OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 15 March 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 15 March 2022

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
11th 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:

Alison Keir (Allied Health Professions Federation Scotland)
Dr Graeme Marshall (Glasgow City Health and Social Care Partnership)
Clare Morrison (Royal Pharmaceutical Society)
Julie Mosgrove (Optometry Scotland)
Harjit Sandhu (National Community Hearing Association)
Dr Jess Sussmann (Royal College of Psychiatrists)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 15 March 2022

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Gillian Martin): Welcome to the 11th meeting in 2022 of the Health, Social Care and Sport Committee. I have received no apologies from members.

The first item on our agenda is a decision on whether to take items 3 and 4 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.

We will hear from two panels of witnesses from organisations that represent a range of national health service primary care services in community settings and multidisciplinary teams in general practices. All our witnesses are participating remotely, as are a number of our MSP colleagues.

For our first panel, I welcome Clare Morrison, who is the director for Scotland at the Royal Pharmaceutical Society; Julie Mosgrove, who is vice-chair of Optometry Scotland; Harjit Sandhu, who is managing director of the National Community Hearing Association Scotland; and Jess Sussmann, who is policy lead at the Royal College of Psychiatrists in Scotland.

One of the reasons why we decided to have the inquiry was to draw attention to some of the services to which people could be directed, or could self-direct, to get specific primary care. Anecdotally, we hear that there is not a lot of public awareness about what is out there, so that will be my first line of questioning.

I am interested to hear the witnesses' perspectives on how much difficulty or success there has been in shifting away from the traditional view that people should go to their general practitioner for absolutely everything. The pathways system has been in train for quite a few years. How successful has it been and what is the public awareness of it like? That question goes first to Clare Morrison.

Clare Morrison (Royal Pharmaceutical Society): I am here on behalf of the Royal Pharmaceutical Society, which is pharmacy's professional leadership body. We have members in all sectors of pharmacy, including community pharmacists, pharmacists who work in GP practices and pharmacists who work in the wider NHS and education.

There are around 5,000 registered pharmacists in Scotland. We are a large professional group and the third-biggest health profession after doctors and nurses. As a professional leadership body, the RPS represents the individual pharmacists in their professional practice. We do not represent commercial companies or contractual matters.

To develop our written submission to the inquiry, we held focus groups to gather our members' views and we met pharmacy leaders across Scotland, so we are representing a wider view.

In answer to your question, it is clear that pharmacy already provides a number of alternatives to GP care in primary care, through community pharmacy services, pharmacists working in GP practices and specialist services in community settings. Pharmacists certainly have the professional ability to deliver more but, in order to achieve that, capacity within pharmacy needs to be improved. The key enablers for that are a better skills mix, development of the pharmacist workforce—specifically around independent prescribing—and better digital technology.

To answer your specific question about awareness, I say that levels of public and professional awareness of pharmacy are mixed. Awareness of community pharmacies is high, but awareness of community pharmacists' professional roles and services is lower. Awareness of there being other pharmacists, such as those who work in GP practices, is very low. When we say "pharmacy", people tend to think that pharmacists' roles are very much about supplying medicines, but pharmacy is already much wider than that. A third of pharmacists across NHS Scotland actively prescribe medicines as independent prescribers, and that number is increasing all the time. Therefore, there is a lot of work to do to improve the understanding of pharmacy roles right now, as well as to extend to those roles further.

Julie Mosgrove (Optometry Scotland): I am the vice-chair of Optometry Scotland. We are a non-profit organisation representing the optical sector, which includes optometry practices and the optometrists within practices, as well as dispensing opticians and other staff. We have more than 900 providers across Scotland and I am just representing—[*Inaudible*.]

Optometry practices are generally on the high street and we are well known. You cannot walk down a local high street without seeing an optometry practice, which is much the same as for pharmacy practices. However, despite that, only 2 million people attended eye exams in 2019, so there is still a lot of work to do on uptake. Traditionally, a lot of people think that eye exams just involve getting their eyes tested—if someone has a problem with their vision, they go to the optician—so there is still a lot of work to be done to build awareness of what can be picked up during a routine eye examination.

Another thing is plans for optometry to be the first port of call for all eye emergencies. Along with colleagues in dentistry and pharmacy, we are still building awareness of that change. For any eye problem at all, people should attend the optometry practice rather than see a GP. A lot of work has been done over the years to build relationships and get that message across. In NHS Grampian, the "Know who to turn to" campaign has been running since 2009 to raise awareness. Posters were put up in public places, GP practices and pharmacies to reach out and advise people where to turn first for eye problems. However, there is still a lot of work that could be done to raise awareness.

We also provide domiciliary eye care; 55,000 people attended a domiciliary eye appointment in 2019. There is still a lot of work that can be done to raise awareness of that service for people who are at home and are unable to access an optometry service. Many optometrists coming through the ranks are becoming independent prescribers. They are able to prescribe a certain range of medication specific to their level of competency and more of that could be done. We have capacity—we had it prior to the pandemic and we continue to have that availability. We do not have a backlog, such as that in secondary care. We are on the high street and easily accessible, and we could promote that service more.

Harjit Sandhu (National Community Hearing Association): It is a pleasure to be here today. Thank you for inviting us. I represent audiology providers who work in primary care settings throughout Scotland. Our members work in more than 150 locations, and they provide home care.

Awareness of many primary care professions is generally very limited, largely because primary care is still framed as GPs, rather than the wider primary care professions. Awareness of care that impacts on hearing problems is either relatively limited or poor in general society. Lots of people just accept that hearing problems happen with time. There is a huge opportunity to tackle what is a growing public health challenge.

Raising awareness of the alternatives to GPs for primary care will also bring major benefits for population public health. However, in order to tackle general awareness, there has to be more of a communications strategy to remove the concept that the GP is the single point of access. The evidence that the committee has received from the general public shows that they really want confidence that the alternative pathways are planned routes to care, rather than diversion or avoidance. Giving the public the confidence that those routes have been planned for their benefit and that people are seeing the right person at the right time will be a key enabler.

Dr Jess Sussmann (Royal College of Psychiatrists): I am a consultant psychiatrist representing the Royal College of Psychiatrists in Scotland. Members of the psychiatry profession are experts in providing specialist, potentially lifesaving, care for mental illness within a clear, ethical framework. Our focus is on delivering the best care and outcomes for patients.

When responding to the consultation, we said that we want to ensure that people with severe mental illness who are most likely to need our care are better able to access support and care in their communities. We recognise the importance of meeting the needs of all Scots, but we believe that that should involve our most vulnerable citizens and that support should not cater simply to the majority of people who may have poor mental wellbeing and/or mild to moderate mental ill health.

While recognising that people who need clinical interventions can and should be engaged in health services, we also recognise that some people in our community found traditional methods of accessing healthcare services uncomfortable, which has meant that they did not present until their mental ill health had reached a severe stage.

Our previous campaign focused on the need for there to be no wrong door for accessing the right care for mental ill health in the right place and at the right time. Ensuring that pathways into care from our communities are as accessible as possible is a critical aspect of delivering on that vision.

We welcome the opportunity to discuss how we can better meet the needs of all who may interact with our primary care and community supports and how those pathways can be adaptive to the needs of all Scots, including people with severe mental illness.

To answer the question about awareness, we felt that there was a varying level of knowledge among practitioners. For patients, many access care using traditional methods and their decision to access care in that way is defined by factors such as their culture, geography, health awareness and the availability of signposting information.

However, we also recognise the need for alternative pathways. As I said earlier, there are people in our community who felt very uncomfortable accessing traditional pathways and so did not present until they were very unwell with their mental health needs. We have longstanding examples of that from the past. It is therefore critical that we find other ways to help those individuals come into the service and get the support that they need at an earlier stage.

On alternative settings, we felt that there were many that people could engage with alongside the traditional ones. Religious settings were cited as an example, with some communities seeking religion as an avenue for getting mental health support. We also felt that community resources were worth considering for that purpose, including social capital assets such as youth groups.

Our concern from a practitioner perspective was about the lack of stability in funding for community and social supports, meaning that the landscape is constantly changing. In Hawick, there was a wonderful art group, but when the funding ceased it collapsed and we did not know what other resources were available in the local community that would be equivalent to that. It is about having a constant ear to the ground and maintaining knowledge of quite a flexible and fluctuating setting.

The Convener: Thank you. You have all individually raised some points that I am interested in following up. First, Harjit Sandhu spoke about home care. That is something that I hear about from constituents. In the distant past, they were able to have home visits from GPs. It was a fairly regular thing, but it is a very irregular thing now. It has to be quite a serious situation for that to happen.

You mentioned home visits as something that is part of your normal practice. I do not think that people are aware that they could have those alternative pathways coming into their homes. Will you expand on that?

Harjit Sandhu: I am happy to speak about that from the audiology perspective. Most of the significant and most severe hearing problems occur in older age. People are more likely to have a hearing problem of greater severity if they are aged 80 or over. Therefore, much of the unmet need in our society is in care homes and in populations where people find it difficult to travel, because of mobility issues and so on.

There is, therefore, a large offering—unfortunately, in Scotland, mainly from the independent, private sector—to deliver that home care service, where people can have hearing diagnostics, testing, care and aftercare at home. That inequality of access really needs to be addressed. However, that service is available and it is readily available.

Optometry is a little bit different in the NHS sense, but Julie Mosgrove might explain that to you, because she also mentioned home care.

The Convener: Yes, she did. I will come to Julie next. Are you saying that, at the moment, for audiology, the home care service is mainly in the private sector but is something that could be expanded?

Harjit Sandhu: Absolutely.

The Convener: I will come to Julie Mosgrove now, for the Optometry Scotland point of view.

09:15

Julie Mosgrove: In optometry, home care is available now. It is not available across every optical service provider; there are specialist practitioners who do it. The issue is a difficult one. The biggest barrier is funding and keeping the service viable. A lot of travel is involved, because the practitioners visit not only care homes but individuals in their homes across Scotland. The situation can be difficult if you are driving to someone's house in a remote or rural area. However, as I said, various providers offer the service. In 2019, out of the 2.1 million eye exams that were conducted, only 55,000 people accessed the home service.

The Convener: So, from the point of view of Optometry Scotland, it comes down to communication, but in audiology there is another issue, about funding.

Emma Harper wants to pick up on the points that have been made about geography and the rural issue. Before I hand over to her, I will just say that anyone who wants to comment on anything in particular should put an R in the chat box and I will bring them in.

Emma Harper (South Scotland) (SNP): Good morning. I would like to pick up on what Julie Mosgrove said about remote and rural areas. There are places in our small towns and large villages where people can access optometry services, but there are additional challenges in remote and rural areas. Could you outline some of those challenges in relation to people's ability to access alternative pathways?

Julie Mosgrove: Optometry is well placed at the moment and there is a good network. In the Highlands, for example, more than 60,000 people live within 30 miles of optometry services in Raigmore hospital. However, we need to be able to sustain that level of service. It is the case that job vacancies in the more remote and rural areas might be more difficult to fill and, at the moment, there are issues with vacancies in some areas.

However, the main issue is to do with on-going community eye care and ensuring that a good supply of professionals is coming through to fill those positions. Some future support would definitely help to mitigate the risks. At the moment, if you are looking at putting optometrists into more difficult locations where it is harder to fill posts, you will find that higher salaries help with that, which makes it more difficult to provide the service.

Emma Harper: I have another wee question. Previously, we have talked about additional skills to deliver additional services. For example, in one of our members' business debates, we spoke about the fact that optometrists are often the first people to detect type 2 diabetes, and that would lead to a referral for a blood glucose check. Could that check be delivered in an optometry setting? It would require people to receive additional training to ensure they had the right level of competency and skill.

Julie Mosgrove: Any optometrist can pick up the early stages of diabetes by looking for certain signs at the back of the eye. Some patients have come to my practice with no symptoms of diabetes at all, but I have noticed changes at the back of their eyes that suggest that they might have diabetes or high blood pressure, so I have advised them to go and see their general practitioner. Many of them are shocked by that and are dubious about it until they see their GP, and then they come back and say that they have been diagnosed with high blood pressure or diabetes.

Once someone has been diagnosed with diabetes, they need follow-on care, which involves assessing them through regular eye exams. A lot of that is done in secondary care environments. Some health boards, such as NHS Ayrshire and Arran, do diabetes screenings whereby someone is seen in the community by an optometrist. With additional training, as you say, the optometrist can monitor their condition and look for changes. It requires a bit more equipment and training, but it is something that is happening in pockets across Scotland.

The Convener: Clare Morrison wants to pick up on the question of provision in remote and rural areas.

Clare Morrison: Community pharmacies are very much in our communities across Scotland, including remote and rural communities. The public are aware of the accessibility of community pharmacies. During the Covid pandemic, community pharmacies kept their doors open and were one of the services that were very much available.

I have lived and worked in the Highlands for the past 17 years, so I have seen community pharmacy coverage and some of the more innovative practice that has taken place around pharmacists working in and with GP practices across rural areas. Across the country, all but seven GP practices have input from pharmacists through the pharmacotherapy service, so that covers all the rural practices. That includes in-person services and the use of remote support.

I will highlight data from a recent Ipsos MORI survey of 1,107 adults in Scotland, who were asked about methods of accessing pharmacy services. It was really interesting that 87 per cent said that they wanted to access pharmacy services in person. That is great, because we have that coverage already. However, a lot of people said that they wanted to access pharmacy services in other ways—59 per cent talked about telephone consultations, 42 per cent talked about video consultations and 38 per cent talked about other digital services, such as online messaging. All those ways would improve access for people in remote and rural areas, alongside people travelling and services being provided in locations.

The Convener: Harjit Sandhu wants to come in.

Harjit Sandhu: I will build on a point that Clare Morrison made. Today, we have innovative technologies in hearing care, which allow people's digital hearing aids to be fine tuned remotely so that they can hear better. That means that they do not have to travel as far for every visit.

There is also a large primary care infrastructure across Scotland that is not always mobilised by NHS commissioned services in the same way as other primary care professions. There is a huge opportunity to tackle the inequalities of access in rural communities by reducing the cost to individuals of travelling what are sometimes quite long distances to access care. There are opportunities to reduce inequalities of access.

The Convener: I will bring in a couple of my colleagues. Stephanie Callaghan wants to ask about the diabetes aspect that Emma Harper mentioned.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): I have a quick follow-up question for Julie Mosgrove, who spoke about diabetes being spotted really early and about referring people to their GPs. Does she refer people directly to other primary care pathways or to specialists? Is that appropriate? I am trying to figure out how this fits together. Do people always have to go back to a GP or can onward referrals be made that skip that step if it is unnecessary?

Julie Mosgrove: The approach depends on the condition. If it was diabetes, we would probably refer someone to a nurse to have their blood tests and their blood pressure checked. We can pick up other conditions, too. If a stroke was suspected, the patient would be referred to their GP but, if it had affected their eyes, we would also contact the hospital. We also refer people to pharmacy for certain conditions.

The approach depends on the condition. The majority of our referrals are to a GP or directly to a hospital.

There are other things that we can do—

Stephanie Callaghan: Thank you—[*Inaudible*.] That is great. It is helpful to know that those referral pathways work in primary care services and beyond.

Sandesh Gulhane (Glasgow) (Con): I will talk a bit about innovative practice, which we have heard a bit about, especially in rural areas. I know of amazing work that is being done in NHS Grampian, and I would like Julie Mosgrove to tell us a little more about that and about barriers to rolling that out across Scotland. Does anyone else have examples of innovative work in rural areas that makes life better for our patients?

The Convener: We will go to Julie Mosgrove first, as she was mentioned.

Julie Mosgrove: I am based in Grampian, and I have worked in the system for more than 10 years. We were ahead of the rest of Scotland in setting up, in 2010, the Grampian eye health network, which is the first port of call for all eye emergencies. The reason that it was set up was that an audit of the eye out-patient department found that less than 10 per cent of walk-ins required to see an ophthalmologist; the rest of the cases could have been seen by people in primary care. The network was built up around four main conditions that involve eye-related emergencies, but it has grown from there through collaboration with secondary care and GP practices.

We can prescribe for a range of conditions because of the network in Grampian—we do not need to be an independent prescriber to do that. From 2007, we were able to prescribe certain medications for patients, monitor them in practice and get them back for review appointments, whereas those patients would previously have gone to hospital.

Some treatments, such as foreign-body removal, are simple. In Grampian, an optometrist would be trained to do that, whereas, in Tayside, a patient might have to go to an accident and emergency department to have that done. There are also some medical conditions that an optometrist can work on, supported by a GP. With more and more independent prescribers available, we can prescribe that treatment without having to co-prescribe with a GP. In Grampian, any optometrist is able to do that, and I know that there are pockets across Scotland, especially in remote and rural areas, where they have a good network that also involves ophthalmology support from the hospital and which enables patients to be supported in the best way.

There are different networks, but the one in Grampian is probably one of the best.

The Convener: Clare Morrison wants to come in.

Clare Morrison: One of the services that I would draw attention to is NHS Near Me video consulting service, the very early pilot of which took place in pharmacy services in NHS Highland and other pockets across the country. One of the reasons for that was the need to provide remote pharmacist support in extremely rural areas where there was no community pharmacy, such as isolated areas in north-west Sutherland and some islands.

That pilot developed into the Near Me service, which was scaled up significantly during the pandemic and is now available across NHS Scotland and which enables patients to have complex medication reviews remotely. One of the great things about it is that someone can hold up their medication to their tablet's camera, which means that they do not have to pronounce its name—that can be a barrier for some people. It is also useful to be able to see into people's homes, as that can help you to support them to take their medicines effectively.

We have definitely seen technological innovations such as that in rural areas.

The Convener: Before my colleagues ask more questions, I want to ask Jess Sussmann something. As constituency and regional MSPs, we hear about long waiting times to access mental health care. People who are watching this meeting and heard what you said earlier might be thinking, "I thought that I would always have to be referred to any kind of mental healthcare." Can you give us an idea of how the public could access the services that you are talking about? You mentioned some things that you are doing around outreach, but could you give the public an idea of where they can find that doorway into services that you describe?

Dr Sussmann: A great example of what I am talking about is the primary care mental health teams in Glasgow. People can self-refer to them, and I understand that about 46 per cent of referrals are self-referrals. That would involve an assessment of the person's wellbeing and whether they have a mild to moderate mental health problem. If the team felt that there was something more serious going on, it would refer the person to secondary care.

The Convener: That is another example of good practice, but it has not been rolled out nationwide.

09:30

Dr Sussmann: No, it has not. A difficulty in signposting and in understanding the options relates to how severe someone's illness is. We want to ensure that, when someone is severely unwell, there is a straightforward path through the GP to the appropriate specialist in psychiatric care. With regard to mild to moderate conditions, there should be a variety of options available in the community—anxiety management, relaxation, opportunities for improving access to other people, peer support and so on—and people should be able to choose between those options in order to maximise their health and wellbeing. However, those are not available locally everywhere. There is a postcode lottery in relation to what is available and how those things are sustained.

The men's sheds that are organised by the Scottish Men's Shed Association are a good example of a wonderful resource in the NHS Borders area, which is where I work. It is an organisation for men—at the moment, it is mainly older men who access it—that enables the delivery of peer support in woodwork and all sorts of interesting things, depending on the area and what the individual groups want to achieve. It is about wellbeing and maintaining health, and it is helpful for people with a mild to moderate condition, as they can talk things through with peers and get that support. It provides a level of care that is different from the care that is required by someone who needs to see a GP and then be referred to psychiatric services.

The Convener: I know that you also wanted to come in on the issue of Near Me, which was raised in response to Sandesh Gulhane's question.

Dr Sussmann: Yes. I am a rehabilitation psychiatrist, so my main job is looking after people with chronic schizophrenia, who never entirely recover from their illness in terms of their symptoms and onward difficulties. Although Near Me is a fantastic resource for many, I cannot think of one patient in my rehabilitation service who would feel comfortable using an online service to access any support. All the way through the pandemic, they have chosen to have face-to-face contact, and those who have chosen not to have it, because of anxiety about Covid, have become unwell, so we have had to reinstate face-to-face contact.

The Convener: Gillian Mackay will ask the next questions.

Gillian Mackay (Central Scotland) (Green): Good morning. Are our witnesses concerned about the ability of the NHS to recruit sufficient staff to fulfil the ambitions that are set out in the NHS recovery plan and the national workforce strategy for health and social care? How likely is it that staff will be redeployed or recruited from elsewhere to fill gaps?

The Convener: Would you like Clare Morrison to answer first?

Gillian Mackay: That would be a good idea.

Clare Morrison: Like every profession, pharmacy has difficulties relating to total workforce capacity. However, some things could be done to improve the culture in our workforce, which could lead to an increase in the capacity of staff. Some of the things that we need to do involve making our processes more efficient in all settings. Right now, we have poor information flow in and out of community pharmacy—that issue takes up a lot of time in professionals' days—and we have real variation in the ability of pharmacotherapy services in GP practices to deal with requests for acute prescriptions. Improving some of the issues around those things could create capacity in the system.

We have a lack of digital tools. Introducing an electronic single shared patient record to improve capacity, quality and safety and to underpin referrals would create significant time savings in community pharmacy and general practice pharmacy.

We could also do more to increase the skills mix in pharmacy by investing in more pharmacy technicians and support workers in order to release pharmacist's capacity. We could do more to modernise the dispensing process in pharmacy, and we could consider using digital tools, such as electronic prescribing. Work is going on in all those areas, but we need to accelerate all of that.

We also need much better workforce planning. The Government needs to do workforce planning for pharmacists and pharmacy technicians in the way that it does it for doctors and nurses, but we are concerned that that is not happening at the moment. We are aware that we cannot create an additional workforce. It takes many years to train a pharmacist, so we need to think about the things that we can do right now.

It would be really beneficial to focus on some of the capacity issues and on workforce planning while we look to train more people over the longer term.

Julie Mosgrove: A lot of optometry businesses have had to do workforce planning in order to attract optometrists and dispensing opticians to the practices. We attend careers events at local schools to talk about optometry. I decided to become an optometrist only because I got my eyes tested and needed glasses. That completely shifted my thoughts. Previously, I had not thought of optometry as a career choice; my thoughts had been more about medical careers—being a doctor or a dentist, for example.

Therefore, workforce planning for optometry is about raising awareness at school level and attracting more people to study it at university. In Scotland, until very recently, optometry could be studied only at Glasgow Caledonian University. The University of the Highlands and Islands has now started to offer an optometry course, but we do not have those graduates yet. Therefore, there are now two Scottish universities offering optometry courses. When people leave university, they tend to stay close to where they have studied, so there is the hope that the UHI course will help to keep optometrists in that area.

Overall, as in every health sector, there has been an increase in patient volumes, given the ageing population. Another barrier is that the investment in staff is becoming greater over the years, so the funding stream will need to be addressed to ensure that we protect the workforce.

A lot more could be done, including by raising awareness—starting young and working up—to get people into the sector.

Harjit Sandhu: The NHS recovery plan specifically mentions audiology and its evolution so that it is on a par with the rest of primary care. That means greatly expanding access. The current NHS workforce, which is predominantly hospital based, will not be able to meet that need, but, fortunately, we can double the workforce by using other primary care professions in the same way as optometrists, GPs and pharmacists are using them. In fact, throughout Scotland, many hundreds of audiologists work in the same practices as optometrists and pharmacists. There is definitely both the workforce and the infrastructure to deliver that part of the NHS recovery plan. That is the audiology perspective.

Dr Sussmann: From our perspective, as everyone else is saying, there are staffing crises in mental health services. That includes nursing staff and social workers—it is pretty much across the board. We have problems filling all the necessary roles.

We welcome the expansion of link workers into primary care settings. In NHS Borders, we also have local area co-ordinators to help folk with mental health problems to navigate the resources that are available in their local communities. Having someone who can spend time with folk with difficulties with their mental health and who understands their needs is very welcome, but someone requires a real set of skills to engage with those folk and be able to signpost them and support them to access different resources in the community—alternative pathways.

We are concerned that, unless we have a real look at the workforce and how to plan for it, skilled staff from other settings will just be taken and moved across, which will create other gaps.

Gillian Mackay: The public know that the NHS has been under extreme pressure for the past two years. As we hear more about the impact that that is having on staff, is there a risk that that will impact recruitment? How do we persuade people that the NHS, primary care and the sectors that you all work in and represent are still great places to work? How do we continue to attract people into health professions? Could I go to Julie Mosgrove first, please?

The Convener: Gillian Mackay has offered you the opportunity for a recruitment drive right now.

Julie Mosgrove: It is important to note that times are changing. A lot of people are looking for more of a work-life balance, so that will create a recruitment challenge in ensuring that more people are coming through. In optometry, we have found that people have changed their working hours—for example, they might have dropped from working five days to working four days.

We have to be mindful of that as we recruit generally. When people are on the courses, universities need to be more open to that, because we need to be flexible and not try to keep people set in the role as it might have been previously. That will help to keep a better balance, to attract people into roles and get them to stay in roles.

This is about providing support. Employers need to look after their staff and ensure that everyone is given support. Various forms of support for mental health are available, as the pandemic has certainly taken its toll on a lot of people. People need to be able to access services. As a result of the pandemic, employers are accessing such services more and making them available to employees in order to better support their staff.

It is important that we modify how we recruit and what we are willing to offer.

The Convener: I do not see anyone else wanting to come in on that question. Does Gillian Mackay have a follow-up question?

Gillian Mackay: A couple of Rs have just popped up in the chat box.

The Convener: My heavy hint has worked. I will bring in Clare Morrison first.

Clare Morrison: Pharmacy can be a bit of a hidden profession, so it would be fantastic to have a recruitment drive to promote careers in pharmacy—not just for pharmacists but for other important roles such as pharmacy technicians and pharmacy support workers. We need to increase public awareness of the roles that exist in pharmacy. We should be thinking about the NHS pharmacy first service, community pharmacy and developments in pharmacotherapy services in general practices. Educating people about such services and raising awareness of them would almost certainly make pharmacy seem like a more attractive career proposition.

We need to work with pharmacy employers to improve some of the culture in relation to flexible working opportunities and having a rest break during the working day. That is still a really important issue, particularly in community pharmacy, where people can be expected to work from 8 in the morning until 6 at night without a single rest break. That is a challenge for us. Lots could be done by working with pharmacy employers.

As a professional leadership body, part of our role is about creating a positive vision for the future. Recently, we published “Pharmacy 2030: a professional vision”, which is about maximising and making the best of what makes pharmacy unique—our expertise in medicines. I hope that describing exciting career prospects in that way will attract more people into the profession.

Harjit Sandhu: The question goes to the heart of the inquiry. The public very much appreciate GPs; from service user feedback, we know that people get upset when they cannot access their GP.

I will build on what Clare Morrison said. Sometimes, people do not recognise how valuable other parts of the primary care family are. Raising the profile of the other professions will naturally mean that more people are interested in such careers. For example, audiologists can provide evermore extended services, such as wax management, supporting people through counselling for tinnitus and helping people with long-term hearing loss.

The more we raise awareness, the more exciting and fulfilling the careers will seem, and we will not only attract people but, we hope, keep them in the professions for longer. That will help and be part of the solution.

Dr Sussmann: I echo what everybody has said. The value of a person-centred and helping career and of connections with others is so important to people. We have lost some of that through the isolation of the digital model at the moment. We are getting back into it, thank God, although there will be more hybrid working. I think that working remotely has really harmed people’s relationships and their sense of being part of a team and a group, and we need to recover from that a little bit.

On career development, whether it is in nursing, audiology or other careers, the opportunity to develop different roles and specialisms is vital to recruitment. It is vital that people feel that they can move in a positive direction over the lifetime of their career.

09:45

The Convener: Is Gillian Mackay happy for me to move on to Sue Webber’s follow-up question?

Gillian Mackay: Yes—I am happy for us to move on.

The Convener: Okay—I will bring in Sue Webber.

It appears that we cannot hear Sue Webber, and I do not think that she is muted, so I wonder whether there is an issue. I think that Sue's picture has frozen.

Can you rejoin the meeting, and I will come back to you, Sue? I ask broadcasting to get in touch with you to sort out the technical problems. We will move on, and I will come back to Sue's question on workforce planning once she is back.

David Torrance (Kirkcaldy) (SNP): Good morning to the panel members. Does the primary care system enable a holistic and preventive approach to keeping people well?

Clare Morrison: A really important role of pharmacists is that they provide person-centred care and a holistic approach. Rather than looking at someone just in terms of a specific clinical condition, pharmacists look at the medicines and the entire situation. We need to do more to ensure that a person-centred approach is taken across primary care, but pharmacists absolutely play an important part in that.

I will highlight data on public opinion from the recent Ipsos MORI survey that I mentioned of views on the roles of pharmacists. It found that 95 per cent of people support pharmacists advising on medicines; 87 per cent think that it is important that pharmacists prescribe medicines; 89 per cent think that pharmacists should be the first port of call for common clinical conditions; and 81 per cent think that pharmacists should monitor, review and adjust medicines for long-term conditions. All of that feeds into the public engaging with pharmacists in providing holistic care for people's conditions in their entirety.

Julie Mosgrove: Optometry practices are welcoming places that normalise healthcare, so we take a holistic approach, anyway. On average, patients sit with an optometrist for about half an hour. During that time, we delve into the situation to find out the patient's reason for coming in and whether they are having any issues. We delve into the different areas of their life and ask what they use their eyes for—for example, we ask whether they are on a computer all day at work and what is involved in their hobbies and interests. That is a dynamic and important approach that does not focus solely on one medical condition. We look for a range of conditions and a range of visual requirements. We delve into what the patient needs.

On the holistic side, we talk about general health and issues such as smoking. Lots of areas are involved. Similarly to pharmacy, we do not pinpoint a specific thing; we look at the whole patient.

Harjit Sandhu: I will answer the question in two ways. First, does each of the professions focus on prevention? I think that they do a relatively good job on that. Secondly, is there interprofessional communication to maximise the prevention and public health elements? I am not so sure.

To take audiology as an example, people with hearing loss are at increased risk of depression, dementia, social isolation and other mental health risks, yet hundreds of thousands of people in Scotland who go to see their GP are not referred for an intervention for hearing loss to reduce those risks.

Hundreds of thousands of people who see our pharmacy colleagues are not getting their hearing difficulties picked up. We have a huge opportunity to benefit from the prevention that arises from having interconnectedness across primary care, and I hope that these inquiries will help both in that respect and with onward referral and that, as a result, we will get the massive public health benefit. That is what lies at the heart of Audit Scotland's recent conclusion that the way to put the NHS on a sure footing is to go upstream and do more out of hospitals. I certainly think that there are huge opportunities in that respect.

Dr Sussmann: If we are specifically talking about prevention, we have to take a wider look at socioeconomic issues and the fact that the communities that are likely to develop mental health difficulties are those with the most challenging socioeconomic status.

As for holistic approaches, we in the mental health profession do not just focus clinically on people, their illnesses and their illness models; we also take a broader look at how best they can integrate with communities and have better social, occupational and educational opportunities once they are well enough to achieve them. We then look at the alternative pathways that they can access to make best use of those opportunities and the support that they will need.

The Convener: Emma Harper wants to pick up on something that Jess Sussmann has just said, and then I will come back to David Torrance. [*Interruption*.] Emma's microphone does not appear to be coming on. We have gremlins today.

Emma Harper: There we go.

I will pick up on what Jess Sussmann just said and relate it back to her comment about support for art. I had a case of someone who wanted to use self-directed support money for art therapy to help them tackle social isolation. Their proposal was refused, because it related to art and was therefore not seen as important.

Jess, how do you feel about that sort of support being used to benefit people and tackle social isolation in that way? I know that art therapy is really good for that. I see that you are shaking your head. What are your thoughts on that?

Dr Sussmann: I am very surprised at what you have said. I have patients with chronic schizophrenia who have used SDS to get an art teacher to come to their home and spend time with them there. I would absolutely support all those resources being used in that way.

The difficulty that we had during Covid was that, unlike the council-led care structures, which kept going to a degree through the early stages of the pandemic, lots of the self-directed support just disappeared. As wonderful as it is for people to have the opportunity to choose their support, that support needs to be solid and present in different circumstances.

It is fabulous that people can access and organise the supports that they want to be in place, but lots of our patients need quite a lot of help in that respect. Our social workers help them to access SDS through organisations such as Encompass Borders. It was certainly a problem during Covid.

The Convener: I come back to David Torrance. Do you want to follow up on your question, David?

David Torrance: Thank you, convener. To what extent are primary health care practitioners other than GPs able to promote prevention and self-management? Is a greater focus needed on prevention? Perhaps we can hear from Clare Morrison first.

Clare Morrison: Pharmacy adds quite a lot to prevention, particularly in view of some of the public health services that are available in community pharmacies. Such contracted services cover, for example, sexual health and smoking cessation; there are locally agreed services such as injection equipment provision; and there is also the preventative aspect of talking to people about their wider health when supplying medicines. Pharmacy delivers prevention services when the contractual framework has enabled a community pharmacy to do so.

The pharmacy first service, which is available from all community pharmacies, is really important. Pharmacists provide advice and treatment for common clinical conditions. That management can sometimes prevent people’s conditions from developing or worsening and needing GP care. A lot is happening, but there is always more that can be done.

Harjit Sandhu: Audiology is fundamentally a preventative service. When an audiologist sees a service user, they are limiting the impact of hearing loss on communication. Benefits flow from that, such as a reduced risk of social isolation and mental ill health.

The challenge is that such prevention does not make the headlines. The prevention that hits the headlines comes from the high-level interventions that stop smoking and so on—the strategies that always come from the Government.

We have an ageing population, and we would like to see an active ageing strategy that provides new prevention opportunities and not only primary preventative public health measures, to help our population to age well. Active ageing brings huge opportunities.

Dr Sussmann: [*Inaudible*.]—rethinking prevention in mental health. Our population fluctuates in terms of illness. Accessing the right resource at the right time prevents deterioration that might be long lasting and could have a major impact on a patient’s future.

The stability of community resources is important. The alternative pathways must be stable. People must be able to access services when they need them, and at speed, and those services must be well resourced.

Julie Mosgrove: I will pick up on what Harjit Sandhu said. Optometry and audiology can be very similar. Eye care is predominantly preventative. More than half the patients who attended for routine eye examinations in 2019 were responding to a recall invitation, having been seen a year or two before then.

The eye examination involves taking photos of the back of the eye and documenting what we see. A lot of that is routine. We monitor things over time. We might monitor a healthy eye every two years. We discuss health in general, which includes talking about smoking, exercise, protecting eyes against ultraviolet light and eating a well-balanced diet. Also there is—[*Inaudible*.]—how are family members’ eyes and whether there are conditions that run in the family that could affect the eyes.

Our work is predominantly preventative. We can often end up reacting to things, and part of what we do is reactive, but eye care is predominantly preventative. We look ahead.

The Convener: Jess Sussmann wants to come back in.

Dr Sussmann: To think about the question from the perspective that the optometrists and audiologists gave, severe mental illness brings a much greater risk of physical health problems, such as weight issues, diabetes and increased smoking. Those conditions need specific resources for engagement. Our patients need additional time and understanding to be able to build trust with the person who is supporting them to get the tests, input and care that they need. That should be considered when we think about pathways.

The Convener: We have Sue Webber back, so I will jump back to the theme of workforce issues that we were discussing when we lost her. Over to you, Sue. [*Interruption*.]

We still cannot hear you, Sue—my goodness. Sandesh Gulhane has said that he will be your wingman and ask your question.

10:00

Sandesh Gulhane: Always, convener.

This question, which is for Clare Morrison to start with, is about MDTs and the data that drives decisions. Now that all members of allied healthcare professions are to be fully included in the workforce plan, what would need to happen for you to get the appropriate data that you need? Obviously, as far as training and financial support are concerned, a lot of these groups are businesses, but you will need access to patient data to be able to perform those functions.

The Convener: I will bring in Clare Morrison first. Anyone else who wants to come in should use the chat box.

Clare Morrison: The thing that could be absolutely transformational in enabling multidisciplinary team working is a single shared electronic patient record. Across health and care, information is held in silos, and all professionals waste time chasing it.

There is a safety risk in not having the relevant information when you make a clinical decision, and there is an enormous duplication of effort in, for example, medicines reconciliation. When a patient moves between care settings—for example, when they are admitted to hospital or are discharged back to primary care—the professionals have to check multiple sources of information to ensure that they have the right list of patients' medicines and then they have to update their records.

Having a single shared record where every professional could enter and read information would eliminate all that work and make care safer. The kind of shared record that we are talking about is an appropriate view; in other words, everyone can write in and read what is appropriate to their role. We are talking not about a record in which all the information is available to every profession, but about something that shows the relevant information for a professional to provide safe and effective care for a patient.

If we could enable that kind of working by having that information and communication, it would be transformational. For example, a patient might be seen and prescribed medicine in a community pharmacy setting, but if they had a consultation with their GP a few days later, the GP would need to know what medicine had been prescribed in the community pharmacy. If there were a single shared record, they would have that information to hand immediately. That is what we need across Scotland.

The Convener: I see that a couple of other people want to come in.

Dr Sussmann: I would totally reiterate what Clare Morrison has said. At the moment, we cannot see mental health records from other GP practices, so we cannot be clear about, for example, what tests have been done with patients or what medications they are on without contacting GPs directly. A national digital strategy would also be important in dealing with patients moving around, because it would be incredibly helpful if the patient record could travel across Scotland rather than just within an NHS board.

Julie Mosgrove: I, too, reiterate Clare Morrison's comments. It is frustrating not to be able to access certain information on a patient. With prescribed medication, for example, we face the same barriers that pharmacy faces in having to contact the GP practice or hoping that the patient or a family member has a list of their medications. That does not build confidence, and it takes a lot of time to get access to the information. Likewise, if we saw a patient or sent their information to the GP, the GP or pharmacist might see them the next day, but they would not know what treatment what patient had started. It relates to both sides of the system—our referrals to others and others referring to us.

Harjit Sandhu: I agree with colleagues—Clare Morrison is right. Connectivity is key to getting patient benefit gains from MDT working. In audiology, we have done some good co-working on epidemiology with regard to population needs, and that has involved looking at the type of workforce required to meet those needs. If each profession could contribute to that, we might be able to develop a comprehensive way of matching workforce to need while building in MDT working.

The Convener: Sandesh Gulhane has a quick follow-up question.

Sandesh Gulhane: It is Sue Webber who has the follow-up question, convener, which I will—

The Convener: But you are speaking on behalf of Sue.

Sandesh Gulhane: I am.

Given that the workforce plan is rather GP and NHS-centric, we are concerned about how you can feed into it. Can you tell us about the feedback that you gave? What needs to happen for you to be included? What do you feel that you need?

The Convener: Who do you want to direct that question to in the first instance?

Sandesh Gulhane: It is for Clare Morrison.

Clare Morrison: As I said earlier, and as we have said to Government a number of times now, we are really concerned that effective workforce planning for pharmacists and pharmacy technicians is not done in the same way that it is done for other professions, such as doctors and nurses. There is a significant gap there, which needs to be addressed. Linked to that, we must consider the Health and Care (Staffing) (Scotland) Act 2019, to ensure that there are safe levels of staffing across pharmacy.

We also think that we need to look at effective workforce planning for the future. It is not just a case of analysing the numbers of pharmacists and pharmacy technicians that we have now; we should consider what the future need will be, what the roles will be in the future, what difference additional technology can make and how services can be shaped differently. Workforce planning will need to be done around that. It has not been done yet, and it really needs to be.

On workforce planning, there are two areas that I would like to draw out in relation to what we are talking about today. From a community pharmacy perspective, I have mentioned the pharmacy first service, which is important for improving accessibility to care for patients. An extension to that service, called pharmacy first plus, involves pharmacist prescribers, but it is available only in community pharmacists where the pharmacist is a prescriber. That means that, if a patient regularly goes to a pharmacy that they know well and where the pharmacist is a prescriber, they will have access to that service and will understand it. However, if they go to a different pharmacy where the pharmacist is not a prescriber, that can lead to frustration at the service not being available. We therefore absolutely need more investment in training pharmacists in independent prescribing. Training places are now available—there has been a recent increase in that respect—but I understand that the courses are significantly oversubscribed, so that provision could be further expanded.

The other area that I want to comment on, which is on the GP practice side of things, is the pharmacotherapy service. That is part of the general medical services contract. All GP practices bar seven in Scotland have some level of pharmacist support, which is really good, but last year we worked with the British Medical Association to identify areas for improvement linked to the workforce. We know that, at the moment, pharmacists' clinical skills are not being fully maximised in practices, and one of the reasons for that is that the rest of the pharmacy team is lacking. Pharmacy technicians and pharmacy support workers are needed to undertake the level 1 part of the service. If we had the right staff mix in place, pharmacists' clinical skills could be used more effectively at the higher level of the pharmacotherapy service—level 3—which is where they should be working.

We need workforce planning in relation to the skill mix, alongside other things, such as improved information technology and improved, more effective team working. There is a lot to do.

The Convener: After we have heard from Julie Mosgrove, we will move on to the next theme.

Julie Mosgrove: Optometry has capacity—we are not a profession that is in crisis from the point of view of workforce planning—but more can be done. I think that it was Harjit Sandhu who talked about the need to raise awareness of the profession generally, and that probably applies to all the health professions that we are talking about. We need to show that there is a career pathway and to highlight the other jobs that are available in the sector, because there are different levels. That will help with service sustainability. Given the ageing population that we will have in the future, we will have to keep the pipeline going if we are to sustain the service. At the moment, though, we have capacity.

The Convener: Thank you. We will move on to the issue of self-referral, and Paul O'Kane will lead the questions.

Paul O'Kane (West Scotland) (Lab): Good morning, panel. We have already touched on self-referral pathways, but I am interested in the public's awareness of self-referral. We know that there are initiatives out there, such as pharmacy first, which we have talked about a bit, and the NHS Greater Glasgow and Clyde right care, right place web resource, which tells people where they should go and when. According to research that has been done for the inquiry, public awareness of some of those initiatives is not always high; in particular, public awareness of when to self-refer outwith pharmacies is not high. I think that a lot of people are aware of the pharmacy avenue, but perhaps not other avenues.

My first, broad question, therefore, is: how can we raise awareness of self-referral and people's ability to self-refer? As I have mentioned pharmacies, I ask Clare Morrison to answer that question first.

Clare Morrison: It is a mixed bag when it comes to awareness. Starting with community pharmacy, I think that there is a high awareness of the ability to self-refer to pharmacy first, which you mentioned, but we are concerned that awareness is more mixed in certain populations, particularly among some deprived groups, those with lower health literacy and potentially people in care settings, too. I do not think that there is complete awareness, but there is good awareness among the general population of the ability to self-refer to that service.

That said, with other parts of pharmacy and primary care, awareness of the ability to self-refer to, say, pharmacists who work in GP practices is very low, and that is linked to low public awareness of the roles of pharmacists in GP practices. We have never had a national public awareness campaign on pharmacists in GP practices, despite the contractual change that saw pharmacists' role in that respect going into the GMS contract. It is a new service, and it has taken a little while to establish; however, now that it has been established, now is the time for a national public awareness campaign so that people, including patients, are aware of pharmacists' roles and the ability to self-refer to them. At the same time, we could consider awareness of certain services, such as pharmacy first.

I would also say that some awareness campaigns have tended to focus on not going to A and E but going somewhere else instead of highlighting all the fantastic services that are available in pharmacies. Some more positive public awareness and messaging would be really useful.

Harjit Sandhu: Unfortunately, self-referral to many NHS audiology services is non-existent. People have to go to their GP for a referral, but it is not a medically necessary appointment. The fact is that everybody in Scotland who has the ability to pay can directly self-refer to an audiologist on a high street, which means that there is huge inequality in access to self-referral. Earlier, we talked about prevention, public health benefits and health inequality as a result of unequal access. It is a key issue. Not allowing people to self-refer for things such as impacted wax or hearing loss creates bottlenecks for GP services, too. There are a lot of system effects when we do not promote self-referral.

Historically, it comes down to the idea of the GP as gatekeeper. However, services have moved on, professions have advanced and there are huge opportunities in areas where innovation in care is not really being executed well. Promoting self-referral and sustainable models of self-referral would be great for the system and service users in particular.

Dr Sussmann: Again, I reiterate what has already been said. Those who are more connected to health services will know more about what is available and where and when they can self-refer. A national campaign would be brilliant, but the organisations that people access, such as pharmacies, should also have information on self-referral routes to other things, and the spaces where people already access services could be used to let people learn more about other resources. However, national campaigns would be excellent.

10:15

Julie Mosgrove: National campaigns would be the best approach. From an optometry point of view, the majority of the patients whom we see either have self-referred or are responding to a reminder. We need better signposting everywhere, including in our primary care professions and general practices, so that they are all signposting to the right place.

We could also have targeted promotions in health centres and community centres in key areas and look at places such as cafes and community centres that are attended by people who might not be accessing healthcare at the moment. That would help with promoting health services and ensure that people who have not accessed a service before know who to turn to.

Paul O'Kane: I thank the panel for those responses.

I heard what Harjit Sandhu said about the GP traditionally being the gatekeeper. I think that people are trying to find other avenues. However, some of the written submissions that the committee has received, particularly from the health and social care partnerships, suggest that there is still nervousness about people on a self-referral pathway going from pillar to post and ending up in an emergency setting, because there is no relationship with the first point of contact—the GP.

Do we need to drill down into that to understand who needs to go via the GP as the first point of contact in order to access other services? After all, as some of the panel's answers have suggested, self-referral might be easier for some people than others. Is there an acceptance that we need to look at individuals and their needs?

Harjit Sandhu: That is absolutely right. As we have established, patients accessing pharmacists has become normalised, and the same applies to optometrists.

With some conditions in society that are at a large scale, the professions are well enough aligned to act as first point of contact. Audiology is one of those. If you have an ear or hearing problem, you go to your audiologist, because we have the equipment and the infrastructure. Audiologists are not more qualified than GPs, who are highly qualified, but they are specialists in ear and hearing problems and will be a better first point of contact. However, that is not universally true.

You have hit on an important point—this is about getting the right person at the right time in the right place. It is for us to make representations and say that we believe that a particular service is well suited to being part of primary care, as it can act as the first point of contact. Audiology is unique in that sense, and it aligns with eye care and pharmacy, but I agree that not all professions and not all clinical needs are the same.

Clare Morrison: There are some fantastic examples of GP practice staff effectively triaging patients and signposting them on to other services such as pharmacy first and the pharmacist working in the GP practice.

I just want to draw the committee's attention to Healthcare Improvement Scotland's practice administrative staff collaborative, which works with practice staff on triaging and referral to a number of services, including pharmacy. There is still variation across practices, so looking at that work and whether it could be replicated throughout Scotland would be a really effective way of improving signposting.

The Convener: Stephanie Callaghan has a follow-up question.

Stephanie Callaghan: I want to dig a wee bit more into the issues that Paul O'Kane has raised. The big picture really matters. The GP relationship is established over many years, and it is important to many patients. GPs know their patients and their circumstances, and that relationship allows GPs to have the sensitive discussions that patients might otherwise be unwilling to have.

We have talked about the fact that there should be no wrong door. This might be a question for Clare Morrison and Jess Sussmann initially. Is it realistic for a variety of organisations to have someone who is the key person—the trusted person—to the individual patient, who offers continuity and helps the patient to get access to all the primary care services?

Dr Sussmann: Are you suggesting that the individual who could be the key person for a patient or client would not necessarily be the GP? Is that the nature of the question?

Stephanie Callaghan: I am not undermining the GP's place at all, but we tend to find that individuals will have a particular person whom they connect with, especially as they get older. That will be their go-to person for advice, who could say to them, "You really need to see your GP about that," or "It would be a really good idea to go to your pharmacist."

We have talked about link workers. We do not have them everywhere just now, and that is perhaps part of the issue. Realistically, patients will probably choose their own key person or go-to person.

Dr Sussmann: Absolutely.

Stephanie Callaghan: They trust that person, and they feel that they can rely on them.

How realistic is it for that to happen? Is that understood, and is that part of the system? We talk about the no wrong door policy, but there is also a push to get patients to go in the right direction, either on their own or through a link worker.

Dr Sussmann: It would be fabulous if people felt that they had enough training and experience to be that person for any individual. People who are ancillary and who are in an appropriate setting could be that person. It does not need to be the GP or the practice nurse, as long as they have the confidence to know where and when to guide the person, and the training. To me, as someone who works in mental health, the most important thing is that they have the engagement, the relationship and the trust—the ability to build trust with an individual.

The training bit is additional to that, and it should be something that we can provide. It would be a wonderful thing—

The Convener: Harjit Sandhu wants to come in on that. Sorry, Jess—I did not mean to speak over you. I will bring in Harjit Sandhu and then Clare Morrison.

Harjit Sandhu: That is right. I think that the GP will remain one of the key people—if not the key person—in someone's overall integrated care in the future. In audiology, for example, the difference is that the audiologist helps the person to hear, and all their healthcare interventions are that much easier to go through. Because audiology normally involves looking after people with long-term conditions, there is an opportunity to build up the relationship and, as the audiologist will see people regularly, the service user is more likely to share more with them.

The connectivity that we spoke about earlier, which enables people to move seamlessly through the system, will be key. That involves a joint patient record, integrated care and so on.

To follow on from what Jess Sussmann said, it would be great to have more healthcare professionals whom service users trust to share information with, and for all of us to work together to get people to the right place at the right time.

The Convener: We have also heard about patients not having to tell their story multiple times.

That has come up in not just this inquiry but many inquiries that we have done.

Clare Morrison: I reiterate how important it is to take a person-centred approach. If a person has a relationship with a particular health professional and wants to use that person as their first point of contact into the service, we should try to enable that. During the Covid pandemic, we saw cases in which community pharmacists continued to have their doors open. We saw an enormous increase in the number of people coming in and making requests about how to access different services. Many pharmacists already have those good relationships with people. They may not be able to provide the care, but they can signpost people on to the care that they need.

That brings in one of the other key enablers that we need. I have mentioned the single shared patient record already. That is the most transformational thing that we could have in place.

We could also have a referral mechanism. One of the barriers to signposting and moving people around between different members of a multidisciplinary team is the fear that that will add time to the patient's journey. What happens if a referral is made, but the patient actually needs to go somewhere else? If we had a really clear direct referral mechanism from the pharmacy to the general practice, for example, that would enable the patient journey to be really smooth.

If, for instance, the practice were to triage the patient, the staff there might advise the patient that they would be better off going to their community pharmacy. If the pharmacist then saw them and thought, "In this particular case, my professional opinion is that they need to see a GP," a fast and smooth method is needed to enable that to happen so that the patient would not have to wait for an extra day. That could be achieved through a single shared patient record, but it could also be achieved through other mechanisms.

The Convener: Emma Harper has a question that picks up on something that Clare Morrison said.

Emma Harper: Yes—my question is directly for Clare Morrison. There is a system called ALISS—a local information system for Scotland—which is used to signpost people to local services. Do pharmacists use it?

Clare Morrison: I am not aware of pharmacists using it, but I can check that and come back to you.

The Convener: It would be interesting to know whether any of the other witnesses are aware of ALISS and what it provides. I know that Julie Mosgrove wants to come in anyway in response to Stephanie Callaghan's question, so I will bring her in, and she can also let us know whether ALISS is on her radar.

Julie Mosgrove: Unfortunately, I am not aware of ALISS. I just wanted to agree with Clare Morrison on the need for a referral mechanism. That would avoid patients having to repeat themselves, and it would ensure that information is passed on accurately. Sometimes if a patient is given information and advised to see an optometrist, the information that they were supposed to pass on is lost in translation. A mechanism would ensure that information is consistent and accurate when it is shared between health professionals.

I also reiterate what Clare Morrison said about not delaying treatment. That would be another bonus of having a referral mechanism.

The Convener: I think that Jess Sussman wants to come back in.

Dr Sussmann: Yes—it is on ALISS. One of our social workers referred to ALISS on one occasion but, when we tried to use it, we found that some things that were listed had shut down and some things in the local community of which we were aware were not on the system. There is a question about how useful such resources are if they are not centralised, consistent and continuously updated.

The Convener: Yes—if a resource is not updated, you will never go back and use it again.

I go back to Stephanie Callaghan. We have talked about a single electronic patient record. Do you have a follow-up on that for the witnesses?

Stephanie Callaghan: Yes, I do. It is clear that all the witnesses agree that such a record would be transformational and a massive benefit. Where are we right now on patient record sharing? What progress do you see on plans to improve that? What plans are coming along in the future, and what has come in so far?

The Convener: Do you want to direct that question to anyone in particular?

Stephanie Callaghan: No. It is for whoever feels that it is most appropriate for them to answer.

The Convener: Jess Sussman has put a prompt in the chat box. She wants to come in on that.

Dr Sussmann: I can at least tell the committee a little about the Borders, from my own perspective. At present, mental health services use the same system that the GP practices use, but it is up to individual GP practices to choose whether to share their data and information with us. In other boards, the system that GPs use is different from the system that is used by mental health services. Crazily, in the Borders, the IT system that is being used for patient notes for mental health services is not the same as the one that is used for medicine and surgical services. The approach is not currently joined up, and it is very hard to share electronic records across different platforms.

Stephanie Callaghan: Is there any sign of those issues abating? Are there any plans to rectify the situation, as far as you are aware?

Dr Sussmann: Within mental health, we have a national digital leads group. Individual clinicians have been identified in each board, and some have been given time in their job plans to take part in the group, although most of them have not. They meet regularly to think about how, nationally, we can unify the digital systems. That is only within mental health care—it does not cover GP practices or medicine and surgery.

As I said earlier, we would all like a national platform that means that everybody is on the same platform and speaking the same language. We could then say yes or no to accessing different groups, depending on their relevance to an individual patient at the time.

10:30

Julie Mosgrove: In optometry, we can access the last eye examination date from other optometry practices. That is the only information that optometry practices can share. That does not tell you where the person was tested—it just gives you the date on which they were tested.

In Grampian, we are trialling an electronic record alongside secondary care ophthalmology. The idea is that, if we see a person with an emergency appointment, we can enter information on the record card that can be shared with ophthalmology and, likewise, ophthalmology can share information with us.

I reiterate what Jess Sussmann said: the biggest barrier is systems—system-to-system linking. There are many different systems, and adding in so many different referral mechanisms means that we are just repeating information, which is time consuming. We have to copy and paste information across different systems. That is a big barrier, and it is time consuming and costly. There is still a lot of work to be done, but different health boards are trialling approaches to address that.

The Convener: I will bring in Clare Morrison. We will then need to move on to our final line of questioning. I am sorry—Sandesh Gulhane also wants to come in. I am getting a bit ahead of myself. I will bring in Clare Morrison and then Sandesh Gulhane with a follow-up question. We will then move on to our final theme.

Clare Morrison: Community pharmacists have access to the emergency care summary, although there are issues with log-ins. We have different log-ins for each health board and, if you are a locum and you move around, you can end up with many different log-ins. That affects a number of professions.

In two or three NHS boards, pharmacists have access to a clinical portal, which gives them wider access. Again, there is an issue with log-ins, and the fact that that is not available across Scotland means that information is patchy. A small number of GP practices have enabled remote access to their clinical systems for their local pharmacy teams. In all cases, issues could be overcome with a single shared record.

I will pick up on an earlier point. In the past, one of the issues with achieving a single shared electronic record has been that we have really focused on trying to get systems to talk to each other. Given the many systems across all of health and care, it was really difficult to enable them to speak to each other. A system in which each of the individual clinical systems writes into a cloud-based system would mean that they would write into only one place.

Equally, such a system would mean that each profession would read within its own system. In that way, rather than getting hundreds of systems to talk to one another, you would get every system to talk to one thing—one central platform. That is almost certainly the way to make progress in that area. We have spent years failing to achieve that.

The Convener: Sandesh Gulhane has a follow-up question for Jess Sussmann.

Sandesh Gulhane: On your point about mental health systems, in Glasgow, CAMHS and the general psychiatric service have different systems. Therefore, when I was covering CAMHS, I could not see patients' records. I needed my nurses to open the records so that I could read them, and I needed my nurses to type my notes into the system because I did not have the ability to do that. Worse still, GPs cannot read what the psychiatric service has written. You will appreciate the importance of GPs and psychiatrists being able to read each other's notes. I feel that that is a dangerous situation. What can we do quickly to overcome that?

Dr Sussmann: The system that is used in Glasgow is EMIS; we use the same system in the Borders. We got it after Glasgow, so we benefit from Glasgow kindly supporting us in using some of its additional platforms. It is a nightmare system for everybody involved.

My understanding is that the reason why we do not share some of our records with GPs in the Borders is that GPs are concerned about confidentiality issues. It is a minefield. Like you, I want all those records to be available to everyone at the point that they need to access them—confidentially, as you would expect.

I do not know exactly what the answer is, other than that we need to look at the whole thing again. Health boards are buying platforms individually and then adapting them individually. That does not make any sense to me, especially in relation to mental health care, as people move around quite a lot, particularly when they are unwell. A patient of mine recently ended up in Aberdeen, where there were no records for them. Such things happen a lot. It is a national issue, and it needs a national answer.

You mentioned child psychiatry systems not working with general adult psychiatry systems and your GP systems. Our social work service uses a system that is totally different from ours, as well, so it has to write twice if it wants to give us information.

The whole system is not working. It is broken, and it is not efficient.

The Convener: We must move on to our final theme, which is inequalities. A number of the witnesses have already mentioned it, so we will drill deeper into it.

Evelyn Tweed (Stirling) (SNP): Good morning. I thank the witnesses for their answers to the previous questions, which have been helpful.

My questions are about inequalities. All the witnesses have touched on that theme already. Is there a risk that increased use of alternative pathways to primary care could exacerbate health inequalities?

Clare Morrison: Community pharmacies are in communities throughout the country. That is important for accessibility to all populations. The community pharmacy service helps to address health inequalities in many ways.

We need to address some of the information that we provide. One of our concerns is about the pharmacy first service. We do not have guarantees that we reach all populations. In particular, we have concerns about whether people with lower health literacy have information that they understand about the services that they can access in a pharmacy. Having said that, when they walk into a pharmacy, people will be told about services so we hope that, if people go to a community pharmacy because it is in their locality, that is a way of tackling health inequalities.

You also have to consider the range of services that are available. Some services that pharmacies already provide can help to tackle some inequalities. I refer particularly to services on drug use and the public health services that are available in community pharmacies.

Community pharmacies are a way of improving accessibility rather than adding to health inequalities, but we must ensure that the information is available to everyone.

Digital inequality has become increasingly important during the past few years. A lot of people embrace digital services and we know how they improve access to services, particularly for people in remote areas, people who are housebound or people who have caring responsibilities. We have examples of people who are at home with young children and find it difficult to get out to a pharmacy but can access the service remotely. We know how beneficial that is but, on the other hand, we must ensure that we do not create new inequalities for people who cannot access digital services.

The most important thing is to enable choice. We need to provide services in a number of different ways and enable individuals to access the services in the way that they want. Rather than labelling any particular service type or way of accessing it as good or not good, we should tell people about the range of opportunities that they have and ask them which is the best way of accessing those for them.

Harjit Sandhu: I fully support what Clare Morrison said, especially about giving people choice and individualised care. It is right that any system that is designed should focus on how we reduce inequalities in access and health outcomes.

We have a huge opportunity to address inequalities. GPs do not have the capacity to see the growing population. If we carry on the way that we are going, we can be almost certain that inequalities will increase and worsen. At the beginning of the evidence session, we talked about home care for people with hearing loss and allowing people access to hearing care services based on clinical need, not ability to pay. There are huge opportunities.

Julie Mosgrove: I reiterate what Clare Morrison said. I am not concerned about primary care coming into the community. Optometry practices are accessible. Every community has access to the service. There is a welcoming atmosphere, and we are normalising healthcare. In 2019, across all communities, the lowest uptake for eye exams was 26 per cent and the highest was 30 per cent. That is actually quite good uptake, considering that everyone gets an eye exam every two years. Although there is a gap between the lowest and the highest uptake, it is relatively small. The biggest thing is to ensure that there is awareness that the NHS funds eye examinations and that support can be provided towards glasses, depending on a person's circumstances.

It is about awareness. I would not be concerned about primary care coming into the community. We need to ensure that we get the messaging out that eye exams are funded and that help is there if people need it.

Dr Sussmann: Our members talked about the economic impacts of Covid on wellbeing and cited the Scottish Government's Covid mental health tracker, which showed that, post Covid, the key indicators of whether someone is experiencing depressive symptoms, thoughts of suicide or higher psychological distress were related to whether they had experienced a change in working circumstances. People who had been furloughed or lost their jobs had higher rates of symptoms in all those areas. That needs to be looked at.

I want to make some points about challenging stigma. A survey by See Me found that more than two thirds of people—71 per cent—with mental health problems are still experiencing stigma or discrimination, with work colleagues cited as one of the key groups in that regard. When we think about alternative pathways and access, we need to include those with the most severe mental illnesses in those groups, so that they are not always separated and using specialist resources that happen somewhere else in the distance. That is generally the experience that I have with my patients. We have to create additional resource and structures for them, because they cannot be catered for within the standard set of options. That concerns me a lot.

For instance, with smoking cessation services, from which our patients benefit hugely, the average smoking cessation plan would involve perhaps six sessions sitting down with a specialist to talk through the options. However, for our patients, it would take months of engagement and time spent building a trusting relationship before the actual work on reducing smoking can take place, and there would need to be an understanding that folk might miss a few appointments because of their mental health problems. Things like that need to be accounted for to reduce the stigma and to deal with the fact that people have to go to a different place to be treated.

My final point is on parity of esteem. When we talk about health inequalities, we need to bear in mind that those with severe mental ill health have among the lowest life expectancy and lowest rate of employment of any group. Alternative pathways need to be supplemented by wider socioeconomic support to enable people to build the stability in their lives that can secure a prolonged recovery. Those things need to be considered in thinking about inequalities.

The Convener: Evelyn, do you have any follow-up questions?

Evelyn Tweed: The witnesses have covered my second question.

The Convener: I thought that that might be the case. Sandesh Gulhane wants to come in on inequalities.

Sandesh Gulhane: What assessment has been made of the link between access to alternative pathways and digital exclusion?

The Convener: Who is that addressed to?

Sandesh Gulhane: It is important to hear from everyone, but I will start with Jess Sussmann.

10:45

Dr Sussmann: One of the teams that I work in is the rehabilitation team for people with chronic schizophrenia. At the beginning of Covid, we surveyed all 120 patients in the service. Although 40 to 50 per cent of them had a smart device, none of them was willing to use it to talk to us or to access other services—they wanted face-to-face contact. Probably because of the nature of their illness, they did not feel comfortable with or confident about using devices for that purpose. They wanted direct input and physical contact with us, so that they could see our body language and other aspects in engaging with us.

That is vital for people, because most communication is not verbal but is through body language, and that is especially important for that group of people. Accessing digital resources is difficult for them, and they would much prefer all their contact to be face to face.

I hope that that answers the question but, if there is a follow-up, I will happily take it.

Clare Morrison: Ipsos MORI recently surveyed 1,107 adults in Scotland and asked them to tick all the ways in which they want to access services. They did not say that they always want to access a service digitally, but they want it as an option. That goes back to what I said about options. For sure, the highest figure was that 87 per cent want to access services in person—although, interestingly, that means that 13 per cent do not want to do that in person—but 59 per cent also want telephone consultations, 42 per cent want video consultations and 38 per cent want other digital services. It is about enabling choice and ensuring that all our services are available, whenever it is clinically appropriate, in a variety of ways.

I will just draw attention to the Scottish Government's public consultation in the summer of 2020 to gather public opinion on video consulting. That was a survey of more than 5,000 people. It is probably worth reflecting on the data in that, rather than the smaller data set that I have just spoken about, which involved around 1,000 people.

Harjit Sandhu: I reiterate what Jess Sussmann and Clare Morrison said about choice. We also need to make sure that the approach is appropriate to the service. With telephone consultations, which increased during Covid, it is self-evident that they do not work for people who depend on British Sign Language. At the same time, Scotland has led on providing a BSL service, which improves inclusion and access to health services. It is about tailoring the approach for appropriate care.

In terms of audiology and innovation, because we deal with a chronic condition, lots of people with certain conditions do not want to come in—they want to get on with their lives. They welcome remote fine tuning of hearing aids and remote follow-up using wi-fi and so on, whereas some people really want that human interaction and struggle to hear on the phone or in remote meetings. It is all about choice and tailoring care to the individual.

The digital approach has to enhance services. Before we implement a model of care, as long as we test it against key thresholds of enhancing access and reducing inequalities, we can limit the impacts of digital exclusion.

The Convener: Thank you. We have really enjoyed listening to you this morning. Thank you for everything that you have told us—there is lots for us to think about. It is interesting that there are common themes running throughout all your services and disciplines.

I suspend the meeting to allow the next panel of witnesses to onboard. We will take a 10-minute break.

10:48

Meeting suspended.

11:00

On resuming—

The Convener: We continue our evidence taking as part of our inquiry into alternative pathways to primary care. I welcome our second panel of witnesses, who join us remotely: Alison Keir is the professional practice lead of the Allied Health Professions Federation Scotland; and Dr Graeme Marshall is the clinical director of Glasgow city health and social care partnership.

Good morning. I do not know how much you heard of our discussion with our first panel of witnesses, but some of the questions and issues that we put to them will also be put to you.

I will begin where I began at 9 o'clock, when I asked about public awareness and public perception of a shift away from the traditional mindset that going to their GP is the only way for people to access primary care. What are your thoughts? Where are we on that? Have we begun to see such a shift? Are there still issues with public awareness? What do we do to address those? Those are big questions to start with, which introduce a theme that will run throughout our time together.

Alison Keir (Allied Health Professions Federation Scotland): Good morning. My title is not quite right. I am here today in my capacity as chair of the Allied Health Professions Federation Scotland.

The Convener: I apologise.

Alison Keir: I am the professional practice lead of the Royal College of Occupational Therapists. My roles have been merged together.

The Convener: We have made you into a hybrid. I apologise for that. Thank you for putting us right.

Alison Keir: I am here today on behalf of the Allied Health Professions Federation Scotland, which is a group of 12 allied health professional bodies. The AHPFS provides collective leadership and representation on issues that are common to AHPs.

I listened to the previous discussion. It was interesting to hear the perceptions about access to primary care and GPs. The world is changing, but it is patchy at the moment. For example, if someone were to contact NHS 111 and ask about back pain, they would be referred back to a GP, because we do not have physiotherapy coverage in 100 per cent of the GP practices in Scotland. Where there is coverage in the practices, that would be appropriate, but callers often have to go back to their GP because there is not coverage in all areas.

We know that people who get to see a physiotherapist are really happy. Recent figures from Glasgow show that 92 per cent of people who saw a physiotherapist would recommend them to someone else and that they were happy or satisfied that they had seen a physio as the first point of contact.

One respondent told your inquiry that people may become aware of practitioners only when their family needs them. That is an issue. People do not know who else does something else if they have never experienced them before.

We can add that to the patchy picture around Scotland, whereby someone might be able to see a physiotherapist in one practice, an occupational therapist in another or a podiatrist or a speech therapist in a different practice. The picture is not consistent across Scotland and, because people do not experience the same thing across the country, it becomes hard for us to get our messaging together.

Dr Graeme Marshall (Glasgow City Health and Social Care Partnership): Although I am the clinical director for Glasgow city, I am mainly here as a jobbing GP. I have been a GP at the Gorbals health centre in Glasgow for almost 30 years. I can give an example of what happens.

Quite recently, I was asked to talk to a relative of a lady who was struggling at home. She had not fallen but was at risk of doing so, and she was struggling with her Zimmer frame at home. I said, "Great! I've got a rehabilitation team that's full of physiotherapists, occupational therapists, nurses and dieticians who can come out and see your auntie to get her back on her feet and do their best for her," but the relative said, "No, I want you to visit." When I asked why that was, she said, "It's because they're not doctors." That perception is out there—it is a wrong perception, but it is genuinely there.

I work closely with physiotherapists; that is one of my responsibilities in Glasgow city, so I know the figures that Alison Keir was talking about. I know how much the patients value physios, when they get hold of them, so I back up what Alison said. The public perception is changing, albeit slowly.

Another example is optometry. The experience that my patients get from optometrists in Glasgow city is excellent. My colleague Frank Munro, whom I work closely with, sees my patients and provides them with a massively better service than I do. He knows much more about eyes than I ever could. I did a 10-week course on eyes nearly 30 years ago and I have a small light on my wall. He has slit lamps, computers and years of expertise, so it is much better for patients to see the correct professional than it is for them to just see the GP. How do we change that? I have a few ideas, but I will let you ask the next question.

The Convener: I am happy for you to talk about your ideas, because that is what my next question is about. We were all nodding along as you said that certain people think that the GP is it; they demand to see a doctor and look on those other specialists as being a lesser option or think that they are being fobbed off. We will always have that issue with a certain demographic, particularly older people, because, throughout their lives, they have always had access to a GP. While we are on the subject, what more do you think could be done to give the public confidence that alternative pathways do not mean a lesser service?

Dr Marshall: I hear a lot of my colleagues say that we need to advertise alternative pathways more, but I do not think that that would work. I do not think that national ads on TV or radio—for example, to say that going to see the optometrist is a better option—would be overly convincing.

I think that the answer is multidisciplinary working. To put it in context, when I started nearly 30 years ago, we all sat in our silos, and practice nurses were just starting. There was not really an option outside of GPs. Even 10 years ago, we were quite siloed. I did my work, the nurse did her work, the district nurses did their work and pharmacists worked in their pharmacies. Now, lots of different professionals tend to work together. It is not just a case of having multidisciplinary team meetings; we work together. I work closely with pharmacists, community practice nurses, our rehab team, district nurses, practice nurses, advanced nurse practitioners and the Scottish Ambulance Service—we all work together.

The way forward is a gradual response to us learning and working together, in order to get patients seen by the correct person on a day-to-day basis, so that patients are introduced to the whole concept of a team, rather than just an individual running a service. Does that make sense?

The Convener: Yes. I certainly have experience of that in relation to a change to a local GP service. It was one of the most difficult public meetings that I have had but, ever since, in general, people have had a good feeling about the change, because they know that, when they see a nurse practitioner or a physio in the practice, they are getting specialist care. Therefore, the nervousness about different strands has abated somewhat.

Alison Keir, I would like to get your perspective on what we can do in order to have not only better public understanding of the options, but confidence in the options that are out there.

Alison Keir: I absolutely agree with Graeme that MDT working is key. That involves different pathways, with different members of the team being seen as appropriate. They are the right people to see; they are not an alternative to a GP, but they are the right people in the right place with the right skill set to help patients. It is a case of experiencing that and the team being confident to share that experience with service users.

It is also a question of understanding that health is not all about medical needs. The social determinants of health impact hugely on people's general health, and a wider MDT will have a knowledge of housing, of the importance and the economic benefits of working or volunteering and of how those wider things impact on people's health. Therefore, different members of the team can have an impact on the whole of the patient's life, which impacts on their health in a more general sense.

The Convener: That is a good springboard for talking in more depth about multidisciplinary teams, on which Gillian Mackay has questions.

Gillian Mackay: Good morning. Do you feel that the Government has undertaken sufficient workforce planning to ensure that multidisciplinary teams will be in place to allow delivery of the GP contract?

Alison Keir: We are on a journey with workforce planning, and I am delighted that the Scottish Government has made a specific commitment to improve AHP workforce planning. Work has now started on that. We need to find a swift and efficient way to plan our future workforce because, in future, our workforce will look different. Historically, we perhaps worked more in secondary care, but we know that our offer is increasingly in primary care, and we need to grow and develop our workforce to meet that need. That includes planning who we are, where we are and what that means in terms of education and placements.

It is really important not to look at workforce planning around team members but to understand it from the point of view of population health need. We need to ask what it is that our population in Scotland needs and who can meet that need, and to plan the workforce from that point of view, rather than saying that we need X number of physiotherapists, occupational therapists and dieticians. It is important for us, collectively, to understand what our population needs, to work out who in the MDT has the skill set to best meet those needs and to workforce plan on that basis.

Dr Marshall: The GP contract was originally set up on the premise that there were not enough GPs, and I think that that is correct—there are just not enough to go around. Therefore, we thought that we could bring in other valued professionals—pharmacists, physios, mental health workers and links workers—to take some of that work off our hands. It turns out that we do not have enough pharmacists, physios, dieticians or mental health workers either, so it is false to think that there is a workforce out there to supply to us.

Workforce planning is needed to bring those people in, but that will not happen tomorrow. We are talking about highly trained people who require years of training and lots of work experience to get to the requisite standard to meet the service requirements, so that workforce will not come along tomorrow. Although the GP contract was, in general, a good idea, it might perhaps have been useful at the time to have thought about looking at who was available to take on those roles.

Gillian Mackay: Thank you for those answers. Has the Government undertaken sufficient planning with regard to how infrastructure will need to change to accommodate an expanded multidisciplinary team? Do practices have the physical capacity, as well as the IT infrastructure, to accommodate that team? I suppose that that leans into the issue of data sharing, which we discussed with the previous panel.

The Convener: We will go back to Graeme Marshall.

Dr Marshall: The IT is okay—the IT in general practice is fine. I have a role in secondary care, too, and the IT is much better in primary care.

There is planning to recruit more medical students. I also work at the university and I know that more doctors are being taught, and my pharmacy colleagues say that more pharmacists are being trained. Alison Keir will be better able to talk about workforce planning for AHPs, but I think that there is planning to increase the numbers of all those professions. Whether they will all want to go into general practice is another matter.

One of the problems that we have in primary care is with the retention of staff. A lot of people come into the roles and think, “This is great!”, but then—for want of a better phrase—they get a better offer. They might want to work nearer home because they have family commitments or they might have other good reasons for moving away, which means that people who have been employed soon move on. There are other workforce constraints that I will not bore you with, but it is hard not just to recruit people into primary care, but to retain them.

Alison Keir: In terms of the workforce for primary care, when it comes to MDTs, we are probably looking at locality working rather than practice-based working. There are often not enough AHPs for every practice, so we will need to adopt more of a locality-based model, in which we cover several practices based on population need.

Our experience of data sharing is patchy, particularly where we work in integrated teams. If we are working across health and social care, as many AHPs do, we are often working with different systems. We might need to input information more than once or to move between desks in different offices, because different computers are linked to different systems. That is not an efficient way of working. There is definitely work to be done on integrating health and care information.

11:15

On data, we need to have a better understanding of allied health professionals. Our work on that has started. Historically, our systems have logged very little information about our AHPs in Scotland. We might know their profession and band, but we do not know where our specialties are. Doctors and nurses can pull much more information than AHPs can. We are in discussion with NHS Education for Scotland on how we can provide better data to prove who our AHPs are and where we work, so that there is evidence on where we make a difference.

The Convener: Sandesh Gulhane has some questions in that area.

Sandesh Gulhane: I ask these questions on behalf of Sue Webber. I will direct the first one to Dr Marshall, and then I will ask a wider question.

In December, the BMA was not happy about the shortage of doctors in Scotland. The new workforce strategy talks about having 800 new GPs by 2027. In 2019, Audit Scotland was not very happy with that and threw that claim into doubt. Dr Marshall, what is your assessment of the workforce strategy?

As far as the roles of AHPs are concerned, how can we do better workforce planning to ensure that we get what we need?

Dr Marshall: You are putting me on the spot. I do not take part in day-to-day workforce planning—that is above my pay grade—but, in relation to teaching, I know from lecturing at the University of Glasgow that we are training a lot more junior doctors now, as a lot more people are coming through. In fact, the lecture theatre at the University of Glasgow is now not big enough to accommodate them. We are struggling to get tutors because there are so many people training to become doctors. That is great—I am more than happy with that—but I do not know where they will go.

There is no doubt that medical students see primary care as a bit of a Cinderella service, and that might even be encouraged by their peers. General practice is a great profession to be in. I enjoy working in it and it has variety. Students who come through will be able to see that, and if people like me can encourage them to work in primary care, they will become doctors and populate our surgeries, but that will not happen tomorrow. As with our AHP colleagues, years of training will be required. It takes a good 10 or 12 years before someone becomes a GP, so those people will not come through tomorrow, but I think that they will come through. People will have thought about that, and doctors are being trained appropriately.

The Convener: We will get the perspective of allied health professionals from Alison Keir.

Alison Keir: The figure of 800 GPs is an interesting one and has been around for a few years. There has been discussion about whether that figure could be complemented by wider MDTs. It comes back to having the right person in the right place.

I will give two examples. In NHS Forth Valley, first-contact practitioners and physiotherapists who do musculoskeletal work have certainly contributed to GPs being able to offer longer appointments. GPs have been able to extend appointments from 10 minutes to 15 minutes because first-contact practitioners have been doing different things to free up their time.

In NHS Lanarkshire, occupational therapists seeing people with frailty and mild to moderate mental health problems has reduced the number of return appointments to GPs for that population by 52 per cent. Widening a GP practice's MDT gives a different focus, and it helps our GPs, because other people have different skill sets to help our population.

Emma Harper: I have a wee supplementary question on general practice. The Scottish Government has established the Scottish graduate entry medicine programme, which is a four-year training programme to support general practices in rural areas. Are you aware of, or do you have experience of, ScotGEM?

Dr Marshall: I work in Gorbals health centre in the centre of Glasgow. You could not be any less rural if you tried—we are right in the middle of the city—so I do not have any experience of working with it. I apologise for that. I have heard of it—that is the best that I can do for you.

The Convener: We have put Dr Marshall on the spot somewhat. We now have questions from Paul O'Kane.

Paul O'Kane: Good morning to the panel. I want to focus on the signposting journey. Throughout the evidence that we have taken so far, we have heard that one of the barriers to signposting is perhaps the constantly changing landscape of service providers. There are also barriers for patients in relation to communication and understanding what is available. How can we improve people's understanding of what is available and the communication that exists to let people know about it?

Alison Keir: That is a tricky problem that has been going on for ever and ever, and the question is, how do we tackle that? Graeme Marshall mentioned that he was not keen on public campaigns, but I think that there is a role for them, because we need the population to understand that there is a wider workforce who are the right people for them to see. That needs to happen alongside the work with our MDT, which increases our confidence in each other and in our ability to work differently.

As professionals, we need to be confident in how we work in a new world that lets us talk about a wider group of people who can help patients. Alongside that, we need to prepare the population for seeing a bigger group of people. There is also a challenge around systems at the moment; people will often wait for a long time for an allied health professional. If we could shift to earlier intervention, so that people are seen at an earlier point in their journey, that would improve how effectively we can help people.

We also need to think about our language around that. In children's services in Scotland, we have changed the language from "referral" to "request for assistance"; "referral" is quite a medical dependent-type term, whereas "request for assistance" is a much more enabling approach.

How do we get to that model in which there is a phone call and we direct you to the right person, rather than there being a phone call and then you end up on a waiting list, perhaps for some time, to see the right person, and then when you see them, it might not be the right person after all? How do we change our systems to have earlier, more supportive conversations with people, so that they can get the right help or seek their own solutions sooner in their journeys?

Dr Marshall: As far as accessing the right people goes, I think that my receptionists are the critical admin staff or care navigators or signposters or whatever you like to call them.

It is correct that people still contact their GP as the first port of call. Then what happens? People have to have trust in what will happen when they phone their GP. I do not like the prolonged messages that you can get when you phone some practices. I phone a lot of practices in my clinical director role and get, "If you have a chest pain, call this number; if you have an eye problem, call that number." I do not like that.

However, when you come through to the practice receptionist, they have to be trusted to keep things confidential and to be professional—as they are. We had recent training for our practice staff on signposting to get people to the right places. In smaller practices such as mine—I have only 3,500 patients—it might be easier to do, because there are not that many people to signpost to. In the larger practices, although it might be complicated, it might be more fruitful, because you can get an advanced nurse practitioner, an advanced physio practitioner or a support pharmacist—you can get somebody who is able to deal with your inquiry.

People having trust that they will be put through to the right person when they are making the first phone call to the care navigators or whatever you want to call them is the best route to go, I think.

Paul O'Kane: Is your sense that it is working effectively when someone is signposted to an AHP or whoever and they go on that journey, or do people sometimes go round the houses, for want of a better expression, and end up back at the GP?

Dr Marshall: Again, this is only a personal view, but they do not come back to me. We got a link worker recently, and she is great. Everything that goes to her stays with her and does not get punted back.

My practice support pharmacists, although they keep changing, are excellent. Again, if you have medication inquiries, that is the place to go—they know much more about medicines than I do—and when people go there, they do not come back. My sense is that they do not come back to me because they must have seen the correct professional, who took care of the issue. I am not being modest here—those professionals are honestly better than I am, so why would patients come back to me?

Paul O'Kane: That is very helpful.

The Convener: David Torrance has questions about the role of receptionists, which has been mentioned already.

David Torrance: To what extent do the public recognise the increasingly complex role of GP receptionists?

Dr Marshall: I suppose that I would have to ask the public, but I sense that people understand it more. I have a personal example: although patients can continue to phone us, they can also ask us questions via an IT platform on our website if they want to do so, from which we can navigate them to the correct place. Usually, my receptionist or care navigator does that, rather than me.

If a patient has a question about their medicines, it goes to the pharmacist; and if they have a social or monetary problem, they can also be directed appropriately, as we have a money adviser on board. Patients have a reason to be satisfied with the service and the outcome that they get. It is fine if patients want to be dissatisfied, but I have not had negative feedback. The data that we have seen so far is that patients are very satisfied with the IT fixes that we have.

The professionalism of our receptionists should be respected. They work at a high level of confidentiality and their level of training is high. An

A and E consultant had a go at me recently; he said that he is fed up of hearing about highly trained receptionists. However, they are highly trained and valued. It is a different job now. Thirty years ago, they were busybodies at a desk who wrote down the names of people and chatted. Now, I almost do not know what they do—they are always working hard and doing things on their computers. They are extremely highly trained and very professional. It is worth listening to their opinions.

David Torrance: How can the workings between patients and receptionists be improved? All four receptionists in a practice in my constituency have resigned because of a lack of support from GPs and the level of abuse from the public; the practice will have no receptionists by the end of the month. How can we support receptionists and how can we improve the patients' interactions with them?

Dr Marshall: The easy answer—at least, part of the answer—is training. Any training is good. We routinely put our staff through training. Even when I do not think that the training will be of any use, I still do it, because letting staff know that they are valued is terribly important.

How do we stop the abuse? Perhaps, those long messages at the start of the phone call make it difficult to get through to GP surgeries—I cannot deny that it is difficult to get through to them—and making them shorter would reduce frustration. I have said in public to Glasgow GPs that they should make their messages shorter so that it is easier to get through. To hear "Press 1 for this" and to then be cut off is not good and increases frustration. From our side, improvements need to be made, because contacting the practice should be relatively easy. From the other side, abuse is unacceptable—you cannot abuse folk.

The Convener: Thank you. Stephanie Callaghan has questions on the role of the receptionist.

Stephanie Callaghan: The Healthcare Improvement Scotland practice administrative staff collaborative has seemed to improve triage and referral to the appropriate professionals. Could that be rolled out more widely?

Dr Marshall: It would be valued. We took a private pathway for that. The standard of training that I would have liked was not there, so we employed a private company to train our care navigators to do what they do.

As I said earlier, any training is good, but having high-quality training would be ideal. I have seen that approach work, and I think that doing something like that would be excellent.

11:30

Alison Keir: I would like to come back in on the idea of the receptionist being the first point of contact. We are in a time of change and we expect the population to know about all these changes, and the receptionist is the first person they speak to. The idea goes back to the concept of getting messaging across to the public about what they can expect. We need to support our GP receptionists in a different way so that they can make the public aware that it is good to see different people and that what is important is that they see the right person. That would ensure that the GP was not on the receiving end of complaints from unhappy people who expect to always see a GP.

It is not so much about training; it is about the messaging. The current situation is unacceptable for our GP receptionists. They are the first point of frustration for a population that is not fully aware of the ways in which the world is changing. We need to help people to understand that a bit more.

Stephanie Callaghan: Patients often see the GP receptionist as being a kind of gatekeeper who can, on occasion, be determined to keep them out. How can we improve the perception of GP receptionists and support staff in the practices? Is Health Improvement Scotland's practice administrative staff collaborative a route towards that, or is there something else that could change?

Alison Keir: I am not hugely familiar with the staff collaborative, so I cannot comment on that in particular, but I think that there is an MDT role in supporting our receptionists. They are a key member of the MDT, and we have to think about how the members of the wider team, who are doing different things from what they did five or 10 years ago, can work with the receptionist to help them to understand what those new roles look like, so that the receptionist can have confidence in their ability to make different offers to people who phone up.

Paul O'Kane: Last week, we heard some evidence about the requirement for protected learning time for everyone who is involved in a practice, which includes reception staff. Other people have talked about how we can protect that time properly. Dr Marshall, I do not know whether you have had experience of, for example, being part of NHS 24 or of covering phone lines in your practice, but I believe that that there might be ways of ensuring that people feel that they are getting a service from their practice while putting in place protected learning time for everyone who works in the practice. Can you say something about that?

Dr Marshall: In Glasgow, we used to have a protected learning event—it was called SMILE, but

I cannot remember what that stood for. It was not NHS 24 that covered our phone calls; that was done by the GP out-of-hours service. All staff, including receptionists, went along to an event at Hampden where we were trained on different things. Our receptionist went to one meeting and I went to another. Those events were enjoyable and valuable, but they became impossible to arrange in practical terms, because there were not enough doctors or staff to cover attendees, so we ended up not being able to hold them. We did not want to stop holding them, but the service was not able to provide cover.

Going forward, multidisciplinary training should be seen as being as good as other things. Currently, if there was a cardiology event, I would go to that and, if there was an event about how to take phone calls better, our receptionist would go to that. However, I think that we should be trained together. There is no harm in all the professions learning each other's roles. That would enable people to see what strengths other people have but also what inefficiencies are present in their roles. It would be useful to have discussions following those sessions to allow us to see what we can and cannot do.

I reckon that as much as 80 per cent of patient contact could be dealt with by anyone in the professional team, as long as there are pharmacists and physiotherapists in the team. If we train together, we can learn together, so I would value the return of multidisciplinary training rather than just protected training. We should do it all in a oner, and I think that patients would benefit from us all knowing what everyone else in the team does.

Sandesh Gulhane: Dr Marshall, I want to pick up on David Torrance's question about the abuse that reception staff take. I, too, am a jobbing GP; receptionists allow us to do our job, and without them we simply could not function. I remember coming through to reception and seeing one of my receptionists in floods of tears over something that had been said to her. Every time I am at work, I hear about things that have been said that have made our reception staff feel hurt and upset. Demand and frustration are leading to that. Abuse is completely unacceptable, as you rightly said. What more can be done to make that clear and protect our reception staff?

Dr Marshall: Current practice is that, if someone says something unacceptable to a receptionist, they are sent a letter that says, "You cannot do that, and if you do it again, you will be removed from the practice list." It really is not that common for it to happen again, but if it does, the person comes off the list. However, I do not think that people learn from that; they just move on to the next practice. It is not a massive deterrent.

What would I do? There are people who have become recurrently abusive and have been removed to our challenging behaviour rehabilitation service, whereby they can see only a certain GP in certain circumstances, but that is pretty rare.

Most of my patients are nice, respectful and decent. The problem is that when people see a bad apple behaving badly they think, "Oh, they're all like that," when mostly people are not like that. Most of my patients are absolutely fine. Bad behaviour happens—I do not like it and the receptionists certainly do not like it, and doctors should back up their receptionists—but the majority of my patients are fine.

Patients certainly should not be allowed to behave badly and should be sanctioned in some way. Removal from the list and referral to the CBRS seems to be the only things that happen just now. I cannot think of another pathway.

Emma Harper: The receptionist is primarily the person who takes the phone calls and triages cases. I have heard that some GPs in my area answer the phones and triage calls, identifying themselves as Dr X or whoever, and that their experience has been different and not as traumatic. Could we measure that approach? I am not suggesting that we require GPs to triage, but is it worth considering different experiences? Is there a perception that a receptionist who answers the phone does not have a clue about how to triage, when in fact they are pretty much specialists at that? Should we look at how attitudes differ, depending who answers the phone?

Dr Marshall: I do not know how you would do that other than through a paper audit.

I talked about electronic ways of making contact. Those do not suit everyone—they do not suit deprived patients, for example—but if someone contacts the practice in that way, they will be contacted by someone who is not the receptionist. If they want to talk to me about their health problem, I will contact them, either remotely, via telephone or video call, or face to face, if that is appropriate. That is a way of getting directly to a doctor. I do not know how you would measure it, but electronic communication seems to be a way forward and I back up the use of that pathway.

The Convener: Evelyn Tweed has a question on link workers. Oh—sorry. I have just noticed that Alison Keir wants to respond to Emma Harper or perhaps Sandesh Gulhane. I will come to you first, Alison.

Alison Keir: Thank you. Graeme Marshall talked about people training together. I cannot emphasise too much the importance of that. Training must include our receptionists, so that we are all part of a primary care MDT in which we support people differently but give equal value to all members of the team. Shared training is key to how we support all our staff and consider their wellbeing in our newly created primary care teams.

The Convener: Apologies for nearly missing you—that is the juggling act of the hybrid meeting for you.

Evelyn Tweed: Dr Marshall, in your comments on link workers, you spoke very positively about yours. When you were speaking, I had a wee look online at the numbers between different health boards, and I see that provision is quite patchy. Do you view the link worker as having a key role in your practice for making things work?

Dr Marshall: Yes, I do, now that I have experienced it—just like patients experiencing the best service, I experienced it, too.

You know how the GP contract works: the money is separated—it is ring-fenced money. Originally, it was ring fenced for deprived practices, as the people there might be less socially adept—they could find it harder to access services and they might be less au fait with doing that. However, I really think that such provision might work across the board. I experienced how much time link workers have and how much expertise they have. I was surprised at how good they were on mental health, housing and benefits. I am very confident in referring as many people as I can, and I see link workers almost as a sensible, central adult who people can link with so that they can be directed to the correct type of service. From my experience of them, I think that they are really valuable.

I have not seen the numbers for how much link workers detract from the GP workforce. They might take some of my work away; the ones who know the system appropriately take some of my work away. If someone was to phone up and talk about having trouble with an employer or say that they could not access something, I would not know how to do it, but the link worker does. She provides an excellent service for my patients.

The Convener: Alison Keir wishes to come in on link workers.

Alison Keir: Absolutely. Ours is a very valuable member of our new-shaped teams. It is important to consider how link workers can link with allied health professionals in teams. An occupational therapist might be working on a specific treatment plan to help somebody to use public transport again. How can the AHP and the link worker work jointly on those objectives for people? A physiotherapist might set an exercise programme for somebody, but the person needs to get to their local health centre. There is a really nice link there between the AHP and the link worker. Together, we can get the best outcomes for people with their everyday lives and tasks.

The Convener: Stephanie Callaghan wants to pick up on something from our questioning to the previous panel around patient data and records.

Stephanie Callaghan: We touched on the single electronic patient record during Gillian Mackay's questions, and I have a further question on that. Going back to what Clare Morrison of the previous panel said—all the other witnesses agreed with her—having a single electronic patient record would be transformational, with all the different health professionals being able to access things at the same time, together with social care, social work and so on. Clare also suggested having a single cloud system that all the other different systems can talk to, so that the information is available to everyone.

My first question is whether you guys agree that it would be transformational to have a single electronic patient record. Secondly, does it sound realistic to have an integrated cloud-based system that all the other different systems could talk to? That would be really helpful. I suppose that that pulls in the previous question about link workers, with everyone having access to all the information.

Alison Keir: The single patient record is a great idea. It is empowering and it lets the individual be at the heart of the things that are important to them. My knowledge about single cloud systems is not good enough to allow me to comment on that, but a system that brings things together into one place—a safe place from which information can be retrieved—can only be better for the individual. Some people will have more trouble managing their own records than others. Some people find it easy and some people find it hard. We need a safe back-up, and the cloud is perhaps our new solution for doing that. If we are thinking about empowerment, self-management and helping people to think about their own health, a single patient record is certainly a part of that journey.

Dr Marshall: You would be mad not to think that it is a good idea. There is quite a lot of transfer of information, however. I can go on a clinical portal and see what has happened in secondary care, for example.

When we talk to patients who are being referred to Money Matters or to links workers, or any of those people, we tell them that we are going to share certain information and ask them whether that is okay. Sometimes that is written down, and sometimes it is verbal. There is good sharing of information within primary care, but would I like to see what is happening in the CareFirst IT system or in social care? Yes, I absolutely would.

11:45

We used to have multidisciplinary team meetings, and I would have loved to have had access to CareFirst and social care information, but that was not available. It would be great to have it available, because it would give you all that you need to know on what is happening with someone in social care. If someone has child protection issues, you need to know what is happening in order to make appropriate decisions.

It is like playing a football team. We are playing on one pitch and we say, "Oh well, I'm used to going to Tannadice, but social care are playing at Dens Park—it's across the road, so I can't access it." Some access to the whole system would be fantastic.

Stephanie Callaghan: That is great. I think that we all know the joys of having to copy and paste stuff, and we would rather avoid it.

Emma Harper: I am interested in social prescribing, which is also known as community prescribing. In the previous session of Parliament, both David Torrance and I were members of the Health and Sport Committee, which did an inquiry into social prescribing and talked about it as an investment rather than a cost. I am interested to hear whether you think that there is scope for wider use of social prescribing?

Alison Keir: Absolutely—I am interested in social prescribing and offering different solutions to people to help them to achieve good health and wellbeing, whether that involves community walking groups, leisure centres or cooking classes. Those are all things that we need to do in our everyday life, but they also keep us well. We need to think about health in a much broader sense rather than taking a traditional view on simply prescribing medicines. It is about enabling people to access a wider selection of things that they need and want to do, to let us all live the best life that we possibly can. Social prescribing is important, highly appropriate and good for people.

Dr Marshall: My experience of social prescribing comes via our Healthcare Improvement Scotland colleagues who introduced that element to our primary care improvement plan in Glasgow. It was only a pilot, but it was excellent and was welcomed. Indeed, GPs in the north-east took it on board and ran with some of it, and it is producing good outcomes for patient satisfaction.

Again, however, there is a question around whether it reduces workload. It has definitely improved people's care and satisfaction levels where it has been available. Of course, links workers are going to be pivotal if we are making those referrals or prescribing such solutions, because they know the services. In the Gorbals, it has been huge, with registered third sector providers available, but I just do not know about it. My son went to a music session down in the Gorbals—I had never even heard of the place; I have never been there since I moved away 30 years ago. Having people out there with the knowledge to prescribe is important, because I can ask someone else to do that—[*Inaudible*.].

Emma Harper: Are the link workers who are signposting people using the ALISS system, which is the national Government-funded local information system for Scotland? I am aware that there might be issues around keeping that system up to date. That is my first question—are the link workers either directing people through ALISS or using it themselves?

Secondly, Dumfries and Galloway basically dingied ALISS and set up its own DG Locator service, which is updated at regional rather than national level. Do you have any thoughts about how we should direct people? Is it the link worker's job to link into the ALISS system or other systems?

Dr Marshall: The issue with ALISS is that it is such a massive piece of work; it needs TripAdvisor so that people know what the good and bad parts of it are. That is done through local knowledge.

I know from frequent meetings that we are very well co-ordinated with our links workers through Kathy Owens—they already talk to one another and find out what is best in the area. If there is more than one links worker in a postcode area, they find out what the most appropriate service is and what works best and is most effective. That is done locally rather than through ALISS, which I understand is a massive piece of work and a massive resource.

Local knowledge of what is best is needed. I agree that something like what has happened in Dumfries and Galloway is needed, but, even on a postcode-to-postcode basis, we are going to do our best.

Alison Keir: Use of ALISS is patchy—some people use it, some do not, and sometimes it is up to date and sometimes it is not. It is about how we empower people. It might not be that we use people to access services on someone else's behalf. How do we help people to have the skills to access services in their own right? Goal setting through an intervention from an allied health professional might help someone to regain skills that they have lost.

There are two levels: someone can access services for a person, but there is also a need for us to work with people to help them to do that themselves. That is a role of AHPs who work on an assets-based approach, helping people to work on things that are easy for them in order to regain their productivity and be active participants in their lives again.

Emma Harper: We know that social prescribing—singing in a choir for pulmonary rehabilitation, walking football and so on—works and makes people feel good. However, are we measuring the benefits accurately enough? Is there a risk that social prescribing will be seen as a replacement for what is perceived as more appropriate care?

The Convener: The committee had an interesting response to its survey on that. Someone said that they would be offended if they were given a social prescription. That is always in the back of our minds.

Alison Keir: It is important to have an outcome-focused approach to everything that we do. What matters to the individual must be the starting point of any intervention. For some people, the most important thing will be singing in the choir; for others it might be reading their child a bedtime story; and for others it might be going to work. It is about understanding what drives the person and then working out how we meet that need. In part, that might be done through social prescribing to help someone to engage in an interest, but it is about the wider team working on the basis of what matters to that person. Therefore, that comes through everything and every discussion that we have. It is seen not as an alternative but as true listening, because we are there to help people to achieve the things that are important to them. It is about the right person in the right place at the right time. It is important to take that approach.

Dr Marshall: I agree with what Alison Keir said, but with the proviso that experience makes a difference. As I said, my experience of coming across services and realising how good they are will apply equally to patients when they come across such services and realise, for example, that pulmonary rehabilitation is great. I used to co-chair the respiratory managed clinical network for NHS Greater Glasgow and Clyde. Before then, I did not know about pulmonary rehabilitation, but I found out how good it is and about the outcomes and how much difference it makes. It is one of the only things that keeps people with chronic obstructive pulmonary disease alive and living longer. It is so important to realise and understand that. Although, as Alison said, the approach must be patient centred, if people come to understand how good these services are, they might come to accept these approaches more.

Evelyn Tweed: We have heard a great deal about the public not knowing much about self-referral—how to do it and so on. How do we do it better? How do we get the message out?

Alison Keir: That is a challenge when our systems somehow still stop us encouraging people to self-refer. I will go back to what I talked about at the beginning of the meeting. NHS 111 encourages people to go to their GP because services are not the same in every GP practice. Sometimes, the default position is to encourage people to go back to their GP because the GP will know what is available locally, which is disabling for people. Until we have less patchy provision, that is the challenge. It is really difficult for people to navigate through a complicated system that, often, health professionals do not fully understand. If you are at the point of need, it can be really hard to work your way through that system.

We therefore need clear messaging and MDTs to be developed to ensure that we are confident of not only our own offer but our offer to each other in the team, which brings us back to our receptionists. As a result of that, the conversations start to change.

We are at the beginning of a journey that should be much more about self-referral, but it is not as easy as, say, encouraging people to phone up and ask for something, because they do not quite know what to ask for. If someone asks for something in Glasgow, they might get it, but that might not be the case for someone else in, say, Dumfries.

Moreover, our teams are still developing into a shape that is new compared with what it used to be, and that must continue to ensure that we are all confident about what we are offering and how we can help people. It is much better for service users that we have this vision for the future with extended MDTs, but we are at the beginning of the journey. Some people are further on than others, but it is hard to give a consistent message when the picture at the other end is not consistent itself.

Dr Marshall: In Glasgow, there is self-referral for some things such as physiotherapy and certain mental health services, the theory being that, if patients go through the process of accessing such things themselves, they will be much more likely to attend. I do not know whether that is the case, but that is certainly the theory.

Alison Keir is right: the situation is patchy. Some practices do things that others do not; indeed, even within health boards, it is not a universal thing. Some services like knowing the patient’s background, but with self-referrals, you do not know a patient’s history—their drug history and so on—in the way that you would through a formal referral from, for example, the Scottish care information gateway, which allows you to know a lot more about a patient and their background. Self-referral is good and might well encourage attendance, but it has its deficiencies, too.

Evelyn Tweed: Self-referral might not be the best pathway for some people and might lead them down the wrong avenue, so how can we ensure that they access the most appropriate health practitioner for their needs?

Dr Marshall: I go back to my point about navigating through either a trained receptionist or some electronic means that allows people to see what they are getting. I am not trying to plug or sell such a system, but I have to say that, when I get a message from a patient, I do not get it over the phone or get someone else's interpretation of it; instead, I get a written paragraph or two about exactly what it is that they want or need. That gives them time and ensures that they do not get nervous about speaking to me; they get the opportunity to write down exactly what they want, and I can ascertain from that what they want and get a much better idea of what they need. I can then put them on to the appropriate service, whether it be provided by me or someone else, to solve their health or social care issue. In some ways, that is probably a much better avenue for people to tell us what they actually need and want and for us to direct them better.

The Convener: Alison, do you have anything to add?

Alison Keir: The issue is how we have these conversations about requests for assistance and give people the opportunity to explain their needs. I know that, in Lothian, they have the Three Conversations approach, in which, first of all, they try to unpick what people are asking for and then help to direct them on the right journey instead of putting them on a waiting list. We have an early conversation to help people to get to the right people quickly.

The Convener: I want to ask a quite specific follow-up to Evelyn Tweed's line of questioning. Something that happens to pretty much every woman is menopause, and it seems to me that that aspect of women's healthcare could be ideal for self-referral. It can be quite obvious to someone what is happening to them, because they fit the age profile and have the symptoms.

However, at the moment, the pathway goes through a GP and it can take quite a long time before the person can get any treatment, even though people know that they are perimenopausal pretty much when it happens to them. In the same way that people can self-refer to family planning clinics and so on, could the women's health plan and some of the things that are happening around menopause present an opportunity for a real step-change in self-referral for menopause care?

I am not quite sure who should respond to that question. Perhaps we can hear from Dr Marshall, first of all.

Dr Marshall: That sounds fair. Menopause is not quite as simple as you might think; there are lots of statistics on the difficulties involved. When I talk to a person about hormone replacement therapy, I mention the risks of breast cancer, as well as benefits in relation osteoporosis and cardiovascular benefits.

12:00

It is not a simple conversation. It is not simply a case of saying, "Oh—the menopause. You'll need HRT, then." It is necessary to weigh up the pros and cons and to give the patient an understanding of what they will be dealing with. At the end of that conversation, I often say, "I want you to take on board what I've said. Here's the written information—phone me back," because I do not want to have just one conversation about something that is very important to someone's life. There can be various pros and cons, depending on the patient's family history. It is not as simple as just providing the ability to self-refer quickly. Maybe it is because I am an older man, but I find that it is a complicated conversation to have.

The Convener: Where I am coming from is that, anecdotally, I have heard from a lot of women that, because menopause is complex, they feel that they need specialist care, so they opt to pay to go to a private menopause clinic. That brings us back to health inequalities, because that is not available to everyone.

Dr Marshall: NHS Greater Glasgow and Clyde has the excellent Sandyford sexual health service, which is run by Becky Metcalfe. It is a very good service, but it is under a lot of pressure because of the numbers it is having to deal with and because of sickness rates. From what Dr Metcalfe tells me, we are almost lucky to have it at all. It would be difficult to put more pressure on that service. As HRT can be done in primary care by suitable practitioners, I would be loth to ditch it elsewhere, unless a new service could be funded and introduced, which would be fine. It might be hard to use our existing services.

The Convener: Alison, do you have anything to add?

Alison Keir: We are including allied health professionals in the women's health plan work. A lot of women fall out of employment at that time, because things are really hard for them. If there was intervention from a different group of professionals, that might not happen. We need to think about the scope of help that could be provided by a wider group of professionals.

The Convener: Our final theme of questioning will be led by Sandesh Gulhane.

Sandesh Gulhane: I want to touch on inequalities. The issue is very pertinent to Dr Marshall, as someone who works in Govan. I will ask a question that I also put to the first panel. What worries do you have about the link between alternative pathways and digital exclusion?

Dr Marshall: I work in the Gorbals. I am under pressure now, knowing that you, too, are a doctor.

I am very lucky to have, as a junior partner in the practice, John O'Dowd, who used to be a public health consultant. He has a special interest in inequalities, so he talks to me about that. There is exclusion. These days, although not everyone has a phone, most folk do, so they have some IT access. It is true, however, that people who are health savvy get the service first. Dr Helen Irvine, who is a public health doctor, used to say that most of the extra money that is put into health is picked up by the people who are highest in the Scottish index of multiple deprivation—the least-deprived people access it, but the unmoneyed unwell need to be accessed. I am not entirely sure how we will do that.

Most of my time as a GP is taken up with the worried well or the frail elderly, who definitely need care. The unworried unwell—the undiagnosed diabetics and the people with hypertension who smoke and drink in the pub all day—are not accessing me, but we need to access them in some way. We could use IT. It is important and appropriate that we have some kind of campaign to get those people in to see us.

Alison Keir: Having a bigger MDT in a practice is a huge asset in tackling health inequalities. The social determinants of health and the wider issues that cause ill health are to do with work and employment and economic factors. The allied health professionals are skilled in helping people with housing, helping them to consider how they can get back into work or stay in work, and helping them to think about how they fill their time, which are all things that keep us well.

In relation to health inequalities, having a wider group in the primary care team is really important, but that is a challenge for digital inequalities. I agree with Dr Marshall: lots of people access the internet by phone, so we need to remember that. There is a cost to digital access and there is the issue of infrastructure. In Glasgow city that is fine, but you do not have to go far outside Glasgow before there is no broadband. There are pockets in which there are no access, so we cannot move entirely to digital solutions, because not everybody can access them and some people need to see a person.

We need to consider a wider range of options to support people and not be channelled more and more towards just a digital offer, because one size does not fit everybody. How can we do things differently in our localities? How can we use local libraries and other infrastructure to offer people different types of non-digital access that might not be through GPs? There are different ways to get to the people who are harder to reach. How do we get to where people can find us, so that we become more accessible and more part of the population? We want people to see that healthcare professionals are not just there in bad times, but are there as part of the community to help people to keep well.

Sandesh Gulhane: I will pick up on that. I recently visited a citizens advice bureau in Glasgow and was told that it is embedding its services in GP practices. It has found that its engagement and the work that it does are better when a healthcare professional tells a patient that they have to see the citizens advice bureau than it is when citizens turn up to its office to ask for help. If we were to extend putting CABs in GP practices, especially ones such as Dr Marshall's, would that free up time not just for GPs but for allied health professionals, because the social aspect would be being provided by a specialist service?

Alison Keir: Absolutely; it is about who is in the team to support people and where the best place is to support them. I also have experience in carers support services in GP practices. Some people might not go to a carers centre, so if there is a pop-up stand in the GP practice, that is an opportunity to pick up people at the right time.

Where do people find it most comfortable to access services? They might not access them where the services are, so how do we take services to people in an easy-to-access way, which would be better for everybody?

Dr Marshall: We have recent experience of the Money Matters service being embedded in general practices. Previously, we had Gemap Scotland services in north-east practices, which worked extremely well. I cannot cite the numbers, but I have seen that the amounts of money that they gained for patients from our health improvement colleagues were enormous. Like it or not, money helps people's health.

Such services provide huge benefit to patients and they are trusted. A person sitting in a GP surgery is much more trusted than when the patient has to go 200 yards down the road to—[*Inaudible*.] We used to have in the Gorbals a separate place that all five practices accessed. That did not work as well as services being in the health centre and there being someone in a room down the corridor whom patients can directly access.

Someone asked earlier whether there is room for all those people—there is not, but if we had room for them to sit in my surgery and see patients, we would have them there, because as soon as someone mentions social security I think, “Right, I have someone here who can help.” Having never accessed social security, I do not know about it, so it is great to have someone in my practice who is trusted and can get access to the patient’s medical records.

The Convener: A couple of members have follow-up questions.

Emma Harper: I have a quick supplementary question about digital exclusion and pop-up health checks. I am aware that the local NFU Scotland branch in Dumfries and Galloway went to an auction mart and did blood pressure, vital signs and blood glucose checks. Should we consider pursuing pop-up health checks at auction marts or in empty shops in town centres?

Alison Keir: Healthcare has to be made accessible to people. I know that there have been pop-up shops for occupational therapy in Ayrshire; if somebody wanted advice about a grab rail or a ramp they could go and ask and not be put on a waiting list. Preventative care needs us to be there when people need us, rather than people being put on lists to see us. If we can get to them sooner, we can pick up problems. If we are not around and people do not have access to us, problems can become bigger than they should. Such provision is a good idea.

Dr Marshall: I am not an academic, but from what I have seen—which is, obviously, related to screening—there is no evidence behind that approach. Screening has to be evidenced and proved to work. We had a system in the poorer areas in Glasgow through which we offered access to screening, but the people who needed it did not access it. They stayed at home and the people who were health savvy accessed it. I would say that when something like that is offered, it does not work, but I bow to my public health colleagues who know much more about that than I do.

The Convener: The final questions are from Carol Mochan.

Carol Mochan (South Scotland) (Lab): Dr Marshall made an excellent point when he talked about how people’s access to money is linked to health.

My question is on allied health professionals. The evidence that we have heard today and on other days makes it clear that they can help in terms of inequalities in health. Do we have enough information about which AHPs are in primary care settings and whether there is a weighting towards areas that might need more of that support? Is more work needed on that?

Alison Keir: There is absolutely a need for more work to be done on that matter. The question is how we link that support to our population health needs. This relates to my point about it not being about asking for a specific number of physios, occupational therapists and dieticians, but about understanding population need and working out who has the skills to meet that need. More work is definitely needed to ensure that support fits with whether there is greater or lesser need. We are not quite there yet, but that is, absolutely, something that we want to develop. It is better for our population if we understand them better and are therefore better able to meet their needs.

The Convener: Do you want to follow up on that, Carol?

Carol Mochan: Yes—I will do so very quickly as I know that we are tight for time.

Is there somewhere to which you could direct the committee where we could ask for that work to be done? Would it be NES? Where could we get that work progressed?

Alison Keir: NES would be really helpful in progressing work around social deprivation and our population figures. It would be a good point of contact.

Carol Mochan: That is lovely. Thanks very much.

The Convener: That brings us to the end of questions for our second panel. I thank Dr Graeme Marshall and Alison Keir for their time and for all the information that they have given us. It has been very helpful.

At our next meeting, on 22 March, the committee will continue to take evidence in our inquiry into alternative pathways to primary care.

12:13

Meeting continued in private until 12:36.

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