



Borders Health & Social Care Partnership

Primary Care Improvement Plan

2018 – 2021



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Foreword

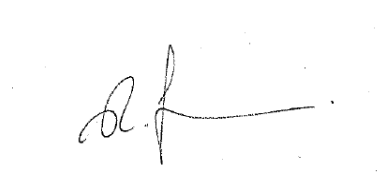
I would like to introduce Scottish Borders' updated Primary Care Improvement Plan as part of the Scottish Governments transformation of Primary Care essentially improving services for all.

From 1st April 2018 we now operate a new contract for our GPs across the country and here in the Scottish Borders we are looking forward to progressing the 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 updated plan developed by the professions within Primary Care are 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 our on-going 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

Scottish Borders

Financial Year: 2019/20

Introduction

This document forms the updated Scottish Borders Primary Care Improvement Plan (PCIP). 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. It is also consistent with our local priorities and objectives 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 updated PCIP is a dynamic working document and through on-going liaison with all stakeholders will continue to 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 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 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:

“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 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 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 collaboration between Health Boards, GP Sub Committees and Health & Social Care Partnerships (HSCPs) is key to prioritising 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 dwellings. In addition, the cross-border flow of patients is an important 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 (Programme Board)

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 plan was developed and updated through working with GPs, the Primary and Community Services (P&CS) team and a wide range of stakeholders. The PCIP has been shared with bodies including the GP Sub-Committee, the IA and NHS Borders amongst others.

Following agreement, the IA issued directions to NHS Borders to implement the plan. This will be the responsibility of the Primary Care Strategy Board (PCSB). The Board has been established and meets on a bi-monthly basis. It includes representatives from the GP Sub-Committee, Cluster Quality Leads, IA and NHS Borders (including the Primary & Community Services team).

The PCSB has commissioned project groups to deliver implementation of 6 work streams identified as being key requirements of the GMS contract provision within the Scottish Borders. These are:

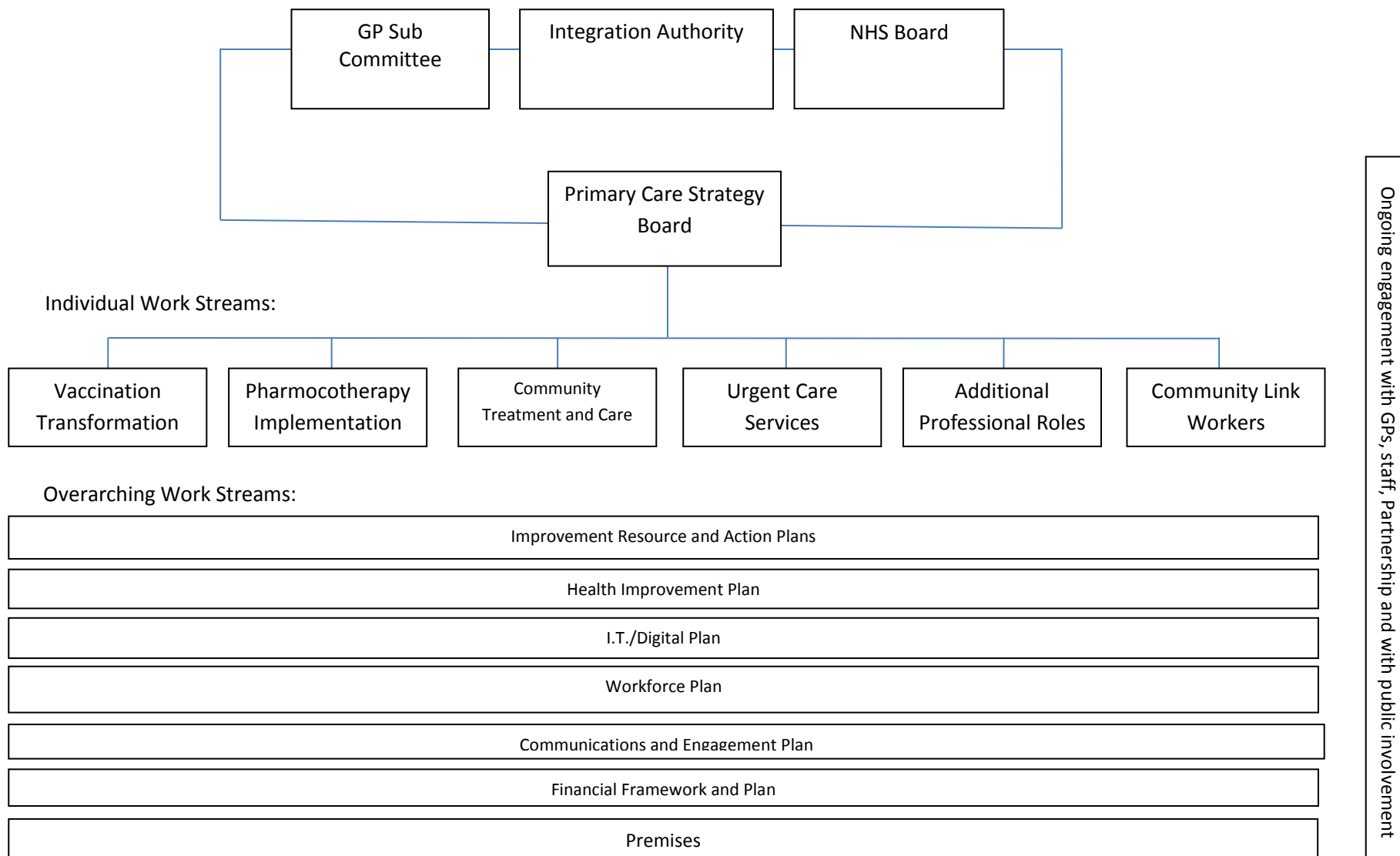
- Vaccinations Transformation Group;
- Pharmacy Services (via the Primary Care Prescribing Group & Pharmacotherapy Oversight Group);
- Community Care & Treatment Group;
- Urgent Care Group;
- Physiotherapy First Point of Contact Group;
- Primary Care Mental Health Group (to include Community Mental Health Professionals & Community Link Workers).

There are additional groups in place relating to premises (re-invigorated) and the newly established IT/ehealth group that will provide the foundations of transformation. During 2019/20 another work stream will be added to review appointment booking & administration services.

Each work stream will have an identified project sponsor, lead and/or practice representative and provide monitoring reports for submission to the PCSB. They will develop Key Performance Indicators (KPI's) clearly linked to outcomes, enabling shared learning and ensuring evaluation takes place. These will closely link to the Scottish Government's reporting template to be completed every 6 months. Project management methodology will be followed within each of the streams.

Public representation will be progressed in each group and via NHS Borders Public Reference Group (PRG). Consideration will be made to the re-establishment of Practice Patient Groups (PPG's).

The overall governance structure is shown over the page.



Work Streams within the Primary Care Improvement Plan

This section provides information on progress during year 1 for each of the 6 key priority areas and the proposals for both year 2 (2019/20) and year 3 (2020/21).

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 consists of the following elements:

- Pre-school Programme;
- School based Programme;
- Travel vaccinations and travel health advice;
- 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 by the end of the plan period (i.e. 31st March 2021).

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). They have committed to deliver all VTP elements of the contract by March 2021.

The local VTP Business Change Manager (BCM) will act as the catalyst for change and is working on:

- Reviewing the current delivery model;
- Exploring opportunities within alternative facilities including the future option of Health Board provision (through centralised Hubs potentially at Kelso, Hawick, Peebles, Duns, Galashiels or the Borders General Hospital);
- Investigating 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;
- Prioritising patient safety;

- Replicating the current high level of attainment of childhood and adult immunisation in General Practice;
- 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;
- Workforce considerations;
- 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 the full 3 years of the plan in recognition of the time required to provide robust processes that ensure public safety (our main priority) with assurances that structures, roles and governance are established. During year 1 pertussis vaccines (whooping cough for pregnant women) has been transferred from general practice to NHS Borders midwives (one of the at risk elements). A review of the outcomes and learning from the implementation will occur prior to instigating the other elements of the work stream. At present cost information is being developed on the strands of the programme.

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. NHS Borders Public Health Department will re-create the current patient experience from beginning to end of the vaccine journey and will map the present vaccine demand by each element of the VTP. 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 		<ul style="list-style-type: none"> • Continuation of 0-5 years programme work • Shingles (start) • Travel 		<ul style="list-style-type: none"> • Shingles (completion) • Flu & Pneumococcal vaccines 65+ • Flu Vaccines (for those at risk)

Priorities for the Vaccine Transformation Programme are still under negotiation. Options will be reviewed regularly with discussion taking place at the GP Sub-Committee meetings. More detail will be added to the plan as it is reviewed.

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.

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 be included in total enhanced team. 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 IA to increase pharmacy support to practices by expanding the current Pharmacy First services to include treatment of infected bites and exacerbations of Chronic Obstructive Pulmonary Disease (COPD).

During year one 3WTE experienced Prescriber Pharmacists and 2.2WTE Pharmacy Technicians were recruited. Further recruitment to build upon the pharmacy service roll out will take place during year two. The anticipated costs for 2019/20 are expected to be £379,974.

These services will cover core hours during the working week (i.e. Monday to Friday) and equates to approximately one Pharmacist per 10,000 patients.

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, the unified repeat prescribing system across the whole of the Scottish Borders has been the first priority and responsibility of the NHS Borders Pharmacy department.

The annual Scottish Borders Pharmaceutical Care Services plan will provide more detail on the transitional 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

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.

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 was not a priority of the PCIP in year 1. The on-going 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 has been and will continue to be during year 2:

- 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 local 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 clinical supervision 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 (as they implement, 'House of Care').

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:

Year 1	Year 2	Year 3
<ul style="list-style-type: none"> •Review current capacity practice •Demand & capacity scoping exercise 	<ul style="list-style-type: none"> •Develop Community Care & Treatment Service Plan •Implementation of locality treatment and care operational arrangements linked with wider community health provision 	<ul style="list-style-type: none"> •Progress to Borders wide implementation

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 a further pilot took place within the South Cluster. The aim was to measure the benefits of the role and share learning from practices working collaboratively.

There continues to be wide ranging views about how this work stream should develop and which professional is the most appropriate to provide urgent care. Discussions will continue with the Scottish Ambulance Service (SAS) to enable the reintroduction of services (following positive evidence from the pilot schemes) at a later date. In the meantime, service redesign will focus on ANP's initially.

Commencing in January 2019, the recruitment of ANP's to cover the clusters in West and South is being progressed. The development of a local training pathway to enable Band 6 nurses to progress into these Band 7 roles is also being pursued. This is to address workforce difficulties and forms part of the ANP strategy that NHS Borders has in place.

To support the development of the ANP model it is planned to recruit a part-time senior nursing leadership role for 24 months. This role would be focussed on delivering the ANP model as well as supporting nursing within practices.

This would be at a potential cost of £259k in year 2 (see the funding elements below).

Priority for investment	Outline	Funds
Recruitment to a Primary Care Advanced Nurse Practitioners (ANP) Team	Recruitment of 6 x Band 7 ANP roles	£239,000
	Support development of existing ANP's working with Practices	£20,000
Leadership role	0.5 x Band 8a	£31,066
Total		£290,066

A simple timeline of this work stream is shown below:

Year 1	Year 2	Year 3
<ul style="list-style-type: none"> •SAS pilot in South Cluster •NHS Borders ANP strategy developed •ANP pilot in Knoll Community Hospital •Begin recruitment of nurses to ANP roles 	<ul style="list-style-type: none"> •Develop local training pathway •Demonstrate ANP roles working in two cluster areas (West & South) 	<ul style="list-style-type: none"> •Recruit remaining practitioners for coverage of all areas

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:

- First Contact Physiotherapy Service;
- Community Mental Health Workers.

5a. First Contact Physiotherapy (FCP) Service

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. This approach is being implemented within the Scottish Borders.

The First Contact Physiotherapy (FCP) service has recently recruited 4 x Band 7 physiotherapists that are covering East and Central Cluster. Once imbedded the intention is to expand to the other cluster areas and explore sustainable models of service provision.

Priority for investment	Outline	Funds
Musculoskeletal focused physiotherapy services	<ul style="list-style-type: none"> Appointed 4 x Band 7 First point of contact physiotherapists Expand service in year two (options are to replicate East Cluster i.e. costs provided or explore an alternative model) 	<p>£191,462</p> <p>£191,462</p>
Total		£382,924

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.

In year one the goals were to implement one single line management structure for the Public Health Advisors and provide a robust model of services. During January 2019 the NHS Borders Wellbeing Service was launched. Following implementation a review will take place:

- 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 will be provided;
- Make increased use of technology e.g. mobile telephone applications;
- Also for consideration is the application 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 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.

NHS Borders has in place a team called, 'The Scottish Borders Adult Mental Health Local Area Co-ordination (LAC) Service' whose remit is to provide, 'empowerment for people who have experienced mental health issues or mental illness'. Their role is to encourage and enable individuals who have experienced mental health issues or mental illness to live active, independent and purposeful lives in their community. They work closely with Scottish Borders Council (SBC) Community Link Workers who collaborate with individuals with a learning disability, their carers, and other organisations to enable them to pursue their personal outcomes within their own local communities.

With these two roles already in existence it has been evaluated as appropriate to expand their remit in order to fulfil the needs to the MoU. Therefore, the team will be expanded during year two.

Priority for investment	Outline	Funds
Employ additional Local Area Coordinators (LAC's) & Community Link Workers (CLWs)	Expand current work force to 4WTE LAC's & 4WTE CLW's	£110,795

7. I.T and Data/Information Collection

‘The NHS National Digital Service is developing a national health & social care digital platform which will allow relevant real-time data and information from health & care records to be available to those that need it, when they need it, wherever they are, in a secure and safe way’.

In the period prior to this being delivered it is essential to improve digital technology for use in primary care. The Primary Care Digital Improvement Plan 2019/20 (still in draft) sets out the standards & expectations which Health Boards are to meet. This will include projects such as GP IT re-provisioning, SPIRE, the Primary Care website project, GP2GP (in 2 phases) & OOH GP IT.

Nationally there is a Primary Care Digital Programme Board at which Health Boards will provide progress updates. In addition to this there will be a GP IT Service Management Board that will lead on contracts for existing GP IT systems.

The draft plan states that the, ‘people who use the technology need to be at the heart of any plan’ and, ‘the people who use it must also be supported to build their digital skills’. This will require, ‘a consistent approach to training primary care staff’. ‘Local GP IT facilitators (Louise Murray within NHS Borders) play an essential role’ and this role, ‘will become increasingly important as GP practices transfer to new clinical IT systems’. The plan is clear in that the, ‘views of the users of primary care digital technology need to be clearly represented’. This will be executed via an additional sub-group of the Primary Care Strategy Board as part of the overall PCIP.

There will be financial investment, ‘to improve GP IT hardware’; however, the amount is unknown at this point in time.

Specific pieces of work have been identified on the draft digital plan. These include:

- Server improvement – ‘move to cloud-hosting as it provides greater cyber security and will assist with remote access and integration with other systems’;
- ‘Secure internet connection with sufficient bandwidth and latency is fundamental’ therefore the Scottish Government’s “Reaching 100” project ‘aims to connect all of Scotland to superfast broadband by the end of 2021’;
- Wifi – investment will be made during 2019/20 ‘to allow Health Boards to install secure wifi in all GP practices for staff and public wifi for patients’.
- NHS National Services Scotland (NSS) has contracted with EMIS Health, Microtest Ltd & Vision Health to provide GP clinical IT systems. Implementation is planned to begin in the summer of 2020 & completed by December 2022. The current preferred operator within the Scottish Borders GP practices is EMIS Health & we will plan on this basis.
- It is intended that by 31st March 2021, ‘all consulting rooms’ will have twin screens, ‘to improve safety allowing management decisions to occur with all relevant data at the same time’. ‘All clinicians will be equipped with mobile devices’, Windows 10 to be implemented (by 14th January 2020) followed by Office 365 (by 31st March 2021);

- The Scottish Borders is a pilot area for the upgrade of GP2GP & this was preceded by the implementation of Docman version 75500. Upgraded deployments of these will continue;
- Other specific projects include an options appraisal for a national referrals infrastructure (by July 2019), move to a national GP Order Communications system, rollout of the national clinical decision support programme, home & mobile health monitoring (i.e. use of Florence® in the Scottish Borders) to facilitate self-management for example, blood pressure monitoring amongst others, national NHS website for use by individual GP practices (to include the mapping of practice boundary areas);
- 'In 2019/20, the Scottish Government will provide £2m to Health Boards to fund the digitalisation of paper records, freeing up space within GP practices which can be used for clinical and training purposes';
- 'Each Health Board should have an IT service level agreement (SLA) in place with its GP contractors'. NHS Borders has an out-dated SLA that will be reviewed during 2019/20 to ensure it is fit-for-purpose & relates to the delivery of the PCIP;
- 'Health Boards will jointly designate Data Protection Officers (DPOs) with those of their GP contractors who wish them to do so at no cost to GPs'.
- 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;
- Project support will be provided when implementing, 'House of Care';
- 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;
- Added transparency to local decision making by creating space on the most appropriate website. This will include relevant meeting dates, remits, documents and minutes.

* From the draft Primary Care Digital Improvement Plan 2019/20

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.

During the first year of the plan one GP practice and one branch surgery have applied and been accepted for the Scottish Government's Sustainability Loan Fund. There is potential for a further practice premises to apply during 2019/20. The process to implement the fund will be progressed in year two.

The processes and procedures relating to leased premises will also be released during year two and discussion with the relevant practice has begun.

Overseeing this progress is the NHS Borders Primary Care Premises Group that reformed during year one of the plan.

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

- Evaluating current GP practice premises (including capacity, condition & suitability);
- Developing a premises strategy around the entire Primary Care estate (to include GP practices);
- Creating a maintenance schedule (with clear areas of responsibility and to include fixtures & fittings such as vaccine fridges). NHS Borders Capital Planning & Estates Departments will lead on these.

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. This will be assisted by the national mapping exercise;
- Improving practice sustainability (including GP recruitment & retention) by promoting use of the Practice Sustainability Assessment Tool as recommended by the national group (a GP Clinical Lead is being recruited for this purpose);
- A process surrounding the setting up of new practices is to be established (in 2019/20);
- Certificates and fee charges (Scottish Government guidance to follow);
- 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, concluding in 2019/20 with adjustments over the remainder of the plan 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 plan is the National Health and Social Care Workforce Plan: Part 3 Primary Care (<http://www.gov.scot/Publications/2018/04/3662>). NHS Borders Human Resources (HR) Department will develop this.

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. This will involve learning, developing and improving together. They will work in collaboration with the Primary & Community Services team.

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 following requirements:

- Data;
- Health Intelligence Analysis;
- Facilitation (leadership provided through the clusters);
- Improvement Advice (national collaboration);
- Leadership (training for cluster leads).

'Better use of data and analytical tools' is the focus of cluster working. 'Investment will be made in 2019/20 to support GPs in improving the health of their local population utilising data and the new analytical tools available'. These include the Scottish Primary Care Information Resource (SPIRE), the Primary Care Information (PCI) dashboard and the Local Information Support Team (LIST).

Early in 2019/20 the Scottish Government (jointly with the BMA) will provide further guidance on cluster working. It is not available at this time therefore the plan will be updated once the guidance is published. In the meantime finalised recruitment process and job description will developed in partnership with the GP Sub-committee relating to the future appointment of these roles.

At present there are 4 GPs cluster lead positions at a cost of £46,080 per annum. A recurring funding source still needs to be found.

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



‘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.

Funding for OOH services sits outside the Primary Care Fund (PCF) yet service provision has an impact on daytime GP services.

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) – including phlebotomy. 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 is still very much in its infancy. This aims to combine clinicians from both Primary and Secondary Care.

Smooth and cohesive interface working will benefit not only GPs and the wider MDT but the overall patient experience within the Scottish Borders.

12. Budget Planning

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.

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.

The IJB Business Partner, situated within NHS Borders Finance Department, will work closely with the P&CS team to support them and will provide regular financial updates on expenditure related to the plan.

Funding of the 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 totalled £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. Confirmation will be provided as the allocation letters are released to NHS Borders from the Scottish Government. This is summarised on Table 1 below:

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

The funding will be released in two separate amounts just as in 2018/19 (tranche 1 delivered £561k, tranche 2 £240k – this is being carried forward). The second tranche was not released during 2018/19 due to slippage in expenditure. This will be accessed during 2019/20 alongside the increased allocation of £1m.

Several assumptions have been made that are important to note: the first being the level of allocation increase, 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].

The actual level of expenditure recorded at the end of December 2018 is £97k. This is compared to the projected expenditure figure of £182k for the same period (see Table 2).

Table 2:	Estimated/Planned Expenditure (6 Months during 2018/19) £000's	Year-to-date (YTD) 'Budget' in 2018/19 £000's	Actual Expenditure (to December 2018) in 2018/19 £000's
2018/19 Allocation (1 st Tranche – 70%)	561		
Expenditure:			
Vaccine Transformation Programme (VTP)	(60)	(30)	0
Pharmacotherapy:			
Pharmacy First & Prescription for Excellence (PFE)	(87)		
PCIP Priorities	(102)	(51)	38
<i>Pharmacotherapy Sub-total</i>	<i>(189)</i>		
CT&CS (incl. ANP's)	(106)	(53)	59
Additional Professional Roles:			
MSK Physiotherapy	(96)	(48)	0
Community Link Workers	0	0	0
TOTAL	110	182	97

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

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 still needs to be developed for Primary Care. NHS Borders HR department will lead on this piece of work.

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 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 to be developed taking into consideration the existing workforce employed within GP Practices in the Scottish Borders. This will underpin an enhanced understanding of the present Primary Care workforce and be utilised to inform the development of a local workforce plan. The next phase of this work will be completed by December 2019. The information will be used to inform the development of proposals for years 2&3.

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 are engagement, finance, recruitment (workforce recruitment is a major concern and therefore training of current staff may be an alternative option) and capability.

15. Engagement and On-going Development

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

16. Summary

The reviewed GP contract was released in November 2017 and agreed by the GP community in January 2018. It has provided the opportunity for transformation of Primary Care services across the Scottish Borders. The initial 3 year Primary Care Improvement Plan (PCIP) provided a backdrop for the main areas of focus in reshaping this facet of Primary Care. This update builds on that initial plan.

The key philosophies underlying the contract are communication, transparency and collaboration and the implementation of the plan is being 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 seamless change. Projects and pilots schemes are already taking place with the opportunity to continue those that add value to services we commission.

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 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 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 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 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 Scottish GMS contract; and enables the move towards a 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 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 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 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 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 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 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

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 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 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 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 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

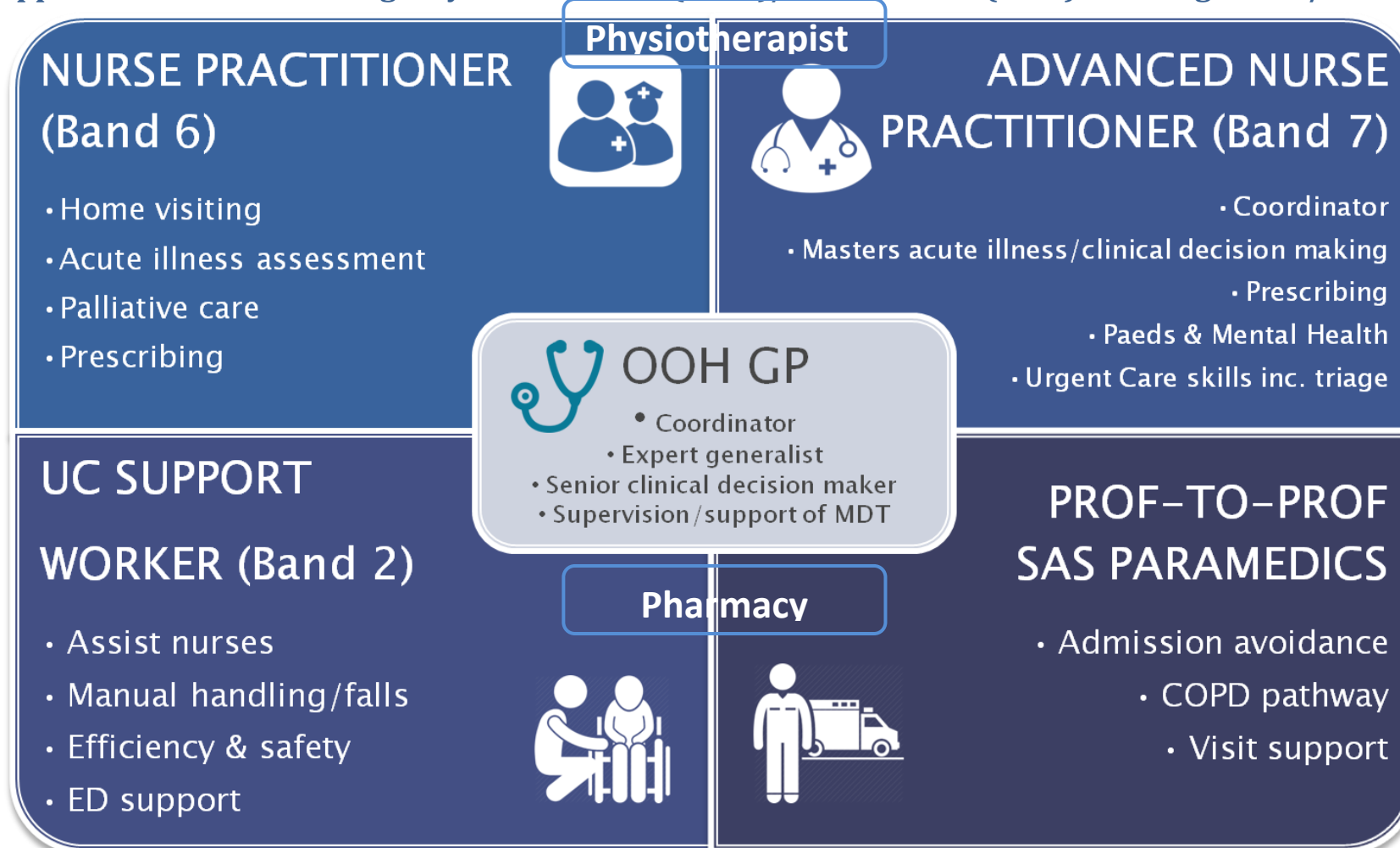
Date: 10 November 2017

Signed on behalf of the Scottish Government

Name: Paul Gray, Chief Executive, NHS Scotland

Date: 10 November 2017

Appendix 2: Borders Emergency Care Services (BECS)/Out-of-Hours (OOH) Working Model/MDT



Courtesy of Dr Rebecca Green