NHS Circular: PCA(M)(2019)08
Population Health Directorate
Primary Care Division

Scottish Government
Riaghaltas na h-Alba
gov.scot

Dear Colleague

NATIONAL GUIDANCE FOR CLUSTERS. A RESOURCE TO SUPPORT GP CLUSTERS AND SUPPORT *IMPROVING TOGETHER*

Summary

1. Since their introduction in 2016, the Scottish Government has encouraged GP Clusters to develop at their own pace, recognising that every GP Cluster is unique, with different priorities and different levels of capacity to deliver change.

2. There are now approximately 147 GP Clusters around Scotland, broadly aligned within, and across, the Integration Authority areas, all with the intention of learning, developing and improving together for the benefit of local communities.

3. Given the significant changes happening in primary care, we recognise that now is the right time for national guidance. This will help clarify the role of GP Clusters in the context of wider developments in Primary Care, including the new GMS Contract and Memorandum of Understanding (MoU), agreed between the Scottish Government, BMA, Health Boards and Integration Authorities, that together set out a key role for GP Clusters in quality improvement.

4. This guidance has been developed in collaboration with the Scottish Government, the Scottish General Practitioners Committee of the BMA (SGPC), the Royal College of General Practitioners (RCGP), Scottish Primary Care Clinical Leads, and informed by input from Health Improvement Scotland (HIS).

5. The guidance sets consistent definitions of the Practice Quality Leads (PQLs) and Cluster Quality Leads (CQLs) core role and functions, sets out recommended minimum expectations for Clusters, key relationships with the wider system, and describes what support Clusters need to best enable their growth.

20 June 2019

Addresses

For Action

Chief Executives NHS Boards, NHS National Services Scotland, PC Leads

For Information

GP Practices

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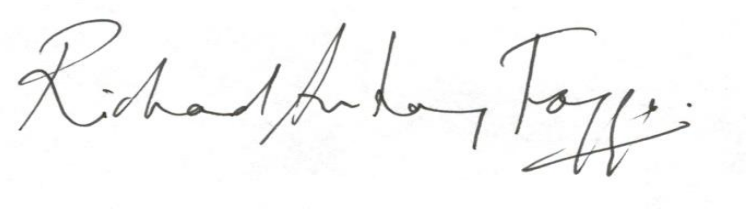
Action

6. NHS Boards are requested to circulate this document and ensure that their primary medical services contractors are aware of this new guidance.

Yours sincerely



RICHARD FOGGO
Deputy Director and Head of Primary Care Division.

National Guidance for GP Clusters

A resource to support GP Clusters and support *Implementing Improving Together*

CONTENTS

EXECUTIVE SUMMARY

1. This guidance has been developed in collaboration with the Scottish Government, the Scottish General Practitioners Committee of the BMA (SGPC), the Royal College of General Practitioners (RCGP), Scottish Primary Care Clinical Leads, and informed by input from Health Improvement Scotland (HIS), in order to;

    - Clarify and promote consistency for the core role and function of Practice Quality Leads (PQLs) and Cluster Quality Leads (CQLs).
    - Describe key relationships that enable GP Clusters to influence wider system quality improvement.
    - Describe the support and resource requirements for GP Clusters.
    - Signpost GP Clusters to interactive quality improvement resources: www.i-hub.scot

2. This guidance is intended for use by:

    - Cluster Quality Leads
    - Practice Quality Leads
    - Those in Cluster support roles (practice managers, board administration staff)
    - Health Boards
    - Integration Authorities (IAs)
    - GP Subcommittees and GP Clinical Leads

3. Since their introduction in 2016 there has been support, such as through the Improving Together collaborative, to encourage GP Clusters to develop at their own pace, recognising that every GP Cluster is unique, with different priorities and different levels of capacity to deliver change.

4. There is a recognised need to support GP Clusters to create a balance between their intrinsic role - focussed on quality improvement, flowing in to their extrinsic role - to influence wider system changes and improvements.

5. There has been dedicated national funding in place since 2016 agreed by Scottish Government and SGPC. to allow Practice Quality Leads to participate in GP Cluster working. This was intended to help create the right conditions for them to grow and flourish.

