OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 8 October 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 8 October 2019

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HEALTH AND SPORT COMMITTEE

23rd 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:

Gail Anderson (Voluntary Action Orkney)
Dr John Anderson (NHS Health Scotland)
Caroline Cherry (Clackmannanshire and Stirling Health and Social Care Partnership)
Anne Crandles (NHS Lothian)
Jane Cumming (Penumbra)
Ainsley Dryburgh (Fife Forum)
Suzanne Martin (Scottish Association for Mental Health)
Susan Paxton (Scottish Community Development Centre)
Gerry Power (Health and Social Care Alliance Scotland)
Claire Stevens (Voluntary Health Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 8 October 2019

[The Convener opened the meeting at 09:30]

Primary Care Inquiry

The Convener (Lewis Macdonald): Good morning and welcome to the 23rd meeting in 2019 of the Health and Sport Committee. We have received apologies from Miles Briggs and David Stewart, and on behalf of Sandra White. I ask everyone in the room to ensure, please, that mobile phones are switched off or to silent mode. Although it is acceptable to use mobile devices for social media, please do not take photographs or record proceedings.

Agenda item 1 is our third evidence session in the second phase of our primary care inquiry. I welcome to the committee Ainsley Dryburgh, who is the local area co-ordinator at Fife Forum; Caroline Cherry, who is the service manager of adult assessment and partnership, communities and people at the Clackmannanshire and Stirling health and social care partnership; Gerry Power, who is the director of integration at the Health and Social Care Alliance Scotland; Dr John Anderson, who is organisational lead for primary care at NHS Health Scotland; and Anne Crandles, who is the social prescribing and community link worker network manager at NHS Lothian.

I am sure that members of the panel will have seen evidence that we have been given in writing and during previous evidence sessions. That evidence has stimulated interest in a number of areas that are within the witnesses' experience and expertise. On the basis of the areas in which you work and the important questions on definitions, what do you understand primary care to encompass in relation to health and care services, public health and infrastructure? Who is responsible for oversight and the overall vision, purpose and drive of primary care?

Anne Crandles (NHS Lothian): I can talk only about my sphere, which is the Edinburgh health and social care partnership. I work as part of the primary care support team, underneath our strategic lead for primary care. In my experience, primary care means general practice, pharmacy, link working, social prescribing, premises and supporting general practitioners and their primary care improvement plans. The responsibility for that goes up through the hierarchy of the primary care support team and the Edinburgh health and social care partnership, and on to the integration joint board. That is the limit of my experience, so it would be wrong for me to say anything else.

The Convener: Who else would like to have a crack at explaining the wider picture?

Gerry Power (Health and Social Care Alliance Scotland): For the Health and Social Care Alliance Scotland, primary care is at the forefront of access to health and social care services. We see the benefit of integration in primary care through projects such as the community links practitioner programme, which Anne Crandles alluded to, which is about linking the front door of health and social care with wider aspects of the third sector and organisational support for individuals. Therefore, primary care is a gateway not just into secondary and tertiary care, but into the vast scope of statutory, third sector and independent sector services. It is a vital first step for many people.

In the past, primary care has not had the support that it requires to support individuals to access services, but increasingly—especially through community links practitioners, for example—the gateway is starting to open wider to the expanse of services that are available in the community. That is delivery of integration at a very practical level.

The Convener: John Anderson—given your role in NHS Health Scotland and your Government perspective, what is your understanding of the scope of primary care?

Dr John Anderson (NHS Health Scotland): There is a traditional view of the scope of primary care, but the view has been expanding in recent years. The heart of primary care is still general practice, augmented by the full range of medical, nursing, dental, ophthalmic and allied health profession services and professionals. Those are, largely, directly accessible by the public. Accident and emergency services is an exception in relation to its direct access to secondary care.

As colleagues have said, we need increasingly to consider primary care as including a wider range of community and third sector organisations, because we will increasingly have to look to such organisations to improve the health and wellbeing of the population. That is not something that general practice and primary care in its traditional role can be required to undertake on its own, and it probably would not be successful if it tried.

The picture on overarching governance and authority is complex and ranges from Scottish Government authority to health and social care partnerships and IJBs. There are also the professional organisations, such as the Royal College of General Practitioners, and the unions and professional organisations such as the British Medical Association, which have big parts to play.

It is a complex picture: the take-home message is that collaboration and co-operation across the various governance authorities are critical if we are to make the changes that we need to make in order to modernise primary care.

Ainsley Dryburgh (Fife Forum): Fife Forum works directly with GP surgeries, which we see as being primary care. We take referrals from anyone in the GP surgeries—nurses, including mental health triage nurses and district nurses, and podiatrists, for example. My role is to lessen surgeries' workloads by taking on people who need non-medical appointments.

Caroline Cherry (Clackmannanshire and Stirling Health and Social Care Partnership): Like Gerry Power, I think that primary care is about wide access to local services. I am very much involved in third sector work with local people. I am also very much involved in prevention and wellbeing.

Primary care is much wider than the health professional role that was how people have traditionally seen it. We talk to people about how to avoid using their GP surgery and about how best to keep well and healthy in the community. That involves a wide range of colleagues and partners.

Emma Harper (South Scotland) (SNP): Primary care must be delivered in rural areas throughout Scotland. I am interested in whether there are particular problems with planning and delivering care in rural areas and, if so, whether that is reflected in the allocation of resources and in national guidance.

The Convener: Who wants to respond to that?

Gerry Power: As a third sector intermediary organisation, the alliance covers the whole of Scotland. Our experience of primary care services is very much focused on a couple of aspects—primarily, community links practitioners.

The issue is how allocation of community links practitioners is delivered across Scotland and whether areas of deprivation in urban and rural areas are tackled equitably. We are focused on urban delivery of services, as we operate within Glasgow. However, I understand from colleagues that there are issues in terms of how allocations are made in rural areas.

Anne Crandles: NHS Lothian has an urban focus, too, but we have been to visit colleagues in NHS Highland to discuss issues around community link working and the planning and strategy that are required. That is on-going work.

Caroline Cherry: I want to speak about the opportunities and challenges of working in rural areas. Our pilot project in the south-west of the partnership's area covers a fairly rural area. In terms of inequality, there are clearly transport issues in that area, which comes up time and again: people tell us that one of their major challenges is travel to appointments and services. We need to think about the opportunities for people to access consultations digitally online, because the reality is that many older people cannot continue to travel.

On opportunities, rural communities tend to be more resilient. People have a sense that they are all in it together, so they all have to use what they have, which means that they can be more imaginative and use resources slightly differently.

Emma Harper: That point about accessing consultations digitally is important. Wigtownshire, which is in the south-west of Scotland, is piloting the mPower project and community health synchronisation, or CoH-Sync, which provide means by which people can have consultations using iPads and other digital technology. That is one way of tackling rural issues, especially in areas where transport is a real challenge.

Caroline Cherry: Yes.

We have also been doing much better promotion of digital provision for much older people, in particular. We have to get past the barrier of older people's lack of ability to access services digitally. We have been going out to do presentations and talk about how people can use their iPads to make appointments and so on. We need to do much more of that so that people understand what they can do for themselves.

Emma Harper: Last week, I asked questions about general practice clusters—about what works, what does not work and what can be done differently. I am interested in how integration authorities and GP clusters are developing, and in how we can support that work. Do people in the national health service and health and social care partnerships—the managers, the cluster leads, the GP leads and everyone else—understand what we need to achieve in terms of primary care objectives and supporting optimal clinical outcomes?

Ainsley Dryburgh: I work directly from the surgeries in Cowdenbeath and Lochgelly in Fife. I feel that the overall view is the same: everyone wants the best for the patients and wants fewer people to have appointments for non-medical reasons. Everyone with whom I work directly takes that holistic approach.

Anne Crandles: Although we do not work in GP clusters per se, we work with them wherever possible. For example, if we are recruiting a new community link worker, we ask a local GP or the cluster quality lead to join the interview panel so that there is real involvement by the general practices. In an area in the south-west of

Edinburgh—the Pentlands GP cluster—we are doing an interesting test of change that sits apart from the national programme of link workers in partnership with industry. We are considering the elderly population and social isolation with six practices. Although that work is in a very early phase, we are beginning to pick up referrals from it.

09:45

Gerry Power: I was in a meeting with primary care colleagues two weeks ago, and my experience is that there is an incredible amount of enthusiasm for the investment in practices, particularly around community links practitioners and practice pharmacists.

Anecdotally, funding for community links practitioners is allocated on the basis of the highest priority, working down through the practices. That means that some practices in clusters get an allocation for a community link worker, while a neighbouring practice does not, because it is a slightly lower priority.

Of course, the concern is whether allocation of the 250 community links practitioners will ensure that all the practices that would benefit from community links practitioners are allocated practitioners. We might find a cluster in which the majority of practices have a links practitioner or another bit of primary care investment, while a neighbouring practice does not. That might lead to disparities in that cluster area, which we might need to address through more investment on things for which the whole cluster requires investment. That is some feedback from primary care.

Anne Crandles: I take Gerry Power’s point. However, in Edinburgh, we considered the primary care improvement plan and resource allocation based on practices’ population size and other factors. We offered practices the opportunity to use some of the resource for link working, so that if they choose to use a community link worker, we can spread the resource out from the national programme to mainstream practices. That is helping with the equity issue in Edinburgh.

Dr Anderson: NHS Health Scotland’s area of expertise and understanding is use of population health data in a public health context to address population health challenges and health inequalities at cluster level. There is a requirement for additional data, intelligence and information at cluster level to enable clusters and the people who work in and around them to understand the health needs of the local population.

The coming into being of public health Scotland in April next year, which will bring together the skills and expertise of the Information Services Division, Health Protection Scotland and NHS Health Scotland, will offer a major opportunity to increase the local intelligence and data that we can provide to clusters to help them to understand local priorities, identify service gaps and make service improvements.

I echo colleagues’ comments that there is a huge degree of enthusiasm and optimism for improvements in and around clusters. However, to take advantage of that enthusiasm, they will need support from public health organisations, such as the new public health Scotland.

Emma Harper: What role and responsibility do the public have in engaging with primary care services and in understanding the new language of GP clusters and things such as that? Could more be done to engage or inform the public? What role do the public play in developing their own services?

Ainsley Dryburgh: In Fife, we have broken the area into seven localities and we regularly have locality meetings. The public are invited along to those meetings in order to be included in the discussions about what is needed for that particular area. Each locality runs differently, depending on the needs of the locality. The public are involved in those meetings.

The Convener: Do you get a high level of involvement, or does it vary a bit?

Ainsley Dryburgh: The involvement depends on the locality.

Caroline Cherry: My comment is not so much about GP clusters. Our submission mentions our role in working consistently with a local community for a considerable time. Our community reference group, which is for older adults, involves third sector providers; the group has links to GPs and health and social care. I think that the group has helped to shape what older adults want their local priorities to be.

