The Scottish Parliament
Pàrlamaid na h-Alba

SPICe The Information Centre
An t-Ionad Fiosrachaidh

SPICe Briefing
Pàipear-ullachaidh SPICe

Primary Care in Scotland

Lizzy Burgess

This briefing outlines how primary care operates in Scotland to inform the Scottish Parliament's Health and Sport Committee's inquiry into "What does primary care look like for the next generation?".

29 May 2019
SB 19-32

Contents

Executive Summary

1. Primary care is normally a person's first point of contact with the NHS and it is where most patient contacts occur.

2. Primary care is provided by generalist health professionals including GPs, Nurses, Dentists, Pharmacists, Optometrists and Allied Health Professionals (AHPs) such as podiatrists and physiotherapists. The primary care team also includes non -clinical staff such as administration staff, managers and receptionists.

3. The Scottish Government's vision for the future of primary care services is of "general practice and primary care at the heart of the healthcare system. People who need care will be more informed and empowered, will access the right professional at the right time and will remain at or near home wherever possible. Multidisciplinary teams will deliver care in our communities and be involved in the strategic planning of our services" [1] .

4. The Scottish Government hopes that the transformation of primary care will help to put in place long-term, sustainable change that can better meet changing needs and demands [2] .

5. The Scottish Government's Scottish Budget: 2019-20 puts the budget for Community Health Services at £1.854 billion. This includes primary care services, community pharmaceutical services, general dental services, general ophthalmic services, mental health services and additional support for social care.

6. There are 31 Integration Authorities (IAs) in Scotland. These IAs have developed Primary Care Improvement Plans.

7. Like all areas of health and social care, primary care faces a number of challenges iaround an ageing population and an increase in the number of people with long term conditions.

8. The Scottish Parliament's Health and Sport Committee is running an inquiry into the future of Primary Care in Scotland, posing the question: **What does primary care look like for the next generation?**

Primary Care

For most people, primary care is their first point of contact with the National Health Service (NHS) and it is where the majority of patient contacts occur [3] . In 2011/12 GPs and practice-employed nurses combined had an estimated 24.2 million face-to-face consultations with patients [i].

Primary care is provided by generalist health professionals including GPs, Nurses, Dentists, Pharmacists, Optometrists and Allied Health Professionals (AHPs) such as podiatrists and physiotherapists. The primary care team also includes non -clinical staff such as administration staff, managers and receptionists.

In May 2017, a number of professional organisations representing clinical staff drew up an agreement, the future of primary care in Scotland: a view from the professions, which explained what is meant by the term 'primary care' and included a set of shared principles (see Annex A). It stated that:

> " 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."

NHS Boards are responsible for providing or securing primary care services for their populations. (The responsibility for running the NHS in Scotland is predominantly devolved by the Scottish Government to the 14 territorial health boards).

---

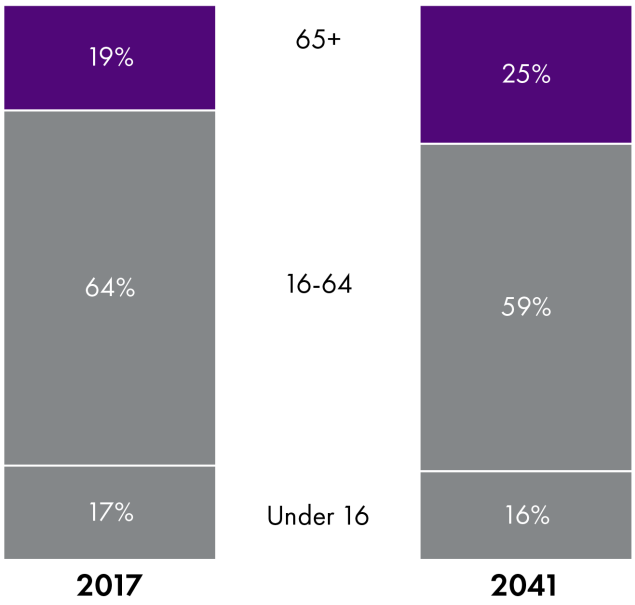
i ISD published information on the number of consultations until 2012/2013 when the Practice Team Information (PTI) data collection ceased. This information should become available through SPIRE but currently no timelines exist to when this might be likely [4] .

The Case for Change

As with many areas in the health and social care sector, primary care is facing an increase in demand for services placing increasing pressures on existing resources. Projected demographic changes will see the number of older people increase in relation to the number of younger people, as well as an overall rise in the number of older people.

The number of people aged 75 and over is projected to increase by 27% over the 10 year period, 2016 and 2026, and by 79% over 25 years (between 2016 and 2041) [5] .

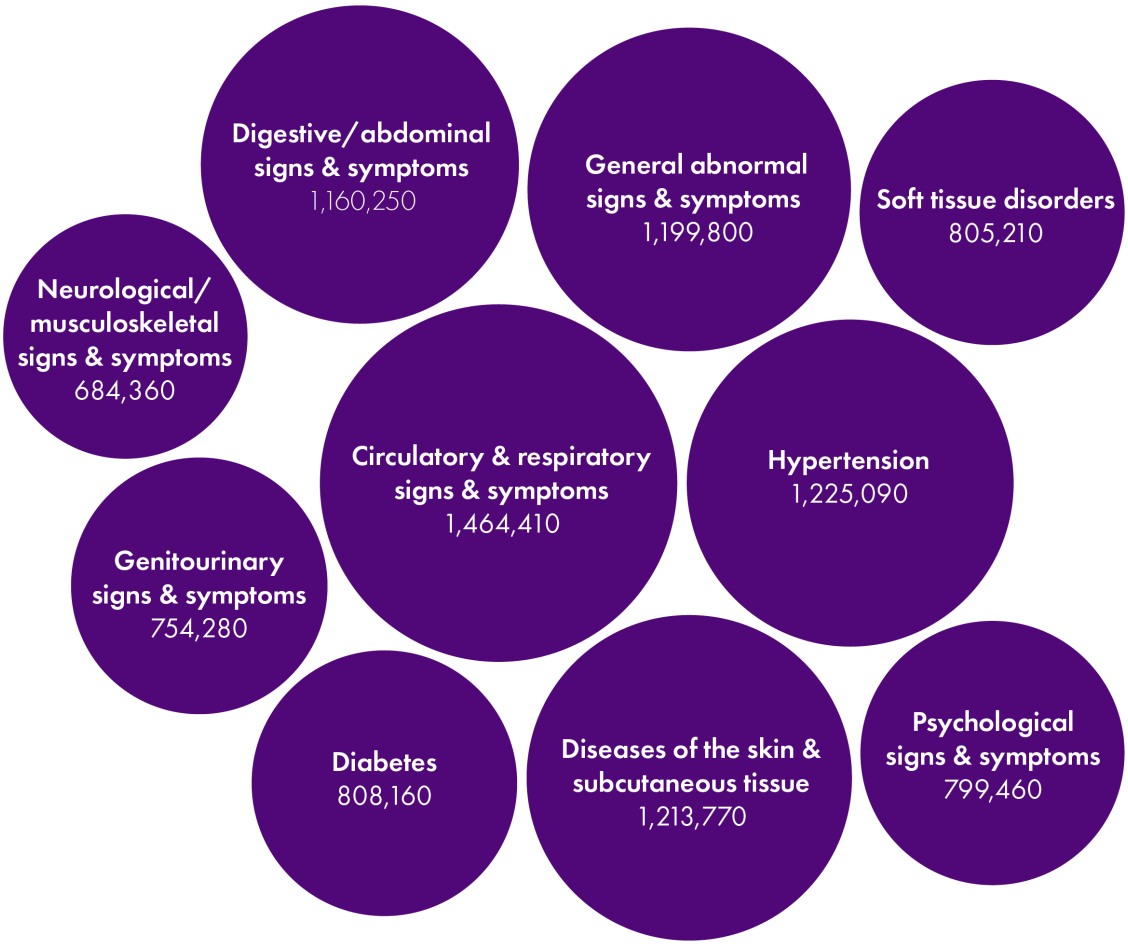
Figure 1: Projected age of Scotland's population between 2017 and 2041



National Records of Scotland

This demographic shift will impact right across the health and social care sector. An increase in chronic conditions, such as diabetes, and changing models of care that see a move from acute to community care will result in a considerable impact on primary care services and resources.

Figure 2: The most common conditions for seeking a GP or practice nurse consultation 2012/13.



ISD Scotland (latest available data is from 2012/13 from the Practice Team Information data).

Experiences of care

In 2015, the Scottish Government launched a national conversation on what a healthier Scotland would look like. This asked three questions:

1. What support do we need in Scotland to live healthier lives?
2. What areas of health and social care matter most to you?
3. Thinking about the future of health and social care services, where should our focus be?

A summary report was published in 2016, Creating a healthier Scotland - What matters to you. This highlighted a number of key themes:

- leading healthier lives - focusing on preventing illness, education and responsibility.
- wellbeing and connected communities - focusing on the importance of mental health and wellbeing, early intervention, social isolation and the role of communities.

- person centred care - focusing on self management, continuity of care, involvement and information.
- social care and caring - including the role of unpaid carers and the importance of respite care and information.
- a responsive and seamless journey of care - the importance of an accessible and flexible service and the need for joined up care.
- pressures and priorities - including the role of the third sector and learning from good practice.

Experience of General Practice

The Scottish Government undertakes a biennial Health and Care Experience Survey which asks about people's experience of:

- accessing and using their GP practice and Out of Hours services
- aspects of care and support provided by local authorities and other organisations
- caring responsibilities and support

The results from the most recent (2017/18) survey showed that:

- 83% of people rated the overall care provided by their GP practice positively. This was down two percentage points from the last survey and down seven percentage points from 2009/10.
- 76% of people were happy with their GP practice opening hours.
- 67% of people rated the arrangements for getting to see a doctor in their GP practice as excellent or good. This is a decrease from the previous surveys. In 2009/10 81% people rated the arrangement positively.

Primary Care Policy

The Scottish Government has produced a number of polices which signal the desire to move care out of hospital and into the community, where possible. In 2011, the Scottish Government published a strategic vision for achieving sustainable quality in the delivery of healthcare services across Scotland. The 2020 Vision's [6] ambition was that:

> " by 2020 everyone is able to live longer healthier lives at home, or in a homely setting."

This highlighted the importance of primary care as part of the wider health service.

The National Clinical Strategy for Scotland, published in 2016, contains proposals for how clinical services need to change to provide sustainable health and social care services. It notes that "effective primary care, with universal coverage, can significantly improve outcomes for patients, and deliver the most cost-effective healthcare system" and signalled a transformation in primary care.

> " There are a range of changes that will support transformation of primary/community care, such as the move to integrated health and social care from April 2016, and the new GP contract in April 2017. We will build a greater capacity in primary care, centred around practices, by enhancing the recruitment of doctors to general practice, by increasing the adaptation of technological solutions to increase access and improve decision making, and by developing newer, extended, professional roles within primary care, such as Advanced Nurse Practitioners, Pharmacists and Allied Health Professionals. This will provide the range of skills needed to meet the changing and complex needs of communities. The strategy describes the rationale for an increased diversion of resources to primary and community care. Stronger primary care across Scotland should and will be delivered by increasingly multidisciplinary teams, with stronger integration (and where possible, co-location) with local authority (social) services, as well as independent and third sector providers. "

The strategy goes on to comment that "increased investment in primary care will ensure the sustainability of secondary care services by allowing an increasingly elderly population with multi-morbidity to be treated more appropriately in primary care".

The National Clinical Strategy for Scotland also introduced the concept of "realistic medicine". Realistic medicine aims to put the person receiving health and social care at the centre of decisions made about their care and aims to encourage shared decision making. In 2017, the Chief Medical Officer for Scotland published Realising Realistic Medicine . This sets out the aim that, by 2025, anyone providing healthcare in Scotland will take a realistic medicine approach.

The Scottish Government's vision for the future of primary care

The Scottish Government's vision for the future of primary care services is for:

> “ general practice and primary care at the heart of the healthcare system. People who need care will be more informed and empowered, will access the right professional at the right time and will remain at or near home wherever possible. Multidisciplinary teams will deliver care in our communities and be involved in the strategic planning of our services. [1] ”

The Scottish Government has developed six primary care outcomes which it has mapped into the national outcomes and integration outcomes.

Figure 3: The Scottish Government's Primary Care Outcomes

Scottish Government: Primary Care Outcomes Diagram

The Primary Care Team

The primary care workforce is made up a of range of occupations. Within primary care there are four independent contractor groups: medical (GPs), dental, pharmaceutical and ophthalmic. These practitioners are usually independent of the NHS and are contracted to provide services on behalf of NHS Boards.

Box 1: Independent Contractors

General Practitioners (GPs) are doctors who specialise in primary care. They are registered in the General Practitioner Register of the General Medical Council. Most GPs are independent contractors. This means that they are responsible for running the business affairs of the practice and employing and training practice staff. A small number of GPs are in salaried positions employed directly by an NHS Board or a GP Partner.

Some GPs are part of the GP Retainer Scheme. This is for people who are unable to commit to a full-time post but wish to continue to maintain and develop their skills. A GP registrar or GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. A locum GP is a fully qualified GP who works at the practice on a temporary basis to cover for the regular doctors when they are away from the practice [7] .

General Dental Practitioners and Public Dental Service Dentists provide primary care dentistry. General Dental Practitioners (GDPs) are independent contractors who provide General Dental Services (GDS) on behalf of NHS Boards in their own practices. Public Dental Service (PDS) dentists are employed by NHS Boards primarily to provide GDS to patients with special care needs and to areas with no available GDS.

Community Optometrists are all independent contractors providing NHS services on behalf of the NHS Board. Optometrists directly employed by the NHS to work in hospitals may or may not also undertake additional work in the community under General Ophthalmic Services arrangements with the NHS Board. In 2012, around 6% of registered Optometrists in Scotland were employed by the NHS [8] .

Community Pharmacists are all independent contractors providing NHS services on behalf of the NHS Board. Pharmacists directly employed by the NHS are unlikely to work in a community pharmacy setting. Pharmacists and pharmacy technicians also work in GP practices and can either be directly employed by the GP practice, provided through managed service, or be a community pharmacist providing sessional work. Pharmacists and pharmacy technicians working in GP practices aim to improve multidisciplinary team working and medication management.

The primary care team is much broader than the independent contractor groups and can include a range of other professionals. For example:

Box 2: The Wider Primary Care Team

General Practice Nurses work in general practice and are often employed directly by the practice.

Community and Primary Care Nurses work with people in community settings such as health centres, their own homes and GP practices. Many nurses have additional skills and knowledge and are Nurse Practitioners and Advanced Nurse Practitioners[ii] [10] .

Community Mental Health Professionals (eg nurses, occupational therapists) can work with individuals and families assessing their mental health needs, providing support for conditions such as low mood, anxiety and depression [11] .

District Nurses are qualified nurses who have undertaken a specialist qualification in community health.

Community Midwives provide care and support to women and their families while pregnant, throughout labour and during the period after a baby's birth.

Health Care Assistants work across healthcare disciplines under the direction and professional accountability of registered practitioners, such as Nurses, Physiotherapists and Pharmacists [10] .

Health Visitors are qualified nurses or midwives who have completed specialist training in children and family health.

Allied Health Professionals (AHPs) are a group of health professionals who prevent illness, diagnose, treat and rehabilitate people of all ages [10] . AHPs include:

- Art Therapists
- Dieticians
- Drama Therapists
- Music Therapists
- Occupational Therapists
- Orthoptists
- Orthotists
- Paramedics
- Physiotherapists
- Podiatrists
- Prosthotists
- Diagnostic Radiographers
- Therapeutic Radiographers

- Speech and Language Therapists

Pharmacy Technicians can be involved in monitoring clinics , medication compliance reviews, medication management advice and reviews.

The dental workforce can include Dental Nurses, Hygienists, Therapists and Dental Technicians, Clinical Dental Technicians and Orthodontic Therapists [10] .

The optical workforce can include Dispensing Opticians and Optical Assistants.

Non-clinical staff also play an important role in the effective delivery of primary care services. For example:

Box 3: Non-Clinical Roles

Practice Managers are involved in managing all of the business aspects of the practice. They are involved in contract management and monitoring, team co-ordination, business planning and staff management [7] .

Practice Administration Staff are responsible for organising patient appointments, managing communications, prescription requests and administration. Receptionists will also have a role in supporting patients with information on available services.

Community Link Workers aim to improve patient health and well-being, reduce pressure on general practice and tackle health inequalities [10] .

Some members of the primary care team are employed directly by a practice. Others, such as community nurses and health visitors, are often employed directly by the NHS through Agenda for Change (which provides common pay scales, terms and conditions for NHS staff).

ii Advanced nurse practitioners (ANPs) are experienced and highly educated registered nurses who manage the complete clinical care of their patients, not focusing on any sole condition [9] .

Regulation of Healthcare Professionals

The regulation of healthcare professionals is reserved to the UK Parliament. However, there is collaboration between all the parts of the UK on regulation. All people working in one of the regulated professions must be registered with the relevant Council to practice legally anywhere in the UK. Primary care regulators include:

- Nursing and Midwifery Council (NMC)
- General Medical Council (GMC)
- General Dental Council (GDC)
- General Optical Council (GOC)
- General Pharmaceutical Council (GPhC)
- Health and Care Professions Council (HCPC)
- General Osteopathic Council (GOsC)
- General Chiropractic Council (GCC)

All of the regulators are overseen by the Professional Standards Authority for Health and Social Care.

Each of the healthcare regulators have protected titles. These are enshrined in legislation and are used by health professionals to indicate their field of practice to patients and the public. For example, protection for the title ‘osteopath’ comes under the Osteopaths Act 1993. Only those with the appropriate registration are authorised to use the title [12] .

Workforce Planning

The Scottish Government has published a National Health and Social Care Workforce Plan, in three parts.

- Part 1 – a framework for improving workforce planning across NHS Scotland
- Part 2 – a framework for improving workforce planning for social care in Scotland
- Part 3 – Improving workforce planning for primary care in Scotland

Part 3 of the plan, published in April 2018, deals with primary care and focusses on developing, building and expanding multidisciplinary teams. It aims to set out how the primary care workforce will be supported. It sets out the role of primary care services, the shape of the primary care workforce, how the workforce will need to change to meet anticipated need, how multidisciplinary teams will be strengthened and how data can be used in workforce planning [13] .

It sets out recommendations, next steps and lists supporting actions and a number of commitments, including the publication of a Primary Care Monitoring and Evaluation Strategy 2018-2028 (see Annex B).

It also makes, and restates, a number of commitments by the Scottish Government to strengthen the workforce:

- Increasing the number of GPs by at least 800 by 2027 (announced December 2017)
- Allocating an additional £500 million for primary care by 2021 (announced in October 2016). This includes:
    - training an additional 500 advanced nurse practitioners
    - training an additional 1,000 paramedics
    - Putting 250 more community links workers in GP practices
    - the expansion of mental health workforce
    - enhanced roles and improved access to Allied Health Professionals (AHPs) in primary care.
    - all GP practices will have access to a pharmacist
- Investment in out of hours services

The Scottish Government is expected to publish an integrated health and social care workforce plan in late Spring 2019.

In relation to workforce, a recent Audit Scotland report, Health and social care integration: update on progress, notes that:

> “ Workforce pressures are a clear barrier to the implementation of integration plans and workforce planning is a particularly important element of strategic planning. Workforce planning remains the formal responsibly of councils and NHS boards. However, IJBs (Integration Joint Boards) need to work closely with their partners to ensure that their plans for service redesign and improvement link with and influence workforce plans. IAs (Integration Authorities) must be able to demonstrate what skills are required to ensure they can deliver services in the right place at the right time. IAs identify not being able to recruit and retain the workforce they need as a risk. The contribution of the third and independent sector should be part of workforce planning. (p.29). ”

Audit Scotland is currently undertaking further work on the NHS workforce and intends to publish a report on workforce planning and primary care in August 2019.

Workforce Data

ISD Scotland collects information on the NHS workforce.

General Practitioner workforce

In December 2018, ISD Scotland published General Practice - GP Workforce and practice list sizes 2008–2018. This includes information on the number of GPs and GP practices in Scotland and number of patients registered at these practices (as headcount).

At 30 September 2018 there were 4,994 GPs (headcount) working in general practice in Scotland. This is an increase of 75 compared to 2017. Prior to 2018, the number of GPs had remained roughly constant at around 4,900 since 2008 [14] .

The Primary Care Workforce Survey reports aggregate information on the general practice workforce. It includes an estimate of the whole time equivalent (WTE) of GPs, registered nurses (including nurse practitioners/advanced nurse practitioners) and other clinical staff employed by Scottish general practices.

Issues with the data available on the primary care workforce have, to some extent, been addressed by the 2018 GP contract, which will be discussed in more detail later in this briefing.

The main findings from the 2017 workforce survey were [15] :

- While the estimated headcount of GPs working in Scottish general practice has changed very little over time, the estimated Whole Time Equivalent (WTE) of GPs has been declining since 2013 (from 3,735 in 2013 to 3,575 in 2017; a decrease of over 4%).
- The estimated WTE of registered nurses and Health Care Support Workers employed by general practices increased between 2013 and 2017, by 9% and 33% respectively.
- Nearly a quarter (24%) of responding GP practices reported current GP vacancies, compared to 22% in 2015, and 9% in 2013. In contrast, only 6% of responding GP practices reported vacancies for registered nurses.
- Over a third (36%) of GPs and more than half (55%) of nurses working in Scottish general practice are aged 50 years or over.
- Within GP Out of Hours (OoH) services, 10% of the GPs worked 1,000 hours or more over the year and their total annual hours accounted for nearly half (46%) of the total GP hours worked.
- All NHS Boards reported having to take actions due to being unable to fill GP OoH shifts as planned. The most common actions taken to fill shifts were for staff to work longer shifts and increased rates/financial incentive.

Optometrist workforce

In 2016, there were approximately 1,453 optometrists and three ophthalmic medical practitioners (headcount) providing a community eyecare service in Scotland. In addition, there were approximately 410 qualified dispensing opticians registered in Scotland [10] .

Pharmacy workforce

In its workforce plan the Scottish Government used the number of registered pharmacists as a proxy for the overall pharmacy workforce. In January 2018, there were approximately 4,800 registrant pharmacists and 2,100 pharmacy technicians with a registered home address in Scotland [10] .

Dentist workforce

The number (headcount) of primary care dentists in Scotland has been increasing since 2014. In 2018 there were 4,994 dentists working in primary care, compared to 4,911 in 2014 [16] .

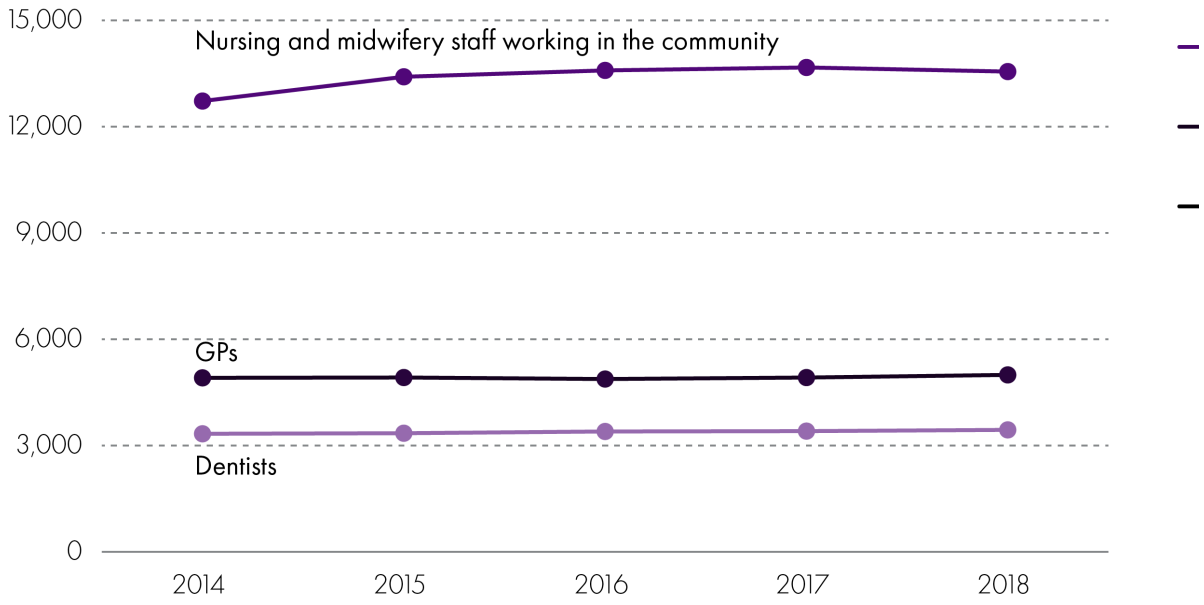
Community Nursing and Midwifery workforce

The number (headcount) of nurses and midwives working in a community setting has risen since 2014. In 2018 there were 13,555 nurses and midwives working in community settings compared to 12,723 in 2014 (this does not include those working in general practice) [17] .

Allied Health Professionals

In 2018 there were 11,667 AHP staff in post working across the NHS in Scotland [17] . Data is not currently available on the number of AHPs working in primary care or in a community setting [10] .

Figure 4: Comparison of number (headcount) of primary care dentists, GPs and nursing and midwifery staff working in the community, 2014 to 2018.



ISD Scotland, GP Workforce and Practice list sizes, Dentists, Non-medical trend

Training

GP training

To practise as a GP, it is necessary to complete a recognised medical degree, an MBChB Medicine, which is normally a 5 year course. Following this, graduates must complete two years of foundation training before undertaking three years of specialist GP training before being entered on the General Medical Council's (GMC) GP Register.

In October 2018, the Cabinet Secretary for Health and Sport launched the Scottish Graduate Entry Medicine (ScotGEM) MBChB Programme. This programme is designed to develop doctors interested in a career as GPs within NHS Scotland. It is a four-year graduate entry medical programme which focuses on rural medicine and healthcare improvement (ScotGEM is subject to approval by the GMC - this is expected to be completed prior to graduation of the first cohort of students in September 2022).

Applicants for the GP training programme in the UK apply through the General Practice National Recruitment Office (NRO). In 2018 there were 347 General Practice Specialty Training places in Scotland, of which 84.15% were filled.

Optometrist training

To practise as an optometrist it is necessary to complete a four year undergraduate course, a BSc (Hons) Optometry. This is followed by a one year pre-registration training programme overseen by the College of Optometrists, and professional examinations. They are required to register with the General Optical Council (GOC). Optometrists can also undertake additional postgraduate training which entitles them to extend their scope of practice and operate as a supplementary or independent prescriber [18] .

Pharmacist training

The initial education and training of a pharmacist comprises a four-year Master of Pharmacy (MPharm) degree and a one-year pre-registration training programme (managed by NHS Education for Scotland). Pre-registration trainees then have to pass a national registration assessment before registering as a pharmacist with the General Pharmaceutical Council (GPhC).

Dentist training

Dentists are required to complete a five year Bachelor of Dental Surgery (BDS) course . There is also a Gateway to Dentistry course which is a widening access route prior to the BDS Dentistry course. Dentists are entitled to register with the General Dental Council (GDC) after successfully completing a BDS course [19] . Information on other Dental Care Professionals can be found in the NHS Education for Scotland publication Dental Workforce in Scotland 2018.

Nursing and Midwifery training

Nurses and midwives need a relevant degree and must be registered with the Nursing and Midwifery Council (NMC). The NMC also sets standards of education, training, conduct and performance for nurses and midwives in the UK. As part of nursing training, people choose from one of the four specialisms (adult, children, mental health, or learning disability).

The Chief Nursing Officer (CNO) in Scotland has outlined a commitment to Maximising the contribution of the Nursing, Midwifery and Health Professions (NMaHP) workforce and pushing the traditional boundaries of professional roles [20] . It is possible for nurses to continue with their professional development and work in roles such as Advanced Nurse Practitioners (ANPs), district nurses and school nurses [21] .

Allied Health Professionals training

For the majority of AHP professions, training is four years for an undergraduate BSc programme and two years for a post graduate MSc programme. There are exceptions such as Arts Therapists and Paramedics. More information on how to train to become an AHP and other careers in healthcare can be found on the NHS Education for Scotland website NHS Careers.

Cost of Training

The cost of training primary care staff varies by profession. The estimated cost of training a GP in Scotland, in 2018 was £450,172 [22] .

Funding for training

Dental Undergraduate Bursary Scheme/ Dental Student Support Grant

Eligible students studying a Dentistry (BDS) degree at a Scottish University who started their course before 2017-2018 could apply to the Dental Undergraduate Bursary Scheme (DUBS) for a bursary of £4,000 for each clinical year of their course. In return for the bursary, students were required to commit to up to five years (full time equivalent) work as a dentist in NHS Scotland [19] .

From 2017, dental students in Scotland can apply for a Dental Student Support Grant (DSSG) of £4,000 if they have an annual household income of less than £34,000 and are allowed to live and work in Scotland after graduation. Students who are awarded a DSSG must agree to work for the NHS in Scotland for 12 months for each year of their grant (the time must be worked in one unbroken length of service).

Nursing and Midwifery Student Bursary

Some pre-registration nursing or midwifery students are able to apply for a bursary. This bursary is not income assessed. The income rates for 2019-20 are £8,100 for the first three years and £6,075 for the fourth year. Some people are also eligible for the Dependants' Allowance, Single Parent Allowance, Childcare Allowance, Disabled Students' Allowance and help towards clinical placement expenses.

Cost of Primary Care

The Scottish Government's Budget: 2019-20 puts the total Health and Sport budget at £14.307 billion, of which £1.854 billion is for Community Health Services.

It is worth noting that the budget for NHS employed primary care staff, such as Community Nurses and Allied Health Professionals, comes primarily from NHS Board allocations, which are not included in the table below.

Figure 5: Health and Sport, Community Health Services, Spending Plans (Level 3) Scottish Government, 2018

Resource	2019-20 Budget £m
Primary Care Services	931.2
Community Pharmaceutical Services	191.9
General Dental Services	416.6
General Ophthalmic Services	108.4
Mental Health Services	85.5
Additional Support for Social Care	120.0
Community Health Services Total	**1,853.6**

Scottish Government Commitments

In a letter to the Health and Sport Committee in February 2017 the then Cabinet Secretary for Health and Sport made a commitment to increase (each year until 2021-22) the share of the NHS budget for mental health and for primary, community and social care.

> “ more than half of frontline NHS spending will be in community health services by 2021-22 ”

The Scottish Government's response to the Health and Sport Committee's pre-budget report confirms that, in 2017-18 (the most recent cost data available), spending on primary and community health services (which includes community services, community hospitals, GPs, Dentists,community prescribing, NHS 24 and Scottish Ambulance Service, resource transfer other local authority and other) accounted for 49.6% of frontline NHS spending.

In the Health and Social Care: medium term financial framework the Scottish Government committed to increasing the funding for primary care to 11% of the frontline NHS budget by 2021/22. The Scottish Government's response to the Health and Sport Committee's pre-budget report noted that, in 2019-20, the total spending on primary care is expected to represent 9% of the frontline NHS budget.

Figure 6 shows health and social care expenditure in 2016/17 by setting - hospital, primary and community care and social care.

Figure 6: Health and Social Care Expenditure 2016/17 (£m)

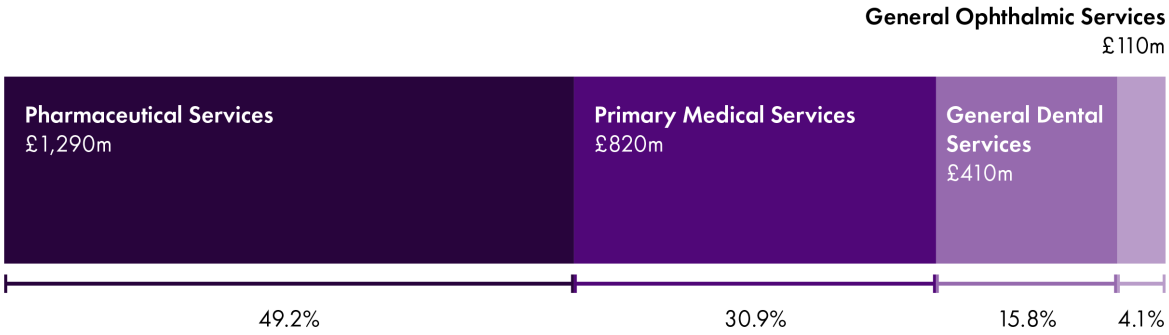
Scottish Government Medium Term Health and Social Care Financial Framework, October 2018

Cost Book

In terms of actual expenditure, the Scottish Health Service Cost Book provides a detailed analysis of where resources are spent.

Family health services include primary medical services (local GP practices) as well as local pharmacy (including drugs dispensed), dental and ophthalmic services. The cost book shows that, in 2017/18, £2.6 billion was spent in this sector. Costs within the family health services have risen by 9.4% in cash terms since 2013/14 and by 2.9% in real terms [24].

Figure 7: Family Health Sector Operating Costs, 2017/18



ISD Scotland. Scottish Health Survey Costs. 2018

Medicines expenditure makes up 83.4% of the pharmaceutical services costs - this is the spending on medicines resulting from GP prescriptions.

Primary care also includes some community services. The cost book shows that, for the year ending March 2018, £2.4 billion was spent on community services. This covers services delivered outside hospitals, such as district nursing, health visiting, home dialysis, GP out of hours services and prevention services, such as breast screening and health promotion [24] .

Paying for Services

Most services offered by GPs are free of charge, but some services can be charged for such as accident or sickness certificates for insurance purposes [25] .

Eye and dental examinations in Scotland are available free of charge. However, some people need to pay for 80% of their dental treatment (up to a maximum of £384 per course of treatment) and/or towards the cost of their glasses/contact-lenses [26] .

From 2011, Scottish NHS prescriptions dispensed in Scotland have been free of charge.

Some people are eligible for help towards paying for health costs. More information can be found in Help with Health Costs: Quick Guide.

Primary Care Service Planning

Integration Authorities

The Public Bodies (Joint Working) Scotland Act (2014) required NHS Boards and Local Authorities to integrate the governance, planning and resourcing of adult social care services, adult primary care and community services and some hospital services.

Under the Act, 31 integration authorities (IAs) were created. The IAs have developed Primary Care Improvement Plans, which were shared with the Scottish Government in July 2018. Links to these can be found in Annex C.

Each of the IAs were required to establish at least two localities. Localities are intended to provide an organisational mechanism for local leadership of service planning, to be fed upwards into the integration authority's strategic commissioning plan [27] .

Localities are intended to have real influence on how resources are spent in their area. Localities bring together local GPs and other health and care professionals, representatives of the housing sector, representatives of the third and independent sectors, carers' and patients' representatives and people managing services [28] .

The Scottish Government's guidance on localities notes that they must:

"

- Support the principles that underpin collaborative working to ensure a strong vision for service delivery is achieved. Robust communication and engagement methods will be required to assure the effectiveness of locality arrangements. "
- Support GPs to play a central role in providing and co-ordinating care to local communities, and, by working more closely with a range of others – including the wider primary care team, secondary care and social care colleagues, and third sector providers – help improve outcomes for local people."
- Support a proactive approach to capacity building in communities, by forging the connections necessary for participation, and help to foster better integrated working between primary and secondary care [29] . "

GP Clusters

GP clusters were introduced in 2016/17. They are small groups of GP practices who work with local partners to develop outcomes which can be used to help planning and drive improvement.

Each GP practice has a Practice Quality Lead who engages with the local cluster, and each cluster has a GP designated as a Cluster Quality Lead. The 2018 GP contract seeks to further embed the cluster quality approach.

Improving together A National Framework for Quality and GP Clusters in Scotland sets out the role of clusters and the national support available for improving quality in GP clusters through quality planning, quality improvement and quality control.

Figure 8: The role of the GP cluster

Learning network, local solutions, peer support	Collaboration and practice systems working with Community Multidisciplinary Team and third sector partners
Consider clinical priorities for population	Participate in and influence priorities and strategic plans of Integrated Authorities
Transparent use of data, techniques and tools to drive quality improvement	Provide critical opinion to aid transparency and oversight of managed services
Improve wellbeing, health and reduce health inequalities	Focus on improving clinical outcomes and addressing health inequalities

Data on primary care, at a practice level, is collected in the Scottish Primary Care Information Resource (SPIRE) . It can be used by practices, integration authorities and health boards forquality improvement, local service planning and public health intelligence/ research. The roll out of SPIRE is still underway in a number of health board areas [30] . It is not currently clear what information from SPIRE will be publically available.

Independent Contractors

As outlined earlier in this briefing, there are four independent contractor groups in primary care: medical (GPs), dental, pharmaceutical and ophthalmic. These practitioners are usually independent of the NHS and are contracted to provide services on behalf of NHS Boards.

General Ophthalmic Services

In 2006, the National Health Service (General Ophthalmic Services) (Scotland) Regulations provided for free NHS eye examinations. The regulations encouraged the profession to manage patients in the community where it was safe to do so and improve the quality of the referrals that were made to the Hospital Eye Service [31] .

In 2016 the Scottish Government commissioned a review of community eyecare services provision in Scotland. The Community Eyecare Services Review, published in April 2017, made a number of recommendations focusing on:

- Public perceptions and awareness
- Interdisciplinary and inter-agency working
- Primary care ophthalmic services
- Enhanced optometric services in the community,
- Diabetic retinopathy screening
- The quality of care in care homes and care at home.
- Low vision support services
- Support for people with complex needs
- Primary and secondary care interface
- Data and information
- Clinical governance
- Development of workforce data
- Education and training
- Consideration of equipment requirements

A low vision service provision in Scotland review was also undertaken in 2017.

The National Health Service (General Ophthalmic Services) (Scotland) Amendment Regulations 2018 aim to support Optometrists and Ophthalmic Medical Practitioners as the first port of call for all eye related problems, including emergency eye examinations.

The majority of individual Optometrists are employed by body corporates[iii], and the body corporate (not the Optometrist) is the entity that has the direct contractual arrangement with the NHS Board to provide General Optical Services. Most dispensing opticians are employed by the body corporate [18] .

General Dental Services

General Dental Services are currently delivered by General Dental Practitioners or General Bodies Corporate on behalf of the fourteen NHS Boards. The arrangements for the provision of General Dental Services are governed by the National Health Service (General Dental Services) (Scotland) Regulations 2010 . There is no formal written contract between NHS Boards and General Dental Practitioners or General Bodies Corporate [32] .