6. The 2018 GMS Contract was supported by a Memorandum of Understanding (MoU) agreed between the Scottish Government, BMA, and senior representatives of Health Boards and Integration Authorities. The MoU sets out our shared understanding of the key role GP Clusters will play in quality improvement:

    "Health and Social Care Partnerships will support and facilitate GP Clusters to ensure their involvement in quality improvement planning and quality improvement activity as part of whole system improvement."

7. There are now approximately 147 GP Clusters around Scotland, broadly aligned within, and across, the Integration Authority areas, all with the intention of learning, developing and improving together for the benefit of local communities.

8. Improving Together Interactive is an online resource to support GPs working in clusters. This includes a range of case studies that demonstrate the innovative work many GP Clusters have achieved in a short time.

9. However, we also recognise that there is emerging variation in GP Cluster development across Scotland. A Cluster Quality Lead (CQL) survey carried out by Health Improvement Scotland in June 2018 indicated that a range of pressures contribute to this variation including:

    - CQL time allocated for quality improvement work,
    - Learning and development support available to GP Clusters, and
    - Administration support and funded time available to enable their work.

10. This variation is recognised as being wider than perhaps anticipated or is helpful. This guidance has been prepared with consideration to those issues, and is intended to address unhelpful variation, support improvement, and provide a baseline, for all GP Clusters.

This guidance sets out recommended minimum expectations for Clusters and the wider system support required to enable and develop the Cluster role and function.

It is not intended to replace or direct Clusters already meeting or exceeding these expectations of activity or resourcing and support.

Any area that is looking to develop the capabilities of its Clusters can use this guidance to ensure they have a clear understanding of their core intrinsic and extrinsic roles, that they are using all national and local data available to inform their work, and that they are maximising the local and national support available to achieve this.

INTRODUCTION

11. In 2015, Scotland became the first country in the UK to abolish the QOF system of GP payments, and shifted the focus away from pre-set goals for quality improvement, towards clinically led quality improvement centred around the needs of local populations.

12. To support ongoing focus on continuous quality improvement GP Clusters were formally introduced in Scotland in the 2016/17 GMS agreement between the Scottish GP Committee of BMA Scotland and the Scottish Government. The arrangements for clusters were first set out in Improving together: A National Framework for Quality and GP Clusters in Scotland.

13. A GP Cluster is a professional grouping of general practices, represented at monthly meetings by Practice Quality Leads (PQL), which may take place either face to face or by video conference depending on individual circumstance or need.

14. Each GP Cluster requires a Cluster Quality Lead (CQL) whose role is to facilitate quality improvement work across the Cluster and liaise with locality and professional structures. A typical Cluster might include 4 to 8 practices covering 20,000 to 40,000 patients, although this will depend on the practice sizes and the geography of the local area.

15. Improving Together set out the principles of working with relevant local partners to agree a set of outcomes supported by an evidence-based approach to improving quality and promoting collaborative working across health and social care systems. It described both intrinsic and extrinsic functions:

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 Integration 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.

Source: Improving Together: A National Framework for Quality and GP Clusters in Scotland

16. The Chief Medical Officer's annual reports, Realistic Medicine (2016) and Realising Realistic Medicine (2017) called for changes in the way care is delivered in Scotland. The Chief Medical Officer has challenged healthcare professionals to consider how we can build a more personalised approach to care, reduce harm and waste, manage risk better, reduce unwarranted variation in health, treatments and outcomes and find innovative ways to improve the way healthcare is delivered in Scotland.

17. GP Clusters were introduced as professional groupings of GPs from practices to address intrinsic (in and between practices within the cluster) and extrinsic (between Clusters and their wider local system) clinical quality and outcomes. They are intended to consider how to work together to improve the outcomes for their patients both in their practices and in their local community. They should advise on changes to clinical and care pathways to local health and care services in the community, or to those of secondary care, to improve patient outcomes either by suggesting alterations to local services or of those in secondary care (in collaboration with hospital specialists). By their very nature, GP Clusters are local groupings of practices and discussions and focus will be on local clinical care and services to improve outcomes.

