HEALTH AND SPORT COMMITTEE

AGENDA

22nd Meeting, 2019 (Session 5)

Tuesday 1 October 2019

The Committee will meet at 9.00 am in the James Clerk Maxwell Room (CR4).

1. **Pre-Budget Scrutiny 2020-21 (in private):** The Committee will consider a revised draft report on its Pre-Budget Scrutiny 2020-21.

2. **Primary Care Inquiry - Phase Two:** The Committee will take evidence from—
   
   Jonathan Burton, Chair, Scottish Pharmacy Board, Royal Pharmaceutical Society;

   Matt Barclay, Director of Operations, Community Pharmacy Scotland;

   David McColl, Chair of the Scottish Dental Practice Committee, British Dental Association;

   David Quigley, Chair, Optometry Scotland;

   and then from—

   Dr Andrew Buist, Chair of the Scottish GP Committee, BMA Scotland;

   Dr Carey Lunan, Chair, the Royal College of General Practitioners Scotland;

   Dr David Hogg, Portfolio GP, the Rural GP Association of Scotland;

   Karen Murphy, member of the Rural and Remote Patients Group, and signatory on Petition PE01698, Medical Care in Rural Areas;

   Dr Anne Mullin, Chair, The Deep End GP Group;

   Dr Amjad Khan, Director of Postgraduate General Practice Education, Scotland Deanery, NHS Education for Scotland.
3. **Primary Care Inquiry - Phase Two (in private):** The Committee will consider the evidence heard earlier in the meeting.

4. **European Union (Withdrawal) Act 2018 (in private):** The Committee will consider a draft letter to the Scottish Government requesting an update on preparedness for a no deal exit from the EU.

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The papers for this meeting are as follows—

**Agenda item 2**

PRIVATE PAPER

PRIVATE PAPER

Witness written submissions

**Agenda item 4**

PRIVATE PAPER
HEALTH AND SPORT COMMITTEE. WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM Royal Pharmaceutical Society in Scotland

Considering the Health and Sport Committee’s report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities?

Transformational change is required to address the challenges the NHS will face with an aging population living longer with more long term conditions. We have answered the committee’s questions looking at where there are gaps in the current ways of working and how pharmacists can contribute more to prevention and treatment across our NHS.

The public report supports many of the areas where we have been advocating for change. This includes pharmacist led medication review, prescribing, monitoring of long term conditions, public health, improved referral systems and social prescribing. We are pleased to read that most people are happy to have their health records shared with pharmacists and to have consultations with other members of the healthcare team as well as their GP. It is important that the results of this report are translated to a national realisation of the broader nature of primary care.

Medicines are the third largest expenditure in the NHS, but we know that around 61,000 unplanned admissions to hospital are due to medicines. Pharmacists are the experts in addressing medicines related issues. They have an important role in working with other health and social care professionals to ensure safe systems are in place wherever medicines are used, and to maximise the investment the NHS makes in medicines. New models of care need to focus on providing the public with access to the pharmaceutical expertise to keep them safe, to self-manage and to prevent unnecessary admissions to hospital. To accomplish this there must be pharmacists wherever there are medicines, both strategically in planning services and operationally at local levels.

National Drivers for change

Progress has been made in recognising the contribution pharmacists can make to the NHS with new roles in GP practice, the recent commitment to extend the minor ailment service and initiatives such as Pharmacy First in community pharmacy. There are many examples of innovative practice from vanguards of the profession, working with local GPs to integrate services, sometimes with more than one pharmacist on site to deliver the breadth of services community pharmacy has potential to achieve.

While there are many areas of exemplary practice, there is also variation and national drivers are not yet in place with to encourage a business and practice model which optimises the clinical expertise of pharmacists, particularly in the community sector.

The current system does not guarantee that a patient receives the pharmaceutical care required. GPs do not have time to always explain about medicines. There are two core roles for every patient facing pharmacist to keep patients safe and optimise their treatment:

- Clinically checking prescriptions to ensure that the prescription is correct, with the right dose for the patient, identifying issues with adherence, safety & effectiveness.
- Counselling patients on their medicines and ensuring they have all the information they require.
However, contractual incentives in community pharmacy still focus mainly on rewards for supply and items of service rather than a holistic package of care which ensures time spent advising patients.

Our members tell us that despite their commitment and best efforts they do not always have the time to spend with patients as they would like due to the volume of prescription items prescribed and their absolute focus on patient safety in the dispensary.

Patient care from community pharmacy should focus on the clinical care delivered along with supply and be resourced accordingly. Robotics, automation and more pharmacy technicians to support dispensing would free up pharmacists’ time to be with patients and provide clinical care in keeping with their education and expertise.

Better use of existing resources
Advantage must be taken of all available resource and expertise. In future all patient facing pharmacists wherever they are practising will be independent prescribers. This expertise must be harnessed with integration across the wider primary care team.
Community pharmacy has potential to be a community health hub providing first access to the NHS. We know from the MINA studyii that outcomes for common clinical conditions are similar whether people are treated at A & E, GP appointments, or community pharmacy, which is more readily accessible and cost effective. This work has begun successfully with Pharmacy First but could be further expanded to provide the transformational change in services required. Co-location of NHS and voluntary sector services in community pharmacies would provide patients with an integrated approach to health and social care and provide social prescribing to local resources.

The link below shows just one example of how community pharmacy can be first port of call, triaging common clinical conditions, linking with NHS resources to support self-care, working with the local health board and GP practices to provide an integrated service. Robotics and innovative IT solutions have been used as well as up to three pharmacists in this model where the community pharmacy has been transformed to a community health hub. https://www.cadhampharmacy.com/triage-clinic-award-winning-care There are many more initiatives and examples of good work across Scotland, but national drivers are needed to incentivise best practice and encourage new models of care.

Public Health and Prevention
There is potential for community pharmacies to be public health and healthy living hubs, focusing on obesity management, lifestyle changes, social prescribing and vaccinations to increase capacity and uptake. Smoking cessation services have already been shown to be most successful where pharmacy support staff have been involved and this could be expanded to provide more public health and prevention initiatives. The new community pharmacy framework in England now has a quality payment for Healthy Living Pharmacies, extending the previous local successes to a national requirement for all pharmacies by 2020iii.

Integrated Care
Community pharmacists need to work more closely with colleagues in GP practice and secondary care as well and the wider multidisciplinary team. Despite being based in a retail environment over 90% of community pharmacy business is NHS related. Work is required to fully integrate the pharmacy, dental and optical primary care contractor services into the NHS, more closely aligning with GP services and being resourced for clinical care provision. There are examples in practice where local services are provided from both GP
practice and community pharmacies to improve capacity, uptake and patient outcomes e.g. Asthma reviews.

3 people die every day in the UK from asthma and 2 of these could be prevented⁴. 368,000 people (1 in 14) are currently receiving treatment for asthma in Scotland. Only a third of people with asthma have an annual asthma review with inhaler check and a written action plan. People without an action plan are 4 x more likely to have an emergency admission to hospital.

In one local enhanced service people who have repeatedly not attended practice nurse annual reviews are reviewed in community pharmacy when picking up their next prescription, working to identical protocols as in GP practice. In addition, many pharmacist independent prescribers have targeted this group of patients to improve asthma management and outcomes. This type of integrated working could be formalised with synergy between GP and pharmacy contractual services and to target those other long term conditions where prevention is crucial e.g. diabetes.

There is also a greater need for more understanding of roles across health and social care professionals, so that everyone is clear on roles and responsibilities, and where the expertise lies at each point in the patient journey. This is equally important for the public who must realise that not always seeing a GP is an enhanced service rather than a diminished one. Health literacy in schools from an early age to inform around how to navigate the NHS will be essential in the longer term to improve public understanding.

Pharmacists are the best placed profession to work with the wider multidisciplinary team to provide the holistic expertise required to oversee the complex care regimens required to treat patients with several long-term conditions. Clinical guidelines focus on single therapeutic areas and are not always appropriate for patients with co-morbidity. This will become ever more important as our population ages and more people live longer with more long-term conditions.

**IT and Sharing of Information**

There are two disconnects in the current system; between health and social care and between primary and secondary care. Both need to be addressed in future models of care. Timely sharing of information between pharmacists in hospital, GP practice and community is essential and an important element of keeping people safe as the move with their medicines across our health and social care systems.

While we support the development of a nation a digital platform, the timescale for this is too long. Some essential steps need to be taken to decrease the risk to patient safety over the next ten years. Measures will need to be put in place as a priority to provide community pharmacists access to health records. Scotland is now lagging behind England and Wales in this respect. With several professions including pharmacists now independent prescribers it is becoming even more important that all the appropriate information is available before dispencing occurs. The Adastra system could be adapted for a two way system between GPs and community pharmacy and other health care professionals. There is potential for smarter use of online platforms and technology for prescription ordering, appointment booking and patient self-management.

Community pharmacy is the only place where out of hours services will send patients for ongoing treatment without their summary information following them. Pharmacists will use their expertise in all aspects of medicines to ensure this high-risk area is minimised, but it is an avoidable risk which needs to be addressed. Sharing of information would support closer
monitoring of high-risk medicines where complications are most likely to arise and cause re-admissions to hospital. As treatment becomes ever more complex, good pharmaceutical care becomes even more essential and the system must acknowledge this to ensure ongoing patient safety.

Duplication of resources needs to be eliminated with protocols and information shared between healthcare professionals (HCPs). Often patients report having repeat tests and monitoring and having to relay their own information to different HCPs. Having shared information across the professions could substantially reduce the need for duplication.

**Waste**

We know that up to half of all medicines prescribed are not taken as the prescriber intended and that most waste results from changes in prescribing, changes in a patient’s disease state and non-adherence to their prescribed regimen. It has been shown that only about half of medicines waste can be avoided and this is most effective when linked to improving the quality of care and health outcomes. Addressing inappropriate polypharmacy has led to improved quality of care in our frail elderly but more could be done to encourage “de-prescribing” and joint decision making for patients on repeat medication with long term conditions, embracing the principles of the “Realistic Medicine” report delivered by the chief medical officer in 2016 and its follow up reports.

