

Cabinet Secretary for Health and Sport
Jeane Freeman MSP



Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0300 244 4000
E: scottish.ministers@gov.scot

Lewis Macdonald MSP
Convenor
Health and Sport Committee
Room T3.40
The Scottish Parliament
Edinburgh
EH99 1SP

26 November 2019

Dear Lewis

RESPONSE TO HEALTH AND SPORT COMMITTEE ON PRIMARY CARE INQUIRY

Thank you for your invitation to speak to the Committee on 5 November as a contribution to your Inquiry into primary care.

Thank you also for your letter of 12 November seeking further information on a number of areas that were raised during my appearance at the Inquiry. I agreed to write to you to provide this information.

Please find responses to the Committee's questions from the evidence session, as well as responses to the additional questions raised, in the attached annexes.

I hope this is helpful.

A handwritten signature in black ink, which appears to read 'Jeane'.

JEANE FREEMAN

Questions asked at the Committee session on 5 November

The Committee asked:

On the target of 800 additional GPs, you offered to share the Government's modelling on how that figure was reached (Column 43). It would be helpful if your response includes information on how policy, patient and population outcomes were factored into the modelling.

Response:

A detailed response of the Government's modelling and methodology is set out at Annex C.

You also said that an alleviation package would be announced very shortly to help doctors with pension tax bills (Column 44). We would welcome more information on this, including the cost to the public purse? What other ways have been considered to address retention issues with this particular group of doctors?

Response:

The Scottish Government is working closely with stakeholders to explore the options available to mitigate the impact of the UK Government's pensions taxation rules on NHS Scotland staff and service delivery.

On 18 November 2019 the Scottish Government announced a time limited policy which allows those NHS Scotland staff affected by the AA the ability to temporarily withdraw from the NHS Pension Scheme and receive their employers contributions back as a basic pay enhancement of 18.365%. This is designed to ensure that vital staff have an alternative choice to reducing their working hours, thus protecting front line service delivery. The policy takes account of employer's National Insurance Contributions to ensure it remains cost neutral to the public purse. Scotland is the first UK nation to adopt a national approach to recycling of employer contributions.

Pensions tax policy is reserved and any changes to the NHS pension scheme in Scotland require the full consent of HM Treasury. This constrains the changes the Scottish Government can apply. The only way to fully address this issue is for the UK Government to take swift action to review the tax rules that are at the root of this crisis

On the question of Community Link Workers (CLW) you offered to share information on the location of the current cohort of CLWs and information on plans for the CLWs yet to be deployed (Column 48). We would also appreciate information on how the scheme is going to be monitored and evaluated into the future. We do not need to see the evaluation of the pilot projects.

Response:

It is for local areas to manage their plans for implementation, including where link workers should be placed. The Scottish Government monitors progress through the Primary Care Improvement Plans and implementation trackers.

The second set of Integration Authorities' Primary Care Improvement Plans were received in October. From this we calculated that, as at September 2019, there were 112 Community Link Workers now in post. Based on these returns we assess that we remain on track to meet the 250 commitment by the end of this parliament.

As per guidance from the Office of the Chief Statistician, we will not be releasing unpublished data until after the election.

We will write to the Committee again after the election to provide a further update on numbers of Community Links Workers.

The CLW programme is one of the 6 key services set out in the GP Contract MOU – all of these services are monitored and evaluated through the Primary Care Improvement Plans and implementation trackers.

We also published our *National Monitoring and Evaluation Strategy for Primary Care* in Scotland in March 2019. This strategy sets out the overarching national approach and principles for how we will evidence and understand the reform of primary care between now and 2028.

You committed to consider how the concerns and views of patients could be incorporated into the negotiations of Phase 2 of the GMS contract (Column 51). The Committee would be grateful if you could keep us informed of your developing thinking in this area.

Response:

A key objective of the GMS Contract is to improve patient outcomes, and the Scottish Government is committed to engaging comprehensively with patients as part of the development of Phase Two and the impact of Phase One. I note the Committee's particular interest in this matter and I will keep the Committee updated as our plans to do this are developed.

Naureen Ahmad offered to share information to update the Committee on the Scottish Government's response to Professor Sir Harry Burns's review on developing a set of standards and indicators to better understand the contribution of multi-disciplinary primary care (Column 54)

Response:

The Sir Harry Burns' review notes that targets and indicators have an important place in our health and care system but only as part of an overall approach to improvement and learning. The review suggests that our current targets and indicators are, in the main, working and are helpful but that there is a need for a more sophisticated approach with a greater focus on the use of improvement approaches, and avoiding a narrow view of performance.

While the Burns Review did not specifically consider what indicators or measures may be available to better understand the contribution of the primary care multidisciplinary team, the Scottish Government has since developed and published (March 2019) the National Monitoring and Evaluation Strategy for Primary Care in Scotland. This strategy sets out the overarching national approach and principles for how we will evidence and understand the reform of primary care between now and 2028.

The focus of the strategy is informing strategic policy decisions, understanding the impacts of policy at a national level (including the expansion and development of primary care multidisciplinary teams), and being able to provide an evidence-based account of what difference primary care reform has made for individuals, communities, the workforce and the wider system. The strategy recognises the need for a small number of national measures that track system-level progress. To address this we have developed a set of high level indicators across the six primary care outcomes. These are included at Annex 2 of the strategy and will be further discussed and developed with stakeholders over the coming months.

The development of this indicator set follows the model in the Institute for Healthcare Improvement whole system measures white paper¹, which describes the importance of having a balanced set of system level measures which provide:

- A conceptual framework for organising measures of care quality;
- A specific set of quality metrics (that can contribute to the Scottish Government's broader set of strategic performance measures);
- A relatively small number of "big dot" measures which track system level change within primary care at a high level;
- A balance among structures, processes, and outcomes measures.

In line with the conclusions of the Burns Report, to more fully understand the impact of the reform of primary care the evaluation will adopt a phased approach across the ten years, with an evolving portfolio of studies and data collections mapped against actions, activities and intended outcomes to capture learning and analyse the

¹ Martin LA, Nelson EC, Lloyd RC, Nolan TW (2007) "Whole System Measures". IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement.

contribution of different actions and inputs. Early evaluation priorities, as set out in the 2019-20 workplan, include understanding the changing primary care workforce and assessing the progress in implementing the 2018 GMS Contract (including delivery of the Memorandum of Understanding).

Understanding the impact of the reform of primary care sits within the wider context of health and social care integration. Integration Authorities report annually on local performance, with the Ministerial Strategic Group for Health and Social Care (MSG) providing the forum for shared leadership and oversight of progress with integration.

You offered to share with the Committee an update on the work underway in sharing the Emergency Medical Record (Column 58).

Response:

I am grateful to the Committee for its engagement with the public on information sharing. The Scottish Government, having consulted with SGPC, is now going to consult with the Information Commissioner's Office on the expansion of access to the Emergency Care Summary system to community pharmacists, general dental contractors and independent prescribing optometrists, who are vital members of the wider primary care team. The expansion of access to medication information to these clinicians will help them provide safer and more effective care to the people they serve but it is important that this is done in a way which protects people's rights under data protection law.

In addition, SGPC and representatives of Health Boards have agreed a national template information sharing agreement to be used by GP practices and Health Boards. This will support appropriate and secure sharing of information by staff to improve patient care.

You offered to provide the Committee an update on how the Primary Care Transformation Fund was being used (Column 59). The Committee would appreciate if this could include a breakdown of activity by each Integrated Joint Board (IJB), how this activity has been evaluated and how it will inform ongoing transformation.

Response:

The Scottish Government is investing a total of £161.5 million in the Primary Care Fund (PCF) in 2019-20. There are a number of elements to the overall Fund:

- Primary Care Improvement Fund;
- General Medical Services;
- National Boards; and
- Wider Primary Care Support including Out of Hours.

Primary Care Improvement Fund (PCIF)

Primary Care Transformation Fund is the predecessor of the Primary Care Improvement Fund. In 2019/20, £55 million of the £161.5 million Primary Care Fund was allocated to Integration Authorities (“IAs”) (via Heath Boards).

As in 2018-19, these funds are used to deliver the priority services set out in the Memorandum of Understanding:

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

The money delegated through this fund can only be used by IAs to implement primary care improvement in direct support of general practice as set out within the MoU. Our expectation is that any unutilised allocation from last year should be invested in the implementation of PCIPs the following year before accessing new funding.

The Committee raised a concern that Primary Care funding had been used by Edinburgh Integrated Joint Board to reduce debt and not for its intended purpose. My officials have subsequently contacted Edinburgh Integrated Joint Board who have confirmed that the Primary Care Improvement Fund has been used for the purposes for which it was provided and has not been used to reduce debt.

The Memorandum of Understanding (MoU) establishes a national governance framework in which IAs must operate, based on their statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) (“the Act”) in commissioning primary care services and service redesign to support the role of the GP as an expert medical generalist.

The MoU commits IAs to produce Primary Care Improvement Plans (PCIPs) that demonstrate how the funding will enable the redistribution of work from GPs to others and to optimise the role and functionality of the wider MDT.

A full breakdown of activity by each IA is at Annex D.

You proposed to send information regarding the Government's plans for a public information campaign on how primary care is changing

Response:

We continue to work with RCGP and key stakeholders to agree an approach on public engagement for primary care.

A stakeholder workshop was held on 3 July and initial scoping work has been commissioned externally to develop a range of options.

A qualitative research study is underway, and a further stakeholder workshop is being scheduled for the end of this year to discuss findings and develop actions going forward.

Additional asks from the Committee:

In light of the [NHS in Scotland 2019 report](#) which recommended the Scottish Government in partnership with NHS boards and integration authorities should “develop a new national health and social care strategy to run from 2020 that supports large-scale, system-wide reform, with clear priorities identifying the improvement activities most likely to achieve the reform needed”. What steps is the Government taking to meet this recommendation, and what are the anticipated timescales for this?

Response:

We already have work underway to develop our longer term approach and to deliver balanced and sustainable services. As part of this we will continue to engage with our partners across health and social care services, and will set out our next steps in due course.

We are also currently finalising a review of our progress against the delivery plan, and we will communicate this in due course.

What guidance does the Government issue to ensure the quality improvement priorities of GP clusters align with the strategic commissioning plans and outcomes for localities of the health and social care partnerships?

Response:

The Scottish Government published National Guidance for Clusters: A Resource to Support GP Clusters and Support Improving Together in June 2019. The Guidance provides clarity and consistency for the core role and functions of GP Clusters, Practice Quality Leads and Cluster Quality Leads. It describes key relationships for GP Clusters that will ensure quality improvement priorities of GP clusters align with the strategic commissioning plans and outcomes for localities of the health and social care partnerships.

It sets out an expectation that GP Clusters should work with and communicate effectively with locality partners to ensure there is mutual understanding of roles and objectives. This could include working with HSCPs to develop and agree Primary Care Improvement Plans which direct how resources in support of the new GP contract are allocated. GP Clusters can contribute to combined professional advice provided to commissioning and planning processes of the HSCPs and NHS Boards through participation in the GP tripartite group (made up of GP Subcommittees of Area Medical Committees, NHS Board and Integration Authority GP leads, and Cluster Quality Leads).

What specific levers does the Scottish Government have to ensure the new model of primary care best meets the needs of communities and is sustainable?

Response:

Key levers include the new GP contract and MOU, and investment in primary care, including support for premises and a range of workforce initiatives.

The Memorandum of Understanding (MoU) published alongside the 2018 GP Contract, sets out the principles by which primary care redesign will be delivered. The two documents taken together establish the long term vision for sustaining and enhancing General Practice and Primary Care (the 2018 Contract) and the governance framework to achieve it (the MoU).

Importantly, the MoU also sets out an agreed understanding that the specific nature of implementation and related service redesign is required to be in accordance with seven key principles: Safe, Person-Centred, Equitable, Outcome focussed, Effective, Sustainable and Affordable.

The MoU commits Health and Social Care Partnerships to develop and agree their Primary Care Improvement Plans (PCIPs) in collaboration with local GPs via the GP-Subcommittee and Health Boards.

The National Code of Practice for GP Premises sets out plans for Health Boards to provide GP contractors with interest-free secure loans (“GP Sustainability Loans”) to reduce the risk of premises ownership and to support the transition to a model where GP contractors are no longer required to provide their premises. In support of this shift, the Scottish Government has committed to providing an additional £30 million by 2021 (£10 million per year) through the establishment of a GP Premises Sustainability Fund.

The Scottish Government is also committed to recruiting 800 more GP’s over the next decade and supporting and retaining the existing workforce. This is supported by £7.5 million investment in 2019-20 to improve GP recruitment and retention, £2 million of which is specifically to support remote and rural initiatives to attract and retain GPs in rural communities.

We have also committed to a significant expansion of the multidisciplinary team, including the training of 500 advanced nurse practitioners, 250 Community Link Workers to be in place by 2021, and 1000 paramedics to work in the community. General practice will further be supported by ensuring all practices are given access to a pharmacist by the end of this parliamentary period.

How is the Scottish Government fully incorporating the centrality of AHP roles into the strategic planning of health and social care services?

Responses:

We are creating an increasingly robust evidence base for workforce planning decisions through a greater understanding of complex demand and supply issues. This is informing the decisions and actions we take and is enabling us to plan ahead at the point when a workforce issue is identified.

Scenario planning uses evidence-based assumptions that can be revised and triangulated with workforce data. This is an important tool for workforce planning at national, regional and local levels, it can help employers to visualise the workforce they need and inform the decisions they take in the future.

How does the Scottish Government ensure the views of young people are considered in future policy development?

A key objective of the GMS Contract is to improve patient outcomes, and the Scottish Government is committed to engaging comprehensively with patients as part of the development of Phase Two and the impact of Phase One. I note the Committee's particular interest in this matter and I will keep the Committee updated as our plans to do this are developed.

What actions are the Scottish Government taking to meet the recommendations of the Audit Scotland report [NHS workforce planning – part 2](#) on the primary care workforce

Response:

We welcome this report from Audit Scotland. It makes clear the vital role primary care plays in delivering our long term vision of shifting the balance of care towards community and preventative care. We recognise the demographic and recruitment/retention challenges being set out here.

However it is important to note the context which is that the latest figures show a new record high number of NHS staff, with seven consecutive years of growth. This is being supported by record funding as well as an additional investment of £850 million to reduce waiting times.

We have a record number of GPs working in Scotland and we are committed to increasing numbers by at least 800 in the next ten years. We are also investing an additional £250 million in direct support of general practice by 2021.

The new GP contract and investment in multi-disciplinary teams will increase capacity in primary care allowing patients to be seen at the right time by the right person. It will help reduce GP workload, making the career even more attractive to new doctors.

Can you give confirmation of if/when national data on clinical activity and demand in primary care will be available and what this will include? (as called for by the Office for Statistical Regulation). And outline how this will be made publicly available.

Response:

As part of the new GP Contract introduced in 2018, we agreed with the BMA on the need to gather activity and capacity data to contribute to the sustainability of general practice and primary care, as well as to support GPs to identify individuals with more complex needs and to deliver anticipatory care planning more consistently. We have agreed that practices will provide agreed information on consultation rates, consultation types, health care professional being consulted and complexity within consultations.

This information will be extracted using the SPIRE data extraction tool currently being rolled out. We are working with the SPIRE team at Information Services Division (ISD) to develop the specifications of the data extracts.

We're also collaborating with ISD and other Primary Care stakeholders to develop a comprehensive set of statistics and indicators that provide a Scotland-wide, joined-up picture of in-hours data as well as the facility for closer analysis of smaller areas such as Health Boards. ISD are working towards completing this work by Spring 2020, and our work around activity data will inform this work.

This data will be published on the ISD website and therefore available to all users. We will consult with users, working with the Office for Statistics Regulation throughout this process, to ensure this development meets as many user needs as possible.

What steps are being taken to ensure developments in technology are accessible to everyone in the country?

Response:

Scotland's Digital Health and Care Strategy highlights the opportunities that technology offers to empower citizens to better manage their health and wellbeing, support independent living and gain access to services through digital means, and to support a shift in the balance of care. The Scottish approach to Service Design is being adopted for services, with citizen engagement that enables the co-design of products and services that meet their needs and delivers sustainable, fit for purpose service models.

The Committee is particularly keen to understand when you believe that an individual's health records will be accessible to all the primary care professionals that need read/write access?

Response:

If we are to realise our vision for a fully integrated health and social care system we must utilise technology to support new ways of working and to provide health and care teams with the information and tools that they need. At the moment, data sits in many systems and needs to be extracted using a slow, costly process which presents significant challenges around information governance.

Initiatives, such as the development of the National Digital Platform (NDP) and of clinical portals will create an infrastructure that will allow us to collect information and make it available across Scotland. The objective is to have a core data set that relates to the individual and that has appropriate governance around it, so that, whether a person is in any health or social care setting, staff can view the appropriate information that they require in order to offer the best possible care.

We must continue to support and develop digital technology to improve workflow, enable multi-disciplinary teams and ensure our services are fit for purpose. The data available to staff via Clinical Portal and TrakCare, has resulted in improved person centred care and has maximised the available resource to deliver safer and better care for people.

We recognise that much of the data available to staff can only be viewed and improving read and write access for staff is an objective for the NDP. One of the reasons for selecting the ReSPECT work as an initial product for the NDP is that it is intended to be accessible and updatable by people from different disciplines potentially working for different organisations with the effect all of them have access to the same up to date 'single version of truth'. This would only be one component of a single patient record and the process to extend that functionality out more widely will take time.

The newly agreed national template GP – Health Board Information Sharing Agreement also recognises that it can be appropriate for Health Board staff to have read and write access to GP clinical systems. This is an important staff in enabling multi-disciplinary team working.

The Committee have a keen interest in the survey responses you are seeking from GP practices on workforce numbers, activity, income and expenses and would appreciate being updated once that data has been collected and analysed. Please confirm that aggregated data will be made publicly available and periodically updated.

Response:

As agreed with the BMA, activity information needs to be made available to the practice, the cluster, the HSCP and collated nationally to support sustainability,

planning and the evolution of the extended multi-disciplinary team. We expect wherever possible to make information available publicly in accordance with data protection legislation, good practice in publishing statistics, and the Scottish Government's commitment to open data and transparency.

Description of methodology: 800 more GP commitment

Introduction

International comparisons show that countries with health systems based on strong primary care infrastructure have better outcomes in terms of population health, access, co-ordination experiences and a lower and more proportionate use of resources. Studies within countries are consistent in showing greater improvements in health following policy initiatives directed at strengthening primary care, including increases in the supply and use of primary care practitioners and clinical improvements in primary care practice.

Given this evidence, the Health and Social Care Delivery Plan sets out the Scottish Government's vision for the future of primary care. That vision is of enhanced and expanded multi-disciplinary community care teams, made up of a variety of professionals each contributing their unique skills towards delivering person-centred care, and improving outcomes for individuals and local communities.

The commitment to increase the GP workforce by at least 800 (headcount) over the next 10 years was developed via a two-stage process:

- Estimating GP workforce trends over the next ten years using the best available data. This assumed no new interventions to increase workforce numbers so essentially represented the 'do nothing' or 'baseline' position.
- Estimating likely future demand for general practice services, including taking account of current GP vacancies.

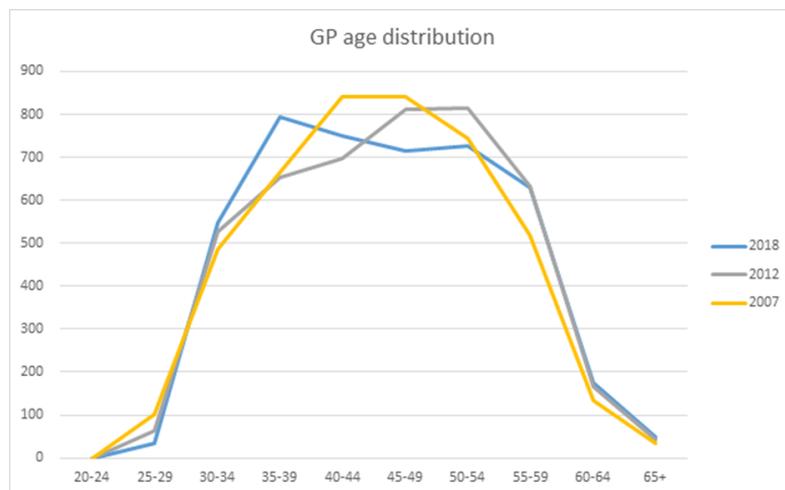
Combining both estimates provided an overall estimate of the potential growth in the GP workforce required to meet future demand. It was recognised (see p55 of the *National Health and Social Care Workforce Plan: Part 3 – Improving workforce planning for primary care in Scotland*) that the commitment to increase GP numbers by at least 800 would require constant monitoring and review, based on better quality data. This includes not only more frequent GP workforce data but data on the scale and impacts of expanding the wider multidisciplinary primary care team.

Estimating Future trends

Using trend data from the past 5 years on the age and sex profile of the GP workforce, the number of newly qualified GPs, rates of qualified GPs joining (e.g. moving to Scotland from elsewhere) and leaving (e.g. through retirement) the workforce, we can model future trends in GP numbers.

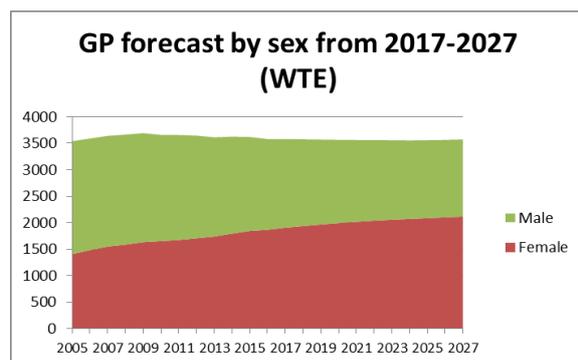
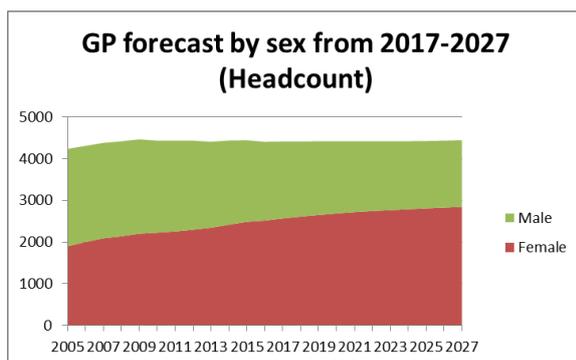
For GP 'leavers', the key issue is retirements, which are heavily age-related. For that reason, age-specific leaver rates were calculated. Since 2012, the GP workforce has become more 'youthful', with a lower proportion over 50 (see plot below). During that

time, we've had relatively high leaver numbers, which is partly (though not entirely) down to large numbers of retirals. All else held equal, this should result in lower leaver numbers over the next few years, as there are now fewer GPs over 50.



For GP joiners, we also calculated age-specific joining rates for newly qualified GPs as well as joiners (or rejoiners) from elsewhere.

Average joiners and leavers rates were applied to 2016 GP data to forecast future years. Whole time equivalents (WTE) were derived from headcounts by applying conversion rates by age group and sex from the GP workforce survey 2015 results. As shown below (and included in the primary care workforce plan, p55), this modelling estimated that the number of GPs in the workforce will remain broadly stable up to by 2027 on a 'do nothing' scenario. This holds whether headcount numbers or whole time equivalent are used in the model.



Using a slightly different methodology, in their recent *NHS workforce planning – part 2 The clinical workforce in general practice* report, Audit Scotland reached similar conclusions that the future GP would remain broadly stable if no additional action was taken.

Addressing future demand

To estimate the potential need for more GPs over the next decade, it was then necessary to consider increases in demand for health care services. To make

projections of the potential scale of the implications of changing demography for the demand for health care, we:

- assume that current rates of provision of health care by age and sex represent the appropriate level of demand for health care;
- assume no change in non-demographic factors such as innovation in medical procedures and drugs, changes in the real cost of health service inputs, and changes in health service productivity;
- combine the rates of provision by age and sex with the NRS population projections (principal variant) to estimate future demand for health care.

This generated a five-year (2019-2023) average increase in demand of 0.9%. A 1% increase in demand equates to an additional 45 GPs (headcount) per year; that is 1% of the current number of GPs as of 2017 (circa 4,500). Over ten years, to meet increasing demand from changing population demographics we would therefore require 450 additional GPs. In addition, there are currently a significant number of GP vacancies across Scotland. The 2017 Primary Care Workforce Survey suggested a vacancy rate of 5.6% of total sessions. This equates to the equivalent of around 250 GPs below capacity.

Taken together, to address existing vacancies and to meet future demand for healthcare services driven by an ageing population, we estimated that the GP workforce would have to increase by additional 700 headcount / 570 WTE over the next decade.

The then Cabinet Secretary for Health and Sport decided that in order to reflect the need for additional capacity a stretching target was required and a commitment of at least 800 more GPs was set. This increase in capacity should be seen alongside the significant expansion of the wider primary care MDT aimed at improving patient experience and outcomes, and reducing GP workload. As noted above, we will monitor and review our workforce commitments as more detailed data becomes available.

Annex D

Breakdown of activity

Allocation by Integration Authority: overview of full £55 million breakdown

NHS Board Name	NRAC Share	IA Name	IA NRAC Share
Ayrshire & Arran	4,066,292	East Ayrshire	1,332,761
		North Ayrshire	1,493,895
		South Ayrshire	1,239,636
Borders	1,157,757	Scottish Borders	1,157,757
Dumfries & Galloway	1,634,556	Dumfries and Galloway	1,634,556
Fife	3,746,267	Fife	3,746,267
Forth Valley	2,985,792	Clackmannanshire and Stirling	1,403,426
		Falkirk	1,582,367
Grampian	5,442,475	Aberdeen City	2,160,984
		Aberdeenshire	2,335,986
		Moray	945,505
Greater Glasgow & Clyde	12,252,662	East Dunbartonshire	996,699
		East Renfrewshire	856,116
		Glasgow City	6,630,481
		Inverclyde	906,493
		Renfrewshire	1,861,561
		West Dunbartonshire	1,001,312
Highland	3,544,391	Argyll and Bute	1,018,692
		Highland	2,525,699
Lanarkshire	6,786,096	North Lanarkshire	3,523,902
		South Lanarkshire	3,262,193
Lothian	8,169,106	East Lothian	1,011,042
		Edinburgh	4,586,942
		Midlothian	867,351
		West Lothian	1,703,771
Orkney	266,311	Orkney Islands	266,311
Shetland	270,286	Shetland Islands	270,286
Tayside	4,317,361	Angus	1,186,724
		Dundee City	1,630,085
		Perth and Kinross	1,500,553
Western Isles	360,648	Western Isles	360,648