OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 1 October 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 1 October 2019

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HEALTH AND SPORT COMMITTEE
22nd Meeting 2019, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Matt Barclay (Community Pharmacy Scotland)
Dr Andrew Buist (British Medical Association Scotland)
Jonathan Burton (Royal Pharmaceutical Society)
Dr David Hogg (Rural GP Association of Scotland)
Dr Amjad Khan (NHS Education for Scotland)
Dr Carey Lunan (Royal College of General Practitioners Scotland)
David McColl (British Dental Association)
Dr Anne Mullin (Deep End General Practitioner Group)
Karen Murphy (Rural and Remote Patients Group)
David Quigley (Optometry Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 1 October 2019

[The Convener opened the meeting in private at 09:00]

09:33

Meeting continued in public.

Primary Care Inquiry

The Convener (Lewis Macdonald): Good morning, and welcome to the 22nd meeting in 2019 of the Health and Sport Committee. We have received apologies from Miles Briggs. I ask everyone in the room to ensure that their mobile phones are turned off or to silent, please. Although it is appropriate to use mobile devices for social media, please do not take photographs or record proceedings.

The first item on our agenda was taken in private. Agenda item 2 is the second evidence session in the second phase of our primary care inquiry. We heard from a number of witnesses last week.

I welcome to the committee Jonathan Burton, who is chair of the Scottish pharmacy board of the Royal Pharmaceutical Society; Matt Barclay, who is director of operations at Community Pharmacy Scotland; David McColl, who is chair of the Scottish dental practice committee of the British Dental Association; and David Quigley, who is chair of Optometry Scotland.

You will be aware that this is a broad-ranging consideration of what primary care should look like in the next generation and what changes are happening or should happen. Part of that is about integrated planning across primary care and other healthcare professions. To what extent is integrated planning taking place nationally across all healthcare professions? What is your input to that? Those are nice broad questions to get the discussion going.

David Quigley (Optometry Scotland): Is your question about what has been done or about what could be done?

The Convener: What is happening at the moment? You can also look forward.

David Quigley: My colleagues and I have had conversations about what needs to be done. With regard to implementation, there is a common understanding that there is enormous potential for us to work together on communication, integrated technology, electronic patient records and the ability to find out quickly what is required of us in order to meet patient needs. Clearly, the matter of infrastructure is another question.

The willingness and the opportunities are there. There is, for example, a massive opportunity to raise public awareness. Everyone knows, in various portions, what is required in sharing information, whether by paper leaflets, social media or the press. We need to share the information that other people need in order that they can make the right decisions about where to go and when. That does not necessarily mean information about where to go—it could be information about where not to go. People should not need to travel unnecessarily or to make unnecessary appointments.

The Convener: Is planning for those purposes going on? Is that your experience of health work?

David Quigley: No.

David McColl (British Dental Association): On the back of what David Quigley has said, I note that the BDA feels that information technology integration is crucial to everything that happens in health. We have clunky IT systems that do not talk to one another. Even in secondary care, there are systems that do not talk to one another, so people cannot measure exactly what they are doing. We cannot interface with secondary care very well.

We have a very clunky referral system called the Scottish care information—SCI—gateway, which is a bolt-on to the dental services that we have. It takes 10-15 minutes to fill in a field, and there is nothing that can pre-populate the system. As David Quigley said, we need access to electronic care summaries, because we spend an inordinate amount of time with patients going through and updating their medical histories. An electronic form would really help practice.

Matt Barclay (Community Pharmacy Scotland): I would echo much of what my colleagues have said. However, a lot of work has gone on. We have had the national clinical strategy, the transformation moneys and the out-of-hours review that was led by Sir Lewis Ritchie. How effective all that has been in changing practice to date is questionable.

I reiterate what my colleagues said about information sharing. In a community pharmacy context, day-to-day information sharing certainly needs to improve. It would be really good if that work was joined up. Things are happening in the background on information-sharing arrangements, following conclusion of the general medical services contract, but improved arrangements are certainly far from the reality.

There is willingness, as can be seen in the fact that all the bodies that are represented here today are part of the primary care clinical professionals group, which meets regularly. The group was, largely, created because there was so much work going on and there was a realisation that all primary care professionals needed to look for commonality and to work, as a group of professions, towards common goals. That willingness on the professions' side needs to be matched on the other side.

Jonathan Burton (Royal Pharmaceutical Society): It is difficult to integrate healthcare services when the professionals in the services cannot easily communicate with one another. We see that in community pharmacy practice, and it is echoed in other contractor professions that sit outside the general practice surgery model.

It is, for example, difficult for us to access patient records. Changes are starting to be made in some areas, but access to basic electronic care summaries is still not commonplace in community pharmacy. In pharmacy, the range of services and the complexity of care that we offer are forever increasing. We lack not only the ability to see records but to populate them with a record of the care that we provide. That limits integration. Every minute that we spend struggling with communication with our colleagues is a minute away from patients.

The Convener: We will have brief supplementary questions from Sandra White and Brian Whittle.

Sandra White (Glasgow Kelvin) (SNP): David Quigley talked about awareness. Would it be a good idea to have a Government campaign to make the public aware of what they can access? It could be funded by the Government or the national health service, and it could be something like the see me campaign.

David Quigley: We need awareness raising, whether through marketing or public relations, and the approach needs to be consistent. A number of information platforms are available to us all online, through smart devices and on paper in practices and surgeries.

Sandra White: I mean a television campaign, for the public.

David Quigley: I am talking about a public information campaign of some description, but it would have to be done across a variety of platforms. TV alone would not do it.

Brian Whittle (South Scotland) (Con): I was going to ask later about information technology infrastructure but David McColl and Jonathan Burton have raised the issue early. I agree 100 per cent that we require a central IT system that all clinicians can access and give input to, but currently we do not have that. However, the fundamental question that has to be answered is this: from a clinical perspective, who owns patient data and who should own it? There are lots of issues and thought processes around that. I have my own thoughts.

David McColl: With patient data and the electronic care summary, we do not need access to the whole patient record. The contractors that are represented here need access to only some of the record. The most important things for us are current medical history and current medication, and any interactions that arise from that. We do not need access to the whole patient record.

Brian Whittle: I completely advocate layered access to patient data in an IT system, depending on whether the clinician is a GP, a pharmacist or whatever. However, my specific question is this: who should own the patient data?

David McColl: That is really a legal question, is it not?

Brian Whittle: I do not know about that.

David McColl: You would probably need a team of lawyers to delve through the general data protection regulation to find out who actually owns patient data. At the end of the day, the patient has a right to access their patient data, so does the patient own it? Alternatively, does the contractor own it? We should remember that the contractor funds all the clinical software—it is not supplied by the NHS or the Government.

Maybe it would be different if the information was held centrally and was cloud based. Matt Barclay and I were talking earlier about the fact that contractors have choice about the clinical systems that they operate. My view is that we should not have choice: we would probably prefer to have one system that would be upgraded and maintained throughout the NHS. That would make NHS delivery a lot easier. If the data were to be held in a cloud, who would own it? Would it be the NHS and, ultimately, the Government, or would the patient own it?

Brian Whittle: The issue—

09:45

The Convener: Let us not have a dialogue; let us have a wider conversation.

Matt Barclay: We are on a journey, on which the right first step is probably to give the professional networks wider access to information. Ultimately, if we want to inform and empower patients, they should own their data and authorise the right professionals to see the data at the right time. That is the end point for me. I appreciate that

there are GDPR and information governance issues in that regard.

Brian Whittle: I agree.

Matt Barclay: Good.

David Quigley: I concur with Matt Barclay. The patient should own their data. GDPR would, thereafter determine how contractors would be able to use the data.

Jonathan Burton: We should be aiming for a centralised digitised record, of which the patient has ownership. Professions that are arguing for increased access to records and increased ability to write into records should be mindful that we need to take patients with us on the journey: their consent is essential. We should use the appropriate information in the appropriate way.

The Convener: That brings me back to the answers to my first question, from which I got the sense from all of you that there are barriers to integration, which is not yet happening. We have followed a couple of lines of inquiry around that. Who is responsible for delivering change and the level of integration that is sought? Who should take the lead?

Matt Barclay: It must be the Government that takes the lead. The first paper that the primary care clinical professions group drafted was on digital-enabled health technology, a facet of which is health information sharing. All the professions agreed that a once-for-Scotland approach is the right one. We have 14 health boards and 31 health and social care partnerships; my view is that that fragmentation across Scotland creates issues for integration.

David Quigley: On a positive note, collaboration is important. Initiatives can come from all parties; what matters is what we do with those initiatives. The Government obviously has to take its place in supporting initiatives.

Over the past couple of years, we in optometry have used a highly collaborative process. We have managed to land electronic submissions for payments—other colleagues had already achieved that. For us, the experience was very collaborative and co-operative, and it benefited everyone, because the approach saves time and money. Contractors get paid more quickly and there is less waste in the system.

There is the potential to do a lot together. It does not matter where an initiative comes from; what counts is who makes it land at the end of the day.

David McColl: I agree with Matt Barclay that delivery of integration has to be Government led. If we leave things to individual boards, they will all do slightly different things, in slightly different ways and we will—again—end up with systems that cannot communicate with each other.

Emma Harper (South Scotland) (SNP): We have a variety of systems and communication is working fabulously. Now we are ready to collaborate, as David Quigley described.

I am interested in the wider role of professions such as dentistry, optometry and pharmacy in providing healthcare in collaboration. In submissions to the committee it was suggested that community pharmacy could have an increased role in providing health advice, and Community Pharmacy Scotland said:

> "We would like to see Community Pharmacies as a location that patients are referred to when they have a medical concern which does not require a GP's appointment".

It was also suggested that optometry should be the "first port of call" for all eye-related problems.

I would be interested to hear about any discussions that have taken place about the enhanced role for community pharmacy. Are pharmacists best placed to undertake anticipatory care and preventive work?

Matt Barclay: Discussions are taking place. In April 2020, there is to be an evolution of our contract, to extend the minor ailment service so that it covers more services. For example, the scheme will cover services to do with urinary tract infection and impetigo that GPs have traditionally provided. That type of thing is happening. To go back to Sandra White's point about public awareness, we would look for a public awareness campaign to go hand in hand with that to signpost people to the community pharmacy.

David Quigley made a point about collaboration between professions. There is nothing to stop informal collaboration as well. Organisations such as Optometry Scotland and Community Pharmacy Scotland have certainly worked in the past to create referral pathways between community pharmacists and optometrists. I know that local practices can see that approach embedded in an informal way—I am sure that Jonathan Burton would echo that. A patient may come into a community pharmacy with an eye complaint, and it will not quite have the tools to deal with that, so the patient will be referred to our optometry colleagues. Such referrals happen daily—people realise when they have to refer patients. We are looking for community pharmacies to be a generalist first port of call for common clinical conditions, so that we can take pressure off other areas of the health service.

Jonathan Burton: I am a practising community pharmacist. It is fair to say that, over the past 15 years, the pharmacy contract and the range and depth of the services that we offer have continually

evolved. We are at a point at which we have to look at the resource that needs to go behind the complexity of what we do and the breadth of the service offering. We need to look at the training, the continuing professional development and the support that are needed to maintain that first-port-of-call access service. I very much consider myself the first port of call, but the lack of infrastructure and integration makes that challenging in a time when an increasing number of patients are coming to see us. The evolution has been positive, but we need to take a serious look at the resources.

I am a massive fan of referring to optometry, but the process is rather clunky. It is not my place to comment on optometry remuneration, but I was very pleased to see supplementary eye examinations mentioned in the Optometry Scotland submission and the fact that more support is probably needed to make those appointments more available. I very much second that. We are the first port of call—the guys people walk in to see—and we need to be able to refer to one another easily. That involves GPs and the professions that members see represented here today. However, a resource ask comes with the increasing complexity and the increasing workload.

The Convener: The issue is also relevant to both of the other professions, so they should feel free to comment.

David Quigley: Most optometry practices are on the high street, and when you are on the high street, you do not turn people away. There is huge potential for us to continue to offer that opportunity to the public.

Since 2006, when general opthalmic services were reintroduced across the board, we have had the opportunity in optometry to compare and contrast ourselves with, for example, England, where the volume of out-patient work has increased by 40 per cent; in Scotland, it has increased by 8 per cent. We can therefore demonstrate that we are keeping people out of secondary care and hospitals.

With regard to education, we now have a very willing group of clinicians who are much better placed to use the skills that they were trained to deploy. That was not the case beforehand. With the introduction of independent prescribing and other enhanced training, we are able to do more in acute eye care. That goes back to what was said about awareness raising. The more members of the public are aware of that, the more they will come directly to us.

I think that availability was mentioned. Many practices are open six, if not seven, days a week, and many are able to offer extended hours. If we are able to work in an environment in which we can facilitate and provide for that, there are endless possibilities.

David McColl: We are one of the few professions in the industry that sees patients who are otherwise well, so we have an opportunity to pick up a lot of other disease processes. Diabetes springs to mind; we could certainly pick up the pre-diabetic condition. It is unusual that we see people every six months who are otherwise well.

David Quigley: On that point, some research was produced recently by Dr Zangelidis at the University of Aberdeen about how the detection of high blood pressure had improved as a result of people having routine eye examinations, because the condition was being detected as a matter of course.

Emma Harper: We have had debates about how optometrists can be key in the detection and referral of type 2 diabetes. That is quite valuable. My sister is an ophthalmic nurse specialist, so I hear all about eyes and so on. She works in Carlisle, and there is definitely a difference from the care and treatment in Scotland, which seems to be a lot more positive.

If everybody was to collaborate, how would we fund all the training requirements? Do we need more pharmacists or optometrists?

The Convener: Simply saying that we need more money for everybody will not quite do the trick. With that health warning, I will take David Quigley first.

David Quigley: I was not about to say that.

New provision in optometry is being created at the University of the Highlands and Islands in Inverness. There has long been a massive shortage of optometrists in Highland and Grampian, and that will ease if more optometrists come out of the UHI. The vagaries of supply and demand have made the cost of providing optometrists shoot up in those areas, so increasing the supply into those areas will help to address that. From a practical point of view, that will to a certain extent help with the cost of delivering optometry.

With regard to funding, we need to evaluate the efficiencies. We have demonstrated that we can save £71 million, whether that is in cash or by redeploying resources in secondary care. It would be good if an opportunity could be created to monetise that and bring it back. In our case, fees have not increased for 10 years. Although rent and rates have not moved very much over that period, the cost of people has increased massively.

You mentioned the detection of diabetes and other diseases. We are very grateful that, 10 years ago, we were granted funding for fundus cameras, which allow the next generation of tomographers

to do a much deeper dive into the retina, which makes the detection of all manner of ailments, including diabetes, much easier. We have had some great discussions recently about generating a centralised artificial intelligence database so that we can start to remotely diagnose and track any changes every time an examination is carried out. Again, that needs a bit of investment and collaboration, but it is all there.

