

DELIVERING THE NEW 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND

Recommendation:-

To note the introduction of the new GP contract, and the development of Primary Care Improvement Plans.

To endorse the draft Memorandum of Understanding on GMS Contract Implementation

Purpose of Paper:-

- Outline the content of the proposed new 2018 General Medical Services (GMS) Contract in Scotland;
- Outline the draft Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards, including the requirement for Primary Care Improvement Plans to be developed by 1 July 2018

Key Issues to be considered:-

Any Patient Safety /Patient Experience Issues:-

The new contract aims to maintain and improve access, improve quality of care and enable patients to access the most appropriate professional.

Any Financial Implications from this Paper:-

The implementation of the General Medical Services contract for Scotland will be enabled by £250million per annum phased additional investment by 2021 in support of General Practice.

Any Staffing Implications from this Paper:-

The new contract supports the development of new roles within multi-disciplinary teams working in and alongside GP Practices. The contract also plans the transition of the GP role into an Expert Medical Generalist. These changes will require local and national workforce planning and development.

Any Equality Implications from this Paper:-

None at this stage but the impact on different groups will be reviewed throughout implementation

Any Health Inequalities Implications from this Paper:-

The proposals aim to address health inequalities and improve population health

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:-

No

Highlight the Corporate Plan priorities to which your paper relates:-

The new contract aims to support transformational change in primary care, and are therefore integral to the Board's Moving Forward Together transformational plan

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BACKGROUND

1. On 13 November 2017, the Scottish Government published the draft 2018 General Medical Services Contract in Scotland.
2. Following a poll of GPs in Scotland, the new contract proposals were agreed by the Scottish General Practitioners' Committee on 18 January 2018.
3. Regulations are now being finalised to be laid before Parliament, to enable the new contract to be implemented from 1 April 2018.
4. The contract aims to improve access for patients, address health inequalities and improve population health including mental health, provide financial stability for GPs and reduce GP workload through the expansion of the multi-disciplinary team.
5. The intended benefits for patients of the proposals in the new contract 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.
6. The intended benefits for the profession of the proposals in the new contract are:
 - A refocusing of the GP role as Expert Medical Generalist;
 - A new workload formula and increased investment in general practice;
 - 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.
7. The contract moves to recognise the GP as the Expert Medical Generalist (EMG) and senior clinical decision maker in the community. 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;
8. The draft contract is the culmination of negotiations between the Scottish GP Committee (SGPC) of the British Medical Association (BMA), and the Scottish Government. The formal negotiations were informed and supported by a range of other forums including GMS Reference Group (jointly chaired by Andrew Scott, Director of Population Health, Scottish Government and John Burns, Chief Executive NHS Ayrshire & Arran) and tri-partite meetings between Scottish Government, BMA, and nominated Chief Officers of Integration Authorities.
9. The new contract is set out in a Contract Framework with a number of supporting documents, including:
 - Draft Memorandum of Understanding (MoU)
 - Premises Code of Practice
 - Pay and Expenses review
10. The new contract will support significant development in primary care. The draft Memorandum of Understanding (attached) 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).

11. 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, as employers and partners to General Medical Service contracts.
12. 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.
13. 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.

KEY PROVISIONS

14. **Development of Primary Care Improvement Plans.** The Memorandum of Understanding sets out requirements for IJBs to develop Primary Care Improvement Plans, with the following requirements.
 - The plan will outline how new funding will be used to establish an effective multi-disciplinary team (MDT) model at Practice and Cluster level by March 2021.
 - These plans will be developed in collaboration with local GPs and others and should be agreed with the GP Subcommittee of the Area Medical Committee (or representatives by agreement locally) 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;
 - IJBs will be accountable for delivery and monitoring progress for the local Plan;
 - Where more than one IJB is covering a NHS Board area, the IJBs must collaborate in relation to effective and efficient use of resources.
15. **Multi Disciplinary Team.** The MoU outlines the priorities for development of the multi disciplinary team over a three year period. This has been informed by tests of change across Scotland, including the New Ways programme in Inverclyde which acted as a demonstration site for primary care transformation. The priorities are:
 - Vaccination services (staged for types of vaccinations but fully in place by April 2021)
 - 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)
 - 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;
 - Urgent care (advanced practitioners, nurses and paramedics) undertaking home visits and unscheduled care;

- Additional professionals for multi-disciplinary team dependent on local geography, demographics and demand (e.g. physiotherapists focusing on musculoskeletal, mental health services)
- Community Link Workers

16. 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 will continue to be employed by Practices and Practice Managers will contribute to the development of the wider Practice Teams.

