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By Email.

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Dear Lewis

Thank you for your letter of 10 June 2020. I have set out below my responses to your further questions.

Financial reporting by Integration Authorities

Integration Authorities are local government bodies, as defined by section 106 of the Local Government (Scotland) Act 1973 and, as such, have their own individual governance arrangements for the reporting of financial information. In order to deliver effective scrutiny, prior to consolidation of reporting at a national level it is essential that each Integration Authority undertakes appropriate due diligence in accordance with its locally agreed governance structures and reports accordingly to its own (Integration Authority) Board. In addition, each Integration Authority's financial reporting process is dependent on the completion of the financial reporting from its relevant Local Government and NHS funding partners.

I have asked my officials to continue their work with Integration Authorities to consider further opportunities for shortening the timescales for consolidated financial reporting. In considering such opportunities it will clearly be necessary to ensure that the quality of local scrutiny is not compromised, and remains in line with the basis on which Integration Authorities were created. In terms of responding to the Committee's wider concerns about public scrutiny of spending by Integration Authorities, I would also note the information that is made available as a matter of course by Integration Authorities through their own websites and public meetings. This includes details on budgets, financial reporting, and annual accounts.

Investment in the community

First and foremost, the decisions about community investment that I set out in my letter of 12 May, are made in order to improve quality of healthcare services and to ensure that patient care remains the top priority. Taken together with our total package of investment across both primary and secondary care, these initiatives support the release of savings from hospital

services that are then reinvested across hospital services and transferred to support community services.

Given the interdependencies between our range of services and investments, it would not be possible to quantify and attribute specific financial benefits for each individual commitment. In this context and in order to respond to your questions as helpfully as possible, I have provided further detail below on the wider value that we expect each of the relevant investments to realise for secondary care.

Community link workers

Expansion of the multi-disciplinary team (MDT) is vital to the reform of primary care services, to ensure that patients are seen by the right person at the right time. Community Link Workers (CLWs) are a key part of the MDT. They offer non-clinical, holistic support to patients, tackling key detriments of poor health such as low income, debt, unemployment, poor housing and social isolation, which can all impact heavily on a patient's physical and mental wellbeing, and left without support, can lead to further appointments with primary or secondary care. The CLW programme is building on successes in Deep End practices and from early adopter sites. The work of CLWs is also a form of social prescribing.

CLWs support people to live well by strengthening connections between existing community resources and primary care. Individuals are assisted to identify health issues and personal outcomes, and then supported to overcome any barriers to addressing these issues through the use of local and national support services. By assisting GP practices in this way, CLWs free up capacity thereby allowing GPs to spend more time with patients with complex clinical needs. This can be directly beneficial in reducing inappropriate admissions to acute services.

District Nursing

Our future vision for district nursing in Scotland will see district nurses playing a pivotal role as senior practitioners in integrated community teams of healthcare support workers, registered nurses and advanced nurse practitioners. Such teams will be used to promote health and wellness in people's own homes or communities through enablement of self-care and delivery of personalised health outcomes.

The refocusing of the district nurse role reflects the Scottish Government's public health approach. This is underpinned by fundamental principles, which support early health interventions and minimise the need for acute care, such as:

- promoting prevention;
- practising relationship-based care;
- promoting self-care and independence;
- enabling people to manage their own health;
- basing interventions on evidence from research and evaluation and knowledge of individuals and communities; and
- getting it right for every person every time.

As part of integrated teams, district nurses will have defined high-level generalist competences and be able to work flexibly and in partnership with their communities as well as other professionals including social care and voluntary workers and carers. This flexibility will also enable district nurses to work across hospital and community boundaries with the aim of

supporting people to stay longer at home and in their communities, reducing hospital admissions. The realisation of this investment will become evident over time as more care is moved to the community.

Advanced Nurse Practitioners

Advanced nurse practitioners (ANPs) are experienced and highly trained nurses who act as senior clinical decision makers in a diverse range of health and care settings. ANPs will play a crucial role in taking forward the Scottish Government's aims to transform Primary Care and shifting the balance of care from acute settings to the community. Advanced practice is characterised by high-level autonomous decision-making, including assessing, diagnosing and treating (including prescribing for) patients with complex multidimensional problems. ANPs also have the authority to refer, admit and discharge within defined clinical areas.

As a result of the £3 million funding to train additional ANPs, 155 nurses had completed the training as of 30 November 2019 with a further 550 still working towards qualification. Of the 155 newly qualified ANPs, one-third are now working in the community, general practice or in social care settings and are contributing to the improvement of care for patients through the introduction of more joined up, anticipatory and preventative health interventions. As with the refocusing of the district nursing role, it is expected that this will have benefits in reducing unnecessary hospital admissions.

Where ANPs are working in secondary care, they are also making a significant impact by maintaining or improving access to services and improving continuity of care for patients. For example, in NHS Greater Glasgow and Clyde, ANPs in the nurse-led minor injury units are helping to keep around 70,000 patients out of the Emergency Department and ANPs in the GP out-of-hours service are seeing a significant number of patients, helping ensure a sustainable service. ANPs in the Care Home Liaison team have been providing medical and nursing care to care homes throughout the current pandemic. In NHS Lothian, the Emergency Department (ED) at Royal Infirmary of Edinburgh has a well-established ANP workforce with a new nurse led Minor Injuries Unit in 2019 helping to improve patient safety and flow within the ED department.

Pharmacy

Through our Primary Care Fund investment in pharmacy, NHS Boards have been supported since 2015 to build capacity in GP practices through the provision of pharmacists with advanced clinical skills. The core aims of this approach are to i) improve clinical outcomes for patients; ii) improve the quality and safety of prescribing; and iii) support the sustainability of GP practices and practice case workload.

The primary role of practice-based pharmacists is to deal with medicine-related problems and issues that are common to GP practices, while also supporting patients to manage long term conditions. The support they provide covers improving medication management systems such as formulary compliance, hospital outpatient requests, and repeat prescribing management. For example, pharmacists can provide polypharmacy and medication reviews – including the review of high risk medicines – as well as directly managing patients with complex, multiple conditions. The polypharmacy guidance published by the Scottish Government in 2018 indicates that 11% of unplanned hospital admissions can be attributed to harm from medicines. The aim of polypharmacy reviews is to reduce such admissions by reducing the number of medications taken by patients, thereby providing financial benefits to the system

and tangible benefits to the patients themselves. Earlier this year, it was estimated that £7 million of savings were generated by polypharmacy reviews in 2019-20.

Finally, there is an important role for GP practice-based pharmacists, who work closely with hospital pharmacists, community pharmacists and care homes to ensure seamless care and the reduction of medication-related harm. Medicine reconciliation is performed by pharmacists whenever care transfers across the interfaces.

Paramedicine

The development of the Specialist Paramedic role has resulted in a number of specialists working directly out of GP practices, carrying out clinics and conducting home visits to patients where appropriate. This is in line with our aim to ensure that patients see the appropriate healthcare professional to manage their condition.

The Scottish Ambulance Service continues to work closely with Integration Authorities and other key local health providers to establish alternative pathways of care, which avoid hospital admissions. As SAS increases its 'see and treat' rates, more patients are seen at home or in a community setting thereby preventing the need for conveyance and admission to hospital.

The use of specialist paramedics, responding through a dedicated paramedic response unit to lower acuity patients who may not require onward conveyance, also ensures that more emergency ambulances are available for emergency response and to transport patients from GP surgeries to hospital.

Ophthalmology

The General Ophthalmic Services (GOS) budget comprises the following expenditure:

- NHS funded eye examinations, including primary and supplementary eye examinations;
- Optical vouchers, which are issued to eligible patients to help with the cost of glasses and contact lenses;
- Allowances paid to optometrists for Continuing Education and Training (CET) which is required for continued professional registration with the General Optical Council; and
- Grants paid to practices for supervision of pre-registration trainee optometrists.

While expenditure on optical vouchers, CET allowances and the pre-registration trainee supervisor grant have broadly remained stable in recent years, expenditure on NHS eye examinations has increased in line with rising patient demand. As noted in my previous response, this is mostly in supplementary eye examinations, which prevent unnecessary referrals to the hospital eye service, while ensuring that conditions are monitored on an on-going basis.

While fees for the regular primary eye examinations (which account for around 76% of all eye examinations) have remained unchanged since 2010, additional demand has been driven by the rapid growth of some supplementary eye examination types which are paid at a lower rate of funding. Approximately 85% of supplementary eye examinations involve a £24.50 fee, with the remaining 15% paid at a higher fee of £38.

As a result of the Scottish Government's continued investment in the GOS budget, and specifically the provision of free universal NHS funded eye examinations, more patients are

able to be managed within the community without needing a referral to the Hospital Eye Service – this can be seen in Hospital Eye Service outpatient data that shows, adjusted for population size, Scotland has approximately 50% fewer new patients in ophthalmology than in England, which has a less comprehensive GOS eye examination structure and funding settlement.

I trust that the further detail set out in this letter is sufficient to respond to the Committee's supplementary queries.

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