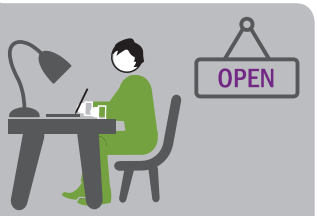
THE 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND

A CLEAR ROLE FOR SCOTLAND'S GPs

BETTER CARE FOR PATIENTS

MANAGEABLE WORKLOAD



REDUCED RISK

INVESTING TO MAKE IT HAPPEN

BETTER HEALTH IN COMMUNITIES

BMA

Healthier Scotland
Scottish Government

THE 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND

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FOREWORD

Shona Robison
Cabinet Secretary for Health
Scottish Government

Alan McDevitt
Chair
Scottish GP Committee, British Medical Association

We are delighted to attach a joint statement of policy that will underpin a new distinctively Scottish General Medical Services contract due to take effect in 2018.

This document is intended primarily to provide an accessible explanation to Scotland's GPs of the changes we propose to effect in the new contract. The proposed changes will complement the complex wider contractual framework that underpins the provision of General Medical Services in Scotland. It will also be of significant interest to those planning and managing General Medical Services.

This document is the result of significant constructive engagement, over an extended period, between the Scottish General Practitioners' Committee of the British Medical Association and the Scottish Government, as the parties authorised to negotiate the provision of General Medical Services. All the commitments made in this document and the ambitions for future change set out are shared and agreed.

We believe this is a landmark step on a journey already begun.

On 3 November 2016 we wrote to all general practitioners in Scotland[1] setting out our shared vision for general practice in Scotland. We restated our commitment to general practice, and the essential generalist care it provides, with Scotland's GPs supported to be the expert medical generalists in our communities.

We equally recognised the fundamental challenges faced by general practice, not least growing workload and increasing risk. Given these challenges, we emphasised the need to ensure stability as we transform through taking a measured, step-wise approach.

We have already taken substantial practical steps on that journey, not least the removal of the Quality and Outcomes Framework and introduction of GP cluster working, and this joint statement of policy sets out the next practical steps we will take to deliver on our shared vision and to meet the challenges facing general practice.

1 http://www.gov.scot/Publications/2016/11/7258/0

We believe that the policies set out in this document will provide the secure foundation that general practice needs. It recognises that general practice is an essentially collaborative endeavour, collaborative in terms of the enhanced multi-disciplinary teams that are required to deliver effective care; the joint working between GP practices in clusters; and, essentially, as part of the wider integrated health and social care landscape.

More effective sharing of information and sharing of responsibilities is essential to better manage the challenges of increasing workload and risk. And if we can better manage these challenges it will achieve our most fundamental aim, which is to provide the very best care for the people of Scotland.

Shona Robison
Cabinet Secretary for Health

Alan McDevitt
Chair, SGPC

EXECUTIVE SUMMARY

The contract offer proposes a refocusing of the GP role as expert medical generalists. This role builds on the core strengths and values of general practice – expertise in holistic, person-centred care – and involves a focus on undifferentiated presentation, complex care, and whole system quality improvement and leadership. All aspects are equally important. The aim is to enable GPs to do the job they train to do and enable patients to have better care.

This refocusing of the GP role will require some tasks currently carried out by GPs to be carried out by members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care. Integration Authorities[2], the Scottish GP Committee (SGPC) of the British Medical Association (BMA), NHS Boards and the Scottish Government have agreed priorities for transformative service redesign in primary care in Scotland over a three year planned transition period. These priorities include vaccination services, pharmacotherapy services, community treatment and care services, urgent care services and additional professional services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services. GPs will retain a professional role in these services in their capacity as expert medical generalists.

The funding of general practice in Scotland will be reformed and a phased approach is proposed. In Phase one, starting from April 2018, a new funding formula that better reflects practice workload will be introduced. A new practice income guarantee will operate to ensure practice income stability. The new funding formula will be accompanied by an additional £23 million investment in GMS to improve services for patients where workload is highest.

In addition, the contract offer proposes to introduce a new minimum earnings expectation to ensure no GP partner earns less than £80,430 (including pension contributions) NHS income for a whole-time equivalent post from April 2019. Evidence indicates this will benefit approximately one fifth of GP partners in Scotland.

GP and GP practice workload will reduce and refocus under the proposals, as the wider primary care multi-disciplinary team is established and service redesign embedded. By the end of the planned transition period, for example, GP pharmacists will deal with acute and repeat prescribing and autonomously provide pharmaceutical care through medication and polypharmacy reviews - all tasks currently requiring GP time.

We will ensure that engagement with patients, and other professionals delivering primary care, is a key part of the development and delivery of any service redesign.

A Memorandum of Understanding (MOU), in development between Integration Authorities, SGPC, NHS Boards and the Scottish Government, will set out agreed principles of service redesign (including patient safety and person-centred care), ringfenced resources to enable the change to happen, new national and local oversight arrangements and agreed priorities.

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2 Integration Authorities were established by the Public Bodies (Joint Working) (Scotland) Act 2014 and are the statutory bodies responsible for the planning, design and commissioning of primary care services in Scotland. These responsibilities are typically delivered through Health and Social Care Partnership (HSCP) delivery organisations.

The contract offer proposes significant new arrangements for GP premises, GP information technology and information sharing. The effect of these arrangements will be a substantial reduction in risk for GP partners in Scotland, and a substantial increase in practice sustainability. Sustainable general practice is critical for better care for patients.

Under the proposed contract offer, a new GP Premises Sustainability Fund will be established, with an additional £30 million investment over the next three years. The investment will support a long term shift that gradually moves towards a model which does not presume GPs own their own premises. A new National Code of Practice for GP premises sets out how the Scottish Government will achieve a significant transfer away from GPs of the risk of providing premises. By 2023, interest free secured loans – "GP Sustainability Loans" – will be made available to every GP contractor who owns their own premises. NHS Boards will gradually take on the responsibility from GP contractors for negotiating and entering into leases for GP practice premises.

New contractual provisions will reduce risk in information sharing by clearly setting out the roles and responsibilities of GP contractors and NHS Boards in relation to patient information held in GP patient records. The contract will recognise that GPs are not sole data controllers of the GP patient record, but are joint data controllers along with their contracting NHS Board. GP contractors will not be exposed to liabilities beyond their effective control. The proposals on information sharing have been developed with the support of the Information Commissioner's Office – Scotland.

Practice core hours will be maintained at 8am-6.30pm (or as previously agreed through local negotiation). Online services for patients will be improved and online appointment booking and repeat prescription ordering will be made available where the practice has the functionality to implement online services safely.

Service redesign, as set out in the MOU, will allow for longer consultations for patients where they are needed – in particular for complex care of patients with multi-morbidity, including co-morbidity of physical and mental health issues.

GP cluster quality improvement – introduced in the 2016/17 GMS contract in Scotland – will be further embedded. GP cluster core functions include an intrinsic function to improve care for their practice populations through peer led review and an extrinsic function to meaningfully influence the local system on how services work and on service quality. There will be a refreshed role for the GP Sub Committee in enabling this extrinsic function by facilitating the provision of combined professional advice to the commissioning and planning processes of Integration Authorities and NHS Boards.

GP clusters will have a clear role in quality planning, quality improvement and quality assurance. Existing analytical support from Information Services Division of NHS National Services Scotland will be further embedded. Practices will supply information on practice workforce and on demand for services to support quality improvement and practice sustainability.

The proposed contract offers new opportunities for clinical and non-clinical employed practice staff, including general practice nurses and practice managers and receptionists. The contract will support general practice nurses to focus on a refreshed role as expert nursing generalists providing acute and chronic disease management, supporting people to manage their own conditions where possible. Practice managers and receptionists will play an important role in supporting and enabling the primary care multi-disciplinary team to function smoothly, to the benefit of patient care.

1 INTRODUCTION

A strong and thriving general practice is critical to sustaining high quality universal healthcare and realising Scotland's ambition to improve our population's health and reduce health inequalities.

The 2018 Scottish General Medical Services (GMS) Contract has been developed by the (SGPC) and the Scottish Government to re-invigorate general practice and to re-energise its core values. It aims to create a dynamic and positive career for doctors and ensure that patients continue to have accessible, high quality general medical services.

The contract will be supported by a MOU between the Integration Authorities, SGPC, NHS Boards and Scottish Government. The MOU represents a statement of intent from all the parties to deliver the wider support and change to primary care services required to underpin the contract.

For the purposes of this document, we refer to Health and Social Care Partnerships (HSCP) as delivery agents of Integration Authorities, responsible for the planning and commissioning of primary care services.

NATURE OF THE CONTRACT

Since the inception of the NHS, general practice has developed as an independent contractor model. Some of the great strengths of general practice exist because of the independent nature of GPs under this model and their ability to prioritise and advocate for their patients.

After consideration and wide discussion, both the SGPC and the Scottish Government have agreed that the GMS contract will continue as an independent contractor model. In the BMA "The future of general practice" survey 2015, 82% of GPs supported maintaining the option of an independent contractor status for GPs.[3]

While the majority of general practice is intended to be delivered through the independent contractor model, we recognise there is an important, continuing role for non-GMS contractor GPs, often in a salaried positions, in a wide range of circumstances. The new contract will continue to specify that salaried GP contracts should be on terms no less favourable than the BMA Model Contract.

Our vision is that GPs will continue to run their practices to deliver GP care to their list of patients. However, practices will now be expected to carry less risk compared to previous contracts and be more embedded in the wider health and social care services in their communities. GPs will play a critical role as expert medical generalists and senior clinical leaders within those services.

3 https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-surveys/future-of-general-practice

In *Distilling the Essence of General Practice*,[4] following in-depth consideration by RCGP Scotland on the future of general practice, the authors reflect consensus that "contracts should be used to enable rather than limit developments in general practice". The Scottish Government and SGPC agree with this consensus, and the aim of the proposed new contract is to be just such an enabling contract.

General practice – the context

"General practice provides continuing, comprehensive, coordinated and person-centred health care to patients in their communities.

GPs and GP-led multi-disciplinary teams manage the widest range of health problems; providing both systematic and opportunistic health promotion, diagnoses and risk assessments; dealing with multi-morbidity; coordinating long-term care; and addressing the physical, social and psychological aspects of patients' wellbeing throughout their lives. GPs are also integrally involved in deciding how health and social services should be organised to deliver safe, effective and accessible care to patients in their communities.

With general practice carrying out 90% of patient contacts in the health service, it is the bedrock of the NHS."[5]

GPs – Expert medical generalist

"GPs are expert medical generalists who provide the first point of contact with the NHS for most people in their communities. They may deal with any medical problem, 'from cradle to grave', and by providing continuity of care to their patients, families, and communities, they contribute hugely to keeping the nation healthy.

General practice is a unique discipline. Rigorous scientific and clinical medical training and the ability to apply the evidence appropriately in community settings, places general practice at the centre of the NHS. This knowledge and skill set – when combined with the discipline's holistic, relationship based philosophy and broad generalist practice, distinguish the discipline in large measure from other medical disciplines."[5]

This document is organised into a further seven chapters that set out the proposed changes to the GMS contract and our vision for the future of primary care services in Scotland.

4 Gillies, J. (et al) (2009) Distilling the Essence of General Practice: a learning journey in progress. *BJGP*

5 http://www.rcgp.org.uk/training-exams/becoming-a-gp/what-is-general-practice.aspx

THE ROLE OF GPS IN SCOTLAND - EXPERT MEDICAL GENERALISTS

Barbara Starfield's "four Cs"[6] of primary care acted as a guiding principle throughout the negotiations:

- contact – accessible care for individuals and communities
- comprehensiveness – holistic care of people - physical and mental health
- continuity – long term continuity of care enabling an effective therapeutic relationship
- co-ordination – overseeing care from a range of service providers

The 2018 Scottish GMS contract is intended to allow GPs to deliver these four Cs in a sustainable and consistent manner in the future.

These four pillars of primary care are also evident in the landmark Royal College of General Practitioners report on *Medical Generalism*.[7] The ethos of generalism described in this report includes comprehensiveness, co-ordination and continuity. Generalism, by definition, is a form of care that is person - not disease - centred. It is precisely the type of medicine needed to meet the challenge of shifting the balance of care, realising *Realistic Medicine*,[8] and enabling people to remain at or near home wherever possible.

The future will see general practitioners in Scotland fulfilling roles supporting a wide range of clinical professionals, working as an expert medical generalist and senior clinical decision maker within multi-disciplinary community teams. The key contribution of GPs in this role will be in:

- undifferentiated presentations
- complex care in the community
- whole system quality improvement and clinical leadership

Chapter two sets out this vision in more detail

PAY AND EXPENSES

The GMS contract introduced in 2004 served a purpose for that time. No longer did GPs have individual contracts with the NHS. Contracts were with practices who were encouraged to provide a wide range of services outwith those provided directly by GPs. Alongside this came a structured attempt to promote quality improvement, the Quality and Outcomes Framework (QOF). Over time, QOF has been subject to much examination about whether its intended purpose was wholly achieved or brought about unintended consequence.[9]

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6 Starfield, B. (1992) *Primary Care: Concept Evaluation and Policy.* OUP, New York.

7 http://www.rcgp.org.uk/policy/rcgp-policy-areas/medical-generalism.aspx

8 http://www.gov.scot/Resource/0049/00492520.pdf

9 http://www.SSPC.ac.uk/media/media-486342_en.pdf

The 2004 GMS contract also loosened the link between the income received by practices and the number of GPs. This has broadened the range of incomes of GPs in Scotland. While some have benefited from this (often as a result of entrepreneurial skills, hard work and long hours) others, despite all efforts, have found themselves financially compromised with difficulty recruiting new GPs, and keeping their practice viable. This is why, underlying all the proposed changes is a key intention to improve the sustainability of practices.

Proposed changes to the way that practices are contracted and funded in Scotland are ultimately intended to re-establish the link between practice income and the provision of GPs to the community. Most of the payments to practices will be intended as income for the right number of GPs, for paying for a core team of employed staff, and for meeting the necessary expenses of running the practice. As change progresses, the intention is that GPs are paid to be GPs rather than to provide a wide range of other services. The proposed changes are also intended to reduce the transactional business elements of the relationship between GPs and the rest of the system. These elements have, at times worked against the development of the collaborative relationships in health and social care necessary for good outcomes.

Chapter three sets out our proposals around pay and expenses, including a new workload formula and increased investment in general practice.

MANAGEABLE WORKLOAD

The consultation remains the foundation of general practice. It is where the values of compassion, empathy and kindness combine with expert scientific medical knowledge to the benefit of patient care and mental and physical health. The role of the modern GP, however, is wider than patient consultations. Repeat prescriptions, test results, home visits, telephone calls and other communication with patients and other services can all form a significant part of the GP day.

Chapter four sets out our proposals to provide additional primary care staff to work alongside and support GPs and practice staff to reduce GP practice workload and improve patient care. These additional staff will underpin a transformational service redesign over the next three years with the development of the multi-disciplinary team to support general practice.