In 2018, the Scottish Government published an Oral Health Improvement Plan which outlined 41 commitments (Annex D).

Community Pharmacy

The provision of NHS Pharmaceutical Services is governed by the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009. NHS pharmaceutical services are provided under NHS arrangements with local and high street retail pharmacies. These arrangements are managed by the local NHS Board who is responsible for ensuring that the communities it serves have appropriate access to NHS pharmaceutical services. Funding of these arrangements is as required by the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009 and laid down in the Scottish Drug Tariff [33] .

The Scottish Government undertook a Review of NHS Pharmaceutical Care of Patients in the Community in Scotland in 2013 and published Prescription for Excellence, in September 2013. This outlines a number of action points to be taken forward to 2023. In August 2013, Achieving excellence in pharmaceutical care: a strategy for Scotland was published. This outlined nine commitments with associated actions.

1. Increasing access to community pharmacy as the first port of call for managing self-limiting illnesses and supporting self-management of stable long term conditions, in-hours and out-of-hours.

2. Integrating pharmacists with advanced clinical skills and pharmacy technicians in GP practices to improve pharmaceutical care and contribute to the multidisciplinary team.

3. Creating the conditions to transform hospital pharmacy services to deliver world leading pharmaceutical care.

4. Providing the focus, resources and tools to support the safer use of medicines.

5. Improving the pharmaceutical care of residents in care homes and people being cared for in their own homes.

6. Enhancing access to pharmaceutical care in remote and rural communities.

7. Building the clinical capability and capacity of the pharmacy workforce.

iii A body corporate is a group of persons incorporated to carry out a specific enterprise.

8. Optimising the use of digital information, data and technologies for improved service delivery.

9. Planning for sustainable pharmaceutical care across Scotland.

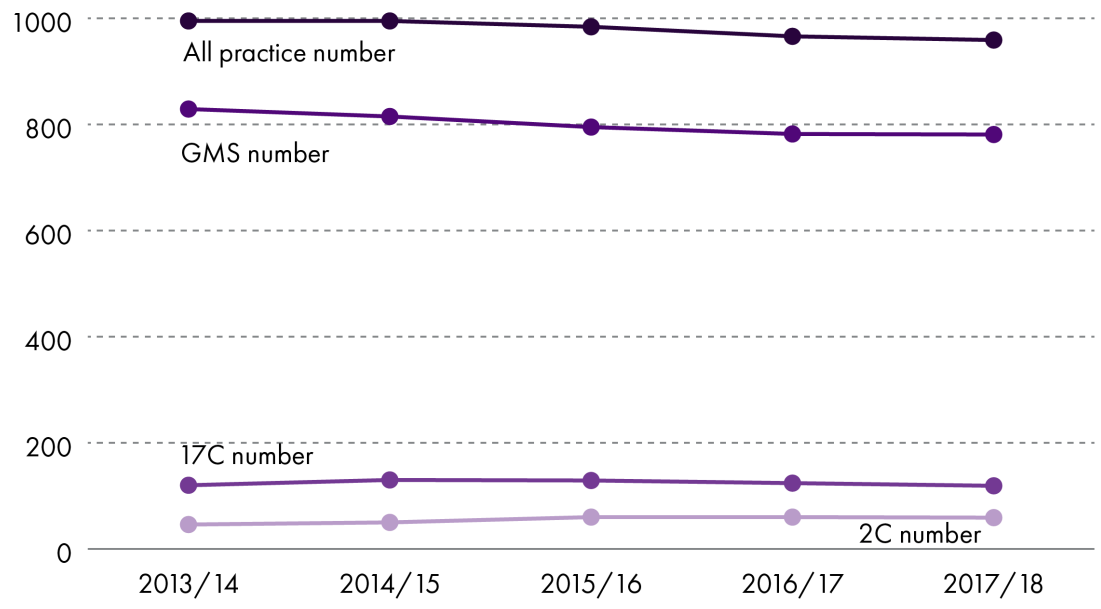
General Medical Services

NHS Boards are responsible for providing GP services and have a number of options for doing so [34] . NHS Boards can contract with a practice under the Scottish General Medical Services (GMS) contract, run their own practices or negotiate a local contract. NHS Boards are not allowed to contact with commercial bodies[iv].

The Primary Medical Services (Scotland) Act 2004, established three types of general practice contract in Scotland.

- **GMS/17J**: A General Medical Service (GMS) practice is GP run and has a standard, nationally negotiated contract in place. The majority (84%) of practices in Scotland are run by GPs with a GMS/17J contract in place.
- **17C**: These practices are GP run and have a locally negotiated agreement between the NHS Board and the practice. This enables, for example, flexible provision of services in accordance with specific local circumstances.
- **2C**: An NHS Board run practice where all GPs and practice staff are salaried to the local NHS Board [14] .

Figure 9: General Practice contract types, 2008-2018



General Practice Data Tables, ISD Scotland

iv Tobacco and Primary Medical Services (Scotland) Act 2010

The 2018 Scottish General Medical Services (GMS) Contract

The 2018 Scottish General Medical Services Contract Offer was published on 13 November 2017. The contract is supported by a Memorandum of Understanding between the Scottish Government, the British Medical Association (BMA), Integration Authorities and NHS Boards. On 18 January, the Scottish GP Committee of the BMA agreed to proceed to implement the new 2018 GP contract. This decision followed a poll of the profession, in which 71.5% were in favour of the new contract.

The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018 and The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2018 were considered by the Scottish Parliament's Health and Sport Committee on 20 March 2018 and came into force on the 1 April 2018.

The 2018 GP contract sees GPs as fulfilling roles to support a wide range of clinical professionals, working as an expert medical generalist and senior clinical decision maker within multi-disciplinary community teams. It notes that the key contribution of GPs in this role will be in:

- undifferentiated presentations[v]
- complex care in the community
- whole system quality improvement and clinical leadership

The GP contract sets the structure for pay and expenses, the workload formula, the wider primary care team, infrastructure and introduces measures to reduce the risks for GPs as independent contractors. It also sets out the role of the multidisciplinary team and the practice team, including general practice nurses, practice managers and practice receptionists.

A number of supporting materials and evidence were also published by the Scottish Government including:

- Scottish Allocation Formula GMS workload model
- A Review of GP Earnings and Expenses
- Scottish Allocation Formula – General Medical Services Unit cost formula review

The 2018 contract introduced a new funding formula and a phased approach for reform.

---

v The 20-18 GP Contract notes that people are often able to self-differentiate in their own presentations. For example, a person presenting with shoulder pain may choose to see a physiotherapist as a first point of contact if such a service is as responsive as their GP practice. This is also the case for minor illness and injury, where, if there is an advanced practitioner or other service available locally, patients may choose that practitioner rather than seek a GP appointment. However, undifferentiated presentations require the skills of a doctor trained in risk management and holistic care with broad medical knowledge.

From April 2018, the new GP workload based resource allocation formula (the GP Workload Formula) replaces the existing Scottish Allocation Formula (SAF). The new formula was developed as part of a 2016 review of the SAF [12] and was informed by the 2017 Review of GP Earnings and Expenses.

The changes to the formula are intended to better address the needs of both deprived urban areas and isolated rural areas.

It re-estimates the number of consultations per patient, based, in the main, on their age, sex and the deprivation status of the neighbourhood in which they live.

It also changed the correction factor (Minimum Practice Income Guarantee) and core standard payments (previously QOF payments) to a consolidated global sum and so the former have ceased to exist as separate funding streams. The Scottish Government had attempted to make these changes in a protected way to ensure that no practices lose funding.

From April 2019, the Scottish Government has introduced a GP partner whole-time equivalent minimum earnings expectation of £80,430 (inclusive of pension contribution) for a whole-time post.

From April 2020. The Scottish Government intends to introduce an income range that is comparable to that of consultants and directly reimburse practice expenses. As this would change GP practice funding and GP income, this will be subject to negotiation and a second poll of the profession after specific details (including financial details) are available [35] .

The 2018 GP contract also notes that the "non-expert medical generalist workload needs to be redistributed to the wider primary care multi-disciplinary team". As part of the service redesign a number of services will be reconfigured by 2021. These include: [35]

Vaccination Services which will move away from a model based on GP delivery to one based on NHS Board delivery, through dedicated teams.

Pharmacotherapy Services will be available to GPs and all practices will receive pharmacy and prescribing support. By 2021, phase one will include activities at a general level of pharmacy practice including acute and repeat prescribing and medication management activities. This is to be followed by phases two (advanced) and three (specialist) which are additional services and describe a progressively advanced specialist clinical pharmacist role [36] .

Community Treatment and Care Services such as the management of minor injuries and dressings, phlebotomy, chronic disease monitoring and related data collection will move from GPs to integration authorities.

Urgent Care Services advanced practitioners will be the first response for home visits. These services provide support for urgent unscheduled care within primary care, providing advance practitioner resource such as a nurse or paramedic for GP clusters and practices as first response for home visits, and responding to urgent call outs for patients. They work with practices to provide appropriate care to patients, allowing GPs to better manage their time [36] .

Additional Professional Roles will provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting. For example: musculoskeletal focused physiotherapy services and/or community clinical mental health professionals [36] .

Community Links Workers will be based in or aligned with a GP practice or Cluster. The link worker will work directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support. This could be due to the complexity of their conditions or rurality [36] .

The 2018 GP Contract also aims to introduce new measures to manage and reduce the risk for GPs, as independent contractors, in owning and maintaining their own practices, being an employer and a data controller.

In November 2017 the Scottish Government published a National Code of Practice for GP premises that signalled the move to a model, over a 25 year period, where GPs no longer own their own premises.

A GMS Oversight Group has been established by the Scottish Government to oversee the implementation by NHS Boards of the 2018 GMS contract and the implementation of the Integration Authority's Primary Care Improvement Plans.

More detail is available in the 2018, General Medical Services Contract in Scotland and the BMA's Scotland GP Contract FAQs.

Data

Phase 2 of the contract is the move to a guaranteed income range and direct re-imbursement of expenses. This phase is subject to further negotiations and another poll of

the profession. To inform phase 2 of the contract, data collection is needed on the current expenses of running a GP practice, the income of salaried GPs and the income of GP partners, as well as the hours worked by individual GPs [35] .

Data collection is due to start Spring/Summer 2019 and, whether this data is regularly updated or available “live”, will depend on what is agreed as part of Phase 2 negotiations of the contract. Further information on Phase 2 is available in the GP Contract .

All premises used to provide GMS will be surveyed in 2018/19. This will provide the data which NHS Boards will require for their premises plans.

In its report, on the NHS in Scotland 2018, Audit Scotland noted that [37] :

> “ There continues to be a lack of public data on important areas of the healthcare system. The focus remains on acute hospitals and there is limited public data on primary care, for example the number of people seeking GP consultations, and the reasons for referrals on to secondary care. This makes it difficult to assess overall demand or better understand changes in demand and plan how to meet it. ”

Factors Impacting on Primary Care

There are number of factors which impact on the delivery of primary care in Scotland. Many of the issues cut across the health and social care sectors and are not restricted to primary care.

Sustainability

Some of the key messages of the NHS in Scotland 2018 report, by Audit Scotland, are that [37] :

- **"To meet people's health and care needs, the NHS urgently needs to move away from short-term fire-fighting to long-term fundamental change.** The type of services it offers, and the demand for those services, have changed significantly over the 70 years since the NHS was created. The challenges now presented by an ageing population means further and faster change is essential to secure the future of the NHS in Scotland."
- "The scale of the challenges means decisive action is required, with an urgent focus on the elements critical to ensuring the NHS is fit to meet people's needs in the future."
- "Ensuring effective leadership is also critical. Much more engagement and information is needed about how new forms of care will work, what they cost and the difference they make to people's lives. Without this, it will continue to be difficult to build support among the public and politicians to make the decisions needed to change how healthcare is delivered in Scotland."

The sustainability of health and social care is not just an issue facing Scotland but is a challenge across the UK and in many other countries. In 2017, the House of Lords published a report looking at The Long-term Sustainability of the NHS and Adult Social Care . This made 34 recommendations covering issues such as service transformation, workforce, funding the NHS and adult social care, innovation, technology and productivity, public health prevention and patient responsibility and a lasting political consensus.

The Kings Fund has also published work on How health care is funded . This looks at the main models used to finance health care: taxation, private health insurance and social health insurance.

Scottish Government's Health and Social Care: Medium Term Financial Framework

In October 2018, the Scottish Government published its Health and Social Care: medium term financial framework which covers the period from 2016/17 to 2023/24. In terms of health and social care expenditure it notes that:

> " Expenditure and activity are at record levels and growth trends across the developed world indicate that the level of funding will only need to increase. However, with greater pressures on the system, this will also require change in the way services are delivered."