Matt Barclay: As Jonathan Burton said, the complexity is increasing, certainly in community pharmacy, due to the number of people who are coming to see us as a first port of call. I would echo Jonathan's call for resource to go into the training to match that. We are working in partnership with the pharmacy and medicine division to develop the contract in that direction. I mention in my submission the extension next year of the new pharmacy first and minor ailment services. We are also looking at a co-ordinated independent prescribing strategy, because we see it as an end point for community pharmacists to have independent prescribing status for dealing with patients who come through the door. We have that skill set in mind, too.

It is easy to say that more money is the answer, but we are working within our financial envelope to shift money from certain areas to support what we and the Government department see as strategic areas. We are not looking for huge amounts of money to supplement that but, as Jonathan Burton says, we need more resource to support the direction of travel, certainly for community pharmacy.

Emma Harper: I have a final question, which might be for David Quigley. Is there any resistance to using optometry as the primary place where people go for emergency eye treatment and so on?

10:00

David Quigley: There should not be. In the past, there might have been resistance from ophthalmology for inappropriate referrals. There was a feeling that, if things become too sophisticated and detection methodology improves too much, people begin to overrefer. However, that has proved not to be the case. The better diagnostic methods are and the better the equipment is, the more accurately we can refer. We have shown that in Grampian, where the workforce had a higher level of training in the Grampian eye health network. That has been a hugely collaborative exercise, which has been repeated to an extent in Lanarkshire and Ayrshire, involving ophthalmology and optometry. A lot of those barriers were broken down. That should be emulated. Many more people were retained in the community and far fewer were referred, and the accuracy of referring increased enormously to over 80 per cent. That is an exemplar that we would love to emulate throughout the country.

Emma Harper: How long does it take to break down the barriers? Is it six months? When you reflect back on the process, do you think that it has taken five years for people to realise that they can go to pharmacy as a first point of contact or to optometry for eye health exams?

Jonathan Burton: I will respond to that and I also want to skip back a couple of questions, if that is allowed, convener.

The Convener: Sure.

Jonathan Burton: It is an evolutionary process. Ten or 15 years ago, eyebrows were occasionally raised when pharmacists referred to our clientele as patients rather than customers. Thankfully, those days are long gone.

To go back to the previous question about the acceptability of our service to others in the medical professions, the majority of GPs are supportive of our front-line role in community pharmacy and of having GP practice pharmacist colleagues working shoulder to shoulder with them in their buildings. We all have a role to play.

It is not just about easing the workload or the pressures on any one profession. It is often said that our work saves GP time, but it is not about that; it is about making sure that patients have good access to the appropriate level of care so that we can all do what we are best at.

In our submission, we mentioned transformational change. Looking at the pharmacy picture, we would like to see a continuation of the evolution in community pharmacy practice so that our remuneration and training support pharmacists who offer patients a package of care, not just a package of medicine. As we have said many times before today, the complexity of what we do is ever increasing.

On what the public want, the evaluation of the minor ailment service, which was an independent evaluation that was done by the two schools of pharmacy, showed that patients value accessibility. They value being able to speak to somebody they are familiar with. They also value the fact that they do not need an appointment. It takes resources to offer those sorts of services in the community. I feel that that is the right way to offer care. We are fortunate to have such amazing networks of pharmacies, optometry practices and dental practices across the country, and we need to use the fact that we are close to where our patients are.

The Convener: Sandra White has a brief question, and then we will go to Brian Whittle.

Sandra White: My question has been answered, thank you.

Brian Whittle: If we are going to maximise the skill set of a pharmacist, do you agree that we want pharmacists to have more time with patients? Anecdotally, I have heard from quite a number of pharmacists that we could train staff in helping to dispense medicines so that the pharmacist does not have to do that constantly. However, I also hear that, as soon as that happens, the staff get pinched by secondary care. We are always talking about the number of clinicians we need; are we failing to look behind that at the support network?

Jonathan Burton: Are you asking whether we have a workforce crisis in pharmacy?

Brian Whittle: No. I did not mention the word "crisis"—I would never use that word.

Jonathan Burton: We have a finite number of pharmacists who work in Scotland. There are quite a few of us—more than 4,000—and we are the third-largest profession, but it is fair to say that our skills are in demand.

We all know that medicines can be wonderful things and can do fantastic things for people's health. However, they can be risky and can sometimes cause harm, which is why our profession's knowledge and skills are sought after. That has led to some fundamental changes to the GMS contract. Many of our pharmacist colleagues are now actively working side by side with GPs and nurses in practices, which is very positive.

As I said, we are a finite workforce. We are in hospitals and community pharmacies, and there is only so much of our time to go around. We need a more highly trained support staff. We have a very hard-working workforce, who already do a lot of dispensing and technical activities for us. It is fair to say that transformation has probably been more rapid in hospital practice than it has been in community practice. There are many underlying reasons for that.

We need to ensure that we are able to put our pharmacists where they are needed, which is right in front of the patient. At the moment, we have some issues with that. Our workforce is becoming increasingly stretched, and the Royal Pharmaceutical Society does not believe that that is in anybody's interests—least of all patients'. It is positive that pharmacists are able to work in general practices but, if our services are taken away from hospital wards and community pharmacy consultation rooms, that will have a negative feedback effect on those general practices. We need to ensure that patients get accessible and safe healthcare and do not always gravitate towards general practice for anything and everything.

We need to look at our workforce planning. We have a lot of workforce surveys, which throw off a lot of interesting information, but so far we do not have a coherent plan that takes account of the fact that patients are now fellow professionals who need us in a lot of different settings. Wherever there are medicines, there needs to be pharmacist input, whether it is administrative and technical or whether it is right there with the patient, the doctor and the nurse. That is becoming increasingly difficult.

The Convener: Thank you very much. You have given us some food for thought.

I think that David Stewart has a brief supplementary, and then I will let in George Adam.

David Stewart (Highlands and Islands) (Lab): I will let George Adam come in first, then I will come back to workforce planning.

George Adam (Paisley) (SNP): During the summer, we went on an away day at which we met members of the public. One of our tasks was to redesign the health service so that it worked as we would want it to. Every one of us moved away from the idea of people going to their GP, as Jonathan Burton said, towards the health hub ideal. With that in mind, if the witnesses had a blank canvas to work on, what would you see as your profession's involvement in prevention and ensuring that we promote the health agenda?

David Quigley: I quite like the notion of health hubs but, if they were on the edge of communities, travel and so on would be involved. We should try to create things within existing provision. For example, we are located where we are located, so if the public are aware that more services are available—

George Adam: I am sorry to interrupt, but, if someone gets ill, they go to their GP regardless, which has a knock-on effect on the surgeries. The hubs would be part of the system, but that was not the main issue; the main issue was the fact that the public already get the idea of accessing other professionals and professions. That is the point that I am trying to get at. How would you make the system work, if you had a blank canvas?

David Quigley: If we had a blank canvas, we might want optometrists to become the GPs of the eyes, for example, which we have spoken about. I do not know whether that is nearer to answering your question.

Fundamentally, we need to start getting people to go where they need to go, given their particular symptom or the part of their anatomy that is involved.

It is a question of reducing unnecessary travel and unnecessary visits. Anyone who goes to receive any form of medical care will already have

a degree of trepidation, and concerns about whether they are in the right place or the right department, whether they are going to see right person and how long they will have to wait will only add to that trepidation. As has been mentioned, if someone is in a familiar environment where they are comfortable and can get to know the people, it will be much easier for them if whatever concerns they have are addressed and dealt with there, rather than having to be referred anywhere else.

Matt Barclay: It was interesting to read the evidence from the meetings that the committee had with the public in phase 1 of its inquiry. It was heartening that the public did not regard the status quo as an option and that they wanted the evolution to continue. They also mentioned the professionals they most want to see; I think that mental health professionals were top, followed by physiotherapists and pharmacists. That was heartening. A large majority wanted their information to be shared—that is fine.

Although a community pharmacy operates in a building and our GP and other health profession colleagues operate from a building, it is more a question of creating a virtual hub, through which patients are transferred seamlessly. That might involve public awareness to make sure that people know which professional to see, and that they see them at the right time for the right reason. There needs to be such awareness within the profession, too, so that we can refer people on. There also needs to be a link to secondary care expertise as and when that is required. As a generalist, I can go only so far, but the ability to refer people on to experts is important.

I do not know whether that answers George Adam's question, but that is what I would like to see happening in the future. I would like us to still be at the heart of communities, with patients coming to see us as and when they require to do so. I hope that we will have an upskilled workforce at the front and the back, so that the technical stuff is done and the pharmacists who see patients up front will be able to share that with the wider primary care workforce.

David McColl: The concept of what we would do if we had a blank canvas is a very interesting one. As someone who has been in the same practice for 32 years, I think that prevention is the key. Currently, we are not that well funded for prevention; everything is loaded on to treatment.

When it comes to prevention, the skills mix is key. It does not necessarily take a dentist to deliver prevention. Enhanced duties dental nurses and therapists could do it, led by dentists. I would start by investing in prevention now.

George Adam: My next question follows on from that. I always use the example of my wife Stacey, who has multiple sclerosis, which is a long-term condition. She keeps telling me that I should stop talking about her MS, because she has another two chronic conditions—she likes to brag about these things. She is quite proactive in managing herself through the system, although it has taken her a while to get to that position. In managing herself, she will talk to her MS nurse, but she rarely goes to the GP, because she probably knows more about MS than he does.

For your professions to be helpful to the patients who come to them, they need to be empowered. How do your professions empower people to get through the NHS? That is probably an easier way for us to get people through the system than the idea of re-education and redeveloping the system.

Jonathan Burton: I absolutely agree with that. Anybody who works on the front line will say that they are part health professional, part navigator and part adviser. We feel that we could build on that significantly in community pharmacy if only we were better linked into the system. The issue comes back to the arguments about central patient records, electronic communication and the need to make referral between different agencies as slick as possible. If we can navigate a patient through the service and explain to them why they need to see their dentist or—if they have gravitated towards us with an eye problem—their optometrist and can smoothly facilitate their being moved on to the right service, that is a powerful message in itself.

I spend a lot of time working with young people, as I work in a pharmacy that serves a predominantly student population, and it is a joy to be able to teach people how to use the NHS properly at that early stage in their adult life. People really respond to that.

10:15

The issue involves being the first point of contact, helping people with their symptoms and picking up on things that need referral, but it is also partly about educating people about how to use the service and how to practise appropriate self-care and look after themselves. I am an independent prescriber and, in my pharmacy's consultation room, I have two pads on my desk: a prescription pad and a pad of TARGET—treat antibiotics responsibly, guidance, education, tools—self-care leaflets that explain to people common symptoms of illnesses, how long they should last, when it is necessary to see a doctor and why it is not appropriate to take antibiotics. I tear more sheets off the self-care leaflet pad than the prescription pad. That is where we need to be.

David Quigley: That was very well put—I could not agree more. David McColl's point about prevention is also important. That is something that primary care providers can take on board, as there is a need to enhance people's knowledge and put more emphasis on their role in looking after their own health.

The only other thing I would mention is that, at the other end of the spectrum, there will be an increasing number of people who are unable to visit premises, which means that anything that they can access safely online will become increasingly important. What sits in between that is the issue of what we do with the provision of domiciliary services. Only about 25 per cent of the people who are eligible for optometry home visits receive that service. How many people in that group are developing other medical issues as a result of not being seen when they could be seen? The issue goes back to communication and awareness raising, but the point is that an increasing number of people cannot come to any of us, and they will require more visits at home.

George Adam: Are you saying that, in order to make everything work, information sharing is the number 1 priority, so that you guys can ensure that you have the access that you need when you and the patient need that to happen? That is a pretty basic question, but I want it on the record.

The Convener: I see nodding heads.

George Adam: Nodding heads do not help in the *Official Report*.

Jonathan Burton: Yes, then.

Matt Barclay: Yes.

David McColl: Yes.

David Quigley: Yes.

The Convener: I think that everyone concurs.

David Stewart: Jonathan Burton touched on workforce planning in his answer to Brian Whittle. How effective is workforce planning in your occupations?

David Quigley: It is a difficult area. With regard to professional colleagues who are on various registers, we know that they are registered and that they are listed with various health boards but we do not know whether they work full time or part time, so we do not know how many hours are being delivered. Central listing, which we have been aspiring to for some time, will give us a better idea of who is where and when they are there, and that, in turn, will give us a better opportunity to make provision wherever it is required. However, it is not an exact science. As everyone will be aware, the demographics of many of the vocational professions have changed significantly in the past 10 to 15 years. Adding in such factors makes everything more complicated.

David McColl: As David Quigley says, workforce planning is not an exact science, and we have never quite worked out how it should be done. Given the demographics that are involved, you do not know who works full time, who works part time, who has left the profession for a while, who has returned to the profession after a break and so on. We are finding that a lot of younger practitioners are leaving dentistry, which can be a stressful working environment. We need to find out why they are leaving dentistry. We spend £250,000 on training professionals, only for them to leave after two, three or four years. Some are leaving dentistry; some are going to Australia and further afield. We have to look at why they are leaving.

The Convener: Do you have a view?

David McColl: We work in a stressful environment. Our regulator, the General Dental Council, has not helped—I think that everyone probably knows that. We are trying to address that issue and get local resolution in Scotland without things having to be repatriated to the GDC in London.

Patients' expectations are high. Certain things are not deliverable under the current NHS system. It is multifactorial.

David Stewart: The two Davids on the panel—David McColl and David Quigley—have made relevant and, frankly, scary points. At its most basic, we do not know how many full-time or part-time members of staff there are. It must be extremely difficult to plan for the future without having the basic data that enables you to make projections.

David McColl: It is very difficult. We are hearing that practitioners who have come out of training and are in the first two or three years of their working lives do not want to work a full week. They do not want to work any late nights, they do not want to work any weekends, and they want eight weeks' holiday a year. I do not know whether that just reflects people's expectations when they start a career. I do not know what the rest of the panel thinks.

David Quigley: It is déjà vu all over again. The challenge is that people's aspirations are globalised and can be based on anecdotal information from wherever it is that people get their information from.

I met a dean of one of the medical faculties, who said that after foundation year 2 a huge proportion of doctors just vanish for a while, because people have had seven years of intense work and study and want to take time out. That is understandable.

In my discipline, I have noticed that it is increasingly the case that newly qualified people are leaving, not necessarily permanently but to take time out. Also, as David McColl said, people who have just qualified are looking for part-time work. We need to look at who we are recruiting to education programmes, and we need to manage people's expectations from a very early stage. That is part of the challenge. I cannot speak for dentistry and pharmacy, but I can say that a proportion of the optometry cohort is made up of people who are not suited to general practice and dealing with the public, face to face. That is an issue.

People's aspirations around work and willingness to work are an issue. My dad is a retired GP, and he could talk to you all day about the hours that he put in when he was a junior doctor. That apprenticeship mentality just does not exist now. People are going straight for gold, and if they do not get it quickly they look for alternatives. There are a number of factors.

Matt Barclay: I recognise many of the challenges that my colleagues from dentistry and optometry have highlighted. Pharmacy is no different in that regard. We are not a controlled profession—our numbers are not controlled in the way that happens for medicine, teaching, nursing and so on—so it is difficult to plan.

Jonathan Burton mentioned that we have run a couple of workforce surveys in community pharmacy, to try to get an understanding of the numbers of pharmacists and support staff out there. That has presented a few challenges, and we realise that we need to do more work to understand the numbers a bit better, because the surveys have not given us a clear picture.

