17 October 2016

Dear Neil,

HEALTH AND SPORT COMMITTEE EVIDENCE SESSION ON GPS AND GP HUBS – 27 SEPTEMBER 2016

I write in relation to my appearance before the Committee on 27 September to provide evidence on GPs and GP hubs. As a follow-up, I agreed to provide some further information on a range of areas including: the Graduate Medical School, evaluation of Primary Care Transformation Funded (PCTF) pilots, the development of the multi-disciplinary approach and data which covers savings from preventative spend. I hope this information assists the Committee in concluding their initial examination on the topic of GP recruitment.

Graduate Medical School

On 14 June I announced that the Graduate Entry Programme will be delivered by the medical schools in St Andrews and Dundee in collaboration with the University of the Highlands and Islands. The Programme is currently being developed. Applications will open to students in spring 2018 with courses beginning in the autumn of that year (subject to GMC approval which is underway).

This initiative will provide additional routes to attract those who wish to work in NHS Scotland and will also widen participation and diversify the medical workforce. This innovative new programme will give students the chance to experience how rewarding, challenging and diverse careers in primary care and remote and rural medicine can be. It will extend medical placements from the NHS into independent and third sector settings, making community experience a central feature of the course. This will help to equip the graduates with the ability to work across health and social care boundaries. This programme will have an element of bonding which is currently being developed.
Evaluation of Primary Care Transformation Fund projects and key themes emerging

This is a developing area of work, as the Committee is aware. However, we have already identified a number of key workstreams as part of our emerging evaluation framework, and are currently seeking further detail from all our partners on their local work. As this develops, and the Scottish School of Primary Care proceeds with the development of their evaluation framework, these workstreams are likely to be further refined:

- **Theme 1. Multi-disciplinary models** – this will include the development of advanced nurse practitioners, MSK Physiotherapists, and development of optometry
- **Theme 2. Clusters & Hubs** – this will include supporting development of cluster infrastructure, cluster based design of multi-disciplinary models (co-ordinated care models/frailty/ACP and MDT development of urgent care hub
- **Theme 3. Mental Health** – this will include supporting mental health needs in a primary care setting, primary care mental health for children and young people
- **Theme 4. Alternative/ Improved Pharmacy/ Prescribing models**
- **Theme 5. Supporting Citizens: Public Information/ Redirection/ Co-ordination**
- **Theme 6. Technology**

The Committee had asked for more information about the emerging multi-disciplinary team (MDT) approach, and the role of the third sector. It is for local areas to decide on how they configure and develop their MDT approach as appropriate to their local need and circumstances. The Scottish Government is supporting a number of tests involving different MDTs.

We recognise that the third sector has an important role to play in how we transform our primary care services, and the sector will be a key partner in our advisory group structure as we progress this work.

**Savings from spend in primary care**

I have provided more detailed information on the primary care role in preventative spend in Annex A.

**Data sharing and legislative changes**

We want to integrate, and improve the availability of, information for secure and appropriate use by health and social care professionals, and improve access by patients to their information and services such as online booking. However, it is fair to say that the information sharing landscape is complex, as it involves GPs, Health Boards, Health and Social Care Partnerships, local authorities and the third sector. The challenges here are a mixture of technical (different networks and systems); organisational; and legal (e.g. existing Data Protection and other legislation).

We have launched an ‘Information Sharing Toolkit’ to help public sector organisations negotiate and then document the information sharing agreements that are necessary, and are continuing to develop our Scottish Wide Area Network (SWAN) so that it has the capacity and flexibility for new services.
The biggest forthcoming legislative change in this area – affecting the whole of the UK – is the EU General Data Protection Regulation. Boards are preparing for this in a number of ways:

- Raising the bar in terms of security, launching the NHSS Information Security Policy Framework and a programme of work around improving our controls.
- Looking again at roles and responsibilities to make sure they are fit for purpose going forward.

I hope this helpful, please get in touch if we can provide any further information that would be of use to the Committee.

SHONA ROBISON
ANNEX A

PRIMARY CARE: SAVINGS FROM PREVENTATIVE SPEND

International comparisons show that countries with health systems based on strong primary care infrastructure have better outcomes in terms of population health, access, co-ordination experiences and a lower and more proportionate use of resources.

Studies within countries are also consistent in showing greater improvements in health following legislative and/or administrative policy initiatives directed at strengthening primary care, including increases in the supply and use of primary care practitioners and clinical improvements in primary care practice. Clearly it is not simply the amount of money that is spent but how it is spent – countries vary significantly in their ability to translate a similar level of resources into health outcomes.

More systematic primary prevention in general practice has the potential to improve population health outcomes. In the long term, general practice can impact on the prevalence of particular long-term chronic conditions by targeting lifestyle factors, such as alcohol consumption, smoking, diet and exercise. Research shows up to half of cancers, three-quarters of cardiovascular disease and 80% of strokes are preventable.

Primary prevention is an excellent use of resources compared with many treatments and is cost effective. For example, 5 minutes of advice in a general practice setting to middle-aged smokers to quit smoking can increase quit rates and save £30 per person for a cost of £11 per person. While prevention in childhood provides the greatest benefits, it is valuable at any point in life.

Significantly, common lifestyle risk factors cluster by deprivation, which has a significant effect on life expectancy. Addressing this clustering by identifying those at risk and intervening early and appropriately is one of the most effective ways in which GPs can reduce widening inequalities in life expectancy.

Systematic and scaled-up secondary prevention – for example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure – has been found to be is a cost-effective, clinically significant and fast way to tackle inequalities in health.

Improved access to general practice has the potential to significantly reduce the demand for A&E attendances and unnecessary ambulance call outs. Research has shown that the proportion of attendances that could have been dealt with in general practice is between 15%-26%.

In the medium term, improved access to general practice could support patients to take a more pro-active approach to managing their conditions. This is estimated to have the potential to lead to an 8-11% reduction in avoidable admissions (that is, admissions for ambulatory care sensitive conditions).

Between 12% and 18% of all NHS expenditure on long-term conditions is estimated to be linked to mental health problems. Across a range of conditions, each patient with co-morbid depression costs health services between 30 and 140 per cent more than equivalent patients without depression.
Improving the way we respond to co-morbid physical and mental health problems would have an impact in terms of patient experience and clinical outcomes, with integrated models of disease management being found to deliver savings four times greater than the investment required (as have enhanced models of liaison psychiatry in acute hospitals).