IMPROVING INFRASTRUCTURE AND REDUCING RISK

As independent contractors running a practice, GPs are exposed to risk in a number of ways. This can be through the ownership and maintenance of practice premises, through acting as a data controller sharing information with the wider NHS, and through the risks of being an employer.

Chapter five introduces a number of significant new measures designed to manage and reduce these risks to GPs.

BETTER CARE FOR PATIENTS

With a focus on Barbara Starfield's four Cs, chapter six sets out the benefits the new contract will bring to patients. The proposals will help people access the right person at the right place at the right time, as described in the Scottish Government Primary Care Vision and Outcomes (see annex). In particular the chapter focuses on:

- maintaining and improving access (contact);
- introducing a wider range of health professionals to support the expert medical generalist (comprehensiveness);
- enabling more time with the GP for patients when it is really needed (continuity); and
- providing more information and support for patients (co-ordination).

In addition, the chapter sets out the critical role of meaningful patient engagement in ensuring services are designed in ways that meet the needs of individuals and communities.

BETTER HEALTH IN COMMUNITIES

Scotland's health and social care workforce continues to be at the forefront of a wide range of improvements in the safety, effectiveness and quality of care and treatment. General practice in Scotland took a distinctive path on quality improvement through the establishment of GP clusters in 2016/17 - enabling a peer-led, values-driven approach to quality improvement. The proposed new contract further embeds the cluster quality approach.

THE ROLE OF THE PRACTICE

The final chapter sets out the wider role of the practice and practice team, including general practice nurses, practice managers and practice receptionists.

Overall, the proposals represent both significant investment in primary care and significant change. At the heart of any change must be the core principle of patient safety. That is why our planned approach is of a three year transition with changes to services only taking place when it is safe, when it is appropriate, and when it improves patient care. By working together in this way we can build a GP service for the future, one that meets the changing needs and demands of the people of Scotland and enables GPs to do the job they train to do.

A range of supporting materials and evidence including the review of the Scottish Allocation Formula, the Premises Code of Practice and the Review of GP Earnings and Expenses will be published on the Scottish Government website. (http://www.gov.scot/Topics/Health/Services/Primary-Care/GP-Contract).

The next chapter sets out our vision of the role of the GP as an expert medical generalist.

2 THE ROLE OF GPs IN SCOTLAND – EXPERT MEDICAL GENERALISTS

Key Points

- The GP as expert medical generalist will focus on undifferentiated presentations, complex care and quality and leadership. All are equally important.
- GPs will lead and be part of an extended team of primary care professionals.
- GPs will have more time to spend with the people who need them most.

INTRODUCTION

The Scottish Government and the SGPC share a vision of the role of the GP as the expert medical generalist in the community. This is not a new role – generalism has always been at the heart of general practice: holistic care that sees the person as a whole in the context of their community is the very strength of general practice that we wish to enhance.

However, the context that GPs now work in is changing - multi-morbidity is more common; people are living longer and the demands on GPs have been growing. The challenge is ensuring GPs have the space and the time to carry out the expert medical generalist role that their communities need.

We intend to meet this challenge by focusing the role of the GP on activity that requires the skills of a doctor. The GP will be supported by an extended multi-disciplinary team that will be responsible for some of the activities currently being performed by the GP, where that is safe, appropriate and improves patient care. Practice workload will be more manageable, with patients consulting with the most appropriate professional in the team. Chapter four, describes how we will tackle rising GP workload in more detail.

We anticipate that an enhanced role for the GP as senior clinical leader in the community will lead to greater professional esteem. It will remain a challenging role, and a rewarding one.

THE GP AS EXPERT MEDICAL GENERALIST

In the previous chapter we introduced Barbara Starfield's four Cs of primary care - contact, comprehensiveness, continuity and co-ordination. Her pioneering research clearly demonstrated the benefits of strong general practice for the population and for the wider health and care system. The international evidence is clear – health and care systems with strong primary care demonstrate better population health outcomes more equitable outcomes and better cost efficiency than systems with relatively weak primary care. The aim of this contract – and wider primary care transformation – is to strengthen general practice for the benefit of all in Scotland.

Successfully addressing the health needs of individuals and communities requires an approach that makes the best use of the unique skills and experience of GPs and of other professionals in primary care. We expect that a modernised role for GPs will encourage recruitment and retention and strengthen the crucial role of general practice and primary care within the wider health and social care system.

We are proposing a refocused role for the GP from 2018. This will incorporate the core existing aspects of general practice and introduce a renewed focus on quality and the sharing of system wide clinical knowledge. It will acknowledge the GP's expertise as the senior clinical leader in the community, who will focus on:

- undifferentiated presentations
- complex care in the community
- whole system quality improvement and clinical leadership

A key change in the contract offer is the proposal that GPs become more involved in complex care and system wide activities, necessitating a refocusing of GP activity. As we refocus the GP role, we expect GPs to be less involved in more routine tasks, with these tasks being delivered by other health professions in the wider primary care multi-disciplinary team. To achieve this, the training needs of GPs and members of the wider primary care multi-disciplinary team, will need to be considered, developed and delivered. The third part of *National Health and Social Care Workforce Plan: Part 3 Primary Care* will set out plans for the development and training of GPs and this wider primary care multi-disciplinary team and is due to be published early 2018.

UNDIFFERENTIATED PRESENTATIONS

Seeing patients who are unwell, or believe themselves to be unwell, will remain a core part of general practice as it is the basis for the continuous development of the clinical skills required of a generalist and is essential for good patient care.

GPs are, however, a limited resource and their capacity to see patients is finite. There needs to be a balance between access to GP appointments, access to other health professionals where that is more appropriate, and encouraging patients to seek self-care advice, where appropriate. This will enable GP time to be available when really needed by patients.

The key direct clinical care role for the GP as expert medical generalist is in undifferentiated presentations which require the skills of a doctor trained in risk management and holistic care with broad medical knowledge. Often this care is delivered through the continuity of consultations over time.

People are often able to self-differentiate in their own presentations. For example, a person presenting with shoulder pain may choose to see a physiotherapist as a first point of contact if such a service is as responsive as their GP practice. This is also the case for minor illness and injury, where, if there is an advanced practitioner or other service available locally, patients may choose that practitioner rather than seek a GP appointment.

New models of care will require other health professionals to be more involved in meeting immediate patient needs as part of a wider team (see chapter four for further details). Working alongside GPs, other health professionals need to be able to efficiently assess and treat patients, within their clinical competence. It will be essential that they are able to complete episodes of care without recourse to the GP on a significant number of occasions.

GPs will retain oversight to ensure the service, as a whole, is working and patient needs are met. Other clinicians will work independently within their competencies as part of the extended team with mutual decision support.

GPs will be of particular importance in supporting and managing people with undifferentiated presentations especially in the context of multi-morbidity and complexity and will maintain longitudinal patient contact to support that role.

GP practices act as a patient gateway to ensure that people can access the right care. Patients should experience contacting the practice, either in person or remotely, as a way to obtain advice on how best to have their needs met safely, effectively and efficiently by services. GPs should oversee and manage this process to ensure it is effective and that patients can see the right person at the right place at the right time.

COMPLEX CARE IN THE COMMUNITY

As workload capacity is freed up, a key part of the GPs expert medical generalist role will be leading a primary care multi-disciplinary team to deliver care to patients with, for example, multiple co-morbidity, general frailty associated with age, and those with requirements for complex care (e.g. children or adults with multiple conditions, including mental health problems, or significant disabilities).

What do we mean by complex care?

Complex Care is most commonly the clinical care of patients who have multiple disease presentations. Such patients may have two or more diagnoses which, as they occur in the same individual, are therefore connected and interacting. Evidence based guidance and decisions which may be appropriate for one diagnosis may not be appropriate or may conflict with those for the other conditions. This uncertainty requires shared decision-making with patients and carers. Complexity can occur in the context of mental and/or physical ill health, at any age including end of life. The GP acts, as the expert medical generalist, giving advice on managing and treating these uncertainties to increase the likelihood of achieving the agreed outcomes.

The system, with the contribution of GPs and GP practices through cluster quality improvement, will be focused on knowing its population and assessing where there is potential to achieve better outcomes. GP clusters were introduced in Scotland with the 2016/17 GMS agreement between the SGPC Committee and the Scottish Government. In professional groupings of five to eight practices, clusters enable peer-led, values-driven quality planning, improvement and assurance.

Each GP practice will be supported with appropriate information to proactively identify the cohort of patients requiring complex care and to then work with others to devise an appropriate care plan to ensure patients receive the optimum care and support.

One of the main aims of this change in focus is to provide care to patients with complex needs at home wherever this is appropriate. Where care at home is desirable and adequately supported it is better for patients. GPs spending more time on patients with complex needs would help to ensure that admission to acute care should only be to achieve a specific outcome, or for an assessment or treatment that can only be provided in a hospital setting.

GPs will also be involved in establishing care plans for patients with complex needs, including anticipatory care plans, which can be used by community teams to enable patients to be cared for in their own homes for as long as possible. As the expert medical generalist in the community, GPs will also support these community teams, when any expert GP input is required.

WHOLE SYSTEM ACTIVITY – QUALITY IMPROVEMENT AND LEADING TEAMS

Ultimately all GPs must have regular protected time to be able to develop as clinical leaders. The intended outcome is that they become fully involved in assessing and developing services intended to meet the needs of their patients and local communities. Currently, only Practice Quality Leads (PQL) have access to protected time, although different GPs in the practice can perform that role over time.

The next step in this journey is to create additional protected time for each practice, to enable GPs to develop their clinical leadership role. Therefore, from April 2018, each practice will receive resources to support one session per month for Professional Time Activities. There is a clear intention to achieve, over time, regular protected time for every GP.

GPs are senior clinical decision makers and leaders. As such, and with a clear focus on outcomes of relevance for patients, they will assess the overall performance of their own practice, practices within their cluster, and the wider community team, leading to suggestions for improvement that will in turn be evaluated by them and others. This will require GPs to have influence to direct change within the wider health and social care system. Indeed, for wider health and social care to be successful, meaningful involvement of GPs is required.

Whilst some GPs may not see themselves attracted to broader leadership roles and responsibilities, all will need to be involved in improvement activity in both their practice and the wider system through cluster working. Any significant improvements in patient outcomes are only likely to be achieved if every senior clinician is engaged in these activities at some level.

GP training

The evolution of primary care will require training for doctors wishing to become GPs to have a renewed focus on the skills required to be an expert medical generalist: in leadership, multi-disciplinary team working and peer-led quality improvement. Increased time and wider expertise may be required for training practices, with review of funding for training to ensure appropriate support for the necessary expansion of medical training in the community.

ESSENTIAL SERVICES, ADDITIONAL SERVICES AND ENHANCED SERVICES

The refocusing of the GP role to expert medical generalist has implications for the current contracted service elements of Essential, Additional and Enhanced Services.

We are proposing the following service refinements in the new contract:

Essential Services

Essential Services will remain unchanged in the proposed new contract. The fundamental core principles of general practice – care based on the registered practice list, generalist care of the whole person and sufficient consultation time for patients according to their clinical needs – align with Essential Services.

Additional Services

The agreed direction of travel is to reduce the over-specification of services in the contract wherever it is safe to do so. That will begin with the proposed new contract.

For instance, latest evidence[10] suggests there is no longer a requirement for a separate Additional Service for minor surgery. GPs may still provide treatments which would have previously fallen under the Additional Service at their clinical discretion under core services. The Enhanced Service for minor surgery will continue.

Out of Hours

There will be changes to arrangements for out of hours services. Instead of the current opt-out arrangement a new opt-in Enhanced Service will be developed for those practices that choose to provide out of hours services.

The new out of hours Enhanced Service will have a nationally agreed specification, building on the quality recommendations within Sir Lewis Ritchie's out of hours review *Pulling Together*[11] and covering areas such as record keeping, anticipatory care planning, key information summary, use of Adastra and NHS24.

This will contribute to a consistency of approach to the provision of unscheduled care services across Scotland where practice-based service level agreements are in place. There is also an opportunity to develop a nationally agreed quality and person-centred specification which could be used by all NHS Boards to test and benchmark their current local service level agreements.

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10 https://cks.nice.org.uk/warts-and-verrucae#!scenaico

11 http://www.gov.scot/Resource/0048/00489938.pdf

Enhanced Services

We have agreed a general principle (with the exception of the new out of hours approach) against the expansion of the number of Enhanced Services under the proposed new contract.

Chapter four describes the Vaccination Transformation Programme which will transfer responsibility for the delivery of vaccinations from GPs to NHS Boards. On completion, to the satisfaction of the SGPC, Scottish Government and local delivery and commissioning partners, the relevant Additional and Enhanced Services for vaccinations will no longer be included in the Scottish GMS contract. In rare circumstances it may be appropriate for GP practices, such as small remote and rural practices, to agree to continue delivering these services through locally agreed contract options.

The current direction of travel on maternity medical services – where responsibility already largely lies with other parts of the community team – is expected to continue. Similarly, for contraceptive services, current provision by other professionals and teams is expected to continue.

There is, at this stage, no real alternative to delivering many of the current Enhanced Services provided by practices and no intention of reducing the funding to practices. Any further changes will need to be carefully planned with a rate of change that ensures patient safety, quality of service and practice stability.

The continuation of locally determined Enhanced Services is for NHS Boards and local practices to agree. The expectation nationally is that Enhanced Services funding is not removed from practices as services are transitioned to NHS Boards over 2018-2021, as doing so could be destabilising to the system. As mentioned previously, there is an intention to reduce the transactional business elements of the relationship between GPs and the rest of the system. These at times, have worked against the development of the collaborative relationships in health and social care necessary for good outcomes.

At the start of this chapter we set out our belief that the enhanced role of the GP as senior clinical leader in the community will lead to greater professional esteem and that while the role will remain challenging, it will be a rewarding one. The cornerstone of this enhanced role is the GP's skill and expertise in dealing with undifferentiated presentations, complex care in the community and whole system quality improvement and clinical leadership.

We also recognise that GPs should be appropriately remunerated for their work. Chapter three sets out our proposals for pay and expenses.

3 PAY AND EXPENSES

Key Points

- A new practice income guarantee will operate to ensure practice income stability.
- A new funding formula that better reflects GP workload will be introduced from 2018 with additional investment of £23 million.
- A new minimum earnings expectation will be introduced from 2019.

INTRODUCTION

The SGPC and the Scottish Government recognise that an appropriate and secure level of income is a key prerequisite to attracting GPs to the profession and ensuring the future viability of general practice. Existing GPs need to be adequately rewarded for the work they do. GP trainees and anyone considering a career as a GP needs to have a clear understanding about the rewards of the career.

THE NEW FUNDING MODEL AND A PHASED APPROACH

We recognise that the current funding arrangement is complex, leads to uneven funding allocations and needs to be reformed. We also recognise that practices require funding stability. To deal with these historical shortcomings of the current system, we are proposing:

From 1 April 2018:

- To introduce a new funding formula to better address practice workload (details are provided below).
- That new arrangements will include the correction factor (Minimum Practice Income Guarantee) and core standard payments (previously QOF payments) in a consolidated global sum. The funding associated with these elements of the 2004 GMS Contract will be subject to the new formula and would cease to exist as separate funding streams thereafter.
- To make these changes in a protected manner so that no practice will lose funding. To maintain funding stability the Scottish Government has committed investment of an additional £23 million to fund the practices that receive a greater formula share and protect all other practices.
- That seniority arrangements remain unchanged
- That there will be no out of hours opt-out deduction under the new arrangements. Nationally, 6% will be deducted from the 2017/18 Global Sum prior to applying the new funding formula. This will conclude the opt-out arrangements made under the 2004 GMS contract.

From 1 April 2019:

- The government will introduce a GP partner whole-time equivalent minimum earnings expectation. On current evidence around one-fifth of GP partners earn less than a whole-time equivalent income of £80,430 (inclusive of pension contribution), based on partner shares of total practice GP income. We agree that no GP should receive less than £80,430 (inclusive of pension contribution) for a whole-time post. This is a first step towards greater income security that will be further bolstered in the following years.

From 1 April 2020 we propose to:

- Introduce an income range that is comparable to that of consultants
- Directly reimburse practice expenses
- As these measures would again change GP practice funding and GP income they will will be subject to negotiation and a second poll of the profession after specific details (including financial details) are available. Negotiations on this phase will include arrangements for the protection of GP income and practice expenses.

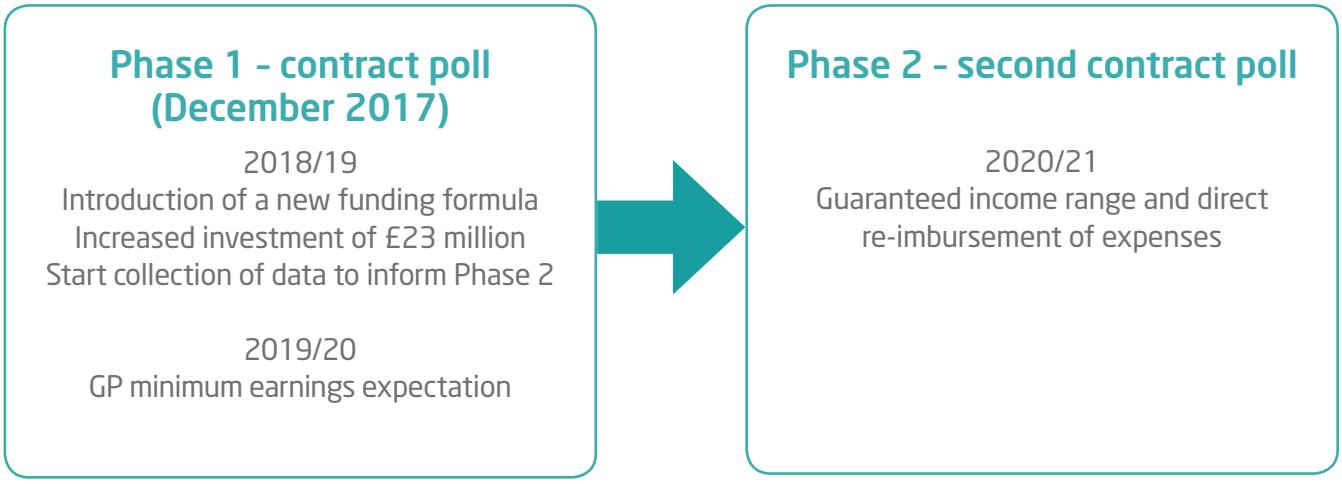
Underlying this investment are a number of key agreements:

- To invest £250 million in direct support of general practice by 2021/22
- To ensure that proposals stabilise practice income
- To ensure that an allocation mechanism better recognises the demand for GP and other staff time for any given practice population
- To develop a process that, at its endpoint, provides all GPs a guaranteed income on a range comparable to that of consultants and reduces risk through the direct reimbursement of premises and staff costs
- To ensure that there will be no loss of funding to general practice. Any disputes regarding funding will be ultimately reviewed by the Scottish Government and SGPC
- To ensure that practices can expect that support services they are provided with locally will continue

We have agreed that GP income should not be subject to arbitrary variation and should instead reflect the value a GP's work as an expert medical generalist. Ultimately, this can only be achieved by providing practices with the necessary funding for expert medical generalist work and the necessary expenses to support this work.

To achieve this, we propose two separate phases of transition:

Figure 1: Two-phased approach to funding



PHASE 1 - INTRODUCTION OF A NEW FUNDING FORMULA

The current funding model under the 2004 GMS contract has led to a disparity of income and expenses between practices in Scotland because it is based on a methodology that performs two distinct functions simultaneously:

1. It allocates resources to GP practices according to population requirements and differences in costs; and
2. It determines GP partner pay as the difference between this funding and GP practice expenses.

While this arrangement incentivises GP partners to use their funds in the most efficient way to maximise their income, differences in local circumstances that are not captured adequately by the formula lead to differences in costs, income and provision of services.

Phase 1 sees the introduction of a new GP workload based resource allocation formula (the GP Workload Formula) to replace the existing Scottish Allocation Formula (SAF).

The new formula was developed as part of a 2016 review of the SAF.[12] It re-estimates the number of consultations per patient, dependent, in the main, on their age, sex and the deprivation status of the neighbourhood in which they live.

The new formula is a methodological improvement to the previous SAF. It is based on the best available evidence and as such it more accurately reflects the workload of GPs. Compared to the workload-related weightings of the original SAF, the new formula gives greater weight to older patients and deprivation.

The impact of deprivation on the workload of a practice is better reflected in the new workload formula than the previous SAF. Methodological improvements mean both deprivation in urban areas and isolated pockets of rural deprivation are better addressed by the new formula.

With the introduction of the new formula, GP practices will be protected from any potential funding losses. To this end, the Scottish Government has committed to invest an additional £23 million to fund the practices that receive a greater share under the new formula while protecting all other practices. This additional investment is to improve services for patients in areas where workload is highest.

We will monitor the impact of the funding formula during implementation.

Increased investment of £23 million

We have calculated the impact of the new formula on GP practice funding for each GP practice in Scotland. This information will be provided to your GP practice in a separate letter in November 2017.

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12 http://www.gov.scot/Topics/Health/Services/Primary-Care/GP-contract

The guarantee to protect GP practice income and expenses in Phase 1 will continue until there is a proposal acceptable to the profession for the introduction of Phase 2. Future funding uplifts will apply to all GP practices' share of the total, derived by the new formula during Phase 1, including the new income guarantee. Population increases will apply to the formulasum only.

PHASE 1 - MINIMUM EARNINGS EXPECTATION

In early 2017 the Scottish Government and SGPC commissioned a review of GP earnings and expenses in Scotland.[12] The review found significant differentials in income and expenditure in the sample of 109 practices, with around one-fifth of GP partners earning less than £75,000 (including any private work, excluding employer superannuation) in a whole-time equivalent post.

We propose that no GP partner should receive less than £80,430 (including employer pension contributions) NHS income pro-rata up to a whole-time equivalent (40 hours) from April 2019.[13] This extra income will be provided through NHS: National Services Scotland Practitioner Services Division (PSD) on the basis of the income, hours and session information.

Start collection of data to inform Phase 2

We considered a single transition to an agreed income range with pay progression and direct re-imbursement of expenses (staff and premises), but there are a number of reasons why it is necessary to split the transition into two phases:

- We need time to develop the administrative capacity to enable the direct re-imbursement of expenses and payment of income.
- We need time to collect data to allow us to calculate the impact on individual partners if the funding model is replaced.
- We therefore cannot calculate the total cost and provide ministers. Parliament and the profession with the necessary assurance of the affordability of the preferred model.

In order to prepare for Phase 2 we need to fully understand the current expenses of running a GP practice, the income of salaried GPs and the income of GP partners as well as the hours worked by individual GPs.

This data is necessary to calculate partners' earnings entitlement and the total costs of introducing a consultant comparable income scale. We have agreed that all GP practices will be required to provide this data (earnings, expenses, hours/sessions) in a similar way to the data already provided for pension purposes.

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13 Minimum earnings expectation is £80,430k per WTE GP in the practice, including employees and employers superannuation, and including all NHS practice income earned within practice opening hours, pro-rated to a WTE of at least 40 hours per week, and excluding all non-NHS income earned within practice opening hours.

To ensure confidentiality data will be held and processed by NHS National Services Scotland Practitioner Services (which currently handles GP income data for pension purposes) and only anonymised, non-identifiable data for the purposes of analysis will be provided to government, NHS Boards or the SGPC during Phase 1, In Phase 2 this data will be required to authorise payments and provide supporting information to ensure appropriate individual GP practice resourcing.

PHASE 2 - INCOME RANGE AND EXPENSES RE-IMBURSEMENT

In Phase 2, which is subject to further negotiations and another poll of the profession, an income range with pay progression for GPs (comparable to that of consultants) and direct re-imbursement of expenses (staff and premises) will be introduced. Negotiations will include the arrangements for protection of GP income and GP practice expenses.

Direct re-imbursement of expenses and an income range for GPs will remove the direct link between the new formula and practice funding. Instead, the new formula will act to define the GP input and an expenses 'norm' for a practice. This will guide the allocation of primary care resources across the country but will not be used to allocate money directly. The formula will indicate the necessary resources of individual practices to meet patient demand. The flexibilities that will be required under this proposal will be negotiated between the Scottish Government and the SGPC and presented to the profession before the poll for Phase 2.

Meeting the primary care needs of the people of Scotland

The intention of Phase 2 is that the new formula will inform the establishment of a baseline of the number of GPs required to meet the primary care needs of the people of Scotland. The determination of the baseline will be subject to negotiations and is also dependent on how much variability at a practice level is agreed to be allowed.

Once a baseline is determined, the new formula will help define the optimum GP supply required every year to deal with the workload generated by a growing and ageing population. This puts the onus on the Scottish Government to ensure sufficient training numbers and provide the necessary funding to enable the number of general practitioners to grow in line with overall workload. Further detail on initiatives to increase GP supply in Scotland will be contained in the forthcoming *Health and Social Care National Workforce Plan: Part 3* on primary care.

Phase 2 and GP pay

Under these proposals for Phase 2, GPs will have assured income and pay progression, providing stability. The allocation of GPs across GP practices will be informed (but not wholly determined) by the workload formula to allow for some flexibility while broadly ensuring the provision of GPs reflects population need.

In necessarily small remote GP practices, extra resources will continue to be made available to ensure long-term sustainability. Remote GP practices will, as they do now, continue to provide a broader range of services more appropriate to remote settings.

Phase 2 and GP Expenses

The composition and necessary amount of GP practice expenses will change over time in the context of the extra resources to be provided to the practice as part of the development of the wider multi-disciplinary approach.

We know that rural GP practices have, on average, higher expenses per patient than urban ones. Partly, these can be explained by the diseconomies of scale of small GP practices and the costs of dispensing, or having one or more site/branch surgeries and we recognise that these differences will need to be addressed by proposals for Phase 2.

We agree that GP practices need sufficient time to adjust their resources and that there needs to be sufficient flexibility to allow appropriate funding to account for exceptional circumstances.

This chapter started with a recognition that an appropriate and secure level of income is a key prerequisite to attracting GPs to the profession and ensuring the future viability of general practice. We believe that the proposals outlined deliver on these needs. We also recognise that as well as being rewarded financially for doing their work, GPs need to have a manageable workload. Chapter four explains how we plan to deliver this.

4 MANAGEABLE WORKLOAD

Key Points

- GP and GP Practice workload will reduce.
- New staff will be employed by NHS Boards and attached to practices and clusters.
- Priorities include pharmacy support and vaccinations transfer.
- Changes will happen in a planned transition over three years when it is safe, appropriate and improves patient care.
- There will be national and local oversight of service redesign and contract implementation involving SGPC and Local Medical Committees.

INTRODUCTION

We know that workload is currently one of the most challenging aspects of being a GP. We are introducing measures to address this by:

- continuing to reduce contractual complexity
- improving primary/secondary care interface working
- building a wider primary care multi-disciplinary team

Reducing contractual complexity

The process of reducing the contractual complexity of the Scottish GMS contract has already begun. In 2015 the Scottish Government and the SGPC announced that Scotland would become the first country in the UK to remove the Quality and Outcomes Framework (QOF). QOF no longer incentivised the direction of travel needed with respect to demographic change (an ageing population and increasing multi-morbidity), because the disease specific, procedural basis of QOF encouraged diseases to be viewed separately. This was counter to the holistic, person-centred care required for the increasing numbers of people with multiple long term conditions.

In April 2016, the remaining 659 QOF points were retired and transferred to the general practice core standard payments, signalling one of the first steps towards the development of the new contract, and a significant shift towards placing greater trust in the clinical judgment and professionalism of GPs. Transitional arrangements for quality assurance were introduced in the Statement of Financial Entitlements 2016/17 alongside the removal of QOF. These included early instructions for the creation of GP clusters in Scotland, setting the direction for the new contract.

Other arrangements have also been improved while the new contract was being developed. These include removing the discretionary element for parental leave and sickness leave locum cover payments so all eligible GP practices will receive these payments. We have also created an occupational health service that all GPs and GP practice staff can access, and improved the re-imbursement rate for appraisals.

The new contract will build on these improvements to further reduce contractual complexity. Some of the proposed simplification of the contractual landscape was set out in chapter two. Our proposed changes to the GMS regulations will include updates on dispute resolution, closing practice lists and defining the practice boundary. These changes are described more fully in chapter eight.

Improving interface working

- To ensure effective working between primary and secondary care, we will continue to implement the recommendations of the *Improving General Practice Sustainability Advisory Group* as set out in its report on November 2016.

Within the recommendations there are a number of broad themes including effective primary and secondary care interface working. Interface working will be better achieved through well-functioning primary and secondary care interface groups. These groups will support NHS Boards and HSCPs to reduce GP workload and provide a better patient experience by removing the need for GP involvement when it is not clinically necessary. The recommendations include:

- Improved processes for routine follow-up of hospital procedures and results of tests
- Allow the issuing of fit note certificates by secondary care providers at the time of discharge, where the condition being treated is the cause of a temporary disability
- More efficient use of the primary care multi-disciplinary team by ensuring secondary care staff request patient visits by the most appropriate professional for their condition e.g. social care or district nurse
- Changes to the referral pathway for patients who do not attend (DNA) hosptial appointments to remove the need for GP referrals

Building the primary care multi-disciplinary team

In line with commitments to be made in the MOU referred to in chapter one, HSCPs and NHS Boards will place additional primary care staff in GP practices and the community who will work alongside GPs and practice staff to reduce GP practice workload.

Practices will be encouraged to use the additional capacity created by reducing GP provided services to focus on activities that directly support GPs as expert medical generalists. We will increase protected time to allow GPs to maintain and develop their training and skills, and those of their practice teams.

SERVICE REDESIGN - 2018-2021

To enable and empower GPs to function as expert medical generalists, non-expert medical generalist workload needs to be redistributed to the wider primary care multi-disciplinary team, ensuring that patients have the benefit of the range of expert advice needed for high quality care.

Local areas are already beginning to reconfigure primary care by redistributing workload to the multi-disciplinary team as capacity becomes available.

An MOU between these local commissioning and delivery partners, the SGPC and Scottish Government is in development. It sets out agreed principles of service redesign, identified ring-fenced resources to enable the change to happen, national and local oversight arrangements, and the priorities for the transfer of responsibility for service delivery.

These agreed principles include patient safety and person-centred care. Patient engagement in the planning and delivery of new services will be critical to their success.

It is intended that GPs will become better embedded in HSCPs as senior clinical leaders working in collaboratively with managers to achieve better outcomes for patients.[14]

To help ensure sufficient, visible change in the context of a new contract, we have agreed to focus on a number of specific services to be reconfigured at scale across the country. These include:

- vaccinations services;
- pharmacotherapy services;
- community treatment and care services;
- urgent care services; and
- additional professional clinical and non clinical services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services.

To ensure the continued delivery of high quality, safe, person-centred care, the transition will happen over an agreed period of time.

Primary Care Improvement Plan

Each of the 31 HSCPs in Scotland will develop a Primary Care Improvement Plan which will outline how these services will be introduced before the end of the transition period in 2021. These Plans will be overseen by a GMS Oversight Group with representation from the Scottish Government, the SGPC, HSCPs and NHS Boards. This group will be formed to oversee implementation by NHS Boards of the Scottish GMS contract and implementation by the HSCPs of the Primary Care Improvement Plans. Plans will include clear milestones for the redistribution of GP workload and the development of effective primary care multi-disciplinary team working.

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14 Don Berwick's concept of the need to move to an Era 3 of medicine was a guiding touchstone during the negotiations. https://www.advisory.com/daily-briefing/2016/04/12/berwick

As well as the requirements on the HSCPs to develop Primary Care Improvement Plans, NHS Boards with HSCPs will develop clear arrangements to deliver the commitments in respect of the new Scottish GMS contract. These arrangements include the priority areas of service redesign set out below and must be agreed with the local GP Subcommittee of the Area Medical Committee and the Local Medical Committee (LMC).

Leadership and management

Under the new contract GPs will be concentrating on their role as expert medical generalists with a focus on improving outcomes for patients. There is an explicit understanding that part of this role will be senior clinical leadership of these multi-disciplinary teams.

Line management of much of the primary care multi-disciplinary team staff will be provided through the employing authority (usually NHS Boards). This will include the provision of employee support, training, cross cover and cover for holidays and other absences. The purpose of the line management is to support staff in their role as a member of the primary care multi-disciplinary team attached to one or more practices and their patient lists.

While all professionals involved in patient care have a leadership role to play, the senior clinical leadership role of doctors will be outlined in the GP role in Primary Care Improvement Plans. Not all GPs will feel that they have all the skills to undertake this role, but training will be available and be part of core curricula in the future. Leadership which is intended to improve outcomes for patients will clearly require collaborative working with a wide variety of professionals who will be involved in primary care multi-disciplinary teams. Various members of these teams will also undertake leadership roles to achieve changes and improvements.

There are many examples of effective teams whose membership have different employers. Many GPs will have had experience of this with district nurses and other professionals not directly employed by their practice. The MOU is a clear statement of intent to deliver this form of team working. We have agreed shared principles to ensure these teams operate in optimum ways to the benefit of patient care.

Some of these primary care multi-disciplinary team members will be attached to individual practices but inevitably, in some cases, resources may have to be shared between different practices. GP clusters will have an important role in facilitating cross practice working including developing common working practices and pathways.

We believe that the best way to deliver relationship-based care to patients is through the effective relationships between the members of these primary care multi-disciplinary teams.

VACCINATION SERVICES

In 2017, as part of the commitment to reduce GP workload the Scottish Government and SGPC agreed vaccinations would progressively move away from a model based on GP delivery to one based on NHS Board delivery through dedicated teams. The Vaccinations Transformation Programme is reviewing and transforming how we deliver vaccinations in Scotland. Delivery will move away from the current position of GP practices being the preferred provider of vaccinations on the basis of national agreements.

The vaccination services delivered by the programme will form part of the Primary Care Improvement Plan in each area. It is expected that each area will make meaningful progress over the first two years of transformation to demonstrate commitment to the change.

The aim of the programme is to reduce workload for GPs and their staff. This will mean that other parts of the system, with primary care multi-disciplinary teams, will begin to deliver vaccination services instead of GPs. This will be a step towards enabling GPs to focus their time on expert medical generalism, whilst ensuring that patients' needs are met through the reconfiguration of services which will make the best use of the mix of skills in primary care. How this programme is delivered will vary regionally, depending on local circumstances and factors.

The funding that was historically associated with the delivery of vaccinations will remain within general practice. An additional £5 million is being invested in 2017 to start the Vaccination Transformation Programme ahead of the delivery of the proposed new contract.

The Vaccination Transformation Programme will draw in expertise from across the NHS and will take three years to complete. Transition to the new model will be planned to ensure that it can operate safely and sustainably, and changes will be made only in line with an agreed process (detailed in the Primary Care Improvement Plans).

The Vaccination Transformation Programme can be divided into different work streams:

1. pre-school programme
2. school based programme
3. travel vaccinations and travel health advice
4. influenza programme
5. at risk and age group programmes (shingles, pneumococcal, hepatitis B)

We expect HSCPs and NHS Boards to have all of these programmes up and running by the end of the 3-year transition period - in April 2021. The order and rate at which HSCPs and NHS Boards make the transition may vary but progress is expected to be delivered against milestones in each of the 3 years.

1) **Pre-school programmes** in NHS Board areas such as Lanarkshire and Tayside are already established. This is a complex, time-critical programme and HSCPs and NHS Boards that do not currently provide this service will, early on in the transition period, prioritise the adoption of lessons learned from service delivery and workforce development in those areas that have already introduced the service.
2) The **school based programme** is already established across all areas delivering influenza vaccine and HPV vaccine to girls.
3) **Travel vaccinations and travel health advice** are currently a significant time burden on GP practices and the Vaccination Transformation Programme will prioritise optimal alternative options for re-provision in the first year.
4) The **influenza programme** will tackle the seasonal challenge of delivering to those in certain age categories and those at particular high risk. HSCPs will plan how they deliver vaccinations to the high volume over 65 category. Pre-school and school age children could have this vaccination delivered by their respective programmes. Consideration needs to be given to particular risk groups such as pregnant women and adult at-risk groups, and how vaccines can be provided in a way that is safe efficient and acceptable to patients.
5) For **at risk and groups programmes,** consideration needs to be given to providing relevant vaccines to eligible patients in a way that is safe, acceptable, and which maintains, or increases uptake.

PHARMACOTHERAPY SERVICES

Multi-disciplinary team working is crucial to reducing GP workload. The proposed contract includes an agreement that every GP practice will receive pharmacy and prescribing support.

The GP Pharmacy Fund has already enabled 160 pharmacists and 34 pharmacy technicians to be appointed to posts in over one third of GP practices across Scotland.

We are investing £12m in the GP Pharmacy Fund in 2017/18. We intend that investment in this service will continue under the new contract to allow more pharmacists and pharmacy technicians to work in general practice, reducing GP workload and improving patient care.

As part of the proposed contract, we would also introduce a new pharmacotherapy service to allow GPs to focus on their role as expert medical generalists, improve clinical outcomes, more appropriately distribute workload, address practice sustainability and support prescribing improvement work.

Case Study – Pharmacy support in Caithness

Pharmacists and pharmacy technicians are already developing an increased, specialised role within primary care multi-disciplinary teams. They are well placed to support GPs to focus on their role as expert medical generalists by ensuring workload is distributed more appropriately, undertaking prescribing improvement work, and providing medication reviews and specialised clinics.

In Caithness in NHS Highland, pharmacist prescribers are embedded in the primary care MDT. One pharmacist, who works in a GP practice with 5,447 patients, has taken over all the medication reviews that were previously provided by the practice GPs, and completed a total of 2,811 reviews in an 18-month period. This includes re-authorising repeat prescriptions and transferring suitable patients to serial prescribing. They also triage all daily acute requests, carry out all medicines reconciliation for hospital discharges and clinic letters and manage individual patients requiring more intensive medicines input, such as dose titration of a pain medicine. Caithness pharmacists also provide domiciliary medication reviews for patients in care homes and patients receiving care at home, reducing the number of visits required by GPs.

The pharmacist input has resulted in a marked reduction in GP time spent on medicines-related activities, enabling them to focus on other activities. Patient response has also been overwhelmingly positive.

"Having an in-house pharmacist has shown many benefits for patients including reducing polypharmacy, being able to monitor more closely patients on high risk medications, and supporting patients though medication changes after hospital discharge."

GP, Caithness

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.

In order to increase the pool of qualified pharmacists to provide the pharmacotherapy service, additional funding has been secured to increase the number of pharmacist training posts from 170 to 200 per year from 2018/19. This will ensure that there is sufficient capacity to deliver the pharmacotherapy service within the proposed timescales.

By April 2021, every practice will benefit from the pharmacotherapy service delivering the core elements as described below. Some areas will also benefit from a service which delivers some or all of the additional elements described below. The level of additional services available in different areas will be dependent on workforce availability which will build throughout the three years leading up to 2021 and beyond.

Figure 2: Core and additional pharmacotherapy services

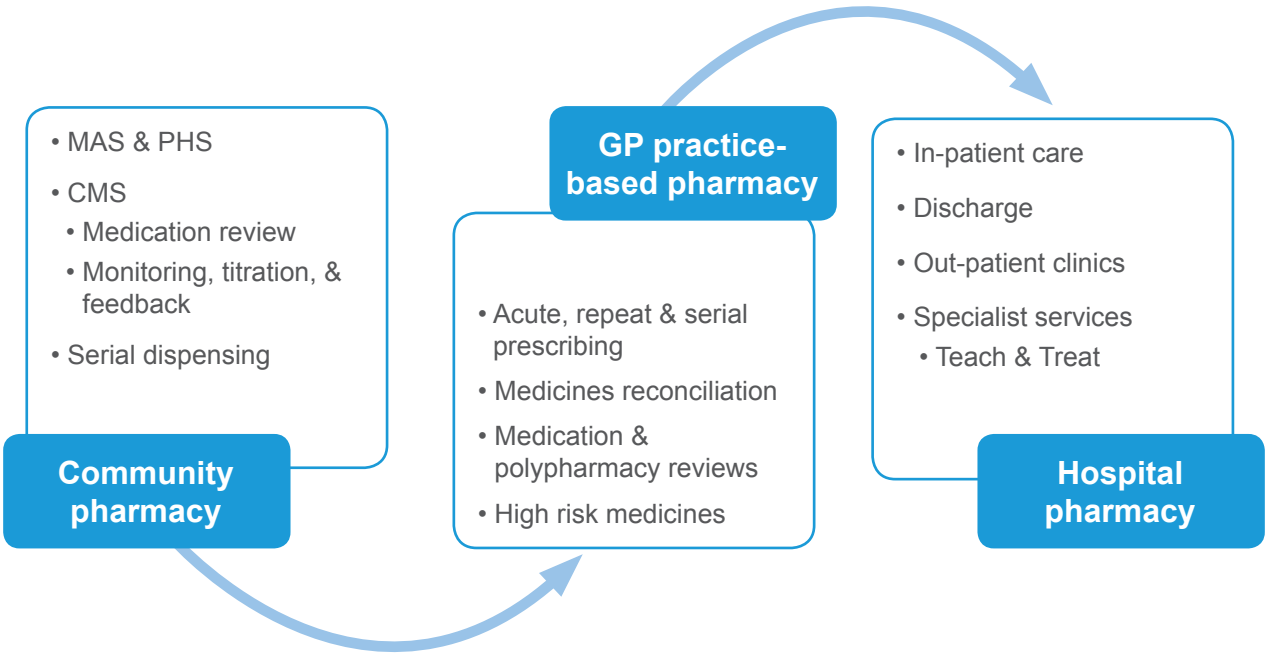
CORE AND ADDITIONAL PHARMACOTHERAPY SERVICES		
	Pharmacists	**Pharmacy Technicians**
Level one (core)	• Authorising/actioning[15] all acute prescribing requests • Authorising/actioning all repeat prescribing requests • Authorising/actioning hospital Immediate Discharge Letters • Medicines reconciliation • Medicine safety reviews/recalls • Monitoring high risk medicines • Non-clinical medication review Acute and repeat prescribing requests includes/ authorising/actioning: • hospital outpatient requests • non-medicine prescriptions • installment requests • serial prescriptions • Pharmaceutical queries • Medicine shortages • Review of use of 'specials' and 'off-licence' requests	• Monitoring clinics • Medication compliance reviews (patient's own home) • Medication management advice and reviews (care homes) • Formulary adherence • Prescribing indicators and audits
Level two (additional - advanced)	• Medication review (more than 5 medicines) • Resolving high risk medicine problems	• Non-clinical medication review • Medicines shortages • Pharmaceutical queries
Level three (additional - specialist)	• Polypharmacy reviews: pharmacy contribution to complex care • Specialist clinics (e.g. chronic pain, heart failure)	• Medicines reconciliation • Telephone triage

15 Pharmacist Independent Prescribers can action (instigate and sign) prescriptions, non-prescriber pharmacists can action prescriptions but they still require to be signed by a prescriber.

As outlined in the MOU, the pharmacotherapy service will evolve over the three year transition, with pharmacists and pharmacy technicians becoming embedded members of the core practice clinical teams. While not employed directly by practices, the day-to-day work of pharmacists and pharmacy technicians will be co-ordinated by practices. Pharmacists and pharmacy technicians will take on responsibility for:

a) Core elements of the service, including: acute and repeat prescribing, medicines reconciliation, monitoring high risk medicines
b) Additional elements of the service, including: medication and polypharmacy reviews and specialist clinics (e.g. chronic pain)

Figure 3: Integrated pharmacotherapy service



COMMUNITY TREATMENT AND CARE SERVICES

Community treatment and care services include many non-GP services that patients may need, including (but not limited to):

- management of minor injuries and dressings
- phlebotomy
- ear syringing
- suture removal
- chronic disease monitoring and related data collection.

There will be a three year transition period to allow the responsibility for providing these services to pass from GP practices to HSCPs. By April 2021, these services will be commissioned by HSCPs, and delivered in collaboration with NHS Boards that will employ and manage apprporiate nursing and healthcare assistant staff. Phlebotomy will be delivered as a priority in the first stage of the Primary Care Improvement Plans.

Local circumstances and demand will determine where it is most appropriate to safely situate these services. It is expected that many of these functions will be provided in the GP practice premises for patient convenience and the benefits of having these services carried out with the close support of the wider practice team. This would also enable easier sharing of necessary data and the patient records.

In some areas, (for reasons of premises, practicality or geography) the NHS Board may operate these services from separate facilities. The principles agreed by the parties to the MOU will ensure that patient safety, person-centred care and sustainability remain at the heart of these services as they develop, wherever they are delivered.

Patients should be able to conveniently and confidently access community treatment and care services. In some circumstances it may be appropriate for certain GP practices, such as small remote and rural GP practices, to locally agree to deliver these services. If GP practices locally agree to deliver community treatment and care services, then support will be provided in the form of either expenses for the required practice employed staff capacity, or the deployment of NHS Board employed staff.

It is expected that community care and treatment services will be available for use by primary and secondary care. For example, pre-hospital clinic bloods could be carried out for a requesting consultant without having to involve the GP practice staff. The consultant's name would be on the test result to avoid unnecessary GP involvement.

It will be clear in the agreement represented by the MOU that local arrangements will determine how services will be provided. This will help to remove the responsibility for service provision away from GPs to the HSCPs, allowing GPs to focus upon their expert medical generalist role. NHS Boards and HSCPs will work with practices to plan and manage service transfers in a way that ensures patient safety and maximises benefits to patient care.

Delivery of the Vaccination Transformation Programme, pharmacotherapy service and community treatment and care service are priorities, and responsibility for these services will be transferred to HSCP by the end of the transition period in April 2021. Within that timeframe, delivery at a local level will vary based on local factors such as the extent to which comparable services are already in place, upon local geography, and prioritisation based on local demographics and demand.

URGENT CARE SERVICES

In addition to these priorities, the MOU will support the redesign of other services to reduce GP workload and free up GPs capacity to focus on their expert medical generalist role. These redesigned services will focus on urgent and unscheduled care, and developing the roles of other clinical and non-clinical professions, working in the practice, to support physical and mental health.

The Scottish Government and SGPC have agreed that another area of GP workload that needs to be addressed is urgent unscheduled care including the provision of advanced practitioner resource as first response for home visits.

A number of tests of change in Scotland over the last two years have focused on the role of Scottish Ambulance Service (SAS) paramedics in primary care. Evidence from pilots in Inverclyde, Hawick and Kelso shows that support (such as responding to urgent call out to patients) allows GPs to provide appropriate patient care. Relevant support includes advanced practitioner resource, such as a nurse or a paramedic, for GP clusters and GP practices, serving as first response for home visits.

The MOU will support the implementation of sustainable advance practitioner provision in all HSCP areas, based on local service design. These practitioners will assess and treat urgent or unscheduled care presentations. This will allow GPs to focus on scheduled appointments with patients most in need of their skills as expert medical generalists. Where service models are sufficiently developed, advanced practitioners will also directly support GPs expert medical generalist work by carrying out routine assessments and monitoring of chronic conditions for vulnerable patients at home, or living in care homes.

It is expected that the workload for paramedics would mean that most GP practices would not have sole access to a paramedic. It is likely that paramedics would work across a number of GP practices to meet patient needs. GP clusters will play an important role in enabling this service to ensure effective working and good patient outcomes.

Paramedics and specialist paramedics can practice in all aspects of urgent, unscheduled, and emergency presentations as needed, underpinned by GP review and consultation with the GP and wider multi-disciplinary team where required. A specialist paramedic in urgent and emergency care is a paramedic who has undertaken, or is working towards a post-graduate certificate in Specialist Paramedic Practice. They will have acquired, and continue to demonstrate an enhanced knowledge base, complex decision making skills, and competent judgement in urgent and emergency care. Paramedics (as non-specialists) can also provide care and support to patients in primary care, both in and out of hours as part of a wider primary health and care team.

Case Study - Paramedic Support in Inverclyde

Part of the Inverclyde tests of change included SAS supported transformational change in GP clusters. Regent GP practice in Greenock piloted paramedic support in general practice using a Trainee Specialist and a Paramedic; and Gourock Health Centre retained a Specialist and a Paramedic.

Baseline data was collected for the month of June 2016. In that month, practice paramedics carried out by Regent 102 home visits from Regent practice and 106 from Gourock. The average time taken for visits was 34 minutes. This includes travel time and updating patient records. In the first three months following paramedic support to practices being put in place, the percentages of home visits carried out by GPs reduced by over 60%. In addition to home visits, paramedics are also able to assess urgent presentations within the surgery. Referral rates to secondary care are very similar between GPs and paramedics. The most common conditions seen are acute respiratory illness, abdominal and back pain, UTIs and falls. Feedback from staff and patients so far has been positive. The GPs report they are happy with how the model is working and relationships between the professional groups continue to develop.

ADDITIONAL PROFESSIONAL SERVICES

Additional professional roles will provide services for groups of patients with specific needs that can be delivered by clinicians other than GPs, serving as first point of contact in the practice setting as part of the wider multi-disciplinary team. These include (but are not limited to) physiotherapy services, community mental health services and community links worker services.

Physiotherapy services focused on musculoskeletal conditions

Musculoskeletal problems frequently cause repeat appointments and are a significant cause of sickness absence in Scotland. The majority of a GP's musculoskeletal caseload can be seen safely and effectively by a physiotherapist without a GP referral. However the existing patient pathway often includes an unnecessary delay while initial non-physiotherapeutic solutions are attempted prior to access to a musculoskeletal physiotherapy service. There are variable waiting times across the country for access to face-to-face physiotherapy.

Physiotherapists are already well situated to work collaboratively with primary care multi-disciplinary teams and support the GP role as a senior clinical leader. Physiotherapists are an expert professional group. They have a high safety record and are trained to spot serious pathologies and act on them. Physiotherapists utilise their wider knowledge and skills as part of their assessment. A first point of contact service could also be seen in the context of the wider muscoloskeletal pathway.

Under the new contract, HSCPs will develop models to embed a musculoskeletal service within practice teams to support practice workload. In order to provide a realistic alternative for patients, access times must be comparable to those of general practice. Priority for the service, such as focusing on elderly care, will be determined by local needs as part of the Primary Care Improvement Plan.

Case Study - Physiotherapy services in Inverclyde

Inverclyde piloted the use of an Advanced Practice Physiotherapist (APP) as an alternative first point of patient contact within the GP practice. Since August 2016, an APP has worked in three GP practices with a total patient list of 14,000. Reception staff at each practice were trained to offer patients APP appointments where appropriate. To date the APP has provided over 1000 consultations, most of which would otherwise have been GP appointments. 94% of patients were seen once and did not need a further appointment with the physiotherapist.

GPs at one participating practice, Lochview practice in Greenock, noted a number of benefits. By seeing the majority of patients with musculoskeletal conditions the APP has freed up GP appointments. GPs are able to use their time more effectively by focusing on patients more in need of their expertise, and are spending more of their patient facing time on complex care needs. In qualitative evaluation, the pilot was rated highly by GPs, practice staff and patients, with patient feedback in particular being extremely positive.

'Of all the work that's ever been done in GP practices, this has been the one that feels like it has truly taken work away. Patients are safer - there is quicker access to the most appropriate intervention because triage assessment conducted by the physiotherapist gets people to the right place sooner'.
(GP, Greenock)

Community mental health services

Community clinical mental health professionals (eg nurses, occupational therapists), based in general practice, will work with individuals and families assessing their mental health needs, providing support for conditions such as low mood, anxiety and depression. The outcome sought is improved patient care through rapidly accessible, appropriate and timely mental health input.

Community Links Worker Services

A Community Links Worker (CLW) is a non-clinical 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. They often serve a socio-economically deprived community or assist patients who need support because of for example, the complexity of their conditions. As part of the Primary Care Improvement Plan, HSCPs will develop CLW roles in line with the Scottish Goverment'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 of care and support.

Rural support

The rural and remote GP shares much of the same generalist workload as their colleagues in urban areas. In many areas, being a rural GP means being the expert medical generalist providing the broadest range of skills because of their remoteness, because they usually have smaller primary care teams and because the locality services that may be available in areas with larger populations may not be available.

Many remote and rural GPs have chosen to work where they do in part because it fits with their desire to provide a more complete primary care service to their patients and see delivery of some services as welcome opportunities to engage with their patients. In some rural areas where there are larger list sizes, there will be the opportunity to move the responsibility for some services like immunisations to reduce workload pressures.

The service redesign described above requires practices to be involved via their GP clusters, so they have a say in how services will work locally.

Workforce

The introduction of the services described above relies on the establishment of a new workforce which will be part of practice teams but not employed by practices. These practice-attached staff will be largely employed by NHS Boards, embedded in practice teams with their day-to-day work co-ordinated by the practice.

Patient safety will be fundamental in delivering this workforce at scale. Taking the paramedic support service as an example, at all stages of the roll-out, we will ensure the capacity and capability of the workforce is sufficient. This means that the safety of patients requiring urgent unscheduled care is assured and core Scottish Ambulance Service performance is protected. This will require consistent and reliable provision of paramedic staff working in primary care teams, with appropriate training and education, supervision and support arrangements. Positive relationships between colleagues in the primary care multi-disciplinary teams will be crucial. This approach to attached staffing will be taken in the development and roll-out of all services – the principles for which are outlined in the MOU.

Further detail on delivering this new workforce will be in the Scottish Government *National Health and Social Care Workforce Plan: Part 3 Primary Care.*

As this chapter sets out, an expanded primary care multi-disciplinary team will bring substantial workload benefits to GPs and deliver better services and outcomes to patients. As well as improvements to workforce we will introduce measures to reduce risk and improve infrastructure in general practice. These are explained in chapter five.

5 IMPROVING INFRASTRUCTURE AND REDUCING RISK

Key Points

- The risks associated with certain aspects of independent contracting will be significantly reduced.
- GP Owned Premises: new interest-free sustainability loans will be made available, supported by additional £30 million investment over the next three years.
- GP Leased Premises: there will be a planned transition to NHS Boards leasing premises from private landlords
- New information sharing agreement, reducing risk to GP contractors.

INTRODUCTION

As independent contractors, many GP practices carry the responsibility for providing staff and infrastructure to support GPs and services to patients. With this responsibility can come risk which can include the risk of changes in funding. As outlined in chapter three one of the overarching aims of reforming practice funding is to increase practice stability and reduce risk. As outlined in chapter four, proposals for the NHS Boards to largely employ the expanding primary care multi-disciplinary team are specifically intended to avoid increasing the clinical and administrative risks of being an employer.

This chapter describes new measures to improve infrastructure and reduce risk in areas such as ownership of premises, IT and information sharing.

PREMISES

Practice premises are increasingly perceived as an unwanted liability by potential GP partners; and this has become a barrier to recruitment, retention and retirement.

The Scottish Government and SGPC recognise and support a long-term shift that gradually moves towards a model which does not presume GPs own their practice premises.

To this end the Scottish Government and the SGPC have agreed a National Code of Practice for GP Premises ("the Code") which sets out how the Scottish Government will support a shift, over 25 years, to a new model in which GPs will no longer be expected to provide their own premises. The contract offer proposes that from 1 April 2018, the Code will be introduced and revised Premises Directions will take effect. The Code sets out how the Scottish Government will achieve a significant transfer away from GPs of the risks of providing premises.

To enable this transfer of risk, the Scottish Government will make available assistance of up to £30 million by 2021 (£10 million per year from 2018) to GPs with premises related liabilities. This will be through the establishment of a GP Premises Sustainability Fund. This represents a 24% increase in funding for supporting GPs with premises (compared to 2015/16, the latest available figures).

GP Owned Premises

The Code sets out the measures the Scottish Government will provide to assist GPs who own their premises. These measures include interest-free secured loans, known as GP Sustainability Loans, to be resourced through the new GP Premises Sustainability Fund.

These GP Sustainability Loans will be made available to every GP contractor who owns their premises by 31 March 2023. The loans will help stabilise general practice as a whole. They will allow partners to release capital without destabilising their practice, reduce the up-front cost of becoming a GP partner, and make general practice more financially rewarding. The loans will encourage GPs to become partners in practices which own their premises.

GP Sustainability Loans

All GP contractors who own their premises will be eligible for an interest-free loan, including those in negative equity.

The loans will be for an amount of up to 20% of the Existing-Use Value of the premises and they will be secured against the premises.

Loans will be funded from the GP Premises Sustainability Fund.

NHS Boards will have the power to top-up the amount of the loans where they decide that there are exceptional circumstances.

The loans will be repayable if the premises are sold or are no longer used by the GP contractor for the provision of general medical services under a contract with an NHS Board.

The loan will have no effect on Notional Rent or borrowing cost payments. There will be no abatements due to a loan.

A system for prioritising applications will be put in place. To ensure that assistance is given first to those who need it most. However, all GP contractors who own their premises will be eligible to receive a GP Sustainability Loan by 31 March 2023.

The Scottish Government envisages that once the first cycle of GP Sustainability Loans is complete (2023) a further five yearly cycles will begin to further reduce the risk to GP practices which own their premises. The Scottish Government intends that these five year cycles of investment will continue until the transition to the new model where GPs no longer own their premises is complete (by 2043).

More information on GP Sustainability Loans can be found in the National Code of Practice for GP Premises.

GP Leased Premises

The Scottish Government's long term strategy is that no GP contractor will need to enter a lease with a private landlord for GP practice premises. NHS Boards will gradually take on the responsibility from GP contractors for negotiating and entering into leases with private landlords and the subsequent obligations for maintaining the premises. NHS Boards will ensure that GP contractors are provided with fit-for-purpose accommodation which complies with the standards set by the Premises Directions.

GP contractors who wish to continue to provide their own accommodation will be free to do so. They will continue to be eligible to receive rent re-imbursements under premises directions.

NHS Boards will support GP contractors who currently lease premises from private landlords. The Code sets out what GP contractors who lease their premises need to do to ensure that their NHS Board takes over the responsibility of providing their premises.

There are three ways in which NHS Boards can take on the responsibility of providing a GP contractor with practice premises. These are:

- negotiating a new lease for the GP contractor's current premises, with the NHS Board as the tenant
- accepting assignation of the GP contractor's current lease
- providing alternative accommodation for the GP contractor when its current lease expires

If a lease expires before 1 April 2023, the most likely course of action is for the NHS Board to negotiate a new lease or provide alternative accommodation.

If the lease expires after 1 April 2023, NHS Boards will take on the existing lease from GPs where:

- The practice has ensured that its premises are suitable for the delivery of primary care services and are sufficient to meet the reasonable needs of its patients
- The practice has met its statutory obligations regarding the premises
- The practice has provided all relevant information to its NHS Board
- The practice has given sufficient notice to its NHS Board of its need for assistance
- The practice has registered the lease with the NHS Board
- The practice has the agreement of the landlord to the assignation of the lease (and the other necessary conditions)
- The practice has complied with its obligations under its existing lease
- The rent represents value for money

Premises Survey

All premises used to provide GMS will be surveyed in 2018/19. This will provide the data which NHS Boards will require for their premises plans. Contractors will be contacted by the surveyor appointed by the Scottish Government to arrange a survey of their premises at a convenient time. This is essential if NHS Boards are to effectively support practices with premises issues in the future.

Risk of being an employer

Under the new contract GPs will be not be exposed to increased risks from being an employer as the joint intention of the negotiating parties is for the increased primary care team to be employed by NHS Boards and deployed in practices – details are outlined in chapter four.

Under Phase 2 of the funding changes it is proposed that practice expenses will be directly re-imbursed. This will include staff costs and those associated with staff sickness, maternity, paternity and adoption leave, including staff cover for long-term sickness and maternity leave.

GP CLINICAL IT SYSTEMS

NHS Boards have commissioned a procurement competition to provide the next generation of GP clinical IT systems for GPs in Scotland. This is being undertaken by NHS National Services Scotland.

The new systems will be more intuitive and user friendly. They will be quicker and more efficient, with increased functionality. They will be underpinned by strong service levels and performance management, with clear lines of responsibility and accountability, providing, overall, a more professional GP IT Service.

All GP practices will transition to the new systems by 2020. GPs will continue to have the right to choose a clinical IT system from those which have been approved by the Scottish Government.

The following groups will provide governance for Primary and Community Care eHealth:

Primary and community care e-health governance

GP IT Committee

Under the new contract, NHS Boards will remain responsible for providing integrated Information Management and Technology (IM&T) systems and telecommunications links within the NHS. However the Scottish Government will set national standards which will be developed with the assistance of a new GP IT Committee. The SGPC and RCGP will form this committee along with GPs and managers expert in information technology. These standards will be agreed between the Scottish Government and the SGPC.

The eHealth Strategic Assurance Board

The eHealth Strategic Assurance Board will provide strategic direction to the development of digital technology in NHSScotland and act as the senior governance group for the escalation of issues.

The Community Care Portfolio Management Group

The Community Care Portfolio Management Group will provide direction to the development of digital technology within the community and primary care sectors in line with the overall strategy set by the eHealth Strategic Assurance Board. It will also deal first with issues escalated to it by the governance boards of individual projects. It will escalate issues to the eHealth Strategic Assurance Board where appropriate.

Primary Care Contracts and Service Management Board

The Primary Care Contracts and Service Management Board will review the performance, financial status, and key issues and risks of the GP clinical IT system. This group will play the same role for the Community IT clinical system which is in an early stage of procurement.

INFORMATION SHARING

The proposed contract will set out the roles and responsibilities of GP contractors and NHS Boards in relation to information held in GP patient records. The contract will support adherence to the Data Protection Act 1998 and help prepare GP contractors and NHS Boards for the new General Data Protection Regulations (due to come into force in May 2018).

The new contractual provisions will reduce the risk to GP contractors of being data controllers. The contract will recognise that contractors are not the sole data controllers of the GP patient record but are joint data controllers along with their contracting NHS Board. The contract will clarify the limits of GP contractors' responsibilities. GP contractors will not be exposed to liabilities beyond their effective control.

The work of identifying the roles and responsibilities of GP contractors and NHS Boards has been carried out with the assistance of the Information Commissioner's Office in Scotland, and in collaboration with stakeholders who have provided expert guidance as well as practical experience of managing patient data. This includes the Caldicott Guardians Forum, SGPC, RCGP, Central Legal Office, NHS National Service Scotland, and relevant teams within the Scottish Government including the E-health Division and the Chief Medical Officer. The proposed new provisions are also consistent with the General Medical Council (GMC) Confidentiality guidance.[16]

16 http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

6 BETTER CARE FOR PATIENTS

Key Points

- **The principles of contact, comprehensiveness, continuity and co-ordination of care for patients underpin the proposals.**
- **GP time will be freed up for longer consultations where needed – improving access for patients.**
- **There will be a wider range of professionals available in practices and the community for patient care.**

INTRODUCTION

The joint Scottish Government/SGPC Memorandum published in November 2016, described the aim of the negotiations to develop a contract that helps to reinvigorate the core principles of general practice in primary care, and frees up more time for the role of the GP as expert medical generalist. The four C's of primary care, discussed in chapter one, are: contact, comprehensiveness, continuity, co-ordination.

GPs recognise these attributes as the qualities patients value most in general practice; they are the key strengths of general practice and the guiding values underpinning the negotiations.

This is why the focus of the transition over the next three years is to move away from the over-specification of services as described in chapter two – to progressively, though not entirely, move away from Additional and Enhanced Services – and to focus on the core role of the GP as expert medical generalist.

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. It is equally important that other health care professionals are part of the redesign process. We will therefore ensure that engagement with patients, and professionals delivering primary care, is a key part of the development and delivery of any service redesign.

This chapter is structured around the four Cs. The first section addresses how we will maintain and improve accessible contact.

The second section addresses comprehensiveness of care in the context of the multi-disciplinary team. The third and fourth section address how patients will have continuity of care and how that care will be co-ordinated.

CONTACT – MAINTAINING AND IMPROVING ACCESS

Improving patient access to primary care and general practice is multi-faceted. Access in general practice is influenced by a range of issues: the location of the practice; when it is open; how easy it is to make appointments; and the speed of access to appropriate care.

Speed is not the only aspect of access that matters to people. Convenience – how easily people can make appointments; who those appointments are with; and when those appointments are – also matters. Being able to see a practitioner of choice also matters to some groups. The importance of these different aspects of access – ease of making appointment; time to appointment; time of appointment and choice – varies among different groups.

We have agreed that practice core hours will be maintained at 8am to 6.30pm (or as previously agreed through local negotiation), and that practices will continue to be required to provide routine services to patients during this period as appropriate to meet the reasonable needs of their patients.

More accessible information on surgery times within these practice core hours will be available to help patients easily identify when they can see a GP and/or other healthcare professionals.

The Extended Hours Directed Enhanced Service will be maintained. It will be clearer to patients when their local GP practice offers care in Extended Hours and when appointments with GPs and other practice staff are available within the Extended Hours period. Services provided by healthcare assistants may also be available during Extended Hours periods.

There will be improved convenience for patients in how they can access their local practice. Under the proposed new contract, GP practices will be required to provide online services to patients such as appointment booking and repeat prescription ordering, where the practice already has the existing computer systems and software required to implement online services safely.

COMPREHENSIVENESS – A WIDER RANGE OF HEALTH PROFESSIONALS WITHIN THE EXPERT MEDICAL GENERALIST CONTEXT

Ensuring patients have sufficient time with their GP when it is needed means recognising that not all patient needs at all times require the expertise of a doctor. The agreement on service redesign reflected in the Memorandum of Understanding will underpin the contract and allow GPs to have more time to deliver the type of care that only their skills and training can provide. At the same time, comprehensive patient care will be maintained within an expanded primary and community care team, with GPs having a more prominent clinical leadership role.

The discontinuation in Scotland of the single disease-focused approach to quality represented by the Quality and Outcomes Framework, has been a major step in creating a renewed focus on whole person and whole community health. This renewed commitment to a more holistic approach to quality and outcomes is being supported by the development of peer-led GP quality clusters. Clusters, in addition to improving quality and patient outcomes across GP practices, will have a leading role in advising on quality, patient experiences, and patient outcomes across the wider primary, community and social care landscape.

Significant new investment in expanded teams of clinical and non-clinical professionals working in practices and localities will widen patient choice and ensure that GPs are able to focus on their expert medical generalist role. As set out in chapter four, additional professionals will include pharmacy; nursing; allied health professionals (physiotherapy, and paramedics and other urgent care practitioners); and non clinical support workers (e.g. links workers).

Seeing the right person at the right place at the right time will sometimes mean not seeing a GP first, if this is appropriate. This might represent a significant change over time, both to how work is carried out and patients' experience. Emerging evidence from the testing of new models of care in Inverclyde indicates patients can adapt quickly and respond positively to improvements brought by this model. For example, high levels of patient satisfaction have been recorded among those people who have accessed new first point of contact acute musculo-skeletal physiotherapy care in a group of practices in Inverclyde.

Realistic Medicine, Person Centred Care and Expert Medial Generalists

Scotland's Chief Medical Officer (CMO), Catherine Calderwood, published her first annual report *Realistic Medicine*[17] in 2016. The report explores whether improved healthcare can be achieved by combining the expertise of patients and professionals in a more equal relationship; through building a personalised approach to care; increasing shared decision making; reducing unnecessary variation in practice and outcomes; reducing harm and waste; managing risk better; and improving innovation. The CMO's second annual report, *Realising Realistic Medicine*[18], continued the debate - with widespread support and contributions from national and international clinicians, leaders in medicine and public health and stakeholders representing the public and patient voice.

The values of Realistic Medicine are wholly aligned with the values of general practice supported decision making; holistic care that focuses on the person - mind and body - not the disease; care that skilfully manages clinical risk with every encounter - these attributes of realistic medicine are already the hallmarks of general practice. Moreover general practice has a strong history of innovation, learning and collaboration and GP clauses offer an opportunity to revitalise and strengthen these traits over time.

Re-focusing the GP role as expert medical generalist enables GPs to further pioneer the practice of realistic medicine among their medical colleagues. General practice provides just the right amount of medicine for the best possible outcome to individuals and populations. The principle of shared decision making extends to genuine discussion and engagement with the public about how care is best delivered. All four parties to the MOU are committed to public engagement in the development of Primary Care Improvement Plans.

17 http://www.gov.scot/Resource/0049/00492520.pdf
18 http://www.gov.scot/Publications/2017/02/3336

CONTINUITY - TIME WITH A GP WHEN IT IS REALLY NEEDED

Continuity of care – the development of lifelong therapeutic relationships between doctor and patient – is a distinctive hallmark of general practice. The aim of the workload reduction measures described in chapter four is to free up GP capacity for those times when only the expertise of a doctor is sufficient. Scottish Government and SGPC agree it is not appropriate to contractually define consultation lengths, as that will continue to be a matter for clinical judgement. Freeing up capacity, through the redesign of services over the next three years, will allow for longer GP consultations when required by patients, particularly for complex care.

We agree that the independent contractor model of general practice is a benefit to continuity of care as it encourages a strong and enduring commitment from GPs to their community of patients.

The new proposed contract reduces current risks to practice stability and sustainability, for example, by addressing some of the key risk factors relating to rising workload, premises ownership and employment of staff. This in turn will make the partnership model more attractive to newer generations of GPs.

CO-ORDINATION - INCLUDING MORE INFORMATION AND BETTER HELP TO NAVIGATE THE SYSTEM

The 2004 GMS contract requires each practice to make a practice leaflet available to patients. This requirement will remain and the practice leaflet will continue to include important information for patients about the practice and how they can access available healthcare services in their local surgery. This includes: the name of the contractor; partners and all healthcare professionals who deliver services; how to register with the practice; the practice area; and the opening time of the practice premises; as well as how to access services in core hours of 8am to 6.30pm.

The Scottish Government and SGPC have agreed to modernise access to, and provide a consistent platform for, the supply of this key information for patients. This will involve better use of NHS 24 - the national agency for health advice and information in Scotland.

NHS24 will develop a national standardised website for each practice in Scotland that will contain all the key information required in the practice information leaflet. It will also consistently signpost practice patients to reliable self-care information and to wider health and care services in the community. This website will be made available at no cost to individual GP practices. Once available, practices will be able to choose whether to use this service or another service, but all practices will be required to make practice information available to patients digitally.

In summary, ensuring continuity, comprehensiveness, accessible contact and co-ordination for patients lies at the heart of the proposed new contract. As well as treating the individual, the proposed new contract offers a better contribution by general practice to local population health and ensuring the needs of the community are met.

The next chapter will cover the wider role of GPs and GP Clusters in population health, planning of local services, quality planning, quality improvement and quality assurance, and supporting information for quality and sustainability at local, regional and national levels.

7 BETTER HEALTH IN COMMUNITIES

Key Points

- GPs will be more involved in influencing the wider system to improve local population health in their communities.
- GP clusters will have a clear role in quality planning, quality improvement and quality assurance.
- Information on practice workforce and activity will be collected to improve quality and sustainability.

INTRODUCTION

GPs, working with colleagues across health and social care, continue to be at the forefront of a wide range of improvements in the safety, effectiveness and quality of care and treatment.

For over 10 years, the Quality and Outcomes Framework (QOF) largely defined the approach to quality in general practice. It was introduced in the 2004 GMS contract with the intention of providing improved, or consistently high, quality of care, whilst offering GP practices an opportunity to increase funding via an incentivised payment scheme.

Whilst the quality of care delivered in general practice has undoubtedly improved since the beginning of the century, the extent to which QOF contributed to this improvement is contended. There is some evidence to suggest that in the early years it accelerated the pre-existing trajectory of improvement in managing those chronic diseases that were included, and achieved greater equality in the standard of care across practices. However over time, and for a variety of reasons, this effect became diluted and perhaps had the unintended consequence of crowding out other chronic conditions not included.

A systematic review published in The British Journal of General Practice[19] concluded that any replacement for QOF needs to consider the evidence of effectiveness of pay-for-performance in primary care, and the evidence of what motivates primary care professionals to provide high-quality care.

19 http://bjgp.org/content/early/2017/09/25/bjgp17X693077

IMPROVING TOGETHER

Improving Together[20] a new quality framework for GP clusters in Scotland offers an alternative route to continuously improve the quality of care that patients receive by facilitating strong, collaborative relationships across GP clusters and localities. At the heart is learning, developing and improving together for the benefit of local communities.

As described in chapter two, GP clusters are professional groupings of general practices that meet regularly, with each practice represented by their Practice Quality Leads (PQL). Each GP cluster has a Cluster Quality Lead (CQL) who performs a co-ordinating role and liaises with locality and professional structures. This requires supporting measures such as the existing contractual provision for protected time. It also requires: infrastructure to support leadership; data provision and analysis; and facilitation and improvement activity within local governance structures. Clusters may be of different sizes, influenced by local circumstances and geography, but as a principle, they should be viable for small group work.

Improving Together describes the agreed 'intrinsic' and 'extrinsic' functions of GP clusters in Scotland. The intrinsic function refers to the role of GP clusters in improving the quality of care in their cluster through peer-led review. The extrinsic function refers to the critical role GP clusters have in improving the quality of care in general practice and influencing HSCPs regarding both how services work and the quality of services. The dimensions of these intrinsic and extrinsic functions are set out in the table below.

Figure 4 - Intrinsic and extrinsic functions of clusters

INTRINSIC	EXTRINSIC
Learning network, local solutions, peer support	Collaboration and practice systems working with Community MDT and third sector partners
Consider clinical priorities for collective population	Participate in and influence priorities and strategic plans of Integrated Authorities
Transparent use of data, techniques and tools to drive quality improvement - will, ideas, execution	Provide critical opinion to aid transparency and oversight of managed services
Improve wellbeing, health and reduce health inequalities	Ensure relentless focus on improving clinical outcomes and addressing health inequalities

20 http://www.gov.scot/Publications/2017/01/7911/10

As clinical leaders in the primary healthcare team, GPs will actively contribute to the clinical governance and oversight of service design and delivery across health and social care as part of the extrinsic GP cluster role.

CQL will work in close collaboration with the already established medical advisory structure including: Medical Directors (Primary Care) (usually AMDs); Clinical Directors; Locality Strategic Planning Groups; and GP Sub Committees in NHS Boards.

The GP Subcommittee of the Area Medical Committee should be responsible and funded for local arrangements to ensure effective collaboration between the GP Subcommittee, NHS Board medical directors, and CQL. The GP Subcommittee will be responsible for co-ordinating the agenda for this tri-partite collaboration and facilitating combined professional advice to the commissioning and planning processes of the HSCPs and NHS Boards.

GP Subcommittees need to be adequately funded to carry out these roles (as well as day-to-day advice to the Board and its representative committees). NHS Boards and HSCPs should be able to demonstrate to the Scottish Government that they are appropriately supporting these activities. It is recognised that, in many areas, the GP profession chooses to have the same members in the GP Subcommittee as from the LMC. Local discussion should enable the funding of the GP Subcommittee to be clearly seen as funding those activities separate to the LMC activities.

GP CLUSTER WORKING AND LOCAL POPULATION HEALTH

GP practices participate in cluster working through their PQL. The PQL engages with the CQL, the rest of the GP cluster and attends GP cluster meetings. The practice will provide agreed local and national data extractions to enable intelligence led quality planning, quality improvement and quality assurance.

Cluster working will contribute to the development of local population health needs assessments undertaken by public health and local information analysts. They will also provide professional clinical leadership on how those needs are best addressed.

The NHS National Services Scotland Local Intelligence Support Team (LIST) service has been supporting GP cluster working in Scotland since April 2017. This analytical support to clusters will continue and expand under the new contract.

Case Study - List analytical support for clusters

LIST analysts have already been working with clusters and practices across Scotland to help analyse data and introduce improved ways of working. These have included:

- safely reducing the number of home visits through the use of telephone triage
- analysis of appointment demand to inform staff scheduling
- analysis of data to create a health needs assessment for homeless patients
- gathering evidence to assist plans for GP services in relation to new housing development
- using data to help identify High Health Gain patients, to facilitate anticipatory care planning and additional preventative support measures

These initiatives help to both reduce GP workload and improve patient care.

"The main thing we want to take forward is a more in depth analysis of our frequent attenders, looking at who they are seeing, when, why and how often, and looking at interventions which may help them to better self-manage and use the service as appropriately as possible. We are hopeful that this could free up some capacity in the system and improve the right person right time goal". GP Inverclyde

"LIST have analysed our appointments data - we have now made some changes which has improved capacity and helped us to prioritise the patients. The DNA rate has also significantly reduced". Practice Manager - Lothian

There is enormous potential for improving local population health, including mental health, through GP clusters, better data on population health needs and better intelligence and facilitation through LIST analysts. The aim is for GPs to have a bigger impact on public health as an expert medical generalist than they do as service providers for services that can be safely delivered by other health professionals.

NHS Boards, as the lead agency for protecting health, will continue to be responsible for planning and responding to public health incidents. Operational management locally will remain the responsibility of NHS Boards, drawing on the expertise and support of a range of local partners, including GPs and NHS Board staff. NHS Board staff will support with screening, prescribing, prophylaxis and nursing as appropriate.

QUALITY PLANNING

Quality Planning is a structured process for designing and organising services to meet new goals and patient needs. This includes setting aims, identifying practice populations, identifying patient and carers' needs, developing plans to meet that need, and developing measures to ensure that the aim is met.

Agreement will be needed on the balance between local and national priorities for GP clusters to focus their quality improvement activity each year. GP clusters themselves will be critical in identifying priorities locally with the inclusion of regional/national priorities as required. The former will primarily lead the improvement agenda with the latter playing in on an as required basis only.

Thus GP clusters must decide the majority of their own clinical priorities in their own locale using both information gathered by analytical support and their own deep knowledge and understanding of the communities they serve.

GP clusters working and quality planning

GP practices will participate in cluster working and through cluster working will contribute to the development of cluster quality improvement plans.

Cluster quality improvement planning will be supported by training in quality improvement if required.

2018/19 – quality improvement planning and activity for many clusters will be based on existing Transitional Quality Arrangements (TQA)[21] information. This activity will be better enabled, as more analytic and public health support goes on line. Clusters will initially review comparative data between cluster practices on areas such as disease registers, referral, prescribing, access and use of unscheduled care to identify variation, peer-based learning, and areas for improvement supported by external resources. Maintaining comprehensive disease registers will remain critical to underpin activity in quality planning, quality improvement and quality assurance.

QUALITY IMPROVEMENT

Quality Improvement is a continuous process. On an individual level doctors have a professional responsibility to maintain their skills and knowledge and contribute and comply with systems to protect patients.[22] GPs will continue to be registered with the GMC, undergo annual appraisal, learn from Significant Adverse Events, contribute to confidential enquires and comply with NHS Complaints procedures and Duty of Candour legislation.

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21 http://www.isdscotland.org/Health-Topics/General-Practice/Primary-Care-Information-and-TQA/

22 http://www.gmc-uk.org/guidance/good_medical_practice.asp

GP practices will engage in quality improvement activities as agreed through GP cluster quality improvement planning. Practices will supply information to HSCPs and NHS Boards on their workforce and demand for their services to improve sustainability and facilitate service redesign. GP clusters work with the wider system, in particular HSCPs, to achieve whole system quality improvement.

GP clusters and quality improvement

GP practices will engage, as agreed in GP clusters, in quality improvement activities, including providing comparative data[23] and sharing best practice.

GP clusters will work with the wider system, in particular HSCPs, to achieve whole system quality improvement for patients.

QUALITY ASSURANCE

GP practices will participate in a cluster quality peer review process, whereby their quality improvement activity and quality data will be reviewed by their local GP cluster. Support will be offered as appropriate.

The Healthcare Improvement Scotland Quality of Care Approach will involve an increased emphasis on local systems of assurance. Service providers will use the quality framework domains to evaluate the quality of care they provide and identify areas for local improvement work. As GP clusters mature, practices and clusters will be expected to take part in the peer-led values driven assurance process. The methodology for this will be negotiated by the Scottish Government and SGPC.

GP clusters and quality assurance

GP practices will participate in a cluster quality peer review process, whereby their quality improvement activity and quality data will be assessed by their local GP cluster and support will be offered as appropriate. That support could take the form of written advice and/or a supportive practice visit from peers and a local manager.

23 In normal circumstances, providing information means allowing appropriate electronic extraction of information where that is the preferred option by the GP practice.

SUPPORTING INFORMATION FOR QUALITY AND SUSTAINABILITY

GP clusters will need information to support their intrinsic role of peer-led quality work and their extrinsic role with wider systems. Some of the data for the new quality arrangements has already been identified in the TQA. To fulfil both intrinsic and extrinsic functions GP clusters will need a combination of nationally agreed information and locally agreed data.

The new quality arrangements will be supported by new technologies, such as the Scottish Primary Care Information Resource (SPIRE). Currently SPIRE software is being rolled out across practices in Scotland - this is expected to be complete by April 2018.

Nationally and locally agreed (by SGPC and the clusters respectively) datasets will be supplied by practices and the use of automated extraction tools, such as SPIRE, is recommended as good practice. Practices will not be contractually required to use SPIRE and may choose not to use it at all. In those circumstances, practices must still provide the information required by the national and local datasets.

The existing dataset for the TQA will be the starting point for an agreed national dataset under the new GMS contract. This will enable clusters to build on their experience under the TQA to date, and on the existing work by NHS National Services Scotland Information Services Division to develop easily accessible data dashboards to support quality improvement in general practice.

GP practices and clusters will continue to be supplied with information on prescribing, outpatient referrals and admissions to hospital to support quality activity in these areas.

To contribute to the sustainabillity of general practice and primary care, GP practices will engage in the collection or extraction of information on activity and capacity. This information will be used transparently to inform and influence the development of the extended primary care teams.

To support GPs to identify individuals with more complex needs and to deliver anticipatory care planning more consistently, practices will continue to be supplied with risk predictive information based on the current High Health Gain Potential predictive tool. Work is ongoing to assess the value and to improve the predictive power of this and other case finding tools.

GP practices have reported a considerable increase in workload over the last five years, with more patient contacts, more clinical letters, more results and a higher proportion of consultations with people who have very complex problems who require more time.

Since the cessation of the Practice Team Information survey in Scotland there has been a lack of comprehensive national information on changing rates and complexity of GP consultations.

This information needs to be made available to the practice, the cluster, the HSCP and collated nationally to support sustainability, planning and the evolution of the extended multi-disciplinary team.

In addition, practices will be required to supply regular information on the workforce employed in their practices. This dataset will be used to triangulate locally with other sustainability factors, such as GP vacancies, increasing deprivation, and local house building. The purpose is to support GP practices, GP clusters, NHS Boards and HSCPs to identify and address sustainability challenges using a whole system approach.

GP cluster working, data extracts, and supporting sustainability

GP practices will provide agreed information on consultation rates, consultation types, health care professional being consulted and complexity within consultations. This will be done using SPIRE electronic extraction unless the practice wishes to collect the information itself.

GP practices will participate in assessment of capacity using the third available appointment method. Support will be provided to allow this to be undertaken electronically[24].

GP practices, through cluster working, will be involved in discussions about, and provide advice on, sustainability issues using activity, demand and workforce data.

This chapter describes the proposed arrangements for continuous quality improvement in general practice in Scotland. The next chapter summarises proposed changes in the role of the practice and changes in other underpinning regulations.

24 It is acknowledged that those practices with open access arrangements will be supported with alternative arrangements.

8 THE ROLE OF THE PRACTICE

Key Points

- General practice nursing will continue to have a vital role under the proposed new contract.
- There will be new enhanced roles for practice managers and practice receptionists.
- In addition, a number of clarifications and improvements to the underpinning GMS and Primary Medical Services (PMS) regulations will be made.

INTRODUCTION

The table below sets out how the activities of the practice team might be expected to change in the next three years. The examples given below under the heading of each professional are indicative only, not exhaustive. More information on the services mentioned in the table is set out in chapter four.

Figure 5: Services in 2017 and 2021

2017

General practitioners
Independent contractor – based in the practice

- Default primary medical service provider
- Undifferentiated presentations- patients who are ill/believe themselves to be ill, who require diagnosis
- Complex care - including patients who have more than one diagnosis or medical issue
- Clinical leadership of the practice team to improve patient outcomes
- Home visits
- Delivery of chronic disease monitoring
- Chronic disease management
- Delivery of some nursing services (treatment room)
- Repeat prescribing, serial prescribing, 'specials', and polypharmacy reviews.
- Reviewing results (large Docman activity)
- Leading practice team/practice management

2021

General practitioners
Independent contractor – based in the practice

- Default responsibly for a reduced number of primary medical services
- Undifferentiated presentations- patients who are ill/believe themselves to be ill, who require diagnosis and cannot choose to see other health professionals
- Complex care - including more time with patients who have more than one diagnosis or medical issue
- Clinical leadership of extended primary care team to improve patient outcomes
- Fewer home visits but more complex and often as part of team assessment and support
- Oversight of chronic disease management
- Reduced volumes of Docman – outpatient and self-ordered test results
- Leading practice team / practice management
- Leading clusters
- Influencing local system

2017

General Practice nurses
Employed by the practice

- Treatment room services
- Chronic disease monitoring/management
- Vaccinations
- Minor injury, dressings

Practice manager
Employed by the practice

- Contract management
- Contract monitoring
- Business planning
- Contract and other regulatory compliance
- Staff management

Receptionists
Employed by the practice

- Organising patient appointments
- Managing communications to/from the practice
- Managing prescription requests/enquires
- Operating call/recall systems
- Administration

2021

General Practice nurses
Employed by the practice

- Minor illness management
- Chronic disease management
- Supporting GP to deliver care planning
- Monitoring lab results

Practice manager
Employed by the practice

- Contract management
- MDT coordination
- Contract monitoring
- Business planning
- Contract and other regulatory compliance
- Staff management

Receptionists
Employed by the practice

- Organising patient appointments
- Supporting patients with information on available services
- Managing communications to/from the practice
- Managing prescription requests/enquires
- Operating call/recall systems
- Administration

New for 2021

Pharmacotherapy services
HSCP/NHS Board Service

- Repeat prescribing, serial prescribing, 'specials', shortages
- Medication and polypharmacy reviews.
- Medicines reconciliation
- Medication enquiries
- Monitoring lab results for high risk medicines

Urgent Care Services
HSCP/NHS Board Service

- Assess and treat urgent and emergency care presentations
- Home visits
- Falls

Additional Professional Services
HSCP/NHS Board Service

- Acute musculoskeletal physiotherapy services
- Community mental health services
- Community link worker services

New for 2021

Community Treatment and Care Services
HSCP/NHS Board Service

- Management of minor injuries and dressings, phlebotomy, ear syringing, suture removal
- Chronic disease monitoring – routine checks, and related data collection
- Screening test results will go directly to requesting physician
- Monitoring lab results to pharmacist/general practice nurse
- Carrying out requests from secondary care

Vaccination Services
HSCP/NHS Board Service

- Provide all vaccinations previously provided by GP practices.
- Travel vaccines and travel health advice

Case Study - community treatment and care services in Lanarkshire

In Lanarkshire, most GP practices have access to a 'Treatment Room' (TR) service which enables a range of procedures, many of which were previously provided by a GP or GP employed-staff. The service provides core services which includes, amongst others, wound management, venepuncture, injections and ear irrigation.

For routine needs, patients are provided with appointments at health centres. However, both GPs and Board run treatment rooms have retained flexibility in how they provide services in order to deliver the best experience for the patient. For example, some GPs will take blood samples when the patient is in their practice if they have a view that there is an urgent need or to do so or it is clinically appropriate for the patient.

The service is also helpful in allowing a range of patients, where appropriate, who would previously have required a domicillary visit from a District Nurse to now receive such treatment in a more appropriate clinical setting. This is also more efficient than a domiciliary service with attendant treavel time between visits.

TR services are staffed, where possible, with an appropriate skill-mix to reflect the range and quantity of interventions.

GENERAL PRACTICE NURSING

General practice nursing is an integral part of the core general practice team. The profession provides primary care services, mainly through GP independent contractor employment, including general nursing skills as well as extended roles in health protection, urgent care and support for people with long term conditions.

General practice nurses had a key role in the achievement of QOF points as part of the 2004 GMS contract. However, many in the profession felt that QOF greatly increased bureaucratic workload and had a negative impact on consultations, supporting "box ticking" rather than facilitating holistic and person-centred consultations. The new general practice landscape in Scotland will enable general practice nurses to have more meaningful person-centred consultations.

With a dedicated community treatment and care services delivered through HSCPs the 2018 GMS contract will support GPN to focus on a refreshed role in general practice as expert nursing generalists. They will provide acute and chronic disease management, enabling people to live safely and confidently at home and in their communities, supporting them and their carers to manage their own conditions whenever possible.

To fulfil the challenges associated with the increasing complexity and demand of primary care in Scotland the role and career pathway of general practice nursing will need to adapt and evolve. A 'one size fits all' approach may not be appropriate for all posts, but there will be a common pathway to a lead general practice nurse or advanced nurse practitioner careers. At the present time variation in terms of both job titles and training is evident within general practice nursing.

To support an enhanced role safely integrated into general practice it is critical that there are agreed role definitions supported by a robust career and educational framework. The Transforming Roles General Practice Nurses Group was established by the Scottish Government in 2017 to refresh the role and educational requirements of general practice nurses. This work will be taken forward jointly by the Scottish Government's primary care and Chief Nursing Officer Directorates in 2017/18.

GPNs require a significant breadth of knowledge and need to access appropriate structured education and training. Investing in general practice nurses provides a valuable opportunity to deliver a highly skilled 'fit for purpose' profession. The Scottish Government has invested £2 million in 2017/18 for additional training for general practice nurses in recognition of the importance of this role in the future delivery of care to patients in the primary care setting. This training will enhance the skills of general practice nurses so that they are better equipped to meet the increasingly complex needs of patients. This training enhancement will also make it easier for patients to access the right person at the right time.

The Transforming Roles General Practice Nurses Group will oversee the continued funding of training for general practice nursing to enable the on-going development of this critical workforce during the three year transition period as outlined in the MoU.

Given the changes in service redesign in primary care, demand for nursing staff in the community will increase. We anticipate continued employment of the nursing workforce in primary care by both NHS Boards and Independent Contractors. There will also be opportunities, if individuals wish, to change roles to take on new opportunities in the community treatment and care services; in general practice nursing, and in advanced nursing practice.

PRACTICE MANAGERS AND PRACTICE RECEPTIONISTS

Practice Managers play a key role ensuring the smooth and efficient day-to-day running of practices and the long term strategic management and co-ordination of primary care, including supporting the development of the multi-disciplinary team.

The role of the primary care manager was introduced in the 1980s as a senior receptionist/office Manager role. With the introduction of the Red Book contract in 1990, which coincided with the introduction of the first IT systems into general practice including automated call and recall systems and electronic appointment systems, the role began to evolve and become more commonplace.

The 2004 GMS Contract formally recognised the contribution effective practice management has on reducing the administrative burden on clinical staff and included a core competency framework for practice management.

Since 2004 the role of practice managers has adapted to meet a number of new challenges such as the development of practice IT systems; larger practice employed clinical and administrative teams; the increasing complexity of the GMS contract; and payment processes including the management of regularly changing QOF criteria and Enhanced Services. Practice managers have had a key role as facilitators of many of these changes. Indeed, many practice managers are now in senior management roles, however there nevertheless remains large variation in practice managers' roles, responsibilities and skills from practice to practice.

GP practice in Scotland has a highly skilled and experienced practice manager workforce. These managers have skills and experience which will be vital to ensure the success of the proposed new contract.

Practice managers already have a wide range of skills which will be essential for the future including financial management, IT management, HR management, contract management, leadership and facilitation, Quality Improvement skills, change management, communication and patient engagement skills. Work is ongoing with NHS Education for Scotland to identify and meet practice managers' training needs. Career development and succession planning will also be important considerations going forward.

The introduction of the proposed 2018 contract will increase the need for highly skilled practice managers with wide ranging, adaptable and versatile skills. In addition to continuing to manage the practice employed team, they will work more with the wider primary care system including GP clusters, NHS Boards, HSCPs, and emerging new services.

Alongside the changing role of practice managers, the roles of receptionists and other non-clinical staff in the practice have also evolved.

Practice receptionists have an important role supporting patients and enabling practices to run smoothly.

Opportunities to develop the skills of practice receptionists to support patients with information on the range of primary care multi-disciplinary team services available, or to increase their role in the management of practice documentation and work optimisation, are currently being explored with Healthcare Improvement Scotland (HIS). HIS will be working with GP clusters to develop training and resources to support these staff.

There is also a wide range of practice administrative staff carrying out a diverse number of tasks from prescription management, medical secretarial skills and IT management including call and recall, to documentation management, health and safety monitoring, and finance management. These staff are a highly skilled and adaptable workforce who will continue to have an important role in general practice in the future.

Strong leadership by practice managers supported by their teams, and by the practice GPs will be hugely important to the success of the proposed new contract and new ways of working.

IMPROVEMENTS TO REGULATIONS AND OTHER ISSUES

In addition to the proposals set out in previous chapters, a range of clarifications and improvements will be made to the underpinning regulations for General Medical Services contracts and Primary Medical Services contracts. These, and other issues not contained in underpinning regulations but pertinent to general practice, are set out below.

Indemnity

In the spirit of reducing risk for GPs, the Scottish Government and the SGPC are working collaboratively with Medical Defence Organisations to seek the best solution for indemnity in Scotland, following the announcement of changes to the discount rate in February 2017 and subsequent announcement by the UK Department of Health of its intention to introduce a state-backed scheme. The solution will take into account the indemnity needs of partners, locums and sessional GPs.

Temporary Residents

Practices are currently paid to treat Temporary Residents under the Temporary Patient Adjustment provisions of the Statement of Financial Entitlements. Before the 2004 contract this treatment was paid for by the temporary residents' fees, emergency treatment fees and immediately necessary treatment fees under the Red Book. All contractors currently receive a payment for unregistered patients as an element in their global sum allocation. The amount each contractor receives is generally based on the average amount that, historically, the contractor's practice claimed for treating such patients each year under the Red Book prior to 1 April 2003.

The Temporary Patient Adjustment leaves practices exposed to the risk of their number of Temporary Residents fluctuating while the resources to treat them remains constant. Under the new contract, practices will be required to report on numbers of Temporary Residents in 2018/19 to allow the Temporary Patient Adjustment to be reformed and uplifted on the basis that funding will follow activity as soon as practicable and by 2020/21.

Data also will be collected on activity around care homes to ensure that funding follows activity on a similar basis to Temporary Residents.

Dispensing

The current arrangements for dispensing in Scotland will not change under the proposed new contract. As part of the preparation for a Phase 2, we will establish a short-life working group to consider the current dispensing arrangements and look for any mutually beneficial improvements. Relevant interest groups will be consulted to ensure their views are incorporated.

Challenging Behaviour Scheme

All NHS Boards are required to establish a Violent Patients Scheme, the underlying purpose of which is to ensure that there are sufficient arrangements in place to provide general medical services to patients who have been subject to immediate removal from a GP's patient list of a general medical services contractor because of an act or threat of violence.

Under the new contract, this Directed Enhanced Service will be revised to introduce a greater degree of consistency across NHS Boards ensuring that practices and staff are protected from patients who have been violent or threatening.

Practice Areas

The current regulations provide limited information and guidance on practice areas beyond the need for practices to refer to their area by reference to a sketch diagram, plan or postcode in their practice leaflet. The new contract will clarify how practice areas should be agreed as part of the contract between NHS Boards and practices. The regulations will introduce processes for the formal variation of practice areas to ensure that NHS Boards do not make unilateral decisions and patient wishes are respected. This will enable practices to make changes in a timely fashion whilst ensuring that the interests of other practices in the vicinity are taken into account by NHS Boards.

Patients will retain the right to remain on the list of a practice if they live outwith a boundary which has been reduced. Not all patients will wish to remain on the list of a practice which no longer covers their area, and NHS Boards will be empowered to help practices rationalise their lists where patients are willing, even to the extent of assigning patients to practice lists which are otherwise closed where practices agree.

Practice List Closures

Under the current regulations practices must apply to their NHS Board to submit a notice to close their patient list. Closing a practice list is a last resort for a practice and the process for closing lists is intended to function as a failsafe to ensure that NHS Boards work with their contractors to keep lists open for patients wherever possible.

Under the new regulations, if NHS Boards have not completed discussions concerning support with practices within three months, a closure notice will be considered as accepted. Where assessment panels do not accept applications to close practice lists they should nonetheless agree the increase in terms of either a percentage of the current number of patients or an actual number of patients which would trigger a closure of the list.

Contract Disputes

The NHS Dispute Resolution procedure provides an inexpensive way for parties to the GMS contract to hold each other to account. Under the new contract the Local Dispute Resolution procedure will be formalised giving practices confidence that their disputes are recognised and are being taken forward

within specified timescales. Local dispute processes will address practice boundary and list closures. The constitution of local resolution panels will include: a representative from the NHS Board; a representative from the LMC; and an independent chair.

Certificates fees and charges

GPs are not always the best or only person to provide the various certificates prescribed in current regulations and this will be reflected in new regulations which will make alternative and routine providers clear.

The new regulations will provide a list of certificates which, through primary legislation, GPs are entitled to charge for providing. The regulations will be clear that other work falls outwith the GMS contract.

Emergency Responders

GPs have a professional duty to provide immediate and necessary treatment due to accident or emergency in their practice areas. However GPs should be understood as a last resort for these situations and the new regulations will reflect that.

Patient checks

The new regulations will clarify that while new patient checks will still be required, they can be conducted by members of the wider multi-disciplinary team.

All practices are currently required to offer patients who have not been seen within 3 years and patients aged 75 years and over (on an annual basis) appointments. Patients are not obliged to take up the offer.

As all patients are entitled to request an appointment with their GP regardless of when they last attended, these specific provisions will be removed from the existing regulations.

New practices

The arrangements for Phase 2 will include developing proposals for creating new practices. This will usually be in areas where the population is growing rapidly and established practices are unable to expand their patient list further. The proposals will include specific financial support for new practices while their list size is growing, and a mechanism to target size and a mechanism for establishing new premises. Additional funding for supporting new practices will not affect the funding of other practices as funding in Phase 2 will be practice specific.

Community hospitals

The current local arrangements for community hospitals in Scotland rest with HSCP and are unaffected by the proposed new contract. As part of the preparation for Phase 2, consideration will be given to reviewing the current arrangements and how they align with the proposed new contract and the role of the GP as expert medical generalist. Relevant interest groups will be invited to contribute to such a review process.

Primary Medical Services ("17C")

Alongside updating the NHS (General Medical Services Contracts) (Scotland) Regulations 2004 (17J), the Scottish Government and the SGPC have also agreed to update the NHS (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004. This will ensure that both contracts will support the transformation of primary care services and deliver significant benefits to patients, GPs and practice staff. The proposed changes outlined in this document will apply equally to both GMS contracts and 17C agreements. The intention is that practices in 17C and 17J will, in future, have equity of access to funding.

The revised sets of Regulations will not remove the right for any practice which currently operates under a 17C agreement to choose to revert to a 17J contractual status.

AFTERWORD

Much of the content of this document has focussed on improving the terms and conditions for GPs in Scotland – in particular, maintaining income stability, reducing workload and reducing risk. The ultimate reason behind all these proposals is to improve patient care. There is clear evidence to link workforce morale with better patient experience – with the new contract we have the opportunity to create a virtuous circle that delivers a thriving future for GPs and for patients.

In itself, a contract can never be the sole answer to the challenges facing primary care. However, the manner in which a contract is developed, agreed and implemented can demonstrate underlying common aims and purposes for mutual benefit. In complex and challenging times, a collaborative approach to a common vision certainly appears, based on our experience, far more productive and more likely to succeed.

We hope that the collaborative relationship which we have created to agree this contract will set the tone for the future of primary healthcare in Scotland. We have developed what could be called a Scottish Negotiating Approach which we agree has been essential to delivering this significant change. We set out initially to both develop and agree a vision for general practice and its place in the Scottish NHS of the future. We had no difficulty in agreeing that the very strengths of general practice are those core values which we wish to enhance and support to meet the needs of the people of Scotland. This is a bold statement of confidence that Scottish general practice is the right kind of medicine for the future.

Both the contract, and the surrounding support structures of the primary care multi-disciplinary team, are intended to enable GPs to be GPs. This approach will underpin delivery of the new contract as well as setting the direction for future development beyond the first three years.

This document describes a very significant degree of necessary system change. It is essential that patient safety and confidence is maintained during this change. Successful delivery will therefore require the support and commitment of all those in the health and care system. We all have a vested interest in the success of general practice and the primary care system for our patients, our families and our communities.

We all have to be active in managing our own care and health. To support this the contract is intended to ensure that GPs are available when needed to help the people of Scotland achieve the best agreed outcomes for their health. GPs will also have a clear role in assessing how well the health and care system delivers these outcomes and advising on how we might better improve on them. There will be better primary care services for patients, more time with a GP when it is really needed, quicker access to other healthcare professionals in the community and a more convenient, wider range of services.

We believe that these changes will enable the GPs of Scotland to make the best contribution possible to achieving better health outcomes. For those who are, or may aspire to become, GPs in Scotland, we invite you to join us in delivering, for the people of Scotland, better health and better care.

Shona Robison
Cabinet Secretary for Health

Alan McDevitt
Chair, SGPC

ANNEX

NATIONAL OUTCOMES			
Our children have the best start in life and are ready to succeed	We live longer, healthier lives	Our people are able to maintain their independence as they get older	Our public services are high quality, continually improving, efficient and responsive
We start well	**We live well**	**We age well**	**We die well**

PRIMARY CARE VISION	
Our vision is of general practice and primary care at the heart of the healthcare system. People who need care will be more informed and empowered, will access the right professional at the right time and will remain at or near home wherever possible. Multidisciplinary teams will deliver care in communities and be involved in the strategic planning of our services.	

HSCP OUTCOMES				
	People can look after own health	*Live at home or homely setting*	*Positive Experience of Services*	*Services improve quality of life*
Services mitigate inequalities	*Carers supported to improve health*	*People using services safe from harm*	*Engaged Workforce Improving Care*	*Efficient Resource Use*

PRIMARY CARE OUTCOMES		
We are more informed and empowered when using primary care	*Our primary care services better contribute to improving population health*	*Our experience as patients in primary care is enhanced*
Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care	*Our primary care infrastructure – physical and digital – is improved*	*Primary care better addresses health inequalities*

GLOSSARY

BMA – the British Medical Association, the registered trade union for doctors in the United Kingdom.

CQL – Cluster Quality Lead, a GP appointed by a NHS Board to coordinate a cluster.

EMG – Expert Medical Generalist, a GP when they are performing those GP roles and duties only a GP can do.

GMC – General Medical Council.

GMS – General Medical Services, the range of healthcare services that is provided by general practitioners under a General Medical Services contract with an NHS Board.

GMS contract – the national Scottish General Medical Services contract entered into under section 17J of the National Health Service (Scotland) Act 1978.

GP – General Practitioner, a doctor specialising in primary care and registered in the General Practitioner Register of the General Medical Council.

GP partner (as opposed to a GP) – a Partner in a GMS or 17C medical services practice.

GPN – General Practice Nursing.

HIS – Healthcare Improvement Scotland.

HSCP – Health and Social Care Partnership, the organisations formed as part of the integration of services provided by NHS Boards and Councils in Scotland.

IA – Integration Authority. Statutory body resposible for the planning design and commissioning of primary care services in Scotland.

LMC – Local Medical Committee, the local committees of the BMA representing general practitioners.

MDT – multi-disciplinary team, where primary care professionals work as an integrated team.

NHS – National Health Service.

PMS – Primary Medical Services.

PQL - Practice Quality Lead, the GP quality leadership role in practice.

PSD – Practitioner Services, the division of NHS National Services Scotland which, among other roles, processes payments for practices.

QOF – Quality and Outcomes Framework.

RCGP – Royal College of General Practitioners, the professional body for GPs.

2004 Contract– the national GMS contract prepared in accordance with the rules set out in The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004.

SAF – the Scottish Allocation Formula.

SGPC – the Scottish General Practitioners' Committee of the BMA.

TQA – Transitional Quality Arrangements.

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