Cabinet Secretary for Health and Sport  
Shona Robison MSP

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

Mr Neil Findlay MSP  
Convener  
Health and Sport Committee

By Email.

14 December 2016

Dear Neil,

Primary Care in Scotland

Thank you for your letter dated 9 November 2016 which sets out the Committee’s views following the conclusion of their inquiry into GP and primary care hubs.

My Vision For Primary Care

In my letter to the Committee in September I included a copy of the Scottish Government’s Primary Care Vision and Outcomes Framework which sets out a clear vision. That vision puts general practice and primary care genuinely at the centre of a community health service, improving outcomes for local communities. Effective, sustainable and accessible general practice is needed by everyone - so we all start well, live well and age well. We share a vision of the future role of the GP as the Expert Medical Generalist in the community; focussed on complex care, undifferentiated presentation and local clinical leadership. This is exactly what is needed to focus GP time on those patients who need them most, including those with palliative and end of life care needs.

Shifting the Balance of Care

We announced on 16 October that by the end of this parliament, we will have increased spending on primary care services to 11% of the frontline NHS budget. That means, by 2021, an additional £500M will be invested in primary care. The reflection of this in budget documentation in the intervening years will be a matter for the budget development and review process, and will be subject to scrutiny and approval by the Scottish Parliament.

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Primary Care – Savings on Preventative Spend

We are working closely with NHS Health Scotland and the Scottish School of Primary Care (SSPC) to develop an ambitious, long-term evaluation of Primary Care Transformation.

This is in addition to, and will complement, the evaluation of Primary Care Transformation Fund projects described in my letter of 17 October. While the evidence is clear that investment in primary care leads to improved population health and more proportionate use of resources, we recognise the continuing difficulties in demonstrating the cost effectiveness of preventative approaches.

However, through the evaluation we will look at how we can measure the long-term gains achieved through greater investment in preventive activity and new models of delivery in primary care.

As you are aware the Scottish Government is investing £1.25m, over three years, in the Scottish School of Primary Care which will evaluate test of change pilots, primarily those projects funded by the Primary Care Transformation Fund and the Primary Care Mental Health Fund, in order to provide evidence to support different models of primary care. This will:

- Develop a national evaluation framework for new models of care being funded by the Scottish Government and identify what their components are, how they are expected to work (theory of change) and what the expected short, medium, and long-term impacts or outcomes are.
- Identify the impacts, learning, spread and sustainability of these new models of care.

The new Mental Health Strategy will set out our focus on outcome measurement which will be critical in driving forward improvements in mental health and mental health service delivery. Key performance indicators and mental health quality indicators are in development to aid these decisions and evaluate wider mental health services across Scotland, and this will include primary care. As part of this wider work to improve clinical outcome measurement and quality improvement across all services, we are working alongside the SSPC to develop evaluation and outcome measures that will help determine the most effective models to roll out nationally which will deliver the best outcomes for patients in primary care mental health services, with a view to supporting their sustainability thereafter.

We plan to deliver practical support to mobilise and engage partnerships, localities and clusters including, for example, six monthly networking/learning exchange events and building a dynamic on-line community for discussion/learning via a Primary Care Transformation "Knowledge Hub".
The Primary Care Fund investment to support test of change is time limited, until 2017/18 (the final round of funding from April 2017). We expect evaluation to identify the most successful projects and that individual Health Boards and/or Independent Joint Boards will want to support the continuation of these tests via mainstream funding.

The community hubs in Fife and Forth Valley are a three year project. The Scottish Government is funding the first year - the training year only. In years two and three the GP fellows will be employed by the Health Board and work in the hubs (also Health Board funded.)

I welcome that the Committee intend to visit the Wester Hailes Healthy Living Centre. I myself have visited the Centre in March 2015 and the First Minister in September 2015. It is a fantastic example of how both health and social care services can be brought together to meet the needs of the community.

The Edinburgh Headroom Project, based at the Centre continues to receive Scottish Government support. Funded initially from the Primary Care Modernisation programme in 2014 and now via the Primary Care Transformation Fund. It is an example of collaborative working at local level with GPs engaged with local authority community services to ensure better outcomes for those living in areas of concentrated deprivation. The project also participated in the National Conversation on Creating a Healthier Scotland.

Defining the multi-disciplinary team or "hub"

The hub is about multidisciplinary working and the application of the hub is different in different localities. The members of a multidisciplinary team do not all necessarily work out of the same premises, although they can nonetheless work as a team. The multidisciplinary team model applies both in and out of hours, and it will apply for urgent care hubs and community health hubs, which you have heard a lot about. The common theme is multidisciplinary working.

The community hubs in Fife and Forth Valley are one approach being tested. It should also be noted that they are really about intermediate care, and as tests of change they will be evaluated. If we get positive results, then we do expect them to be one of the models for the future.

Developing the primary care workforce

Our plans to introduce a national and regional workforce planning system across the NHS in Scotland will help to deliver the vision set out in the National Clinical Strategy. The production of a national health workforce plan in 2017 will be the first step in this process, and as part of this we will take account of the needs of healthcare professionals within wider primary care teams as we move our proposals forward.
We are taking the time to agree a clear and coherent approach with stakeholders across health and social care, including before sharing detailed plans more widely. We are also working to gather data about healthcare professional numbers and requirements across the whole primary care workforce, and to inform models of multidisciplinary care.

**Pharmacy**

The first strategy for pharmaceutical care in Scotland, The Right Medicine, was published in 2002 and identified that the skill and expertise of pharmacists had been underutilised. Since then there has been a range of national and local initiatives to develop the ways in which pharmacists roles can be extended to improve the public’s health; provide better access to care; deliver better quality services for patients, users and carers; and work as part of extended clinical teams.

In 2006, the funding arrangements for community pharmacy in Scotland was changed marking a shift away from a focus on dispensing to one that is service based and making better use of the pharmacists clinical skills. The changes comprise services such as the Minor Ailment, Public Health and Chronic Medication Services.

These services allow community pharmacists to improve the public’s health with an NHS smoking cessation service and access to emergency hormonal contraception; provide a range of NHS treatments for common self-limiting conditions; and to improve the pharmaceutical care of patients with long term conditions by helping them get the maximum benefit from their medicines. In addition, pharmacists in hospital and primary care are working as part of interprofessional clinical teams working with doctors, nurses and others to ensure patients receive the best pharmaceutical care regardless of their care setting. This has been underpinned by strengthening the education and training of pharmacists and establishing an infrastructure which supports them in delivering these services.

We continue to work with NHS Education for Scotland (NES), territorial health boards, and other partners to gain an understanding of the pharmacy workforce in the NHS in Scotland. In addition, we have invested £16.2m over three years to recruit up to 140 wte pharmacists in to GP practices to work as part of the multidisciplinary team within the practice. We continue to monitor the progress towards recruitment of these pharmacists and will build on this in order to meet the Programme for Government commitment that every GP practice will have access to a pharmacist with advanced clinical skills within the lifetime of the current parliament.

**The GP’s role in hubs**

There will be limits to what one professional can and possibly should do for a patient, if we are to maximise the impact of each professional’s role in delivering the best possible care to patients.
We want to ensure that patients are supported to make the right choices about which professional is best placed to help them ‘first time’ and in order to achieve this we plan to:

- significantly increase capacity in the other professionals to be more readily available to patients, where possible in or close to, the GP setting; and
- raise awareness, in both the profession and public, of the availability of that fuller range of professionals, and how to access them.

None of the above support would preclude a GP or other professional from providing additional support when they are seeing a patient with a problem that primarily sits within their professional responsibilities.

In October 2015, we agreed to move away from the overly complex and bureaucratic QOF to peer led quality improvement. We have also introduced a new approach to improving the quality of outcomes for people – GP practices working together in clusters in every locality, represent the most significant contractual change over many years in Scotland.

**GP recruitment and numbers**

The Committee’s support for contextualised admission into medicine is welcome and is, in fact, an issue already being progressed as we implement the measures outlined in our medical education package announced by the First Minister on 10 February 2016. The overriding objective is to achieve a more sustainable medical workforce in Scotland, and specifically to improve recruitment rates into General Practice (GP). As I have made clear, this is a multi-factorial issue necessitating a range of actions, and requires concerted effort by Government, both Secondary and Medical schools, Health Boards and GP practices, the GMC and others.

Our Widening Access objectives are already showing positive signs for entry into Medicine this year, and I am grateful to our Medical Schools in bringing about improvements, and for their willingness to work with us to make further changes that meet the requirements of our future workforce in Scotland.

There is evidence that applicants from a widening access background are more likely to choose GP as a specialty, and that pupils from remote and rural locations are more likely to return to work in remote and rural locations. We need to translate this into more proactive promotion of opportunities in secondary schools, positive role models, practical placement experiences, and develop our pre-medical entry programme in partnership with medical schools and colleges to improve the chances of those who possess the desirable aptitudes can be supported to meet entry requirements.

Efforts are indeed being directed into attracting people to return to the profession and the Scottish Government’s GP Recruitment and Retention fund will look at how best to tackle this going forward through a range of innovative projects across the country.
The GP Returners and Enhanced Induction programme run by NES is being supported through this fund. NES confirm that the numbers of returners coming back to Scotland since last year has tripled with over 20 GPs choosing to return in the past year, and there is a steady stream of GPs returning from Australia.

We are also working closely with NSS to develop SHOW (Scotland’s Health on the web) to provide a one stop shop for all information regarding GP vacancies, training opportunities etc. and this aims to be a national resource.

With effect from 1 June 2016 the Scottish Government has issued instruction that will simplify and standardise the application process for prospective GPs who now wish to work in Scotland. They will only be required to complete a standardised application form which, if approved, will include them (if they request) on every Health Board’s performers list, allowing them to work across Scotland. This is phase one of a two phase process. Stage 2 is to further develop the application process by the addition of an enhanced IT-based solution to the existing General Practitioner Computer Database (GPCD) which will create a national performers list for Scotland, including the likelihood of expanding to include other contractor groups such as the current Optometry database (OPCD).

The Scottish Government is working with colleagues in ISD and NSS to ensure that clusters and the wider primary care system are provided with accurate and timely data as the provision of this data is a crucial underpinning of the Continuous Quality Improvement process.

Importantly, we are working with the profession and relevant others to ensure that individuals in clusters are supported with not just data but training and public health and analytics support to ensure that the right data is both created and best used to support local improvement, with a clear focus on outcomes of interest to the local population served by the cluster and wider system.

**Patient Perspectives**

As part of Health and Social Care Integration, there are various ways in which service users and communities can have their voices heard in terms of service planning and design. Local partnerships must produce a strategic commissioning plan which sets out their local priorities for health and social care services. To ensure the needs of local communities and service users are met, the Scottish Government has provided routes for involvement in the strategic planning process via locality planning forums and strategic planning groups. Health and Social Care Integration enables a bottom-up approach to service planning and allows for communities to be embedded in the process.
One of these routes is through the Our Voice framework. The Scottish Government is supporting the Scottish Health Council and the Health and Social Care Alliance Scotland (the Alliance) to develop a national peer support network for the carer, third sector and public representatives on Integrated Joint Boards. Through Our Voice, the Scottish Health Council and partners including the Alliance are working at local level to support a wide range of people – including those whose voices are often missing, such as young people, carers, and those with lived experience of a long-term condition – to get involved in conversations about the planning, delivery and improvement of local support and services.

Other elements of the developing framework supporting meaningful engagement with people on the transformation of primary care include the national Our Voice citizen’s panel, which involves 1,300 people, broadly representative of the Scottish population, who are willing to feed back their views on health and social care. The first Our voice Citizens’ Panel survey in October included questions related to social care support, better use of medicines, and improving oral health.


In terms of patient education, NHS Inform has recently undergone a completed redesign and has been enhanced in response to user feedback. NHS Inform’s Self Help Guide isn’t new it’s been a feature of the service for the past 6 years. It provides advice and guidance and signposts people to alternative points of healthcare such as pharmacies. It does not replace necessary medical intervention but can identify the point at which the service user should contact their GP/111 or A&E services.

People have become familiar with accessing services in this way. Indeed, between calls and website visits, in Oct 2016 the NHS Inform service had over 200,000 visits. That’s over 200,000 people who may otherwise have chosen to visit their GP for advice on common conditions of a self-help nature such as seasonal illnesses like colds and coughs, putting added and unnecessary pressure on the GP service.

**Information Sharing**

A review of the future capacity requirement for SWAN recommended that all GP sites should be upgraded from a minimum of 1 MB to 10 MB, Fibre to the Cabinet (FTTC), broadband over the next 2 years. The estimated upgrade cost is £3.5 million. Completion of the upgrade is dependent on the Scottish Government’s commitment to deliver 100 per cent superfast broadband access by the end of the 2021.

As part of the Digital Services Development fund, we commissioned an analysis of GP systems and processes. The findings and recommendations from this are now available and were set out in a framework issued to all Health Boards. This is attached in the powerpoint slide (Annex A) along with a sample copy of the funding letter which gives more background (Annex B).
This has informed the distribution of approximately £2.1m to Health Boards for General Practice systems enhancement, and will inform the distribution of the additional £2m funding announced in March 2016. The analysis has established a baseline of the current operating arrangements in General Practice and identified potential practical ‘quick wins’ alongside longer term technology enabled opportunities to free up clinical and administrative staff capacity.

