OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 20 September 2016

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 20 September 2016

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HEALTH AND SPORT COMMITTEE
5th Meeting 2016, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
*Miles Briggs (Lothian) (Con)
*Donald Cameron (Highlands and Islands) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Alison Johnstone (Lothian) (Green)
*Richard Lyle (Uddingston and Bellshill) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Aileen Bryson (Royal Pharmaceutical Society)
Theresa Fyffe (Royal College of Nursing)
Linda Harper (NHS Grampian)
Dr Elaine McNaughton (Royal College of General Practitioners)
Christopher Rice (NHS Shetland)
Gabrielle Stewart (Allied Health Professions Federation Scotland)
Elaine Thomson (Royal Pharmaceutical Society)
Dr Sian Tucker (Royal College of General Practitioners)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 20 September 2016

[The Convener opened the meeting at 10:00]

Subordinate Legislation

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

The Convener (Neil Findlay): Good morning. Welcome to the fifth meeting in 2016 of the Health and Sport Committee, in the Scottish Parliament's fifth session. I ask everyone in the room to switch off mobile phones, as they can interfere with the sound system.

Agenda item 1 is subordinate legislation. We have before us today one instrument that is subject to negative procedure: the Health and Care Professions Council (Miscellaneous Amendments) Rules Order of Council 2016 (SSI 2016/693). There has been no motion to annul the instrument lodged and the Delegated Powers and Law Reform Committee has not made any comments on it.

I invite members' comments.

No member has any comments, so does the committee agree that we will make no recommendation to Parliament on the instrument?

Members *indicated agreement.*

The Convener: Thank you very much.

General Practitioners and GP Hubs

10:01

The Convener: Agenda item 2 is on general practitioners and GP hubs. We will have two evidence sessions. I welcome to the committee Dr Sian Tucker, who is clinical director of the Lothian unscheduled care service and a representative of the Royal College of General Practitioners; Aileen Bryson, who is the head of policy for Scotland at the Royal Pharmaceutical Society; Gabrielle Stewart, who is the Scotland policy officer for the College of Occupational Therapists and a representative of the Allied Health Professionals Federation; and Theresa Fyffe, who is the director of the Royal College of Nursing.

We are not expecting opening statements, so I will move to questions. Before I do that, I declare an interest in that my daughter is a trainee occupational therapist.

I will open up the questioning. What is your understanding of how the GP hub model is operating?

Dr Sian Tucker (Royal College of General Practitioners): I am aware of three types of hubs, but I am not sure which one the committee is interested in. Do you want me to expand on that?

The Convener: Yes.

Dr Tucker: The first model is the urgent care resource hub, which was postulated by Lewis Ritchie in his report from last year. That model suggests initially bringing together in a hub all out-of-hours services, including GP, community nursing, third sector, mental health and social care services. Since the publication of Lewis's report, money has been made available to each health board from the primary care transformation fund for developing new models of care, including the urgent care resource hub. Although the model was initially postulated for out-of-hours services, it could be used 24/7.

I do not know whether members are aware that the Scottish Government and NHS Education for Scotland are piloting in NHS Fife and NHS Forth Valley what they call community hubs, which have GPs at their heart. They take GPs who have just qualified after getting the certificate of completion of training. They do a fellowship for a year, working with hospital colleagues and learning new skills. After that, for two years they work in health-board-funded positions as community physicians. The two community hubs are run slightly differently: the Fife pilot is a day hospital model, in which the GPs work with integrated teams, and

the Forth Valley pilot also has some in-patient beds.

The third type is integrated hubs—or locality hubs—that have been developed across the country by the integration joint boards. They bring together services—usually in-hours services—and provide a single point of access for GPs and patients.

Hubs are quite widely used at the moment, and those are the three models that I am aware of. As I said, I am not sure which ones you are interested in.

The Convener: That is very helpful.

What are the opportunities to change how care is provided through the hub models?

Theresa Fyffe (Royal College of Nursing): Therein lies a problem that has just been described very well. We are using the word "hub" in many different ways, so perhaps we should unpick that. Sometimes a hub is seen as a structure, a building or a co-location of services. That might be helpful, but it is not if it means that patients, the public or more junior staff have to travel long distances to access that structure.

A hub can also be seen as a network, such as the one for trainee GPs. However, if we are talking about integration, we are talking about a wider network—not just of health care professionals, but of professionals from social services, the third sector and other sectors. We support the network model, because we need to work together so that we can deliver.

I hope that you have had the chance to see the set of principles that were put together by all the primary health professionals that came together. We believe that it is important to focus on primary care, and to be clear about where services are and about the support that people need. Sometimes that is not easy because some of the funding model pilots that you will hear about tend to focus on one professional group—for example, GPs—rather than on a multidisciplinary team. That focus is what we are hoping to get across today. It can come from across the team and can be supported in a way that drives multidisciplinary or multi-agency working. It is important to drive things that way as we are at the heart of primary care within the community.

Alison Johnstone (Lothian) (Green): The issue of allied health professionals was highlighted in your written submission. We are moving towards multidisciplinary collaboration, but the nature of workforce increases still seems to be uniprofessional. As an example, you pointed out the increase in the number of GPs—not that I am suggesting for a minute that that is not needed. What support do we need to facilitate the move to a more collaborative model?

Gabrielle Stewart (Allied Health Professions Federation Scotland): Audit Scotland pointed out that, regarding workforce planning, there has not been a shift in funding from the uniprofessional approach towards multidisciplinary teams.

The other thing that has not happened is that there has not been a look at the people who are going to their GPs' doors who could instead be seen by an AHP. We appreciate that we would all like a larger workforce, but we should also use the workforce more intelligently. We suffer from a lack of statistics around allied health professionals, which we could use to build a body of evidence—AHPs are often not recognised within the statistics that are produced by the Information Services Division or others—so an analysis of who is coming in the door would be useful.

We also suffer because people's perception of what we do is not right. We have a good example in Brechin on triage into physiotherapy, where they are treating backs and knees but not thinking about the broader role of physiotherapy in public health and occupational therapy. Other AHPs suffer from misconceptions about what they can do.

Aileen Bryson (Royal Pharmaceutical Society): I agree with the sentiments that have already been expressed. The lack of clarity about what a hub is came up in all kinds of ways when health and social care integration was first talked about. We have seen lots of emerging virtual hubs; I agree with Theresa about not concentrating too much on the building, but instead at looking at how we service the local population. We originally thought that that was what the hubs were to be about and, although the committee papers talked about GP hubs, our response talked about community hubs. We should be thinking in the round.

From a pharmacy perspective, we are pleased to see increased recognition that pharmaceutical care is an essential part of patient care and that, with that, there is willingness to have pharmacists as part of the multidisciplinary teams. That has happened in all the different models that are emerging, which is very heartening for us.

We were also pleased that the circular that came round about the new funding for 140 pharmacists noted a commitment from the Government to evaluate the new models. We have to evaluate everything that is being done so that we have something robust in place in the long term. That resonates with the comments about pilots, because when there is good work going on with lots of pilots, sustainability can be a problem.

Alex Cole-Hamilton (Edinburgh Western) (LD): At a previous meeting, the committee was made aware of the nuka system of care model in Alaska. I understand that it comprises a GP, a pharmacist, a mental health practitioner and administrative support. I might not be entirely right about who is in the team, so correct me if I am wrong on that. The approach has led to significant advances and to reduced waiting times—in fact, there are no waiting times, because people are just seen on the day that they want an appointment. In the community hubs that exist now, should there be spokes in that wheel that are not there at the moment? What professionals would you like to see more of in the team?

Dr Tucker: With the urgent care resource hub, which is being developed under a multiprofessional funding model rather than a GP-funding model, we have realised that physiotherapy has a big part to play, so we are looking at adding that to the hub. One thing that was highlighted in Lewis Ritchie's report and which is often forgotten is use of the third sector, particularly in relation to mental health. In Lothian, the number of mental health calls to the out-of-hours service has increased by 41 per cent in the past four years, so we really need to address that. At the moment, all those calls are dealt with by GPs, which is not necessarily the best use of resources.

We should, therefore, increase mental health services. Although we have been given money to set up an urgent care resource hub, it is not recurring funding, so we cannot employ lots of new staff; we have to rearrange what we have. That is one of the challenges, particularly in relation to mental health, and one way to get over that might be to use the third sector, which is brilliant at some mental health care and which provides some 24/7 services.

