Rural Flexibility and Options Appraisal – Guidance to Support Primary Care Improvement Plans

Introduction

This document provides further clarity to previous Scottish Government guidance about the circumstances where GPs would continue to deliver services that would otherwise be transferring to Health Board employed staff as part of the implementation of the 2018 GP Contract and associated Memorandum of Understanding (MoU).

Our Shared Vision for a Transformed Primary Care Service

The 2018 GP Contract Offer and MoU set out a transformative new direction for Primary Care services in Scotland as well as putting in place much-needed investment and support for Scotland's General Practitioners. The Scottish Government and BMA agreed that the £250 million Primary Care Improvement Fund to be invested from 2018 to 2021 (and then continued in core funding thereafter) should be used primarily to recruit Health Board clinical staff in order to quickly relieve the mounting pressure on GPs with high, unsustainable workloads, and to urgently begin supporting the GP role so that we attract more trainees and retain more experienced GPs for longer.

The Contract came into effect in April 2018 and commenced a three-year period of transition, supported by a £250 million Primary Care Improvement Fund dispersed to HSCPs, to allow this transformation to take shape. Our ambition at the end of this period is for board-employed multi-disciplinary teams (MDTs) - supported by GPs providing expert leadership – to provide the following services:

- Pharmacotherapy
- Community Links Workers
- Vaccination Transformation Programme
- Additional Professional Roles (including MSK physiotherapists and mental health)
- Community Treatment and Care Services
- Urgent Care Services

The Memorandum of Understanding sets out the seven key principles that should guide primary care redesign, namely that any redesigned services should be:

- safe for patients and staff;
- outcome focussed;
- affordable.
- person-centred;
- effective;
- equitable;
- sustainable;

Our expectation is that HSCPs, in collaboration with Health Boards and GP Subcommittees, use these principles in planning all service redesign and should in particular inform the development of Primary Care Improvement Plans (PCIPs).

We recognise that delivering primary care transformation is occurring within a complex local landscape of work to address specific local challenges and population need. As part of our continuing engagement with HSCPs on PCIPs and the Rural General Practice Working Group, we have been asked for further clarity regarding the

circumstances under which an 'options appraisal' for MoU service redesign flexibility is appropriate.

What do we mean by Options Appraisal?

'Options appraisal' in this case refers to any process used by Primary Care Improvement Programme Boards to determine whether it is necessary for one or more local GP practices to continue delivering one or more services intended to transfer to board-employed MDT under the MoU. This process is in addition to the wider options development process that all HSCPs will be undertaking through Primary Care Improvement Plans.

The Scottish Government and BMA have agreed that the following principles, governance and funding arrangements should inform options appraisal processes to enable the continuation of GP-delivered services within Primary Care Improvement Plans.

The Options Appraisal Process

a. Principles

The exact form of an options appraisal will vary depending on the circumstances to be determined locally; there is no requirement for a 'one size fits all' approach when deciding if an options appraisal should be undertaken. The following principles should applied in all cases:

Exceptional Circumstances – All options for service redesign should be considered as part of the wider options development process before the HSCP decides that a GP-delivery options appraisal is necessary.

Evidence-based – The options appraisal process for considering GP-delivered services should be guided by the 7 MoU principles (safe, person-centred, equitable, outcome focussed, effective, sustainable and affordable). There should be clear evidence under each of the relevant MoU principles to show that a GP practice must continue to provide service. Weighting for these principles should be decided locally.

Developed collaboratively at all levels – Where there is agreement that an appraisal is needed, HSCPs should lead the appraisal work via PCIP Programme Boards and this should be developed as part of the Primary Care Improvement Plan process. We recognise that options appraisals are likely to be driven by local concern and therefore HSCPs should demonstrate engagement with the stakeholders outlined in the MoU: the affected GP Practice, other practices in the local area, GP Sub-committee, patients, carers and communities. This engagement should be captured and included as evidence in support of the recommendation of the option appraisal. If one or more practices must retain a service following an options appraisal, HSCPs should engage with those practices to consider what other MoU services can be transferred as a priority.

Limited to Remote or Rural Areas – We are in a crucial transitional phase towards achieving our vision of a transformed Primary Care service. We appreciate that asking

HSCPs to show ambition in PCIPs will, conversely, also rely on a degree of stability within local systems to give innovative models a space to develop and grow. Our expectation is that HSCPs will, as far as practicably possible, aim to implement MoU service redesign for as many services and practices as possible.

However, throughout this process, we have been listening carefully to concerns of service redesign partners and it is clear that the potential need for GP-delivered services is focused around the challenges of remote and rural General Practice. HSCPs should only consider applying this process where PCIP partners in rural, remote and island areas seek an options appraisal. While we recognise that in some very remote and rural areas, an options appraisal for the entire locality or geographic area of an HSCP may be appropriate, in general our expectation is that appraisals will consider individual or small groups of rural practices.

HSCPs may wish to consider the Scottish Urban Rural Classification – particularly categories 4,5,7,8 – to identify practices in remote and rural areas. However, we recognise that local factors such as GP and MDT workforce, and staff skills, training requirements, transport links and resilience can influence whether an options appraisal for a rural practice is required.

b. Scope of Process

We recognise that MDT workforces may require time to recruit, train and develop new skills and capacity. HSCPs can undertake an options appraisal for any of the services, or aspect of one service, intended for transfer under the MoU.

Some HSCPs are maximising economies of scale by exploring ways to combine MoU services into single delivery models, for example by using the same MDT staff to deliver Vaccinations and Immunisations, Community Treatment and Care Services (CTACS), and Urgent Care together. Some HSCPs have also sought to maximise workforce capacity and patient outcomes by targeting one aspect of one MoU service with dedicated MDT teams, such as childhood immunisations, while GPs continue delivering other aspects of the service until there is sufficient MDT staff to safely take over the remainder of the service.

Ambitious delivery models are entirely possible and indeed encouraged within the PCIP and options appraisals process, provided they are supported by a strong evidence basis informed by the MoU principles and this guidance.

c. Governance of Process

Options appraisal processes should be led by HSCPs, in collaboration with local PCIP partners and include views from other relevant stakeholders. HSCPs can undertake an options appraisal for any of the services, or aspect of one service, intended for transfer under the MoU.

To avoid creating undue additional administrative burden, the process should be part of the local HSCP PCIP structure, with agreement required between the Local Medical Committee, Boards, HSCP and other relevant partners on the evidence gathering process, resource requirements, timescales and sign-off.

It is vital that options appraisal processes have robust reporting mechanisms in place. The PCIP and PCIP tracker regularly shared with the Scottish Government should highlight any areas that are part of an options appraisal process or where exceptional circumstances have been agreed. The PCIP should also outline which practices it applies to, summarise the process, provide a rationale for the final decision (based on evidence), and the agreed timescale for review of the decision.

Our expectation is also that, as MDT services mature, they can be extended to some practices where options appraisals previously indicated a GP–delivered service was required. Where it is agreed that one or more GP Practices will continue to deliver services, that decision should be regularly reviewed on a regular basis and should incorporate changes of circumstances such as the uptake of innovative technology or the growing availability of the MDT workforce. The timeframe for this review should be agreed locally, but at least annually, and the ongoing status of each options appraisal should be included within the PCIP reporting cycle. Any review of an options appraisal should continue to be informed by stakeholders e.g. the affected GP Practice, other practices in the cluster, GP Sub-committee across the local area.

Nationally the Oversight Group will have a role reviewing PCIPs and trackers to ensure a consistency of approach to the process. As part of this role, they will also review the decisions and supporting evidence to ensure this process has been followed.

d. Funding

Service redesign is being accelerated through a three year period due to be completed by April 2021. This involves delivering the expanded workforce and transfer of some services away from practices to successfully implement the MoU priority areas and enable GPs to become Expert Medical Generalists. The priority for Primary Care Improvement Funds is to implement the contract priorities to ensure an expanded workforce and reduced workload for GPs. At this stage the PCIF is to be wholly used to fund the new service delivery transformation arrangements.

Although significant progress has been made, there is still some way to go until most practices across Scotland will have transferred services particularly vaccinations, and community care and treatment services. In line with their local areas' agreed PCIPs, substantial transfer is intended in years 2 and 3 and therefore the majority of practices in urban as well as rural settings are still providing these services. Until the extent of delivery at the end of the implementation period is known across the country, any future funding mechanism cannot be put in place.

The PCIP trackers received every six months will be used to track progress and level of service transfer to ensure there is no inequity in delivery. The negotiating parties will continue to be informed by advice from the Remote and Rural Working Group, as well as the GMS Oversight Group and also appropriate wider consultation. The Scottish Government and BMA intend to evaluate and agree funding arrangements. as we move to the end of the MoU transition period by April 2021.