Dear Cabinet Secretary for Health and Sport,

Primary Care in Scotland

Following the conclusion of our brief inquiry into GP and primary care hubs the Committee have asked me to write to you with a note of our thoughts and seek further information on a range of areas which arose. Also included within this letter are our views in relation to GP workforce and recruitment. While the focus of this letter is on GP’s we are undertaking a separate piece of work considering recruitment and retention relating to other health professionals and will be writing on that subject later this year.

As part of our autumn inquiry work we held two evidence sessions, received a number of written submissions looking at what we termed GP hubs as well as hearing from yourself. This was an attempt to understand ongoing proposals and work designed to put general practice and primary care at the heart of the healthcare system.

We recognise “there is a growing consensus the NHS needs to focus on the development of preventative models of care. This is driven by the on-going financial challenges facing the health care system, with rising demand and relatively flat funding in real terms. Such approaches focus on proactive rather than reactive management of patients with long term conditions and multi-morbidities. Clearly GPs...
are at the centre of care provided in the community, and are able to influence the level of demand for other care settings."

- We are grateful for the outline information in this regard provided in the annexe to your letter of 17 October and would welcome hearing the detail of the ways in which preventative spending is being evaluated and its cost effectiveness assessed.

At the outset we understood this to be a complicated and wide ranging transformation agenda which in its current guise is in its infancy and consequentially in many aspects it would be premature to come to definitive conclusions. However we are clear the success of this work is fundamental to the delivery of transformative and preventative healthcare, changes which are imperative if, given current demographics and financial challenges, appropriate care is to be provided to the population.

Even in a short inquiry we encountered no shortage of effort or initiatives. Initially it was difficult to identify clearly the fundamental purpose. Our first witnesses described 3 types of hubs and we later discovered there were (at least) 85 test sites to provide new models of care, 2 community hub test sites and 8 test sites relating to out-of-hours care. And at every turn we discovered a range of (central) funding being made available to support these developments.

We also heard about the decline in investment in primary care in recent years and your ambition to increase the percentage of overall central health spending in primary care to 11% which we welcome.

- Can you provide an indication of when you would expect this ambition to be reflected in the Scottish Government’s budget?

Shared Vision?

Primary care is the main point of contact for the public with the NHS and deals with the majority of patient contacts.

There is no shortage of vision for health in Scotland, whether it be the 2020 vision, the National Clinical Strategy for Scotland, the integration of health and social care or the CMO’s work on Realistic Medicine and we were interested to identify how this initiative fitted in and what it was primarily designed to achieve. Are, as was suggested by the First Minister, these hubs the future model for the delivery of primary health care?

We were told most, if not all, of the initiatives were being driven locally to meet a multiplicity of needs both urban and rural as well as a wide range of demographics. This we were advised was not a top-down initiative but being driven locally to meet local needs.

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1 Deloitte report for the RCGP “Spend to Save: The economic case for improving access to general practice” 2014
We heard agreement on one aspect of commonality in relation to multi-disciplinary working and of working closely together which are clearly imperatives if the transformation is to be delivered. At its heart we consider the GP hub has to be about the way the public access services and the way in which the staff providing services access the patient.

**Who's involved in making this work?**

There was less agreement as to who would be involved in working together, the “dream team”. During the course of our inquiry we noted, at various times, the following participants would be involved:

Advanced Nurse Practitioners
Allied Health Professionals
Community Nurses
Debt counsellors
Family Nurses
GP’s
Health Visitors
Link Workers
Mental Health Professionals
Occupational Therapists
Paramedics
Pharmacists
Physiotherapists
Practice staff
Social Care Staff
Voluntary sector
Welfare Rights workers

While we recognise local needs will require a different mix of services to be available we agree there needs to be at the core a set of healthcare professionals available, including at least the GP, pharmacist, physiotherapist and nurse.

We were not aware from our limited inquiry of the active involvement of all of the participants above in the development of pilots or consideration of how the new models of working might impact on other professions. Theresa Fyffe from the RCN said that workforce planning across the teams is not good enough at the moment and that:
“We would not have a clue about the projected number of pharmacists, physiotherapists, OTs or nurses in the primary care team because we tend to focus on how many GPs there are”

The Committee considers it crucial that, however primary care may develop in the future, the Scottish Government must look beyond General Practitioners by involving and assessing the impact on the wider healthcare team.

**The GP’s role in hubs.**

All seem to agree the General Practitioner should be the glue holding the team together. We heard around 25-30% of current GP workload was on inappropriate work which could be undertaken (better) by somebody else. It was suggested the GP should be the last person dealing with many things given the skills of the wider team.

However two GPs we heard from, representing the wider profession, indicated “one of the most cost-effective and cheapest ways of getting through the biggest numbers of roles is for GPs to do all things in a oner.” We recognise this may be the case in a world of comorbidity. Also the potential for a one stop shop while visiting your GP could be more cost effective than visiting lots of different medical professionals with the concomitant risk of missing the bigger picture.

If the aim is to improve healthcare while addressing pressures on GPs we are concerned about the risk of a contradiction with the sentiment above. This could arise when it is set against the importance of the multi-disciplinary team and mutual recognition of the knowledge and expertise of other staff in contributing within the team to meet demands and healthcare needs. This has the potential to impact on the motivation of GPs in relation to the hub model, their integration into a team environment, risk aversion in trusting the (advanced) skills of others and the inevitable change to their existing role that is required if the hub is to be a success.

- We would welcome from the Scottish Government detail in relation to the mechanism by which they will ensure full co-operation and participation from GPs in the development and delivery of a true multi-disciplinary team partnership.

**GP recruitment and numbers**

Given recent publicity and concerns around GP numbers we held a separate session to assist us in understanding the concerns being expressed. We heard concern around existing numbers, vacancy rates, current age profile and prospective retirements in the coming years. GP representatives spoke about perception and expectation of medical students having changed, suggesting general practice was now considered an unattractive option due to its negative portrayal. This is further

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2 Official Report 20/9/2016 column 27
3 We acknowledge recruitment concerns expressed in other professions working in GP hubs – and the committee is conducting further work on this.
compounded by the ‘badmouthing’\textsuperscript{4} that goes on in medical schools which leads to GPs being viewed as second class medics. Some work was being undertaken to address this, but the Committee believes any attempts to boost recruitment are unlikely to be successful without first addressing the negative perception of general practice within medicine.

We recognise Scotland is competing in an international market place to recruit and retain the very best doctors and heard that with five internationally recognised medical schools we are able to attract quality students from across the world. But many do not stay and practice in Scotland. We support initiatives to encourage such retention.

Increasing the number of medical school places is more likely to be successful in increasing numbers of candidates for future local medical posts if the increase in places is locally targeted. We heard that those who are educated and undertake their training locally are more likely to remain in the locality. We will support targeted measures by the Scottish Government such as golden handcuffs\textsuperscript{5} linked to student support.

Witnesses discussed selection criteria for university admission and attempts to widen access through contextualised admission policies. While it is too early to say how successful these have been we support efforts to widen access and recruit locally. We do wonder if by targeting academic high flyers and perhaps not fully recognising the importance of other skills relating to communication, collaborative working etc. and the student’s motivation for pursuing a career in medicine, medical schools are automatically reducing the potential pool of those desiring a career in general practice. Equally we would also like to see some support being given to those who indicate on application a desire to ultimately practice locally.

- To that end we support contextualised admission and suggest the Scottish Government, who fund many of the student places, consider whether changes to the current largely academic based approach might be beneficial in increasing numbers seeking to enter general practice.

Equally, while noting current initiatives now being undertaken by the professional bodies to increase recruitment and retention, addressing the current difficulty requires co-operation across the profession, universities and government.

- We also consider efforts should be directed into attracting people to return to the profession and would welcome details of work being undertaken in Scotland in this regard.

The Committee also believes more work is required in ascertaining the number of GPs required in Scotland. This appears to be hampered by the lack of basic data on whole time equivalent numbers and vacancies, as well as those who have chosen to

\textsuperscript{4} Dr Mack -

\textsuperscript{5} For example as is currently being trialled in Wales
work in Scotland who originate from the rest of the EU including in particular the Republic of Ireland.\footnote{In relation to Brexit issues we will have more to say when considering our more general work into recruitment and retention.}

- We would welcome details of proposals to improve the accuracy and timeliness of data collection.

Overall we consider there is an absence of a clear vision setting out what primary care should look like in the future.

**What about the patient?**

We were disappointed that none of our witnesses, either orally or in writing, voluntarily made any reference to the views of the service users. We heard a lot about the need to meet patients as well as local needs but no indication of their role, how or whether their needs and views were being assessed (or evaluated). Disappointingly we heard no mention of any attempts to raise awareness of initiatives. Consideration needs to be given to the perceptions users have of primary care services with a view to educating the user that the most relevant medical professional for them to see might not always be the GP.

- We would welcome detail of how input from local communities is being incorporated into the developments and testing being undertaken and of attempts to include education of users as suggested above.

**Hubs and test sites**

We have noted the many identified test sites and in particular that evaluation will be an on-going process over the coming years. We understand the evaluation work is inbuilt into all test sites, undertaken locally and that through the Scottish school of primary care a national evaluation is being prepared. We welcome the commitment to ongoing learning and the intention to roll out what works as this is identified.

We heard concerns around successful pilot programmes being discontinued through lack of ongoing funding and also the reluctance of people to take on jobs when they know funding is for a restricted period. We also heard about difficulties in shifting resources to pilot schemes. All of this has the potential to impact upon the viability of testing.

- We would welcome greater detail of the aspects being evaluated within the themes emerging from the pilots, together with detail of the support being supplied centrally and the criteria in place to determine the success or otherwise of existing pilots.
- We would also be interested in what central funding is available to allow the continuation of successful tests through into implementation.

**Information Sharing**
Witnesses discussed “virtual hubs” and it is clear co-location is not a pre-requisite of team and multi-disciplinary working although locality separation will not work without good and regular communication. An important aspect of communications is ready access to information and records. All professional witnesses indicated difficulties in accessing patient information whether as a consequence of data protection concerns or the incompatibility of systems. Without cross-disciplinary access a hub cannot succeed efficiently and effectively.

Yet we heard that in one pilot in the Borders a community pharmacist was given access to records because he was the only health professional around on a Saturday afternoon.

We recognise, in some mainly rural areas, using new technology is hampered by poor connectivity, although we heard of a number of schemes utilising remote and/or virtual access to provide services. While remote services can undoubtedly be enhanced with improved technology there are numerous existing innovative examples across the country which could and should be shared and replicated.

- Your response of 17 October agrees “the landscape is complex” and we would welcome further detail relating to the ways in which the proposed SWAN will seek to address these and improve data sharing together with an indication of the timescale and costs involved.
- We would also welcome detail of arrangements in place to allow the best and most innovative practices to be shared and replicated.

Health Inequality

We are interested in the work of the National Links Worker Programme working with GPs at the Deep End in Glasgow and the success the new Community Links Practitioner has shown, making an impressive impact on targeting health inequalities.

Elsewhere concern was expressed to ensure the hub model had addressing inequality at its heart and avoid adversely impacting on those most in need. Those experiencing health inequalities must be design participants as well as being given access to information about local changes to services.

- Given our earlier concerns about the involvement of service users generally we would welcome information about how this concern is being addressed.
- We support changes to the Scottish allocation formula to better reflect the health inequality dimension of practices’ populations and look forward to further detail on how that is to be achieved in the next round of allocations.

We have heard from a range of people about the work being undertaken at the Wester Hailes healthy living centre and we will endeavour to visit the centre in early course.

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7 Scottish Wide Area Network
8 Submission from Alliance for 20/9 meeting
We recognise change can take time\(^9\) but expect it to be achieved far quicker than was suggested to us (in excess of 14 years) in relation to the underutilisation of the skills and knowledge of pharmacists.

We would be grateful if you could reply to the Committee by 14 December.

Kind regards,

Neil Findlay

Convener to the Health and Sport Committee

\(^9\) OR 20/9 col 12