23 million income guarantee associated with the new GMS contract.

National NHS Boards will also receive letters setting out the outcomes associated with their funding allocations.

Out of Hours Fund

IAs will be expected to maintain and develop a resilient out of hours service that builds on the recommendations set out in Sir Lewis Ritchie's report *Pulling Together*, building effective links and interface between in and out of hours GP services.

Therefore, IAs will receive an in-year NRAC allocation *additional* to the Primary Care Improvement Fund of £5 million for investment in Out of Hours.

A separate letter will set out further detail before the end of May on the allocation and use of the £5 million.

Wider Elements of Primary Care Fund

Funding from the Primary Care Fund outwith the IA-led allocation includes:

- Support to GP sustainability recommendations and national evaluation;
- Support to GP Recruitment and Retention; and
- Funding for National Boards to support primary care transformation.

Future funding profile

To aid in preparation of the Primary Care Improvement Plans, IAs and Health Boards should note that the Primary Care Fund is expected to increase substantially over the next three years. The Scottish Government has announced its commitment to increase the overall PCF to £250 million by 2021-22. The detail of the funding breakdown within that is a matter for Ministers and the annual Parliamentary budgeting process.

However – *strictly as a planning assumption, and subject to amendment by Ministers without notice* – IAs may wish to note our expectation that the Primary Care Improvement Fund will increase to approximately £55 million in 2019-20, £110 million in 2020-21, and £155 million in 2021-22. This will, as this year, be distributed on an NRAC basis.

All PCIF in-year allocations should be considered as *earmarked recurring* funding. It should be assumed therefore that staff may be recruited on a permanent basis to meet the requirements set out in the MoU. We will engage with IAs and others on any plans to baseline these funds.

Linked non-Primary Care Fund funding

Linked funding from outwith the Primary Care Fund in 2018-19 includes:

- The £10 million annual Premises Fund to fund interest-free secured loans to GP contractors who own their premises, as set out in the National Code of Practice for GP Premises.
- The £11 million Mental Health 'Action 15' fund, which will be the subject of a separate letter this month from Penny Curtis.

National trends in funding for primary care

In March 2017 the Cabinet Secretary for Health and Sport announced that in addition to the funding for the provision of general medical services, funding in direct support of general practice will increase annually by £250 million by the end 2021-22. In 2017-18 £71.6 million was committed through the Primary Care Fund in direct support of general practice. Further investment will see this increase over the three financial years from 1 April 2018 to £250 million in 2021-22.

This forms part of the commitment during this Parliament to extra investment of £500 million per year for Primary Care funding. This will raise the primary care budget from 7.7% of the total NHS frontline budget in 2016-17 to 11% by 2021-22.

ANNEX C

SUMMARY OF KEY POLICY DEVELOPMENTS IN PRIMARY CARE 2017-18

GMS contract offer: key elements

The contract offer to GPs[7], 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 builds on the core strengths and values of general practice, involves a focus on undifferentiated presentation, complex care, and whole system quality improvement and leadership.

This refocusing of the GP role will require some tasks currently carried out by GPs to be carried out by members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care. Integration Authorities, the Scottish GP Committee (SGPC) of the British Medical Association (BMA), NHS Boards and the Scottish Government have agreed priorities for transformative service redesign in primary care in Scotland over a three year planned transition period. These priorities include vaccination services, pharmacotherapy services, community treatment and care services, urgent care services and additional professional services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services. GPs will retain a professional role in these services in their capacity as expert medical generalists. The contract offer also sets out new opportunities for GP-employed practice staff.

The contract improves the formula used to determine GP funding, and proposals for the next phase of pay reform, and proposes significant new arrangements for GP premises, GP information technology and information sharing. The effect of these arrangements will be a substantial reduction in risk for GP partners in Scotland, and a substantial increase in practice sustainability.

Practice core hours will be maintained at 8am-6.30pm (or as previously agreed through local negotiation). Online services for patients will be improved, and online appointment booking and repeat prescription ordering will be made available where the practice has the functionality to implement online services safely.