18. The 2018 GMS contract, negotiated and jointly agreed by the Scottish Government and the Scottish General Practitioners Committee of the BMA, further emphasised the role of GP Clusters in influencing the wider system to improve local population health and in taking a lead in initiatives relating to quality planning, quality improvement and quality assurance. The Improving Together collaborative has helped to develop these themes with support from others for example LIST data analysts, however it must be recognised that GP Clusters (and indeed the wider system) will continue to need time, resource and support to fully mature and contribute to all aspects.

19. It is the shared expectation of the Scottish Government and SGPC that through the GMS Contract GP Clusters are supported to deliver their extrinsic role through participation in the GP tripartite group of:

    - GP Subcommittee of the Area Medical Committee
    - NHS Board / Integration Authority GP leads
    - CQLs.

20. The 2018 GMS contract states; "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 CQLs. The GP Subcommittee will be responsible for co-ordinating the agenda for this tripartite collaboration and facilitating combined professional advice to the commissioning and planning processes of the HSCPs and NHS Boards."

21. The core role of Clusters is clearly set out in the GMS contract and delivery of the extrinsic role should not prevent GP Clusters being able to continue with their key intrinsic roles which focus on quality improvement, support and collaboration within and between neighbouring practices.

22. It is the responsibility of GPs within the GP Cluster, as well as the Health Board/Integration Authority Medical Leads and the GP Subcommittees to protect the space and time required for Cluster intrinsic roles. Should there be concerns regarding this, they should be addressed by the Cluster in conjunction with these parties.

23. Factors that have been identified as necessary for GP Clusters to function effectively and contribute to local quality improvement have been identified in early research into effective cluster working (Rohrbasser et al 2017). The most significant of these are:

    - To ensure there is appropriate support to help GP Clusters develop and to use facilitation for GP Clusters to improve their capabilities, skills and knowledge;
    - and that the individuals within a GP Cluster have an understanding of the principles and practice of quality improvement.

24. The survey of Cluster Quality Leads carried out by HIS in 2018 confirmed the significance of other factors including:

    - Local GP leadership and engagement from the clinical community.
    - Administrative support and engagement with the local health and social care partnership.
    - Easy access to local and relevant national data.
    - Local autonomy to determine which topics/clinical areas to address.

25. This guidance seeks to support Cluster development, and to better enable their role in influencing the wider system in partnership taking into account what we have collectively learned so far.

26. The Improving Together site *iHub* (https://ihub.scot/improving-together) will continue to provide a single gateway to access resources and materials for GP Clusters. This will be supported by a named champion in each board area, who will help to signpost and to support the development of the site at local regional and national level. The site already contains a number of case studies.

THE ROLE OF THE PRACTICE QUALITY LEAD (PQL)

27. The contractual requirement for GP Contractors and for Practice Quality Leads is set out in Schedule 6, Part 10 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018 and Schedule 1, Part 10 of the National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2018.

28. As of 2017, the Scottish Government has provided funding to ensure every Practice Quality Lead has protected time to participate in Cluster working for two sessions per month. They are the nominated lead for quality in their practice.

29. Every GP practice should have an identified PQL, and GP Cluster meeting frequency should be every 4-6 weeks. This requirement is set out in NHS Circular PCA(M)(2016)(6) and funding to support the PQL role this is set out in the GMS Statement of Financial Entitlements.

30. Working on behalf of their practice, the PQL will lead and support the practice team to consider and prioritise their quality improvement agenda, recognising the needs of their own practice and local population, and how this connects with the priorities of the GP Cluster and the wider system. The PQL should have responsibility for collating information and providing feedback from the practice to the Cluster, and to communicate and lead on GP Cluster priorities on behalf of their Practice.

31. In order to support their quality leadership role**,** support for and access to improvement methodology should be available through Integration Authority or Health Board Quality Improvement resources. This should be in addition to relevant data provision and data intelligence support.

32. Any additional PQL commitment (over and above that set out in the Regulations) should be clearly defined through an Service Level Agreement or similar, should reflect the additional support available, and be agreed with the practice and the cluster.

