OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 24 September 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 24 September 2019

CONTENTS

HEALTH AND SPORT COMMITTEE
21st 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:

Clare Cable (The Queen's Nursing Institute Scotland)
Dr David Chung (Royal College of Emergency Medicine Scotland)
Sara Conroy (The Chartered Society of Physiotherapy)
Theresa Fyffe (Royal College of Nursing Scotland)
Kim Hartley Kean (Allied Health Professions Federation Scotland)
Joanna Instone (British Dietetic Association)
Alison Keir (Royal College of Occupational Therapists)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health and Sport Committee

Tuesday 24 September 2019

[The Convener opened the meeting at 09:30]

Primary Care Inquiry

The Convener (Lewis Macdonald): Good morning, and welcome to the 21st meeting in 2019 of the Health and Sport Committee. We have received apologies from Alex Cole-Hamilton. I ask everyone in the room to ensure that their mobile phones are turned off or to silent. Although it is acceptable to use mobile devices for social media in the room, please do not take photographs or record proceedings, as we will do that for ourselves.

The first item on the agenda is the first evidence session in the formal second phase of our primary care inquiry. With us on our first panel of witnesses, we have Kim Hartley Kean, who is the head of the Royal College of Speech and Language Therapists' Scotland office, and is representing the Allied Health Professions Federation Scotland; Sara Conroy, who is a professional adviser to the Chartered Society of Physiotherapy; Alison Keir, who is the policy officer for Scotland at the Royal College of Occupational Therapists; and Joanna Instone, who is the head of external affairs at the British Dietetic Association. We have about an hour for this panel.

To start, I would like each member of the panel to answer a question. How do you define "multidisciplinary team", and what is the role of your profession and other allied health professions in it?

Kim Hartley Kean (Allied Health Professions Federation Scotland): The Health and Care (Staffing) (Scotland) Act 2019 provided, for the first time, a statutory definition of "multidisciplinary team". If I remember correctly, it means the team of health professionals who are required to meet the needs of the individual. The multidisciplinary team is also defined in the 21 principles that were set out by the primary care clinical professionals group.

However, in the view of the Allied Health Professions Federation Scotland, the definition of a multidisciplinary team that is contained in the Scottish Parliament information centre briefing, the general practitioner contract and other such documents is too narrow. It needs to be much broader. The multidisciplinary team in primary care needs to involve not only the GPs, the nurses and the few AHPs that are mentioned in the General Medical Council contract or the workforce plan—that is, occupational therapists and physiotherapists. Rather, it should extend well beyond that to include speech and language therapists, art therapists, dieticians and the 14 professions that compose the AHPs.

Sara Conroy (The Chartered Society of Physiotherapy): For me, the multidisciplinary team needs to include everyone who can make a difference to patients. I completely echo Kim Hartley Kean's point that it must include all the professions. Sadly, we often talk simply about doctors and nurses and we forget that there are a lot of other professionals whose input is required if we are going to change the health of communities. GPs, nurses, the families, the AHPs and stacks of other people are all needed to make sure that the patient has a good experience and has their needs met.

Our role within the multidisciplinary team involves helping patients regain their function and their independence and to get back on their feet so that they can make the most of their lives and contribute to their communities rather than get home from hospital, close the door and never see fresh air again. We are sadly lacking in that regard at the moment. We should not think of the multidisciplinary team as involving only doctors and nurses, as they are not the ones who will help the patient get back their independence once they leave hospital.

Alison Keir (Royal College of Occupational Therapists): I also echo what has been said, but I would go further, because I believe that we also need to think about the multidisciplinary team including our social care colleagues, such as social workers and support staff, as well as, increasingly, our third sector colleagues.

Occupational therapists are a finite resource. In our model, we view ourselves as experts, but we are happy to share our skills to upskill other people in the primary care team to give the best response for people at the best time.

We have missed out the patient, who is, ultimately, part of the team. Do we need to make a shift to dealing with the patient as the expert in their condition, moving away from a medical model of care to a more patient-focused social model?

As occupational therapists, we work with all population groups, but we put our main offer for primary care around frailty and older people, around people who, because of ill health, have problems with being at work or getting back to work, and around people with mild to moderate mental health problems, who are often deemed not unwell enough for mental health services and who could be supported differently if we helped

them sooner, rather than when they get to crisis. We would also like to provide support earlier for people with long-term conditions who are beginning to display functional decline, because we know from the evidence that if we are involved earlier people have better outcomes and it costs less.

Joanna Instone (British Dietetic Association): I echo what my colleagues have said about the definition of the multidisciplinary team: it is all the allied health professionals, and it is centred around giving personalised care to the patient and achieving the outcomes that the patient wants and that are relevant to them. The dietician very much has a role to play. As you can imagine, nutrition is integral to practically all disease states including cardiovascular disease, mental health problems, diabetes, obesity, renal disease and liver disease, but dieticians are often forgotten. We are a very small profession—in Scotland, there are 681 dieticians for a population of 5.4 million so there are not many of us—but we have an integral part to play. We need more dieticians in the primary care role.

The Convener: Thank you. It is interesting to consider the four answers. The first answer, from Kim Hartley Kean, said that the definition is too narrow and every other witness extended it further. There is clearly a sense on your side of the table that narrow definitions are a problem. What is your sense of the public perception of the multidisciplinary team and how primary care is delivered, given the centrality of that to future plans?

Kim Hartley Kean: From reading the inquiry's phase 1 report, I would say that the public seem to have a more AHP perspective on how primary care should focus than we see in official documents. That is incredibly heartening. The majority of both men and women would be perfectly happy to see other professionals—your survey identified all the AHPs that they would be keen to see as first-point-of-contact professionals—so I feel that the public want to do things differently.

As Alison Keir said, we need to shift away from the medical treatment approach to primary care to a more person-centred model. In essence, GPs and our colleagues in what we would narrowly define as primary care at the moment need to start behaving a bit more like AHPs. The public seem to be asking for that; they want a person-centred, patient-led approach and they want to be owners of their own records and self-management. We would say that the public are absolutely right in wanting services that are a bit more like the way that AHPs are already delivering them.

Sara Conroy: Yes; I think of the example of first-contact practitioners in GP surgeries seeing patients with musculoskeletal conditions. Satisfaction has been really high and that model is being rolled out across Scotland at the moment, in light of the GP contract. We have shown that the roles are not a substitute—they are the experts. AHPs are experts in their own right, having gone through a difficult four-year honours degree course to get where we are. We are not there as substitutes but because we should be there, and there are many other professions that could step up, such as community respiratory teams and teams that work with the frail and elderly. On the principles of realistic medicine, patients do not just want more drugs and surgery; they want to get back on their feet, play with their grandchildren and get out, and that is what AHPs have to offer.

The public are certainly onside. We also need to make sure that the public know what they can expect. Too often, patients come out of hospital and feel isolated and alone. They do not know that those services exist, basically because they are so thin on the ground. Someone might be waiting for weeks to see a physiotherapist or an occupational therapist who would help them to get back on their feet and think about getting out or back to work—we cannot afford to ignore those services. They are what the patients want, and they would reduce social care costs and help people to contribute to society. The public are onside, but there is work to be done to remind them of the potential of all our professions, because we are so thin on the ground.

The Convener: There is a brief supplementary from Brian Whittle.

Brian Whittle (South Scotland) (Con): I could not agree more with Joanna Instone about the requirement for more dieticians. That could solve a lot of problems in our society.

The convener asked about the public's perception of how they would like their treatment to be. We have heard a lot of evidence, including anecdotal, about the public's perception that they come to you so that you will make them better. Part of a dietician's role, and that of physiotherapy and occupational health, is to enable the public to help themselves to get better, but our evidence suggests that there is still a bit of work to do on that. Do you agree? Patients want you to give them a magic pill, basically.

Alison Keir: I absolutely agree that we need a culture change, so that people understand that their GP might not necessarily make them better. For someone who has a long-term condition, it is about having strategies to help them to manage the condition. That is a very different approach from pitching up to somebody who gives them medicine that makes them feel better. It is about helping to break down what the problem is, setting and reviewing goals and taking a very person-

centred approach that is about what matters to the patient in their everyday occupation. That is not what people expect when they go to their GP at the moment, so we need to shift that perception.

Joanna Instone: Another perception that patients have is that they need to see somebody face to face. A lot of what dieticians do is education at a group level, which could be face to face but could also be online. We need to break that down and shift the perception.

Emma Harper (South Scotland) (SNP): I am interested in what Joanna Instone said about having more dietetic advice in primary care. Last week, at the cross-party group on diabetes, Brain Whittle, David Stewart and I heard about some interesting research on some folks who are now in remission from their type 2 diabetes and not taking any meds any more. That was partly due to good, sound dietetic advice for people who are participating in some of the studies, which show that they are doing really well. What does primary care mean to each of you?

Sara Conroy: To me, primary care is all the services out in the community—not just GP-led ones—that will allow the patient to live well in their home environment, which is what we aim for. There are community respiratory teams, community rehabilitation teams, and teams that look after the frail and elderly, which are all out there and not GP led. They are not funded through acute services or the GMS contract, so they are in a kind of no man's land in the middle. That is where we need to concentrate, if we are going to change primary care and support patients to live well in their communities.

09:45

Kim Hartley Kean: To expand on that, in the SPICe briefing and the paperwork around this inquiry, there is a big gap in the information on provision that is already out there in the community, with which GP practices are not linking up. The majority of AHPs work in teams, of which GPs are not an integral part. We are not engaging with them, and it would be great to join those aspects up.

I can give you a few examples. AHPs are core to community learning disability teams, community mental health teams, children and young people's services, falls services, community rehab teams, dementia care, weight management, pain management and adverse childhood experience related services. None of those services in which AHPs operate are mentioned anywhere in any of the inquiry paperwork. They are already going on, and there is an enormous disconnect.

The view of my colleagues in CSP, which I wholly support, is that we need a whole-systems approach. We have to start to think of primary care as including both what happens in the GP surgery and GPs connecting up with all the other services that prevent a lot of people ever going anywhere near their GP.

Most of the AHPs are already first-point-of-contact practitioners. You can self-refer to almost all AHPs already. People do, and they get therapy and the best provision and support that they need; they carry on with their lives and the GP never sees them—nobody in primary care does.

We have to start taking cognisance of the fact that primary care in the community is much broader than the narrow focus that we have been looking at. If we could get those aspects joined up, we would be in a much better position.

Alison Keir: There is also a need for earlier intervention. Primary care needs to shift away from when people first have a fall or a problem, to when they are first unsteady. If we intervene sooner than we have traditionally, we could have much better outcomes for people; we could keep people better for longer and it would cost less money. We need to shift primary care further upstream.

Joanna Instone: I echo that point. Primary care should also include prevention. Lots of schemes that are run by dieticians in schools or in communities help to prevent illness. In Scotland, we also have two consultant dieticians in public health, who deliver schemes in the community. We need to make sure that we can supply a whole-system approach, which includes making affordable healthy food available to people, and preventing the impact of food that is less healthy. We need more abundant, locally sourced food for our populations.

Emma Harper: There is obviously a disconnect in collaboration between GP practices and the way that services are provided. It is obvious to me that allied health professionals are crucial to delivering many services across primary and secondary care. How would you see health and social care integration and primary care of the future being delivered in conjunction with secondary care? Looking at aspects of prevention, we need AHPs in community, secondary and primary care. What needs to change?

Kim Hartley Kean: Having read all the submissions from all my colleagues, and being fully signed up to the primary care clinical professions group principles, I suggest that, fundamentally, we need to change the beliefs and attitudes that are expressed about other services, and specifically about AHPs, up, down and across the health and social care agencies, and—I would suggest—in the Parliament, Government and mass media.

We have an attitude or belief, which is communicated in papers and in how we talk about other services, that AHPs are somehow peripheral or an optional extra. In the paperwork on the GP contract and in some of the reports that you have seen, AHPs are described as if they are second-class clinicians. There is a view that AHPs and the services that we provide consist of tasks that GPs simply do not have time to do but that they could do if they had the time. That is not what is going on. AHPs do not do jobs that GPs could do if they had the time. We do jobs that GPs do not have the knowledge and skills to do—they could not do them even if they had the time. We have to start challenging that attitude.

We need an education programme on the key facts about AHPs to be instigated across agencies, from top to bottom. Perhaps there could be a core common undergraduate module for everybody involved in health and social care. That would enable some relationships to develop further down the line. We need to change the narrative and the language about AHPs, and we need to take every opportunity to challenge some of the misinformed views about what AHPs do.

As long as we have the attitude and misinformed belief that everything is about what happens in the GP surgery and we are not enabling a conversation with all the other services because they are somehow secondary, we create cultural barriers within health and social care, which prevent us from moving forward with a more joined-up, integrated approach.

Alison Keir: With the integration of health and social care, we have a new opportunity through the locality plans. We have locality plans for each integration joint board, which tell us about the population in an area and the challenges for that population. For example, occupational therapists in Fife know that a particular general practice has a challenge around people who are not at work. The options that a GP can offer to those people are limited. Medicine will not necessarily get them back to work. However, an occupational therapist is now going into that practice to help people as they consider what skills they need to get back to work, while working with employers, addressing the particular need that was identified through the locality plan and linking that to the staff in the practice.

For older people, we need to have a greater acceptance of the evidence that we increasingly find in front of us. For instance, work carried out at Newcastle University and the University of Strathclyde has followed the course of function decline as we age. As we age, we will all lose function. However, we increasingly know that getting old does not necessarily mean that we become disabled. Older people can be fit and independent. We know that there is a pattern to loss of function. We know that, when people first cannot cut their toenails, there is significance in that, because it is then followed by their not being able to walk a certain distance or to do their shopping. We know that through evidence.

We know that, if we, as therapists, get involved at that time, an intervention will cost about £2,700, which will add five good years back to the person's life. That lets them be more independent for five years, for a relatively small cost. At that point, people have the ability to regain their function. Traditionally, we get involved when people are really dependent. When people have lost that function and need major house adaptations and large care packages, an intervention at that time will cost £40,000, and we cannot change the person's function. We have missed the window to do that by that stage. We really need to think about when we intervene. That should be sooner.

The Convener: Before we come to Sara Conroy and Joanna Instone, I have brief supplementary questions from Sandra White and David Stewart.

Sandra White (Glasgow Kelvin) (SNP): What do our witnesses think about the GP contract? Under those contracts, GPs are seen as local clinical leaders. Is that detrimental to moving on, given what the witnesses have been saying?

Kim Hartley Kean: That is an example of language that is unhelpful in a multidisciplinary team. I have to be careful here: as members of that multidisciplinary team, our GP colleagues do an important job, but everybody in the team does a valuable job in order to deliver the person-centred care that the public ask for.

We must stop communicating a narrative that says that other clinicians are not able to make independent decisions and are not autonomous clinicians who hear what matters to patients and enable them to live the lives that they want to live. We also need to stop the narrative in the public sphere that leads people to say that if they have not seen their GP, they have not received primary care. We must start changing how we talk about this and, on this stage in the Parliament, in the media and in boardrooms, we need to start breaking down those misbeliefs. For example, despite the narratives that keep rolling on, physios do more than MSK, OTs do more than mental health, and speech and language therapists do more than kids. We have to change the conversation. Until we change the conversation here, in the media and in boardrooms, we will not change the beliefs in the community. I was heartened to read that the public seem to be saying: "I want my health service to do what matters to me. I want to be able to do the things that the AHPs enable me to do."

Joanna Instone: I like the primary care home model, with the patient going into the GP practice and through an informed triage system, and being directed to the most appropriate professional for their symptoms and story. That does not necessarily mean that they will see the GP first. For instance, if the patient has gastroenterology symptoms, they might be directed via the triage system to the dietician, who would do the assessment and, if there were any red flags, would refer the patient to the GP. The GP is not necessarily the leader. I echo what Kim Hartley Kean said: the GP is part of the team. That is how I envisage primary care in the future.

Alison Keir: I echo that. GPs might or might not be the leaders. In Grampian, the stroke service in the community hospital was traditionally led by a GP, but it is now led by an occupational therapist. The length of stay has reduced by two weeks, because the approach to care is different. It is a goal-centred, what-matters-to-you approach to care, rather than a medical model. Sometimes, different professions are better placed to be the leaders.

David Stewart (Highlands and Islands) (Lab): I will go back to the useful point that Alison Keir made about indicators of independence—for example, the inability to cut toenails being followed by problems with mobility.

I will use another example from our cross-party group on diabetes, whose membership includes three members of the committee. The example involves the monitoring of foot pulses. We know that, in diabetes, poor circulation in the foot is one of the main reasons for amputation. Diabetic nurses have told me of their concern that some care homes were not monitoring pulses, with the obvious effect that they were not aware of potential amputations. Such things are key. Alison Keir gave a good example in that regard.

The Convener: That is more a point than a question.

David Stewart: Yes.

Emma Harper: We have had feedback about embedding welfare specialists in GP practices. They are not allied health professionals but they are professionals who help patients. Recently, I heard about somebody who was given antidepressants instead of debt consolidation advice and support.

We need to look at everything that is going on with the patient. The current perception is that GPs are the gatekeepers or leaders, and we build care around the GP practice. Are you saying that we need someone to triage the patients? If so, the triager would need to be very knowledgeable in order to know to which specific allied health professional to direct people.

10:00

Joanna Instone: We have looked into that in dietetics in great depth. In Somerset—rather than in Scotland—we have a dietetic-led gastroenterology clinic in primary care. The clinic has given an algorithm to the receptionist, who asks a question and, depending on the answer, moves on to the next question, and then determines whether to refer the patient to the clinic dietician without seeing the GP, or—if they are already under the care of the GP for that condition—to refer them straight to the GP. There is a way to do that without putting too much onus on the receptionist. Receptionists are not medically trained, but they can follow a simple algorithm, which will enable the patient's direction to be determined without too much stress.

Sara Conroy: The start of Emma Harper's question was about how to join things up and think about the funding in primary care. It is about looking at a patient pathway. I agree that not every patient has to end up in a GP's surgery and not every patient who comes out of hospital needs to go back to the GP, but they do need help and services. We need to ensure that things are not siloed: we must look at the whole pathway and ensure that the funding follows the patient, rather than having separate funding for acute care and for the GP contract, with IJBs and, probably, AHPs in no man's land. Who funds that bit in the middle? It is about joining everything up and ensuring that we do not have funding silos.

At a recent meeting on the future of AHPs in primary care, we talked about many examples, including community respiratory teams, which use dieticians, OTs, physiotherapists and nursing colleagues to work in the community with patients who have chronic obstructive pulmonary disease to keep them away from hospital and enable them to self-manage. We talked about that as an example of the real added contribution that we could make. It was suggested that that does not come under the GP's budget—once that patient is in a blue-light ambulance, they do not really mind. The question is: whose budget does it come under? It will save money for the GP and for secondary care and it will improve that patient's life and is what they need, but whose budget covers it?

We need to join things up and look at having pathways that allow the funding to follow the patient rather than sit in silos.

Kim Hartley Kean: What Emma Harper has described is a one-door policy, which makes a lot of sense because everyone knows where they have to go. Patients go into the GP surgery or the primary care hub and somebody signposts them—perhaps using an algorithm—to whomever would seem to be the best person for them to see

initially. That could be any first-contact AHP, which is basically all of us. The alternative would be to have many doors through which people could be signposted to the right people. Why would we want to narrow it down to one door?

I have talked about teams. We have community mental health teams, community learning disability teams and loads and loads of AHPs out there in the community who are perfectly capable of signposting patients to the appropriate people. In fact, we already do that—we refer people to our colleagues all the time. If we were to start thinking about enabling people to access services in the way that they find easiest, we might conclude that the person whom they bump into already could be the most helpful. That approach would be much more fluid, as opposed to requiring people to go to another place to access services—although there is also the benefit of clarity when people are given something that says, "This is your primary care hub".

If the objective is to ensure that people get to the right person at the right time as quickly as possible, we need to create multiple ways for them to do that. However, that will work only in the context of much better public awareness—informed by a positive attitude to multiple doors—of who is available, what they do and what they can do for a specific individual.

If we do that, we will need put in serious investment. At present, the promotion of AHP services tends to be down to the AHPs themselves, who are busy clinicians. They are trying as far as possible to send tweets and raise awareness—they run stands everywhere—but that will not cut the mustard in terms of changing attitudes.

The Convener: There is an argument that a single door is helpful for the patient.

Emma Harper: There is a bit of ambiguity, as we have heard, given the fact that GP practices are independent and employ their own staff. I guess that I am moving on to a different subject. The new vision appears to anticipate that the proposed model would blend seamlessly with the employment of staff by health boards and local authorities. Would any variation in the current model of employment in GP practices, which employ their own staff rather than using national health service staff, present any new challenges in realising the future vision for primary care?

Sara Conroy: In England, where physios have taken on first-contact practitioner roles for MSK patients, some GP practices now employ their own physios directly. In Scotland, most of our staff are employed directly by the health board. That is important from the point of view of governance and training, and it allows for succession planning to ensure that there are links with more junior staff coming through.

I think that you are asking whether it would be challenging if GPs employed those staff directly. I think that it would be, certainly given the models that we use for working and for training and development.

Joanna Instone: I cover the whole United Kingdom, including Wales, which is doing some research into how different unique professionals work together in the multidisciplinary teams. That research will help with ensuring that each team works properly and that staff are supported, no matter what, in relation to continuing professional development, pastoral care and supervision. All those aspects of looking after a member of staff are important, whether they are in community services or in a GP practice. A professional who is a lone individual, as it were, in a multidisciplinary team still needs that support; where that support comes from is the question that really needs to be answered.

Sara Conroy: That is what I was trying to say—you have said it much better.

George Adam (Paisley) (SNP): Good morning. I will come at my question from a different angle, given the way that the discussion is going. I was going to ask about cultural change, but we have already discussed that to a degree.

I will highlight one of the interesting aspects. During the summer, we had an away day where we got together with members of the public and discussed how to design a primary care delivery service from scratch. Nearly every one of us—at the west coast away day at least—came to the conclusion that GP practices were not the be-all and end-all, which is effectively what you are saying today.

I have been an elected member for years and years; my hair used to be brown. [*Laughter*.] Since I became an MSP—and when I was a councillor—we have discussed the same topic over and over. I have read more reports on the subject than I can remember—in fact, I probably do not remember half of them. How do we stop talking about it and create the cultural shift that we need? What is your role in all that?

The Convener: That is a big question.

Alison Keir: We need to be bold. We spent a lot of time doing tests of change, and we gather bits of evidence, but what do we do with that evidence? That is what the committee describes in its phase 1 report.

We have some evidence on the benefit of our role in primary care. Although we do not have evidence from across Scotland, I argue that the evidence that we do have is completely

transferable. We know that we can reduce return visits to the GP by more than 50 per cent. Surely such evidence is strong enough to show that we just need to make that change.

I have also talked about the evidence showing that if we see people earlier, we have better outcomes and save money. We probably have enough evidence to know that we need to change things. We also know that we cannot carry on doing what we are doing. There needs to be a real drive from Government to do things differently and to be bold and take that forward.

Kim Hartley Kean: I absolutely echo that. We have all this evidence and then the narrative becomes one of a conversation about the crisis in one profession, when actually there is a crisis across the multidisciplinary teams in terms of the workforce. That should inform the thinking.

We need to act on the published policies. All the primary care policies that we see talk about AHPs and multidisciplinary teams, so let us act on them.

We also need to act on the evidence base, as Alison Keir has just said. To do that, we have to improve AHP service capacity through funding, workforce planning, education and training.

In order to make the change in the decision making that happens in Government and at board level, whether at IJB or health board level, we need intelligence about AHPs to be at the table, and it is not at the table at the moment. We therefore need to establish all-AHP-informed leadership on those boards. Once that happens, all the evidence that Alison Keir and the rest of us have talked about will be repeatedly referred to when decisions are being made. That evidence will be up to date and it will not be overshadowed by unfortunate wrong beliefs and attitudes about AHPs. Only an AHP leader will know that there has been a test of change somewhere in Scotland that has created a huge difference, so we need that intelligence around the board table. At the moment, we do not have someone informing those decisions about the investment in the workforce and the services that we set up. We need to start reflecting the evidence in our decision making, and we can do that only if someone who knows about all that intelligence is at the table when the decision is made.

Joanna Instone: The professional associations can take a role, but that needs to be supported through the NHS or Government. We need to promote the role of dieticians and all AHPs in primary care to the public—and to GPs, because they are not necessarily aware of how to use AHPs. I add a note of caution to that because, at the same time, we do not want to raise expectations that we are not able to meet because we do not have enough of the AHPs that people will be crying out for once they have seen the awareness campaign.

Sara Conroy: We are seeing that with FCP MSK roles in GP practices. Through the contract, GPs asked for 280 additional physios to work in those roles. However, we also have recruitment and retention issues. We have 70 or so in post and we have a commitment to increasing the workforce over the next three years. The decision seems to be stuck. We promised that for last January's intake, but it looks like we will also miss it for this January's intake.

There has to be a vision for the future. We have to make plans, but we do not have proper workforce planning for the AHP profession. We do not even get a mention in the SPICe paper and we cannot tell you how many AHPs there are out there. If we do not know that, how can we plan for the future and plan new models?

We can make huge differences—we all know that—but we need to fund them, think about the future and make sure that there is a supply of physios coming through.

10:15

George Adam: Part of the ongoing debate on the cultural change that we talk of is people self-managing long-term conditions. In my opinion, you guys are an important part of that. I always use the example of my wife Stacey, who has multiple sclerosis, because it was a physiotherapist who taught her how to walk properly with her crutches, after she had had them for about 10 years. A doctor would not have made any difference in that scenario. How do you get yourselves into the position of being there for an individual when they are looking for that kind of help? That is the difficulty.

Sara Conroy: We are continually shouting about that and have done lots of research. On pulmonary rehabilitation, for example, the Cochrane review said that we do not need more evidence. We know that self-management works and that we can teach patients with COPD the skills to self-manage, which we know reduces hospital admissions and prescription costs. However, we still do not have that service universally for everybody across Scotland.

So, what can we do? We can continue to put the evidence out there, but as Kim Hartley Kean said, we need seats at board tables and we need to ensure that when policy is made it does not get lost in the civil service bit in the middle, and does not come back to the board as being about having more doctors or nurses, with AHPs not even being on the agenda.

We know that what AHPs do can make a big difference to people with long-term conditions or are frail from, for example, MS, stroke, cardiac illness or COPD. We cannot help patients to live with those conditions without AHPs, including physiotherapists, being involved. We have the evidence, but we need the investment.

Kim Hartley Kean: Would people would wait to see an AHP if they knew that, through a self-referral system, all they have to do is phone their local AHP services—for example, the speech and language therapy service—to say that they might need help? People do not know that, so they do not self-refer. They therefore have to wait and to go along a pathway—hoping that the GP or whoever they are dealing with knows what speech and language therapists and other AHPs do—on which they might get a referral or be signposted to an online resource. However, we would not need such a pathway if people knew to which AHP services they could self-refer. A person who is having problems with swallowing, for example, can phone a speech therapist directly for help.

The Convener: I am pleased to tell witnesses that the discussion is on the BBC's online coverage of Parliament this morning, so all the good awareness points that are being made are reaching a wide audience.

Kim Hartley Kean: Magic!

Alison Keir: George Adam mentioned cultural change: we need to focus on that. I give the example from Wales of a young lady with a disability whose care was managed in a traditional medical way. However, when she was asked what her own goals were, she said that she wanted to be able to put her child to bed and to go shopping. The medical model, however, meant that her incontinence, fatigue and medication were being managed so that, over a two-year period, she had more than 200 interventions from therapists, nurses and doctors, but was not putting her child to bed or going shopping.

Instead of starting by looking at the medical problem, we should start by asking the patient what is important to them. That is where AHPs are ideally placed to help people. We should start with what patients want to do, then look for solutions to help them to do that.

George Adam: Alison Keir's point leads on perfectly to my final question. Can you give me, from your professions, examples of innovation and new working within the current system making a difference to people's lives? Alison Keir has kind of done that already.

Alison Keir: I reiterate that we would push for care that starts with what matters to the patient. That is not a more expensive option; it is an option that lets us tailor what is needed instead of working round what we think is needed, which is a different thing.

Lewis Macdonald: Thank you. We have supplementary questions from Emma Harper and Brian Whittle.

Emma Harper: I have a quick question for Sara Conroy. The Government is due to publish a respiratory care action plan before the end of the year. I assume that you believe that the plan should contain pulmonary rehabilitation, given that we know that the evidence is that PR keeps folk out of hospital. As the convener of the cross-party group on lung health, I know about the respiratory action plan that is due to be published. Do you support PR being included?

Sara Conroy: Yes. PR has to be in the plan.

Brian Whittle: My question, which I was going to ask later, follows on from what George Adam said.

We are hearing a lot about the Government emphasising training of 800 new GPs. I have always questioned whether that is actually what we need. I am sure that you know where I am going with this question. How much input did AHPs have into the development of the new GP contract? How much influence should you have over whether the focus should be on delivery of service, rather than on numbers of GPs? I am not convinced that finding the number of GPs that we are short of will deliver the service that we need in the future. The culture must change from the top—the Parliament—down.

Sara Conroy: Absolutely. The change has to come from the top. We were not very involved in the general medical services contract. I am a physiotherapist; we were lucky to get a snippet in there to highlight the difference that having physiotherapists and MSK physiotherapists in GP practices can make. We have demonstrated time and again that it frees up GP time, reduces secondary care referrals, and reduces prescription costs.

There are lots more examples. We cannot manage the conditions of the frail elderly population, for example, without occupational therapists and physical therapists. We have touched on respiratory conditions. We have to be involved in all those things.

It is disappointing. We had the national clinical strategy a couple of years ago and we talked about healthcare and social care, but what about the big bit in the middle—rehabilitation, which enables patients and gives them better quality of life. If we continue to produce papers such as that one, which ignore the huge contribution that AHPs can make in the community, we will just get more of the same. GPs cannot just continue to give

tablets in order to manage frailty and multiple long-term conditions, and we cannot keep people in hospital. We have to look at that big bit in the middle, fund it properly and embrace what AHPs want to deliver for the population.

The Convener: I know that there are witnesses who want to add to that; I am sure that they will have that opportunity in the next area of questioning.

David Stewart: Can you describe workforce planning for your individual workforces? Will it meet the demands of the new plans that we have for delivering primary care in the future?

The Convener: Let us start with Kim Hartley Kean. I know that Sara Conroy has already said a little bit about the workforce, so we will come back to her.

Kim Hartley Kean: Do you mean what is the workforce plan for AHPs?

David Stewart: Yes.

Kim Hartley Kean: As Sara Conroy has already said, there is no workforce plan. As everyone else is, we are waiting for the integrated workforce plan. We want it to deliver action to address common and specific allied health professions' workforce issues.

I will describe what the issues are and then what the solutions might be. The common workforce issue for AHPs is that there are too few funded posts to meet demand and provide the transformative health and social care that we want. It is not necessarily the case that we have too few AHPs or people who are trained to do AHP jobs—there just are not enough jobs. I can give you many examples.

That is the common issue, but the various AHPs also have specific workforce issues. There is huge demand to join some professions, but there are too few training places available to allow access to AHP degree or other courses. I am sure that Sara Conroy will touch on that.

There are problems in attracting people to join other allied health professions. Not enough people are being educated or are willing to fill available posts. The common problem is that we need more AHPs. However, how we provide more people will be different for each profession. For example, we have no problem getting people to apply to become speech and language therapists, which is my profession, but we do not have enough training places. Once people are trained, despite there being enormous need, there are not enough jobs for them to go to. That is demotivating for people.

What do we want to see in the integrated workforce plan? As I said before, we must stop focusing on the crisis in one profession: it is a multidisciplinary team issue. As several of my colleagues have said today, we need to act on the evidence of clinical need and the impact that each profession has on that need. We must improve the capacity of the AHP workforce by addressing the general problem in respect of jobs to go to, the supply of AHPs to that workforce and all the nuances around that.

Sara Conroy: Kim Hartley Kean has covered most of the issues. On the back of the GMS contract, the primary care transformation plan has given us workforce planning in physiotherapy. That is for MSK, which is one small part of our profession. When the difference that we could make was recognised, all of a sudden we were asked for new physiotherapists to work at an advanced level, within the next three years. For the first time, we will be in the workforce plan and we will have funded places.

However, it is little and it is late, and it is about just one small part of our profession. Our contribution across the piece—within hospitals, mental health services and communities—should be looked at, and we should consider what the future might look like.

There is no problem recruiting to undergraduate physiotherapy places—the number of people who apply is three times greater than the number of places. We have recruitment issues across Scotland. There are not enough physiotherapists to fill available posts, yet in funding and planning for the places we are still way behind nurses. For the past 10 years, there has been no increase in the number of physiotherapists being trained. That is due to funding issues. For all the professions, a lot needs to be looked at.

Alison Keir: It is also about asking whether the jobs are in the right places. Historically, the jobs have been in secondary care, but the evidence suggests that we are better placed in primary care. The jobs have not caught up with that, yet. At the moment, the number of occupational therapists is roughly equal to the number of jobs, but if that changes and we do things differently, our workforce will look different.

David Stewart: I have a question about poaching—which is not the correct technical term—or moving from one setting to another. I will give an example. I was speaking to a GP in Elgin, who had recruited a community pharmacist. That was great but, subsequently, the firm on the high street had problems recruiting a replacement for that pharmacist. Are you familiar with such issues in your various occupations?

Alison Keir: Yes—but there is an opportunity to do things differently. We might keep the specialist area of expertise but also work with different colleagues. In housing services, we trained

housing officers to do basic grab rails. Previously, patients went on a waiting list for an occupational therapist to do that. We cannot be everywhere, so we have looked at how we can use our workforce to best effect.

Joanna Instone: I would echo a lot of what my colleagues have said—in particular, in respect of jobs not coming up in primary care. Dieticians who work in primary care as first-contact practitioners need skills that are not, at the moment, taught in university when they study for their degrees or their master's degrees, so they need to be trained. We need to address that. The British Dietetic Association determines the curriculum for that training. Internally, we need to do joined-up thinking, but that needs to go hand in hand with jobs being available in primary care.

10:30

Sara Conroy: On the pharmacy example, I was in NHS Highland last week, which wants to roll out MSK FCPs quickly. To do that, the board took 12 posts from the core service to prop up the FCP posts in GP practices. That is another example of the pathways not being looked at. The person might be able to see a physiotherapist relatively quickly at that first point of contact in the GP practice, but there is no core service if they need on-going therapy. There are huge issues, and we are robbing from Peter to pay Paul. Moving posts is about having representation on IJBs. As Alison Keir said, that is where we will make the difference. If we are not at the table, how can we ensure that the posts are created?

David Stewart: I want to ask Sara Conroy, in particular, about the tools that are used in workforce management. One is the Information Services Division dashboard, which looks at vacancies and turnover. Is that a useful tool for you?

Sara Conroy: No, that dashboard is not useful. I ask boards and service leads across Scotland what their vacancy rate is. NHS Grampian, for example, tells me that the rate is up to 40 per cent. The rate in the MSK service in NHS Ayrshire and Arran is sitting at about 30 per cent. However, the data in the ISD dashboard tells me that the vacancy rate for physiotherapy across Scotland is sitting at between 2 per cent and 4 per cent. There is a huge discrepancy.

David Stewart: Why is that?

Sara Conroy: I do not know. We are discussing that within our profession at the moment. We are asking questions about why the data is so skewed and why what everybody is reporting on the ground is so different from what is shown on the ISD dashboard.

David Stewart: Have you contacted ISD to say that there is a mismatch?

Sara Conroy: We have a meeting on Friday to discuss our next steps around that. We have asked each board to provide their figures, which is where we are getting figures of 40 per cent and the like. There is certainly a big mismatch. I do not know whether other professions are finding the same.

Joanna Instone: Another limiting factor is that only two universities in Scotland can train dieticians—I can speak only for dieticians—and take on a cohort of only 30 each year. If we need to grow the workforce that goes into primary care, we need to think about providing more university places to train students.

David Stewart: That boils down to the funded numbers that are allocated to each university, so it is an issue that the Scottish Government needs to look at.

Joanna Instone: Yes.

Kim Hartley Kean: I will briefly pick up on David Stewart's question about whether, in shifting therapists to an area, we lose them to another. There is certainly evidence to suggest that that is happening in children and young people's services. For example, speech and language therapists are working a lot more at universal and targeted level, and are rightly creating communities around children to help their outcomes. However, the therapists cannot also do the traditional one-to-one direct specialist work, so that is an issue.

My colleagues from podiatry have made a submission to the committee; I want to highlight that they, too, are experiencing high vacancy rates, particularly in NHS Grampian. There are big gaps, and we experience what Sara Conroy described, which is that what we hear from our members about vacancy rates and issues is not always the same as the ISD figures.

David Stewart: That is very useful.

The Convener: That is helpful for the committee for when we come to take evidence from the Government.

Miles Briggs (Lothian) (Con): Good morning, panel. Following on from David Stewart's question about where we are in terms of workforce, how is the situation being taken into account for future workforce planning? Is the Scottish Government basing its predictions on the ISD figure? What feed-in do your organisations have to the workforce plan?

Sara Conroy: I do not really think that there is a workforce plan. There is not a lot of thought being given to AHPs. The only reason why

physiotherapy has had any workforce planning in the past goodness knows how many years is because of the GMS contract and the first-contact practitioner MSK posts that have been asked for. For other services, such as community rehabilitation services, COPD services, acute hospital services and so on, no workforce planning is being done at a high enough level to predict what might be needed.

We know that we have an ageing population and that patients who have comorbidities are living longer. I think that it was Alison Keir who said that you can grow old and not be disabled; you might still be able to function, to go out, and to have a good quality of life. You might need our service if you are to do that, but nobody is looking at the changing demographic and thinking about how many more AHPs we need. I do not think that it is happening, full stop.

The Convener: Who should be doing that?

Sara Conroy: Workforce planning is done for the medics and the nurses, and I would like to think that the Scottish Government is workforce planning for the entire multidisciplinary team. We can all show our worth and what we can do, and how the public needs us. It should be the Scottish Government doing that.

Kim Hartley Kean: I want to illustrate that point and back up what Sara Conroy said. We have had a GP contract that has communicated the right messages about what AHPs do. We have had a national clinical strategy that failed to mention AHPs at all. We have had a leadership gap in the Scottish Government for some time—there has been no chief health professions officer in post for a number of years, although the post is now being recruited for.

The capacity and the way in which we are planning at national level have not engaged AHP intelligence and information as they need to do if we are to deliver the service that people say that they need and want.

Miles Briggs: I want to pick up on George Adam's question—and perhaps we could write to others, who are not giving evidence to the committee, about this. When we did the public sessions, it was interesting to hear where people would put services if they designed them themselves. Most people talked about people having a right to referral, instead of the GP being the gatekeeper to every service. When asked how they would access services in their world, they jumped to technology. We know how bad technology is throughout the health service, so that solution does not exist. I am interested in what Kim Hartley Kean said. Could you or the other witnesses recommend to the committee how we could create that solution for the work that we are about to do? How would we break down the barrier, so that patients could access the services that your members provide?

Sara Conroy: That is about access, but it is also about availability once you can access services. My profession has had self-referral for a long time in community services.

However, people have to know about what we offer and how to go about getting it. Once somebody has self-referred, if they have to wait for 12 weeks or 15 weeks or 16 weeks, is that really a service? If you come out of hospital and you need that service when you are weaker and more frail and need to get back on your feet, is waiting for 16 weeks really a service?

The solution would look like a well-resourced service to which people could self-refer, and somebody would turn up at their door. Some areas have the NHS 24 musculoskeletal advice and triage service by which people can be advised or signposted to a website. There is a place for that, but there is also a need for services and signposting. Signposting does not always have to be to health professionals; it could be to the third sector or to voluntary organisations that can help, advise and support people to get back on their feet. We have to get better at signposting to those organisations.

Joanna Instone: I will give Miles Briggs an example. If someone in England has irritable bowel syndrome, they can look at the NHS online health information site. If they look up IBS, they can access a webinar that gives them information about how to self-manage their condition, and, at the end, tells them how to self-refer to a dietician. That is one way in which technology is used in England. I would love to see that spread across Scotland, using the NHS inform service. That is one way of not just providing education but enabling people to refer themselves to a local service, if, after that education, they still think that they need to see a dietician.

Miles Briggs: Finally, with the waiting times that we currently see across AHP services, are self-referrals currently being discouraged, given that we have to control supply in some way? Is that something that your members are reporting? How can it change?

Yesterday I visited a community pharmacy in Edinburgh and we talked about the work that is going on there. I was told that people often say that they will go and check that the doctor is happy first: people still want to access their GP, even though they have already accessed an allied health professional. The GP is often seen as being in charge of the multidisciplinary team. That is still a barrier in GP surgeries. How do we collectively look towards something different? Until we have a

flat model, it is difficult to see how we could change that.

Kim Hartley Kean: Allied health professionals are actively encouraging people to self-refer. As Sara Conroy said, most AHPs work on self-referral. The issue is that people—our colleagues in the health and social care family and the general public—do not necessarily know that they can self-refer or that all those clinicians are not directed by the GP but have the skills to take on referrals and to assess, treat and discharge people as independent clinicians. That message is not being clearly communicated to enough people, as I said.

The links between socioeconomic disadvantage and poor health and wellbeing outcomes are irrefutable. We also know that in socioeconomically disadvantaged communities there are many people who have a communication disadvantage. That means that, for whatever reason, they might have difficulties accessing things online, reading letters and so on. Last year, the Scottish Health Council published quite a detailed report on what we should be doing to make that information and communication door inclusive to many members of the public and to inform them about what it looks like. As Sara Conroy said, the well-resourced services behind that door are essential. We would encourage people to self-refer to allied health professionals in the full knowledge of what each therapist does.

Joanna Instone: The answer to Miles Briggs's question is confidence. We need the confidence of patients, which comes from raising awareness. I would hope that it would come through the associations for the professions, and through the Government and the NHS. People value what they hear from the NHS, perhaps more than they value what they hear from the professions. That needs a cultural shift, which might take time.

I will give you an example of what dieticians face. It is not that people think that doctors know better. We are battling against nutrition experts online. There are a lot of charlatans out there who do a four-hour course and call themselves nutritionists. They put it out there that people need to drink celery juice and that it will cure cancer. Often, when a patient comes to a dietician, we have to unpick and undo a lot of misinformation. That is what we have to do battle with. To answer the question, it is about awareness raising.

10:45

Miles Briggs: The key point in my question was about information to the public. In the winter crisis two years ago Annie Wells and I visited a general practice in Glasgow. The first thing that we saw on the board as we walked in was, "Why are you here?", which was not the most welcoming message. However, it was trying to get people to the right healthcare professional—to send them to an optician or across the road to the pharmacy. The question is, what would you like information to the public to look like? A public information campaign can often get lost, and we have heard about communication issues, which Kim Hartley Kean highlighted.

Alison Keir: In our children's services, we have moved to a model of requests for assistance rather than referral. What happens is that people are contacted very soon after they have contacted a service, and it might well be that they are signposted elsewhere. Previously, everybody was put on a waiting list. The earlier contact that we have now gets the right people on to the waiting list, so the waiting list is shorter and people are seen more quickly, and the approach also means that people have had a conversation. It stops the anxiety and enables questions to be answered quickly. Therefore, we actively encourage people to come to us quickly, rather than going on to a waiting list and being faceless.

The Convener: Thank you. My apologies to witnesses and members, but we are rapidly running out of time. There are brief closing questions from Sandra White and David Torrance.

Sandra White: Lots of my questions have been answered, so I will be sharp and to the point. Obviously, we need to promote awareness—not just to the public but to GPs—and a culture change in public understanding. However, as the witnesses said, there is a gap. Anyone can go to the GP; it is the first port of call. How do we move past that? As witnesses said, people are not aware of the services that you provide. They go to the GP and then into hospital and the opportunity just disappears. You have perhaps already given the answer, but what can we on the committee do to ensure that the public are aware of the services of allied health professionals?

Kim Hartley Kean: It is really key that what you say as MSPs and committee members communicates your understanding of and knowledge and beliefs about AHPs.

Sandra White: I am sorry to interrupt, but that is not what I am trying to ask. People are directed to GPs, who are the gatekeepers, and somewhere along the line the AHPs are lost. Nobody knows where to go after that. Why can we not go straight to the AHPs? What is stopping us—the public—doing that?

Kim Hartley Kean: My first reaction is that people do not know that they can come directly to us.

David Torrance (Kirkcaldy) (SNP): What are your frustrations, and the barriers, around information sharing and governance?

Joanna Instone: It is a lot to do with the computerised technology that we have, which can sometimes be a barrier to sharing information. It depends how well the locality is set up with information sharing between colleagues and the doctor. What was the other part of the question?

David Torrance: What are your frustrations, and the barriers, around information sharing and governance?

Joanna Instone: The governance part is to do with making sure that we are collecting the right information and keeping it confidential. In sharing information with colleagues, when I last practised as a dietician about four years ago, the information was sometimes on paper and sometimes in technology. A lot of effort is required to keep both systems going at the same time, which detracts from seeing the patients. That is my frustration.

The Convener: If any of the witnesses wants to answer the questions from Sandra White or David Torrance, they should do so now.

Sara Conroy: We need information technology systems that can speak to each other. In primary care, I think that there are three different systems, but even when we have the same systems, they might not speak to each other.

I hear frustrations from physios working in primary care. Although they are independent prescribers, they are unable to prescribe because of the system's requirements. For example, in order for someone to prescribe, the system might require a Nursing and Midwifery Council number or a GMC number. Therefore, although the physios have done additional training, someone else still has to write their prescriptions for them.

There are even more issues in remote and rural areas. Again, that is to do with accessing IT systems, particularly when people are out on the road. It is all about IT, IT and IT.

Kim Hartley Kean: There are many frustrations. I will give an example from podiatry. In some areas, the podiatry service is well connected to the health board portal. There are lots of benefits to that, such as direct referrals from GPs and access to patients' medication records and emergency care summaries. However, that approach is not widespread and there is inconsistency when it comes to making AHPs a part of the multidisciplinary team information-sharing approach.

I draw attention to the primary care clinical professions group's paper on information sharing and I pick up the issue of things being patient centred. It should be the patient who owns their records and decides who they can and cannot be shared with.

Alison Keir: We have talked about the problems of not being able to share information in health. Today, we started off by talking about what primary care is, and we said that it covers not just health but social care and the third sector. Therefore, the problem of sharing information is even bigger. We cannot share information in our health agencies, and we want to extend our team. At the moment, our IT systems do not talk to each other.

The Convener: We have a one-line supplementary from Brian Whittle. I think that we have already had one answer.

Brian Whittle: If self-referral is to be successful, should the patient own their own data?

Alison Keir: If we are moving to a model of patient-centred care, we have to view the patient as an expert in their care, so, yes, I think that there is definitely an argument for that approach.

The Convener: On that very important point, I thank the witnesses for their attendance. Emma Harper has reminded me that she is hosting an event for AHPs in the garden lobby next February. I know that the engagement with all today's witnesses will continue throughout our inquiry. We might also want to follow up with witnesses one or two points that we did not reach today. I hope that you will be happy to respond to our inquiries, should we write to you.

I briefly suspend the meeting to allow a changeover of witnesses.

10:52

Meeting suspended.

10:57

On resuming—

The Convener: I apologise to our second panel of witnesses, who have been patiently waiting. I am delighted to welcome to the committee Theresa Fyffe, who is the director of the Royal College of Nursing Scotland; Dr David Chung, who is the vice-president of the Royal College of Emergency Medicine Scotland; and Clare Cable, who is the chief executive and nurse director of the Queen's Nursing Institute Scotland. We had expected a witness from Unison Scotland, but we received their apologies yesterday because, unfortunately, they had to withdraw.

I will ask the same questions that I put to the previous panel. How do you define the multidisciplinary team? What will its future role be?

Theresa Fyffe (Royal College of Nursing Scotland): The RCN is a member of the primary care clinical professions group, which is evidence of our commitment to multidisciplinary planning. We represent 60,000 professionals in that group.

When done well, multidisciplinary team working is about getting the right resources, planning and care for people and utilising the best of individual professions. The unique contribution of professionals is critical to MDTs.

One of our frustrations is that, sometimes, when people talk about multidisciplinary team working, they say that everyone does everything as one whole team. MDT working is about planning care, making decisions on care, assessing and evaluating that care and then focusing on outcomes for people, but each of the professions makes its own unique contribution to that care.

Dr David Chung (Royal College of Emergency Medicine Scotland): Emergency departments sit at the interface between lots of things. A lot of people who go there do so not necessarily because they have had—I will use the old parlance—an accident or an emergency but because they are in crisis or something is not happening elsewhere. Multidisciplinary working is fundamental to how we approach any of the difficulties that we face, and we are increasingly seeing examples of good practice in that.

People come to an emergency department because, for example, they have been labelled as having a mental health issue. However, as we know, their issue could in fact be due to acute distress, or there could be forensic issues. They come to us because they know that their issues can be dealt with much better.

When we are talking about multidisciplinary teams, we are referring to the involvement of medical professionals, nursing professional and allied health professionals. However, increasingly, it also means the involvement of social work.

There are innovations such as the navigator scheme, which signposts people who come to most departments to other agencies within the community. There are good examples, but perhaps the ability for us to signpost and access all the other resources that exist outwith emergency departments needs to be made uniform throughout emergency medicine in Scotland so that the people who attend emergency departments get the help that they need. They often do not need help from a doctor, a nurse, or a physio, for example. They might need help with something else in their lives, and we are uniquely placed to do that. We are happy to engage with this new multidisciplinary way of working, which 20 years ago probably was not thought of as being core to accident and emergency business.

11:00

We are where we are. People come to us because the lights are on. It would be much better for us to get people the help that they need so that they did not have to access lots of other types of care from elsewhere.

We feel that multidisciplinary care reflects helping people to sort out many different things in their lives, and not just in a medical way.

Clare Cable (The Queen's Nursing Institute Scotland): Building on the earlier responses, I think that the important fact is that we all support individuals, families, and communities. As Theresa Fyffe says, that might not mean one coherent team working with an individual; it is complex.

In the vision for primary care in Scotland—the 21 principles that the primary care clinical professions group put together—we talked about a network of primary care professionals across the public, third and independent sectors. That is a helpful way of looking at the multidisciplinary team. It is not just multidisciplinary; it is about agency and a network of professionals working across the sectors.

The Convener: It is fair to say that the witnesses on today's first panel felt that the definitions that the Government and the NHS use are too narrow and do not specifically acknowledge all the different members of the multidisciplinary team. Do you share that view?

Clare Cable: "Nurse" as a term is used to group a huge number of specialist professionals together. In the primary care team, general practice nurses and district nurses will be working in general practice but, equally, there are primary care nurses who work across the age span—health visitors, school nurses, and so on. People are providing primary care in less obvious settings. Occupational health nurses work with people in workplaces; school nurses work with people in a school setting; prison nurses work with people who are incarcerated or in the criminal justice system more widely.

It is important to be thoughtful about that broad definition of where primary care is delivered, because it is delivered across settings. Sometimes we focus on the general practice or the community clinic hub and forget that primary care is delivered where people are.

Theresa Fyffe: In the earlier witness session, we heard a lot about how we get that message out to people and the community. The language that we use does not make it easy for them to know that there is a team in different place.

We also focus a lot on buildings. We refer to the practice, and it is a building, and a range of disciplines, agencies, volunteers and voluntary services work outside that building. Earlier, I heard a comment about a door, and that is about access to services, which is what we should be talking about, because we would then be clearer about what a team is and how it looks.

Nursing is a huge component of that multidisciplinary team, and it is the only component that provides a 24-hour service alongside out-of-hours services from other cover such as GPs.

It is important to understand the different elements of the team, and we as the professionals group called for getting that message to the public. We need to get the public to understand the message. The committee's work has shown that the public understand the message far better than we have realised, and they want to understand how to access the team members in the right way.

Dr Chung: I will second what has been said. It is important to stress that it is interagency. If you say "multidisciplinary team" to me or any other emergency medicine doctor, we think about things such as child protection and adult support and protection. As I said, it is as much about the other agencies, such as the local authority, as it is about all the other healthcare professionals. In my head, the term "multidisciplinary team" does not exclude anybody. I found that the main problem is that, if they do not already know about them, people might not know who is part of the team. As we have improved things, I have become aware of the availability of services that, previously, I had no idea about. That is as much a challenge for people working in healthcare as it is for the public.

Emma Harper: I asked the previous panel about defining primary care. What is your response regarding the definition?

Clare Cable: We are core members of the primary care clinical professions group. We worked so hard in that group to be thoughtful together about what we are talking about. The definition that we came up with feels good. It feels as though it captures all those elements to do with local knowledge, clinical expertise and the enabling relationship with individuals, families and communities that is at the heart of primary care. It is about working in family groups and communities to enable people and individuals to live well. That is at the heart of primary care.

Dr Chung: My reflex response is to say that the emergency department is not primary care but, being pragmatic, I acknowledge that, for various parts of the population, it is becoming what they think of as primary care. Perhaps the definition of primary care is the first place that people go with whatever problem they have. Traditionally, we think that there are urgent or non-urgent matters and that some should be seen in what people think of as primary care—in, for example, the health centre. However, for whatever reason, society and people's attitudes are changing and, in order for their needs to be met, they have decided in increasing numbers to come to the ED.

Such definitions form a working definition. Traditionally, primary care has been everything outwith a hospital. That is how most hospital clinicians have it in their heads. If you say to them, "What do you think about primary or secondary care?" They will say, "We are secondary care. That is primary care." As I said, if we are to improve patients' lives and, inevitably, by doing that, make our working lives easier, we must realise that the lines have to blur a wee bit. Perhaps primary care is more about empowering patients to make choices and do things closer to home. Sometimes, the care will start at home and stay at home. Sometimes, the care will start somewhere else, but we need to shift it towards the patient. Roles that were traditionally secondary care have a place in that process.

Emergency medicine is at the tide line between the two. If we think about it in that way, traditional primary care is the sea, secondary care is up on the beach and, depending on what is going on—where the moon is—emergency medicine might be a bit of both.

Theresa Fyffe: The problem with the definition of primary care is that it comes back to what the public understand. Recently, I had a personal experience, in which I needed self-managed care, which is an important component that we are trying to encourage people to have. I went to my GP to say, "I want to go to this service." He said, "Absolutely—I will write a letter for you." It should not have happened in that way. I knew where I needed to go. To my frustration, I did not realise that it was a two-week appointment process. I went on holiday; the letter came in and I came back to find the letter. I phoned and they said, "No, you are off the list. You have to go back to your GP." Fortunately, I have a GP who allows me to email him. I said, "Look, I am here again. Would you please write that letter again? I was on holiday." That is not the proper use of a GP's time. The GP has a unique contribution to make to primary care. As David Chung said, the public understand that it is everything that is not hospital-based care. Primary care is all that care in the community and it is as much about voluntary and interagency services as it is about us as healthcare professionals.

Emma Harper: I have a supplementary question. The submission from the Royal College of Emergency Medicine Scotland says:

"The emphasis of funding and health policy priorities should not be on either Primary Care or Emergency Care but on the entire health and social care service."

It also talks about the co-location of services, whereby primary care facilities are located on the same site as the emergency departments. It would be interesting to hear your wider thoughts on that. That might be quite a challenge in rural areas.

Dr Chung: As I said, there is a blurring of emergency care and primary care in and out of hours. In emergency medicine, at least half the volume of our workload is out of hours—there are more out-of-hours hours in the week than there are in-hours, but our workload is roughly 50:50. I work in Crosshouse in Kilmarnock, which has the fourth busiest emergency department in Scotland and I am a full-time ED consultant. The majority of our children now arrive out of hours: some 65 to 70 per cent of children who come to our emergency department come outwith the hours of 9 to 5, Monday to Friday. That is what the populace is choosing to do.

When the Royal College of Emergency Medicine talks about co-location—and this is what Professor Sir Lewis Ritchie alluded to in his report on out-of-hours care four years ago—we are saying that there may be some advantages to having everything on the same site. People come to where the door is open, which is the emergency department, because their learned behaviour is that they can rock up there at any time of day or night and something will happen—it might not necessarily be the best thing, but they will get something—so it could be beneficial to have other services available there, too.

I stress that those services are absolutely not part of the emergency department. What we are suggesting would mean, for example, having out-of-hours GP services on the same site—as there are in Grampian, which is a very good model. When I trained in Glasgow, the Glasgow emergency medical service would be an out-patient service, but we could refer patients to different services. Having mental health workers, allied health professionals or a single point of contact for social work and so on in the same place makes it much easier in some ways. It is attractive because the services are all on one site, they can co-ordinate and they can speak to each other. We might even be able to say to a patient, "Actually, you don't need to come up, because they are going to come out and see you." That is about information sharing. There are some challenges in that, which I alluded to earlier, such as in IT, different communication systems and so on.

When we talk about co-location, we are talking about having out-of-hours care on the same sites as much as possible, so that, if someone comes to the site and they do not necessarily need to come to the emergency department, the service that they require is there and they do not have to go to another site that may be 3 or 4 miles away, with all the transport problems that that creates.

I understand that there might be some issues for remote and rural sites, where someone might have to travel 60 or 70 miles, but in the central belt, most of the distances we are talking about make it an attractive idea. It is only that people have grown up being used to the idea of things being within walking distance that makes it difficult. I have friends who live in the south of England who think that it is totally normal for their nearest hospital to be more than half an hour away, whereas people in Glasgow would think that that is the worst thing in the entire world.

The Convener: That is interesting. In the evidence that we have heard, the general trend—I was going to say "from every witness", but that would be an exaggeration—is that we should move services away from hospital into the community, but the implication of what you are saying would appear to be the reverse.

Dr Chung: It would be for certain things—we mainly mean GP out-of-hours services. There might be co-ordination spaces for those people who are not working in the centre. We think that having them close to where people access services from us would have some advantages. That just echoes what Professor Sir Lewis Ritchie said. The people doing the job might not be anywhere near the site, but there might be someone there who says, "Right, we are the ones organising what is happening," which would make the communication between services much easier, because we are all in the same building.

Theresa Fyffe: As I said earlier, I am always concerned when we focus on the building, but I understand David Chung's point. I went to visit a location where they have done that and I saw that it goes back to doors: go in one door, back out and then into another door. I am concerned about the mileage and transport issues that there would be for people in remote and rural areas. For example, I would have to drive 30 miles to reach my A and E, whereas my community-based service is only 10 miles from where I live.

We have to remember that we are trying to change the way in which the public think about which service is the right one for them to go to. We are not doing enough on that, which would help. NHS 24 also has a role to help guide people to the right services. However, I understand why the emergency medicine practitioners feel that way, because the onslaught of people coming to A and E out of hours often comes about because they have not been able to access the services within the period that is covered by the daytime service.

11:15

The Convener: Like Emma Harper, I will pick up on a comment that was made in one of the submissions. The Queen's Nursing Institute Scotland said:

"The challenge is to go beyond cooperation toward genuine collaboration and integration."

Will Clare Cable expand on that and say how that fits into the definition and scope of primary care?

Clare Cable: We are beginning to get there, in relation to co-operation. As we heard from the previous panel, the challenges with IT continue to vex us all, as we try to ensure that collaboration really helps and that practitioners are able to refer to one another. No matter with whom a person has their first conversation, anyone in the team should be able to connect them to the person with whom they really need to have the conversation or to support them by giving them the information that they need. The issue is about working together much more fully, rather than someone saying, "Actually, I'm not the right person; you need to speak to that person." If someone has a relationship with somebody, it might well be that they are the right person to take the conversation forward. We need real collaboration in the team to be able to support and accompany an individual or a family at the right moment—a moment of crisis—perhaps to a point at which they can engage with wider services on the next stop to recovery and rehabilitation.

The fact that people have different employers and there are different agencies can sometimes get in the way. Co-operation is getting better, but achieving real collaboration will require us to look much more systemically at the things that hinder a seamless journey for individuals who access services.

Emma Harper: I asked the previous panel about variation in employment status. The problem is related directly to the fact that GPs are independent practitioners and employ their own staff, but we are now putting national health service employees behind the doors of GP practices. What challenges will come from the fact that different employees will report to different levels within a chain of command?

Theresa Fyffe: When we talk about an integrated workforce, we are talking about a workforce for integration. It is about how a workforce works with the way in which a service is provided, whether it is through an integrated system or general practice, as we described. All the staff who are needed to work in a multidisciplinary and multi-agency way of providing services could never fit in one building. We have a tendency to employ people with particular roles and bring them into the building, but the issue is how teams work in the collaborative way that Clare Cable described. It is not possible to have one workforce that is employed entirely by one employer. If that happened, how would we work differently with the voluntary sector and other services? It is about taking a different approach.

The Royal College of Nursing recognises that when we talk about an integrated workforce, it is possible that there are places where a team being employed by the one employer would be the right way forward. However, our work has shown that, with the right ways of working, the right principles for what is trying to be achieved and a common goal, people can work as a team together and focus on that approach. When the work on integration first came about, we interviewed integrated teams whose members had different line managers, and they were very clear on their focus and outcomes. There is probably a place for taking a different approach with some teams, but I do not think that that should happen in primary care, because, for the system to work, we could not possibly have every member of staff in one building.

Emma Harper: What can be done to mitigate the challenges?

Theresa Fyffe: We have spent a lot of time debating district nursing with the Royal College of General Practitioners and the British Medical Association. District nursing is one of the most important roles in the 24-hour service, for the GP practice and for other services, so a lot of time was spent on saying that district nurses needed to be based in GP practices. However, given the mileage that district nurses cover to see their patients, that was not possible.

There are successful ways of working with district nursing within general practice. It all comes back to my point about access. That is why we called for multidisciplinary records sharing and the means to enable people to access the same technology, always remembering that the person who holds the record is the important person in all this.

It is about working without walls and it is about working differently. That is happening for district nursing. Sometimes there is alignment and sometimes there is not, but district nurses can deliver services without being employed by or based in a practice, and they are doing so successfully across Scotland.

Dr Chung: Emma Harper raised a more general issue about how people work in silos. Lots of people who work for the same employer, and perhaps under the same managers, are quite happy to be in silos and not to talk to or co-operate with each other.

Some of that boils down to leadership and how people view their roles. If there is a shared vision and people are happy with how their jobs are defined and feel that everyone is working towards the same goal, who employs them need not matter at all. Our work cuts across many different line managers; some are very good and—I will be honest—some are not so good. The issue is not that the salary comes from a certain place or resource; it is whether the person sees the role that they are doing as being their job.

That is important to work out. There might be a more negative experience if someone has a very prescribed definition of their job and does not want to be phoned about anything that does not fall within that definition. Another person might be happy to say, "I can help you with this, but you might need to speak to someone else about that." That is just human nature. I do not think who employs the person will have a lot of direct bearing on the issue; local culture and leadership will have more to do with it.

Emma Harper: Effective leadership, whether a team is led by a nurse, a paramedic or whoever, is important. It is important that we continue to invest in leadership.

Dr Chung: Yes.

Clare Cable: It is about collective leadership. How do we invest in the skills that enable people to lead across systems and across teams? It is not about hierarchy; it is about people's ability to co-ordinate and influence across quite complex landscapes. That is a slightly different skill set, which people have traditionally developed under the banner of "leadership". Thought must be given to the skills that people will need in the future to ensure that they are able to co-ordinate care for individuals and families, and have the authority to do so even when the services and interventions that are required are not delivered by the same employer or by the system within which they work.

Brian Whittle: We have talked about how A and E has been thrown into the mix of primary care, and we have talked about GPs, nurses, midwives and all the various AHP disciplines. We hear the word "crisis" being used across all those disciplines. I wonder whether there is a tension between the disciplines and, perhaps, some protectionism in that regard. Are people trying to ring fence investment and protect their own disciplines? We heard that from the previous panel. Is tension developing about who should be involved in a multidisciplinary team?

Theresa Fyffe: I would not say that there is such tension between disciplines. I think that the tension is being played out because workforce planning has not incorporated a multidisciplinary approach. You heard my colleagues on the previous panel say that there has never been clear evidence of workforce planning for some professions—or a clear account of how it has been done. They are right.

You will remember that this committee was involved in the work that led to the passing of the Health and Care (Staffing) (Scotland) Act 2019, which was intended to provide for a multidisciplinary approach to workforce planning. It is not about having a single tool or methodology for a single multidisciplinary team; there are unique tools, but there is, if you like, a multidisciplinary toolbox. There is a commitment to taking such an approach.

The tension comes when, as the previous panel said, there is a perception that primary care is about only doctors and nurses, and that gets played out. Our commitment to the multidisciplinary approach has been clear. Along with the RCGP, we were one of the instigators of the multidisciplinary primary care clinical professions group, because we believe that by working together, we can all understand better what our unique contributions are and where we can share common working around access, technology and so on. The tension has been more to do with how it has been portrayed by the media, and with the absence of correct multidisciplinary workforce planning.

The Convener: We have heard from social care staff their concerns about the communication between district nursing and social care. Is that part of what needs to be resolved?

Theresa Fyffe: I agree with that, because it is exactly as David Chung said—the way of working has been that one group is siloed to work a particular way. However, the chief nursing officer for Scotland led a working group on transforming roles, to which the RCN is party. The role of district nursing has been stated clearly—district nurses are the linchpin of 24-hour care and they have a responsibility to engage and work with all the other parts of the service. Sadly, different technologies, different records and different ways of working create difficulties, and putting everything into one building does not change those issues. The way to change things is to be clearer about our expectations of the team and how it should be liaising with social care and others.

Some of the tension that exists is about whether something is seen as social care entirely, although in Scotland we have decided that people with complex health needs can be discharged from hospital care to community and primary care. Some of the tension comes from saying that it is either social care or health. The whole point of health and social care integration was about

recognising that we need both arms to deliver care, and we are committed to that approach.

George Adam: One of the things that I was talking about with the previous panel was how we get to that culture change, because we have all been talking about it for a while now. I might just be getting old and grumpy, or older and grumpier—

David Stewart: Certainly grumpier. [*Laughter.*]

George Adam: Basically, how do we move forward? David Chung raised the issue of how A and E is currently used. For example, if it is after 5 o'clock on Friday evening and something goes wrong, an individual will think that the GP practice is shut and social work shut about three hours ago, so they will rock up at A and E. The current culture is that the staff at A and E have to deal with all those situations. That is a basic example. How do we get the culture change that we want?

Dr Chung: Out-of-hours primary care—I am not saying the out-of-hours GP, although the out-of-hours GP is a large part of that care—has a role to play. It is probably being underused for a variety of reasons. Public perception is a problem—I still meet people of all ages who swear blindly, "I had no idea there was an out-of-hours GP." GPs have their own challenges; they are trying to maintain their staffing in the face of severe challenges. However, when people rock up to A and E, if it helps if we can say, "You are in the wrong place but I can tell you where you need to be." That is why we talk about colocation. In Grampian, a GP will meet you and say, "You need an out-of-hours GP and this is where they are." That is an example of how it works. I accept that there can be a problem in other geographical areas.

It is about being able to signpost people to the right service and say, "We can't see you here but someone can see you tomorrow." For many social care and mental health issues, A and E has provided, by default, a sort of safety net for all manner of things, whether the individual themselves views it that way or another agency says, "We're shut now but if you have any problems, just go to A and E." Patients tell us that they have been told that all the time. I am not sure that I always believe them—I am not that naive—but there is certainly a culture of doing that.

It is about being able to say, "You don't need to be seen today—you are safe. If you phone this place, they will arrange for someone to come to see you tomorrow." It is about being able to access your optician or all the other good services that are available. There has definitely been progress when it comes to people seeing the right professional at the right time. It is partly about pathways, as has been alluded to, and it is partly about IT.

However, people learn from other people, and that is how culture change happens. Human experience is learned, taught and shared mainly by word of mouth, whether that is face to face or on social media. That is how things are done. If somebody says, "If you go up to Crosshouse hospital with your kid, it's fantastic," the word is out, whereas if they say, "We went to the hospital but ended up seeing the GP instead, and they were miles better," or, "I went to the hospital, but then I realised that I could actually go on this app and get seen the next day," behaviour will change. People have to learn that there is a better way, rather than just be told that it is better. The services need to be there, and they need to be accessible. That will help, but it is going to take a little while.

11:30

Theresa Fyffe: The integrated teams in communities recognise the issue, so often—particularly on a Friday evening—they have services running until 8 o'clock or 9 o'clock. We have the aspiration that district nursing will move to a 24/7 service. We worked with the Government up to 2018 on the requirements for district nursing, only to stand still, so we do not have a 24/7 model through which people can access services. We are now in 2019 with no commitment to that work and no announcement of an investment, yet we have a 6.5 per cent vacancy rate and 60 per cent of district nurses are between 55 and 60, which, as we all know, means that they are going to go from the service.

That takes me back to the commitment to workforce planning. Sometimes we are not understanding how to provide services in a way that ensures that people know, for example, that they can access community services that they thought normally ended at 4 or 5 o'clock right up to 8 o'clock on a Friday evening.

We then come on to the whole picture and how we would model such a service. I agree with Dr Chung that there are different ways in which we can use technology. There are people who do not use technology well—which is one of the challenges—but, for people who wish to use technology, we should educate and encourage them to do so and to use models that will allow them to get appointments. I make my appointments that way entirely and I use any service that is available to me when I am travelling, such as an airport community pharmacy or a high street pharmacy. However, it is not in the nature of people to think that way, and that is what we have to change. We have to say to people, "If you have an eye problem, why would you go to your GP? You should go to your ophthalmologist". That option is not known by most of the public until

someone does it and says to someone else, "I went to the ophthalmologist and they gave me the best advice that I could have got."

Unfortunately, we are still promoting a traditional model. That takes us back to Brian Whittle's question. The media presents a traditional model and when we talk about gatekeepers, that relates to the traditional model for GP services. It has to be different now. We have to think differently and we have to help the public to understand that that is how services are going to be delivered.

Clare Cable: The other cultural shift is to a more anticipatory model of care. The Scottish Government spends a lot of time looking at the nuka model from Alaska and the house of care model. Those models feel like important things to invest in and sustain, because when people are empowered and enabled to take more responsibility for their own health and become experts in their own health, those anticipatory conversations happen in a timely way—and hopefully not at 4 o'clock on a Friday. That way, there is more understanding of what individuals need in order to stay well, and the steps that they might take if they begin to experience deterioration.

The cultural shift is also about the continuous shift to realistic medicine, self-management and the models of primary care that better enable them, so that anticipatory care becomes the norm in every conversation. That way, people feel better equipped to deal with health deteriorations or crises when they happen and they know where to go. However, such anticipatory conversations have to become core—that is the case in some places, but we still have not given people the time to have those conversations well.

George Adam: On the back of what Clare Cable said, part of the cultural change issue relates to managing long-term conditions. I mentioned my wife, Stacey, who has multiple sclerosis. She can work her way through the system and deal with it, but there are others who cannot. For instance, she will go to her MS nurse rather than her GP, because her MS nurse knows more about MS—in fact, Stacey probably knows more about MS than her GP does.

How do we get people to a place where they are empowered and feel that they can do that? What is your role in ensuring that we push this agenda forward and empower people so that, as Theresa Fyffe said, they have the attitude that you describe and proceed in that way? Many folk do not do that; their first thought is, "GP."

Dr Chung: We have been thinking about definitions of primary care. From listening to the views around the room, it seems to be implicit in people's minds, whether subconsciously or not, that primary care is Monday to Friday, 9 to 5. However, we are talking about various issues. There are situations in which people have planned issues that they can deal with, but in a lot of cases—certainly those that we deal with—that is not how it works. People do not plan for their child to be unwell on a certain day, for an acute flare-up of their chronic condition or those sorts of things. As we have said, it is difficult for people to access the advice or help that they need at 5 o'clock on a Friday, which is when these things tend to happen.

In some ways, therefore, we need to consider not only location but timing. We have talked about district nurses being fundamental to the story. Accessibility of services is part of what primary care is, or is not, seen to offer. Maybe that needs to evolve a wee bit. I say "evolve", but one could argue for the different model that we had 30 years ago, when GPs were providing primary care, although perhaps in an unsustainable way. Ensuring that people are able to access the advice and support that they need outwith Monday to Friday, 9 to 5, might well mean that, on the whole, we end up working less because we deal with problems in a timely manner. Things do not get worse, backlogs are not created and the people who are doing the job, while they might perceive it to be more onerous, find—as I have found—that it is better.

I have been working in accident and emergency for 20 years, and my work-life balance is the best that it has ever been. I keep trying to tell people that working more weekends and evenings actually means that my working life, and the care that my patients get, is better. However, on the whole, in society and in medicine especially, there seems to have been a paradigm shift to 9-to-5 working as the only way forward. It is kind of bound up with our identity. Primary care needs to move a bit beyond that. People in our profession need to see that their lives, and their patients' lives, will be better if they blur things a little more, maybe not over seven days but by working 12 hours a day from Monday to Friday. Doing that will make things easier.

David Stewart: I want to talk about workforce planning, which has been touched on already. It is clear that it is vital to the sustainability of primary care. Can you talk about workforce planning in your occupations and how satisfied you are with it?

Theresa Fyffe: Workforce planning will be an integral component of the implementation of Health And Care (Staffing) (Scotland) Act 2019—the safe-staffing legislation. We worked hard with the committee and others to make it clear that if we do not get workforce planning right, we are never going to get out of the cycle—as a colleague

said earlier—of crisis management with the workforce.

It comes back to the need to be clear about which tools and methodology are to be used to assess workforce planning. In the earlier session, I heard a discussion about the difference between what the boards might report and what is actually required. A few years ago, we went through a period in which workforce planning was designed entirely according to what we could afford, and the numbers that were produced were based on that rather than on what we needed. The Government had to make a call on nursing numbers based on that data.

The district nursing modelling that we have done in collaboration with the Government is the best that we have ever seen. It is a new model that involves working with data sets from across the whole Government health department, and it is absolutely superb. The data were brought together and we came up with a growth model for district nursing that allowed us to stand still. It does not necessarily assuage the impact of a full 24-hour service, which is where we believe we need to go to enable the public to access services, but it is a way for us to go forward. We have said that that modelling should happen in relation to the issues that we have with mental health nursing, for example. In child and adolescent mental health services, for instance, it would enable a better understanding.

The issue is how we do multidisciplinary workforce planning and how we get the right methodologies and tools to identify the unique contributions. My final point is that nursing is a 24-hour service, so we have to measure workload over 24 hours and take account of the various interventions from different professions, which might cover different periods in the day. That is the challenge. Unfortunately, there is a current belief that we can use one tool to measure 24-hour services as well as the different interventions that are necessary from physios, occupational therapists and dieticians. It is not possible to do it in that way.

We need to take a multidisciplinary approach to workforce planning and do the methodologies per professional group. When there is collaboration and shared working, that can be recognised and built in, and workforce planning can be built up in that way. That is how I would like to see it go forward, but we are not in a good place on workforce planning at the moment.

David Stewart: Those were insightful comments. The general sense is that it is about what you can plan if you cannot measure.

We also have to recognise the scale of the workforce, particularly in nursing. I remember years ago when John Reid took over as Secretary of State for Health at Westminster, he said that there were more people employed in the NHS than were employed by the Red Army and Indian Railways, which I thought was interesting. I am not sure whether we can learn anything about workforce management from the Red Army, but it is a huge scale of operation.

We heard earlier about the ISD dashboard and the issues about how accurate it was for other occupations.

Theresa Fyffe: The triangulation of the data that we used in the modelling for district nursing helped to counter those issues. A number of data sets were applied to our modelling, which helped to get us the growth model that we required.

It was about bringing all those data sets together. The people who generate that data were delighted to be in the same room together, because they want it to make an impact on what we are doing.

We have got stuck in our workforce planning model, which has tended to be quite traditional. Unfortunately, Brian Whittle's comment about disciplines looking like they are fighting over the same pot of money is true. We would say that nursing is 20 per cent of the workforce in the NHS, and we have shifted a significant amount of complex care to the community, but we have had no significant change in the workforce in the community, which was the point of that district nursing model.

It is about understanding what our goals are and where we want to get to, and developing workforce planning methodologies that enable us to be clearer about planning. Then we can have the debate about what we can and cannot afford. We should not determine the financial balance from the start. That is not a good way to go forward.

Dr Chung: I have alluded to silos. Medical workforce planning is a somewhat opaque process. It has taken me about two years to get to this point, but I might just have a clue about what has gone on, and that should tell you all that you need to know about how clever the process is.

There appear to be different silos with different goals, needs and dynamics. On the one hand, common sense would say that we should work out what we need to create a safer, sustainable service for patients and staff. As Theresa Fyffe said, perhaps we should not think about the money to start with but work out what we need to make sure that everybody has got what they need, what services are essential, and what we are going to provide.

Unfortunately, we divided up service and training. NHS Education for Scotland can therefore say, "We will give you this many doctors for training. Training is the thing that we are interested in—we are not interested in service provision." It might be interested in service provision, but that is not its main call. Service is then left to each individual health board and hospital and so on.

We could look at the big picture. Service and training influence each other. In a department that is not well staffed, the training will be rubbish. That might be why we see poor results in GMC surveys and people saying things like, "The culture places us under strain."

I am able to say with some pride that four emergency medicine departments in Scotland are in the top 10 for trainee satisfaction. Other specialties in other hospitals are not, because there is a lack of co-ordination between service and training.

Training should not be divorced from service. I need to be careful what I say but, even as chair of the Scottish board of the RCEM, it has taken me a good while to be able to say what we think the number of emergency medicine doctors in both training and consultancy should be. The processes are difficult to understand. It is not just me; other heads of college have said the same thing.

Whatever bodies and organisations are involved at the moment, Scotland would be better served by their input being better co-ordinated.

11:45

Clare Cable: The Royal College of Nursing has done fantastic work on that. The other group that the committee might want to think about are the nurses who do not work in the NHS. Workforce planning in the Government has tended to focus on the NHS workforce, but the way in which we have defined primary care means that we are talking about a wider workforce. We need to be thoughtful about nursing staff who work in social care, care homes and occupational health nursing, who all have a vital role to play in primary care.

The Scottish Government and the Royal College of Nursing have done significant work on care home nursing. However, it is important that the committee is mindful that the issue is broader than NHS workforce planning, given that we are thinking about primary care in the round.

David Stewart: I will keep my final question short, as I am conscious of the time. How important is the role of staff in planning and evaluating new models of care?

Theresa Fyffe: I think the staff are important, as are the patients. A member said that if someone has a particular long-term condition, they often know more about their care than other people do. It is about staff being engaged. There is a lot of work going on around pathways for patients and staff will be engaged within that. It comes back to whose voice is heard and how that voice is heard for all the different disciplines.

There are some examples of very good multidisciplinary teamworking on the planning of care and pathways. David Stewart mentioned diabetes, which is a really good example: the transfer of that service to a different model has come from disciplines working together. The same is true of cancer services. It seems to be easier when someone has a long-term condition or the service boundaries are clear. The provision of services that have different models is harder to get right, because it is not always clear who else needs to be in the picture.

For example, there was a change to our pharmacy model. For years, my focus was only on pharmacy in hospitals, but now I understand fully how to engage with pharmacy in the high street and in communities. It is a different way of looking at it. Sometimes we are very fixed in how we set the pathway.

Clare Cable's point is correct: we often do not pay enough attention to the provision of services in the care home sector and those who provide services in that integrated space. That might not be captured so well, because they have a different model. The integrated health and social care space is a new way of thinking and we have not yet caught up with how to capture that in our planning and sharing.

Dr Chung: One thing that I really like about my current role is that I get to go to events about very good Scottish Government initiatives on things such as out-of-hours primary care and the four-day week. Doing that has put me in a room with people whom I have not met before, whom I then speak to, which means that I find out about other things that I did not know about. That is happening on a national scale.

As vice-president of the college, it is my role to speak to people in the college and at higher levels and to find ways to work together. That could be replicated at local level in relation to integration. Although the integration agenda is the right way to go and there are some great examples of working together, that work does not happen in a uniform way. When I am in a room with different people, I become aware of services that I never knew about. If people stay in their silos, they will not be aware of those other services.

I want to be clear that much of the workforce planning that would benefit emergency medicine is not workforce planning in emergency medicine. I

am probably unique among everyone here in saying that—perhaps I am a bad college VP for saying it. However, more than anything, what affects us is what is happening in primary care in the community. Crowded emergency departments are often caused by exit block. That comes down to issues in social care and the ways in which people work, such as bringing people to hospital as a safety net when we should be assessing them in their homes, where we would be doing it much better.

All those things need to work in a different way. We need to get all the disparate people in the room together—locally or nationally—so that they can all understand what they are all doing. If they are stuck in their own silos they will not understand that.

Sandra White: My coughing perhaps does not make me a great advert for the health committee.

The committee has also been conducting its inquiry in communities; I welcome the gentlemen who is sitting at the back of the gallery who was on one of the public panels.

The panel has answered some of the questions that I was going to ask. However, my overarching question is this: what is your experience of the public's understanding of the need for change in primary care? Do people still expect to see their GP first, as the gatekeeper? What roles might your professions have—or do they have—in explaining that things are changing and that there is not just acute or secondary care, but primary care? How does that work in the community? That is three questions, I think.

Clare Cable: The committee's work on getting public perceptions was really encouraging. As was mentioned in the previous panel session, what came across was readiness and openness about change, and about patients seeing different people and seeing the right person. That shift in attitude will happen rapidly as the public experience care from nurse prescribers, allied health professionals and competent optometrists—who are all fabulous in their specialist realms.

In addition, there is the role of technology and—as we heard earlier—the opportunity to find information online, and to follow that up with a face-to-face or digital conversation. There is increasing readiness.

However, for people who are older and frail, continuity in relationships is at the heart of the issue. It might be their relationship with a GP, a district nurse or a community mental health nurse. We need to ensure that our workforce planning enables that continuity for people who need on-going enablement and recovery support. There is no one-size-fits-all solution in this landscape, but whether we are talking about young families who need advice or older people with long-term needs, there is openness to change.

Dr Chung: I agree. People are suspicious of change and new things. Their experience might suggest that there is a certain way that they should be treated. It is very difficult, because a lot of people feel that the safest place to be is acute or secondary care in a hospital. They might hear people say, "You're in the best place" when it would, in fact, be better for them to stay at home and to have their mental health needs and all sorts of other things assessed at home. However, at the moment, rightly or wrongly—usually, wrongly—people do not believe that.

Clare Cable is right. Giving people better experiences will rapidly change that belief. I have noticed that the pace of education within communities can be lightning-quick for certain matters. Within six months, the people know that a form of care is available and want it. We see that all the time. It happens by giving people the opportunity to experience a better way. Just telling them is not going to work.

Theresa Fyffe: I believe that there is a shift, but we are a long way from where we need to be, which is why we are clear that more public engagement is needed. We can also think about what general practices can do and how they share information. My earlier point was that having to go via a GP to get a service that could have been a straightforward self-referral will not change people's mindset and make them think that they do not need to do that.

I do not like what Miles Briggs mentioned about the board asking people in a surgery asked why they were there. That is not educating or supporting people. People should be given information on the services that are available to them and on how to access those services. Some practices do that very well: they have signs, posters and information leaflets saying what people can do. We have made a shift away from how it used to be, but we have much more to do.

It is about the learned experience that David Chung talked about. People do not understand and are concerned about where services are when the building is closed. That is the weak link. They then go to the next building, which is the accident and emergency department. I understand why people do that—especially, for example, a young mum with an ill child, who needs to go where she will get help.

We have to improve the public's understanding of how to access services in their community. That is done well in some places, but it is not consistent. It is a learning experience.

I was disappointed to see the generational aspect. It was always said that older people do not

get it, but younger people access services in buildings services just as much as older people do. I was disappointed because I thought that, if we could make the change, it would be younger people who would use technology and all those things. Something is going wrong if they believe that rocking up to the building is the best way to get their services. That is not positive.

Sandra White: I am the MSP for Glasgow Kelvin, so I might ask Miles Briggs which surgery he spoke about earlier. I emphasise that I have never seen anything like that in any surgery that I have visited.

Theresa Fyffe hit the nail on the head: people still think that they have to rock up to their GP. Is it incumbent on all the professions—the panellists professions and GPs—to signpost people? The biggest worry is that people who do not know how to access a service go to their GP, who is a gatekeeper, to access it. How do we get over that?

Theresa Fyffe: I go back to the point that the GP being a gatekeeper does not equate to leadership. The gatekeeper role is the GP's traditional role—people went through their GP for all services. I recall being at a meeting years ago at which someone said that they wanted to bring back the model that was seen in the TV programme "Dr Finlay's Casebook", but that is not how our services are today. Leadership is about leading and working with multidisciplinary teams and enabling services to be open to people.

In our use of language, we talk only about the GP, so I can understand why what gets across to the public is that they can only see a GP—although I firmly believe that GPs make a unique contribution to the multidisciplinary team. However, if we talk instead about "the team", the people who experience that will have their mindset changed—people from across the generations will be able to fully understand. We need to invest in a public information-sharing model that really shows people what services there are and where they can go. We must remove the concept that "leadership" means having to go to the GP for the bit of paper to get to the next service. It was a real shock to me—because I had believed that, as a self-managing person, I would be able to do this—to realise that I could not get to a service. I was gutted. I thought that that is that the right message.

Emma Harper: Theresa Fyffe said that we have not caught up, so change needs to happen. We often hear that IJB integration is slow: I know that transformational change is hard for folk. The Royal College of General Practitioners has called for a national education programme to make folk aware of the change that has been proposed. Do we need to tell folk to hurry up and get on with it, or should we be a wee bit more patient and support the engagement and training that the RCGP has called for?

Theresa Fyffe: There are different elements to the issue. The primary care clinical professionals group, which the RCGP is part of, is clear that we need a public engagement model. Public engagement can be done through education and through sharing information. If we give people the right information that is clear about how to access services, they will not need education but will think, "I need that, so I'm going there." You might want to use a number of different models.

The programme for government includes elements that are going to be looked at, but it refers only to GPs. District nurses, for example, were not mentioned—my other AHP colleagues would probably say exactly the same. I firmly believe in the unique role of the GP, which we need in the team, but we keep on presenting things in that way.

That is like saying that people can access a hospital only through seeing a consultant. Years ago, models were developed to enable GPs to get people into hospital for access to different types of decision making, so we are forging ahead both in having advanced clinical decision making by professionals other than GPs, and in MDT working, but we are trailing behind in terms of bringing the public with us in understanding of what we are trying to do. We need a concerted effort on that if we are to realise the change.

12:00

Clare Cable: We need to take engagement a stage further. Education is, of course, really important, but we also need co-production, and we need to ask people where they wish to access those conversations. Some young people might not feel confident about attending a GP practice, and would like to access healthcare advice elsewhere. Primary care professionals such as school nurses and looked-after children's nurses need to be able to refer people directly to others, and to signpost young people, without having to do so via a GP. The principles that we put together for the vision for primary care are clear that the ability to refer from professional to professional is key. As part of considering engagement more widely and thinking about where people wish to access health conversations, we need to think differently about how we give information and how we enable direction to a range of services from different starting points.

Dr Chung: The 17 to 35-year-old age group has always been the biggest attending emergency departments, and it is getting bigger. Although more older people are being admitted to hospital, they are not necessarily attending emergency

departments more—it is young and youngish adults who are coming to us. They might decide to come to us for primary care issues: we say that we are not trained to deal with those and will give them a bad service. I do not know exactly why they go to A and E. Perhaps we should ask them why and whether accessibility or expertise is the most important thing for them.

There is also big growth in attendance at A and E of children from nought to four. However, we are kind of responsible for that because of what we have told people through campaigns on things such as sepsis, so we just have to live with that.

When we break it down, we find that many younger adults come with mental health issues. We need to ask what people's needs are, why they choose to come to emergency departments and what approach would suit them better.

David Torrance: How do the barriers relating to information sharing and governance affect primary care, and what can professionals do to mitigate problems?

Theresa Fyffe: To go back to our primary care professions group, one of our first areas of work was about ensuring that the person's record—it is actually their record—can be accessed by all the disciplines that might require it. There is a barrier to that. Traditionally, access has been only within the medical team, so there is a concern about how to manage access for other disciplines. Work is going on in NES to find a technology that will allow that access, so technology is one of the barriers.

Clare Cable referred earlier to collaboration. We fully respect that every discipline that is part of the person's journey has access to the person's record and can provide it with information, we improve the process. It was not difficult to make that commitment.

What was more difficult was that the people who were developing the models were stuck in thinking that the process happened only in one way, or were concerned that one discipline would be unhappy about its model being taken away. Obviously, there has been a lot of investment in technology for GP practices, but there has been very poor development of digital technology for district nurses and others. It is almost as though it was decided that we would sort things out for GPs then not get it right for all the others. We need to look at the whole system. A workstream in NES is trying to do that now. The barrier will be in persuading people to give up something that they have fought hard to get, when they are not convinced that what they will be given instead will be right for them. People often get hung up on whether technology works for them.

For community services staff who are out on the road, the only way that we can go forward is to enable access to digital technology, so that they can get information quickly to and from the GP practice, without having to drive 30 miles to a computer. Timely access to information could make all the difference to the issue that David Chung referred to. If we can get the services right, people might get what they require in-hours, rather than somebody picking up a message later and thinking, "If only I'd known about that new prescription or that change." That would make a difference to care. If people could see that, they would not be as concerned about access as some professional groups have been.

Miles Briggs: I will pull together some of the themes around the Government's 2020 vision. We have a year before we can judge whether that has been achieved. The vision set challenges to change services. Have we achieved that?

Clare Cable: When it comes to being truly visionary we have a way to go, as is set out in the vision. Earlier, Theresa Fyffe mentioned resourcing. The vision that more care would be provided close to home has not been matched with resources to support that, and that will not change in 12 months.

The other part of the vision is the emphasis on primary prevention, secondary prevention and anticipatory care, in order to prevent the unnecessary hospital admissions that continue to happen.

Dr Chung: There are examples of good practice that correspond with what is in the vision. However, the challenge has been to achieve that uniformly in every area. It is a common situation: there is a good policy document and its aims are appropriate—because they were produced in consultation with professionals, as opposed to someone from Deloitte or KPMG—but achievement varies. The challenge is that we have 12 months left. Some areas are doing what the vision set out, but we perhaps need to challenge others and ask why their area is not. All areas have the same resource issues, but some places are achieving the vision within a resource envelope that is similar to another place that is not. It is tricky.

The NHS long-term plan for England specifies things that we could say, we are doing in Scotland, but what is different about it is that it says that if something is not being done in 18 months, someone will be asked a very hard question that might mean that they will lose their job. It is probably the most controversial thing that I will say today, but perhaps we should ask the question. If places can do it, what have they done and what can other places learn to make it happen there?

Theresa Fyffe: The people around the table know how hard we had to work to include care

homes in the Health and Care (Staffing) (Scotland) Act 2019. That told me that we had not changed our thinking. We were happy to shift people with health needs from hospital to care homes and still refer to it as a social care model, but we have people in those places with the most complex health needs that I have ever seen. They are being provided with amazing care, but that was a hard struggle, because we still have an NHS model in our heads. Despite integration of health and social care, I see no evidence of change in some areas.

I agree with David Chung and Claire Cable about models of practice. There was frustration about the primary care development fund. It put out money, like throwing out seeds for lots of flowers, and the idea was that innovation would come from that. Evaluation of the funding showed that although we have good models tested they are not implemented sustainably. Why is that? I would have preferred that two or three key areas that must be sustainable were identified for primary care funding, and that we had had to invest in a way that would drive change, rather than doing the flower-seed throwing, which has not converted into real change.

I do not agree with David Chung that people should be sacked for what they do, given that I am in a trade union.

Dr Chung: The NHS in England said that—not me.

Theresa Fyffe: However, there should have been clear questions about why there have not been changes. The nursing workforce is only 20 per cent of NHS Scotland's workforce in the community. We should think about how much care we have shifted to the community without considering that we would need to increase the number of district nurses, school nurses, practice nurses and others. That is testament to our not having followed through on the vision.

Miles Briggs: I will sum up what we have heard from both panels. The real challenge is to have boots on the ground to do the work, and to allow people to access the right healthcare professionals. Three versions of a national workforce plan are being developed. Do you have confidence that the plan will meet the challenges that we have been talking about?

The Convener: I ask for answers to be very brief.

Clare Cable: I will give an example that shows that there are seeds of hope. NHS Fife has a team of advanced nurse practitioners doing weekly care home rounds in every care home in Kirkcaldy in order to support people's care in a homely setting. That is a good example of investment being made in the right place in order to keep people in a homely setting.

Dr Chung: The Academy of Medical Royal Colleges and Faculties in Scotland is working on workforce planning as we speak. A document will be published soon that will have a number of recommendations. We should listen to the academy, because the fact that it thinks that its voice has not been heard is a wee bit telling, in relation to where we take medical workforce planning.

Theresa Fyffe: It will be a tough order to move from what was fragmented NHS workforce planning to integrated health and social care workforce planning. We do not have matching data sets that help with that. I understand why we have done what we have done, but it was a very tough call. As a result, some parts of workforce planning have been lost in trying to achieve an integrated workforce plan. In the end, the plan is at such a high level that we do not quite understand what it means, so the approach needs to be questioned.

Brian Whittle: The issue might not be about technology but about changing management, because the technology exists to be able to do all the integrated collaboration and communication work. We can boil it down to a single question about the implications of data sharing: who should own patient data?

Dr Chung: The patient should own it.

Clare Cable: The individual patient should own it.

The Convener: That is what I call brief, succinct and unanimous replies.

I thank the witnesses. As with the previous panel, we have not completely covered all the territory that we would have liked to have covered. We will write to the witnesses, if we may, to ask particularly about evaluation, which is inevitably an issue that finds itself at the end of the agenda. That does not mean that it is not important—it is critical. We will drop the witnesses a line about those points.

12:13

Meeting suspended.

12:14

On resuming—

European Union Exit Statutory Notification

Healthcare (European Economic Area and Switzerland Arrangements) (EU Exit) Regulations 2019

The Convener: Agenda item 2 is consideration of a Scottish Government proposal to consent to the UK Government legislating under the Healthcare (European Economic Area and Switzerland Arrangements) Act 2019, in relation to the Healthcare (European Economic Area and Switzerland Arrangements) (EU Exit) Regulations 2019. The purpose of the instrument is to give effect to reciprocal healthcare arrangements with those countries following the United Kingdom's exit from the European Union. We have received no comment on the instrument from the Scottish Parliament information centre or the office of the solicitor to the Scottish Parliament. We must decide whether to give consent to the instrument.

David Stewart: I suggest that we give consent. The regulations will ensure the status quo—that we maintain what exists. The key point is that the funding will still come from the UK Government, which is vital. We all agree that reciprocity is important, so I certainly support the Scottish Government's proposal.

The Convener: On timing, it is worth noting that the plan was that the instrument would be approved by the committee in order for an order to be laid in the House of Commons on 2 October. The UK Parliament was prorogued, but we wanted, nonetheless, to stick to that timetable. As members will have heard, the prorogation of Parliament has been ruled to have been unlawful by the UK Supreme Court, but we do not know what the consequences of that will be for what happens to UK legislation in October.

If members are content, the committee can simply consent to the Scottish Government taking the matter forward. It will, no doubt, negotiate further with UK colleagues. Do members agree to that?

Members *indicated agreement.*

12:16

Meeting continued in private until 12:32.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba