OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 8 March 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 8 March 2022

CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
10th Meeting 2022, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

*Paul O'Kane (West Scotland) (Lab)

COMMITTEE MEMBERS

*Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
David Torrance (Kirkcaldy) (SNP)
*Evelyn Tweed (Stirling) (SNP)
*Sue Webber (Lothian) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Val Costello (Citizens Advice Scotland)
Margaret McKay (Riverside Medical Practice Patient Participation Group)
Wendy Panton (Scottish General Practice Professional Nurse Lead Group)
Hannah Tweed (Health and Social Care Alliance Scotland)
Dr Chris Williams (Royal College of General Practitioners)
Dr Anurag Yadav (British Association of Physicians of Indian Origin)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 8 March 2022

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Gillian Martin): Good morning, and welcome to the 10th meeting in 2022 of the Health, Social Care and Sport Committee. I have received apologies from David Torrance.

The first item on our agenda is a decision on whether to take item 3 in private. Do members agree to do so?

Members *indicated agreement.*

Alternative Pathways to Primary Care

09:00

The Convener: Our second item is two evidence sessions as part of our inquiry into alternative pathways to primary care. They are the first of our sessions on that inquiry.

Before we start, I will mention an informal meeting that I was at last night with service users and some third sector representatives, who attended to talk about their experience of alternative pathways to primary care. I would be grateful if some of the members who attended could give a quick summary of what they heard.

Certainly, in the session that I chaired, there was a lot of enthusiasm for green spaces therapies, but there was concern that not enough patients were being referred to them and that there was a lack of understanding of what was out there, including among referring general practitioners. There was a worry that, although there were quite a lot of really good projects out there, people who could benefit from them—particularly the most vulnerable of people, who could benefit the most from them—were not signposted to them or did not have access to the information in order to access them. In short, there are a lot of good things out there but there is an issue with communication.

We heard about some good things, but one person said that she had heard about some attitude problems, with medical professionals, in particular, being quite dismissive of social prescribing as an option. That was a bit of a worry. I do not know how widespread that attitude is, but that was certainly one person's point of view. Emma—you were in another session.

Emma Harper (South Scotland) (SNP): Thanks, convener. There was a bit of a mix of views. Some people had an absolutely excellent experience of accessing alternative pathways and for others it was the complete opposite. A lot of the challenges were about communication, how signposting is delivered and what pathways or social prescribing options are out there.

All those people defined what social prescribing meant, but it was very new to them and when they called the GP practice the receptionist could be the absolute barrier to any progress. Those were a couple of the issues that came up.

People also asked why they could not make online appointments and why they could not just get text messages to remind them when there was an appointment. They raised the issue of joined-up computer information data systems, as well.

Some of the points are the same as those that we heard in the social prescribing session that we had in the previous parliamentary session, so it will be interesting to hear everybody else's thoughts this morning.

The Convener: Yes, and the points echoed quite a lot of the things that came through in our survey, which is, of course, available to the public. Sue—you were also in a session last night.

Sue Webber (Lothian) (Con): Most of the people there did not have anything particularly positive to say. They were all aware of the various healthcare professionals who are out there, but they were not aware of possible pathways to access them. Everything is still coming through the GP, who is still the primary point of contact. Signposting to other healthcare professionals is also very limited.

It was quite disappointing to hear about the reality of what many people face on the ground in a number of sectors. There was no experience of self-referral to taxpayer-funded services, but there were a couple of examples of self-referrals to alternative services that are provided by third sector organisations. It is clear that a lot of improvement is needed.

Only one person mentioned a social prescribing referral. Again, that was via a GP practice. It was a referral to active gym sessions in the local authority area.

There were a lot of concerns about people's different skill levels and abilities to navigate and find alternative services. The online approach was one of the main tools. Finding a phone line that would open the door was helpful, but a lot of the referrals were to third sector organisations or via the GP. That shows where the bottleneck is and that there is still a lot of work to do.

Like Emma Harper, I reiterate the level of frustration that many people feel about getting to see their GP and about the receptionist at the door stopping them going further.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): A lot of the things that have been mentioned came up. Self-referral, waiting lists and being left in limbo were issues. People felt that they did not hear anything for quite a long time.

Another issue was that there is not enough information and people struggle to access the pathways. People who are already vulnerable—elderly people and people who are in poverty, or do not have confidence, or are suffering from depression, for example—were highlighted, and the lack of knowledge of autism came up.

There were some positives, as well. Social prescribing is seen as particularly good for people who do not have great connections in the local community and feel a bit isolated. It has made a massive difference to them. People were also getting some really good services through pharmacies, including the ability to access urgent medication to prevent an ambulance having to be sent at very short notice.

Evelyn Tweed (Stirling) (SNP): I was in the same group as Stephanie Callaghan and I thought that the session was really good. The responses were quite a mixed bag. I took from the session that people were quite positive that there were alternative pathways, but the big issue is access and how to get the message across to inform people that alternative pathways are available. There was much discussion about how we could do that better.

The Convener: Thank you very much, colleagues.

I thank everyone who joined us last night. The session was very informative.

With our first panel, we will focus on the patient's perspective on accessing primary care and navigating alternative pathways. That leads on very nicely from the summaries that we have just been given.

I welcome to the committee Val Costello, who is a patient adviser in the Citizens Advice Scotland patient advice and support service; Margaret McKay, who is the chair of Riverside medical practice patient participation group; and Hannah Tweed, who is a senior policy officer at the Health and Social Care Alliance Scotland. I thank the alliance for being very helpful in getting people to our meeting last night.

To what extent have the public, and bodies such as yours, been involved in the co-design of primary care services, particularly given that the GP contract has changed and different strands of practitioner are now available in GP practices, and given everything else that we have talked about relating to the alternative pathways that people might be able to be referred to?

Val Costello (Citizens Advice Scotland): Good morning. I work for the patient advice and support service that is run by CAS in Lanarkshire.

The main problem that we find is with patients' knowledge of their own health and their health literacy. If they do not know what is wrong with them, they cannot possibly self-refer, so they go back to the GP. That is a major issue for people who are not aware of what can be wrong with them and people who have health literacy issues.

Another big problem is with the capacity of alternative pathways—whether alternative practitioners such as physiotherapists and nurse practitioners have enough capacity to deal with those patients. The patient advice service has found that waiting times after referral to physio and other pathways can be very long. If a person is in pain, they will go back to their GP. That is a problem for our patients.

We also find that there is not enough public awareness of alternative pathways. That really needs to be improved. Aye, we are having problems with it. People who access and use alternative pathways have positive things to say about them, but the problem is with getting to that point.

There are also digitally excluded members of the general public who cannot access things online and do not have access to mobile phones, which is an issue for them. Those are probably our findings from the patient advice service.

Margaret McKay (Riverside Medical Practice Patient Participation Group): I chair the patient participation group for the Riverside medical practice in Musselburgh, so anything that I say this morning is based on the experience of one practice in one local authority area, which is East Lothian.

You asked about the extent to which patients have been involved in co-production of primary care services. I direct you back to the point at which the new GP contract came into force. That is clearly a contract between the Scottish Government and representatives of GPs in Scotland and, although I appreciate that a contractual arrangement is between two parties, it seems to me that patients were the one group of people who were not really involved. The impact on patients was not looked at, and nor was how patients were to understand the rationale for the changes that took place.

My view, based on our experience in Riverside practice—one of the largest practices in Scotland, with 19,000 patients—is that, in the main, there has been an abysmal failure in getting over to the public that general practice is changing, why it is changing, why it needs to change and what will be put in place to ensure that healthcare needs are fully taken account of.

A co-ordinated communication plan is needed at national and local levels—by that I mean health board or local authority—and even more at practice level. A story should be told to explain that general practice is changing, why that is and what will be done, and that patients will see different people but can have confidence in the plans. That messaging has happened in some places, but it has been fragmented, lacking in coherence and has certainly not been integrated. In our experience, the result has been that until most patients come up against an alternative pathway they do not have any idea about what is happening.

I put out a call to find out about people's experiences of direct referral to physios, and the response that I received from patients who had had that experience was very positive. However, a certain group of patients is more likely to find their way through the pathways that exist at the moment—the patients who are more able and who have time to navigate through them.

I think that we should take a step back, because people need to understand why general practice is changing, which I think is not well understood at all. Therefore, we find pockets of resistance—which could just be because people are not used to the process—in which people question why they should see an advanced nurse practitioner, for example, even though he or she might be the best person to handle their particular circumstance.

We need to ensure that services are not fragmented and that somebody, somewhere is holding on to the experiences, needs and history of patients. That person can be the patient, but a key member of their health team should also hold that. Until now, that has been the usual practice.

The Convener: Thank you, Margaret. That is very helpful.

Margaret McKay: I urge the committee to take that step back and help people to understand the fundamentals of why GP practices are changing.

The Convener: Thank you.

09:15

Hannah Tweed (Health and Social Care Alliance Scotland): The question of co-production is a really interesting one. At a basic level, I am not sure how much meaningful understanding there is—among people who access services or across the board—of what co-production is.

We have some examples of where it is being done well. I have colleagues who work with a local information service for Scotland, who did a fair amount of work to speak to people who access the service and to hear what they need from it in order for it to work. That service—I am sorry, I should have provided a glossary—is a website that enables people to search, by postcode or keyword, for what services are available in their area. The services are often, although not exclusively, in the third sector. That information service was co-produced and co-designed with people, with a focus on what works.

Colleagues who work in general practices across Scotland, including deep-end practices, have also been working along those lines and talking about which forms of access work for people. However, that is not happening everywhere; there is variable practice. That links to Margaret McKay's point that there needs to be communication about why things are happening in order for discussions to be meaningful. If people do not have basic comprehension of the reasons for the approach and what the alternative proposals are, it is much harder to have discussions about design.

We have examples in which the approach is working well and is improving outcomes for people, which is the bottom line that everyone is working towards. I can give you more detail on those, but I am not sure how much information you want, at this stage.

The Convener: My colleagues will probably ask for more details when they ask their questions. I was nodding along, particularly when Margaret McKay talked about how the approach is communicated. We have all seen in our areas where the approach is being communicated well and where there has been reactive communication about the change. It can be problematic until people actually access the service. If they get a good service, they are completely fine about it, but the initial reaction to change is that there has not been proactive information sharing about what is going on.

An issue that came up last night, and in our survey, is the role of receptionists. In many cases, people are worried that the receptionist is a gatekeeper, rather than a facilitator to their accessing healthcare. Before I hand over to Sandesh Gulhane for his questions, I will quickly go round all of you for comments on that. What are you hearing from the people to whom you speak?

Hannah Tweed: We certainly hear about that perception, although whether it encompasses all experiences is another matter. We have spoken to a range of people for whom that is their perception and experience. Others expected that to be the case but were pleasantly surprised by the good experiences that they had. There is a real mixed bag—if I can be that informal.

There is a real need for something along the lines of the house of care model, to signpost people explicitly. It comes down to communication about the role of the receptionist as facilitator. When that is done well, it really helps people and the process is streamlined, but it needs to be followed through with meaningful support for those staff, because that knowledge does not come just like that. Staff need to be supported and enabled to signpost people effectively and to link them into communities. They need the resources to do that.

Also—to return to the comment about waiting lists—adequate timelines are needed so that people do not feel that they are just being put off. A service might be the right place to refer the person, but if that means a six-month or eight-month wait, it is not an effective immediate intervention.

Margaret McKay: Obviously, receptionists have a range of skills and attitudes. There certainly needs to be a clear platform, in all practices, in respect of how the receptionist operates. I would like to take a step back from the individual receptionist, because in our practice the issue is that the receptionist is almost forced to be the gatekeeper, because it is so difficult to get through to the practice.