In summary, as defined in the 2018 General Medical Services Regulations and 2018 Primary Medical Services Agreement:

- **Each practice must have a PQL who is a GP.**
- **They are the nominated lead for quality in their practice .**
- **Practices must contribute meaningfully to the quality improvement work of the cluster.**
- **The minimum requirement is 2 sessions per month (fully funded centrally within GMS).**

THE ROLE OF THE CLUSTER QUALITY LEAD (CQL)

33. It is expected that GP Clusters will have direct involvement and influence in improving the quality of all health and social care services provided to patients registered within their locality. This will include services that are not provided by GP practices in the community including those provided by secondary care. This is described in NHS Circular PCA(M)(2016)(6).

34. Each GP Cluster of PQLs will have an identified Cluster Quality Lead (CQL). The 2018 GMS Regulations and 2018 PMS Agreement state:

> *"Cluster Quality Lead" means a person who is a member of a cluster that is appointed by a Health Board to represent that cluster to the Health Board."*

35. Both the 2018 GMS Contract Regulations and 2018 PMS Agreement also describe the process for appointing CQLs as follows:

> *"Where a Health Board is considering appointing a Cluster Quality Lead, that Health Board must consult a Practice Quality Lead who is a member of that cluster prior to offering an appointment."*

36. The decision on who should be CQL should be mutually agreed by the PQLs of that GP Cluster. CQLs take their authority from the cluster practices and are at all times both accountable to and empowered by practices, but cannot direct practices in the cluster. CQLs should retain the confidence of their Cluster practices at all times. NHS Circular PCA(M)(2016)(5) sets out:

> *"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."*

37. The CQL appointment should follow the relevant organisational HR processes. Some areas may choose to offer a contract of employment, whilst others may consider sessional payment direct to the practice. Whichever process is chosen, this should be formally agreed in writing. CQL funding is provided by the IA/HSCP.

38. Where there is difficulty appointing a CQL this should be brought to the attention of the IA/Board GP medical lead and GP Subcommittee as appropriate.

39. The CQL's core role and function is to:

- Support the work of the GP Cluster, linking closely with Practice Quality Leads.
- Co-ordinate and provide professional clinical leadership for, and on behalf of, their GP Cluster in regard to quality improvement, quality planning and quality assurance.
- Actively engage with other CQLs, the Board / Integration Authority leads and GP Subcommittee as appropriate to help ensure good processes are in place

in their Cluster to enable quality planning, quality improvement and quality assurance. The structure of this relationship will depend on local landscapes, but all CQLs should feel they have adequate fora with which they can engage with these stakeholders.

- Contribute to the combined professional advice provided to commissioning and planning processes of the HSCPs and NHS Boards through participation in the GP tripartite group.
- The CQLs should be aware of, and may already be part of, other local groups, or existing networks and the GP tripartite structure should be seen as a means of enabling collaboration and joined up discussions within the local system.

40. Each CQL should have:

- A role descriptor outlining their continuous quality improvement role, including time commitment and funding arrangements.
- In order to fulfil the expectations of this role, a time commitment of an average of 4 sessions per month is recommended. This recommendation is based on feedback from CQLs currently undertaking the role and a Board survey which showed a sessional range of 2-4 sessions, with a variation in payment mechanisms and rates. Board/IAs should work with their Local Medical Committee to mutually agree arrangements that reflect local circumstances.
- Payment to support this leadership role should be commensurate with the requirements of the role.
- The CQLs role description should clearly set out their role and function within the wider system. The CQL role is funded by the Board/IA and should include participation in the GP tripartite group, coordinated by the GP Subcommittee through agreed local arrangements as set out in the 2018 GMS contract.
- In order to support their quality leadership role**,** support for and access to improvement methodology should be available through Integration Authority or Health Board Quality Improvement resources. This should be in addition to relevant data provision and data intelligence support.
- It is expected that each CQL will have accessed quality improvement training (or equivalent) within 18 months of their appointment. Each Board / IA will be expected to facilitate this.
- A clear statement (or terms of reference) setting out how this arrangement will work for each IA.