The project has identified core processes within General Practice, including those around access to information and records, and reviewed and documented current working practices and processes, identifying common challenges and opportunities. A wide range of stakeholders were involved in compiling this evidence, including GPs and practice staff. This work is likely to inform digital developments in Primary Care beyond the scope of the £6m Digital Services Development Fund. We will work with Boards to monitor their use of this funding, and to share good practice.

Health Inequality

As the committee is aware the Scottish Government is funding the Links Worker pilot programme in Dundee and Glasgow, The programme sees a dedicated individual working in GP surgeries, helping patients on a one-to-one basis with non-medical problems that are making them feel unwell.

The Scottish Government has committed to increasing the number of community Links Workers in disadvantaged areas to 250 over the next five years, with 40 to be recruited in year one, to ensure that anyone who needs psychosocial support receives it. The twin objectives of this programme is that it will enable people to live well within their community, thereby reducing inequalities and also help to ease pressure on general practices. The impact of Links Workers is currently being evaluated concluding at the beginning of next year.

The focus is on the areas of greatest deprivation but also reaching pockets of deprivation and rural communities which are not necessarily within the “Deep End” GP Practices boundaries.

Tackling health inequalities is one of our primary care outcomes, and we set out how this will be reflected in development of the future contract in our recent memorandum with BMA [http://www.gov.scot/Publications/2016/11/7258].

I welcome the Committee’s work and continued interest, not only relating to GP recruitment and GP hubs but to the important wider transformation of Primary and Community care. Through our clear vision and extra investment, I am confident that we can work together and ensure we are moving in the right direction to improve our health and care services fit for the future.

Best wishes,

SHONA ROBISON

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DIGITAL SERVICES DEVELOPMENT FUND

Framework - Analysis of GP systems and Processes sent to Boards

Annex A: Framework associated with Works
### Framework for Increasing Clinical and Administration Staff Capacity

![Diagram representing the framework for increasing clinical and administrative staff capacity.](image)

- The diagram groups the opportunities identified by clinical and administrative practice staff by priority based on the effort / likely cost to deliver and potential benefit in terms of clinical and/or administrative capacity saving.
- The groupings are based on capacity saving benefit only and do not incorporate secondary benefits such as patient experience.
- This provides a framework to guide future investment by priority area. However, given Health Boards and practices are in very different starting places not all opportunities may be relevant to all Boards and should be reviewed alongside the context in which an investment decision is being made.
- This framework was reviewed and validated at a project workshop attended by a sample of key stakeholders.

### Implementation Effort / Indicative Cost

**Opportunity Key**
- **High Level Opportunity** (Implement Existing National Solutions)
- **Medium Level Opportunity** (New National Solution Required)
- **Low Level Opportunity** (New National Solution Required)

### Themes
- Automation
- Interfacing
- Online Services
- Technology Enablers

### Suggested Priorities
- **Priority Grouping 1:** Foundation
- **Priority Grouping 2:** Transitional
- **Priority Grouping 3:** Advanced
- **Priority Grouping 4:** Capacity Search
# Themes and Guiding Principles

A number of recurring themes were highlighted by clinical and administrative staff that describes the direction of travel for general practice and the technology areas of primary importance. The diagram below summarises these themes alongside proposed guiding principles that future investment decisions can be tested against.

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<th>Theme</th>
<th>Automation</th>
<th>Interface</th>
<th>Online Services</th>
<th>Technology Enablers</th>
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<tbody>
<tr>
<td>Description</td>
<td>Improve clinical and administrative processes through automation and reduction of paper records and forms through exploiting technology.</td>
<td>Better working across the interface between primary, community and acute care to improve access to assessment, diagnostics and treatment.</td>
<td>Empowering patients to take greater control of their health and wellbeing by increasing online access to services.</td>
<td>Ensuring practice technology is fit for purpose and staff are supported through effective training and mentoring.</td>
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</tbody>
</table>
| Guiding Principles            | • Processes should be paperless where possible through direct data entry and electronic transfer.  
• Data should be collected once and stored with minimal redundancy.  
• Minimise inappropriate variation in clinical practice and processes via standardisation. | • Provide universal access to the patient record (where it is deemed appropriate), allowing for seamless flow of information across care settings.  
• Drive more effective and efficient processes via improved communication and documentation between care providers. | • Provide greater choice to patients via online service, facilitating self-service and access to appropriate personal clinical records.  
• Decision making and design shall be the result of direct participation by the relevant practice staff and end users. | • A robust system architecture to support rapid and reliable response times for all end users.  
• Adequate and appropriate hardware (workstations, printers, peripherals, mobile devices and network connectivity) will be available.  
• End users have training and mentoring for all systems they use.  
• Decision making and design shall be the result of direct participation by clinicians and other practice staff. |
ANNEX B

DIGITAL SERVICES DEVELOPMENT FUND

PRIMARY CARE DIGITAL SERVICES FUND (SAMPLE LETTER)

Directorate for Health Performance and Delivery
eHealth Division

Enquiries to: Justine.murray@gov.scot / 07733308407

Chief Executive, NHS x

Director of Finance, NHS x
eHealth Lead, NHS x
Primary Care Clinical Lead(s), NHS x

22 November 2016

Dear x

Primary Care Digital Services Development Fund

The Primary Care Digital Services Development Fund is part of the wider Primary Care Transformation Fund. Its purpose is to support and accelerate the use of digital service by GP practices.

Your Board’s funding through the revenue stream of Workstream 2

I am pleased to advise that we will be allocating the following funding to your Health Board for Workstream 2 of the Digital Services Development Fund. This comprises a ringfenced weighted NRAC allocation of that part of the Digital Services Development Fund designated for the systems enhancement in 2016-17. Allocation of this funding follows a Review of Practice Systems and Processes by Deloitte and our subsequent engagement process with stakeholders.

NHS x: £x

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**Share of additional capital funding**

In March 2016, the Cabinet Secretary for Health and Sport announced an additional £2m capital funding for 2016/17 for the enhancement of GP technology.

We understand some Boards would prefer revenue funding to optimise deployment of the funds within the timeframe. We are exploring an internal cross budget transfer to increase revenue and decrease capital; we expect this to be clarified within the next two weeks and we will be in touch again to confirm NRAC allocations.

**The Framework for increasing Primary Care capacity**

The allocated Workstream 2 funding (both revenue and capital streams) is specifically for the implementation of the Model Practice Framework (Annex A) developed by Deloitte following the review of GP Practice Systems and Processes. The Framework shows a range of Options for Boards to select from depending on the degree of digital maturity locally as set out in the baselining exercise that you have submitted.

The expectation is that Boards will use this funding to take forward initiatives in the High Impact / Low Effort, High Impact / Medium Effort or Medium Impact / Low Effort categories (i.e. those boxes towards the upper right hand side of the attached Framework) according to your local need and identified level of digital maturity. The initiatives available to select from are those identified as being a Board Level Opportunity (i.e. those boxes with a grey left hand border on the attached Framework).

**Conditions of funding**

We expect discussions to take place locally with LMCs on prioritising the use of your Board’s funding allocation. Primary Care Clinical Leads are copied in to assist with any local communication needed to take this forward. We ask you to identify to us the local group or governance arrangements that will be used to support local Implementation so that there is an ongoing means of stakeholder engagement.

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We want to work with you to develop a monitoring process that reflects your baseline starting point with the intention that this is both useful to you locally and enables quarterly monitoring nationally to the Primary Care Digital Services Board. Importantly this will be about understanding change from a qualitative perspective, the inputs in terms of facilitation support and collaboration with clinical leads, and the outcomes in terms of benefits to GPs and Practices.

To this end we ask you to identify an individual(s) who will be responsible for on the ground implementation and engagement with GPs and Practices to work with Justine Murray, Change Manager, on developing a monitoring process that relates to your chosen priorities.

Please could the identified individual contact justine.murray@gov.scot to begin developing the monitoring process in your area.

**Distribution of funding**

Your Digital Services Development Fund Workstream 2 revenue funding for 2016-17 will be transferred at the next available Board Allocation window. Your share of the stream which is currently capital funding will be transferred once we have agreed the basis of the funding. (capital/revenue)

**Background**

The Primary Care Digital Services Development Fund has three workstreams in place and the funding split and distribution mechanism is as follows:

**Workstream 1: Online Services.** £1m nationally split by weighted NRAC formula (£800k in 2016-17 – already distributed; £200k in 2017-18).

**Workstream 2: Systems enhancement.** £4m nationally (£2.7m in 2016-17; £1.3m in 2017-18). The 2016-17 allocation breaks down as follows: £320,000 for GP IT reprovisioning; £218,500 for review of GP Practice Systems and Processes; £2,161,850 weighted NRAC to NHS Boards for systems enhancement (this funding). An additional £2m capital, announced separately, is also available for systems enhancement in 2016-17 only and will be confirmed to you as above.

**Workstream 3: Innovation and research.** £1m nationally over the 2 years. Innovative pilots and tests of change to be run and evaluated for potential national roll out. Three projects already underway in 2016-17, testing change around e-consulting, clinical decision support and co-production of GP digital services.

Yours sincerely

**Eddie Turnbull**  
Head of eHealth

**Note:** Annex A is a separate document in PowerPoint format.

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