Pharmacists and technicians have been moving to the new roles that were created as part of the pharmacotherapy element of the GP contract, which is a priority area. The intention is for about 600 pharmacists to do that over six years, and the moves started three years ago. That is putting a strain on the community pharmacy workforce, which we need to understand more.

As my colleagues described, people have different expectations. For example, pharmacists want to undertake portfolio working and take on different roles in different areas. That can bring benefits, but it can also present a challenge when we are looking to provide continuity and quality of care in certain sectors. There are opportunities. Like Jonathan Burton, I see the move to have pharmacists in GP practices, as advocates for the profession and to work with GPs and nurses, as positive. We can use that approach in a positive way. However, there are a number of challenges for the workforce.

David Stewart: Would it help if your occupation were to be a controlled occupation? What would the steps be to get more sophisticated workforce management in the future?

Matt Barclay: I am not sure that the universities would thank me for saying anything about that. I think that they like how it sits at the minute.

Being a controlled occupation may help, because if we could control the numbers nationally and the funding was there to support that, a controlled intake to support the needs of the modern pharmacy workforce would seem to make sense.

We are undergoing a review of the pharmacy undergraduate course, which involves looking at everything from recruitment and admissions to a lot of the points that David Quigley has raised, such as whether we are getting the right people into the profession through to funding, quality and governance. We are doing that review in the background, hand in hand with all the stakeholders.

The Convener: I think that Jonathan Burton also has something to say.

Jonathan Burton: To answer the initial question, a lot of workforce information gathering is going on, but not as much planning. Obviously, information is needed before we can plan, so that is understandable in a way. With the development of the GP contract, fantastic work is being done by pharmacists, who are being parachuted into practices that are struggling, to be frank. They are putting their full expertise into helping those patients get a good standard of care. Our colleagues are doing some really great work.

However, it is a pressured environment. The Royal Pharmaceutical Society gets feedback from all sectors of the profession, and the feedback from our members who are working in GP practices is that the pharmacotherapy component of the GMS contract has brought them some significant challenges with regard to whether their time is being used in the best way possible for patient-facing care or in a more technical, administrative sense to keep practices functioning smoothly. We need to be mindful of those issues, which are all about making sure that people are doing the best job that they can with the skills and knowledge that they have—we are not quite achieving that yet. We have spoken before about the negative impact on the rest of the service of a possible lack of planning around the sheer numbers of pharmacists and technicians that we need in order to provide great care in those practices.

We are talking about primary care, but the impact is in local communities for small teams in community pharmacies, and we are also talking

about the expertise to which junior and senior doctors and patients have access in our hospital service, where people are really poorly and need secondary care. The issue affects the whole system, and we need to plan better how we use pharmacists across the piece.

David Quigley: I would like to finish on a positive note. The University of the Highlands and Islands is to increase the number of optometry graduates, initially by about—we hope—25 to 35 per cent, which will make a huge difference in the north and north-east. The programme will be community based and will mirror the University of Melbourne's programme. We believe that it will be transformational because the students will experience community optometry from a very early stage, which will help to iron out some of the challenges that I mentioned earlier.

David Stewart: That takes me nicely into my last question, which is about the demands of working in remote and rural areas, of which I have some experience, from representing the Highlands and Islands. I will start by asking David McColl about dentists, for whom there is an allowance of a maximum of £9,000 to encourage them into remote and rural areas. How effective has that been and what demands and challenges for the profession have you picked up in Dumfries and Galloway and the Highlands and Islands, for example?

David McColl: New graduates all want to be in the central belt. No one really wants to move out, and it is understandable that not all young people might want to be in remote and rural areas, which would probably not suit everyone. Any enhancement that you can provide to try to recruit people to remote and rural areas would be good.

One of our worries is about the corporatisation of dentistry, with corporate bodies buying up dental practices. If a corporate body owns a dental practice in a remote and rural area and that practice is not delivering an income, it might shut it down. I think that that happened in Inverness—in the past four weeks, a practice there shut down. The chap who ran the practice did not work in it and he could not get staff to work in it. The allowance is the way that we attract people to work in remote and rural areas.

10:30

The Convener: Is your point that a professional in a traditional-model contract in which they operate the business is more likely to remain rooted in the community?

David McColl: Yes, I think so. There is a very high turnover of dental staff in corporate-body dental practices and there is no real continuity of care. To provide such care, the standard model of the family dental practice is probably the best model.

The Convener: Do other witnesses have comments to make about rural practice?

Matt Barclay: We are hearing from rural members about the workforce challenge of getting people to work in practices, too. I see, through correspondence among the professions, that really good innovation is happening in remote and rural areas. NHS Highland's NHS near me project is an excellent example of that. Clare Morrison, who is a pharmacist, is leading on that work and is developing virtual consultations with remote patients in a very different way. A lot of things can be taken from that innovation and used elsewhere.

In general, we are certainly hearing that workforce challenges are the main concern for some of our members in remote and rural areas.

David Quigley: David McColl mentioned students. Students who have lived in Glasgow for four years do not want to leave, for whatever reason. Irrespective of where they come from, getting them back there is a real challenge. UHI's ethos will change that. However, that will not necessarily address everything, because some communities are even harder to reach. The provisions should be eased up for those that offer domiciliary care or for mobile organisations that are already in that arena, perhaps by encouraging or making it easier for them to operate in more remote communities. If they have the facility to be mobile in someone's home, they could be mobile in a church or community hall, for example, and provide the service there. I think that the only issue in the past has sometimes been getting the regulatory bodies to agree that such premises are fit for purpose, and so on.

Organisations should be provided with more encouragement to do that. However, it is still about getting the professionals in situ. I think that UHI will help us to address that issue.

Sandra White: Before I go back to my original question, which was about awareness raising, culture and education, I have a small supplementary to David Stewart's question about services, particularly pharmacies, in the local community.

In my Glasgow Kelvin constituency, I see a lot of requests to open up community pharmacies, opticians and other services. Most of the requests are to open up pharmacies. A number of them get refused—I do not know why, but they do. We have a lot more students in Glasgow, so we need more pharmacies and doctors, particularly for the universities. Why do those requests get refused? Is there a limit on how many community pharmacies, opticians or dentists there can be in an area? Who blocks the requests?

Matt Barclay: I can certainly talk for community pharmacies. A control-of-entry system operates. A person cannot open up a pharmacy anywhere—they need to demonstrate whether a pharmacy is necessary or desirable in a given area. A legal test is applied as part of a pharmacy practice's hearing. Those involved in the hearing will be the applicant and perhaps those who do not want the pharmacy to open.

A system is in place to control the numbers in pharmacy. Opening up the system to the free market might have an impact on service provision. We have members who can invest in their premises and in their staff in Glasgow, for example, simply because they know that another pharmacy will not be able to open in a street in their area. Those members put resource back into their business as a result of having that comfort. However, there is a process through which an application for a new pharmacy can be made. If the legal test is passed, pharmacy contracts are granted.

Sandra White: I do not want to get into the legal aspect of the issue. However, in my Glasgow Kelvin constituency, which has had a large influx of overseas students, the corporate companies seem to be blocking individual pharmacies from opening. I do not know whether the situation is the same with the other professions.

David Quigley: There are no limitations on numbers, apart from the practicalities of running a viable business operation.

David McColl: The same applies to dentistry. There are no restrictions on the number of dental practices.

Sandra White: The issue is only with pharmacies. I will remember that.

We all agree that awareness raising is absolutely necessary. To raise awareness, we need to change the culture—education has been mentioned. It is not just about changing the culture among the general public; professionals need to be aware of what is available.

I was impressed to hear Jonathan Burton mention the two prescription pads. David Quigley said that it might be quite complicated to have TV adverts and so on. How can we raise awareness about prescription through TV adverts? Having an advert about the two prescription pads would be great. Will it be difficult to raise awareness? Is there enough awareness among health and social care professionals of what is happening on the ground? Do they need to be educated and made aware of what exists, so that people do not need to turn up to their GP?

David Quigley: It is clear that we have an awful lot of cross-party agreement on the issue; culturally, we are in the same space. In many cases, the agreement extends in relation to GPs and secondary provision. Once we agree a common purpose, it is much easier to promote and market what we are trying to achieve. Before we promoted anything, we would want to check who was on the same page, because it is much easier to promote something when everyone is on the same page. There should be internal public relations first, and then there should be marketing.

David McColl: Sandra White makes an interesting point. All the contractors who are here today have been largely marginalised over the years, in relation to secondary care. You asked whether we know what is going on on the ground. The answer is probably no—we do not really know what happens within a general practice, how its processes interact with secondary care or what is happening in secondary care. We need better communication to find out what is going on on the ground.

Jonathan Burton: A lot of it comes down to communication and how we all link up. As I said, we can help patients on their journeys, but those journeys need to be smooth. We need reassurance that, when we refer somebody, a good process is in place.

In our submission, we mentioned the possibility of more interaction with school-age children on healthcare and self-care, so that we help people from an early age to have a bit more knowledge about the system and the expectations. We need to look at our undergraduate training and at opportunities for postgraduates to link up with other professions. It was only during my clinical skills training, which I did as part of my common conditions clinic offering, that I really started to appreciate the impact of community optometry on eye care. That understanding has substantially increased the number—and, I hope, the quality—of referrals. I am sure that there are opportunities to get such messages across earlier in people's careers.

Sandra White: This is a small point. I know that dentists go out to schools to provide dental education. I should declare an interest, because my daughter benefited from that. Would that approach be helpful for all the professions?

Matt Barclay: It is about self-care and people having a good start by knowing a little, not necessarily about a particular profession but about the NHS more generally, so that they can look after themselves.

Sandra White: Thank you.

David Torrance (Kirkcaldy) (SNP): I was going to ask about data, but I think that my questions have been answered.

Community pharmacies are often integral to small communities. Are they better placed than the Government to educate the public about the services that are out there? Everyone says that the Government should advertise services, but should community pharmacies do that?

What role does social media play in that regard? Many small towns and villages have a Facebook page and are quick at posting about the good things that are happening locally.

Matt Barclay: Jonathan Burton talked about how the best advert for any profession is how the professional deals with the patient who is in front of them, whether they help the patient at the time or signpost them to another service. Maybe we could shout a bit more about what we do in our local communities. Some of our members do that, to be fair.

However, there needs to be an overarching message from the centre about the policy intent and the various strategy documents—we have one in pharmacy. If there is to be a fundamental change in how primary care is delivered, we need that message, to support the professions.

For example, Community Pharmacy supports encouraging people to go to the right person at the right time—the pharmacy first message. That message can be put out through pharmacies. Social media has a large role to play. There is a positive message to put out about what all the different professions can do. To answer your question, we need a mixture.

David Quigley: George Adam made the point about starting all over again with a blank sheet of paper, and Jonathan Burton and David McColl talked about prevention. Prevention is not ruled out the moment when someone attends an appointment with a professional to talk about a medical condition or attends a pharmacy to get medicaments; it is an on-going process, and people can always make the decision to take control of their wellbeing and take steps to start or stop doing various things. If I was starting all over again, I would make the preventative agenda the thread that ran through everything.

Once there is a common thread of that nature, we can get the message out to the public. That is probably more about public relations than it is about marketing. Facebook and so on are fantastic, but we need to be careful about what we put on social media—as we all know. However, having that common thread as a message to the public is something that we are all in a position to support. A strapline could be included in every piece of literature, every prescription, every leaflet, every poster and every advert on television or radio. We are pretty much there, but it would be helpful to agree a common strapline or thread.

Alex Cole-Hamilton (Edinburgh Western) (LD): I want to ask not about workforce, but about a couple of areas that we have covered, to a degree.

The first area is prescribing, so my question is for our friends from pharmacy. This committee is very aware that a big component of health inflation comes from GP prescribing. That is not the fault of GPs; it is a symptom of our times, given that we have an ageing population and people are presenting with multiple co-morbidities.

I want to ask about the culture in pharmacy. If someone presents with a long script of medications and they tell the pharmacist why they have been prescribed all those medications, what happens if the pharmacist thinks that there is a simpler way of dealing with the issues, which does not involve so many medications? What happens if the pharmacist disagrees with the GP and thinks, “If you have this condition, that medication won’t do you any good at all”?

10:45

Matt Barclay: I will allow Jonathan Burton to speak to this as well. Certainly, if a patient came into the pharmacy in which I was a locum on a Saturday and said what you indicated, and if we are really living the values of the NHS and putting the patient at the centre, I would listen to that patient. I would work with that patient to understand what their understanding was and what better solution there could be. I would then have a conversation with the patient and the GP to try to get the prescription amended.

It is an interesting question, because an element of our contract involves the chronic medication service—I will call it that as I think that most of the committee will be familiar with that name, although it actually has a new name—whereby we support people with long-term conditions around their prescriptions in order to reduce waste and ensure that they get the best from their medication and have the lowest number of side effects. As we know, the more medications that people are on, the more at risk they can be from side effects. We have to work with that and contractualise it more in a community pharmacy context. It is certainly the job of my organisation to work in partnership on that and build on what we have started.

The answer to Alex Cole-Hamilton’s question is that we would deal with a patient’s query, because the patient’s needs are paramount. However, we need to have that recognised in a contractual sense in order to move it on.

Alex Cole-Hamilton: But you need to make a direct referral back to the GP if you disagree with the patient.

Matt Barclay: Yes, that is ultimately what we have to do at the minute. Jonathan Burton and I are both independent prescribers; I do not practice, but Jonathan does. If we have independent prescribing authority, we could decide to prescribe. However, many pharmacists will not do that if the patient's condition is not within their area of competence, because they need to be professionally competent. Jonathan Burton is a great example of what we tend to do as generalists, as he uses in communities his generalist knowledge in the area of common clinical conditions and pushes that on.

However, for diabetes and cardiovascular conditions, for example, we would need a certain level of expertise before making any decisions. That is not something that a pharmacist would take on at the minute. It is about having a chat with the patient, understanding their needs and then referring back to the GP and having a conversation with them to get the changes that the patient desires, if that is appropriate.

Jonathan Burton: Again, it is about making the best use of people's skills wherever they practise. As a community pharmacist, I am good at making lots of high-quality, brief interventions—that is the utopia for me. I am a spotter and I can spot things, because I know patients. I can see patterns and see when something is not quite right. However, I do not always have the time, or sometimes might not have the expertise, to deal fully with the issue that I have recognised. That goes back to transformational change and looking more at the package of care rather than just a package in terms of contract remuneration and the structure of the service.

I would like to see more partnership working through our pharmacist colleagues working in GP practices and, indeed, with GPs, because there are a number of magic ingredients there. I am the guy who knows the patient well and can spot where there is an issue or possibly one on the horizon; I can communicate with my GP practice colleague and they could do, on my advice, a more in-depth review of that patient's medication. I could liaise closely with them, and we should be working together on those problems.

As I said, my expertise is being a spotter, dealing with acute conditions, having a public health role and being able to make appropriate referrals where needed. Where my GP practice colleague will come in is where a deep dive into a patient's complex medication history is needed, for example, and the pharmacist can work shoulder to shoulder with the GP on that.