In summary:

- **Each GP Cluster must have a CQL who is a nominated GP from their practices.**
- **They will work to attain quality improvement training.**
- **They will work with their GP Cluster to identify agreed actions and priorities.**
- **They will co-ordinate the quality improvement agenda for their GP Cluster taking into account their local population health needs and landscape.**
- **Along with other CQLs they will work in collaboration with Board / IA Primary Care medical leads and the GP Subcommittee as part of the GP tripartite group.**
- **The recommended requirement is an average of 4 sessions per month which must be mutually agreed and fully funded.**

SYSTEM SUPPORT FOR CLUSTERS

41. NHS Circular PCA(M)(2016)(7) (GP clusters – Scotland – A One Page Guide for GP Practices for 2016/17) sets out:

> *"The board/partnership will be expected to fund secretariat support to the Cluster and can fund additional Cluster meetings as required."*

42. This should be clearly described for each GP Cluster, taking into account local requirements to enable effective cluster function. The exact format of this support should be locally determined and might be in the shape of purely secretariat support or more formal project support depending on the local landscape and need.

43. Secretariat support for CQLs is critical if they are to fulfil and strengthen their role as clinical leaders. Where this capacity is readily available there is clear evidence of effectiveness. The required administrative support, such as that required to organise meetings and produce minutes, should be identified and agreed with the GP Cluster so that CQLs have sufficient dedicated time to enable service Quality Improvement work. Support can be deployed where appropriate from a range of sources including funded practice manager support for GP Clusters. Where necessary Board/IAs should work with their Local Medical Committee to mutually agree arrangements that reflect local circumstances.

44. Requirements for GP Clusters should include:

- Consideration of a Terms of Reference agreed by the GP Cluster to support their work.

- This document should set out for example: frequency of meetings, designated Chair, use of deputies, membership, timings, quoracy, deputy arrangements, and clarity around funding or finance arrangements, recognising that GP Clusters do not directly employ staff or hold budgets.

- A Cluster Quality Improvement Plan, as outlined in the GP Contract Offer document published by the Scottish Government and BMA, will be helpful to avoid duplication of effort by taking account of Integration Authority and Health Board strategic plans, such as Primary Care Improvement Plans.

- GP Clusters should have, as a minimum, named links and methods of access for the following:

    - GP Sub Committee and Board/IA GP Clinical Leads.

    - Public Health consultant.

    - Organisational Development/ leadership development.

    - Board Realistic Medicine Lead.

- Primary/secondary care interface links.
- Finance support (if required to support interpretation and planning).
- Administrative support should be suitable to support the work plan of clusters and this could include project management support.
- Learning opportunities including personal development, action learning and opportunities to contribute to research.
- Access to data and intelligence through data sets and LIST analyst support.

- It is recommended that every CQL should have accessed Quality Improvement training opportunities and completed within 18 months of CQL appointment.

- In normal circumstances CQLs should be appointed for a mutually agreed term, usually of up to three years subject to appropriate review arrangements. Towards the end of the contracted term the cluster should have the chance to review the appointment and decide which PQL is best placed to continue in the role. Incumbent CQLs can be re-appointed if the cluster believe the individual is the most suitable.

- Opportunities to contribute to IA clinical care and governance committees where this may be appropriate from a quality assurance perspective.

45. It must be recognised that Cluster development is still at an early stage, and the vision set out in the 2018 GMS Contract Offer and Memorandum of Understanding will take time to achieve. Primary care reform must also be considered in the context of wider health and social care integration, which is also at an early stage in its journey.

These expectations should therefore be considered as an opportunity to provide a level baseline for all GP Clusters, and from which we can further build on the exceptional potential of Clusters as they mature and develop their clinically led contribution to Quality Improvement within the wider system at local, regional and national level.

COLLABORATIVE WORKING :THE GP SUBCOMMITTEE AND GP CLUSTERS

46. The 2018 GMS Contract Offer document sets out the strengthened role of the GP Subcommittee.

    "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 CQLs (the GP Tripartite Group). The GP Subcommittee will be responsible for co-ordinating the agenda for this tripartite collaboration and facilitating combined professional advice to the commissioning and planning processes of the HSCPs and NHS Boards."

