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The Scottish Government
Riaghaltas na h-Alba

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Dear Colleague

Directorate for Population Health Improvement and the BMA Scottish General Practitioners Committee

Communication on supporting materials to Health Board Chief Executives, Health and Social Care Partnership Chief Officers and practices in relation to the Transitional Quality Arrangements (TQA) for the 2016/17 General Medical Services (GMS) Contract.

Introduction

We are writing to you to follow up an earlier letter of 7 January, in order to provide further details of the GMS Contract TQA for 2016/17.

We are fundamentally changing how the contribution general practice makes to patient outcomes is expressed in the GMS Contract. At its heart this means moving away from the bureaucratic "top down" approach of QOF and relying more fully on the professionalism of GPs and maximising the benefits from promoting that professionalism in a structured collaborative context. This is the "peer-led, values driven" approach.

This is not a change that can happen overnight; it's a journey not an event. However, by removing QOF from April 2016 we make a very positive start. We will seek to embed this change more fully from April 2017. Deputy Chief Medical Officer Gregor Smith will convene a group with broad representation to consider further changes. Your contribution to that group's work, through your RCGP or LMC representative, would be welcomed.

Between now and April 2017 we want to introduce a comprehensive national approach to GP "cluster working". Clusters are small groups of practices – perhaps up to 6-8 - agreeing with relevant local partners a clear set of outcomes and a means to review those outcomes collaboratively; improving outcomes through further cycles with those same outcomes, or moving on to other outcomes across the patient pathway, in a repeating pattern; underpinned by an evidence based approach to improvement, including clear measures of success; and promoting a more deeply collaborative way of working with others in the local health and social care system.

This principle - of practices working more closely together to the benefit of patients, practices and the wider health and social care system - is reflected in both the Localities Guidance (link below) issued to support health and social care integration and both the BMA Scottish GP Committee vision and UK RCGP 2022 vision.

http://www.gov.scot/Publications/2015/07/5055

We recognise that some boards and partnerships are already working with groups of practices on local quality issues and this development, including the recognition of the Practice Quality Lead and Cluster Quality Lead roles set out in the TQA, should further support that work. Equally, we know that other areas have not yet started to work in this way. We recognise therefore that the transitional arrangements we have put in place have to accommodate this variation, while remaining consistent.

What follows are details of transitional arrangements for 2016/17, making clear what is expected of practices and local systems, along with the required supporting materials.

Background/Rationale for change

The Cabinet Secretary for Health Wellbeing and Sport announced on Thursday 1 October 2015 that:

"I have instructed my officials to work with the BMA to dismantle the Quality and Outcomes Framework in preparation for the new contract in 2017 by developing a transitional arrangement for quality in 2016/17 in Scotland. QOF has delivered many innovations, but its time is past. Scotland's GPs need a new and different future, starting in 2016.

I want to move towards a system of values driven governance that reflects and is sensitive to the different needs of the different communities that you serve. Allowing the best use of expertise to be shared across clusters of practices…the new Scottish GP will be at the heart of quality and improvement."

This announcement was made in response to a clear general view from the profession and others that QOF had 'run its course' and that it was time to move to a new model that was more fit for the intended future model of general practice.

Making the right kind of change

At the same time as the GMS contract moves to have a focus on working more closely with other parts of the wider primary, secondary and social care systems, to better understand and address outcomes that really matter to the individuals and communities that they serve,

there is a pressing need to have an approach that better meets the needs of patients, populations, practices and the wider health and social care system.

This means that we need an approach and focus that:

- meaningfully engages every GP in the quality agenda; and
- provides an opportunity for GP leadership that has an influence, impact and benefits that are much wider and greater than the individual and practice level benefits gained to date with QOF.

What does that mean for boards and partnerships?

A critical part of the mechanism for engaging GPs in the wider health and social care agenda, as set out in the earlier integration materials (including guidance for localities), is the role and function of what we have now called **Cluster Quality Leads** (CQLs) in TQA 2016/17. These individuals are the critical link between clusters of practices and the wider system. Whatever the name, this is a role and function that may well already exist in your board/partnership area.

We realise that many board and partnership areas will already have mechanisms to ensure comprehensive and meaningful engagement with GPs on many of the issues outlined later in this guidance. We absolutely want to build on these existing arrangements and avoid duplication or complication. Equally however any existing work will need to recognise any distinctive elements of the new approach set out in this guidance. We would expect Local Medical Committees to be involved in working out what is needed in localities and to support cluster working.

The person in the Cluster Quality Lead role has to be identified, appointed and empowered by the cluster and wider partnership and accountable to them in delivering change to improve outcomes for their patients. This is core business. However if boards and partnerships need assistance in accelerating or developing this they may wish to seek to access funding from the recently announced Primary Care Transformation Fund.

Transforming GP and mental health services

However, whether or not boards and partnerships have a CQL like role and function operating by 1 April 2016, **it will be essential that they have such a role and function operating by 1 April 2017**.

Funding for the CQL role (and any work asked of PQLs beyond what is specified by the GP contract) will require funding from outwith the GMS funding envelope.

Further, each board and partnership will need to be clear on its practice cluster arrangements by the end of stage 1 i.e. which practices are in which clusters, by the end of the first quarter of the 2016-17 contract year (by 30 June 2016 – see below 'A four stage approach to TQA 2016/17'). The development of GP clusters must involve practices and Local Medical Committees.

An Important Principle

While dismantling QOF and transferring the associated 659 points to core GMS funding removes a significant administrative burden, the continuing provision of high quality clinical

care will still rely upon the professionalism of GPs and their staff to provide all of the relevant elements of the care that they (the GPs and their staff) consider to be clinically appropriate to their patients i.e. removing the link between achievement and payment by dismantling QOF does not remove or reduce the obligation on general practitioners to treat patients in a clinically appropriate way.

Supporting Framework(s)

We have also agreed with the profession, the need to ensure where possible, that GPs and their practice staff continue to receive the benefits of a 'quality framework', that supports them in managing a range of long term conditions i.e. provides prompts for clinical care on the GP clinical IT system, although we are clear that the provision and use of any such framework will not be linked to payment.

A four stage approach to TQA 2016/17

Stage 1 – first quarter of 2016/17 (1.4.16 to 30.6.16)

Practices agree who will fulfil the Practice Quality Lead role and that person will work with the local partnership liaison person and LMC representatives to agree the cluster arrangements i.e. which practices are in which cluster.

The practices will start to consider the issues outlined in Annex A, with a view to agreeing what actions arising from them, or other agreed cluster alternatives, will be taken forward in stage/quarter 4.

Stage 2 – second quarter (1.7.16 to 30.9.16)

Practice Quality Leads* and the partnership/board and LMC, identify, appoint and empower a Cluster Quality lead and agree the time commitment to which this role will need to be resourced and how it will operate locally. The CQL role will be resourced by the partnership/board.

The practice continues considering the issues outlined in Annex A, with a view to agreeing what actions arising from them, or other agreed cluster alternatives, will be taken forward in stage/quarter 4.

* Any activity above 2 hours per month in the practice for the PQL will require additional resourcing by the partnership/board and it is expected that boards and partnerships will want to gain the benefits of fully involving practices, via their PQL, in the appointment of a Cluster Quality Lead.

Stage 3 – third quarter (1.10.16 to 31.12.16)

The PQLs* and CQLs begin to build relationships locally via the clusters, between and across practices, primary and secondary care, health and social care and between the public and third/voluntary sectors

Practices and the local system start to consider the issues arising from the activities outlined in Annex A, and any the other issues that might be local priorities, and agree by the end of this quarter which to take action on in quarter 4

* Any activity above 2 hours per month in the practice for the PQL will require additional resourcing by the partnership/board

Stage 4 – fourth quarter (1.1.17 to 31.3.17)

Practices and the local system take action on the priorities agreed at the end of quarter 3 and agree evaluation/outcome measures that will demonstrate quality improvement.

Conclusion

We hope that you will agree that this TQA framework for 2016/17 is both workable and proportionate. It will, we believe, go some way to meeting the profession's concerns around workload and avoidable bureaucracy, and will reinforce our joint desire to move to a greater reliance on professionalism and trust, and above all represent significant progress in our joint efforts to improve patient care.

We also believe that the TQA outlined above, and detailed in the attached Annex, will stand us in good stead for the joint quality work that we (SG and SGPC) will be taking forward towards the 2017 Scottish GMS Contract.

In conclusion I hope that you will be able to give your full support to these exciting developments and find the attached supporting materials in Annex A helpful but please do not hesitate to get back to me if you wish to discuss any aspect of this letter.

Yours sincerely

RICHARD FOGGO
Deputy Director and
Head of Primary Care Division
Scottish Government

ALAN McDEVITT
Chairman
Scottish General Practitioners' Committee
British Medical Association

Attachments/Inclusions
Annex A. What should practices consider as potential cluster working priorities for action in quarter 4 (1.1.17 to 31.3.17)

Annex A

Glossary
Practice Quality Lead (PQL) *– one GP from each practice with the responsibility and protected time to link with the Cluster Quality Lead*

Cluster Quality Lead (CQL) *– a GP from the cluster with the responsibility and protected time to provide a Continuous Quality Improvement leadership role in the cluster, and to liaise between the practices and board/partnership on quality improvement issues of mutual interest*

Issues for practices to consider for possible action in quarter 4 (1.1.17 to 31.3.17) under TQA 2016/17:

1. Registers, coding and lifestyle advice

How to maintain disease registers within the GP clinical system and coding based on diagnoses, and to offer appropriate* lifestyle advice, when patients are diagnosed with a long term condition.
* Definition of appropriate and exact timing to be determined by the GP practice.

2. Flu immunisation

How to continue efforts to maintain high levels of flu immunisation in all at risk groups but with a particular emphasis on patients with CHD, Stroke and TIA, Diabetes and COPD.

3. Quality, safety and prescribing

How to continue to engage in Quality, Safety, and Prescribing activities as described below.

a. Access

For 2016-17 the practice will review their last two annual Practice Access Activity Reports, using an agreed national template, for evidence of any recurrent themes and take actions they consider appropriate at a practice, cluster, partnership or national level in quarter 4.

The practice may have access to a cluster access report, which will be based upon the individual practice access activity reports (PAARs) previously provided by practices within the cluster (or whatever practice arrangements pre-dated clusters) to boards over the previous two contract years and will include any board/partnership wide, or national, learning from aggregated reports or storyboards from practices' cycles of change, that might help them to consider what more could be done to improve access arrangements in the practice and cluster.

When the clusters have been formed there will be the opportunity for practices to discuss the learning from their review of their previous access activity reports (PAARs) and any aggregated reports provided to them. In the cluster discussions there will also be an

opportunity to discuss how access could be improved in and across the practices in the cluster.

b. Complex patients and Anticipatory Care Plans

The practice will receive a list of 'high risk' patients i.e. those expected to benefit most from an Anticipatory Care Plan (ACP), due for example to a high risk of admission, health cost, health time, or expected health gain, and will decide which of those patients (or any others from their knowledge of the practice population) would in the view of the practice benefit from the provision of an ACP. Practices will review existing ACPs in a way and time that they determine to be appropriate.

The practice will be involved in an assessment of the quality of their Anticipatory Care Plans (a template to be provided), including their content and the local system will assess the use to which they are put out with the practice e.g. following an assessment/admission to hospital, or contact with an OOH service.

When the clusters have been formed there will be the opportunity for practices to discuss the quality of their ACPs and how useful/well used they have been out with the practice. In the cluster discussions there will be the opportunity to discuss how they could be improved and better used across the patient pathway.

c. Quality prescribing

GP practices will continue to work with the NHS Board prescribing advisors and prescribing support pharmacists, where available, to agree appropriate actions related to prescribing and seek to evidence change.Change will be demonstrated in the annual prescribing report provided to practices as part of this process.

Note: Practices will participate in the above noted activity and bring their conclusions to the cluster in order to begin to develop peer based quality and the role for GPs in improving outcomes for patients. Where a practice does not engage, or any issues arise from this quality peer review process that indicate that the practice may require support to undertake the activity, or address any issues arising therefrom, then the practice will be offered support as appropriate from the cluster. That support will take the form of written advice and/or a supportive practice visit from peers and a local manager aligned to the cluster.

These formative and supportive visits, where required, will allow constructive discussions; identifying areas of priority for action, support the sharing of best practice and will determine the basis for any other peer support that might also be required.