I will give an illustration. If you call our practice when the line opens at 8 o'clock—in fact, if you call at almost any time—the first message that you will get is that you are likely to have to wait half an hour to get through. If that is the first message that they get, the patient's blood pressure—I do not mean in a medical sense—will start to rise. When you get through, the level of contact and communication with the receptionist is almost predetermined, because patients have been hanging on for so long and have been told not to go off because they will lose their place in the queue. It is perhaps unfair to "blame" the receptionists, because in our experience they are forced into that gatekeeping role, because it is in most cases impossible to get through to the practice in under half an hour. Sometimes we blame the wrong person.

The issue is, in fact, access. The medical care in our practice is highly respected and commented on, but most patients would say that access to the practice is devastatingly poor. If we do not tackle that issue, receptionists are put in a very difficult position, because they are having to give that message, which is unfair on them and on patients. The mechanisms for getting through to the practice need to be looked at.

The Convener: It is about the system working for everyone.

Val Costello: I agree with Margaret McKay. Receptionists are in a no-win situation. When people call, receptionists have to take basic information, which is seen by patients as triaging, so they want to know what qualifications receptionists have to triage their health condition.

Patients also have to cope with confusing procedures. They get text messages to say that their blood-test results are in and they should make an appointment, but they cannot get an appointment. They wonder why the text message cannot say, for example, that they can have a telephone appointment on Thursday at 10 am. That would make things much easier, but instead patients have, as Margaret said, to phone at 8 o'clock every morning to try to make an appointment. Such things build distrust and dislike of receptionists, which puts them in a very difficult position.

Sandesh Gulhane (Glasgow) (Con): It is important that I say that I am a practising working GP and was doing GP work on Monday. It is interesting to hear about receptionists, because without our receptionists there would be zero access to us. It is distressing to hear about the abuse that our receptionists get when they tell me what some people have said to them. I know that it comes from frustration, but there is a level of abuse that is unacceptable; it seems that the line is often crossed.

I want to go back to a point that Margaret McKay made. In April 2018, the new GP contract came into effect. Among other things, it aimed to reflect the role of GPs and to reduce their workload in order to allow them to concentrate on things that only GPs can do, so that they can be the expert medical generalist. Has that shift been communicated to patients? What more can do we do to get it across to patients?

Margaret McKay: I hope that I have made it clear that I think that the shift has not been satisfactorily communicated to patients. The first step involves knowledge and understanding, but the measures that are put in place in order for the objective to be achieved are also important.

I will give an example to illustrate that. I am here to represent a patient participation group, not a practice. Alternative pathways are linked with our practice. When patients ring the practice, while they are on hold they are given three telephone numbers—one is an 013 number, one is an 0162 number and one is an 0300 number. On one of those numbers people are told about direct access to physiotherapy, on another they are told about community treatment and care options for wound care and advanced phlebotomy, and on the third number they are told about mental health services. Patients get a message about those three numbers while they are on hold, but their objective, at that point, is to get through to the practice. They are also told not to go to an accident and emergency department unless the issue is urgent and doing so is essential, and they hear about NHS 24.

The objective is to free up GPs so that they can concentrate on patients who have complex needs or multiple problems, but we have not ensured that alternatives are put in place in a coherent manner. The various services all have different opening times and different telephone access numbers, and it is extremely difficult for patients to make sense of all that.

I realise that I am speaking about only one practice in one local authority area, but what I have described is certainly not uncommon in that local authority area. If we are to have alternative pathways, there needs to be coherence and integration. Services need at least to mirror one another's opening times and availability. That is not the case at the moment. From a patient's point of view, the system is confusing and frustrating, which, sadly, gets people angry.

The Convener: Do any of the other witnesses want to come in? I should have said at the outset that if you want to add to anything that has been said, you can put an R in the chat box in BlueJeans.

Val Costello: I agree with everything that Margaret McKay said. If a patient is ill, poorly or in pain, they get all those messages over the telephone, but they really just need to speak to someone. That is when they start to get angry and there is a stand-off between the receptionist and the patient, which is not good for anyone. Receptionists are in a no-win situation, but they are definitely seen as gatekeepers rather than as the gateway to help.

Hannah Tweed: I echo the comments about abuse of any staff—or, indeed, any person—being unacceptable. I will speak about the experiences of the 59—I think—community links practitioners who work across Glasgow and West Dunbartonshire; I cannot speak about the experiences of such practitioners Scotland-wide.

When community links practitioners have built up established contacts and trust with individuals who are supported by them, they can sometimes provide alternative routes. If people are struggling to get through to other services or are not sure where to turn, but have a good relationship with a community links practitioner, that can allow them to be signposted via social prescribing to community services and a range of other services, or sometimes to be directed back to their GP or other specific medical professionals. That can be useful for people, because they will be speaking to someone they know, trust and have built a relationship with over, in some cases, years.

I am not saying that that does not also happen with reception staff; in some instances, it does. However, it is useful for people to have that alternative communication pathway, so that the frustration that can lead to the situations that colleagues have described can be mitigated.

09:30

The Convener: We will move on to talk about alternative health practitioners.

Sue Webber: I thank the witnesses for their comments so far. It has been really enlightening to have the reasons and justifications explained so concisely. That has made it clear to us where some of the issues lie.

Margaret McKay and Val Costello said that the long waiting times to see alternative health practitioners are also undermining the ability to alleviate the pressures on general practices, because everything is still funnelled through them. We know that patients are likely to default to their GP if they have to wait too long. What must happen if we are to make meaningful improvements to access to alternative health practitioners?

Val Costello: Public awareness of the alternative pathways needs to be improved straight away. Everyone knows about pharmacists, but they do not know about the other pathways that are available. People in the older demographic tend to self-care; people in the younger demographic can look things up on a computer because they are computer literate and that works for them.

There being more awareness of alternative pathways would help but, as I said and as we agreed, capacity is an issue. Is there capacity in all the possible alternatives for them be fully used? I do not know whether they have the capacity or not. Are there ways to find out how long a person will wait if they self-refer to physiotherapy today? Would they have to wait for long time? What should they do in the meantime while they wait for an appointment? All that needs to be looked at. We need to work on those things.

Margaret McKay: [*Inaudible*.]—part of an overall plan that, as one committee member said, is about redefining the role of the general practitioner. It should be made clear to people that they have a right to a service if they have a particular need.

You will appreciate that I can use only the examples that I am aware of. Unlike what we heard from a member, a direct referral to the physiotherapy service in East Lothian appears to be quite straightforward. There is a relatively short waiting time and there have not been many complaints. However, that is a relatively new method of accessing a service.

The people who are accessing that service in the early stages are what I would call the savvy patients. The availability of that service will become more widely known, as it should: it is there as an alternative and should be known to everyone. I assume that there would then be a pressure point at which waiting times would grow. We desperately need to ensure that all patients, and not just the savvy ones, know about the available alternative services.

That is one of the major concerns for our patient participation group. Some people do not have access to practices' websites, or cannot navigate them well, because they do not have access to technology or do not have the skills. Some people do not have the confidence to self-refer. We need to take a step back. How do we promote the service? How do we ensure that it is available to all patients and not just to those who find their way to the top of the list, wherever they are?

Sue Webber: We have spoken about the fact that 10 per cent of people still will not accept an appointment with an alternative health practitioner, even if one is available, but will want an appointment with a GP. Why might that be? Are there legitimate concerns regarding the availability of alternative health practitioners? We have spoken about communication being consistent and national and so on, but we do not have consistent services, so we cannot have a national message. What are your thoughts on that?

Margaret McKay: I agree. What I am talking about cannot be just one message; there must be messages at national, health board and local practice levels, delivered in a coherent and co-ordinated way. There is no point in there being just one message. There has to be a plan to communicate the changes to all the groups that are involved, and to give them the same messages.

We have heard from patients that when they have had direct experience of an alternative practitioner and it has been a good experience, they are fine. It is about people understanding what an advanced nurse practitioner is, for example. Terms such as "musculoskeletal specialist" are not helpful. Certainly to me, and to most people I know, that is a physiotherapist.

When there is change, we need to look at how the patient will understand it and we must try to put the message over from the patients' perspective rather than from the professionals' perspective. It is nonsense that professionals get upset because they are referred to as "practitioner" rather than "advanced practitioner". What matters is what the patient understands and how they experience things.

Stephanie Callaghan: I thank the panel members for coming. I have a question for Margaret McKay. She mentioned that we need co-ordinated national and local messaging to the public. I totally accept that that is the case. What difference has the patient participation group made in her area? How effective has it been and what positives can we take out of it to improve the experiences of patients more widely?

Margaret McKay: Our patient participation group was established at the end of 2018, when two practices merged, and the aim was to find out the implications of that for patients. We carried out one survey at the end of 2018 and one at the end of 2019, in which we interviewed 100 patients out of 600 attendees at flu clinics. That is a small number compared to the 19,000 patients in the practice, but it is quite a good response from 600 attendees. By the way, that was before Covid-19. Although many of the issues that we are talking about have obviously been exacerbated by the pandemic, they were there before it.

We asked patients two questions: what is going well at the practice and what could be improved? As I have been saying this morning, the issues were about access. Once people actually got through and saw the relevant practitioner, whether it was the nurse or the GP, they spoke highly of the service. The key issue was getting into the service, and that remains the case. Given that it remains the case, we might ask what difference the patient participation group has made. All that we can do is keep bringing it to the practice's attention that that is the key issue for patients and that there are ways in which the situation could be improved. We are happy to be a test bed whenever any changes are to be made, whether they are to opening hours, the message on the telephone system or whatever.

If patient participation groups are used well—if they are used as a test bed for changes—they can be useful and effective. If they are not used as a test bed for changes, one would ask what role they have.

Emma Harper: The inquiry is about alternative pathways to primary care. In the previous parliamentary session, the Health and Sport Committee held an inquiry about social prescribing for physical activity and sport. I am not saying that everybody needs to take up cycling and running, but we know that access to the outdoors can be beneficial, that men's sheds can support people and that joining walking groups can be helpful. I am interested to hear from the witnesses about their experience of patients' general attitudes towards social prescribing.

Val Costello: Social prescribing is beneficial for a certain group—what Margaret McKay would call the "savvy" group, which is the group that is aware that self-care works and that social activities can help and can alleviate issues—but it does not seem to work for the other groups. That is down to a lack of public awareness. We have talked about that on the national level, but, at local authority level, if people knew what was available to them, what they could join and what the process would be for joining it, it might increase the uptake and, therefore, reduce the need for them to see the GP. However, people are not aware of what is available and will always go back to their GP because they view them as the gateway to alternative methods of getting better.

Hannah Tweed: That is an interesting link to social prescribing and, specifically, exercise. When I spoke to our team of community links practitioners before coming to the meeting and when writing—[*Inaudible*.]—we heard a lot of stories about people who live in the areas of highest socioeconomic deprivation in Glasgow and West Dunbartonshire according to the Scottish index of multiple deprivation.

I like the term "savvy patients", which Margaret McKay and Val Costello used. Some of the patients in those areas are savvy, but many have more limited digital access so are not necessarily within that category. However, because they work with links practitioners, they still get referrals and see the benefits of them. We heard from people who sought support for mental health problems and were referred to different community groups and support groups, such as those for allotments or outside mindfulness engagement. Particularly during the pandemic, people were more engaged with outdoor spaces and continued to access them.

We are seeing positive outcomes from such prescribing. People are reporting that they do not want to access GP services as often but are getting other services involved, experiencing better outcomes for themselves and feeling better in themselves. Those are all things that people want.

We have seen a real increase in people seeking support from links practitioners. Between 2019 and 2020, we had a 74 per cent increase in referrals, which was huge. Even allowing for the fact that we had a staff increase, it was still a really substantial increase. In 2020-21, there was a 60 per cent rise. It is partially a consequence of word of mouth. Within the areas that I referred to, people are beginning to talk about social prescribing and are saying that it worked for them, so we see a knock-on effect from that. That cannot happen instantly. It is slow but, as it builds, we get momentum.

