

**RSE RESPONSE TO SCOTTISH PARLIAMENT'S HEALTH AND SPORT  
COMMITTEE INQUIRY ON THE FUTURE OF PRIMARY CARE**

The Royal Society of Edinburgh (RSE) welcomes the inquiry from the Scottish Parliament Health and Sport Committee into the Future of Primary Care in Scotland. The inquiry comes at a critical point for primary care and the healthcare system in Scotland as there is general acceptance across the system, and Scottish Government, that primary care needs to be the major source of care in the future.

We support the approach taken by the Committee in gathering evidence from public surveys and panels to inform their Phase One report, as well as the research from the Scottish Parliament Information Centre (SPICe). However, it is important that this inquiry distinguishes between scientific evidence and lay opinion. Phase Two is crucially important as it provides an opportunity to generate and draw upon research evidence and data sources as well as input from health professionals. The Committee's final report on the future of primary care must be firmly grounded in evidence, while also taking account of public opinion.

Significant changes across the system, most notably a substantial shift of resources from acute and secondary care, will be necessary for primary care to become the major source of care in the future. Resources will be required to support staffing as well as the development and evaluation of GP clusters and multidisciplinary teams. The ambition of the Scottish Government to recruit an additional 800 GPs and improve the provision of primary care is supported. However, this will require significant resource to develop new physical infrastructure in communities to help accommodate new staff numbers and demand.

Additional resources will help to improve the provision of care through clusters and multidisciplinary teams but will also allow professionals to focus on research and professional development. Research evidence is a crucial, but underfunded, resource for the development and sustainability of primary care in Scotland. There are contrasting trends in numbers of academic GPs (roles that combine research, teaching, and clinical work), the capacity, and funding to conduct primary care research between England and Scotland. With Scotland falling behind, efforts need to be made to encourage more graduates to become academic GPs and to improve the level of funding and support available to primary care research in Scotland.

The collection and sharing of patient data will be critical to the development and future of primary care. Scotland is in an advantageous position to collect and share data across different levels of the healthcare system due to the unique Community Health Index (CHI) Number. However, the Scottish Government has failed to fully grasp this opportunity, failing to collect and share data across the whole system. Improvements must be sought through the delivery of new strategies on data sharing and collection; these strategies should be well resourced and regularly evaluated. They should address challenges in the collection of data in the social care sector as the provision and consequently, the data are mostly controlled by the private and voluntary sectors.

Achieving change throughout the system will face a significant challenge in political and public acceptance. It will be important for the Scottish Government to embark on efforts that will help change the current political, professional and public expectations. This will be achieved through sharing of scientific evidence and routine data showing improvements in health and efficiency of resources.

Summary

## Introduction

1 The RSE, Scotland's National Academy, welcomes the Scottish Parliament Health and Sport Committee's Inquiry into the Future of Primary Care in Scotland. The inquiry comes at a critical point for primary care in Scotland as technology development creates new opportunities, while challenges arise from an aging population and increasing prevalence of multi-morbidity (co-occurring diseases in one patient) and pressure on resources, including staffing and the balance of funding between generalist and specialist services. An RSE working group comprising expertise and experience in primary care, medicine, nursing and health data prepared this response. We would be pleased to discuss our comments with the Committee should members consider this helpful.

## General Comments

- 2 The RSE welcomes the work carried out to date by the Committee and the SPICE on primary care in Scotland. The Committee's Phase One work focussed on collating views from the public through public panels and surveys. We welcome and recognise the importance of gathering views from the public that can help inform the discussion and decisions around the future of primary care in Scotland.
- 3 While it is important to gather views from the public, there is a risk that views around healthcare can be misinformed as they are often based on anecdotal experience and opinion. It is important that this inquiry distinguishes between scientific evidence and lay opinion. Evidence comes from research, professionals, and the availability of routine data to generate intelligence.
- 4 The Phase One report presents principles and views from the public on what primary care is and should be. It does not, however, present evidence of whether or not particular innovations are likely to achieve their goals. Phase Two is crucially important as it provides an opportunity to generate and draw upon research evidence and data sources as well as input from health professionals. The Committee's final report on the future of primary care must be firmly grounded in evidence, while also taking account of public opinion.
- 5 We agree with the definition of primary care used in the Phase One report, whereby it is the first point

of contact with the NHS and for many patients the starting point of personalised continuity of care. In practice, this is usually through community-based services involving GPs, community nurses, physiotherapists, occupation therapists, midwives and pharmacists.

- 6 The future primary care system should aim to meet the needs of all communities in Scotland, urban and rural, which will increasingly necessitate meeting the needs of the rising number of older people with multi-morbidity, requiring continuity of personal care outside hospitals for as long as possible.
- 7 Primary care will not develop satisfactorily, nor achieve its full potential, without a substantially re-configured system for the collection and use of data to measure performance, share learning and support decision-making. New types of evidence and intelligence are needed on the processes of primary care at three levels:
  1. Building strong patient and family/carer narratives, based on what is important to them.
  2. Building strong local systems, linking the intrinsic strengths of general practice hubs (contact, coverage, continuity, coordination, flexibility, long term relationships and trust) with other community resources and services.<sup>1</sup>
  3. Building consistency throughout the system so that there is less variability, inefficiency and inequality across primary care in Scotland.

## Responses to the Questions

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

### Current System

- 8 Currently, healthcare provision in Scotland is dominated by secondary<sup>2</sup> and acute care<sup>3</sup>, as well as specialist services in primary and secondary care. The main generalist function of primary care, providing unconditional care for all patients, has been neglected in both financial and development terms, with a focus in recent years on building new infrastructure, notably hospitals, and increases in specialist funding. In comparison, community-based healthcare has experienced marginal increases in funding.

1 Gillies, J; Mercer, S; Lyon, A; Scott, M; Watt, G, (2009). 'The Essence of General Practice; a learning journey in progress.' Brit J Gen Pract ;pp167-176.

2 Secondary care is the treatment provided by professionals with specific expertise.

3 Acute care is short term treatment for a severe injury or episode of illness

- 9 Nonetheless, research and work around primary care from government and other research bodies makes clear that primary care should be the major source of care in the future as we move to a more community-based approach. This will restore the previous balance across the healthcare system but will also significantly increase the primary care component.
- 10 Achieving this will require gradual and sustained transitioning of resources away from secondary and acute care to primary and social care. This will require systemic and cultural change across public services as well as buy-in from the public. Initially, the practice of generalist clinical care, whereby frontline clinicians respond unconditionally to patients' problems without specialist referral, should be bolstered so that patients can be managed more effectively and for longer in the community.
- 11 The misalignment and increasing specialisation of healthcare provision has led to the fragmentation of care, often resulting in a lack of coordination and continuity which is not helpful for patients, especially those with complex multimorbidity. This misalignment stems partly from Scotland's poor performance in collecting information, evidence and data on community needs and the delivery of services, which would evaluate and analyse existing approaches and interventions.
- 13 However, Scotland has performed relatively poorly in sharing patient data across different levels of the system, despite most people wanting their data to be shared, as evident in the Phase One report. The Scottish Government has failed to fully grasp the opportunities that sharing of healthcare data across service systems provides, and this should be one of its main objectives, as it will be critical in enabling primary care to be the major source of care in the future.
- 14 In moving towards a more community-based approach the Scottish Government must think more strategically by planning for the next 20 years and beyond. Evidence and data must inform policy decisions around healthcare and show how we can best deliver integrated care for an ageing population. The RSE understands that the Government is working to operationalise the new Digital Health and Care Strategy. This must examine how new platforms can be used to collect data and how these can help to measure performance, share learning, and inform community-based interventions.

### *GP Clusters & Multidisciplinary Teams*

- 15 There are challenges to the sustainability of the entire health workforce in Scotland, especially in relation to general practice as it struggles to attract graduates to work as GPs or specialist practitioners. The Scottish Government aspires to increase the number of GPs by 800 over the next decade, to increase nursing numbers and to have a quarter of medical undergraduate contact time in primary care to encourage more undergraduates to become GPs.<sup>6</sup> To achieve these objectives, high quality clinical placements are required as well as an improvement in existing practice infrastructure. Undergraduate education and postgraduate training require sufficient academic GPs to lead the curricula.