That is a good combination if we are looking at tackling medicines-related harm and unwanted prescriptions. The core of Alex Cole-Hamilton's question is how we deal with prescription items that slip through the system but probably need what we would call a bit of deprescribing attention. However, it is not just about stopping things; it is about ensuring that we make the right decisions and that patients are on board with that. That needs a bit of teamwork, which means that we have to be linked up. It all goes back to the sharing of records and being able to share messages and have conversations easily.

Alex Cole-Hamilton: We on the committee are getting our heads around the emergence of social prescribing, particularly in GP surgeries. In your professions—dentistry, optometry and pharmacy—alongside delivering the treatment that you offer or the medication that you dispense, social prescribing would involve you making tacit or explicit recommendations that, for example, someone should try to get at least an hour's physical exercise a week or change their diet and so on. Do you feel encumbered by a sense that you are there to provide one service, which means that engaging in social prescribing would be an overreach?

David McColl: That is an interesting point. Having been in the same practice for a long time, and having seen the same people and their families every six months for 30 years, I can say that that is what we do every time that we see a patient—that is something that we do as part of a family dental practice. However, that is not recorded or funded. As a healthcare professional, my job is not just about dentistry. We have to give people advice on exercise and on mindfulness if they are struggling at a certain point in their life. There is a raft of stuff going on out there that is not measured.

David Quigley: I agree that that is an interesting point. I think that my colleagues—particularly the recently qualified ones—would feel that that is a line that they would not have the mandate to step over. Obviously, we are working around the head and neck, so there are lots of things that we see. However, in addition to that, if you are a clinician of any kind, you will be in a position to comment on whether people smoke or have an unhealthy lifestyle. I think that my colleagues would heartily embrace doing what you are talking about, but they would need to be given a mandate for it, possibly by our own regulator, before they felt that they were in a position to do that.

Matt Barclay: We have a public health element to our contract, regarding things such as smoking and sexual health, but what you are describing probably goes a step further. We have those conversations as part of the short, sharp interventions that Jonathan Burton talked about, but I think that I would probably echo what the others have said: that is not something that is

measured or recorded. The issues can come up informally as part of a wider discussion but, if we want to bring that in, it would involve ensuring that we had the capacity to do that, as it would probably involve longer consultations and so on.

Jonathan Burton: There are two aspects to the issue of what could be labelled social prescribing. One involves a question of whether we need more structure and regulatory back-up for that sort of activity, and the second involves the fact that we would need more time and space to develop those relationships with the patients whom we look after, because there is an issue of trust involved—people need to trust you if they are going to listen to you. That trust sometimes takes a little time to build, so having supportive practice structures that enable practitioners to stay in one place for a significant amount of time and develop those relationships—and having contractual arrangements that give us that little bit of extra time with our patients—could be impactful, whatever label you want to use for that.

Brian Whittle: I would like to return to an important point that was raised in response to David Stewart's question on workforce planning.

We have heard evidence to the effect that there was no real methodology around how to achieve the Government's target of 800 new GPs. We also heard from AHPs about the impact that they can have in primary care, especially in a GP surgery. However, there is no audit of AHP numbers, so we do not know how many there are, and today, we have heard from you that we do not know how many practitioner hours are involved in the provision of dentistry, optometry and pharmacy services. How on earth can we have an effective workforce plan if we do not know the numbers that are involved in clinical activities and cannot take everything into account?

David McColl: It is possible in dentistry. Everyone who works in NHS dentistry in Scotland has an NHS list number, and we all have to have a combined practice inspection every three years. We could collate all that information to see how many hours are being worked. In primary care dentistry in general dental practice, people know roughly how many hours they have worked. However, the problem that we see when we interact with secondary care is that people do not know who is doing what, where they are doing it or how many people are doing it. As primary care, we find that incredible, because we think that secondary care is a really controlled environment. They are all salaried employees and we cannot understand why people do not know who is working where and how many people are doing it. We could get those figures for primary care.

David Quigley: Centralised listing will make a huge difference with optometry. As 99 per cent of all episodes go through eGOS, we know exactly how many patients we see and what kind of appointments they are. We have that information, and we will be much better placed once we have centralised listing. Although the two sets of data will not necessarily allow us to know precisely, at least we will have an idea, through the numbers, of how many clinics are being delivered. The spread of appointment episodes is quite narrow, so we will know pretty much what would correspond with one individual clinic. It will be much easier once we have that information.

Matt Barclay: David McColl just reminded me of something. Jonathan Burton mentioned earlier the information gathering that we have had through a couple of iterations of workforce surveys in community pharmacy. However, in the past, the concept of a performers list has also been mooted, which we at Community Pharmacy Scotland are supportive of. It is well known in GP land as well, and might help us to understand, to a degree, who can do what and where they are. At the minute, we do not have anything like that at health board level.

The movement of pharmacists and technicians across the interfaces and within primary care means that it is difficult to get a handle on exactly what we need. However, to go back to David McColl's point, it can be done.

Jonathan Burton: It is fair to say that the change in the workforce in pharmacy is very rapid at the moment, which is, in itself, one of the issues. It is quite obvious that we are in an information gathering stage, but there is very little planning for after that. We need to consider not only how many people we have and where they are, but what they are doing.

My working day has changed immensely over the past three or four years. We operate a mixed consultation/dispensing model. The more complexity we see, the more unpredictability there is, and the more time we spend with the patient sat in front of us. What exactly are my colleagues in GP practices doing? Is it administrative; is it technical, around prescribing; or is it clinical review? How does that picture look at the moment? We need a lot more granularity and detail.

The Convener: The final question is from Emma Harper.

Emma Harper: I will try to be quick. We have talked this morning about public health, prevention, collaboration and having IT systems that are wonderful and talk to each other. However, that is about people who come to you, as dentists, optometrists and pharmacists. What about the folk who do not access healthcare? There is another challenge when we consider

poverty, health inequality and the folk who really need healthcare. I am thinking about the inverse care law. How do we help those people to get the support that they need?

David McColl: That is a very interesting question. My practice is in Govanhill in Glasgow, which is a very deprived area. We have had many challenges over the years. One of the ways that we have picked up people who do not normally access dentistry is through the childsmile programme. Parents bring in their children and they get advice about teeth brushing and diet in a non-clinical environment, and, because the parents see how the practice operates in a family-friendly way, they end up making appointments themselves. I do not think that those people would ordinarily access the service. It is all about prevention, and I believe that we can get people in through doing something in a non-invasive way, outside of the clinical environment.

Jonathan Burton: If we look at community pharmacies across Scotland, we see that they are distributed more heavily in areas of deprivation. There may be underlying historical reasons for that, such as higher dispensing volumes, but there is a real opportunity, which is being partially exploited at the moment. When we look at the ease of access to services such as the minor ailment service, and the number of children who are treated through those services, we see that there is a massive opportunity to interact with families who are in low-income brackets. We also have pharmacists who work with the homeless and we have a long history of close working relationships with substance misuse clients and services. We are in the trenches on this one.

David Quigley: It is about breaking down the barriers that stop people wanting to come in. With optometry, for example, there is the suggestion that if a person requires something non-medical, such as a visual correction, there is an associated cost. However, the NHS obviously provides that free of charge for persons who are eligible. It is about breaking down the barriers and making people aware that the provision is there, and that it is free.

The Convener: Excellent—thank you very much. I thank all our witnesses for a very full evidence session. We will briefly suspend and will resume with our next panel in a few moments.

11:00

Meeting suspended.

11:05

On resuming—

The Convener: I again remind everyone to ensure that mobile phones are off or on silent, and not to take photographs or record proceedings.

I am delighted to welcome our second panel of witnesses. Dr Andrew Buist is chair of the Scottish general practitioners committee of the British Medical Association; Dr Carey Lunan is chair of the Royal College of General Practitioners Scotland; Dr David Hogg is portfolio GP from the Rural GP Association of Scotland; Karen Murphy is a member of the rural and remote patients group and signatory to petition PE1698, which is on medical care in rural areas; Dr Anne Mullin is chair of the deep end GP group; and Dr Amjad Khan is director of postgraduate general practice education with the Scotland Deanery, under NHS Education for Scotland.

I am sure that you have all followed at least some aspects of our inquiry, and that you will know the scope of what we are seeking to do, which is to look a generation ahead and to answer a range of questions on future delivery of primary care. I know that some of you were in the room for the previous panel, when we heard from other health professions that are involved in delivery of primary care.

I will start with a question for all of you. What do you see as being the role of the GP—as a senior clinical leader, as it has been described—within multidisciplinary teams? What is your vision for how that role should work alongside the other professional roles within multidisciplinary teams?

Dr Andrew Buist (British Medical Association Scotland): I refer to our new GP contract, which started last year. Our aspiration is to allow GPs more time to be expert medical generalists. We have always been expert medical generalists, but too much of our time has been taken up doing things that other healthcare professionals can do as well or better. Because we are experts in diagnosis, our job should be to concentrate on dealing with people who are unwell and we do not know why.

We should also spend time dealing with complex care, and with patients in our increasingly ageing population who have multiple long-term conditions and are best looked after by generalists.

GPs should be part of a multidisciplinary team that is based around the practice, with nurses, pharmacists, physiotherapists and other healthcare workers working closely together to improve patient outcomes.

Dr David Hogg (Rural GP Association of Scotland): I clarify that I am now a portfolio GP in

East Lothian, but I am still a member of the Rural GP Association of Scotland and was chair of it when the new contract was proposed and was going through. That was after nine years of being a rural GP on Arran. I thought that it would be helpful to give that context.

We often talk about the hub and spoke model in considering the design and delivery of primary care for our communities. Particularly in rural areas, GPs are often the hub that helps to network the assets that are available in the practice. GPs have a pivotal role in oversight—we see everything and anything from people of all ages, and all types of presentations, from mental health to acute medicine. In the rural context, that extends to emergency care. That oversight gives us a perspective on how we can design an effective primary care model that includes our colleagues in all other sectors. That is where the strength of the expert medical generalist particularly applies.

Dr Carey Lunan (Royal College of General Practitioners Scotland): I am a GP in a deep end practice in Edinburgh. The role of GPs as senior clinical leaders is very wide. A lot of it is about the clinical role, which involves seeing the patients who have the most complex health and social care needs, and providing an holistic model that tries to address people's needs in the context of their lives and communities.

There are many other roles that are less well measured that GPs provide in teams. As our teams expand and we work more closely together as multidisciplinary teams, our role becomes increasingly about mentorship, teaching and training our future workforce. We have a crucial role to play in teaching medical students and influencing them to become GPs. We know that one of the main factors that influence medical students in choosing a career in general practice is adequate placements in the community and positive role models to whom they can relate. Teaching and training our future workforce is a big part of the work that we do.

We also provide other roles in the community through co-ordinating care across multiple interfaces—not just in health, although health is the big one—including between acute and community settings, across health and social care settings, and between in-hours and out-of-hours settings.

GPs have a wide range of leadership roles. In our patient-facing roles, the advocacy role on behalf of patients is very important, particularly for patients who do not have a political voice. That is particularly important in areas where there is health inequality.

How can we make all that happen? There has been some discussion about growing the GP workforce alongside growing the MDTs. However, in order to support teams to work well we need adequate IT, so that we can communicate well, safely and efficiently.

We also must not underestimate the importance of building relationships in teams—especially in new teams that have not always worked together. Unless there is protected time for people to come together to learn about and understand each other's roles and remits, the team will become fragmented and will be less productive and positive than it could be. Time is really important.

Dr Anne Mullin (Deep End General Practitioner Group): Thank you for asking me to come to the committee. I work in a deep end practice in Glasgow and I chair the deep end GP group. I agree with everything that has been said so far. GPs are holistic practitioners who provide family-centred medicine over several generations. Historically, we have always worked in teams in general practice. However, given the complexity of healthcare now, it is important that we begin to understand where we are in the system, while protecting and maintaining the resilience of general practice as a profession.

Continuity of care is pivotal; the gatekeeper role of the GP is extremely important to the health of other aspects of the health service, including acute secondary care and the associated teams that we work with, such as those in social care.

We might talk about the social and health integration partnership project—or SHIP project—later. It provided detail of what that co-operation looks like and how we might work towards it.

In deep end communities, the challenge is to deal with all the issues that contribute to health inequity. We know that we are not all born equal, but there is a lot that the system can do to reduce health inequity. That is our challenge in deep end communities, where there is such a concentration of deprivation-related issues.

The Convener: Carey Lunan mentioned the need to understand how other professionals work, and to have working relationships with other professionals. How much is that the case at the moment? The Scottish Government's vision for primary care very much revolves around multidisciplinary teams. Some have said that there has always been a team approach, but it is clear that the vision is to develop that approach. How much mutual understanding is there of what needs to be done?

Dr Hogg: I will lean heavily on my experience of rural practice: I spent nine years on Arran.

We work very closely with our colleagues, in part because they are part of the community. In most rural situations people wear several hats; rural GPs, like other professionals in such communities, often wear the hats of other services. That is not to claim that we can do anything—it is about cross-boundary professional competencies. What I mean is that, when I was on call on Arran, for example, I might also be the pharmacist and would take requests for medication in our community hospital from holidaymakers who had run out of medication. I might be called out by the ambulance service because it was busy or there was no paramedic crew on duty that day, so I would be asked to go out and be the paramedic.

he Scottish terms and conditions committee's agreement has caused us real problems in district nursing provision and out-of-hours provision; I have regularly been through times when we have had no district nursing provision overnight. On an island, the question is this: who else can do that? The answer is that it is the GP.

11:15

We serve our communities—it is an absolute privilege to be a GP. I am sorry that we have, in the current contract discussions, had to highlight some of the negatives or concerns about primary care. We want to serve our communities, which means that we have to help our colleagues. If we look back to 1912 and the Dewar report in Scotland, we see the strength of rural practice: rural areas are great ecosystems for understanding how we can deliver team-based primary care. The Dewar report on the Highlands and Islands was the blueprint for the NHS.

We are ready, and we are waiting to see effective and realistic aims to expand the multidisciplinary team model, but it has to be realistic. Rural GPs have flagged up concerns where we see things not working as fast as is being claimed or as was anticipated.

Dr Lunan: In reality, the experience of how teams gel and understand each other's roles is pretty variable across the country. There are lots of reasons for that. Anecdotally, there are things that work well—for example, when the people in the teams are involved in the creation of the teams. It can be quite a difficult start if people are placed in organisations that they have not necessarily chosen, in areas of Scotland where they might not necessarily feel comfortable working. Involvement in the recruitment, interview and induction processes is important in ensuring that people feel valued and part of the team—and that they have been chosen and have themselves chosen to go to a particular place.

In addition, people get better understanding of each other's roles if they do formal things such as work shadowing. That probably happens less across primary care teams than it does between medical teams in hospitals and those in the community. The RCGP is keen on having that model to give a formalised structure to GPs spending half a day walking in someone else's shoes, then reflecting on what has been learned and bringing that back to the team. There is no substitute for spending time with someone in order to understand the challenges that they face, and then considering how your systems might impact on them and vice versa. That approach often creates some easy wins.