09:45

That links into earlier comments about how things are communicated, which needs to be embedded in the community. As well as national messaging, sustained engagement with specific areas is needed. That is particularly true in population groups in which there may be a lower level of digital literacy or other factors that might make communication via email round robins more problematic.

We have a surprisingly large reported increase in the use of services and in outcomes, which is welcome. There is a real shift in how people are seeking support.

Emma Harper: We have seen how the pandemic has made people engage more in daily walks and in accessing the outdoors. Has there been a shift in knowledge about social prescribing because of the pandemic? We know that people have been really isolated and that telephone befriending services were therefore set up. That would be seen as social prescribing that is not about sport but about tackling isolation to support wellbeing. Has the pandemic led to an increase in awareness of social prescribing?

Hannah Tweed: I think—

The Convener: Is that question directed to Hannah Tweed?

Emma Harper: Yes.

Hannah Tweed: I am sorry. I assumed that it was directed to me and I jumped in. I apologise if I stepped over someone.

I do not have concrete evidence of that, but I think that there are reasonable indicative findings to show that. We have found that our links practitioner referrals have been going up substantially and that the number of people accessing a local information system for Scotland—ALISS—to seek befriending services online and all sorts of different forms of community-based support has gone up by 34 per cent, I think, during the pandemic. I cannot give the specific statistics off the top of my head, but I can get them. There has been a notable increase.

That is probably linked to the fact that how people could seek support was and is more limited. I am aware that our links practitioners made a real effort to manually phone around the people they supported pre-pandemic to ensure that it was not just people who could email who were supported. They tried different forms of communication in addition to generic letters going out. They picked up the phone and made an effort. That must also be an important part of engaging people with alternative forms of support and of wider engagement with what it means to be healthy and supported.

Val Costello: That has happened during the pandemic, but I think that people now think that things have gone back to normal, that they have tended to fall away a bit from that and that they are going back to their old and trusted method, which is contacting their GP practice. That will always be the way when there is a change: people will want to go back the way. Awareness of things such as walking groups needs to be reinforced all the time. Public awareness that they are still available and that there are other methods has to be increased. That is the main issue.

Emma Harper: My final question is about community links workers. When I last looked at the data, in March 2021, 218 links workers had been registered or looked at on the Scottish Government's website, and it looks as though we are on track to have around 323 by March this year. Community links workers are supposed to help to direct people to the alternative pathways, services and social prescribing that are out there. How can links workers' communication on the alternative pathways and social prescribing that are available for people help to support them?

Hannah Tweed: It is really welcome that we are seeing an increase in the number of links workers. I would be really interested in whether we are on track for X number of them and where that information is from, because I want to read it. My understanding is that we are well on the way, but I think that the figure is sitting at the equivalent of 189.3 full-time links practitioners, so there is still room for the expansion to continue.

When links practitioners always work within a certain area, that is a much easier sell—for want of a better phrase—because people will have understood the concept through word of mouth or by seeing advertising, for example. When links practitioners are brand new to an area, we have found that it is really important that the messaging goes out in a range of forms, including in easy-read format, and that the materials are accessible. The messaging should be in community languages, particularly in areas where large numbers of the population have English as an additional language.

There should be an effort to engage with seldom-heard-from groups. We should ensure that they know how to access services and know that they, to use Margaret McKay's phrase, have the right to access services. That is key and should be a deliberate part of the introduction of links workers in a practice. We should also ensure that practices are fully aware of the situation and that the local community organisations to which links workers might refer people have established relationships and expectations. The initial legwork that community links practitioners have to do in introducing themselves to people and organisations in the community can be part of an effective common strategy. That will allow links practitioners to know the capacity of such organisations, so that they do not refer people to organisations that cannot accept new members and so on.

We should expand the provision of CLPs as broadly as possible, so that that route is considered to be not an alternative route but the norm. It should be how Scotland delivers a range of care. People should be able to seek support from a finance community links practitioner or from a community links practitioner as well as from a GP or nursing practitioner. That should become the norm. We need to work towards having that level of information and breaking the barrier that puts so much pressure on the GP system, which has all the knock-on effects.

Margaret McKay: The R that I put in the chat box related to the question about the range of alternative pathways, which was asked before the most recent question about community links workers.

It is important to consider how consistent and permanent the alternatives are in relation to social prescribing, which has been talked about. One of the difficulties is that, very often, the initiatives that spring up either are entirely volunteer led—which is great if the initiative can be sustained—or are set up on a short-term pilot basis. If we want major change in something as profound as the health service that is provided, such initiatives have to be sustained and underpinned.

I want to make it clear that this point does not relate to the patient participation group, because we have not discussed it. However, it seems to me that, given that the role of public health has been so important and powerful during the pandemic, surely there might be a read-over in how we can use the public health service to, for example, demonstrate to youngsters that going to a football club—in our area, football teams are full of young people—is part of keeping them healthy. If that could be linked to the committee's more strategic concern—if public health could encompass and reference all the other ways in which we can keep ourselves healthy or grow healthy and strong—that would be a benefit to come from the pandemic. That is just an observation.

We cannot get away from the fact that general practices are under incredible strain. Therefore, if there are to be alternatives—for example, CTAC centres, where people can go for wound care or for hospital blood tests—those services have to be available at pace and in numbers, so that patients can be drawn away satisfactorily from general practices. Otherwise, the system will not work.

There is a resource issue. Alternatives are being established, but that is happening without it being clear whether there is a right to them or whether they are just something that happens if the local health and care partnership chooses to support them and puts in money in that way.

There needs to be a drilling down into how the alternative pathways are being set up, managed, run and implemented and what we are learning from them. It came as a great surprise to patients in our practice when they discovered that they did not go to get wounds dealt with at the GP practice any more, because that was not publicised. That has been pretty basic for generations, so we cannot expect patients to happily settle for that if they do not know about it in advance and do not understand why it is happening.

The Convener: Hannah Tweed wants to come back in briefly before I bring in Gillian Mackay.

Hannah Tweed: It is just a quick riff off the back of Margaret McKay's comment about sustainability, which I completely agree with, as it is pretty key. We have found relatively high staff turnover as a direct result of the fact that links practitioner contracts are relatively short term. It is not because of dissatisfaction with the work or the support that people are providing in communities; it is because they are on one-year contracts. People need stability if they are to pay the bills.

If we are expanding the links practitioner pathway and other alternative routes, there is a question about how those are funded to ensure that they can really build on—[*Inaudible*.]—connections that matter so much to the role.

Gillian Mackay (Central Scotland) (Green): I thank all the panel members for giving us their thoughts. Some respondents to the committee's survey expressed a pretty negative view of social prescribing. Some said that it was not the type of care that they wanted or expected to be offered when seeking help from their GP. One respondent said that they would be "insulted" if they were directed to those services. Another said that it represented an "easy way out" for the GP.

The benefits of social prescribing are well documented. Does the panel think that the negative attitudes towards social prescribing stem from a lack of awareness of it or explanation of the benefits? Does there need to be a greater culture shift with regard to what care people can expect in accessing their GP?

I will go to Hannah Tweed first, as she is nodding lots.

Hannah Tweed: The short answer is yes. We have definitely heard such comments. We have heard from people who, to be blunt, felt short changed when they were redirected to links practitioners. In most cases, people then began to understand and were supported. In our area, of those who were referred, a fairly high proportion sought help from links workers and accessed services. I do not know the statistics off the top of my head, but it was 11,000 and something out of 11,000 and something.

A culture change is needed, however. We need sustained communication to expand that, particularly where the concept is new. That is where support for reception staff is important. They can help people to begin to understand that this is not about being palmed off and that it involves professionals who have in-depth knowledge of local support networks.

It is also important that people know that they can seek dual sources of support—they can seek support from GPs or medical professionals about part of what they are seeking help for. For example, the second highest amount of our support from community links practitioners was for poverty-related issues. It is much better if support with filling out personal independence payment assessments or with social care or social security comes from links practitioners rather than from a GP. It is about splitting up the support and communicating clearly where the respective expertise lies.

That is not an easy job, and there is no quick fix. It is a matter of sustained and continued communication about the value. That needs to come from medical professionals as well as from links practitioners and other members of the community. It is a group effort to communicate people's respective expertise.

The Convener: I do not know whether any of the other panellists wants to come in. If you do, I remind you to please use the chat box to let me know, and I will come to you.

10:00

Gillian Mackay: I have heard GPs raise another concern about social prescribing, which is that it takes less time to explain a drug prescription than it does to explain a method of social prescribing, such as a nature prescription. Is lack of GP time a barrier to patients understanding and engaging with social prescribing? Are the rationale behind and benefits of social prescribing being properly explained to patients? How can we raise awareness of social prescribing if GPs have limited time to explain it properly?

Val Costello: I think that the main answer must be health literacy. If people do not know what is wrong with them, they cannot self-refer and use alternative methods; they must go through the GP practice, whether that is to see a GP or the nurse practitioner. If they do not know and are not aware, that will always be the first port of call.

When someone goes to the GP practice and the GP offers an alternative, that may not be what the patient wants. I completely understand that. They are looking for a tablet that will cure everything, although that does not always happen. We need a lot of education about and knowledge and public awareness of alternative methods. That comes down to health literacy. What do patients know? How savvy are they about their own health and the methods that might alleviate their problems?

Citizens advice bureaux get a lot of referrals from community link workers that tie in with what Hannah Tweed said. It is well known that people who are physically ill are emotionally low. Other environmental factors come into play too, such as someone's situation with benefits, employment and housing. That all comes through the CABs' doors. We are a quick fix. We are always here, but we only do a patch-up job before people move on. This comes down to health literacy and to public knowledge and perception.

Stephanie Callaghan: I have a question for Hannah Tweed. Do link workers have formal qualifications or undergo formal training, or is there a huge advantage to drawing in people who have a range of experiences, skills and community connections and who can connect well with patients?

Hannah Tweed: Our link practitioners come from a range of backgrounds, which has been really useful in informing their practice. We have an internal system of on-going training, communication and support for individuals. To the best of my knowledge, that works well.

I have not asked my colleagues for their opinion on formal qualifications. I am leery of speaking about something about which I do not have information. I apologise for my bluntness. I think that it is an interesting proposal. If it was to be taken forward, it would be valuable to see a range of consultation on what that would entail and the pros and cons, and different elements, of continuing professional development.

I refer you back to my comment about keeping people in the role and building on expertise. It is important that we do not end up in the same situation as our colleagues in social care, where people move away from the profession and good support is lost, partly because of additional demands.

I am happy to speak to my colleagues and come back to you, if it would be useful to have direct input from people working in that role. Please let me know if that would be beneficial.

Evelyn Tweed: Good morning, panel, and thank you for your contributions so far. My questions are on digital services. Do you feel that patients have—and do patients feel that they have—direct control over their health with such services? How can we improve them? That question is for Val Costello in the first place and then anyone else who wants to come in.

Val Costello: Those who are digitally included and know what they are doing can easily navigate the digital services that are available. However, as you will know, that sort of thing is not for everyone. That means that we are left with a vulnerable group of people who do not know how to do it and are excluded from seeking the help that they need. At that point, they might either turn to the GP or, indeed, stop bothering about their health and try to make do and cope with their condition, instead of seeking the help that they need. There is definitely a huge gap in that respect. The digital services approach will work for the younger demographic and the more tech-savvy, but for those who are digitally excluded, there is a gap that needs to be filled.

Margaret McKay: As we say in our written submission, this is one of the major concerns for us as a patient participation group. Perhaps I can give you an example. In our practice, you can get a repeat prescription only by doing it online or by going to the pharmacist, but there is no consistency in what each pharmacy offers in that respect. That is a very obvious example of where a group of patients are likely to be excluded from a very basic and simple service. As I said, that is one of our biggest concerns. If you are able to access the practice website and the various services listed on it—which, I have to say, can be quite confusing, as they all have different numbers and opening times—you will be able to work your way through to what you need, but there are people who are not in a position to take that first step. Far from improving health equality, some of these changes are increasing health inequalities. That might seem like a very strong statement; however, we not only believe it but believe that we can evidence it.

I would certainly ask the committee to consider the matter really seriously. If promoting health equality is a fundamental objective of GPs on the ground or Scottish Government ministers, the digital divide must be taken into account and redressed to ensure that the changes that are coming in as a result of the changes to GP practices do not increase health inequalities. That is our fear.

Evelyn Tweed: We have heard evidence that the public are accessing digital services a lot more and, indeed, have done so during the pandemic, but I have heard comments this morning about the move away from that to people going back to their GPs more often and so on. How are we going to get the message out about alternative pathways, doing things slightly differently, digital services and so on? I think that Val Costello touched on that, and I wonder whether she has any more thoughts on the matter.

Val Costello: We had a very good television campaign to promote walking, getting out and getting some fresh air, but that has definitely dropped off the radar. We—I say “we”, but I do not mean “me”—also have a radio campaign for reception staff in GP practices, and I think that it is giving out a very positive message. However, all the services that we offer have to fit with local authority as well as national aims. As you all will know, practices are run in completely different ways from one another. You have to phone some practices at 8 o’clock, or between 1 pm and 3 pm to get blood-test results, for example, but it is different at other practices.

Again, information about all of that can be found on the website, but some people cannot use the website, so how should the information be promoted? It must be in the local press, on the local radio and on posters on the walls in the GP practice. The information has to be out there so that people can see it. It might be a better use of the message that people get when they phone the GP practice if they were given a list of services rather than being told to call this number or that number or to do this or that. We need to improve the public’s knowledge of alternatives and of how they can find out about services. Those services have changed but we have not changed how we let people know that they have changed.

The Convener: I want to ask about mental health support—particularly the online mental health support that young people have been accessing and benefiting from during the pandemic—and about learning from its success and continuing with it. Do any of the witnesses have experience of online services that have worked for particular demographics? How can we incorporate learning from what happened during the pandemic into a longer-term strategy? I am thinking about those who want online services; I am not saying that they are right for everybody.

Val Costello: We help people to keep their progress going. If they have been referred to go to an online service such as Breathing Space or another service that the GP has prescribed, they will often phone the patient advice service and say that they do not think that it is working or ask what they should do when they come to the end of it. Our role is to keep everyone engaged so that they know what they are doing next. Sometimes we do that by contacting the GP practice on someone’s behalf or by encouraging them to contact their community psychiatric nurse or mental health team to discuss what they should do next.

There have been some successes. Again, however, it comes down to the people who can access that type of service and, as Margaret McKay said, there is a huge gap between those who can and those who cannot. The more we put our services online, and the more health services that go online, the wider that gap becomes and the more isolated people who cannot access those services become. That is a real shame because we have had anecdotal evidence of those services working.

The Convener: However, they are not right for everyone.

Hannah Tweed: There is an interesting challenge there. I am curious about the results of online mental health services: how intersectional those services are, where they work and where they do not work, and how the information and data are being collected, reflected upon and used to inform policy.

This is anecdotal—I am not claiming otherwise—but we have heard from some people who welcome online as a much more flexible method of accessing services, particularly folk for whom going out and about to appointments is much harder either because of personal mobility issues or care responsibilities.

We have also heard from individuals who have been directed to online services not because those services are the best fit but because their waiting lists are shorter. I have a specific anecdote of someone who was directed to an online mental health support service, and they went for that because the waiting list was shorter. They were told that, if the online service did not work after a couple of sessions, it would be no problem for them to go back on the waiting list for in-person services. In practice, that did not happen; they just got discharged and were sent to the back of the queue. It is really hard to challenge that sort of system.

There is something about transparency, consistency and making sure that there are options to raise such problems, particularly for those for whom even just going out and seeking mental health support takes such a lot of emotional and cognitive energy, which they might have limited access to at that point in their lives for a compound list of reasons. It is important to drill down into the demographics to look at where things are not working and why, and to use that information to challenge and develop, and to make sure that we are talking about digital choice.

I think that this riffs on Margaret McKay's comment about digital being great, but it should not be digital first. Instead, we must have digital choice to give people a range of access points. We need to be cautious that we do not lose the good practice that has been developed during the pandemic—we need to keep that and build on it—but we must also ensure that everybody is heard.

I am thinking of certain practice-specific things such as services that offer online mental health support, but which will work only if you have a quiet room where no one can overhear you. If you have childcare responsibilities, that ain't happening, if I may be so blunt. We need to look down at that level of detail to see what these things mean and how other things can be accommodated to ensure that the system suits as many people as possible and to find out where it might need to shift.

10:15

Emma Harper: I have a quick question. Hannah Tweed mentioned ALISS, the local information system for Scotland, which is funded by the Scottish Government and delivered by the Health and Social Care Alliance. I would be interested to hear the panel's thoughts and perceptions of how it is working, because it is a digital and online service that directs people to the social prescribing that is out there.

Hannah Tweed: Obviously, I will answer that question as the representative of an organisation that is part of ALISS, so I will own that bias from the outset.

For part of the population, ALISS is a really excellent resource, although I offer that thought with the caveat that it should not and cannot operate in isolation. It must be part of a wider package. However, for those for whom online access suits, it is really good, because it is community based. Organisations offering support services can update their own records and information practices or, indeed, offer different forms of communication. As a result, you will often find phone numbers as well as website addresses.

We know that GPs as well as community links practitioners use ALISS as a resource to see what is available, so it is not always about individuals having to access the website themselves. A more flexible approach can be taken if digital access is difficult.

We saw a 34 per cent increase in use in 2020-21, which indicates increased use, if nothing else. Interestingly, we have also seen nearly four times the number of referrals to ALISS from NHS Inform, so a lot more people are seeking support via that route. I welcome that, because the more routes that people have to access information that will help them, the better. I see no harm in that, as long as there are alternative routes for those for whom the digital approach does not suit.

The Convener: Our final line of questioning is on health inequalities. I know that we have touched on that issue throughout the session, but I call Gillian Mackay to ask some questions on it.

Gillian Mackay: This has already been touched on, but I am concerned about the inverse care law. As services come under increasing strain and become more difficult to access because of waiting lists and practitioners having to see more people with more complex issues, and as the system becomes more complicated to navigate, with people expected to self-refer to different services, is there a risk of the inverse care law becoming more entrenched and those with lower levels of health literacy becoming less likely to engage with health services? If so, how can we mitigate that risk? Perhaps Hannah Tweed can answer that question first.

Hannah Tweed: That is a risk, and we have to be very aware of it in our plans and communications. Val Costello has commented on this already—indeed, everyone has done so, I think—but really targeted and deliberate communication will be important in ensuring that those areas where fewer people are able to access information are consciously developed.

However, that will require quite detailed analysis of the data that is being collected on, for example, who is accessing different services directly instead of through GP referrals, and there will need to be intersectional analysis of how all of that is broken up. Of course, people will need to be happy to share such information and should have access to the information that is being held about them. After all, everything needs to be general data protection regulation compliant. That will be a really important piece of work, with the onus of responsibility perhaps on Public Health Scotland or other colleagues in the sector—who might not thank me for saying so.

Without that intersectional analysis, things will be missed, which could lead to a real and serious risk of entrenching the existing health inequalities that we know exist and that have been exacerbated by the pandemic. If those inequalities are not responded to, they will get worse. That would be inexcusable, given the current awareness of the situation.

The report by general practitioners at the deep end reflected on the need to reset the balance between specialist and general services as part of that access point. It is important to draw on the expertise of people who work in deep-end GP practices. Those are the areas with the greatest health inequalities and they are most likely to be affected. That is where the expertise lies, and the people who access those services should be part of the process, along with the data.

Margaret McKay: I hope that it has been clear throughout our discussion that this is the most serious concern for our local patient participation group. My answer to your colleague’s question is that there is a definite risk.

I referred to the high level of satisfaction with direct referrals to physiotherapy. I will give a brief illustration, which I also put in my written submission. A patient could self-refer. There might be no physiotherapy available at the local health centre, but the patient could be offered a next-day appointment in North Berwick, which is a 32-mile round trip. The patient might have access to transport or enough money to pay for a taxi to get there. However, if someone is on a basic level of income or has caring responsibilities, or if they have young children at home, how on earth would they make that 32-mile round trip to take up one of the alternative pathways that is being promoted?

I leave that with you as an example and emphasise the major risk of the fragmentation of primary care services. That is not an argument against involving other specialists in patient care, but we must ensure that there is clear co-ordination and understanding of roles and that services are not fragmented.

Val Costello: I reiterate what everyone has said. Targeted communication is key. Things are beginning to open up. We must ensure that all third sector people and organisations know about the alternative pathways and that they are able to cascade that information to their users. There should be targeted communication to carer groups, parent groups and every sort of group. That communication should come from local authorities as well as being distributed nationwide.

The Convener: Paul O’Kane has some final questions.

Paul O’Kane (West Scotland) (Lab): A number of witnesses have commented on the potential for alternative pathways to increase—[*Inaudible*.] We have heard that in many of the answers.

I want to get a sense of the mitigations that we can put in place. We have heard about some of those, particularly digital mitigations, although it is still not clear how we can ensure that people have digital access. That is a bigger question and goes beyond health. Do the witnesses have ideas about any mitigations that could be put in place immediately?

Val Costello: I am not sure. We offer patient advice services in citizens advice bureaux. If people cannot use digital services, we will do that for them and with them. However, there is a wider issue that has to be addressed nationally, so that people can access the services that they need. Right now, we have an excluded group. That is unfortunate—more than that, it is tragic, because those people might need services and cannot access them. That is just not right. We have to ensure that the process is all encompassing.

Margaret McKay: I will not say more about the digital gap, but it is absolutely clear to our patient group that, when alternative routes are being planned and services are being removed from where patients normally expect them to be—that is, the GP practice—they need to be available within the same walking or transport distance to that GP practice. For example, in an area the size of East Lothian, if a wound care service is being removed from a GP practice and is to be located in a CTAC centre, it is no good having two CTAC centres, with one in Haddington and one in Musselburgh.

Alternative provision has to be within the same striking distance that patients expected from their GP practice; otherwise, you are building in inequality, because people need to have access to transport. For people with caring responsibilities or young children, it is difficult to be away from home for a long period, so by planning services in that way you are building in inequality. You need to consider where the patient lives. If the patient has to go to an alternative place to their local GP practice for services that are being transferred to an alternative route, that place needs to be at least as readily accessible—or, better still, even more accessible.

Paul O'Kane: Margaret McKay's observation was helpful, because public transport is a key issue in reducing isolation. However, does anyone else have a reflection on the digital element? We see challenges with library services and other places where people normally access IT if they do not have regular access. Obviously, the situation has been compounded by the pandemic, but there are challenges with the availability of services that are run by local authorities. Macmillan Cancer Support offers a cancer service in many libraries, which is helpful and welcome. Do we need more engagement with library services and more funding for them, perhaps from the health stream, to support libraries as hubs?

Val Costello: The Scottish Government already has a contract with CAS for the patient advice and support service—that is what we provide. Should any patients need access to digital services, they can get it via their patient advice and support service. There is one worker, and sometimes two, in each local authority, and those workers can help patients to access digital services. There is no doubt that we are very busy, but we can and do help. We do not capture everyone we need to help, but our service is up and running.

