HEALTH AND SPORT COMMITTEE

AGENDA

5th Meeting, 2016 (Session 5)

Tuesday 20 September 2016

The Committee will meet at 10.00 am in the James Clerk Maxwell Room (CR4).

1. **Subordinate legislation:** The Committee will consider the following negative instrument—

   Health and Care Professions Council (Miscellaneous Amendments) Rules Order of Council 2016 (SSI 2016/693)

2. **GPs and GP hubs:** The Committee will take evidence from—

   Dr Sian Tucker, Clinical Director, Lothian Unscheduled Care Service, Representative Royal College of General Practitioners;

   Aileen Bryson, Head of Policy Scotland, Royal Pharmaceutical Society;

   Gabrielle Stewart, Policy Officer for Scotland College of Occupational Therapists, Representative of Allied Health Professions Federation;

   Theresa Fyffe, Director, Royal College of Nursing;

   and then from—

   Dr Elaine McNaughton, GP and Deputy Chair (Policy), Royal College of General Practitioners Scotland;

   Elaine Thomson, Locality Team Leader (Pharmacy) Dundee Health and Social Care Partnership, Representative Royal Pharmaceutical Society;

   Christopher Rice, Senior Charge Nurse, NHS Shetland;

   Linda Harper, Associate Nurse Director, NHS Grampian.

3. **GPs and GP hubs** The Committee will consider the main themes arising from
the oral evidence heard earlier in the meeting.

David Cullum
Clerk to the Health and Sport Committee
Room T3.60
The Scottish Parliament
Edinburgh
Tel: 0131 348 5210
Email: david.cullum@parliament.scot
The papers for this meeting are as follows—

**Agenda item 1**

Note by the clerk  
HS/S5/16/5/1

**Agenda 2**

Royal Pharmaceutical Society - written evidence  
HS/S5/16/5/2

Allied Health Professions Federation Scotland - written evidence  
HS/S5/16/5/3

PRIVATE PAPER  
HS/S5/16/5/4 (P)
Overview of instrument

1. There is one instrument for consideration at today's meeting:
   
   - The Health and Care Professions Council (Miscellaneous Amendments) Rules Order of Council 2016 (SI 2016/693)

Background

2. The rules scheduled to and approved by this Instrument, amend the following four Health and Care Professions Council ("HCPC") Rules: the Health and Care Professions Council (Registration and Fees) Rules 2003 (scheduled to SI 2003/1572); the Health Professions Council (Investigating Committee) (Procedure) Rules 2003 (scheduled to SI 2003/1574); the Health Professions Council (Conduct and Competence Committee) (Procedure) Rules 2003 (scheduled to SI 2003/1575); and the Health Professions Council (Health Committee) (Procedure) Rules 2003 (scheduled to SI 2003/1576).

   The Policy note from the instrument is attached at Annexe A

3. An electronic copy of the instrument is available at:
   

4. There has been no motion to annul this instrument.

5. The Committee needs to report by 24 October.

Delegated Powers and Law Reform Committee consideration

8. The Delegated Powers and Law Reform Committee considered this instrument at its meeting on 6 September and determined that it did not need to draw the attention of the Parliament to the instrument on any grounds within its remit.
POLICY NOTE

THE HEALTH AND CARE PROFESSIONS COUNCIL (MISCELLANEOUS AMENDMENTS) RULES ORDER OF COUNCIL 2016

2016 No. 693

The above Instrument was made in exercise of the powers conferred by articles 5(2)(b), 7(1) and (2), 9(2), 26(3), 32(4), and 41(2) of the Health and Social Work Professions Order 2001 (“the 2001 Order”). The Instrument is subject to negative procedure.

Background

1. The rules scheduled to and approved by this Instrument, amend the following four Health and Care Professions Council (“HCPC”) Rules: the Health and Care Professions Council (Registration and Fees) Rules 2003 (scheduled to SI 2003/1572); the Health Professions Council (Investigating Committee) (Procedure) Rules 2003 (scheduled to SI 2003/1574); the Health Professions Council (Conduct and Competence Committee) (Procedure) Rules 2003 (scheduled to SI 2003/1575); and the Health Professions Council (Health Committee) (Procedure) Rules 2003 (scheduled to SI 2003/1576).