We need to be open to new ideas about whom we can use and how we can use them. Certainly, the third sector would feed into that.

Gabrielle Stewart: In Wales, occupational therapists are working on a project with GPs on mental health alongside art therapy services. There are AHPs who support people with mental health issues into work. We also need to think about the employability aspect.

Theresa Fyffe: The nuka model that Alex Cole-Hamilton mentioned would fit well in Scotland. Later, the committee will hear evidence from very remote areas of Scotland. We always have to consider the geographical issues. Too often, the city models drive what goes on, although somebody in Glasgow might have quite a distance to travel to get from one side of the city to the other. I come back to the point about access—it is about how patients access services and how the staff who provide the services access them. If there is limited public transport, they cannot do that.

On Lewis Ritchie's report, we were part of that work along with others who are at the table today. At the time, when we considered out-of-hours services, we all said that it is so obvious that, although there is a link with daytime services, we tend to treat the two differently. As a group, we did an amazing piece of work on out-of-hours services and came up with a new model that would drive that forward, but we have often been frustrated because we should have looked at the whole picture. That is what was needed, because in fact it does not matter who finishes at 5 o'clock; it is about continuity and how we ensure that that change of practice happens. Many of my GP colleagues tell me about that 4 o'clock call on a Friday afternoon before they actually face thinking about the weekend.

There is something for us to learn on that. I wish that we had had the courage to make one model for the whole 24 hours rather than using what was already there. In the out-of-hours service, the multidisciplinary approach is well recognised and well established as the way forward, but that is not yet necessarily the case in the day service; it exists in principle, but it is not being carried out. An example is information technology and e-health. At the moment, under the GP-funded e-health model, GPs might not talk to other professionals, such as pharmacists. I do not mean that GPs should not have what they need but, yet again, we are doing something that is stratified for one group when the idea that we should be pushing forward is that patients should expect all of us, as healthcare professionals, to be able to talk to each other and share information.

Ivan McKee (Glasgow Provan) (SNP): I thank the witnesses for coming.

I want to raise two points. One is about the GP resource, which is an expensive and constrained resource. Clearly, the objective of a lot of the work that we are talking about is to move much of the work that GPs do to other professionals. How far down that road have we gone? In a perfect world, if we had a blank sheet and free rein to design the thing, how much further down that road could we go? How much of what GPs do today could be done by other professionals?

I thank Dr Tucker very much for her run-through of the three types of hubs. I was struggling to take notes, so maybe you could go back through that but with specific emphasis on the funding models that lie behind them. You hinted that the hubs are funded in different ways, which might be part of the reason for the differences.

Finally, in your view, how are community hospitals different from the community hubs that we are talking about?

10:15

Dr Tucker: As far as funding is concerned, there are three different types of community hubs, so far. The community hub pilots in NHS Fife and NHS Forth Valley came out of the seven-day sustainability task force and are funded through that and done in conjunction with NHS Education for Scotland. I am not sure whether that is three-year fixed funding or what the plans are for it, but there is an evaluation plan to see how that looks.

For the urgent care resource hubs, the £10 million from the primary care transformation fund is currently being handed out to boards so that they can use the money as they wish; they might not all use it to develop urgent care resource hubs. That is one-year fixed funding; there is no recurring funding.

The integration joint board locality hubs are being funded by the integration joint boards. Again, that is being done by reorganising what they already have because there is no new money for that.

Those are the funding streams. None of the community hubs that I am aware of—certainly not the urgent care resource hubs—would require patients to travel to them. The urgent care resource hub would have either a geographical or virtual location with staff sitting in it. For out-of-hours services, for example, we have hubs that take calls from NHS 24 and pass on the work to GPs in the GP emergency centres. It would therefore not be the case that patients would have to travel to a new location; the new location would organise the work and send it out to the community nursing teams or deal with it by phone.

As far as the GP resource is concerned, there are two issues. First, I am not sure that we should be focusing on improving the work of others, including nurses, physios and pharmacists, in order to replace GPs. Work should have been done a long time ago to recognise the needs of a multidisciplinary team; the issue has come to the fore now because of the GP crisis.

Secondly, we should recognise the unique skills that GPs have and what they can bring to patients, as opposed to saying that because we do not have enough GPs we are going to parachute in other people to cover the work. I would turn that around and say that primary care and community care involve a whole multidisciplinary team, so we need to recognise the different jobs that people can do. There is work being done on that, and the new GP contract will probably move that further forward as GPs concentrate more on what only they can do in terms of complex care and so on. However, it is important to value the multidisciplinary team members for what they bring and not just for the gaps that they can fill—if that makes sense.

Ivan McKee: Yes and no. I do not disagree that what GPs do is very valuable, but that is not the same as saying that GPs should also be doing things that they do not need to be doing.

Dr Tucker: I absolutely agree that GPs are doing things that could be done by other people.

Ivan McKee: What I was trying to dig into was whether you could estimate how much of that they do. I know that that is difficult, but is it half of what they do or is it 10 per cent? How far down that road have we gone? At the end of the day, that is where the solution lies, is it not?

Aileen Bryson: That is very difficult to quantify. I agree with Sian Tucker about looking at the bigger picture and the longer term. However, small pieces of work have been done that indicate how things are at the moment. There are figures that show that 6 per cent of people who turn up at accident and emergency and around 10 per cent of those who turn up at a GP practice could be dealt with by the minor ailments service in a community pharmacy. To go back to what was said about the third sector, work needs to be done to educate the public about going to the right person at the right place at the right time, if that service is available for them.

Some work has been done with the new funding to examine how much time each day GPs spend on medicine-related queries and acute prescriptions in their surgery. It varies by practice obviously; every practice is completely different. It might be one and a half to three hours a day, or it might be 40 to 50 acute requests that can be dealt with by the pharmacist. That is where the evaluation will be important because we do not know those figures yet. We just have the principles to guide us on making sure that everybody contributes what they can.

The Welsh are using the phrase, “Only do what only you can do”, which is an interesting little nutshell. Although there is a crossover in that everybody does a little bit of everything when they have a person in front of them, there is something to be said for that phrase. It is about us all contributing what we have that is unique, but linking those things together. As Theresa Fyffe said, information technology is one of the enablers, but we do not have that at the moment.

Theresa Fyffe: We are talking about transition. We do not have the data that would demonstrate what Ivan McKee is asking for, but we should get it. I agree with Sian Tucker: it is not about not wanting GPs, and not about recognising their

expertise while not wanting nurses or physios; it is about valuing expertise. A good multidisciplinary team builds on relationships and on bringing their best to the team. That is what we should be after.

The public needs to understand that. Unfortunately, however, we are using a message that talks just about the GP practice while we are also telling the public that when they go there they will be seen by a nurse, a physio or whatever. We should make the message better. If we do not, people will tend to think that there is a crisis in the service. There is a shortage of GPs, but there are also shortages of other professionals and that is not often debated.

Community hospitals have a vital part to play, but not everywhere has a community hospital. That is what I meant by not being focused on buildings. Some people have designed models that are based around buildings, but if they did not have the building, they would have nothing on which to focus the model. That is why we are saying that we need to be more "virtual".

I also agree without question with Sian Tucker that how the urgent care resource hub works within out-of-hours services is not about a building, but about the focus of the team. Community hospitals have a good part to play in that. They are seen as part of the community and can enable people to be more local because they are where they need to be.

Ivan McKee asked how far we can go. We have come far, but we have not got clear the referral processes that allow professionals to act independently; we do not have the means by which all teams could access patients' records in the same way. It is not much use our saying to the patient or the public, "I'll see you and treat you but I can't do what I need to do" or that we might make the wrong recommendation because we do not have all the information. We have to be brave, which is hard because we tend to think of patient records as belonging to one group, so we have to find a way of working with them across all the disciplines. We are talking more about processes that we could improve in order to make that happen.

Gabrielle Stewart: I fully support that. Access is hugely important, and we do not want GPs acting as gatekeepers or referrers to other services that people could access directly.

It is also about educating people. A GP can directly access an AHP but the public will not necessarily know that, so there is a lot of work to do around forming an intelligent network that understands what the resources are and how to access them. That also applies to the third sector.

Donald Cameron (Highlands and Islands) (Con): I have a question about pharmacists. Yesterday I visited a high-street community pharmacy in the Highlands. I am sure that this will be familiar to the witnesses, but the pharmacists there said that, with more infrastructure, more investment, and improved IT for things such as accessing patient records, they could do a lot more. Here we are talking about putting pharmacists into general practices. This might be an unfair question, but which of those models is better?

Aileen Bryson: There is no better model; we have to look right across the piece. Two thirds of the profession work in community pharmacy. If we are to have the capacity to work as multidisciplinary teams in and out of hours, we have to use every resource that we have already. It is about working smarter.

Theresa Fyffe referred to the response on out-of-hours services that we worked on collectively across the professions. There were lots of ideas in there, including ideas about developing community pharmacy working in tandem with pharmacists who work in GP practices. It is ideal for a community pharmacist to liaise with a pharmacist who works in the GP practice—they can talk pharmacists' language to each other and deal with medicine-related queries quickly. That pharmacist should be a conduit. There are models that involve people working part time in community pharmacy and part time in the practice, which has advantages as well. We need to consider all models and think about what works best in each locality. In some places, there is only the community pharmacy—geographically, there are not many other health professionals there—so they have to have different models.

IT is an enabler. First there has to be a culture of sharing information between the professions, but the IT helps with that.

At the moment, there is no one ideal model. We have to bring all sectors of the profession together and be smart about how we develop the services.

You should remember that what is out of hours to a GP practice is not out of hours to a community pharmacy, because they are open much longer hours. In one pilot in the Borders, a community pharmacist was given access to records because he was the only health professional around on a Saturday afternoon.

There are lots of different ways of working and lots of things going on. We need to have a look at everything in the round to bring it together. Your question is not unfair, but it is a difficult one to answer.

Donald Cameron: I agree. There is a tension, and we do not want to replicate resources. However, at the same time, I am interested in

pharmacists in the community and in GP practices working together.

Aileen Bryson: It can be done. There are some good pilots involving different models.

We have all talked about workforce planning in various ways, but workforce planning will be important, because we need to ensure that we support all the various sectors. We know that pharmacists are keen to work in GP practices and are moving from other sectors. We do not want to disadvantage one part, which needs to be developed as well. I agree with what Gabrielle Stewart said about referrals. There are a lot of instances where people have to go through the GP, but we could work in a much smarter way so that the process is more person centred and the patient journey is much smoother. That would enable us to get it right for that person the first time. Some legislative changes and some contractual changes would need to be made in order for that to happen. The phrase "transformational change" is not overly dramatic, because that is what is required.

Dr Tucker: We already work closely with community pharmacies in the out-of-hours period. Most boards have what is called the professional-to-professional line, which means that, if someone presents at a community pharmacy, the pharmacy can contact a GP and the person will get a call back within 15 minutes, so they do not have to go through NHS 24. We find community pharmacies incredibly useful. I agree that the more skills they have to manage patients, the more helpful that will be for us, because, as Aileen Bryson says, they are often open out of hours, and we have a close working relationship with them.

Maree Todd (Highlands and Islands) (SNP): I declare an interest as I am a pharmacist and am registered with the General Pharmaceutical Council.

I worked for 20 years as a clinical pharmacist in a psychiatric hospital, specialising in mental health. We talk about our profession as being hidden in full view, so I suspect that my colleagues around the table might benefit from hearing a little bit about the different roles that pharmacists have—hospital pharmacy, hospital clinical pharmacy, community pharmacy and so on—and about what primary care pharmacy has been and what it will be in the future.

Having been a pharmacist for all those years, I know that there has long been a recognition that our level of education and knowledge is underutilised in the health service—the Government recognised that in 2002. What have been the barriers to bringing the profession on and enabling pharmacists to participate more fully in healthcare? If the fact that pharmacists are underutilised was recognised back in 2002, why has that not happened by 2016?

Aileen Bryson: These things take time. As Sian Tucker mentioned earlier, the driver at the moment is the shortage of GPs. It is fantastic that that has driven things forward much faster. However, we must look at the longer term and the bigger picture.

Our profession has not been very good at shining our light, because the focus has always been on supply. We have not been good at emphasising the fact that patient safety is intrinsic to that supply, which means that people are never given a medicine until the pharmacist is confident that it is safe for the person to have it. We have not been very good at getting that message over to the public.

10:30

There are a lot of other layers in there. We are moving from what I call the Harry Potter world of lotions and potions in the previous century to a situation in which there is more complex care. People who are in a care home now would have been in a geriatric hospital 20 years ago. As a result of the shift between secondary and primary care, the latter is being asked to do much more than it previously did.

We are moving into an era in which, as we all know, there are demographic changes. People are living longer, and there are many more medicines. When I started practising, someone with diabetes would have had two or three medicines—now, it is not unusual for them to have 15.

We do not make up medicines any more—we produce the pharmaceutical care to ensure that the complex array of medicines is safe, and we try to minimise the number of medicines that somebody is on. We are not good at letting people know that we have the five-year master's degree, and that pharmacy is all about specialising in all aspects of medicines.

We are currently involved in a group through the prescription for excellence agenda in which we are talking about valuing medicines. It is about getting the public and patients involved so that they can get a better idea of what we do. People know what a doctor or nurse does, but nobody knows what a pharmacist does; the allied health professionals probably suffer in the same way that we do. We have to be much better at getting the message out there so that, when we have our hub—not a GP hub, but a team—we ensure that people understand where to come to get advice.

We have done some visits and met some members of the committee, but we are happy

outside this meeting to discuss further bits and pieces.

The Convener: I could not help but see Dr Tucker smile when you said that the shortage of GPs was fantastic. [*Laughter*.]

Aileen Bryson: Don't look a gift horse in the mouth.

Gabrielle Stewart: I have one more point around leadership and who is commissioning and making decisions. We have sometimes struggled to get representation at the top tables so that we can share our expertise. I believe that GP clusters will be formed and will not necessarily be coterminous with the integration joint boards, and that there will be a quality cluster lead for each of those clusters. We want to ensure that that is truly multidisciplinary and reflects the input of the people who can make a difference to the health of people in Scotland.

The Convener: If we cannot define hubs, perhaps we have a chance of defining clusters. Does Maree Todd want to come back in?

Maree Todd: I am interested in some of the barriers to community pharmacy getting more involved in the multidisciplinary teams. Aileen Bryson mentioned how straightforward it is when there is just one pharmacy and one GP practice, but it is much more challenging in the usual high-street set-up where anybody from any GP practice can walk into a community pharmacy looking for pharmaceutical care. I have done my prescribing course, and I know that one of the challenges is that it is very difficult for a community pharmacist who has the prescribing qualification to prescribe for people who come through the door. Their prescription pad is linked to a GP practice, and they cannot prescribe for just anyone who comes in.

For my colleagues round the table who are not pharmacists, could one of you explain some of the barriers to community pharmacist getting involved in more rounded clinical practice?

Aileen Bryson: In the past, the funding was set up so that a community pharmacist would go to the GP surgery and have a back-fill locum pharmacist working in the pharmacy. Community pharmacy suffers from being in a retail environment, which differentiates a pharmacy from being in a practice or a surgery. Patients do not immediately have the same attitude when they go into what they see as a shop. They do not see the background work that is done before they get to the end point of a package. It is about the package of care, not the package.

There have been funding and legislative issues, and contractual difficulties present barriers. Anecdotally, we hear concerns about confidentiality—for example, when someone is speaking over a pharmacy counter. That is why consulting rooms were funded, way back, as part of "The Right Medicine: A Strategy for Pharmaceutical Care in Scotland". There is an issue with people understanding that confidentiality in the pharmacy is exactly the same as it is in a GP surgery with reception staff. Community pharmacies suffer structurally in that respect.

If the IT links were put in and we joined up the services, the community pharmacist could be doing very many of the same things that the pharmacist in the GP surgery is doing. That would not be difficult to do. The more the public saw that the services were joined up, with referrals being made from the practice and between the different professionals, the better. We know that people who should go to the minor ailments service turn up at GP practices. We want them to be sent to the minor ailments service so that they understand that that is where to go, rather than taking up time having that treatment in the practice.

Those barriers are there, but they are not insurmountable. If policy makers took a slightly nuanced view and provided the necessary funding, many improvements could be made. As part of the out-of-hours developments, short-term, medium-term and long-term measures were identified that could be put into place quite quickly to take down many of the barriers and enable the public to understand that the community pharmacy can be a go-to place.

We need to think about things on two levels. First, there is the accessibility element, which is provided by having a health professional on a high street, where people can ask for information. Secondly, there are the pharmacy staff, who can help with public health and the area of healthy living. There needs to be greater recognition of the fact that there are two different things going on.

Colin Smyth (South Scotland) (Lab): It has been mentioned a couple of times that the driver for the emphasis on the hub model is the current GP crisis, fantastic or otherwise, but Theresa Fyffe made the point that there are other difficulties in other parts of the primary care workforce at the moment. To what extent do you think that the other primary care professionals involved are prepared for the proposed changes? From a capacity point of view, how readily can the other health professionals pick up work from GPs? One example is the proposal to recruit 140 pharmacists. Where will those pharmacists come from?

Theresa Fyffe: Workforce planning across the teams is not good enough at the moment. We would not have a clue about the projected number of pharmacists, physiotherapists, OTs or nurses in

the primary care team, because we tend to focus on how many GPs there are. That is the data that we tend to refer to when we talk about primary care. We need to get a better understanding of what the baseline is and what the growth is. My colleagues have mentioned that those disciplines must be looked at as part of workforce planning.

We have had funding provided for 500 advanced nurse practitioners, but there are not 500 advanced nurse practitioners out there. Those nurses are being developed but, unfortunately, as soon as one area develops a set of them, another area will rob it, because it, too, is short of them. Therefore, the notion that there are always other professionals available is mistaken.

I want to come back to Maree Todd's comments. Working in a multidisciplinary way is a better way of professionals working with respect for one another. The issue is not just whether there are barriers for pharmacy; it is whether there are barriers for the team. I have mentioned a few of the barriers that exist, which include IT, means of referral, means of access and ensuring that professionals respect one another's integrity. The issue is how we get over those barriers; it is not a case of using one kind of professional rather than another.

As someone who has been around a long time, perhaps we have moved away from siloed professional thinking to better, multidisciplinary thinking. A few years ago, we would not have had many shared opinions on such matters; we would have been concerned only about our own profession.

My final point is about the transition and funding. We are really into pilots and testing at the moment, so we pilot and test everything, but I am worried that none of that seems to lead to a change. If you have a service that is in development in a board that is very short of money—I have been in that place—and someone says that money is available, you will take it, because you want to try something. However, it is extremely hard to shift the resource from what you currently provide and to use it to employ the people you need in the teams on a permanent basis. People might have ideas about having a wider team, but they will not have the long-term funding to make that happen, because the pilot or the test ends. If I was a manager out there at the moment, I think that I would be at a loss as to which of the pots of funding it would be best to use and what would enable me to make the transition that we need to make in the longer term.

It is not always possible to develop the necessary staff, employ them and get them into place to ensure better team working. That is a perennial problem, particularly in parts of Scotland where there are problems with recruitment.

The Convener: Is the temporary nature of the more-pilots-than-Heathrow scenario a barrier to people going into something, because they think, "I will be in it for only a year or two and then it will be over"? If that is the model that we are heading for, how will it become sustainable?

Theresa Fyffe: Our workforce planning is predicated on how many posts you have. If you are piloting and testing, you do not have a post, as the pilot is temporary. When you are planning your workforce, you might say, "I need 15 ANPs, " but people will not say that if they know that they cannot employ 15 ANPs. It comes down to the funding that you have and, if you were to train people, you could not put them into a post because you do not have the funding. We are in a difficult place.

I like pilots, but we are now doing too many. We think that pilots and testing are transformational change, but I am with Aileen Bryson when she says that transformational change is about doing something much more radical than piloting and testing; it is about saying, "This is the team that we need and this is how we need to do it," and being prepared to do workforce planning. People will not go into a job that they know will end in a year. The training for ANPs is—rightly—really hard and requires a huge commitment. It is important that that is the case, but why would someone do that if they do not think that they will get a job at the end? We have to find a way of making the permanent changes that are needed rather than being reliant on funding that will run out within two or three years.

Dr Tucker: Because the funding is shorts term, we all have to look at using what we have in a different way. As Ivan McKee said, we do not know what percentage of GP workload can be transferred over, so we are not yet sure how many of everything we will need. It is essential that we reorganise what we have and that we have the funding and the time and space to do that. We can then look at what we need by measuring, getting some figures and doing an evaluation. That is where we will need the money; we will need money going forward.

It is brilliant to develop multidisciplinary teams but, as has been said repeatedly, the GP workforce crisis is one of the main issues. However many multidisciplinary teams we develop, we will not be able to replace GPs, nor should we want to do so. We will therefore have to grow our GP workforce even to stand still because, in addition to the GP workforce crisis, the changing demographics and the amount of care that is required are also drivers for the development of multidisciplinary teams. As part of the 2020 vision, people want to be cared for at home or in a homely setting, and to do that we

have to change our view, because currently everybody talks about hospitals—they are always in the press—and takes an acute view, so there is not a big view about primary care. For the national health service to be sustained, it will have to be about primary care.

Clare Haughey (Rutherglen) (SNP): Thank you very much for the briefing papers, which were helpful, as they set out a vision of what the multidisciplinary team could do. However, I have heard a series of responses that indicate that there is a lack of statistics and evidence about how GPs' time could be spent better or about things that they are doing that other professions could pick up. How will we demonstrate that, in the long term, the development of the multidisciplinary team is of benefit to everyone? What are you doing, as professional groups, to look at statistics and to build up an evidence base and a baseline?

Gabrielle Stewart: Pilots that have used AHPs have been very successful and we will have the statistics and the evidence, but there is no forward funding because they have been funded on a temporary basis. Some fantastic programmes have been stopped because the money has not gone with them.

Another concern is what incentive there is to work in a multidisciplinary way. It is about being collegiate, trust and a lot of other things, but we must also ask what the incentive is. There is a GP crisis and we also have other ageing workforces. We need to see the workforce as a whole workforce and as a whole offer and understand that true offer. I sometimes think, "What is the dream team?" We do not know that yet, and it might be different in different places.

We need to test things out, but we also need to make take some brave steps, because at the moment we are just tinkering with pilots. I agree with Theresa Fyffe that we need to be much braver. All the professional bodies have their own evidence base and their own stories that can be shared; the question is how we pull all that together in a systems and network-based approach and how we understand the whole workforce's full offer.

10:45

Alex Cole-Hamilton: My question is in two parts. Earlier, we heard that right now 10 per cent of people who present at GP surgeries could be dealt with by the local pharmacy's minor ailments service. I realise that we cannot quantify this exactly, but is there some way that, if we resolved the IT issues, pharmacists could have better access to notes and see what people were already taking? Bearing in mind the issue of public awareness, how much more of that GP workload could be taken by community pharmacists if we got everything right?

Secondly, the committee is aware that one of the biggest growth areas with regard to demand on the health budget is GP prescribing. That is about the demographic, the ageing population and people living longer and needing more support. If more of that support came through pharmacists, would there be an opportunity to rationalise or reduce that demand through the added expertise that pharmacists have in prescribing? I am, of course, not seeking to belittle the prescribing powers of GPs.

Aileen Bryson: As Sian Tucker said earlier, this is not all about taking the workload off GPs; it is about filling the gaps in patient care to ensure that each of us around the table and all the other professions who are not represented today contribute in our unique way and in such a way that the patient actually gets the most benefit from the whole primary care team.

Pharmacists have always played a role in the governance of and decisions on prescribing, but that happens in the GP practice and the managed service more than it does in the community. Going back to referral systems, I think that there are times when changes need to be made to prescribing in which things can quite easily be done with an independent prescriber in the community without actually having to go back to the GP. That would be a very simple way of saving time. After all, we both know what the end of the conversation is going to be, but legally, we still have to go through the process. However, lots of small things can be done to save time.

At the moment, our minor ailments service is suitable for certain parts of our population, who use community pharmacy as the first port of call. If that is okay for some of the population, why is it not okay for everybody? I understand that the Government is committed to having a look at reviewing the system, which is something that we would whole-heartedly support. The service could be widened out, and other things could be done within it. For example, a few years ago, there was a project in which pharmacists were given minor illness training. They were able to do it quite quickly; although this was used out of hours, had it been used in hours, in normal day-to-day business, it could have helped with appointments at the GP surgery.