We have local and national knowledge. We have extensive knowledge of how the NHS works and of each of our local GP practices. We are here and available for use, so please promote the patient advice and support service, because we are here to provide that support.

The Convener: We are about to run out of time, but I will come to Hannah Tweed for a final quick comment.

Hannah Tweed: I echo what Val Costello said. Plus, on the proposals for libraries, we are all in favour of libraries and community provision, but recent closures have tended to be centred in areas of high deprivation. Going back to the conversation on health inequalities, if we were to go down the route that Paul O'Kane suggests, I would strongly recommend targeting specific interventions and focusing on areas where there is most likely to be need and digital exclusion, to ensure that we are countering that.

The Convener: That is a good point to end on. I thank the three of you for your evidence, which has been helpful. You have raised points that I am sure we will follow up with subsequent panels.

We will take a break, and we will be back at 10:40 with our next panel.

10:30

Meeting suspended.

10:40

On resuming—

The Convener: Welcome back. Our second panel also contributes to our inquiry on alternative pathways to primary care and will focus on the perspective of doctors and nurses in GP practices. Joining us online, I welcome Wendy Panton, who is a senior nurse in NHS Lanarkshire; Dr Chris Williams, who is joint chair of the Royal College of General Practitioners Scotland; and Dr Anurag Yadav, who is a general practitioner and is representing the British Association of Physicians of Indian Origin.

Sandesh Gulhane will open the questions.

Sandesh Gulhane: For anyone who did not watch the first evidence session, I declare an interest as a practising GP.

My question on our first theme is about the new GP contract that came in in 2018. The idea of the new contract was to widen services and allow people to get more without necessarily seeing their GP, and the GP was very much supposed to be the expert general practitioner. However, what we have found with the contract is that there seems to be huge variability across the country. My question is especially for Dr Yadav, as he is from a more rural community. Has the contract impeded your ability to work and access for patients?

Dr Anurag Yadav (British Association of Physicians of Indian Origin): Thank you for giving me the opportunity to talk in this important forum. As Sandesh Gulhane rightly said, I am from a rural community practice; I am a full-time GP at Teviot medical practice in Hawick. I also have a clinical teaching role at the University of Edinburgh and am an honorary clinical senior lecturer there.

Scottish general practice has gone through quite a lot of change, which has mostly been positive, starting from when the quality and outcomes framework was initially abolished. That was a big change. The GP contract from 2018 had a very good vision to improve general practice in

Scotland. Putting more funding into primary care and having more collaborative working in the multidisciplinary team were positive things that we want general practice in Scotland to move forward with, but there are challenges. The biggest one is the delay in the contract. It has been marred by delays in relation to the targets. The initial target in 2018 was to accomplish many things by 2021, but I understand that things such as the Covid pandemic are beyond everybody's control. That target is now 2023. There has been a bit of a lack of planning and a lack of staffing, which has been a big hurdle. We have good services—they are very promising—but the lack of staffing is a big issue that keeps things from progressing further.

Another important thing that I will point out is that there has not been much communication with the general public about primary care. Patient expectation was not taken care of when the changes were made, so we definitely want more patient education and awareness so that they can see what changes are coming in primary care, such as the changes in signposting and social prescribing. Those are very important things that are possible only if the public are on board. They are important areas that will help to reduce the workload of general practice and help us to see more of our core group of patients who need more medical attention. That will help to make our workload more manageable.

10:45

The Covid-19 pandemic has brought healthcare inequalities to the forefront. The GP contract has been trying to deal with that, but the issues will take a long time to be fixed. There are inequalities in attainment and other problems for ethnic minorities. In addition to that, geographic differentiation can be seen in achievement in different things such as primary care. Chronic diseases are more common in more deprived areas, which is not a new thing but it is more exposed. People who have economic issues—poverty, low income or homelessness—have become more exposed, and the disparity is more exposed for people with disabilities or chronic conditions.

It is a similar situation for social and cultural issues, which are coming to the forefront, too. We should do more about that. Although we are moving forward from the 2018 contract, I would like more input to tackle those issues, mainly in regard to the staffing crisis, which is paramount. Social and cultural issues are very important, as I said, and I want to highlight what BAPIO is doing in that regard. We have a vision and, because we have special expertise in and experience of how people manage language and cultural barriers, we want to partner with the Scottish Government to make the situation more workable for the whole population and particularly ethnic minorities in Scotland.

Staffing is very important. BAPIO has a vision for how to manage practice workload in primary care. In England, BAPIO has a primary care project that is a work in progress. We have arranged a wheel-and-spoke model for ambulatory care, whereby GPs can refer to an urgent care facility where doctors look after patients and get investigations done—it is a one-stop shop. That will reduce the workload that goes to hospitals and that of primary care.

On the workforce shortage, we have thought about getting doctors from abroad—from India or other countries. They could be trained by BAPIO for two years in India and then come here to do part of their training for two years, with one year working in hospital and one year in a primary care setting. That would help in running the ambulatory care unit project. I will conclude there.

Dr Chris Williams (Royal College of General Practitioners): My clinical work is as a GP in Grantown-on-Spey, but I am here as the joint chair of the RCGP, which is the professional membership body for GPs in the United Kingdom.

We support GPs at all stages of their career, from when they are medical students considering general practice, through training and qualified years and into retirement. The college has devolved councils in Scotland, Wales and Northern Ireland, and we have approximately 5,000 members here in Scotland. We are proud to have patient representatives, who feed into and help to sense check what we are thinking and learning.

We were not involved in negotiating the GP contract that came in, but we are obviously heavily interested in seeing the changes improve what is available for our patients. We are interested in conditions that mean that working in general practice is sustainable. I was struck by a comment of Margaret McKay's earlier this morning about how patients are to understand and pick up that lots of changes are going on through the contract. Things are constantly changing in general practice; we are constantly adapting to the world around us and to the health and social care challenges out there. However, we saw some specific changes through the contract and, as was just alluded to, there were attempts to make the workload manageable.

Based on survey responses and evidence given already it is clear that a lot of people try to access general practice for a very wide range of things, and we want access needs to be met and for people to have an easy, straightforward route in. Val Costello was right to pick up on the health literacy aspect of this. Our starting point is that a lot of people across Scotland do not know what is wrong with them; they have fears and concerns and they want answers in a time that will allow them to get on with all the other things going on in their lives.

Part of the college's role in the new contract is in trying to understand the refocused purpose of the expert medical generalist, and some of what was said earlier cut to the heart of that. Some things are complex, and some issues are difficult for people to raise, so they might think those who are not GPs will not understand them. That might be because they know and trust their GP, or it might be because they see a GP as someone who brings a set of skills and an ability to understand difficult problems that are not clear. I guess it comes down to GPs being able to navigate all sorts of territory and not needing a flow chart to do so; they can understand the complexity of an issue and the risk that it carries.

However, the root of some of the issues that are being discussed today is that we do not have a large enough GP workforce. We have known for some years that we do not have a large enough whole-time equivalent workforce. Some of the contract's measures are built in to try and give support for that, and mixed in with this inquiry is the element that we are picking up on new ways of working. We are also trying to understand a bit about how third sector organisations and assistance can bring in new ways of doing things and ways for people to understand their health and do things that are not medicalised.

Wendy Panton (Scottish General Practice Professional Nurse Lead Group): Thank you very much for this opportunity. I work with NHS Lanarkshire, but today I am representing the Scottish general practice professional nurse lead group. The group has leads from the majority of the 18 territorial and non-territorial boards, and we represent all nurses working in general practice, whether they are general practice nurses or advanced nurse practitioners. I am not working as a GPN at present—I work as a senior nurse—but I have almost 20 years' experience as a practice nurse.

The original question was about what impact the GP contract has had. That is quite a difficult question to answer, bearing in mind what has happened during the past two years because of the pandemic and its impact. I can speak only from a nurse's perspective on what impact the GP contract has had. The contract was between the Government and GPs, who employ practice nurses and ANPs working in general practice.

As a group, we feel that the idea of the general practitioner—the doctor—being the first port of call is quite an outdated approach and not really a reflection of current practice in general practice. GPNs and ANPs are highly trained, highly skilled individuals and, the majority of the time, are the first point of contact for long-term conditions, which are a huge part of general practice.

We also felt that the general public have not been informed about the skill set that those nurses have. That should be better reflected. I have heard anecdotally from ANPs that, when some patients are given an appointment with an advanced nurse practitioner, they say, "Oh, I didn't know that I would just be seen by a nurse." The public need to be made aware of what the nurses' skill set is, how they have been trained and the vast experience and expert knowledge that they have.

We also thought that the term "alternative" does not demonstrate the professional role of nurses working in general practice. In fact, nurses who work in general practice are essential, not an alternative. "Alternative" could have connotations that the patient will experience lesser care whereas it is the complete opposite. The nurse will certainly be working at a level within the scope of practice. Perhaps, to allow clarification, it could be stated what the nurse is. To the general public, a nurse is a nurse whereas, in fact, there are different specialties, such as general practice nurses, advanced nurse practitioners and district nurses.

The lack of knowledge and communication about what has happened is not anybody's fault, really. The past two years have been unprecedented and the situation continues. The changes that the GP contract made in relation to, for example, CTAC, immunisation and urgent care were always going to go ahead. They might appear to the general public to be because of the pandemic when, in fact, the plan was in place prior to that. If people did not know that, they cannot be expected to have that knowledge.

Exciting times are ahead. There are lots of great opportunities for nursing within general practice.

Sandesh Gulhane: I have to say that my practice nurses are better than me when it comes to chronic disease management. They are very skilled members of staff.

Dr Williams and Dr Yadav both spoke about a staffing crisis in GPs. Approximately 800 new GPs are coming online by 2027, but the worry is that they will be wiped out through retirements or changing working practices. To ensure that patients have access to the people they need to see, what can we do, along with increasing practice nurses, to improve recruitment and retention of not only GPs but all staff?

Dr Williams: I suggest several things. First, general practice needs to be a less pressured environment. Some of the digital changes that have been introduced are an attempt to make it less pressured. The ability for somebody to make an electronic consultation request by going to a web page and submitting a message to the practice, often in a structured form, helps to reduce the number of people who try to make telephone calls first thing in the day. Across the team, we need an environment in which people have enough time to think, work with colleagues and develop the new elements that we have.

11:00

The new contract has helped to broaden the skills mix that is ready and waiting in GP surgeries. Bringing in first-contact physiotherapists has been an excellent move, and pharmacists add another dimension. The skills mix has really improved. However, as was alluded to earlier, I do not think that patients easily understand that every time they call. Often, patients have to go on a journey to learn who is in the practice and how the practice is organised.

The ability of our practice teams to understand one another and describe what they do has been limited, to some extent. We do not provide information on the internet as well as we could. Throughout the Covid pandemic, there have been a lot of rapid changes in how practices are able to communicate with the population. I absolutely take on board what was said earlier about digital tools not being for everyone. Some people have to use the phone because they do not have the appropriate technology, the skills or the desire to use some of the digital tools, so we need to keep the phone lines open.

We need to look at the evidence on the things that we are doing and understand whether they are helping. When we have a system of multiple moving parts, trying to get that data and interpret it is difficult. A lot of our research on how the changes have been received comes through telephone interviews of people who have used the services or are involved in providing them. We absolutely need more data in order to understand what we are doing. We need to understand where the pressure points are, and we need to ensure that there is appropriate resource to support areas that are under pressure.

The Convener: I do not know whether any other witness wants to come in. I should have mentioned at the outset that, if a member has directed their question to one person, that does not mean that everyone else is excluded. If you have something to say, please put an R in the chat box, and I will bring you in.