### *Patient Data*

- 12 As technology develops, the collection and sharing of patient data are crucial to achieving a successful change towards a more community-based approach. With a nationwide healthcare system that ensures each patient has a unique Community Health Index (CHI) Number, Scotland is in advantageous position to collect and share data across the system, particularly across secondary and primary care systems. The use of the CHI can help link data across services and health boards which can be used to inform research and treatment. There are already examples within the NHS in Scotland where the integration of services through using the CHI Number has improved service. A notable example is NHS Tayside's approach to the treatment of diabetes.<sup>4, 5</sup>

4 Doonan, P; Leese, G; (2000). 'Hospitalizations for People with Type 1 and Type 2 Diabetes Compared With the Nondiabetic Population of Tayside, Scotland'. *Diabetes Care Journal*, Vol 23, No 12.

5 Leese, G; et al (2012). 'Impact of health-care accessibility and social deprivation on diabetes related foot disease'. *Diabetic Medicine Journal*.

6 Scottish Government, (2018). 'Supporting the Next Generation of NHS Staff'. URL: <https://news.gov.scot/news/supporting-the-next-generation-of-nhs-staff>

- 16** The developments of GP clusters and multidisciplinary teams are welcomed. These will take time to develop and have an impact on the delivery of services. Clusters bring professionals together to provide more efficient services at the primary care level. Their success will depend on having access to sufficient funding and the extent to which they can support cultural change in joint working and care provision. To ensure clusters and teams are sufficiently staffed, increased investment in career paths for the medical, nursing and advanced health practitioner workforce will be necessary. Increasing the resources for Advanced Nurse Practitioners could have a positive effect in the delivery of primary care as international research suggests that an increase in nurse-led primary care leads to patients receiving similar or better quality of care, longer and more satisfying consultations, and faster follow up appointments.<sup>7</sup> This may however require a change in patient expectations which are currently focused around treatment from GPs. Achieving a change in delivery would help GPs to focus their time and work with more complex patient needs, as well as improving opportunities for professional development.
- 17** Changes in the provision of community-based primary care should explore the potential of the co-location of multidisciplinary services in primary care. However, successful joint working depends on productive relationships, rather than geographical co-location per se. There are examples, globally, of the successful co-located speciality care within primary care settings, improving patient and provider satisfaction, reducing waiting times and costs.<sup>8,9</sup> The embedding of attached staff within primary care teams is also more effective than simple co-location<sup>10</sup> as has been shown with financial advice workers. This will require new and improved physical infrastructure to accommodate professionals and an increase in demand. Different models and approaches could be piloted and evaluated in rural and urban locations in Scotland and, if successful, scaled up nationally.
- 18** The success of the GP clusters will also depend on resources and the quality of staffing. Incentives may be needed to attract health professionals to substantial careers in local communities, so that they are present for long enough to make a contribution within the community. The successful delivery of primary care relies on the continuity function of care, equipping professionals with cumulative knowledge of community, family and patient histories. Such information data is not easily captured but can manifestly inform and improve treatment. Research has shown the importance of the continuity function, with 18 out of 22 studies showing that continuity of care helped reduce mortality.<sup>11</sup>
- 19** The success of GP clusters will depend on the strength of each local system, comprising the strength of working relationships between general practices and other community-based services and resources for health in the community; which includes measures for prevention provided through community care services.

### *Cultural and Behaviour Change*

- 20** Cultural and behavioural change occurs gradually, not least because shifting resources across from secondary and acute care to primary care will be challenging. The RSE recognises the difficulty in doing this, especially given the political sensitivity of moving resources away from hospitals to primary care. This will place the Scottish Government in a tough political situation. However, if funding is not guaranteed for the primary care system it will not be able cope with increased demand.

