NHS Greater Glasgow & Clyde

NHS Board Meeting

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DELIVERING THE NEW 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND
Update on the Development of the Primary Care Improvement Plans

Recommendation

The NHS Board is asked:

- To note the development of six Primary Care Improvement Plans, one for each HSCP within the Greater Glasgow and Clyde area
- To note progress with this and other aspects of implementation of the new GMS contract
- To agree the proposed governance and reporting arrangements including agreeing to receive an annual report on the implementation of the new GP contract.

Purpose of Paper

To provide an update on the implementation of the new General Medical Services contract including the development of Primary Care Improvement Plans in each HSCP

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. As new services develop, the impact on patient experience will be reviewed.

Any Financial Implications from this Paper:-

Plans are supported by a new Primary Care Improvement Fund with a share of £10.2m in 2018/19 for NHSGGC to be allocated in full to HSCPs. This is expected to rise for the following three years. The scale and pace of change is explicitly linked to available finance and workforce. However, further modelling is required to assess the three year requirements and overall affordability of the contract commitments.

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. This will involve the creation of a large number of new roles and posts working within primary care, employed by the NHS Board. This requires robust workforce planning, support to the development of new teams and roles, and consistent approaches across GGC.

Any Equality Implications from this Paper:-

EQIA will be carried out for each Primary Care Improvement Plan

Any Health Inequalities Implications from this Paper:-

Primary Care Improvement Plans set out how they intend to address inequalities in line with local population health needs.

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

Risk assessments have been carried out for specific aspects of the contract implementation. Specific issues highlighted include:

- Workforce: availability of staff, capacity for training and development for new roles; risks across professions if there is movement of staff
- Finance: uncertainty over the three year funding trajectory, and some unknowns about the full costs of the commitments to develop new services
- Capacity: the new contract and Primary Care Improvement Plans represent a major change programme with significant leadership and change management capacity required.
- Supporting the ongoing sustainability of practices as the new services develop
- Premises: availability of accommodation for new staff and longer term property strategies to ensure fit for purpose premises

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

The plans aim to support transformational change in primary care, and are therefore integral to the Board's Moving Forward Together programme

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DELIVERING THE NEW 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND

Update on Progress and Implementation

BACKGROUND

1. The new Scottish General Medical Services contract was agreed in January 2018 and new regulations were introduced to Parliament on 1 April 2018. The NHS Board and each Integrated Joint Board received a paper in February 2018 setting out the requirements of the new contract and the proposed approach to implementation.

2. The new 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.

3. 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.

4. A range of key provisions were set out in the new contract documentation and accompanying Memorandum of Understanding (MoU). The MoU sets out an agreement between Integration Authorities, the Scottish General Practitioners Committee of the British Medical Association, NHS Boards and Scottish Government on principles of service redesign, ring fenced resources to enable change to happen, new national and local oversight arrangements and agreed

priorities. This included a commitment for each Health and Social Care Partnership (HSCP)to develop a 3 year Primary Care Improvement Plan (PCIP).

5. 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.

6. The contract and MoU set out a planned transition over three years commencing in 2018/19. A substantial programme of change is required to achieve this transition working through our 6 HSCPs with the 236 general practices across NHSGGC.

7. This paper provides an update on progress with implementation of the new contract, setting out action in relation to:
   - The Memorandum of Understanding and development of Primary Care Improvement Plans
   - Funding
   - GP Premises and new GMS regulations
   - Governance and reporting arrangements
   - Evaluation

MEMORANDUM OF UNDERSTANDING AND PRIMARY CARE IMPROVEMENT PLANS

8. The Memorandum of Understanding set out requirements for Integration Authorities through their Health and Social Care Partnerships to develop Primary Care Improvement Plans which outline how new funding will be used to establish an effective multidisciplinary team (MDT) model at Practice and Cluster level by March 2021. These plans had to be agreed with GP Sub Committee of the Area Medical Committee as the formally agreed advisors on general medical service matters.

9. Primary Care Improvement Plans for each of the six HSCP areas have now been agreed with the GP Sub Committee and subsequently approved by each of the Integration Joint Boards.

10. The MoU required PCIPs to be developed in collaboration with a range of stakeholders in line with IJB strategic planning responsibilities. The plans reflect local needs and priorities and set out:

    - How the multi-disciplinary team will be developed and will function at practice level and at cluster level
    - Available resources and spending plans
    - Assurance, accountability and dispute mechanisms
    - How the new delivery model will align with wider community services
    - How funding will enable the shift of work and responsibility from GPs to the wider MDT, with clear milestones for progress/delivery

11. The MoU was clear that the extent and pace of change to deliver the changes to ways of working over the three years (2018-21) would be determined largely by workforce availability, training, competency and capability and the availability of resources through the Primary Care Fund.

12. Specific commitments are set out within the MoU, some of which are mirrored by a contractual commitment to transfer responsibility for service delivery away from GP practices by March 2021. The specific commitments are:

    - Vaccination Transformation Plan.Transfer of responsibility for vaccination and immunisation delivery.
    - Pharmacotherapy Services. Provision of a comprehensive pharmacy service including acute and repeat prescribing and medication management activities Transfer of responsibility for a range

- 'Treatment room services'. Community phlebotomy, chronic disease monitoring and wider treatment room services (e.g. wound dressing, ear syringing)
- Urgent Care (ANP/paramedic). Initially focused on new advanced practice roles to undertake home visits and other urgent care
- Link Workers. Building on the existing community link worker pilots.
- Other MDT: MSK physiotherapy; mental health workers

13. Across Greater Glasgow and Clyde, there was agreement with the six Health and Social Care Partnerships, that plans should be developed within a common GGC wide framework. This set out a structure for the plans, agreed principles and common approaches.

14. Co-ordination of the development of the plans has been through the GGC Primary Care Programme Board which has whole system representation including GPs, acute services, staff partnership GP Sub/LMC,and has met monthly to:

    - Provide direction and oversight for the development of Primary Care Improvement Plans (PCIPs) in line with the Memorandum of Understanding
    - Shape local PCIP content where relevant and where there is a need for whole GGC HSCP consistency
    - Enable sharing of good practice and consistent approaches where appropriate

Throughout the period of PCIP development, the Corporate Management Team have been kept updated with a detailed presentation was provided in July 2018.

15. Within each HSCP a process was established to develop and agree the plans with extensive engagement. This includes with GPs and practice staff, Cluster Quality Leads, GP sub committee, HSCP staff, patients, families, carers and communities and external partners including SAS and NHS24. The GP Subcommittee identified an HSCP based representative to work with each of the 6 HSCPs on the development and agreement of the plans.

16. It is recognised that the plans at this stage are 'initial plans' which will describe year 1 commitments and a direction of travel for subsequent years. Further work will be required on both the implementation of the plans and the development of models for the areas which are less well developed.

17. An agreed principle for the development of the PCIPs was that early priority should be given to the areas where there is the strongest evidence base. The following areas have been identified as early priorities across all plans:

    - Expanding pharmacist support to practices
    - Vaccination Transformation Programme, starting with pre-school.
    - Treatment rooms and phlebotomy

18. Further work will be required during the first year of the plans to scope activity and delivery models in more detail for some of the priority areas, particularly urgent care and mental health. Engagement with SAS and NHS 24 particularly on urgent care and the role of paramedics has been limited to date and will need to be further developed as part of the next stage.

19. There are clear challenges around workforce, both in terms of availability of workforce at a sufficient scale to support all practices across GGC and in terms of the change process required to support effective working for new teams. In order to meet all requirements of the new contract and develop the MDT across all practices in Greater Glasgow and Clyde, an estimated additional workforce of between 800-1000 posts may be required. Robust workforce planning, integrated with wider workforce planning process across HSCPs and the Board is therefore required. Availability of key staff groups will require action at national level on training places. Staff Partnership representatives are involved at all levels.

20. Those issues which are beyond local control (e.g. training numbers) will continue to be raised through the New GP Contract National Oversight Group which brings together representatives from Scottish Government, NHS Boards, Scottish General Practitioners Committee (SGPC) and HSCP Chief Officers.

21. Within the GG&C areas HSCPs are committed to the following principles:

    - Approaches across GGC should share consistent principles and pathways, role descriptors and grading, scale (numbers of staff per practice/ patient population)
    - Recruitment should be co-ordinated across GGC where appropriate taking account of existing professional lead and hosting arrangements.

22. While the PCIPs are initially focused on the priority areas in the MoU, they are required to respond to local priorities and needs including the specific demographic and health profile in each area. Plans are expected to set out how they will address inequalities, both through the development of new services and teams and in decision making about distribution of resources. This is a potential tension where the approaches to meet the needs of the local population may not align directly with the MoU priorities.

23. Practice sustainability remains a concern with some practices facing significant challenges with recruitment and management of increasing workload. Consideration has been given to 'quick wins' which can support practices (both generally but also for those facing most pressure to) as the new teams are developed, and to prioritising additional resource to support those practices in particular need.

24. As part of the development of the plans, a clear need for effective programme management support has been identified to ensure the timely delivery of commitments and ensure that robust management and governance arrangements are in place. There is also a requirement for change management and organisational development capacity to support the development of the new teams and effective ways of working. Evidence from previous tests of change including the Inverclyde New Ways programme, Link workers and Govan Social and Health Integration Partnership (SHIP) is that change and development capacity, time and support are all critical to success.

25. Moving Forward Together (MFT). PCIPs and MFT have been developed in parallel and are mutually reinforcing. MFT envisages the development of an enhanced community network which goes beyond the changes identified in the new contract and MoU. The PCIPs are an opportunity to build an infrastructure and base for further developments that will complement delivery of MFT over time.

FUNDING

26. Funding for the delivery of Primary Care Improvement Plan commitments was confirmed by Scottish Government on 23 May 2018 in a letter which set out the new Primary Care Improvement Fund (PCIF) and allocations.

27. The PCIF is £45.7m across Scotland in year one, with an expected rise over the next four years to £55M in 2019-20, £105M in 2020-21 and to £155M in 2021-22. This is inclusive of some existing commitments and combines a number of previous separate funds. While the 18/19 allocation is confirmed, the increases in subsequent years are unconfirmed and are indicated to be for planning purposes only and will be subject to the annual Parliamentary budget process.

28. Although confirmed funding rises over a period of 4 years, the MoU and its commitments cover a 3 year period to March 2021. PCIPs reflect both the 3 year commitments where required and the fact that there will be further development in year 4 as funding is available. Long term affordability of the MoU commitments remains unclear and as plans develop we will seek to model at scale what the implications are and ensure that no commitments are made which are

not sustainable within the expected funding. This will require ongoing dialogue with Scottish Government about the affordability and flexibility of key commitments including Pharmacotherapy and the Vaccination Transformation Plan.

29. Funding is allocated by NRAC with the NHSGGC share being £10,219,379. Funding is expected to be allocated in full to HSCPs and the NRAC share for each HSCP is clearly identified. 70% of the allocation will be received initially with the remaining 30% to be allocated in November 2018 subject to submission of spending plans to Scottish Government. Where spend will not take place in year, this funding will be held over as an earmarked reserves until the following year.

30. The PCIF is part of a wider package of £115m funding in 2018/19 which supports the wider contractual commitments including the new workload formula which distributes funding directly to practices. This also includes a number of national commitments, and funding to national boards including NHS 24, SAS, NES and HIS.

31. The PCIF is being planned alongside separate allocations for out of hours primary care (£5m nationally) and for Mental Health commitment 15 (£11m nationally).

PREMISES

32. Premises. The new contract supports a long-term shift towards a model which does not presume that GPs own or provide their practice premises.

33. 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.

34. Around 50 practices who own their premises across NHSGGC have expressed an interest in the sustainability loans. The loan agreement, process and timescales is currently being finalised between Scottish Government and the Scottish General Practitioners Committee of the British Medical Association.

35. Further guidance on leases was issued on 30 August 2018. PCA(M)(2018)08 (GP premises leased from private landlords) requires Board to establish a register of those leases it is willing to take on. A process for this is currently being developed through the GMS Premises Group and Property Committee.

36. A national survey of GP premises has been commissioned and will commence in October 2018. This will provide detailed information on GP owned and leased accommodation. A similar process across Greater Glasgow and Clyde in 2008 provided comprehensive information to inform future planning for GP premises, including prioritisation for premises improvement grants and planning for new health centres. The new survey will help to inform future strategic planning for premises and enable due diligence and impact assessment to be carried out where there is a request for the Board to consider taking on an existing lease.

37. The development of the new multi disciplinary teams, coupled with the direction of travel of the new premises directions, will require a more strategic approach to planning for accommodation and premises taking account of independent contractor premises and health centres.

IT SYSTEMS and INFORMATION SHARING

38. 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 (GDPR) are met.

39. 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.

40. There are a range of ehealth enablers to ensure that the new MDTs can work effectively and that practices redesign their processes to make the most of the potential benefits. This is being considered further as part of the NHS Board's new digital strategy and through Moving Forward Together.

41. The new contract regulations state that Health Boards must appoint a jointly designated data protection officer where this has been agreed with the practice. If a jointly designated data protection officer has not been appointed, the practice must nominate a person who will work with the Health Board's data protection officer to protect personal data and the implementation of Health Board guidance, templates, and policies. This is a requirement under GDPR and is consistent with the joint data controller role of Health Boards and GP practices. Practical arrangements for supporting this are currently being agreed with the Board's Data Protection Officer in discussion with the Information Commissioner's Office.

GENERAL MEDICAL SERVICES REGULATIONS

42. The regulations which underpin the contract between Boards and GP practices have been updated as part of the new contract changes. Variations to contracts in line with the new regulations have been issued to all practices in NHS Greater Glasgow and Clyde, with new contracts in place where required.

43. The new regulations included changes to the eligibility to be a contract holder, including clearer requirements on minimum time requirements for partners to work within practices. This is being implemented for any partnership changes from 1 April 2018.

44. The new regulations introduce clearer guidelines on processes to be followed where practices wish to request a list closure (whereby they do not register new patients for a period of time) or wish to vary their practice area (the catchment from which they will accept new registrations). Local processes for this are being reviewed in line with the new regulations and agreed with the Local Medical Committee.

45. The regulations introduce a more explicit requirement for practice to provide data on workforce, activity and quality. Arrangements for capturing and analysing this, including access at NHS Board, HSCP, cluster and practice level, are currently being developed across Scotland with the Information and Statistics Division (ISD). This will give significantly enhanced data for planning purposes and to assess the impact of the changes both within primary care and the wider health and care system.

QUALITY

46. The new contract includes an ongoing commitment to Quality Improvement through the model of GP Clusters. Clusters are professional groupings of general practices that should meet regularly, with each practice represented by their Practice Quality Lead (PQL). The key role of

a cluster is to improve the quality of care within the practices and extrinsically through localities, with a focus on quality planning, quality improvement and quality assurance. This is supported through the provision of data and analysis support from the Local Improvement Support Teams (LIST) from ISD Scotland.

47. Clusters are now well established across NHSGGC with 40 clusters in place involving all practices and each with a Cluster Quality Lead. The clusters have been key structures for engagement on the development of primary care plans, as well as supporting sustainability and quality improvement in practices through peer support and review. Clusters and their role in quality will continue to be supported and developed in line with forthcoming additional guidance and development of agreed national and local datasets.

IMPLEMENTATION, GOVERNANCE and REPORTING

48. Integration Joint Boards (IJBs) have responsibility for planning and commissioning primary care services which integrate with locality services and are responsive to local needs.

49. Integration Joint Boards have responsibility for the development of Primary Care Improvement Plans through their HSCP and for ensuring the delivery of the commitments set out within them. Each Integration Joint Board has therefore established reporting arrangements to provide assurance and accountability for delivery.

50. The NHS Board has responsibility for contracting for the provision of primary medical services. Each GP practice holds a contract with the NHS Board. NHS Boards are also responsible for the pay, benefits, terms and conditions for those employees engaged in the delivery of primary care services, and for the ownership and lease of premises for delivery of NHS services.

51. The NHSGG&C Primary Care Programme Board (PCPB) has been established to guide and oversee the development of PCIPs across the 6 HSCPs and to ensure there is a coordinated and coherent approach to planning and delivery where required. The PCPB is chaired by a Chief Officer and brings together HSCP representatives with Primary Care Support (Board wide service hosted by Renfrewshire HSCP) and leads for system wide priority areas. This enables a collaborative approach to implementation and further planning, to ensure that local and system wide requirements are met.

52. The Primary Care Improvement Plans have to deliver the required changes set out in the GP contract, specifically to establish services to enable a transfer of responsibility for some services away from GP practices. The NHS Board therefore needs assurance that the collective impact of the plans will be sufficient to meet the contractual requirements.

53. It is therefore proposed that an annual report is brought to the NHS Board to set out progress on implementation of the Primary Care Improvement Plans and related contract requirements. This will build on the regular reporting through IJBs

54. Other aspects of the contract changes set out above fit within already established governance structures and reporting arrangements as set out in the NHSGGC Standing Financial Instructions and Scheme of Delegation. Examples of this include:

- GP Premises: processes and individual decisions to be agreed through Finance and Planning Committee in line with the Scheme of Delegation.
- IT: eHealth strategy group with escalation to Finance and Planning Committee in line with the Scheme of Delegation
- GMS regulations and contract changes: Primary Care Programme Board with escalation to Finance and Planning Committee in line with scheme of delegation.
- Vaccination Transformation Programme (impact on immunisation rates): Public Health Committee

- HR and staff governance including workforce planning staff governance committee

EVALUATION

55. Evaluation of the new contract, and in particular the impact of the Primary Care Improvement Plans and the development of the new Multi Disciplinary Teams, will take place at a number of levels.

56. A national monitoring and evaluation framework will be published shortly. This will set out a core set of high level indicators, as well as evaluation of specific elements of change in conjunction with the Scottish School of Primary Care and Healthcare Improvement Scotland. This will consider how the changes brought in by the new contract contribute to the national Primary Care Outcomes as part of the contribution of primary care to the wider health and social care outcomes.

57. Across NHSGGC an evaluation framework is also being established. This is seeking to answer some key questions on the implementation and impact of the new contract and establishment of the multi disciplinary team including:

    - Have we shifted non-complex work to the wider MDT and concentrated complexity on GP resource?
    - Are the new ways of working improving professional satisfaction and sustainability in primary care?
    - Are patients confident and satisfied in their use of the new primary care system?
    - Are patient outcomes and safety sustained and improved under the new system?
    - Have we improved equity across primary care?
    - What are the impacts of the new GP contract on the wider health system (not just healthcare)?

58. The initial approach will focus on establishing baseline measures and indicators, and on patient / staff / GP practice satisfaction. The next phase of evaluation will focus on outcomes at patient, practice and wider system level. This will be informed by improved data available nationally on activity and quality indicators.

59. Within each HSCP, evaluation is part of the Primary Care Improvement Plans. This will be taken forward within the overall Greater Glasgow and Clyde framework, with specific local action using improvement methodologies to gather local data on the impact of change at a small scale as part of a cycle of continual improvement and to inform the further development of the new models.