The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 1 April 2014

Session 4

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HEALTH AND SPORT COMMITTEE
11th Meeting 2014, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr John Budd (Lothian Deprivation Interest Group)
Dr Andrew Buist (British Medical Association Scotland)
Dr Pauline Craig (NHS Health Scotland)
Lorna Kelly (NHS Greater Glasgow and Clyde)
Professor Graham Watt (General Practitioners at the Deep End)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Tuesday 1 April 2014

[The Convener *opened the meeting at 09:45*]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the 11th meeting in 2014 of the Health and Sport Committee. As usual, I ask everybody to switch off mobile phones and BlackBerrys, as we do not want them to interfere with our business this morning. Officials and some members are using tablet devices instead of hard copies of the committee papers.

Agenda item 1 is a decision on whether to take in private item 3, which is consideration of our work programme. Do I have the committee's agreement to take item 3 in private?

Members *indicated agreement.*

Health Inequalities

09:45

The Convener: Agenda item 2 is a return to our themed work on health inequalities. This is our second round-table session on access to services and involves a number of academics and professional bodies. I welcome you all. I invite everyone to introduce themselves before we start with the first question.

I am the MSP for Greenock and Inverclyde and the convener of the Health and Sport Committee.

Professor Graham Watt (General Practitioners at the Deep End): I am a professor of general practice at the University of Glasgow and I represent general practitioners at the deep end.

Bob Doris (Glasgow) (SNP): I am an MSP for Glasgow and the deputy convener of the Health and Sport Committee.

Nanette Milne (North East Scotland) (Con): I am an MSP for North East Scotland.

Dr Pauline Craig (NHS Health Scotland): I am the head of equality at NHS Health Scotland.

Aileen McLeod (South Scotland) (SNP): I am an MSP for South Scotland.

Rhoda Grant (Highlands and Islands) (Lab): I am an MSP for the Highlands and Islands.

Dr John Budd (Lothian Deprivation Interest Group): I am a GP at the Edinburgh access practice, which used to be the Edinburgh homeless practice. I also work with the drug and alcohol service in Lothian and I co-ordinate the Lothian deprivation interest group. The group consists mostly of GPs but includes other primary care workers and some social care workers, and we work for high-quality, accessible primary care services for deprived and disadvantaged communities and groups.

Colin Keir (Edinburgh Western) (SNP): I am the MSP for Edinburgh Western.

Gil Paterson (Clydebank and Milngavie) (SNP): I am the MSP for Clydebank and Milngavie.

Lorna Kelly (NHS Greater Glasgow and Clyde): I am the head of policy at NHS Greater Glasgow and Clyde. I also represent the NHS Greater Glasgow and Clyde primary care deprivation group.

Richard Lyle (Central Scotland) (SNP): I am an MSP for the Central Scotland region.

Dr Andrew Buist (British Medical Association Scotland): I am a GP in Blairgowrie and the deputy chairman of the Scottish general practitioners committee of the BMA.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am an MSP for Mid Scotland and Fife. I refer to my entry in the register of members' interests: I am a fellow of two of the medical colleges.

The Convener: Thanks for that. Richard Lyle will kick off the questions.

Richard Lyle: Good morning. We have seen various reports, including one in particular by general practitioners at the deep end, which the witnesses may or may not have read. The report, which is entitled "What can NHS Scotland do to prevent and reduce health inequalities?", makes various suggestions, including

> "Additional time for consultations ... Support for serial encounters and the productive use of long term relationships"

and

> "Attachment of staff from area-based services",

and mentions a number of other things. My question is particularly to the BMA but also to the other witnesses. The BMA's submission suggests that

> "An integrated approach to health inequalities is essential for reducing these health differences".

I would be interested to hear Dr Andrew Buist's view on the deep-end GPs' report.

Dr Buist: As I said, I am a GP in Blairgowrie. It is not one of the deep-end practices, but we have pockets of deprivation within Rattray, so I am familiar with some of the problems that are described in the deep-end report.

The solution to health inequalities lies with local services, and action starts with primary care, not in hospitals. Only by tackling health inequalities through primary care with public health support can we reduce health inequalities. By local services, I mean a one-stop shop that is built around a GP surgery, with a GP, a social worker, a community psychiatric nurse, a drug and alcohol worker and a benefits adviser all in the one place. That arrangement would tackle the transport issues that cause difficulty for many deprived people.

I refer the committee to the Kerr report, which is an important document that the Scottish Executive commissioned in 2005. In the executive summary, Professor David Kerr said that we need to

> "view the NHS as a service delivered predominantly in local communities rather than in hospitals; 90% of health care is delivered in primary care but we still focus the bulk of our attention on the other 10%—our current emphasis on hospitals does not provide the care that people are likely to need."

In 2005, we spent 9.4 per cent of the national health service budget on general practice. Since then, the percentage of NHS spend on general practice has reduced to 7.8 per cent. That is why we support the national campaign of the Royal College of General Practitioners—which is, unfortunately, not here today—to increase the percentage of NHS spend on general practice to 11 per cent by 2017. We—that is, politicians, health boards, the media and subsequently the public—have insufficient focus on primary care, and we need to do something about that.

The Convener: Does anyone want to pick up on that theme?

Professor Watt: A very important issue is the extent to which the Scottish NHS has historically been and is still orientated towards hospitals and a hospital culture that is based around single diseases and specialties. It is an old paradigm, and most of the research in the universities is based on the same paradigm. That means that the huge number of patients nowadays who have several conditions and do not fit into single disease specialties are not the focus of attention. The evidence base does not inform how best to look after them. A big paradigm shift is required in our focus, away from the narrow hospitals focus to the broader, unconditional approach of primary care. That is very much an integrated care challenge: we are not short of resource; rather, we are short of joined-up resource.

There are three reasons why dealing with that is more difficult at the more deprived end of the social spectrum, one of which is the inverse care law. The committee recently spent a couple of hours with the Cabinet Secretary for Health and Wellbeing in which neither he nor members raised the inverse care law as an issue. We found that astonishing. It is a historical issue that continues in good and bad times; it is not an austerity or prosperity issue. It is a question of whether the NHS, in addition to providing universal coverage and access, provides the means for front-line practitioners to deal proportionately with the problems that patients present. That is not a problem in hospitals, but it is a big problem in primary care because of the flat distribution of manpower. That is just one of the problems. Our evidence focuses exclusively on it because it quickly disappears off the table. If the committee does one thing, it must address the inverse care law.

There are two other factors. One is the ability of some social groups to access and use the service more effectively than others, which Tudor Hart pointed out in his paper. I believe that, at the committee's meeting last week, it touched on the problems that people in deprived areas have in accessing a multiplicity of services, which are often not local, familiar or timely. Creating improved links at that end of the social spectrum is absolutely key. A service that increasingly configures itself to deal with a consumerist culture and which encourages people to self-help and self-manage is the wrong approach for people with multiple problems in deprived areas.

The third problem also stems from the beginning of the NHS. It is to do with the gap between the centre of the NHS and primary care—let us call it the independent contractor status. There are good and bad things about that. It has been very good for pioneering approaches to practice, but not good for consistency between practices. The system has had a problem engaging with general practice, and if it is to be rebuilt from the bottom up, more effective engagement is needed.

The deep-end programme is an interesting initiative because, until 2009, the general practices dealing with the most deprived 10 per cent of the population had never been convened or consulted by anybody, so all the deep-end representation is new. We hope that the initiative can be built on. The situation cannot be transformed overnight, but there are certainly lots of places in the country where it would be possible to build on the intrinsic advantages of primary care—contact, continuity, coverage, relationships and trust—and for practices to work as hubs that link, through link workers and other resources, to what is around them in order to provide continuity of personalised care for everybody, whatever their problems.

The Convener: Andrew Buist's objective of raising the overall share of the NHS budget for GPs to 11 per cent will not necessarily deal with your inverse care law.

Professor Watt: There are two related points on that. The Royal College of General Practitioners and the BMA are absolutely right that primary care generally is underresourced for the task that it faces—there is absolutely no question about that. However, within that, the flatness of the distribution of manpower is a problem. At the deep end, once the day is done, you cannot do any more. So, as we say in our written submission, unmet need accrues and is not recorded.

The problem with looking at manpower is that it is 10 years since the Government was able to collect data on whole-time equivalents because, since the new contract was introduced, the contract is with practices rather than individuals. We have made a bit of an issue of the whole-time equivalent manpower data, but it is difficult to keep the data up to date and complete, even though the ISD survey last September confirms the picture that we recorded 10 years ago.

If, instead of manpower, we look at practice funding—the amount of money that goes to general practices, which is used to pay GPs and receptionists and for premises and everything else—we find that the average spend in the most recent year for which data are available was £123 per patient per annum. That means that, in Scotland, just over £10 per patient a month goes on the whole of general practice. In the most deprived fifth or 20 per cent of the population—that is not a small marginal group; it is a big whack of the population with a million people in it—the average spend is £118 per patient per annum. In the most affluent fifth of the population—another million people—the average spend is £123. Therefore, about 5 per cent more is being spent on the most affluent fifth than on the most deprived fifth. We cannot address health inequalities on that basis.

On the general point, everybody agrees that the origins of health inequalities are outside the health service. The health service's role is to deal with the health inequalities that exist and to prevent them from getting worse. We can narrow them by mitigating the severity and slowing the progression of the problems that people have so that it is later or perhaps not at all that they have emergencies and are admitted to hospital. The historical problem is that the health service has probably been producing inequality rather than narrowing it, because of the inverse care law. Clearly, dealing with that is just one of a number of policies that are required to address the fundamental problem. Our criticism of recent policy papers on health inequalities is that they have correctly focused on the early years but have incorrectly underemphasised the role of the NHS.

The Convener: I will let others try to respond, and two or three committee members want in.

Rhoda Grant: Convener, can I ask a question just for clarification?

The Convener: I am worried about getting clarity and a simple yes or no, and I want to bring in other witnesses. I have you on my list, Rhoda, and I will let you in.

Does any of the other witnesses wish to respond?

10:00

Dr Craig: Health Scotland's research points to three roles for the NHS on health inequalities. The first, as Graham Watt says, is about mitigation and how we can do better for people who are impacted on by social inequalities. I completely agree with him that we have to think very differently about how we do that. The people in areas of deprivation, for example, are not homogeneous groups, and we need to take into account issues other than deprivation. That is a problem with population databases: if we focus just on routine data and look at deprivation, we miss a lot of small, marginal population groups, particularly new migrant groups that come into Scotland. There is an issue about how we do that mitigation. Primary care is clearly the gateway to many other NHS services. However, there are also questions about what happens once people get into services—for instance, are they referred on adequately, and do they continue to get the right kind of support that they might get in primary care?

That mitigation role is crucial for the NHS, but we also have roles in prevention and undoing health inequalities, although those roles are smaller. Prevention can be done partly through the NHS, but mostly in partnership with other public sector organisations. It is about really understanding communities and neighbourhoods and what the issues are. The issue of unmet need is impossible to get at just by looking at population data or data gathered through service provision. We need to look beyond that much more in order to understand the different groups in society.

The NHS can also contribute a wee bit to undoing and reducing health inequalities, because we have very good epidemiology research, and we really understand the links between social circumstances and health. However, we could use that information much better if we were able to work better, in an integrated way, at policy level as well as at neighbourhood level.

There are three different approaches that we can take: mitigation, prevention and undoing. However, we really need to get the mitigation right and look particularly at equity in health services, rather than at inequality. It is not just about providing the same service for everybody; it is also about understanding what needs to happen to achieve equity and being able to flex our universal services to deal with certain population groups or individual situations.

Dr Budd: I echo what Andrew Buist said about the unique role of primary care in tackling health inequalities for individuals, families and communities. Primary care has a unique relationship with patients and families—it is very different from other health services in that regard.

I also work in a drug service. We like to think of ourselves as a community-based service. We have limited contact with families and work with people for short periods of time. We seek to discharge people and get them moving through the service. Primary care does not do that; it works with individuals and families over their life course and in their social context. Primary care could be utilised much more effectively to address wider issues; it could work to address the prevention of inequalities through more involvement in community projects and with social issues. Some welfare officers work in primary care, and that could be expanded hugely.

The health and social care integration agenda could offer a really good opportunity for more effective working between services. However, at a meeting that I attended in Perth that was organised by the Scottish Government there were virtually no GPs, yet it was recognised that GPs are key to the effective integration of health and social care. There is an increasing need to enable GPs, including GPs from practices in deprived areas, to participate in the debate on how that might work.

Although primary care offers medical interventions and a bio-medical approach to addressing health issues, it also goes much wider and can start to tap into some of the social issues that are key to addressing inequalities.

Lorna Kelly: I want to build on some of the points about resources that have been made in the context of general practice. The issue of resources applies more widely to the broader primary care team and community services that have been referred to. That is an issue both of the absolute share of resources that primary care and community services have and of how those are distributed within services.

It is clear to boards that there are a number of drivers that push resources in the opposite direction. Many of the targets apply largely to hospital-based services and there are lots of pressures that push boards towards investing more in hospital services. The money that is available for primary care and community-based services is limited.

There are differences in the ability to apply resource to need. Health boards have a degree of autonomy in relation to how they share out that funding among community-based services according to need—they may do so on the basis of deprivation or other indicators. Nationally, resource allocation for general practice is done differently. Therefore, there are differences in the ability to distribute the resource according to need.

I will also pick up on Pauline Craig’s point. It is relatively straightforward for us to understand the Scottish index of multiple deprivation and to think about how we might distribute resources according to that, but the needs of some smaller groups, such as groups with protected characteristics, are much harder to see from the routine data that we have.

The Convener: There are a number of issues arising out of all of that. Nanette Milne and Rhoda Grant want to ask questions.

Nanette Milne: I found that to be interesting and quite salutary. I agree that we need to focus much more on primary care. With regard to integration of health and social care, I must admit that during our consideration of the Public Bodies (Joint Working) (Scotland) Bill I went on quite a lot about the importance of involving general practitioners at locality level in planning, because the reason why community health partnerships fell down was that GPs were not actively engaged.

I want to mention something in connection with the report that Richard Lyle asked about. Having looked at the 10 measures for addressing current and future health inequalities, I note that one important group that does not seem to be mentioned anywhere is community pharmacists. Pharmacists see themselves as the gateway to health services, particularly in some of the more deprived parts of the country. In the old days, my mother would take me to the chemist if there was something wrong before she would go to the doctor, and I get the feeling from pharmacists that that still happens. What are the witnesses' views on the importance of community pharmacy?

The Convener: That could be tagged on to the question about whether the Public Bodies (Joint Working) (Scotland) Bill provides opportunities for integration and what impact it will have. It might be useful to get a response in those terms.

Professor Watt: A general issue is that everybody thinks that they are part of the solution, but nobody thinks that they are part of the problem. There are too many hubs, so too many people see themselves as being the centre of something. It is generally true, however, that general practices have productive relationships with their local pharmacies and that, having made that step, they would not want to go back.

The question is: what is the best relationship? The magic bullet in primary care is a continuing relationship of some sort, based on mutual knowledge and understanding. There is a place for a variety of people in that; it is not about just one person. For people who have multiple problems, particularly mental health problems and other problems in their family, there is a substantial task, so I find it difficult to see how their treatment could be delivered in a mainstream way through pharmacies, where there will be other customers waiting in the queue to be served.

My answer to your question about whether pharmacies are important is that they are, but everything must be in its proper place.

Nanette Milne: It may be about signposting.

Professor Watt: Yes.

Dr Buist: I will be back at the committee in four weeks to address the Government's policy on prescription for excellence, which I support. The idea is that we need to engage community pharmacy more with general practice, because pharmacists have a huge amount to offer in terms of patient care. I am fortunate that, in Tayside, we have had a practice pharmacist who for many years has been hugely helpful with such things as drug reconciliation when someone is discharged from hospital, reducing drug interactions and the mistakes that often cause harm to patients. Prescription for excellence proposes to spread that practice across Scotland. If that is achievable, it will be good for patient care.

Dr Budd: In my work with the addiction service, I am based in a community pharmacy. It has been interesting to see the relationships that pharmacists have with patients; it is often an informed and caring relationship. I have a prescribing pharmacist colleague who is examining how pharmacists could become more involved in chronic disease management—in particular, for people who are on long-term prescription treatments.

The deep-end work, the work of Stewart Mercer and numerous papers have shown that one of the difficulties is the increased workload in deprived practices. It takes time to get GPs and other healthcare workers working in a joined-up and integrated way. Time has to be set aside to promote and maintain those working relationships, but in the 14 or 15 years for which I have been working in Muirhouse in north-west Edinburgh, that time has become shorter. We see less of our colleagues in social work and mental health teams, and we work in a less integrated way. Unless that is recognised and we are enabled and resourced to take the time, integration will not work, because people will keep their heads down, do what they have to do and try to get through the day.

The Convener: It is important to talk about the wider partnerships, although the question was specifically about community pharmacists.

Lorna Kelly: I echo some of what John Budd said. One of the most important things that the primary care deprivation group in NHS Greater Glasgow and Clyde has done—building on the deep-end work—is to get people out of practice and into a room with others who work in the same area. That has enabled GPs and community staff from health and social care to understand one another's existence, their roles and how they might connect to them. A simple example is a GP and a community psychologist sitting next to each other at a meeting and not understanding each other's roles at all or how to access each other's services.

We should not underestimate the challenge in enabling people to understand the range of services and how they can be accessed, especially given that general practitioners spend the vast majority of their time seeing patient after patient and therefore do not have the time to go out, meet people and understand what is going on in the services around them.

We need to find good ways of enabling GPs to engage with the wider community when they are under a huge amount of demands and pressure. That engagement is necessary not only for integration to work but for the primary care team and the full range of community services to work effectively, and for primary care to have access to services and to play the gate-keeping role that it can valuably play.

Rhoda Grant: I was interested in what Graham Watt said about the amount of money that is spent on people in deprived areas and in the most affluent areas. Andrew Buist said that there is a flat distribution of funding for GPs; I want to know how that disparity in handing out money comes about.

I am also interested to know about access to services. We heard last week about transport and access to services. Should there be more practices and, indeed, more hubs in deprived areas to allow people to access services? I have difficulty accessing my GP and I live within walking distance of the surgery. It must be much more difficult for people who have transport issues on top of access issues.

10:15

Dr Buist: I will try to address the question about finance distribution. I suspect that the reason for the £5 difference in spending per patient to which Professor Watt referred might be due to the rural effect. As a rural MSP, Rhoda Grant will understand that it costs more to provide services in a rural area. On an island such as Colonsay, there is one GP for 150 patients; there cannot be less than one GP. In an urban area, a GP could have 1,600 patients. There are economies of scale that will probably account for that small £5 difference.

It is important to understand that there is a sum of money called the global sum for the whole of Scotland. It is divided up by the Scottish allocation formula, which is a workload-based formula, not a needs-based formula. It is based on evidence—on the amount of work in looking after patients. The biggest determinant of that is age. In fact, some damping down of the age factor had to be done because, although a huge number of consultations and amount of time are required to look after a 90-year-old, practices in more deprived areas are, paradoxically, protected from that in some ways because the biggest indicator of health inequalities is people dying early.

Professor Watt: Andrew Buist is right that the 5 per cent difference is due largely to the additional costs of primary care in remote and rural areas. On average, about 20 per cent more is spent per head in remote and rural areas because of the easily understood problems of remoteness and geography. In the deep-end practices, the remoteness is of a different type: it is remoteness from good health, which is more difficult to see. Another explanation is that, in affluent areas, the practices tend to be bigger and, in deprived areas, they tend to be smaller, which probably results in efficiencies being achieved in affluent areas.

Andrew Buist is absolutely correct about the workload that is associated with frail and elderly people, who need more house visits because they cannot come to the surgery. They also take longer in consultations. That is a very important issue about which there is not a great deal of data. It is a separate issue from the one that we are talking about and exists in practices in which people’s longevity is a fact. If we are talking about health inequalities, longevity is an aspiration.

Dr Craig: NHS Health Scotland is beginning to become aware of another factor. We have started to do some analyses of DNAs, or did not attends, who are the people who do not turn up at services. We have not completed those analyses yet—they are almost done—but the interim results show that DNAs are very much socially patterned. People from deprived areas are more likely not to turn up at services, or to turn up late, which may result in heavier use of services.

Such analyses are not done routinely in health service analyses—they are done as research projects. We are not well set up to look at data in such a way as to really understand some of that unmet need or exactly how people in different areas or from different groups use services differently. We are starting to look at data linkage research—the DNAs analyses—to try to tell us a bit more about that, but it looks as though we are not really taking those issues into account when we plan services at the beginning.

That might also be linked to one of the issues that I was thinking about in relation to the earlier question about community pharmacists. If we rely on people coming to services and articulating their problems, we will again miss people with unmet needs because of difficulties such as their not speaking English or their being unable to manoeuvre their way around services and to find the gateway to them. Perhaps we are not doing enough analysis of who is not using services.

Dr Budd: Rhoda Grant asked whether increased resources or hubs would improve access in deprived areas. Over the past five to seven years, there has been increased pressure on the whole primary care team. That has meant that members of the team who would otherwise be working in a much more outreach-based way—such as district nurses, health visitors and community midwives—are now increasingly under pressure and are less able to do that.

A good study that was done in Craigmillar in south-east Edinburgh examined the workload of one midwife team in two neighbouring areas. It found that a higher workload was associated with enabling women with multiple social, mental health and drug problems to access the service. Just getting those women involved took up a huge amount of the midwives' working day, before they tried to deal with the increased number of morbidities and problems from which the women suffered.

Therefore, it is certainly important to enable the primary care team to improve patient access. That could be done through, for example, use of new types of workers, such as clinic support workers, who have been used in sure start projects and so on to facilitate engagement. A good patient attendance support project in Craigmillar—sadly, it lost funding—involved receptionists working in a much more outreach-based way to enable patients to engage with primary and secondary care. Such things are not hugely expensive, but they would make a huge difference in enabling patients to access primary and secondary care. If we are to start to meet some of the unmet need, we have to think about the notion of enabling, and perhaps extending the reach of, the primary care team.

Lorna Kelly: On the issue of DNAs that Pauline Craig raised, our analysis in Glasgow showed that the DNA rate for the most deprived quintile is much higher than that for the most affluent quintile.

I will make a point about the connection between hospital services and primary care and community-based services. In particular in relation to children in vulnerable families, there are opportunities to improve vastly the relationship between secondary care and primary care so that there is much better knowledge about when patients do not turn up, which will help in identifying the most vulnerable families. Not turning up for appointments can be a symptom of much wider problems in a family.

A second point about hospital-based services is that they are used disproportionately by people from deprived areas. That is particularly the case with accident and emergency services. In NHS Greater Glasgow and Clyde, nearly 50 per cent of our A and E attendances are from the most deprived populations, compared with a spread of around 34 per cent across the population. So people are accessing services, but they are accessing them in a different way. It is a challenge for us to respond appropriately to that, because A and E facilities are set up to treat a presenting issue and then send people away. However, if someone has multiple presentations, usually with underlying chronic disease, mental health or addictions issues, we need a better way to connect from A and E back to primary care community services, where we can develop an on-going relationship with the person and have some chance of dealing with their underlying issues. That relationship is crucial across the system.

Professor Watt: On that point, if primary care is underresourced and lacks time, the work will spill over into sectors such as A and E, as sure as night follows day.

On DNAs, it is a pity that my colleague from Possilpark Petra Sambale is not here, because she would speak passionately about her patients being asked to travel longer distances to hospitals as a result of centralisation, which leads to them DNA-ing and, rather than going up the ladders, going down the snakes to the bottom of the queue and out of the system. That is why one of the main arguments in the deep-end practices is that the referral distances between the hub and the rest of the wheel need to be short. One way of doing that is to bring services closer to the hub through attached workers. That is not a solution for every practice, because some practices' case load volume would not justify it. However, in mental health, for example, there is surely a sufficient burden of need to justify—at least as an experiment—the attachment of mental health workers, so that the referral distances can be that much shorter.

Homeless people and other marginal groups have access problems in a way that the most deprived 1 million do not. The problem of the most deprived 1 million is not access; it is what happens when they use their access. There is a lot to learn from homelessness services—I found that out at a recent conference in London to review homelessness services in England, where homelessness and services to respond to it are a growth industry. Services there are good, as are our services in Edinburgh and Glasgow. In England, a personalised approach has been developed to the needs of patients in the group, who have problems of attaching and engaging with services. People in England are also good at providing an integrated approach, because other services are configured around the homelessness services.

In a sense, that is a model for the rest of primary care. We are dealing with patients who are difficult to engage. It was said at the conference that the phrase "hard to reach" should be deleted from the lexicon and replaced by "easy to ignore". Such people are easy to ignore. Homelessness services have found useful ways of developing services around patients who are easy to ignore and difficult to engage with. We need that model more in the main stream than it is at present.

Bob Doris: I will go back to statistics that Dr Buist and Graham Watt cited. Graham Watt referred to a 5 per cent gap between the spend on the poorest 20 per cent and on the wealthiest 20 per cent. Dr Buist said that the moneys from the health service budget that are spent in GP practices have fallen from 9.4 to 7.8 per cent and that the aspiration was for that figure to be 11 per cent by 2017. I know that the numbers are important, but they are just numbers. I am interested in the trend; there might be an explanation for the gap. In five years, will that gap have narrowed or shifted? I make the same point about the percentage share for GP practices.

I am keen to hear about the outcomes and where the moneys would come from for changing those figures. John Budd and Graham Watt talked about new initiatives that might happen—for example, acute care has been mentioned. One of the big ideas of health and social care integration is to pick away at the acute care budget and put money back into communities. Local authorities are keen on that, but they are less keen on picking away at local authority budgets and putting that money into new community initiatives.

I would like to get on the record from our witnesses where the shift will come from—local authority or acute budgets—to put money into communities. In a GP hub, do GPs have to control the budgets directly? Are we talking about co-location and integration rather than about GPs always leading? I completely share all the worthy aspirations that we have, but how do we take them forward and monitor that?

Dr Buist: It is important to understand that the percentage has fallen not because less money is going into primary care, but because the new money that has come into the system has been diverted disproportionately to hospital care. The variation between the most deprived and the least deprived areas could be adjusted by changing the formula that divides the money, but that would mean moving money from rural and elderly practice areas to deprived practice areas.

I believe that we need to shift more money from other parts of the system into primary care, to provide services more locally and to keep people in their communities, so that they do not need to get two buses to hospital. The key to that is to crack healthcare and social care integration. It is essential that we involve general practitioners from all types of practices—deprived practices and less-deprived practices. We need to get working GPs looking at services and how they are provided, at patient pathways and at getting social care and healthcare working more closely together. Provisions to enable that need to be written into secondary legislation.

10:30

We need to make it possible for GPs to get away from their practices for an afternoon a month in order to get involved in that. The early signs are that that will be difficult. We are seeing early signs of a workforce crisis appearing in general practice. That is happening for several reasons. General practice has lost popularity with young doctors coming into the profession. Older doctors are leaving slightly earlier, in their late 50s, rather than hanging on into their early 60s.

We are also losing doctors in the middle of their careers. Last week, women outnumbered men in the general practice workforce across the UK for the first time—I think that that is a good thing—and when they go away to have their families, they are not coming back into the profession. One reason for that is that they are, frankly, burnt out. The workload is becoming intolerable. We are battle weary. That is not particular to practices providing care in more deprived areas; that applies across the whole spectrum of general practice.

I have been a general practitioner for 20 years. Yesterday, I saw 40 patients face to face over an 11-hour day. There was almost no spare time. Lunch was five minutes. That is in marked contrast with 11 years ago. In those days, I might have had two hours to myself in the middle of the day. The day starts earlier and finishes later, and the bit in the middle is gone. General practitioners are absolutely weary. They are increasingly working part time to try to cope with the demands.

We need to do something quite quickly to stabilise the workforce, or the situation on Cumbrae, of which you are aware, could start to develop in other areas. It is proving difficult to run a practice on Cumbrae. It is being run with locums and it is costing about double the cost of the routine service. That will particularly hit rural areas first, as well as deprived areas and out-of-hours services. It will make locums increasingly difficult to find. That is important, as it is the locums who will provide the backfill that will allow the GPs to get away from their practice to get involved in health and social care integration.

Professor Watt: The deep-end project would never have happened if there had not been the possibility of backfill. What do deep-end GPs have in common with Dracula? They only come out at night. During the day, they are seeing patients. It might seem expensive, but actually it is not expensive. It is a small investment in order to get people out of practice to reflect and to meet colleagues.

As regards the general question and the data that I gave earlier—which the committee could get from ISD, the Information Services Division of the NHS in Scotland, if it asked the question—very few official analyses are based on groups of practices serving different parts of the population. They tend to be based on geography, which corresponds to NHS management rather than the distribution of need within the population.

The figure of £120 a year is £10 a month per patient in a deprived practice. That does not seem a lot. A small increase in that sum does not seem a lot to me, but it would make a huge difference within practices.

The bottom line is that, if the health service is not at its best where it is needed most, that will widen inequality, which is what the committee is trying to address. That is a political question, ultimately. If it is left to the service to work out who should get what, that results in not an evidence-based policy but a noise-based policy: the people who make the most noise get the most resource. That is our historical experience. There is a need for informed decisions to put values and principles into effect. Even if times are difficult because of austerity, we are surely not saying that equality and equity are things that we can afford only in the good times. That sounds like a rather English debate to me, not a Scottish debate.

Dr Craig: I will build on a couple of points. There is an opportunity through the integration of health and social care to think differently about inequalities. Rather than base our planning on routine data for the whole population, we can bring some data and research to the process from what we know about rurality, homeless services and services that have been responding to migrant groups. The knowns around those services need to be built into health and social care integration planning, so that we think about inequalities at the very beginning and do not rely on an equality impact assessment, which just protects us from legal recourse, to be done at the very end of the process. We must put thinking about equality up front, so that we think first about the people who do not come to the services and then think about the whole population, instead of thinking about the whole population and then worrying about the people who do not come.

I am slightly worried by the prospect that we might go down the route of projects and initiatives to bridge that gap. Our experience so far is that projects and initiatives can do a huge amount to bring people into services, but if they are not part of the mainstream services, the projects and the individuals involved in the initiatives disappear over time and we are left with whole-population approaches in the mainstream services that continue not to meet the needs of the people who are not able to come forward. We should build such thinking into our planning at the very beginning. The new process of health and social care integration gives us the opportunity to think differently about equalities.

Dr Budd: I agree with Pauline Craig about the importance of using the infrastructure that we already have—the infrastructure of primary care—and building on it.

Bob Doris asked about integration and funding with regard to local authorities. I work in the Edinburgh access practice. It is part of the access point, which has co-located social work and housing services. We work closely with third sector colleagues in homelessness and provide a joined-up and partnership-based approach, which is vital when working with patients with multiple and complex needs.

A key part of how we work is our relationship with the third sector. Their work on the street to identify and engage with vulnerable and isolated individuals has been key. They will often work over a period of time with folk—perhaps drug users—who are not involved in services. They establish relationships and bring them into the mainstream services. That process of fostering engagement can take quite a while. We have seen over the past few years that such services have disappeared as a result of tendering and commissioning by local authorities. As far as I can see, there is virtually no outreach street work for homeless people in Edinburgh.

One issue that has led to that situation is tendering and commissioning on an outcomes basis, because when an organisation has tick-box outcomes to fulfil, the service does not want patients who will not tick the boxes and the people who will not tick the boxes will be the most vulnerable and most chaotic—the ones with the biggest problems. Perversely, we end up with services for vulnerable and marginalised people that exclude them, because they will not tick the outcome boxes and the service will therefore not get funding. Increasingly, we are seeing that the patients who are most at risk are least able to access our services. An issue for local authorities is how services are funded and monitored.

One of the great advantages of primary care is that we do not tick boxes and exclude people. We do not have referral criteria; we will take anybody and work with them as long as they are willing to come and work with us. No other service in health offers that.

We definitely need more help to deal with the increased workload, particularly in deprived areas, and we need to think about how we can enable people to engage effectively with us and use what we have to offer. When you work with patients who have multiple and complex needs, it is not just a matter of them turning up and everything being okay; it is about long-term, slow, on-going relationships and work. As Richard Simpson knows through his work on addictions, these small steps can take years and you see very few outcomes; it is a developmental approach, because you are dealing with people who have had significant developmental issues from birth and sometimes from before birth.

Dr Simpson: My head is bubbling with different things, but I will concentrate on a couple of issues. I have been in general practice and 30 years ago we had an attached social worker, an attached CPN and an attached school nurse. They were all withdrawn from the practice. The school nurse retreated into the school. She used to come once a month, which meant that we were able to discuss issues such as asthma management and epilepsy management in school, and share information. The social worker was attached to three practices, two of which were the most deprived in our area. Child registration for protection dropped, but child referrals from the practice to the social worker went up, so there was a very positive outcome.

That was thirty years ago. It seems to me that the pattern since then has been the gradual withdrawal of services, so that even in deprived areas health visitors are no longer co-located with the practice, which is utterly shocking. That degree of integration is required for the development of a network of individuals who support people and families with need. We can sit here for as long as we like and talk about health and social care integration structures at the top and the bills that we pass, but unless we get things right at the coalface it will not work.

I come to my question, convener. The 17C contract—a contract made through an agreement under section 17C of the National Health Service (Scotland) Act 1978—has been in place as an alternative to the standard independent contractor general medical services contract for something like 12 years, yet it is not being used in many areas to create a service. As part of the move towards a new contract with general practice, which is being talked about openly and which I welcome, do we need to think about a much more fundamental shift from the 1948 model of general practice? What do witnesses think about the potential for creating a completely new contract?

Under the Labour-Liberal Democrat coalition and, I think, under the Scottish National Party a number of multidisciplinary centres have been created—one or two in West Lothian and one in Ayrshire—and have been referred to repeatedly. There has been co-location of mental health teams, social work, housing, benefits officers and general practice at those centres. Have they been evaluated? They are expensive—the physical building is expensive—but the co-location of those teams seems to be the ideal. Is there any evidence that that is the case?

Dr Buist: The BMA is in discussion with the Scottish Government about revising the GP contract, but that is not the whole solution. One of the things that came in in 2004 was the quality and outcomes framework, which was a good thing and I am sure that Graham Watt will say that it improved standards across all practices. Things such as diabetic care became more standardised and had less variation. It helped reduce health inequalities, so it was a good thing, but over the years the QOF went too far and became too much about ticking boxes. Fortunately, last year we started to reverse that trend and make it a more professionalised contract. We will continue to work with the Scottish Government to make a more professional-based contract, so that we get the more hard-to-reach patients, rather than avoid them because they do not fit the boxes.

The model of general practice is sound. Last year, the Commonwealth Fund said that UK general practice was at or near the top for every parameter that it looked at. The problem that we face, as the King’s Fund said, is a chronic lack of capacity in general practice. The only way that we can address that is to increase the share of the NHS budget that goes into general practice.

10:45

Which contract underlies that does not matter so much. My view is that a national contract is better, because it reduces variation between areas. You can give additional funding through a section 17C contract or the GMS contract. It does not matter—the underlying problem is inadequate funding going into general practice. Graham Watt referred to the cost of £120 for a whole year’s general practice care, but the cost of one A and E attendance is £100 and the cost of one out-patient attendance is £112. On average you get six face-to-face contacts per year, which has risen from four face-to-face contacts 10 years ago. One of the reasons why we are so battle weary is that we are seeing more and more consultations for the same resource.

The Convener: Richard Simpson made a point about hubs. It should not be about just the GP. A hub can provide increased capacity and offer other services, such as advice on housing benefit and so on. When people come to see me, they are extremely upset; they are ill with worry. The hub idea is not necessarily about just the GP; it is about the co-location of social work or housing or mental health services—perhaps the Scottish

Association for Mental Health is up the hill, for example.

Dr Buist: Absolutely. I addressed that in my opening remarks. The GP practice is the natural hub around which to build the extended primary healthcare team, along with CPNs and social workers. Not only does it make things more convenient for the patient, it also means that there are shorter lines of communication between the different workers. We meet over the kettle and we continue working to exchange information about patients. If we work in different buildings, such exchanges do not take place.

Professor Watt: As I said before, the service has too many hubs—services that see themselves as centres and which deal with their own problems of resources through having waiting times and rationing access, making things difficult for patients with multiple morbidity.

Spike Milligan described a machine that did the work of two men, but took three men to work it. That is the health service in a nutshell. We cannot afford it. We need to imagine a machine that does the work of two men and takes only one person to work it. That is general practice, not because of GPs but because of the intrinsic features of general practice: it has contact, coverage and continuity. Coverage deals with the equity issue. Continuity means that there are multiple opportunities to start; not everything has to be done today, as it does with initiatives. That needs to be built around.

The most difficult issue is the sharing of power, resource and responsibility, because of how the system has developed. The adoption of power and responsibility at the practice end is a tender plant. It will not be transformed overnight; we need to develop and grow it.

There is a proposal before the Government at present, which is based on the Govan health centre, where there are four deep-end general practices. In partnership with the director of the local CHP and social work, there is a plan for a bit of additional capacity to address the inverse care law, with attached social workers—not inventing that concept but going back to it—and link workers to link to community resources for health, plus protected time to allow the practices to work together and with others within the locality planning process. Lots of things there have the potential to grow. It is as much a cultural development as a managerial development. It will take time. It cannot be given too heavy a burden of expectation, because the problems that we are addressing will not be transformed overnight.

On the question of the contract, there is a quotation written on the outside of this Parliament by a man called Andrew Fletcher, who wrote:

> "if a man were permitted to make all the ballads, he need not care who should make the laws of a nation."

The contract is the laws. The ballads are the songs that people are singing: the cultural and shared values within the system that are much more important than the contract within which people work. It has to do with the quality of relationships, and not just the mutuality and trust between practitioners and patients but that between the leaders at the top level and those at the ground level. Sometimes, the quality of the relationships between the top and the bottom is much worse than it is between practitioners and patients. We need to have the same ideas of co-production, based on mutuality and trust, at all levels of the service.

QOF was expensive. Its most important achievement was to introduce consistency of information recording and organisational arrangements within all practices because it had virtually 100 per cent engagement. Very few things have 100 per cent engagement. It accounted for about a fifth of earnings. There is a slight gradient towards deprivation, but the difference across the range is £2. For enhanced services, the gradient goes the other way. The global sum is flat. QOF has therefore not been a particularly progressive measure. As we know from practice team information—PTI—data, the problem with QOF is that only 12 per cent of consultations in general practice involve a QOF condition. What is happening in the rest of consultations? How are they valued and incentivised? That is what Andrew Buist was talking about. We need to get back to rewarding GPs for working with the more complex kind of patient.

The Convener: There is a lot of agreement around the table that we have an issue. We have half an hour left—perhaps Richard Simpson can help with his next question. I am anxious to address the contradictions in policy and in share—how the resources are allocated—and what we should be doing about them. We will discuss the evidence that we have received with ministers, and there are some challenges in there.

Dr Simpson: In the first session, the Parliament discussed the Arbuthnott formula, which has now been replaced by the NHS Scotland resource allocation committee—NRAC—formula. One of the exclusions from the technical side of that has been general practice. The data was simply not there and, as far as I understand it, it is still not there. The ability to distribute, or to require health boards to use the formula to distribute, is just not there. That is a really sad lack, and I hope that we will have the members of NRAC before us to explain it. They were supposed to do the work to get the matter sorted out, but I do not think that that has been done.

The other aspect is that the money that has gone to health boards on the basis of the general distribution for deprivation has been used for all sorts of pilot schemes. The initial formula goes back to 1976. The money was used for initiatives such as the have a heart Paisley programme and the midspan studies. Such projects have all been add-ons. Instead of general practice being used as the hub, where there is continuity, the only place where people are registered with a general practitioner—often for life—is in such groups. I am convinced that the keep well programme will demonstrate the same thing. Such programmes have not achieved any real improvement in outcomes at all. A lot of money is being spent on those programmes, which have not proved to be effective. The other issue is health checks. There is no evidence relating to our conducting health checks for people who are aged between 45 and 65, yet we are spending a lot of money on that.

Do the witnesses feel that there are areas where there might be redistribution of funding? The ones that I have mentioned might not be the appropriate ones, but are there areas from which we can take the money that is currently being spent in order to use it more effectively elsewhere? Should we require NRAC to give us a much better distribution formula for deprivation in primary care, as opposed to secondary care, where that consideration is applied at the moment?

Dr Buist: The minister, Alex Neil, came to our conference two weeks ago and told us something that we welcomed—that the territorial boards will be required to evidence in their local delivery plans a significant increase from April onwards in their spend on primary care, with above-inflationary uplifts. We were told that investment in primary care is essential, and Mr Neil said that the integration agenda and the 2020 vision could not be delivered without it.

Where would we spend the money? We need to get the average list size down. The average whole-time equivalent GP in mainland Scotland has around 1,500 patients, which is too many people for the type of care that is being provided. That might have been okay 40 years ago for the type of care that was provided then, but it is far too many patients now. We need to expand the primary healthcare team to include more district nurses, health visitors and counsellors.

We also need to invest in infrastructure. There has been almost no investment in new premises in Scotland over the past 10 years although the population has increased by about 250,000 in that time. That increase is unevenly distributed, with Lothian, south Fife and the Forth valley experiencing higher rises than elsewhere, and that is impacting on current services. Many practices in those areas—in Lothian, in particular—are closing their lists because they are bursting at the seams. They cannot provide the care that people need with the space and the workforce that they have. We must invest in new premises. As was mentioned earlier, we need to build new and perhaps bigger premises in deprived areas, and single-handed practitioners should perhaps be brought together into hubs with the other services attached.

In addition, we must invest in out-of-hours care, which is a bit of a Cinderella service although it provides a good standard of care compared with the patchwork arrangements down in England. Those services are, however, underresourced compared with some secondary care services, and they are vulnerable. The workforce is moving away because the support is not available.

Professor Watt: On the question of NRAC and the Arbuthnott report, we had the best intentions and the best methods and statisticians. To some extent, we had the best data—although, as Pauline Craig points out, the data that we get is not necessarily the data that we want.

Systematically using activity as a proxy for need takes no account of unmet need. The deep-end practices are unable to generate activity that reflects need, so it goes unrecorded. NRAC specially commissioned health economists in York to find unmet need, but they could not do so because they were sitting at a desk in York. If they had been sitting at a desk in Govan, Possilpark or Easterhouse, they would not have had a problem in finding unmet need.

The trouble is that using other measures of need, such as mortality, frightens the horses because the arithmetic implies very substantial changes that would be politically undeliverable. The argument has to be for progressive change over a period of time, not change overnight.

The points that Andrew Buist makes about recruitment are important. That will have impacts across the service, so it is not a particularly deep-end issue, although it is particularly important for the deep end. We have an advantage in Scotland in that the areas of most severe deprivation are concentrated around Glasgow, where lots of people want to work. We do not have the problems of underdoctoring there that exist in south Wales and in parts of London and Birmingham. We have a high-quality workforce in deprived areas in Scotland, and we are probably better placed internationally than anywhere else to show what a needs-based service could deliver. That is one of the challenges for Scotland to address.

What we need at the deep end are models of professional careers and opportunities that inspire the next generation. That will require not financial reward so much as professional reward.

The leadership role in deprived areas must be recognised and supported, in addition to the clinical role, so that in 10 or 20 years' time we will have a cohort of people who are leading the development of hub-based local health systems at ground level, in partnership with other leaders in healthcare. We do not have that at present although we have the potential to build on the deep end.

It is not just about the deep end, however. Everything that is argued for the deep end should be applied pro rata across the system. If we simply solve the deep-end problems, that will not address Scotland's inequalities, which are patterned across the population. The policy must be a pro rata one across the board, although the deep end is a place to start.

11:00

I would like to see much more support for leadership roles in that area of the health service, because the role cannot be imagined from far away; it can only be developed locally on the basis of local knowledge of premises, populations and colleagues, and that approach must be enhanced. The type of leadership that is required is not the same as that which is required of a clinical director in a CHP or of someone on a secondment to the Scotland Office who works in a big bureaucracy. It involves leadership in the local microeconomy of a general practice within a local community. At present, leadership in such contexts tends to be exceptional and notable because of its novelty. We should make it more mainstream.

The Convener: I will address some of those points. We started by saying—rightly—that what we are discussing is not an issue only for the health portfolio. It can mitigate the effects, and I presume that everyone agrees that health should be taking a lead given that it is the only portfolio that includes health inequalities as a priority. However, does the demand to shift a greater share of resource from hospitals to GPs and to increase the number of GPs not contradict the argument that the issue is only for the health portfolio? If we are going to give more money to that area while reducing money to local authorities, there will be an impact on social workers.

Would the money be shifted only to GP practices? Would it be just for recruiting nurses? Home helps and care workers deal with many vulnerable people from day to day and have more contact with them. They perhaps spend too short a time with people, but they are there every day.

Where should the investment go if we are serious about ensuring that the issue is not simply about health? Where should the bigger share of the money go when we are cutting housing and local authority budgets because of pressures? The arguments are a bit contradictory, in my view.

Dr Budd: You are right about the frail elderly having home helps and care workers, but the vast majority of my patients do not have any such help. Working in a deprived area, I see that what marks out the adults with a chronic illness is the fact that they are younger.

From the work that Graham Watt and Stewart Mercer have done, we know that patients in deprived communities develop multiple long-term morbidities 10 to 15 years earlier. Most of those patients do not have care workers or home helps although they may come into contact with GPs and the people who run the practices, such as district nurses—the same people who are under most pressure in providing general services to communities. Unless we resource the primary care teams, not just GPs, to improve access for vulnerable patients with multiple morbidities, we will not be able to do that.

Lorna Kelly: I want to pick up on how information and policy drive the way in which resources are allocated. I commented earlier that a number of drivers cause boards to invest more in acute hospital care. That happens partly because those drivers are, by their nature, easier to count and to put money into. Drivers such as A and E waiting times, the 18-week referral-to-treatment target and the need to have more senior decision makers working seven days a week are all easy to quantify.

It is easy to say that, if we want everybody to be seen within a certain timescale, a certain number of additional doctors and nurses is needed. However, that drives more and more money into secondary care. We do not have an equivalent for primary care because we cannot see patients who cannot get appointments, and we cannot quantify the increasing demand in a way that leads us to ask what numbers and services we need, whether in relation to GPs or in relation to other health and social care services. There is not the same hard edge that drives the debate about resource allocation both within boards and at the national level.

The other issue that I want to pick up on is whether we should put money into healthcare or social care. The problem of delayed discharges is still driving spend in the acute setting, and concerns around social care funding mean that people are staying in one of the most expensive parts of the system—an acute hospital—with all the knock-on consequences that that has.

The overall balance of funding across health and social care is important because a problem that is removed from one part of the system simply pops up in another part, as Graham Watt pointed out. Those areas that cannot and would not want to close their doors, such as general practice and A and E, are the last resort for a number of people, and there is a risk that people will get stuck in a place that is not appropriate, which is not the best use of resource.

Dr Craig: The issue for me is not so much where we put the money as the outcome that we are trying to achieve. If we are trying to achieve an earlier and better response to the needs of people who are less likely to be able to articulate their needs, that is where we need to put our money.

We must understand the need and provide a service that wants to do that. At the moment, the policies are not clear. We talk about health inequalities in vague terms, and it is not clear what that means for the NHS or those whom we want to target our resources at. If policies continue to be based on population data and on an expectation that people will come forward to services, we will not meet the need and will continue to have more people going to A and E.

The issue is how to reach people. Perhaps the initiatives that Richard Simpson mentioned did not achieve the health outcomes that were expected, but evidence emerged from them of how much effort must go into improving people’s access to specific services. For example, a huge amount of effort is put into homelessness services and services for Gypsy Travellers, but most of that work is not funded or is project funded rather than funded as part of the mainstream. If we set a different outcome for our services that was about providing services to people in those situations, that could help us to decide whom we need to employ in order to meet those needs.

Lorna Kelly: Keep well is a good example of an initiative whose funding is gradually being withdrawn because the health outcomes have not been obvious from the work that has been done. Funding such as that is used creatively by health boards to do things that meet the needs of the local populations, and it is a resource that is used in primary care. When it is gone, you do not necessarily see where it went or ask why it did not work. If the message is that we should put more funding into mainstream primary care, projects might stop and funding may disappear off into something else.

There needs to be discipline around some of the national projects and initiatives, so that we ask why things did not work, whether they did not work because they were add-on projects and how we can learn from those experiences and mainstream such initiatives into practice. By mainstreaming I mean not just continuing the funding for a particular project, but looking at the core resources, particularly around our universal services, and asking how they can be shored up and how they could achieve the same outcomes as, or even better outcomes than, the separate initiatives with project-based approaches.

Professor Watt: Keep well was good at processing a large proportion of the population to assess their cardiovascular and other risks, but the infrastructure that was good for that was not good for what was done next, which was about the continuity of care that people need not just for their cardiovascular health but for everything else. That is the disjunction, and it is why I am not sorry to see keep well come to an end. It had reached the end of its useful life and the resources needed to be used in a different way.

You made an important point, convener. After all the discussion, are we talking just about giving more money to GPs? We are clearly not, and if the proposal is framed in that way it is an unattractive option. The way in which GPs are paid through their contract is that the available funds are for both income and service development. Clearly, there is a conflict of interest there. To increase the channel of funds through that route is unpopular with other practices, which see deep-end GPs potentially earning more, although I think that, in general, they earn less. The aspiration is simply to earn the same as everybody else and, after that, professional rewards are sufficient—financial rewards are not required.

The model of simply giving money to GPs is unattractive to the NHS because it sees GPs as being unaccountable for public health needs and for service development. Therefore, it is unhelpful to frame the proposal in that way, as that is a guarantee of nothing happening. Something rather different is needed. There must be an injection of additional clinical capacity into deep-end practices, but not to address the inverse care law, as that would frighten the horses and is unnecessary. As I have heard the cabinet secretary say, we need something to ease the pressure on GPs and allow other things to take place.

The other ingredients are attached workers, social work, health visiting and protected time for the development of a leadership role in partnership with other leadership roles in local health systems. We need models of developing local health systems around practice hubs, which would involve all the players that we have mentioned this morning. I have heard people say to the committee that if only GPs were salaried that would solve the problem, but I do not think that it would. We must value the potential of professional leadership within localities, partly because of the long-term commitment that is made. GPs are in the communities for longer than almost everybody else. When a *Holyrood* magazine reporter interviewed three Govan GPs, I was able to tell him that there was 60 years of experience in the room—that was among just three GPs. There is an enormous amount of cumulative knowledge and experience of local populations, which must be valued and supported.

Only a relatively small amount of the money that would be needed to develop a local health system around a practice would be channelled through the practice. Much more important than that would be the development of a leadership role so that the practice would engage more effectively with what was around it. That recipe cannot be rolled out everywhere immediately. As Hugh MacDiarmid said, we do not want tradition; we want precedents to learn from. The only way forward is to invest significantly in spearhead local health systems from which we can learn and to share that learning.

Dr Budd: I agree with what Graham Watt says.

The other issue we have not really touched on is to do with training. We have talked a little about the professional culture and raising the aspirations of new doctors to work in deprived areas and to see the need for the NHS to be at its best where it is needed most. NHS Education for Scotland has been involved in funding a scheme with health inequality fellows for the past four or five years. The equivalent of two whole-time health inequality fellows has been placed in deprived practices. One half-time post is with me at the homeless practice in Edinburgh. It has been a hugely successful project and, although it is very small scale, it could easily be scaled up. It gives people who finish their GP training the opportunity to extend it and to see working in deprived communities with patients with multiple complex needs as something of a sub-speciality for GPs that raises the professional culture in terms of working in practices in deprived areas.

That scheme is also a huge resource for the practices that the fellows work in from the point of view of the clinical work they can engage with and the research that they do. To an extent, it frees up GPs to get involved in some of the other areas that we have talked about, such as partnership working with social care or engagement in the integration agenda. Particularly in a postgraduate area, training could be scaled up very easily and would have multiple effects. That would be highly productive for patients and for practices.

11:15

The Convener: Are there any other questions?

Aileen McLeod: I want to ask about one of the measures in the deep-end GPs' report, which is around the new link worker programme.

How does the panel see that programme working in terms of the role of the new link workers attached to the deep-end GP practices and the contribution that they will make to helping us to reduce health inequalities? We know that the programme is being supported by the Scottish Government, the Health and Social Care Alliance Scotland and SAMH, and that it will help the staff in primary care become better at identifying the local support groups and organisations that are available in their communities and at being able to better match what is available to the specific needs of patients.

The Convener: Is there anyone with any experience of that?

Professor Watt: I am on the executive group of that project. It is a very important and timely project that builds on quite a lot of previous work but now it has the full-time link worker posts in seven deep-end practices. I know that the seven individuals who have been appointed are of very high calibre as regards what is required to operate in the role.

It is too early to know how the project will work, but we know from previous projects such as the links project and the bridge project that link working is not something that you can make happen by pressing a switch. We are talking about a multiplicity of links with different organisations and pathways that people could follow. Some of them will work; some of them will not. Some patients will be up for it; others will not be.

If the project is allowed to develop slowly, by trial and error, and a system is developed that is customised to each practice, I am very hopeful that it will work. If it is rolled out as a blueprint whereby people try to tick boxes, it will not work.

The project is an extremely important part of the jigsaw because it potentially links practices to everything that is going on around them. One of the unintended consequences of the QOF was that it made the practices very introspective—they did not look so much at what was going on around them. I do not know whether that problem will be solved by a new person whose job is a link worker, but it is certainly the way forward at present.

The link worker project is only one part of the jigsaw linking the practice to community resources in the third sector for health and social wellbeing. We need something very similar to improve the links with other services, such as mental health, addiction and health visiting. If there is a problem with attached workers and we cannot have them, we need some kind of link with secondary care, for example. All those links need to be identified and worked on.

At the end of the day, a local system is simply the sum of the relationships that are contained within it; the quality of those relationships or the social capital is what the system is comprised of. We are very good at managing the financial resources in a system, but we are not very good at managing the human resource. A local health system depends on multiple relationships. If those are not the most productive relationships at present, they require work and effort to make them work. That will not happen overnight, but that has to be the direction of travel. Earlier, I mentioned Spike Milligan's machine. We need a machine that does the work of two men but which takes only one man to work it. That is only going to happen if that man has very good relationships with everybody who could put their shoulder to the wheel.

Dr Budd: The Lothian deprivation interest group sees the development of the link worker project as an extremely positive move. In the south-east of Edinburgh, in Craigmillar, there is a project with community renewal—an organisation that you might be familiar with—that is looking at case management. The project is about working on a one-to-one basis, over a period of time, with patients with multiple complex needs who are not engaging with any services and linking them in and supporting them to make use of services. It seems to be producing really positive results. That is something that the link worker might well move into, because it is not just about signposting and information; it is about enabling people to engage with the resources that are in the community.

We know that there are many projects that offer all sorts of things but which local people do not engage with. One of the issues that came out of keep well was that of how we enable people to engage effectively with the resource that is there. The provision of someone such as a link worker is extremely positive, and I think that GPs would be very supportive of that.

Lorna Kelly: The link worker programme is being tried out in Glasgow, and we are also connected to it through CHP services. We are keen to find out from the evaluation the impact of not only the link worker role but the additional resource—after all, the pilot is providing additional resource to practices to fund link workers. We need to find out whether it is the additional resource that is making the difference and, if so, whether that resource would be better used elsewhere, or whether the real issue is having a link worker. That will help us with some of the questions that we have been grappling with about the amount of additional money that we might want to put in and what we would do with that money if we had it.

Professor Watt: It is important that we learn from this. Although we might be able to imagine solutions to many of the issues that we have identified, we cannot be sure that we have found the perfect one. The important thing is to determine the direction of travel and to make a commitment not only to learn from the pilot, but to share that learning.

However, as Andrew Buist has pointed out, we lack that infrastructure—practices do not have the means to meet and share and compare experiences and views. The deep-end project shows what can come out of providing such infrastructure. Routine data and statistical ranges can be used to determine outliers, which we can then try to manage, but what we want to do is to shift mainstream behaviour by influencing professional norms of what people feel is acceptable and what they aspire to. In the absence of routine data, that can be done only on the basis of shared views and experiences. Committing services not only to developing new ways of doing things but to learning from those things—and sharing that learning—is a really important part of the prescription for the future.

The Convener: Thank you for that. As members have no more questions, I ask our witnesses whether they have any issues that they wish to put on the record but which have not yet emerged in our discussion.

Lorna Kelly: I simply want to bring in the patient's voice. Last year, we engaged with groups with protected characteristics. A lot of our conversation this morning has centred on deprivation, but we looked at groups with disability and groups of different sexual orientation and different races and religions and so on, and one of the very strong messages that emerged from that engagement was the extent to which people valued primary care. They valued it because they could build a relationship with their practice and because practices knew about their personal circumstances.

For example, if a disabled person had a personal assistant or particular access requirements, the practice knew about them and understood who might come with them and how all that worked. However, whenever they accessed other services, particularly those in hospitals, they had to explain themselves over and over again, and they experienced the fear and uncertainty of not knowing whether their needs would be accommodated, of missing an appointment that they would be called for and so on.

That evidence supports much of what we have been saying in the context of deprivation about the value of primary care and the relationships that it involves, although the sense is slightly different with regard to smaller or more marginalised groups that we have not talked about as much. They really value those relationships, the knowledge that practices have of individuals and the way in which those services can respond to their needs.

The Convener: That timely reminder brings us back to the evidence that we heard last week on gatekeepers and transition and, indeed, some of the work that we have carried out on the transition from children's to adult services, which raised similar issues about trust and continuity of care in the move from one system to another. We appreciate your underscoring of all that.

Professor Watt: Now that we are on to final points, I simply note that our submission ends with what I think is a really important conclusion. Although universal coverage is very important—as Pauline Craig has pointed out, it gives everyone equal access—it does not allow practitioners to respond proportionately to need, which brings us back to the equity issue that Ms Craig highlighted. It is often assumed that, because we have universal coverage, we have solved the problem.

One of the reasons why Americans find it so difficult to imagine that there are health inequalities in the NHS is because they think that universal coverage has solved the problem. It has solved one problem, but it has not solved the problem of responding proportionately to need. The committee might adopt that principle as something that the health service could be called to account on in its delivery.

Dr Buist: We have made the point that there is a need to find a way to provide greater investment in primary care and to build the services around the primary care team in the local hub.

I will make a final point about the need to stabilise the workforce. There are signs that we are on the cusp of a recruitment and retention crisis. Something needs to be done very soon to promote general practice as a career choice; the opportunity could also be taken to emphasise the benefits of working in deprived areas and, indeed, rural areas. We need to do something about retaining doctors and having returner schemes for doctors so that they do not leave the profession for ever, because if they are lost to the service that is not a good use of the major amount of resource invested in training them. We also need to do something to encourage GPs who are coming towards the end of their careers to stay on for a few years longer.

Finally, if any members of the committee would like to visit a general practice, I would be delighted to arrange that so that they can see what a general practice is like today.

Dr Craig: We have some tools that help us to consider equity in the system and to think better about proportionate universal services, but we need more push in the system to enable us to do that. We need to provide equity analysis. Such research is still fairly marginal, so we need something system wide that enables us to bring that information to the fore and build it into the tools for planning.

Dr Budd: I also extend an invitation to members of the committee to visit my practice. We operate as a hub—a one-stop shop—as we are co-located with social work and housing. We have an extended primary care team with attached workers, including CPNs and addiction workers. It is the kind of model that we have been talking about this morning and which could be a basis for integrated working. It might be useful for committee members to come along and see how it works, to find out about its strengths and weaknesses, and to hear what we have learned over the years in developing our service.

Professor Watt: An example of what Pauline Craig is talking about is access to specialists. The use of hospitals for emergencies pretty much reflects need, because there is nothing to stop people being admitted, but people's use of non-emergency hospital services—either as out-patients or cold admissions—does not have the same slope; it is much nearer to being a flat distribution.

There are many reasons why that might be the case. The main one is the number of social processes that are involved in getting into hospital to see a specialist. It is partly to do with how patients present and how that initial encounter ends. Once patients get into the system, equity is pretty good. As Iain Gray said in the Public Audit Committee when it looked at cardiology services, there are problems in encouraging people to use the services to which they are entitled. The social patterning of access to specialists would be a very good issue to look at to start the sort of work that Pauline Craig has described.

The Convener: As none of our other witnesses would like to comment, Bob Doris has a final question.

Bob Doris: You inspired me to make a final comment, convener, because you mentioned gatekeepers to the system and Lorna Kelly spoke about marginalised groups. The committee has done really well on a cross-party basis to establish a Scottish way when it comes to access to healthcare. I get the sense from some of the witnesses that there would be no appetite among them to support Lord Warner's comments that the

NHS should be a subscription-based service. I can only imagine the additional barriers to access that that might create. Given the topicality of the issue, it would seem weird not to put a comment on that on the record when the committee is considering access to primary health care.

Dr Buist: I read those comments this morning. I think that it would be a very retrograde step to go down that route.

The Convener: Dr Buist speaks for you all.

I thank you all for giving your valuable time this morning and for the evidence that you have provided. The committee looks forward to continuing its work on this theme and, with your help, to maybe making incremental differences.

11:30

Meeting continued in private until 12:00.

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e-format first available
ISBN 978-1-78457-135-1

Revised e-format available
ISBN 978-1-78457-150-4

Printed in Scotland by APS Group Scotland