



## SCOTTISH EXECUTIVE

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Primary and Community Care Directorate  
Primary Care Division

To:  
Chief Executives of NHS Boards  
General Medical Services Leads  
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Dear Colleague,

### **SCOTTISH ENHANCED SERVICES PROGRAMME FOR PRIMARY AND COMMUNITY CARE – DISCUSSION PAPER RESPONSES**

The purpose of this letter is to present a summary of responses to the recent Primary Care Division's discussion paper on the Scottish Enhanced Services Programme.

As of 3 August 2007, 48 returns were received from a range of individuals and organisations, including responses from the Royal College for General Practitioners, NHS Boards, Community Health Partnerships, medical professionals and specialist or voluntary organisations.

Overall the responses revealed support for the approach to the programme. In particular, the opportunity for joint working between primary and community care providers and the flexibility for local service design were welcomed.

However, some concern was voiced, including comments on the limited time in which to finalise services prior to October 2007 and the limit of 10% of the funding allocation for the optional 'local' service.

Responses suggested general agreement with clinical specifications, although there was a mixed response to the childhood obesity and flexible appointment sessions specifications.

A more detailed summary of responses in relation to the key elements of the discussion paper is attached at Annex A.

This summary document and individual responses (where permission has been given for responses to be made public) will shortly be placed on the SHOW website. Arrangements can also be made to view hard copies of individual responses by contacting the Scottish Executive Library on telephone number 0131 244 4565. Responses can be copied and sent to you, but a charge may be made for this service.

Comments received through the responses to the discussion paper have been considered in finalising arrangements for the Scottish Enhanced Services Programme. This letter should be read in conjunction with [Circular PCA\(M\)\(2007\)10](#), which gives details of the next steps in the delivery of the programme.

May I take this opportunity to say thank you to everyone who took the time to respond to the discussion paper on the proposed Scottish Enhanced Services Programme. Your comments were valued and have helped to inform the policy process.

Yours sincerely,

DR JONATHAN PRYCE  
Deputy Director, Primary Care Division.

## **The Responses**

1. By 3 August 2007, a total of 48 responses were received from a range of stakeholders including representatives of NHS Boards, Community Health Partnerships (CHP), voluntary and specialist organisations, academia and the Royal College of General Practitioners (RCGP).

## **The Process**

### **Approach to the Programme**

2. The new approach to the Scottish Enhanced Services Programme (SESP), including the move to encourage other health and community care professionals to participate in delivering services, has been welcomed.

3. However, caution was raised over the extent to which all services would be developed in every area and the risk of patchy provision across Scotland. It was also suggested that the minimum of three services risked diluting outcomes from such services and that the approach, with its action plan, interim and final reports, risked being over bureaucratic.

4. One respondent suggested that the programme should be appraised and evaluated early in the process.

### **Timeframe and Funding**

5. Some responses suggested that the timeframe to begin services in October 2007 was unrealistic which would leave little time to develop services, negotiate with contractors and submit an action plan. A number of responses suggested that January 2008 would be a more realistic time to commence services.

6. Some responses stated that 18 months was not long enough a funding period for these services to achieve the desired outcomes, and some suggested 2- 3 years as a minimum timeframe.

7. There are views expressed that suggest that funding from 2007/08 should be able to be spent in 2008/09, to allow appropriate funding to be spent at the right time in development and delivery of services. One response also suggested that scales for certain services (appearing to reflect the 2006/07 DESs) should have been set nationally.

8. Several responses commented on how funds would be allocated, with four respondents reflecting on previous arrangements. Another four responses, agreed with the proposed allocation. One respondent suggests that the allocation formula could help address health inequalities. Another two responses stressed the need to consider rurality within the allocation, whilst one response felt that allocations should be focused on population data. A number of responses claimed that the limit of 10% of allocation for the 'local' service option was too restrictive.

### **Local Flexibility**

9. There was wide support for local flexibility in service choice and development, with one response suggesting that this could extend to sharing of experience and good practice to support wider learning. However, one respondent cautioned that local decisions should be realistic and evidenced based.



## **Partnership**

10. The principle of partnership working was welcomed by respondents with many encouraged by the prospect of developing full partnership models, inclusive of the voluntary sector and local authorities. Some suggested the development of partnerships could be difficult with the possibility of potential providers vying for funding in competition with potential partners.

11. It was also said that the establishment of partnerships might require more time and it was proposed that a more realistic start date for services would be January 2008 rather than October 2007.

## **Sustainability**

12. Concern was expressed over the limit of 18 month funding but there appears a strong desire to ensure benefits to patients through service redesign in the long term. A view was expressed that as there is no guarantee of funding beyond 2008/09 then an exit strategy is needed.

## **The Specifications**

### **Adults with Learning Disabilities**

13. There is general support for the service specification. Suggestions have been given regarding involving GPs with specialist interest, the voluntary sector, community pharmacists and service users in developing the services in local areas. Other suggestions include a stronger focus on how to meet identified need and how to support young people with learning disabilities in their transition to adulthood. There was also a suggestion that there was a strong link between this service and the carers' service, as carers were integral in supporting uptake of screening and access to services for people with learning disabilities.

14. One concern expressed was that where this clinical area was less resourced than other large priority areas then the service could be disadvantaged. However, another view was that this service along with Cancer and Urgent Referral and Carers risked crowding out other clinical areas as there was already significant resource put into these services.

### **Alcohol and Brief Interventions**

15. Responses have been very positive, recognising that hazardous and harmful drinking is an issue that can be addressed within primary care. It is suggested that services can build on lessons learned from the 'Keep Well' pilots and research from Robert Gordon University which looks at the role of community pharmacy. One response suggested it was important to ensure a link between alcohol specification and national targets. Another respondent raised a note of caution that there needs to be recognition of the limit to GP care in this area and where other services should be utilised.



## **Cancer and Urgent Referral**

16. This enhanced service has been well received, and comments have largely revolved around refining minor elements of the specification. Responses suggest that there is a desire to build on the positive changes to working practice that the 2006/07 DES introduced and to disseminate audit results to learn from experiences.

## **Falls Prevention and Bone Health**

17. Views were expressed that this service should be extended to include all those at risk of falls, for example, wheelchair users and those at risk of osteoporosis. The service is welcomed but responses indicate that a preventative approach involving dieticians and pharmacists and all primary and community care key players should be considered in development.

## **Care for Adults with Diabetes**

18. The response to this proposed service has been positive. In particular it is seen to address the needs of the 'Long Term Conditions Framework' and 'Delivering for Health'.

19. However, one respondent claimed that there are considerable resources already being invested into diabetic services and there was potential for duplication of effort. Another response raised concern that the focus seemed to be on transfer of funds from secondary to primary care, but that the increase in prevalence of diabetes could affect this aim. One respondent also suggested that some groups of patients would be best served out with primary care.

20. Overall there was strong support for redesign of the services. One respondent suggested that patient and family education with CHP based specialist dietetic and nursing staff support to clinics should be developed. One response linked this service to childhood obesity services, assuming that obesity services focus on the whole family, as this could help prevent the onset of diabetes and improve care for adults with the condition. Another response suggested including an objective to help identify those at risk of developing diabetes through other illness or medication.

## **COPD**

21. Views expressed included linking the service to the Chronic Medication Service component of the new pharmacy contract, into smoking cessation services and encouraging involvement of the voluntary sector. It was also underlined that there has already been development work for this service in Angus and Tayside which could be built upon in the wider area.

## **Childhood Obesity**

22. There appears to be a mixed message regarding the childhood obesity service. Whereas most responses saw this as an important clinical area, many were less sure about how this service could be delivered through the SESP. One respondent stated that GPs are very critical of 'medicalisation' of what they see as a social issue. However, respondent also suggested that there may be scope to deliver the objectives via local authority services.

23. Some responses argued that there is limited evidence to say that interventions through enhanced services would address obesity, where others disagreed. One response referred to research groups from Leeds and Glasgow that appear to offer models of practice. Another respondent suggested it would be interested in taking part in research to support evidence.

24. Where it was agreed that childhood obesity should be seen as a priority, there was agreement that this requires a multidisciplinary and early intervention approach. One practical suggestion was that the obese children of adults attending Counterweight clinics could be targeted through a family based Counterweight approach.

### **Carers**

25. This has been broadly welcomed. The key suggestions were around strengthening the specification. In particular these focus on the need to establish a lead on carers issues at a NHS Board level; the role of the voluntary sector, including but not exclusive to the Princess Royal Trust; and the importance of targeting and supporting emotional and physical needs of carers.

24. Responses suggested a need to focus on carers of people with learning disabilities and young carers. Responses to other services within the SESP also linked carers of people with other long term conditions to this service.

### **Flexible Appointments**

25. There was a mixed response to this service. On the one hand some responses have been supportive, and can see how this would complement extended hours and improve access. Others see this as politically driven and feel that it is impractical due to the lack of support from GPs themselves. There was also some discussion around the potential for high costs due to overheads and contractual issues. There was also reference to a potential knock on effect for GP staffing or Out of Hours (OOHs) services.

26. One response suggested that cost effectiveness needed to be considered carefully and if this was to go ahead, there would need to be reassurances that workload would not increase.

PRIMARY CARE DIVISION  
PRIMARY AND COMMUNITY CARE DIRECTORATE

AUGUST 2007.

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38 responses have been published on SHOW, and can be viewed by clicking on the appropriate number below -

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