47. It has become clear, as the new contract implementation has taken place, that it is useful for GP Clusters to be able to discuss local ways of working with the new extended multidisciplinary teams (MDTs). Discussing clinical pathways and protocols for working with these new staff is an appropriate clinical quality activity.

48. The GP Subcommittee of the Area Medical Committee is elected from all GPs to represent GPs and provides advice to the health board and, through their devolved powers and responsibilities, to health and social care partnerships. The GP Subcommittee is enabled by Part 1, section 8 of the National Health Service (Scotland) Act 1978 and is the only statutory advisory structure with elected members representing GPs and retains its role outside the GP tripartite group. One such role is working with HSCPs to develop and agree Primary Care Improvement Plans which direct how resources in support of the new GP contract are allocated. Practices will continue to provide input directly to GP Subcommittee on such matters.

The extrinsic function of GP Clusters

49. GP Clusters have an important extrinsic function in improving the quality of the care their patients receive in the local health and social care system. Effective engagement across the interface with secondary care clinicians and other stakeholders such as social care services and the third sector will be essential to achieve better patient outcomes. In doing so, they should consider how they can interface with existing local collaborative arrangements, including locality planning, to support the quality agenda.

50. The extrinsic function of GP Clusters refers to the overview of the quality of local services and board wide services. This will be facilitated through participation in the GP Tripartite Group which is intended to act at a Board wide pathway at commissioning level and is less likely to have a role at local level.

Cluster work and Cluster Quality Improvement Plans should be capable of influencing and having impact on locality planning and locality priorities. Clusters should be meaningfully consulted on locality and strategic plans with a voice and ability to influence change.

A mutual understanding and good communication of roles/objectives between the GP tripartite group, cluster and locality planning groups is important to support collaborative work.

It is recognised that the GP tripartite group will provide combined professional advice to the planning and commissioning process for HSCPs and Health Boards.

DATA AND INFORMATION

51. GP Clusters are expected to gain influence and importance with time. Clusters should review practice-level quality in a peer-based manner and the PQL has a key role in enabling this. Initially GP Clusters could, for example, review comparative data between practices in a cluster on areas such as referral, prescribing, coding, access and use of unscheduled care to identify variation, learning and areas for improvement.

52. Data will be available to the GP Cluster from several sources including the practices themselves and from the CQL.

53. Each GP Cluster should have the opportunity to work closely with their named NSS LIST analyst to support them. The LIST team can provide a wide range of support to GP Clusters to evaluate, interpret and understand local data. A wide range of examples showing how LIST can deliver this is available on their website.

54. Using a combination of locally agreed and nationally available data, GP Clusters should contribute to whole system working and improvement.

55. GP Clusters are required to have access to a range of data sets, both at individual practice and at cluster level. ITi hosts a datazone, with links to the ISD GP Cluster page.

56. LIST analysts have worked with individual GP Clusters to help bring together data that is meaningful and relevant to them. As clusters mature and develop, there may be a need to consider national standard datasets to further support quality improvement, but the main focus at this time is to ensure consistent data recording and to support GP Clusters to develop in this area.

To support the quality and integrity of data sets, it is essential that all practices in the GP Cluster continue to use appropriate coding and to maintain practice disease registers in accordance with the guidance set out in the Transitional Quality Arrangements.

QUALITY PROCESSES AND NATIONAL SUPPORT

RCGP

57. RCGP Scotland has a key role in supporting the further development and implementation of strategies and supporting policies for designing and delivering quality improvement throughout Scotland for general practice to improve patient outcomes. It is committed to supporting on-going and new training for quality improvement work in practices and at cluster level, working alongside NES, HIS and the Scottish Government.

58. RCGP Scotland aims to support integration of quality improvement activity into the role of all members of the primary health care team and supports the inclusion of the patient/public voice in designing quality improvement activities.