Thinking about interdisciplinary teaching and training is also very useful. That means that if there are medical students in the practice, we have to ensure that they shadow all the members of the team, including those who are out in the community. For medical students, there is a move towards sharing any learning that is core to generalism.

However, external factors can sometimes put stress on teams, particularly when there is coverage in the media, such as about GPs being replaced. That is not helpful for anyone, because it makes us all feel uncomfortable. The change is all about collaboration, and not about substitution, so it is unhelpful when the headlines are all about substitution.

When we get together as primary care professionals every few months in our primary care clinical professionals group—that is a bit of a mouthful, but it is a really useful group—we talk about our common interests and how we can challenge the negative rhetoric about the wider MDTs and roles.

Dr Buist: Most practices have always had district nurses and health visitors, but we have not always had pharmacists, physios, or mental health workers in our teams, so that is new. As Carey Lunan said, the situation varies across the country, although it is developing and moving in the right direction.

One of the limiting steps in the roll-out of the contract is the availability of the new workforce: we are short of pharmacists, physios and advanced nurse practitioners. However, they are coming into practices. Once they are in the same building and we meet them regularly, they become part of the team, so we share patients and we share the kettle—we have a cup of coffee and discuss patient care—and that all breaks down the interprofessional barriers and allows us to make progress.

The Convener: Thank you. There was a mention of interdisciplinary teaching. Would Amjad

Khan like to comment on that in terms of promotion of multidisciplinary teams?

Dr Amjad Khan (NHS Education for Scotland): The role of the GP in the primary healthcare team is essential, and successful primary healthcare teams are essential to the whole NHS. It is in our interests to make sure that the team works well, that we all know what others do, and that we understand one another's roles. Interdisciplinary training and teaching are essential in order for that to occur. At NHS Education for Scotland, we want to make sure that there is capacity to do that in primary care. We are trialling that in the near future to ensure that there will be capacity to train pharmacists, paramedics and others in order to increase provision.

The Convener: When we spoke to members of other professions this morning and last week, we got the sense that there is a risk of fragmentation of care if people are treated by different professions, and a risk that patients might get lost in referrals between professions. Do any witnesses wish to comment on those risks and how they might impact patients?

Dr Buist: I go back to my point that, if the team is built around the practice and if everyone is based there, rather than being half a mile down the street in another building, they will come into contact with other healthcare workers daily. It is really important that the primary care team is based in a hub, as David Hogg called it, so that there is interaction between healthcare workers. That would avoid the risks that the convener described.

Dr Hogg: There is a lot of talk about connectivity and IT, which has become a bit of a cliché answer to the question about how to work better together. However, GPs are still waiting for our GP system to be updated. It is significantly late.

It has to be highlighted that, if we are moving towards an enhanced model of MDT care—which we are all signed up to because it makes sense; we like working with our colleagues and I think that they like working with us—we have a lot to learn from one other, and IT is a big barrier. I cannot email a consultant except from my personal email, so their reply goes to my inbox instead of to the patient's notes. I have been a locum in practices in East Lothian and on Arran, and there has been a clunkiness to the system.

If we are serious about working together, we need to work out how connectivity and IT can help the interfaces. That is something about which there is despondency: we are still waiting for the new GP IT re-provisioning project to come to fruition. It will be a key part of our moving forward.

Dr Lunan: We are talking about the importance of continuity versus the importance of managing workload. It is sometimes difficult to square that circle, because we need to be able to share out the clinical needs of a population to the most appropriate people, when it is safe and effective to do that.

That will be an important part of the model, but some patients really benefit from continuity of care—frail elderly people, people with very complex social problems, people with difficult to manage long-term conditions, and people with dual diagnoses of, for example, chronic pain and addiction. Such patients really benefit from having a named clinician. The clinician does not have to be a GP, although they often are, in reality.

A lot of evidence shows that continuity saves lives. A patient who has been known over a period of time and has built up a relationship of trust is more able to engage in shared decision making and to have realistic medicine provided because of better understanding of their values. People are more likely to disclose their concerns earlier to somebody whom they know. Continuity is not just a nice thing to have that people like: it is important in respect of morbidity and mortality. It saves lives.

As we expand our teams, we need to have every safety net in place to ensure that the information is still captured and that clinicians can still speak to one another about people whom they are worried about. A lot of that is about IT and the time that is needed to build teams and to have meetings to discuss complex patients.

Dr Mullin: Carey Lunan made a good point about time. Extra time for us is crucial, because it allows GP practices, and whoever else has pressures because of patients' complex needs, to provide empathetic care. Such care can prevent unscheduled admissions and pull fragmented systems together. Extra time gives the GP time to be a leader in the practice and the cluster.

Relationships depend on good communication skills and continuity, but they also depend on GPs having protected time, which we demonstrated in the social and health integration partnership project. With that work, we started to affect GP demand because we were addressing patient needs in a coherent and cohesive way with other services including housing, mental health and whatever other services needed to be involved. Social services were crucial in a lot of cases. However, time is never factored into the health economy as something that is important, so there should be a cost for that.

The Convener: That is an important point.

Dr Khan: Continuity is, as we have heard, important for good patient outcomes, but it is also important for job satisfaction. Our trainees tell us

that continuity is important to them. If we are to have successful general practice with more people working in it, they need the sense of being valued and the job satisfaction that continuity of patient care brings.

David Torrance: Good morning, panel. What are the current barriers to data collection on primary care cost, activity and demand?

The Convener: A couple of witnesses have already mentioned the importance of IT. What barriers should be highlighted here?

Dr Hogg: Trust. That is what underlies a lot of our current concern. Frankly, our experience is that, whenever we are asked what we do, particularly by health boards, it often feels as if the aim is to take something away or work out what we can do without. That is based not only on my experience but more so on listening to my colleagues, not just those whom I have contacted more recently to check that my perspective is up to date but those to whom I have listened over the past nine years. I was chair of the Rural GP Association of Scotland, so a lot of my time has been spent listening on the phone to GPs' concerns.

We have a data collection exercise just now to tease out income and expenses for practices. It is public money and it is undoubtedly important that we are accountable and that we work out how we get value for money for the taxpayer. However, our "Looking at the right map?" report had a direct list of constructive suggestions for the contract proposal when it first came out, and in the middle of the triangle diagram that we used to summarise our concerns was "Trust". I could go into examples, but I do not want to impinge on others' time. The issue for me is trust and knowing what people are going to do with the data. We are very aware that it is important to work out how we are spending that money, but information has been misused or misrepresented unhelpfully in previous times, which has placed a lot of practices on the back foot.

We know that independent contractual models work. It costs two or three times more to run a practice if a salaried service is put in. I was in Arran for six years and I know that we have an accountability to our community, our GP partner colleagues and the health board, so we work out how to make efficiencies. We have direct management of our teams, which is important.

To tie that briefly into the MDT side of things, GPs like to have a degree of trust with colleagues. An MDT roll-out that does not involve GPs shaping and determining how that will happen for their communities raises again the question of trust. These are our communities and it is my colleagues' spouses, children and relatives who are directly affected by how they can access the healthcare that is provided.

I hope that that answers the question. For me, trust has to be restored.

Dr Mullin: There is an issue of joined-up thinking across health, which is becoming very siloed, with in-hours general practice, out-of-hours primary and secondary care and all the other services that come into that and are part of the primary care team. We need to think about the GP hub, and how, through the HSCPs, we start to connect with other services in a way that is consistent across the piece. The problems that we see in out-of-hours care that spill over into accident and emergency referrals or people walking into A and E have their roots in in-hours general practice, which is under stress because of all the issues that we have talked about.

I do not see the joined-up planning being done yet. I do not see impact statements being made for what it means for out-of-hours services when an in-hours GP is struggling to provide a service, or for what it means for A and E if out-of-hours services are struggling. We need better and more consistent joined-up planning.

11:30

Dr Lunan: I agree with everything that has been said so far. I want to go back to the IT infrastructure in general practice, which is also very variable across the country and in which there are many differences across the health boards. That makes it very difficult to roll out data collection tools, such as the Scottish primary care information resource—SPIRE—that would be very useful for the planning of our future healthcare services. There are swathes of health boards that are not able to use that yet because the IT infrastructure is not up to speed.

Investment in the basic functions is important in order to get the data, which is very important to informing services. Otherwise, we measure the things that are easy to measure, such as the number of people who turn up to A and E, the number of bed days that people spend in hospital and the number of unscheduled attendances and admissions to hospitals. However, we do not have very good data on primary care at all—out-of-hours data is better than in-hours data, but in-hours data is very poor. Without the data, we cannot demonstrate the work that is being done or show what we need to improve.

There is a key role for the GP cluster model. For such clusters to be as up-powered as possible, they need to have project and data analyst support—they have some of that—as well as administrative support, and much more support with evaluating the ideas and projects that they

are involved in. The role of clusters is to determine what quality improvement work needs to be done at a local level, based on the needs of the local population. Each cluster represents six to 10 practices, with one GP from each practice coming in to do the quality improvement work. However, that is the future of quality improvement and it should be hugely informed by local data. Up-powering the role of clusters and ensuring that the new guidance that has just been launched is embedded and acted on is hugely important.

Dr Khan: I have a brief point on that. When I have been asked for data as a GP, it always seemed more worth while if I knew what it was about—what was to be done with the data and what was the reason for its collection. If there is information about why we are collecting something and why it is important, that would help. Also, to pick up on what Carey Lunan has said, not everything is countable. I can count that I have seen 15 patients, but some of those may not have required a prescription, or I could have spent half an hour with someone who has had a death in the family. How can I count that? Not all data is equal. We need to be clear what we are collecting and why.

David Torrance: Dr Hogg, you mentioned that you are in the process of collecting data on expenses and costs. Do you know when that will be completed?

Dr Hogg: I am sorry, but it is not me who is collecting that data—I understand that the Scottish Government and the Scottish general practitioners committee have started the exercise to ask practices for that information. Dr Buist would be better placed to answer that question.

Dr Buist: We are just about to put the data collection programme out to all 950 practices in Scotland to get information on their income, practice expenses and workforce—how many hours everyone works. That should be going out this month. The practices will have a month to return the data and the Information Services Division will analyse it from December onwards. Hopefully, we will get the first cut of that anonymised information to the Scottish Government and the BMA early next year and we will use that information to begin modelling phase 2 of the new contract.

George Adam: I have a quick question on what David Hogg said about salaried GPs costing two or three times as much. When you talk about salaried GP practices, do you mean board-employed GP practices?

Dr Hogg: Yes.

George Adam: We have been told that no one can quantify that figure. We were also told that GPs would say that salaried practices cost more. Can you provide the committee with anything that would quantify that, or is it just something that GPs say?

Dr Hogg: I understand that the evidence for that comes from work that has been done by the Scottish Government, through Richard Foggo's team. Again, I think that Dr Buist might be better placed to comment specifically on that. I will be brief, as I know that time is important, but I can make some comment to the committee. There is experience. I have been lucky enough to enjoy speaking to and collaborating with colleagues not just in Scotland but on the international rural stage, and I know that the international stage is ripe for lessons about different funding models for primary care in particular.

After nine years on Arran as a GP, I totted up what I had done—a back-of-the-envelope job—and it is probably equivalent to what most rural GPs are providing. In that time, I carried out 22,000 GP consultations, spent 610 nights on duty, did 384 ward rounds, responded to 152 British Association for Immediate Care Scotland—BASICS—pre-hospital care emergency requests, which were all voluntary, for when the Ambulance Service did not have a suitable resource to send out to someone, spent 129 weekends on call and taught 59 medical students. What I am trying to say is that, if we have valued clinicians working in rural areas effectively in teams, there is so much more synergy. The amount of good will is enormous. The BASICS calls are a good example of that. I do not get paid for responding to those calls, but I do it because I want to serve my community and it makes sense.

When I was paid as a GP to oversee the delivery of Arran medical group services—as I was for six years as a partner, along with my five colleagues—I had an investment in my community. When we start to detract from that, it means that when it is quarter past 5 and there is an issue that needs to be sorted out, the GP has a bit less ownership, control and drive to sort it out at the end of their day. When someone is a salaried GP, they have a bit more clout to be able to say, "Sorry, I am not responsible for that any more," and can pass it on to someone else. We are at risk of losing that personal investment if we bring in more salaried or 2C health board-run practices.

George Adam: I was not questioning anyone's professionalism. I was just asking for the audit trail—follow the money. You have not really told me why salaried practices cost two or three times more.

Dr Hogg: That is based on discussions—

The Convener: It might be more appropriate to hand that question over to Andrew Buist.

Dr Buist: I agree with everything that David Hogg said. Promoting the partnership model is a key driver behind the new GP contract. We know that it is good for patients and the taxpayer and, by and large, GPs prefer it. We can provide you with the information that you are seeking. The information that I have seen so far is that 2C or salaried practices to the board tend to be about twice as expensive. However, there is always the suggestion that the management costs that are provided by health boards are not fully included. Such practices will be included in the data collection that we are about to embark on. There is also some evidence that the indirect costs of those practices are higher, too, in that referral rates are sometimes higher from salaried practices than they are from GMS practices. We can provide you with more detail on that.

George Adam: Thank you.

Emma Harper: Dr Lunan answered some of my questions about GP clusters. I am interested in further exploring what GP clusters are and how we can make them work better, particularly in rural areas, such as in Dumfries and Galloway, in the south of Scotland. Can you tell us a bit more about whether the clusters work, how they could work better and whether we need a more structured approach? What outcomes are we are looking for from the clusters?

Dr Lunan: In essence, clusters are groups of practices that come together to share learning, ideas and data on what needs to be improved at a local level, depending on the needs of the local population. It is a big concept and clusters are the main driver of quality improvement in general practice following the abolition under the contract of the quality and outcomes framework two or three years ago. The intention is that every practice is involved in quality improvement by having a dedicated GP who works with the wider team on quality improvement at practice level and then feeds that in at cluster level so that there is more learning across clusters.

Clusters are still quite a new concept, having been running for only two or three years. We have a group of three GPs called local advocates who have been doing outreach work with clusters across Scotland. Basically, they try to find out what is working well, what is not working so well and what could be done better.

Clusters have two main roles, one of which is an intrinsic one that is about practices building relationships with other practices, sharing learning and innovative ideas and troubleshooting locally; the other role is an extrinsic one that is about influencing bigger systems, which means feeding into health boards, integration joint boards and health and social care partnerships to try to influence and improve at local level. In general, the intrinsic functions are working well, because people can naturally do them quite easily, but the extrinsic functions are proving to be more difficult, because they are about building new relationships across interfaces that might historically have been more difficult to broker.

A lot of what would make clusters more powerful and influential is about allowing them the time to meet and be involved in meetings that allow them to fulfil their extrinsic roles and be consulted more as a professional advisory group. Clusters suffer from a bit of mission creep because a lot of people feel that they will save the world. Clusters would love to save the world, but they do not have the capacity to do that, so they have to be quite strict about what they can and cannot take on. That was one of the reasons why we, together with the SGPC and the Scottish Government, created some guidance with other stakeholders about what is and is not the role of a GP cluster and how clusters could be best supported. Some of that is about resourcing their time and some of it is about giving practical support to clusters.