The contract sets out how analytical support from Information Services Division of NHS National Services Scotland will be further embedded. Practices will supply information on practice workforce and on demand for services to support quality improvement and practice sustainability.

Memorandum of Understanding

The Memorandum of Understanding (MoU) with Integration Authorities, the British Medical Association, NHS Boards and the Scottish Government[8] set out the

[7] British Medical Association and Scottish Government (2017), *The 2018 GMS Contract in Scotland* http://www.gov.scot/Resource/0052/00527530.pdf

[8] http://www.gov.scot/Resource/0053/00534343.pdf

principles underpinning primary care in Scotland, including respective roles and responsibilities.

The seven key principles for service redesign in the document are:

- Safe
- Person-Centred
- Equitable
- Outcome focused
- Effective
- Sustainable
- Affordability and value for money

The MoU provided the basis for the development by IAs, as part of their statutory Strategic Planning responsibilities, of clear IA Primary Care Improvement Plans, setting out how allocated funding will be used and the timescales for the reconfiguration of some of the key services currently delivered under GMS contracts.

The MoU underpins the new Scottish GMS contract; and enables the move towards a new model for primary care that is consistent with the principles, aims and direction set by the Scottish Government's National Clinical Strategy (NCS) and the Health and Social Care Delivery Plan.

Workforce Plan

The third section of the National Workforce Plan[9] was published on 30 April 2018.

Scottish Ministers have committed to a significant expansion of the wider Multi-Disciplinary Team (MDT), including the training of an additional 500 advanced nurse practitioners, 250 Community Links Workers to be in place by 2021 in practices serving our poorest populations, and 1,000 paramedics to work in the community. General Practice will further be supported by ensuring all practices are given access to a pharmacist by the end of this parliamentary period. An additional investment of £6.9 million will be made in nursing in primary care, particularly general practice nursing and district nursing.

The publication of *National Health and Social Care Workforce Plan: Part 1 – a framework for improving workforce planning across NHS Scotland*[10] 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 of the Workforce Plan – *A framework for improving workforce planning for social care in Scotland*[11] – published jointly by the Scottish Government and COSLA, set out a whole system, complementary approach to local and national social care workforce planning, recognising our new integrated landscape.

[9] http://www.gov.scot/Publications/2018/04/3662
[10] http://www.gov.scot/Resource/0052/00521803.pdf
[11] http://www.gov.scot/Resource/0052/00529319.pdf

Part 3, the primary care workforce plan, marks an important further step in that journey. It addresses the following main issues:

- how primary care services are in a strong position to respond 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 self-management.
- The shape of the existing primary care workforce, including recent trends in workforce numbers
- The anticipated changes in the way services will be reconfigured to meet population need
- How the MDT will be strengthened to deliver an enhanced and sustainable workforce
- Our approach to recruiting 800 more doctors into general practice over the next decade and supporting and retaining the existing workforce
- 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.
- A commitment to work alongside partners including the RCN to understand the requirements for sustaining and expanding the district nursing workforce. By September 2018 we will better understand the requirements and investment needed to grow this workforce.

Other key policy developments

GP Clusters

The approach to quality which began with the move away from the Quality and Outcomes Framework introduced in the 2004 GMS contract will continue. Following the publication of *Improving Together: A National Framework for Quality and GP Clusters in Scotland*[12] in January 2017, work is now underway to continue to develop the collaborative learning role of GP clusters, to help identify and improve the quality of services in their locality. Healthcare Improvement Scotland and National Services Scotland, through Local Intelligence Support Teams (LIST) will continue to support clusters to gather intelligence to establish what these priorities are, and how to collect and evaluate data to determine what action is needed. Work is now underway to further refine the National Framework, with input from Integration Authorities, and this work will continue in 2018/19. Support should be made available from Public Health locally to help identify suitable cluster outcomes for improvement.