I will add something to the mix on top of Sandesh Gulhane's questions. There was widespread national messaging on the GP contract and on the qualifications and expertise of the various health professionals, as Wendy Panton mentioned. There is also the issue of local information being provided about how a practice works, who is in the practice and what they can do. In the earlier session, our three witnesses all mentioned that the front-end system of a surgery can often add to people's frustrations, particularly if they are put in a queue. In my area, some surgeries have systems in which, after a certain period of time, the line goes dead.

I want to throw that into the mix. How can things be done better locally in relation to proactively speaking to patients or changing the front-end systems? What capacity exists to alleviate the frustrations and improve knowledge?

Wendy, you have been nodding away while I have been speaking, so I will come to you first. You will not do that again. [*Laughter*.]

Wendy Panton: There obviously has to be more communication. You said that there was a national drive to provide information about what each profession does, but I do not think that the information relating to general practice nursing was articulated very well. In relation to what was said in the earlier session, the information about a general practice nurse related to injections and dressings and, for us as a group, we felt that that was a very outdated description of the role of a general practice nurse.

On getting knowledge out to the public nationally, there has to be more information locally. Patients are not attending GP practices because, obviously, we have had to change our way of working as a result of the pandemic. Prior to that, when patients saw a doctor, practice nurse, physiotherapist or pharmacist, perhaps there would be lots of information on the screens in the GP practice, for example. That was a really good way to capture people, but we have lost that now, because patients are not going into surgeries in the way that they used to. They are not able to drop into most practices now. That is fair enough, but we have lost that way of getting knowledge through. If I was not there, perhaps somebody else would be there to pass on a message.

We definitely have to look at more local ways of doing things. We have lost a lot of local things. People are not reading local newspapers, for example. We must think about how we can best get knowledge out. Not everybody uses Instagram and Facebook. Although those are very good ways of getting information out, they are not for everybody. There should be more targeted local information through workplaces and schools, for example.

Dr Yadav: I totally agree with Wendy Panton about having local information at the front end so that people are informed. That said, with the pandemic and the contract changes, lots of changes have been made centrally, there have been lots of practice changes, and new services have been put in.

Giving local information to the local population is important. How services work and how patient needs are met in each practice is slightly different. There is certainly a lack of communication and information to give the public a broader view of the changes through which ANPs have started to work as clinicians in primary care. They have been in the role, but the role has been enhanced. Those changes have been happening gradually, but they have been suddenly catalysed by the Covid-19 pandemic.

The information to the public was not intense to start with, and there is still a lack of public uptake of ANP appointments. Patients still prefer to see a GP. I totally agree with Dr Gulhane that nurses do a brilliant job. What our ANPs do in seeing patients is absolutely marvellous. When a patient sees an ANP, there is initial hesitation, but confidence builds up over time, and the service runs smoothly. There is a lack of communication. As I have said, we want more national coverage in addition to the local coverage, which is important.

There is a lack of staff morale because of a lot of negative media coverage, a lack of resources and a lack of staff. That has a knock-on effect on staff. People find it difficult to recruit another person for a post, because fewer people are available, and we get fewer staff if morale is lower. Through the primary care improvement plan, we have funding to get physios and pharmacists, but we are not getting them. There is a knock-on effect.

Better funding, working conditions and staff morale are needed. Chris Williams talked about improving information technology services. IT could be made more efficient so that people do not struggle with it. We have different systems in primary care that do not talk to one another. If we can make the IT more efficient, that will make people’s working lives better and, in turn, that will have an impact on patients. The happier the staff are, the happier and more positive the patient outcomes will be.

The Convener: Thank you. Wendy—

Dr Yadav: [*Inaudible*.] Sorry.

The Convener: Sorry to interrupt you. We crossed over there. That inevitably happens sometimes in hybrid meetings.

Wendy, I think that you want to comment on sustainability.

Wendy Panton: Yes. We have the crisis of GPs, but also a crisis of GPNs. Given that we have an ageing workforce, how do we get young fresh talent into general practice nursing? Obviously, I believe that it is one of the best professions in primary care, and I am passionate about getting new nurses into it.

We are not exposed to general practice nursing during our nurse training. We definitely need to look at getting university placements in general practices, but that is dependent on our GP employers working with us to get student nurses in and expose them to general practice nursing.

When a doctor becomes a GP, there is obviously a training programme for them. In general practice nursing, there is a GPN course that NHS Education for Scotland does, which is excellent, but people are not guaranteed a place on that. We do not have a structured education programme. Lots of nurses are doing masters-level modules in long-term conditions and so on, but there is no way to consolidate those into a recognised qualification.

There are also variations between practices on payment. There is no standard within the NHS agenda for change. It all depends on the practice. A nurse who is doing the job in a GP practice can be on completely different pay and conditions from somebody who is doing the same job in another practice. There are no uniform pay and conditions or terms of employment, which puts a lot of people off. We are employed not by the NHS but by the GP, so we do not always have the same terms and conditions. People can negotiate them with the employer, but not everybody feels confident about doing that, especially if they are early in their career. It takes time to build up those skills.

There are lots of different things that affect how nurses get into general practice and whether they stay in it. The attrition rate can be quite high, perhaps because people feel that they are not getting support. Everybody is really busy, and we do not have the time that we perhaps had when I started in general practice. We were always busy, but we seemed to have more time and be able to get a wee bit more support. That seems to have tailed off a wee bit, so the post is not as attractive as it used to be. We need to make sure that we get nurses into general practice and look at what the new and refreshed role is, because it is changing.

The Convener: That is really interesting—particularly your points on training.

Paul O’Kane has some questions.

Paul O’Kane: Good morning, panel. The theme that I am focusing on is the patient perspective. You have already said a lot about that in your answers, which is most helpful, but perhaps I can drill down a wee bit into what patients said in response to our call for views. One thing that they highlighted is a negative perception of reception teams in general practice. We can all probably relate to some of that. When we consider people's attitude towards those staff, they are often seen as gatekeepers or, negatively, as barriers to seeing a GP, which is often wrong.

How can we communicate better on the triage pathway that now exists in many practices? Triage pathways are perhaps clearer in emergency medicine than they are in general practice. I am keen to understand your experiences of that and how we can continue to communicate with patients.

The Convener: Would you like to put your question to anyone in particular? Shall we go to Dr Williams first?

Paul O'Kane: Yes. Thank you, convener.

11:15

Dr Williams: There is a particular dilemma around what we are doing to support our receptionists. In some places, we see them as care navigators, recognising that we have equipped them with knowledge of the healthcare system and have tried to give them enough knowledge to help them to direct someone who is describing a certain set of symptoms to a place where they can be seen quickly. We want them to have a role where they can find a place in the system that has capacity. As was highlighted earlier, that will not always match patient expectations or those of the patient's relatives, especially if there is a degree of urgency to the call and if they have had a long wait to get through to speak to someone. That reflects a system that is running hot and in which there is activity everywhere.

Something that we need to do that might not be immediately intuitive is to increase the number of training activities as a team—GPs, receptionists, practice nurses, pharmacists, first-contact physios and the wider team beyond that. To do that properly, we need to close our doors to everything but emergencies. That does not need to happen often, but it needs to happen multiple times a year. We might describe it as protected learning time or PLT. It has been very difficult for us to secure that. In the past, there have been arrangements that allowed NHS 24 to cover some of the phone lines in an afternoon, for example, when we would not expect many of our patient population to phone in with an urgent query that needed to be dealt with the same day.

Only if we are able to close our doors, pause, take a breath and share our experiences of how the different parts of the system are working will we ensure that our receptionists can speak to patients and their relatives in a way that is maximally efficient. That will allow them to pick up on patients' concerns, give them an appropriate place to go and options where possible. My plea would be for the development of the team, especially given the new territory that we are in.

Paul O'Kane: That was a helpful answer. You mention how to create space for training, perhaps by diverting people to other pathways, and NHS 24 having a bit of a support role. What are your experiences of things like NHS 24? I know that people are directed there more often as an alternative to presenting at accident and emergency but, in the past wee while, we have seen frustration with the accessibility of that service, with 240,000 unanswered calls in a two-month period. The convener mentioned frustration with phones ringing out at GP surgeries, too. Are our alternative systems for phone advice up to par and able to support people?

The Convener: No one in particular has indicated that they want to come in on that, but perhaps we could hear from Dr Yadav.

Dr Yadav: I totally agree with the points that have been made. I emphasise that, thinking about the patient journey in the national health service, the receptionist is the first point of contact, whether the patient has an acute emergency or a chronic condition. As we say, the first impression is the best impression. The reception is a very important part of a general practice. I agree that we need more staff training and funding for that. Recently, we have been getting signposting training, but we need more time dedicated to that.

NHS 24 has been brilliant. We have had a few sessions in the past for which we had NHS 24 cover, but that has gradually been withdrawn. We find it quite difficult to get training sessions for the practice and even for the GPs because of a lack of NHS 24 cover. Personally and in the practice, I have noticed that what NHS 24 has done in relation to patient consultation has been brilliant. The amount of work that it has done has been tremendous and the patient expectation has been managed very well.

During the normal working day, if there is an emergency that has to be dealt with by the general practice, NHS 24 directs people to GP practices to be managed further on. In general, patients will contact the GP, unless it is an emergency, in which case they will contact NHS 24. I am full of praise for NHS 24, the way that it works and its management of patients.

I would like more NHS 24 input as cover for staff training, especially reception training, as well as more capacity and communication to patients. For example, when the latest changes to the vaccination project were made, we suddenly had umpteen calls from patients requesting vaccination appointments, because they had not seen that there was a new number to call and that GP surgeries were no longer the point of contact. More information to patients would help receptionists and general practice to manage the work.

Before coming here, I had a discussion with our reception staff, and their overwhelming comment was that they wanted to raise the issue of communication with patients and how things are communicated. At the end of the day, improvements in that respect would improve their work life, because there would be fewer demands on them and it might stop the phones ringing all the time.

Wendy Panton: I echo everything that Dr Yadav has just said. I wonder whether any thought has been given to a training package for receptionists, such as courses or modules that they might have to do. Forgive me if this is already in place as part of their induction programme; I am talking about not just signposting but consultation and communication skills and how to de-escalate things. That could be provided in protected time or it might be something that they do before they start their role on the front line.

We are all in agreement that “receptionist” might not be the best term to use, but whatever term we are using—perhaps “care navigator”—we need to ensure that those people have training in communication, de-escalation, signposting and everything that their role encompasses. I am mindful of the importance of that.

Evelyn Tweed: I want to follow up Dr Williams’s point about training. He said that it is quite difficult to set aside days on which to close practices for training and so on. Is there a general issue with training and planning, and with having time to look to the future? Even if we get the communication right on alternative pathways, will GPs actually have time for that training?

Dr Williams: I will describe some elements of the training, for clarity. In some practices, training goes on all the time in that we have foundation-year doctors, GP specialist trainees and medical students. We have a wide range of professionals who are there to work but also to learn.

The events that I am talking about involve the scheduled closure of non-emergency services for a period of a few hours, typically mid-week, when we expect a lower number of emergencies to come through. We can then undertake activities such as hearing presentations about cases that have or have not gone well or about upcoming changes to services.

We have heard comments about whether GPs know about certain types of non-medical intervention that are running. A patient might be aware of a green initiative or another initiative and wonder why an individual GP does not know about it, but we are often subjected to large volumes of information. How do we understand which services are up and running in an area and which are coming to a close? We need team events to cover the breadth of that information, so that all members of the team are up to speed with the rapidly evolving and changing landscape.

There is sometimes a question about why a person did not know about one part of the system. That is because there is so much change, and it is continual. Unless we can sense check between clinical teams and the wider administrative teams that play into that, we face difficulty in providing consistent experiences for our patients.

The Convener: Dr Yadav wants to come back in.

