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WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

PRIMARY CARE IMPROVEMENT PLAN

Report by Chief Officer, Health and Social Care

PURPOSE OF REPORT

1. To update members on the GP Contract and the associated Primary Care Improvement Plan which the IJB is required to agree with the GP Sub-committee by July 2018.

COMPETENCE

2. There are no HR, legal or financial constraints to the recommendations being implemented.

SUMMARY

3. The Scottish Government and British Medical Association (BMA) have agreed a new GP Contract to support the ongoing development of primary care services in Scotland. The contract will refocus the GP role as expert medical generalists. This role builds on the core strengths and values of general practice – expertise in holistic, person-centred care – and involves a focus on complex care, as well as whole system quality improvement and leadership. The aim is to enable GPs to do the job they train to do and enable patients to have better care.

4. 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 through a memorandum of understanding. 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.

5. The funding of general practice in Scotland will be reformed and a phased approach is proposed. In Phase One, starting from April 2018, a new funding formula that is meant to better reflect practice workload will be introduced. A new practice income guarantee will operate to ensure practice income stability – so no GP practice in Scotland will lose income as a result of the new contract (despite local media reports to the contrary). The new funding formula will be accompanied by an additional £23m investment to improve services for patients where workload is highest – although it is notable that no GP Practices in the Western Isles will benefit from this resource. On the other hand, we anticipate that £45m will be disseminated nationally to support the first year of reforms, in which case we may have access to as much as £300,000 to support the reforms. This figure, however, has yet to be confirmed by the Scottish Government.

6. The IJB is required to agree a Primary Care Improvement Plan with GPs to identify how additional funds are implemented in line with the Contract Framework. The Plan will outline how

these services will be introduced before the end of the transition period at March 2021, establishing an effective multi-disciplinary team model at Practice and Cluster level. These plans will be developed in collaboration with local GPs and others and should be developed with the GP Sub-committee as the formally agreed advisors on general medical service matters. Any specific contractual elements must be agreed with the Local Medical Committee. IJBs have a statutory duty and the infrastructure established to consult in relation to Strategic Planning and stakeholders should be engaged in the plan's development. Integration Joint Boards will be accountable for delivery and monitoring progress for the local Plan

7. The attached paper at Annex 1 has been written for the GP sub-committee, which will be the forum used to agree priorities between the GP community and primary care management (the latter being the Chief Officer, Medical Director, Associate Medical Director and Primary Care Manager). The paper will provide a foundation on which we can build a primary care improvement plan.

RECOMMENDATIONS

8. It is recommended that the IJB discusses the attached paper (Annex 1) which will go to the GP sub-committee on the 27th March for agreement.

Ron Culley
Chief Officer
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WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

Annex 1

TRANSFORMING PRIMARY CARE IN THE WESTERN ISLES

PURPOSE

1. This paper has been prepared for the GP-Sub Committee. The purpose of the report is to :

- Outline the content of the proposed new 2018 General Medical Services (GMS) Contract in Scotland;
- Outline the Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards;
- Outline the requirement for Primary Care Improvement Plans to be developed by 1 July 2018
- Identify the initial thinking and steps that need to be taken to deliver on the above.

BACKGROUND

2. A strong and thriving general practice is critical to sustaining high quality universal healthcare and realising Scotland's ambition to improve our population's health and reduce health inequalities. On 13 November 2017, the Scottish Government published the draft 2018 General Medical Services Contract in Scotland. The benefits of the proposals in the new contract for patients are to help people access the right person, at the right place, at the right time, in line with the Scottish Government Primary Care Vision and Outcomes. In particular this will be achieved through:

- Maintaining and improving access;
- Introducing a wider range of health and social care professionals to support the Expert Generalist (GP);
- Enabling more time with the GP for patients when it is really needed; and
- Providing more information and support for patients.

3. The benefits of the proposals in the new contract for the profession are:

- A refocusing of the GP role as Expert Medical Generalist;
- Phase 1 of Pay and Expenses, including new workload formula and increased investment in general practice, including minimum pay protection.
- Manageable Workload – additional Primary Care staff to work alongside and support GPs and practice staff to reduce GP workload and improve patient care and
- Improving infrastructure and reducing risk, including management/ownership of premises, shared responsibility as data controller for information sharing, responsibilities for new staff.

4. The contract, which was agreed following a positive result to national poll of the profession, is the culmination of negotiations between the Scottish GP Committee (SGPC) of the British Medical Association (BMA), and the Scottish Government. It is set out in the following documents:

- Contract framework
- Premises Code of Practice
- Draft Memorandum of Understanding
- Letter describing the Memorandum of Understanding

5. The new contract will support significant development in primary care. A draft Memorandum of Understanding between Integration Authorities, SGPC of BMA, NHS Boards and Scottish Government, sets out agreed principles of service redesign, ring-fenced resources to enable change to happen, new national and local oversight arrangements and agreed priorities. The initial implementation requirements are set out in the MoU for the first three years (April 2018-March 2021).

6. The MoU recognises the statutory role of Integration authorities in commissioning primary care services and service redesign. It also recognises the role of NHS Boards in service delivery, employers and partners to General Medical Service contracts. The MoU provides reassurance that partners are committed to working collaboratively and positively in the period to March 2021 and beyond to deliver real change in local health and care systems that will reduce workload and risk for GPs and ensure effective multi-disciplinary team working for the benefit of patients.

NEW GP CONTRACT

7. The aim of the new contract is to achieve:

Sustainable funding:

- New funding formula that better reflects GP workload from 2018 with additional investment of £23 million. Nationally, 63% of practices gain additional resources, although this is heavily skewed in favour of urban practices;
- Practice income guarantee that means the 37% of practices who are not gaining additional resources will see their funding maintained at current levels, which includes all of the Western Isles practices;
- A new minimum earnings expectation will be introduced from April 2019. This will ensure that GPs in Scotland earn at least £80,430 (whole-time equivalent – and includes employers' superannuation).

Manageable workload:

- GP practices will provide fewer services under the new contract to alleviate practice workload. New primary care services will be developed and be the responsibility of IJBs / NHS Boards.
- There will be a wider range of professionals available in and aligned to practices and the community for patient care. New staff will be employed mainly through NHS Boards and attached to practices to support development of the Expert Medical Generalist role;
- Priority services include Pharmacotherapy support, treatment and care, and vaccinations ;
- Changes will happen in a planned transition over three years commencing in 2018/19 and there will be national oversight involving Scottish Government, SGPC and Integration Authorities and local oversight involving IJBs NHS Boards and the profession, including Local Medical Committees, and the GP Sub-Committee of the Area Medical Committee.

Reduced risk:

- GP owned premises: new interest-free sustainability loans will be made available, supported by additional £10 million annual investment;
- GP leased premises: over time there will be a planned programme to transfer leases from practices to NHS Boards;
- New information sharing agreement, reducing risk to GP contractors with NHS Boards as joint Data Controllers.

Improve being a GP:

- Move to recognise the GP as the Expert Medical Generalist (EMG) and senior clinical decision maker. In this role the GP will focus on three main areas: undifferentiated presentations; complex care in the community; and whole system quality improvement and clinical leadership;
- GPs will be part of, and provide clinical leadership to, an extended team of Primary Care professionals;
- GPs will be more involved in influencing the wider system to improve local population health in their communities. GP Clusters will have a clear role in quality planning, quality improvement and quality assurance;
- GPs will have contractual provision for regular protected time for learning and development.

Improve recruitment and retention:

- GP census will inform GP workforce planning;
- Explicit aim to increase in GP numbers with a workforce plan due to be published in early 2018.

THE 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND (Contract Framework or Scottish Blue Book)

Key aspects of the new contract and MoU requiring early action are summarised below.

8. **Development of Primary Care Improvement Plan**:

- IJBs will set out a Primary Care Improvement Plan to identify how additional funds are implemented in line with the Contract Framework;
- The Plan will outline how these services will be introduced before the end of the transition period at March 2021, establishing an effective multi-disciplinary team model at Practice and Cluster level;
- These plans will be developed in collaboration with local GPs and others and should be developed with the GP Sub-committee as the formally agreed advisors on general medical service matters. Any specific contractual elements must be agreed with the Local Medical Committee.
- IJBs have a statutory duty and the infrastructure established to consult in relation to Strategic Planning and stakeholders should be engaged in the plan's development;
- Local and Regional Planning will recognise the statutory role of IJBs as commissioners. IJBs will give clear direction to the NHS Board on its function to secure these primary care services;
- In developing and implementing these plans, IJBs should consider population health needs and existing service delivery;
- Integration Joint Boards will be accountable for delivery and monitoring progress for the local Plan

9. **Key Priorities**

Existing work has shown the benefits from working with a wider multi-disciplinary team aligned to General Practice. The MoU outlines nationally-agreed priorities over a three year period (April 2018-March 2021);

- The priority new services and staff are:

  i. Vaccination services (staged for types of vaccinations but fully in place by April 2021)
  ii. Pharmacotherapy services – made up, by 2021, of level one core (acute prescribing, repeats, discharge letters, medication compliance reviews); followed by level two additional advanced (medication review, resolving high risk medication problems); level three additional specialist (polypharmacy reviews, specialist clinics)
  iii. Community treatment and care services (e.g. minor injuries and dressings, phlebotomy, ear syringing, suture removal, chronic disease monitoring) with phlebotomy delivered as a priority in the first stage;
  iv. Urgent care (advanced practitioners, nurses and paramedics) undertaking home visits and unscheduled care;
  v. Additional professionals for multi-disciplinary team dependent on local geography, demographics and demand (e.g. physiotherapists focusing on musculoskeletal, mental health services)
  vi. Community Link Workers

- New staff will be employed predominantly through the NHS Board and work in models and systems agreed between each HSCP and local GPs;
- New staff should, where appropriate, be aligned to GP practices or groups of practices (e.g. clusters).
- Where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices.
- Existing practice staff continue to be employed by Practices; and
- Practice Managers will contribute to the development of the wider Practice Teams.

10. **Improving Together Cluster Framework:**

GP Clusters are professional grouping of general practices that should meet regularly with each practice represented by their Practice Quality Lead. The 2017 Scottish Government document - Improving Together - is a quality framework for GP Clusters that shapes continuous improvement of the quality of care that patients receive and states:

- Cluster purpose is to improve the quality of care within the practices and extrinsically through localities;
- Clusters priorities for 2018/19 will support the current Transitional Quality Arrangements;
- Clusters will provide advice in the development and implementation of Primary Care Improvement Plan(s);
- Practices will provide activity and capacity information to enable quality improvement work to progress and deliver;
- Clusters will be supported by Local Intelligence Support Team (LIST) analysts and Healthcare Improvement Scotland support to HSCPs;
- The peer review process for Clusters is still being negotiated.

11. **Funding:**

Over the period of implementation through 2021, £250m of new funds will be invested in support to General Practice. The funds will support the new practice funding formula, national support arrangements, premises support and the development of the multi-disciplinary team.

- The Scottish Draft Budget proposals for 2018/19 published in December 2017 confirmed a first phase of funding of £110m for 2018/19;
- A letter was circulated in November 2017 to Practices setting out the implications from the new proposed funding formula and allocating the £23m. No practice has a reduction in funding – although no practices within the Western Isles gain from this additional pot;
- A proportion of the £110m for 2018/19 – expected to be £45m - will be allocated using the NRAC formula to support the development of multi-disciplinary teams in line with the MoU. Primary Care Improvement Plans will set out how these funds will be used.

As indicated above, the specific Western Isles allocation has yet to be confirmed, although we know that we will not benefit from the £23m additional investment which will be routed to urban practices in line with the new formula. Moreover, the pre-existing Primary Care Transformation Fund monies are assumed within the overall quantum made available. In order to deliver maximum leverage locally, the IJB has decided to clear any funding obligations attached to the Primary Care Transformation Fund, fund these projects separately from reserves (at a cost of £80,000) and build in a further £50,000 one-off investment to support the development of multi-disciplinary working. Should the Scottish Government confirm that £45m will be distributed to local partnerships to support MDT working, this is likely to deliver circa £300k to the Western Isles.

12. **The Wider Role of the Practice:**

- Practice core hours will remain as 8am – 6.30pm (or in line with existing local agreements);
- Practices can opt in to provide Out of Hours services and there will be a new enhanced services specification;
- Practices will continue with extended hours directed enhanced service where they chose to do so;
- The intention is that there will be no more new enhanced services but as there is no alternative to delivering many of the current enhanced services, there is no intention of reducing these and the funding to practices would continue to be available. Any further changes will need to be carefully planned with a rate of change that ensures patient safety, quality of service and practice stability. So for example, it is anticipated that monies previously attached to the DES for vaccinations will stay with the GP practice, with the funding burden shifting to the IJB. This will allow practices to invest the liberated resource into other clinical priorities and shift the workload on GPs.
- Role and training of Practice Nurses – with the introduction of dedicated treatment and care services, General Practice nurses will be enabled to support holistic and person centred care supporting acute and chronic disease management enabling people to live safely and confidently at home;
- Role of Practice Managers and Receptionists will change. It is recognised that Practice Managers and other practice staff already have a wide range of skills that will continue to be essential for the future. In addition they will work more closely with the wider primary care system including GP clusters, NHS Boards, HSCPs and emerging new services;
- Information technology investments – it is intended that all GP practices will transition to a new clinical IT system by 2020;

- The contract will set out the roles and responsibilities of GPs and NHS Boards in relation to information held in GP records. The contract will recognise that contractors are not the sole data controllers of the GP patient's record but are joint data controllers along with their contracting NHS Board.
- Practices will be required to provide activity, demand and workforce data (through the new SPIRE system unless practices wish to collect the information themselves) and to participate in discussions at cluster level on sustainability and outcomes.

WORKPLAN

13. The GP Sub-committee met on 23rd January to discuss how best to deliver on the aspirations of the new contract and develop the Primary Care Improvement Plan. It was recognised that it would be important to proceed on a collaborative basis, to ensure that the final product is co-produced by the Primary Care Management Team[1] and the GP community together.

14. It was agreed that in advancing the work, it would be important to have regard to the following principles of reform:

- At its heart, the Primary Care Improvement Plan would need to capture the **patient voice**, to ensure that the service reforms are focused on the needs of the community we serve. It was recognised that this would entail significant amounts of public engagement work, as well as work undertaken to ensure that reforms were focused on a key set of outcome improvement measures;
- It would also be important that the **resources** made available by the Scottish Government are used equitably and strategically, to ensure that all practices benefit from the investment and wider reforms. As part of this, GP Sub-committee and the Primary Care Team would agree initial investment priorities.
- The Improvement Plan should be **evidence based** and based on an objective **assessment of need** and gaps in service. This would entail understanding how the primary care system functions as it is just now and would identify key changes that would be capable of delivering on the twin aims of reducing GP workload and building multi-disciplinary teams.
- The work should be **co-sponsored** by the Primary Care Team and the GP Sub-committee in order to deliver a product which all parties recognise and sign-up to. This will mean that in addition to management colleagues being identified to lead specific work-streams, GPs from the local community are matched against those areas of work. This will be supplemented by discussion with each practice as part of a Western Isles engagement process and through discussion with Locality Planning Groups. Consideration will need to be given to the mechanisms for freeing-up GPs to participate in this programme.
- The Primary Care Improvement Plan will enable the development of the expert medical generalist role through a reduction in current GP and practice workload. By the end of the three year plan, every practice should be supported by expanded teams of NHS Board employed health professionals providing care and support to patients.
- Finally, primary care is a very effective public health vehicle, and care should be taken to ensure that general practice continues to be at the forefront of health improvement strategies.

[1] Medical Director, Associate Medical Director, Primary Care Manager and Chief Officer

15. The new contract requires a shift in *how* we do business as much as changing *what* we do. Specifically, using the GP sub as an axis for agreement between the GP Community and Primary Care Management Team is an important development which will require a culture shift and new ways of working.

16. The proposed content of the Improvement Plan is set out at Annex A, and will rest on the following principles:

- The Primary Care Improvement Plan will take account of local priorities, population needs and existing services and will build on local engagement.
- Plans by July 2018 will be initial plans and will set out the process for how primary care will be developed in subsequent years.
- Priorities in year 1 should be clearly defined and aligned with specific resource allocations
- The Plan will demonstrate how *all* practices will benefit from additional support; care should be taken not to exclude any practice
- Active support should be given for the development of the GP role as expert medical generalist and refocusing of activity within practices, as workload shifts.

17. The requirement for engagement in the development of the plan is clearly set out in the MoU:

HSCPs should establish local arrangements to provide them with advice and professional views on the development and delivery of the Primary Care Improvement Plan. Arrangements will be determined locally and will take account of the requirement to engage stakeholders. The HSCP Primary Care Improvement Plan should be agreed with the local GP subcommittee of the Area Medical Committee

18. HSCPs have a statutory duty via the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 to consult a wide range of local stakeholders and professional groups on their Strategic Plans and take decisions on the size and shape of local health and social care services on a collective basis based on dialogue with the local communities and service users. In relation to the development of the Primary Care Improvement Plan that would include (but not be limited to): Patients, their families and carers; Local communities; SAS and NHS 24; Primary care professionals (through, for example, GP subcommittees of the Area Medical Committee and Local Medical Committees); Primary care providers; Primary care staff who are not healthcare professionals; Third sector bodies carrying out activities related to the provision of primary care.

19. In order to ensure that the provision of any new or reconfigured service has a patient-centred approach to care based on an understanding of patient's needs, life circumstances and experiences, it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. HSCPs should ensure that patient engagement is a key part of their Primary Care Improvement Plans.

20. Plans for developing the multi-disciplinary team will require new and expanded roles and changes to existing roles. Staff Partnership involvement in the development of the plans is therefore essential.

21. In addition to engagement on the development of the plans, consideration should be given to engagement on the implementation and development of multi-disciplinary teams to ensure that these work effectively at practice and cluster level. This should include the full range of practice staff including practice managers who have significant existing skills and knowledge in enabling effective working practices for multi-disciplinary teams.

Work-streams

22. It is envisaged that in pursuit of the above, the following work-streams should form and report to the GP Sub-Committee.

Work-stream	Management Lead	GP Lead
Vaccination services	Dr Maggie Watts	Dr Dave Rigby Dr Annemiek Kok
Pharmacotherapy services	Dr Angus McKellar	
Community treatment and care services	Dr Kirsty Brightwell	
Urgent care	Stephan Smit	
Multi-disciplinary team, community capacity and Community Link workers	Ron Culley	
Practice Administration, Reform and Support	Stephan Smit	
The role of the expert generalist, Quality Improvement and Patient Outcomes	Dr Kirsty Brightwell	
Primary Care Workforce Planning	Dr Angus McKellar	
Primary Care Resources/ Shifting the balance of care	Ron Culley	

23. These work-streams may require specific working groups to form, or may simply be about identifying colleagues to develop proposals. The purpose will be to produce a statement of intent that is capable of forming part of the Primary Care Improvement Plan, along with implementation timelines. The Plan itself will be put together by the Primary Care Management Team in consultation with the GP-Sub Committee.

Timeline and Milestones

24. The following milestones are suggested as a way to gauge progress:

Month	Milestone
March 2018	Agree approach and allocate work Work streams form following GP sub (27th March) Update to IJB (22nd March)
April 2018	Work streams underway Desk-top work undertaken to develop plan and narrative content
May 2018	First Draft Primary Care Improvement Plan to GP Sub (4th May) Further work undertaken
June 2018	Final Draft agreed by GP Sub-Committee Plan ratified by IJB (21st June)
July 2018	Implementation

Year-1 Priorities

25. Having considered priorities at the GP sub-committee and through the quality cluster work, it is suggested that year one priorities will include:

- Agreeing a programme of transformation for vaccinations, including the identification of resources required to give effect to the proposed changes;
- Building capacity to support referrals from practices to patients presenting with chaotic lives and low-level mental health problems;
- Establishing effective governance and capacity in respect of primary care pharmacy.

26. It is suggested that if we are able to deliver on these reforms in year 1 of the plan, subsequent years will be able to use additional resources to lead on the other national priorities.

RECOMMENDATIONS

27. The GP Sub-committee is asked to :

(i) Assign GP leads to each workstream;
(ii) Agree to the milestones;
(iii) Agree to the principles of reform at paragraph 14;
(iv) Discuss the skeleton of the improvement plan at Annex 1;
(v) Agree year-1 priorities

CONTENT OF PLAN

Chapter 1: Policy Context
National policy
GP Contract/MOU

Chapter 2: Primary Care in the Western Isles
Population needs assessment; demographic and epidemiological trends;
Profile and reach of existing primary care services, including local challenges and opportunities (e.g. workforce, practice sustainability).

Chapter 3: Vision, aims and priorities
To reflect the agreed aims and principles as set out in the guidance

Chapter 4: Engagement process
How the plan has been developed and who has been involved

Chapter 5: Strategic Priorities

Delivery of MOU commitments
For each of the six priority areas, set out a statement of intent
Year 1 deliverables
Expected developments in years 2/3

Existing transformation activity
Future plans for any existing pilots or transformation tests of change
Additional local priorities

Wider primary and community care objectives
Community Pharmacy, Optometry and Dentistry: linked developments and priorities
Community Services: Any proposed changes to how wider community services will align to practices / clusters
Interface with Acute Services

Chapter 6: Resources
How new earmarked funding and any residual PCTF funding will be used in support of the plan
How any other additional sources of funding will be used in support of the plan
Other resources or realignment of funding
Shifting the balance of care

Chapter 7: Implementation
Process for engaging with clusters and practices
Leadership and change management capacity and support
Multi-disciplinary team development: how practices, clusters and the wider MDT will be supported to develop new ways of working
Workforce requirements

Chapter 8: Evaluation and outcomes

Key success indicators over the life of the plan and how these will be assessed

Annex B – Outline Resources

Primary Care Fund £m	2018-19	Notes
GP MDT & Transformation	**44.855**	Pharmacy, community links workers, GP recruitment and Retention, PCTF, OOH, Vaccination Transformation Programme
GMS:		GP Additional Support: Oxygen, occ health, parental leave, sickness, appraisal, workforce survey and GP retainers scheme
Formula/Income Protection	23.000	
Protected Learning Time	2.500	
Rural package	2.000	
GP Additional support	3.075	
GMS Total	**30.575**	
National Boards	**12.800**	Cluster support (HIS and LIST), SAS Strategy/national board transformation, practice nurse training
National Support	5.570	National Support: Primary care development, GP sustainability recs, community eyecare review, Scottish School of Primary Care national evaluation
GP IT	0.000	
GP clusters (PQLs)	5.000	
Pharmacy Training & Education	4.000	
Pharmacy MDT/GP clinical supervision	2.200	
GP Recruitment and Retention	5.000	
Primary Care Division Total	**21.770**	
Total: Primary Care Fund	**110.000**	

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