Therefore, we should expand the minor ailments service, review how it works and think about how we can have better direct referrals to all the other professionals without having to go through GPs unnecessarily. That would mean that people would contact the GP only when they needed to do so. There has always been the red-flag system, in which the pharmacist will make a referral, and that

happens all the way through in a kind of domino effect. There is a lot that can be done, and we would really welcome a review of the minor ailments service and a look at how we better triage people and use that opening, with its accessibility and long hours, as the first port of call. For example, there are some pharmacy first pilots, and we would like them to be opened out more.

The Convener: As we are running short of time, we will need quick questions and answers.

Gabrielle Stewart: I just wanted to highlight that some AHPs are also prescribers and to say a little bit about the associate physician and link worker roles that are often mentioned. Instead of bringing in new professions and new roles, we should think about the existing workforce, which can fill some of those posts and support people through their professions more successfully instead of having these unregistered workers. We need to think about the workforce as a whole and be very careful about announcing new workforces without really understanding the offer from the current workforce.

Theresa Fyffe: That is a good point. As I said, it is often not about relationships and structures but about who wants to employ people and likes to have line management responsibility. We have a bit of a focus on thinking we will find a new role but we have a team with which we could work differently.

Clearing data is key. ISD must change what it records and what it starts to do with data. The primary care workforce survey comes out shortly. As you will see, it is only about those who are employed in general practices and does not capture all the others whom we have just been talking about. Therefore, we need to get better data.

Miles Briggs (Lothian) (Con): The real new gatekeeper in a GP hub would be reception staff. How can they receive professional development to ensure that they direct people to the right professional? For example, 30 per cent of people who present in a GP case load should go directly to a pharmacist and 15 per cent are phoning up to get advice on medication and repeat prescriptions. How can that conversation be had when someone phones up to ensure that they do not ask to see their GP and then the GP finds out where to send them?

Dr Tucker: In the urgent care resource hub, which we are talking about, most patients still go through NHS 24 and so will have had triage. The Highland hub also has a GP or clinical presence in it some of the time so that immediate support is available and receptionists are not put under pressure to make clinical decisions. In the out-of-hours service in Lothian, some of the money for which we have bid to the Scottish Government is for putting our receptionists through customer training and increasing their training. It is a matter of concentrating on trying to get training for the wider team and not just for the medical or nursing staff within it.

There are no plans that general practices would change the way that they work at the moment. They will not all suddenly change into GP hubs. Therefore, reception will be important for signposting. A lot of that is done already. In general practices, there are lots of posters and a lot of advertising about where people can get help. We need to be smarter about that.

As mentioned in the Ritchie report, we also need to think about more national patient education not just about where patients can go to get help but about self-care because younger patients in particular now contact healthcare professionals about a lot of self-care. Certainly, as a GP working in the out-of-hours service, I deal with many things that my granny would have told me about when I was little.

Alison Johnstone: We have been focusing on ensuring that people see the right professional at the right time but do the witnesses have a view on how the primary care reforms will help to tackle health inequality? Some of the reforms are being driven by the fact that people are living longer but there are many people who are not living longer and they are hard to reach. What are the witnesses' opinions on whether the reforms will help those people?

Theresa Fyffe: That is why I keep referring to access. Some of what we are doing is virtual models but we must not become focused on the building. We know already that there is an issue with some people whose lifestyle is not such that they would turn up at an appointment in a centre so, with the new reforms, we must not put at risk the chance of people getting to the service that they require and make it more difficult for them to get to it. If we open up care in the way that we want to with other disciplines, there will be more chance to ensure that people have accessible services because there will be more people to whom they will be able to go if they feel that they have a barrier with a particular professional. It can happen that they perceive that a particular professional is not paying attention to their needs.

All through the out-of-hours work with Lewis Ritchie, I kept saying that we must not do anything that maximises inequalities. We must be careful, because professionals can be good at fixing things up so that they make it better for themselves but not necessarily for the people who need the service.

Dr Tucker: We aim to offer new routes and not shut any down so, if patients turn up and want to see their GP, that service will still be available. We are not talking about shutting anything down; we are talking about giving more choice and, we hope, providing increased access for people who find it daunting or intimidating to access services through the normal routes.

The Convener: I have a couple of matters to raise. On patient education, I have always felt that everyone should get something like the "Yellow Pages"—or whatever—that would come annually, that people would keep and that would guide them through what they should do. Has any of that been—I shudder to say this—piloted? [*Laughter*.]

Dr Tucker: There was a know who to turn to campaign, which highlighted who to go to for what in different areas. An app has just been developed, too, with which patients can find out what services are open and accessible in the area. I do not know of any phonebook or "Yellow Pages"-type directories.

The Convener: I was just talking about something similar—a guide that someone would keep in the house, which they could refer to at any time and which would tell them the pathway that they should take if they have ailment A or B. You mentioned an app. I bet that most members of the committee did not know that there was an app.

Dr Tucker: The app is in development; it is not out there yet. The know who to turn to campaign started in Grampian, I think. Leaflets and other things were sent out—

The Convener: Was it only Grampian?

Theresa Fyffe: Not many places do it.

Dr Tucker: No.

The Convener: The campaign is certainly not in my area.

Dr Tucker: It has come out a wee bit further than Grampian.

The Convener: How will we know whether the work has been worth it? How will we assess whether it has produced the goods and been value for money?

Aileen Bryson: With healthcare it is difficult to make targets and to quantify things, because if you focus on one thing, other things can be skewed. However, there are qualitative ways to look at services. We are encouraging pharmacists to audit their practice in order to benchmark. You can look at patient surveys on the quality of life for patients in care homes, including measures on better appetite, less swallowing difficulties and whether there is less time for the staff to do the medicine rounds. You can look at unplanned hospital admissions and referrals. There are lots of markers. However, as Sian Tucker mentioned, we must have the time to do that work. That brings us back to what has already been said about thorough and robust evaluation of what is available and the different ways of looking at healthcare. Different measures can be taken.

Theresa Fyffe: We should go for outcomes with indicators. That takes me back to my previous point—the data that we currently collect tells us some things, but not whether we are going to get there. The data that has been gathered for some time has fitted the service as it is, but we have to step back and think about the new model. We have to find the outcomes and the indicators, change our data collection and, consequently, start to get somewhere with it.

Dr Tucker: As well as asking patients whether they prefer the hub model, we need to ask staff. An incentive in working in a multidisciplinary team is that it is fun. We need people to work in the health service; we need GPs and all the other professionals. Therefore, we need to look at how we make it an attractive career.

Gabrielle Stewart: The issue ties in with health inequalities, because we need to ensure that the people with whom we are communicating understand us. I can imagine that my Royal College of Speech and Language Therapists colleagues who are sitting behind me are silently screaming that we need to be a communication nation. We need to ensure that people who experience health inequalities have access to all the information and the services.

The Convener: Thank you very much. We have no time so I do not want anyone to come back in on this, but I am really surprised that no one has mentioned social care in the whole hour of evidence.

Dr Tucker: I mentioned it at the beginning.

The Convener: Maybe you did and I missed it. If I did, I apologise.

Aileen Bryson: I mentioned it at the beginning, too.

The Convener: Here we go. [*Laughter*.]

Alex Cole-Hamilton: You just were not listening. Pay attention.

The Convener: It is a big issue that we did not get into; perhaps we should in the future.

10:58

Meeting suspended.

11:06

On resuming—

The Convener: I welcome to the meeting our next panel of witnesses: Dr Elaine McNaughton, who is a GP and deputy chair of policy for the Royal College of General Practitioners Scotland; Elaine Thomson, who is locality team leader in pharmacy for Dundee health and social care partnership and a representative of the Royal Pharmaceutical Society; Christopher Rice, who is a senior charge nurse in NHS Shetland; and Linda Harper, who is associate nurse director for NHS Grampian.

We are not expecting any opening statements and will move straight to questions. We have limited time available to us, so short questions and short answers would be helpful—and not everyone needs to answer every question. Who would like to ask the first question?

Richard Lyle (Uddingston and Bellshill) (SNP): Good morning, panel, and welcome. You will have listened to our discussion with the first panel of witnesses. One of the areas that we did not go into too much with them related to the fact that, in the main, doctors have had their own premises over the years, and have been leaders, managers, employers, and, indeed, accountants—they have managed everything in their own practice. The GP contract is currently being renegotiated, and we hope that it will be settled by 2017. In what direction do you think that the contract should go? We have one doctor and other health professionals on the panel, and I wonder whether you agree that doctors should be concentrated with other professionals rather than owning the practice.

Dr Elaine McNaughton (Royal College of General Practitioners): You are referring to the independent contractor status that GPs currently hold. The new contract will not bring any fundamental change to that model. There is sufficient evidence out there to show that that model is undoubtedly the most cost-effective way of delivering primary care at the moment. We could have a huge, wider debate around whether that model facilitates or creates barriers to the constructive things that were discussed by the earlier panel.

Within the model, however, we still have a very strong underpinning philosophy of team working; in fact, I suggest that the model supports team working. GPs take on responsibility for employment and for the management of the unit and continue as leaders within the model, but they work very much in a mutually valued team.

My own experience is interesting. In November, I will have been in my practice for 30 years. I hear all the discussion about teams, but when I moved into general practice 30 years ago, one of the things that I valued most about being a GP was being a member of a comprehensive team. In my building, I had a full team of district nurses, practice nurses and community psychiatric nurses, I had a midwife working with me and I had visiting consultants—all those people worked in my practice.

We are not talking about a new model; we are talking about overcoming barriers that make maintaining that underpinning philosophy more challenging. I do not think that the new contract will change the model substantially, and I am not sure that it will necessarily overcome the barriers that were discussed earlier, even if that point is considered. The royal college has said repeatedly that we need to have a sufficient number of GPs to continue the model.

The convener asked for short questions and answers, but I want to mention another challenge that we face with teams, which is that of creating a culture in which each individual professional feels confident, supported and trusted in making decisions. If we are to fully develop those roles, as was discussed earlier, each professional needs to feel safe in their role. The current climate is perhaps creating an unspoken barrier to the professional development of each of the professionals and to their fully embracing the model that was discussed with the earlier panel.

Richard Lyle: You talked about people feeling "safe in their role". Pharmacists dispense prescriptions and, as far as I am concerned, could sign them. In any role that I have had on this committee or its predecessor, every time that I have spoken to a doctor they have told me that they spend an hour or a couple of hours signing prescriptions. Nowadays, we have pre-signed documents, computers and printers. I think that I know the reason for this, but I want you to tell me why a prescription cannot come off the printer and be used straight away. Most prescriptions are repeat ones. Why cannot we stop doctors spending all that time checking and shift that responsibility to someone else?

Dr McNaughton: We would say that, in fact, we absolutely can do that, if the right structures are in place to support it. The royal college has jointly produced a paper with the Royal Pharmaceutical Society that describes exactly that role for pharmacists who work in practices. Some administrative and legislative processes need to be sorted in order to allow pharmacists to sign their own prescriptions but, provided that a pharmacist feels that they are working within their competence, and provided that they are suitably supported by safe systems that allow that process to happen, we would absolutely support it.

For any of us who work in practice, the key thing is to have helpful and supportive systems. That applies to GPs as much as to pharmacists with regard to safe prescribing.

Elaine Thomson (Royal Pharmaceutical Society): We already have systems in place that allow us to take some of that workload away from GPs. The chronic medication service allows us to assess suitable patients and, if they are stable and well controlled, are managing their medication and have no issues, to put them on a serial prescription, which is for up to a year. That prescribing has been assessed as safe for those people.

The assessment can be done by a GP or a pharmacist who works in a practice but, equally, the community pharmacists who work with such people daily can assess how well controlled, motivated and stable they are and we can then give them the option of a one-year prescription. If somebody was getting a prescription every two months, that reduces their contacts with the GP from seven to one and, if they were on monthly prescriptions for whatever reason, that reduces their contacts from 13 to one. That service has a load of safeguards to ensure that people are supported with their medication and are reviewed to identify any issues that they have with taking it, any safety issues or any side effects. That is a whole new service that will take away some of the workload from GPs. Pharmacists can set up those things and they can assess and review patients, so it can definitely happen.

11:15

Linda Harper (NHS Grampian): It all comes back to the multidisciplinary team. Other disciplines such as nurses and AHPs can prescribe; indeed, many nurses run their own chronic disease management clinics, where they see the patient and sign the repeat prescription, if that is within their area of competence. It is all about team working and working together to support everyone in their workload.

Christopher Rice (NHS Shetland): I have to agree—there is a systems issue here. As an advanced nurse practitioner, I have the legal right to prescribe and do so on a daily basis, working with my pharmacy colleagues and GPs.

In Shetland, we do quite a lot of anticipatory care, which allows those of us who work in the community to anticipate what we are going to prescribe and to put in place mechanisms and frameworks to support people in the community. Instead of having to go to the GP, patients could get drugs in their own homes, which prevents GP admission and frees up GP time, too.

As Linda Harper has pointed out, we need to stick within our competencies with regard to prescribing. Working in the GP practice, I see numerous prescriptions—hundreds of them—and the GP simply flicking through them; I would need to sit down and go through each one of them. I therefore think that this is both a time and a process issue.

Clare Haughey: I want to pick up an issue that I raised with the previous panel. I guess that what I am hearing is that other professionals are doing lots of prescribing work, which saves time with regard to GP prescribing. How are you recording and quantifying that? How much GP time have you saved through employing advanced nurse practitioners or having pharmacists in GP practices?

Linda Harper: In the main, I work in the out-of-hours arena, where we have a multidisciplinary team that includes doctors, nurses, social workers and mental health nurses—although we have sort of lost them, which has been a big loss to the team. We continually assess our prescribing, and we have an annual patient experience—

Clare Haughey: I am sorry to interrupt, but you are not actually answering my question. How much time or money is being saved, and how have you quantified that?

Linda Harper: It is very difficult to identify how much time we have saved, but I note that the team itself has gone from being a full GP team to a mix of 65 per cent GP and 35 per cent nurse practitioner. That has resulted in GPs not having to spend so much time writing prescriptions for patients, because we see the patients ourselves. However, we have never audited the time that that sort of work takes.

I suppose that it will take a different amount of time at different times; it will depend on how complex the assessment of the patient is. It could take—

Clare Haughey: I am sorry to interrupt again, but I am very much aware that we are running out of time. Christopher Rice mentioned a change of practice in Shetland. Has NHS Shetland looked at what happened before and how much has been saved as a result of that change?

Christopher Rice: Again, we have issues with the sustainability of GPs, so we have just employed five advanced nurse professionals. We are producing statistics for ISD on the amount of work that community nurses and nurse practitioners do.

Again, this is a systems issue. For example, last Friday, I spent six hours doing statistics for ISD and numerous other things that took me away from patient care. There should be something

integrated in our computer systems and in the pathways to record that sort of thing, but we do not have that at the moment.

Clare Haughey: So the answer, essentially, is no.

Dr McNaughton: How I quantify my 10-minute appointments is a very complex question. There have been many attempts to try to quantify the time that is allocated to different elements of the work. Quite frankly, that is not practical, and certainly within the constraints of the day-to-day work and workload pressures, it is not possible.

The fact that many projects are done in small boxes, if you like, makes it very difficult to quantify things more broadly. A fairly recent study looked at the use of pharmacists in certain roles in chronic disease management, and I have to say that, in cost-effective terms, things are not looking terribly optimistic. We are certainly not looking at cost savings in the model that we have described. I think that there is sufficient evidence to show that one of the most cost-effective and cheapest ways of getting through the biggest numbers of roles is for GPs to do things all in a oner. That might be a very crude approach, but it has been suggested. The reality, however, is that we have a very stressed workforce that is struggling to deliver, so we have to be creative. You are absolutely right that, in order to do that in a meaningful way and assure the public that we are making the best use of resources, we need to have some answers.

The issue is complex. It is difficult to tease things out and bring them down to the black-and-white level that you are asking about—I do not think that we will ever manage to do that. We will simply have to assemble as many complementary pieces of evidence as possible within the context in which we are working. I suspect that, if we were to do what has been suggested, GPs would run one-man shows in a way that would produce an extremely cost-effective service, but it would be a service that would not provide the best care for the patient by any means.

We need to look at the wider picture and consider the quality of care that patients are getting. We must have the right person providing the right care for each patient in the right area, and we must get our heads around the complexities of what measurements will be useful and helpful in contributing to that.

The Convener: Are you saying that the process is driven by the lack of GPs, rather than the desire to improve patient care?

Dr McNaughton: No, I think that it is not—

The Convener: I know that what you are saying is not a stark as that, but is that first point the principal driver?

Dr McNaughton: The other principal driver, which was referred to in the earlier session, is the changing demographics of our population. Many more patients with multiple conditions and increasingly complex needs must be looked after at home or near to their home. It is important to remember that that is the case across their care, because, as was mentioned earlier, investment in social care is crucial to what we are talking about. One of my biggest frustrations as a GP is when, even though I have community pharmacy support, district nursing team support and other support, I cannot manage my patient at home because I have insufficient social care support. That happens every day.

To answer your original question, not having the clinical expertise of GPs and the holistic, comprehensive skill base that they have to offer is one driver, but the other significant driver is the need to meet the significantly changing needs of patients.

Maree Todd: I am interested in the various models of practice. You talked about being a GP and running a team, and you mentioned several different kinds of nurses. Traditionally, allied health professionals and pharmacists were not part of such teams. How might they be incorporated into the GP team? Is that happening across the board? I am aware that there are big practices near where I live in the Highlands that do not have any nurse prescribers, which seems astonishing—I would have thought that, nowadays, nurse prescribers should be providing the regular healthcare for chronic illnesses, for example through asthma clinics.

I would also be interested in hearing about the level of uptake of the chronic medication service. How many of the target population are using that scheme? What are the barriers to using it?

In our discussion with the previous panel, we touched on the minor ailments scheme. I have heard people talk about that being expanded and I would love to hear from the panel about whether people are talking about making that available to more people or about it covering more illnesses. I have heard from my community pharmacy colleagues that there are pilots on treating urinary tract infections, impetigo and, possibly, exacerbations of chronic obstructive pulmonary disease. How do people see that reducing the workload of GPs and directing some of the work towards community pharmacists?

Dr McNaughton: You are right to say that, in practice, the pharmacy role is new and expanding. Community pharmacists have always played a big role, but their inclusion in the team is something new. From a GP point of view, and from the point of view of pharmacists' development, that is quite exciting.

On allied health professionals, in the time of GP fundholding—1990 onwards—we used our funding to set up open-access physiotherapy in our practice. The patients loved it and found it a very useful resource, and we all worked as a team on the same premises. We know that that concept works and so it is important to support such models.

Your other point was correct, as well: there is huge variation in what is going on. Elaine Thomson talked about the chronic medication service, and there is huge variation in that as well, for a variety of reasons.

Something that has been raised as a current potential perceived barrier is the sharing of patient records. That is critical. If we are talking about having community pharmacists treat UTIs and exacerbations of COPD, we need to be able to share information across all the healthcare professionals who are delivering care, otherwise we will not get the holistic care of patients that we really need to hold on to and that the college supports in our vision document about what good primary care should look like in patients' outcomes.

There is a lack of understanding about the legislative challenge that is involved. GPs are currently the data controllers of patient information, so we carry legal responsibility for the confidentiality of that information and for the systems that support it. I do not know what the solution is, and I suspect that everyone in the room will have a different idea about it. However, the issue needs to be addressed legislatively if we are to get over it. If we are to have true sharing and comprehensive records that the right professionals can access in the right way, we need to revisit the model and have a legislative process that supports that.

Elaine Thomson might want to talk about the chronic medication service.

Elaine Thomson: In the interests of time I will just pick up on the CMS and the minor ailments service. The chronic medication service has been going for a few years and the uptake is not as good as it could be. There are various reasons for that, some of which are to do with IT—as usual; it is always to do with IT. The system is quite back to front, in that the patient has to register with the community pharmacy before the GP practice can set up the serial prescription, so that all needs to be refined. With any new system, there are loads of IT issues—we review and revamp it, change it and develop it as we go.

Some of the issues are patient factors. I have talked to people about getting set up on such schemes, but they like the independence of going to the GP to get their prescription or going out to the pharmacy every week, so some cultural things need to be changed. We are balancing that against practice workforce pressures. We need to do work on rolling the service out a lot further, because it could have a massive impact on GP workload and on the pharmaceutical care that we provide. It is an ideal service for allowing us to improve the care that we give—it takes our function away from being purely about supply and focuses on care.

The minor ailments service is currently available to people who do not have to pay for prescriptions. We would like it to be extended to everybody, so that anybody with a minor illness could go to the community pharmacy and be treated for that illness. We are also looking at how we could develop the service beyond what it can currently prescribe for to cover some more complex conditions, so that we can start moving more people away from GP practices and into community pharmacies. Through NES, we now have the common clinical conditions training course, which is upskilling pharmacists to diagnose and manage more than is covered by the minor ailments service. However, we need to develop a lot more independent pharmacist prescribers and sort out all the issues that we have around pharmacists generating prescriptions.

Alison Johnstone: Will Dr McNaughton expand on a couple of points? You said that we are talking not about a new model but about overcoming barriers to maintaining the model that you have practised with for some time.

You also spoke about insufficient social care support being a barrier. Does that discussion around inadequate social care support need to form a greater part of the discussion on primary care reform?

Dr McNaughton: Absolutely and without question. Health and social care integration was underpinned by a recognition that it might be a more efficient and collective way of addressing the combined needs of patients. There is no question but that social care is crucial.

We have talked about involving others, such as the third sector and voluntary agencies. There is a wider team who can deliver significant support to patient care as a whole.

The very short answer to your question is yes, absolutely.

11:30

Christopher Rice: I totally agree. We have two models: a rural one and an urban one. I live in a world where the shops close at 5 o'clock at night, there is a half-day on Wednesday and Sunday is a wash day. That means that we have issues in

terms of finite access to resources. Shetland has a population of 22,000 and we can access only minimal resources for health and social care. The money is there, which is great, but we do not have the physical resources to put it in place. Since health and social care merged, we have a board that works on the ground, because people like me integrate within health and social care to deliver care packages for our patients. However, it does not work in terms of middle management due to simple facts of logistics, IT systems and how the joint board works. That needs to be addressed to combine with all the out-of-hours reviews.

Dr McNaughton: On the question of models, I think that we need to be creative about them. What I was saying was that we are working on the basis of a principle—an underpinning philosophy of having multiprofessional teams working together. However, how that is actually delivered in practice will vary enormously, depending on the context in which it is being delivered, the needs of the patient population that is being served and, of course, the geography, to which Christopher Rice just referred. There is no question but that all those things need to evolve, so the pilot sites that are testing various ways of delivering the model are certainly going to help by feeding into the intelligence around it.

However, there is no doubt that what I described is not the way things have been for a number of years across Scotland. I am aware that what happened in the practice and community in which I worked was relatively unique, because the community setting and the geography facilitated it, as did the management systems and structures of the different healthcare professionals and how they were managed and deployed. Therefore, there is no doubt that there will not be one model that fits all.

As I said before, other professionals being able to feel confident and work autonomously is a question of cultural development. They need to have a feeling of confidence and freedom about working within their own competence area without fear. There is a culture in the healthcare system that we are working in at the moment that needs to be overcome.

So, all the aspects that I have described can contribute.

Alex Cole-Hamilton: I was struck by the revelation in the earlier evidence session that 10 per cent of patients who present to GP surgeries could be dealt with in the minor ailments service. In the margins of this meeting, I was speaking to someone from the Chartered Society of Physiotherapists who pointed out that as many as 30 per cent of patients who present with musculoskeletal conditions could be dealt with by physiotherapists. Dr McNaughton, you touched on barriers in terms of data control, which is a legislative issue. Can you expand on that and identify any other potential barriers to moving some of the workload out of GP surgeries and on to other professions?

Dr McNaughton: As was alluded to earlier, we have a workforce challenge across each professional group. I have two nurse practitioners in my practice, but I felt jolly guilty because I pinched them from other places where they were equally needed. There is no doubt that there is a workforce challenge, which is perhaps a key barrier.

There is another issue for GPs that is difficult to measure. When I have my 10-minute consultation with some patients, I will deal with their musculoskeletal problems and sort out their medications, but actually they came to see me about something different. The issue is therefore how we evaluate that and make the consultation efficient and effective. A great deal of that will have to be about patient choice; patients will need to be helped with regard to the information that they receive about who the most appropriate person is to access for their particular need at a particular time. However, how we deal with the holistic care of patients and the other issues that present in consultations, including associated mental health problems, stress in society and other things that impact on patients who present with problems, will be a complex, evolving process. There will be work to do, so that patients learn about how their needs can best be met.

Given the skills in our team, there is no doubt that I am absolutely the last person who should be dealing with many, many things that patients present to me; I should seek my colleagues' help where I can. Similarly, when a patient presents to the physio or the pharmacist, it is likely that the professionals will need to seek help from one another. That is key to making the system work well. Patients' needs are complex; a patient rarely presents to me with a single problem—that is true for patients who go to physios, too. The challenge is how we deal with that in the most efficient way.

Elaine Thomson: There is a lot that we need to do. We have talked about increasing awareness among patients about how they access services; we also need to do work with the wider team, so that people know who they can signpost to. I know that I can refer to a physio or a dietician, but I am not sure that my community pharmacy colleagues have the same referral pathways. That takes us back to what the convener said about the "Yellow Pages". We have had books such as he proposed, to enable health professionals to refer with confidence to the appropriate place.

As teams develop, so will the referral pathways. There is much more acceptance that a

pharmacist, a physio or a nurse can refer patients to other professionals, to whom we might not have been able to refer in the past.

Clare Haughey: I declare an interest: I am a mental health nurse, registered with the Nursing and Midwifery Council. We have not touched on mental health, which plays a huge part in the volume of presentations to primary care services. How does the panel see the role of mental health professionals in supporting GPs, AHPs and so on in the primary care setting?

Dr McNaughton: Mental health professionals will need to become an integral part of the team and one of the signposting options for patients. We know that there is a huge amount of mental illness. There is a spectrum of mental illness and mental and emotional distress, and we need to be wise to how we deliver the service. In that regard, we have all responded to the call for views on the 10-year mental health strategy.

Key to all this will be the interface and the network literacy that supports how we integrate with each other. The interface will be critical. Mental health will be a crucial part of the primary care team.

The Convener: Linda Harper, you said that you lost the mental health nurses from your team. Will you talk about that in responding to Clare Haughey's question?

Linda Harper: Mental health nurses are key to out-of-hours care and general practice. We had mental health nurses in our team, but workforce is an issue and it is about having enough mental health nurses—

Clare Haughey: Sorry to interrupt. You said, "our team"; which team is that?

Linda Harper: I am talking about the out-of-hours team in Grampian. We have a multidisciplinary team, and we used to have mental health nurses with us overnight, which was good for the team and for patients. However, due to workforce changes, the team went to the Royal Cornhill hospital, so a patient is now seen by a GP or a nurse with us and then referred on, rather than the patient having direct access to a mental health nurse. We need more mental health nurses.

The Convener: Why did the mental health nurses move?

Linda Harper: They went to support the team at Cornhill.

The Convener: There were not enough mental health nurses, so nurses were taken out of your team and put into a hospital setting.

Linda Harper: In essence, yes.

Miles Briggs: I want to ask about expanding capacity beyond health professionals and into the third sector. How is the relationship with the third sector being built up, so that people can be referred for social prescribing, for example? We do not want the next barrier to be one that prevents people from sending patients beyond the hub team to other people who might be key to addressing their health concerns.

Dr McNaughton: It varies across Scotland. My experience has been very positive; we have third and voluntary sector representation in our multidisciplinary weekly team meetings in the practice. I know that that is not the case in all practices.

The health and social care partnership planning structure should facilitate that process. Whatever structure works within the context of the geography in which it is being delivered will direct how that should be done effectively. It has to be a practical approach, finding pragmatic solutions for the way forward.

The Convener: Several times, people have mentioned the shortages in various professions. We have approximately 1,000 GP practices and funding for an additional 140 pharmacists, and potentially we are supposed to be rolling out this hub model. If we cannot staff what we have now, how on earth are we going to roll out that model or develop it? Realistically, can you see that happening without a huge injection of cash from somewhere?

Linda Harper: It goes back to the earlier point about needing to be able to sustain these models. It is about having funding not just for one year, so that we can offer substantive posts to people. In saying that, I know that there are difficulties in some areas around recruiting nurses to the universities to complete training. I do not know what it is like in pharmacy, but we have to encourage people to think about healthcare services, social care and caring and encourage them to come into those professions; we need to make it a profession that they want to join and are proud of.

Dr McNaughton: For GPs, the direction of travel is in the wrong direction. The number of GPs is reducing and we are facing a huge retirement bulge, which we have been highlighting will happen for as long as 10 years now.

There are a number of challenges around recruiting GPs into general practice. As Dr Sian Tucker alluded to in the first panel, we have just launched our think GP campaign to try to promote what an attractive career option coming into general practice is for doctors. However, there are some fundamental challenges with recruiting through the system. We recognise that only

approximately half of our medical students are Scotland domiciled, so we have a big challenge in retaining the number of medical students that are being trained in Scotland.

It is important to increase the amount of general practice exposure within undergraduate training to encourage people into our specialty; 100 new training places have been created and advertised and we are in the process of making appointments, but unfortunately we are not going to fill those places or anything like it. In fact, we still have a number of unfilled places for GP training from the previous recruitment round, so we are not attracting potential future GPs at this point in time.

The college's role is to do everything that we can to promote the GP option at every stage in our career flow process, but it is a real challenge and a real concern. It is very difficult to see how we can sustain models, both in and out of hours, for the whole team, including GPs, without a shift of resources into primary care to support that. That is absolutely the answer to your initial question.

Elaine Thomson: The convener is right that having 140 new pharmacists across 1,000 practices in Scotland will not go very far. However, we are talking a lot about transformation, and a lot of this is about doing things differently. It is about utilising the resource that we have to the best of our ability, so it is about utilising the skills of pharmacists and all the other professionals as well.

In the first evidence session, someone talked about prescribing demands. We know that 50 per cent of medication is not taken as it was intended to be taken when it was prescribed. When I go into peoples' houses day to day, there are bucketloads of medication that is not being taken as prescribed.

We need to start talking to people about the outcomes that they want for their health. If we deliver the care properly, some of the workload will naturally reduce in the longer term, because people are being given the services that they want. We are currently thinking about how we deliver services based on the current demand, but that does not necessarily mean that that will be right as time goes on. Things will change as the years go on.

11:45

The Convener: Do any of you have evidence of change happening, whereby people are no longer sitting with buckets of medicines and tablets?

Elaine Thomson: Yes.

Dr McNaughton: Yes. One of the things that has facilitated that for me, as a GP, is the introduction of pharmacy technicians into practices. They go out to people's homes and look at the medications and delivery systems and work with their pharmacy colleagues on medications and prescribing.

"Realistic Medicine: Chief Medical Officer's Annual Report 2014-15" is a reminder to all of us. Realistic medicine is fundamental to general practice. We consider patients' needs and prescribing in the context of the whole patient. We look to be much more realistic in what we prescribe. Moving away from our quality and outcomes framework will facilitate that. A lot of prescribing was target driven, so moving away from the QOF will rationalise it. There will be changes in how we deliver care and it will be important to be more efficient with the support that we need to ensure that patients follow what they should be doing and are informed appropriately to do that.

Elaine Thomson: We have data from some of the work that we have done in care homes on medication reviews, using a multidisciplinary approach, and we can see what happens through time to the amount of medication that is prescribed for people. I have data on the number of high-risk medicines that have been stopped, the number of untreated conditions for which we have started treatment and the changing costs through time. The data exists and, as we develop more and more of those models, it will get more robust.

Linda Harper: It is not just about medicines; a huge amount of cost relates to dressings. We have done a piece of work on that locally, as other areas will have done. When we write a prescription, a patient might have a box of 40 dressings but need only two. In one large practice in our area, £1,000 per month could be saved by doing things differently. Different areas are considering the best way to serve the patient and be cost-effective.

The Convener: There are no more questions, so I thank the witnesses for attending.

As agreed, we now move into private.

11:47

Meeting continued in private until 12:03.

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