Dr Hogg: A question was asked about how to enable clusters to function in rural areas. To echo other points that have been made, it is about time and resource. It is about freeing clinicians up to be able to meet through good-connectivity videoconferencing or, indeed, travel to meet one another, which is pivotal.

The other point is to allow the cluster model and concept to evolve. It is difficult to put a group of people together who someone else thinks will get on; it is almost like planning a dinner party. It is important that clusters can evolve and that clinicians can find for themselves where they will get the most benefit. It is important to have access to colleagues in similar settings and the possibility of sparking new ideas.

We must allow the cluster model to develop. It has seemed a bit top down so far. How we support rural colleagues to access clusters comes down to time and resource. I hope that that answers the question.

Emma Harper: Should the cluster model be about sharing allied health professionals? Evidence that has been submitted to the committee indicates that a lot of people attend GP practices for mental health needs or mental health assessment. There are issues around whether it would be better to have consultations of 15 minutes rather than 10 minutes in order to assess the patient. Would it be better to have psychologists embedded in primary care rather than in secondary care, or even to have social workers taken out of local authorities and put into primary care, in order for the approach to addressing patients' needs to be better and more holistic?

Dr Mullin: The SHIP project did a lot of that work. We were the GP hub and we were connecting with services that we thought should be colocated with us in the health centre rather than distant from us. We spent the first year developing the MDT. We had an MDT structure previously, but it involved only health visiting and discussing a very defined patient group with district nurses. We expanded the MDT to become the holistic primary care team that we have talked about at deep end meetings.

11:45

The first year was spent deciding where our territory was and how we would work together. It takes a bit of work, and time, to build up the teams and to decide who else the team will connect with, such as housing, third sector organisations or Home-Start. We cannot just transplant that into a process and expect it to happen straight away—it will not.

We have already talked about data, so I will make a quick point. We developed localised data sets in the SHIP project, specifically to look at complex multiple morbidity, because the ISD data sets give systems analysis and numbers, but the information is not joined up. That was an important element of the data collection. The multimorbidity tool has now been used by other practices in clusters to help them to define their patients, so that they can predict who will be high users of the health service and will probably need to have quite a bit of time spent with them, and to plan and work with other organisations.

Dr Lunan: Emma Harper asked about sharing AHPs. I know that some clusters have felt a collective bravery about trying out something new across a cluster. For example, the cluster that I am part of has had the great fortune to have a practice-based physio, which has allowed us to try out new models. There is scope to try things in clusters.

It would be useful and powerful to see the whole of the GP workforce included in cluster working; largely, at the moment only practices are involved, rather than locum GPs, sessional GPs and out-of-hours GPs, who also have a huge amount that they can bring to thinking about the bigger picture.

Dr Buist: I am thinking about the cluster and mental health, as an example. Ideally, the cluster would look at the extrinsic activity of the community mental health team—a cluster might have eight practices using one community health team. The cluster could look at the data on the use of that service by their patients. Ideally, each practice would have a mental health worker of its own, within the hub of the practice. The cluster could consider and analyse the activity in the community mental health team and perhaps suggest improvements to get the appropriate balance in where patients seek mental health support, whether that is in the practice from the mental health worker, or through referral to the community mental health team. Those are the sort of evolving improvements that we aspire to make.

Dr Hogg: It is important to recognise that primary care systems are well-evolved ecosystems. They are often unique systems that have been tailored and developed to meet the needs of their communities. They are particularly fragile in rural areas, where small changes can result in knock-on effects that are not always apparent. That is why it is important to enable local clinicians—not just GPs, although GPs are an important part of that conversation—because we know our communities, no matter what kind of centre we are working in.

In rural areas in particular, there has been a fear that the MDT provision—or other provision through the current contract—is defined by a top-level approach. For example, I know a rural GP who has been offered a pharmacist for half a day per fortnight. If they could say, “I don’t want a pharmacist for half a day per fortnight”, but take the funding for that, it would not make any difference to managing their workload and making the practice more sustainable, although that is what it is all about. Making the service available to practices and giving them a say in what they would like and what they feel would most support their service is key. Some practices have already invested heavily in recruiting a pharmacist or a counsellor and those practices are feeling a bit left out—if they already have those people, but that has not come through the top-down approach, that is not recognised or funded.

We must recognise the fragility of the ecosystem and give practices the flexibility to deliver and shape the services that they know—through their contact with patients—their patients need.

Dr Buist: I went up to Caithness and Sutherland back in August and visited practices in Lochinver, Ullapool, Brora, Wick and Thurso, and the message that David Hogg described was the one that I got. I was struck by a GP in Ullapool saying that he did not want salami slices of services—he wanted a whole person. I have taken that away to give it some thought.

Beyond phase 1 of the GP contract, rural practices need a different approach. We always said that there would need to be flexibilities in small and remote practices. For example, in the smallest practices, it will be appropriate in many cases that the practice delivers vaccination services. Flexibility is needed in those areas.

Dr Mullin: I will again mention the SHIP project—I know that I am going on about it. We had a pharmacist who worked between the four practices as a shared resource. Urban deep end practices can share resources; the practices just need to work out how much of a pharmacist they need and come to an agreement. It is achievable.

Emma Harper: Welfare and benefits specialists are starting to colocate in GP practices, which is showing a benefit. I heard a story recently of somebody being described anti-depressants when what they really needed was a debt consolidation specialist. Debt was causing that person anxiety, so they needed support with that, rather than simply diazepam.

Dr Mullin: The Parkhead welfare worker was modelled on exactly that. There was an economic benefit for all the patients who participated, but it was not just about that. When patients are lifted out of poverty, they are empowered to use services a bit more. There is evidence of that.

The challenge is with occupancy and where we put the workers—we have a links worker now as well. You do not want to duplicate services, so if you have a links worker and a financial adviser, there is a risk that you will fragment the advice that you offer. However, for urban practices—deep end practices, in particular—due to the concentration of deprivation in those areas, those workers could be a shared resource in a health centre. There are ways around the challenge.

The Convener: Thank you very much, colleagues. I am conscious of time, so I want to move on to the GMS contract and, in particular, its evaluation.

Earlier this year, the Scottish Government published "Primary care: national monitoring and evaluation strategy". Audit Scotland commented:

> "There are no measures that would allow the Scottish Government to monitor the direct impact of the GMS contract, including the intended effects on the role of the GP, recruitment and retention, and any impact on staff or patient care."

Is more work needed, or are more mechanisms for measurements needed, to evaluate the effectiveness and impact of the new GMS contract?

I thought that there would be a rush of evidence on that question. [*Laughter*.]

Dr Lunan: I will go first.

The short answer is yes. We have to remember that the primary care landscape is changing really rapidly, and we need to ensure that any future models of care are based on evidence, just like anything that we do in healthcare. Things might feel good and seem to be working well, but that is probably not a good enough level of evidence on which to base such a seismic shift.

That is where the role of the Scottish School of Primary Care comes in. As a primary care-based, high-quality research organisation, it can measure and evaluate different tests of change and models of care with a level of robustness that is not necessarily achieved if they are looked at in isolation. Earlier this year, at the SSPC's conference, there was a presentation of the summary from looking at 204 tests of change around Scotland.

The learning from that was not surprising: it was that the pilots were too short to draw any conclusions; that, as expected, there was a rise in GP workload before a fall—the fall had not yet begun—and the rise was to do with mentoring, training, support, inductions and welcoming new members into the team; and that short-term pockets of funding can sometimes be more damaging than no funding at all, because they generate expectation about a service and hope that things will continue, but they do not.

Therefore, my plea is that the evaluation has to be on-going, high level and funded, and it has to inform what future models of care look like. I do not think that we know the answer to a lot of the questions with regard to what the impact will be. We hope that it is good, but we do not know that it will be, and there may be unintended consequences, such as rising workload in other parts of the workforce, which we need to take into account when we are thinking about how we fund and monitor it.

Dr Mullin: The SHIP project, which has now been mothballed, was a three-year project from the tests of change money. It was probably the most comprehensive tests of change project, because we were setting out to build a holistic model through MDT working. It had many aspects that are aligned with the new GP contract, but the issue of GP time is not really aligned with the contract as an economic costing.

The point of the SHIP project was that it retained older GPs, whom we know were retiring because they were fed up, and attracted younger GPs because of the mentoring that it involved. That process has been replicated with the pioneer scheme, which is important, because we want to make the experience good for younger GPs who are not ready for partnership and who may be wary about coming to deep end practice. We want to make them realise that, with a bit of support, they can be deep end GP partners. In that project, the protected time was crucial, but it seems to be one of the main sticking points. However, we have a costed report on the project that has been accepted by Richard Foggo to have a look at, and his team has the report.

Therefore, there is an alternative. We have a lot of data from the SHIP project—although it is a relatively small data set, it is enough to start to make conclusions about the data.

The Convener: Given what you have described, does the SHIP project fall into the category of things that the health service has tried and which have worked very well, but which have then been set aside?

Dr Mullin: I would say so. That was really disappointing, because it was a holistic process—we would start in year 1, spend a year working out the ground work for the project and then build up the relationships, only for them to finish after three years. It is illogical: we should keep rolling out the project, as its base provides the educational process for the other practices that come on board. We showed that we could share managerial staff, pharmacy staff and physio staff across practices in an urban setting.

Karen Murphy (Rural and Remote Patients Group): I fully understand the need for evaluation. My concern for the past 18 months—it will continue to be a concern—is that phase 1 implementation has happened and we are risking rural and remote areas in terms of recruitment and retention of GPs, morbidity and continuing problems for patients.

Evaluation is really important, and it is good to hear that there is some understanding that there needs to be a more flexible approach in rural and remote areas. However, I want to know when that will happen, because the contract has already had a detrimental impact. For example, there are questions about the impact on mortality—I think that Dr Helene Irvine and Professor Wilson submitted information about that—and although there is no correlation, there are indicators out there that, in rural and remote areas, there are impacts on patients' lives.

It is all very well talking about evaluation, but what concrete measures can be put in place so that we retain our GPs? It is wonderful to hear about multidisciplinary teams, but the practice of which I am a patient—I can only talk about my own experience—has no health visitor and no district nurse. We are reliant on somewhere else for health visitors and district nurses, let alone wonderful things such as mental health workers and other multidisciplinary team members.

I became interested in the issue because it is so difficult to live in a rural and remote area. Yes, we want multidisciplinary teams, but it is not practical or feasible in those areas. Therefore, if a GP or similar service is the best way forward, we need to hang on to GPs. If the multidisciplinary approach, which is a salami-sliced approach, is not going to work, how can we retain and recruit GPs? To me, it seems that the GP contract does not necessarily recognise the particular role that GPs have in such a community.

12:00

It is a fine-tuned thing. When I was in my 30s and I moved home, it was important to me that the schools were there. In retirement, it was important to me that the GP was there. I am a young, well person. I am concerned that, for my neighbours and other people in villages and communities like mine, access to healthcare will be difficult.

Earlier, I listened to witnesses in the first panel talk about social media and encouraging people to think about where else to go for healthcare. That is lovely, but I live in a village where information is passed on with a poster in a bus stop. The committee is discussing fine, high-level stuff. In urban communities, I understand the need to educate people to go to a pharmacy, but when the pharmacy is 40 minutes away and the bus runs only every three hours, it will be more difficult.

The situation should be evaluated, but I would like to see speedy responses. Our petition asked for that. To me, the remote and rural short-life working group was the slow life working group. We still seem to be in that situation.

Dr Hogg: As part of the evaluation, we must ensure that we listen to patients. Thank you for taking Karen Murphy before me, because she made some of the points that I was going to mention.

Our patients are among the best judges of how services are run. For negotiation reasons, patients were not so involved in the design of the contract. The contract seeks to shape the future of primary care in Scotland. Therefore, it is essential that we have the patient view. It is great that Karen Murphy and people who work with her felt confident in raising their concerns, particularly to the Public Petitions Committee. We have already heard evidence that they have submitted to the committee.

We need to recognise that the current experience is that things are slow. There is good agreement across rural GPs and our medical and political leaders that progress is slow. Rolling out the contract was always going to be a big step, but it is slow and we have to understand the effect that that has on despondency among clinicians.

A lot is said about recruitment to rural areas. It is great to see some of those innovations, but our view is that the best mechanism for increasing recruitment is retention. Historically, Australia and New Zealand have been attractive for people to move to, because they see happy, supported GPs and doctors in those areas. The contract has

devalued rural practice. We might or might not have time to go into that. We have already written and spoken a lot about the concerns over that. A lot of rural GPs feel fragile about what is happening. They have seen the measure of their workload fall, in some cases, by 82 per cent, compared with what they deliver. There is a problem in rural areas that GPs are feeling devalued.

I want to come here with solutions to how we address that. There is a limited amount of rural proofing evident in the GP contract, as well as in other parts of Scottish Government policy. The STAC arrangements for payment of non-medical staff are another good example. In Scotland, 20 per cent of the population is rural and 98 per cent of the landmass is rural. We should aspire to a stage at which—not just in healthcare, but in many policy areas—there is a mechanism by which policies and decisions go through a rural-proofing process. Canada and South Africa do that well and Australia does it to some extent. Our biggest disappointment was that we have evidence of things coming through from the contract that have sidelined not just rural GPs but rural communities. There is mileage to be made in how we take things forward constructively.

Dr Buist: To reassure Karen Murphy, the future role of the GP was central to the new GP contract—not just in rural areas but across the country. A measure of the success of the contract will be GP numbers starting to rise. Over the past few years, we have seen a fall in the number of whole-time equivalent GPs. We want to turn that round.

One of the petition's aims is to avoid a postcode lottery. We actively seek to address that. There is evidence that, rather than avoiding a postcode lottery, we already have one for the funding of general practice in rural areas. I know that the convener is originally from the Western Isles. The practices in North Uist, South Uist and Barra there are of similar size—they all have list sizes of between 1,000 and 1,500 patients—but South Uist gets £174 per year per patient, on average, in North Uist the figure is £230, which is £56 more, and in Barra it is £264, which is £94, or 50 per cent, more. We do not understand why that is the case and we need to. It is what we are seeking to understand through the data collection that we are about to embark on. It may be because one of the practices has higher staff expenses or that the earnings are widely different in the different practices. The data will show that.

Dr Mullin: We have talked a lot about that in the deep end group. We see the contract as just a way to pay GPs. From our point of view, it does not address issues around the inverse care law and the inequality divide, which is getting wider again. We support the argument that the issue of what is a reasonable income for a GP should be part of a national conversation within the profession. The profession is somewhat divided; we do not know what rural GPs do and they do not know what we do, and we are not joined up in thinking about income. The SHIP project put the contract and income aside. There was strong financial governance and none of the money that was given to the project went into profits for the GPs; it went into the staff and the development of the project. That is also key for clusters when they start to move forward and mature as organisations.

The Convener: Thank you. That is an important area that colleagues might want to come back to before we are done. However, I am conscious of the time, so Brian Whittle will explore the IT issues that have been raised with the committee.

Brian Whittle: I was pleased that David Hogg mentioned IT almost immediately. I should have said at the start that I was director of a communication and collaboration platform for healthcare before I was elected. It is an area of particular interest to me.

Given the time that is available and the need for efficiency, we ask our GPs to be involved in multidisciplinary working in hubs and GP clusters, and to be the interface between primary and secondary care through AHPs and the third sector. However, my overwhelming feeling is that the evidence shows that that is being inhibited by the lack of effective IT solutions, data gathering and evaluation. Does anyone want to comment on that?

The Convener: A couple of witnesses have already mentioned how lack of effective IT inhibits effective partnership working.

Dr Buist: I agree that IT needs to be better. We try to keep our frail elderly people at home in their community and avoid admitting them to hospital, which often means carrying out home visits. We rely on our computers when we are in our surgeries, but when we are on a home visit we do not have access to the person's information. We cannot see when they last had a blood test, and we cannot read the hospital letter that arrived the previous week. The technology exists that would allow us to access that information on home visits, and the information could often make a huge difference to what we would decide to do.

That is also an issue for out-of-hours doctors, who sometimes work without access to full patient records. We need to do something about that.

Dr Lunan: There was a big survey—I think, in 2015—of clinicians across NHS Scotland about their priorities for IT. Perhaps unsurprisingly, making basic IT work well was at the top of the list,

and at the bottom of the list came the high-tech stuff around remote technology and telemedicine that hits the headlines. Such high-tech stuff is great, but unless we have basic IT that works well and is efficient, reliable and safe, none of the other stuff can follow.

Brian Whittle is absolutely right: the ability to share clinical data between the community setting and the acute setting is crucial to safe interfaces of care. Often, that ability is missing. Patients expect us to be able to see what has happened to them in hospital, and they expect consultants and teams who look after them in hospital to be able to see what happens when they are out in the community. However, that does not happen; patients are always surprised about that.

In addition, the lack of sharing of clinical data inhibits the amount of anticipatory care planning that we can realistically do.

I have a big interest in the matter, having done this work for five years as a clinical lead. GPs and other members of the primary care team can create care plans for patients who have complex health and social care needs, using a piece of IT called the key information summary, which can then be shared across interfaces. However, the system does not work well. We can see the KIS well in the out-of-hours setting, but it cannot always be seen in the hospital setting. It cannot be seen in the community pharmacy setting, in the care-home setting or in the social care setting.

That means that all the difficult conversations that have been recorded about patients' beliefs, desires and wishes about how far they want treatment to go are not seen when they need to be seen. The KIS also cannot be seen by ambulance services on the way to an emergency. There are significant issues to do with our ability to communicate patients' wishes about what they want to happen.

NES is doing work on the shared digital platform to link up health and social care and to make the system much more collaborative. I am not sure what the timescales are for that work, but we all say that a system that works better cannot come soon enough.

Dr Hogg: I get quite excited when I think about the possibilities of IT—not least because we are coming from a situation that is not particularly great. Some of us are still using systems from 2005 or 2010; we are not keeping up to date. When we log on—I will not say the names of big internet companies, but we all know which search engines we use—we get excited when we think about how much data we gather in the health service and how it could be used.

I would like to be able to draw, easily, a chart of a patient's kidney function over the past six months. Even that is quite challenging with the systems that we have. There are ways of doing it, but they are clunky and involve going through menus. Why cannot we have a better system? I really hope that our new GP IT system will deliver what I am looking for. It might do that, but I do not know. We should be able to log in and see a dashboard that tells us about the patient. We have that to an extent, but it is all very clunky.

We are talking about working well in teams and bringing multidisciplinary teams together. On Arran, we merged our three GP practices in 2012. I am a bit of a nerd and a geek, at times, and I have an interest in IT. We set up an internet platform that proved to be an essential part of bringing three previously separate GP teams together. We called our platform Wilma, because our shared drive was called Fred. We went for a Flintstones theme—

David Stewart: That does not sound very modern. [*Laughter*.]

Dr Hogg: Wilma helped with questions such as which number to phone for the ambulance service or pharmacy, how to refer to a particular service—which is useful for locums and new colleagues—and how to share audit information.

IT is such an important platform, but we work in the dark ages so much that it is almost a joke. In some out-of-hours sessions that I do, I get a nice feeling when the printer prints out a prescription, because that feels like a mini success in the practice. We need to move on from that.

There is hope for the future. Estonia has led the way on patient health records and integrating systems. Lots of exciting work is also happening as a result of the GP contract, so now is the time to look at countries such as Estonia and see what they are doing right. There is a load of good stuff to look at. We could do amazing stuff with a clinician-supported system that does not come just from IT designers.

Dr Mullin: In the SHIP project, the social care worker would bring their laptop to multidisciplinary team meetings and we would bring our laptops. Our data would be on our laptop and the social worker's data would be on theirs, which meant that we could share information. A lot of the time, the human interface has to be given parity with the IT interface. We often get excited about IT developments, but some IT developments will widen the health inequality gap, particularly in deep end practice areas, if equity statements are not built into them.

Nonetheless, the ability to share information at our MDT meetings was invaluable. We would know who a person's named social worker was and we could update our records and share information, which was vital. If systems remain

separate, particularly in health and social care, and there is no interface—a human or an IT interface—we will not get the joined-up working that we really need for complex care planning.

The key information summary is an important tool, but only GPs can fill it in and that takes time, because it is a complex document. Now that we have addiction workers who write in case records, I do not see why district nurses and health visitors could not fill in the summary when they have time. In fact, a range of people could input to and upload the document. However, the percentage of patients who have a summary is nowhere near as high as it should be.

12:15

Dr Khan: I echo what people have already said: IT is very important. Our younger doctors who are coming through are IT literate, and they use their phones for all their normal business—consider banking facilities. Our younger patients are also IT literate, so we need an effective IT system; otherwise, we will not be serving some of our patients well.

The Convener: Carey Lunan said that NES is doing work on that. Can you offer the committee a timeline for the work on joining up the IT systems?

Dr Khan: I do not know the timeline, but I can get that information.

The Convener: That would be much appreciated.

Brian Whittle: As much as I am just warming up on the subject, I realise that time is short, so I will just ask one brief question, although it is central to the whole issue. Who should own patient data?

Dr Buist: It is the patient's data. We are just in the process of agreeing a national data-sharing agreement, in which GPs and the health boards are the joint data controllers. We have just about completed the legal inputs and the template that will go out to each health board. Each health board will then have to make an agreement with each practice. That will allow the health board to share the information that comes from the GP—which is so important for good-quality patient care—and it will comply with the relevant protections and the general data protection regulation that protect against patients' information going where it should not go. It is the patient's data, but GPs and the board are the joint data controllers.

Dr Hogg: Sometimes, the fear is retrospective. To what extent can the data that has already been recorded about patients be shared? That is a really important question. For a number of years now, it has been the case that much of my time is spent managing anxiety about waiting times. Patients come in and say that they are worried, and want to know where they are in the queue. We need a system that is almost like the system in a large shop—I will not name any names—where you can take a ticket and can see yourself moving through the queuing system.

We are asking patients to take more responsibility for their health and to engage more with self-management and self-care, but we are not giving them adequate tools.

If I said to one of you, "We should refer you to orthopaedics," I would have no idea how long it would take. In the time until the person is seen by an orthopaedic consultant, or whichever specialist, anxiety builds up; patients carry anxiety with them. One of the most effective ways to make patients feel included and reassured is to give them access to information about when things will happen. A simple thing might be access to patient records, blood results and prescriptions. We already have online ordering. Why not have a system that improves the primary care and secondary care interface whereby, if someone wants to know where they are in the queue, they can access the information and do something about it, if necessary?

At the moment, the system is too nebulous. There is trust involved when a GP refers a patient, but the patient does not really know what will happen after that point. We have to do better when it comes to prospective information, as well as doing better in what we record about patients. Does that make sense?

Brian Whittle: Yes.

The Convener: We will move on to training and workforce issues.

David Stewart: I would like to discuss GP training. One of the excellent initiatives that I have come across is the Scottish graduate entry medicine programme—ScotGEM—which is designed, as you know, to interest doctors in careers as GPs. What is your assessment of that programme?

Dr Khan: ScotGEM began last year, with 55 training positions involving a four-year training programme, primarily linked with training in the community. It also offered bursaries, as long as the students agreed to work in Scotland for each year for which they took the bursary. It is a welcome addition to the training for doctors, and has the specific aim of increasing the percentage of doctors who work in primary care.

David Stewart: Would any other panel members like to contribute?

Dr Lunan: I will do so briefly. I cannot give you a formal assessment of the programme; Amjad

Khan would be best placed to do that. We welcome any initiative that grows the GP workforce and encourages medical students to choose a career in general practice. ScotGEM also has a focus on remote and rural communities, which is welcome.

A wider point is that training in the community with ScotGEM obviously involves a significant teaching commitment. There is currently a capacity issue in general practice with regard to our ability to undertake the level of teaching that we would ideally like to offer in order to influence future career choice.

John Gillies chaired some work on increasing the capacity of undergraduate training in general practice. At present, general practice makes up approximately 9 per cent of the medical curriculum—91 per cent of the curriculum is not based in general practice, which means that students have very little exposure to general practice, so are less likely to choose it. We would like the amount to increase to 25 per cent, so we are very supportive of the Scottish Government target in that respect. However, we recognise that there are quite a lot of challenges related to that target, to do with the premises that are needed to house students and the resources that are required to free up clinicians to teach.

I make a general plea in that respect. ScotGEM has managed to recruit trainers successfully out in the community, but there are possible unintended consequences in respect of how that impacts on teaching across Scotland more generally. We need to build capacity across the whole undergraduate curriculum.

Dr Khan: I will pick up on Carey Lunan's point about capacity. There is a capacity issue throughout Scotland. NES has set up a multidisciplinary educational capacity group that is led by my colleague Moya Kelly, who is sitting at the back of the room. Pharmacists, paramedics and other allied health professionals are looking at how we can combine training and do it together out in the community. We are hoping to pilot new initiatives later in the year.

David Stewart: On a related point, you might or might not be aware that the programme for government, which the First Minister announced recently, includes a commitment for a new medical school. Does that give us an opportunity to get young people—or indeed, people of all ages—from disadvantaged backgrounds to become GPs or consultants, or to work in other roles?

Dr Khan: There is no doubt—research has shown this—that once people have qualified, they tend to practice in the area from where they come. Anything that promotes training in specific areas is a good thing. Some thought would be needed about where the new medical school should be located to ensure that areas that are deficient in doctors are able to benefit from it.

David Stewart: I will follow up one point before I forget it. You will know that one of the retention issues is that we tend to retain doctors in areas where there are already medical schools. An obvious simple question is whether we could consider areas in Scotland that do not have a medical school. I am sure that a number of members would ensure that we put in bids very early in the process.

Dr Khan: Yes, there are areas that we can look at. People tend to go back and work in the area that they come from, but they also go to areas where there are other opportunities for them and for their spouses and families. It is a complex subject, but there is no doubt that if there is opportunity for people in the area that they are from, they will go there. In England, medical schools are already being placed in areas where positions are hard to fill.

Dr Mullin: The deep end group is very interested in that issue. My colleague David Blane has written a paper—several papers, actually—about the challenges around undergraduate and postgraduate teaching in general practice. The group is trying to educate GPs in training and at medical school about the challenges and the positives of working in deep end practices, and to raise the standard. There are issues around capacity and the number of trainees who go to deep end practices.

Again, it comes back to knowing each other's roles. Medical students should probably know what the experiences of a rural GP and a GP in a deep end practice are like, so a bit of joined-up teaching is required at that level.

Some hospital specialists might have been in general practice and understand what it is, but all GPs have worked and trained in hospitals, so the balance is not right.

Dr Hogg: Rural practice on the international stage can offer great examples of where we might want to take things in Scotland using a team-based model. I have two very good examples that might be of interest to the committee: Dr Roger Strasser's work in northern Ontario, developing a medical school that focuses on community needs, assets and multidisciplinary team learning; and the model in Stellenbosch in South Africa—Ian Cooper has written about it—where from the outset pharmacists and nursing teams are mixed with medical students. If we get that right at the start of training, it paves the way for us to work together more effectively, not least because we have a better understanding of how everyone else works.

I recall from my experience on Arran that I was frequently called out to support ambulance crews. That means that when the crews turn up at our community hospital and bring a patient to A and E, I have a good perspective on their skills, how I can get them to help and perhaps reasons why they have not been able to do something that we might have done pre-hospital.

One of my favourite phrases is "Knowledge without perspective is a higher form of ignorance". The more perspective that we can have on how we are going to deliver primary care in Scotland, with all the different challenges that that involves, the better. On Arran, we had more than 90 applications a year for our elective scheme. That was partly because people saw some of the videos that we produced, in which they saw us feeling happy and valued—at that point—in what we were delivering. It comes back to my point, which RGPAS is very keen to reiterate: retention underpins everything. If the GPs working across Scotland are happy, keen, enthusiastic and feel supported, that is where the medical students will find that their learning is most supported and they feel more motivated. Let us not focus too much on recruitment and get drawn into that—it comes back to retention, and if we can get that right, other things will follow.

Dr Lunan: I am a huge fan of widening access to medical school in every way that we can. We are a diverse population and we need a diverse medical profession who have a good understanding of many of the life issues that we deal with in general practice every day. I know that charities and projects such as the reach programme have done a huge amount to increase access, particularly in Glasgow. The RCGPS has supported that at a local level by working alongside those projects and charities. I am a great supporter of that.

I want to go back to the discussion on choosing general practice as a career. We mentioned the importance of placements and early adequate exposure to general practice, and to positive role models who enjoy their job, so that students think, "That is what I want to do when I grow up", but there is a third thing that is also important. This came from an RCGP survey that was carried out two years ago, called "Destination GP". The study polled a huge number of medical students to find out what factors had influenced their decision whether or not to become a GP. We know the first two factors, which we mentioned earlier, but the third factor, not surprisingly, was whether they had heard negative things said about general practice as a profession—largely negative things that they had heard in the hospital setting and from academics and peers. It is very sad that that still happens.

There is an awful lot of work to be done around understanding one another's roles and remits across the profession and generating far higher levels of respect. A lot of that work is about building the interfaces of care and bringing people together to understand the jobs that they all do. There are also roles for the royal colleges, the BMA, NES, the media, politicians and policy makers, and the General Medical Council, too, in breaking down those barriers that make people think that becoming "just a GP" is second choice to becoming a specialist—it is not. We have to challenge that idea if we want to grow our workforce in the future. Any medical school that is established in 2019 or in the future must have that in mind.

Emma Harper: I have a brief supplementary. We are talking about growing our own workforce, but it seems as though we are all competing for the same weans. If someone in Scotland is healthcare inclined, they might become a physio or a nurse, or whatever they choose. How important is it to recruit and then retain from the European Union? Our birth rate is falling, so it is really important that we welcome people who come from other countries, including those in the EU.

The Convener: Who wants to respond to that, very briefly?

12:30

Dr Mullin: I think that that is a crucial point. My partner in practice is from Romania, and he is a valued GP who has chosen to live and work in Scotland. I think that, if he was not there, it might have taken us longer to recruit someone, because he had been trained in Govan. We find that, if someone is trained in a deep end practice and they see that it is a possible career choice, they will stay and go on to partnerships in deep end communities elsewhere.

Dr Khan: It is important to have people from the EU, but that is not the only place that people come from. Lots of graduates from countries across the world have played a huge and important part in the development and success of the health service, and we must not forget them.

We have special arrangements for doctors from places such as Canada, New Zealand and Australia, and we are just developing arrangements to ensure that GPs from South Africa and the Republic of Ireland are able to come to Scotland and work here without having obstacles placed in their way.

Getting people from all over the world is an important part of any health system, and especially our UK one.

Alex Cole-Hamilton: I want to ask about recruitment, too. As we know, the Scottish Government has set a target of recruiting 800 new GPs by 2027. Are the members of the panel aware of why that target was seen to be the number that we need? How likely is it that we will achieve that target?

The Convener: Those are two big questions.

Alex Cole-Hamilton: Not everyone has to answer.

Dr Lunan: I am not entirely clear how the figure was arrived at. I think that the Audit Scotland report suggested that we are not entirely sure what the modelling is for future GP workforce needs. Our concern has always been that, although it is welcome to see a commitment to 800 additional GPs, that is a headcount figure, and we need to understand that there is a massive variation in what that might look like, particularly given the diversity of GP working patterns. In a worst-case scenario, a headcount figure of 800 might mean that there are 800 GPs doing half a day a week. Alternatively, it could mean that there are 800 GPs doing five days a week. If we are to be able to do reliable workforce planning, we need to think about our ability to do whole-time equivalent planning, which is how most workforce planning is done in the rest of the UK in relation to GPs and other medical specialties.

It is important to know what the figure of 800 new GPs will mean. Based on current workforce patterns, it is likely to represent 460 whole-time equivalent GPs, which starts to paint a different picture.

Alex Cole-Hamilton: I am sorry to interrupt, but are you concerned that the Scottish Government's adoption of a headcount target is a cynical move on its part, as it allows it to say, "Look, everyone: we've got 800 new doctors," whereas, actually, we need to drill down into the figures to see how many full-time equivalent doctors we have?

Dr Lunan: We just feel that full-time equivalent workforce planning is more reliable and enables us to know what the future workforce will look like. We know that the whole-time equivalent GP workforce in Scotland is declining, although the headcount workforce has gone up slightly. Between 2013 and 2015, I think, the GP whole-time equivalent workforce fell and the secondary care workforce rose—the consultant workforce went up by 15 per cent and the GP workforce declined by 4 per cent, in whole-time equivalent terms.

We need to think about what we want our healthcare service to look like and how we can deliver the national clinical strategy, which involves caring for more people at home or a homely setting, if we do not mirror that with a workforce that looks to build community-based professionals.

You ask how likely it is that that figure of 800 GPs will be achieved. It is difficult to know, because there are so many factors that that will rely on, including getting more people into medical schools who want to be GPs; people having more exposure to general practice during training; people choosing general practice as a career; and people deciding to stay in general practice. That last point is important because, as we have said, retention is actually the biggest part of recruitment—it is a separate process, but you know what I mean. It is like transfusing someone as they continue to haemorrhage—unless you stop the bleeding, the situation is not going to get better.

We need to get better at understanding why people leave general practice. We do not have a full understanding of that, because the reasons are different at different points of people's careers.

In the first few years after qualifying, the challenges and the doubts are different from those in the middle part or at the end of someone's career, when there are different reasons why people may be choosing to step down. Without knowing in more detail what those reasons are, we cannot present solutions.

Dr Khan: I cannot give an answer in relation to the figure of 800 additional GPs. In some ways, the number is not important, because it is about having the right number of GPs to fulfil what we need from the health service. A multipronged approach to recruitment is needed and it is never going to be done in a day or a year. It is about increasing medical school numbers, which has happened; increasing the attractiveness of becoming a GP; giving more foundation doctors experience in a GP practice to ensure that they are then more likely to choose general practice as a career; and increasing GP placements—the GP100 scheme a few years ago increased the number of GP trainees in the system.

As Carey Lunan mentioned, retention is also very important. There are a few schemes to help with that—the GP returner scheme, to attract back GPs who have left; the GP retainer scheme; the stay in practice scheme, which is a new scheme; and the enhanced induction scheme.

It is also important to consider that many of the doctors who are qualifying now do not want to work full time; they want to work less than full time. We need to make the job attractive and make sure that their work-life balance questions are answered.

Alex Cole-Hamilton: Many of us around the table have had strong representations about the pensions issue, which is disincentivising GPs from

working later into their careers. Another group of doctors who have come to see me are recently retired doctors; a number of them have intimated that they would welcome the opportunity to go back into practice for two or three sessions a week just to keep their hand in. Even though they have perhaps been retired just for a couple of years, they face impediments to that. Should we make it easier for those doctors to come back on stream?

Dr Khan: There is a system for them to be able to come back. There is a two-year mark—normally, somebody who has been out of practice for more than two years requires some sort of induction to get back in. We work with the health board because doctors need to be on the performers list in order to be able to practise as a GP. The GP returner scheme allows us to try to provide them with the appropriate experience that they need. We try to help them as much as possible and we try not to put obstacles in their way. I agree that we need to make it as easy as possible.

The Convener: We will go back to the wider question that Alex Cole-Hamilton asked.

Dr Buist: I do not know where the 800 figure came from—I suspect from somewhere in St Andrew's house. As Amjad Khan said, the number does not really matter. What is clear is that we need more GPs, particularly more GP partners, because the Scottish population is ageing and, as we get older, we all develop long-term conditions. Patients in that category end up in hospital with great ease; they block beds in A and E and then they get stuck in a medical ward because of delayed discharge. It is absolutely crucial that, wherever possible, we care for them in the community. Most of the time, that is in the patients' best interests.

The other important thing that we need to do is to develop a mechanism for introducing additional doctors into the country. At the moment, we do not have that, but under phase 2 of the new GP contract, we will have a new mechanism that will allow us to introduce additional GPs.

At the moment, if someone wants to introduce an extra orthopaedic surgeon into their department, they just employ them. Practices cannot do that; we do not have a mechanism to do that. If the population of Dunfermline suddenly expands and a new practice is needed, we do not have a mechanism to create that new practice. However, in phase 2, the new contract will deliver a mechanism to do that. We need to be able to monitor workload better and introduce a new workforce with additional GP time to meet patient needs.

Dr Hogg: Again, we should look to our international confrères, who have considered the important concept of the pipeline model of recruitment and retention: they look at who is coming and where the leaks are, or where people choose to move careers for more positive reasons. If we are going to invest in 800 new doctors, that has a cost in itself. We need to work out what will happen to the 800 doctors as they move through the system. It goes back to the point about retention—we have covered that already, but it is so important. The contract has devalued the work of rural GPs—rural GPs are now feeling devalued.

We have mentioned the EU. I have colleagues who originate from the EU and who are feeling destabilised and vulnerable because of the contract side of things; they are also feeling very vulnerable—including for their families—because of what is happening with the EU negotiations. That is another aspect: some of the leaks from the pipe will be those valued and extremely experienced colleagues who are currently delivering excellent care.

The pipeline model must be considered. The best way of keeping the water in the pipe—my analogy might not work here—and achieving better recruitment overall is to have supported and valued doctors, clinicians and teams in the system. Let us not lose sight of that, despite all the headlines.

Sandra White: I hope you forgive me, but I want to go back to what we were originally talking about, which is our inquiry into primary care. My question is about how you, as professional GPs, can help to deliver the primary care aspirations that the committee heard about by working together with community practitioners. I have not heard an awful lot about that from the panel yet, but perhaps that is because of the questions that you have been asked.

Some of you may have sat in on the evidence from our first panel of witnesses, who I asked about education awareness, culture change and that sort of thing. In written evidence, we read that there

"needs to be a clear and comprehensive public information campaign about how to access health services, and what to expect within each setting, and from each healthcare professional".

I have not heard any answers on how you are all going to work together. I have heard about clusters and hubs, but in the evidence that I have heard there has been no mention of community pharmacies or optometrists. There was mention of physiotherapists, but the evidence that we heard earlier was that physiotherapists are being taken from the community settings and used in hospitals and doctors' surgeries. How are you going to work together, so that people do not have to go through the GP as a gatekeeper and have to wait for an

appointment for those services, given that GPs do not work from 9 in the morning to 10 at night?

How do you envisage working with local community services? I am not for one for top-down working—as far as I am concerned, it is about the community up. Many of those community services are really in the community—they are in my high street and people can access them when they are in the shopping centre. How will you work with all those other community services?

Andrew Buist mentioned the flu vaccine. Pharmacies are more than happy to give vaccinations, therefore freeing up GP time. Some communities have that service on their doorstep; if they do not, people can go out into communities.

Sorry about all that, but I want to know how you are going to do that.

Dr Buist: The BMA and the Royal College of General Practitioners have been in discussion with the Government about that. We are very enthusiastic about the need for a national conversation. I am sure that Carey Lunan will say more about that after me.

Primary healthcare is changing and we need to bring the patients along with us. If the discussions are just at practice level, that takes a lot of time and patients get confused by what is happening. We need a national conversation to explain that people do not always need to see the GP first, that it is okay to see a nurse, a physio or a pharmacist and that sometimes the receptionist in a practice will act as a navigator to signpost patients—

12:45

Sandra White: I am sorry to interrupt you. You mentioned a national conversation, which is what the BMA has said that it wants. The allied health professionals who gave evidence this morning talked about using leaflets, posters, TV adverts and so on. Would that be a better way of changing the culture, given that it is the public that we are trying to reach? It seems that we have to change the professionals' culture, too. How long will it take to have a conversation, with no action?

Dr Buist: GPs are up for that change. I think that a national conversation starts the process and we can then carry on the conversation at local level.

Let me quickly pick up on the point about flu vaccination. I am keen that community pharmacy should pick up not just flu but travel vaccinations. There is enormous potential in that regard. Community pharmacies are spread out throughout the country and are very accessible to patients, so that is a good model to use. We are seeking to move immunisation out of general practice, so that GPs can concentrate on what they do best, which is looking after patients who are unwell.

Dr Lunan: I could not agree more with Sandra White; thank you for asking the question. Over the past two or three years, practices have been changing how they deliver care, at varying speeds. Some practices have been more fortunate in having members of the MDT come to join them; others have not had that opportunity. Some practices have chosen to change the receptionist's role significantly, so that it has become a care co-ordinator role.

What has not happened alongside those changes is a national engagement campaign about why the changes are happening and what they mean. We hear from GPs across the country that patients often experience high levels of confusion, distress or frustration when they phone practices and have their calls answered by someone whom they would have traditionally experienced as just a receptionist but who asks questions that appear sensitive, in an attempt to link the patient to the right person, in the right place and at the right time. Patients worry about confidentiality and many people really struggle with a system that is very different from how they used to access GP services.

Practices are therefore having to do that education work at a very local level. It is happening in different ways across the country: some practices have information screens in their waiting rooms; some practices have produced leaflets; some have spoken to their community pharmacist; some have information on their websites; some have messages on the phone that explain the changes; and some have changed the title and badge of the receptionist who answers the phone to "care co-ordinator"—and have changed those people's training and job descriptions.

At the end of the day, however, unless you let the people who use services know what is happening and why, it is difficult for practices to take the changes on locally.

The college did a survey last year, to find out how the changes were going at the front line, and we found that the vast majority of practices had receptionists or care co-ordinators who reported that, in their conversations with patients about signposting them to other colleagues in the team, patients were getting upset or annoyed. Patients felt that rationing was going on and did not understand why things were happening. Care co-ordinators were finding their jobs very difficult, emotionally, although they were just trying to do what we were asking and training them to do. When patients came to see their GPs for their 10-minute appointments, we would spend about half the time explaining why what had happened was

not a bad thing and was what we had asked our receptionists to do. We were having to explain that it was about seeing not a replacement GP but someone who might be more qualified to deal with the person's problem.

Sandra White: Is that why there should be a national campaign? It would take things out of doctors' hands and free up their time. The public need to know what is available for them before they reach the stage of phoning the doctor.

Dr Lunan: Yes, and there has been a commitment from the cabinet secretary to a national campaign, and the Scottish Government has offered leadership, working with healthcare professionals and patients, to consider what the messaging should look like, what works well and what does not work so well.

That work started just in the past two or three months. I hope that it will make a big difference and enable people to make best use of the service and feel that there are good reasons behind many of the changes that are happening, so that they do not experience distress and frustration when they phone their practices.

The Convener: Finally, we—oh, I see that there is a late bid from Anne Mullin to say something.

Dr Mullin: We now have big posters in our waiting room telling people what they can go and see a pharmacist about, but it takes time to educate patients when they have previously seen the GP as the person to go to for everything. We have an attached physio for three years, which has come through the SHIP project, but it has been difficult to get across to people the concept that they can self-refer.

However, a lot of patients are aware that they can self-refer. GPs should not see sore eyes any more; patients should go straight to the high street optician, but it takes time to embed that. The national conversation should be a rolling process; it should not stop after one conversation. We are talking about a complex system that changes. We find that system difficult to navigate at times, so patients who do not have access to hospital phone numbers and so on will also find it difficult, and for deep end communities, health literacy can be a big issue. We have to remember that any changes that we make will affect everybody. The links worker is an important point of contact for us. They are embedded in the practice, which is really important.

Dr Hogg: Interesting things are happening. One of the practices that I work in is about to roll out the CWIC—collaborative working for immediate care—system, so that patients are signposted from the outset. I agree with Anne Mullin that it is a complex system for us clinicians. We are exposing that complexity to patients, so it is no wonder that we are struggling to get that level of self-care.

My answer to the question is responsiveness. There is something tricky about the situation when I say to a patient that they can self-refer to a physio. Physios are fantastic colleagues and have so much to offer—sometimes we, or even they, undersell what they can do—but when patients call a phone line, sometimes they get the impression that they are being prevented from seeing someone and on top of that they are told that there is a waiting time of 40 weeks.

We need the system to be responsive. At the end of most health messages—Australia has done some work on GPs' views on this—people are told, "If you are concerned, go and see your GP". There are two aspects to that. One is that we should resource the system so that it is responsive—we have a fantastic system in which people can access a GP free of charge, which is great. The other is that we need to work out how we can help patients to understand the complex system that even we clinicians who work in the service struggle to understand.

The Convener: Thank you, and I thank all today's witnesses for what has been a very full evidence session. Oh—I see an even later bid from Andrew Buist.

Dr Buist: I have one final brief point, which has to be made. There are tensions between rural, elderly practices and urban, deprived practices, but a fundamental problem that the committee needs to be aware of is that there is a lack of investment in general practice. Our share of NHS resource has dropped from 9 per cent to less than 7 per cent. Our colleagues in the Royal College of General Practitioners have been campaigning for 11 per cent, which is what we need to deliver the national clinical strategy. All our problems relate to the fact that general practice in Scotland is underinvested.

The Convener: Well done for not missing that last opportunity. There were a number of questions that we did not reach, and witnesses may wish to offer additional information to the committee, so we will be in touch with all today's witnesses and we will be grateful for responses to any further questions that we have for you.

12:53

Meeting continued in private until 12:59.

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