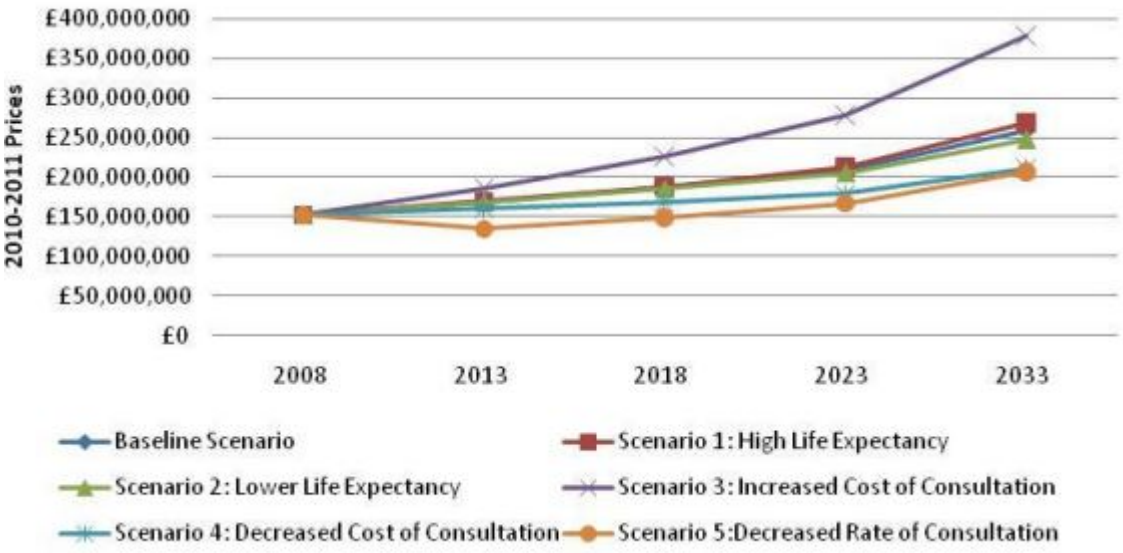
This demand is predicted to continue to grow, and it is estimated that if the system does not adapt or change, there will be a net increase in costs of £1.8 billion over the period to 2023/24 - driven by growth in the population, public demand and price pressures.

The Scottish Government has planned to reshape expenditure with a "gradual rebalancing of expenditure towards care delivery outwith a hospital setting". It refers to the Health and Social Care Delivery Plan (2016) which brings together a number of policy initiatives that have been designed to reform how care is delivered. However, questions remain as to whether the reforms will deliver the savings needed to ensure the sustainability of the health and social care system.

Cost of Primary Care Scenario Planning

A research paper by the Financial Scrutiny Unit (2010) suggested, using scenario planning, that the cost of primary care for those aged 65 and older will rise by 70 per cent in real terms by 2033. It notes that demographic change alone will likely not be enough to bring down spending. Without state intervention the spending on primary health care alone stands to double and may even triple under some scenarios. The forecasts show that modest reductions in the cost of consultation and the rate of consultation are associated with reductions in spending on primary care. Therefore, policy interventions in these areas are most likely to help mitigate spending increases.

Figure 10: Public Expenditure Forecast: Primary Care Consultations for people Aged 65+



Financial Scrutiny Unit Briefing: The spending implications of demographic change

Practice Sustainability

In 2016, the Scottish Government established a short-life working group, the Improving Practice Sustainability Group. The purpose of this group was to help the Scottish Government better understand the current workload pressures facing general practice with a view to making a set of recommendations on how general practices in Scotland could be supported to improve their sustainability by addressing those pressures over the short, medium and longer term. It's report Improving Practice Sustainability: Recommendations of the Short Life Working Group made four recommendations:

1. Enact a Sustainability Action Plan for managing sustainable General Practice Workload that contains short, medium and longer term actions
2. Develop a Practice Sustainability Network that both shares and supports current and future learning on practice sustainability across Scotland
3. Promote the use of, and share the learning from, a Practice Sustainability Assessment Tool
4. Create a longer term Practice Sustainability Group

This report also included feedback from the health boards and highlighted issues around practice sustainability issues, how they presented, how the board were able to assist practices, the advice issued and what national support would help better anticipate and manage practices facing sustainability challenges.

On 22 January 2019, the Scottish Government published Improving General Practice Sustainability Group: 2019 Report, which provided an update on the programme of work undertaken during 2017/18 to implement these recommendations.

Out of Hours and NHS 24

Since the introduction of the Primary Medical Services (Scotland) Act 2004 GPs have been able to opt out of providing services out of hours[vi] (OoH) and local NHS Boards are responsible for providing OoH services for most people.

The 2018 GMS contract maintained practice core hours at 8am to 6.30pm (or as previously agreed through local negotiation).

ISD Scotland collects information on primary care OoH services. Out of Hours Primary Care Services in Scotland 1 April 2014 – 30 April 2018 reported that:

- Each year across Scotland, around 870,000 patients use OoH Primary Care services, resulting in just under a million consultations.
- Home visits account for 1 in 5 (187,000) contacts with OoH Primary Care services. Over half of contacts (57%) take place in a Primary Care Emergency Centre.
- Children under 5, women in their twenties and people aged 75 and over were the most common age groups contacting OoH Primary Care services.
- Treatment was completed by OoH Primary Care services for just over half of the patients who were in contact with them. 3% of contacts with services resulted in a referral to A&E or Minor Injuries Unit.

The Scottish Government published the Report of the National Review of Primary Care Out of Hours Services ("The Richie Review") in November 2015. This report noted that:

vi Services outwith the hours of 08:00-18:30 on weekdays, all day Saturday and Sunday, and public holidays.

> “ The demand for urgent care is growing – particularly for rapidly increasing numbers of frail older people with multiple long-term conditions and complex care needs". The present situation for OoH services is fragile, not sustainable and will worsen, unless immediate and robust measures are taken to promote the recruitment and retention of sufficient numbers of GPs and other multidisciplinary team members working in both daytime and OoH services.”

The Scottish Government's national health and social care workforce plan: part three notes that Boards will be expected to maintain and develop a resilient out of hours service that builds on the recommendations of the OoH report and on the work on improving health and social care service resilience over public holidays.

The new 2018 GMS contract sets out that:

> “ There will be changes to arrangements for out of hours services. Instead of the current opt-out arrangement a new opt-in Enhanced Service will be developed for those practices that choose to provide out of hours services. The new out of hours Enhanced Service will have a nationally agreed specification, building on the quality recommendations within Sir Lewis Ritchie’s out of hours review Pulling Together and covering areas such as record keeping, anticipatory care planning, key information summary, use of Adastra and NHS24. This will contribute to a consistency of approach to the provision of unscheduled care services across Scotland where practice-based service level agreements are in place. There is also an opportunity to develop a nationally agreed quality and person-centred specification which could be used by all NHS Boards to test and benchmark their current local service level agreements.”

In February 2019, the Directions which provide the legal framework for Out of Hours Services were revised to implement the changes announced in the 2018 GMS Contract. The NHS Circular on the Directions noted that:

> “ The ongoing commitment and expertise of GPs to Out of Hours services is essential and must be secured; it is not affected by the removal of Out of Hours from the GMS contract. Rather the removal of Out of Hours from the GMS contract gives Health Boards a greater flexibility to arrange GP led Out of Hours services with a committed workforce [38] . ”

NHS 24

NHS 24 is a special health board. It is the national contact centre organisation for NHSScotland and is responsible for providing a range of telehealth services to people across Scotland. NHS 24 also supports and facilitates developments in telehealth and telecare to improve the health and wellbeing of the population [39] .

NHS 24 runs NHS inform which provides health and care information through its website, freephone and webchat service. The NHS 24 111 service provides urgent health advice.

Remote and Rural Primary Care

The provision of healthcare in remote and rural areas faces a number of specific issues. Including the recruitment and retention of staff can be an issue as well as the large distances that some people have to travel to access services.

Rural GPs and the new contract

In relation to primary care, a number of rural GPs have voiced their concerns over the Scottish Government's new GMS contract. In a letter to the Cabinet Secretary for Health and Sport, the Rural GP Association of Scotland (RGPAS) highlighted concerns that the workforce allocation formula "seems heavily weighted against rural communities" [40] .

A petition, PE01698: Medical care in rural areas, has been lodged with the Scottish Parliament. This calls on the Scottish Government to: ensure rural and remote GP representation on the remote and rural short life working group, adjust the Workload Allocation Formula (WAF) and address remote practice and patient concerns raised in relation to the new GP contract.

The 2018 GMS contract offer notes:

> " We know that rural GP practices have, on average, higher expenses per patient than urban ones. Partly, these can be explained by the diseconomies of scale of small GP practices and the costs of dispensing, or having one or more site/branch surgeries and we recognise that these differences will need to be addressed by proposals for Phase 2"

The Cabinet Secretary for Health and Sport has said that (S5W-16567): methodological improvements in the new workload formula means that deprivation in urban areas and isolated pockets of rural deprivation are better addressed and that the pact of the new funding formula will be monitored during implementation.

The Scottish Government's Equalities Impact Assessment (EIA) of the 2018 Regulations on the GP contracts stated that "there will be a positive impact on GPs working in practices in rural areas".

> " The new funding formula is based on expected workload, and gives greater weight to older patients and deprivation – this includes older patients in rural areas and pockets of rural deprivation. We recognised that this meant that some practices in remote and rural locations would receive less funding. We mitigated this risk by introducing a new income and expenses guarantee to ensure that no practice in Scotland would be worse off under the new formula. "

Remote and Rural General Practice Working Group

The Scottish Government has set up a Remote and Rural Short Life Working Group. A Scottish Government press release noted that:

> " The new remote and rural short life working group will also ensure the contract is delivered in a way that works well for rural communities and look at what more can be done to support rural general practice."

The Group is chaired by Sir Lewis Ritchie and membership includes GPs from a variety of rural communities and representation from the British Medical Association (BMA), the Royal College of General Practitioners (RCGP) and the Rural GP Association for Scotland (RGPAS). There are also representatives from NHS Boards, Integration Authorities, the public. Membership has been expanded to include nursing and allied health professional representatives [41] .

GP Dispensing Group

The Scottish Government has also established a GP Dispensing Group to consider the implications of implementing the 2018 GMS contract on dispensing GP practices, including the role of pharmacists and pharmacy technicians. This group has considered the challenges faced by dispensing practices, the majority of which are in remote and rural areas.

The Rural and Remote Incentive Scheme

In 2017, the Scottish Government introduced a Rural and Remote Incentive Scheme which aims to make positions in rural locations more appealing to GPs. Under this scheme support will be provided to rural and remote practices, including 'golden hello' payments of £10,000 to GPs taking up their first post in a rural practice, and relocation packages of up to £5,000 [42] .

More information on general practice in remote and rural areas can be found on the Rural GP website.

Remote and Rural Dental Services

There are a range of incentive payments for dentists working in remote areas. The remote areas allowance is paid annually, up to a maximum of £9,000, to dentists working in remote areas [43] .

Health Inequalities

The Scottish Parliament's Health and Sport Committee undertook an inquiry into health inequalities in Scotland in 2013. As part of this, the Committee looked at the relationship between access to primary care health services and inequality. It reported on the following themes: the impact of poverty and deprivation, people with disabilities, carers, the inverse care law[vii], access, funding and need, "did not attends" and Accident and Emergency use and resourcing the primary care team.

In December 2012, Audit Scotland published Health Inequalities in Scotland. This report stated that appropriate access to healthcare is an essential part of reducing health inequalities. It focuses on the challenges GPs face when tackling health inequalities and around accessing other primary care services (p22-26).

A lack of access to, or differential uptake, of health services is not the main determinant of health inequalities in Scotland. However, it is important that services provided by the NHS

vii The inverse care law describes the relationship whereby the availability of good medical care tends to vary conversely with the need for it in the population served.

and other public services do not exacerbate health inequalities [44] . Policies which improve service accessibility, such as the location of primary health care and other core services, and improving transport links, have often been cited as being more likely to be effective in reducing inequalities in health [45] .

In the report What can NHS Scotland do to prevent and reduce health inequalities? GPs from the Deep End practices (the 100 practices which have the highest proportion of patients in the 15% most deprived deciles under the Scottish Index of Multiple Deprivation) proposed a set of measures to address current and future inequalities in health. These were:

- Additional time for consultations with patients, including targeted appointments for the neediest patients.
- Support for serial encounters and the productive use of long term relationships
- Attachment of staff from area-based services (social work, mental health, addictions, child health) to general practices or groups of practices, on a named basis.
- A national enhanced service for practices to address the needs of vulnerable families.
- Development of a lay link worker role connecting practices and patients with community resources for health.
- Support for training and leadership development within and between practices and linked to locality planning.
- Protected time for practices to share experience, information, learning and activity on a cluster basis, following the examples of the Primary Care Collaborative and Links Project.
- A new partnership between leadership at the top and bottom of the NHS, based on mutual understanding, accountability and respect.
- Evaluation and research based on and informing the person centred work of general practice, especially in very deprived areas.
- A greater focus by all central NHS agencies on the support for general practices serving very deprived areas, beginning with an audit of what these agencies currently do in very deprived areas.

