

General Practice: Contract and Context

Principles of the Scottish Approach

BMA

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The Scottish
Government
Riaghaltas na h-Alba

General Practice – Contract and Context - Principles of the Scottish Approach

1. Introduction

1.1 On 15th December 2015, in a debate in the Scottish Parliament, Shona Robison, the Cabinet Secretary for Health and Sport, set out her Vision for primary care and general practice:

- General practice and primary care at the heart of the healthcare system.
- People who need care more informed and empowered than ever, with access to the right person at the right time, and remaining at or near home wherever possible.
- Multi-disciplinary teams in every locality, both in and out of hours, involved in the strategic planning and delivery of services.

1.2 This document re-states that vision; locates it in the wider context of health and social care integration in Scotland; describes how it is guiding discussions on the future contract and context of general practice; and describes how Scottish Government and the Scottish General Practitioners Committee (SGPC) of the BMA will work together, and with wider stakeholders, to achieve it.

1.3 On 15 October 2016, in a landmark announcement the First Minister committed to invest an additional £500 million a year in primary care by 2021/22. This will bring the share of NHS frontline spending on primary care to 11%. This generational shift in investment will be the foundation of delivering the vision for primary care and general practice.

1.4 However, we recognise that general practice is facing challenges here and now: increased workload; increased risk relating to staff and premises; recruitment and retention. All of our efforts are focussed on positive change in general practice in Scotland that addresses these challenges in the here and now *and* help us achieve our long term vision.

1.4 The intended audience for this document is primarily GPs, though we hope the update is also of interest to the full team of primary care professionals who work in our communities. It recaps key progress in the last 18 months in Scotland, and signposts key stages over the next 18 months.

2. How we work

2.1 The Scottish Government and the SGPC are the two parties to the negotiation on GP contractual matters in Scotland. Our ultimate interest is the same: a sustainable future for general practice, which allows general practice to play a critical role in improving the health of our communities. This means we focus on shared interests and we work together to identify the best solutions to mutual objectives. We have seen significant progress taking

this collaborative approach which includes the removal of the bureaucratic Quality and Outcomes Framework (QOF) and introduction of GP clusters.

2.2 We understand and agree that progressing on this shared interest requires discussion that goes beyond the GP contract to the wider context. We will need to invest in particular in primary care workforce and infrastructure (physical and digital) if we are to develop the multi-disciplinary teams that will help realise our vision. These changes go beyond the GP contract and require wider engagement. As this wider engagement develops, with Health and Social Care Partnerships (HSCPs) and others, our expectation is that the GP contract focus more specifically, as it should, on evolving the role of the GP.

2.3 We discuss these wider terms too in a collaborative way, with a wider set of stakeholders. The Scottish Government has an advisory Reference Group on the GP contract, comprising NHS Health Board Chief Executives, HSCP Chief Officers, NHS Board medical, finance and planning directors and the Chief Nursing Officer. A range of short life working groups - on premises, GP workload, clusters - are currently developing advice and future options on these key issues. In addition to Scottish Government and SGPC; membership of these groups includes Royal College of General Practitioners, representatives from HSCPs and Health Boards and wider Primary Care stakeholder groups.

2.4 We consider this collaborative approach to both negotiations on the contract and discussions on the context a strength of the approach in Scotland.

3. Scottish Government Primary Care Vision and Outcomes

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
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 person 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

3.1 The vision puts general practice and primary care genuinely at the centre of a community health service, improving outcomes for local communities. Effective, sustainable and accessible general practice is needed by everyone – so we all start well, live well, age well and indeed die well. We share a vision of the future role of the GP as the Expert Medical Generalist in the community; focused on complex care, undifferentiated presentation and local clinical leadership. This is exactly what is needed to focus GP time on those patients who need them most, including those with palliative and end of life care needs.

3.2 The context in Scotland for general practice is Health and Social Care Integration – the single biggest public service reform in Health and Care in Scotland. HSCPs are, since April 2016, responsible for the commissioning, planning and delivery of all community and primary care services in their localities – including general practice. The nine Health and Wellbeing Outcomes ('HSCP outcomes') set out in the integration legislation are depicted in the centre of the figure above. The specific contribution of primary care (and general practice within this) is set out in the six Primary Care outcomes. These are:

Outcome 1: We are more informed and empowered when using primary care

Outcome 2: Our primary care services better contribute to improving population health

Outcome 3: Our experience as patients in primary care is enhanced

Outcome 4: Our primary care workforce is expanded, more integrated and better coordinated with community and secondary care

Outcome 5: Our primary care infrastructure – physical and digital – is improved

Outcome 6: Primary care better addresses health inequalities

3.3 The first three outcomes are concerned with the nature and culture of demand for services. More empowerment and better information will enable more self-care, for both routine and chronic conditions. Improving population health and enhanced experience – including better access to wider primary care services – will contribute to overall lower demand on the health and care system.

3.4 The second three outcomes are enabling outcomes. They describe the nature and characteristics of the underpinning interventions required to deliver the vision. They include an expanding workforce – both in primary care in general and in general practice specifically – and improved infrastructure including GP premises and IT.

3.5 General practice already requires a team approach. It relies on clinical and non-clinical staff in medicine, nursing, healthcare assistance, and practice management. Our approach is to extend this core practice based team to include other professionals – initially pharmacy, with enhanced pharmacists available to every general practice in Scotland.

3.6 Depending on local population need, the practice based multi-disciplinary team will also include allied health professionals (including paramedics playing a larger role in the community in and out of hours) and non-clinical professionals whose roles are to help people navigate the wider health and care system, such as practice receptionists, links workers and community connectors.

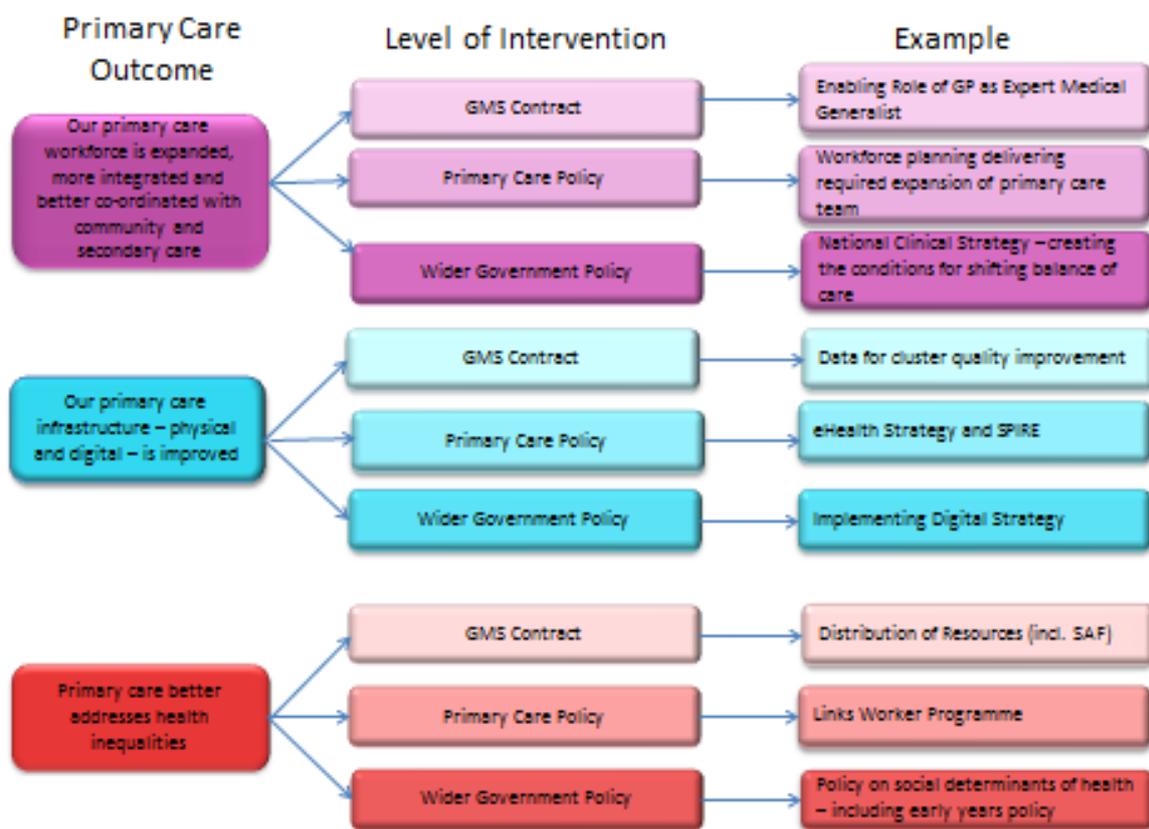
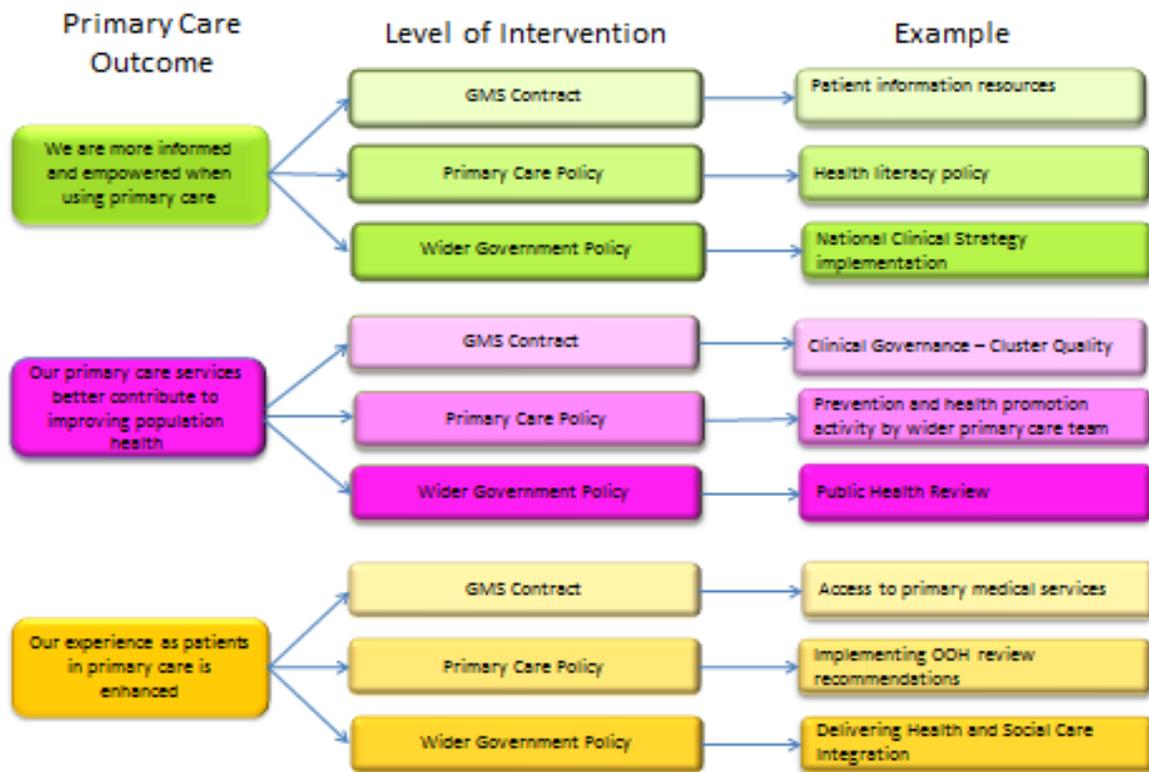
3.7 GP practices, clusters, and localities will know what is needed to make improvements to services in their areas. The Primary Care Transformation Fund is enabling a wide programme of tests right across Scotland, built on suggestions by local partners. At its heart is testing the multidisciplinary approach to patient care. This involves primary care professionals - pharmacists, physiotherapists, mental health professionals, advanced nurse practitioners and others - meeting the needs of patients, freeing up GPs to focus appropriately on undifferentiated presentations, complex care and provide clinical leadership.

3.8 How to ensure we have the right long term spaces for this team based general practice in the future is under active consideration by the Premises Short Life Working Group.

3.9 Better addressing health inequalities through our primary care services will require action primarily beyond the GP contract. In addition within the contract, the Scottish Allocation Formula weights practice funding by various factors that affect workload, including deprivation, rurality and age. The formula has been reviewed, and we are currently considering the impact at practice level as part of any overall changes to how GPs are funded. We need to look beyond the contract to other interventions and ways of supporting general practice in areas of high deprivation.

3.10 We understand and agree that delivery of the primary care outcomes is not possible solely through the GP contract. And we are clear that delivery requires additional investment. The Government's manifesto committed to shifting the balance of funding to primary, community, social care and mental health in each year of this Parliament. On 15 October 2016 the First Minister made a landmark announcement, committing to increase annual investment in primary care by £500 million by 2021/22. This will see the share of NHS frontline spending dedicated to primary care increase to 11%. This increased investment will help deliver our shared vision for general practice in the short and long term.

3.11 The principle – that delivering the outcomes needed requires three levels of intervention - contractual, primary care policy and investment and wider government policy and investment – is an important element of our agreed approach in Scotland. It is depicted below.



4. GP Contract – recent changes and next steps

4.1 The last 18 months in Scotland have seen considerable change in the GP contract. In October 2015, we agreed to move away from the overly complex and bureaucratic QOF to peer led quality improvement. GPs are already telling us they notice a difference in the quality of their consultation with their patients, that consultations are feeling less cluttered.

4.2 The 2016/17 contractual agreement introduced a new approach to improving the quality of outcomes for people – GP practices working together in clusters of 4 to 8 practices covering 20,000 to 40,000 patients (much clearly depends on practice size and the geography of the local area).

4.3 We have worked collaboratively to introduce these changes – and we consciously retain those elements that are core to general practice: contact, comprehensiveness, continuity and coordination. This includes basing teams providing personalised care around the GP registered patient list as it enables fuller knowledge of individual patients and their families; continuity of their care and understanding of the health needs and priorities of the list population – critical for influencing wider system changes to improve care.

4.4 In many ways, these changes – abolishing QOF and the creation of GP practice clusters in every locality – represent the most significant contractual change over many years in Scotland. The pressing issues now are more contextual – delivering the funding plan; the workforce plan and the infrastructure plan the Cabinet Secretary committed to in her March 2016 speech to the Scottish Local Medical Committee Conferenceⁱ. Much progress has already been made since March – new maternity and paternity pay rates delivered; single application to the performers list in use; occupational health delivery agreed and support to practices for emergency oxygen underway.

March 2016 – Commitments to SLMC		
Commitment	Update – developments since March 2016	Next Steps
Funding Plan	Manifesto commitment to increase the share of the budget to primary care	FM announcement 15 October 2016; Spending Review /Draft Budget December 2016; parliamentary process; Final Budget February 2017
Workforce Plan	National Workforce Plan currently in development – will contain focus on primary care	Consultation Draft published end 2016. Full version Spring 2017.
Infrastructure Plan	Premises Short Life Working Group established – due to conclude October 2016	Cabinet Secretary to consider options recommended by group
Action on workload	Improving Practice Sustainability Short Life Working Group established	Group to report Autumn 2016 – SG &SGPC agree priority actions

4.5 The nature of changes to the GP contract require careful planning in line with the planned increase of both funding and staff resources, and the need to ensure overall stability. This does not fit well with a making contractual change in one year but represents a measured step-wise approach to changing the GP contract and primary care.

4.6 The two key contractual issues are GP pay and GMS services. On pay, we recognise the picture presented in annual reports of the Review Body on Doctors and Dentists Remuneration (DDRDB) of insufficient evidence on the details of GP expenses for the DDRDB to present recommendations to Ministers.

4.7 We agree, in principle, that we need better information and evidence to inform both accurate recompense of expenses and options for the long term trajectory on GP pay in Scotland. To this end, we have agreed to jointly commission a review of general practice funding, pay and expenses to provide a proper, robust evidence base for improved decision making. This will take place in 2017, and inform options from 2018.

4.8 In transforming the role of the GP to be the ‘Expert Medical Generalist’ in the community – focussing on complex care; undifferentiated illness; and outcomes, quality and leadership – we are making the best use of GP skills – managing uncertainty, holistic person-centred care and clinical leadership of an expanded team. We will have to ensure that the

services specified in the GMS Contract are appropriate. A number of the current GMS services would seem better planned and delivered by Health Boards and HSCPs. We will work with those partners to ensure the safe and effective transfer of as many of those services from out of the GMS Contract as possible, leaving the GMS funding in place with practices. It may be that GPs remains involved outwith the GMS Contract. We expect a short national review in early 2017. National Contract negotiations will reflect these changes and any changes will be on the basis of our agreement on financial stability until April 2018.

4.9 There will be further contractual change in 2017 (which we expect to commence in October 2017). We continue to negotiate how to modernise the contract, improve access to general practice and improve the attractiveness of general practice as a career.

4.10 Improved access and better care for people in communities requires all members of the primary care and general practice team working as effectively as possible, on the aspects of care best met by their training, experience and skills.

5. Next Steps

5.1 We are committed to ongoing engagement and communication as negotiations and discussions progress. We continue to negotiate to reach agreement that will improve health and improve care.

5.2 We will consider carefully the advice from working groups on premises, workload and quality. And, with partners including the Scottish School of Primary Care, we will learn the lessons from the extensive programme of testing new models of care underway in each health and social care partnership area. This testing will inform decisions to invest significantly, in particular in primary care workforce and infrastructure, both physical and digital.

5.3 In March 2017 the parliamentary process for the Budget Bill will be complete. We will subsequently publish our joint agreement that will contain firm agreed plans for funding, workforce, infrastructure, workload and new ways of working.

ⁱ <http://news.scotland.gov.uk/Speeches-Briefings/Speech-to-BMA-annual-conference-Scottish-Local-Medical-Committees-23b8.aspx>