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
Convener
Health & Sport Committee

By Email.

1 March 2021

Dear Lewis

RE: What should Primary Care look like for the next generation? Phase II

Thank you for your report published 16 February 2021. The Scottish Government has carefully considered the contents of the report, and welcomes the opportunity to provide responses to all of the referenced points throughout. I attach our responses at Annex 1 to this letter.

Also enclosed are the responses to the questions and comments raised at Annex A of your report, which relates to the *Scottish Government Response to the Health and Sport Committee Inquiry into the Supply and Demand for Medicines.*

I welcome the opportunity to debate the important findings of the report in the Parliament on 3 March 2021. This Scottish Government response to the report should clarify any issues going into the debate next week.

I'd like to take this opportunity to thank you and your Committee for the work undertaken to produce this helpful report. I trust you will find that attached responses satisfactory.

JEANE FREEMAN

Annex 1: Formal Scottish Government response to Committee report

Report Reference Requiring Response	Response Provided
58. We ask the Scottish Government if it accepts the need for a shift in Primary Care to focus more on the needs of local communities and less on ill-health?	The Scottish Government is focused on delivering a world-class public health system that delivers the right care, in the right place, at the right time to improve population health and address inequalities, of which shifting the balance of care is a key aspect. Key integration delivery principles for Integration Joint Bodies' strategic plans, including primary care, are ensuring health and social care services are delivering in a way that is integrated from the point of view of service-users and engaged with the community, including third sector organisations. Specific to Primary Care, one of the key principles of the Memorandum of Understanding implementing the GP Contract Offer is that multi-disciplinary teams are person-centred based on partnerships between patients, their families and those commissioning and delivering healthcare services to provide care which is appropriate and based on an assessment of individual needs and values.
59. We are concerned the guidance on localities could be too narrow and overly focus on the role of the GP. We consider the guidance should be strengthened and take account of the National Clinical Strategy aims to move away from a clinical model and widen locality aims to have more of a prevention focus, and thus seek deliverables before involvement with GPs. The work of the third sector and others in supporting residents must be fully integrated and incorporated into locality planning.	
61. We ask the Scottish Government how this monitoring of community healthcare is achieved and reported.	Progress towards the implementation of the priority areas of the GP Contract Offer as set out in the Memorandum of Understanding is monitored though the completion of biannual trackers and Primary Care Improvement Plans by Health and Social Care Partnerships. These trackers and plans are analysed and findings shared with the National GMS oversight group. The GMS contract forms one crucial part of wider ongoing reforms to primary care in Scotland. Our approach to monitoring and evaluating this wider programme of

	reform is set out in our Primary Care Monitoring and Evaluation Strategy.
88. The impression given from the evidence we heard that the AHPs and others are not part of the MDT requires to be addressed. We are clear AHPs, and others, play an invaluable role in enabling people to live an active life and encourage the Scottish Government to include the full range of staff involved in supporting health care when planning future workforce.	We agree with the Committee that AHPs play an invaluable role in enabling people to live active lives. The 2018 GP Contract Offer states that development of the MDT includes additional professional clinical and non clinical services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services. This workforce requirements for these roles considered within the Integrated Health and Social Care Workforce Plan.
89. Work needs to be undertaken to ensure all, including the public and members of the MDT, recognise other clinicians are able to make independent decisions. And they all share concerns and an interest to identify what matters to patients and crucially what is required to enable them to live the lives that they want to live.	We believe that the best way to deliver relationship-based care to patients is through the effective relationships between the members of primary care multi-disciplinary teams. All professionals involved in patient care have a leadership role to play. Leadership which is intended to improve outcomes for patients will clearly require collaborative working with a wide variety of professionals who will be involved in primary care multi-disciplinary teams. Various members of these teams will also undertake leadership roles to achieve changes and improvements. Depending on health needs a GP may not be the most appropriate person to help – our messaging to the public and health professionals (including the MDT) reinforces the message that delivery of health care is about seeing the right person in the right place in the right time.
90. We note the wider role given to GPs in relation to the management of the MDT within clusters, and are concerned to ensure appropriate training and	Line management of much of the primary care multi-disciplinary team staff will be provided through the employing authority (usually NHS Boards). This will include the provision of employee support, training, cross cover and cover for holidays and other absences. The

skills are provided to them to allow this to be achieved to maximum advantage.	purpose of the line management is to support staff in their role as a member of the primary care multi-disciplinary team attached to one or more practices and their patient lists. GPs, as expert medical generalists, are expected to deliver a clinical leadership role. We are expanding exposure to MDT working through implementing the Gillies Report, giving medical students opportunities to observe the workings of MDT through their placements. This is invaluable experience as they go onto become future leaders. We must not lose sight that all professionals involved in patient care have a leadership role to play. To facilitate this, we are sponsoring the NES/RCGP/ SSSC Leadership for Integration programme aimed at primary and social care professionals that aims to enable participants to lead more collaboratively and effectively in delivering integrated care.
91. We recommend a clear set of performance and improvement indicators are identified for universal use within the national monitoring and evaluation strategy with the results published regularly. We also ask how benchmarking across clusters is to be undertaken, and how learning and improvement is to be disseminated across the country.	An initial set of National Indicators for Primary Care were included at Annex 2 of the Primary Care Monitoring and Evaluation Strategy. We will work with stakeholders to develop these and promote their use as more data becomes available. Public Health Scotland have developed a set of Cluster profiles which enable comparison of data between GP Practice, Cluster, Health and Social Care Partnerships, Health Board and Scotland.
92. We recommend the national monitoring and evaluation strategy make clear the linkages between the MDT and clusters and identifies ways in which the effectiveness of the MDT can be assessed.	Noted. One of the key evaluation questions set out within the Strategy relates to the impacts national programmes and investment have had on supporting the development of extended MDTs, and why.
93. We also repeat the question posed in our report on the supply and use of Medicines and ask when all GP practices will include pharmacy staff. And we seek confirmation appropriate adjustments have been made	H&SCPs have indicated around 90% of practices report having full or partial access to level 1 pharmacotherapy services as at August 2020. We anticipate that all practices will have access to pharmacy staff by 2022/23.

to the number of pharmacy training places to allow this to be realised and maintained.	There are approximately 240 students each year who graduate from the two schools of pharmacy in Scotland. To support the pipeline of new pharmacists we extended the number of NHS pre-registration pharmacists places we fund nationally from 170 to 200 in 2018, which seen a further 30 pharmacist trainees stay in Scotland to complete their pre-registration training. From 20/21 pre-registration places have increased again to 215, further increasing the pipeline of new pharmacists.
106. We note information to be collected under SPIRE goes some way to allowing MDT output and outcomes to be assessed, but ask the Scottish Government when this will be available and whether it will be available to practice level thus allowing learning from best practice areas to be identified. As part of phase 2 of the GP contract it is essential there is a requirement on the MDT to provide data on activity, salaries and other costs.	We note the Committee's recommendation regarding phase 2 of the GP Contract. Work is ongoing to understand practice workload, including MDTs. Work to date has included an initial sample data extract from SPIRE, from practices who opted in to the data request, and discussions with the GP profession and health analysts about appropriate ways for accurately measuring activity and complexity. In addition to exploring electronic data extracts from GP systems we are also undertaking bespoke surveys with practices just now. Practice level data is being shared with the practices that have completed the survey, to help them identify trends at a practice level.
107. We also recommend all HSCP primary care improvement plans make clear the role of all staff within the MDT. We would also like to see more plans giving lead roles to other members of the MDT and the wider community including third sector representatives.	HSCPs should establish local arrangements to provide them with advice and professional views on the development and delivery of the Primary Care Improvement Plan. Arrangements will be determined locally and will take account of the requirement to engage stakeholders. A key part of the Primary Care Improvement Plan is to outline how the MDT will be developed at practice and cluster level to deliver primary care services in the context of the GP Contract Offer Delivering improved levels of local care in the community must rely on effective collaboration between GPs, HSCPs, NHS Boards and other partners, both in and out of hours, valuing the respective contributions of those who deliver these services. Community Link Workers also

	have an important role in in bringing general practice and third sector services closer through mapping community assets and raising awareness amongst practice staff of support for patients that they can tap into. This will require clear articulation of the respective roles and responsibilities of GPs and other members of the primary care team both generally and in respect of each of the services set out in a HSCP Primary Care Improvement Plan. We are also sponsoring HIS to deliver the Practice Administrative Staff Collaborative focusing on the development of practice admin staff to implement safe and effective processes to improve to improve care navigation to make the best use of GP practice appointments and resources in order for patients to be seen by the right per at the right time in the right place. The Pharmacotherapy Collaborative is also working with GP practice teams and pharmacy staff to bring together their collective experience and develop a national package to support the transition of patients from repeat prescriptions onto a serial prescription.
108. We recommend the Scottish Government review annex 3 of the national monitoring and evaluation strategy to widen those who are responsible for contributing evidence, to include those practising within and supporting the MDTs.	The Scottish Government is committed to make best use of evidence from across the MDT, including from those involved in the delivery of care. We are also due to refresh membership of the Scottish Government's Primary Care Monitoring and Evaluation Strategy Steering Group, which already had good MDT representation. The Primary Care Evaluators Network, hosted by Public Health Scotland, similarly has strong MDT representation.
109. We were also told the Scottish Government had agreed with the BMA the need for practices, clusters and HSCP's to have available activity information. We ask the Scottish Government what information this will contain, when it will be available and how it will be made available in the public domain.	A survey is currently live with practices in Scotland, offering them a chance to provide weekly information on the number of appointments (broken down by type) undertaken each week, as well as the total number of possible appointments in the week. The survey also asks about GP and MDT staff time in a given week. We ask about any staff- hours lost (e.g. due to illness, annual leave) that couldn't be covered (e.g. by locums). Taken together these give a crude measure of demand in the system. Practice level data is available to each practice that has completed the survey via a secure database and will be updated

	weekly. Public Health Scotland are working on providing Scottish Government with aggregated Scotland level data for analysis.
114. We acknowledge the Government's commitment to increase GP numbers is intended to strengthen primary care, but it appears to reflect the position before agreement on the new contract, with its much greater emphasis on the Multi-Disciplinary Team. We recommend this commitment is recast, to commit to an appropriate number of MDT professional staff, including both GPs and other professions, which can deliver the intended benefits to primary care as a whole.	We note the Committee's recommendation. The Integrated Workforce Plan for Health and Social Care incorporates workforce requirements of all elements of the MDT within Primary Care and includes specific commitments to recruit additional numbers of physios and community link workers as well as GPs.
123. We ask the Scottish Government to provide the updated costs of the hubs and indicate the numbers of patients they have seen and detail how the impact this has had on primary care and A&E services are being monitored.	We have delivered around £30 million of investment to Health Boards in 2020-21 to set up and run the pathway. GPs do, however, work in the centres. Where they do, they will have local arrangements with their boards in terms of pay – there is no national pay position for working in the pathway. Between 23 March 2020 and 10 February 2021, over 280,000 consultations for advice or assessment were conducted through community hubs and assessment centres. The Community Pathway was developed at the start of the pandemic as a new patient pathway, specifically to meet the new demand from patients presenting with Covid-19 symptoms in the community.

	Their introduction meant that the majority of the increased caseload associated with COVID were diverted away from GP practices and A&E services and through the Community Pathway. As part of this system-wide endeavour GPs do, however, work in the centres.
129. The Committee believe in future workforce planning within primary care, must also take account of the third sector.	We note the Committee's recommendation. Revised workforce planning guidance for NHS Scotland, Integration Authorities and their commissioning partners in local authorities was published alongside the Integrated Health and Social Care Workforce Plan. This guidance references the need to consider the implications of planning activities for third and independent sector employers delivering commissioned services.
139. We recognise addressing this lies principally with Health and Social Care Partnerships and we would urge them to lead the design of more holistic and seamless primary care services with the primary focus on patient needs. There is an opportunity for HSCPs to incorporate innovative design thinking into PC Improvement Plans. Designs that include consideration of all aspects and representatives of the wider primary care team, hubs, out of hours services, and including third sector partners and essentially with public involvement in the design.	Guidance issued to HSCPs around the development of Primary Care Improvement Plans clearly set out that they should consider how the new MDT model will align and work with the wider community based (and where relevant acute) services. To ensure that the provision of any new or reconfigured service has a patient-centred approach to care based on an understanding of patient's needs, life circumstances and experiences it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. In terms of the guidance HSCPs should ensure that engagement with patients and third sector bodies is a key part of their Primary Care Improvement Plans.

157. We consider prevention activities should also be delivered elsewhere, such as through schools, in the workplace and through community initiatives. We look forward to seeing how this will be encouraged by Public Health Scotland working with GPs and other public agencies.	Public Health Scotland have prioritised the following programmes of work to support and maintain communities that are inclusive, empowered, resilient and safe: • Co-creating healthy, sustainable places • Local data and intelligence • Housing and homelessness • Health harms. By developing a wider reach across local ecosystems using data and actionable intelligence, the PHS Local Intelligence Support Team is supporting local systems to come together for joint planning and focus their collective efforts with citizens at the heart of an outcomes focused approach. This creates improved opportunities to shift the balance of care wider into community sectors and third sector organisations. Public Health Scotland undertakes a broad range of partnership work with schools, colleges and universities, employers, workplaces, prisons, communities and third sector-based services to empower and support people to take greater responsibility for their own health.
161. We agree with the Scottish Government on all of this, and ask for detail as to how a move towards the prevention of illness is going to be enabled and by whom. Also, how are the public are to be empowered to take more responsibility for their own health and within what timescale all of this will take place.	Following significant cross-sector engagement, in June 2018 the Scottish Government and COSLA published six Public Health Priorities - a 10 year foundation for whole system action that encompassed social, economic and physical environments. They support national and local partners across Scotland working together to improve healthy life expectancy and reduce health inequalities in our communities. Action on Scotland's public health priorities will continue to prioritise preventative measures. We will continue to work closely with Public Health Scotland and COSLA to support local partnerships to enable them to create the conditions for good health across our communities. For example, by bringing together multi-disciplinary teams working closely with communities and supported, where appropriate, by national teams' expertise and knowledge.

	Making it Easier - Scotland's Healthy Literacy Action Plan (2017-2025) sets our plans to support people to have sufficient knowledge, understanding, confidence and skills to cope with the complex demands of modern health care. Meeting people's health literacy needs and communicating in meaningful ways empowers them to be active members in their healthcare. This is key to delivering person-centred care and builds toward shared decision making and self management for people with long term health conditions. It also improves the safety and effectiveness of the care we provide, and helps address health inequalities.
178. Efforts must be made to make social prescription accessible to all, including making better use of existing community facilities (places of worship, school, community centres). We reiterate the recommendation made in our December 2019 report, Social Prescription, an investment, not a cost, that 5% of Integrated Authority budgets should be allocated for social prescription.	As the Cabinet Secretary for Health and Sport advised the Committee in her February response to the Committee's report on social prescribing, the Scottish Government recognises and values the contribution which social prescribing can make to helping people to take part in physical activity and sport, as well as to experience the physical and mental health benefits of a wide range of other activities available within their local communities. The Scottish Government has committed to establishing a short life working group to examine social prescribing of physical activity that will identify and communicate examples of best practice and co-produce resources for practitioners. The establishment of the Working Group has been delayed by the COVID-19 pandemic but will recommence shortly. We continue to work with partners who are delivering social prescribing initiatives. As previously explained, The Public Bodies (Joint Working) (Scotland) 2014 Act places a duty on Integration Authorities to create a strategic plan for the integrated functions and budgets that they control, and how they will best meet the needs of their local population. In developing and publishing their strategic commissioning plan, each Integration Authority should undertake a strategic needs assessment to ensure that they can best match resources to local need. Therefore they are best placed to fully understand what would work well for their population. We would encourage integration authorities to regularly review

	their policy on social prescribing with their stakeholders and decide on the resources that they can direct to this.
185. We recommend the Government lead work with GPs, HSCPs, Health Boards and the NHS on devising an information campaign to inform the public on what their primary care service will look like, what they can expect and when, consult them on their priorities and bring them along with the required transformation.	Throughout the pandemic we have engaged closely with the public regarding how the delivery of primary care services has changed because of Covid and to support effective care navigation - particularly the role of self-care, NHS Inform and Community Pharmacy. Recent key pieces of work include a national door drop containing a 12-page '*Guide to NHS Scotland Services this winter*' booklet. We have also developed a new NHS Inform primary care landing page featuring Q&A videos with representatives from the four independent contractor groups, and created a digital communication toolkit providing resources for practices, professional bodies, HSCPs and NHS Boards. We have also worked closely with HIS on their *Care Navigation in General Practice: 10-Step Guide* and accompanying workshops to help support practice staff communicate effectively with patients. In response to the work published by the ALLIANCE and HIS Community Engagement team, we will work with HIS and NES to develop an integrated package of support to enhance the development of practice administrative staff and work collaboratively with general practice to provide effective training about clear, inclusive communication with patients to improve accessibility. We will work with NHS24 to continue the roll out and utilisation of gp.scot practice websites and with digital and ehealth colleagues on the utilisation of Near Me, Digital Asynchronous Consulting and other supplementary digital channels in general practice post-covid. Prior to the pandemic, work had begun on developing a national conversation with the public on what primary care services will look like in the future. This work had to be paused but is now resuming and will engage with key stakeholders and patients to build on the findings of the ALLIANCE and HIS reports. We will continue to work closely with colleagues in urgent

	care and elective care in order to take a person centred, whole system approach to primary care transformation.
206. While we recognise some actions will have been completed, and the following section of this report will update with information we have received since Covid struck, we ask the Scottish Government for an update on each of the above recommendations. For each of those which have not been implemented and/or are not fully functioning, the update should detail the reasons and provide the expected date when implementation will have been completed.	The Digital Health & Care strategy was informed by the External Expert Panel based on their extensive learning from around the world. We carefully considered their recommendations and they fed our priorities which were identified under 6 key Domains. We will update on progress as part of the Digital Health and Care strategy refresh this year.
217. We ask the Scottish Government to set out its expectations of the role of Health Boards and the IJB's in developing and implementing new IT systems and ways of working and how consistency across the country can be assured.	We work closely with NHS Boards and Local Government Digital Office (COSLA/ Health and Social Care Partnerships) to plan and manage the transition process and, through our revised governance, will continually review existing projects and investment to ensure best value and alignment to future strategic direction. We have recently established a Digital Citizen Delivery Board (Chaired by Peter McLeod of Care Inspectorate) and Enabling Technology Board (Chaired by Ann Moises) reporting into a Strategic Portfolio Board co-chaired by Jonathan Cameron, Scottish Government and Lorraine McMillan, Chief Executive at East Renfrewshire Council Our strategy refresh will also re-confirm the joined-up nature of the strategy and will continue to be a joint strategy with COSLA with an important emphasis on collaboration.
218. We ask the Scottish Government and Health Boards if they believe their current IT investments are	Evidence and evaluation is critical to supporting implementation of digital health. For example, Near Me has been subject to two separate independent evaluations from Oxford

adequate for the services they aspire to provide? And we ask them to indicate how they evaluate and measure the strategic value received from digital investment and how they will ensure IT spending on IT infrastructure increases to at least 4%.	University, the findings from which have directly influenced how, when and why video consultations are best used, including in primary care. In conjunction with work underway as part of the wider Digital Strategy for Scotland, we are developing a benefits realisation and measurement framework to ensure best value and maximum impact from digital health & care investment. As part of the National Business case for Hospital Electronic Prescribing and Medicines Administration (HEPMA) it was recommended that there was a strategic approach to shared learning in relation to implementation and resource. In October 2020, Healthcare Improvement Scotland (HIS) through the Area Drugs and Therapeutics Committees Collaborative (ADTCC) began the strategic approach to shared learning through development of a learning system. The learning system will create a systematic approach to sharing knowledge gained and identifying challenges during implementation and business as usual. A Shared Learning Network has been set up to enable the learning system function and provide a link to all the NHS Boards. The strategy refresh will still have many of the same core principles and values from the 2018 Strategy. We will look to build up the digital maturity of our organisations and explore opportunities for further shared learning networks.
219. We also request the Scottish Government to provide a clear timeline on when they expect the “One for Scotland” approach to be fully operational.	“Once for Scotland” has been a long standing direction of travel for digital health and as such is already fully operation. As a result of Covid we have saw accelerated, “Once for Scotland”, approach for Near Me video consulting, Microsoft Teams implemented across our NHS estate, Information Sharing barriers addressed at speed, digital supporting our care home residents, greater remote monitoring and self-management of conditions from home. We have also saw a greater emphasis on quality assured public information being made available via NHS Inform which is Scotland's national health information service.

	We will continue to progress with “Once for Scotland” opportunities wherever possible but it is more important that we are flexible, user led and be adaptive to meet the needs of different people across Scotland.
222. We ask the Scottish Government when the new strategy will be published and what evaluation of success of the 2020 strategy has been undertaken. We also seek an indication of when the strategy will be delivering outcome data relating to the use of medicines.	The refreshed Digital Health & Care Strategy will be published by Summer 2021. The strategy refresh will still have many of the same core principles and values from the 2018 Strategy. We will look to build up the digital maturity of our organisations as well as our workforce capabilities, developing our core IT infrastructure and adopting the Scottish Approach to Service Design. The benefits realisation work and measurement framework will help us evaluate what we have done and what we are planning to do in the future. To date this work has highlighted some areas of improvement in the previous strategy, most notably around data – for example, who owns it, who controls it, who directs its use and how it is maximised for public benefit. The refresh will see an increased emphasis on some key and important emerging areas – Data, Vaccines, Digital Inclusion and Climate Change.
224. We ask the Scottish Government to update progress on this empowerment and indicate when the new service delivery models referred to will be delivered and available to the public?	Throughout remobilisation and adult social care planning we have seen a real emphasis on digital capabilities being increased and far more areas are interested and engaging in digital work. In the Programme for Government 2020, we committed to making Near Me a default option in how people can access health and care services and we expect that to continue to grow. We will also see digital being used more to engage and manage peoples conditions from home. An example being the work being taken forward by Local Government Digital Office to move to a digital telecare service to see how important a step change that could mean for the 180,000 users of telecare in Scotland. The opportunities are there and it is an important

	that we build on this cultural change to adopt digital first approaches wherever possible so that they become an integral part of our business as usual processes. We have learned a lot about developing digital services during the pandemic. Digital inclusion is now more than ever at the forefront of almost anything that we do and is a joint responsibility for everyone. Before the New Year, we supported almost 50% of our care homes to increase their digital capabilities, providing them with a device (iPad) and connectivity if it was required to support their residents to stay connected and access public services as part of the Connecting Scotland Programme. We are committed to having in place a clear approach to developing the modern workforce and the necessary leadership to drive change. A suitably skilled and diverse workforce, with user design at its heart, is essential for the delivery of integrated care and embrace new ways of working. The Digital Citizen Delivery Board oversees the successful development and delivery of digital programmes and approaches across health, care and housing empowering citizens to better manage their health and wellbeing, support independent living and gain access to services through digital means. This includes an appropriate focus on service design, citizen engagement, culture, skills, scale up and implementation. The vision for the Scottish Approach to Service Design will be reflected in our strategy refresh.
226. We ask the Scottish Government the extent to which this remains the position and how such tensions are being addressed.	This is an issue we monitor closely. We will soon publish a National Information Governance (IG) review report which will inform the wider Digital Strategy refresh later in the year.
236. We applaud the widespread adoption of Near Me and ask the Scottish Government to indicate how this	We recognised in the Programme for Government 2020 that this will continue to be a core component in delivering modern health and care services going forward. What we've done

is being monitored and evaluated. In particular, what steps are being taken to ensure its use is patient-centred and not simply being adopted to meet the needs of clinicians? We recognise the significant benefits that can accrue from its use as a triage tool but have reservations that a default use may widen health inequalities and ask the Scottish Government how this potential problem is being addressed.	by developing a service like this is not only allow a minimum level of service to continue but crucially we're moving toward a place where we can routinely offer the public more choice over how they engage with our health and care services and we must embrace that as service providers. The original development of Near Me service in Scotland was in response to equality issues raised, and, around remote and rural and socio-economic impacts. The early development of the service was co-produced with service users, public, partners and academics. The equality impact analysis has further helped with the identification of potential impacts of Near Me on people with protected characteristics. The process has helped us to shape our plans for ongoing public and staff engagement so that we can address and mitigate any potential negative impacts and improve use and access of Near Me. A copy of the published EQIA is available at: near-video-consulting-programme-national-equality-impact-assessment.pdf
254. We recommend the Scottish Government take steps to ensure the Cabinet Secretary's view on the question of data ownership is reflected in reality, either in terms of the second stage of the GMS contract or in the roll-out of the Government's e-health plans.	Noted. The Scottish Government is clear that patients need to have a voice in understanding of and influence over, how patient data is used to help ensure the provision of care. Our work on the refresh of the Digital Health & Care Strategy will help inform the creation of a dedicated Data Strategy for Health & Social Care in Scotland which will help align major programmes of work together. The data strategy will look to address the issue of ownership, also highlight the work we are doing with NESTA on data dialogues and a recent report they published as part of that (Dialogues about Data: Building trust and unlocking the value of citizens' health and care data | Nesta)

Supply and Demand of Medicines Report Responses

Report Reference Requiring Response	Response
1. Progress in establishing the short life working group to examine social prescribing of physical activity, its remit, membership and deadline for completion of its work	As noted in various recent updates to the Committee, the Scottish Government has committed to establishing a short life working group to examine social prescribing of physical activity that will identify and communicate examples of best practice and co-produce resources for practitioners in the many roles which make up the overall system. As also recently advised, the establishment of the Working Group has been delayed by the COVID-19 pandemic, in the light of the extraordinary pressures on the healthcare sector at this time. Work to establish the group will resume as soon as it is feasible to do so.
2. Progress in establishing tracking monitoring arrangements for the new pharmacotherapy service introduced as part of the 2018 GMS contract and when the first report on this will be available	One of the early priorities identified in the Primary Care Monitoring and Evaluation Strategy as understanding the implementation of the Memorandum of Understanding, including Pharmacotherapy, and the 2018 GMS Contract for GPs. We are reviewing the strategy and associated workplan in the light of covid and will publish a refreshed plan for 2021/22.
3. How many Community Link Workers are now in post;	We remain on track to exceed our target of recruiting 250 Community Link Workers across Scotland by the end of the Parliament. As of March 2020 there were 217 Community Link Workers in post, all of whom have played a crucial role in supporting patients during the pandemic and helping those who are shielding.
4. Details of the process under which Link Workers have been allocated and which practices they have each been associated with	Community Link Workers are allocated based on local need in each area. Integration Authorities make decisions on implementation, including how many links workers they need, their key deliverables, and where they are placed, therefore ensuring local areas have the autonomy that was agreed with Chief Officers at the outset of the 250 national commitment, and to enable local areas to use their local knowledge to best make use of resources. Data

	on where Community Link Workers are placed is held by Health and Social Care Partnerships
5. When the first monitoring report of the new GMS contract will be available showing progress in this area;	As above, one of the early priorities identified in the Primary Care Monitoring and Evaluation Strategy as understanding the implementation of the Memorandum of Understanding, including Pharmacotherapy, and the 2018 GMS Contract for GPs. We are reviewing the strategy and associated workplan in the light of covid and will publish a refreshed plan for 2021/22.
6. What training is provided to health professionals including specifically GPs to ensure they are competent in the areas set out in the WHO Global Action Plan for Physical Activity	Public Health Scotland has developed a range of training and other resources for health professionals, including GPs, to support them in incorporating the National Physical Activity Pathway (NPAP) into existing practice. These were set out in our responses to the Committee's Enquiry into the Social Prescribing of Physical Activity and Sport, to the Supply and Demand for Medicines Report. This included the NPAP implementation guidance, e-learning opportunities such as the new Encouraging and Enabling Physical Activity module, and resources such as Moving Medicine. Public Health Scotland is also working with academic partners and physical activity providers to co-produce Quality Standards for Physical Activity Referral, to achieve greater quality and consistency in the design and delivery of referral programmes in Scotland.
7. What evidence they base the statement upon that "We believe that we continue to make progress on social prescribing and changing the culture of the way healthcare is practised in Scotland" with specific reference to social prescribing;	Our response to the Committee's report on the Social Prescribing of Physical Activity and Sport set out wide-ranging areas of work across the Scottish Government and partner organisations to realise the benefits social prescribing can bring. These can be summarised as: • Building capacity in primary care and other settings to provide integrated support which includes a social prescribing element, e.g. community link workers and mental health workers;

	• Delivery programmes and support for community-led initiatives aiming to increase physical activity, improve overall physical and mental health, and/or tackle health inequalities; • Supporting local work to develop effective interfaces between healthcare practitioners and community-based programmes.
8. Where the data required under National Physical Activity Pathway guidance is reported and published in line with the guidance produced by NHS Health Scotland and how the results are being monitored and compared across Health Boards;	NHS Health Scotland conducted an audit of NPAP implementation in 2017/18 which evidenced some implementation across all NHS Boards. An audit of NPAP across all NHS Boards in 2020 by Public Health Scotland was postponed due to the COVID-19 pandemic, and will be rescheduled when feasible.
9. Confirmation the e-learning module "Encouraging and Enabling Physical Activity" which supersedes the e-learning module "Raising the issue of Physical Activity has been launched and details of usage to date;	The e-learning module 'Encouraging and Enabling Physical Activity' was launched on the 16th December 2020. As of 14th February 2021, 201 practitioners have completed the e-learning module.
10. When production of the delayed Quality Standards for Physical Activity Referrals will be completed and published	As stated in our response to the Committee's Inquiry into the Supply and Demand for Medicines, the development of the Quality Standards for Physical Activity Referrals has been delayed due to the COVID-19 pandemic, with many stakeholders from the leisure and fitness sector unable to engage in the co-production process as planned. It is now anticipated that the Standards will be ready for publication by summer 2021.
11. When the evaluation of mPower designed to create cross-border services for older people living with long term conditions will be concluded and reported	The mPower Project remains an important priority as it seeks to develop innovative cross-border services for older people living with long-term conditions. The project's funding body, the SEUPB, approved an extension of the project on 27th January 2021 which permits implementation activities to extend until 31st May 2022. The project evaluation will be concluded by 31st July 2022. mPower is on track to deliver its targets on digital interventions

	and wellbeing plans, as well as shared learning activities. The mPower team have received a mid year preliminary evaluation report and are using these findings to inform their approach.
12. When the blood pressure taskforce will report its findings and when the various evaluation studies in progress will be reported;	The impact of Scale-Up BP on long term blood pressure control and on heart disease and stroke is being evaluated by a joint Napier and Edinburgh University project led by Janet Hanley and funded by the British Heart Foundation. This work was delayed due to covid-19 but has now restarted. As this is looking at long-term outcomes it does not report until 2023 however we expect there will be some interim findings. In parallel with this, the TEC Programme will be providing a report on the roll out of the system which will be available by September this year. The High Blood Pressure Task Force was put on hold due to COVID-19 but are now looking at how to embed the aims, objectives and membership of that group within the new Heart Disease Improvement Plan. The following publication was published in June 2020 and underlines the beneficial effects of telemonitoring on BP lowering Telemonitoring at scale for hypertension in primary care: An implementation study (plos.org)
13. What targets have been set for the various programmes established to support and build capacity among community organisations who are contributing to improve the health and wellbeing of people in Scotland, what monitoring and evaluation is taking place and what progress has been made since the targets were established;	No specific targets have been set. The approach to monitoring and evaluating specific policies will be developed and agreed with stakeholders on a case by case basis.
14. When ALISS will be brought up to date;	A Local Information System for Scotland (ALISS) is a web-based resource which maps community assets and connects people with local sources of support that will enable them to manage their own health conditions more effectively. It is available online across Scotland to both the public and healthcare practitioners. Funded by the Scottish Government and

	delivered by Health and Social Care Alliance Scotland (the ALLIANCE) - The system was co-produced with people living with long term conditions and is available to be used as a support for social prescribing and primary prevention activities. The ALISS team continues to work with a range of groups and individuals who have information to contribute through partnership and engagement activity. The Team collaborates with organisations to take responsibility for adding and updating their own information to ALISS. There are also options for others including citizens and professionals to participate in adding and managing this information. As part of developing and building the system, the ALLIANCE has been working in partnership with NHS 24 and Macmillan Cancer Support to develop Scotland's Service Directory, which forms part of the NHS Inform website. Through this partnership the information contained in the ALISS database can also now be accessed through Scotland's Service Directory alongside other information provided directly by individual Health and Social Care Partnerships providing a more comprehensive picture of statutory, Third Sector and community resources available across Scotland." Through a service design approach to both technical development and engagement activity ALISS has a continued focus on delivering an improved service driven by user needs. Following recent research and stakeholder feedback there are plans to implement improved functionality and governance processes to how its data is reviewed and maintained. This includes automatic notification reminders for users contributing information and review periods for information listed.
15. While recognising it takes time for the impact of interventions under the healthy living strategy to prevent ill health and reduce health	We published the Diet & Healthy Weight Monitoring Report in October 2020. As set out in the report: • The publication reports the latest results against the obesity indicator framework originally developed to monitor progress against the Scottish Government's Prevention of

inequalities to be realised, what measures have been established to enable this to be undertaken and when does the Scottish Government expect information to be reported. In particular, when will the effects of the current pandemic in these areas be reported	Obesity Route Map published in February 2010. The Route Map has now been superseded by the Diet and Healthy Weight Delivery Plan and Active Scotland Delivery Plan published in summer 2018. New monitoring and evaluating arrangements for these plans will be established and will include reviewing the future of this publication. • This is a compendium publication bringing together data mostly already published by various other sources. At the time of reporting, there were no new data available for the prevalence of type 2 diabetes, total and saturated fat, free sugars and healthy living awards indicators. In terms of monitoring in relation to the pandemic, the following may be of interest. • Scottish Health Survey - gov.scot (www.gov.scot), which includes among other things, **Scottish Health Survey: 2020 update**. • Food in Scotland Consumer Tracking Survey Wave 10 | Food Standards Scotland • COVID-19 Consumer Tracker Wave 5 | Food Standards Scotland • Exploring the impact of COVID-19 on food and drink retail purchasing patterns in Scotland | Food Standards Scotland • The Scottish Diet - It needs to change 2020 update | Food Standards Scotland
17. When the 2013 audit of school sport facilities will be updated and what progress has been made since that audit in widening access to school Facilities	As set out in our response to the Committee's Inquiry into the Supply and Demand for Medicines, Sport Scotland has been working with local authorities to encourage and support them in widening access to school sport facilities following its audit of community access to school sport facilities conducted in 2013. Although this work has been affected by the COVID-19 pandemic, this has involved working in partnership with local authorities to support various aspects of their planning, including facilitating the development of local sport and sport facilities strategies, and supporting operational planning at individual school level, including developing Community Sport Hubs within schools.
18. Having recognised the importance of long-term funding stability for the third sector when	We recognise the importance both of long-term funding stability and of timely payments for the third sector to fulfil its vital role in Scotland's communities. The Scottish Government has committed to seek to extend three-year rolling funding where possible and we are

will the Scottish Government start allocating them three-year contracts	actively progressing this work. To provide early certainty, our practice is wherever possible to confirm future grant offers before the preceding funding period ends. We are of course constrained to a degree by the wider UK budget cycles and single year payments Obviously this has serious implications for the Scottish Governments ability to invest over the longer term. We hope that future UK Spending Reviews will offer sufficient multi-year budget information to better enable longer-term funding arrangements.
19. When Integration Authority strategic plans covering social prescribing will be reviewed	The Public Bodies (Joint Working) (Scotland) Act 2014 places a duty on Integration Authorities to develop a Strategic Plan for integrated functions and budgets under their control. These plans should be based upon a Strategic Needs Assessment of local people's needs, taking account of specific care groups including those with long term conditions. All Integration Joint Boards have a current Strategic Plan and the PBJW Act places a duty upon the IJB to review the plans every three years.