Similar to some rural GPs, some GPs working in deprived areas have criticised the new GP contract and funding formula, saying that funding for some practices in the most deprived areas of Scotland will worsen under the new GP contract [46] [47] . In a letter to the Scottish Government, Dr Helene Irvine, Consultant in Public Health Medicine, NHS Greater Glasgow and Clyde, highlighted her concerns about the new GP contract and revisions to the Scottish Allocation Formula. These included, "The failure of the new SWAF to address unmet need in the socially deprived".

The Scottish Government's Equalities Impact Assessment (EIA) included a Health Inequalities Impact Assessment (HIIA). This reported that there will be a positive impact on GPs whose patients live in areas of deprivation. It stated that:

> " The new GMS contract package includes an improved workload formula under the Statement of Financial Entitlements directions which has a positive impact for most GP practices located in deprived areas, and for practices with large elderly populations. The majority of Deep End practices will receive increased funding from this investment. "

The Role of Technology

Recently, there has been much discussion and debate about the role digital technology could and should play in primary care and in furthering the preventative agenda[viii]. In 2017, the Scottish Parliament's Health and Sport Committee undertook an inquiry into Technology and Innovation in Health and Social Care.

The Committee heard about a number of potential opportunities for the use of technology in health and social care such as remote and self monitoring, the use of analytics and artificial intelligence, access to information and the development of telehealth and video consultations. Key issues for primary care include data sharing, communication, access to patient records and the development of an electronic patient record.

In response to the Committee's call for evidence a joint submission was submitted by the health professions working in primary care. Principles for a technology-enabled health and social care service: A view from the health professions working in primary care. This stated that:

> " It is clear to us that the transformation of primary care with a wider primary care team cannot be achieved without the sharing of information amongst health and social care professionals and their teams. "

It went on to say that a number of key areas need to be addressed. Namely, the need for a collaborative approach, the importance of confidentiality and consent, improving patient outcomes, the importance of a "once for Scotland"[ix] approach and the role of information governance [48] .

Scotland's Digital Health and Care Strategy

The Scottish Government published Scotland's Digital Health and Care Strategy in April 2018. The strategy aims to focus on how digital technology can support people, and sets out the following ambition [49] :

viii "Spending public money now with the intention of reducing public spending on negative outcomes in the future" (Professor Gerry McCartney, NHS Health Scotland).

ix "Once for Scotland" refers to the integration and co-ordinate services within the Scottish public sector.

> “ I have access to the digital information, tools and services I need to help maintain and improve my health and wellbeing. I expect my health and social care information to be captured electronically, integrated and shared securely to assist service staff and carers that need to see it… …and that digital technology and data will be used appropriately and innovatively:”
>
> - to help plan and improve health and care services”
> - enable research and economic development”
> - and ultimately improve outcomes for everyone.”

In April 2018, the Scottish Government also published the Report of the independent external expert panel , which informed the Digital Health and Care in Scotland strategy. An independent panel of UK and international experts was asked to advise the Scottish Government on how digital technology can support Scotland's aim for high quality health and social care services with a particular focus on prevention, early intervention and supported self-management.

Work is currently underway on the development of a national digital platform for heath and social care data. This work is being led by National Digital Service which is based in NHS Education for Scotland (NES).

There have been a number of recent developments across the primary care professions. For example, an electronic patient record is being developed for ophthalmology that with enable patients with stable chronic ocular conditions to be discharged into the community to be managed by Optometrists. It is hoped that the electronic patient record will also support Optometrists in providing joined up care for patients with an underlying ocular condition and support their care within the community and hospital [22] .

Multidisciplinary Team Workforce

Under the 2018 GP contract GPs are expected to become "less involved in more routine tasks, with these tasks being delivered by other health professions in the wider primary care multi-disciplinary team" (MDT) [35] .

As discussed previously, this service redesign is supported by a Memorandum of Understanding (MOU) which represents a statement of intent from all of the parties needed to deliver the wider support and change to primary care services in order to underpin the contract [36] .

The development of the primary care multidisciplinary workforce is a key focus for the successful implementation of the new GP contract. As discussed previously, the Scottish Government has published a National Health and Social Care Workforce Plan and is expected to publish an integrated health and social care workforce plan in 2019.

Audit Scotland's overview of the NHS in Scotland 2018 observed that the workforce plan largely focuses on what needs to be done, rather than on setting out what the medium to longer term workforce will look like. It goes on to say that "there is a need to better understand future demand and to provide a breakdown of the cost of meeting this demand. The National Workforce Plan does not provide this information".

In relation to the GP contract it notes:

> “ The success of the new GP contract is dependent on resolving issues such as premises costs and increasing the number of GPs and others, such as pharmacists and paramedics, to develop multidisciplinary teams. ”

The recruitment and retention of multidisciplinary teams and the influence and career progression of allied health professionals are also important in the successful implementation of the 2018 GP contract.

Sharing Best Practice and Evaluation

Healthcare Improvement Scotland's (HIS) ihub runs a number of national programmes which aim to support health, social care and housing partners. It has a Primary Care Improvement Portfolio that includes: the dentistry in primary care collaborative, the primary care sepsis collaborative, reducing pressure ulcers in care homes, pharmacy in primary care, Improving Together Interactive for GP clusters and the practice administration staff collaborative.

In March 2019, the Scottish Government published a National Monitoring and Evaluation Strategy for Primary Care. The sets out the approach and principles for how the Scottish Government intends to evaluate the reform of primary care until 2028. [50] The Scottish Government also intends to establish a Primary Care Monitoring and Evaluation Steering Group.

The Scottish School of Primary Care has also recently published a national evaluation of new models of primary care in Scotland. This made eight recommendations.

1. Primary care transformation should focus on a smaller number of larger projects, conducted over a longer period of time, with agreed goals and outcomes and sufficient support for robust quantitative evaluation.

2. Role clarity, role support, governance, and clear communication channels are required as the primary care landscape becomes more complex. Strengthened support for collaborative leadership and multidisciplinary team working is required at all levels.

3. Patient, carer, and community involvement is essential. The aim should be participation in the co-design of projects and service developments, rather than 'information campaigns' after the changes have been made.

4. Further work is required on how primary care can best address, or mitigate the effects of, health inequalities. This should build on existing evidence, and learning from the 'GPs at the Deep End', but include vulnerable groups living in less deprived areas.

5. Rural proofing of health services should be considered as a systematic approach to ensure the needs of rural populations are considered in the planning and delivery of health services.

6. The success of primary care transformation requires a step change in workforce planning, capacity, capability and leadership to address workforce and capability challenges across all clinical disciplines.

7. A strategic, integrated approach to the evidence required to guide the ongoing transformation of primary care is required. Monitoring and evaluation should be accompanied by dedicated funding for high priority applied research in primary care in Scotland to fill the many evidence-gaps.

8. Consideration should be given to a large-scale demonstrator digital primary care transformation project with clear co-designed and co-produced outcomes and rigorous evaluation.

Conversation with the Public

The Scottish Government's Equalities Impact Assessment reflected on the importance of public engagement in the implementation of the 2018 GP contract. It stated that:

> " Further engagement with patients, equalities groups and the primary care workforce is crucial to the successful implementation of the contract and transformational service redesign."

In November 2018, the Primary Care Clinical Professions Group wrote to the Cabinet Secretary for Health and Sport about public engagement around the new GP contract. In the letter the Professions noted that:

> “ patients are increasingly experiencing very different models of primary care access and delivery and one of the key factors to the success of these is acceptance by and support from the public. This will require a program of communication and public engagement to build confidence in the changes. We believe that the public's understanding of the transformation of services will be central to achieving its aims”

It went on to comment that:

> “ We believe it would be enormously beneficial and supportive to primary care if this engagement and education was delivered as part of a national campaign, and we would like to offer our support to develop this in collaboration with Scottish Government.”

The minutes of the Remote and Rural General Practice Working Group from December 2018 noted that there needs to be some engagement with the public that they might not see a GP in the future but another member of the multidisciplinary team. It was advised that "Ministers acknowledge this, but are thoughtful about the approach as a national advertising campaign may not be the best way. Further discussions on this issue planned in the new year".

There has also been some discussion regarding the language used to explain the changes to primary care and that the narrative should be around 'enhancement' rather than 'replacement'.

Audit Scotland

Audit Scotland has published a number of relevant reports including:

- Health and social care integration: update on progress
- NHS in Scotland 2018
- NHS workforce planning - part 2 this will look at the pressures affecting the primary care clinical workforce, with a focus on GPs and wider multi-disciplinary teams, including nurses, pharmacists and allied health professionals. Due for publication August 2019.

Scottish Parliament Action

The Scottish Parliament's Health and Sport Committee has agreed to run an inquiry into the Future of Primary Care in Scotland, looking at the question:

> " **What does primary care look like for the next generation?** "

The Committee has looked at issues around primary care on a number of occasions including:

- Short inquiry into GPs and GP hubs (2016)
- Recruitment and Retention (2016)
- Access to primary care health services and inequality (2014).
- PE01698: Medical care in rural areas (2018)
- Integration Authorities Consultation with Stakeholders (2017)
- Technology and Innovation in Health and Social Care (2017)

Complaints

NHS services

People who have a complaint about NHS care or treatment can use the NHS complaints procedure. To make a complaint, people should contact the feedback and complaints team at the relevant health board. More information is available from Citizens Advice Scotland: NHS Complaints.

The Patient Advice and Support Service (PASS) is an independent service which provides free, accessible and confidential advice and support to patients, their carers and families about NHS healthcare.

The Scottish Public Service Ombudsman (SPSO) is the final stage for complaints about public services in Scotland, including councils and the NHS. The SPSO can look at complaints about the service provided by the NHS and complaints about clinical treatment, once the organisation's complaints procedure has been completed.

GP practices, dental practices, pharmacies and optometry practices

GP practices, dental practices, pharmacies and optometry practices have their own complaints procedures. It is also possible to make a complaint about professional misconduct to the practitioner's professional or regulatory body - one of the Councils listed above.

The Dental Complaints Service of the General Dental Council runs a service for complaints about private dentistry. The Optical Consumer Complaints Service is an independent mediation service for consumers of optical care and the professionals providing that care.

Annex A: A vision for primary care in Scotland: 21 principles

1. Primary care is generalist in nature. It focuses on the whole person across the complete life span, and not on any single health condition or part of the body. It encompasses both physical and mental health.

2. Primary care services are focused on supporting people to regain or maintain personal independence and wellbeing, on managing long-term conditions, or on enabling a peaceful and dignified death.

3. Primary care services are provided by a network of primary care professionals across the public, third and independent sectors. These networks are built around individuals' and families' health needs and desired outcomes.

4. Primary care services are easily accessible to everyone in every local community.

5. Primary care professionals are available at all times to provide co-ordinated, generalist care and support in communities. Outside of core service hours the focus of primary care professionals is on dealing with health issues which cannot wait until the full primary care network is available.

6. The full range of services available across the primary care network is informed by evidence, responsive to assessed population need and shaped by individuals and families within a locality.

7. The design, resourcing and delivery of primary care services recognises the needs of people whose lives are negatively affected by inequalities, isolation and/or the wider social determinants of health.

8. The design, resourcing and delivery of primary care services address the needs of a mobile population.

9. Primary care professionals use a mixture of clinical and social approaches to support people to achieve their identified outcomes, providing preventative support, treatment and ongoing care as required.

10. Primary care professionals optimise individual wellbeing and outcomes through building enabling relationships with people and focusing on continuity of care, supported self-management and asset-based approaches.

11. Within primary care networks, professionals work in partnership with each other and develop and maintain trusting and respectful relationships based on parity of esteem.

12. How professionals in these networks work together effectively to support an individual or family achieve their desired outcomes is more important than focusing on the buildings in which they are located.

13. All primary care professionals are trusted and enabled to work to the full scope of their competence, for the benefit of people in the local community.

14. Leadership for quality in primary care is the responsibility of all professions.

15. The co-ordination of care and support services for an individual or family is led by the professional most appropriate to their needs and desired outcomes at any given time.

16. Primary care professionals have direct and timely access to specialist advice and clinical decision-making support from acute, primary care and social care colleagues whenever they, or their service users, need them.

17. Primary care professionals are able to refer directly to each other and to colleagues outside the core primary care network.

18. Individuals and families have direct access to primary care professionals within their communities.

19. The primary care network has the necessary infrastructure to support safe, quality care, including suitable and sustainable staffing levels and skill mixes in all settings and appropriate access to all electronic patient records.#

20. The primary care workforce uses up-to-date digital technology that enables people to receive flexible, efficient and effective care, wherever it is provided.

21. All primary care professionals are accountable to their individual regulators and share a commitment to continuous professional development and quality improvement.