Community Eyecare

As indicated in last year's letter, the Community Eyecare Services Review[13] required Integration Authorities to consider the full eyecare needs of their communities when planning and commissioning services. Work is now underway in taking forward the recommendations, particularly around revising the General Ophthalmic Services Regulations. We would expect Integration Authorities to continue to work with

[12] https://beta.gov.scot/publications/improving-together-national-framework-quality-gp-clusters-scotland/documents/00512739.pdf?inline=true
[13] http://www.gov.scot/Publications/2017/04/7983

optometrists and NHS Board Optometric Advisers in considering how eyecare services can be delivered more effectively in their area, as work to implement further recommendations around clinical and quality improvement will continue in 2018/19.

Oral Health

On 24 January 2018, the Scottish Government published the *Oral Health Improvement Plan* (OHIP)[14]. The OHIP sets the direction of travel for oral health improvement and NHS dentistry for the next generation, and has a strong focus on preventing oral health disease, meeting the needs of the ageing population and reducing oral health inequalities. This does not form part of the PCIF, but appropriate links should be identified where possible.

Pharmacy

Our strategy 'Achieving Excellence in Pharmaceutical Care'[15]. was published in August 2017, and sets out the priorities, commitments and actions for improving and integrating NHS pharmaceutical care in Scotland over the next five years. It is driven by two main priorities: Improving NHS Pharmaceutical Care and Enabling NHS Pharmaceutical Care Transformation.

Achieving Excellence emphasises the important role the pharmacy team in NHS Scotland has to play as part of the workforce, making best use of their specialist skills and much needed expertise in medicines. It describes how we see pharmaceutical care evolving in Scotland along with the crucial contribution of pharmacists and pharmacy technicians, working together with other health and social care practitioners, to improve the health of the population, especially for those with multiple long term and complex conditions.

[14] http://www.gov.scot/Publications/2018/01/9275
[15] http://www.gov.scot/Resource/0052/00523589.pdf

ANNEX D

CORE REQUIREMENTS OF PRIMARY CARE IMPROVEMENT PLANS REQUIREMENT 1: PREPARATION OF PRIMARY CARE IMPROVEMENT PLANS (PCIPS)

The MoU requires IAs to:

1. Develop three-year Primary Care Improvement Plans (PCIPs), consulting NHS Boards and other partners. These must be agreed with the local GP Subcommittee of the Area Medical Committee, with the arrangements for delivering the new GMS contract being agreed with the Local Medical Committee (LMC),and
2. Through the Plans, commission, deliver and resource (including staff resources) the six priority services identified in the MOU and the Contract document ("Blue Book") in support of the new GP contract.

Process

Initial Plans, with evidence of appropriate local consultation and agreements, will be completed by 1 July 2018 and shared with the National Oversight Group by the end of that month. They should be kept under review and updated at least annually.

The Plans are to be developed collaboratively with advice and support from GPs; and explicitly agreed with the local GP Subcommittee of the Area Medical Committee (and, in the context of the arrangements for delivering the new GMS contract, explicitly agreed with the Local Medical Committee).

Key partners and stakeholders (including patients, carers, and representatives of service providers such as the third sector) should be as engaged as possible in the preparation, publication and regular review of the Plans. There will also be a need for appropriate engagement with specific professionals and groups. For example, on the pharmacotherapy service, Directors of Pharmacy and others such as area pharmaceutical committees (or area clinical forums) and local pharmacy contractors committees will have a strong need for engagement on its implementation locally.

We appreciate that achieving full engagement within the challenging initial timescale for the PCIP may be difficult, and some of the more detailed dialogue may take place after the plans are submitted. They will be living documents, and regularly reviewed and updated.

Content

The transfer of services in the six priority areas (detailed under Requirement 2 below) will be a major component of PCIPs, and we expect that PCIPs will show a funding profile for each area.

