Primary Care Improvement Plans – Iteration 2 – 2019/2020 - Guidance

Context

1. The National GMS Oversight Group comprises senior representatives of the four signatories to the Memorandum of Understanding on implementing the 2018 GMS contract: Scottish Government; British Medical Association; Integration Authorities and NHS Health Boards. The Oversight Group most recently met on 23rd January 2019, where it agreed the future reporting cycle of Primary Care Improvement Plans.

2. The first iteration of local Primary Care Improvement Plans were required to be shared with Scottish Government by end July 2018. These plans covered the period April 2018 to end March 2019. As we approach a new financial year, we expect all Integration Authorities to be creating the second iteration of these plans to cover the period April 2019 to end March 2020.

3. As stated in the 18th February 2019 letter from Richard Foggo, Head of Primary Care, Scottish Government, the second iteration of PCIPs should be drafted in collaboration with the GP Sub Committee and agreed with the relevant Integration Joint Board as soon as practicably possible after 1st April 2019. In addition, an agreed Local Implementation Tracker, covering the period July 2018 to March 2019 inclusive, is required to be completed collaboratively by local partners and shared with Scottish Government by 30th April 2019. All updated Primary Care Improvement Plans and Local Implementation Trackers should be developed and agreed by the relevant GP Sub Committee.

Memorandum of Understanding

4. The Memorandum of Understanding (MOU) effectively provided agreed guidance from the four parties of the Oversight Group to local partners for use in developing the first iteration of PCIPs. The core tenets of the MOU remain agreed and in place – in particular, that the development of primary care redesign in the context of delivery of the new GMS contract should accord with seven key principles to ensure that services are:

- Safe
- Person-Centred
- Equitable
- Outcome focussed
- Effective
- Sustainable
- Affordable

5. Importantly, the MOU also sets out an agreed understanding that the specific nature of implementation and related service redesign is required to reflect local

circumstances. No one size fits all. While the contract offer[1] and the MoU set out six key priorities for service redesign, the MOU states:

> *"Plans must determine the priorities based on population healthcare needs, taking account of existing service delivery, available workforce and available resources".*

6. This is relevant for all different geographies and communities across Scotland. For example, for remote and rural geographies, the contract offer states *"in rare circumstances it may be appropriate for GP practices, such as small remote and rural practices, to agree to continue delivering …services through locally agreed contract options".* We would expect to see evidence that options appraisals have taken place, and agreed with the local governance arrangements relating to primary care redesign, before this decision is taken.

7. Continuity is one of the core values of primary care as set out in the contract offer – this must be reflected in PCIPs to maximise continuity of care in establishing the new services and expanding the multidisciplinary team.

8. **The second iteration of PCIPs should set out how local partners are ensuring continuity of care as implementation of the MOU progresses**. In this context, it may be helpful to note the MOU states:

> *"The expectation should be that, where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices".*

Local Workforce Planning

9. The new Local Implementation Tracker will capture intelligence on a regular basis on local workforce recruitment activity and projections as the multidisciplinary team expands.

10. Effective workforce planning to enable primary care reform requires actions at national, regional and local levels. The forthcoming National Integrated Health and Social Care Workforce Plan will include proposed national actions building on the insight and intelligence provided by the first PCIPs.

11. The analysis of the first iteration of PCIPs found that the expression of local workforce planning approaches was generally weak across the plans and description of specific local actions and levers to increase workforce supply (including consideration of workforce skill mix) were generally absent from plans.

12. Plans to address workforce supply should be complemented by plans to address issues of workforce capability that go beyond those of professional competence. It is expected that these will consider the skills necessary to deliver successful user-led service redesign in a collaborative, multidisciplinary environment.

---

[1] *The 2018 General Medical Services Contract in Scotland. https://www.gov.scot/publications/2018-gms-contract-scotland/*

13. **The second iteration of PCIPs are required to have clear sections on local actions related to workforce planning and supply and how potential gaps will be addressed.**

Patient Engagement

14. Both the MOU and the Primary Care Improvement Fund allocation letter of 23 May 2018 stress the need for effective engagement of patients and service users as plans are developed. The MOU states:

> *"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 the patient's needs, life circumstances and experiences, it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. HSCPs should ensure that patient engagement is a key part of their Primary Care Improvement Plans".*

15. Analysis of the first iteration of PCIPs considered by the Oversight Group indicated that while there was evidence of strong engagement between HSCPs, Health Board professional leads, and the GP profession (in both co-producing and agreeing the plans) engagement with the wider public and patient engagement activities were less consistently evident across the first iteration of plans.

16. **The second iteration of PCIPs should set out how local partners are ensuring that patient engagement is a key part of their plan.**

Infrastructure

17. Both physical and digital infrastructure are key enablers of service redesign.

18. In relation to physical infrastructure specifically, all Health Boards are required under CEL 35 (2010)[2] to have Property and Asset Management Strategies. As well as covering NHS owned property, they are required to include other assets used for the delivery of NHS services such as property held by independent contractors and leased premises.

19. In relation to Primary Medical Services in particular, all Health Boards are required to

"*have in place a plan for the development of premises to support the provision of Primary Medical Services. This plan must be approved in consultation with the local Area Medical Committee. This plan should be updated annually and be consistent with the Health Board's wider Property Strategy.*" [3]

---

[2] A Policy for Property and Asset Management in NHS Scotland CEL 35(2010) : https://www.sehd.scot.nhs.uk/mels/CEL2010_35.pdf

[3] Primary Medical Services – (Premises Development Grants, Improvement Grants And Premises Costs) Directions 2004, Direction 8 available at www.sehd.scot.nhs.uk/gpweb/7/index7_dir.html

20. It is necessary for service plans to be developed in order for Health Boards to then plan the development of premises to support those services. Accordingly, Integration Authorities and Health Boards must work closely together in these planning processes.

21. In relation to digital infrastructure, the costs of supplying hardware and providing software licenses to additional staff to support primary care service re-design are core workforce costs that must be identified in PCIPs.

22. The second iteration of PCIPs should set-out what local processes are in place to identify both the physical and digital infrastructure needed to support Primary Care service re-design. They should also set out what resources are required locally for both physical and digital infrastructure.

23. **The second iteration of PCIPs must demonstrate that Health Board's plans for the development of premises to support the provision of Primary Medical Services have taken account of the need to support Primary Care service re-design.**

Funding

24. The analysis of the first iteration of PCIPs identified that 18 of the 31 IA areas included indicative funding profiles for more than one service priority for the initial three year period covered by the MOU. The analysis of in-year returns showed further refinement of expenditure profiles. The new Local Implementation Tracker will routinely capture PCIF spend and profiled expenditure against each of the six areas of service redesign. **It is our expectation that all IAs will now be in a position to complete this element of the tracker in full.**

Evaluation and understanding impact

25. The Primary Care Improvement Fund allocation letter of 23 May 2018 asked local partners to include in their PCIPs consideration of how changes will be evaluated locally.

26. **The second iteration of PCIPs should include a description of how changes are being monitored and evaluated locally.**

National GMS Oversight Group
March 2019