AGENDA ITEM NO 7

Report No. IJB 19/18

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 21 FEBRUARY 2018

DELIVERING THE NEW 2018 GENERAL MEDICAL SERVICES CONTRACT IN THE CONTEXT OF PRIMARY CARE DEVELOPMENT IN ANGUS

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

The purpose of the report is to provide an update on progress regarding the local implementation of the recommendations set out in the Primary Care Strategic Framework and highlight the content of the new 2018 General Medical Services (GMS) contract in Scotland and some of the requirements, opportunities and challenges it will bring for both NHS Boards and Integration Authorities.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board:

(i) notes the report and acknowledges the work already progressed as part of the wider Primary Care Strategy agreed in 2015. A summary of recommendations is attached in Appendix 1.

(ii) recognises the key milestones required for new GMS contract implementation.

(iii) notes the requirement for the Angus Health & Social Care Partnership (HSCP) to produce a primary care improvement plan by 1 July 2018.

(iv) requests an updated status report regarding the primary care improvement plan at the meeting on 27 June 2018.

2. BACKGROUND

The increasing demands placed upon all health and social care systems, with our changing demography and associated financial and workforce challenges are well documented. The key role of primary care and in particular general practice in delivery of key national strategies such as the National Clinical Strategy and the National Health and Social Care Delivery Plan is well recognised.

Both the Primary Care Strategic Framework (Appendix 1) and The 2018 General Medical Services Contract in Scotland prioritise and outline some of the changes required to create a sustainable model of primary care and general practice.

This paper aims to describe some of the current challenges within Angus general practices, the developments over recent years and the key principles and requirements of the new GMS contract which was approved by the profession in January 2018.

3. CURRENT POSITION

Demand on general practices continues to rise, with an 11% rise in consultations with GP teams in Scotland in the last 10 years. NHS funding received by general practice has fallen nationally from 9.8% of the total NHS resource in 2005/6 to 7.8% in 2012/13.The whole time equivalent population of GPs in Scotland fell by 2.3% between 2013 and 2015. Nationally more than 1/3 of GPs are over the age of 50, with a larger percentage of newer GPs choosing to work in a salaried position rather than as GP partners, and many opting for portfolio or part-time careers. NHS Scotland have been unable to recruit its target numbers of GPs in recent years, and this year's fill rates in Tayside to the GP training programme are below 60%. While practice nursing numbers nationally have remained relatively stable, it is worth noting that in 2015 53% of the practice nurse workforce was over the age of 50.

There are 16 general practices in Angus with a total patient list size of 110,583 which includes some patients who live in surrounding HSCP/Board areas. Similarly some Angus residents will be registered with practices in neighbouring HSCP/Board areas. Reflecting the general population growth in Angus, Angus practices have seen a gradual increase in practice populations over recent years at cluster level. Some larger towns in Angus – Montrose, Forfar and Arbroath have more than one practice serving the local community. Many towns have only one town based practice - Carnoustie, Monifieth, Brechin, Edzell and Kirriemuir. This current distribution of general practice provides some opportunities and challenges for service planning both currently and in the context of the new contract.

Historically general practice engagement with Angus HSCP and the Community Health Partnership/Local Health Care Co-operative previously is robust, with clear ongoing communication and planning through the Angus Clinical Partnership Group.

The Tayside Strategic Framework, attached as Appendix 1, summarises a number of areas of ongoing development across NHS Tayside. Although progress has been variable, the priorities included are in keeping with the new GMS contract and it is anticipated that most areas will continue to be considered within the context of the local primary care improvement plan with some also supporting the delivery of the Angus Care Model.

The Primary Care Transformation Programme and Fund has resulted in the additional investment of £4.38m in Tayside between 2016-18, with two funding streams intended to address primary care, mental health and out of hours. A regionally appointed programme manager is currently overseeing this programme under the leadership of the Primary Care Transformation Board. The early planning for local care centres/cluster hubs within Angus has been supported by this programme.

Progress and/or challenges to date worth highlighting include:

(i) GP Cluster Quality Improvement. Introduced in the 2016/17 GMS contract in Scotland to embed quality planning, quality improvement and quality assurance, supporting robust GP clinical leadership in each cluster, with each practice identifying a Practice Quality Lead (PQL) and all PQLs within a cluster self selecting a Cluster Quality Lead from within their group. Within Angus we have been fortunate that the GP clusters established are aligned to our localities, and that the GP cluster has engaged with each Locality Improvement Group (LIG). It is recognised that further development of the interface between the clusters and the LIGs is required moving forward.

Enhanced analytical support to support the work of the clusters is available in Angus, with some early mapping work underway to support the clusters to support quality improvement and practice sustainability.

GP Clusters are well engaged in the Angus Clinical Partnership Group, supporting the ongoing planning and review of clinical pathways and services including interface issues with secondary care services. The Angus Clinical Plan is developed and agreed within this forum.

GP practices are increasingly using Datix to highlight incidents or risks, particularly those related to interfaces between services, supporting organisational learning and identifying areas of risk for address.

GP Clusters are participating in regular Angus wide meetings to address the ongoing financial pressures related to prescribing and all practices are progressing actions aimed at reducing variation in practice and increasing compliance with the Tayside Formulary.

(ii) GP recruitment and retention. While the national challenges regarding GP workforce are highlighted above, the local impact of this has been visible for more than 3 years in Angus, having been a principal reason for Brechin Health Centre becoming a 2c (NHS Tayside managed) practice in October 2015. A number of Angus practices have faced challenges recruiting GPs, with a number experiencing ongoing vacancies.

The medical staffing shortages in Brechin created an opportunity to test and develop the multi disciplinary team further which has provided useful evaluations regarding the possible models and outcomes of enhanced multi-disciplinary and multi-agency teams based within general practice. This has included a practice based musculoskeletal service delivered by advanced physiotherapists, social prescribing led by Voluntary Action Angus, a practice based mental health and wellbeing nurse (from the Community Mental Health Team) and Listening Therapies delivered by the Spiritual Care Service. The evaluations from these developments are influencing local, regional and national discussions re the future shape of primary care based services.

Academy Medical Centre and Ravenswood, supported by Primary Care Improvement Funds, have been testing new models of care in General Practice, based on the learning from the Southcentral Foundation Nuka model. This model aims to further enhance the relationship between the general practice team and the patient, with a focus on supporting health and wellbeing. A social prescriber from Voluntary Action Angus and practice based health psychologist are supporting health behaviour change and a more holistic approach to the management of health and ill-health.

The Career Start programme progressed and coordinated regionally which aims to increase the recruitment and retention of recently qualified GPs to Tayside has proven successful regionally, although to date it has only resulted in the recruitment of two new GPs to Angus, one of whom is still in post. This programme aims to support portfolio careers, an increasingly popular choice for GPs, with clinical sessions split between general practice and a specialty.

It is proposed that GP recruitment and retention will continue to be managed regionally moving forwards.

(iii) Multi-disciplinary working including Enhanced Community Support (ECS). Models supporting multi-disciplinary working have been developing in Angus over many years. Over recent years many practices have significantly developed their models of multi-disciplinary and multi-agency working, supported partly by the roll-out of Enhanced Community Support.

(iv) Childhood Vaccinations. As part of the Tayside Primary Care Strategy, vaccinations for all under 5s are now carried out by an extended vaccination team, shifting workload away from general practice. Funding of £431k to support this shift has been made available from 2017/18 regionally. A regional event is planned for spring 2018 to further plan for the transfer of all vaccination services by April 2021.

The new Scottish GMS contract

The draft contract is set out in the following documents:

(i) Contract framework "the blue book"

(ii) Premises Code of Practice

(iii) Draft Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards

(iv) Letter of intent describing the Memorandum of Understanding

The contract is based on four guiding principles of primary care:

(i) Contact – accessible care for the individuals and communities

(ii) Comprehensiveness – holistic care of people – physical and mental health

(iii) Continuity – long term continuity of care enabling an effective therapeutic relationship

(iv) Co-ordination – overseeing care from a range of service providers

The aims of the new contract are to achieve:

Sustainable funding:

New funding formula that better reflects GP workload from 2018 with additional investment of £23 million. Nationally, 63% of practices gain additional resources, with the remaining 37% maintaining current income levels.

The Scottish Draft Budget proposals for 2018/19, published in December 2017, confirmed a first phase of national funding of £110m for 2018/19. A proportion of the £110m for 2018/19 will be allocated using the NRAC (NHSScotland Resource Allocation Committee) formula to support the development of multi-disciplinary teams in line with the Memorandum of Understanding.

Primary Care Improvement Plans, developed by each HSCP will set out how this funding will be used.

Manageable workload:

GP practices will provide fewer services directly under the new contract to alleviate practice workload. New primary care services, based on local population needs, will be developed and be the responsibility of IJBs/NHS Boards - necessity has already resulted in the development of some such services to support a small number of practices in Tayside.

There will be a wider range of professionals available in, and aligned to, practices and the community to provide patient care. New staff will be employed, mainly by NHS Boards through IJBs, and attached to practices to support development of the Expert Medical Generalist role. It is anticipated that new staff will be aligned to GP practices or clusters.

Priority services as outlined in the contract proposals, and in no particular order, to be developed include:

(i) Pharmacotherapy support – made up, by 2021, of level one core (acute prescribing, repeats, discharge letters, medication compliance reviews) followed by level two additional advanced (medication reviews, resolving high risk medication problems) and level three additional specialist services (polypharmacy, specialist clinics).

(ii) Community care and treatment services in each locality (e.g. minor injuries and dressings, phlebotomy, ear syringing, suture removal) with phlebotomy delivered as a priority in the first stage.

(iii) Vaccination services – staged for types of vaccinations but fully in place by April 2021.

(iv) Urgent care – advanced practitioners, nurses and paramedics undertaking home visits and delivering unscheduled care.

(v) Additional professionals for the multi-disciplinary team dependent upon local geography, demographics and demand.

(vi) Community Link Workers

Changes will happen in a planned transition over three years, commencing in 2018/19, and there will be national oversight involving Scottish Government, Scottish General Practitioners Committee (SGPC) and Integration Authorities, and local oversight involving IJBs, NHS Boards and the profession, including Local Medical Committees.

IJBs will each set out a 3 year Primary Care Improvement Plan to describe the actions to be undertaken (by April 2021) to establish an effective multi-disciplinary team model at practice and cluster level, and the resource framework supporting implementation. These plans will be developed in collaboration with NHS Boards and should be developed in conjunction with the GP Subcommittee (or representatives of by local agreement). Any specific contractual elements must be agreed with the Local Medical Committee.

Integration Joint Boards will be accountable for the delivery and monitoring of progress for the Local Plan, but there is a requirement for collaboration between IJBs within NHS Board areas in relation to effective and efficient use of resources.

Reduced risk:

GP owned premises: new interest-free sustainability loans will be made available, supported nationally by additional £10 million annual investment which will be managed at a national level.

GP leased premises: over time there will be a planned programme to transfer leases from practices to NHS Boards.

New information sharing agreement: reducing risk to GP contractors with NHS Boards as joint Data Controllers.

A Tayside Assets and Infrastructure Board has been established, under the leadership of e-Health director, and will report through the Primary Care Transformation Board and NHS Tayside Board providing a collaborative and planned whole system approach for premises and IT infrastructure.

This aspect of the new GP contract will have significant implications for NHS Boards in respect of premises management, including the requirement to manage the takeover of lease agreements.

This will require to be done in close collaboration with each HSCP, who will be responsible for agreeing future models of service delivery, reflecting national, regional, local and cluster priorities.

Improve being a GP:

A move to recognise the GP as the Expert Medical Generalist (EMG) and senior clinical decision maker. In this role the GP will focus on three main areas: undifferentiated presentations; complex care in the community; and whole system quality improvement and clinical leadership.

GPs will be part of, and provide clinical leadership to, an extended team of primary care professionals.

GPs will be more involved in influencing the wider system to improve local population health in their communities. GP Clusters will have an increasing role in quality planning, quality improvement and quality assurance. Clusters will provide advice in the development and implementation of Primary Care Improvement Plans and will have ongoing support from the Local Intelligence Support Team (LIST) analysts.

GPs will have contractual provision for regular protected time for learning and development.

Improve recruitment and retention:

A national mandatory GP census will better inform GP workforce planning.

An explicit aim to increase GP numbers by 800 over the next 10 years with a workforce plan due to be published in early 2018, which will also include a requirement to consider the workforce implications of the extended multi-disciplinary team.

This will again require close collaborative working between NHS Tayside Board and the 3 partnerships with respect to workforce planning, partnership engagement and HR support.

The Wider Role of the Practice:

Practice core hours will remain as 8.00 am to 6.30 pm (or in line with existing local agreements).

There will be a new enhanced services specification for practices to support work in the out of hours period.

Practices will continue with extended hours directed enhanced service where they chose to do so. The intention is that there will be no more new enhanced services but as there is no alternative to delivering many of the current enhanced services there is no intention of reducing these and the funding to practices would continue to be available. Any further changes will need to be carefully planned with a rate of change that ensures patient safety, quality of service and practice stability.

Role and training of Practice Nurses – with the introduction of dedicated care and treatment services, general practice nurses will be enabled to support holistic and person-centred care supporting acute and chronic disease management to enable people to live safely and confidently at home.

The role of practice managers and receptionists will change. It is recognised that practice staff already have a wide range of skills which will continue to be essential for the future. In future they will work more closely with the wider primary care system including GP clusters, NHS Boards, HSCPs and emerging new services.

Information technology investments – it is intended that all GP practices will transition to a new clinical IT system by 2020.

The contract will set out the roles and responsibilities of GPs and NHS Boards in relation to information held in GP records. The contract will recognise that contractors are not the sole data controllers of the GP patient's record but are joint data controllers along with their contracting NHS Board.

Practices will be required to provide activity, demand and workforce data (through the new SPIRE (Scottish Primary Care Information Resource) system unless practices wish to collect the information themselves) and to participate in discussions at cluster level.

GPs will remain independent contractors, noting however the increasing number of salaried GP posts in a range of contexts.

4. PROPOSALS

Dr Alison Clement, Clinical Director and Ms Rhona Guild, Primary Care Manager will oversee the development of the primary care improvement plan in close collaboration with the wider HSCP management team, general practices and GP Sub Committee, with regular reporting through both the Clinical Partnership Group and Executive Management Team. It is proposed that the proposed implementation plan be discussed at the Angus IJB meeting on 27 June.

5. FINANCIAL IMPLICATIONS

Over the period of implementation, £250m of new funds will be invested to support general practice. This will include a new practice funding formula, national support arrangements, premises support and the development of the wider Multi Disciplinary Team.

The Scottish Draft Budget proposals for 2018/19 (published in December 2017) confirmed a first phase of national funding of £110m for 2018/19, which will build on the funding already received.

A proportion (to be confirmed) of the £110m for 2018/19 will be allocated using the NRAC formula to support the development of multi disciplinary teams in line with the Memorandum of Understanding. Primary Care Improvement Plans will set out how this funding will be used.

Locally through the Primary Care Transformation Fund, the following allocations to support transformation (including out of hours) include:

2016-17 £2.01m
2017-18 £2.37m

Additional information regarding financial allocations to support implementation of the new contract is awaited.

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List of Appendices:
Appendix 1: Primary Care Strategic Framework

Appendix 1

SERVICE PLANNING

- GPs should work increasingly as part of an extended multidisciplinary team of health and social care professionals, and increasingly the patient and their carers within a locality framework. NHS Tayside will support the formation and development of these localities.
- Support should be given to ensure that all practices in Tayside are engaged with the integration agenda, and have an active part in shaping it. This should be in accordance with the best available evidence and meet mutually agreed outcomes. They should help shape new and innovative models of care, supported by a new contractual framework which will have an emphasis on person centred care, safety and quality.
- There should be an established clear understanding of the roles and accountabilities of each member of the MDT, who will be expected to work "at the top of their licence" which needs to be underpinned by explicit professional governance arrangements.
- Local communities must be supported to contribute to the better management of their own care recognising and addressing inequity and being equal partners in co-producing services that meet their needs. They should "know who to turn to" and be offered alternatives to the traditional GP model.
- Pathways of care should be co-produced, address inequity and focus on the whole patient journey, beginning with prevention. To empower the "prepared patient" there should be investment in self management, and access to a wide range of information, including early person centred care planning conversations.
- The locality hub model should be tested, and spread if evaluation positive.
- Resource is made available to support the delivery of the new Scottish GP Contract.

INTERFACES

- Opportunities should be extended to developing more prospects for shared education and learning across the primary/secondary care interface. This should incorporate data for learning and improvement.
- GP's working as integral members of an extended team (*similarly to 2. Service Planning*) must be willing and engaged partners in the developing agendas of the new Integration Joint Boards. All Boards should support contractor engagement and recognise the resource required to enable this.
- Contribute to the development of a local information system to successfully introduce the single electronic patient record.
- Patient safety and quality in Primary Care is recognised as the bedrock to delivering services within the multi-disciplinary team, and should be a priority for investment and development, utilising local and national clinical and academic expertise. This should inform clinical and care governance and include resource and support to implement clinical and care governance support systems such as Datix with clarity around how Primary Care will contribute to both existing and emerging governance structures.
- The opportunities and interfaces offered by new contractual frameworks are explored and actively developed. The opportunities offered by the new GP Contract and Prescription for Excellence must be explored, with a jointly agreed improvement agenda.
- Supporting the recommendations of the Ritchie Report: A Tayside wide Out of Hours Strategic and Implementation Plan incorporating all Ritchie Report recommendations should be supported.

SERVICE PLANNING

- The work to develop patient focussed, evidence based end to end pathways of care should be strengthened and made a Board priority. Initial pathways should focus on the areas of: frail elderly, dementia, management of complex or undifferentiated illness, and the deteriorating patient in the community. The economic and health impact of these pathways, and the shift into the community should be measured.
- There must be a better understanding of access and demand across all parts of the system, supported by data and intelligence to inform and improve pathways of care. Service planning should be both whole system and supported at locality level, utilising integrated resources, and reflecting the needs of the local population. This should be reflected in locality level integrated resource frameworks.
- In order to manage more complex care within the community, there must be rapid access to local diagnostics, named teams and readily available resources to support care at home.
- There should be facilities and resource within each locality to support care within the local community - the current bed model should be reviewed as a priority, with resource freed to consider new and innovative models of providing step up and step down care supported by the whole MDT. This must include provision for end of life care.
- National reviews and recommendations relating to health visiting and district nursing should be implemented without delay.
- A new model of immunisation delivery must be developed and implemented as a strategic and public health priority.
- Develop a Primary Care Out of Hours Service based upon an MDT model of care operating in-hours with the emphasis upon achieving seamless transitions to support episodes of unplanned care.

INFRASTRUCTURE

- A long term strategic capital plan for Primary Care should be developed. This must take account of PFI buildings, and consider new contracting opportunities.
- Services and facilities must develop in places where demographic demand is growing. These must be planned and designed in partnership.
- The e-Health Strategy must take cognisance of not just the medical interface, but expand to consider the growing need for single record multiple interface freely mobile working. Patient access must be considered in this context. This will require significant and sustained investment and should be considered within the context of the Board's eHealth Local Delivery Plan.
- IT systems should be developed to support maximum data set extraction and sharing, supported by robust data protection and governance arrangements. Data sets should support whole system planning, and should increasingly reflect the integrated resource available within each locality.

WORKFORCE & LEADERSHIP

- A Tayside wide strategic package of initiatives should be put in place as a priority to support practices currently facing recruitment difficulties and to prevent other practices experiencing these difficulties. A specific Primary Care workforce plan should be considered.
- Put in place arrangements to support effective medical leadership and management development.
- Primary Care should play an active part in the Academic Health Science Partnership.
- Models to support flow of staff and encourage learning and development across the interface should be developed. To support the patient journey across the interface, and support our staff to explore new ways of working, away from traditional models of hospital based to more community based care and prevention.
- We must support an improvement culture, with quality and safety- underpinned by clinical and care governance, at the heart of everything we do.