We have to move from a consultation-based model to one in which we get local groups that greatly involve older adults or adults in general. We set up the community reference group in a particular area because the local people decided that older adult care was one of the top three priorities, so it fitted for us to look at what we could do.

We have done a lot of work on self-management, befriending, loneliness and isolation. Again, the focus has been on the prevention parts in which people can get more involved. I think that that has worked well.

Gerry Power: Individuals and communities play a vast role in supporting themselves. I will mention two examples that are important in primary care. House of care is a model that has been delivered in GP practices. It is very much a partnership between the primary care team and the individual. It is about understanding the whole asset-based approach. It is also about co-production and understanding that an individual patient brings something to the relationship with the primary care professionals and that, by working together, they can help each other to understand what the individual and the practitioner can do. That model, which is being rolled out across Scotland, is very successful in the GP practices that use it.

The second example is the use of a local information system for Scotland—ALISS—which is an open platform search engine. It enables communities and individuals to describe what services are available locally. The system is available to the public; it is also used by practices and community links practitioners to identify what self-help and community supports are available.

There are tools and models available that support the role of individuals to take on more in looking after their health. Clearly, those things need to be promoted in a bigger way and more widely, so that people can understand how they can help themselves.

Anne Crandles: I echo everything that Gerry Power said. We use databases in Edinburgh and we have conversations with patients about what matters to them, too.

To strengthen what we do with the public, next year we will be adding to the criteria for our third sector partners that they commit to having patient focus groups in their premises that we can tap into and get direct feedback on the services that we provide. That is very much the basis of our intended approach.

Dr Anderson: I agree with my colleagues. The evidence shows that closely involving patients in the planning and delivery of local services can help to increase their personal power to influence service provision in line with local community needs. Community-led approaches can enable primary care to be far more effective at the prevention of illness through empowering people to influence the development of services that enhance their health and their wellbeing across the wider community.

Emma Harper: Caroline Cherry said that she had to spend considerable time with people. What does that mean? As a former nurse, I understand that health and social care is complicated. We are trying to implement transformational change. Are we keeping up? Are we changing fast enough? Is everybody adapting well enough? If considerable time is needed to engage people, what else could be done to support faster change?

Caroline Cherry: We spent considerable time with people because we were piloting a new approach and we needed to test it out.

There are models that we could look to—whether we call them patient forums or local health and care groups—to get people involved and get them to come along and talk about their health and social care issues, the services that they want in an area and the focus on prevention and self-management.

We have had a reference group meeting every two months for about two years. We have had some good evaluation and feedback, but it has taken people a long time to understand it. I think that health and social primary care is still quite complicated and a lot of changes are happening. Therefore, it is about bringing people on that journey, supporting them and genuinely trying to build relationships.

We have also piloted a resource worker, who is a bit like a community link worker. That resource worker has been key—sometimes it is about being able to talk to people in more depth and to link people into the group. It is a very active local group, which, I would say, is now much more empowered to think about what it wants and needs in its area.

Brian Whittle (South Scotland) (Con): I will move on to the primary care budget and start with a general question. Do you think that the primary care budget as part of the overall health budget is appropriate at the moment? Is it at the right level? That is an easy question. [*Laughter*.]

Dr Anderson: Thanks for that.

Brian Whittle: That was a hospital pass.

Dr Anderson: NHS Health Scotland, as an organisation that gathers high-level research and evidence to inform health decision making, is probably not best placed to judge the precise funding allocation that, for example, general practice or primary care should receive as part of an overall budget.

From general reading, I can tell you that the RCGP and the BMA, for example, have both independently called for 11 per cent of the healthcare budget to be made specifically available to general practice. The rationale behind that is that general practice is involved in the delivery of proportionate universal care in responding unconditionally to need that presents with compassion, long-term relationships, trust building and patient-focused outcomes. Increasing the sustainability, capacity and capability of primary care to undertake the day job would, by logical extension—which is certainly the argument of the RCGP and the BMA—increase the ability of primary care, but specifically that of general practice, to address health inequalities and deliver on population health challenges.

Our organisation does not have specific evidence on what exactly the figure should be, but the BMA and the RCGP have papers and some degree of evidence on the issue. I think that they refer to European countries that have similar figures in terms of percentage of budget.

Brian Whittle: Nobody else wants to answer the question—they have dodged it.

If we take the question further and look at the allocation of budget to primary healthcare, do you think that the split among the various elements of primary healthcare is in proportion? I am getting blank looks. We are obviously looking at primary care and community care services and the third sector. Are we able to fund them proportionately?

Gerry Power: From the perspective of the third sector, there are a vast amount of resources out there, and it is about understanding how they can be best supported. We are open to that, through integration, and to involving the third sector more in the provision of health and social care. For example, the majority of social care is provided through the independent third sector anyway, so we need to recognise that that sector is a key player in providing social care.

At local level, third sector organisations must not simply be seen as a default position for a lack of resources in primary care, healthcare or social care. The opportunity that we have through the health and social care partnerships—the IJBs—is to look at this as part of a collective of resources. We should not consider the third sector as sitting to the side somewhat; we should see whether it can provide services that complement and possibly enhance the services that are provided through statutory care.

10:00

It is about making best use of a resource that already exists and understanding that those services are partners, not an adjunct, and so should be integrated fully with services that are provided by the statutory sector. There should be parity of funding for those organisations, but that requires a mindset that we should fund third sector organisations for certain things and statutory organisations for others. Both organisations and systems can complement each other, but they have to be funded on the basis of parity and consideration of which sector is best to provide the services.

Anne Crandles: I am sorry, but I cannot answer Mr Whittle's bigger questions. However, I would like to reinforce the comments that Gerry Power has just made. We are aware of how much pressure we put on third sector colleagues through social prescribing, admin signposting and community link working. We want to keep flagging up that the sector needs to be resourced if we are to continue to do that. The sector does good work, but we need to be able to refer with confidence and know that we are not burdening our third sector colleagues.

Brian Whittle: I want to explore that a little further. I have a specific interest in what the third sector can deliver, particularly in areas such as drug and alcohol services. The third sector is at capacity, because of the way in which it is funded. We have introduced IJBs and funding provisions to transform the way in which we deliver healthcare services, which suggests that there is an opportunity to look at the way in which we fund the third sector and make better use of what it can deliver. I will ask the same question again. I am hearing that that is what we want to do, but is it happening? If not, what needs to happen to leverage the great work that the third sector does?

Anne Crandles: We need to recognise the great work that we are doing and not take it for granted. To turn your question on its head, there are definite gaps in services. We need to gather proper intelligence on those gaps and ensure that there is equity of service and a local need that is met. There is mapping to be done before we think about the resourcing, so that it can then follow intelligently. There is initial exploring work to be done. Before we get round to how we do it, we need to know what we are doing.

Gerry Power: There are barriers, such as the longevity of funding and the fact that for many third sector organisations funding might be over three years, at the very best, although it is often less than that. That makes it difficult to plan services and to work in partnership.

Procurement is another issue. For example, we hear that it is difficult for health and social care partnerships and IJBs to invite specialist organisations to design services, because that might be seen to give them preferential treatment and therefore they are sometimes excluded from the strategic planning of those services.

Those are particular areas of difficulty. There is also an issue of trust. Are third sector organisations rather than statutory organisations trusted to provide services?

Those barriers still need to be overcome. The alliance recently commissioned a piece of independent research called "We Need to Talk About Integration", which involved asking people how it feels for them. Statutory providers, rather than third sector providers, were asked what some of the barriers were, and they raised the issues that I have just mentioned. There are still barriers around the commissioning process and involving third sector organisations in the provision of services. There is a lack of trust and a fear of the risk in some statutory sector organisations. Those issues are still preventing statutory and third sector organisations from designing services in a way that transfers them to third sector organisations that may be better placed to provide them. That is still a concern. The paradigm for how we provide services is shifting, but there is still some way to go.

Dr Anderson: I echo what my colleagues have said. From the general practice perspective, it is important to remember that, in referring to third sector and community resources, GPs and other members of the practice team have a responsibility to ensure that patients receive quality support for as long as they need it. The use of the third sector by general practices and primary care requires long-term relationship development and time for trust to be built up so that referring practitioners understand that, when they refer a patient to those services, the patient will receive a good service, improve and get better. That will give the GP the confidence to send other people to that service.

I have been told by many people—our organisation, which works extensively with community and third sector services, is often told this—that service stability and funding longevity are critical issues that underpin the development of long-term relationships and trust between referrers and providers. That does not tell us how much to spend on them, but it tells us that stability and funding are critical issues to look at.

Brian Whittle: Two questions arise from that. First, are we fully aware of what is available in that environment in the third sector, and do we need to audit that? Secondly, should we put together a framework that third sector organisations should aspire to use in order to gain that level of trust? Is that the direction of travel that we should be going in?

Dr Anderson: I will give a brief answer from my understanding. My third sector and community sector colleagues will, of course, have a far greater depth of knowledge than I have in those areas, and I will leave the question of service level agreements and formal written arrangements to them.

We are aware that the ALISS mechanism comprehensively maps third sector resources and makes them available via the web to whoever wants to access them. Typically, we now see in general practice an increasing role for community link workers and other social prescribers in and around the practice in using those resources. A key aspect of the role of link workers, for example, is ensuring that they know exactly what is available in their area, building relationships with providers and keeping a rolling, up-to-date catalogue of what they can refer patients to.

That possibly helps to answer Brian Whittle’s first question.

Gerry Power: The recent ministerial strategy group that looked at integration made a number of recommendations, one of which was that, on the broader front, healthcare organisations need to understand better what is available for third sector organisations and to respect the contribution that third sector organisations make. At the ministerial level, there is a recognition that more needs to be done on that.

Although a framework has been issued to IJBs that asks them to indicate how well they think that they are doing in engaging the third sector, we would like to see a bit more evidence of how that is working. We would like to see a tool being used, such as the public sector improvement framework, which the Improvement Service uses, to identify specifically how health providers at the health and social care partnership level right through to the primary care level are engaging.

Although tools such as ALISS might be able to inform what is available in the third sector, more needs to be done to understand what is available at the local level. ALISS will give a snapshot of what is available. It is an open platform: people put on it what they want. However, it is about what services are available locally and we do not have a full picture of that. The ministerial strategy group report helps to push that further, but more work needs to be done to understand what is available.

Anne Crandles: I want to pick up on some of those points, too. We tend to use our third sector interface’s red book, which is a similar idea to ALISS. In Edinburgh, we know where the resources are—that is in a database—but we are not so sure about the gaps. Where are the missing fishing clubs, or the areas that lack lunch clubs? That is what we need to map.