<sup>7</sup> Laurant M, et al (2018). 'Nurses as substitute for doctors in primary care', Cochrane Review. URL: [https://www.cochrane.org/CD001271/EPOC\\_nurses-substitutes-doctors-primary-care](https://www.cochrane.org/CD001271/EPOC_nurses-substitutes-doctors-primary-care)

<sup>8</sup> Elrashidi, M et al (2017). 'Co-located speciality care within primary care practice settings: A systematic review and meta-analysis', Science Direct Journal, URL: <https://www.sciencedirect.com/science/article/pii/S2213076417300465>

<sup>9</sup> Ramlakhan, S et al (2016). 'Primary care services located with EDs: a review of effectiveness'. BMJ, URL: [https://emj.bmj.com/content/33/7/495.short?casa\\_token=FoOBt6ZCWWJgAAAAA:kvJw\\_AaTqn8uyPKAqxjQVJyvOOLfNJddM3otVkgqegqcCEJjdURqUbuFrqgPvuUb-N8nYFsrHYI](https://emj.bmj.com/content/33/7/495.short?casa_token=FoOBt6ZCWWJgAAAAA:kvJw_AaTqn8uyPKAqxjQVJyvOOLfNJddM3otVkgqegqcCEJjdURqUbuFrqgPvuUb-N8nYFsrHYI)

<sup>10</sup> Egan, J; Robison O (2019). Integrating money advice workers into primary care settings: an evaluation. Glasgow: Glasgow Centre for Population Health, 2 [https://www.gcph.co.uk/assets/0000/7293/Advice\\_workers\\_in\\_deep\\_end\\_GP\\_primary\\_care\\_setting.pdf](https://www.gcph.co.uk/assets/0000/7293/Advice_workers_in_deep_end_GP_primary_care_setting.pdf)

<sup>11</sup> Gray, P (2018). 'Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality'. BMJ.



- 21** Making use of available data and research evidence to demonstrate that successful primary care results in fewer people in A&E and hospital beds will be critical. This could be useful to build cross party support for the redistribution of resources. Research on other healthcare systems suggests that increasing resources for primary care interventions can result in improved health outcomes. For example, changes to organisational structures in the primary care systems in Brazil<sup>12</sup> and England<sup>13</sup> resulted in wider improvements across general health and a reduction in hospital visits. Public confidence in primary care will also be important to gain support in the redistribution of resources; depending largely on people's and family members' experience of improved care. We understand that the Scottish Government is developing an approach to public engagement campaign focused on primary care.<sup>14</sup> This should aim to inform people of the benefits of primary care and the changes in approaches, such as more questioning and more time with nurse practitioners.
- 22** We believe that these changes will also help to maintain and increase the capacity of professionals to contribute to research, in partnership with academic institutions and co-designing the development and evaluation of new ways of working. Engaging professionals in this way could also help to attract, develop and support local leadership roles and careers within primary care professions.

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

*Staffing*

- 23** Staffing shortages are one of the biggest barriers to delivering a sustainable primary care system in both urban and rural areas. Recruitment and retention difficulties are leading to GP and related staff numbers being in short supply and decreasing, posing a threat to the delivery of primary care in Scotland. The number of GPs who are partners has decreased from 3,721 in 2013 to 3,396 in 2018<sup>15</sup> and 26% of existing GPs think they are unlikely to be working in general practice in the next five years.<sup>16</sup> This has resulted in NHS boards taking over more practices due to

lack of staff. Current staffing levels are insufficient to cope with a substantial change in approach and demand, which will require significant action to attract people into primary care.

- 24** Staff resources within primary care are also affected by changes in workplace culture. There is now an expectation for a level of flexibility in professional careers that allow people to move within and across professions, developing their skills and expertise. Currently, roles within surgeries such as that of a GP, are not particularly flexible and do not appeal to medical students. In comparison with general practice, hospitals appear to present more attractive careers for graduates with clearer routes for career progression, better remuneration and professional development. Such disincentives apply particularly to careers in academic general practice.
- 25** There is ample evidence showing that undergraduates spending more time in high quality GP placements can increase positivity towards GP careers and uptake into general practice. In this context, the report expected later this month from the Board for Academic Medicine may be instructive to policy makers in Scotland.
- 26** There has been a gradual move to encourage medical graduates and current professionals to become GPs, but this is not occurring fast enough particularly in rural and remote regions. There has not been enough funding to support the shift in resources towards a community-based approach. There are ways to enable practices to take on more work, but this depends on a critical mass of frontline staff and investment in premises to accommodate them – including a core of GPs – which consequently relies on funding.
- 27** The Scottish Government will need to consider increasing resources for staffing in primary care and community care, as well as developing incentives to retain and attract people into professions such as GP and community/district nursing. Otherwise, primary care provision will be negatively affected.

<sup>15</sup> Audit Scotland (2019). 'NHS workforce planning - part 2', pp 6-7

<sup>16</sup> Royal College of General Practitioners (RCGP) Scotland (2018). 'GP Forward View'.

## Patient Data

- 28** While Scotland is in an advantageous position to collect patient data, it struggles to bring it together and share it between parts of the healthcare system and other public services, particularly social care. Currently the data that exist across the system are fragmented. There is no cohering function that brings together the data from secondary and acute care that can effectively serve the primary care system, particularly data on discharges and follow up. Efforts should be made to explore the potential to develop a support function that will bring all relevant data across primary care together which would help the delivery of care in both rural and urban areas.
- 29** The integration of social care presents a significant barrier in sharing data, as this is a sector dominated by private and voluntary sector providers and therefore the collection and sharing of data is challenging. Currently the only available data in social care is inspectorate data which is not as detailed as data from other NHS services.<sup>17</sup> The lack of available social care data presents a major gap in healthcare data and a barrier to delivering a sustainable primary care system. The Scottish Government should explore mechanisms for obtaining data from the social care sector. This could include looking at procurement and new regulation, as required, to ensure there is uniform data across the service.
- 30** The pace of technological change is fast, and this could have significant benefits for primary care. However, the level of pressure currently on the health and care system presents a barrier to implementing new technology. The NHS typically focusses on addressing immediate issues and needs; so longer-term planning is less evident. Additionally, despite public support for the sharing of data, as evident in the Phase One report, questions around the public and political acceptance of the collection, storage and sharing of sensitive patient data still remain. A coordinated campaign may be necessary to gain public and political acceptance. The NHS can only review how it provides care for the whole population if it

has information about the whole population. Routine NHS data is the only possible source of such information. Individual data are needed, not for individual scrutiny but as a contribution to the total picture. The NHS needs to produce and popularise examples of this process in action and the benefits it leads to.

- 31** Developments around data collection such as NES Digital Service<sup>18</sup> with its aim to improve the quality and delivery of health and social care data are welcomed. There is recognition that NHS Scotland's technology and data are fragmented, and change is needed. Improvements in the delivery of care are now heavily reliant on digital strategies from government that have, historically, struggled to be fully implemented. It is imperative that strategies such as the Digital Health and Care Strategy<sup>19</sup> and new strategies under development for AI and data<sup>20</sup> are implemented effectively, evaluated robustly and sufficiently resourced to fully benefit the primary care system.

## Research Capacity

- 32** Research evidence is a crucial, but underfunded, resource for the development and sustainability of primary care in Scotland. In evaluating solutions to the challenge of addressing multimorbidity and social care in both urban and rural contexts there are two issues which distinguish such research from conventional approaches. First, unlike most specialist research which excludes people without defined inclusion criteria, research on multimorbidity needs to be inclusive. While such patients vary hugely in their combinations of problems, their needs for a particular type of care (i.e. unconditional, personalised continuity of care) are similar. Second, local systems for the delivery of such care depend so much on local factors that they cannot be pre-specified. They emerge over time, based on trial and error. Internal evaluations inform on progress; external evaluations assess outcome and value for money. Scotland needs a research workforce and research methods to produce research evidence out of this environment.<sup>21</sup>

<sup>17</sup> Information Services Division Scotland (2016). 'Scottish Care Home Census'. URL: <https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/2016-10-25/2016-10-25-CHCensus-Report.pdf>

<sup>18</sup> NES Digital Service (2018). 'What is the NDS?' <https://nds.nes.digital/>

<sup>19</sup> Scottish Government (2018). 'Scotland's Digital Health and Care Strategy: Enabling, Connecting and Empowering'. URL: <https://protect-eu.mimecast.com/s/fxstCYWnJHA3DOt0T4Bp?domain=gov.scot>

<sup>20</sup> The Data Lab (2019). 'Developing an AI Strategy for Scotland'. URL: <https://www.thedatalab.com/news/developing-an-ai-strategy-for-scotland/>

<sup>21</sup> Guthrie, B; Gillies, J (2019) Calderwood C, Smith G, Mercer S. Developing middle-ground research to support primary care transformation. *British Journal of General Practice*; 67 (664): 498-499. DOI: <https://doi.org/10.3399/bjgp17X693209>

**33** There are contrasting trends in GP numbers, the capacity, and the funding to conduct primary care research between England and Scotland. Academic GP numbers in England increased by 22% between 2010 and 2018 but decreased in Scotland by 25% from 2004 to 2010.<sup>22</sup> Although these comparisons are not in the same time period, we expect new figures on academic GPs to be released this year. Recent research illustrates that Scottish GP numbers increased by 2.4% from 2013 to 2018,<sup>23</sup> however it is unclear if this has affected the number of academic GPs. Additionally, there has been a continuation of the Clinical Excellence Awards in England but not in Scotland. This is one of the reasons why there have been no cross-border professorial appointments in academic general practice from England to Scotland since 2006. Additionally, there are significantly fewer opportunities for research funding in primary care in Scotland compared to England. This is due to lack of access or presence of research bodies and initiatives that operate in England, such as the National Institute for Health Research School for Primary Care Research and leading academic centres for primary care.

### *Public and Political Expectations*

**34** The RSE has highlighted to the Committee the importance of ensuring that the final report provides a clear distinction between lay opinion and expert scientific evidence. Public and political opinion may act as a barrier to effective changes. For example, the Phase One report highlights that there is an expectation from the public that ‘MOT’ / check-ups are a necessary service from primary care. This opinion is not backed by scientific evidence as research suggests that general check-ups are not the most appropriate intervention to improve population health in primary care.<sup>24, 25</sup> Rather, a limited selection of carefully chosen preventive actions is

warranted, for targeted age- sex- and risk-groups, based on research appraised for its quality.

### *Health Inequalities and Demographics*

- 35** Scotland has some of the largest health inequalities in the world;<sup>26</sup> this is affected by the distribution of our population across rural and urban areas as we have the most rural population in the UK. Health inequalities will require a holistic approach across all public services.
- 36** Despite having more than double the prevalence of premature mortality and multimorbidity, consultations in general practice in deprived areas of Scotland are shorter than consultations in the most affluent areas (by 20% for patients with multimorbidity) and have poorer outcomes, especially for patients with mental health problems, which is the commonest co-morbidity in deprived areas. This longstanding feature of primary care in Scotland should be addressed.<sup>27, 28</sup>
- 37** The delivery of primary care services in rural and urban settings may differ, and what works in urban areas may not work in rural areas. Therefore, approaches should be ‘rural-proofed’ which will ensure that planning and policy in areas of health and social care takes account of geography, population sparsity, digital provision etc.<sup>29</sup> This has been proposed as a systematic approach to ensure the needs of rural populations are considered in the planning and delivery of health services, involving a four-stage analysis process: impact on rural areas; scale of impact; how policy can be tailored; and how to further adapt approaches. Rural proofing should form part of future planning for primary care in Scotland, owing to our relatively large remote and rural populations.

<sup>22</sup> Medical Schools Council (2018). ‘Clinical Academic Survey.’ URL: [https://www.audit-scotland.gov.uk/docs/health/2012/nr\\_121213\\_health\\_inequalities.pdf](https://www.audit-scotland.gov.uk/docs/health/2012/nr_121213_health_inequalities.pdf)

<sup>23</sup> Audit Scotland (2019). ‘NHS workforce planning - part 2.’

<sup>24</sup> Frank, JW; Jepson, R; Williams AJ (2016). *Disease Prevention: A Critical Toolkit*. Oxford: Oxford University Press.

<sup>25</sup> Capewell, S; McCartney, M; Holland, W. (2015). ‘NHS Health Checks—a naked emperor?’, *Journal of Public Health*, Vol.37, No.2, pp 187-192.

<sup>26</sup> Scottish Government (2018). ‘Long-term monitoring of health inequalities: December 2018 report.’ URL: <https://www.gov.scot/publications/long-term-monitoring-health-inequalities-december-2018-report/>

<sup>27</sup> Mercer, SW; Watt, GCM (2007). ‘The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland.’ *Ann Fam Med* ; 5(6): 503–510.

<sup>28</sup> Mercer, SW; Zhou, Y; Humphris, GM et al (2018). ‘Multimorbidity and socioeconomic deprivation in primary care consultations.’ *Ann Fam Med* 16(2): 127–131.

<sup>29</sup> Scottish School of Primary Care (2019). ‘National Evaluation of New Models of Primary Care in Scotland.’ Scottish School of Primary Care, University of Glasgow. URL: [http://www.sspc.ac.uk/media/Media\\_645962\\_smxx.pdf](http://www.sspc.ac.uk/media/Media_645962_smxx.pdf)

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

**38** We believe that the current Scottish Government strategy, ‘Primary Care: National Monitoring and Evaluation Strategy’<sup>30</sup> provides a good basis on which the performance of multidisciplinary teams and GP clusters can be monitored and evaluated. GP clusters are at an early stage and their impact will be felt gradually as they develop. Research from the Scottish School of Primary Care indicates that there is general support for the clusters but there are areas that need to be developed. A large proportion of GP survey respondents commented that there is very little data that supports their work and primary care research.<sup>31</sup>

**39** Monitoring of performance relies on routinely provided data but there is recognition that data provision and use within clusters requires improvement. Emergent patterns of care need both initial research evidence on effectiveness and value for money and subsequent intelligence to inform services on how they are performing during “real-time” operation. The use of Local Intelligence Support Teams (LIST) as they develop may be of use here, as well as future research evidence from the Scottish School of Primary Care.

**40** There is scope to develop a systemic mechanism which encourages the sharing of routine data from clusters that, in turn, helps to monitor and share their performance on outcomes, preventions and health inequalities. The monitoring and evaluation of how patient data and records are used and stored could be done through the Scottish Primary Care Information Resource.<sup>32</sup> This resource would allow significant input from stakeholders to help bring examples of good practice to the attention of fellow professionals, service managers and policy makers. Examples of good practice can be piloted and then evaluated at both rural and urban levels within the primary care system. This would help ‘rural proof’ interventions and may lead to further developments or changes in how interventions are implemented. There is a need to be able to evaluate the performance of primary care holistically, by highlighting how changes in its structure and functions are impacting on the wider healthcare system. Evaluation must take into account that high-quality, sustainable delivery of primary care leads to “non-events,” such as the prevention, postponement or lessening of complications and consequent reductions in the need for secondary or acute care.

**30** Scottish Government, (2019). ‘Primary care: national monitoring and evaluation strategy’, URL: <https://www.gov.scot/publications/national-monitoring-evaluation-strategy-primary-care-scotland/pages/12/>

**31** Scottish School of Primary Care, (2018). ‘2018 Scottish GP Survey’.

**32** Scottish Primary Care Information Resource, (2019). ‘Keeping my information safe’. URL: <https://spire.scot/keeping-my-information-safe/>

## *Additional Information*

This Advice Paper has been signed off by the RSE General Secretary. Any enquiries about this response should be addressed to Paul Stuart, Policy Advice Officer (email: [pstuart@theRSE.org.uk](mailto:pstuart@theRSE.org.uk))

Responses are published on the RSE website (<https://www.rse.org.uk/>)

The Royal Society of Edinburgh, Scotland's National Academy, is Scottish Charity No. SC000470

*Advice Paper (Royal Society of Edinburgh) ISSN 2024-2694*