Annex B: The Scottish Government's key recommendation and actions in reforming primary care services, from the National health and social care workforce plan: part three [51]

	Recommendations	Supporting Actions
Facilitating primary care reform	1. Reform of primary care is driven by developing multidisciplinary capacity across Scotland. Workforce planners including NHSBoards, Integration Authorities and General Practices will need to consider the configuration of local multidisciplinary teams that offer high quality, person-centred care. 2. In recognition of an ageing workforce, local planners have responsibility for workforce planning and managing anticipated levels of staff turnover. 3. The implementation of the new GPcontract will require services to be reconfigured to maximise workforce competencies and capabilities, and ensure people see the right person, at the right time and in the right place. 4. The National Workforce Planning Group will play a strategic role in implementing the recommendations of part three of the plan, and strengthen the development of approaches for the primary care workforce. 5. An integrated workforce plan to be published later in 2018 will move towards a better articulated joint vision for health and social care workforce planning	• Increasing in funding in primary care by £500 million by the end of 2021-2, including £250 million direct support of general practice. This investment will see at least half of frontline NHSspending going to community health services. • Implementing the terms of the MoUover the next three years through the development of local Primary Care Improvement Plans. • Establishing a National Oversight Group to support service change over the next three years to ensure that patients receive the right service at the right time from the right profession. First meeting of Group in Spring 2018. • Three year Primary Care Improvement Plans to be submitted by Health and Social Care Partnerships (HSCPs) by July 2018 setting out proposals to transform and improve local services. • Working with partners to support the health and wellbeing of the workforce. • Continuing to help local partners test new ways of delivering primary care services through the Primary Care Transformation Fund. Publication of evaluation report by end 2018. • Publishing an integrated workforce plan later in 2018 bringing together progress on Parts 1-3, allowing us to move towards a better articulated, holistic vision for the health and social care workforce.
Building primary care workforce capacity	6. Significant investment will be made available over the next 3-5 years, as part of the First Minister's commitment to an additional £500 million for community health services, to plan for, recruit and support a workforce in general practice, primary care and wider community health, including community nursing. 7. Scotland's multidisciplinary primary care workforce will become more fully developed and equipped, building capacity and extending roles for a range of professionals, enabling those professionals to address communities' primary healthcare needs. 8. As part of national, regional and local activity to support leadership and talent management development, planners will need to continuously consider staff training needs in their workforce planning exercises; invest appropriately so that leaders in primary care are fully equipped to drive change; and	• Delivering an additional 2,600 nurse and midwife training places over the life of this Parliament, including a 10.8% increase in places for 2018/19, to ensure we can recruit and train the next generation of staff. • Investing £3 million to train an additional 500 advanced nurse practitioners by 2021. • An investment of £3 million over three years into training and education needs of general practice nursing.

	Recommendations	Supporting Actions
	enhance opportunities for the primary care workforce to further develop rewarding and attractive careers.	• An additional £3.9 million over three years into training and education needs of the wider community nursing team, including district nurses. • By September 2018, we will work alongside partners, including the Royal College of Nursing, to better understand the requirements and investment necessary to grow the District Nursing workforce. • Increasing the number of health visitors by 500, supported by funding which has increased over four years to £20 million annually, recurring. • Working with our partners to deliver our commitment to expand medical school and training places, helping deliver a commitment to recruit at least 800 (headcount) additional GPs over the next 10 years. • Investing in the Scottish Graduate Entry Medicine (ScotGEM) programme, a new four year course in medicine focused on general practice and remote and rural working commencing Autumn 2018. • Recognising the unique recruitment and retention challenges, offering a package of enhanced support for GPs working in remote and rural areas. • The establishment in Spring 2018 of an*Increasing Undergraduate Education in Primary Care Working Group*to consider ways of increasing undergraduate education in primary care settings. • Delivering a marketing and recruitment campaign in 2018-9 to promote Scotland as a great place to work as a GP, and to attract individuals into nursing and midwifery careers. • A marketing campaign to attract individuals into nursing and midwifery, allied health professional and other health and social care careers. • Delivering on our commitment that allGP practices to have access to pharmacist support by the end of 2021.

	Recommendations	Supporting Actions
		• Increasing the mental health workforce in A&Es,GP practices, police station custody suites by 800 by iinvesting £12 million in 2018-19, with annual investment thereafter rising to £35 million by 2021-22. • Developing an enhanced role for allied health professionals in supporting patients' needs, including promoting prevention and self-management with improved access. • Recruiting 250 Community Links Workers by 2021 to help address patients' holistic needs. • Training 1,000 paramedics to work in the community, helping to reduce pressure on A&E services. • Enhanced training and support for practice managers and practice receptionist to develop their roles, supported by continued investment.
Improving data, intelligence and infrastructure in primary care	9. More integrated workforce data for primary care is required, in the context of the workforce data platform being developed byNHS Education for Scotland. 10. Local planners should consider workforce planning tools (such as the six step methodology) in developing their workforce strategies to address local population needs. 11. Planning for future staffing in primary care should identify and make use of available guidance and intelligence on local recruitment and retention issues, and of wider developments in workforce data and scenario planning. 12. The Scottish Government will publish the Primary Care Monitoring and Evaluation Strategy 2018-2028 by June 2018.	• Enhancing workforce data across three broad GMS contract areas: workforce, GPincome and expenses, and quality improvement. Submission of enhanced data to commence by end of 2018. • Improvements underway in collection of AHP, pharmacy and optometry workforce and activity data. • Developing the NESworkforce data platform and supply modelling during 2018 to drive more integrated workforce planning. • Delivering the next generation of GPclinical IT systems in Scotland by 2020 to help enable facilitate efficient and effective working. • The Primary Care Digital Services Development Fund, 2016-2018 delivering a wide range of systems enhancements, infrastructure improvements and innovative trials of new tools and technologies. • Investing in local analytical (LIST) capacity to inform and drive service design; 65

	Recommendations	Supporting Actions
		analysts (WTE) in place by April 2018. • Continuing to support the roll out of the Scottish Primary Care Information Resource, with 85% of GP practices able to use SPIRE by the end of June 2018 with the remainder able to use it by December 2018. • Publishing a monitoring and evaluation strategy to capture and share learning from the reform of primary care in by summer 2018.

Annex C: Primary Care Improvement Plans

Aberdeen City	Aberdeen City Health and Social Care Partnership: Primary Care Improvement Plan
Aberdeenshire	PDF available on request
Angus	Tayside Primary Care Improvement Plan 2018 to 2021
Argyll and Bute	Argyll and Bute Primary Care Improvement Plan (pages 37-86)
Clackmannanshire and Stirling	Forth Valley Primary Care Improvement Plan 2018 to 2021
Dumfries and Galloway	The Primary Care Improvement Plan for Dumfries and Galloway
Dundee	Tayside Primary Care Improvement Plan 2018 to 2021
East Ayrshire	Ambitious for Ayrshire Implementation of 2018 General Medical Services Contract 2018-2021
East Dunbartonshire	PDF available on request
East Lothian	East Lothian Primary Care Improvement Plan
East Renfrewshire	East Renfrewshire Primary Care Improvement Plan
Edinburgh	Edinburgh Primary Care Improvement Plan
Falkirk	Forth Valley Primary Care Improvement Plan 2018 to 2021
Fife	Fife Primary Care Improvement Plan (p.75-100)
Glasgow	Glasgow City Primary Care Improvement Plan 2018-21
Highland	North Highland H&SCP Primary Care Improvement Plan
Inverclyde	Primary Care Improvement Plan
Midlothian	Midlothian Primary Care Improvement Plan
Moray	Primary Care Improvement Plan for Moray 2018-2021
Na h-Eileanan an Iar	Western Isles Health and Social Care Partnership: Primary Care Improvement Plan: 2018-2021
North Ayrshire	Ambitious for Ayrshire Implementation of 2018 General Medical Services Contract 2018-2021
North Lanarkshire	Lanarkshire Primary Care Improvement Plan
Orkney	Primary Care Improvement Plan 2018-21 (Orkney Health and Care)
Perth and Kinross	Tayside Primary Care Improvement Plan 2018 to 2021
Renfrewshire	Renfrewshire Primary Care Improvement Plan
Scottish Borders	Borders Health and Social Care Partnership - Primary Care Improvement Plan
Shetland	Primary Care Improvement Plan 2018-21
South Ayrshire	Ambitious for Ayrshire Implementation of 2018 General Medical Services Contract 2018-2021
South Lanarkshire	Lanarkshire Primary Care Improvement Plan
West Dunbartonshire	West Dunbartonshire Primary Care Improvement Plan
West Lothian	West Lothian Primary Care Implementation and Improvement Plan 2018-2021

Annex D: Scottish Governments Oral Health Improvement Plan: Commitments

1. The Scottish Government will ensure dentistry is featured in future strategies on alcohol, smoking and diet.
2. The Scottish Government will ensure the new population health improvement body to be established by 2019, recognises dentistry and improving oral health as a priority
3. The Scottish Government will change payments to dentists and introduce a system of monitoring to ensure that all dental practices provide preventive treatment for children.
4. The Scottish Government will introduce an Oral Health Risk Assessment
5. The Scottish Government will introduce a clinically-proven programme of periodontal care for patients with periodontal disease and those with high risk of developing it.
6. The Scottish Government will explore the potential for introducing general health checks for adult patients whilst attending for routine dental checks.
7. The Scottish Government will introduce a new three-year Community Challenge Fund for Oral Health Improvement. We will host an event with our partners to help develop the key components of the fund.
8. The Scottish Government will ensure that payments for practice-based allowances reflect the social deprivation status of the patients in the practice.
9. The Scottish Government will establish a single working group to provide strategic oversight to all national oral health improvement programmes and ensure we maximise our oral health improvement effort.
10. The Scottish Government will ensure the PDS actively pursue shared care arrangements with local ‘high-street’ dental practices.
11. The Scottish Government will introduce arrangements to enable accredited GDPs to provide routine preventive care in care homes. These practitioners will also work with care home staff and the PDS to ensure the maintenance of good oral health and hygiene.
12. We will work with organisations such as the Care Inspectorate to ascertain how we can continue to raise the profile of oral health care in care home settings.
13. Once we have sufficient numbers of accredited GDPs in place, the Scottish Government will introduce new domiciliary arrangements for people who are cared for in their own home.
14. The Scottish Government will work with Chief Officers within HSCPs to establish how we can work together to improve the oral health of people who are cared for in domiciliary settings.

15. The Scottish Government will work with NHS Boards to ensure that adequate secondary care data is available on which to establish primary-secondary care pathways.

16. The Scottish Government will introduce a system of accreditation that recognises GDPs with enhanced skills enabling them to provide services that would otherwise have to be provided in HDS.

17. The Scottish Government will ensure that the clinical pathway across Scotland is safe, consistent, clear and effective.

18. The Scottish Government will develop the standard of NHS oral health information on self-care, treatments available, costs and services to be made available to the public by dental practices and dentists.

19. The Scottish Government will streamline items of service payments to GDPs.

20. The Scottish Government will work with NHS Boards to introduce a Director of Dentistry in each Board area.

21. The Scottish Government will: introduce regulations to provide NHS Boards with more powers to refuse potential applicants; introduce arrangements for a single database of listing information for NHS Boards; and explore options in order to gather relevant information on bodies corporate.

22. The Scottish Government will work with the dental profession to provide NHS Boards with more powers to prevent GDS being provided from practices where there is clear danger to patient care.

23. The Scottish Government will work with NHS NSS to reconfigure the DRO and DA service to ensure a more effective and responsive service in the future.

24. The Scottish Government will consider how the functions of the SDPB can be subsumed within NHS NSS.

25. The Scottish Government will: publish a pathway to support dental practitioners locally; and when necessary, ensure that NHS Boards use disciplinary procedures and NHS Tribunal where appropriate.

26. The Scottish Government will work towards a single database of quality improvement information for NHS Boards with appropriate access for dental teams and the public.

27. The Scottish Government will: commission the development of a National Framework for Quality Assurance and Improvement across NHS dental services, using the HIS report as a starting point; and, work with HIS and NES on ensuring an overarching quality approach to

28. The Scottish Government will establish a Dental Workforce Planning Forum chaired by the CDO to provide regular workforce planning across the dental team.

29. The Scottish Government will develop programmes for promoting working in remote and rural areas.

30. The Scottish Government will establish an EU dentist's network which will provide the opportunity for dentists from the EU to engage with the CDO on issues which are a consequence of Brexit.

31. The Scottish Government will commission a short-life working group to look at models of OoH NHS dental care and the patient's OoH care journey. This group will report to the CDO with recommendations on how OoH care should be taken forward in the future.

32. The Scottish Government will commission NES to develop a General Dental Practitioner Fellowship Programme to enhance clinical skills, develop quality improvement skills and support remote and rural working.

33. The Scottish Government will work in partnership with NHS Boards and NES to ensure protected learning time for practice staff.

34. The Scottish Government will introduce an occupational health service for GDPs, members of the dental team and other practice staff.

35. The Scottish Government will work with the Scottish Funding Council and the universities to widen and improve access to dental education in Scotland.

36. The Scottish Government will work with NHS Boards and NSS to ensure that any PV issues are dealt with.

37. The Scottish Government will actively consider how we can increase the engagement and participation of the dental profession in HSCPs through our programme of stakeholder engagement.

38. The Scottish Government will establish a number of short-life working groups to take forward the actions set out within this plan.

39. The CDO will produce a bi-annual newsletter to provide an update on progress toward implementation.

40. The Scottish Government will run a number of roadshow events to discuss the implementation arrangements for the OHIP.

41. The Scottish Government will work with the Scottish Health Council to develop a Patient Forum.

Bibliography

1 Scottish Government. (n.d.) Primary Care Outcomes Diagram. Retrieved from https://www2.gov.scot/Resource/0051/00514411.pdf [accessed 28 March 2019]

2 Holyrood. (2016, September 2). Health professionals issue joint primary care vision. Retrieved from https://www.holyrood.com/articles/news/health-professionals-issue-joint-primary-care-vision [accessed 29 May 2019]

3 The Scottish Parliament. (2016, December 09). The National Health Service in Scotland. Retrieved from http://www.parliament.scot/ResearchBriefingsAndFactsheets/S5/SB_16-100_The_National_Health_Service_in_Scotland.pdf [accessed 20 March 2019]

4 ISD Scland. (2019, March 21). Personal Correspondence.

5 National Records of Scotland. (n.d.) Projected Population of Scotland 2016 (based) Key findings. Retrieved from https://www.nrscotland.gov.uk/files//statistics/nrs-visual/prog-pop-16/pop-proj-2016-scot-nat-pop-pro-info.pdf [accessed 05 March 2019]

6 Scottish Government. (2011, September). Strategic Narrative - Achieving sustainable quality in Scotland's healthcare. Retrieved from https://www2.gov.scot/Topics/Health/Policy/2020-Vision/Strategic-Narrative [accessed 17 January 2019]

7 Royal College of General Practitioners. (2011, July). It's Your Practice: A Patient Guide to GP Services. Retrieved from https://www.nhs.uk/choiceintheNHS/Yourchoices/GPchoice/Documents/rcgp_iyp_full_booklet_web_version.pdf [accessed 01 January 2019]

8 NHS Education for Scotland. (2013, July). Optometry in Scotland Education & Workforce Report. Retrieved from https://www.nes.scot.nhs.uk/media/3067450/nes_optometry_ed_wf_report_2013.pdf [accessed 01 February 2019]

9 Scottish Government. (2017, December 22). Transforming nursing, midwifery and health professions roles: advance nursing practice. Retrieved from https://www.gov.scot/publications/transforming-nursing-midwifery-health-professions-roles-advance-nursing-practice/ [accessed 03 April 2019]

10 Scottish Government. (2018, April). National Health and Care Workforce Plan - Part 3 - Improving workforce planning for primary care in Scotland. Retrieved from https://www.gov.scot/Publications/2018/04/3662 [accessed August 2018]

11 The Scottish Government. (n.d.) The 2018 Scottish General Medical Services (GMS) Contract. Retrieved from https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=2ahUKEwjMnNaRj4niAhUxRxUIHcS3BLIQFjAAegQIARAC&url=https%3A%2F%2Fwww.bma.org.uk%2F-%2Fmedia%2Ffiles%2Fpdfs%2Fcollective%2520voice%2Fcommittees%2Fgpc%2Fgpc%2520scotland%2Fthe-2018-general-medical-services-contract-in-scotland-contract-framework.pdf%3Fla%3Den&usg=AOvVaw0WM8fFWchBu5C3lPTRHcFh [accessed 07 May 2019]

12 The Council for Healthcare Regulatory Excellence. (2010, February). Protecting the public from unregistered practitioners Tackling misuse of protected title. Retrieved from https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/tackling-misuse-of-protected-title-2010.pdf?sfvrsn=d8c77f20_10 [accessed 03 April 2019]

13 Scottish Government. (2018, April). National Health and Social Care Workforce Plan: Part 3 - Improving Workforce Panning for Primary Care in Scotland.. Retrieved from https://www.gov.scot/publications/2018-gms-contract-scotland/ [accessed 01 February 2019]

14 ISD Scotland. (2018, December 2018). General Practice - GP Workforce and practice list sizes 2008–2018. Retrieved from https://www.isdscotland.org/Health-Topics/General-Practice/Publications/2018-12-11/2018-12-11-GPWorkforce2018-Report.pdf?57906740904 [accessed 20 March 2019]

15 ISD Scotland. (2018, March 6). Primary Care Workforce Survey Scotland 201. Retrieved from https://www.isdscotland.org/Health-Topics/General-Practice/Publications/2018-03-06/2018-03-06-PCWS2017-Summary.pdf [accessed 22 January 2019]

16 ISD Scotland. (2018, September). Dentists (September 2018). Retrieved from https://www.isdscotland.org/Health-Topics/Workforce/Publications/2018-12-04/Dentists_S2018.xls [accessed 08 May 2019]

17 ISD Scotland. (2018, December 04). Non-medical trend. Retrieved from https://www.isdscotland.org/Health-Topics/Workforce/Publications/2018-12-04/Non-Medical_Trend_S2018.xls [accessed 08 May 2019]

18 Scottish Government. (2019, April 23). Personal Correspondence.

19 NHS Education for Scotland. (2018, November 14). The Dental Workforce in Scotland 2018. Retrieved from https://www.nes.scot.nhs.uk/dental-workforce-2018.html#25_dentists_on_the_general_dental_council_register [accessed 08 May 2019]

20 The Scottish Government. (2018, April 23). TRANSFORMING NURSING, MIDWIFERY AND HEALTH PROFESSIONS ROLES. Retrieved from https://www2.gov.scot/Topics/Health/NHS-Workforce/Health-Professionals [accessed 06 March 2019]

21 Chief Nursing Officer Directorate. (n.d.) Paper 2 Advanced Nursing Practice. Retrieved from https://www.nes.scot.nhs.uk/media/4031450/cno_paper_2_transforming_nmahp_roles.pdf [accessed 06 March 2019]

22 Scottish Government. (n.d.) Personal Correspondence.

23 Scottish Government. (2018, December 12). Scottish Budget 2019-2020. Retrieved from https://www.gov.scot/publications/scottish-budget-2019-20/ [accessed 28 January 2019]

24 ISD Scotland. (2018, November 20). Scottish Health Service Costs Year ended March 2018. Retrieved from https://www.isdscotland.org/Health-Topics/Finance/Publications/2018-11-20/2018-11-20-Costs-Report.pdf?53498476744 [accessed 07 March 2019]

25 BMA. (2019, January 15). Why GPs sometimes charge fees. Retrieved from https://www.bma.org.uk/advice/employment/fees/why-gps-charge-fees [accessed 22 May 2019]

26 Scottish Dental Practice Board. (30, October 2018). Primary Care Dentistry in Scotland Annual Report 2017/18. [accessed 12 March 2019]

27 The Scottish Parliament. (2016, August 24). Integration of Health and Social Care. Retrieved from http://www.parliament.scot/ResearchBriefingsAndFactsheets/S5/SB_16-70_Integration_of_Health_and_Social_Care.pdf [accessed 2019 March 2019]

28 Scottish Government. (2015, July 3). Localities Guidance. Retrieved from https://www.gov.scot/publications/localities-guidance/pages/12/ [accessed 14 March 2019]

29 Scottish Government. (2015, July). Localities Guidance. Retrieved from https://www2.gov.scot/resource/0048/00481100.pdf [accessed 28 March 2019]

30 ISD Scotland. (2019, March 21). Personal Correspondence.

31 Scottish Government. (2017, April 19). Community Eyecare Services Review. Retrieved from https://www.gov.scot/publications/community-eyecare-services-review/pages/7/ [accessed 09 May 2019]

32 Scottish Government. (2016, September 15). Scotland's Oral Health Plan: consultation on the future of oral health. Retrieved from https://www.gov.scot/publications/scotlands-oral-health-plan-scottish-government-consultation-exercise-thr-future/pages/5/ [accessed 2019 May 2019]

33 Scottish Government. (n.d.) Pharmacy. Retrieved from https://www2.gov.scot/Topics/Health/NHS-Workforce/Pharmacists/Pharmacy [accessed 2019 May 2019]

34 The Scottish Parliament. (2009, May 07). Tobacco and Primary Medical Services (Scotland) Bill. Retrieved from https://www.parliament.scot/SPICeResources/Research%20briefings%20and%20fact%20sheets/SB09-34.pdf [accessed 21 March 2019]

35 Scottish Government. (2017, November). THE 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND. Retrieved from https://www.gov.scot/publications/2018-gms-contract-scotland/pages/3/

36 The Scottish Government. (2017, November 2017). Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards. Retrieved from https://www2.gov.scot/Resource/0053/00534343.pdf [accessed 27 March 2019]

37 Audit Scotland. (2018, October). NHS in Scotland 2018. Retrieved from http://www.audit-scotland.gov.uk/uploads/docs/report/2018/nr_181025_nhs_overview.pdf [accessed 20 March 2019]

38 NHS Circular: PCA(M)(2019)0. (2019, February 22). Retrieved from https://www.sehd.scot.nhs.uk/pca/PCA2019(M)02.pdf [accessed 21 May 2019]

39 NHS 24. (n.d.) Our Strategy 2017-2022. Retrieved from https://www.nhs24.scot/data/uploads/PDF/NHS_board/Plans/corporate/Strategy%20_2017_2022.pdf [accessed 21 March 2019]

40 Rural GP Association of Scotland. (2017, December 12). Realistic Rural Medicine and the Proposed New GP Contract. Retrieved from http://ruralgp.com/wp-content/uploads/2017/12/171212-Shona-Robison.pdf [accessed 25 March 2019]

41 The Scottish Government. (2018, December 21). Scottish Government submission of 21 December 2018. Retrieved from http://external.parliament.scot/S5_PublicPetitionsCommittee/Submissions%202019/PE1698_G.pdf [accessed 26 March 2019]

42 The Scottish Government. (2017, December 01). 800 more GPs for Scotland. Retrieved from https://www.gov.scot/news/800-more-gps-for-scotland/ [accessed 26 March 2019]

43 Scottish Dental. (2019, January). STATEMENT OF DENTAL REMUNERATION. Retrieved from https://www.scottishdental.org/wp-content/uploads/2019/01/Amendment-No-140.pdf [accessed 21 May 2019]

44 McCartney, G. (2013, January 09). What would be sufficient to reduce health inequalities in Scotland?. Retrieved from https://www2.gov.scot/Topics/Health/Healthy-Living/Health-Inequalities/Equally-Well/Equally-Well/MTF3a [accessed 26 March 2019]

45 Medical Research Council. (2007, October). Inequalities in health in Scotland: what are they and what can we do about them?. Retrieved from https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/mrccsosocialandpublichealthsciencesunit/programmes/

46 Pulse. (2019, February 22). Funding for deprived practices under Scottish contract may 'worsen health inequalities'. Retrieved from http://www.pulsetoday.co.uk/news/hot-topics/nhs-finances/funding-for-deprived-practices-under-scottish-contract-may-worsen-health-inequalities/20038301.article [accessed 26 March 2019]

47 The Scotsman. (2017, December 23). New GP contract is unfair, say Govan doctors Read more at: https://www.scotsman.com/news/uk/new-gp-contract-is-unfair-say-govan-doctors-1-4646468. Retrieved from https://www.scotsman.com/news/uk/new-gp-contract-is-unfair-say-govan-doctors-1-4646468 [accessed 26 March 2019]

48 The Scottish Parlaiment. (2017, July). Principles for a technology-enabled health and social care service. Retrieved from http://www.parliament.scot/S5_HealthandSportCommittee/Inquiries/TINN062_Collaborative_response_from_health_professions_working_in_primary_care.pdf [accessed 26 March 2019]

49 Scottish Government. (2018, April 25). Scotland's Digital Health and Care Strategy. Retrieved from https://www.gov.scot/publications/scotlands-digital-health-care-strategy-enabling-connecting-empowering/ [accessed 26 March 2019]

50 Scottish Government. (2019, March 27). Primary care: national monitoring and evaluation strategy. Retrieved from https://www.gov.scot/publications/national-monitoring-evaluation-strategy-primary-care-scotland/pages/3/ [accessed 21 May 2019]

51 Scottish Government. (2018, April 30). National health and social care workforce plan: part three. Retrieved from https://www.gov.scot/publications/national-health-social-care-workforce-plan-part-3-improving-workforce/pages/10/ [accessed 22 January 2019]

SPICe The Information Centre
An t-Ionad Fiosrachaidh

Scottish Parliament Information Centre (SPICe) Briefings are compiled for the benefit of the Members of the Parliament and their personal staff. Authors are available to discuss the contents of these papers with MSPs and their staff who should contact Lizzy Burgess on telephone number 85392 or lizzy.burgess@parliament.scot.

Members of the public or external organisations may comment on this briefing by emailing us at SPICe@parliament.scot. However, researchers are unable to enter into personal discussion in relation to SPICe Briefing Papers. If you have any general questions about the work of the Parliament you can email the Parliament's Public Information Service at sp.info@parliament.scot.

Every effort is made to ensure that the information contained in SPICe briefings is correct at the time of publication. Readers should be aware however that briefings are not necessarily updated or otherwise amended to reflect subsequent changes.