OFFICIAL REPORT
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Health and Sport Committee

Tuesday 5 November 2019

Session 5

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Pàrlamaid na h-Alba

Tuesday 5 November 2019

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HEALTH AND SPORT COMMITTEE
25th 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:

Naureen Ahmad (Scottish Government)
Chaloner Chute (Digital Health and Care Institute)
Bob Doris (Glasgow Maryhill and Springburn) (SNP) (Committee Substitute)
William Edwards (NHS Greater Glasgow and Clyde)
Jeane Freeman (Cabinet Secretary for Health and Sport)
Aidan Grisewood (Scottish Government)
Scott Heald (Information Services Division)
Lynne Huckerby (NHS 24)
Geoff Huggins (NES Digital Service)
Phillip McLean (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 5 November 2019

[The Convener opened the meeting at 09:31]

Primary Care Inquiry

The Convener (Lewis Macdonald): Good morning, and welcome to the 25th meeting in 2019 of the Health and Sport Committee. We have received apologies from Sandra White—Bob Doris is attending as a substitute member for her—and Alex Cole-Hamilton. I ask everyone in the room to ensure that their mobile phones are switched off or to silent mode, please. Although it is acceptable to use mobile devices for social media in the room, please do not take photographs or record proceedings, as we do that for ourselves.

Agenda item 1 is to take further evidence in the committee's primary care inquiry. We will take evidence from two panels this morning, the first of which will focus on the role of technology in the delivery of primary care. I welcome to the meeting Scott Heald, who is associate director of data management and strategic development at the Information Services Division of the NHS in Scotland; Lynne Huckerby, who is director of service development at NHS 24; Geoff Huggins, who is director of the NES digital service; Chaloner Chute, who is chief technology officer at the Digital Health and Care Institute; and William Edwards, who is e-health director at NHS Greater Glasgow and Clyde.

I will kick off the questions. Is it your view and experience that the once-for-Scotland approach is being carried forward across Scotland? Do significant variations continue to exist at board or area level? I am open to answers to those questions from any or all of the witnesses to get the discussion under way.

William Edwards (NHS Greater Glasgow and Clyde): It is important to say that a sequence of technology strategies have been in place in Scotland for a number of years and there has been an aspiration to set the strategic context at the national Government level. In that context, each of the health boards has had to move forward its digital and technology agenda within a framework that is largely centred on a set of outcomes, and each health board has had to work to those outcomes.

I recognise that there is variation across Scotland. I can speak only from the NHS Greater Glasgow and Clyde perspective and my knowledge of other boards, but there is variation in the use of technology in each board. The important point to note is that the Government has carried out a digital maturity assessment, which will lead to improvements or concerted efforts to raise the use of technology in certain areas across health board boundaries. Those efforts might focus on primary care as a whole, or they might look at the acute environment, the data sharing that needs to exist to support tertiary referrals or the elective centre programme.

Geoff Huggins (NES Digital Service): It is eminently sensible that we should be thinking about technology to support health and care on a once-for-Scotland basis. That is the direction that the strategy set when it was published in April 2018, and I think that that continues to hold. We have a population of 5.4 million people, and that size of population is good for many things, such as clinical care and research. That is exactly the way to go.

On whether we are getting there and how quickly, I think that there are two forces in play. One is about trying to mitigate the challenges of running the current system with the current technology. That tends to involve a lot of work to address interoperability, data sharing and data transfer, which probably feels like maintaining the existing system, but those are things that we need to do. Alongside that, we have the work on the platform and the work of national Government to take us closer to the once-for-Scotland approach. We are doing that work with boards and national entities.

Lynne Huckerby (NHS 24): I agree that the once-for-Scotland approach absolutely is the right one. I can say from the NHS 24 perspective that there are great examples of products and services that have transitioned from project level to scale, such as NHS inform and some of work that we are doing on primary care digital services.

As part of our approach, we must consider how we design services and take forward engagement with our citizens; it is absolutely about how we engage with people and co-design and develop services together with the public. Across the system, there is certainly a will to develop a once-for-Scotland approach, and taking on board community and individual needs is an important aspect of that.

Scott Heald (Information Services Division): May I bring in an information aspect to all this, given our remit in ISD? I completely agree that once-for-Scotland is a sensible approach. If it makes sense to do something once, we should do it once.

Primarily as a result of the new general practitioner contract, we have found that we have a lot more staff who are based locally and are working with local GP clusters. It is important to recognise that priorities vary across the country, so we are trying to tailor our services so that we support appropriate local working at cluster level, while working at national level where it is appropriate to do so.

In essence, we have a mixed economy of local and national teams. If we hear that there is a lot of commonality across the local landscape, we feed that into the national teams, so that we can do things once across the country. However, it is important to recognise that local areas do not necessarily have the same priorities. We must take that into account when we are thinking things through.

Chaloner Chute (Digital Health and Care Institute): I absolutely agree with what has been said. I guess that there is a bit of nuance that we hope that people will start taking into account when they use the once-for-Scotland mantra, which is that, although there are many infrastructures and assets that we should have once for Scotland, there is, as Lynne Huckerby said, a diverse range of users, groups and regions, each with different needs in relation to the experience of digital services. One person might be on a council care pathway in one part of Scotland; another might have multiple learning difficulties in a different area. We therefore need to be able to flex the experience, while using the same plumbing, if you like, by which I mean the same core assets. I agree with that point and I want to reinforce it.

We just need to figure out where the line is and what the core assets are, such as the national digital platform stuff and NHS inform’s core set of quality-assured guidance, which everyone uses. Such things are critical on a once-for-Scotland basis, but the user experience can flex, depending on need.

The Convener: Last year, the independent external expert panel suggested that Scotland had not, up to that point, had a coherent national approach to such matters. Given the panel’s initial responses, is it fair to say that your sense is that we are getting there?

William Edwards: I think that we are getting there. There have been a number of new initiatives, such as the launch of the national digital platform, which will create a central infrastructure that will allow us to collect information and make it available across Scotland. Until now, data has largely been held at health board economy level, so the national digital platform will provide opportunities.

I think that the Scottish Government recently committed to put in place a senior role in the Government to oversee digital reform, which is a useful step forward, and the digital maturity assessment should get us to a level at which we will see a reasonable standard of digital technology across all boards, regardless of boundaries.

Geoff Huggins: A couple of weeks ago, I spent the day with Professor Bengoa, who was one of the members of the expert panel. We talked through where we had got to on the development and the architecture. He was very positive about the experience, saying that it reflected the sort of modern technology that he would expect to see in a system in a country of Scotland’s size. The challenge is about moving from the policy, strategy and design phase into the implementation and execution phase, which is where the real work gets done—that is where the challenges now lie.

Bob Doris (Glasgow Maryhill and Springburn) (SNP): I listened to that with interest. The submission from NHS Greater Glasgow and Clyde, which is in my briefing, shows that it absolutely recognises the benefit of all that, saying that it “underpins” the work of “professions and agencies”. However, the submission goes on to say:

> “models of care will also need to adapt to take advantage of that and there are some key enablers which are required to support this including robust information sharing agreements”.

Although I think that I know what that means, it would be helpful to have a concrete example of where NHS Greater Glasgow and Clyde thinks that information sharing agreements are not robust enough and how changing them could improve the care. When I speak to my constituents, they do not want to hear about those arrangements; they want to know how actions that are taken will benefit their patient journey.

William Edwards: Until now, the journey that we have been on has been about ensuring that the appropriate information is available to those who need it, in order for them to provide care to our citizens. I read with interest the “Principles for a technology-enabled health and social care service: A view from the health professions working in primary care” report that was submitted to the committee. It was useful, because it outlined the ready access to information that primary care practitioners require in order to make a difference to the patient journey. It also outlined that the basic healthcare summary data that is collected in acute and GP practice should be made available to practitioners more widely, such as dentists and pharmacists.

However, to make that happen, we have to go through a number of steps under the current framework on information sharing. In my board area, for example, there are six health and social care partnerships, so we have to put in place data sharing arrangements with six local authorities to enable information to flow seamlessly to the clinicians who need it. In the general practice landscape, we have 240 general practitioners in NHS Greater Glasgow and Clyde, so, again, we have to put in place a data sharing arrangement for each of those. Although the desire to do that is there, it is a cumbersome process to set up and put in place the agreements that we need, before technology can do the job that it can quite easily do.

The Convener: Some of what William Edwards described is the function of the NES digital service.

Geoff Huggins: The other thing that we see is a move away from a model of data sharing, whereby I send the data that I hold about somebody to somebody else, towards one that is based on the idea of appropriate clinicians having appropriate, read-write access to the records that they need to see. That is beginning to change the model and the way of thinking about it.

At the moment, because data sits in all these different pockets, we need to move it around for somebody else to see it, whether that is sending it electronically as a PDF or in some other format. The objective is to have a core data set that relates to the individual and that has appropriate governance around it, so that, whether a person is in a residential care home setting, in accident and emergency or in a secondary care setting, the clinician can see the appropriate information that they require in order to offer a patient excellent clinical care. That requires a different way of thinking about information governance. Some of the work that we have seen—and some of the work that NSS is doing on Office 365—also supports us in that.

Chaloner Chute: Following on from William Edward's example—so that we do not get too focused on the data sharing component or the data architecture—I note that a capacity building exercise also needs to happen in relation to, for example, community pharmacy. By and large, community pharmacies are not set up to contribute to clinical records in the way that we might want them to be. For example, as part of the shift in the balance of care, a person can get their blood pressure checked in a pharmacy and be given their results on a post-it note to take away with them, but when they go to see their GP, their GP will take a new reading, which means that there has not been a win for anyone.

A piece of work is needed to ensure that the community pharmacy organisations have the capacity to say what they can contribute and what they would like to see to make those agreements happen in the first place. In the past, those organisations have been off to one side. To an extent, we have been waiting for the existence of some sort of clinical record of power to which they will then have full access. As Geoff Huggins was saying, that is not the way in which it would work.

09:45

Bob Doris: That is helpful. Mr Edwards gave some concrete examples of how the information is to be used, and Mr Huggins helped me when he turned it around and said that the issue concerns not information sharing but access to the relevant data for the right professional at the right time, and building up an overall picture of essential information to support a patient at whatever point they are in their journey, depending on who they are engaging with.

My colleagues will look at ownership of data in a second, so I do not wish to explore that in my follow-up question, but I want to look at the report of the independent external expert panel which, according to the briefing in front of me, is essentially saying that we are quite good at collecting the data in a health service sense but that there is a weakness or lack of expertise in how we consistently capture that through local authorities, never mind through the once-for-Scotland approach in social care. Can one of the panel members put on record some of the barriers to capturing that data in a consistent form in a social care environment, and how we might start to address them?

Scott Heald: I can offer a perspective from the work that we have been doing in ISD. For the first time, we have begun to collect social care data at individual level. That is under way.

There are two challenges. One is the local infrastructure to collect the information in local authorities in the first place. Doing so in a consistent format has been challenging, which has led us to rethink the ways in which we prescribe the types of data that we want to see being collected and used. We have successfully moved to focus much more on what is available locally. We now have social care data at an individual level from 31 of the 32 local authorities. We have aggregate-level data for the other local authority, and we have been able to successfully link that data to health data to give examples of pathway analysis that we can do between what is happening between social care and the health service.

There are barriers around the capacity in local authorities to collect data, and in information governance. As William Edwards described, for Glasgow we have had to put numerous data sharing agreements in place between local authorities, health boards and NSS, to allow that sharing and transfer of data to happen. However, having done it once, we have found that continuing those processes on a recurring basis is much more straightforward. Having cracked it the first time, we have made progress and are now seeing the dividends.

William Edwards: My point is tied to Mr Doris's earlier question. Even if we look at how we might do things differently, the current legislative framework would require us to seek agreement and sign off of the data sharing agreement from each body.

Scott Heald alluded to the fact that it has become easier; once a data sharing agreement has been agreed with one local authority or health and social care partnership, in Glasgow, our approach is to replicate that same agreement across all the partnerships. We also share those agreements with other entities across Scotland to ensure that we are not all reinventing the wheel.

It is also important to note that there is a difference between the performance data that ISD collects on how health and social care partnerships are performing and the data that we need to make available to our front-line clinicians and those who require the baton of care to be passed to them.

A real-life example in the work of NHS Greater Glasgow and Clyde is the moving forward together programme, which is a NHS board-owned initiative, working with the six health and social care partnerships. It is trying to redesign services into what they need to be for the future. That involves us using the data sharing that is in place with social care and the social work systems across the six partnerships to make data available to the acute sector, which then allows the acute sector to make decisions on discharge planning and whether there are home care packages in place. It is important to realise that the boards and partnerships desire to move in that direction, but I go back to the point that there is variation in the use of technology across the board areas.

The Convener: George Adam has a brief supplementary question.

George Adam (Paisley) (SNP): It is purely so that I understand where we are going. I am trying to work it out. I liked the metaphor that Chaloner Chute used when he talked about the plumbing already being there. Effectively, the metaphor is that the house is built and the plumbing is there, so it is difficult to adapt that. The public sector has never been great at delivering information technology systems and providing access to them, but you already have systems in place. How challenging is it for you all to deliver change?

Chaloner Chute: I will start with the caveat that I do not deliver operationally—we are an innovation centre. The challenges are not so much technical; they are to do with the fact that we have a big legacy estate and we have procured services for five or 10 years. We cannot just switch over to a new thing—there is always a lag or delay. I guess that we are trying to build the plane while flying it. We need information-sharing agreements in the network of different organisations now, but at the same time that is not the way to do it. Instead of figuring it out 32 times, the way to do it is to create a national clinical data repository, create the data once, and then ensure that social care has the right permissions and can contribute to and read from that, as Geoff Huggins described.