Good communications and understanding across the wider health and social care interfaces with both services and professional groups (e.g. primary/secondary, community health and social care services, district nursing, out of hours services,

mental health services) will also be required to address direct patient care issues, such as prescribing, referrals, discharges, follow up of results and signposting. An important principle here is that each part of the system respects the time and resources of the other parts. There should not be an assumption that patient needs or work identified in one part of the service must be met by another without due discussion and agreement. This should ensure that patients do not fall through gaps in the health and care system.

Wider spending on those services should form part of IAs' broader strategic planning and commissioning role, and it would be helpful if PCIPs could reference how these services will work together.

IAs, in preparing PCIPs, should also consider the underpinning need for strong collective leadership from all parts of the local system, and how best to support it. Measures to build the leadership capability of GP Sub-Committees, and Cluster Quality Leads, as well as wider capability and capacity, should form a key part of Plans. NHS Education for Scotland is likely to be a key partner for IAs in delivering programmes to support that capacity-building. PCIPs may also address practical support to the programmes of work, such as coordination or programme management.

Wider considerations

Connection to Action 15 of the Mental Health Strategy

Primary Care Improvement Plans should show clear connections to the plans being prepared under Action 15 of the Mental Health Strategy for delivery of 800 more mental health staff in general practice, Accident and Emergency, prisons and police custody suites over the next three years. Penny Curtis will be writing to you separately on this matter.

Some of the same staff may be counted both as part of the MOU delivery (for example as part of the development of primary care mental health and/or the work on links workers) and the delivery of the general practice element of the 800. This is acceptable, and Penny Curtis's letter will set out how we expect additionality to be accounted for in terms of the 800. It would be helpful to see any cross-over clearly articulated in both PCIPs and existing plans (or those in development) regarding Action 15 of the Mental Health Strategy.

Inequalities

Whilst we recognise that the key determinants of health inequality lie outside general practice services and health care generally, there remain opportunities to strengthen the role of general practice and primary care in mitigating inequality. All PCIPs should include a section on how the services will contribute to tackling health inequalities. The community links worker service will be one aspect of this, as will the developing quality improvement role of GP Clusters, but IAs will wish to consider what more can be done to ensure there is parity of access for all groups, and that the workload of GPs in the most deprived areas is manageable.

IAs are also subject to the new Fairer Scotland Duty which came into force from April 2018. Guidance on the new duty is available on the SG website[16]. The duty aims to ensure that public bodies take every opportunity to reduce inequalities of outcome, caused by socio-economic disadvantage, when making strategic decisions. We would therefore strongly encourage IAs to consider how they can meet their obligations under the duty as they develop their PCIPs. In particular, all IAs should have completed an inequalities assessment, and make reference to this in their PCIP.

Sustainability

All IAs should also consider the sustainability of general practices in their area including the recruitment and retention of local GPs. Where there are specific sustainability issues, these should be discussed with GP representatives, and consideration given to how the PCIP can best support the sustainability of general practice locally.

National support will continue to be made available through the multi-partner Improving General Practice Sustainability Advisory Group which, over the past year, has made significant progress in delivering the practically focused recommendations for reducing workload pressures, including actions to improve interface working and improved signposting of patients to appropriate primary care services and to self-care. During 2018 the Group will focus on supporting local partners to address local sustainability issues.

Rural, remote and island communities

The needs of rural, remote and island communities should be addressed in PCIPs if they form part of the IA area.

The expectation is that the contract workload reduction measures and new services must be made available to *every* practice where it is reasonably practical, effective and safe to do so.

The service redesign requires practices to be involved via their GP clusters, so they have a say in how services will work locally.

Governance

A new National Oversight Group with representatives from the Scottish Government, the SGPC, Integration Authorities and NHS Boards will oversee implementation by NHS Boards of the GMS contract in Scotland and the IA Primary Care Improvement Plans, including clear milestones for the redistribution of GP workload and the development of effective MDT working, including with non-clinical staff.

At local level, Integration Authorities will hold Health Boards and Councils to account for delivery of the milestones set out in the Plan, in line with the directions provided

[16] http://www.gov.scot/Publications/2018/03/6918

to the Health Board and Council by the Integration Authority for the delivery of Strategic Plans.