Dr Yadav: Sorry, but I just want to add something on the point that I made earlier about communication. A common theme that I have come across in primary care is patients’ general perception of confidentiality in relation to reception staff. Patients are generally not confident about sharing confidential information with reception staff.

We say on notice boards—and we give this information to patients—that the reception staff are bound by the same confidentiality agreement as everybody in the practice is bound by. They are part of the confidentiality scheme. However, that probably does not fill patients with confidence. The majority of the professional staff are bound by professional regulations such as the General Medical Council or Nursing and Midwifery Council regulations, whereas, from a patient’s perspective, there is nothing to regulate reception staff and no confidentiality statement. I would like more communication on that in a broader sense, probably from the Government, so that everybody knows that they can discuss their confidential information with reception staff.

A common frustration among reception staff, which is a kind of knock-on effect of the lack of appointments, is that there is a lack of support structure and a lack of places where they can signpost patients to. That leads to more frustration, which is probably experienced by reception staff more than by any other staff.

11:30

The Convener: Those are all excellent points.

Gillian Mackay has some questions on social prescribing.

Gillian Mackay: Good morning, panel. What do you see as the main barriers to GPs engaging with social prescribing? That question is perhaps for Dr Williams in the first instance.

Dr Williams: I would probably cite a lack of time and available capacity as being high on the list, but I would also highlight a lack of knowledge of the services that are available. As was mentioned in the previous evidence session, there are many sources of support and schemes that are in a pilot phase or that have received some funding but that do not continue over time. Keeping track of those individual schemes, their administrators or the people who run them, the contact details and so on is difficult.

ALISS was mentioned as being capable of tracking some of those schemes. It needs to be made available to everyone who lives in Scotland and beyond, because it has a very useful interface and is searchable. If the information is updated, people will be able to understand what is out there.

There is very much an argument for other professionals, such as links workers, having the ability to help patients to navigate some of these structures, because they might be better able to keep up to date with, and keep in touch with, multiple organisations that are providing different specialist support, and they could ensure that that support is available to patients who might not realise that it is there. In other words, they would be matching people up to what is available, useful or of interest to them.

Something else that I picked up in the survey responses was the range of reactions to GPs suggesting things that might not be conventional medicine or that a patient going into the consultation might not have thought of as being available or as benefiting them. I will highlight how we work in that respect. We will suggest a range of different things to a patient or the people with them, and some options might stick in the memory as being highly suitable or highly unsuitable. The issue is how we navigate the information landscape, in which respect ALISS is a superb and underused resource. If some resource were to be injected into it or if we were able to make more people aware of its existence and what it can be used for, that would, I think, be a very helpful step.

Gillian Mackay: Dr Williams mentioned links workers, but, with their limited capacity and the financial strain that people are facing as a result of the cost of living situation, there is concern that much of their time is being taken up with helping people to apply for benefits, as a result of which they do not have as much time to engage with social prescribing. What are the panel's thoughts on that? Do we simply need more links workers, or should that part of their role be separated out and allocated to, for example, welfare rights advisers in GP practices? Perhaps Wendy Panton can respond first.

Wendy Panton: You make a good point. A financial adviser might be a better option, but that would be yet another person that the patient would have to see. The patient or service user might feel that they were being pushed from pillar to post. However, given that the priority is finding out what matters to the patient, what you have suggested would certainly be a good step.

As Dr Williams said, ALISS is very much underutilised. The issue is getting that service up and running and making staff aware of it. There are competing priorities for GPs, GPNs and others. When a patient comes in, expecting perhaps a prescription for something, and we tell them, "Actually, your diabetes will get better if you do X, Y and Z," they—not all patients, but some—are quite resistant to that. For us to prescribe them such a thing can be quite challenging.

The Convener: Dr Williams wants to come back in.

Dr Williams: When it comes to welfare rights assistance, including the support that people need to manage their lives and health and to prevent financial problems from becoming health problems, we are—absolutely—supportive of putting that resource into settings where people can reach it, including the general practice setting. However, there is a slight difficulty in how many people we can get into any one building on any given day, and the physical space of much of the general practice estate is already fully utilised. Some of the digital initiatives that we have seen have started because we are out of physical space.

Going back to a point that was made earlier this morning, if patients have to travel a long distance to access services, will those services be underused? We absolutely want general practice to be in the heart of communities, and that includes innovations on welfare advice.

The Convener: Emma Harper has some questions about signposting, which will pick up on some of the things that have been mentioned.

Emma Harper: Good morning, panel. Some of the information that I was looking for has been covered by Dr Chris Williams, who talked about the benefits of ALISS.

Our briefing papers say that Healthcare Improvement Scotland's "Care Navigation in General Practice: 10-Step Guide" recommends that individual practices collate and maintain their own lists of local service providers. GPs know their own locations, but is it realistic to expect them to collate and maintain their own databases, when programmes such as ALISS are out there? There are also regional programmes. For example, in Dumfries and Galloway, DG Locator is accessible and has an app. How do you feel about Healthcare Improvement Scotland's recommendation that GPs keep their own database of places for social prescribing?

Dr Williams: Generally, I am fond of Healthcare Improvement Scotland's contributions with regard to quality improvement and how we evaluate whether the changes that we make to our systems are working so that we can see whether what we are doing is helping.

I have to say that I had an email this morning about a green scheme that is launching in our area, but, when I jumped on to ALISS, I could not find it there. There are such examples of the different systems not being up to date or synchronised. I certainly see ALISS as a resource that can help practices keep track of some of the changes to the multiple different organisations that do multiple different things. I am happy with that recommendation.

Emma Harper: I have had a look on ALISS myself, and I cannae find any mention of men's sheds in Dumfries and Galloway. I know that we have them from Stranraer to Lockerbie, so there is an issue about the system being at its most up to date and accurate.

What steps can be taken to support general practices in providing effective signposting? That might involve care navigators or other methods, but what is the best way of communicating to people what is out there?

The Convener: I will bring in Dr Williams first. I remind the other witnesses that, if they want to contribute, they should use the chat box.

Dr Williams: In so many ways, general practices do things according to local connections. Earlier, we heard that some patients get their information from the walls of waiting rooms rather than from websites. Practice teams tend to know the most useful ways of getting out a message and how to get the message to the people whom we are trying to reach.

There is so much information, and it comes from different directions. There are constant stories in the media about new types of treatment or the gaps in healthcare systems that have been recognised for groups of patients. Sometimes, there will be a range of inquiries on one topic that has been mentioned in the press.

Our communication systems need to be dynamic, and we need to make the best use of technology in order to keep track of the information. As I have said, ALISS is available to cover wider organisations, including those in the third sector. There is also a job in keeping track of the hospital systems to which we refer people. We need to understand how those systems are functioning this week compared with how they were functioning a year ago and which waiting lists might be causing our patients discomfort and difficulty.

The range of inquiries that we field daily, just on the hospital treatment side of things, is massive. That is before we get to other organisations that are, in some ways, less well connected or less visible to general practice. Ideally, we would like to keep track of all such services, but it is tricky.

Dr Yadav: I want to emphasise some of the points that have already been made. Social prescribing is very important, especially in tackling loneliness, but there are practical issues. I totally agree with Healthcare Improvement Scotland that GPs should maintain lists, but, as Dr Williams has said, it is quite difficult for us to do that, because many of the services have not been formed by GPs but are run by third sector or voluntary organisations. The onus is on them to inform GPs about what services are available. We can certainly direct patients to the relevant services once we get that information.

There is a practical point about trust in some services, how efficient they are and what capacity they have. In many cases, we end up signposting patients to services only to find that they have stopped working. Unless we have proper and more unified communication about the availability of such services, it will be difficult and challenging to ask practices to keep chopping and changing the lists. GPs are asked to direct patients to the services, but they might not be very well informed about how efficient they are or their working capacity.

I would appreciate some kind of central active database of services that GPs could access directly. Such a database could be maintained, and GPs could tap into it, as they do with ALISS.

11:45

Wendy Panton: I think that it would be a very arduous and difficult task for a GP practice to maintain a database and keep it up to date. It would involve asking GP practices, which are already at stretching point, to do yet another thing.

I do not think that GPs, nurses and physios can be expected to know absolutely everything that is out there. As much as we would like to be able to maintain all that information, it would be really difficult to do so; as a result, access to clinical link workers for practices should be equitable throughout Scotland. The patient does not have to physically see the clinical link worker physically, but they should have access to them via telephone or the attend anywhere service. It is the link worker's role and job to know those things; they have access to that information to ensure that the patient does not miss out on what is out there. There are so many excellent services, but practice staff would find it a difficult task if they were asked to have all that knowledge.

Emma Harper: In relation to its report on social prescribing, which I have in front of me, Support in Mind Scotland says:

> "25 to 50% of GP appointments focus on non-medical issues, such as social isolation, financial struggles and bereavement."

I am aware of RCGP training for signposting, but does that training also cover signposting for social isolation and financial struggles? That question is for Dr Yadav or Dr Williams.

The Convener: I will bring in Dr Yadav.

Dr Yadav: As has been said, signposting is a very important part of the job, and the RCGP has provided signposting training for our staff. However, it would be a challenge for GPs to keep a tab on what is happening locally. As I have said, some services keep changing; we do not have any say in the working pattern of many of them, and some of them have funding issues. I have referred patients to services that were working, only to find out, once I had asked them to self-refer, that the services had stopped in the area. It then falls back to the GP to manage the patient's issue, which could have been dealt with more efficiently if the services had been running or if we had known that the service had stopped. It is good to have those services, but we would like the parties that establish them to proactively inform GPs about them, so that we can keep a note of them, and to inform us if they are stopping.

The Convener: I call Sue Webber.

Sue Webber: We have had a lot of information today. Given what we have heard about the challenges with signposting and the immediate and medium-term pressures we face as we come out of the pandemic, what solutions do you suggest we use to tackle those issues of signposting, funding and changing services? What short-term solutions could we implement quickly to alleviate the immediate pressures of coming out of the pandemic? That question is for Dr Williams in the first place.

Dr Williams: Before I answer that, I will pick up on the previous question about signposting training, as it was about an RCGP resource. I am quite happy to look into what the training covers, especially if there are areas where the committee thinks that the training could be strengthened. I am happy to go back and see what updating and rewriting we can do to make sure that it is as contemporaneous as it needs to be.

As for solutions, one clear solution relates to the public messaging side of things. It is difficult for individual patients to understand everything that has changed in the past few years. There have been lots of messages about the changes caused by Covid, but the agenda of primary care reform with regard to the composition of teams in general practice surgeries and the change in the mix of skills there has been in the background, too.

We need to get that message out to counter the narrative about people being fobbed off when there are genuine efforts to get them to someone who can help them or who can start their journey of assistance. We should be clear that we are trying to avoid the harm that comes from people waiting for a service that is having difficulties with availability or waiting to see certain people who have certain roles.

There are some misunderstandings about referrals. For some of our first-contact physiotherapists, the system is not one of referrals but of appointments to allow people to be seen within a short time so that their health can be assessed. That is different from the historical role of physiotherapists. People associate physiotherapy with being given rehabilitation instructions or exercises to do, but the first-contact physiotherapy model is different.

Interestingly, when we look at those schemes, we see that they do not free up general practitioner time in the way that was envisaged but provide a quality service for patients, and that service brings skills into the practice that other members of the team can benefit from. We need to communicate the strategic elements of the service to the population whom we serve, which is our patients and their relatives.

Dr Yadav: I would say the same. First, we need more information for GP practices about the available resources. Secondly, we need more training for staff on signposting as well as more funding for it. More time should be dedicated to it, and there should be NHS 24 cover during training time.

Thirdly, I would emphasise the need for increased public communication to give people more confidence in taking up those services. If there is an easy way for patients to access those services, or to self refer, and if the information is out there, that will be a step forward with regard to signposting.

Evelyn Tweed: My questions are about service design. We often hear from the public that they have not been involved in the changes to GP services. To what extent, and in what way, has the public been involved in co-designing primary care services? How has the general practice workforce been involved?

Wendy Panton: We heard service users say earlier that they do not feel that they had been involved very much. I echo those sentiments.

I can say from my GPN perspective that, when services have been transferred from general practice to health and social care partnerships, there has not been much involvement of GPNs or other practice staff in that process. They could be using their expert knowledge to help with service design. There are many things that communication can help with in order to progress things, and I say that service users and other members of staff should also be involved.

The Convener: Perhaps we can get a GP perspective on this from Dr Yadav and Dr Williams.

Dr Yadav: I totally agree with Wendy Panton. There has been some public involvement, but we would definitely like more public involvement with regard to the changes that have been happening. The 2018 GP contract, which we have talked about, has resulted in lots of changes for GPs and, indeed, lots of new ways of working. As I said, there has been some patient involvement, but information on all that has not been made available to the public and patients. It is coming out gradually and at a slower pace than what is happening on the ground. We definitely need more public and patient involvement in any further decision making on changes to primary care.

Dr Williams: Practices get a lot of feedback from their patient population, but as for formal consultations on major service change, I do not think that there has been the sort of consultation that would occur if, for example, a large hospital were being built or there was some other multimillion-pound endeavour.

As I said earlier, general practice is in an almost constant state of change. How we do things—how we schedule our appointments, the technologies that we use, the people on our teams and so on—is in continual flux. The 2018 contract changed some of that, so it would be interesting for health boards and health and social care partnerships to get feedback on how that is working. After all, there are changes still to come. We are still waiting for the contract to bed in fully, and there are steps to be taken beyond that.

Reference was made earlier to primary care improvement plans, which are submitted in order to track where we are with implementing the contract, with the number of physiotherapists, pharmacists and other types of workers who are employed, and so on. They give us some sense of where things are, but the pace of change has been different in different board areas and health and social care partnerships. It will be difficult to bring together feedback on that. I recognise, too, the importance of seeking users’ views on service design.

The Convener: Do you have any supplementary questions, Evelyn?

Evelyn Tweed: My other question has been covered, convener.

The Convener: I call Stephanie Callaghan.

Stephanie Callaghan: One point that has been made is that service design should be informed by evidence. How can we build a more effective evidence base to improve service design? What lessons do we need to learn to improve the future design of alternative pathways? That question is for Dr Williams, first.

12:00

Dr Williams: On evidence, one big change that we will see in the coming months is that we will have the ability to understand system activity, in hours in general practice. We have always had data at individual practice level about how many people are being seen and how appointments are used, but it has been difficult to get greater oversight of that. We do not want to extrapolate in ways that do not pick up on what is actually happening.

Particularly where activity is displaced or we are making changes to one part of the service, we want to see the impact on other parts of the service. In general practice, we now have technical means to extract that information from GP clinical systems and, for the first time in Scotland, to get much higher-level information on what activity is occurring at cluster or board level. The data can also be role specific and can show the sorts of things that are happening and compare them across different points in time.

The Convener: I do not see any of our other panellists wanting to come in. If you want to come in, please let me know in the chat box. I will go back to Stephanie Callaghan for a follow-up question.

Stephanie Callaghan: My second question is for Wendy Panton. What specific actions should be prioritised to improve service delivery? Should scaling up successful things to national level be a priority? For example, our papers mention an Audit Scotland case study about Highland Council’s introduction of primary mental health workers. The evaluation of outcomes from that showed that 78 per cent of young people and 95 per cent of parents felt that the support had mostly or completely helped their situation.

Wendy Panton: We absolutely have to evidence and showcase what is happening in primary care, in general practice. We have to work with and involve primary care improvement teams in PDSA—plan, do, study, act—tests of change. I am definitely keen for that to be done, because we want to focus on the good things that are happening in general practice in primary care.

I am sorry—could you repeat the first part of your question?

Stephanie Callaghan: The question was about what specific actions should be prioritised to improve service delivery. The second part was about whether that approach should be one of the priorities.

Wendy Panton: Absolutely—mental health should definitely be a priority. It is all down to individual practices. Practices will all have different priorities and their patients will have different needs. We need to bring in that local perspective, with quality improvement teams working with general practice. Lots of really good improvement work is done in general practice, but it is perhaps not evidenced and showcased in the way that it could and should be. We need individual things for individual practices.

Stephanie Callaghan: I will pick up on that. Is there a conflict between the evidence-based approach and the idea of patient participation and co-production? Is there a problem with the two pushing up against each other at times? How do we get the two to integrate and work effectively together?

Wendy Panton: I cannot fully answer that, but my initial thought is that there should not be a problem. We want to involve service users in any quality improvement. How can we evaluate it without their input and thoughts? My initial reaction is that there is no issue, but I would be keen to hear other people’s thoughts.

The Convener: Do any of the other panellists want to come in on mental health support workers?

Dr Williams: Thank you for raising that matter again, because I do not think that our answers have fully covered the mental health aspects or, as has been highlighted, the desire for easy and straightforward access from primary care settings. We mentioned earlier that patients and their families might not fully understand how services are organised, but there is a key advantage in understanding that in relation to primary care mental health workers. The individuals who work in the service are deployed through primary care and are not part of a secondary care organisation, so the priority is the ability to focus on delivering services in community settings on behalf of a community service, with the emphasis being on primary care, because community mental health teams are often not attached to secondary care.

I also want to mention the question about the evidence base and whether there is a conflict between people’s experience and the evidence that we are building. On the qualitative research side of things, we are, at the moment, without clear data on the numbers of people going through the system at different points in time, and on outcomes. The interviews that our researchers do are in many settings in all parts of the system—including exercise referral schemes, link workers and first-contact physios. Different groups across different parts of the country are being assessed. Those interviews will pick up on the sentiment that is expressed by people who have used the service as well as the thoughts of people who are developing and delivering the service.

The Convener: We move on to the final area of questioning, which is inequalities.

Sue Webber: Patient representatives in the first panel talked about health literacy and the fact that there might be—I am trying to find the words—“savvy patients” who are able to direct themselves to alternative pathways and are more aware of their conditions. However, there are people who are not in that position who still, ultimately, need to see the GP to get a primary diagnosis. In the process of promoting effective use of alternative pathways, how can we ensure that everyone’s route into primary healthcare is protected and that we do not discriminate against the people who need to see the GP in order that they understand what is going on? I am sure that you will all want to respond to that question.

Dr Yadav: That is a very important area in which lots of work needs to be done. It is an area that has been highlighted, since the Covid-19 pandemic, in relation to inequalities in healthcare, attainment of good health and access to healthcare, which are very different in different subgroups. The ways in which people with chronic illnesses, disabilities or learning difficulties access healthcare are quite different. That is also the case for people who speak different languages and have different cultural backgrounds. That has all been highlighted.

Just to give you crude data, I note that the numbers of patients who unfortunately died of Covid-19 and the numbers of people who were dying from other conditions were quite high. Problems because of inequalities could cause more than four times the mortality rate in a pandemic in, say, 10 years’ time. That is crude data that has been extrapolated in our local health board when we had a meeting on inequalities. It is a very important area; how to manage it and get on top of it is a big challenge.

An important part of that is communication with patients to inform them of how they can access services. In terms of language barriers, we need to use interpretation services more. We also need more awareness of the various cultural backgrounds of staff and the public.

During the Covid pandemic, we have changed how we work. We used to have more than 90 per cent face-to-face consultations; now, when we are still not fully post-pandemic, we are up to only 50 per cent face-to-face consultations. There are still a lot of telephone and video consultations for the right reasons. Some patients want that, but it is difficult for people who have language barriers to do telephone or video consultations, especially if they are not IT literate, which is especially the case with elderly people.

How to make the service accessible to all and reduce the strain on it to make it more equitable is a big challenge. The main things that I want to move forward on are making the service more accessible to all and getting more data on where deficiencies are so that we can improve the situation.

Sue Webber: When we talk about inequalities, we are talking not only about patient awareness but about geographical variations in services. To what extent can equality of availability and access to alternative pathways be ensured? I am thinking particularly about some of the rural challenges that we face, and the lack of consistency.

The Convener: Is that question for a rural GP?

Sue Webber: Yes. I was looking at Dr Williams, who is up in Grantown. Wendy Panton might also be able to help.

Dr Williams: Some services need the person to be in a physical location. We have learned quite a lot about services that we can provide remotely. I will hammer home the point that some of the learning points are about services that we did not think could be delivered remotely. We think of physiotherapy as a service that is very hands-on, with people being in the same room, but through the pandemic we have found that some elements of that service can be delivered without people being in the same physical space. A lot—not everything—can be done by telephone.

I absolutely take on board the point that, especially in sparsely populated rural areas, there are difficulties with scale and how many physical locations one person is able to cover when their work is distributed across a sparse population.

I come back to the digital disparity and inclusion issues. If our starting point is that we accept that some people cannot use digital services and that some people cannot travel, we should try to create capacity around those individuals and communities. One of the difficulties that we currently have is in how we identify people who do not have a smartphone, will never have one and cannot use digital services. There is a section of our patients who could use some of those services; it would be possible to upskill them and doing so would create capacity for the people who cannot travel and are unable to use devices.

Part of how we shift capacity around so that we make it more likely that people will have locations where there is a healthcare professional of the type that they need to see is about the part of the population that we can upskill. There are difficulties in terms of clarity about whose responsibility it is to upskill patients and family members, where that is possible and whether it is in touching distance, and how we keep records.

12:15

Our systems were not designed to collect mobile phone and home numbers. It is difficult to collect information about whether someone has broadband or has used Zoom before, let alone about whether they have tried to do a video consultation with a medical professional. However, many people are surprised by what they can do when they are given a little bit of support.

That does not fully cover the rural difficulties that Sue Webber mentioned. My thoughts are that there are ways in which we can use digital working to ensure that, when people need to be available for a rural area, they can be.

The Convener: I will pick up on what Dr Williams said. I guess that giving people confidence that they are not getting a lesser service is important. Do you have any reflections on that?

Dr Williams: There are a lot of people out there whose vision of general practice is quite outdated in terms of what they expect to be able to access or who might give them assistance.

I come back to the idea that there are lots of positive messages about what we can do for people, in this busy age in which we live. There are ways in which people can access services without having to leave their work for half a day, and we are making all sorts of changes and advances that are not just about trying to shore things up.

It was said by the first panel of witnesses that the messages need to go out through multiple channels and means. They might not be the most exciting news stories for the media to run, so we might need to fund public campaigns to tell people about the services that exist for them here and now, but which are not accessed in the way that they might have accessed services in the past. The change has been so rapid, but we are now at a stage at which we can describe the consistent experience that we hope people can receive.

The Convener: You made a very good point about media coverage and news stories.

Wendy Panton: I cannot speak from a rural perspective about health inequalities, but I reiterate that patients have the right to choose how they access services. Services should wrap around the patient or service user—not the other way round—and everybody should have access to fair and equitable services.

When it comes to health literacy and signposting, that is not necessarily about the GP or general practice. To try to ensure that people are getting the fair and equitable services that they deserve, patients, their carers or their families could have the option of accessing another human being, whether by telephone or another means, through a service—not a named person—that they can link to if they have questions about signposting.

The Convener: That is a good point to end on. I thank all three of you for your time and for everything that you have told us. Both panels of witnesses have been excellent and have given us a lot to chew over.

At the next meeting on 15 March, the committee will continue taking evidence in our inquiry on alternative pathways or, as we should perhaps start calling them, just pathways to primary care. I am looking at Wendy Panton, because she made a good point about that at the start of the evidence session.

That concludes the public part of our meeting.

12:19

Meeting continued in private until 12:42.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba