



Borders Health & Social Care Partnership

Primary Care Improvement Plan (GMS Contract)

2018 – 2021



Contents

Foreword.....	3
Introduction	4
Background	4
Governance	8
Scottish Borders Context	10
1. The Vaccination Transformation Programme (VTP)	10
2. Pharmacotherapy Services	12
3. Community Treatment and Care Services (CT&CS)	14
4. Urgent Care (Advanced Practitioners)	16
5. Additional Professional Roles	18
6. Community Link Worker (CLW)	20
7. I.T and Data/Information Collection	20
8. Premises.....	21
9. Other Areas.....	22
10. Cluster Working	22
11. Beyond General Practice.....	24
12. Budget Planning.....	24
13. Workforce.....	27
14. Risk	29
15. Engagement and Ongoing Development	29
13. Summary.....	29
Appendix 1: Memorandum of Understanding	30
Appendix 2: Primary Care Improvement Plan Summary Table	31
Appendix 3: Borders Emergency Care Services (BECS)/Out-of-Hours Working Model/MDT.....	432
Appendix 4: Primary Care Strategy Board (PCSB) Draft Terms of Reference	43

Foreword

I would like to introduce Scottish Borders' first Primary Care Improvement Plan in connection to the GMS Contract as part of the Scottish Government aim to improve Primary Care Services for all.

We now operate a new contract for our GPs across the country and here in the Scottish Borders we are looking forward to a greater joining up of services supporting our local communities.

The Borders is a wonderful and beautiful place in which to live and work. It does however provide some particular challenges around access to Health and Social Care Services.

The new legislation and this new plan developed by the professions within Primary Care is intended to better utilise our resources to meet these challenges.

It is not the final statement on Primary Care in the Scottish Borders, it is however our clear statement of intent, and we will continue to work across the professions and with the people of the Borders to provide a Primary Care Service, fit for purpose, for now and for the future.



Robert McCulloch Graham

Chief Officer, Scottish Borders Health and Social Care Partnership

Primary Care Improvement Plan (GP Contract)

Scottish Borders

Financial Year: 2018/19

Introduction

This document forms the first Scottish Borders Primary Care Improvement Plan (PCIP) linked to the new GMS Contract (2018). The PCIP has been developed as a requirement of the national Memorandum of Understanding¹ between the Scottish Government, Integration Authorities (IA), the Scottish General Practitioners Committee (SGPC) of the BMA and NHS Boards, however, it is consistent with our local priorities and objectives also set out within the Scottish Borders Strategic Plan 2016 to 2019 and NHS Borders' Clinical Strategy which reflect the commitment of the Scottish Borders Health and Social Care Partnership (H&SCP) and its partner agencies to continuously improve the quality of treatment, support and community services provided to the population.

The PCIP therefore forms a crucial strand of a transformational programme for Primary Care Services overall which will be reflected in an emerging and overarching Primary Care Strategy.

This initial PCIP is a dynamic working document and through ongoing liaison with all stakeholders will be revised as the work streams progress and implementation proceeds.

Background

National Context

On 13th November 2017 the new GMS contract was published and was accepted by the GP community in January 2018 through a ballot of the profession. The new contract is underpinned by four key documents:

- The Scottish GMS Contract Offer Document²
- The National Code of Practice for GP Premises³
- The National Health Service (GMS Contracts)(Scotland) Regulations 2018⁴;
- Memorandum of Understanding (MoU) – to cover the transition period between 2018 and 2021

¹ *Memorandum of Understanding between the Scottish Government, Integration Authorities, BMA and NHS Boards: GMS Contract Implementation in the context of Primary Care Service Redesign. (Nov 2017)*

² *The Scottish GMS Contract Offer Document 2017 (<http://www.gov.scot/Publications/2017/11/1343>);*

³ *The National Code of Practice for GP Premises 2017(<http://www.gov.scot/Publications/2017/11/7592>);*

⁴ *The National Health Service (GMS Contracts)(Scotland) Regulations 2018*

The new contract aims to refocus the role of GPs as Expert Medical Generalist's (EMG's) working within a Multi-disciplinary Team (MDT) in which the GP will focus on:

- Undifferentiated presentations;
- Complex care;
- Local and whole system quality improvement;
- Local clinical leadership for the delivery of General Medical Services (GMS).

Within the contract documents, the role of the Expert Medical Generalist is described as the following:

“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.”

To enable the development of this EMG role, there will be a shift over time of GP workload and responsibilities - this will require a wide range of tasks currently undertaken by GPs to be completed by members of a wider primary care multi-disciplinary team where it is safe and appropriate to do so, while also demonstrating an improvement for patient care.

In support of the implementation of the new contract in the context of Primary Care Service redesign, a Memorandum of Understanding (MoU) was agreed in November 2017 between Scottish Government, Integration Authorities, the Scottish General Practitioners Committee (SGPC) and NHS Boards. This is a key document that summarises the entire process.

It is a requirement of the MoU that Integrated Authorities develop and review a local Primary Care Improvement Plan (PCIP). The aim of the plan is to identify and integrate key areas to be transformed in order to achieve the GP contract goals with the expectation that reconfigured services will continue to be provided in or near GP practices.

The MoU states six nationally agreed priorities, which are evidence-based, for transformative service redesign in Primary Care in Scotland over a three year planned transition period between 2018 and 2022. These are:

- Vaccination services;
- Pharmacotherapy services;
- Community Treatment & Care Services (CT&CS);
- Urgent Care (Advanced Practitioners);
- Additional professional roles:
 - MSK Physiotherapy;
 - Community Clinical Mental Health Professionals;
- Community Link Worker's (CLW's).

GP's will retain the lead professional role in these areas in their capacity as EMG's.

The MoU also outlines some key enablers of change linked to Premises, Information Sharing Arrangements and Workforce. Within the latter, it highlights the workforce implications of the MDT:

“As part of their role as EMG’s, 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 listed above 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”

Financial resource to support delivery of the PCIP’s will be provided through the Primary Care Fund from the Scottish Government and, on the whole, will be allocated on an NRAC basis (National Resource Allocation Committee formula). Local engagement between Health Boards, GP Sub Committees and Health & Social Care Partnerships (HSCPs) is key to prioritise the work streams within the plan and subsequently agree the internal funding arrangements.

The MoU is provided on Appendix 1.

Local Context

Scottish Borders covers an area of 4,743 square kilometres (1,831 square miles), with a population of approximately 118,484 people registered with a GP practice and a population density of 25 persons per square kilometre (compared to 65 persons per square kilometre for Scotland). Thus, suggesting a less densely populated geography.

The population distribution is based mainly within 13 towns ranging in size from around 2,000 to nearly 15,000 and many smaller villages and individual houses. Cross-border flow of patients is also a consideration particularly around Newcastleton, Coldstream and Eyemouth.

Following the implementation of The Public Bodies (Joint Working) (Scotland) Act 2014, one Health & Social Care Partnership/Integrated Authority was established covering Scottish Borders as a whole and with the responsibility for the strategic planning for a range of services provided by NHS Borders. Within the Scottish Borders Integrated Authority, 5 localities have been established: namely Berwickshire, Eildon, Cheviot, Tweeddale and Teviot. Four Quality Clusters are now in place in line with the revised GMS Contract and they span across the five localities.

There are currently 23 GP practices in Borders, with 18 health centres owned by NHS Borders.

The two overarching local strategic documents are Scottish Borders Strategic Plan, developed through the IA and NHS Borders' Clinical Strategy. Both are focussed on enabling people to access the right care and support to meet their needs in the right way, in the right place and to deliver services in an integrated and person-centred way.

Scottish Borders Strategic Plan has at its core the following three objectives:

1. We will improve the health of the population and reduce the number of hospital admissions;
2. We will improve the flow of patients into, through and out of hospital;
3. We will improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them.

NHS Borders Clinical Strategy holds as its vision:

“To provide personalised, evidence based care as close to home as possible. Working with people to define treatment goals and optimise outcomes. Supporting people to stay well; treat illness and manage crises.”

The aims of the Clinical Strategy are as follows:

- Greater focus on prevention of ill health and reduction of health inequalities;
- Integrated community teams to provide support for prevention of illness to intensive care at home;
- Admission to hospital will only be required for specialist care;
- Proactive approach to Realistic Medicine;
- Sustainable, safe, high quality services across the care pathway informed by evidence supported by eHealth and digital technologies;
- A workforce that has the capacity, capability and adaptability to meet future demands.

Significant transformational change programmes are underway across the IA and NHS Borders with the aim of reshaping and improving resources in line with these principles and objectives in order to provide sustainable, safe service models within the means available. Part of this work will see the development and redesign of community services and will enable people to be supported within their own home and local communities wherever possible. The principles and aims of the PCIP along with its implementation are consistent with and inexorably linked to this wider Primary Care agenda.

Governance for the PCIP

A, 'GP Away Day' was held on 22nd May 2018 at which each area of the plan was explored, including the governance arrangements for the development and implementation of the Primary Care Improvement Plan (PCIP).

The draft PCIP was produced and updated through working with GPs, the Primary and Community Services (P&CS) team and a range of stakeholders. The PCIP has been widely shared with bodies including the GP Sub-Committee, the Clinical Executive Strategy Group and the NHS Borders Board amongst other groups in draft format. The final version of the PCIP will address the comments, concerns and suggestions of all stake holders and final agreement from the GP Sub Committee will be sought prior to submission to the Integration Joint Board (IJB) of the IA on the 20th of August for ratification.

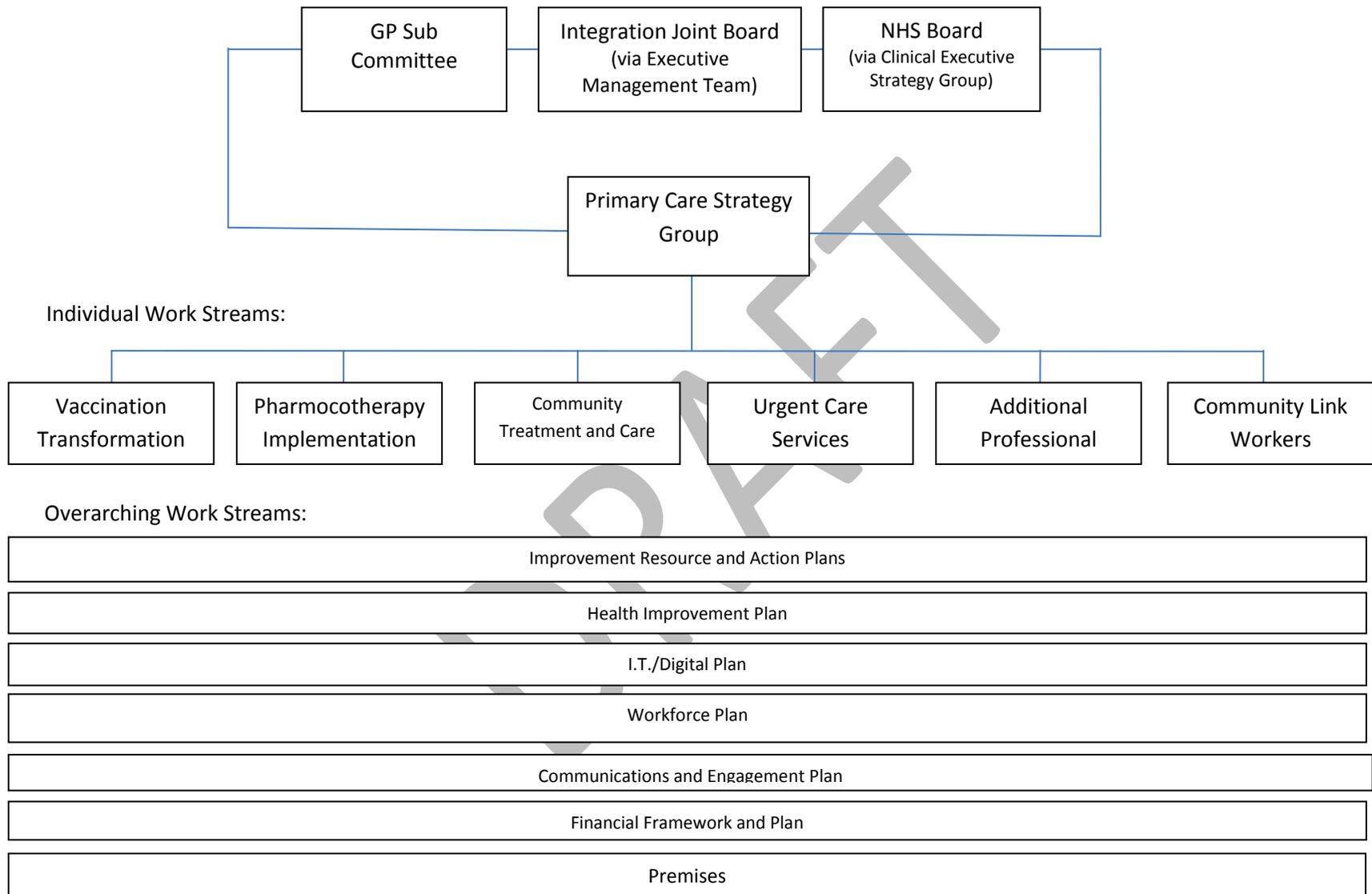
Following IA agreement, the IA will issue relevant directions to NHS Borders via the Board on the implementation of the actions from the plan. The implementation of the actions will then be the responsibility of the Primary Care Strategy Board, currently being established, which will act as a steering group (Terms of Reference on Appendix 4) to the relevant work stream project groups.

Monitoring reports will be provided to the IA, GP Sub-Committee and NHS Borders Board (through the Executive Management Team and Clinical; Executive Strategy Group).

Each work stream of the PCIP has an identified project sponsor, lead and/or practice representative with an operational group in place. These are supported by P&CS and will report into the Primary Care Strategy Board. The overall governance structure is shown overleaf.

Each strand of the programme surrounds the main delivery areas of the PCIP and will develop Key Performance Indicators (KPI's) clearly linked to outcomes, enabling shared learning and ensuring evaluation takes place.

Public representation will be progressed via the individual groups and consideration will be made to the re-establishment of Practice Patient Groups (PPG's).



Ongoing engagement with GPs, staff, Partnership and with public involvement

Scottish Borders Primary Care Improvement Plan

This first PCIP covers a period of three financial years (2018/19, 2019/20 and 2020/21) focussing on the six key areas previously noted. Those underlined are to be prioritised during year one of the transformation. They are:

1. The Vaccination Transformation Programme (VTP);
2. Pharmacotherapy Services;
3. Community Treatment and Care Services;
4. Urgent Care (Advanced Practitioners);
5. Additional Professional Roles:
 - Musculoskeletal (MSK) focused physiotherapy;
 - Community Clinical Mental Health Professionals;
6. Community Link Worker's.

In Scottish Borders, the Primary Care Strategy Group will oversee the implementation of the PCIP:

1. The Vaccination Transformation Programme (VTP)

The Scottish Government announced in March 2017 the intention to develop a Vaccination Transformation Programme (VTP) this recognises both the increasing complexity of vaccine programmes and the changing role of the GP.

The VTP has different work streams including:

- Pre-school Programme;
- School based Programme;
- Travel vaccinations and travel health advice – the MoU has prioritised this for the first year of the Programme, however, a national group has been established that will drive change;
- Influenza Programme;
- At risk and specific age group Programmes (shingles, pneumococcal, hepatitis B).

Each of these work streams will be incorporated into the overall Scottish Borders programme. The aim is to achieve seamless change.

National groups have been established to oversee vaccine transformation programmes within Health Boards. These are the Scottish Immunisation Programme Group and Business Change Manager's (BCM) Group. They will develop national strategies (e.g. information, monitoring, quality, risk management etc.), blueprints and plans that will influence local decision-making.

A Scottish Borders VTP Group has been established to drive forward local transition. This requires key stakeholder engagement and consultation with the local Area Medical Committee (AMC) as well as patient representatives (for example, via the NHS Borders Public Involvement Network).

The local VTP Business Change Manager (BCM) has been recruited and work is ongoing to:

- Review the current delivery model (i.e. via GP's including LES arrangements on a payment per item basis);

- Explore Health Board provision (through centralised Hubs potentially at Kelso, Hawick, Peebles, Duns, Galashiels or the Borders General Hospital);
- Investigate a hybrid model.

A range of considerations and challenges have been identified during the early discussions regarding the delivery of transformation and these will be addressed as part of the programme. They include:

- The current complexity of immunisation programmes;
- Patient safety must be a priority;
- Existing levels of childhood and adult immunisation in General Practice is very high;
- Public and patient expectations must be considered and appropriately managed;
- Existing GP IT systems support immunisation delivery and provide a complete record of an individual’s medical history, reducing risk if inappropriate immunisation;
- Recruitment of an appropriately skilled workforce to deliver an immunisation programme;
- An option’s appraisal is required to agree the most appropriate service delivery model for the new programmes. It will need to be flexible and acknowledge that it may not be appropriate for all areas of the Scottish Borders;
- Immunisation locations will be identified, this will be challenging due to capacity issues within Primary Care premises;
- Delivery of the currently proposed VTP has significant financial implications.

The total programme of change is scheduled over 3 years in order to recognise the length of time required to provide robust processes ensuring the safety of the public (our main priority) with assurances that structures, roles and governance will be established within the first year. It is anticipated that years 2 and 3 will realise a greater realignment of provision outside GP practice.

Different models for each vaccination type (influenza, childhood immunisation, HPV, shingles, travel, pneumococcal etc.) will be developed. The simple timeline for the transition of the individual work streams is estimated to be:

Previously Completed	Year 1	Year 2	Year 3
<ul style="list-style-type: none"> • School programme (including flu vaccines) 	<ul style="list-style-type: none"> • Pertussis/whooping cough vaccine • 0-5 years programme 	<ul style="list-style-type: none"> • Shingles (start) • Flu & Pneumococcal vaccines 65+ • Flu Vaccines (for those at risk) 	<ul style="list-style-type: none"> • Travel • Shingles (completion)

Priorities for the Vaccine Transformation Programme are still under negotiation. Options will be reviewed over the next few months with discussion taking place at the GP Sub-Committee in October. More detail will be added to the plan at this time.

2. Pharmacotherapy Services

The contract states that “From April 2018, there will be a three year trajectory to establish a sustainable pharmacotherapy service which includes Pharmacist and Pharmacy Technician support to the patients of every practice. This timeline will provide an opportunity to test and refine the best way to do this, and to allow for new Pharmacists and Pharmacy Technicians to be recruited and trained.”

This is a fundamental change in the delivery and management of Pharmacy services as they will be based at individual practice level. By April 2021 all practices will benefit from Pharmacy delivering key core services, with some practices receiving additional services where possible.

Core services to be delivered by 2021 include:

- Authorising and action all acute and repeat prescription requests;
- Authorising and action hospital immediate discharge letters (IDL’s);
- Medicines reconciliation;
- Medicine safety reviews/recalls;
- Monitoring high risk medicines;
- Non-clinical medication reviews.

Acute and repeat medicine prescription requests is a large area (a recent audit suggests 15 hours GP time, per practice, per week) which includes the authorising and action of:

- Hospital outpatient requests;
- Non-medicine prescriptions;
- Installment requests;
- Serial prescriptions;
- Pharmaceutical queries;
- Medicine shortages;
- Review of use of ‘specials’ and ‘off-licence’ requests.

This is to be managed by Pharmacists. Beyond this Pharmacy Technicians, who are in many cases already within practices at present, will also focus on:

- Monitoring clinics;
- Medication compliance reviews (patient’s own home);
- Medication management advice and reviews (care homes);
- Formulary adherence;
- Prescribing indicators and audits.

Testing elements of the Pharmacotherapy Service within a practice will be the initial stage of implementation, followed by cluster working then expansion across the Scottish Borders based on a sustainable model. This will be the challenge ahead for current Pharmacy services due to limited available resource (both financial and workforce).

Following the publication of, ‘Prescription for Excellence’ during 2013 and updated with, ‘Achieving Excellence in Pharmaceutical Care’ in 2017 the ethos of, ‘Realistic Medicine’ (also published in 2017) and polypharmacy have been followed.

There are a number of projects taking place within practices including:

- Regular patient facing review clinics (by an independent prescribing Pharmacist);
- Medicines Reconciliation (from hospital discharges when the Pharmacist is in the practice – in future a system is to be put into place);
- Polypharmacy and Care Home reviews;
- COPD/Pulmonary Rehabilitation/Inhaler Reviews;
- The Integrated Joint Board Care at Home-Pharmacy Project;
- Training & supporting practice administration teams to complete non-medication reviews.

Where practices already receive support this would then be included in this total. The capacity impact on practice workload will be assessed during the span of the PCIP.

Furthermore, there are services being delivered within Community Pharmacy which help reduce GP workload. These include:

- The Medicine Review Service;
- Pharmacy First, incorporating treatment for Urinary Tract Infections and Impetigo;
- The Chronic Medication Service (CMS).

At present it is the ambition of the H&SCP to increase this Pharmacy support to practices by expanding the current Pharmacy First services to include treatment of infected bites and exacerbations of COPD.

Pharmacists and Pharmacy Technicians will be employed by NHS Borders and will provide an agreed number of sessions to practices. This timetable will be shared with practices. When these employees are working within the practice they will use the practice's patient record system and work as part of the practice team. To provide daily support, it is expected that some of the time allocated to the practice will be provided remotely. This is to prevent 'batching' of work and help manage workflow.

The team will work under a single governance structure but will have different tasks in different practices as roles and practices develop at varying paces.

Additionally, it is expected that a unified repeat prescribing system across the whole of the Scottish Borders will be the first priority and responsibility of the NHS Borders Pharmacy department.

The resource required to achieve the contract requirements have been estimated on Table 2. This includes the relevant skill mix (with Pharmacists, Technicians & dietetics) necessary to deliver all elements of the plan:

	Baseline Primary Care Fund (£000's)	Pharmacy First (£000's)	Additional Support (PfE) (£000's)	Funding Total (£000's)	Estimated Team Costs (£000's)	Funding Requirement in Year 1 (£000's)
Table 2:						
Year 1	161	24	63	248	452	204

This level of resource will provide services during the working week (i.e. Monday to Friday) during core working hours with approximately one Pharmacist per 10,000 patients. This Pharmacist structure would be supported by technician staff by the end of Year 3.

The annual Scottish Borders Pharmaceutical Care Services plan will provide more detail on the transition process as it identifies the pharmaceutical care needs for both Community Pharmacy and Primary Care as a whole.

A general summary of the aims to be achieved by this enhanced team are:

Year 1	Year 2	Year 3
<ul style="list-style-type: none"> •Develop a unified repeat prescribing system •Ensure a sustainable process for hospital discharge letters •Establish a process for medicines reconciliations 	<ul style="list-style-type: none"> •Embed the repeat prescribing system •Create a process for Level 2 pharmacotherapy services 	<ul style="list-style-type: none"> •Roll out the medication review & high risk medicines processes •Develop support for the Level 3 pharmacotherapy services

A more specific timeline for year 1 is:

2018/19 (Year 1)	Apr 18 – Sept 18	Oct 18 – Mar 19
Process hospital discharge letters	Develop Team Protocol	Implementation
Medicines Reconciliations		
Unified Prescribing System	System Design	Pre-implementation planning/begin implementation

3. Community Treatment and Care Services (CT&CS)

Community Treatment and Care Services are one of the three main priorities for PCIPs stated within the MoU which is aiming to deliver change on a safe and sustainable basis over the next 3 years with the initial focus on phlebotomy during 2018/19.

CT&CS will include but is not limited to the following:

- Phlebotomy;
- Basic disease data collection and biometrics (e.g. blood pressure etc.);
- Chronic disease monitoring;
- Management of minor injuries and dressings;
- Ear syringing;
- Suture removal;
- Some elements of minor surgery.

In the Scottish Borders phlebotomy services have been revised and successfully remodelled historically therefore is not a priority of the PCIP in year 1. This may be revisited as the plan progresses. The initial focus locally will be in the other areas listed.

Currently CT&CS are provided across the Scottish Borders in a variety of ways and involve a range of clinical professions. This section also links with the local transformation programme for community services which is currently underway and will run concurrently with the PCIP. It will reshape community models of care, including community and day hospitals, rehabilitation services and community nursing services. The PCIP is an integral part of this overarching strategic direction for wider Primary Care in the Scottish Borders.

It has been identified that our local treatment rooms have an important role in the delivery of CT&CS, however, they will require a review to establish resources and suitability. There are 10 treatment rooms which provide services to 15 GP practices. Recognising the different starting points and challenges to be overcome in order to provide a consistent and safe service to patients it is important to establish a strong baseline to enable an appropriate treatment room model to be established.

During the first year the focus will be:

- Engaging with and applying national training structures and opportunities via the, 'Transforming Roles Programme';
- Agree set opening times and appropriate staffing levels/skill mix across all treatment rooms and community hospitals;
- Improve appointment booking systems (via the administration teams);
- Ensuring availability for both Primary and Secondary Care.

As noted previously, Community Treatment and Care Services are delivered across the whole primary care community, with links between GP practice's and other IA professionals/services. Community hospitals are a significant resource and redesigned care models have been considered within the recent research undertaken as part of the IA transformation programme.

The work being taken forward as part of the wider transformation programme will be linked with the delivery of this PCIP action point and together the following areas will be covered:

- Developing a Community Hospitals and Intermediate Care Framework;
- Review community employee levels (in Community Hospitals and Treatment Rooms);
- Create an improvement network across these services with connections to frailty and palliative care services;
- Support locality/cluster working through the realignment of the Department of Medicine for the Elderly (DME) Consultant sessions.

The local Minor Injury Units (MIUs) are connected to community hospitals and as such a review of their current demand and the resulting safety implications of continuing or expanding the role of these units will be considered.

Key to these changes is the evolving role of the nursing profession and their training requirements. The national transforming roles programme is currently in phase 1 which is focussing on a consistent

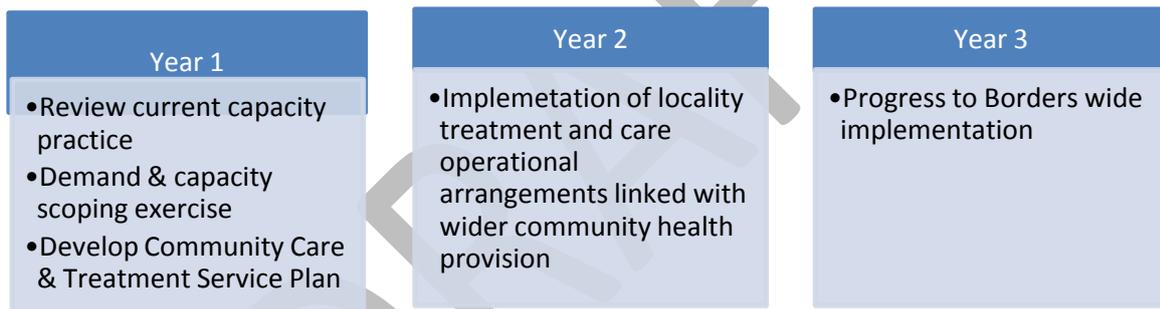
approach to Advanced Nurse Practitioners (ANP's) and developing an integrated community nursing team (containing ANP's, General Practice Nurses, District Nurses, Mental Health Nurses, Health Visitors, School Nurses etc.). The Scottish Borders are committed to being part of this process.

We therefore have the opportunity to support the education and ensuring appropriate clinical supervision is in place for ANP's in Primary Care. There is a survey of ANP education requirements underway with a plan to work to a national definition of advanced nursing practice.

There is very close linkage between the CT&CS work and urgent care with ANP's being the catalyst for change. They will be able to provide professional guidance for treatment room staff going forward as well as support the role of the EMG (see further detail in the next section).

Overall these models are a significant departure from the current process and will require developments in services, Information Technology (I.T), processes and governance in order to transfer the work from practices in a safe and sustainable manner.

The programme of work to establish new models of care is shown below:



In addition a pilot ANP led community hospital model within the Knoll and a formal Scottish Borders ANP training programme are potential developments between now and 2021.

4. Urgent Care (Advanced Practitioners)

To reduce GP workload and free up GP capacity the MoU supports the redesign of urgent and unscheduled care services. This aims at providing advanced practitioner resource (nurse or paramedic) to act as the first response to home visits or urgent call outs from patients. It is probable that these individuals will work across Clusters rather than individual practices in order to meet patient needs.

Testing of this approach has already taken place within the Scottish Borders (Hawick and Kelso) as noted on the GP contract document. During 2018/19 another pilot is in place within the South Cluster. The aim is to measure the benefits of the role and share learning from practices working collaboratively.

There are wide ranging views about how this should develop and which professional is the most appropriate to provide urgent care. As such the evidence of the impact of ANP's and paramedics within current pilots will assist with future service redesign.

Furthermore, recognising the close linkage with CT&CS the urgent care element of the PCIP will focus on ANP's initially.

To support ANP's ability to work at the required levels of clinical competence and enable GP colleagues to progress to EMG's the proposal is to appoint four additional ANP's during 2018/19 (year 1) of the PCIP, with the intention to recruit additional nurses in subsequent years. This will be to support professional leadership of this service, and enable clinical supervision. This would be at a potential cost of £211k in year 1 (see the funding elements below).

Priority for investment	Outline	Funds
Advanced Nurse Practitioners	Recruitment of 4 x Band6/7 ANP roles to support the development of ANP roles within GP practice	£191,462
	Support development of existing ANP's working with Practices	£20,000

It is proposed:

- To appoint four additional ANP's (Band 7) to act as professional leads for ANP's across Primary Care. These individuals will be involved in clinical practice with capacity (potentially 2 days per week) to provide mentorship, supervision and managing clinical competence. This will support the development of additional ANP's in subsequent years, which in turn will support General Practice;
- Once current ANP's in post have achieved the clinical competence levels as set out nationally, the plan will be to incorporate newly recruited members into a consistent approach to advanced practice nursing within the Scottish Borders. The aim will be to have all nurses, working as ANP's in Primary Care, to meet the requirements of clinical competence as described in the national definition above.

Year 1	Year 2	Year 3
<ul style="list-style-type: none"> •Scoping exercise to review current services •Demand and capacity work & agree 2019/20 investment 	<ul style="list-style-type: none"> •Begin recruitment for practitioners working across practices 	<ul style="list-style-type: none"> •Begin recruitment for practitioners working across practices

5. Additional Professional Roles

Additional professionals' role will provide services for groups of patients with specific needs that can be delivered by other professionals as the first point of contact in the practice and community setting; this would be determined by local needs. Examples of this type of role include:

- Musculoskeletal focused physiotherapy services;
- Community Mental Health Workers.

5a. Musculoskeletal focused physiotherapy services

First Contact Physiotherapy (FCP) means patients with a musculoskeletal problem who contact their local GP surgery are offered an appointment with a physiotherapist instead of a GP. An appropriately trained and experienced physiotherapist based within the practice is able to autonomously assess, diagnose and address the immediate needs of a large proportion of these patients, initiating further investigations and referrals where clinically appropriate. This approach puts physiotherapy expertise right at the beginning of the MSK pathway where patients can get the most benefit and in the place where they are most likely to first seek help.

Based on pilots in other NHS Board areas, FCP has been shown to complement the practice's approach with regard to health promotion, early intervention, use of medicines and investigations and onward referral to secondary care services such as orthopaedics. The FCP assesses diagnoses and acts upon the clinical findings, signposting to appropriate community resources and equipping people with the knowledge and advice to self manage their condition. The FCP will also request investigations where clinically relevant and refer onward to the appropriate services.

The intended outcome of FCP is to reduce the burden on stretched GP practices in the Scottish Borders and improve the patient journey through early intervention, signposting, and treatment. Assuring the patient sees the right person first time should reduce the number of steps in the clinical pathway and minimise the time it takes for a patient to receive the appropriate services for their condition ensuring optimal outcomes. A plan is being produced to implement this approach.

Priority for investment	Outline	Funds
Musculoskeletal focused physiotherapy services	Recruit 4 x Band 7 First point of contact physiotherapists	£191,462

5b. Community Mental Health Professionals

Community clinical mental health professionals, based in practices, will work with individuals and their families assessing their mental health needs. The aim is to provide support for conditions such as low mood, anxiety and depression. The subsequent outcome to be achieved is improved patient care through more swiftly accessible and appropriate mental health input.

The 2017 – 2027 Mental Health Strategy (<http://www.gov.scot/Publications/2017/03/1750/0>) is aiming for multi-disciplinary teams to be based within primary care ensuring practices are able to support and treat patients with mental health issues. A test of change is taking place throughout 2018 relating to first responders for those in crisis. This is Scotland-wide.

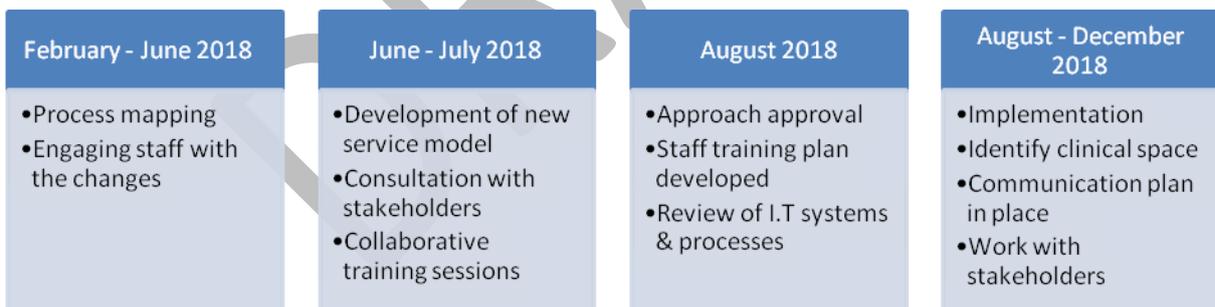
This pilot plus the commitment to recruit 800 mental health workers across Scotland (this equates to 16.5 in the Scottish Borders) will indirectly benefit General Practice. The goal for the Scottish Borders over the lifetime of the plan is to recruit these individuals in line with national guidance.

There is significant complexity around mental health presentations within primary care and as such multi-layered, evidence based interventions is required. Therefore a multi-professional mental health team is required to be integrated with both practices and other mental health teams.

The main aims relating to this plan will be to:

- Implement one single line management structure for the Public Health Advisors;
- On completion of the above assess the use of the current investment and provide a model service for the future (similar to Wellbeing Services in other areas);
- The review will evaluate and provide support for Community Psychiatric Nurses (CPN's), Lifestyle Advisors (LASS) and Counseling Services (including adolescent services);
- Clarity and general improvements to access methods and referral pathways are required;
- Make use of available technologies e.g. mobile telephone applications.

These objectives will conclude during 2018/19 (see timeline below) with active transition happening in year 2 and 3 of the overall plan. Individual plans for consideration could include the use of computerised cognitive behavioural therapy (CBT) and additional mental health professional capacity in practices.



This section will be further developed to address Action 15 of the Mental Health Strategy and has strong linkage with the Community Link Worker (CLW) role.

6. Community Link Worker's (CLW's)

The CLW programme has been established to make connections between individuals and their communities via their GP practice. The aim is to mitigate the impact of the social determinants of health in people that live in areas of high socioeconomic deprivation.

The CLW role will assist people with financial, emotional or environmental problems. These may include housing, debt, social isolation, stress or fuel poverty problems. By providing advice, direction to other organisations/activities in the community or alternatively coping strategies the CLW will ensure people feel more supported in their community.

The main objective for the Scottish Borders over the next 3 years is to access the opportunity to secure CLW's. The Scottish Government manifesto is to provide 250 CLW's over the life of the Parliament therefore the target goal for the Scottish Borders is to enable 5 such roles across the area. Funding will be accessed with an assumption that this will continue.

It is highly likely that these roles will be merged as part of the mental health/'wellbeing' service due to the close linkage with mental health issues. This will also ensure flexibility, as both are amenable to cluster working, which will provide the best coverage across the Scottish Borders.

We will continue to work closely with Scottish Borders Council (SBC) in their work with families and their own community worker schemes.

In the first year of operation this work will be led by our Mental Health Link Worker's who have already made a significant impact working alongside our GP practices. By leading with this group of new staff the IA will develop work practices, and model the approach for demand beyond mental health within the second year of the plan.

More definitive plans will follow a scoping exercise on the overall Wellbeing Service. This will be included on future review PCIP's.

7. I.T and Data/Information Collection

Given the level of technological process in recent years I.T and data provide knowledge and solutions to everyday work. In terms of the GMS contract there are 3 national groups that will influence local development; these are I.T, e-health and data and information. Their recommendations will impact upon local decision making.

Identified areas for progress are listed but not exclusively restricted to:

- Preference for EMIS web as a GP system. The community teams and hospitals are transferring to this system thereby providing good linkage. The outcome relies on the National Procurement Team which has a separate plan of implementation. There will be a standard approach to implementation and training for users etc;
- The offsite storage and back-up of data is being reviewed. One-off funding has been set aside to ensure this risk is resolved;
- Upgrading of Docman and the introduction of GP2GP will take place from August 2018;
- The new contract shares the responsibility for patient data between GPs and the Health Board. The Scottish Government will provide further guidance on the responsibilities for

each party and this is to be published during 2018, in the meantime a data sharing agreement will be developed by the NHS Borders ehealth department;

- There will be a requirement for practices to provide agreed local and national data extracts to enable intelligence led quality planning, improvement and assurance via Quality Clusters;
- Recognising the increasing level of coordination between NHS Borders and GP practices the aim is for dissolution of the I.T SLA to ensure an adequate level of service provision and contingencies provided;
- A Programme of Technology Enabled Care (TEC) with increased use of, 'Attend Anywhere' (online face-to-face consulting software) that will benefit patient interactions as a method of addressing time and travel constraints as well as assisting more remote and rural practices will be implemented;
- The use of mobile applications, websites and social media will be part of the overall Communications Strategy that will link in with the IJB and NHS Borders strategies in order to ensure information sharing;
- Upgraded technologies e.g. practice business continuity laptops via the I.T development fund;
- Added transparency to local decision making by creating space on the most appropriate website. This will include relevant meeting dates, remits, documents and minutes.

8. Premises

The National Code of Practice for GP Premises was published by the Scottish Government in November 2017. The main aim of the document is to highlight sustainability pressures around the GP workforce and premises liabilities and highlights the preference to move away from this to more Health Board owned and maintained premises. From the total 23 practices within the Scottish Borders, there is one GP owned practice and one leased practice with the remainder being within Health Board accommodation. There are also branch surgeries that need to be considered.

From Scottish Government guidance it is clear that each practice will transfer over a period of 25 years to Health Board premises.

Further work is required over the next 3 years. This includes:

- a) GP Practice Premises –
 - Re-establish the Borders Primary Care Premises Group;
 - Evaluate current GP practice premises;
 - Review contract implications and create appropriate processes for the treatment of different practice types (GP owned, Health Board and leased) including applications for the Sustainability Fund;
- b) Local GP Practice Issues – including exploring capacity.

9. Other Areas

Additional aspects of the contract will require revising or updating as more details become available. Operationally the Primary and Community Services (P&CS) Team within NHS Borders will evaluate these, consult with the wider stakeholder group and incorporate changes as necessary.

Identified areas include but are not restricted to:

- An annual assessment of the Enhanced Services (the level of funding will remain the same as indicated by the contract document);
- Practice boundary areas will to be reviewed and clarified (during 2018/19);
- Improving practice sustainability by promoting use of the Practice Sustainability Assessment Tool as recommended by the national group;
- An audit of the impact of temporary residents and recommendations made;
- A process to be established for the set-up of new practices (in 2019/20);
- Certificates and fee charges (Scottish Government guidance is to follow on this);
- Review the current meeting structure, remits and resources to ensure the ethos of the tripartite agreement, transparency and collaboration are achieved (a review will begin in 2018/19 and adjusted over the 3 years as appropriate);
- Local population health needs assessments will be undertaken by public health and by working closely with LIST analysts;
- Workforce planning is integral to all elements of the PCIP and key to more detailed plans is the National Health and Social Care Workforce Plan: Part 3 Primary Care (<http://www.gov.scot/Publications/2018/04/3662>);
- This will include the continuation of accessing the Rural GP Fellowship Programme in conjunction with National Education Scotland (NES). The successful application of Jedburgh Medical Practice for 2018/19 has the opportunity for a GP working a mix of sessions within a GP practice and Acute specialties. The programme for remote and rural classified GP practices is aimed at attracting and retaining, where possible, GPs to the Scottish Borders.

10. Cluster Working

Clusters are groups of practices working together to ensure the provision of high quality care for their patients and communities. They will drive forward continuous improvement, facilitating strong collaborative relationships across clusters and learning, developing and improving together. They will work in collaboration with the Primary & Community Services management team and NHS Borders Public Health Department.

There are currently four clusters within the Scottish Borders (East, Central, West and South – see map). This is to be reviewed within the duration of the plan particularly in terms of access and linkage to other areas and SBC services.

To maximise the potential from cluster working the Scottish Government’s ‘Improving Together’ paper states the requirement of:

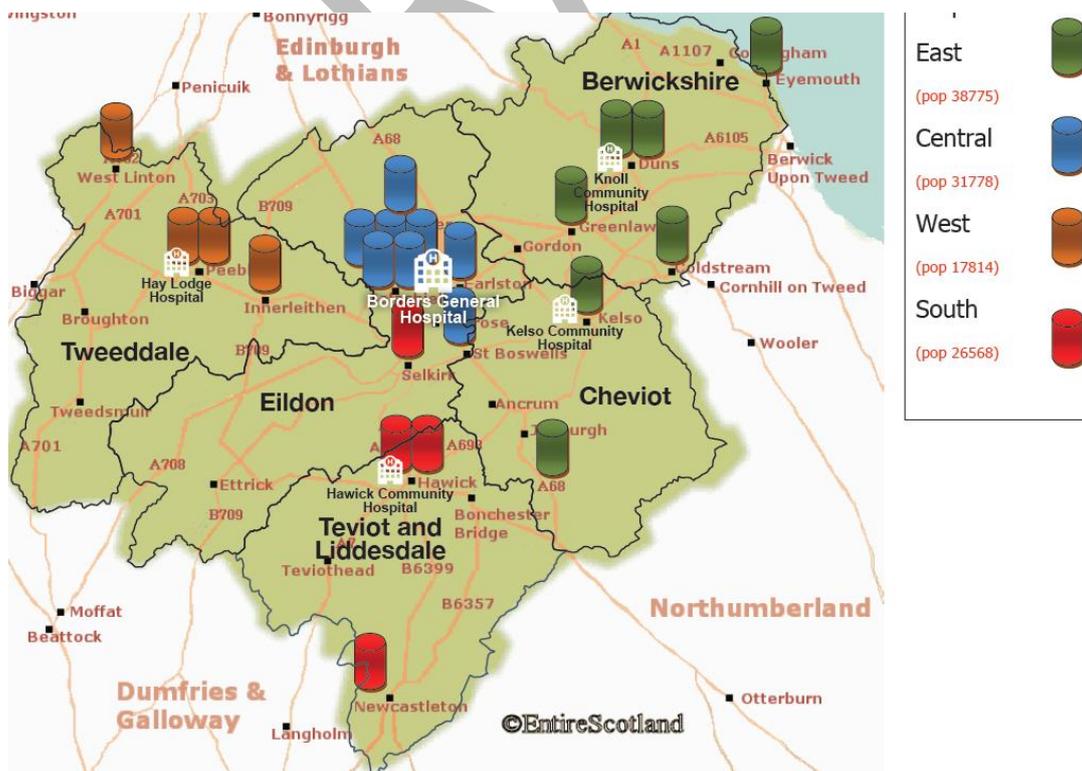
- Data (working in collaboration with the local LIST team);
- Health Intelligence Analysis;
- Facilitation (leadership provided through the clusters);
- Improvement Advice (national collaboration);
- Leadership (training to be considered for the cluster leads).

At present there are 4 GPs holding the cluster lead positions at a cost of £46,080 per annum. A recurring funding source for these will need to be found. Primary Care Improvement Fund (PCIF) resources have been used to progress pilot projects relevant to their local population. These include:

- The Community Acute Rehabilitation Team (CARE);
- The Advanced Practitioner Project;
- Here We Are (Docman Documentation Management Improvement);
- COPD Pilot;
- Medication Reconciliation in Primary Care Pilot Scheme;
- Anticipatory Planning Review – ‘What Matters to Me’;
- New Patient Checks Pilot Scheme.

The pilot schemes will be evaluated with the intention of continuing to support those with added benefits or to stop and invest into new opportunities for change.

The map shows the layout of the practices by IA locality and cluster in the Scottish Borders:



11. Beyond General Practice

a) Borders Emergency Care Service (BECS)/Out-of-Hours (OOH)

'Pulling Together: Transforming Urgent Care for the People of Scotland' by Sir Lewis Ritchie (released November 2015) described a new model of care where a multidisciplinary, multi-sectoral urgent care co-ordination and communication function will be provided at Urgent Care Resource Hubs, which would be configured for both service delivery and training purposes. They would be established primarily to co-ordinate urgent care for OOH services, however, should be considered on a 24/7 basis.

Following tests of change last year, BECS will permanently employ a range of clinical colleagues to support the delivery of cost effective, sustainable urgent care. The redesign is demonstrated on Appendix 3.

Funding for OOH services sits outwith the Primary Care Fund (PCF) and has been confirmed as £105k for the 2018/19 financial year.

b) Interface with Acute Services

Several strands of the PCIP have elements that span both Primary and Secondary Care Services, for example, MSK physiotherapy services, the Vaccination Transformation Programme (VTP) and Community Treatment and Care Services (CT&CS). It is essential that good communication across the care sectors continues and further develops as the PCIP progresses. Formal discussions will take place through the evolving Area Medical Committee (AMC) which will bring together clinicians from both Primary and Secondary Care.

12. Budget Planning

The process, cost and provision of adequate resource must be developed by the IA to ensure a safe transfer of workload. Service redesign will take into account the expectation that, where appropriate, the programme of delivery should continue to be conducted in or near GP practices.

In February 2018 the Scottish Budget Bill confirmed an increase of the Primary Care Fund from £72m in 2017/18 to £110 in 2018/19 (with additional funds for Mental Health and Out-of-Hours). Within this is an allocation totalling £45.75m nationally which is the Primary Care Improvement Fund (previously the Primary Care Transformation Fund, pharmacy, recruitment and retention etc.). This has been merged with the view of providing increased flexibility for individual IA priorities.

It is recognised that the level of transformation expected will be challenging given the level of new funding being invested.

Funding of the new GMS contract is, on the whole, via the Primary Care Fund (PCF). There are various programmes within this, one of which is the Primary Care Improvement Fund (PCIP). This allocation is facilitated through NHS Borders for implementation and totals £962k in 2018/19. This is estimated to increase to £1m in 2019/20 (year 2) and £2.1m in 2020/21 (year 3) as the national pot grows from £72m to £110m. This is summarised on Table 1 below:

Table 1:	Year 1 2018/19 £000's (Confirmed)	Year 2 2019/20 £000's (Estimated)	Year 3 2020/21 £000's (Estimated)
PCIF Allocations	962	1,050	2,100

This is to be released in two separate amounts (tranche 1 will deliver £561k, tranche 2 will be £240k). The second sum will follow the progress report to be submitted to the Scottish Government in September 2018. The assumption is that this funding will be available annually and thus necessary recruitment to progress the PCIP actions will also surmise this.

Previously agreed commitments against this resource leave a balance in the first year of £617k (see Table 2) which will support the prioritised PCIP work streams. There has been no formal confirmation of the resource allocation for 2019/20 and 2020/21, however, the Scottish Government has asked IA's and Health Boards to plan on the assumption that funding will continue.

Table 2:	£000's
18/19 Allocation	962
<i>Pharmacy Commitments</i>	
<i>Baseline</i>	-161
<i>Pharmacy First</i>	-24
<i>Additional Support (PfE)</i>	-63
VTP	-97
Remaining Allocation	617

The planning phase of this transformation process is still underway and four of the six priority areas are able to provide initial estimates of their requirements for the PCIP in year 1. These funding requirements are shown in Table 3. It is clear that the year 1 proposals exceed the resource envelope available; however, given that we are still in the planning stage of this transformation programme recognition is given that realistically only 6 months of the expenditure will apply during the 2018/19 financial year.

The result would be expenditure totalling £364k in 2018/19 with the expectation that the remaining allocation (£253k) is transferred into 2019/20, effectively helping resource the next stage of the plan. Discussions are ongoing with finance colleagues to consider the overall budget management of the plan.

Table 3:	Estimated Full Year Requirement Year 1 £000's	6 Months Total (Remaining 18/19) £000's
<i>VTP (nominal)</i>	120	60
Pharmacy	204	102
CT&CS	211	106
Urgent Care	0	0
Additional Roles:		
MSK Physiotherapy	191	96
Comm. Mental Health	0	0
Total	727	364
Funding Available		617
Remaining		253

Year 1 proposals total £727k, carrying this forward into year's 2 and 3 (taking into account the committed funding) provides a remaining balance each year for further consideration (Year 1 £253k, Year 2 £208k and Year 3 £1m). This is shown on Table 4.

Several assumptions have been made that are important to note: the first being the level of allocation increase (that has still to be confirmed), the uplift applied to the pharmacy element and lastly, the ability to carry forward remaining resources from the previous financial year. The latter should not be a major concern due to the Scottish Government's recognition that funding will, 'clearly fall within the scope of the MoU' and are, 'ring-fenced resources' [letter dated 23rd May 2018 from Richard Foggo].

After funding the full year 1 requirements of £727k this would leave a remaining balance with potential for investment. This needs further scoping work to enable the identification of key priorities and agreement with all relevant parties.

It should also be noted that these figures will change and will require regular updating due to the assumptions made, comparisons with the actual expenditure incurred and the potential for shifting priorities as the PCIP progresses.

Table 4:	Year 1 £000's	Year 2 £000's	Year 3 £000's
Funding Allocation (PCIF)	962	1,050	2,100
Commitments:			
<i>Pharmacy</i>	-248	-271	-541
<i>VTP</i>	-97	-97	0
Remaining Allocation	617	682	1,558
Carry Forward from the previous year		253	208
Estimated Continuing from Year Programme Expenditure	364	727	727
Remaining Balance for Additional Works	253	208	1,039

13. Workforce

The National Health and Social Care Workforce Plan was published in June 2017, Part 3 of that plan, subsequently published in May 2018, outlines the Scottish Government's approach to the Primary Care workforce issues (see below). The Plan sets out a range of options at a national, regional and local level for the recruitment and retention of GPs, including the expansion of the capacity and capability of MDT's. This includes plans for recruitment, training and development of specific groups and roles. As such a Scottish Borders Workforce Plan will need to be developed for Primary Care.

It has been indicated that as part of their role as EMG's, GPs will act as senior clinical leader's within the extended MDT, as outlined in the MoU.

National Health and Social Care Workforce Plan: Part 3 – Improving workforce planning for Primary Care in Scotland (May2018)

SUMMARY OF KEY RECOMMENDATIONS AND NEXT STEPS

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

Facilitating primary care reform

Recommendations and commitments:

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

Building Primary Care workforce capacity

Recommendations and commitments:

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

Improving data, intelligence and infrastructure in primary care

Recommendations and commitments:

- More integrated workforce data for primary care is required, in the context of the workforce data platform being developed by NHS Education for Scotland.

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

NHS Borders Workforce Plan:

A plan is currently under development in order to undertake a review of the existing workforce employed within GP Practices in the Scottish Borders. This will underpin an enhanced understanding of the existing Primary Care workforce and be utilised to inform the development of a local workforce plan. The initial phase of this work will be completed by December 2018. The information will be used to inform the development of proposals for year 2 focused on the 6 priority areas.

14. Risk

Risk assessments and Health Inequalities Impact Assessments will be undertaken across the different work streams and any required action plans will then be developed. The main areas of risk identified at this initial stage are around levels of engagement, finance, recruitment and capability.

15. Engagement and Ongoing Development

The PCIP is a dynamic working document and will be developed through ongoing dialogue and engagement with GPs, GP practice teams, wider IA colleagues, partner agencies and with patients and public involvement.

16. Summary

The updated GP contract was released in November 2017 and agreed by the GP community in January 2018. It has provided the opportunity for transformation in Primary Care services across the Scottish Borders. This 3 year Primary Care Improvement Plan (PCIP) provides a backdrop and highlights the main areas of focus for the IA in reshaping this facet of Primary Care. The key philosophies underlying the contract are communication, transparency and collaboration and the implementation of the plan will be progressed on that basis. By transforming the multi-disciplinary

team and services around the role of the Expert Medical Generalist (EMG) we will achieve a robust and sustainable community model of primary care for the people of the Scottish Borders.

This process must be carried out in an informed, measured and sustainable way. Service delivery will continue as existing practice and will evolve in a phased manner to ensure that seamless change is possible. Many projects and pilots schemes are already taking place with the opportunity to continue those that add value to services we commission.

DRAFT

APPENDIX 1

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 nonclinical 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 multidisciplinary 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 Scotland 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.

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: Alan McDevitt, Chair, Scottish GP Committee of the British Medical Association
Date: 10 November 2017

Signed on behalf of Health and Social Care Partnership Chief Officers

Name: David Williams, Chief Officer, Glasgow HSCP and Chair, Chief Officers, Health and Social Care Scotland
Date: 10 November 2017

Signed on behalf of NHS Boards

Name: Jeff Ace, Chief Executive, NHS Dumfries & Galloway and Chair, Chief Executives, NHS Scotland
Date: 10 November 2017

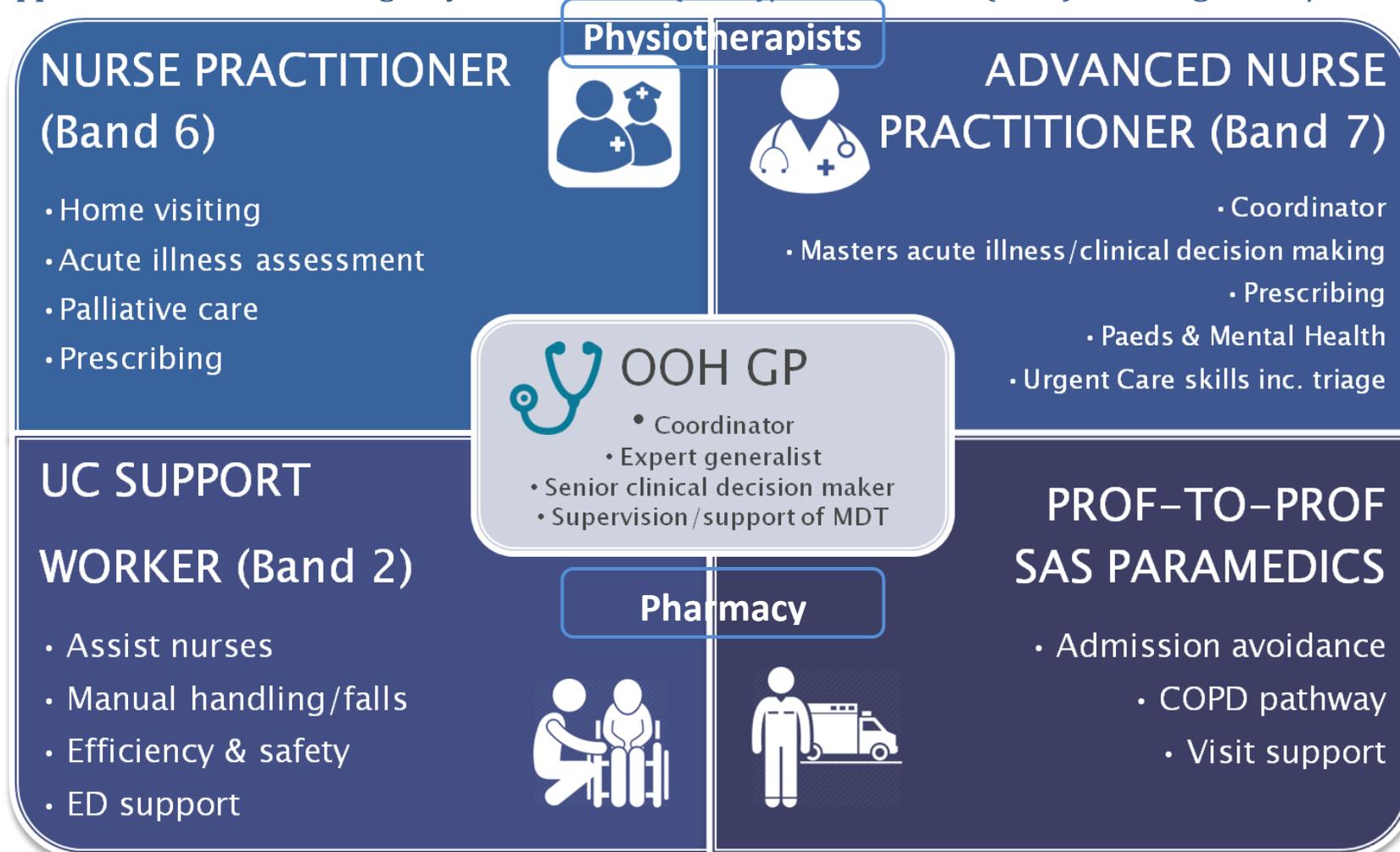
Signed on behalf of the Scottish Government

Name: Paul Gray, Chief Executive, NHS Scotland
Date: 10 November 2017

Appendix 2: Primary Care Improvement Plan Summary Table

	Service Area	Project Sponsor	Project Lead	Target Date	RAG Status	RAG Commentary
1.	Vaccination Transformation Programme (VTP)	Tim Patterson	Trish Wintrup	March 2021	Red	High risk/high priority
2.	Pharmacy	Alison Wilson	Keith Maclure		Yellow	High priority with work programme already underway
3.	Community Treatment and Care Services	Claire Pearce	Erica Reid/Gordon Gowans		Red	High risk/high priority
4.	Urgent Care	Nicola Lowdon	TBA		Green	Cluster project started
5.						
a.	MSK Physiotherapy	Lynne Morgan Hastie	Janie Thomson	March 2021	Yellow	Medium priority with App in post
b.	Community Mental Health Services	Amanda Cotton	Haylis Smith		Yellow	Medium priority with merging process underway
6.	Community Links Worker (CLW)	Rob McCulloch-Graham	Natalie Macdonald		Yellow	Medium priority with merging process underway

Appendix 3: Borders Emergency Care Services (BECS)/Out-of-Hours (OOH) Working Model/MDT



Courtesy of Dr Rebecca Green, BECS

PRIMARY CARE STRATEGY BOARD (PCSB)

Terms of Reference & Remit

Appendix 4: **DRAFT**

Constitution

The Primary Care Strategy Board (PCSB) has been established to oversee and direct the work programme and priorities for the Scottish Borders Health & Social Care Partnership (H&SCP) Primary Care transformation programme. It will provide the role of strategic leadership, scrutiny and review for the Primary Care Transformation Programme.

The group was constituted from July 2018 and will be reviewed on an annual basis.

Membership

IJB Chief Operating Officer (Chair)
Medical Director (Co-Chair)
GP Sub-Committee Representative (Chair of GP Sub-Committee)
Central Cluster Lead
East Cluster Lead
South Cluster Lead
West Cluster Lead
GP Representatives x2
Associate Medical Director
Director of Finance
Director of HR
Lead Nurse for Community
Director of Strategic Change & Performance
Director of Public Health
Director of Pharmacy
General Manager, Mental Health and Learning Disability Services
Public Involvement Representative
Area Service Manager, SAS
General Manager, Primary & Community Services
Contracts Manager, Primary & Community Services
Partnership Forum Representative
Primary Care Transformation Programme Manager

Timescale

The outputs of this programme are set to be completed by the end of March 2021; with 6 monthly review dates beginning from September 2018. The PCSB will meet on a bi-monthly basis though the frequency may be varied subject to agreement with the Chair. A schedule of meetings will be set out in advance.

PRIMARY CARE STRATEGY BOARD (PCSB)

Terms of Reference & Remit

Reporting Arrangements

Members of the Board will be collectively accountable for the delivery of the Primary Care Improvement Plan (PCIP). It is important that nominated members commit to attend the PCSB. Where it is not possible, nominated deputies are encouraged to attend with agreement from the Chair.

The Chief Officer of the Scottish Borders Integrated Joint Board (IJB) will be the overall programme Senior Responsible Officer (SRO). The IJB Leadership Group and the NHS Borders Strategy Group will be supported by the Primary Care Strategy Group. PCSG will consult with the GP Sub-Committee, liaise with Health & Social Care Management Team and negotiate with LMC.

The PCSB will ultimately report and make recommendations to the NHS Board and the IJB.

Role & Remit

Specifically the group will:

- Ensure the implementation of the 2018 General Medical Services (GMS) Contract by 31st March 2021;
- Support the vision and strategic leadership for the Primary Care Transformation Programme;
- Provide governance and scrutiny across all aspects of the Programme;
- Ensure the Primary Care Improvement Plan (PCIP) for the Scottish Borders is robust, effectively monitored with managed timetables and obstacles which may affect delivery removed;
- Ensure consistency and connection between the six priority areas for change;
- Provide regular updates to GP Sub-Committee, LMC, H&SCP, IJB, NHS Borders;
- Ensure sufficient and appropriate linkages between the Primary Care Transformation Programme and other major planning activities within the partnership e.g. efficiencies;
- Ensure that there is an integrated, comprehensive and effective Communications Strategy in place to ensure all stakeholders (patients, staff, public and partner organisations) are informed and involved throughout the process;
- Remit decisions outwith the scope of the group to the IJB Leadership Group;
- Create and monitor the Programme Risk Register;
- Ensure that all Programme Evaluation and Lessons Learned Reports are prepared.

Group Administration

The Board is supported by the Business & Project Support Manager or alternative member of the P&CS Administrative Team. Key activities of the administrative support are:

- Work closely with the Chair;
- Advise on the content of agendas, accompanying papers, minutes & actions;
- Provide advisory support to ensure that appropriate information is communicated to all GP practices & any necessary other parties.

PRIMARY CARE STRATEGY BOARD (PCSB)

Terms of Reference & Remit

The agenda & papers will normally be circulated one week in advance of the meeting. Urgent or late papers may be circulated by email prior to the meeting but tabled papers will be avoided except in extraordinary circumstances.

Minutes of the meetings, as well as the Work Programme & other relevant documents arising as a result of the Committee will be circulated & shared with the LMC, GP Sub-committee, Clusters, Health Board and IJB as necessary.

DRAFT