Directors of Pharmacy will be leading on the implementation of the pharmacotherapy services during the three year trajectory, to ensure governance arrangements are in place, workforce planning and capacity issues are addressed, and the initial momentum is maintained. This will be taken forward through the recently established Pharmacotherapy Service Implementation Group which will form part of the governance arrangements under the new National Oversight Group.

The Vaccination Transformation Programme is overseen by a Programme Board with representatives from the Scottish Government, SGPC, Trade Unions, Health Protection Scotland, Health Boards, and Directors of Nursing. It is responsible for realising the benefits of vaccination transformation nationally, and managing, monitoring and evaluating progress made by each Health Board. The Vaccination Transformation Programme Board links into the National Oversight Group by reporting to the Primary Care Programme Board.

Other stakeholder groups such as dentistry and optometry should also be engaged with.

Evaluation

At local level, all PCIPs should include consideration of how the changes will be evaluated locally.

Healthcare Improvement Scotland and LIST analysts from National Services Scotland will work with IAs to provide support and learning in development of the new services.

At the national level, the Scottish Government plans to publish a 10-year Primary Care Monitoring and Evaluation Strategy in June 2018, setting out our overarching approach to evaluating primary care reform.

We will also publish a Primary Care Outcomes Framework before then, which maps out planned actions and priorities against the changes we are working towards. The Framework was co-produced by the Primary Care Evidence Collaborative, which includes NHS Health Scotland, the Scottish School of Primary Care, Healthcare Improvement Scotland, NHS Education for Scotland, National Services Scotland, the Alliance, and the Scottish Government.

ANNEX E

CORE REQUIREMENTS FOR PRIMARY CARE IMPROVEMENT PLANS 2018-21 REQUIREMENT 2 – SERVICE TRANSFER

The MoU requires IAs to:

1. Develop three-year Primary Care Improvement Plans (PCIPs), consulting NHS Boards and other partners. These must be agreed with the local GP Subcommittee of the Area Medical Committee, with the arrangements for delivering the new GMS contract being agreed with the Local Medical Committee (LMC),and

2. Through the Plans, commission, deliver and resource (including staff resources) the six priority services identified in the MOU and the Contract document ("Blue Book") in support of the new GP contract.

This Annex sets out the six core requirements for service transfer in PCIPs over the three year period.

IAs should work with a range of professionals in NHS Boards and practices, reflecting the service priority areas, to plan and manage service transfers in a way that ensures patient safety and maximises benefits to patient care. The nature and speed of delivery at a local level will vary based on local factors such as the extent to which comparable services are already in place, upon local geography, and prioritisation based on local demographics and demand. The new services should be provided within GP practices or clusters of practices, or be closely located.

Delivery of the Vaccination Transformation Programme, pharmacotherapy service and community treatment and care service (and within that, specifically phlebotomy) have been identified as the key immediate priorities, in that responsibility for these services will be fully transferred to IAs by the end of the transition period in April 2021. However, the other aspects of service transfer should also be considered urgent, and requiring of significant progress over the three years of Plan to deliver the arrangements set out in the MOU and the new GMS contract document.

Service 1) Vaccination Transfer Programme

High level deliverable: All services to be Board run by 2021.

By 2021, vaccinations will have moved away from a model based on GP delivery, to one based on NHS Board delivery through dedicated teams.

The Vaccination Transformation Programme can be divided into different work streams:
1. pre-school programme
2. school based programme
3. travel vaccinations and travel health advice
4. influenza programme
5. at risk and age group programmes (shingles, pneumococcal, hepatitis B)

We expect IAs and NHS Boards to have all five of these programmes in place by April 2021. The order and rate at which IAs and NHS Boards make the transition may vary but progress is expected to be delivered against locally agreed milestones in each of the 3 years, including significant early developments in financial year 2018-19.

The Vaccination Transformation Programme includes all vaccination work in primary care, whether previously delivered by IAs or not. For the avoidance of doubt, this includes childhood immunisations in every case.

Governance and oversight

The Vaccination Transformation Programme is overseen by a Programme Board with representatives from the Scottish Government, SGPC, Trade Unions, Health Protection Scotland, Health Boards, and Directors of Nursing. It is responsible for realising the benefits of vaccination transformation nationally, and managing, monitoring and evaluating progress made by each Health Board. The Vaccination Transformation Programme Board links into the National Oversight Group by reporting to the Primary Care Programme Board.

Service 2) Pharmacotherapy services

High level deliverable: Pharmacotherapy Service to the patients of every practice by 2021.

The GP contract includes an agreement that every GP practice will have access to a pharmacotherapy service. To date, investment from the GP Pharmacy Fund has meant that we have exceeded the initial target to recruit 140 wte pharmacists, together with a number of wte pharmacy technicians. The combined skill mix of these pharmacists and technicians are supporting over one third of GP practices across Scotland. An outturn exercise will be completed shortly confirming the total recruitment figures over the three year period up to the end of March 2018.

The PCIP should set out a three year trajectory from April 2018 to April 2021, to establish a sustainable pharmacotherapy service which includes pharmacist and pharmacy technician support to the patients of every practice. Pharmacists and pharmacy technicians will become embedded members of core practice clinical teams and, while not employed directly by practices, the day-to-day work of pharmacists and pharmacy technicians, will be co-ordinated by practices and targeted at local clinical priorities. Implementation of the pharmacotherapy service will be led by Directors of Pharmacy during the three year trajectory period through the Pharmacotherapy Service Implementation Group.

Pharmacists and pharmacy technicians will take on responsibility for:

a) Core elements of the service, including: acute and repeat prescribing, medicines reconciliation, monitoring high risk medicines
b) Additional elements of the service, including: medication and polypharmacy reviews and specialist clinics (e.g. chronic pain)

By the end of the three year period, PCIPs should be able to demonstrate appropriate delivery of both the core and additional elements of the service in response to local needs.

There will be an increase in pharmacist training places to support this work.

<u>Chronic Medication Service</u>

In addition, PCIPs should also take into account the contribution of the Chronic Medication Service (CMS) available in all local community pharmacies, and ensure the appropriate links between the pharmacotherapy service and CMS are embedded to make best use of total capacity.

Under this centrally funded service, community pharmacists can carry out an annual medication review, as well as regular monitoring and feedback to the practice for patients registered for this service. Involving community pharmacists in the medication review of people with a stable long term condition will support pharmacists in GP practices and GPs to concentrate on more complex care. Making full use of the clinical capacity within community pharmacy can improve the pace and efficiency of delivery of the pharmacotherapy service in GP practices.

Other Centrally Funded Community Pharmacy Services

GP practice teams should also make full use of the other NHS services available through local community pharmacies as part of local triaging arrangements.

Community pharmacists can provide self-care advice on a range of common (uncomplicated) clinical conditions. Children, the elderly, people with medical exceptions, and those on low incomes can also make full use of the Minor Ailment Service (MAS). We will be looking to see how we can develop the MAS on a national basis, based on the outcomes of the extended MAS pilot in Inverclyde.

Smoking cessation support and sexual health advice (including access to Emergency Hormonal Contraception) are also available through the community pharmacy Public Health Service.

Pharmacy First

Also included in your 2018-19 funding allocation are monies to support the continuation of the Pharmacy First service introduced in community pharmacies across Scotland from winter 2017-18.

Linked to the MAS, Pharmacy First allows community pharmacists to treat uncomplicated urinary tract infections in women and impetigo in children without the need for a GP appointment or prescription, opening access to treatment both in and out-of-hours.

Taken together, the NHS Services available through the network of community pharmacies at both local and national levels builds on the role of pharmacists as part of the multidisciplinary team in primary care, making the best use of their clinical skills and providing convenient routes of access to appropriate primary care.

Service 3) Community Treatment and Care Services

High level deliverable: A service in every area, by 2021, starting with phlebotomy.

These services include, but are not limited to, 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 should be delivered as a priority in the first stage of the PCIP.

There will be a three year transition period to allow the responsibility for providing these services to pass from GP practices to IAs. By April 2021, these services will be commissioned by IAs, and delivered in collaboration with NHS Boards that will employ and manage appropriate nursing and healthcare assistant staff.

Community treatment and care services should be prioritised for use by primary care. They should also be available for secondary care referrals if they would otherwise have been workload for GPs (i.e. if such use means they are directly lifting workload from GPs). It is essential that the new funding in direct support of General Practice is only used to relieve workload from General Practice. Work from secondary care sources should be funded from other streams.

IAs should consider how this service might best be aligned with wider community treatment and care services used by secondary care.

Service 4) Urgent care (advanced practitioners)

High level deliverable: A sustainable advanced practitioner service for urgent unscheduled care as part of the practice or cluster based team, based on local needs and local service design.

The MoU sets out the benefits of utilising advanced practitioners to respond to urgent unscheduled care within primary care, including being the first response to a home visit or responding to urgent call outs, freeing up GPs to focus on their role as expert medical generalists. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.

Where service models are sufficiently developed, advanced practitioners may also directly support GPs' expert medical generalist work by carrying out routine assessments and monitoring of chronic conditions for vulnerable patients at home, or living in care homes. These advanced practitioners may be advanced paramedics or advanced nurse practitioners. It is for the IAs, in collaboration with GP clusters, to determine the best provision for their locality.

By 2021, there should be a sustainable advanced practitioner provision in all IA areas, based on appropriate local service design.

Service 5) Additional Professional roles

High level deliverable: In most areas, the addition of new members of the MDT such as physiotherapists or mental health workers acting as the first point of contact.

By 2021 specialist professionals should be working within the local MDT to see patients as the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. Service configuration may vary dependent upon local geography, demographics and demand.

Physiotherapy services focused on musculoskeletal conditions

IAs may wish to develop models to embed a musculoskeletal service within practice teams to support practice workload. In order to provide a realistic alternative for patients, access times must be comparable to those of general practice. Priority for the service, such as focusing on elderly care, will be determined by local needs as part of the PCIP.

Mental health

As indicated in last year's letter, the Mental Health Strategy 2017-27[17] commits to action 23, "test and evaluate the most effective and sustainable models of supporting mental health in primary care, by 2019". It describes the primary care transformation that will improve this - up skilling of all Primary Care team members on mental health issues, the roles of clinical and non-clinical staff, and the increased involvement of patients in their own care and treatment through better information and technology use.

In previous years, nearly £10m was invested via the Primary Care Mental Health Fund (PCMHF) to encourage the development of new models of care to ensure that people with mental health problems get the right treatment, in the right place, at the right time. In 2018-19, further mental health funding is included within the £45.750 million for IAs, and Primary Care Improvement Plans must demonstrate how this is being used to re-design primary care services through a multi-disciplinary approach, in conjunction with how other mental health allocations are being managed (including that of Action 15 within the Mental Health Strategy).

Action 15 of the Mental Health Strategy 2017-2027 is to increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next 5 years we have committed to additional investment which will rise to £35 million in the final year for 800 additional mental health workers in those key settings. The first tranche of funding for Action 15 is set at £11 million in 2018-19. Following detailed consideration of this matter by the Health and Justice Collaboration Improvement Board, a separate letter will be issued to you regarding funding for Action 15, which should be read in conjunction with this letter. It will include a requirement to count

[17] http://www.gov.scot/Publications/2017/03/1750

and monitor the number of additional mental health workers needed to deliver this commitment.

Others

A link could be made, if wished, with community pharmacy as part of Pharmacy First and in support of the GP Sustainability report actions.

Service 6) Community Link Workers

High level deliverable: Non-clinical staff, totalling at least 250 nationally, supporting patients who need it, starting with those in deprived areas.