17. Practice Services

- 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 choose to do so;
- Practices currently deliver a wide range of enhanced services. The intention is that there will be no more new enhanced services but current enhanced services will continue until there is a managed change which is carefully planned to ensure patient safety, quality of service and practice stability.
- 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;

18. Quality: Improving Together Cluster Framework. GP Clusters are professional groupings 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. Key aspects of this are:

- 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 on the development and implementation of Primary Care Improvement Plans;
- 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.
- Clusters will be supported by Local Intelligence Support Team (LIST) analysts and Healthcare Improvement Scotland support to HSCPs;
- 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.

- 19. Funding.** Over the period of implementation, £250m of new funds will be invested in direct support of 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 new funding formula has been introduced with the intention of better reflecting practice workload. This is supported by additional investment of £23m. No practice has a reduction in funding: a practice income guarantee means that any practices not gaining additional resources through the new formula will see their funding maintained at current levels. Within Greater Glasgow and Clyde, an additional £5.4m has been allocated to practices with 184 out of 237 practices increasing their funding.
 - 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).
 - A proportion (to be confirmed) of the £110m for 2018/9 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.
- 20. Premises.** The new contract supports a long-term shift towards a model which does not presume that GPs own or provide their practice premises. This will be a transition over 25 years, supported in the short and medium term by:
- Interest-free sustainability loans of up to 20% of premises value for owner occupied premises, supported by additional £10 million annual investment;
 - A planned programme to enable NHS Boards to take on leases from practices or provide alternative accommodation.
 - NHS Boards must now include GP owned premises and premises leased by GPs from private landlords in their Property and Asset Management Strategies.
- 21. IT systems and Information Sharing.** The contract is underpinned by a new information sharing agreement whereby NHS Boards and GP contractors are joint Data Controllers. This has been developed to enable sharing of data to support clinical care particularly in relation to the extended multi-disciplinary team, and to ensure that the requirements of the Data Protection Act 1998 and the new General Data Protection Regulations (due to come into force in May 2018) are met. Further detail is being developed in the regulations. In addition to this, it is intended that all GP practices will transition to a new clinical IT system by 2020; this is currently being procured at national level.

IMPLEMENTATION IN GREATER GLASGOW AND CLYDE

- 22.** HSCPs have responsibility for planning and commissioning primary care services which integrate with locality services and are responsive to local needs and that work effectively with GP Clusters. Individual GP practices each hold a contract with the NHS Board; effective implementation and a delivery sits as a responsibility with each HSCP working with local practices in their area. The changes envisaged in the new contract with implementation of the priority developments, changes to the role of GPs, training and role of Practice staff, premises, quality planning, improvement and assurance arrangements are significant and will require coordination across the Greater Glasgow and Clyde area in order to be efficient and effective.
- 23.** Across Greater Glasgow and Clyde, the six HSCPs will therefore collaborate with each other and with NHS Board functions on the development of the Primary Care Implementation Plans.

- 24.** Each Primary Care Improvement Plan will be developed in collaboration with the GP Sub Committee of the Area Medical Committee building on existing collaborative working arrangements as part of an agreed GGC wide approach, and approved by the relevant IJB.
- 25.** Contractual arrangements are currently supported through a number of NHS Board functions including Primary Care Support and Development (hosted by Renfrewshire HSCP), Premises Support (Facilities), Finance and IT support (eHealth).
- 26.** The Chief Executive will work with Chief Officers and others to ensure appropriate arrangements are in place for reporting on implementation of the new GP contract through Board Committee structures. .

**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

Introduction and Context

The principles underpinning the approach to general practice in Scotland were set out in a document *General Practice: Contract and Context – Principles of the Scottish Approach* published by the Scottish General Practitioners Committee (“SGPC”) of the British Medical Association (BMA) and the Scottish Government in October 2016, noting that the Scottish Government and the SGPC are the two negotiating parties on commercial general practitioner (GP) contractual matters in Scotland. This Memorandum of Understanding (“MOU”) between **The Scottish Government, the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards** builds on these arrangements and represents a landmark statement of intent, recognising the statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) (“the Act”) of Integration Authorities in commissioning primary care services and service redesign to support the role of the GP as an expert medical generalist. The MOU also recognises the role of NHS Boards in service delivery and as NHS staff employers and parties to General Medical Services (“GMS”) contracts.

For the purposes of this MOU, we refer to Health and Social Care Partnerships (HSCPs) responsible for the planning and commissioning of primary care services.

As an Expert Medical Generalist (as defined in the [Scottish GMS contract offer document](#) for 2018 the “Scottish Blue Book”), the GP will focus on:

- undifferentiated presentations,
- complex care,
- local and whole system quality improvement, and
- local clinical leadership for the delivery of general medical services under GMS contracts.

Expert Medical Generalists will strive to ensure robust interface arrangements, connection to and coherence with other parts of the wider primary care team (e.g. nurses physiotherapists), health and social care community based services and with acute services where required. The EMG will be supported by a multi-disciplinary team (MDT); maximising the contribution of both clinical and non-clinical staff in medicine, nursing, allied health professions, links workers, practice management, administration and others.

Delivering improved levels of local care in the community will have a clear benefit for patients and must rely on effective collaboration between GPs, HSCPs, NHS Boards and other partners, both in and out of hours, valuing the respective contributions of those who deliver these services. This will require clear articulation of the respective roles and responsibilities of GPs and other members of the primary care team both generally and in respect of each of the services set out in a HSCP Primary Care Improvement Plan (see Sections F and G of this MOU).

The development of primary care service redesign in the context of delivery of the new GMS contract should accord with seven key principles:

Safe – Patient safety is the highest priority for service delivery regardless of the service design or delivery model.

Person-Centred - Partnerships between patients, their families and those commissioning and delivering healthcare services work to provide care which is appropriate and based on an assessment of individual needs and values and is outcome focussed, demonstrates continuity of care (in the context of both professionals and services), clear communication and shared decision-making. Having regard to the five principles underpinning the Health and Social Care Standards: dignity and respect, compassion, to be included, responsive care and support and wellbeing.

Equitable – fair and accessible to all.

Outcome focused – making the best decisions for safe and high quality patient care and wellbeing.

Effective - The most appropriate treatments, interventions, support and services will continue to be accessible, provided in the most appropriate place by the right person at the right time to everyone. Changes to service delivery should not result in any diminution of care or outcomes for patients.

Sustainable – delivers a viable long term model for general practice that is resilient in the context of the wider community care setting on a continuous basis; and promotes and supports the development of the skill mix within the practice setting.

Affordability and value for money – Making the best use of public funds; delivering the general practice model within the available resources; with appropriate quality assurance processes.

An important determinant of success will be how the planned changes are implemented, seek to influence and depend on wider services.

This change has already started with the move away from the Quality and Outcomes Framework introduced in the 2004 GMS contract. The new approach introduced by the GMS Statement of Financial Entitlements for 2016-17, sees GP practices working together in local Clusters with their HSCP and NHS Boards to identify priorities and improve the quality of services and outcomes for people.

Further key enablers for change include:

(1) Premises: The National Code of Practice for GP Premises sets out how the Scottish Government will support a shift, over 25 years, to a new model for GP premises in which GPs will no longer be expected to provide their own premises. The measures outlined in the Code represent a significant transfer in the risk of owning premises away from individual GPs to the Scottish Government. Premises and location of the workforce will be a key consideration in delivering the multi-disciplinary arrangements envisaged in the HSCP Primary Care Improvement Plan. Details on the criteria for lease transfer and for accessing interest free loans will be set out in the premises Code of Practice and summarised in the GMS contract offer document which sets out the terms of the proposed new Scottish GMS contract.

(2) Information Sharing Arrangements: The Information Commissioner's Office (ICO) has issued a statement that whilst they had previously considered GPs to be sole data controllers of their patient records; they now accept that GPs and their contracting Health Boards have joint data controller processing responsibilities towards the GP patient record.

The new GMS contractual provisions in Scotland will reduce the risk to GPs of being data controllers by clarifying respective responsibilities within this joint controller arrangement. These contractual changes will support ICO's position that GPs are not the sole data controllers of the GP patient records but are joint data controllers along with their contracting NHS Board. The contract will clarify the limits of GPs' responsibilities and GPs will not be exposed to liabilities relating to data outwith their meaningful control.

The new contractual provisions will lay the foundations for increased lawful, proactive and appropriate sharing of information amongst professionals working within the health and social care system for the purposes of patient care.

(3) Workforce: The national health and social care workforce plan published on 28 June 2017 noted that Part 3 of the Plan, which would determine the Scottish Government's thinking on the primary care workforce, would be published in early 2018 following the conclusion of the Scottish GMS contract negotiations. The Plan will set out a range of options at national, regional and local level for the recruitment and retention of GPs and the expansion of the capacity and capability of the multi-disciplinary team. This will include plans for recruitment, training and development of specific professional groups and roles.

A. Purpose and aim of the MOU

This MOU will cover an initial 3 year period 1 April 2018 to 31 March 2021 and is structured to set out the key aspects relevant to facilitating the statement of intent the document represents:

Section A – Purpose and aim

Section B - Parties and their responsibilities

Section C - Key stakeholders

Section D - Resources

Section E - Oversight

Section F – Primary Care Improvement Plans

Section G – Key Priorities

It provides the basis for the development by HSCPs, as part of their statutory Strategic Planning responsibilities, of clear HSCP Primary Care Improvement Plans, setting how additional funding will be used and the timescales for the reconfiguration of services currently delivered under GMS contracts. Plans will have a specific focus on the key priority areas listed at Section G of this MOU with the aim of transitioning their delivery by the wider MDT between 2018 and 2021.

Taken together with the Scottish GMS contract offer document, the National Code of Practice for GP premises, and the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018, this 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.

In addition, The *National Health and Social Care Workforce Plan: Part 3 Primary Care*, to be published following agreement on the new Scottish GMS contract, will set out the context and arrangements for increasing the Scottish GP and related primary care workforce and both the capacity and capability of the multi-disciplinary team.

This MOU will be reviewed and updated by the parties before 31 March 2021 through arrangements that will be agreed by March 2018

B. Responsibilities (of parties to the MOU)

The respective responsibilities of the parties to this MOU are:

Integration Authority responsibilities (typically delivered through the Health and Social Care Partnership delivery organisations):

- Planning, design and commissioning of the primary care functions (including general medical services) delegated to them under the 2014 Act based on an assessment of local population needs, in line with the HSCP Strategic Plan.
- The development of a HSCP Primary Care Improvement Plan, in partnership with GPs and collaborating with other key stakeholders including NHS Boards that is supported by an appropriate and effective MDT model at both practice and Cluster level, and that reflects local population health care needs.
- Collaboration with NHS Boards on the local arrangements for delivery of the new Scottish GMS contract.
- Section 2c of the National Health Service (Scotland) Act 1978 places a duty on NHS Boards to secure primary medical services to meet the reasonable needs of their NHS Board area. To achieve this, NHS Boards can enter into GMS contracts. HSCPs will give clear direction to NHS Boards under sections 26 and 28 of the 2014 Act in relation to the NHS Board's function to secure primary medical services for their area and directions will have specific reference to both the available workforce and financial resources.
- Where there is one or more HSCP covering one NHS Board area, the HSCPs will collaborate under section 22 of the 2014 Act in relation to the effective and efficient use of resources (e.g. buildings, staff and equipment) to achieve coherence and equity across service planning, design and commissioning.
- Ensuring that patient needs identified in care plans are met

Scottish General Practice Committee responsibilities:

- Negotiating, with the Scottish Government, the terms of the GMS contract in Scotland as the negotiating committee of the BMA in Scotland.
- Conducting the poll (and any future poll) of its members on the terms of the GMS contract in Scotland.
- Representing the national view of the GP profession.
- Explaining the new Scottish GMS contract to the profession (including communication with Local Medical Committees (LMC) and GP practices).
- Ensuring that GP practices are supported encouraged and enabled to deliver any obligations placed on them as part of the GMS contract; and, through LMCs and clusters, to contribute effectively to the development of the HSCP Primary Care Improvement Plan.

NHS Territorial Boards responsibilities:

- Contracting for the provision of primary medical services for their respective NHS Board areas
- Ensure that primary medical services meet the reasonable needs of their Board area as required under Section 2C of the NHS (Scotland) Act 1978.
- Delivering primary medical services as directed by HSCP as service commissioners.
- Arrangements for local delivery of the new Scottish GMS contract via HSCPs
- As employers, NHS Boards will be responsible for the pay, benefits, terms and conditions for those employees engaged in the delivery of the priority areas set out in Section G.

Scottish Government responsibilities:

- Setting the legislative framework underpinning the commissioning of primary medical services by HSCPs and delivery by NHS Boards.
- In collaboration with NHS Boards and with HSCPs, shaping the strategic direction and the development of commissioning guidance in respect of primary care that is in line with the aims and objectives set out in National Clinical Strategy and the Health and Social Care Delivery Plan.
- Providing financial resources in support of the new Scottish GMS contract and primary care transformation (including the transfer of services) in line with the Scottish Government spending review process.
- Making arrangements with stakeholders to meet the future GP workforce requirements both in terms of numbers and education and training.
- Agreeing the metrics and milestones against which progress will be measured; with regular progress reporting as part of the existing statutory arrangements for reporting performance against Strategic Plans.

C Key Stakeholders

HSCPs must collaborate with NHS Boards as partners in the development and delivery of their Strategic Plan (and the associated Primary Care Improvement Plan). Local and Regional Planning arrangements will need to recognise the statutory role of the HSCP as service commissioners; and the partnership role of NHS Boards as NHS employers and parties to the GMS contracts for the delivery of primary medical services in their Board area.

In addition to this, 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

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.

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.

D. Resources

General Practice funding – through the GMS contract funding allocated to NHS Boards, general practice funding represents a significant element of the public investment in community and primary care. The published draft Primary Medical Services budget was £821 million in 2017-18 – funding the remuneration of 4,460 General Practitioners; the c.3000 practice staff they employ, both nursing and non-clinical, and the non-staff expenses of running practices. This investment enables over 23 million healthcare interactions every year. The Primary Medical Services investment funds the part of the system that is the first port of call for most people's healthcare needs most of the time. In addition to the direct care enabled by this investment, the clinical decisions GPs make – whether to treat; how to treat; whether to refer to further specialist treatment – have a much wider impact on the health and social care system. The "GP footprint" is estimated to be as much as four times the

direct investment in Primary Medical Services. This investment through the contract is, therefore, critical to the sustainability of the whole health and care system.

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 invested through the Primary Care Fund in direct support of general practice. Further investment will see this increase over the 3 financial years from 1 April 2018 to £250 million 2021-22.

Process

Specific levels of resource will be agreed as part of the Scottish Government's Spending Review and budget processes and allocated in line with the arrangements set out in this MOU.

Where appropriate these resources will be allocated to HSCPs through their NHS Board partners in line with the Scottish Government's National Resource Allocation formula (based on population need and taking account of geography and of life circumstances, including deprivation). Resources will be spent for the purposes set out in this Memorandum and in line with each HSCP Primary Care Improvement Plan to enable the transition to be managed and implemented effectively. The HSCP Plans must demonstrate how the funding will flow/be used to enable the redistribution of work from GPs to others and to optimise the role and functionality of the wider MDT. HSCPs will agree these Plans locally. These plans will be developed in collaboration with local GPs and others and should be developed with GP Subcommittee (or representatives of by agreement locally) as the formally agreed advisors on general medical service matters. However, the arrangements for delivering the new GMS contract will be agreed with the Local Medical Committee. Integration Authorities will hold their officers to account for delivery of the milestones set out in the Plan, in line with their responsibility to ensure delivery of Strategic Plans, and through regular reporting to the Authority. Key partners and stakeholders should be fully engaged in the preparation, publication and review of the plans.

The resources and any associated outcomes and deliverables (aligned to the Scottish Government's National Performance Framework and the six Primary Care Outcomes) will be set out in an annual funding letter as part of the Scottish Government's budget setting process.