Policy Objective

2. The policy behind this Instrument is to make amendments to the Rules to:

   • Improve the range of online services for applicants and registrants.
   • Remove the character reference requirement for applicants while retaining the self-declaration.
   • Allow panel Chairs to give directions about the case management of fitness to practise cases without the need for a preliminary hearing.
   • Update the Practice Committee Rules so they refer to the ‘Health and Care Professionals Council’ rather than the ‘Health Professionals Council’, which reflects their change of name in August 2012.

3. Further details of the proposed changes are set out in the attached Department of Health Explanatory Memorandum, in paragraph 7, headed “policy background”.

2
Consultation

4. The HCPC consulted on the proposed amendments to the Registration Fees Rules and Practice Committee Rules between 5th October 2015 and 15th January 2016. A range of stakeholders were informed about the consultation, including professional bodies and employers and information regarding the consultation was published on the HCPC website, social media and in the HCPC newsletter.

5. The HCPC received 103 responses to the consultation, of which, 90 responses were made by individuals and 13 were made on behalf of organisations (6 were professional bodies and 3 were employers). The vast majority of respondents agreed with the proposal regarding electronic communication, the majority of respondents agreed that the HCPC should remove the requirement for a character reference and replace it with a self-declaration, and the majority of respondents agreed with the proposal on the amendments to the Practice Committee rules (further information contained in paragraphs 9.1 – 9.6 of the DH Explanatory Memorandum).

Guidance

6. No guidance will be issued by the HCPC.

Impact Assessment and Financial Implications

7. The impact on business, charities or voluntary bodies is minimal. The amendments may have a slight impact on registrants with businesses, however the change has no burden on costs and the amendments are viewed as a benefit. There is no impact on the public sector.

8. An Impact Assessment has not been prepared for this Instrument because the potential impact on business foreseen falls below the threshold for producing one.

Monitoring and Review

9. The HCPC regularly reviews its Rules; there is no requirement for a formal review of the amendments.

Scottish Government Health and Social Care Directorates

17 June 2016
Pharmacists working in Community Hubs

The RPS believes health and wellbeing will be improved by ensuring workforce plans recognise and use the skills and experience of pharmacists to support patients who take medicines as part of a comprehensive health and social care team approach within people's own localities.

Current situation

The NHS treats more people than ever before. Scotland, like many other countries, has seen treatment regimens become more sophisticated as people are living longer, many with complex conditions that may require more pharmaceutical care to support safe and effective self-management. Complex care, involving many medicines being taken, sometimes causes unintended harm, especially in our frail elderly population.¹

In Scotland, every year we have 61,000 unplanned hospital admissions² and in the over 65s around 17% of these are medicines related, many of which could have been prevented.² We know that approximately 50% of medicines are not taken as intended by the prescriber³. This contributes to waste but more importantly means that patients do not receive full benefit from their medicines. The effects of non-adherence to prescribed medicines is not to be underestimated and has been quoted as being responsible for 47% of asthma deaths, an 80% increased risk of death in diabetes and a 3.8-fold increased risk of death following a heart attack⁴.

¹ Polypharmacy and medicines optimisation. Making it safe and sound. The King’s Fund 2013.
² Health Improvement Scotland, Safer Use of medicines, August 2015.
The 2010 York report\(^5\) stated that adherence could be improved with better understanding around the use of medicines and this concept is one of the principles embedded in pharmaceutical care.

Medicines are one of the most important interventions in modern day healthcare. They can help avoid premature death, cure illness and significantly improve the patient’s quality of life. However, medicines can carry risks as well as benefits, and patient safety is a core focus for pharmacists wherever they are practising.

In Scotland 102.61 Million prescription items were dispensed in the community in 2015/16 at a cost of £1.10 Billion\(^6\) with 1 in 5 Scots taking 5 or more medicines. This figure rises to almost 60% in the over 75 age group\(^2\).

Table 1 below shows how the number of medicines taken increases with age.

![Graph showing the number of drug classes dispensed in the last 84 days in 2010](image)

Given the role medicines continue to play in today’s NHS and the shared desire to avoid harm and conserve resources, it is now even more important that we look at how we use our available resource and optimise skill mix. Scottish Government has acknowledged since 2002\(^7\) that the pharmacy profession is an underutilised resource. The PINCER\(^8\) study in 2010 found that pharmacists play a critical role in reducing medicine errors in general practice and that pharmacists working with GP practices can significantly increase the quality of their prescribing. The PRACtICE

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study by the General Medical Council found that 1 in 20 prescriptions contained either a prescribing or a monitoring error, and that in 1 in 550 items that error was clinically significant.

Pharmacy is a science based profession with students spending five years training in all aspects of medicines development and use, including time spent in the science of medicinal chemistry and pharmacology to give them a unique education in how medicines act in the body and interact with each other. They are trained to provide pharmaceutical care, which includes taking responsibility for the outcomes of treatment as well as ensuring safe and effective use and supply of medicines. Wilson and Barber in their Review of NHS Pharmaceutical Care of Patients in the Community in Scotland stated that to be most effective pharmaceutical care requires good communication and shared understanding with patients and local prescribers which must be delivered within a framework of multi-disciplinary co-operation; meaning that the pharmacist works in partnership with the GP, the nurse, the social care worker and any other professional involved, to arrive at optimal treatment for the patient, and that therapeutic partnership also extends to the patient and any carers involved.

Pharmacists are generalists by nature with specific expertise in the use of medicines. Therefore they take a holistic approach to patient care and medication review. This will be increasingly important as people live longer, perhaps with several long term conditions (LTCs) where the use of clinical treatment guidelines for individual disease states become more complex. Working in the wider primary care team, and with social care colleagues, will allow pharmacists to help tackle the problem of polypharmacy. Furthermore, the provision of pharmaceutical care to people in care homes, supported care settings and those with LTCs should become the norm in every local community across Scotland. By ensuring a pharmacist is integrated into the community hub team, we can improve patient outcomes and patient safety wherever medicines are included in a patient’s care plan.

As a member of the multidisciplinary team (MDT), there are key areas where the pharmacist’s expertise is necessary, such as:

- reviewing medication regularly (polypharmacy reviews) to improve patient safety and outcomes e.g. preventing unplanned hospital admissions, particularly for patient taking high risk medicines
- providing continuity of care between primary and secondary settings including discharge planning
- reviewing medications post discharge and when patients transfer between health and social care settings
- anticipatory and end of life care

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9 Investigating the prevalence and causes of prescribing errors in general practice: The PRACTiCe study, General Medical Council, 2012


11 Dr Hamish Wilson and Professor Nick Barber. Review of NHS Pharmaceutical Care of Patients in the Community in Scotland 2013
ensuring cost effective and evidence based use of NHS resources

clinical governance and ensuring safe systems and processes are in place wherever medicines are used

treatment, monitoring and support of people with long term conditions

ensuring optimum pharmaceutical care is delivered to people in care homes, supported care settings and our vulnerable populations in the community

education and training of social care staff involved in medicines administration

a point of contact for medicines information within the local health and social care team, and for patients

interfacing with pharmacy colleagues in community, hospital and across other care settings and providers.

The King’s fund when reviewing polypharmacy\(^1\) has recommended that there should be clearly defined roles for doctors, nurses and pharmacists, working coherently as a team. They acknowledge that primary care consultations for patients with several LTCs may take longer than normal, and that instead of disease specific clinics patients should have all of their LTCs reviewed by a team of health professionals. Since medicines will inevitably be a significant part of that care then pharmacists must be included in the general healthcare team to ensure patient’s benefit from the different expertise available across the range of health and social care professionals.

Scotland is not alone in recognising the need for new models of care to address the challenges of future demographics. The Welsh Government is also currently exploring ways to improve and expand primary care using primary care clusters. These clusters embody a broad team of health and social care professionals and they have recognised the advantages of including pharmacists as fully integrated members of the cluster (hub) team.

**IT Support and Sharing of Information**

The National Clinical Strategy\(^{12}\) has acknowledged that IT solutions have not kept pace with clinical expectations. One of the key enablers to successful multidisciplinary working will be one single patient record, accessible appropriately by everyone caring for a patient, with the patient’s consent.

Information about a patient’s medicines, allergies, side effects and previous treatment is now generated and stored in several different places within and outside the NHS and healthcare professionals do not have a full picture of their patients’ care.

As hubs develop further the lack of joined up information across primary and secondary care and between professionals involved in a person’s care will eventually hamper the provision of clinical care. Read and write access to one single patient record is essential, with patient consent, to ensure information can be shared appropriately with all professionals involved in providing patient care, in order to keep patients safe and prevent avoidable harm.

\(^{12}\) A National Clinical strategy for Scotland. Scottish Government. February 2016
Pharmacists have many examples of where access to patient records would improve patient care, particularly when patients are transferring across different health and social care settings, and in the out of hours period. The example in appendix 1 illustrates the positive outcomes which can be achieved with appropriate access to the patients’ health record.

Where links have been established within MDTs in community partnerships, sharing of information and closer working arrangements has proved advantageous in gaining a fuller understanding of the requirements of person centred care from both health and social care perspectives in a manner which was not previously possible. However lack of access to all relevant patient information can mean that patient care is not optimal and the full potential contribution of the MDT cannot be realised.

The way forward

The Chief Medical Officer’s report “Realistic Medicine” has outlined clearly the need to reduce harm from overtreatment, the unrealistic approach of single treatment guidelines and the need for shared decision making. The report states that this requires system and organisational change to promote the required attitudes, roles and skills in healthcare professionals, and that care will increasingly be given by well led multi-disciplinary and multi-sectorial teams in community settings.

The questions which therefore must be asked are:

- What needs to change?
- How can the system make better use of these different skills available to improve patient care and reduce the avoidable harm caused by medicines?
- How can pharmacists and GPs work closer together with other members of the health and social care team to bring a synergy to their practice?
- How can we build sustainability into the system to drive the longer term changes required to reduce hospital admissions due to medication incidents and sub-optimal treatment, as well as encouraging self-management and a shift towards prevention?
- How do we measure success?

It is our understanding that “hubs “can be virtual or physical or a combination of both.

Whichever models are chosen to fit the needs of the local population there are several options for the pharmacists’ role as part of the MDT. Making better use of our limited resources, the best possible patient care will come from pharmacists practicing where they can make the most difference to patient care, and by ensuring that the tasks they undertake are patient-facing specific to their skill set.

- Direct NHS services already account for between 80-90% of community pharmacy workload but much more can be achieved by further integrating

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community pharmacies into new models of care as members of the wider health and social care team. This will ensure out of hours and in hours services are synchronised and patient information derived from pharmaceutical care in the community is included in health records. Sharing of information and a broad team approach to care is essential for patient safety. It will also allow development of new services that benefit from the accessibility and expertise of clinical pharmacists working in community, many of who are already independent prescribers.

- Building on the existing prescribing support pharmacist roles, many new posts have been funded in response to the current shortage of GPs. The RPS and RCGP have been working together to develop guiding principles regarding pharmacists working with or in GP practices for both GPs and pharmacists to ensure patients and the practice benefit fully from the additional pharmaceutical care that pharmacists can provide.

- Case reviews by multidisciplinary health and social care teams can identify patients where a medication review is required. This can support re-enablement and allow social care to tailor care packages and help improve adherence to prescribed medicines. This in turn can free up social care capacity and help minimise risk of hospital re-admissions.

- There is also a requirement for pharmacists to be present at strategic levels e.g. Strategic Planning Groups in Community Health and Social Care Partnerships, to ensure pharmaceutical care is appropriately embedded into community planning.

- Pharmacists must be involved in local clinical governance arrangements and training to ensure safe medicines systems are in place across community partnerships e.g. care homes, supported care settings, sheltered housing and where care packages are in place.

Collaborative working between health and social care teams within community hubs is key to improving patient outcomes. Trust and respect needs to be built between pharmacists and their GP colleagues to enable shared decision making around prescribing decisions and treatment plans, and to ensure everyone is working to their maximum potential in delivering patient care.

Going forward we must also ensure that pharmacists who work in community pharmacies are further enabled to work with GPs and other health and social care colleagues to improve care of patients. There are many opportunities for development which will be mutually beneficial to patients and to both professions. The recent report from Professor Lewis Ritchie\(^\text{14}\) has cited many examples of how this could be taken forward both out of hours and in hours to relieve pressure on GP surgeries and A&E departments. The joint submission from pharmacy

organisations\textsuperscript{15} suggested several short and longer term solutions, including building on the current minor ailment service and utilising the increasing numbers of pharmacist prescribers.

**Conclusions**

By ensuring the right skill mix within the health and social care team and the appropriate provision of care and services for patients and the public closer to home, pressures on hospitals and A&E departments will be eased, allowing resources to be further focused on longer term prevention in primary care which will be necessary for sustainability in the NHS. Health and Social Care Partnerships and community health hubs have a unique opportunity to shape and support this work to ensure that the local population has access to the services they require.

The transformation of primary care, the development of multidisciplinary hub teams and further collaboration between pharmacists and GP practices will fundamentally improve patient outcomes and reduce pressure at the pinch points in the current system.

We believe the current three year funding and new pharmacist posts gives an ideal opportunity to robustly evaluate the new ways of working with a view to ultimately providing a national strategic approach to holistic person centred care in the primary care setting.

**How do we measure success?**

Improvements in health outcomes can be difficult to measure in isolation and targets can inadvertently impinge negatively on other parts of the system but qualitative markers for pharmacist contributions should be agreed in partnership with the GP, pharmacist and patients to optimise care and to support a person centred approach. As well as improvements to quality of life, improved self-management and reductions in demands on social care, it is possible in some diseases to directly measure reductions in hospital admissions or measurable improvements in clinical markers. Audits in community pharmacy can measure impact on GP and A&E appointments.

Appendix 1 gives a good example of the contribution pharmacists make to the MDT and the positive impact that results from providing optimal pharmaceutical care.

Appendix 1

Collaborative working example - The Community Respiratory Team (CRT)

The CRT is a physiotherapy-led multidisciplinary team comprising of physiotherapists, nurses, occupational therapists, pharmacists, a dietician and health support workers with close links to respiratory nurses in the early supported discharge service (ESD), and a weekly sessional input from a respiratory physician consultant. The aim of the team is to optimise respiratory care delivered at home to patients with Chronic Obstructive Pulmonary Disease (COPD), improving community care and self-management of the condition and thus reducing the risk of hospital admissions.

Background

COPD is a complex disorder with many associated co-morbidities including cardiovascular disease, depression, anxiety, diabetes and osteoporosis.

It has been recognised that patients with multiple morbidities are more likely to die at an earlier age, more likely to be admitted to hospital, have a poorer quality of life, and are more likely to be prescribed multiple drugs with consequent poor adherence.

Traditionally, disease management guidelines and patient pathways have been devised around single disease entities. This single disease centred approach has encouraged the development of multiple treatment regimens with increased potential for adverse drug interaction and poor adherence.

This suggests that there is potential to improve management and outcomes for many patients being treated for COPD and their co-existing long term conditions. As a result there is an increased need for integrated working at a practice level, with a strong suggestion that integrated working with community teams, including pharmacists, can improve outcomes, with the potential to reduce overall consultation times, increase patient satisfaction, reduce polypharmacy and reduce hospital admissions.

As part of the multidisciplinary CRT the remit of the pharmacist includes delivering comprehensive medication reviews to at risk patients.

Adverse reactions to medicines are implicated in 5-17% of hospital admissions and drug related side effects are linked closely to the number of medications a patient is taking.

In addition to a COPD medication review the pharmacist provides a holistic review to ensure all medication requirements are met, and potential harm from medication minimised. This can involve recommending changes to treatment, addition of new treatments for unmet needs or discontinuing treatments no longer required or causing adverse effects.
Results

Internal referral criteria were developed to help identify patients who would most benefit from the input of a pharmacist. A range of pharmaceutical care issues were identified, and have been recorded since November 2015.

The total number of referrals to the pharmacists since November 2015 can be seen in the table below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Total referrals to pharmacy</th>
<th>Total referrals to CRT service</th>
<th>% of total service referrals made to pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov 2015 – June 2016</td>
<td>254</td>
<td>726</td>
<td>35</td>
</tr>
</tbody>
</table>

The types of interventions made by the pharmacists, and the percentage of each intervention is shown in the graph below. The interventions marked with an asterisk are the ones considered to be “high impact” interventions.

Recommendations are made to GPs, and these are either accepted or not accepted by the GPs. The table below shows the number of recommendations made by the pharmacists, and the number of those that are accepted by the GPs.

<table>
<thead>
<tr>
<th>Date</th>
<th>Number of GP recommendations made</th>
<th>Number of recommendations accepted</th>
<th>% accepted</th>
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</thead>
<tbody>
<tr>
<td>Nov 2015 – Jun 2016</td>
<td>261</td>
<td>228</td>
<td>89%</td>
</tr>
</tbody>
</table>
Patient feedback has also been extremely positive, with anecdotal comments such as:

“They made sure I was taking my medicines properly and again nobody has ever sat down with my inhalers and medications and went over this stuff before. The service was so good, I understand my inhalers much better now”

“They even had a girl out to explain all my medication and the tablets. 100% information”.

“I had a lady pharmacist come in and explain everything to me. She came in to make sure I was doing them properly. I was happy with that”.

“When I had the Ventolin one you push down the pharmacist came and she put me onto the round steroid 500 one and that’s been a lot of help as I can use that a lot better. I’ve found a benefit in that, all the years I’ve had that other one and I’ve never used it properly. I’m on antidepressants too and I’m not sure what I’m supposed to feel. I’ve not been sleeping well but it’s got a bit better since I started the tablets. The pharmacist advised the doctor to prescribe these. I'm back in bed now and not on the settee as I had been lying on there for 6 weeks”

These results show how effective and important the role of the pharmacist is within the multidisciplinary team and is an excellent example of collaboration across the professions, each contributing differently to improving patient care.

Many of these patients would not have been reviewed in such a timely manner without the input of the CRT, and the necessary access to the patient health record. This could have led to hospital admissions due to poor control of their COPD through either excessive dosing/under-dosing, not using inhalers correctly, confusion over changes particularly after hospital discharge, and subsequent non-compliance due to side effects from medications.

(Thanks to Greater Glasgow and Clyde health board prescribing support unit for this example)
Six Recommendations

1. Increase awareness across the primary care workforce and the public generally of the AHP role, impact and availability of direct access to AHPs

Knowing who the right person is can be very difficult if there is little knowledge of the AHP offer. A greater awareness by all health care professionals and policy makers is required if the AHP contribution to the redesign of primary care services is to be realised. Our diverse and unique skill set will effectively help address the challenges we currently face. For example, where nurses were used to triage GP patients to physiotherapy these staff were initially unaware that physiotherapists could treat anything other than backs or necks. AHPs have a key role to play in the most common reasons people visit their GPs (see table below). If people were more aware of and understood the AHP roles and how AHPs can be accessed directly, unnecessary GP appointments could be reduced significantly.

2. Primary Care redesign to enable direct access to AHP services through better screening or triage and rapid referral.

Many AHP services already have direct referral but often the GP is used as the referral route. With better awareness coupled with effective screening or triage and referral at point of contact with a GP Hub, the use of unnecessary GP appointments can be avoided, ensuring people see the right person at the right time, first time.

3. Contracts with independent GP practices to provide clear incentive for developing direct access to multi-disciplinary services

The AHPFS welcomes the National Clinical Strategy call “We will build a greater capacity in primary care, centred around practices...by developing newer, extended, professional roles within primary care, such as Advanced Nurse Practitioners, Pharmacists and Allied Health Professionals. This will provide the range of skills needed to meet the changing and complex needs of communities.” The RCGP has also clearly stated that multi-disciplinary primary care
is required. In order to ensure change and consistency throughout Scotland contracts with independent GP practices will need to enable and encourage this shift.

4. Workforce planning and development to reflect the changing demands on the multi-disciplinary team, the assets (e.g. interface with other sectors) already available in that team, and new models of care rather than the alternative uni-professional focus

Workforce increases in Scotland have often been uni-professional such as 500 more health visitors or 100 more GP training places. These uni-professional increases fail to recognise the complex nature of addressing people’s needs and can inadvertently create bottle necks in other services e.g. an increase in GPs to reflect the increase in frail elderly falls without an increase in the AHP workforce who provide a falls service aimed at reducing falls, just creates a waiting list for AHP falls service.

5. Funding of primary care to reflect 2020 vision of balanced, multidisciplinary teams

Audit Scotland, in their March 2016 report ‘Changing Models of Health and Social Care’ state “The shift to new models of care is not happening fast enough to meet the growing need, and the new models of care that are in place are generally small-scale and are not widespread.”

The AHPFS is aware of many initiatives that include AHP’s working in primary care but as Audit Scotland has noted, despite being successful they are often pilots supported only by temporary funding. Budgets need to shift to reflect new, effective models of care. See http://www.audit-scotland.gov.uk/report/health-and-social-care-integration

6. Support for the principles in ‘The future of primary care in Scotland: a view from the professions’

The AHPFS was very pleased to contribute to the joint statement on the Future of Primary care and indeed to have been acknowledge and invited by the health and sports committee to give evidence. AHPFS is a federation of 12 professional bodies representing 11,369 (WTE) staff in NHS Scotland, who are key to achieving the 2020 vision. Support for these principles and continued inclusion and joint working will be paramount if we are to develop health and social care services that are fit for the future. See http://www.rcgp.org.uk/rcgp-nations/~/media/Files/RCGP-Faculties-and-Devolved-Nations/Scotland/RCGP-Scotland/The-future-of-primary-care-in-Scotland-2016.ashx

The new role of Link Workers in GP Hubs has overlap with common practice within the AHPs, who regularly interface and work in partnership with colleagues across primary, secondary and tertiary health care; third sector providers; social care, education and other community provisions.

For further information contact:
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Sara Conroy Chartered Society of Physiotherapy conroys@csp.org.uk
Gaby Stewart College of Occupational Therapists Gabrielle.Stewart@cot.org.uk
Examples of AHP contribution to primary care

<table>
<thead>
<tr>
<th>Most common need – Most Deprived Areas</th>
<th>AHPs involved in evidence based care pathways (in addition to GPs)</th>
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<tbody>
<tr>
<td><strong>Musculoskeletal needs</strong></td>
<td>Physiotherapists, Radiographers, Podiatrists, Podiatry and physiotherapy routinely refer directly to radiography without going through a GP makes so much sense reducing pressure on GPs, streamlining the pathway for people and reducing cost. Physiotherapists working in GP practices as first point practitioners for Msk conditions providing timely assessment diagnosis, advice, prescriptions, injections and onward referral if required. Impact data shows a reduction in referrals to secondary care specifically orthopaedics, a reduction in radiology referrals, an increase in the time GPs have to spend with complex cases and high patient satisfaction scores. In one pilot where the physiotherapist were independent prescribers; 58% (n=390) patients were advised OTC medication. Only 7% returned to their GP or required a stronger prescription.</td>
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<tr>
<td><strong>Heart and Circulatory e.g. Stroke</strong></td>
<td>Physiotherapists, Speech and Language Therapists, Occupational Therapists, Dieticians, Paramedics Primary Care: Advanced and Specialist Paramedics work embedded within GP Practices, Out of Hours Primary Care Emergency Centres, for the Scottish Ambulance Service and as part of multi-disciplinary specialist teams providing advanced assessments and decision making within these bases or in patient’s homes. They administer a broad range of medications, refer through the full spectrum of health and social care services seeking to negotiate person-centred outcomes in partnership with their patients, carers and relatives that encourage ownership in their care, reduce unnecessary hospital admission and facilitate future self-management.</td>
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<tr>
<td>Mental Health</td>
<td>Occupational Therapists, Speech and Language Therapists, Art Therapies, physiotherapists</td>
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<td>In 2014/15 stress accounted for 35% of all work related ill health cases and 43% of all working days lost due to ill health</td>
<td>Examples include non-verbal Creative Action Methods Assessment and 10 weeks 1:1 weekly psychological therapy with a 14 year old ceased Self-harm and suicidal thoughts, symptoms of depression and anxiety disappeared, family and social interactions improved and patient joined voluntary activity group for respite, social inclusion</td>
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<tr>
<td>Depression and anxiety are the third most common reasons for people visiting their GP.</td>
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<tr>
<th>Respiratory</th>
<th>Physiotherapy, Speech and Language Therapists</th>
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<tr>
<td>Physio Therapy led Community Respiratory Team. - supporting patients with COPD, promote self-management and reduce the impact of their disease - alternative pathway to hospital admission - 90% of urgent referrals seen in 1 day, 19% reduction in hospital admissions, average saving of £3000/patient.</td>
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<table>
<thead>
<tr>
<th>Endocrine and metabolic (including diabetes and obesity)</th>
<th>Dieticians, Occupational Therapists, Physiotherapists, Paramedics</th>
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<tr>
<td>Currently around 1 in 5 of all patients with diabetes will develop a foot ulcer at some point in their life, with many of these resulting in amputation. But with the correct medical care from a multi-disciplinary team of health care professionals, including podiatrists, research indicates that 75% of diabetes related amputations could be avoided.</td>
<td>(Holstein, P., Ellitsgaard, N., Bornefeldt Olsen, B., Ellitsgaard, V. (2000) ‘Decreasing incidence of major amputations in people with diabetes’, Diabetologia, 43, 844-847)</td>
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</tbody>
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<p>| Other care groups AHPs provide services for | |
|-------------------------------------------||
| Dementia / Alzheimer’s / Frail Elderly | Speech and Language Therapists, Occupational Therapists, Physiotherapists |
| 70% of acute and primary care budgets are spent on | Occupational Therapy - Pro Active Falls Prevention and Frailty Recognition Project – GPs Clerical Staff identifying patients for the project. Total savings per year £10,400 |</p>
<table>
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<tr>
<th>care for people living with long-term conditions - accounting for 50% of all GP appointments (TCSW and RCGP, 2014). Many people with multiple long term conditions will also have frailty. Older people living with frailty have the highest levels of unplanned admissions into hospital and are the highest users of services. (Mytton et al, 2012)</th>
<th>Orthoptics: Throughout Scotland Orthoptists are “making the difference, given the chance” In areas such as falls protection (stroke rehabilitation), early years Framework (Vision Screening), dementia strategy (LVAs) and improvements in services such as glaucoma, diabetes and heart related problems. Physiotherapy led falls prevention programmes saving £2.50 for every £1 spent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health</td>
<td>Occupational Therapists, Speech and Language Therapists, Dieticians, Physiotherapists</td>
</tr>
</tbody>
</table>
| Dietitians – Cow’s Milk Protein Allergy – education to improve ID and management in primary care has potential to improve time to symptom resolution, improve families’ QOL and reduce healthcare visits | Speech and Language Therapists-An estimated 250,000 Scots have communication support needs. A Scottish Government commissioned review of the literature [http://www.scotland.gov.uk/Publications/2007/06/12121646/0](http://www.scotland.gov.uk/Publications/2007/06/12121646/0) showed compared with the general population people with SLC are more likely to
- have difficulty accessing information required in order to utilise services
- live in socially deprived areas.
- experience negative communication within education, healthcare, criminal justice system and other public services
- be unemployed or employed at an inappropriately low level
- be victims of or be convicted crime
SLTs advise and help services develop communication inclusive environments thus can improve service access and response to that service; reduce health inequalities and the factors affecting health. |
| AHPs make the difference – given the chance |