Community link workers are based in or aligned to a GP practice or cluster and work 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, rurality, or a need for assistance with welfare issues.

As part their PCIP, IAs should assess local need and develop link worker roles in every area, in line with the Scottish Government's manifesto commitment to deliver 250 link workers over the life of the Parliament. The roles of the link workers will be consistent with assessed local need and priorities, and function as part of the local models/systems of care and support. However, the primary intention of this work is to act as one of the ways in which local systems can tackle health inequalities, and therefore the expectation is that the first priority for link workers will be more deprived areas.

It is essential that IAs work together to ensure that they have identified a **national trajectory towards 250 additionally-provided staff** (which could include upskilled staff or those receiving new contracts) by the end of the period. It will be for the national Oversight Group to maintain oversight of this national trajectory.

The 53 'early adopter' link workers who are already in post in areas of higher socio-economic deprivation are the foundation of the build-up towards 250, and continuation of these posts should be considered to be a priority. It is, however, entirely for IAs to decide whether any changes to the scope, oversight, employer or lead responsibility for these posts are required in the light of emerging learning and the developing PCIPs.

The 'early adopter' posts were not initially distributed on an NRAC basis, so Health Boards and IAs should, where necessary, work collaboratively within their area to jointly resource early adopter link workers. This is also the case for additional link workers that may in future be specifically jointly targeted by IAs on areas of the highest deprivation within a Health Board.

This joint working in support of the overall commitment to link workers can be reflected in PCIPs for all the IAs concerned, and will be welcomed.

Such a joint approach should be considered especially where it is considered that continuation of the early adopter service in an IA could disproportionately impact on funding available in that IA for other activities under the MoU.

Support for this work is available to IAs from ScotPHN (Kate Burton) who can support IA work to develop and implement the role of link workers during 2018-19; and from NHS Health Scotland on the development of local evaluation and learning.

ANNEX F

END YEAR REPORT

We would be grateful for a high level report on spend, impact and plans for any carry forward for your overall spending from the Primary Care Transformation Fund in 2017-18. This should include a high level breakdown of the outcomes achieved in 2017-18 across in hours, out of hours and mental health funded by your 2017-18 Primary Care Transformation Fund allocation. When responding, it would also be helpful if this could also include an explanation of how any underspend from 2016-17 that your Integration Authorities were able to carry forward into 2017-18 was spent.

A template for your use is below.

Test of Change Summary Table		
IA Name		
Primary Care Outcome[18]	*Select from the table of primary care outcomes that best fits your test of change*	
Primary Care Outcome	*add a secondary outcome if appropriate.*	
Section 1: 2017-18 actual spend		
Funding allocated to this test of change in 2017-18		£
High level breakdown of actual spend incurred:		
Actual spend		£
Total underspend carried forward to 2018-19		£
Plans for use of the underspend in support of Primary Care Improvement Plans:		
Impact & key learning points:		

[18] Primary Care Outcomes:

1 We are more informed and empowered when using primary care

2 Our primary care services better contribute to improving population health

3 Our experience as patients in primary care is enhanced

4 Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care

5 Our primary care infrastructure – physical and digital – is improved

6 Primary care better addresses health inequalities

ANNEX G

OUTLINE 2018-19 INTEGRATION AUTHORITY FINANCIAL REPORTING TEMPLATE, DUE FOR RETURN BY SEPTEMBER 2018

IA area

Confirmation that PCIP, agreed with the local GP Subcommittee of the Area Medical Committee, is **in place (date submitted)**

Summary of agreed spending breakdown for 2018-19 by service area, with anticipated monthly phasing

Actual spending to date against profile, by month, by service area

Remaining spend to end 2018-19, by month, by service area

Projected under/ over spend by end 2018-19

Is it expected that the full second tranche will be required in 2018-19?

Please return to:

Laura Cregan
Primary Care Division
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Or by email to:
Laura.cregan@gov.scot