**Enablers for new ways of working include:**

- Sharing of information across the health and social care teams with one patient record providing read and write access as appropriate.
- Move to a model of remuneration for clinical services in community pharmacy practice with supply attached rather than focus on payment for supply and items of service only. “It’s about the package of care not the package”
- Formalise ways of working between independent prescribers in community pharmacy providing the core contractual Care and Review service, working closely with GP practice colleagues, to provide a wraparound repeat prescribing service, focusing on patient safety and improving health outcomes.
- Annual medication reviews for long term conditions from community pharmacies as part of the Care and Review service. These are no longer a remunerated item in the new GMS contract and workload needs to be moved to ensure patient care. Further work could be done to synergise the pharmacy and GP contacts to maximise the expertise available from both professions.
- Incentivise appropriate “deprescribing” to remove unused items from repeat medication lists and reduce waste.
- Expansion of the role of pharmacy technicians in community practice and in the dispensary in a similar way to the hospital system, allowing pharmacists to focus on face to face pharmaceutical care with their patients.
- The clinical check for every new or changed prescription is a core element of pharmacy practice and should be formalised and resourced as such. It identifies prescribing errors, patient adherence, suboptimal treatment and the need to step down/reduce therapy.
- Patient registration with the community pharmacy of their choice for regular medication reviews with IT enabled to share information of services provided elsewhere.
• Appropriate skill mixes to provide the level of service commissioned by the NHS. In some places this could mean more than one pharmacist, supported by robotics, automation, pharmacy technicians and administrative support.
• Community dispensing of hospital discharge medication at a pharmacy of patient’s choice.
• Direct referral systems to access treatment in hours as well as out of hours expanded to include referral to other HCPs as well as GPs and social care when required.
• Universal use of NHS Inform symptom algorithms by all front-line staff (community pharmacy counter staff, GP receptionists) could minimise variation in triage and improve referral systems

What are the barriers to delivering a sustainable primary care system in both urban and rural areas?
Sharing of information and interoperable IT systems are required. There is an opportunity to use digital solutions to have remote consultations with both community and GP practice pharmacists to save travel time. The advantages of this for care home patients were outlined in our recent report, “Putting Residents at the Centre of Care Home Services”. This can also be beneficial in rural areas where travel time and availability of healthcare professionals can all be a barrier. IT could also be used in urban areas to improve access for housebound and working people who do not find it easy to access services during routine office hours.

Sustainability can depend on ensuring that changes in one part of the system do not have unexpected effects on other sectors. Recruitment has traditionally been an issue in rural areas as this is now also impinging in urban areas as well. The new GMS contract has encouraged movement across pharmacy sectors from community and hospital to work in GP practice which has potential to create shortages across the profession. Modelling on the requirements for the new GMS contract would indicate that there will be a substantial shortfall in the number of pharmacists and pharmacy technicians required to fulfil the new pharmacotherapy service. Anecdotally we are hearing that this is already adversely impacting on filling community and hospital posts in some areas.

How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?
Evaluation of these elements of care will be long term and will also depend on many other determinants of health including housing, employment and demographics. Metrics can be used but will not deliver a complete picture. These could include:
Patient satisfaction with access to and quality of treatment; Hospital admissions; Calls to out of hours; Referral rates; Medicine related unplanned admissions to hospital; Inappropriate attendance at A and E departments; Changes in disease prevalence against time.

i Health Improvement Scotland, Scottish Patient Safety Programme. Pharmacy in Primary Care

ii Community Pharmacy Management of Minor Illness (MINA) Dr M. Watson, Final Report to Pharmacy
Research UK, January 2014

accessed 28/8/19

iv Asthma UK annual report 2018

v Evaluation of the Scale Causes and Costs of Waste Medicines, YHEC/School of Pharmacy, University of London, November 2010.
HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM COMMUNITY PHARMACY SCOTLAND

1. Considering the Health and Sport Committee’s report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities?

Community Pharmacy Scotland welcomes the public’s response to the Health and Sport’s primary care enquiry. We believe that Community Pharmacy has the potential to support the health and public health priorities of local communities and we have explored below the many ways in which Community Pharmacy already addresses some of these points.

We believe that Community Pharmacy can play a greater role in supporting Scotland’s primary care provision and welcome the work of the Health and Sport committee in this area. Below we have listed the changes that we believe are necessary to support a better delivery of primary care in Scotland.

Use of Technology

The computer systems used in primary care need to be able to share relevant patient information

- Community Pharmacy Scotland is supportive of role-based access to patient records.
- Currently, there are a range of technology manufacturers who supply the computer systems used in Community Pharmacies. These systems are not currently enabled to interact with GP systems to share relevant patient information.
- In addition to this, Community Pharmacies are not routinely informed of changes to patient prescriptions when people are released from hospital. This creates a high-risk transition of care and can lead to wastage of medicines.
- There is siloed medical information for every patient across GP surgeries and Community Pharmacies. This creates extra work for pharmacists who often need to call a patient’s GP if they have any queries or problems with the medication which had been prescribed. It can hinder the supply of medication, especially if the patient needs an ‘emergency supply’ of their regular prescription medicine, which happens if a person is travelling and has forgotten their medicines for example.
- We note and welcome recent local developments which have extended clinical portal access to community pharmacists and continue in our calls to extend this across the country. However, until such times as this access includes the ability to record pharmacy interventions, it is inevitable that no single member of the primary care
multidisciplinary team will have a full picture of the patients’ health – nor will the patient have a single record of their care.

- The long-term viability of our primary care system requires further integration, especially where technology is involved.
- Community Pharmacies provide a range of services which can be of huge benefit to people, such as the Minor Ailment Service or the Pharmacy First Service (further details of these below). Both of these allow pharmacists to offer patients free NHS consultations and to prescribe or provide medication to people who have specific symptoms, yet pharmacists would be able to give much more tailored advice if they could have better access to information about patients. In addition, being able to add details of any care interventions (e.g. Minor Ailment consultations or vaccinations) on to a patients’ record will give everyone involved in their care a holistic view of their health status.

Wearable devices and digital development

- Community Pharmacy Scotland is looking to work closely with partners such as the Digital Health Institute to look at innovative ways to harness wearable technology and the role that Community Pharmacy can play in monitoring and managing hypertension as well as other long-term conditions.

The development of NHS services delivered by Community Pharmacies

The Minor Ailment Service is a world-leading service which is set to be extended in March 2020

- The Minor Ailment Service (which is currently restricted to certain qualifying groups, such as the over 60s, under 19s and those in receipt of certain benefits) is available in every Community Pharmacy in Scotland and is intended to allow people to receive advice from a trained healthcare professional. This service is aimed at helping people with common complaints such as colds, gastro-intestinal issues or throat issues.
- The Minor Ailment Service is due to be expanded to everyone registered with a Scottish GP from March 2020. This extension will also incorporate the Pharmacy First Service and will result in a combined service which is intended to provide significant front-line healthcare. The Pharmacy First service allows people who are suffering from an uncomplicated urinary tract infection or a common skin complaint, impetigo, to go to their pharmacy and after a consultation from their pharmacist, they can receive prescribed medication which is normally only available from prescribers from their pharmacist directly.
- From independently commissioned research, we can show just how useful and popular the Minor Ailment Service is with those who have used it. Close to 90% of participants rated the service 10 out of 10 and 60% of those who used the service
said they would have gone to their GP if they could not have accessed this service at their community pharmacy. Please see: https://www.cps.scot/nhs-services/core/minor-ailment-service/mas-report/

More Community Pharmacists trained as Independent Prescribers

• The Scottish Government recently offered fully supported funding for an independent prescribing course specifically tailored for community pharmacists. On completion, this allows pharmacists to prescribe any medication within their scope of competency and gives them advanced consultation and patient assessment skills.
• Our vision for the use of this qualification in the community pharmacy network is to develop a ‘common clinical conditions’ service which further increases the ability of pharmacy teams to address episodes of acute illness in the course of a single patient interaction e.g. assessing patients for suspected chest infections. This model is much less restrictive than the current Pharmacy First services and in the fullness of time will replace them entirely.
• There are already a few common clinical conditions services led by independent pharmacist prescribers in the community across Scotland, and in these areas the service has transformed the way that members of the local community access care, leaving GP colleagues to focus on their role in managing patients with more complex health issues.
• In order to realise this vision, we will work with colleagues in Scottish Government, Health Boards and HSCPs to establish a sustainable funding model and workforce plan.
• The Scottish Government are working with us and other stakeholders to overhaul the current initial education and training of pharmacy students from the 4-year MPharm undergraduate degree and 1-year pre-registration training to an integrated 5-year degree. Executed well, this will have graduates/registrants entering the workforce more ready to engage with these future services to meet the changing healthcare demands of the nation.

Medicine Care and Review Service

• The Medicines Care and Review Service will replace and build on the success of the Chronic Medication Service (CMS).
• This further develops the role of community pharmacists in the management of individual patients with long term conditions.
• The model is based on patient need, clinical practice and quality improvement
• It is patient centred, supports self-management, promotes a partnership approach between the pharmacist, the patient and other healthcare professionals, ensures systems are in place to help minimise adverse drug reactions and address existing and prevent potential problems with medicines. It also provides for structured follow-up and referral interventions as, and when, necessary.
Patient-centred approaches to accessing services

Community Pharmacies are accessible, located in almost every community throughout Scotland and provide continuity of care to local people

- There are 1257 Community Pharmacies in Scotland. Almost all Community Pharmacies are open 6 days a week, with some being open 7, and cover more hours than a traditional working day.
- We believe that Community Pharmacy is one of the most accessible parts of the primary care system, operating almost entirely without appointments even where access to a healthcare professional is required. When it is not, people are triaged and seen by the most appropriate member of the team who is trained to address their needs. The times when appointments may be used are for specialised clinics that pharmacies may run, such as for private travel vaccinations.
- When you visit your community pharmacy you will see the same pharmacy team and they will be able to build up a record of the medicines which have been dispensed and the advice that has been given. This means that they will be able to build up a more complete picture of an individual’s health, as well as getting to know that person.
- Most community pharmacies have consultation rooms, where patients can have a private consultation with the pharmacist or a member of the pharmacy team, if required.

Community wide approach to well-being

- We believe that pharmacy teams are in an ideal position to help inform people on how to better manage their health and conditions proactively. The location of Community Pharmacies in the heart of almost every community means that they are the ideal location to support people to live in healthier ways. For example, there is a Scotland-wide service to help people stop smoking, which involves people going back to their pharmacy to receive support to quit. Many pharmacies are able to offer diet and lifestyle advice, as well as signposting to local community provisions that can help support a healthier lifestyle.
- They are an easy to access resource in every community and have the clinical expertise to provide advice - they are not only the experts in medicines but are trained to help people to manage their own conditions in many ways. The upcoming extension of the Minor Ailments Service will fundamentally change the way people access care, and we’d love to discuss this in greater detail with you.
- Better linkage and referral pathways to and from other local services would help to make navigating the care experience easier for patients and healthcare professionals alike. Ideally these would be electronic referrals.
- Social prescribing would be an area of action that we could support from our Community Pharmacies – pharmacies are a great resource to find out about local
services, have many services linked to supporting people to live a health lifestyle and are easy for people to pop in to and discuss any well-being issue that they may be facing. We would welcome the opportunity to be part of the delivery of social prescribing, although as it stands at the minute Community Pharmacies do not take part in social prescribing and so CPS will not put in a response to the consultation on social prescribing.

More effective triage for primary care services

- There is a significant amount of non-urgent medical care and advice that a Community Pharmacist can provide.
- We would like to see Community Pharmacies as a location that patients are referred to when they have a medical concern which does not require a GP’s appointment – the first port of call. A considerable amount of NHS resources can be saved through people seeing the correct healthcare professional for their needs and so improving the public’s understanding that Community Pharmacy is best for non-urgent medical care and advice will help to alleviate some of the pressure on our GPs and A&E.
- They are a great local hub for the dissemination of information and they already display posters about services they provide or for awareness raising around common health concerns. In a more informal capacity, all members of the pharmacy team should be in the position to signpost people to local services.

We are, however, concerned when it comes to service/workforce planning: the implementation of the new GP contract has created roles for NHS pharmacists within GP surgeries to provide pharmacotherapy services from there. While this service development will undoubtedly be beneficial to patients, the problem is that a huge number of pharmacy posts have been created without planning the workforce requirements of the whole system (including secondary and community care). We are seeing a pressure on recruitment and retention in Community Pharmacy in rural and urban areas, and in large pharmacy chains and small independents alike.

2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

There is a level of divergence in services provided by health and social care partnerships (HSCPs) across Scotland, which is leading to a confusing system with different types of care are available in different areas. This is a problem as there appears to be siloed information across Health Boards and resources tend to get spent on developing services in each Health Board, when best practice could be shared among them to save considerable time and resources.
When the new GP contract was negotiated in 2018, the Scottish Government and HSCPs agreed to help refocus GP workload so that they were able to spend most of their time coordinating care for patients who have complex needs, as this is precisely what GPs are trained to do. As detailed in the section on workforce pressures, while this development is an innovative way for GP surgeries to develop, it has resulted in a situation where there are not enough qualified pharmacists or pharmacy technicians available for the vacancies across community, hospital or GP practice pharmacy. We don’t believe that the impact on Community Pharmacy was taken into account when the new GP contract was negotiated, and it demonstrates clearly the danger that making major changes to part of the primary care system can pose when a holistic view of the sector is not taken.

As detailed in the previous answer, there are considerable communication barriers in terms of sharing relevant patient information across different primary care providers. A more integrated computer technology system would have the potential to greatly improve this situation.

3. How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?

We believe that primary care clusters should be established, with community pharmacy, GPs, optometrists and dental teams amongst others able to work together to design and implement meaningful service change. These clusters should have access to data analysts/ISD to figure out how to evaluate outcomes – it is not the primary skill set of the people working in clusters so support will need to be provided e.g. ISD LIST teams.

Support for service planning should also be provided and crucially a platform for recording, reporting and sharing change initiatives should be made available. This can be populated with evidence of impact on outcomes including anecdotal reports of improvement or failure and learning from cluster teams.

Knowing that improvements actually have an impact on outcomes will in itself drive further improvement and engagement of teams. Publicising improvements or unsuccessful changes properly on a national platform will see good practice spread, rather than the learning be confined to a local area, only to be repeated again in several other places across the country, wasting time and effort.
1. Considering the Health and Sport Committee's report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities.

BDA Scotland members consider it is difficult to specify what changes are needed. Each local community will require different changes, some may not need any. Members suggest that it should be up to the ‘local community’ to decide. A method of deciding what is considered as a ‘local’ community is its size and therefore its needs should be developed so it is possible for each community to make their own assessment. It is unclear if ‘local community’ means a General Practice (GP) catchment area, an entire city such as Edinburgh, an Island such as Skye, or an entire Region such as Highland, Fife or Tayside. The scale of changes would depend on the above being better defined.

BDA Scotland members suggest that primary care requires additional funding, although it is an efficient service. Government has stated that they will not take funding from secondary care to fund primary care. However, BDA members believe adequate funding is required for both primary and secondary care. A lot more work is done in primary care than was previously carried out in secondary care, and members are concerned that funding has not transferred across the services proportionately. As an example, it is cited that it is very difficult to have a patient referral seen at Glasgow Dental Hospital, therefore, it leaves dental practitioners stressed, anxious and frustrated. It is important to highlight that local dental hospitals are not giving primary care the backup that has been given in the past and is now needed. Members question whether all referrers from primary care are asked by their local dental hospital for feedback on their performance, and whether patients are asked for their feedback.

BDA Scotland members suggest that there needs to be better accountability and transparency between the two services, and that these issues must be addressed by Scottish Government.

Some BDA Scotland members suggest that NHS Boards are thought to be protective of secondary care and that many senior managers come from within secondary care. BDA members suggest that this needs to change, with a better mix from primary and secondary care, and as noted above, adequate funding is required for both services.
BDA Scotland members urge that in future an interface is required between primary and secondary care. It is members understanding that in some instances secondary care is refusing to see patients for treatments for example, endodontic and periodontic treatments which primary care practitioners feel unable to carry out either because of funding, knowledge or clinical ability. BDA Scotland has made these issues known to Scottish Government on numerous occasions and members would highlight that this must be addressed by them, not just for dentistry but also for medicine.

BDA Scotland members believe that there are inefficiencies within secondary care and that these should be addressed. Members also consider that whilst many reviews are undertaken within secondary care, there are often no visible positive outcomes.

2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

BDA members suggest that staffing levels are currently insufficient in both primary and secondary care. This includes medically trained staff for example, general practitioners, but also those involved in technology support and the development of any project and its management. One obstacle, is a lack of trained staff participating in projects, for example, there is a decline in general practitioner numbers, thought to be because it is no longer considered an attractive career. Members suggest that the issues listed above must be addressed.

Cost is a substantial factor in any change, and a new system is unlikely to be cheaper to maintain, particularly if it is technology based and kept up-to-date with technological developments.

Whilst new technologies such as smart phones, apps and the use of email is attractive, it must not be forgotten that there are some who choose not to or are unable to access this type of technology. There are still many people who do not have an email address or a smart phone. Some people cannot use touchscreens, for example, those with impaired sight. BDA members suggest an inclusive system for all is required, and not just the young and IT literate.

3. How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?

BDA Scotland members suggest that monitoring health outcomes can be quantitative or qualitative. The former would rely on proper data recorded now, and then compared with data recorded over several years. The latter is more likely to be used to assess how communities ‘feel’ circumstances are improving regardless of the actuality.
BDA members suggest it would be more useful to measure the point or age at which morbidities start to increase in a population/community than measure life expectancy. This type of monitoring would be more easily achieved if records and patient data were centrally located, however, members understand that this raises data security issues that would need to be managed.
HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM OPTOMETRY SCOTLAND

1. Considering the Health and Sport Committee’s report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities?

Optometrists - Background Information

Optometrists are the first port of call for all eye emergencies. Optometrists can diagnose a variety of conditions such as diabetes, hypertension and eye conditions such as cataract, glaucoma, macular degeneration. They can also diagnose, manage and treat acute eye conditions helping to prevent avoidable blindness, in line with the Scottish Government Prevention Agenda.

Independent prescribing optometrists have completed further training and accreditation. This enables them to treat and prescribe medication to patients for a number of clinical conditions such as ocular infection, dry eyes, conjunctivitis, glaucoma and ocular inflammatory disease such as acute uveitis.

Optometric practices can be located in almost every community across Scotland, and in remote and rural areas easily accessible and within close reach of peoples’ homes; some are open out of hours

Recent surveys across Scotland have confirmed that there are optometric practices in all SIMD 1 and SIMD 2 communities ensuring that people living in deprived communities and have easy and convenient access to an expert eyecare service, in keeping with other initiatives to reduce health inequality.

Most practices are located in retail properties, incurring overheads such as rent and rates, together with extensive capital investment for essential equipment met by the practice owner with no grants or subsidies from the NHS.

The actual costs incurred in delivery of the GOS programme have not been adequately reflected in sustainable increases year-on-year since 2006.

Change required: It would be beneficial to the patient, if optometrists would be paid to keep appointments vacant for emergency presentations.

The investment in Optical Coherence Technology equipment in every practice would allow an enhanced level of diagnosis in the community, earlier intervention and prevention of ocular morbidity and improved referral refinement. This will ensure that referrals to secondary care are based on clinical need, and are more appropriate, reducing
unnecessary referrals. This will increase the capacity in secondary care and help to shorten hospital waiting times in accordance with the waiting time initiative.

Providing access to a Universal patient record card with information about general health conditions and medications would enable IP and community optometrists to prescribe medication for a range of conditions without referral to a GP.

There are an increasing number of patients with diabetes, many with co-morbidities and housebound who are unable to travel to a hospital site for diabetic retinal screening. Clinics are often run in GP practices for more convenience to the patient. With the advent of the new GP contract, some of the room space that was utilised is no longer available for this use. Optometry practices are ideally placed and already fully equipped and staffed to offer delivery of this service.

2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

Currently optometry practices are well placed in all areas across Scotland, including all SIMD 1 and SIMD 2 communities.

For example, in Highland:
- If all of the Highland population had to attend the hospital eye service (HES), the average trip taken would be 92miles (45.5miles each way).
- 34,700 patients live over 90miles away with average of 173miles round trip.
- 60,250 patients live over 30miles from Raigmore, but they ALL have an optometrist within 30miles.

In rural areas, like with other healthcare professions, workforce planning can be a challenge. Employers sometimes have to offer salary uplifts or relocation incentives to entice practitioners to the area.

A more sustainable revenue budget to support the current level of provision (especially in deprived / remote and rural regions), and maintain its geographic reach, coupled with a new capital budget will allow us to deliver a markedly better quality of service to all who would benefit from it.

Raising awareness for the need of regular eyecare will help mobilise older people those, with learning disability, people living under the deprivation umbrella, ethnic minorities to access community optometry practices sooner and again allow for earlier diagnosis and prevent the progression of ocular morbidity.

A targeted eye health awareness campaign will help deal with this issue.
3. How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?

There are optometry practices in every town and city across Scotland, that provide, easy, convenient access for patients without the need to travel to hospital. This also reduces the burden of care on GPs, other carers and secondary care, and reducing the carbon footprint.

Rapid access to an expert eye service allows for more efficient care for patients. As they can often be seen more quickly, a diagnosis can be made, and treatment commenced. This ensures that progressive morbidity is avoided and allows for detection of other conditions, early intervention and prevention of progressive disease and sight loss.

The new GOS service has led to an overall reduction of patients being referred to secondary care. This has allowed for timely intervention in the community, with over 80% of patients being managed in primary care and the remaining benefitting from effective prioritised referral to secondary care.

Further to this, there are exemplar models of optometric care across Scotland. For example in Lanarkshire and Grampian, there are schemes which have fully established optometry as the first port of call for all eye problems. This type of activity has ensured patients are seen in the community by an appropriate clinician, rather than attending secondary care.

All across Scotland, ‘walk-in’ eye casualty facilities have closed and replaced by a booking system for eye emergencies following appropriate triage by community optometrists.

Communication

All members of the multi-disciplinary teams should have a good understanding of the role of all other professionals to ensure adequate communication between carers and effective advice & support for patients. For optometry, this would mean that all of those dealing with patients are aware of the benefits of eye health assessment, particularly for vulnerable groups to help ensure a safe and independent lifestyle, a reduction of co-morbidity, resulting to less risk such as avoidance of falls.

By improving communication and pathways between Primary Care providers would ensure that the patient is at the centre of their healthcare journey and avoiding the risk that they are not receiving the treatment that they require when and where appropriate.

How to evaluate outcomes

One way of evaluating outcomes is to conduct clinical audits. There are already various audits being conducted across Scotland. For example in NHS Grampian, optometrists take part in regular clinical audits relating to their emergency eye care scheme. The data includes the patient’s reason for attending the optometrist, the total number of referrals to hospital by an optometrist and what condition they have been treated for.
Results from an audit in 2018 found that 87.7% patients who presented with an emergency were seen in practice rather than attending secondary care. In December 2016, 329 patients were seen over a 7 day period with 90% seen at the presenting practice. At this same audit, optometrists contacted the hospital for 15% of these patients and out of this, 26% required advice on what to do and only 20 patients were seen by the hospital (6% of total patients attending with an eye complaint). These patients would have all previously attended the hospital.

In NHS Lanarkshire, audits of attendance at A&E before and after the LENS scheme were taken at all three A&E sites across Lanarkshire. These results showed a 60% reduction in eye related A&E attendance over a one-year period.

Patient satisfaction was also monitored and it was found that patient satisfaction with the service was over 95% across a number of parameters of service provision. GPs across Lanarkshire were also contacted and were very satisfied with the service and the care provided for patients.

The walk-in eye casualty at Gartnavel General Hospital was closed following an audit of attendance resulting in increased triage by community optometrists and the establishment of an Acute Referral Centre for prioritised telephone appointments.

How to monitor prevention

Currently on all GOS forms, common conditions are documented. Utilising the ophthalmic data warehouse, an audit into these conditions can be monitored for prevalence. The patient journey can also be monitored through their CHI numbers.

How to monitor health inequalities

Health inequalities can be monitored by measuring the uptake of eye examinations. Utilising information from CHI numbers and from existing GOS data to audit the uptake of specific patient demographics attending for eye examinations, for example, age and gender. Further to this, patient’s postcodes can be monitored in SIMD 1 and SIMD 2 communities to ensure everyone is accessing the service.

Conclusion

Optometry Scotland welcomes the Primary Care Inquiry into how primary care should look for the next generation. Optometrists are already well placed around Scotland providing an excellent eye care service. With future support through GOS and by working alongside other health care providers, they can help support and improve the services provided to the community for the next generation.
HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM BMA SCOTLAND

BMA Scotland welcomes the opportunity to comment on the Health and Sport Committee’s consultation into Primary Care in Scotland.

A broad definition of Primary Care is that it includes care delivered by all of the professions that are signatories to the principles and includes both in- and out-of-hours care, both physical and mental health services, and services provided across all community-based settings.

Primary Care is provided by generalist health professionals, working together in multidisciplinary and multiagency networks across sectors, with access to the expertise of specialist colleagues. All primary care professionals work flexibly using local knowledge, clinical expertise and a continuously supportive and enabling relationship with the person to make shared decisions about their care and help them to manage their own health and wellbeing.

We are now well into the second year of implementing the new GP contract in Scotland and starting to look towards the development of Phase 2. At this stage it is encouraging to see that progress has been made in certain areas. We are very clear that the GP contract has set Scotland on the right direction of travel, however it is equally clear that there is still a lot of work to be done and the pace of change must increase over the next 20 months if we are to see a positive substantial shift and improvement in the way primary care is delivered in Scotland.

The Scottish Government and the health boards, along with Integration Joint Boards (IJBs) and partnerships, must work together to meet their commitments to the contract in full. The core aim of the contract was – and remains – to restore hope to the profession and make becoming a GP an attractive career choice for young doctors by lessening some of the burdens, such as inappropriate excessive workloads, responsibility for employing a large practice-based team, and the risks associated with owning practice premises. This goes for GPs right across Scotland, both urban and rural.

We are seeing some movement on this – with some areas beginning to feel the benefits of the work of multi-disciplinary teams which free up GPs time to spend with the patients who need them the most. But it is also true that we need greater efforts and clarity on how the extra staff to make this happen will be recruited and deployed by NHS boards. The Scottish Government’s forthcoming, but delayed workforce plan should address these issues and we look forward to it being published urgently.

Other positive developments include that from April 2019 a new minimum earnings expectation has been introduced which ensures that GPs in Scotland earn at least £84,630 (whole-time equivalent – and includes employers’ superannuation).
But of course, we cannot forget that there were huge challenges facing us when the contract was signed in 2018. Those deep-seated problems – such as there simply not being enough GPs – were never going to be solved quickly. So it is little surprise there is a mixed picture across Scotland, and varied progress. There is a lot of work to be done. We – BMA Scotland’s Scottish GP committee, the Scottish Government and health boards all have to play our part to the full to deliver our sides of the shared commitment.

As a result it is vital to appreciate the crucial period we are now entering with delivering the contract.

It is time to reduce the risks of general practice, and make becoming a GP a more attractive career choice again. It is only then – when we have enough GPs to deliver the work that is expected of them – can we really deliver the level and standard of primary care Scotland requires. Recruitment and retentions problems remain a real issue and they must be alleviated. Primary Care in Scotland will suffer greatly if they are not.

While of course, we must seek ongoing improvements and ensure the contract works well for all parts of Scotland, both rural and urban, equally it would dangerous to lose focus on the solutions and positive steps forward the GP contract has set in motion. The focus must be on implementation of the deal agreed, which would only be threatened by any dramatic changes in course. That does mean a renewed and clear focus on delivery of all parts of the contract from all partners. Only then will we achieve the kind of long-term stability in the GP workforce that will allow all partners to make progress on some of the more ambitious transformation that phase two of the contract has the potential to deliver. It is in this context that we have set out our answers to the questions posed below.

**Considering the Health and Sport Committee’s report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities.**

BMA Scotland welcomes the opinion that primary care needs to be delivered in a way that focuses on the health and public health priorities of local communities.

Intelligence gathered points to a lack of engagement with local communities currently, so a new mechanism needs to be developed in order to create a more streamlined approach.

Public health priorities for local communities will vary and therefore it’s correct that these decisions are best taken at local level – we believe HSCPs are well placed to deliver on this but have often, to date, been limited by the resources available to communities.

The intention of the new contract is to develop GPs as clinical leaders allowing them to engage in assessing and developing services to meet the needs of local communities, informed by good quality and timely intelligence. To facilitate this, new structures have been developed; GP Clusters where GPs from every practice meet to discuss quality improvement, and the GP Tripartite group (made up of Cluster Quality Leads, GP
Subcommittee and HSCP Clinical Directors). These structures will not have capacity to engage directly with local communities but can consider reports or HSCP strategies developed as a result of community engagement and, crucially, will allow GPs to focus on outcomes of relevance for patients.

GP Clusters and the GP Tripartite group will then be able to use their generalist medical knowledge and experience as clinical leaders of teams to comment on quality of services and to inform commissioning decisions of HSCPs. That should be mostly informed by clinical need and priorities, and we appreciate that this may, at times, need to be reconciled with public demand to make best use of clinical resources.

In addition to this, GPs need to be invested in to give them the protected time required to contribute effectively to these structures: they require a workload shift, with an increased number of GPs to backfill other GPs taking time out of clinical work. HSCPs need to engage more effectively, and directly, with local communities and feed that back to the GP structures.

It is also important to note that the priorities of local communities need to be framed in the realities of a system which is not able to provide everything that may be asked of it. This is the national conversation that BMA Scotland and the SGPC have been asking for.

**What are the barriers to delivering a sustainable primary care system in both urban and rural areas?**

The primary care system currently faces a number of barriers. Workforce supplies are a significant sustainability issue. The Scottish Government’s National Clinical Strategy wants to deliver more care at home or in a homely setting – but in order to deliver this effectively an increased workforce capacity is required: it simply cannot be done properly with the current numbers.

The current workforce within the primary care sector is aging: fewer people are coming in, and more people are going out. Transformation of the primary care sector requires a new workforce *in addition* to replacing those who leave and retire.

Clinical professionals are committed to helping people understand how they will benefit from new ways of offering primary care, and to listening respectfully to concerns and preferences, but progress can often be slow, and change resisted. Ensuring the best outcomes for people using primary care services requires the full clinical team to work together with patients and families, using the full range of face-to-face and technological options, to address health needs collaboratively. This can mean, for example, convincing someone that an appropriate, direct referral to a nurse, physiotherapist or other clinician is enhancing the service primary care provides, not diminishing it.
However, there is a lack of investment in infrastructure to accommodate community care staff – who require good IT connectivity between them – and replace facilities that have outlived their use.

The lack of a national conversation about what kind of health service the public really wants is also a major barrier to delivering a sustainable primary care system. We need to know what is important to them, whilst ensuring they appreciate that there are limits on total expenditure and some things will need to be either/or. Primary care is always expected to be there, and accessible at all times: however, when waiting to see a GP are too long, sometimes the view is that this is because the service is inefficient rather than they simply lack capacity.

Another barrier is that often issues are approached from the wrong side: instead of looking at current hospital workloads and asking what are we doing in hospital which could be done by GPs/Primary Care we should be asking what is going on in General Practice and the community which really needs the involvement, expertise and facilities of secondary care, and what would the most effective patient pathways be, taking account of the use of both secondary and primary care resources?

Finally, a major barrier for primary care – in both urban and rural areas – is the lack of young GPs who have the confidence to take on partnerships, which are the basis of sustainable general practice across the country.

**How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?**

BMA Scotland believes General Practitioners require better intelligence and data on what they are doing and the health outcomes: referrals, A&E attendances, unscheduled care admissions, days occupancy. Prescription costs adjusted for age and sex need real-time data to build the case for improvement and, in some cases, additional investment. GP Clusters working with Public Health and the LIST analysts from NSS will also determine what intelligence is most useful to them, allowing them to improve quality outcomes.

GPs and primary care workforce also need to be aware of the number of children on ‘at-risk’ registers, numbers of suicides, numbers of drug-related harm in order to identify areas that require increased support for these issues.

Data must be gathered in a consistent way across Scotland and across different members of the service. The IT used by the MDT needs to be able to be integrated – this issue is central to what we seek to achieve through Phase 2 of the Scottish GMS contract, whereby in future the case for additional health resources, including additional GP time, additional
health visitors, district nurses, mental health workers, drug and alcohol counsellors, needs to be based on needs and activity.

It is also important that this intelligence is delivered in a positive manner in order to encourage reflection and improvement.

GPs within the GP Clusters and GP Tripartite group will, as senior clinical decision makers, be responsible for assessing performance of their own practices and that of the wider community team, and will evaluate change through considering quality outcome measures. HSCPs and Public Health, along with the Scottish School of Primary Care will have a role also in evaluating the effectiveness of MDT and GP Cluster working – much of which will require long-term studies to capture changes in clinical outcomes which will only become apparent over years.
HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM RCGP SCOTLAND (ROYAL COLLEGE OF GENERAL PRACTITIONERS)

1. Considering the Health and Sport Committee’s report on the public panels, what changes are needed to ensure that primary care is delivered in a way that focuses on the health and public health priorities of local communities.

General practice is at the frontline of the NHS, playing a crucial role in providing primary care to patients in the heart of communities across Scotland. RCGP Scotland members have reported increasing workload pressures, rising patient demand and continued underinvestment in general practice are having a significant impact on them and their patients. Therefore, RCGP Scotland is calling for commitments to urgently bolster the GP workforce and increase the level of spending in general practice to 11% of the Scottish NHS budget. Appropriate resourcing will enable general practice to provide the high quality care that meets the current, and future needs of patients in Scotland.

- **Increase investment to general practice**
  The renewal of general practice must be underpinned by increased funding for service. General practice must receive 11% of the total NHS budget to enable an increased workforce with new roles that create sustainable workload levels, development of teaching and training for general practice, and digitally enabled care for patients.

- **Build a workforce to meet patient need**
  Planning the GP workforce using headcount numbers is not sufficient because it does not take into account the working patterns of GPs. In order to meet the current and future needs of patients in Scotland, general practice workforce planning must be realistic and reflect the differing needs of communities across Scotland.

- **Provide time to care**
  GPs must be given the time that they need to care for their patients. Increasingly, 10-minute appointments don’t work for patients or GPs. With minimum 15-minute appointments being provided as standard, patients would be given more choice over their care. To achieve this, more GPs must be introduced into the system.

- **Improve healthcare systems for the benefit of patients and GPs**
  Urgent investment in IT is required to ensure that systems work more effectively together, improving reliability for clinicians and patients. Before new digital services are rolled out, they must be fully evaluated to ensure that they improve patient safety and reduce health inequalities and clinician workload.

- **Tackle health inequalities**
  GPs play a vital role in tackling health inequalities. GPs serving areas with high socio-economic deprivation should have access to appropriately increased resource, to ensure that the NHS is at its best where patients need it most. Community Link Works should be rolled out to practices across Scotland, with practices in areas of high deprivation prioritised.

- **Promote Scottish general practice**
  Increased exposure to general practice during training encourages medical students to pursue a career in the profession. General practice should be supported through adequate investment to enable 25% of the undergraduate medical school curriculum to be delivered in primary care. GPs who wish to return to general practice in Scotland after moving abroad should be able to do so as easily as possible through adequately funded and publicised return-to-practice schemes.

- **Safeguard the future of the NHS in Scotland**
  We need a National Conversation, led jointly by politicians, healthcare professionals and patients, to promote sustainable use of the NHS and safeguard its future.

2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

In RCGP Scotland’s recent national policy report, From the Frontline, 30 key recommendations were made to reflect the feedback that was received from GPs across Scotland during the report’s development. It is not an easy time to be a GP within Scotland’s primary care system, with workload rising and a diminishing
GP workforce. While From the Frontline explores many current barriers, and proposed solutions, in detail, the following will look at key policy areas where we believe change would result in a more sustainable primary care system for patients and clinicians.

**Workforce**

General practice in Scotland faces significant workforce challenges which must be tackled by policymakers if the future of the profession is to be secured. There are not currently enough GPs working in Scotland to meet rising patient demand. Many GPs are choosing to leave the profession, and we are not recruiting enough new GPs to meet the deficit.

The most recent figures from NHS National Services Scotland’s Primary Care Workforce Survey 2017 show that the estimated number of whole time equivalent (WTE) GPs working in Scotland has been steadily declining in recent years, with levels falling from 3,735 WTE GPs in 2013 to 3,645 in 2015, to 3,575 in 2017. This represents a decrease of more than 4% over the period.

In December 2017, the Scottish Government pledged to increase the GP workforce by 800 additional headcount GPs by 2027. Whilst this was welcomed by RCGP Scotland, no commitment was given however to how many sessions of time these GPs would be expected to provide, making this workforce planning less reliable in terms of accuracy. With increasing numbers of GPs choosing to work part-time, it is likely that these additional 800 GPs will represent a far smaller number of WTE GPs. While we recognise the impossibility of predicting individual GP working pattern intentions, we call for workforce planning to be based on aspirational WTE numbers rather than headcount numbers to ensure more accurate predictions and allow recruitment efforts to be adjusted accordingly.

Workforce challenges are felt particularly acutely in remote and rural areas and in the Out of Hours service, where a range of factors are culminating in a lower number of GPs. A concerning decrease in both headcount and WTE numbers for GP Out of Hours services is reported between 2015 to 2017.

RCGP Scotland’s Key Asks on the topic of Workforce are:

- Policy makers must ensure that workforce planning is based on WTE figures and not headcount to ensure accuracy around the planning and reporting of recruitment efforts
- RCGP Scotland calls for the establishment of a new target for the number of WTE GPs needed in the workforce by 2024/25 to meet growing demand

**Workload**

RCGP Scotland members report a rising workload along with rising patient expectations and demand. We are caring for an ageing population where more and more people are living with multiple long-term conditions. We are experiencing increasing fragmentation of community-based teams, challenges at the interface between primary and secondary care, entrenched health inequalities, continued funding pressures and a diminishing Whole Time Equivalent (WTE) GP workforce. All these factors impact the wellbeing of Scotland’s GPs.

The diversity of GP roles across the country makes workload all the more challenging to understand and measure. Understanding the reasons for poor practitioner wellbeing that stem from issues surrounding workload, and working with key partners to find solutions, is a key priority for RCGP Scotland. For example, the clinical breadth of workload in remote and rural settings, where the wider MDT is less available, can look and feel quite different to the high-volume workload of deprived urban settings, which will often have an element of social complexity. The second phase of the new GP contract (“Phase 2”) will specifically measure workforce, income and workload, encapsulating the range of clinical settings and their specific challenges, and crucially try to measure (and resource) workload based on patient need rather than demand.

RCGP Scotland would like to see moves to enable a “minimum of 15-minute consultation” as standard, because current 10-minute consultations do not afford GPs the time they need to care for increasingly complex care needs of patients, and more people who are living with multiple long-term conditions within communities. This will only be possible by increasing the number of GPs and reducing their current workload.

GPs are at the frontline of healthcare in our communities. We need to continue to address the multiple issues that are impacting our highly skilled, highly dedicated workforce so that they feel valued and can re-discover the joy of general practice.

RCGP Scotland’s Key Asks on the topic of Workload are:
RCGP Scotland involvement in how workload is measured for Phase 2 of the GP contract, to capture and reflect the complexity and diversity of our workload challenges in different settings

Longer consultation length as standard, allowing GPs to engage more meaningfully with their patients and their often-complex needs

The Interface

The “interface” as it relates to healthcare, is the point at which two systems come together, be it primary and secondary care, in-hours and Out of Hours care, health and social care, or within primary care itself across the multiple interfaces of extended multidisciplinary teams.

These systems are independently complex and do not always relate or communicate well with each other. Their different IT systems, cultures and priorities all contribute to this. Consequently, interfaces are points of high risk for patients accounting for 50% of all medical errors, with one third of those errors occurring at the primary-secondary care interface. On the other hand, a well-functioning interface impacts positively on patient safety, efficiency of systems, patient experience, interprofessional relationships and morale. This is what we should be striving for and has underpinned why improving the primary-secondary care interface has been a key priority area for RCGP Scotland over recent years.

Even though there is increasing recognition throughout all areas of health and social care, and among policy-makers, that efforts need to be focussed on improving our interfaces and promoting more collaborative ways of working, many significant barriers still exist. Inadequate IT systems, that do not allow reliable or efficient clinical information transfer across interfaces, are a frequently cited concern by the profession due to the detrimental impact on the quality and safety of patient care, and on wider system efficiency. These also limit the development of clinical decision support (for example, dedicated email advice lines) to enable management of increasingly complex patient needs within the community, with the potential to reduce unnecessary investigation, referral or admission.

Another barrier to improving interface working is the lack of opportunity for clinicians to come together across the interface. Joint learning events are now very rare, as clinician workload across the healthcare system has increased along with their tendency to work in silos. The new GP Contract has taken a small step forward in this regard, with the provision of one protected learning session per month, per practice. This is clearly welcome but is inadequate to allow GPs and other clinicians the time needed to undertake this interface work effectively. An increase in protected learning time will likely improve clinical care and Quality Improvement work, and indeed may help to achieve the aim of growing the GP workforce by building-in time to learn.

RCGP Scotland’s Key Asks on the topic of The Interface are:

- Dedicated interface groups in every Health Board area should be mandatory and not optional, with interface improvement included in the strategic plans of Integrated Joint Boards
- Urgent investment in IT infrastructure is required to improve interoperability, accessibility and the reliability of clinical systems
- Increase overall protected “time to learn” for GPs to allow more opportunity for joint learning and service development with hospital colleagues

The Patient Voice

RCGP Scotland has called for a National Conversation between clinicians, decision makers and the public. That conversation requires two layers. First and foremost is one concerning how society views future sustainable use of the NHS, more than seventy years after its inception and in the face of rising public expectations and demand. The second, and more specific issue for GPs at the current time, is how to engage and educate the public about the new models of primary care resulting from the GP contract in Scotland. These new models involve appropriate delegation of clinical work, traditionally undertaken by GPs, to other members of the wider MDT with receptionists (or “care coordinators”) playing an active role in non-clinical triage and “signposting” at the first point of contact. In addition to the feedback received from the ALLIANCE events, there is much anecdotal evidence from GPs that many patients are struggling to understand, accept and navigate these new systems. This is putting additional strain on practices. This evidence has been reinforced by the results of the latest RCGP annual tracking survey. Two questions were included for Scottish GPs to determine how patients were responding to these changes.

The majority of respondents stated that significant levels of clinical time were being spent educating patients, and that significant numbers of patients were expressing distress, anger or confusion at being asked for additional information by receptionist colleagues when contacting the practice. This has provided
a useful evidence base on the critical need for any local education to be supplemented and supported by a
national information campaign, whilst considering the highly variable levels of health literacy across our
country.

The voice of the modern patient is increasingly a digital one. As technology continues to create new ways
of accessing care, patients and clinicians will need support in using these new systems. There is concern
that without adequate digital infrastructure to support these new models, particularly in remote and rural
areas where broadband speed and mobile signal may be poor, this may result in a new “digital Inverse
Care Law” with the use of such services dominated by those with least medical need. RCGP Scotland calls
for Health Equity Impact Assessments where each new implementation is evaluated for its impact on
practices and patients in more deprived and remote areas. Further research is also needed to fully assess
the impact and potential unintended consequences of new technology on both patient safety and GP
workload.

RCGP Scotland’s Key Asks on the topic of The Patient Voice are:

- Work collaboratively with Scottish Government and Health Boards to develop a public education
campaign about the changing models of care in general practice to support GPs and their wider primary
care teams
- Gain public agreement on how to use the NHS sustainably through a cross-party National
Conversation, led jointly with healthcare professionals and patient groups
- Before wider adoption, all new digital services should be fully evaluated in terms of impact on patient
safety, health inequalities and clinician workload

3. How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored
and evaluated in terms of outcomes, prevention and health inequalities?

The Multi-Disciplinary Team (MDT)

Under the terms of the new GP Contract, the Scottish Government aims to expand the number of other
healthcare professionals working with GPs within a wider primary care MDT. For a number of less complex
medical issues it makes sense that patients can be seen by an alternative healthcare professional, such as
a Mental Health Nurse, Pharmacist, Physiotherapist or Advanced Nurse Practitioner, when it is safe and
appropriate for them to do so. This enables the GP to have additional time to see patients presenting with
more complex or multiple problems, which is when the GP’s medical expertise is most needed. There is a
significant need for more local flexibility to enable safe and efficient patient care with co-ordinated services
led by GPs as expert medical generalists.

RCGP Scotland supports the valuable role other healthcare professionals can bring to patient care in
general practice and regards these as safe and effective clinicians who form an integral part of the wider
enhanced team, both in-hours and Out of Hours. However, we must ensure that these important primary
care professionals will complement and bolster the role of the GP, not substitute it. Nor must it be viewed
as a “sticking plaster” for difficulties in retaining and recruiting GPs, by simply moving workload elsewhere.

As teams expand, we must remain mindful of the potential risk of fragmentation of care. Expansion of the
MDT must be complemented by improvements in IT systems to facilitate safe and reliable communication,
and access to clinical information, to ensure the continuity of care that patients value so highly. We must
also protect time within the working week for the new members of the wider team to both learn together and
build these new teams. Essential ingredients for any successful change management include establishing
relationships of trust, having clarity and respect for each other’s roles and limitations, and having a shared
purpose and goal around patient care.

Clusters

RCGP Scotland wishes to see implementation of the national guidance for Clusters, co-written with SGPC
and Scottish Government, with input from key stakeholders, to allow Clusters to focus on local quality work
as intended. Clusters offer huge potential to share best practice and learning as they mature, but this will
require adequate and consistent resourcing. It is also crucial that high quality primary care data is available
to all Clusters across the country to inform local decision making and measure outcomes. This in turn is
dependent on adequate IT systems to support schemes such as Scottish Primary Care Information
Resource (SPIRE) and the Primary Care Clinical Dashboards, together with local data analyst support.

Health Inequalities
The mechanisms for addressing health inequalities, within existing allocated budget, sit at a local level through local structures (Health & Social Care Partnerships, Integration Joint Boards) and Primary Care Improvement Plans (PCIPs). There is significant variation in how health inequalities are being approached locally within PCIPs and there are varying levels of interest and commitment to address these inequalities in different Health Board areas. There needs to be a more robust and standardised approach, and a better understanding of where the responsibility lies, to address this important issue, be it at a central or a local level.

**Monitoring and Evaluation**

With new models of care proliferating across Scotland, there is a need to develop a robust evidence base to support policy and funding decisions at a local and national level. The Scottish School of Primary Care is a well-respected and valued organisation which is well placed to add value to the current climate of primary care reform, as evidenced in the recent report entitled *National Evaluation of New Models of Primary Care in Scotland.*
Name of petitioner
Karen Murphy, Jane Rentoul, David Wilkie, Louisa Rogers and Jennifer Jane Lee

Petition title
Medical care in rural areas

Petition summary
Calling on the Scottish Parliament to urge the Scottish Government to:
1. Ensure strong rural and remote G.P. representation on the remote and rural short life working group, recently established as part of the new GP contract for Scotland.
2. Adjust the Workload Allocation Formula (WAF) urgently in light of the new contract proposals to guarantee that both primary and ancillary services are, at least, as good as they are now in all areas so patients do not experience a rural and remote post code lottery in relation to the provision of health care.
3. Address remote practice and patient concerns raised in relation to the new G.P. contract.

Action taken to resolve issues of concern before submitting the petition
We and other patients have been contacting community councils, county councils, constituency MSPs, regional MSPs, the outgoing chair of the BMA Scottish G.P Committee, Shona Robison, the Cabinet Minister for Health and Sport and Miles Briggs Shadow Cabinet Minister as well as the First Minister, Fergus Ewing, the Cabinet Secretary for the Rural Economy and Connectivity and Maurice Corry MSP. Small communities have also been sending petitions to HSCPs.

Petition background information
A new G.P. contract implemented on the 1st April 2018 places rural and remote areas at a severe disadvantage in relation to the provision of medical care, and compromises the viability of sustainable communities. There are actions which need to be taken urgently to protect rural and remote practices and ensure the communities they serve experience health equality. There is to be a remote and rural short life working group Short Life Working Group (SLWG), which acknowledges the need for action.

Official Consultation.
The public consultation for the new G.P. contract began in February 2018, only two months prior to its implementation on 1st April 2018. Of the events publicised 6 were in cities with one being held in Portree. Patient pressure led to facilitation packs so rural and remote groups could hold meetings and submit their views, although there was insufficient time for many rural and remote communities to organise their own facilitated groups. An additional video event linking a number of communities in town hubs was also arranged at the last minute, but this was not done in open video format, so did not allow access to all rural and remote patients.

The events did not provide full details of the new G.P. contract and did not explore in the detail needed the detrimental impact it would have on small rural and remote communities. At the time of the engagement the new G.P. contract was already a foregone conclusion and the ‘consultation’ therefore a meaningless exercise. Unfortunately however it was disingenuous in raising patient expectations of quick access to numerous health professionals, which is far from what will happen in rural and remote communities given the complexity of the issues in these areas. We are still awaiting the final report and Governmental response to this ‘engagement’ a month after the consultation ended, so unfortunately are not able to include their findings. This demonstrates the woeful speed with which rural and remote issues are being addressed, it is hoped that this petition will be met with a more timely action.

**Grassroots Action and Activism.**

Because of the lack of notice and poor engagement by the Scottish Government a Facebook page (Rural and Remote Patient Group) and Twitter account (@RuralPatients) were set up to try to establish contact between rural and remote communities and inform them what was happening. Since they have been set up the page has had over 4.1k post reach, 1.5k post engagement and has been shared in Mull, Skye, Benbecula, Lerwick, Dingwall, Ullapool and Fort William, to name a few areas. As a result there is some communication between widely dispersed rural and remote populations, this continues to have a ripple effect as increasing numbers find out the implications of the new G.P. contract.

There has also been considerable interaction by email, telephone and in person from patients who are not on social media, and the issue has been covered in rural and remote local printed media, T.V and community forums as a result. Meetings have been held in small communities; Carradale held a meeting with well over 100 residents attending and subsequently the MSP came to a meeting about the issue, again attended by over 100 people. Luine, Kilmelford, Oban, Conell etc. have all held meetings which have been as proportionately well attended. There is a ‘big picture’ which the Scottish Government are failing to take into account.

**Response to concerns raised by remote G.P.s and patients.**

To date, engagement from the Scottish Government has been felt to be defensive, seeking to deflect enquiries and dismiss concerns. The standard of replies and engagement people are experiencing is very poor, demonstrating a lack of understanding of the complexity of issues and the urgency with which it needs to be addressed. For example, politicians are repetitively insisting to their constituents that core funding will stay the same, but are either ignoring or are ignorant of the fact that the changes will affect enhanced service funding very early in the process, and the core funding subsidy is due to end with phase one, thus undermining provision.

**Underpinning Issues.**

In January 2018 the Scottish G.P. committee and the Scottish Government agreed a new G.P. contract. Despite being hailed as having strong backing and consent of G.P.s only 39% of G.P.s voted and of this only 71% voted in favour of the contract, which means that only 28% of G.P.s voted for it. The contract will have severe detrimental consequences for rural and remote practices, already under represented in patient numbers and always at a disadvantage compared to urban areas.

The BMA have not given the Rural G.P. Association of Scotland (RGPAS) or patients detail about regional breakdown in voting so, in the absence of data, they conducted their own survey. Of 115 members there was a 65% response rate (74 responded) and 89% of the RGPSAS voted no. This information, used in advance of implementation
would have triggered the need for an impact assessment and demonstrated risks to communities. People, already disadvantaged in many aspects of their lives because of where they live are now faced with the consequences of serious inequalities in health care provision.

RGPAS has released data which demonstrates the impact the contract will have on specific areas (https://fusiontables.google.com/DataSource?docid=13SLV8fjU8S5LvhlMcbmUWpK8imunTF2f1f1r_q7#map=id=3). The Scottish Government classifies every postcode on how rural and remote it is and a patient has mapped this against the heat map and confirmed that every one of the 73 very remote and rural practices will see a reduction in funding (see below) which will be balanced by a subsidy only in phase one. Urban areas are however receiving increased funding and resources in phase one.

**GP contract Heatmap data**

See Table 1 of the additional data provided by the petitioner

**The Workload Allocation Formula and The Way Forward.**

This negative effect is due to the Workload Allocation Formula (WAF) which, with surgical provision, targets rural and remote practices and the communities that make up 20% of the population, by reducing their funding. There is something very wrong with a resource allocation system that does not work for one fifth of the population, a concern already raised by Prof. Phil Wilson, an expert in care and director of the Centre for Rural Health at Aberdeen University. However, these concerns have not been addressed by the Scottish Government. The contract itself is a very urban centered model that will work well where there are economies of scale, good transport links, housing employment opportunities etc, but undermines the provision of primary care that has been specifically and individually tailored to meet the demand of rural and remote communities in challenging geographic areas.

Rural and remote G.P.s, patients, Practice nurses and Teams, HSCP and IJBs can already see the obvious pitfalls occurring with implementation of the contract (although in some cases IJBs have been racing ahead with plans, contrary to what the Scottish Government has promised). They also have expressed serious reservations about the use of the WAF in rural and remote areas, so it is disappointing that the BMA and Scottish Government are not acknowledging the difficulties, and the BMA are not paying sufficient attention to RGPAS. The patient groups have demonstrated a groundswell of public support which we trust will not be ignored due to political inertia.

**Praise and Petitioning.**

Urban and rural practice are necessarily very different from one another. There is a lack of acknowledgement of this reality in the new contract. It appears that the idea is to turn the lights out on the rural and remote communities that support and sustain our countryside and food security, by removing the key services that sustain them, including the G.P. Doing this means it won't be long before everyone suffers, including those who live in urban areas - we all need a vibrant countryside, farming and fishing sector to support communities and attract tourism.

The Scottish Government is to be commended for securing a contract which benefits so many citizens, but the table below indicates just how many of the population registered with a practice and living in rural and remote areas, will experience severe health inequality as a result of a decrease in their practice's funding.

**No of patients on list Change under new GP contract**

See Table 2 of the additional data provided by the petitioner.
<table>
<thead>
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<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you wish your petition to be hosted on the Parliament’s website to collect signatures online?</td>
<td>YES</td>
</tr>
<tr>
<td>How many signatures have you collected so far?</td>
<td>0</td>
</tr>
<tr>
<td>Closing date for collecting signatures online</td>
<td>18 / 07 / 2018</td>
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<td>Comments to stimulate online discussion</td>
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HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM Deep End GP Group, Scotland.

“The NHS promise of comprehensive health care based on need and free at the point of use trips off the tongue, but has been hard to deliver especially in primary care… the NHS could and should be a model for wider society, as a gift economy based on giving as well as getting…Inclusive health care, excluding exclusions and building relationships, is a civilising force in an increasingly dangerous, divided, and uncertain world” [1].

The Deep End Group welcomes the opportunity to respond to this consultation from the perspective of frontline General Practitioners in Scotland serving the 100 most deprived populations in Scotland. The Deep End Project originated in Scotland and has now been emulated in Ireland, England and Australia. Deep End work addresses the longstanding but largely neglected NHS issue of the inverse care law [2], with activities and projects involving collaborative working to produce sustainable solutions. The challenge has become how to apply these examples in larger numbers of practices across Scotland.

Of the most deprived 15% of the Scottish population, one third are registered with the 100 most deprived practices as described above, while the other two thirds are registered with about 700 other general practices in Scotland; very few general practices in Scotland do not have Deep End patients [3]. This Deep End response references the projects (Govan SHIP, Pioneer, embedded Welfare workers, and Community Links Workers) we believe are necessary vehicles of primary care transformation across Scotland, but particularly in areas of deprivation where health and social care needs are greatest.

The Deep End Group endorses many of the Panel’s priorities themed around availability and accessibility, communication and trusted relationships. The Panel highlighted several issues that are key to Deep End thinking, e.g. sustained relationships with health staff who know individuals, greater engagement and consultation with patients about services, more effective triage for primary care services, easily accessible information about, and referral/signposting to, services, GPs at the heart of the primary care hub but sharing responsibility with other professionals for care and sign-posting.

The proliferation of specialised services in both secondary and primary care, with referral and exclusion criteria, has resulted in fragmented care for the increasing numbers of patients with complex multi-morbidity, many of whom lack the knowledge and confidence to cope with fragmented care arrangements, involving poor communication, continuity and coordination. Neither patients nor the NHS can afford the results of health care fragmentation and diminished effectiveness of the GP gatekeeper in tackling unmet need and overconsumption of services. This translates into poorly coordinated care, so that complications of physical and mental health conditions are less likely to be prevented, delayed or lessened, resulting in unnecessary pressures on A&E and other emergency services. The strengths of the specialist approach need to be matched by equivalent support to maximise the generalist clinical function, providing unconditional, personalised continuity of care, mostly in the community, for all patients, whatever problems or combinations of problems they may have.

The various Deep End projects are examples of ‘middle ground’ research and practice that demonstrate the difference that GPs and the primary care team could make to health inequalities when resourced adequately. There is a commitment from the Deep End group to expand the experience, evidence and learning across all general practice in Scotland [4].
Long term physical and mental health issues can restrict health and well-being and active participation in community life. In Deep End communities the onset of multi-morbidity occurs 15 years earlier than in more affluent communities [5]. Patients do not present in neatly packaged categories of health needs that fit defined healthcare pathways with an easily identified start and end point. This applies especially to mental health problems - whose ubiquitous nature in primary care, often as co-morbidities, cannot be addressed effectively by supporting mental health services as a separate, referral-based (i.e. arm's length) activity.

To navigate the best services to address a particular patient’s needs requires a primary care workforce that has expertise in risk management, safety netting, and referral into specialist services at the most appropriate time by anticipating a decline in any combination of physical, psychological or cognitive function.

The core team of Primary Care clinicians includes General Practitioners, Health Visitors, District Nurses, Advances Nurse Practitioners, Midwives and Pharmacists. The Primary Care network is expanding, however, reflecting changing demographics and the demands of managing complex multi-morbidity. It includes colleagues from Social Work, Addiction Services, Physiotherapy, Optometry, Community Mental Health Services, Community Links Workers and others from the Third Sector who are co-located, aligned or embedded within GP practices/Health Centres. The external evaluation of the Govan SHIP project [6] provides a detailed account of the challenges to integrating inter-professional working within an expanding health care system.

1. Considering the Health and Sport Committee’s report on the public panels, what changes are needed to ensure that primary care is delivered in a way that focuses on the health and public health priorities of local communities?

- Attention to the learning from Deep End projects could drive the transformational change that is required, including a recalibration of the relationship between specialist and generalist clinical practice. The Deep End Group would encourage the Health and Sport Committee to read Deep End report 32 as a useful overview of this learning, including the “key ingredients” of: protected time for extended consultations and service development, attached workers (financial advisors, alcohol nurses, social care workers, mental health workers), enhanced multidisciplinary team (MDT) working, and coordinating projects involving groups of practices [4].

- Assessment and/or re-assessment of patients’ needs (or, more accurately, their uncoordinated care), was achieved in the Govan SHIP Project, the Care Plus Study and the GP Pioneer Scheme via extended consultations, which helped reset the agenda, establish priorities and shape integrated care. Regular MDT meetings within the practice, and involving key external staff (e.g. district nurses, health visitors, social workers), provide important opportunities to share information (e.g. from different information systems), review cases, plan care and involve new colleagues.

- The Community Link Worker (CLW) Project is helping patients to live well and longer in the community by promoting links with community resources for health and healthy living. The original Deep End programme was not restricted to “social prescribing” but involved one-to-one support for patients with complex problems, i.e. a strengthening of the generalist function within practices. The Deep End Group remains concerned that, despite the initial policy intention, the rollout of CLWs in deprived areas has been partial.
Voluntary and third sector organisations are an important component of this landscape but need secure funding. The Parkhead Advice Worker project is a successful example of an embedded model which evolved from initial conversations and thinking at community level, into a service which delivered to those most in need, whilst giving vital support to those professionals working in areas of high deprivation. Embedding the welfare worker in the practice (not simply co-locating) enabled the establishment of trusted relationships to contribute to both the development and delivery of the services. This should be a generic approach to increase the ability of practices to manage local problems. The outcome of the project demonstrated a positive economic return on investment of £25 benefit generated for every £1 of investment. This model provides valuable learning for all GP practices [7].

Direct funding to the SHIP project afforded additional GP capacity and support to more complex patients, increasing access and time for consultations for patients with long term multi-morbidities. There is a detailed description of the practical use of additional GP capacity in Deep End Report 29 [8]. This funding also ensured significant GP contribution to project and work stream development. The work on information management and evaluation demonstrated how an understanding of demand across health and care services at GP practice level could be developed and created the evidence base through qualitative and quantitative evidence on potential areas for focus, input and investment. One example of significant benefit was pharmacy involvement beyond the traditional role of prescribing support. The SHIP pharmacist identified an average of 2.64 interventions per patient reviewed, demonstrating that there are pharmaceutical interventions to be made for almost every patient on medication irrespective of condition ranging from medication optimisation to changes in high risk medications to improve patient care [6].

Joined up planning for in-hours and out-of-hours GP and primary care services should be prioritised. Both systems employ the same workforce and serve the same patients. They should not be regarded as disconnected from each other as the challenges of complex multi-morbidity apply to both services.

2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

Barriers (and solutions) to delivering sustainable primary care in the Deep End include, in no particular order:

- **Addressing health behaviours and matching healthcare to needs.** This requires localised knowledge and time to engage with patients who are high users of the service. Research has shown that 10% of patients with 4 or more conditions accounted for 34% of unplanned admissions to hospital and 47% of potentially preventable unplanned admissions [9]. During the Govan SHIP project, 1,866 people were identified as high need, equating to 7% of the rolling population. When compared with the overall practice baseline, the SHIP population proportionately:
  - Reflected even higher levels of deprivation
  - Had higher levels of co-morbidity
  - Was skewed towards the younger and older age groups
  - Was skewed towards women aged 17-44

- **Patient Engagement.** This is a particular challenge in DE communities where patients often lack the agency and social capital to engage with planning organisations to influence the provision of their
health care and community needs but with effort it is possible. The Deep End Projects cited in this response have demonstrated the possibilities and value of community engagement.

- **Lack of time.** Pressure of time in Deep End communities and shorter consultations are barriers to providing empathetic care [10]. The extra time that was required to address health care needs in the local population during the SHIP is described in Deep Report 29. All the examples of unmet need required individualised GP and primary care team input but extra GP capacity was crucial for case planning and management. This additional GP capacity facilitated:
  
  I. Extended consultations  
  II. Polypharmacy reviews  
  III. Case review / planning  
  IV. Increased outward facing activity – such as child protection hearings, Adults with Incapacity (AWI) and Adult Support & Protection (ASP) procedures.  
  V. Leadership activities

- **Interface between primary care and secondary care.** Current arrangements provide little opportunity for generalist and specialist clinicians within localities to share experience, problems, views, information and activity particularly around points of risk for patients, e.g. at time of discharge when enhanced community support is required to ensure maximum patient recovery. Reduction of specialist community health services, e.g. Sexual Health Services most recently, can impact negatively on GP capacity as patients are redirected to GP because of increased waiting times. The small but multiple shifts of workload back to general practice are causing more stress on an already stressed system.

- **GP contract.** The GP contract planned changes will help but need to be fully implemented, e.g. vaccinations and travel clinics done by others, including the risk management decisions and judgements associated with this. For example, assessment of capacity, decisions about safety in relation to reactions to previous vaccines, decisions around safety of live vaccines.

- **Use of data.** Data capture and linkage between big data and small localised datasets which both give context to the health needs of the practice population. Govan SHIP gathered extensive data that helped the GPs and the extended team plan preventative health and social care, reduce GP demand and make better use of community support services. There were varied challenges, limitations and solutions involved in developing the data framework that are described in the evaluation [6].

- **Mental Health Services.** It is the Deep End view that mental health – in the widest sense – needs to be prioritised. The SHIP project had a strong focus on mental health recognising the frequency and chronicity of mental illnesses that DE GPs deal with on a daily basis [6]. A transformational change to the delivery of mental health services would include:
  
  I. Consideration of non-clinical responses to distress and suicidal behaviour;  
  II. Alignment of service user expectations with available help to facilitate straightforward access to the right kind of help and to maximise opportunities for self-management;  
  III. Supporting services users and carers to navigate service options and improve ‘signposting’;  
  IV. Moving away from traditional clinical models of referral and discharge from services, towards self-directed care, open access and brief and low-intensity interventions - ‘easy in, easy out’;
V. A commitment to simplifying access routes (e.g. self-referral to PCMHTs) with the use of link workers and "choice" appointments to work out how best to respond to more complex difficulties;

VI. A single point of entry for Mental Health services in OOH would help streamline the referral process and reduce the time that a distressed patient waits to access timeous Mental Health support. There should be less reliance on Police services to be used as proxy mental health services.

- **GP Recruitment and retention.** The particular challenges related to undergraduate teaching and postgraduate training in general practice in areas of severe socio-economic deprivation have been described in detail elsewhere [11]. The inverse care law, the unequal distribution of GP teaching and training, and the particular learning needs required to work in Deep End general practice are barriers to sustainable primary care. Potential solutions should be considered across the medical education continuum, from widening access to medical school for pupils from disadvantaged backgrounds, through medical school and postgraduate training, to improving retention of experienced GPs [11].

3. How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?

- The SHIP reports [6, 8] detail the effectiveness of MDT working which should be embedded in the HSCP cluster structures and scaled up. The principal of cluster working is sound but they remain immature structures with no clear guidance or template as to what their exact role is and it will be some time before they can deliver significant changes to the quality agenda. SHIP provides such a template for geographic clusters while the Pioneer scheme demonstrates how practices within a non-geographic cluster can share learning. The SHIP cluster had a clear aim with an excellent health service manager and clinical lead and individual GPs within the cluster happy to take on additional leadership roles within the cluster. This occurred because GPs had the protected time and support of their colleagues to design and introduce the changes required to facilitate this new way of working.

- The SHIP model of MDT working demonstrated extra value from more joined up management, better use of resources and services, shifting demand between health and social care professionals working to the top of their licence to avoid escalation of problems. This was effective in identifying vulnerability and addressing risk which might not have occurred otherwise.

- Key findings from the external evaluation of SHIP indicated this model of working showed promise for addressing the inverse care law with the GPs having additional capacity to plan for and address complex health and social needs, drawing on the expertise of social care and other health colleagues from within the MDT structure. At its simplest level, the discovery process of the MDT would identify contact details of allocated social workers and GPs allowing for appropriate and timeous (email for non-urgent issues) contact, avoiding system blockages or bottlenecks. One GP suggested that this could sometimes save up to 2 hours per week. Future efforts to develop multi-disciplinary team working should never underestimate the impact of bringing different organisational cultures together and the role of organisational development in planning for this. The SHIP project evidenced the overlap between demand for GP services, social work services and socioeconomic deprivation. This should be a driver for greater integration. Directly creating additional GP capacity may still be required in addition to releasing it through alternative resources to adequately meet patient need in deprived practices [6].
Summary

General practice needs not only to be rescued from underinvestment – resulting in unsustainable workloads, and consequent recruitment and retention challenges – but also imagined, developed and supported for what it needs to achieve in the future:

- Building strong patient narratives especially for patients with complex multi-morbidity (the sixth of patients generating half of NHS work).
- Building strong local health systems, based on GP hubs with embedded workers and links to other services and resources.
- Building a strong overall system, based on collegiality, shared learning and horizontal accountability.
- Supporting the career development of the local leaders of these developments, staying long enough to make a difference.

Response submitted, on behalf of the Deep End GP steering group, by:

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7. The Deep End Advice Worker Project: embedding advice in general practice. Accessed at: https://www.gcph.co.uk/publications/728_the_deep_end_advice_worker_project_embedding_advice_in_general_practice
HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM NHS Education for Scotland

1. Considering the Health and Sport Committee's report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities?

1.1 Primary care is the backbone of our healthcare systems – it is the key to continuity and integration, it is essential for patients, particularly those with complex needs\(^1\). It has been proven to be highly effective and efficient way to address the main causes and risks of poor health and well-being as well as handling the emerging challenges that threaten health and well-being tomorrow\(^2\). It addresses the health needs of all patients and improves the performance of health systems\(^3\).

1.2 The **training** of general practitioners needs to continually evolve to reflect the changing needs of society, and to deliver the goal of the **GP as the expert medical generalist**\(^4\) at the centre of a multi-professional team working across an **integrated health and care system** which ensures that there is collaborative working between the public, voluntary and other sectors for the benefit of the local community.

1.3 Some of these changes are already in train – for example, the educational reforms set out by the **UK Shape of Training Steering Group**\(^5\) are guided by the principal that medical education and training must be configured to meet the needs of patients, while needing to ensure that medical careers remain sustainable and fulfilling, and that central to the delivery of high quality care are those who work and aspire to work in our healthcare services.

1.4 NES is already supporting these changes by delivering flexible training options for doctors in primary care, including a **rural track training** programme\(^6\) which delivers the UK GP curriculum in a remote and rural context, and developing a **remote and rural credential**\(^7\) to support trained GPs working in rural general hospitals. Alongside this, NES provides training fellowships, including in **medical education**, **health inequalities**, **paediatrics** and **leadership** training for GPs\(^8\).

1.5 Although it takes 10 years to train a GP (5 years at medical school and 5 years in postgraduate training), it is recognised that this is the shortest training programme of any medical specialty in the UK. It will be essential, therefore, to ensure that resources continue to be available and refreshed to support the ongoing updating and **continuous professional development**\(^9\) of trained GPs, given the pace of change.

1.6 Whilst recognising the key role of the GP in the primary care team, there is a need to ensure the **development of the whole team**. This will include supporting career frameworks for **nurses** working in the community, in district nursing, public health, health protection, children’s nursing as well as general practice nursing\(^10\).
Pharmacists, and pharmacy technicians working in primary care will also have a key role to play, as will practice managers\textsuperscript{11}.

1.7 It is of note that a key priority to emerge from the committee’s report, and key message from the panels was the development of appropriate technology in support of primary care, including an electronic patient record, shared with all relevant professionals – a single set of records integrated across all care services – and a consistent platform, used for electronic test results, correspondence, etc.

1.8 In this context we would draw to the attention of the committee the development of the NES Digital Service – NDS\textsuperscript{12}. A key deliverable of the Digital Health and Care Strategy is a national digital platform which enables citizens and the workforce to easily access and understand the information they need, where and when they need it. NES has been requested by Scottish Government to lead development of the national digital platform to replace the current model of multiple systems which has led to duplication and placed limitations on our use of data.

1.9 The National Digital Platform will be developed with clinicians and the people who use services, to safely and securely deliver data to better support care, to allow for innovation and service development and to support research and the efficient use of services.’. The platform will be built, tested and rolled out through the development of products that improve the quality of patient care; and will connect to existing infrastructure to minimise disruption.

2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

2.1 Central to the delivery of high-quality care are those who work and aspire to work in our healthcare services. Supply into the primary care workforce – across all professional groups – but particularly the medical workforce continues to present challenges.

2.2 The number of medical graduates coming out of UK medical schools is currently less than the number of year one specialty training posts which we are seeking to fill to deliver the projected requirement for consultants and general practitioners. Substantial increases in medical undergraduate numbers have been announced both in Scotland and the UK, which will significantly improve the position, but it will be some years before these increased undergraduate intakes enter specialty training, and it is likely that further increases will be required.

2.3 It is also the case that some specialties are more popular than others amongst medical graduates, although the service requires almost 1 in 2 graduates to work in general practice. Significant work is required, therefore, to encourage a higher proportion of medical graduates to enter GP specialty training. Initiatives which are planned or under way include (i) working with the Scottish Funding Council and Medical Schools to improve the image of general practice and to increase the
proportion of the undergraduate curriculum which is delivered in primary care, (ii) increasing the exposure of early years (foundation) postgraduate trainees to general practice and (iii) working with the service to support more flexible approaches to working and training – including less than full time working and career breaks.

2.4 The committee will be aware that following an announcement by the First Minster of a 30% increase in GP training places in 2016, NES has substantially re-worked GP training programmes across Scotland, to both increase the number of programmes offered, and to improve their attractiveness. This has resulted in improved fill rates, and we expect to see almost a 30% increase in doctors completing GP training over the next 2 years.

2.5 In addition to improving the supply into the GP workforce, a number of approaches to retaining the existing workforce are essential – including supporting existing doctors through providing coaching, supporting GPs to stay in practice through the ‘Stay In Practice Scheme’\(^\text{13}\), supporting doctors who have left clinical practice to return\(^\text{14}\), supporting those who (for personal reasons) reduce their hours to retain\(^\text{15}\) their skills, and supporting overseas\(^\text{16}\) graduates who come to work in the UK to make a smooth transition into UK practice.

2.6 All of these initiatives, as well as those aimed at increasing the supply of the non-medical primary care workforce, will require a substantial increase in the available educational capacity in primary care. For example, currently, only 9% of undergraduate medical education takes place in general practice – so the ambition to increase this to 25% will require considerable investment in additional teaching capacity.

2.7 Similarly, there are substantial pressures on the available educational capacity for postgraduate training – of the 944 GP practices in Scotland, only 337 support the training of GPs, and only 105 support the training of early years (foundation) postgraduate trainees in a primary care setting. An education capacity group is currently exploring the capacity to deliver training of other health professionals within primary care, the role of clusters in teaching/training, and hub and spoke models to encourage non-training practices.

2.8 The delivery of a primary care workforce for remote and rural Scotland is a key priority. We know from the extensive research into workforce development conducted and commissioned by NES\(^\text{17}\) that ‘location’ is a key driver of the choices doctors make about where they aspire to live, work, and train. In short – doctors commonly aspire to live and work ‘where they came from’, and so the process of selection into undergraduate medical education is critical – not only in terms of widening access generally, but also in terms of ensuring access from a wide geographical area.

2.9 NES has invested in education and training to support the remote and rural health and care workforce, through the Remote and Rural Health Education Alliance (RRHEAL)\(^\text{18}\) supporting inclusive access and at distance educational engagement.
RRHEAL develops educational tools and links to material specifically relevant to teams supporting health and social care for remote, rural and island populations of Scotland.

2.10 For the medical workforce in rural areas, NES has put in place a dedicated (and popular) **rural-track training** programme, provides **bursary support** for training programmes in hard-to-fill areas, developed **rural fellowships** for GP’s following the completion of training, and is working with the service and the General Medical Council to develop a **remote and rural credential** as part of the ‘Shape of Training’ project.

3. **How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?**

3.1 Although primarily an area for the collection and analysis of data by NHS Boards, NES can support this area by building capacity and capability for Quality Improvement across the public service through a range of educational programmes and resources. NES has developed a range of training materials and tools to help individuals and organisations improve their understanding and knowledge of Quality Improvement. Formal face-to-face Quality Improvement education programmes available include the Scottish Quality & Safety Fellowship, the Scottish Improvement Leader (ScIL) programme and the Scottish Improvement (SIS) programme.

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2. WHO Primary Health Care, February 2019. (Link)
3. Van Weel C and Kidd MR Why strengthening primary health care is essential to achieving universal health coverage, CMAJ, 2018, 190, E463-E466 (Link)
5. Report from the UK Shape of Training Steering Group (UKSTSG) 2017. (Link)
7. GMC Credentialing, 2019. (Link)
8. NES GP Fellowships. (Link)
9. Continuing Professional Development – CPD Connect (Link)
10. Career development frameworks for nurses working in the community. (Link)
11. Practice Manager Development (Link)
12. NES Digital Service (Link)
13. GP Stay In Practice Scheme (Link)
14. Scotland GP Returner Programme (Link)
15. Scotland GP Retainer Programme (Link)
16. Scotland GP Enhanced Induction Programme (Link)
17. NEST Medical Directorate Education Research and Innovation Annual Report 2019 (Link)
18. The Remote and Rural Healthcare Education Alliance (Link)
19. Safety and Improvement Resources (Link)