We have a very good relationship with our third sector colleagues in Edinburgh because we work in partnership to deliver the link worker service. We are building trust with general practices around the city as more and more of them start to get involved in social prescribing in the widest sense. However, I agree that we are not so good at getting feedback from the activities to which we refer people. We know where we are sending people and how many we are sending, and we have anecdotal evidence that 60 to 70 per cent of those people report tangible benefits, but we do not have anything concrete. That is something that we want to explore.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning and thank you for coming to see us today. I want to talk about the complementary nature—or lack thereof—of the models of medical care and the social model of care. How would you define the social model of care?

The Convener: That is a good, general question.

Gerry Power: I will have an attempt at answering it.

Alex Cole-Hamilton: Not everyone has to answer the question, but perhaps Gerry Power can start us off.

Gerry Power: Health and social care are inextricably linked—they overlap in the wellbeing of us all. It is difficult to say that there should be a separate social model of care. We keep coming back to community links, because, for practitioners, that link is the key element. How do people present within primary care? Many of the issues that they present with in primary care are much more complex than a GP or a primary care practitioner can deal with in the limited time that is available. Once there is an opportunity for the GP to look into the problems and engage on a longer-term basis, they see that many of the health issues are linked to social issues, such as housing, financial, relationship and weight management issues. Many of the causes of people's health problems are actually social problems.

As I said, the two forms of care are linked. In the primary care context, the social model of care means that we now have resources and recognise that those determinants of health are important—the investments that we are making in those resources are incredibly valuable and are starting to address some of those social issues.

Caroline Cherry: I totally agree—that was very well explained. Everything should be person-centred: we need to put the person at the centre, rather than try to fit them into a model. The role of informal support is crucial. We see the person at the centre, and surrounding them is their community and their informal supports. That is where the community link workers have real connections: they are able to connect people not only to formal services but to informal supports—such as the fishing clubs that Anne Crandles talked about. We spend a lot of time focusing on lunch clubs, tea and tunes, drop-ins and so on. Those are not formal services, but they are the things that keep people well and improve their quality of life.

The social model of care is a person-centred, community wellbeing model. It is very hard to separate the social and community elements from quality of life and health—they are inextricably linked.

Anne Crandles: Edinburgh health and social care partnership is very focused on driving down social isolation, in whichever way we can—whether that is by working with elderly people and popping along to see them, or, as Caroline Cherry said, taking people along to a social activity and getting them engaged and interacting with other members of the community. Tackling social isolation is key.

10:15

Alex Cole-Hamilton: Let us consider that every patient in Scotland—ourselves included—is on a continuum of care, which is bookended by two worthy philosophical points of view. At the wellness and prevention end of the agenda—which, I hope, most of us are on—we keep fit, eat well and sleep as much as we need to. At the far end of the spectrum is the realistic medicine agenda, which involves end-of-life issues and the choices that are being made. I think that every party in the Parliament has signed up to both agendas, but the application of the agendas is perhaps not as good as it could be at local level. How far are we from achieving success at both ends of the continuum? There was quite a lot in that question.

The Convener: It was another very large question.

Alex Cole-Hamilton: Let us take prevention first. What could we do better? We will come back to realistic medicine and end-of-life issues.

Dr Anderson: That is a complex and large question. I will start by saying a little bit about the role of primary care in prevention. It is worth re-emphasising that fundamentally, as I am sure you all know, health inequalities arise from unequal distribution of power, wealth and resource across communities and populations. Such differences give rise to differential experiences of the wide range of social determinants of health, including education, housing, employment, income and access to services. Those differential experiences underpin the differences in health among the population and individuals, and give rise to health inequalities.

Primary care's ability to reduce health inequalities lies mainly at the mitigation end of the spectrum and is therefore limited. However, primary care has a role to play in primary prevention, primarily through action on the social determinants of health. We have heard examples of referral through link workers and of social prescribing to a full range of community and third sector services. It is worth bearing in mind that health and wellbeing are two sides of the same coin; if you dent your wellbeing, you will dent your health in the longer term. Improving people's social inclusion, their involvement in society, their personal resilience and all the other social determinants of health will have an impact on their health in the longer term. The evidence is clear on that. An example of how we can undertake that work effectively in general practice is through routine social inquiry as part of longer consultations.

My view is that providing realistic medicine and maintaining people’s health and wellbeing through community involvement and other things are not so much opposite ends of the spectrum as covering the spectrum. They cover the spectrum because of the principle of proportionate universalism, which is that every patient should receive the care that they need in proportion to their need. Patients who require more help and support—either medical support or community support—should receive more, and those who require a little bit less should perhaps not receive as much.

Realistic medicine comes into play in helping to judge decisions about when patients need more and when they might need a little bit less—particularly a bit less in relation to medicalisation, potentially unnecessary investigations and so on. As the committee knows, realistic medicine is a complex topic. I certainly do not profess to be an expert in it but, having read the papers and the background, I think that we will need to engage with the subject.

I will stop there, so that I do not go on a wee bit too long.

The Convener: That is certainly helpful.

David Torrance (Kirkcaldy) (SNP): How do witnesses plan locally for workforce requirements?

Anne Crandles: From a community link worker perspective, we have come up with a rubric that sets out, for example, that for every 1,000 patients on a general practice’s list who live in areas of concentrated economic disadvantage, we will allocate one day of link worker activity. We have been using that rule of thumb for three or four years. It feels that that is about right, but we have nothing scientific on which to base it. That is the approach that we have continued to apply.

As I said earlier, we recently started to work with an elderly population. We had nothing scientific to base that on, so we just used our previous experience and thought, “This might all take a bit longer, so we’ll halve that and we’ll see.” We take a pragmatic rather than a scientific approach, but we need to start somewhere.

Gerry Power: Although the situation is patchy across Scotland, we have seen that the workforce does not include only the statutory sector; it includes a spectrum of organisations from the third sector and the independent sector, as well as the statutory organisations. When it comes to workforce planning, there needs to be a realisation that the workforce is larger than what is available in the statutory sector. It is essential that the other sectors are involved in planning. That is happening in various places, but not everywhere.

In addition, a decision needs to be taken about which sector or which practitioner is the best one to focus on delivering the services. It is necessary to be open to that. It is not simply a case of saying that we must continue to provide services through statutory organisations. That is difficult for a variety of reasons. There are vested interests and there are risks involved, but there is a need to recognise that the workforce out there goes beyond the boundaries of the NHS and local authorities.

David Torrance: Thank you for those answers.

What is required nationally for you to recruit the required staff? If the staff are available, is the budget there to recruit them?

The Convener: That is a good question.

Gerry Power: I am happy to answer that. I do not know whether the required budget is there to employ all the staff who are required. That is beyond me.

David Torrance: Does anybody else want to answer?

The Convener: John Anderson might be able to provide a national overview.

Dr Anderson: Harking back to the previous question, one way to decide on the workforce requirements of an area is to understand the population needs in that area. From its inception in April next year, public health Scotland will be better placed to support the provision of a wide range of data and informatics that will allow us to better understand the needs of populations, which could be fed into workforce plans and so on.

I am at risk of forgetting the original question.

David Torrance: How can we plan nationally for workforce shortages, such as the shortage of home carers? In my area, there is a huge shortage of home carers, even in the private sector. How do we encourage people into that sector? How should we plan for such situations?

Dr Anderson: The example that I know best is related to general practice recruitment and retention, but the principles will be similar across many of the professions.

My view—which, to an extent, is backed up by the evidence—is that, in many respects, general practice is very like every other job. It must look like a good job to people who want to come into it;

it must be spoken well of in communities; it must be properly paid; proper training must be provided; it must be properly respected; it must offer good career progression and interesting work; there must be a good atmosphere; and the physical and information technology infrastructure must be supported.

I think that those general parameters apply to every role, including home care staff, although there will be specific challenges in some of the lower-paid jobs. I will stop there, as that is not an area of expertise of mine and it might not be wise for me to carry on.

Caroline Cherry: I am involved in commissioning independent providers to provide care-at-home services and an internal care-at-home service. There is a lot of pressure on recruitment. We do not want there to be a competition locally, because there are not enough people.

The issue of home carers or care-at-home workers is quite a complicated one, but I echo John Anderson's comments. It must be an attractive career with training prospects and there must be flexibility to enable people to meet their work-life balance.

We need to value the role of front-line carers. We must do much more, locally and nationally, to demonstrate the fundamental role that they play, because without them a lot of our older adults would not be living at home. It is the primary objective of health and social care to support people to live well at home for longer, and care at home plays a fundamental part in that.

That might not have answered your question. The situation is complicated and a challenge for us.

Ainsley Dryburgh: The point that Brian Whittle made about uncertainty in the third sector, which picks up the shortfall but operates with short-term contracts and cannot plan for the future, is a reason why people are not willing to move into the third sector.

David Torrance: How is information being shared between organisations to enable the multidisciplinary approach that is needed in primary care?

Anne Crandles: Through data sharing agreements, in the first instance. Let me give a bit of context. Our link workers are host-employed by local third sector organisations; they are not employed directly by Edinburgh health and social care partnership. Therefore, we need data sharing agreements between the practices and all the local third sector organisations, and we have to set up nhs.net email addresses, to ensure that information that is shared is secure at all times.

That requires good information technology security and good working relationships between the health and social care partnership and the Caldicott guardian and general manager in each organisation. It requires continuous training for our link workers on the general data protection regulation, for example, to ensure that information is secure across the piece.

Gerry Power: Link workers have access to GP systems, such as EMIS, and record their engagement with clients and patients on the same system as the GP uses. There is sharing of information between individuals at practice level.

Information sharing between organisations in the statutory sector and between statutory organisations and the third sector is patchy. There are concerns about risk and about how much information can be shared. In some ways, it would be nice to have joined-up information for a particular individual, but we must be aware of the risks that are associated with that.

Some of the concern is relevant; some of it might be more about the nature of a third sector organisation with which information might be shared. In my 40 years of experience in healthcare, that has always been a problem. We have always asked who we can share information with and whether we can share information with another department or organisation. There is still a risk associated with sharing information, particularly between statutory, third and independent sector organisations.

Emma Harper: The community link worker is a new role. The idea is to embed such workers in GP practices, especially in areas of deprivation and poverty, so that they can signpost people to non-GP and non-clinical services. There are plans to have 250 community link workers in Scotland. I read somewhere that at least 56 are in post—can the witnesses update us on that? How many community link workers do we have in Scotland? Do they have different roles in different localities?

Anne Crandles: I cannot speak about the national situation but I can speak about Edinburgh. As part of the national programme, we have a head count of 14 community link workers. That was our Government allocation back in 2017. That is 13.2 whole-time equivalents, but we shave a bit off that—0.4—for two people to create team-lead roles, so that there are operational leads out there in the community as well. We are also fortunate enough to have a bit of resource—a 0.6 and a 0.4—from third sector organisation colleagues as well.