Lynne Huckerby: From a practical perspective, NHS 24 has been working with East Lothian health and social care partnership to deliver services differently and support same-day access to primary care. Although NHS 24 has robust technical infrastructure, the GP systems vary across the country, so integration and data sharing have been extremely challenging. We have worked around that challenge, but we aspire to the outputs of a national digital platform. We are focused on how we can integrate the technology and get opportunities to practically make a difference.

Geoff Huggins: We should not underestimate how difficult it is. Across Europe, the country that has probably moved on its technology most quickly in the past years has been Estonia, and that is because it did not previously have a system. When you already have a system, it is remarkably hard to change how it operates and functions.

George Adam described the challenge of delivering technology as one for the public sector, but nearly all the technology that we have is delivered by the private sector in some shape or form under contract. There is a greater role for the public sector in controlling and managing its technology in a different way in future. Many of our problems arise because we have to interact with many different vendors that produce technology for many different markets, and we then have to assemble and construct that in such a way that it works locally to deliver good-quality care. We need a different model of technology, which is what the strategy sets out.

Please remember that this is remarkably difficult. We should still do it, but it is not an easy job.

The Convener: Emma Harper has a further brief supplementary question.

Emma Harper (South Scotland) (SNP): I am aware that there is European funding—Interreg money—for Ayrshire, Dumfries and Galloway and, I think, Northern Ireland for community digital technology implementation through the CoH-Sync, or community health synchronisation, and mPower projects. Does that create a bit of a disparity across other areas? That European Union funding will run out once we come out of the EU. How does it promote the once-for-Scotland approach if different models are being tested elsewhere using other funding?

The Convener: That is a fair question.

Geoff Huggins: We have a lot of different funding streams across the system. In addition to the one that you mentioned, we have programmes such as those that are run by CivTech and Innovate UK and work by the chief scientist office. There are multiple funding streams and not just European funding going into the system to support innovation or technology development across the country. That is one of the challenges that we face. The wider national and international organisations do not co-ordinate between themselves. They fund for good reason, but that adds to the complexity of the situation while at the same time giving knowledge and understanding in the localities in which that takes place. It is a double-edged sword.

Chaloner Chute: I agree with that. As an innovation centre, DHI is constantly looking for funding from beyond Scotland. I guess that the only thing that we can do to help is to follow the standards that have been set. I understand how, ultimately, we would interoperate as part of an architecture for Scotland and try to guide individual clinicians, businesses, research organisations, universities and charities that, by and large, will want to follow their own noses and innovate. If we want to see economic development as part of the process, we should not want to stop that.

However, there is a role for CivTech, the Scottish Primary Care Information Resource, DHI and other innovation centres in starting to apply the standards at the point of submitting applications for money, so that they are not seen as notes tied to a brick that is being thrown over a fence at Geoff Huggins, if I can put it in that way. We need to get to a place in which we can bid on the understanding that it will integrate with our approach.

Lynne Huckerby: I will respond to the specific point about mPower. We are aware of that programme of work and, from a national perspective, it is important that we use NHS Inform and other available national products and services that complement it. I am keen to make the point that evaluation is key in all the programmes, multiple tests of change and proofs of concept that are happening across the country. If we could evaluate effectively and take the learning from it, it would help to build a picture of the need and how we must develop and improve.

Brian Whittle (South Scotland) (Con): I refer members to my entry in the register of members' interests. I am still a director of a company that develops communication and collaboration platforms, including in the healthcare sector.

Good morning to the panel. Do you think that the provision on data controllers in the general medical services contract is there to encourage and allow data sharing as it currently stands?

The Convener: That is the provision that includes health boards as joint data controllers with GPs.

Brian Whittle: Yes.

William Edwards: The new contract certainly allows for a dialogue to take place that probably did not happen before. General practice has largely shared only allergy and prescribing information with clinicians in the wider health economy. As a result of the provisions of the GMS contract, we are now seeing much more dialogue taking place with local medical committees and the Scottish GP committee on what a wider data set might look like and what the roles of others in the wider primary care team might be in contributing towards healthcare records and providing care to the patient population.

Scott Heald: I echo what William Edwards has just said. We need to understand why the contract's provision on simplifying the data-sharing landscape is there in the first place. As William Edwards said, facilitating greater access to records and data for multidisciplinary teams is important. The aim should be to make information governance—IG—an enabler rather than the barrier that it is currently seen as.

One of the challenges is that there are legalities around what we can and cannot do. The contract tries to simplify that in Scotland. In the work that was done, advice was obtained from the Information Commissioner's Office on the appropriateness of the joint data controller status between general practitioners and health boards. I think that the approach represents a step in the right direction. As William Edwards has said, such dialogue was not there before, but it is now. It needs to continue between the local LMCs, health boards and GPs.

Geoff Huggins: I do not think that IG is the main issue with the availability and use of data. The main challenges are in two other areas. The first relates to the technology and the capability to make data available in a way that is usable in other areas, either as a contribution or as part of other technology. With the new contract on GP IT systems, I hope that that will become more straightforward in future.

Behavioural issues are probably the most significant component. When we speak to general practitioners in primary care, we quite often get a sense that they still consider data to be data that they hold on behalf of their people, and there is great nervousness about that information being available to other clinicians or other areas of work. The examples that are often given are that the data might include information about a patient's family that GPs do not want to share, or it might include information that GPs are concerned could be used for a purpose that they do not want it to be used for.

10:00

The other interesting issue in the context of the integration agenda and the change agenda is that there is a nervousness about the consequences if data was more able to flow between different sectors. For example, if I got a test in secondary care and the test result became available, instead of there being a further outpatient appointment, it could be pushed out to a GP to give the result back to me. We can all see why it would be sensible to do that. However, there is a nervousness around workload and resourcing and that the system is reflecting that work might be done in different ways. Those are the real issues in relation to that agenda, and IG is quite an easy way of explaining why things are difficult.

William Edwards: I probably disagree slightly with that. I look at the position that I hold in NHS Greater Glasgow and Clyde and do not think that the technology is a huge barrier to making information accessible to those who need it and those who need to contribute to it. In our board area, we are looking to agree a wider data set with the LMC. I suppose that it would be helpful if that wider clinical information was agreed at the national level and there was an easier mechanism than signing off various data-sharing agreements. That could become part of our board's electronic health record.

To give the committee an idea of the size and scale of what happens, in Greater Glasgow and Clyde we have more than 25,000 active users of the board's electronic health record. They access information seamlessly from three of the six health and social care partnerships. Our health board is federated to the other boards in the west of Scotland and, indeed, the north of Scotland, to support tertiary referral patient flows. The current technology would allow information to be made available to those who need to see it, but some of the dialogue is about who can appropriately see what, if you like.

I have found the work of this committee to be quite useful, because it has allowed me to see the issue from the perspective of community dental practitioners, community pharmacists and so on. Greater Glasgow and Clyde is moving forward access for all community pharmacists to the immediate discharge information that comes from the acute hospitals. Early evidence suggests that that has had a positive impact on patient care—for example, on where there had previously been discrepancies around prescribing. There are some good patient safety stories there, providing that there is access to the data for those who need it.

Brian Whittle: A couple of quite interesting questions have come out of this discussion. The crux of the issue is who owns the patient data. Following on from that is the issue that William Edwards referred to, which is whether we can create a system in which there are different levels of access to data.

William Edwards: Access to the electronic health record in Greater Glasgow and Clyde is role based. Staff are set up with the relevant permissions and privileges, which depend on various clinical reasons or their role. We tend to get into debates about what the role-based access should look like rather than what the right thing to do is for the patient who presents.

Brian Whittle: Who should own the data? That is the key question, especially considering the problems that we have with data sharing.

The Convener: That is the central issue that has come up throughout our inquiry, and it would be interesting to hear the views of all the witnesses on that. I will take Geoff Huggins first.

Geoff Huggins: It is quite clear that the data relating to the citizen and the individual is the citizen's data. When we bring that data together, we effectively have a public asset that is subject to control by boards, GP practices or otherwise. Ownership of the data resides with the individual and it is a component of them.

William Edwards: I echo what Geoff Huggins has just explained.

The Convener: Is that view shared by all the witnesses?

Chaloner Chute: The subject is my hobby-horse, so I apologise for giving a slightly longer answer.

It depends on what we mean by "ownership". To give some background, DHI has done about 70 different co-design projects with people and professionals across Scotland over the past six years, and the issue of data ownership comes up over and over again. From a co-design point of view, the message that is given clearly and most often is, "I want to tell my story once." The national digital platform will start to facilitate that. From a clinical and professional service delivery point of view, I hope that, in the near term, people will be able to say, “Here is my blood pressure reading, and here is my family history” and that information can be reused over and over again.

We need the national health service to be the custodian of core medical data, for public health and service improvement purposes and, ultimately, for research into new medicines, for example. That is the argument that custodianship matters. It means people placing trust in the NHS and individuals understanding that putting their medical data into that pool is good for them, their family and their children and for Scotland.

There is a whole other world of data that is predominantly owned by consumer systems such as Google, Apple, Facebook and Amazon. If we want to get to a world in which the health and care services that we deliver are more personalised and preventative, we need to understand the basis on which we can use information about the way in which people move about their community and about their living environment. How warm is someone’s house? Did their primary carer just move to a different city? Those are the types of life data that we are talking about. The Government cannot necessarily collect such data and combine it in the way in which we would want it to. I will happily take advice on that, but I think that, politically, it would be very difficult to create a rich life context data set and to link it to all the other data sets.

Personal ownership of data matters because, if we give people the ability outside Government systems to gather some of the other data—not core service data but some of their lived-experience data—and make it available on a consented basis to the health and care system in order to help us with personalisation and prevention, we need to figure out how to create a trusting and regulated environment that allows all the other data to be gathered and made useful on the person’s terms.

I can go into a lot more detail on the issue and, if the committee is interested, I can share some papers after the meeting.

The Convener: The committee is certainly interested in that subject.

Scott Heald: I will give another perspective. The examples that William Edwards and Geoff Huggins touched on are about direct front-line patient care and how people can access the data that is needed for that. ISD collects lots of data on what happens across the health service and social care. How that data will be used and what data controllers can and cannot do with the data that they hold are important issues. It is important to point out that Scotland is very rich in the health service data that it holds. We are the envy of many other countries in that regard, and we should not lose sight of that.

We can anonymise individual data so that it can be used in ways that do not identify individuals. That allows us to use data safely in anonymous formats. ISD certainly has lots of experience of how we make data available in different levels of aggregation to allow it to be used. That can facilitate an individual board’s access to Scotland-wide data, so that it can see comparisons around the country.

There are different uses of data and different aspects of information governance that we need to think about. I echo the point that Geoff Huggins made about it being down to individuals. We are in tricky territory, because patient confidentiality is so important and is therefore treated as such. It is crucial that, across the country, we do anything that we can to simplify the landscape. However, I do not want to give the impression that we are not already sharing data and making use of it across Scotland, because we absolutely are doing so. Although the subject is complex and difficult, we are trying to take steps to simplify the system, but we cannot do that at the moment. If we were able to do so, it would pay dividends.

Lynne Huckerby: My view echoes much of what has been said. I firmly believe that data is owned by the citizen. With regard to patient choice, the points are about levels of consent about how far and wide data should be shared and about information and education for individuals on that.

Brian Whittle: The flipside is that the quality of the data that we get out depends on the quality of the data that is put in. I think that the question is about who should be able to input information in a patient record.

Chaloner Chute: In theory, the patient should be able to input data, which involves some trust issues. A relatively simple example is a blood-pressure reading. A person can buy, in Boots, a Bluetooth-connected blood-pressure cuff that sends data to their phone. I could them go into the Apple ecosystem, which stores their blood-pressure readings, and input that data in clinical systems. Our work in Glasgow has shown that.

The clinical governance issue is that the blood-pressure reading is of unknown provenance and does not follow National Institute for Health and Care Excellence guidance. We would need to think about how we could stimulate the market to ensure that the app that is used is the right one, with a medically regulated device, and about how we could prove that the data came from that device. There are ways to do that.

Another issue is that if the patient were to take the blood-pressure reading from a wrist-worn cuff at waist height, it would not be correct, because it needs to be taken at heart height. We would not know that from the data that came in, so a trust exercise would be needed in order to regulate the market and give people choice.

For example, we could say that people should get their own blood-pressure cuff if they have a family history of cardiac conditions, and that we want that to contribute to records so that they do not need lots of routine appointments just to monitor their blood pressure. We would need to make sure that they used the right cuff and that they were taught how to use it so that we could be sure of the data coming into the system. All that is within our gift; if we were to do it for the patient, there is no reason why we could not also do it for the pharmacist or social care provider.

Geoff Huggins: A lot of the issues come down to how we clinically model the data that is held. The approach that we work with uses openEHR software's ontology that sets out the different data components that are relevant to particular events. Blood pressure is the example that is generally used; in addition to the person's reading, the ontology identifies other information that would be relevant, such as their location, their age and the time of day. Various components can be brought in, but the objective of holding the data in that way—as data with metadata—is that it is be machine processable and machine readable. That is the challenge.

We often see data that is of high quality, but it is in a pdf, or in another document or manuscript form, so a lot of work would be involved in finding and using it. The challenge is to capture the data in a way that enables us to re-use it without having to reprocess it each time, including mentally reprocessing it each time. That would probably take us away from our dominant models—documents, pdfs and passing letters through the system. The more machine-processable and machine-readable the data, the more we will be able to do with it. That would bring in patient-reported outcomes, sensor data, blood-pressure data and other forms of data that we want to bring together in order to offer precision public health interventions.

Scott Heald: I agree with all that. I will mention another couple of aspects. First, the appropriateness of the data that is collected is really important, because there is a danger that we will end up being awash with data. It is important to understand what data we need in order to plan and deliver services and to measure outcomes, and it is important to make sure that we can access the data.

In the analytical world, data standards are important; there are lots of recognised data standards relating to the types of stuff that we collect across Scotland. There are also international standards on how to code diseases or operations. It is important that the process adopts and uses those standards, as we do at the moment. That relies on expertise in the health service to keep data consistent : we cannot rely on the citizen to code the relevant conditions relating to heart disease and suchlike.

10:15

As has been touched on, technology can help. As I mentioned in relation to social care data, our traditional approach would have been to try to define data standards that are universally applied across the country, but if that is not possible, it is possible to do the translation elsewhere, as Geoff Huggins alluded to, in order to create commonality across the country. It is important to use data standards with technology, but it is also important that we think through what data we need in order to answer the questions that we have, and that we then collect it appropriately.

Brian Whittle: It is interesting that your answer was about the analytical data. A person who has had a cancer diagnosis can walk into Ayrshire Cancer Support for one-to-one therapy. I am not suggesting that that charity could see the other patient data, but surely it would be useful for consultants and GPs if it could input information on that intervention to the patient data. Should such bodies be able to input data to the system?

Scott Heald: That is a good example. We have been doing a lot of work on the data on cancer across the country. We are looking at how to bring in data that is held by other organisations, such as those in the third sector, whose role is to support patients with particular conditions. We are considering how to bring the extra insight that they have into the data that we already hold nationally. That is doable, but we need to think it through. Again, it comes down to considering the purpose of our having the data and what that adds to the story that we already have about such patients.

William Edwards: Clinical information is collected every day across health board areas. I will go back to the example that Brian Whittle used. Structured data on cancer patients is collected regularly, whether they attend the Beatson west of Scotland cancer centre or services that are provided in other health board areas. The data is then made available across the board's electronic health record. Typically, data is collected in structured and unstructured ways within a board area and then shared across boundaries using federated electronic records. We are now trying to identify the data set that is required at national level, so that rather than having a rich clinical data repository in NHS Greater Glasgow and Clyde, NHS Lanarkshire or wherever, we can build a clinical data repository once for Scotland—as Geoff Huggins and his team have been commissioned to do—to make suitable data available at national level.

Another important step forward is the work on the national digital platform with the aim of moving to a single once-for-Scotland point of access for the citizen. Patients will be able to contribute data, such as in the examples that Chaloner Chute gave. It is important that the data that would be collected in the national digital platform would then be viewable almost seamlessly by the 25,000 users of NHS Greater Glasgow and Clyde's electronic health record. That is the journey that we are on.

The Convener: George Adam has a brief supplementary question, which I will hear, but I am keen to consider ways forward, as well as the barriers that have been highlighted.

George Adam: It is a practical question. I am on the right committee, because my wife Stacey has three long-term conditions, the primary one being multiple sclerosis. On a practical level, she has to go through everything every single time she accesses primary care. How could we design the system so that she would not have to do that?

I am aware that NHS Greater Glasgow and Clyde is running a programme for people with various conditions that gives them access to records, including letters to and from their consultant. I would be interested to hear about that kind of data sharing.

On a practical level, many people have smart watches. Without getting all Cambridge Analytical about it, is there a way that we can access that basic information to help people in the long term?

Chaloner Chute: We did the work to which you referred. We said that there is no reason why users could not share records—such as referral letters from GPs to the secondary care system—with their family, as their informal carers, in order to help them to arrange transport or do whatever else might be required. We showed that it was possible to extract core clinical assets and make them available to the family automatically through a WhatsApp-group style social messaging feed, which would be activated when the referral was made. It is not just the NHS's responsibility to get people from A to B; a bigger circle of people is involved.

I will give a practical example of what is being done in relation to cancer. Members will probably have heard me talk about personal data stores—the idea that I can carry my data with me—in previous evidence. Macmillan Cancer Support is doing a lot of work on that. I agree that a national digital platform is the way to go for how the NHS transacts business clinically and from the point of view of core medical services, because we want a single version of the clinical truth.

The cancer care pathway also involves issues such as who will take care of the patient's dog when they are in hospital, how a patient who is going through chemotherapy can get support with their exercise regime to ensure that they are ready for surgery, and who will deal with the mould in the patient's basement so that they have a house to return to when they are discharged. A range of other questions need to be considered.

Wearables have humidity and temperature-sensing capabilities, and the ability to understand how people's mobility is changing. Macmillan is looking at that stuff, and it has reached out to Glasgow City Council, NHS Greater Glasgow and Clyde and others to ask about the possibility of the person being able to contribute their half of the story. They could tell it once and hold the information themselves. That would mean that Mr Adam's wife could fill in her own form about herself once and keep it up to date. She could consent to that information being made available, and it could be unified with the information that the Government holds on her.

That raises a challenging interoperability query, but Macmillan, the British Heart Foundation and various other charities are starting to think about such things. They touch so many organisations in trying to help the user—they might touch 10 different health and care organisations—and that is the only route that they can see to getting there. That is what the concept of a personal data store is about.

Geoff Huggins: When Mr Adam's wife visits a clinician, the clinician should have in front of him or her the information that is required for them to offer excellent care. Two pieces of work that we are engaged in address challenges that have been identified. The first piece of technology that we have developed that we will deploy is on anticipatory care. We will deploy it in one location in the new year—the initial alpha and beta versions of the technology will be deployed in NHS Forth Valley. It is intended to allow different clinicians to have access to core data about the patient's anticipatory care wishes and plans for the future. That work is requiring us to solve the problem of how care home staff, the Scottish Ambulance Service and primary and secondary care can have a view of the information that will enable them to do their job in the best way.

Alongside that, we have work that we have been discussing as part of the innovative healthcare delivery programme, which is largely focused on cancer. It relates to the commitments in the 2015 cancer strategy in respect of treatment summaries. In that work, we have clinical consensus on the data set that should be available to the citizen and to the range of people who might be involved in providing care. We have agreed that we will, in the new year, do more design work on that in order to identify how we might bring it on to the platform as a national deliverable.

As part of our thinking, we will keep in mind the fact that the model and the technology that we develop should not be just for one group of patients, but should work for patients with MS, dementia or any other condition. In effect, we want to build reusable technology that the NHS in Scotland owns and controls, and which it can build out as we move forward. Those are the challenges that the strategy sets out.

David Torrance (Kirkcaldy) (SNP): Will the panel give us an update on the roll-out of SPIRE—the Scottish primary care information resource?

Scott Heald: SPIRE is overseen by NHS National Services Scotland, and has been deployed to 96 per cent of practices. We are working with the remaining 4 per cent to get the software out to boards; the issue is mainly the need for upgrades of local IT systems on which SPIRE will operate.

We have trained a little more than 1,500 people across the country to use SPIRE. Those people include GPs, although more practice managers are trained to use SPIRE. We have been focusing on cluster use and the development of local reports for use in practices—that is, in essence, the software running against the data that is held in the practice.

We have received positive feedback about how people are making use of SPIRE. For example, we hear that SPIRE is helping with the flu surveillance that happens at this time of year, and that the electronic frailty index has proved to be popular. A recent report—I think that it was in *The BMJ*—highlighted the e-frailty work that we have been doing in Scotland as a model of best practice in making a system available for use in GP practices across the country.

David Torrance: What are the current barriers to data collection and publication of statistics on primary care activity?

Scott Heald: I think that that question is also for me. The barrier is access to data in the first place, I guess. I should probably highlight that we have lots of data about primary care—data about prescribing, dental services and what I call the proxy measures, whereby we can follow pathways from general practice into acute care. Through SPIRE, we will be able to collect data on what is happening in general practice itself, and work is under way to collect more detail about the workforce in primary care.

We recognise that all that information is quite fragmented. Someone going to the ISD website to try to get a coherent picture of what is happening across primary care would find it difficult to do so. Therefore, we are considering what we publish and how, with the aim of relaunching the data that we have available on primary care, so that it is much more coherent and accessible for users. We aim to do that around spring, next year.

Lynne Huckerby: I can give a practical example of a barrier that we have faced in supporting primary care in the context of demand management: practices' ability to understand the demand that comes into them, due to their telephone systems being dated, and robust technology not being available to measure demand. There has been investment, particularly in East Lothian, where there was investment in technology that allows baseline data to be collected, but the picture varies across the country.

David Torrance: A national data repository has been mentioned. Will you update us on the allied health professionals operational measures project and how the information will link to other primary care data?

The Convener: Who is the expert on the AHPOM project?

Scott Heald: It is probably me, on this panel—

The Convener: That is encouraging.

Scott Heald: Although the project is in my area, I am not an expert—I am not as close to that work as I am to other stuff that we have talked about. I can find out more about the project and pass the information to the committee.

The Convener: That would be helpful. Thank you.

Miles Briggs (Lothian) (Con): On the need to prioritise and drive the change that we are talking about, does the panel think that health boards and other organisations see technology as a priority? Last night, I looked at Professor Nora Kearney's paper on her Scottish Government funded investigation into how to improve technology in cancer services.

Everything that we have discussed today, we were talking about 14 years ago. I refer specifically to the patient-held electronic record. Patients, as well as this committee, have highlighted frustrations about why that is not moving forward. I just wonder where the drive for change is coming from.

10:30

William Edwards: Technology features prominently in our health board's agenda. We have a significant commitment from the chairman, the chief executive and the non-executive board members, who own and have signed off the board's digital strategy and subsequent delivery plan, which echoes the national digital strategy. I said earlier that the moving forward together programme is our board's blueprint for redesigning clinical services, and a significant stream of work in the e-health agenda underpins those aspirations.

Miles Briggs made points about citizens' ability to contribute to the statutory healthcare record. Work on that is under way and we see a need to deliver that at pace. Previously, the health service focused on sharing information with those who needed it, those who needed to contribute to a record and those who provided front-line care. However, we are now trying to create a set of standards that will allow others from outside the statutory systems to contribute. That is largely where the work of the digital health platform needs to come into its own; we need to see a clear road map for when citizens and third sector organisations will be able to authenticate information against that, to bring together a more complete record from information generated and collected outside. The DHI also has a role to play in that space. Again, Greater Glasgow and Clyde NHS Board has worked closely with the digital health platform and DHI to try to move that agenda forward, because we see it as pivotal in redesigning some of our healthcare services.

The Convener: That is Chaloner Chute's cue.

Chaloner Chute: I will return the favour through what I will say. The exemplars to which we point—Estonia, Finland and similar countries—spend around 5 to 7 per cent of their budget on the digital agenda, but Scotland, in contrast, spends between 1 and 3 per cent on it. At a fundamental level, we are paying for information technology support but not digital development. Regarding Greater Glasgow and Clyde NHS Board and others, some boards have managed to stretch beyond that quite small sum and have exerted a huge amount of effort to keep business running as usual while trying to change on that kind of money. As an innovation centre, we are attracted by that, because we go where the energy is, but it is hard for boards to do it. Another comparator is that most private sector corporate organisations will spend nearer 10 per cent of their budget on digital development. It is important to note those points.

Another point to note is that although we fund projects, we do not maintain the outputs. For example, we could get in a European fund, a bit of United Kingdom money or a research grant and do a great person-held record project where everything would work, but we would have to try to make a case two years later to someone—we do not know who—about what will happen over the next 15 years. That would be another difficult situation, so we need to bake in more maintenance money for such initiatives.

The Convener: Clearly, an element of this is about seeking a national service.

Geoff Huggins: I have a couple of points. First, I am not persuaded that the issue is always the money. The way in which we talk about the money in digital health is odd, because it is as though we have the health service, and, separately, we have the digital health service. One of the clear messages from the strategy was that we had to stop separating IT from service change and service delivery. As we take forward the modern out-patients work, the access collaborative work and the work on primary care modernisation, technology needs to be baked in, so that it is part of that, and not a separate add-on at the end or the side of it. On how we think about the money, simply costing the IT departments of the NHS makes no sense at all and I would take a step back from that.

The challenge for implementing digital change across different programmes of work, where different people with different perspectives are involved, is relating that back to a common architecture and a common approach to the technology. Without a degree of co-ordination and guidance, that is challenging. However, it is beginning to emerge and come into place in a way that we can be confident about.

Lynne Huckerby: Similarly to Geoff Huggins, I think that technology should be seen as an enabler and not a driver for change. One of my personal hobby-horses is the need for service design, and engaging our citizens in understanding the needs and requirements of a service. By doing so, we not only engage the many, in terms of the population, but ensure equality and address the needs of people who perhaps face barriers to access. The Digital Office has set a standard for Scotland in the Scottish approach to service design. For me, that is a critical point at which we should be developing our services, of which digital is part and parcel.

Miles Briggs: The point that I was trying to make relates to the once-for-Scotland approach. One example of that is the development of a local information system for Scotland to link in mental health services in the community. Once that gets down into GP surgeries—we are talking specifically about a digital front door for primary care in a GP setting—what does it look like? Last week, the committee discussed social prescribing. We heard from a GP from the Highlands, who said in her submission:

> "ALISS has been defunct in our area for ages—no one uses it."

We developed a system that was meant to be a solution, but even clinicians do not have enough belief in it to make it work. Given what you have said and what is outlined for the future, how will we evaluate that to ensure that if we put spend in, things happen? Just like Professor Kearney wrote in her 2005 report, in 15 years' time we could still be sitting talking about this—it is not happening and the benefits have not been realised.

Lynne Huckerby: Over the past few years, in partnership with the Health and Social Care Alliance Scotland and Macmillan Cancer Support, NHS 24 has been developing Scotland's service directory, of which ALISS is a part. The quality of the information that is made available is only as good as the quality of the information that goes in, so we have been working particularly closely with the Alliance and ALISS on how we make best use of and surface that content. We have been working with 20 of the health and social care partnerships across Scotland to ensure that, as far as possible, the content is quality assured. By next July, we will have the remaining 11 health and social care partnerships on board with that. One of the aspects of that development is to ensure that the content is quality assured and relevant for the population.

Geoff Huggins: Miles Briggs was right about testing whether the technology evaluates well with the people who are using it and helps them to do the things that they want to do. We need to have a far greater emphasis on design, because products that are well designed, intuitive, easy to use and help people to do the things that they want to do, get used. Products that do not meet those criteria do not get used, regardless of whether they evaluate well clinically. People will start to use technology that helps them more quickly than technology that is an obstacle. That is why, in the work of the Scottish Government, with the commitment to the standard, and more generally, developing things iteratively in situations and localities is part of the process—because you have to find out whether what you are doing is going to work.

Scott Heald: I was going to make more or less the same point. The other aspect is about developing things incrementally, so that it is not just a big bang, and so that people are not disappointed when they see the big bang after so many years of development. The design and the user input are also important.

Brian Whittle: I will be brief, since I hogged so much time earlier. I am interested in how you think that the NDP will enable information sharing between the primary care multidisciplinary team—because I think that that is the direction of travel that we are moving in—and the acute sector, social care and maybe even the third sector. How will that be an enabler?

Geoff Huggins: As members of the panel have said, the objective is to move towards a situation whereby different clinicians, whether they are in the NHS, local government or the private and voluntary sectors, are able to have read-write access to the same data sets, to enable them to perform the different functions that they want to perform.

I will explain the model that I have in my head. A person who drives a Volkswagen and looks inside the engine will find parts that say "Audi", "Skoda" or something else. Common components are used across different cars, but there are different components that are specific to the particular model. Our objective for the platform is that it will begin to develop common components, whether they relate to citizen authentication, staff authentication, how we hold and archetype the data, or messaging. Beyond that, people should be able to interact with the particular use cases that are seen on the ground, whether they involve somebody being visited in their own home or a consultation to build the technology to reflect the particular workflow that is needed in a GP surgery. The common component aspect becomes the process by which people make the joins. Alongside citizen and staff access, it enables us to deliver services in a different way. Does that answer Brian Whittle's question?

Brian Whittle: Ish.

Geoff Huggins: We do a really good hour-and-a-half presentation, if you are interested.

Brian Whittle: Not today, you don't. [*Laughter.*]

I was interested in the DHI's presentation. I think that the issue is more about a change in management than about technology. How do we ensure that what is adopted cascades down to the front line?

I also want to follow up on what Miles Briggs said about social prescribing. The DHI mentioned the bank of available local community referral options, which sounds great. How do we make that system work?

Geoff Huggins: Some of the people in the gallery are from the product team. Most weeks, they spend their time on the ground in Forth Valley NHS with clinicians in primary or secondary care, talking through how the technology looks before it goes into the production phase. That is a core component of ensuring that there is a good likelihood of what we produce being taken up, without our having to demand that people use it. We want to develop technology that people choose to use because it works for them.

Beyond that, we have identified that a further function is required in relation to implementation support, which is probably more in the space of the improvement and change collaboratives, because understanding the dynamics and thinking about how it can be done at scale very much involves work on a person-to-person and team-to-team basis. Although that work might be done in slightly different ways, because care is configured differently across Scotland, the common elements—the technology that underpins the system—become uniform. That begins to apply a degree of pressure for standardisation.

Chaloner Chute: What I will say is in a similar vein. It is quite easy to get funding for the snazzy bit, which is often technology. The DHI, as an innovation centre, has been funded by the Scottish Government for the next five years. However, when you ask for the change in management money, it is slightly less easy, because you are asking for a group of, in effect, unaffiliated and unrestricted people whose job is to do the hearts and minds work and to spend quite a lot of time changing cultures. It is harder to pin down outputs, other than managing to sign up a health board and moving on to another one.

The DHI has done work on remote control pill cameras and remote gastroenterology, and it is hard yards to get three health boards to agree to do things in the same way. Dedicated people are needed to do that, which can take years, so it is quite hard for us to get the investment in that work. We hoped to get investment for a specific change management function that understands what is coming, prepares the ground, warms people up, recruits people into design exercises with the NDP, DHI and others, creates champions and so on. That requires dedicated roles, which we do not have right now.

10:45

David Stewart (Highlands and Islands) (Lab): I thank panel members for their contributions so far, in which we have looked at a lot of technical detail. I would like to ask a wider question. Clearly, we are living in a time of climate emergency, in which we are all trying to reduce carbon emissions. Where might new technology come into play in doing that in primary care in Scotland?

Chaloner Chute: The measures that are in front of us right now include the attend anywhere scheme. It uses fairly simple technology, and its rationale is that people do not need to move from one place to another to be able to interact. Over time, we will need to move out of the habit of using the face-to-face appointment as the basic unit of the health and care system as we do now. For example, we currently say that, if a patient is in doubt, they should book an appointment. However, quite often, the purpose of appointments is simply to exchange information; patients are asked questions and they contribute information on their needs.

In the world that Geoff Huggins has just described, in theory, we should be able to apply the management by exception model to someone with hypertension and say to them, “If everything is going fine, you have your blood pressure cuff, you are doing exercises and you have given consent to making your data available, we can automate analysis that says that you are in the green zone and we will start face-to-face interaction only if you move into the amber zone.” There is now a different thought process around the idea of not making people travel, on which we can make progress as things move forward generally.

Lynne Huckerby: I agree. In NHS 24, the drive and ambition is to extend channel choice both to people who use our services and to those whom we support in primary care. Chaloner Chute mentioned the attend anywhere scheme, but other measures, such as web chat and messaging, are part and parcel of what we can do to extend people’s choices in accessing services.

David Stewart: I thank panel members for their answers on that point. I want to move on to another key concept, which is the use of the digital front door. Will panel members outline what that means and how its success will be evaluated in the long term?

William Edwards: Earlier, I referred to our board’s aspirations on the moving forward together programme, the reconfiguration and redesign of our services and how we might move away from the current model of referrals and appointments. NHS Greater Glasgow and Clyde has put in place the ability to create a dialogue with citizens, especially patients with long-term conditions. We created an environment in which the statutory health systems were on the right-hand side while, on the left-hand side, we were almost trying to create a set of standards that would allow innovation and small and medium-sized enterprises to disrupt how we currently look after patients with chronic obstructive pulmonary disease, diabetes and various other long-term conditions.

We had in place a digital front door, which we developed across all the boards in the west of Scotland and was a national commission that NHS Greater Glasgow and Clyde was asked to progress. We proved that we were able to sign up patients across various specialties, the effect of which was that their dialogue with clinicians became different. That represented a definite move away from referrals and appointments towards remote management at a distance, so it was a good move forward. That capability will be delivered via the national digital platform. However, as an organisation and through the moving forward together programme, we still require it to be in place now. Although that capability is being progressed at national level, we no longer have it, so it is important that the digital platform delivers in that space.

Geoff Huggins: Over the next three to four years we need to see a fundamental shift in the ability of the citizen to engage directly with the system through the use of technology, to deal with their medication and appointments and to put information that they want back into the system. However, we need to be careful that we are not seeing that from the perspective of the system itself—or what the system feels that it needs. People will use the technology if it meets their needs and helps them to do something that they want to do; they will not use it because it suits us.

For that reason, as we begin the work to build into the platform the technology that allows us to work with citizen access—that is a different sort of technology from an integration layer, which allows information to be passed across into the legacy systems—we think that, to do so, we need to develop it using particular use cases in which the citizen goes through the digital front door to do something that they want to do. It might be to update their anticipatory care plan, to get a version of their treatment summary or to provide outcome information about how the medication that they are on is affecting their health. Therefore, instead of the NHS Digital approach, which is to put an app on the web that notionally allows people to do three or four things and then to encourage 50 million people to download it, our intention is to provide a rich experience so that those who use the technology and find it of value can use it a lot.

David Stewart: My question is for Geoff Huggins, and then the other witnesses might want to come back in. Do you agree that it is about changing the culture? To give an example, the University of the Highlands and Islands does more videoconferencing than all the other universities in the United Kingdom put together. The norm in the UHI is to consider whether a meeting can be done by VC. I have found that, even in the Parliament, where we are pretty well equipped to do that, it is sometimes a struggle to convince committees to have videoconferences—although I exempt this committee from that—when clearly there is a big pay-off in terms of convenience for witnesses and reduction of the carbon footprint.

Geoff Huggins: There are a number of cultural issues. One is about familiarity. People who are familiar with the technology and confident about it will use it. Over the past year or so, we have seen an explosion in that with some of the new technology that is being used across NHS boards.

Another component of the cultural issue is the way in which clinicians or citizens expect things to work. Although we are talking about a change process, we also have fixed ideas about how a clinic works, such as the expectation of seeing somebody in person. Some of those issues perhaps relate to historical power dynamics.

It is not just one channel that needs to change. Chal Chute talked about disruption. The most fundamental change that we can make is to put the citizen more in control of their health. We know that that is good for many reasons and that it requires a different way of doing things.

I am sorry, convener—I know that you need to move on.

Lynne Huckerby: I want to go back to the point about the digital front door. We are seeing early insights and evidence that about 30 per cent of the people we engage with in primary care do not need to have a face-to-face appointment with a GP, so there can be a redirection to self-care and self-management. Digital and online access are critical for people in that regard.

There is also an education point relating to early intervention further upstream and support for health and wellbeing. That is key.

Chaloner Chute: We have given evidence to committees previously that the global systematic academic literature review relating to patient portals, which is the predominant thought process, is not favourable. Globally, the evidence for a link between a centralised patient portal approach and patient benefit is next to non-existent. We are not trying to do that in Scotland, but we are in danger of trying to measure our approach as if we were doing that. If we simply wrap up people's clinical records, give them a login and expect them to go and use those, about 2 per cent will do so.

I basically agree with what Geoff Huggins has described. No one goes on the Ryanair or Flybe website to create an account just in case; they do it because they see a flight that they want to get to a place where they want to go, and there is a registration process as part of that. I urge those at the political level to be careful about applying a measurement of success based on the quantity of people who log into the portal, because that does not reflect the way people use digital services.

Geoff Huggins: The intention of having a different relationship with the citizen is to allow us to do things that we cannot currently do, rather than to do digitally things that we currently do. That is why that relationship has to be part of the process by which data is being created and used in a different way. We see that across the world with things such as chatbots and triage systems that are designed to enable people to get more quickly to an answer that they are comfortable with, rather than being channelled faster into the existing system, because the system is challenged as it is. Adding another channel that enables more people to come in probably does not help us.

David Stewart: You have partly answered my question, but I also want to ask how we measure success, because, as you know, one of the issues across the health service in Scotland is health inequalities. We also have a major issue with the digital divide. Is there a danger that we reinforce that health inequality because many elderly people or those who stay in areas with poor wifi or who do not have a great understanding of IT may be further disadvantaged when they already suffer a health inequality.

The Convener: We will take a question in the same area from Emma Harper and ask the witnesses to respond to both.

Emma Harper: My question is on health inequalities and what we are doing to support people, which is not just a rural versus urban issue. My sister, who is a respiratory nurse consultant, has been doing COPD assessment for patients for 10 years using telehealth models; for 10 years, NHS Dumfries and Galloway has been covering Stranraer and Dumfries in that way. Dave Stewart has already alluded to more VC being initiated in the Highlands and Islands. I am interested in how we support people who do not have normal or routine access to services, people who have poor wifi and people who do not engage digitally.

Chaloner Chute: I will pull out the exact stat, but I think that around 98 per cent of people under the age of 55 own a smartphone. There are different types of access issues. Age is one that you raised, but if we take the under-55 group, access to a smartphone is one of the most democratising and access-improving means that we can have. No other channel will get to 98 per cent of the population. There will always be the 2 per cent and, to an extent, a system cannot be designed for them; I suggest that we have face-to-face appointments and the full service as we know it to handle that complexity. However, for a large proportion of the population, our ability to reach people will be improved if we use tools that they are happy to use. In this case, a smartphone pretty much transcends socioeconomic and various other divides. That is my first argument.

My second argument goes back to the message that we have been giving out. I tried to get my dad to use an iPad. He did not want to use it. One day, he realised that he could watch the cricket on it. The next thing I know, he is banking and booking flights online and all the rest of it. He found something that he wanted to do and now he can watch cricket in any room in the house—no matter what my mum says. In all seriousness, now he is using that technology. It goes back to the same point; if it is useful, people will do it.

Geoff Huggins: We should be measuring the health and care outcomes. There should not be separate digital outcomes. We need some understanding of the digital change, but we are looking to provide better health and care. One of the challenges that we often hear about digital disadvantage and deprivation and age-related perspectives on the use of technology is that, unless something can be used by everyone, we should think about doing or designing it differently. However, I do not think that that is the future. The current system has never operated in that way. People have always taken different approaches to managing and interacting with it. We just have to understand that we cannot primarily or exclusively relate to people through any one particular approach or channel. We have to have the mix so that we meet people where they are. That is the straightforward and sensible answer.

Lynne Huckerby: I agree. One size does not fit all at all. It comes back to the service design approach, and it is critical that we engage with minority groups. Within NHS 24 we have a design principle, which flips the Pareto principle to design for the 20 per cent, thereby impacting the many. We have a recent example of engagement with deaf and hard-of-hearing communities giving us clear insights and understanding of how they want to access services, which will be designed into what we deliver for them.

Scott Heald: This is a good opportunity to refer to public health Scotland, which will come into being next April and of which ISD will become a part. Health inequalities will be a huge focus for the new body. I agree with Geoff Huggins that it would be wrong to think about the technology in isolation, because many things contribute to health inequalities. Having access to good evidence and data to underpin what is going on locally will be important for that and will be a big feature for us when we move into public health Scotland.

11:00

Emma Harper: Asthma UK has videos in different languages of how the best inhaler technique is achieved. My sister will sit with patients and show them the video, because that is the best way for them to understand. The multilingual approach therefore needs to be part of digital technology as we move forward.

Geoff Huggins: I agree. Interestingly, we often get into conversations as to whether we should create such videos. The best answer to that is that there is good stuff out there already on YouTube, which we can usually find within 30 seconds. However, it would probably take us three years to get the money together, commission videos and deliver them. The YouTube videos indicate the kind of ecosystem that we are now in.

Lynne Huckerby: Just to add to that, we also know from people that receiving content through multimedia is preferable to reading content and data. One of our aspirations is to provide content through multimedia resources.

Miles Briggs: I have a supplementary to a supplementary.

The Convener: As long as it is brief.

Miles Briggs: I know that community pharmacists are often frustrated by digital prescribing for asthma patients and monitoring use around that. With regard to potential future technology, where is the link with community pharmacy to ensure that it is a key part of getting a prescription without using the GP as a gatekeeper for that?

The Convener: I will take a response from Chaloner Chute, but I am keen not to open up a new line of inquiry.

Chaloner Chute: As I said previously, we are discussing with community pharmacy a capacity building exercise to understand its role in a digitally enabled, long-term condition management system. Ultimately, we would use a single source of clinical truth and so on. We are therefore on that, but we need to go and find some funds.

Scott Heald: I do not know about this, but the practitioner services part of NSS must be engaging with Community Pharmacy Scotland. I can find out more about that and feed it back to the committee.

The Convener: Thank you. I thank all the witnesses for an engaging and good evidence session and for the additional information that has been promised.

The meeting is suspended briefly to allow a change of panels.

11:02

Meeting suspended.

11:06

On resuming—

The Convener: I welcome colleagues back to continue taking evidence on primary care under agenda item 1. I welcome to the meeting the Cabinet Secretary for Health and Sport, Jeane Freeman, who is accompanied by Scottish Government officials. Aidan Grisewood is deputy director of primary care, Naureen Ahmad is head of GP contract development and implementation, and Phillip McLean is patient engagement and health inequalities team leader.

I will start the questions. Cabinet secretary, what steps is the Scottish Government taking in developing a new health and social care strategy? What role will prevention and primary care play in the development of that strategy?

The Cabinet Secretary for Health and Sport (Jeane Freeman): Good morning, convener and committee members. As you will know, our health and social care strategy is being implemented, but it needs to be refreshed in light of developments across a number of areas, not least in the delivery of healthcare, the introduction of new technologies and important preventative work, which the convener rightly referred to.

We are working on the current delivery through the ministerial strategic group, which I co-chair with my colleague Councillor Stuart Currie, who is the Convention of Scottish Local Authorities health and social care spokesperson. We have a number of key stakeholders on that group, including the interim chair of the new body called public health Scotland, a number of individuals from the Royal College of Nursing and other royal colleges, and people from health and social care partnerships.

The group is working through the outcome of the joint review that we undertook with COSLA of how far we had got on health and social care integration and the next steps to be taken. The group is focused on the overall delivery of those next steps, taking into account what we have learned from Audit Scotland, where we are on the implementation of practice, and where we are on our journey to transform primary care.

All that is being done with a realigned health directorate—I think that it is fair to say that—that is now focused on population health. That is about what more we can do to address health inequalities and how we can refocus some of our work in that area alongside the preventative agenda, which already encompasses the work that we have done on smoking and alcohol, and Mr FitzPatrick's work on drugs.

The Convener: Thank you. I am sure that you have been following the committee's proceedings and are aware of the evidence that many witnesses have provided on the need not for continuation of the status quo or even for development of existing trends, but for significant change. For example, the allied health professions directors Scotland group said that there is a need

> "to move from a traditional medical model to a collaborative, co-produced model of primary care."

Concern has been expressed about whether that will be delivered—for example, under the terms of the new GP contract.

Do you agree that we need to see a significant shift in how we view and deliver primary care?

Jeane Freeman: I think that we are already seeing a significant shift in the way in which primary care is delivered, compared with how it has traditionally been delivered. There are a number of drivers for that. One is phase 1 of the GP contract, which introduces the multidisciplinary team to GP and primary care practices and reasserts the role of the GP as the expert medical generalist who leads the team.

In a relatively short time, we have got to a place in which two thirds of our practices have access to pharmacological support. That is making a significant difference. Allied health professionals are in many of our practices, and the Allied Health Professions Federation Scotland is a member of the ministerial strategic group that I mentioned. The federation is also contributing to the overall work that we are doing on integration, of which primary care and the degree to which we can transform it are essential components.

In addition, the Scottish Ambulance Service and NHS 24 are trialling significant changes in the nature of their services and how they deliver them. I can give two examples. NHS 24 has been trialling the triaging of calls for GP services in Musselburgh and is looking to test the approach in a more rural setting in the Borders, and the Scottish Ambulance Service is trialling having paramedics see and treat people at home rather than taking them to A and E, when that is the clinically correct thing to do.

We are looking at a number of key building blocks towards the transformation of primary care—I have touched on some of them. They are building blocks because transformation to secure primary care's place as a cornerstone of our health service is a journey that will take time.

I am certainly not saying that there is nothing more to do and that we should just continue with what we have set in train. We have set in train the beginnings of a transformational approach, and there will be other innovations and developments for us to take on board as we put the building blocks in place.

One of those, of course, is the use of technologies. For example, a growing number of people are making use of the attend anywhere platform—in the north of Scotland, it is known as NHS near me—and they are doing so not just in relation to primary care. For example, NHS Forth Valley is using attend anywhere extensively in the context of ophthalmology consultants' work with optometrists in the high street. There is expansion to be done in that area and others.

The Convener: Another thing that many witnesses have talked about is the importance of good leadership in transforming primary care and integrating health and care. Are you satisfied that the right governance is in place for those processes?

Jeane Freeman: I think that we have the right governance structures at this point. I am sure that you and colleagues on the committee know that we have gone through a bedding-in process for the governance structures for integration joint boards and health and social care partnerships. I think that there is now greater clarity across the key partners—that is, local government and health boards—about their role and relationship with IJBs. That was part of the joint review work that was done. That is not to say that there is no room for improvement in governance structures but, at this point, I am less keen to focus on structures than I am to focus on what is being delivered for patients.

11:15

The potential role of our GP clusters approach—which, again, came out of phase 1 of the new GP contract—is beginning to show real opportunity for collective leadership from GPs in their clusters and for taking collective decisions about, for example, what areas of multidisciplinary team development they want to focus on.

I will give an example. From looking at the respective patient cohorts of different practices, GP clusters in NHS Forth Valley collectively decided that their priority was the introduction of a physiotherapy service across the practices rather than a pharmacotherapy service. Different clusters are choosing different approaches, and that is entirely as it should be. They are making decisions that make sense, because they are based on the data and experience of the locality.

The Convener: Given that and what you said about the significant role of GP clusters in transformation, how do you ensure that there is coherence between what GP clusters are working on, as you have described, and the priorities that are set by health and social care partnerships? Does the Scottish Government issue guidance on that, or is it negotiated at the partnership level?

Jeane Freeman: There is some guidance on that. However, you have touched on an area on which there is further discussion to be had with the Royal College of General Practitioners and the chief officers and chairs of the IJBs.

In some areas, the approach works well; in other areas, it works less well. When I was previously at the committee with Councillor Currie, I spoke about how every single one of the 31 IJBs does something well and every single one has areas to improve on, and the fact that they are not all the same. We need to get to equity of good practice in core areas across the piece.

How well individual IJBs relate to their GP clusters is similar. To be fair to the IJBs, GP clusters are recent formations, and the clusters need time to work out how they want to operate and what they want to focus on. There is room for us to consider what more we might do to help the IJBs to understand what the clusters are doing and to help the clusters to understand how they can inform the commissioning and planning role of the IJBs.

The Convener: You have touched on the role of clusters in relation to multidisciplinary teams. I imagine that that is one of the areas in which you will want to ensure that there is diversity and that local circumstances are reflected, but also that there is a general understanding of the importance of the multidisciplinary role.

Jeane Freeman: Yes—absolutely. I think that that is increasingly understood. We see that with the two thirds of GP practices that now have access to the pharmacotherapy service, for example. As they, in their clusters, talk to colleagues who might not yet have accessed that, they are our best advocates for the difference that it makes to the service that is delivered to patients and to their individual roles as GPs. The degree to which we work well with the Royal College of General Practitioners is important, because it is of great assistance to us in encouraging the development of good and shared practice.

Brian Whittle: You have alluded to the move towards the approach of looking at the health of the nation, and I think that you will agree that, here in Scotland, we have an unwanted tag that we need to deal with.

We talk a lot about the preventative agenda—that conversation seems to go on ad infinitum—and we recognise that a preventative approach would have a positive impact on the demands on primary care. What is the Scottish Government doing to recalibrate the way in which the NHS delivers its healthcare services and to move towards a preventative approach?

Jeane Freeman: We are doing a number of things. You mentioned the "unwanted tag"—I assume that you were referring to Scotland's tag as the sick man of Europe.

Brian Whittle: Yes.

Jeane Freeman: I think that that tag is increasingly unfair, if we look at the statistics. It resulted from the previous incidence of heart disease, cancer and stroke, and the mortality rate from those. Although we are nowhere near where we want to be in that regard, significant improvements have been made, so I think that that tag is not just unwanted but unwarranted. However, that is not to deny the problems that we have on health inequalities, which are significant, and the differences that exist in life expectancy. We are all familiar with the Glasgow train line map and what that means in terms of health outcomes.

When it comes to preventative health, it is important to say that that is not exclusively the role of the health service. I am sure that everyone will be very familiar with the work of Sir Harry Burns on identifying the key factors that produce health inequalities. The health service has a part to play in tackling those, but so do income, job opportunities, housing and so on. Therefore, the preventative approach needs to be picked up by colleagues in other portfolios and other areas of public service.

In health, the preventative agenda includes the work that we have done on smoking and alcohol, the work that Mr FitzPatrick is taking forward on illicit drug use, the work that is beginning to be done on addiction to prescribed medication, and the work that clinical colleagues are doing on what can be argued is the overprescription of antibiotics and what that means for longer-term health. In the context of the school agenda, Maree Todd is leading preventative work in education with children and young people, and in a health context, we are working with women in advance of and during pregnancy, including on perinatal health. In a number of areas, we are looking to prevent some of the health conditions that we are currently tackling from arising in the following generations.

There are two further aspects that we are looking at, the first of which is what we need to do to improve the reach of our screening programmes. Work is under way to look at all our screening programmes and what more we might do to ensure that they are easily accessible to those groups of people whom we are not reaching at the moment. That includes looking at how and through what means we deliver those programmes. I will give an example of an area in which more work is required. There is an association of football community development trusts—I have forgotten the name of the organisation, but Mr Whittle will probably know what it is called. One of the discussions that I have had with it is about how we might use its work with the community to increase access to and use of some of our screening programmes. It is important for us to be able to detect, and therefore to treat, conditions at an early stage.

I can give another example, which relates to work that NHS Greater Glasgow and Clyde and Glasgow City Council undertook recently. It was not directly health related but, in discussions, they identified that there were sections of the city where, by and large, nobody was employed by the health service. Our health service is, of course, the largest employer in Scotland. Along with the council, NHS Greater Glasgow and Clyde targeted—while ensuring that people had the right qualifications and experience—a number of support role opportunities in those areas so that the health service would come closer to people, because they would know the woman down the road or the guy across the street who worked for the health board. The aim was to make the health service feel more accessible and, by doing so, to change attitudes to and views on accessing services.

The final thing is the work we are looking at with community pharmacies on the role they can play in preventative work and in helping people, for example, to access a smoking cessation service in the areas where we need that to happen.

Brian Whittle: Thank you for that full answer, which I appreciate. We have to be careful that we do not underestimate the challenge. I agree that that tag is not a title that we want to hold, but we obviously have a major issue with drugs, a rise in type 2 diabetes and problems with mental health. We do not want to underestimate the challenge. The trust that you alluded to is the SPFL Trust, by the way.

I have written down “tackling this cross-portfolio”, which you alluded to, and I certainly include the role of the education system in that. Who has primary responsibility for prevention? Given that you said that this is a cross-portfolio issue, how do you leverage the budget in a cross-portfolio way to drive forward prevention?

Jeane Freeman: Because population health and health inequalities sit in my portfolio, it would be reasonable to say that the health portfolio is the key driver here. However, that means that I need to work with my colleagues in housing and local government, in education and in justice—you will know that we are doing some work with Humza Yousaf on health services and suicide prevention in prisons—on what we can do in those areas and how their portfolios can contribute.

As for levering the budget, it is about looking at where we can work jointly. For example, the baby box sits firmly in Maree Todd’s portfolio, but it is the health budget that pays for the baby box. That is a good example of joined-up working: we recognise that our budget should contribute to that piece of work, but it goes out through the area of children and families. Every time we come to budget discussions, which we will again at some point, Derek Mackay increasingly looks for how our portfolios are co-operating in order to deliver shared goals. That co-operation is not just in policy, but about how we use our resources.

Brian Whittle: As an example, Ayrshire College, which I visited last week, is doing some great work on tackling mental health issues, but that is coming out of the education budget. This is where the lines get a bit blurred. You talked about health inequalities. If we deliver a breakfast club, for example, that comes out of the education budget; there is a crossover there between health and education. I do not know how well the Scottish Government tackles such issues.

Jeane Freeman: I think you were at Ayrshire College’s graduation ceremony. It does very good work in my area, as it does in yours. I think that it was last week that I announced the funding and the agreed distribution for the 80 mental health counsellors who will go into further and higher education. Ayrshire College will benefit from that, and that may allow it to redeploy elsewhere some of the resource that it is currently putting into mental health.

We are actively contributing, and the same is true in schools. We have reached an agreement with COSLA on how funding will be distributed for mental health counselling support in schools. Some schools have already taken significant and important initiatives in this area; some have taken one of their teaching posts and, with additional training, that teacher has been the counsellor up to now. I do not want that disrupted if it is working and that individual is trusted in the school, but it is perfectly possible to use the additional resource labelled for mental health counselling in my portfolio to backfill on the teaching side, if it makes sense for a school to do that.

11:30

For a number of areas, different parts of the Government are contributing to the collective aim of doing more to prevent ill health and to help people be more aware of how to live more healthily.

I know that the committee is interested in social prescribing. There is an example of that in East Kilbride, where a primary care practice initiated work around high blood pressure that ticks a number of boxes. Where there is a debate about whether someone’s blood pressure is an indicator of ill health or other issues, they can use an app on their mobile phone to monitor blood pressure every day. That data is fed directly back to the practice, which monitors possible reasons for high blood pressure, including lifestyle, weight and whether the person smokes.

One thing that the practice does is issue a prescription for the local authority's leisure and recreation facilities, where a team is ready to receive that prescription and produce a specific plan for the person. It has been found that, even when a person's engagement with the practice is over because they no longer have a particular health condition or are managing it by losing weight or becoming more active, they continue to go to the gym, take part in the walking club or do whatever they were doing. We are therefore seeing examples where bringing together different public services is producing for the patient a much better outcome than using one public service exclusively.

David Torrance: Does the Scottish Government's definition of primary care fully reflect the range of staff and activities involved in primary care and support a person-centred, patient-led approach?

Jeane Freeman: Yes, I think that it does. Our definition of primary care is based on balancing preventative work with treating ill health. We want to help people to manage their long-term conditions better, to be more informed about what is possible and to be engaged in decision making. That involves access to a range of sets of professional skills that meet the needs of individuals.

I found the work that this committee did on its survey and so on to be very interesting and helpful. It informed our work on how we engage the public more widely in the development areas that we want to pursue. One thing that we know, for example, is that, by and large, the public is ahead of us and health professionals in the use of technology such as apps. People expect us to use technology more and to have greater access to it through apps on their phones or through the internet. We therefore need to catch up with the public on that, because that is where they expect us to go—they would like us to have got there already.

We need to do more of that. The attend anywhere clinic is a good example, as is blood pressure monitoring using an app on a mobile phone. However, the real challenge for us is not those opportunities but how we ensure that, where there is good practice and innovative developments, they are picked up and spread across primary care. Of course, underneath primary care sits a range of contractual arrangements that we have to be able to work with in order to ensure that we get what we need.

David Torrance: What can be done to empower allied health professionals and ensure that they are involved in organising and making decisions about local services and how they are designed?

Jeane Freeman: There are two or probably three aspects. One is the involvement of allied health professionals in the ministerial strategic group on integration of health and social care. The group is very focused on practical improvements and work to deliver the recommendations of the integration review. To help with that, we have seconded a former chief officer of a large IJB to help us to work with other IJBs. That will be almost peer-to-peer work to improve practice.

The second aspect is the recognition of the role of allied health professionals, where that role sits in health boards and its importance across health and social care. That came through strongly in the work that we and the committee did on the Health and Care (Staffing) (Scotland) Bill. There is also work that we need to do to encourage the GP clusters and IJBs, in their planning and commissioning of services from primary care, to be informed about the range of services that allied health professionals, and community pharmacies, can offer.

Another aspect is the conversations that I have had with chief executives and chairs of our health boards about how the boards design and deliver primary care services to be commissioned from IJBs.

The Convener: Do you recognise that some of the evidence that we have heard from AHPs is that the definition of primary care still seems be focused on the role of the GP at the centre, rather than the multidisciplinary team as a whole?

Jeane Freeman: I understand their concern and I hope that they are reassured by what I have said. I do not dismiss that concern. If we want GPs to move into the role that best fits them, which is that of the expert medical generalist—with all the training and investment, that is what GPs should be doing—AHPs will be key to ensuring that that can happen. Increasingly, GPs and the British Medical Association understand that point. I understand why AHPs would have that concern and my job is to reassure them by my actions that the view is not as narrow as their perception of it might be.

The Convener: Thank you very much. We move on to a question from David Stewart.

David Stewart: Good morning, cabinet secretary.

Jeane Freeman: Good morning.

David Stewart: I will move to workforce planning, which I have raised many times during this inquiry, and I will start with allied health professionals. The cabinet secretary will be well aware of the Audit Scotland report that said that almost a third of vacancies for allied health professional posts had been unfilled for three months or more. As the cabinet secretary knows, the Scottish Government does not control the training of those occupations, but it has said that there will be “a more managed approach” to training. Could you outline what is meant by that and explain how the approach will be changed in the future? It is clear that AHPs are crucial for the future development of primary care.

Jeane Freeman: Are you asking what I mean by “a more managed approach”?

David Stewart: Yes.

Jeane Freeman: It is no secret—it is known to all of us—that there are important data gaps in what the Scottish Government knows about where our workforce is and what its numbers are. A key to taking a more managed approach is to have better data. We have to begin to fill in the data gaps to understand better from primary care what is needed in its areas and to know better the profile of our existing workforce, so that we can be more robust in knowing how many we need to put through training to produce the numbers that we will need, to replace those who may be retiring and to increase the size of the workforce in any particular area.

We have the discussed the matter previously, and we all agree that workforce planning is not an exact science by any means. However, we are working on what we can do to focus our planning more on the data that we have and to fill in the data gaps.

David Stewart: I understand that—it seems sensible. Clearly, that will take time. The Government has specific controls over GP training, which I will touch on in a second. Should the Government take a greater role in training in the future? For example, the Government might set long-term targets for AHPs, so that there is better workforce management in four or five years’ time, when new graduates are ready to work in primary care.

Jeane Freeman: That is one option. However, we must remember that there are a number of players in the field, as there are in GP training and in relation to medical undergraduate numbers. The Government’s view about what is needed is informed, in part, by our medical schools, our royal colleges and the data that we have. There are practicalities relating to putting people through the training, the length of time that that takes and what we can do to retain in the Scottish health service the people in whom we have invested training.

We have seen an example of what might be possible with the Scottish graduate entry medicine—ScotGEM—course, and the bursary that links to a commitment to work for the health service on qualification. NES, our education health board, has a central role in the curriculum, training and numbers and in helping us to plan that activity. For doctors, there are the deaneries and so on.

David Stewart has described one way in which we could go, but we need to take all the players with us and to maximise what they offer us through their expertise. With the greatest of respect, we do not want to get into a position in which I decide that we need X or Y without there being a decent amount of evidence behind that decision and the knowledge that the people who will deliver the work are ready to do so. That includes providing AHP training places. Recently, we have done work to ensure that we can offer more training places once we know that those places will be available.

David Stewart: I was in no way suggesting that the Scottish Government should delete the great influence of the professional associations in each case. I was making the point that the organisations that I have spoken to say, “Yes, but we need more funded places at universities to allow the development of workforce planning.” Obviously, that responsibility lies across Government, not only with the cabinet secretary, but a lot of work with her colleagues will be required to provide more funded places. I am sure that universities wish to expand, but there needs to be agreement on the issue.

Jeane Freeman: We have increased the number of places for medical undergraduates, and we have taken steps to ensure that a greater proportion of those places go to Scotland-domiciled students. The number of nursing and midwifery student places has now increased for, I think, eight years. From next year, all such places will carry a non-means-tested bursary of £10,000. We continue to increase the number of training places that are available in dentistry and in AHP work, particularly in physiotherapy.

We have a critical role to play, but we need to marry what we are doing to increase the number of places with improving the data on which we base what we need. So far, we are doing that reasonably well, by and large, but there are undoubtedly data gaps that we need to fill.

David Stewart: You have predicted my next question, which is on GPs. The additional 800 GP places that the Government predicted were generally welcomed, but Audit Scotland had some questions about what modelling the Government did to get to the figure of 800.

11:45

Jeane Freeman: In arriving at the figure of 800, we used trend data for the previous five years on the age and sex profile of the GP workforce, the number of newly qualified GPs, the rates of qualified GPs joining our NHS in Scotland or moving from Scotland to elsewhere and the numbers leaving through retirement, as well as the data estimates of the number of GPs in the workforce, which remain broadly stable up to 2027, which is the point at which we will hit the increase of 800.

Actually, the figure that that process produced—we can give you the detail of how it was all worked out if that would be helpful—was that an additional 700 GPs are required. However, the Government decided to increase that to 800 to allow for the unexpected and the degree to which our calculation, which was based on all the factors that I have just outlined, might be plus or minus a percentage point. That was how we got to 800. The figure is more or less in line with the view of the Royal College of General Practitioners, although I think that its figure is 830.

David Stewart: How do you react to Audit Scotland's criticism that the modelling does not appear to be accurate? Does that relate to your earlier point about data? If you do not have obvious data, it is surely nightmarishly difficult to do such modelling.

Jeane Freeman: It is difficult, although not nightmarishly difficult, to do the modelling. That is why I keep coming back to the point that there are data gaps that we need to fill in order to continue to refine and improve our modelling. After modelling is carried out, it is tested with our colleagues and partners, based on what other work they may have done—in this instance, it was the Royal College of General Practitioners—and estimates are then produced. However, improving the data will undoubtedly improve the modelling, which will improve the outcome. That is why I keep returning to the point about filling the data gaps.

David Stewart: With any modelling, it is important to look at the real world. I know from talking to individual GPs around Scotland, particularly in the Highlands and Islands, and the royal college, that there are a couple of big factors, which the cabinet secretary will be well aware of. One is that pension restrictions, which are a reserved matter, have led to major issues for GPs and consultants who wish to work full time, particularly when they are post-55. That is real-world experience. As the cabinet secretary, you might think that having a certain number of graduates on day 1 will mean that, in 40 years, you will have a certain number of full-time equivalents, but you will not. The reality is that, because of the pension restrictions, work pressures and other issues, it is hard to find full-time GPs who are older than 55.

The other change that I have picked up from my experience is that many GPs do not wish to become the traditional partner in a GP practice; they are happy to be salaried or to have another role in a practice. That affects workforce management. You will not have those full-time people post-55, and you cannot change the pension situation, because it is a reserved issue.

Jeane Freeman: Yes, you are right. That is partly why I say that it will never be an exact science. You mentioned two issues. I will come back to pensions but, setting that issue aside for the minute, work by the Royal College of Physicians and Surgeons of Glasgow and the Royal College of Physicians of Edinburgh on the post-55 medical group has shown that, regardless of pensions, as people approach that time in their career, they want to make changes. They do not necessarily want to leave medicine, but they may want to undertake less onerous rota work or to work fewer hours.

We have that data from the royal colleges. The samples are small but, nonetheless, they are important indicators of trends over time such as the increasing proportion of the post-55 group that is looking to move out of full-time work, totally or in part. That can be factored into our overall planning.

At the other end, we have data from the royal colleges about the number of medical graduates who take time out before their foundation-year training—often, graduates want to go abroad and gain experience—and the percentage of those graduates who come back to us.

We can factor all that in. There is data elsewhere that we can use, in collaboration with colleagues, to make the process slightly more robust by taking account of factors that might otherwise not be taken account of.

The Royal College of Surgeons has a programme for consultant surgeons who are in that older age group and who do not want to leave medicine but do not want to continue being part of the rotas that they have been part of. With our support, the programme is looking at enabling such surgeons to work, for example, outside the urban setting and in more rural settings, and to undertake training work. There are opportunities in that regard.

On pensions, you are absolutely right. The issue could not have been predicted. It happened; a decision was taken, and I think that the UK Government increasingly understands that there are consequences to that decision that are affecting the health service in a range of ways, not only in Scotland but south of the border. Work is under way, which I hope to finalise and agree shortly, to allow us to provide for some alleviation of the pension position for people who are affected in this financial year, while we wait to see what further flexibility the UK Government might introduce from the next financial year.

The Convener: I think that you made an offer to Mr Stewart to share the calculations with the committee. In making those calculations, how far did the Government take into account the changing role of GPs under the new contract? Do the calculations suggest a need to set targets for other members of the multidisciplinary team?

Jeane Freeman: The calculations were made prior to the negotiation and agreement of the GP contract. As the contract rolls out and we see what it means, we will reach a point at which we will revisit the calculations to see whether roll-out—certainly of phase 1; phase 2 is coming—has had a significant impact on them. At that point, we will consider whether we want to make changes. At this stage, we have not done that, because the GP contract is still being implemented in phase 1.

Aidan Grisewood (Scottish Government): May I make a supplementary point? There are a few things that will help us with the modelling. The workforce tool that is going out to practices will give us an accurate picture of not just the number of GPs but the number of sessions worked, including by other workers in the practice, which is an important bit of evidence. We have also undertaken workforce survey work about individuals' wellbeing and job experience. In addition, a data tool is going out on incomes of GP practices. As we go forward and start to use all those tools year on year, we will learn about trends and we will be able to interrogate the data to see whether the issues that we are talking about are having positive or negative effects. Over time, we will be able to build up a better picture. It takes time to build up knowledge about trends and issues that can definitively be related to specific events or the nature of work.

Emma Harper: I am interested in the role of the third sector. The committee has had evidence on the important role of community link workers in signposting and even accompanying people to services and in engaging with third sector partners. Expectations to deliver many services are increasing for the third sector. How do we support and sustain the third sector, especially if conflict arises with competing budgets over who is asking for different pots of money? How will the Government ensure that the sector is adequately funded and involved in the planning, design and benchmarking of services? Will the Scottish Government ensure that the third sector is free from barriers, in order to support collaborative working?

Jeane Freeman: On your first point, community link workers are proving very successful. Recently, I had an email from a GP practice in the east end that extolled the virtues of its community link worker and thanked us for continuing the funding for that. We are nearing the completion of the roll-out of those 250 community link workers by the end of this parliamentary session.

Third sector organisations are represented on that ministerial strategic group on integration. Although I keep talking about it, primary care, as well as what we do in adult social care, is right up the middle of integration. Third sector organisations are part of that. IJBs across the country actively engage with third sector organisations in their planning and, to a degree, in their commissioning. However, that is not the case in every IJB. We need to work with third sector organisations to find out what more is needed to encourage that engagement across all IJBs. IJBs have a responsibility to plan and commission services that best meet the needs of their local population. That does not mean that the third sector will always be the provider. Third sector organisations have to meet the same criteria as any other provider over standards for quality and accessibility of service and value for money. Many third sector organisations work actively to ensure that they do that. For example, Enable Scotland and Sense Scotland recently came together to make a better offer in their area of specialist, necessary provision of high-intervention 24/7 care packages. Third sector organisations are considering what more they might do to increase the engagement and the attractiveness of their offer to the IJBs.

Emma Harper: Because they focus on their community in their locality, community link workers do different jobs in different areas in different boards. A wider range of services might be needed in rural areas—such as my South Scotland region—than in urban areas. How will the Scottish Government evaluate and monitor the impact of the community link worker programme? How do we future-proof the programme?

Jeane Freeman: Thank you for that. In answer to your previous question, I should have said that we have approved three-year funding for third sector organisations. That is a significant advance that was made by my colleague Angela Constance, when she was Cabinet Secretary for Communities, Social Security and Equalities, to provide a degree of stability for organisations in respect of planning.

We commissioned NHS Health Scotland to undertake qualitative work on an evaluation of the first sites to have community link workers, in order to understand the impact that the workers have and to consider how we might develop the role, albeit that it should meet local needs. For example, in the GP practice that wrote to me, the link worker primarily works on financial advice and access to benefit services. Of course, some of the additional work that is done by local staff in Social Security Scotland might free up community link workers to do less of that so that they can concentrate on other areas.

12:00

Naureen Ahmad (Scottish Government): In 2017, the University of Glasgow did a comprehensive evaluation of the link worker pilots. There is a lot to be learned from that report.

Emma Harper: Is NHS Health Scotland responsible for a national training programme for community link workers, or do we—perhaps because what they do is so different—have a national programme after which they receive training locally?

Naureen Ahmad: No. Community link workers are chosen on the basis of their experience and skill sets, so that they can work with patients who are in a wide range of difficult circumstances. Because they are employed on that basis, there is no formal national training programme, but they are provided with bespoke training that depends on the local population's needs.

Brian Whittle: There is an expectation that there will be continued pressure on the third sector to deliver services. We all recognise the sector's ability to shoulder that work, especially the organisations that deal with specialist issues.

I will give a couple of examples that are local to me. Ayrshire Cancer Support and Break the Silence provide specialist mental health services to which the NHS signposts patients. Both organisations report that they have growing waiting lists. Against a backdrop of the increased awareness of mental health issues and the growing budget for mental health, is there a need to look at the framework for how such organisations are financed? They currently have capacity issues, so doing that might allow them to shoulder the load.

Jeane Freeman: As you know, North Ayrshire IJB is the lead IJB for all of Ayrshire for mental health provision and support. Therefore, in that or comparable examples, I would expect North Ayrshire IJB to actively seek, from all the third sector organisations that deliver mental health services in the three Ayrshire council areas, concerns and issues about the nature of the services that they deliver, and where they are in terms of demand versus capacity. I would expect the IJB then to factor into its commissioning and planning whether it can make better use of those services and provide the financial support to see them delivered.

Because of the significant resource that we are committing to integration, IJBs must take the lead in deciding who should be the providers, in our communities, of the mental health services that we need at different stages. That will be a mix of what is done directly through the health board—for example, child and adolescent mental health services and adult psychiatric services—and what the third sector can provide.

Brian Whittle: I appreciate that the Government has a desire and a pathway to achieve that, but the reality is that money is not getting past the IJB, probably because there are pressures across all the services. Given that the IJB holds the purse strings, how do we ensure that the organisations that are running services to which people are being signposted by the NHS get their fair share of the funding in order that they can deliver those services?

Jeane Freeman: That is an important question. I am sure that there are, in mental health and other services, variations of that scenario elsewhere in the country, but there will also be examples of the system working really well. I hope to understand what those variations are—from Brian Whittle and others—and factor that into the work that David Williams is doing on our behalf with all the individual IJBs, so that they can deliver on the joint review's recommendations within its clear timescales.

All the IJBs know that they should give priority to mental health provision. As partners in the exercise, that has been agreed between the Government and the Convention of Scottish Local Authorities. We can perhaps assist them in that, and help them to learn from one another about good practice and areas of difficulty. I am very happy to find out about examples such as Brian Whittle outlined, and I undertake to ensure that David Williams can pick that up in the work that he is doing with the Ayrshire IJBs.

The Convener: Thank you very much. I will bring in Miles Briggs, but first can you tell us when the roll-out of the 250 community link worker posts will be completed? Where will those posts be?

Jeane Freeman: The roll-out will be completed within this parliamentary session—by 2021. We will make sure that we have the information on where they are located. We will also bring together the information to date that we have, if you wish. There will be more to come, and we will make sure that the committee receives it, too.

The Convener: That would be very helpful.

Miles Briggs: Thank you, convener, and good morning to the panel. I want to touch on some of the areas that we have heard about already in relation to the Audit Scotland report. One of the key challenges that it outlined was that the Scottish Government has, to date, introduced major policy changes without having a reliable basis for its plans.

I am concerned about the destabilisation that we sometimes see. With community pharmacy, for example, pharmacists moving into acute GP settings has created a situation in which community pharmacies are now finding it difficult to recruit. Also, pharmacies that I have visited speak about the additional cost of locums. I know that the cabinet secretary has outlined some of her thinking around future proofing that workforce, but where is actual real-world data now being collected to see where there is destabilisation?

Jeane Freeman: Give me two seconds to find my relevant bit of paper.

That is something that we understand is happening. We also see it with, for example, advanced nurse practitioners, for which we are putting significant training in place and for which there is growing enthusiasm among nursing colleagues to take up the opportunities. I was talking to one of our health board chief executives yesterday who said, “I keep training them but I keep losing them”, because they are moving into GP practices and into out-of-hours work. We will almost inevitably go through a period in which we see, as we produce more advanced nurse practitioners, a skewing in respect of where people go to work, before the situation evens out. I am not sure that there was a great deal that we could have done to avoid that.

We need in such instances to talk to community pharmacies, for example, about what more we could do to assist them. We have increased the numbers in training and the numbers of pharmacy technicians. In some instances, a pharmacy technician is appropriate for a GP cluster, rather than there being one pharmacist for a number of clusters with technicians undertaking some of the work.

I think that as we go along the transformation journey we will see the situation tilting back and forth before it settles on a relatively even keel. I asked the health board chief executive whom I mentioned what they would need in order to train more people and what more we could do to smooth the path a bit more. One health board has made significant use of theatre academies and nurse academies to upskill its existing staff and is looking at what more it might do in that respect.

Miles Briggs: The situation is something that we need to monitor—sometimes unintended consequences occur.

I want to move on to GP contracts and a few specific points about phase 2. What do you hope to achieve through phase 2? When do you anticipate negotiations and a poll of professionals on phase 2 of the contract taking place? You have outlined specific concerns in the past, and I know that concerns have been regularly expressed in this committee, about rural GPs. You pointed towards there being almost a second level of the GP contract, or a specifically rural GP contract. Is that your plan?

Jeane Freeman: Phase 2 is, of course, part of the contract’s being negotiated. One of the things that we want to achieve in phase 2—as, I think, does the British Medical Association—is consolidation of stability in funding for GP practices. The data collection that my colleague mentioned earlier is critical in giving us an evidence base on which to enter and conclude those negotiations.

As for rural GP practices, of course we have benefited significantly from the expertise and leadership of Professor Sir Lewis Ritchie. We have been able to consolidate the group of rural practitioners that he leads, which was initially a short-life working group. It is no longer a short-life group: it must give input on that contract, so that when we negotiate phase 2 we are fully aware of the issues that rural GPs want us to address. The group will not be in the negotiations, but it should certainly inform what we do.

We have undertaken to ensure that there is greater clarity around the flexibilities that exist in the current contract. I hope to be able to say a bit more on that shortly. Sir Lewis Ritchie’s report, with a number of recommendations from the rural GP group—partly about phase 1 of the contract and what more we can do within that, and partly beginning to set out what it thinks are the key issues for phase 2—should be with us at the end of this month.

Was there a third part to your question, Mr Briggs?

Miles Briggs: The third part was about having a separate contract. The last time there was a negotiation, rural GPs would have said that they were asked for their views, but were not necessarily part of the contract. The contract often influenced rural GPs’ work differently, specifically in relation to some of the problems that they have highlighted, from not being able to register patients from outside the area to carrying on doing work that we are trying to move away from them, such as vaccinations. Could we therefore have two contracts, one of which is rural-areas specific?

Jeane Freeman: There are two key things to remember. The first concerns what I said about flexibilities in the existing contract. We have made it very clear that there is flexibility for existing GP practices to continue vaccinations: we do not have to centralise that. There are a number of areas where that issue has been resolved, and we will do more on that.

Secondly, the contract comes from a process of negotiation with the BMA, and I do not anticipate its being minded to have two contracts. I can understand why that is—although the BMA has a responsibility to listen to its rural members and to ensure that what it brings to the negotiating table in terms of what it is looking for in that contract includes due consideration of what its rural members have said about phase 1 and phase 2.

Rural GPs have my absolute assurance that we will take proper account of what the group that is working with Sir Lewis Ritchie is saying. The group is generally recognised as being pretty representative of the rural GP community. We will take due cognizance of what it says and we will look to do one of two things. We will either factor that into our negotiating position, where we believe that that is possible, or, where we believe that it is not possible, we will ensure that we explain that to rural GPs, rather than wait until there is a done deal, thereby making them feel as though they have been ignored.

Miles Briggs: On that point, in terms of the patients whom we are trying to deliver services for, in his evidence Sir David Hogg specifically said:

> "Our patients are among the best judges of how services are run. For negotiation reasons, patients were not so involved in the design of the contract." —[*Official Report, Health and Sport Committee*, 1 October 2019; c 48.]

Is there improvement in that respect for phase 2?

Jeane Freeman: That is a very interesting point. We hope that we will negotiate and conclude phase 2 by 2021, although a number of factors will play into that—not the least of which is data collection.

I am not sure that we have given consideration to that point about the patients' view. However, I am happy to commit today that we will give consideration as to how that might be taken forward. When we have reached a view, we will advise the committee.

12:15

Miles Briggs: In recent weeks, there have been issues with destabilisation of GP practices—for example, the Bridge of Earn surgery. My colleague Liz Smith has had meetings with you about that. In order to prevent such situations, how can we monitor unstable practices so that we get ahead of that curve? In the Lothian region, practices often do not flag up their workforce challenges, and then they hand back the keys. Do you have any statistics on practices that have an unstable workforce?

Jeane Freeman: It is the health boards' role to understand where their GP practices are and to identify where there might be areas of risk. We encourage them to get ahead of the curve. That is not always easy for them to do: because GP practices are independent contractors, like any small business, they can operate in a way that means that they are not compelled to give us all the information that the NHS, as a public service, might require in order to plan. Sometimes, the destabilisation happens quickly, with no notice given to the board, so the board could not have foreseen it. In those circumstances, the board needs to have processes in place to respond quickly. The situation could be a bit better but there are constraints around the boards' ability to be fully confident that they understand the situation in all their GP practices and can identify those where they anticipate difficulties.

Naureen Ahmad: We have a sustainability group looking at getting ahead of the curve, which brings together representatives from across Scotland to anticipate any issues that might arise. Mostly, the issues are managed well at health board and partnership level. We want to anticipate the issues by coming together and considering the tools at our disposal to prevent destabilisation from happening.

Jeane Freeman: For phase 1 of the GP contract, we put in place measures such as financial support for rent and the refurbishment of premises—measures that are designed to address the key risk areas around the sustainability of GP practices. Those measures have been well received and have had a significant impact on some practices.

Miles Briggs: If I could—[*Interruption*.]

The Convener: We need to move on.

Miles Briggs: We will write to you on that point, cabinet secretary.

George Adam: Audit Scotland told us that the audit trail for GP surgeries stopped at the GPs' door. It said that it was difficult for the Government or anyone else to move the strategy forward. As we progress with the negotiations, will we be able to follow the public pound?

Jeane Freeman: Audit Scotland is right; I have already touched on the reason for that. We are dealing with independent contractors—and have been since the creation of our national health service; it is not a new phenomenon. Although GP surgeries contract with the health service to deliver a service, they operate as a business. Therefore, when it comes to the provision of data, there are limitations on what can be required of GPs. That is why phase 1 of the GP contract included an agreement that we would conduct the survey that we have already touched on and which will be issued shortly, so that we understand issues around GP practice income, premises and other matters. My colleagues can add to that, if they wish to.

There will be a period of about three months for GPs to provide their returns to us. That will be a step forward in providing what Audit Scotland is entirely legitimately asking for. It should be able to audit the public pound and see where it goes. There are restrictions on doing that that are not of our making—they are part of the system and have been for a long time. However, we are looking to see how far we can go in trying to audit the public pound.

George Adam: On the system, I take on board the fact that having independent contractors in the NHS right from day 1 was a key reason why we were able deliver the service. However, the debate that we are having now seems to be about salaried GPs. The BMA will say that they cost a fortune compared with other GPs, but there is no guarantee that it is right, as it has not given us the figures to confirm that.

How do you see the system going forward, with all the challenges around GPs that we have outlined today? I am not asking you to reinvent the wheel or rebuild the system from scratch. We are where we are. However, we have the independent contractor model—which to this day surprises members of the public, who think that their GPs are NHS employees—and the salaried board model. Will it be a mix and match approach? What do you see as the way forward for delivering the service?

Jeane Freeman: I think that it will be a mixed economy of independent contractors and salaried GPs. That will be driven in part by younger GPs emerging who want to be a GP but who do not want to run a business. People tend to think that salaried GPs appear only when a practice falls over and the health board has to step in. Although that is the case to a degree, increasingly the drive comes from younger, newly qualified GPs, both men and women, who want a different role. They do not want to run a business; they want to see what else they might do as a GP. They may, for example, take on a clinical fellowship, a training role with medical graduates coming through GP training, a role with the local academic institution or any variation of those roles throughout their career. They want to be able to do that and I want to encourage them to do it because that begins to reinforce the status of the GP inside the medical profession, which is really important. I think that a mixed model of independent contractors and salaried GPs will emerge. At the end of the day, the provision of the service to the patient and the maximising of opportunity for innovation and new ways of delivering are the critical things that we want to see.

The Convener: Thank you, cabinet secretary.

You mentioned that, under phase 1 of the contract, GPs have three months to complete and return the survey on matters relating to the public pound. What happens if they fail to meet that requirement?

Jeane Freeman: In the first instance, we would go to the practices that have not returned the survey and ask what the problem is and see whether we can help. There may be questions in relation to which they might not be sure of their answers, which we might be able to assist with. We certainly would not want to jump straight into waving contracts at people, so we will try to help. The BMA will be actively engaged as well, because that requirement is part of the contract that it negotiated, and it is fully supportive of it. We will assist practices that may have half-completed the survey and so on; then, if we are left with one or two that are not returning the survey, we will discuss with the BMA what to do.

The Convener: In entering into phase 2 of the contract negotiations, will you have greater ambitions as to how to enable the tracking, by you and by us, of the public pound in relation to general practice ?

Jeane Freeman: Yes. We will know in part whether that ambition is realisable in the context of independent contractors by how well GP practices respond to the survey and what use is made of the data that comes through. Fully implementing phase 1 and keeping going is important, and I think that that assisted in achieving wider recognition that, notwithstanding independent contractor status, everyone is working for our national health service and for the patients whom we are there to serve. If we can co-operate better in the planning, commissioning, design and delivery of services and the infrastructure that sits underneath, we will deliver better services, so the roles will be increasingly fulfilling.

Brian Whittle: I will move on to the report by Professor Sir Harry Burns, “Targets and Indicators in Health and Social Care in Scotland”, which looked at developing a set of indicators that would allow us to understand

> “the contribution of multi-disciplinary primary care ... to improving outcomes for Scotland’s people.”

Where are we in developing that set of standards and indicators?

Jeane Freeman: Do you mean in order to understand the contribution of the multidisciplinary team?

Brian Whittle: Yes.

Naureen Ahmad: We can get back to you. I do not think that we know where Professor Sir Harry Burns’s review—

Jeane Freeman: Is it in the engagement part?

Phillip McLean (Scottish Government): We have published a primary care monitoring and evaluation strategy, which sets out a framework for the evaluation of primary care reform over the next 10 years. As part of that, work will be undertaken to identify the effect of the expansion of multidisciplinary teams on primary care and the wider system.

Brian Whittle: We discussed social prescribing at the committee's meeting on 29 October, when an effective indicator of success when measuring interventions was said to be that the inequality gap is not widened. At that meeting, Dr William Bird talked about involving people from the areas in the bottom 20 per cent of the Scottish index of multiple deprivation, which I found interesting. Are there indicators to ensure that the 20 per cent are involved in the prevention element? How do we measure that?

Jeane Freeman: With something such as social prescribing, before we leap to how we measure it, we need to look at how we roll out the understanding of its value more effectively. We could target the roll-out in areas of multiple deprivation, as we do with the community link workers, so that, before we measure impact, we make sure that we are focusing on the right places. Part of the realignment work in relation to population health involves looking at how we tackle health inequalities and, within that, focusing on areas in which inequalities are starkest.

Over the past 20-odd years, we have tended to send out our messages on health, healthier diets, exercise and so on on a population-wide basis. The advert showing the best-looking builder I have ever seen with a banana at his ear, supposedly phoning somebody, is still stuck in my head. However, as a consequence of that approach, generally speaking, we have seen that the population has got healthier, although the gap remains.

12:30

My clear view is that I do not need targeted messages about eating more healthily, exercise, smoking and alcohol. I am fortunate; I have huge advantages and, if I am not doing what I need to do, that is my informed choice, because I have access to all that information. We need to target our health inequalities work, so that the changes are more accessible to people. That includes social prescribing. We need to refocus the work so that we get it pointed in the right direction. We want to roll out social prescribing in a phased way and win acceptance of it by patients and the professions. We will then work out how to measure its impact, both qualitatively—how people feel about it—and quantitatively.

A small example is the one that I gave earlier about blood pressure monitoring in East Kilbride. The staff produced data about how the patients who were engaged in that programme felt about ease of access in looking after their own health and the impact on them of checking their own blood pressure and seeing it change when they took certain steps. That was all about social prescribing. Harder data, in relation to drug prescribing for those conditions, were produced at the GP end. There is work for us to do on some of those harder and softer measures, but we need to point the focus of that work in the right direction and build the measures in behind it.

Brian Whittle: I agree with that targeted approach. For clarification, is the Government's objective to target those services to make sure that there is accessibility around a wide range of steps, including social prescribing? Will you then put in place a set of criteria that will give measurable outcomes for the health of that population?

Jeane Freeman: That is exactly the work that Richard Foggo is undertaking. Its links back to an earlier question about the cross-portfolio work. In order better to look after our health, some of the actions on accessibility that we need to take link into local government provision, such as the availability of consumables in areas of deprivation—housing, whether there are enough shops or the right shops and how many licensed premises there are. A range of steps need to be taken.

Emma Harper: With the first panel of witnesses, we talked about the pace of change in relation to technology advances, implementing digital platforms and supporting people. Transformational change can take a long time. My former colleagues in the NHS say that transformational change can take up to 10 years. Are you content with the pace of change? As a previous healthcare employee, I know that, if change does not happen quickly enough, it can be frustrating for many people.

Jeane Freeman: Your timeframe is broadly right. Transformational change runs in a five to 10-year timeline. It is wrong to think that it can happen any quicker. I am never content with the pace of change. I am an impatient person and, when I see good practice not being replicated, I am frustrated. I am impatient with talk of sharing good practice when I want people to stop talking about it and implement it. However, the only way to secure sustainable change is to take people with us. We do not secure it by diktat or instruction.

We need to get the balance right. I am sure that the committee knows that it is clear that peer-to-peer work is hugely successful in the health service. One of the big changes on which the atlas of variation builds started with orthopaedic surgeons auditing their work and looking together at the length of stay and time in operations for patients and the devices that they used. They then looked at who the outliers were and improved their practice as a consequence. That is the core that sits underneath the chief medical officer's atlas of variation, which is used in that way.

GP clusters, in which GPs come together, learn from one another, innovate and develop and implement good practice, are a comparable approach. There is a balance to be struck between my drive to increase the pace of change—I do not think that it is fast enough yet—and the absolute imperative to take people with us; in many ways, they have to lead the change if it is to be sustainable.

Politicians are here today and gone tomorrow, but clinicians are with us for a very long time. Advanced nurse practitioners, physios and leaders in social care are with us for a career. They need to be in the leadership role and be convinced that the change that they are making is one that improves the outcome for those with whom they are working. We can do some things faster, which is why the ministerial strategy group has a set of minimum recommendations that came out of the review; they have a very tight timescale and focus on the minimum that needs to be delivered across all our IJBs and health and social care partnerships.

Health boards have a critical role at their end of that delivery, as does local governments at its. You can pursue some areas of change faster but, overall, the transformation is a process of taking people with us by negotiation, by persuasion and by looking at the levers that we can use. The GP contract is a good example of a lever that can be used to facilitate change.

Emma Harper: We talked earlier about the once-for-Scotland digital strategy and taking a more national approach to digital. As a rural South Scotland MSP, I have an interest in ensuring that no inequality occurs because of a disparity between rural and urban areas. Are you happy that the approach that is being applied across Scotland will reduce the variation between health boards in digital?

Jeane Freeman: I am. That is the intent of the strategy. Where we have the capacity to direct the pace of change, we need to get away from the notion that what happens in health board X will inevitably be different from what happens health board Y, even though the population cohorts that they are serving are not markedly different. That is why, in previous discussions with the committee, I have talked about health boards as the delivery arm of the NHS in Scotland, not as autonomous bodies. There are areas in which we can secure faster change but, overall, those who will deliver it have to be brought with us.

Brian Whittle: We have heard from a variety of stakeholders who are looking at the idea that the ownership of the data should be with the patient. That is fairly universal—apart from the BMA, funnily enough. Does the cabinet secretary think that the transfer of ownership would facilitate data sharing among relevant professionals and tackle the issue of the general data protection regulation getting in the way of more free-flowing information?

Jeane Freeman: My view is that the ownership of the data should absolutely be with the patient. As far as I am concerned, the data that is held in my medical records is my data. I understand the clinical anxiety and concern around that; there is anxiety about the way in which the data is held and about whether the content could be misinterpreted and misunderstood by a layman. We need to work our way through that. We need to reach a point where data sharing is much less of a big deal—I cannot think of another way of putting it—than it is at the minute.

There is some work under way, which I will ask my colleague to talk about, on the sharing of the emergency medical record, which will make a difference for pharmacy and so on. We need to take things step by step. This is partly about what I said to Ms Harper, as people need to come with us. If people are saying that they do not want to do something, we need to understand why they do not want to do it and what concerns they have, so that we can overcome those concerns and reassure people. People may then be entirely with us and reassured—or there may be some concerns left on which we were never going to agree, so we will just have to proceed.

Before I pass to my colleague on where we have got to with the emergency medical record, I would give an example from social security. As you know, in taking over responsibility for disability payments, Social Security Scotland is committed to reducing the number of individual medical assessments that need to be done. Part of that involves being able to confirm an individual's condition from a third party, which could be their GP. There was an initial discussion on that with the BMA, and considerable concern was expressed about another public agency accessing medical records and information. That has been worked through. It is circumscribed, and there are clear protocols about who gets the information, exactly what information they get, what they do not get and how the information is used. Most importantly, where in all of that is the permission of the individual who is seeking that support? There are ways through some of those concerns, but we need to take time and work our way through them.

The Convener: With a view to the time, we will ask your team to provide a note on the emergency medical record later.

Miles Briggs: I wonder whether the officials could write to us on another matter that relates to Emma Harper's question. How has the GPs transformation fund been utilised across Scotland, specifically in different IJBs? In my local IJB here in Edinburgh, that money has been used to reduce debt, not to do the work to transform GP surgeries. I think that the health board has estimated that about £60 million is needed for that. I am interested to find out when the Government thinks money will be spent on transformation. It is sometimes being used to take debts down.

Jeane Freeman: That would be of some concern. There is separate funding for premises, to which I alluded earlier. We will write to you on where we are with the primary care transformation fund, which I think is what you are referring to. We will ensure that you have the information that we have to date.

Emma Harper: I have a final quick thought. When we took oral evidence from Dr Carey Lunan, who is the chair of the Royal College of GPs Scotland, she spoke about asking for a national programme to educate people about changes in primary care. She then discussed the question of what "multidisciplinary team" means, as well as issues around AHPs. Could you write to us about what update is being provided nationally to inform people about that?

Jeane Freeman: There is quite a detailed programme of work going on involving the Royal College of General Practitioners, and we will write to you with that detail.

The Convener: When do you expect to publish the national integrated health and care workforce plan ?

Jeane Freeman: It will be published by the end of this year.

The Convener: Thank you very much.

Jeane Freeman: I wonder whether your colleagues would drop me a line about all the things that I have said we will write to you on. I know that my colleagues will have taken a careful note, but that would be a help.

The Convener: I can assure you that you will get you a note to that effect. I thank you and your team very much for your time this morning—and afternoon. It has been very helpful.

12:44

Meeting continued in private until 12:50.

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