The extent and pace of change to deliver the changes to ways of working over the three years (2018-21) will be determined largely by workforce availability, training, competency and capability, the availability of resources through the Primary Care Fund, and will feature as a key element of the National Health and Social Care Workforce Plan: Part 3 Primary Care.

E. Oversight

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

A National GMS Oversight Group (“the national oversight group”) with representatives from the Scottish Government, the SGPC, HSCPs and NHS Boards will be formed to oversee implementation by NHS Boards of the GMS contract in Scotland and the HSCP 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, including NHS Boards, HSCPs and SGPC where appropriate 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. These may include: GP Contract Implementation Group; GP premises; GP IT, e-Health; Data and Information; Remote and Rural; Nursing; GPN Group; Vaccination Transformation Programme; Patient Groups.

As well as the requirements on the HSCP to develop a Primary Care Improvement Plan as set out in Section D, NHS Boards with HSCPs will develop clear arrangements to deliver the commitments in respect of the new Scottish GMS contract as set out in the Scottish GMS contract offer document. These arrangements will include the priority areas set out in Section G of this MOU and must be agreed with the LMCs.

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 as set out above. The HSCP Primary Care Improvement Plan should 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 as set out above. HSCPs and NHS Boards will discuss and agree locally the arrangements for providing appropriate levels of support to enable this advice to be provided.

Within HSCPs, GP clusters have a critical role in improving the quality of care in general practice and influencing HSCPs both regarding how services work and service quality. Improving Together: a new quality framework for GP Clusters in Scotland¹ provides a framework for how that learning, developing and improving may be achieved. As GP Clusters mature, they will be expected to have a key role in proactively engaging with HSCPs, advising on the development of HSCP Primary Care Improvement Plans and working with their MDT and wider professional networks to ensure highly effective health and social care provision within and across the HSCP area and where relevant across HSCPs.

HSCPs will support and facilitate GP Clusters to ensure their involvement in quality improvement planning and quality improvement activity as part of whole system improvement. *Healthcare Improvement Scotland* will work in support of HSCPs where required to ensure that GP clusters have the support they need to engage effectively in quality improvement activity.

The *Local Intelligence Support Team* (LIST) already provides support to HSCPs and has been commissioned to provide support through HSCPs to GP clusters. This support involves on-site expert analytical advice to provide local decision-makers with meaningful and actionable intelligence, leading to improved outcomes for service users.

F. Primary Care Improvement Plan

The collaborative implementation of the new GMS contract in Scotland should be set in the context of the HSCP Primary Care Improvement Plan. Plans must determine the priorities based on population healthcare needs, taking account of existing service delivery, available workforce and available resources. To support that aim HSCPs will collaborate on the planning, recruitment and deployment of staff.

Some services which are currently provided under general medical services contracts will be reconfigured in the future. Services or functions which are key priorities for the first 3 years from 2018 - 2021 are listed in Section G below. The expectation should be that, where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices.

Additional investment is intended to provide additional MDT staff, which should, where appropriate, be aligned to GP practices to provide direct support to these practices under the oversight of GPs as senior clinicians. It will be important that GPs continue to work to their responsibility to ensure that their premises remain fit for purpose, services remain accessible to patients, that they are responsive to local needs and can maintain continuity of care; all of which will allow GPs to deliver an effective, integrated service as part of the MDT.

The HSCP Primary Care Improvement Plans will be considered alongside the NHS Board arrangements for the delivery of the GMS contract in Scotland in line with the requirements of the Scottish contract offer document.

The Plan should also consider how the new MDT model will align and work with community based and where relevant acute services, subject to wider stakeholder engagement to be determined by the HSCP in line with their statutory duty to consult.

Key Requirements of the Primary Care Improvement Plan:

- To be developed collaboratively with HSCPs, GPs, NHS Boards and the stakeholders detailed in Section C;
- To detail and plan the implementation of services and functions listed as key priorities under Section G, with reference to agreed milestones over a 3 year time period;
- To give projected timescales and arrangements for delivering the commitments and outcomes in the priority areas under Section G and in particular to include intended timescales for the transfer of existing contractual responsibility for service delivery from GPs.
- To provide detail on available resources and spending plans (including workforce and infrastructure);
- To outline how the MDT will be developed at practice and cluster level to deliver primary care services in the context of the GMS contract.
- Initial agreement for the Primary Care Improvement Plan secured by 1 July 2018

G. Key Priorities

Existing work to develop and test new models of care has shown benefits from the effective deployment of other professional staff working within a wider MDT aligned to general practice. The priority between 2018 and 2021 will be on the wider development of the services detailed below. Changes to services will only take place when it is safe to do so. The service descriptions and delivery timescales given here are provided for the purposes of this MOU.

(1) The Vaccination Transformation Programme (VTP) was announced in March 2017 to review and transform vaccine delivery in light of the increasing complexity of vaccination programmes in recent years, and to reflect the changing roles of those, principally GPs, historically tasked with delivering vaccinations.

In the period to 2021, HSCPs will deliver phased service change based on a locally agreed plan as part of the HSCP Primary Care Improvement Plan to meet a number of nationally determined outcomes including shifting of work to other appropriate professionals and away from GPs. This has already happened in many parts of the NHS system across Scotland for Childhood Immunisations and Vaccinations. This change needs to be managed, ensuring a safe and sustainable model and delivering the highest levels of immunisation and vaccination take up. As indicated above, there may be geographical and other limitations to the extent of any service redesign.

(2) Pharmacotherapy services – These services are in three tiers divided into core and additional activities, to be implemented in a phased approach.

By 2021, phase one will include activities at a general level of pharmacy practice including acute and repeat prescribing and medication management activities and will be a priority for delivery in the first stages of the HSCP Primary Care Improvement Plan. This is to be followed by phases two (advanced) and three (specialist) which are additional services and describe a progressively advanced specialist clinical pharmacist role.

(3) Community Treatment and Care Services - 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 will be delivered as a priority in the first stage of the HSCP Primary Care Improvement Plan.

This change needs to be managed to ensure, by 2021 in collaboration with NHS Boards, a safe and sustainable service delivery model, based on appropriate local service design.

(4) Urgent care (advanced practitioners) - These services provide support for urgent unscheduled care within primary care, such as providing advance practitioner resource 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, allowing GPs to better manage and free up their time.

By 2021, in collaboration with NHS Boards there will be a sustainable advance practitioner provision in all HSCP areas, based on appropriate local service design. 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.

(5) 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 (as part of the wider MDT); this would be determined by local needs as part of the HSCP Primary Care Improvement Plan. For example, but not limited to:

- *Musculoskeletal focused physiotherapy services*
- *Community clinical mental health professionals (e.g. nurses, occupational therapists) based in general practice*

By 2021 specialist professionals will work within the local MDT to see patients at 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.

(6) *Community Links Worker (CLW)* is 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 Plan HSCPs 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.

Workforce As part of their role as EMGs, GPs will act as senior clinical leaders within the extended MDT as described in this MOU. Many of the MDT staff deployed in the priority areas under (1) to (6) of Section G in the MOU will be employed by the NHS Board and work with local models and systems of care agreed between the HSCP, local GPs and others. Staff will work as an integral part of local MDTs. NHS Boards, as employers, will be responsible for the pay, benefits, terms and conditions for these staff. Some MDT members will be aligned exclusively to a single GP practice while others may be required to work across a group of practices (e.g. Clusters). Workforce arrangements will be determined locally and agreed as part of the HSCP Primary Care Improvement Plans.

Existing practice staff will continue to be employed directly by practices. Practice Managers, receptionists and other practice staff will continue to have important roles in supporting the development and delivery of local services. Practices Managers should be supported and enabled to contribute effectively to the development of practice teams and how they work across practices within Clusters and in enabling wider MDT working arrangements.

Signatories

Signed on behalf of the Scottish General Practice Committee

Name: _____ Date: _____

Signed on behalf of Integration Authorities (31 individual signatures)

Name: _____ Date: _____

Signed on behalf of NHS Boards

Name: _____ Date: _____

Signed on behalf of the Scottish Government

Name: _____ Date: _____

¹ Improving together: a new quality framework for GP clusters in Scotland

DRAFT