In our tests of change that I referred to earlier, we have 5.4 whole-time equivalent link workers covering 12 practices in Edinburgh. In total, we have almost 20 link workers, and we cover almost

50 per cent of the practices in Edinburgh at the moment. I will allow other colleagues to talk about their allocations.

10:30

Gerry Power: We are a provider organisation for community links practitioners. We have just appointed another 10 so, by the end of this month, we will have more than 30 full-time community links practitioners. I note that the health and social care partnership has awarded other GP clusters to Addaction, which is another provider organisation in Glasgow, which means that there will soon be 40 community links practitioners in the Glasgow area.

The models differ across the country. The model that we operate involves a dedicated full-time community links practitioner for each of those practices. They are paid for by the health and social care partnership. We contract with it to provide them, as does Addaction, and we have an honorary contract within the GP practices.

As I said earlier, there are parts of Glasgow that are classed as deep-end areas of high deprivation. It is certainly not my view, based on information that I have received, that there are sufficient resources to appoint community links practitioners to all the practices in those areas at the moment. I am not quite sure how the 250 will be allocated but, certainly in Glasgow, we could do with doubling that 40 if we are to cover all the practices that are in areas of high deprivation. However, we are moving a significant way towards that.

As I said, models differ. Certain models for community links practitioners share practitioners between practices, but that is not the model that we have in Glasgow, because we feel that it is essential that we have a full-time individual in place. That seems to be working, and they are certainly kept busy.

Ainsley Dryburgh: Like Anne Crandles and Gerry Power, I am a local area co-ordinator. It is a similar role to a link worker or social prescriber, but that is what we call ourselves in Fife.

There are three local area co-ordinators employed by Fife Forum to cover the GP surgeries. Between us, we cover nine surgeries in Fife. The localities that were allocated to us are the more deprived areas. That model is similar to the one that Anne Crandles and Gerry Power operate under. The local area co-ordinators direct clients to a community group that will meet their needs and they go along with them the first couple of times in order to alleviate their nervousness and anxiety about going somewhere for the first time.

We are all full-time workers within the GP clusters.

Emma Harper: How are the referrals made? Are the community link workers the first professionals who are engaged with, or do GP receptionists divert people to a community link worker? How is it decided whether someone goes to a GP or to a community link worker?

Ainsley Dryburgh: In Fife, we take referrals from anybody who works in the GP surgery—a district nurse, a podiatrist, a mental health nurse or a GP. It depends on how the person has presented at their appointment that day. The appointment might be deemed to be a non-medical one and, in that discussion, they will be referred to me. When I meet them, we will have a good conversation to find out what is going on and what their needs are.

The Convener: From the nods around the table, I assume that it is the same model elsewhere.

Caroline Cherry: We have a slightly different approach. I was telling you about our piloting of what we call neighbourhood care, which involves someone we call a resource worker. One of the things that he does is provide health and social care drop-in sessions, which have been provided at all the GP surgeries. We have been encouraging local access to those. People may not be referred to the sessions; they may just go there to ask questions about health and social care. We get quite a few carers coming in and asking questions about local services. Again, that is something that I would be keen to promote.

The Convener: So it is a slightly different model.

Dr Anderson: NHS Health Scotland has just completed a qualitative evaluation of the initial roll-out of link workers to the 50 or so early adopter practices. That is currently in draft and should be available fairly shortly. It will include learning about the various models in use and critical success factors that are vital for effective roll-out.

George Adam (Paisley) (SNP): We have all got mental health issues, but there are people in our communities who struggle with their mental health. Should mental health be viewed primarily as a medical issue, which requires a response right away, or are there other ways that we could work with it in our communities? In some parts of the country, there are men's sheds, which are for men who are isolated—for example because their partner has died—which can lead to mental health issues. If there is intervention at that stage, and if a man gets involved in that type of group, it makes a difference. What role would the third sector have in that?

Anne Crandles: I completely acknowledge the issues around mental health. Link workers are social practitioners, and most of our referrals are people with mental health issues. Our role is to get people with mental health issues to engage—again, there is that issue of social isolation—and get involved in activities while they wait for or receive treatment from mental health services. I do not have any statistics with me to back this up, and it is not the norm, but we occasionally find that, once an appointment comes through, if a person has become well enough engaged in the community, they no longer require that appointment. We can help with men's sheds and many other things, too.

George Adam: The male psyche is such that, if you are a certain age or at a certain stage in your life and your doctor says, "You've got a mental health issue," you are likely to say, "What does he know? I'm no doing that." That is why I mentioned men's sheds and the third sector. I will use the example of St Mirren Football Club in Paisley in my constituency. The club is a 142-year-old institution, and people trust it. I am not sure whether that is right when I go there on a Saturday, but people trust the organisation. How do we reach those individuals and get the third sector effectively at the front line? St Mirren is the perfect example. You talked earlier about funding and how it goes from year to year. Because St Mirren is 142 years old, people believe that it is an on-going institution and that it will continue. Instead of getting people to go down the medical route, how do we deal with people in a way that they are comfortable with?

Gerry Power: I am not a mental health professional. There is a combination of factors, and sometimes it is entirely appropriate for a medical or health model to be followed. I echo what Anne Crandles said. A significant number of referrals that come through our community links practitioners are for areas that I suppose we could associate with mental health. There are big issues of social isolation that can lead to mental health problems. You are absolutely right. Some of the resolution to that is about helping those individuals to engage more in community activities.

I talked about primary care being a portal. It is about opening up opportunities for individuals to engage in community activities. The community links practitioner is just one step. It is about having a dialogue with the individual. A men's shed may be right for one person but, personally, it is not for me—I might prefer to follow the football example. For certain individuals, it is about building a relationship with them to understand how to help.

As colleagues have said, community links practitioners do not simply signpost and tell people to go to certain organisations; the practitioners can accompany people and build a relationship. It is about developing walking groups, taking people fishing or going with them to football or a men's shed. Much of the time, individuals do not want to take the first step. The community links practitioner is the link from the first presentation, which might come through a GP, to the vast array of resources that are available. It is about spending time with the individual to understand what will help them. That could be a men's shed or one of a vast range of other activities. The person might simply want to meet once a week to talk and have a coffee. Community links practitioners do all that. They signpost, but they also work with individuals to identify needs and to accompany them to organisations such as men's sheds to ensure that the individual is comfortable in that setting before stepping back and letting them engage in it. It is about accompanying people on that journey.

The third sector is available, but individuals need to be helped to engage with it and not simply left to their own devices to do that. The third sector can support individuals, but links practitioners help with the transition.

The Convener: We have heard a little about quality evaluation and monitoring, but Brian Whittle has a final line of questioning on that.

Brian Whittle: As you will know, there is a national monitoring and evaluation strategy for primary care for the next 10 years. My simple question is this: how are the partnerships implementing that strategy?

Anne Crandles: I am sorry, but I do not have the answer to that.

Dr Anderson: My colleagues in NHS Health Scotland have been intimately involved with many other organisations in developing the 10-year monitoring and evaluation strategy. It is worth remembering that it is an overall strategic approach to establishing the effectiveness of the changes that we are making, but it has not yet been operationalised—I think that that is the technical term—into a practical evaluation plan. Creating such a plan involves setting specific evaluation goals, understanding what data, intelligence and approaches to evaluation can best be deployed in pursuit of what we are trying to show, and then collecting that data, analysing it and presenting it.

Reflecting the strategy's expressed desire to involve local systems in the evaluation, which is critical, that is the point at which local systems such as HSCPs will be intimately involved in establishing the evaluation priorities and data sources and taking part in the evaluation to show change across the wide variety of changes that are taking place in primary care.

To summarise, it is early days.

Brian Whittle: I wonder whether all the relevant stakeholders are aware of the strategy and will use it to help them to direct evaluation efforts. As a supplementary question, I am interested in who you think should be responsible for the evaluation and monitoring of the services.

Dr Anderson: That is a good question. A comprehensive outcomes framework has been developed to guide local and national evaluation, which has been fairly widely publicised across the system with our partner organisations and across our public health network, for example. I am not particularly sighted on the extent to which that has penetrated local HSCPs and IJBs, although I recognise that, in due course, that will be critical.

I am waffling on there. Sorry, but what was your second point?

Brian Whittle: Who should be responsible?

Dr Anderson: Ultimately, the Scottish Government is the owner of the evaluation strategy, but my understanding is that there is joint responsibility for the delivery of the evaluation across all the partners. As I mentioned, that must include local systems—going right down to the clusters that are implementing new models of primary care transformation, for example—because they are best placed to understand what they are trying to achieve, to guide the evaluation and to help us gather the data that will tell us whether such models are worth rolling out nationally or providing additional funding to.

That was a long answer to a short question, I am afraid.

The Convener: Clearly, we will return to that question of evaluation in due course.

I thank all the witnesses for their helpful replies and information. If any thoughts occur to you after you have left the room, please feel free to drop us a line accordingly. I suspend the meeting briefly to allow the panels to change.

10:45

Meeting suspended.

10:51

On resuming—

The Convener: With us for our second panel we have Claire Stevens, chief executive of Voluntary Health Scotland; Susan Paxton, head of programmes at the Scottish Community Development Centre; Gail Anderson, chief executive of Voluntary Action Orkney; Suzanne Martin, senior public affairs officer at the Scottish Association for Mental Health; and Jane Cumming, director of services and innovation at Penumbra.

As I did with the previous panel, I will begin with a general question. Given the interfaces and interconnections that exist, and how your organisations are affected by those, what is your understanding of the scope of primary care in terms of health and care services, public health and the necessary infrastructure to support that?

Suzanne Martin (Scottish Association for Mental Health): I agree with much of what the previous panel said. Primary care is the front door to health and social care support for the general population. That includes more than GP surgeries, although that is the traditional view of primary care. The third sector has a role to play in primary care, along with other allied health professionals and GPs, in terms of providing support services for the population and identifying and addressing health needs and health inequalities in the population. Primary care also has a preventative role, and I think that the third and voluntary sectors have large roles to play in that regard.

The Convener: If no one wants to add to that, I will ask another question. We are looking at primary care as a whole, so we are also looking at who else is looking at it as a whole. The Scottish Government has laid out its vision and there are other potential ways of looking at it. Can you identify anyone else who has oversight or an overview of primary care?

Claire Stevens (Voluntary Health Scotland): The exciting thing about public health reform is that it opens up the way for the third sector to be more involved and to be seen as more of a partner. Voluntary Health Scotland is a national intermediary and network for health charities and other voluntary organisations that are involved in health. Most of our members have a strong focus on trying to address health inequalities.

Over the past few years, one of the frustrations among voluntary health organisations has been that, although they know that they are an asset in terms of their role as a resource for primary care, they have to batter down the doors of primary care in order to be recognised, acknowledged and involved. That is beginning to change. I think that there is a shift in understanding what primary care is. People are now viewing it more as a collaborative endeavour that is based on partnership, and it is seen as not only a gateway to secondary and tertiary care but to a great deal more within the community that can help to keep people well and healthy.

Jane Cumming (Penumbra): Although primary care is a gateway, it is often not the first port of call for people. I am talking specifically about mental health, which is my area of expertise and therefore what I focus on. People have often sought more informal means of support, so they will arrive at primary care after they have clearly identified that there is an issue. Primary care is a gateway for people to access other services, to receive care and support immediately, such as treatment, an assessment or whatever it may be at that particular point. Often, however, people have sought earlier intervention or prevention before they have got to that point—perhaps not in the way that we would like, or from the range of resource allocation in terms of what is available. There is a wider and more informal area around primary care that should be considered as part of the overall picture, if that makes sense.

The Convener: Indeed it does.

Emma Harper: I am interested in the particular challenges or problems of organising primary care in rural Scotland. We heard from the previous panel that, when the word "rural" is mentioned, people immediately think about north of the central belt. However, South Scotland is a big rural region. I am interested in how the challenges of primary care and the changes that are required for our rural areas are dealt with.

The Convener: Feel free to address the north or the south.

Emma Harper: Addressing both would be good.

Gail Anderson (Voluntary Action Orkney): The delivery challenges are quite significant for an island grouping. That is particularly the case with 13 non-linked isles that depend on ferry and air travel. That can mean a practitioner—whether from the third or the statutory sector—being away for a whole day or overnight for a two-hour session. There are very small teams in our small area, and taking one person out for a day or a day and a half has quite significant repercussions for the rest of the team. Some islands have resident GPs and nurse practitioners, but all the other services are based on our main island—the Mainland—and access to those services from the isles is particularly challenging.

We do not have the infrastructure for technological solutions, which, given the access barriers, would be absolutely appropriate. The islands that would benefit most from technological solutions are the least likely to be able to access them.

Small staff teams, the challenge of delivering, transport issues, and technological and IT infrastructure are all quite significant barriers to making things work.

We should not underestimate the commitment of communities to doing things for themselves. The significance of the third sector in contributing to community-led services has already been well rehearsed. That is happening. Some communities are very committed to sustaining their very small populations and to working with third sector and statutory colleagues to ensure that services are delivered as best as they can be.

Suzanne Martin: I agree with a lot of what Gail Anderson said. IT and technology in general will help to address a lot of the access issues that rural communities face, but they should certainly not be a default for people with mental health problems. People should have the option of what kind of service they receive. Giving people choice in the kind of service that they receive is crucial. We know that, when people have more choice in what their support will look like, they are much more likely to benefit from that support. That goes for everything, from the type of care and treatment that they receive to how they receive it, where they receive it, and what time they receive it at.

I caution that technology should not necessarily be the default for rural communities and they should not miss out on receiving support that they would benefit from simply because of where they are located. I am sure that a lot of the third sector organisations and primary care health professionals who work rurally are aware of that issue and are looking to address it.

11:00

Jane Cumming: I will add to the comments of my colleagues by saying that all the factors that have been mentioned should influence procurement practice and how services are funded and commissioned. I heard a witness on the previous panel talk about there being one full-time GP in a practice in Glasgow, but in rural areas a full-time GP will often be spread across general practice areas. Providing care and support for people in rural areas costs more, because of simple things such as travel between patients, and that is not often recognised when services are purchased. A one-size-fits-all approach does not work. We need to factor all the things that people have mentioned into how we plan services for rural communities in order to provide the choices that my colleagues have spoken about.

Susan Paxton (Scottish Community Development Centre): I will build on what Gail Anderson said about the role of communities in improving services and overcoming the challenges that affect rural communities, in particular. We are involved in work on community-led action planning, which involves supporting communities to identify their priorities and the issues that affect their health and quality of life, and to identify actions that can be taken to address those issues. That will often involve collaboration with service deliverers in that area. We have noticed that communities identify the availability and accessibility of health and care services as an issue that they want to address. That indicates that people in communities and in the organisations that tackle the issues that communities face have an appetite and a willingness to engage with primary care service delivery in order to improve services and to address the challenges that they face.

We need to think about the mechanisms that would bring communities and service providers together, because there is concern that issues that communities identify as important might not coincide with the priorities that service providers identify. There might be no process or mechanism to bring the two together. We want service providers of any nature to respond to the issues that communities identify, including, in particular, the availability of primary care services.

Emma Harper: I will move on to the collaborative engagement that is required between integration authorities and GP clusters. Are the right collaborative approaches being taken, or should we look at other structures to allow collaboration between general practices and health and social care partnerships?

Jane Cumming: There are clear benefits to integration, to streamlining processes and to sharing resources. As was pointed out earlier, the third sector and the independent sector, which, I think, are the biggest providers of social care services, are often not part of the conversation about integration. That could be further addressed to help overall collaboration.

I will build on what my colleague said about involving communities and localities in establishing the priorities in their areas. In relation to giving communities ownership of primary care health services, the involvement and participation that we want will become more meaningful if people see that results have been produced from the forums, the collaborations and whatever structures have been built. It is about whether those structures influence what happens. The critical thing is having the voice coming through that has the power and control to generate results for communities.

Suzanne Martin: As far as collaborative approaches and GP cluster working in particular are concerned, I understand that GP clusters were introduced as a quality improvement mechanism. I am not best placed to comment on the efficacy of GP cluster working, but I agree with a lot of what Jane Cumming and Susan Paxton said about collaborative approaches with people who use services. It is really important to listen to what members of communities have to say about what they would like to see in their communities when it comes to services.

We did some research for a Scottish Government consultation on clinical governance. We found that the majority of people had never been asked what kind of mental health services they would like to be provided in their community. Trying to provide community-based services for people with mental health problems without speaking to those people about what they need and what they would like from the service is problematic.

In relation to our local services, we have good engagement with people when we work with them individually on what they need. It is extremely important that we talk to people and communities so that we can design services appropriately. I was pleased to hear members of the previous panel talk about work that is being done in localities, where meetings are being held that the public can come along to and there are reference groups that the public participate in. That sounds fantastic, and I hope that best practice on working collaboratively with the public and local communities is being rolled out, because that is really important.

Gail Anderson: A collaborative approach is essential, particularly in our area, given the small populations that I mentioned earlier. A piece of work that we have done as the local third sector interface has been to liaise with, initially, seven island communities that were concerned about the level of service that they received, for the reasons that I explained earlier.

As a result of that, we commissioned some research to identify exactly what the issues were for those communities and to focus on the assets that they would bring to any work that we took forward. That piece of research resulted in two recommendations, one of which was that we should pursue, with our colleagues in the integration joint board, Orkney health and care, much more collaborative and co-productive work. That work is on-going. There is a great willingness to involve the third sector in such work in Orkney.

The other recommendation was that we should work with communities to look at the lower level of wellbeing and what could be done in communities to support people to increase their wellbeing and their sense of involvement in their communities, as that would lead to less pull on statutory or medical services. As the TSI, we managed to get funding for that piece of work. We have established a project manager and, with five island development trusts, we have established what we call community wellbeing co-ordinators. Their remit is to build on and update the previous piece of research and to consult their communities on what we could do collaboratively to provide the services that those islands need.

Much of that is dependent on the ability of third sector services to deliver in the islands and on the ability of the islands to deliver collaborative work. An example of that is on the island of Hoy, where the wellbeing co-ordinator has liaised closely with the GP and a unit has been set up that will allow people on the island to access support aids. There is a facility on the main island but, for the reasons that I gave earlier, that is very difficult for people to access. We now have that unit on one of the islands, with the support of the GP. People can come along to find out what is available to them, and they can take away or try out some of the smaller pieces of equipment. That unit is also liaising with Selbro, which is the Mainland's unit, so that appointments can be provided for people who need slightly more support. There is liaison and collaboration between the island, the GP and that provider of aids. That is only one example from that project of what can happen if there is collaboration between statutory services, the community and the third sector.

Claire Stevens: Last year's Audit Scotland report reviewing health and social care integration showed that integration is still very much work in progress. All the organisations in our network would certainly say that. In some areas, the third sector, communities and unpaid carers seem to be very involved in planning and decision making. In other areas, that happens less.

In our written submission, we raised the issue that, for third sector organisations that want to be involved and have resources and assets to bring to the table, the levels of planning, structures and boundaries are increasingly complicated: there are GP clusters, localities, community planning partnerships, social care partnerships and so on. The landscape is quite complex, not only for small voluntary health organisations, but for national health charities that do not necessarily have huge resources on the ground at local level.

Interestingly, our members do not talk to us about GP clusters, other than in Drumchapel and Yoker, where the community-based mental health charity, COPE Scotland, has been working very successfully with the deep-end GP cluster there, which is led by Dr Peter Cawston. They developed the jigsaw project, which was focused on quality improvement for people in the community with enduring and recurring mental health issues, who, it was recognised, were falling through the gaps in services and not accessing those that might be there for them. I commend the report on that interesting piece of work to the committee, because it shows how collaboration can work at local level, not only with the third sector, but with the community partners; the people themselves are very much involved in that project—as are NHS Greater Glasgow and Clyde and other partners.

I have no information as to whether work with that level of collaboration, including with the third sector, is taking place at cluster level in other communities across Scotland, but that example is worth looking at.

Emma Harper: We talk about co-production—that is a new word for some of us—collaboration and multidisciplinary teams working together. Housing also needs to be part of that approach. However, what role does the public have in developing changes to primary care through co-production? Do people have a responsibility? Should they have more of a voice? How do we engage them so that they know that they are part of the co-production model?

Susan Paxton: We have hosted the Scottish co-production network at the SCDC for the past eight years. I agree that a lot of people see co-production as a term of professional jargon that does not mean much to them—even more so for communities and local people. However, it is just a way of working that recognises that local people have strengths and talents and can help to develop solutions to address the particular issues that they experience. Their contributions should be recognised as being of equal important to professional perspectives and understandings.

We work towards co-production and experience a range of interest from across sectors and at different levels of practice. To create the conditions for co-production to take place, we need to build on the strengths of previous quality engagement processes and examples in which communities have previously been involved in decision making, so that the mechanisms are there for them to be informed and to have the skills and confidence to contribute.

In supporting the network to create a body of people who are interested in and practise co-production, we picked up that sometimes we approach consultation with people very much from our own perspective. It is quite often in a service delivery context that we ask people about the delivery of those services, as opposed to asking them what issues might be affecting their health and keeping the engagements on a much broader footing, so that they can then contribute their own lived experience to a range of factors that may then be siloed into a service delivery model.

11:15

To create those conditions, we need to have an open and honest dialogue and ensure that we are not confining people too much in a consultation-type process. I think that people have benefited where that has taken place. That approach sits alongside consultation, as there is a place for consultation where decisions can be predetermined and there is a role for good-quality engagement. All those approaches taken together will allow people to contribute in the way they want to and where they feel they are best able to do that.

Suzanne Martin: I agree with a lot of that. I will give you a snapshot from the research that we undertook. Just under 40 per cent of respondents said that they were not as involved in decisions about the support that they received as they would have liked; about 80 per cent were never asked what mental health services they wanted to have in their area; and about 60 per cent considered that, in the past year, they were not offered the most appropriate support at the right time.

That shows that there is an issue with engaging people who are struggling with their mental health, in particular, about what support they receive and what it looks like, especially in relation to primary care. To tackle that, a lot of fantastic organisations in the third sector have co-production models, which I am sure the committee can look at or maybe has looked at. I heard the interesting and pertinent point made at a conference that co-production needs to be an on-going partnership—there cannot be just one consultation. Co-production should probably take place on that basis.

Alex Cole-Hamilton: My question, which comes back to the disparity between mental and physical health in our society, is primarily directed at SAMH, but I would welcome hearing the views of other panellists, too. We consistently hear that a person who has a physical ailment reports to their GP and then begins a process of treatment, with everyone understanding what is wrong with the patient. However, when it comes to mental health, people often have to retell their story again and again, and reliving those events sometimes subjects them to retraumatisation. Why are we still getting that so wrong? What needs to change?

Suzanne Martin: This is the point at which I get to speak about mental health stigma, so thank you for that. Mental health stigma is still a massive problem. Things have improved, and the mental health conversation has opened up much more, especially at the national level. We have See Me, the anti-mental health stigma and discrimination campaign, which does fantastic work to reduce mental health stigma and discrimination across Scotland. However, we still need to do things to get rid of that completely, and people still find it very difficult to come forward and disclose a mental health problem to someone.

A lot plays into stigma, and addressing it is complex. Take primary care and GP surgeries as an example. Often, tackling stigma is about building a trusting relationship with somebody; it is also about the GP or other healthcare professional the person has gone to see having the skills to have a positive and non-stigmatising conversation about mental health.

You mentioned people having to retell their story over and over. There are barriers to people receiving support for their mental health condition. One of the biggest barriers might be waiting times. Waiting times for psychological therapies and child and adult mental health services support are quite long, for example.

We were the first country to introduce a waiting time for psychological therapies, which is fantastic. However, NHS boards are consistently failing to meet that target, which is problematic. For the first time since the target was introduced, in one quarter this year no NHS boards met the waiting time target for psychological therapies. We have not had an improvement in people's access to key support, such as psychological therapy. We are calling for a review into why NHS boards are failing to meet that target. Such a review could look at what problems are preventing NHS boards from meeting the target, how to address them and how to make support services much more accessible for people so that, if a person asks for help, GPs will feel able to refer them for psychological therapy or other treatment or support without the fear that they will sit on a waiting list.

The issue is complex; stigma comes into it and there are other barriers as well.

The Convener: Please can we maintain a focus on primary care in particular?

Jane Cumming: Mental health problems are generally rooted in people's experiences. A question earlier was about medical and social models, and such factors as trauma, inequality, lack of opportunity, violence and domestic abuse all have to be considered when we look at mental health. The illness approach, like other approaches, is not necessarily delivering for people and leads to some of the blocks and barriers that people face when they look for solutions.

As Suzanne Martin said, part of the issue is simply about people being listened to and heard, and having their experiences validated, as well as having very skilled conversations about what we can do to help. One model that is delivering that approach has been commissioned in a wellness centre in Elgin. It is a walk-in centre on the High Street in the middle of the town—people can walk in and get help fast. They tell their story once and it provides a gateway to other services. We originally anticipated that 400 people would be supported in the first year, but 1,500 people have had support.

That links to the previous example of collaboration that was given. The making recovery real programme, which has also been fundamental, was led in that area by the Scottish Recovery Network to look in collaboration at the needs of a community and how best it can be served. That way of thinking about initial support and the first response for people has value.

Claire Stevens: Across our network of third sector organisations, the single biggest issue on people's agendas for the past three or four years has been loneliness and social isolation, regardless of whether the organisations are charities for mental health or supporting people's physical needs. The links between loneliness and social isolation and poor mental wellbeing—in some cases, mental illness and poor mental health—are well documented, as are the links with physical health.

We did a lot of work to influence what became "A Connected Scotland"—the loneliness and social isolation strategy—and we are involved in its implementation. To go back to the earlier question about how communities and people are involved, that is an example of an issue that has come up from communities, which is why organisations have picked up on it and told us about it.

Last year, we researched the lived experience of loneliness and social isolation and spoke to people from a wide range of backgrounds, including black and ethnic minorities, rural communities and deprived communities. It was interesting that some people spoke about primary care; they went to their GP because they were lonely and socially isolated and did not know where else to go. It was their first port of call, but they would then recognise that the GP did not have the time to really listen to them or to help.

I think that the issue has come through in written responses that the committee received, too. The link with primary care is that there is a need for primary care to be compassionate and to have the time, the resource and the skills to be able to listen to people, because loneliness and social isolation can be addressed at one end of the spectrum of health and wellbeing, where there is time to prevent such problems from escalating and becoming more serious mental health issues.

The Convener: Witnesses' answers have stimulated further comment. We will get another chance to talk about those issues.

David Torrance: Is there adequate engagement to ensure that third sector interfaces are fully involved in how services are designed and delivered, given the important role of the third sector?

Gail Anderson: I can speak only from my experience of engagement with our statutory sector colleagues in Orkney. There is a real desire for us to be involved: we are a member of the integration joint board, and I have been asked to chair the strategic commissioning group. I am on various other partnerships, to make links, and we have a robust third sector forum, through which we engage with our third sector and keep it fully involved. Our role is not to be there always ourselves but to ensure that the third sector can contribute to discussions and engage with and influence our partners, particularly when services are being planned. The third sector brings important knowledge and understanding of the people with whom it works; it is the route to the voices of people who are perhaps not often heard when services are delivered.

There is much that we can still do as a TSI, but in Orkney we are beginning to work effectively.

Claire Stevens: The third sector interface in Edinburgh, the Edinburgh Voluntary Organisations Council, is very involved in all the planning structures and systems for health and social care integration. I understand that there is also a primary care reference group, on which the TSI sits. That has helped to ensure that the third sector is as involved as it can be in planning and the primary care improvement plan.

EVOC told me that it has been helping to train GP receptionists in a basic understanding of social prescribing. The purpose is not to enable receptionists to become social prescribers but to give them a better understanding of what is happening with the roll-out of community link workers.

David Torrance: What planning is the third sector doing to ensure that it has the right workforce?

The Convener: That is quite a big question. The witnesses should feel free to answer about their own bit of the third sector.

Suzanne Martin: SAMH's workforce planning very much depends on the type of service that is being delivered. We deliver a range of services: some are community-based and drop-in services; and others are social care services that support people who have severe and enduring mental health problems.

We find that, in working with people with mental health problems, a one-to-one approach is very effective and increases engagement with the service. We have a service in Aberdeenshire, My Life Dynamic, which works with primary care and receives referrals for people who are struggling with their mental health—they might have low or moderate levels of mental health problems. Staff work with a person on an individual basis to consider what support the person would like and what would help them. They then help the person to get that support and they support them on their journey to recovery. Referrals to My Life Dynamic have more than doubled in the past year and we now work with around 250 people. The one-to-one approach that we take, with a key worker working with one person, is effective in keeping people engaged. The type of staff who are needed in a service will depend on the kind of service.

11:30

Susan Paxton: It is probably fair to say that there is no mechanism for a strategic co-ordinated approach to workforce development for the third sector across Scotland. To be honest, I am not particularly sure that it happens locally.

Claire Stevens and I have been involved in learning programmes supported by NHS Health Scotland to raise awareness of inequalities. Our perspective on that was to ensure that the programmes were not solely for the public health professionals and workforce or, for that matter, the third sector. We advocated a multidisciplinary and cross-sectoral approach to the programmes that were put in place. They were modest and small scale but, from evaluations that were given by participants in the programmes, we found that the understanding from each sector and across disciplines enhanced people's awareness of how they might take action to address inequalities at local level in the course of their work.

Advocating for workforce development and upskilling people to mobilise around common health and wellbeing issues could and should be done in a multidisciplinary and cross-sectoral setting. I guess that the issue then becomes how that can be resourced.

Gail Anderson: I agree with my colleague Susan Paxton that training together helps people to break down barriers and to understand their strengths and areas for development. There are recruitment challenges across Scotland but, particularly in Orkney, it is important that we look at our workforce in its entirety and that the statutory sector and the third sector work together to identify where the strengths and skills are and how each body can support others in the demanding situation in which there are difficulties with recruiting staff.

It is important that the third sector is recognised as a critical part in workforce development.

David Torrance: How do barriers to data sharing affect the third sector's ability to be part of the multidisciplinary team in primary care?

Suzanne Martin: I come back to the earlier point about people with mental health problems having to retell their stories. We would like a situation in which people do not have to go over the same details again and again in order to receive support. If people have received multiple referrals, we would like them to be able to engage with whoever they are receiving support from without having to relive an experience or talk about it, which can be difficult or traumatising. We would like it if people did not have to go over the same details again and again once they have been referred to the support that they need.

Jane Cumming: On the whole, our experience has been mixed. Interestingly, in some areas, we have found data sharing processes to be fairly straightforward, in that we can implement protocols and agreements in a way that enables information to be shared, perhaps using nhs.net email accounts. That happens where people have taken a solution-focused approach, have thought about how to make things happen and have been creative in doing that. In other areas, the process has been much more problematic, perhaps because of some of the issues of trust that were talked about earlier. Understandably, there is anxiety about data sharing at the moment.

I think that there is an opportunity to share the learning, good practice and solutions that have been found in some areas with areas where there seems to be more of a struggle. It would help if we highlighted what can be done. The issue does not have to be a barrier—there are solutions to it; we just have to be creative and share the learning and good practice.

Claire Stevens: I agree. There is a mixed picture, but certainly a number of charities in our network have commented on the fact that there are multiple records that are not shared, which hinders integrated working. For example, in its submission, Marie Curie, which works closely with primary care, mentioned the fact that, if it were able to add information to the key information summary, which is a record that is managed by the GP, it would be beneficial for the provision of joined-up care for people at the end of their lives.

The British Red Cross recently published a report called "Life beyond the ward", which is about what happens to people after they are discharged from hospital and has a strong focus on older people being discharged into what should be integrated care in the community. It contains a case study of an elderly man who was discharged after a relatively short stay in hospital. He was given a copy of a letter that he thought had been sent to his GP. He waited and waited to hear from his GP what the next stage of his care would be. Eventually, he went to see his GP and found out that his GP had not received any letter from the hospital and did not even know that he had been in hospital. It turned out that the patient was supposed to have given his copy of the letter to the GP. That illustrates how those sorts of hurdles make life difficult for patients.

Brian Whittle: I have a question on that point, which relates to a bugbear of mine. If the patient owned that data and was able to suggest who should get access to their data, would that be a solution that you would welcome?

Witnesses *indicated agreement.*

The Convener: I see people nodding, but nods do not count for the purposes of the *Official Report*.

Jane Cumming: That would go a long way towards providing the creative solution that we talked about. The Distress Brief Intervention programme is a good example of data sharing, as it uses a central record that the patient has access to. Doing what Brian Whittle described would go one stage further. We talk a lot about self-management but, in order to co-produce and self-manage, a patient needs access to the information that is held about them. There is an issue about people having to tell their story again and again. Even within the DBI programme, where there are data-sharing protocols and so on, there is still an element of going back over a story that someone might already have told the police or whoever.

As a user of primary care myself, I think that, in terms of my rights as a citizen, the approach that you suggest makes sense if we want people to take more responsibility and to self-manage. We need to think about whose information it is.

Suzanne Martin: Given that the data is information about the patient, the patient should be able to request their medical records and receive that information. If a patient is being referred to a service, they should be able to say that they would like their information to be shared with that service. Of course, there is a right to confidentiality as well. The issue probably comes down to shared decision making, which involves a conversation between health professionals in primary care and the patient. There should be a discussion about what the patient wants to be shared and how that information can be used to support them and ensure that they get the right support, care and treatment. Shared decision making is a huge thing in primary care, and that conversation with the patient needs to take place.

The Convener: On the question whether patients should own their data, I think that I saw nods all round. I ask the other panellists to answer the question in one word.

Claire Stevens: Yes.

Susan Paxton: Yes.

Gail Anderson: Yes.

George Adam: I want to follow on from what Brian Whittle said about data sharing. The biggest issue that we are hearing relates to how people access data and whether individuals have control over their data. My office manager has multiple long-term conditions, and he has access to a database where he can see letters going back and forward between various consultants. I do not know whether that is a pilot, but it empowers him to decide what he will do the next time that he sees his consultant. He spends less time with the consultant, because he has already thought through the conversation before he gets there.

It is the 21st century and we walk about with small computers in our pockets. With all the data protection stuff and everything else, surely it would not need rocket science to enable us to basically just tick a box and say who should get access to our data, including our health data.

Jane Cumming: It is possible to involve people much more in planning and decision making about their care. There are examples of technology allowing people to input data, almost like a health diary. For instance, if I were experiencing a mental health problem and I was under the care of a GP or practitioner, if I could maintain my own record—my own story—I would not have to repeat it, or take up the first half of my appointment going back over the two weeks since I last saw somebody. If we think about it carefully, we can find ways to add value to a person's experience and allow organisations to streamline their processes.

The issue is whose information it is, why we have it and how we are going to use it. If we focus on that, and on how we can benefit a person and improve their experience, there are definitely opportunities. There are already good ideas that are worth looking at.

Suzanne Martin: I agree with Jane Cumming. For us, and for people with mental health problems, it comes back to retelling the story over and over again, which is very unhelpful.

I take Mr Adam's point about focusing on primary care, but the interface between primary care and secondary care is really important here. Let us take young people. If a young person who is experiencing a mental health crisis goes to their GP for support and is referred to CAMHS for assessment, they might receive a face-to-face assessment and have to retell the same story to the CAMHS worker that they told their GP. If they are rejected for support from CAMHS, they might be signposted to a community-based or third sector service, where they might have to tell their story again. If a young person is being forced to retell their story again and again, that is a problem. There are solutions, though. The committee should look at how technology can contribute to data sharing, and to preventing people from having to tell their story again and again. That is what it comes down to. People should not be forced to go over the same details in order to receive support for their mental health.

George Adam: You might have heard the questions that I asked the previous panel. Claire Stevens said that intervention at an early stage for someone with a low-level mental health issue probably prevents the issue from developing. Is mental health an area where medical and social models of care can complement each other? That would not work for everyone, but I gave the example of a certain cohort—older males—for whom it might work. Are there ways that we can get different models of care to join up and work together?

11:45

Jane Cumming: The making recovery real programme is an example of collaboration and finding solutions that work for people within communities. The programme was run by the Scottish Recovery Network in Dundee and Moray. It brought together commissioners, providers, and people who use services, such as families. The people in the area were represented and the programme looked at what they felt were the priorities in their community, then worked together on designing and co-producing solutions. That then informed the commissioners' practice.

Many of the solutions that came out of that dealt with social aspects and addressed some of the social isolation that was talked about earlier, but they focused on communities and did not take a one-size-fits-all approach. In low-level healthcare and treatment, we know that people who have mental health problems experience increased problems with physical health and long-term conditions and so on. Everything has to work together, with the person at the centre, but if we invest more in prevention and early intervention for mental and physical health, and spend more on the former, we will need to spend less on the latter. I hope that the examples that have been generated will do that. We know that people are experiencing pressures when trying to access primary and secondary care.

Gail Anderson: I agree with that. Our communities have also raised social isolation as a real issue for them.

A solution that has come from the third sector is one-to-one befriending, when that works for the person, and, increasingly, group befriending and bringing people together for physical activity and other fun and enjoyable activities that fit their needs and interests.

Two other things have happened in Orkney, particularly for men. There is a men's shed, which is very popular. The other thing that has been set up is the seafarers gathering. Many of the men who take part in that have obviously been to sea and have a shared interest through their profession and work. It is not particularly for men who need help; you can just come along and talk about what interests you with other people who understand what you were involved in throughout your working life. That kind of thing is also being looked at for agricultural workers and farmers.

There are therefore different methods of bringing people together, particularly men, and they focus on their occupation or single points of interest. Dealing with social isolation is absolutely key to the wellbeing strand of early intervention and prevention.

Suzanne Martin: I have two points to make: one about community-based services and one about community link workers. I totally agree that we can do things to better link physical and mental health. Mental health affects physical health, and physical health affects mental health; it is a circle. There have been improvements in recognising that, but a lot more work needs to be done.

On preventing mental health problems or intervening at an early stage, I would give this example. If somebody is struggling with arthritis, whatever healthcare professional they are engaging with, they would want their mental health to be considered as part of the support that they are receiving for their arthritis. If that person wanted support for their mental health or if it was viewed as necessary to their wellbeing, they would be signposted to an appropriate service, possibly in the community. That means that we need community-based services to support people with their mental health, and that there need to be links between GP surgeries and pharmacies and other areas where people are receiving prescription medicines or advice from their doctor or other community services.

That is where the community link workers come in. Our community link worker service in Aberdeen is proving to be effective. The initial findings have shown that seeing a community link worker potentially has a really positive impact on reducing the number of times that an individual might see a GP. The valuation will be coming out later this year, and we will be happy to share it with the committee.

We need to think about health—mental and physical health—in the round, but that does not mean that we should stop talking about mental health. People's mental health should be considered by healthcare professionals when they are receiving support and they should be linked to appropriate support.

Claire Stevens: I thought it very telling when Anne Crandles, who was on the previous panel, said that integration in Edinburgh is driven by the desire and ambition to drive down social isolation and loneliness. That is a very important theme. You may want to look at what NHS Ayrshire and Arran is doing with the three health and social care partnerships in Ayrshire in that regard, because it is taking a similar approach. It considers that tackling those issues early on is a preventative means of saving money upstream, supporting people's health and wellbeing and preventing issues from escalating.

NHS Highland has also done quite a lot of work on the isolation and loneliness of older people and what is happening at community level across the board area. The Scottish Public Health Network is doing a mapping exercise of what NHS boards and health and social care partnerships are doing in relation to social isolation and loneliness.

The original question was about the social and medical models of health. I agree whole-heartedly with colleagues who, in this and the other evidence-taking sessions, have said that the two are inextricably linked.

George Adam: It is interesting that social isolation is a major issue. I have sat next to someone at the football for years. His wife, who had multiple sclerosis and then dementia towards the end of her life, died recently. He was her carer, and, for the past 20-odd years, his whole life revolved around the love of his life. She was in a wheelchair towards the end, but that did not stop them doing anything—they carried on. I asked him how he was doing, which is the classic stupid question that people ask. I had not seen him since his wife's funeral, and I should have known better than to ask that. He answered honestly—which is very unusual for men of a certain age—and said, "I'm not looking forward to the winter, George, because of the long nights, being in on my own and not being able to go out."

The advantage in that scenario is that he is aware of the challenges that are coming, but what about the people who are not? How do we get all the services to join up and make sure that we get those who might slip through the net? If they are sitting in their house, looking at four walls, their mental and physical health deteriorate. If it gets to the stage that they are not going out or seeing anyone, their life starts to change.

Jane Cumming: One of the issues in relation to what you are describing is the use of data and information. We know about life changes, we know about the transitions and we know the factors that influence people's mental health. The issue is using that information to plan responses that we know will make a difference. To return to Elgin, for example—although we do work in other areas—

George Adam: Do not worry. My wife's family is from Elgin, so you can talk about it as much as you like.

Jane Cumming: It is worth a visit, if you have not been.

George Adam: I am never away from the place.

Jane Cumming: When we opened the wellness centre, people were coming, but there was a gap regarding men of a certain age coming through the door. We began a social media campaign called #MENtionIt, to try to address that by reaching out and saying to men that it is okay for them to talk about their mental health and, if they want to do that, the wellness centre is somewhere that they can come to. That is a small example, but it is about pulling together what we know—the information that we have and the things that we know affect people's mental health—and designing what we do around that and making it okay to have those conversations.

The other aspect is to do with the capacity and the awareness of the community. When someone opens up, they need to be confident about the response that they will get. Suzanne Martin mentioned stigma. There is a lot of self-stigma, because people are anxious about expressing themselves, but generally other people are kind.

The Convener: Emma Harper has a supplementary that might be relevant.

Emma Harper: Jane Cumming mentioned stigma and Suzanne Martin mentioned destigmatisation. There are programmes out there; I love the Penumbra one called #MENtionIt. The Scottish Association of Young Farmers Clubs has its "Are ewe okay?" initiative and there are programmes about its being okay not to be okay.

The fact that we are making progress and destigmatising mental ill health means that more people are opening up, which means that more people seek services. I agree with George Adam that the way to go is to get to people early and to have community link workers to direct them to social-prescribing opportunities to tackle isolation, especially in rural areas. Is destigmatisation contributing to more people wanting to access care?

Suzanne Martin: Absolutely, it is. As we continue to reduce stigma, more people will come forward for support. We therefore need to ensure that we provide services to support them.

With regard to early intervention and prevention, George Adam gave the example of engagement with his friend and his wife and the support that they received from healthcare professionals. We would like to see all healthcare professionals considering mental health in relation to all health-related issues, as Jane Cumming has said.

George Adam: My friend’s wife is dead—it was her long-term conditions that were being dealt with. My concern is that he is left in the house—at night he locks the door, puts the telly on, and that is it.

Suzanne Martin: I cannot comment on that situation, but if the individual is known to the healthcare professionals who were working with his wife, we would like them to link him to support, because they know that he has just lost his wife. People’s mental health should be considered when they engage with services, whether that is as a family unit, a couple or an individual. We would like to see people being linked to support when something happens in their life—when they experience a physical health problem or tell their doctor in conversation about a bereavement or a traumatic event. Mental health should be considered as part of the package; there are certainly improvements to be made in that respect.

As Jane Cumming said, we must also raise awareness, and services should be based in communities so that they are easily accessible and people know about them. In Fife, SAMH has a really good service in Kirkcaldy called Sam’s cafe. People can just walk in and talk about whatever they want—it need not be their mental health, although the cafe is designed as a space in which people can talk safely about their mental health, if they want to. We need more community-based services that people can just walk into to talk about their mental health, and we need people to know about them.

We also need healthcare professionals to consider mental health in relation to every aspect of the care that a person receives. That might include care not just of that individual but of their partner, including how they are being impacted as a carer, for example. SAMH has a service in Dundee that supports people who are caring for others. We would like to see more services like that, in which everyone’s mental health is considered and they are linked to support that is appropriate to their individual circumstances, when they need it.

Claire Stevens: I will make a point about community link workers—we have heard a lot about them this morning. The roll-out of 250 community link workers is very encouraging. Emma Harper said that she thinks that 56 new posts have been created, which is also my understanding. However, we do not know where they all are.

This is almost throwing a question back at the committee. It would be interesting for the committee to ask where the new community link worker posts are, whether they are in urban or rural areas and whether they are in the areas that have the highest levels of health inequalities, which is where the funding was supposed to be directed. The committee could also ask what impact those posts are having, including on the capacity of the third and community sectors. There is a quid pro quo, and there needs to be a balance. We cannot endlessly refer and signpost people to services or activities and support people into them if those services are not receiving appropriate investment.

12:00

To use another Edinburgh example, the health and social care partnership has been quite far-sighted in creating nearly 20 additional community link workers and investing in third sector activities that people can then be supported into. However, I am not at all sure that that is happening throughout Scotland. We are getting feedback—albeit that it is anecdotal—that voluntary and community organisations, in particular smaller ones, are starting to feel the strain from the increasing number of referrals without commensurate resource to deal with them.

The Convener: That is an important point that we explored to a degree with the previous panel. We will certainly follow it up.

Brian Whittle: We are looking at the role of the third sector in primary care, given the third sector’s ability to shoulder quite a bit of the load. Specifically in relation to mental health services and drug and alcohol services, which are intrinsically linked with mental health, is the current funding adequate for delivery of services?

Suzanne Martin: I can comment on mental health funding. SAMH’s written submission highlights that mental health spending in Scotland is difficult to track, but we know that, for the first time, the Scottish Government is spending more than £1 billion on mental health, which we welcome. That is about 8 per cent of the overall health budget, which is slightly lower than the figure in England, where just over 10 per cent of the health budget is spent on mental health. It is difficult for us to know just how much of the mental health expenditure goes to primary care and how much goes to specialist care in secondary services.

The Lancet’s commission on global mental health has recommended that high-income countries spend 10 per cent of their overall health budgets on mental health, and that there should be a shift in funding away from hospitals towards community-based services. We support that recommendation. As Claire Stevens noted, initiatives such as the community link worker programme increase the number of referrals to the third sector, so we need to ensure that the community-based services can meet demand.

It is difficult to track mental health funding to see how much goes into primary care and it is difficult to know how much of the primary care spend goes on mental health. However, the figures that we have indicate that we are slightly below the 10 per cent figure.

Susan Paxton: I will say a little about pressures on third sector organisations. Those organisations are particularly adept at bringing in funding from multiple sources to contribute to improvement of health and wellbeing, which has a knock-on effect on our statutory partners and their service delivery.

We are seeing positive developments. Typically, people in the third sector say that they are continually on short-term funding cycles, which does not lend itself to sustainable services and support for communities. Where there are extended funding cycles, for example three-year cycles—I am thinking particularly of the Edinburgh health and social care partnership's inequalities fund—that has opened up funds to a range of newer applications.

The approach has also inadvertently put in jeopardy some of the longer-standing organisations that would have typically received those funds. Although we welcomed the introduction of longer funding cycles, they quite often come with increased competition and leave existing funds with less money. More and more people—not just in my sector—say that they are having to do more with less.

The situation is causing strain. It would be useful to have a better understanding of how third sector organisations contribute, in terms of the money that they bring in to communities and areas, compared with medical services and healthcare provision.

The Convener: Does Gail Anderson want to comment?

Gail Anderson: Susan Paxton largely covered the points that I was going to make about resourcing the third sector.

Brian Whittle: Susan Paxton mentioned competition for funding. We are looking at the proportion of the primary care budget that is allocated to the third sector and how those resources are utilised. Does the way in which we fund the third sector, through primary care, have to change, in order to eliminate the competition that has been mentioned?

Who would have thought that SAMH would now be working with jogscotland? It has made my work here and in the chamber much easier, let me tell you. Is the third sector aligning its services in a way that makes funding it through the primary care interface and IJBs easier?

Gail Anderson: That largely depends on how involved the third sector is, at the planning stage, in bringing its expertise and understanding of the gaps and needs in the population that it serves into discussions about planning local services. The third sector will align its services with what is needed in an area, so its involvement in planning is crucial.

Suzanne Martin: SAMH works in 60 communities across Scotland. We have good relationships with the health and social care partnerships for which we deliver services and we are having positive conversations with them.

We have talked about how annual funding makes life difficult for most third sector organisations, and especially the small ones. It is problematic. I agree with Gail Anderson on the need to talk to the third sector. There is also a need for the third sector to talk to public bodies in order to ensure that services are designed in line with what the third sector does best and what it can provide, and there is a need to talk to individuals about what they would like.

SAMH has good relationships with public bodies and with other national organisations, in the context of delivering services at national and local levels. Improvements could definitely be made, though, and I could probably go on for another hour about how.

The Convener: It is unfortunate that we do not have time to go on longer. I thank you all for an excellent evidence session. The nature of today's discussion has meant that we touched on a lot of issues that we did not have the opportunity to fully explore, so if there are points that you would like to have made, please feel free to provide them to us.

12:09

Meeting suspended.

12:12

On resuming—

European Union (Withdrawal) Act 2018

Food Information, Labelling and Standards (EU Exit) (Scotland) (Amendment) Regulations 2019 (SSI 2019/285)

The Convener: Agenda item 2 is consideration of an item of European Union exit subordinate legislation—SSI 2019/285—which the Scottish Government has categorised as being of low significance on the basis that it

> "makes mainly technical amendments in order to fix deficiencies in domestic law."

That is also the view of the Scottish Parliament information centre and the office of the solicitor to the Scottish Parliament. On 24 September, the Delegated Powers and Law Reform Committee agreed that the instrument should be considered under the negative procedure and with the "low significance" categorisation.

Does the committee agree that the categorisation that the Scottish Government has applied is correct?

Members *indicated agreement.*

Subordinate Legislation

National Health Service (Serious Shortage Protocols) (Miscellaneous Amendments) (Scotland) Regulations 2019 (SSI 2019/284)

Food Information, Labelling and Standards (EU Exit) (Scotland) (Amendment) Regulations 2019 (SSI 2019/285)

12:13

The Convener: Agenda item 3 is consideration of two instruments that are subject to negative procedure, one of which—SSI 2019/285—we have just discussed.

The other—SSI 2019/284—is intended to allow pharmacists in a community pharmacy to supply an alternative quantity, an alternative pharmaceutical form, an alternative strength or a therapeutic equivalent without going back to the prescriber. At its meeting on 24 September, the Delegated Powers and Law Reform Committee determined that it did not need to draw Parliament's attention to the instrument on any grounds within its remit. I invite comments from members.

Emma Harper: I have an interest in SSI 2019/284. I attended an event about bioequivalence of medications and provision by different companies of medicines that are essentially the same. I am interested to find out whether issues of bioequivalence have been explored. Different definitions are used by the World Health Organization, by the Therapeutic Goods Administration in Australia, and in Europe and the USA, where the Food and Drug Administration has its own definition of bioequivalence.

I understand that pharmacists might be best placed to decide whether a drug has bioequivalents, but I also understand that GPs can take a long time to support patients with, for example, anti-epileptic medicines, warfarin and levothyroxine. I therefore think that the issue is not cut and dried.

The Convener: I take your point, which is substantial. We need to report by 6 November. If the committee is so minded, we can seek clarification from the Scottish Government then consider the matter again at our next meeting or the following one. Do members agree?

Members *indicated agreement.*

The Convener: We have discussed the Food Information, Labelling and Standards (EU Exit) (Scotland) (Amendment) Regulations 2019, which are subject to negative procedure. If members have no comments, does the committee agree to make no recommendation on the instrument?

Members *indicated agreement.*

European Union (Withdrawal) Act 2018

Recognition of Professional Qualifications (EFTA States) (Miscellaneous Amendments) (EU Exit) Regulations 2019

Recognition of Professional Qualifications (Miscellaneous Provisions) (EU Exit) Regulations 2019

12:16

The Convener: Agenda item 4 is also on the European Union (Withdrawal) Act 2018 and is consideration of two notifications from the Scottish Government on its intention to consent to United Kingdom ministers making regulations on its behalf in two instruments: the Recognition of Professional Qualifications (EFTA States) (Miscellaneous Amendments) (EU Exit) Regulations 2019; and the Recognition of Professional Qualifications (Miscellaneous Provisions) (EU Exit) Regulations 2019.

Both instruments relate to regulations that were made on 19 February to make amendments to existing legislation to ensure that the system of recognition of qualifications will continue to operate effectively in the event that the UK leaves the European Union without a deal. They are UK-wide provisions, but they obviously apply to regulatory professions that deliver in devolved areas of policy, including health. The instruments will ensure that the current recognition arrangements are maintained and remain in place whatever transpires in relation to Brexit.

The first notification is of the Recognition of Professional Qualifications (EFTA States) (Miscellaneous Amendments) (EU Exit) Regulations 2019, which relate to the rights of European Economic Area, European Free Trade Association and Swiss nationals and recognition of their qualifications in the event of a no-deal Brexit. If members have no comments on the instrument, does the committee agree to make no recommendation on it?

Members *indicated agreement.*

The Convener: The second notification is of the Recognition of Professional Qualifications (Miscellaneous Provisions) (EU Exit) Regulations 2019, which also make a further technical provision to give full effect to the underlying policy of the 2019 regulations, as previously agreed by the committee. If members have no comments on the instrument, does the committee agreed to make no recommendation on it?

Members *indicated agreement.*

The Convener: We move into private session for the final item on the agenda.

12:18

Meeting continued in private until 12:19.

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