59. RCGP has developed a range of resources for practices and Clusters including:

- RCGP Quality Improvement Programme – Resources to support GPs and their practices in quality improvement activities.
- RCGP Innovation Programme - New models of care and solutions to the issues facing the delivery of world leading healthcare.
- RCGP Clinical Toolkits – A collection of toolkit resources which can be used to assist the delivery of safe and effective patient care.
- RCGP Effective Interface - A QI module to assist with identifying and providing solutions to problems that exist at the primary/secondary care interface.
- RCGP/Marie Curie Daffodil Standards – A toolkit jointly developed with Marie Curie to improve standards in palliative care in general practice.
- RCGP Treating Access – A toolkit to improve patient access to primary care.
- Leadership for Integration - A new package of leadership learning support, designed to reshape, develop and deliver integrated care.
- QI Ready - Online quality improvement network
- RCGP e-learning - Modules covering Quality Improvement in Primary Care
- Prescribing and patient safety data reports - Includes an example report and details of how to sign up

60. RCGP Local Advocates have been engaging with CQLs, IA Clinical Directors and Associate Medical Directors (AMDs) for Primary Care to develop an understanding of how GP Clusters are enabled and equipped for quality planning and improvement.

    If you wish to contact your RCPG Local Advocate please email them for further support: infoscotland@rcgp.org.uk.

61. RCGP Scotland Local Advocates have a broad understanding of the types of initiatives being undertaken across Scotland and aim to help reduce duplication whilst facilitating the sharing of innovations, learning and best practice. They are also able to highlight RCGP and other resources which can help enable GP Clusters to function in the most effective way for the benefit of the profession and our patients.

Healthcare Improvement Scotland

62. Improving Together interactive is an online virtual platform created to host and signpost to a series of resources and tools supporting the development of GP Clusters quality improvement and leadership capacity and capability skills. The platform has been developed in collaboration with national partners to deliver a cohesive catalogue of materials and will continually evolve to reflect best practice, share learning and navigate to practical resources, events and networking beyond the virtual space.

63. Improving Together interactive has been developed to support cluster quality improvement activities and has been structured around 6 key zones:

- Data
- Quality Improvement
- Leadership
- Facilitation
- Evidence and Evaluation
- Case studies

64. Within each zone are comprehensive materials to support GP Clusters, including shared examples, links to development opportunities, networking opportunities, webinars , slide sets, international literature and more.

65. HIS will continue to develop the iHub portal as a “one stop shop” for quality improvement in primary care , which will, over time, further support GP Clusters to access an even wider range of knowledge and information through a single site. Board “champions” will be identified, and will be available to help GP Clusters both access, and contribute to, the site.

66. Other key sources of information are linked below:

- British Medical Association
- Information Services Division (ISD Scotland)
- NHS Scotland Education Services (NES)
- NHS National Services Scotland
- NHS Health Scotland
- Royal College of General Practitioners
- Scottish Government
- Scottish School of Primary Care

The ihub portal Improving Together interactive is a one-stop comprehensive resource to support Clusters.

Resources from other key contributors can be found under the headings listed above.

LOOKING AHEAD

67. This guidance is another step in the progress and development of GP Clusters. By contributing to, and receiving support from, the wider system, the role, function and potential of GP Clusters will be better understood and will continue to develop alongside opportunities to meaningfully influence service planning to reflect local population health needs.

68. GP Clusters working in collaboration through the GP tripartite group and other local arrangements will support the development of primary care leadership roles, and support connections to the wider system around access and pathways of care, person centred care planning and help the system better understand variation through use of intelligent data for improvement.Consideration will be given to a nationally agreed CQL rate negotiated by Scottish Government, and SGPC subject to appropriate uplift and superannuation arrangements.

69. GP Clusters are still at an early stage in their development, and their unique potential to drive quality improvement at a local, regional and national level must continue to be nurtured. Support for their development must continue to be a priority for all parts of the system. Cluster working provides a mechanism for project management, organisational development, leadership and management to directly connect with and support practices and clusters.

70. The i-HUB portal will continue to develop as a single access resource, and as Clusters continue to mature further consideration will be given to areas such as data and data intelligence, quality assurance and how GP Clusters support multi-disciplinary team working. With support, the opportunity to build on and strengthen networks, support professional and team development, and through collaboration increasingly influence and direct resources to support local population health needs Clusters will flourish.

71. This guidance is a step in this exciting and transformational journey.