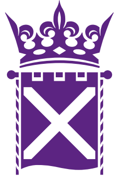

The Scottish Parliament
Pàrlamaid na h-Alba

**Published 17 June 2022**
SP Paper 201
9th Report, 2022 (Session 6)

**Health, Social Care and Sport Committee**

# Alternative pathways to primary care

**Published in Scotland by the Scottish Parliamentary Corporate Body.**

All documents are available on the Scottish Parliament website at:
http://www.parliament.scot/abouttheparliament/91279.aspx

For information on the Scottish Parliament contact Public Information on:
Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

© Parliamentary copyright. Scottish Parliament Corporate Body
The Scottish Parliament's copyright policy can be found on the website —
www.parliament.scot

# Contents

**Membership changes** 1
**Executive summary** 2
**Introduction** 9
**Background** 11
- What are alternative pathways to primary care? 11
- Scottish Government vision for primary care services 12
- Relevant Session 5 Health and Sport Committee work 13

**Patient perspective** 14
- Public understanding of primary care reform 14
- Patients' experiences of alternative pathways 16
- Self-referral 17

**Practitioner perspective** 21
- GP Contract and the multidisciplinary team 21
- Workforce and capacity issues 23
  - Role specific capacity issues 24
  - Workforce planning and recruitment issues 27
- Signposting and the role of GP receptionists 30
  - The role of community link workers 35
  - ALISS (A Local Information System for Scotland) 38

**Role of alternative pathways in preventative primary care** 42
- Screening and early identification 42

**Social prescribing** 46
- Potential for social prescribing 47
- Public attitudes to social prescribing 48
- Barriers to greater uptake 49

**Role of digital health and care** 53
- Risks and benefits of greater use of digital 55
- Single electronic patient record 61

**Annexe A - Note from private informal engagement session** 64
**Annexe B -Extracts from the Minutes of the Health, Social Care and Sport Committee Meetings** 66
**Annexe C - Evidence** 68
- Official Reports of meetings of the Health, Social Care and Sport Committee 68
- Written evidence 68

# Health, Social Care and Sport Committee

To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Social Care and matters relating to drugs policy.

hscs.committee@parliament.scot

# Committee Membership

**Convener**
**Gillian Martin**
Scottish National Party

**Deputy Convener**
**Paul O'Kane**
Scottish Labour

**Stephanie Callaghan**
Scottish National Party

**Sandesh Gulhane**
Scottish Conservative and Unionist Party

**Emma Harper**
Scottish National Party

**Gillian Mackay**
Scottish Green Party

**Carol Mochan**
Scottish Labour

**David Torrance**
Scottish National Party

**Evelyn Tweed**
Scottish National Party

**Tess White**
Scottish Conservative and Unionist Party

# Membership changes

1. The following changes to Committee membership occurred during the course of this inquiry:

    - On 26 May 2022, Tess White MSP replaced Sue Webber MSP.

# Executive summary

Patient perspective

2. The Committee is concerned that responses to the inquiry highlight limited public awareness of primary care reform, resulting in much of the general public not understanding how or why general practice is changing.

3. The Committee welcomes public information campaigns the Scottish Government has so far undertaken but believes more must be done to increase the general public's understanding of changes to primary care. As part of its Covid recovery strategy, the Committee calls on the Scottish Government to set out a coordinated communications plan that aims to increase awareness of primary care reforms. This should include targeted national and local elements and be accompanied by a robust methodology for monitoring and evaluation.

4. To improve patient uptake of alternative pathways to primary care, the Committee calls on the Scottish Government to work with territorial health boards across Scotland to develop best practice guidance on communicating the benefits of alternative pathways and addressing popular misconceptions about these. The Committee recommends that such guidance must be developed in close coordination with measures to improve accessibility and navigability of alternative pathways to primary care, as set out later in this report.

Self-referral

5. The Committee has received evidence that shows public awareness of the option to self-refer varies significantly across different areas of Scotland and between different categories of non-GP practitioner. For instance, while the option to self-refer to pharmacists, opticians and dentists is reasonably well understood, there is far less public awareness of the option to self-refer to other services such as audiology or mental health services.

6. The Committee calls on the Scottish Government to work with GP practices, the RCGP and professional bodies representing non-GP primary care practitioners to develop and deliver a targeted public information campaign that provides practical advice to patients about self-referral across all categories of non-GP primary care practitioner, encompassing the full range of services they are able to offer. This campaign should also address the particular needs of patients with poor health literacy.

7. The Committee has heard evidence that patients are currently unable to self-refer to certain categories of NHS primary care service such as audiology while private alternatives are freely available for self-referral. It is concerned that this situation is exacerbating health inequalities between those who can afford to pay for private services and those who cannot, as well as placing additional unnecessary pressure on GP practices. The Committee calls on the Scottish Government to clarify why self-referral to NHS audiology services is not currently available and what work will be undertaken to make this possible.

8. The Committee also highlights high rates of self-referral to primary care mental health teams in Glasgow and calls on the Scottish Government to examine how this successful approach can be replicated elsewhere with a view to increasing rates of self-referral to mental health services in other parts of Scotland.

9. More broadly, the Committee calls on the Scottish Government, in responding to this report, to set out what health boards are doing to improve opportunities for patients to self-refer to those categories of NHS primary care service that currently require prior GP referral.

10. In circumstances where a patient self-refers to a practitioner other than their GP, the Committee calls on the Scottish Government to examine how health boards could streamline the process that would enable that patient to be referred back to their GP if the non-GP practitioner concludes their pathway is not the best pathway to treatment.

GP Contract and the multidisciplinary team

11. The Committee recognises the ambition behind the 2018 GP Contract in encouraging the creation of multi-disciplinary teams and the potential this offers to ease existing significant work pressures on GPs and to promote greater use of alternative pathways to primary care.

12. The Committee understands the pandemic has contributed to delays in the implementation of certain aspects of the GP Contract, but notes the resulting effect this has had on staff morale and the ability to recruit staff across a range of primary care professions. The Committee believes this will, in turn, have hampered progress in improving access to and availability of alternative pathways to primary care.

13. The Memorandum of Understanding advises the National GMS Oversight Group will review progress with implementation of the GP Contract in March 2022. The Committee would welcome details of any findings of this review that may be relevant to this inquiry. In particular, the Committee requests an update on plans to recruit additional practitioners across multiple disciplines including mental health workers, advanced nurse practitioners, Link Workers and additional pharmacy support and the implications of any delays to these plans for the delivery of alternative pathways to primary care.

Workforce and capacity issues

14. The Committee has been concerned to receive evidence that, in the short term, workforce constraints and delays to recruitment across a number of primary care professions other than GPs are likely to limit the capacity for a significant increase in referrals and self-referrals to alternative pathways to primary care.

15. In this context, the Committee believes urgent action is needed to accelerate planned recruitment and increase workforce capacity across the professions in question and warns that, until these issues have been resolved, the extent to which patients will be able to make use of alternative pathways to primary care, and can be actively encouraged to do so, will be limited.

16. The Committee recognises the significant progress made, under the new GP Contract, towards establishing pharmacotherapy services in GP practices throughout Scotland. At the same time, it has heard evidence that there continues to be substantial variability in the level of service available in individual practices and that workforce capacity and physical workplace capacity continue to constrain service provision in many cases. The Committee calls on the Scottish Government to set out what action it will take to improve workforce planning for pharmacists and pharmacy technicians and to overcome these continuing constraints on service provision.

17. The Committee is encouraged by evidence that optometrists have the potential to offer a wider range of services, including the provision of at-home services and diagnostic and treatment services, which would further ease pressure on GPs. It further notes that Grampian already offers an example of best practice in this regard. The Committee therefore calls on the Scottish Government to assess whether optometry can be funded to fulfil this potential and how existing examples of best practice can be replicated more widely across Scotland.

18. As a first priority, the Committee calls on the Scottish Government to bring forward a targeted action plan to address current staffing challenges that avoids transferring mental health practitioners between settings in a way that only displaces staffing problems rather than sustainably resolving them.

19. The Committee firmly believes that better recruitment and retention of workforce across MDTs are crucial to success in promoting greater use of alternative pathways to primary care. To address this, the Committee calls on the Scottish Government to set out what it is doing to assist health boards to develop an integrated approach to workforce planning across professions in the multi-disciplinary team and to overcome key obstacles to recruitment and retention within these professions, including:

    - Addressing variable salary structures and terms and conditions, for example for general practice nurses;
    - Resolving particular recruitment challenges in remote and rural areas while maintaining viability of services;
    - Employing Community Link Workers on more stable, long-term terms of employment;
    - Addressing revised expectations of employees around flexible working resulting from the experience of the pandemic;
    - Improving recognition of the distinct role of different professions within the multi-disciplinary team;
    - Increasing and improving capacity for non-GP health practitioners to co-locate in GP practices and primary care hubs;
    - Ensuring that recruitment plans are successful in creating additional capacity rather than simply displacing workforce capacity issues from one area to

another.

Signposting and the role of GP receptionists

20. The Committee recognises the importance of effective signposting in helping to reduce the burden on GPs and allow them to fulfil their role as expert medical generalists. At the same time, it recognises that inappropriate signposting could result in poorer outcomes for patients and the need for them subsequently to return to their GP.

21. With a view to further improving signposting practice across the country, the Committee calls on the Scottish Government to make additional efforts to ensure Healthcare Improvement Scotland's 10-step guide and other key learnings from the Practice Administrative Staff Collaborative are systematically disseminated to all GP Practices.

22. The Committee recognises the critically important role GP receptionists have to play as part of the planned transformation of primary care, particularly in effectively signposting patients. Working in conjunction with frontline staff, the Committee suggests it should be possible to define a more appropriate job title that better reflects their role.

23. The Committee pays tribute to the vital role of GP receptionists and has therefore been concerned to hear evidence of public frustration with them, sometimes resulting in aggressive or abusive behaviour by patients, and a common misconception that their principal role is to act as gatekeepers who control access to GP appointments. The Committee is strongly of the view that such behaviour is never acceptable and supports any measures that can be taken to improve patients' understanding of the GP receptionist's role as well as the significant pressure they are often under.

24. The Committee welcomes recent efforts by the Scottish Government, notably through the Right Care Right Place - Receptionist Campaign, to improve patient awareness and understanding of the expanded role of GP receptionists in the context of the Scottish Government's planned primary care reforms.

25. In recognising how the role of receptionists has developed, the Committee highlights the need for receptionist-patient interactions to be improved from both sides and calls for a greater focus on actions to achieve this. Following completion of the Right Care Right Place Campaign, the Committee calls on the Scottish Government to provide an evaluation of its impact and to set out any further measures it plans to take to improve receptionist-patient interactions.

26. The Committee calls on the Scottish Government to provide an update on the work of the Short Life Working Group on the role of GP receptionists. On the back of that, it further calls on the Scottish Government to work with NHS Education Scotland and the RCGP to develop additional best practice guidance that will support GP practices to prioritise ongoing development and training of GP receptionists that assists them in fulfilling their signposting role and makes them feel suitably valued as an integral part of the multi-disciplinary team.

The role of community link workers

27. The Committee heard substantial evidence on the positive role CLWs play in communities where they work, and how they enable and empower individuals to proactively take control of their lives, as well as the particularly valuable role they fulfilled during the pandemic.

28. The Committee notes that, as of October 2021, the Scottish Government had yet to meet its target to recruit at least 250 CLWs to work in GP surgeries in Scotland's most deprived communities. [1] Given the extensive evidence it has heard of the positive role CLWs have to play in facilitating access to alternative pathways to primary care, the Committee calls on the Scottish Government to evaluate each health board's progress in bringing forward updated recruitment plans with a view to expanding the provision of CLWs to every GP practice in Scotland.

29. The Committee highlights the work being undertaken by Voluntary Health Scotland to review the support and training needs of CLWs and to develop a national network of CLWs to enable sharing of best practice and peer-to-peer support. The Committee calls on the Scottish Government to review any additional funding it can make available to support this work.

ALISS ( A Local Information System for Scotland

30. The Committee acknowledges the critical importance of reliable, up-to-date information about locally availably community services for effective signposting to alternative pathways to primary care as well as improving patient and practitioner trust and confidence in these pathways. It recognises the important role ALISS could play in this regard.

31. Evidence has shown that, although a useful resource, the constantly changing landscape of non-GP primary care services in local communities can result in ALISS being unreliable and often out of date. The Committee welcomes the ALLIANCE's acknowledgement that issues around data quality need to be systematically addressed. Once completed, the Committee looks forward to receiving an update from the ALLIANCE on ongoing work to improve the performance and accessibility of ALISS.

32. The Committee believes that significantly improving general awareness of ALISS and the accuracy, reliability and comprehensiveness of information available through the ALISS database are fundamental prerequisites for it to become an authoritative source of data for those seeking to signpost patients towards alternative pathways to primary care. The Committee therefore calls on the Scottish Government, working in partnership with the ALLIANCE, to undertake an assessment of the actions and associated funding required to achieve this.

Role of alternative pathways in preventative primary care

33. The Committee has heard encouraging evidence of the important contribution non-GP primary healthcare practitioners can make towards a more holistic and preventative approach to healthcare, particularly in relation to the early diagnosis

and ongoing monitoring of a range of health conditions.

34. To realise the full potential greater use of alternative pathways to primary care offers in achieving a more preventative approach to healthcare, the Committee calls on the Scottish Government to work with health boards and health and social care partnerships to develop a strategy for improved collaboration on service planning and delivery between different primary healthcare professions.

35. In responding to this report, the Committee calls on the Scottish Government to set out what steps it intends to take, as part of its Health and Social Care Strategy for Older People, to encourage active ageing and, in particular, what role it expects the promotion of alternative pathways to primary care to play in this regard.

Social prescribing

36. The Committee welcomes the increased uptake of social prescribing witnessed during the course of the pandemic and those positive experiences patients have reported with social prescribing during this period. It is concerned by evidence that, during Covid recovery, patients who used social prescribing during the pandemic are reverting back to contacting their GP in the first instance when ongoing use of social prescribing as an alternative pathway to primary care could offer quicker and better health outcomes for them.

37. The Committee notes there is no single national lead on social prescribing, given that responsibility for it is shared between two Scottish Government ministerial portfolios. The Committee would appreciate a response on the rationale for sharing this responsibility, and whether the Scottish Government has considered following other models from other countries in the UK, and beyond, on having one national lead to develop social prescribing policy.

38. The Committee commends work currently being undertaken by CLWs and social prescribing networks to map the availability of social prescribing pathways across the country. Once complete, the Committee calls on the Scottish Government to work with CLWs and these networks to ensure this information is widely disseminated to those responsible for signposting patients to alternative pathways and directly to patients looking to self-refer.

39. The Committee recognises the importance of word of mouth within local communities in promoting greater uptake of social prescribing. At the same time, the Committee has heard evidence that clinicians should be doing more to champion social prescribing as an alternative pathway to primary care and that the RCGP in Scotland should be more actively promoting its benefits to its membership. The Committee calls on the Scottish Government to work with partners to bring forward a targeted communications plan with the aim of raising awareness of social prescribing and its benefits amongst patients and health practitioners and encouraging greater and more effective use of social prescribing as an alternative pathway to primary care.

40. The Committee has been particularly concerned to hear evidence that cost is a critical barrier to access to social prescribing pathways for people on low

incomes. The Committee is therefore keen to understand what measures the Scottish Government will take to address this specific issue.

41. The Committee has heard extensive evidence of the essential role played by the voluntary sector in providing many social prescribing services. The Committee calls on the Scottish Government, in responding to this report, to set out what measures it can take to improve the long-term financial viability of these voluntary sector providers and thereby improve the reliability and uptake of social prescribing as an alternative pathway to primary care.

Role of digital health and care

42. The Committee acknowledges the increasing role of digital health and care and notes its wider use has been accelerated as a result of the pandemic.

43. The Committee believes digital health and care has an important role to play in the future delivery of primary care services in Scotland. However, the Committee recognises such services are not suitable for all patients, all cases or the digitally excluded. It therefore takes the view that other routes to primary care need to be safeguarded in that context. The Committee calls on the Scottish Government, in responding to this report, to set out what measures it will take, as it continues to extend the availability of digital health and care services, to encourage frontline practitioners to safeguard primary care access for the digitally excluded and other categories of patients who struggle to access digital services.

44. The Committee welcomes the Scottish Government's commitment to introducing a Digital app which would work as a front door for access to a range of information and services including booking appointments and receiving results. To enable greater use of digital services as an alternative pathway to primary care, the Committee believes the Scottish Government needs to accelerate this commitment and would welcome an update on when such a service is likely to be available and how it will be rolled-out to GP practices across the whole of Scotland.

Single electronic patient record

45. While accepting that the COVID-19 pandemic will have caused understandable delays to progress, the Committee is concerned that the lack of a single electronic patient record is a major barrier to increased use of alternative pathways to primary care. Until this issue is resolved, it believes expanded use of these pathways will be limited because they will continue to be difficult for patients to navigate, resulting in patients reverting to their GP as a first port of call and in turn placing GP practices under continued strain.

46. The Committee acknowledges the Cabinet Secretary's commitment to accelerate introduction of a single electronic patient record but remains concerned that, until this is realised, it will be impossible to fully embrace opportunities for quicker treatment and better outcomes for patients through the greater use of alternative pathways to primary care. The Committee therefore calls on the Scottish Government, in responding to this report, to provide regular updates on progress and to set out a timetable for the introduction of a single electronic patient record.

# Introduction

47. At its work programme discussion on 5 October 2021, the Health, Social Care and Sport Committee agreed to hold an inquiry into pathways to primary care.

48. The Committee subsequently agreed that the inquiry would have a main focus on alternative pathways to primary care – as distinct from the usual route into healthcare services of visiting a General Practitioner.

49. It was agreed the main objectives of the inquiry would be:

- to establish how widely used by patients such alternative pathways currently are, either through referral by a GP or through self-referral;
- to gather evidence from patients and health practitioners of their experience of using such alternative pathways;
- to assess overall awareness of alternative pathways, both for patients and for health practitioners;
- to investigate whether the most effective use is currently being made of such alternative pathways and how their use could be improved in the future;
- based on the evidence, to make policy recommendations to the Scottish Government and other key decision-makers on alternative pathways to primary care.

50. The Committee issued a call for evidence which ran from 20 January 2022 until 22 February 2022. The Committee sought views on:

- What is the current level of awareness amongst health practitioners and patients of the availability of alternative pathways to healthcare services other than seeing a GP?
- How good is the signposting between general practice and other primary healthcare professionals? To what extent are GPs equipped with the information they need to make onward referrals? To what extent are GP practice receptionists equipped to signpost patients to the most appropriate service?
- What is the level of public awareness of options to self-refer to alternative pathways to healthcare? What is the current extent of self-referrals? How could this be improved?
- To what extent is there available capacity amongst other primary healthcare professionals to take on more patients if there was an increase in referrals from GPs / self-referral by patients?
- What potential is there for greater use of alternative pathways to healthcare to ease current pressures on general practice? What are the potential limitations?
- What scope is there for greater use of social prescribing to ease current pressures on general practice and to achieve similar or even better health

outcomes?

- To what extent is best use currently being made of alternative sources of health and wellbeing information and advice (other than a patient seeing their GP) such as telephone helplines, websites and online therapy? What are the limitations / potential pitfalls of increased use of these resources as an alternative to patients making an appointment with their GP?

51. The call for views received 74 responses from a variety of stakeholders and individuals.

52. The Committee also ran a public survey from 21 January 2022 to 17 February 2022. The survey received 276 responses. A summary of the responses can be viewed here.

53. On 7 March 2022, the Committee held an informal engagement session to hear the patient perspective and the lived experience of people who access primary care services. The people who attended were identified by the Health and Social Care Alliance Scotland (the ALLIANCE ) and Spring Social Prescribing . A summary of the key points raised during the discussion is available at Annexe A.

54. The Committee also held four formal evidence sessions, taking evidence from:

- Stakeholders (focusing on patients perspective and GPs)
- Stakeholders (focusing on other primary care providers and the multi-disciplinary team)
- Stakeholders (focusing on social prescribing and digital health and care)
- The Cabinet Secretary for Health and Social Care.

55. The Committee would like to extend its thanks to all those who engaged with the inquiry, particularly those who provided details of their own personal experiences.

56. Minutes of these meetings are available to view at Annexe B. The Official Reports can be viewed at Annexe C.

# Background

57. In 2019/20 the health service in Scotland cost £13.2 billion . Spending on primary care (family health services and community services) accounted for 40% of this cost (£5.4 billion). £2.8 billion was spent on family health services (including GP, pharmaceutical, dental, and ophthalmic services) and £2.6 billion was spent on community services (including AHPs). In its 2021-22 Programme for Government the Scottish Government committed to increase frontline health spend each year, and to increase primary care spending by 25% over the term of this 6th session of the Scottish Parliament.

58. The healthcare needs of the Scottish population are increasing in complexity. For example:

   - Older people comprise an increasing number and proportion of the population.
   - Health inequalities are wide (and have been exacerbated by the COVID-19 pandemic).
   - Ageing and inequalities are both associated with multimorbidity (the co-existence of two or more long-term conditions).

59. The rise in complexity of patient needs has led to a substantial increase in the primary care workload in Scotland. [2] Problems in maintaining and developing the general practice workforce also exacerbate the challenges.

## What are alternative pathways to primary care?

60. Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. When a person seeks healthcare, their first point of contact is usually with a general practitioner (a GP, or family doctor). Our inquiry, however, is focused on other sources of healthcare that exist in the community, which we term 'alternative' pathways.

61. Alternative pathways to healthcare in the community include:

   - seeing a different 'health practitioner' who works in the GP practice or in the local community, examples of which include:
     - physiotherapists
     - nurses
     - podiatrists
   - being directed to other types of support, sometimes referred to as social prescribing, to improve health and wellbeing which could include:
     - walking groups
     - community groups

    - advice
    - volunteering

- Using telephone helplines or websites to access additional information or online therapy.

62. Primary care providers other than GPs include, but are not limited to, nurse practitioners, pharmacists, optometrists, midwives, dentists, and a range of allied healthcare professionals (AHPs).

63. These practitioners may work within the GP practice (as part of the multi-disciplinary team (MDT)), or at another location in the community. In some cases it may be possible for a patient to 'self-refer' to these services, without seeing their GP first.

64. Although the Committee agreed to use the term 'alternative pathways' in the title of this inquiry, this is not a universally recognised term. Wendy Panton from the Scottish General Practice Professional Nurse Lead Group highlighted during oral evidence that:

> ...the term "alternative" does not demonstrate the professional role of nurses working in general practice. In fact, nurses who work in general practice are essential, not an alternative. "Alternative" could have connotations that the patient will experience lesser care whereas it is the complete opposite. [3]

# Scottish Government vision for primary care services

65. Underpinning its plans for primary care reform, the Scottish Government has established a vision that people needing care will be more informed and empowered, and able to access the right professional at the right time. The Scottish Government's aim is that people should be supported by the most appropriate practitioner for their problems, with a focus on prevention, rehabilitation, and independence.

66. In introducing these reforms, the Scottish Government's intention is that the shift to multidisciplinary working will reduce pressures on services and ensure improved outcomes for patients while freeing up GPs to spend more time with patients in specific need of their expertise.

67. In 2016, the Scottish Government's National Clinical Strategy and Health and Social Care Delivery Plan proposed how the 2020 Vision and integrated health and social care services could be delivered. The aim was to provide sustainable services by making the most effective use of the resources available

68. The Committee heard examples of where this vision was coming to fruition. In NHS Forth Valley, first-contact practitioners and physiotherapists have been seen as pivotal in freeing up GPs' time, allowing them to extend appointments from 10 minutes to 15 minutes.

69. In NHS Lanarkshire, occupational therapists seeing people with frailty and mild to moderate mental health problems have reduced the number of return appointments to GPs for that population by 52 per cent. [4]

# Relevant Session 5 Health and Sport Committee work

70. In 2019, the Health and Sport Committee published the first report from its inquiry ' What should primary care look like for the next generation? '. During this inquiry, public panels from around Scotland voiced their desire for:

- a more patient-centred approach,
- better triage and clear signposting to alternative primary care services, to avoid over-reliance on GPs,
- a preventative focus: to help them remain well and not require primary care services in the first place.

71. In 2021, the Committee published the second report from the same inquiry. After hearing what primary care services people in Scotland wanted and needed, the Committee sought evidence to inform the changes that would be necessary to develop such services. The Committee made several recommendations to the Scottish Government, including:

- To fully implement the multidisciplinary team model
- To deliver a 21st century level of technology and data sharing
- To prioritise a preventative approach.

72. Other relevant previous work includes the Session 5 Committee's inquiries into Social prescribing and Technology and innovation in health and social care.

# Patient perspective

## Public understanding of primary care reform

73. As part of the current inquiry, responses to the Committee's call for views and public survey suggest the changes being made to primary care, and the reasons for them, are still not well understood by the public and many people still expect to be able to see their GP for every health issue.

74. When asked as part of the public survey "how did you feel about not being offered a GP appointment", responses included:

- annoyed, if I wanted the practice nurse I would have asked to see one of them;
- I was told to speak to a pharmacist instead. I felt I was being brushed off and my health issue was not given the attention or care;
- That my issue was less valued; and
- Unhappy. GPs at our practice no longer wish to see us.

75. In written evidence, the Royal College of Physicians and Surgeons of Glasgow indicated understanding of alternative pathways to health care is poor among patients. It noted "patients may be aware generally about alternative pathways, it may be limited about specific pathways. It may also be guided by personal experience of both practitioners and patients and what is available locally."

76. Written submissions to the Committee's call for views included the following comments about patients' awareness of alternative pathways:

- there is limited awareness of alternative pathways because of variability in their provision and consistency of delivery. It takes a very long time to change a population approach to "contact the GP" which has been a common message across society for many years[i];
- Awareness is very low with patients. They still want to see the GP for everything;[ii]
- Very limited from my experience. Tend to call primary care to ask what to try/ where to get information. receptionists staff have had training in signposting but resistance to this is high with people tending to resist change.[iii]

77. The written submission from the Royal Pharmaceutical Society indicates limited patient awareness of alternative pathways or of the existence of multi-disciplinary teams:

---

i Gordon McLeay written submission
ii Lindsey Falconer written submission
iii Rachel Mollart written submission

> There has been no national publicity around changes to the GP practice teams and the roles of different professionals within the team. People only become aware when they are directed to the pharmacist as part of routine contact.

78. During oral evidence, representing Riverside Medical Practice Patient Participation Group, Margaret McKay highlighted that patients were the one group of people who were not actively involved in developing and implementing the new GP Contract. As a result, she felt the "impact on patients was not looked at, and nor was how patients were to understand the rationale for the changes that took place". [5]

    She went on to note:

> ...there has been an abysmal failure in getting over to the public that general practice is changing, why it is changing, why it needs to change and what will be put in place to ensure that healthcare needs are fully taken account of.

79. This was a view supported by other witnesses. Dr Anurag Yadav representing the British Association of Physicians of Indian Origin (BAPIO) noted:

> ...there has not been much communication with the general public about primary care. Patient expectation was not taken care of when the changes were made, so we definitely want more patient education and awareness so that they can see what changes are coming in primary care, such as the changes in signposting and social prescribing. [6]

80. The Committee heard evidence that, as a result of many patients being transferred to online consultations during the pandemic, information boards and screens in GP surgeries have become a less effective means of disseminating localised information about different services available in the GP practice or in the community.

81. Margaret McKay argued for a coordinated communication plan to explain changes being made to general practice and the reasons behind these:

> ...there must be messages at national, health board and local practice levels, delivered in a coherent and coordinated way. There is no point in there being just one message. There has to be a plan to communicate the changes to all the groups that are involved, and to give them the same messages. [7]

82. With the pandemic having been the main focus of health communications over the past two years, the Cabinet Secretary advised he now hoped to rebalance public messaging with the focus now shifting towards the redesign of the urgent care programme:

> As part of that, at the end of last year, we delivered a leaflet to every single household with an accompanying letter from the Chief Medical Officer and the National Clinical Director. That well produced leaflet showed the various pathways for someone to access treatment and what services people could expect from GPs and the other pathways, including Pharmacy First and NHS 24. [8]

# Patients' experiences of alternative pathways

83. Published in 2017, the nationally-representative Our Voice Citizens' Panel showed:

- 60% of people would accept an appointment with non-GP health practitioner instead of an appointment with a GP. 10% would not. A higher proportion (75%) would accept the non-GP health practitioner appointment if they understood more about their role.

- 78% of people would self-refer directly to a non-GP health practitioner if they were happy with previous treatment from them.

84. Many respondents to the Committee's public survey expressed dissatisfaction with being directed to a non-GP practitioner rather than a GP. Respondents felt they were being "fobbed off" and provided with a lower standard of care by practitioners with less training or experience.

85. The Committee's public survey also showed:

- Half of respondents had been directed to a health practitioner other than a GP when requesting a GP appointment.

- There were high levels of uncertainty from respondents about the availability of health practitioners locally.

- Very few respondents had self-referred directly to most non-GP health practitioners.

86. During the informal engagement session on 7 March 2022, the Committee heard evidence of both positive and negative experiences of accessing alternative pathways. Key challenges with accessing these pathways related to communication, delivery of signposting and availability.

87. In its written evidence to the Committee, RCGP Scotland argued :

> ...the biggest limiting factor currently is public attitudes to seeking healthcare from alternative pathways. They are often viewed as less convenient, less accessible, less safe, less quality – patients then often phoning general practice instead.

88. Responses to the Committee's public survey suggest that experiencing long waiting times for non-GP practitioners makes it less likely that patients would use the service again and more likely they would default to seeing their GP. Conversely, some respondents to the Committee's public survey felt that being referred or self-referring to a non-GP health practitioner made better use of everyone's time and expertise.

89. Although initially unaware of what alternative pathways were available, some respondents were happy with being referred elsewhere than their GP once they had been given more information. For example, one respondent said: "I didn't know what the options were, so asked about a GP appointment, and was advised that other professionals were able to deal with the issue, which they did".

90. With a view to evaluating patients' experiences of navigating different pathways to

primary care, the Cabinet Secretary advised the Committee that the Scottish Government has recently commissioned the ALLIANCE to conduct a qualitative survey of patients' experience of accessing general practice and that this will form part of a wider ten-year monitoring and evaluation strategy for primary care.

91. The Committee is concerned that responses to the inquiry highlight limited public awareness of primary care reform, resulting in much of the general public not understanding how or why general practice is changing.

92. The Committee welcomes public information campaigns the Scottish Government has so far undertaken but believes more must be done to increase the general public's understanding of changes to primary care. As part of its Covid recovery strategy, the Committee calls on the Scottish Government to set out a coordinated communications plan that aims to increase awareness of primary care reforms. This should include targeted national and local elements and be accompanied by a robust methodology for monitoring and evaluation.

93. To improve patient uptake of alternative pathways to primary care, the Committee calls on the Scottish Government to work with territorial health boards across Scotland to develop best practice guidance on communicating the benefits of alternative pathways and addressing popular misconceptions about these. The Committee recommends that such guidance must be developed in close coordination with measures to improve accessibility and navigability of alternative pathways to primary care, as set out later in this report.

# Self-referral

94. Self-referral means people are able to refer themselves to a health service without having to see their GP first. Many alternative pathways in primary care allow self-referral which could help people access the care they need more quickly and easily than going through their GP. Self-referral can also help reduce workload pressure on GPs, allowing them to focus on their revised role of expert generalists, as set out in the new GP Contract.

95. The public survey undertaken as part of the Committee's inquiry found that very few respondents had referred themselves directly to most categories of health practitioner other than GPs.

96. Glasgow City HSCP argued for action to encourage a change in behaviour from people automatically seeking help from GPs in the first instance. However, it also acknowledged that such changes can take significant amounts of time to become embedded in practice.

97. Evidence submitted to the inquiry suggests that, while there is a good understanding within the general public of the option to self-refer to certain non-GP primary care practitioners such as optometrists, pharmacists and dentists, patients remain unaware of the full range of services provided by these practitioners.

98. Mental health services were highlighted to the Committee as being particularly

difficult for patients to self-refer to, particularly for those with mild to moderate conditions where pathways other than a GP might offer quicker and better outcomes. Dr Jess Sussmann of the Royal College of Psychiatrists advised:

> We want to ensure that, when someone is severely unwell, there is a straightforward path through the GP to the appropriate specialist in psychiatric care. With regard to mild to moderate conditions, there should be a variety of options available in the community—anxiety management, relaxation, opportunities for improving access to other people, peer support and so on—and people should be able to choose between those options in order to maximise their health and wellbeing. [9]

99. Dr Sussmann explained that around 46 per cent of referrals to primary care mental health teams in Glasgow are self-referrals. She advised that these teams are able to assess whether the patient has a mild to moderate mental health problem or something more serious, in which case they would be referred to secondary care. Despite its success, Dr Sussman noted that this scheme has not been rolled out nationwide.

100. In its written submission, the National Community Hearing Association (NCHA) Scotland outlined current obstacles to self-referral for patients with non-urgent ear and hearing problems:

> The current model of NHS care means each year patients are forced to see their GP for non-medical ear and hearing problems [before being referred to an NHS-funded audiologist in a hospital setting], which can be better managed in primary care audiology settings.

It also stated:

> In some cases, the GP in a pathway adds costs without adding value, resulting in an overall loss of scarce NHS resources. This is particularly true for most ear and hearing problems where primary care audiology is, in the same way as optometrists for eye care problems, much better suited to managing needs, freeing up GP capacity to address medical issues.

101. Harjit Sandhu of the NCHA highlighted the negative impact of patients being unable to self-refer to certain primary care services such as NHS audiology services, which require a GP referral:

> Not allowing people to self-refer for things such as impacted wax or hearing loss creates bottlenecks for GP services... There are a lot of system effects when we do not promote self-referral. Promoting self referral and sustainable models of self-referral would be great for the system and service users in particular. [10]

102. The Committee heard evidence in support of a national awareness-raising campaign on self-referring with a focus on communications in health centres, community centres and cafes.

103. Some witnesses cautioned that the ability to self-refer to other services may not always be the best option and may lead to worse outcomes in some cases. In its written submission, Glasgow City HSCP cautioned:

> We have seen the risk with the Community Assessment Centres and the Covid 19 pathway through 111, for example, that patients may be more likely to end up with care being escalated to emergency departments because there isn't the same knowledge of the patient, access to records and critically a relationship which enables sensitive discussion about options. So there needs to be some caution about creating parallel processes and bypassing practices inappropriately.

104. Written submissions also noted there is a risk that important diagnoses could be missed if a patient is signposted or self-refers inappropriately. The Royal College of General Practitioners Scotland commented:

> Crucially, it is not possible to access the right help (through signposting or otherwise) unless the diagnosis is clear, and that depends on seeing a clinician, preferably early in the patient journey.

105. The Committee heard evidence of patient concerns that self-referral to a practitioner other than a GP could result in unnecessary delay to receiving appropriate treatment in circumstances where that practitioner ultimately concluded that the patient should see their GP instead. It was suggested that enabling alternative practitioners to fast track a follow-up GP appointment in those circumstances would address these concerns.

106. The Royal College of Nursing outlined how poor health literacy can prevent some patients from successfully navigating alternative pathways to primary care:

> Those with poor health literacy are less able to identify or 'label' what is wrong with them and therefore less able to identify and self-refer to alternative pathways. A greater use of alternative pathways, without acknowledgement of this and steps to mitigate against this risk, would only increase health inequalities.

107. The Committee has received evidence that shows public awareness of the option to self-refer varies significantly across different areas of Scotland and between different categories of non-GP practitioner. For instance, while the option to self-refer to pharmacists, opticians and dentists is reasonably well understood, there is far less public awareness of the option to self-refer to other services such as audiology or mental health services.

108. The Committee calls on the Scottish Government to work with GP practices, the RCGP and professional bodies representing non-GP primary care practitioners to develop and deliver a targeted public information campaign that provides practical advice to patients about self-referral across all categories of non-GP primary care practitioner, encompassing the full range of services they are able to offer. This campaign should also address the particular needs of patients with poor health literacy.

109. The Committee has heard evidence that patients are currently unable to self-refer to certain categories of NHS primary care service such as audiology while private alternatives are freely available for self-referral. It is concerned that this situation is exacerbating health inequalities between those who can afford to pay for

private services and those who cannot, as well as placing additional unnecessary pressure on GP practices. The Committee calls on the Scottish Government to clarify why self-referral to NHS audiology services is not currently available and what work will be undertaken to make this possible.

110. The Committee also highlights high rates of self-referral to primary care mental health teams in Glasgow and calls on the Scottish Government to examine how this successful approach can be replicated elsewhere with a view to increasing rates of self-referral to mental health services in other parts of Scotland.

111. More broadly, the Committee calls on the Scottish Government, in responding to this report, to set out what health boards are doing to improve opportunities for patients to self-refer to those categories of NHS primary care service that currently require prior GP referral.

112. In circumstances where a patient self-refers to a practitioner other than their GP, the Committee calls on the Scottish Government to examine how health boards could streamline the process that would enable that patient to be referred back to their GP if the non-GP practitioner concludes their pathway is not the best pathway to treatment.

# Practitioner perspective

## GP Contract and the multidisciplinary team

113. In 2018, Phase 1 of the General Medical Services contract ('the GP Contract') formalised various proposed changes to the provision of primary care in Scotland. Priorities for reform were agreed with Integration Authorities (IAs), the Scottish GP Committee (SGPC) of the British Medical Association (BMA), NHS Boards, and the Scottish Government, and included:

- Recruiting a wider range of healthcare professionals to GP practices, to form 'multi-disciplinary teams' (MDTs).
- Recruiting non-clinical Community Link Workers (CLWs) to help patients navigate and engage with wider services.
- Redistributing key services that could be done elsewhere to NHS Boards (e.g., vaccinations, repeat prescriptions, medicine reviews, minor injuries, and chronic disease monitoring).
- Freeing up GPs to have more time to spend with patients in specific need of their expertise, as expert medical generalists (EMG).

114. The 2018 GP Contract proposed a refocused role for GPs as expert medical generalists. This role would focus on undifferentiated presentations and complex care, allowing GPs to spend more time with those patients who need them most.

115. Regarding the general practice-based MDTs in particular, the 2018 GP Contract set out the Scottish Government's vision for a refocused role of GPs on complex care and system-wide activities. It was envisaged that GPs should be less involved in more routine tasks, and these tasks should be delivered by other health professions in the wider primary care multi-disciplinary team. Under this plan, the professionals in the MDT would have their day-to-day work coordinated by the GP practice but would be employed by Health and Social Care Partnerships (HSCPs).

116. The 2018 workforce plan set out key steps for developing multidisciplinary capacity across Scotland:

- Scottish Government to make significant investment to plan for, recruit, and support a workforce in general practice, primary care, and wider community health.
- Local workforce planners (NHS Boards, Integration Authorities, and General Practices) to consider configuration of local MDTs, and reconfigure services to maximise workforce competencies and capabilities.
- National, regional, and local planners to consider staff training needs to enhance opportunities for the primary care workforce to further develop rewarding and attractive careers.

117. The following year, a joint Integrated Health and Social Care Workforce Plan between COSLA and the Scottish Government set out future workforce

requirements. In particular, the plan:

- Noted the role of the Scottish Government in leading a whole-system approach to workforce planning.
- Noted that effective workforce planning is fundamental to achieving safe, integrated, high quality, and affordable health and social care services.
- Made specific commitments for primary care workforce: increasing training places for physiotherapists, pharmacists, clinical psychologists.
- Set out future workforce requirements and committed to 800 more mental health workers by 2022, 500 more advanced nurse practitioners, 1000 more paramedics, access to pharmacist support for all GP practices, and increasing the GP workforce by 800 by 2026.

118. In 2021 a Memorandum of Understanding (MOU) was published detailing delays to the implementation of the GP Contract, along with revised priorities. This means that progress with recruiting Link Workers and additional professional roles will be slower than initially planned. The revised MOU notes:

> The MOU Parties recognise we have achieved a great deal and it is important we do not lose sight of that. But we must recognise we still have a considerable way to go to fully deliver the GP Contract Offer commitments originally intended to be delivered by April 2021... While this MOU runs until 31 March 2023, the National GMS Oversight Group will review progress in March 2022 to ensure it remains responsive to the latest situation.

119. Giving evidence to the inquiry, Dr Chris Williams from the RCGP Scotland said he believes the new GP Contract has helped to broaden the skills mix that is available in GP surgeries. He concluded: "bringing in first-contact physiotherapists has been an excellent move, and pharmacists add another dimension". [11]

120. The Cabinet Secretary for Health and Social Care told the inquiry that by March 2021, 2,463 staff had been recruited to the multidisciplinary teams—over two and a half whole-time equivalent staff per practice—and that number will have risen significantly over the course of that year. He further highlighted that the Scottish Government has "allocated every penny of the £360 million investment committed to recruit those teams over four years, and we are delivering a further £170 million investment as part of the 2022-23 budget to continue the expansion of those important MDTs". [12]

121. The Cabinet Secretary highlighted feedback from GPs that the GP Contract, and the work it is doing around MDTs in particular, will make general practice a more attractive work proposition for those considering becoming a GP. [13]

122. **The Committee recognises the ambition behind the 2018 GP Contract in encouraging the creation of multi-disciplinary teams and the potential this offers to ease existing significant work pressures on GPs and to promote greater use of alternative pathways to primary care.**

123. The Committee understands the pandemic has contributed to delays in the implementation of certain aspects of the GP Contract, but notes the resulting effect this has had on staff morale and the ability to recruit staff across a range of primary care professions. The Committee believes this will, in turn, have hampered progress in improving access to and availability of alternative pathways to primary care.

124. The Memorandum of Understanding advises the National GMS Oversight Group will review progress with implementation of the GP Contract in March 2022. The Committee would welcome details of any findings of this review that may be relevant to this inquiry. In particular, the Committee requests an update on plans to recruit additional practitioners across multiple disciplines including mental health workers, advanced nurse practitioners, Link Workers and additional pharmacy support and the implications of any delays to these plans for the delivery of alternative pathways to primary care.

# Workforce and capacity issues

125. A key aim of the inquiry was to establish to what extent there is available capacity amongst primary healthcare professionals other than GPs to take on more patients and whether they could therefore accommodate an increase in referrals from GPs / self-referral by patients. This question was included in the Committee's call for views.

126. Before the start of the COVID-19 pandemic, Audit Scotland reported [14] that HSCPs were having difficulties in recruiting and retaining practitioners for the GP practice-based MDTs. Workforce pressures were growing due to increasing demand and were expected to rise further due to the additional reduction in available workforce brought about by EU exit. Due to previously fragmented workforce planning, Audit Scotland recommended:

- The Scottish Government should work with NHS boards and Integration Authorities to model how training and recruitment numbers across all healthcare staff groups will meet estimated future demand for primary care.
- Locally, NHS boards and integration authorities should work together to plan the primary care workforce.

127. The ability of GPs to take on the refocused expert medical generalist role is recognised to be contingent on the recruitment of practitioners into MDTs, as well as the recruitment of 800 additional GPs by 2027.

128. At the same time, the Committee heard that MDTs may need to work on a broader community basis rather than being attached to specific GP surgeries due to currently insufficient numbers of non-GP primary healthcare practitioners.

129. BMA's Scottish GP Committee has warned Scotland's primary care services have a "critical workforce supply problem" and has called for the Scottish Government to

form a credible plan to get recruitment delays back on track. Dr Andrew Buist, chair of the committee, stated:

> We need the physiotherapists, the pharmacists, the nurses who are all key parts of the multi-disciplinary teams we need in place if we are truly to deliver the vision the contract sets out.

130. During oral evidence, Val Costello of Citizens' Advice Scotland's Patient Advice and Support Service highlighted that very long waiting times due to a lack of available capacity were causing people to return from alternative pathways to their GP. Val Costello went on to note:

> ...capacity is an issue. Is there capacity in all the possible alternatives for them to be fully used?...Are there ways to find out how long a person will wait if they self-refer to physiotherapy today? Would they have to wait for long time? What should they do in the meantime while they wait for an appointment? All that needs to be looked at. We need to work on those things.. [15]

## Role specific capacity issues

131. The Committee has heard evidence of a shortage of available capacity in non-GP primary healthcare professions including pharmacy, optometry, audiology and psychiatry.

132. Pharmacy was highlighted to the Committee as a non-GP primary care health profession currently experiencing workforce capacity issues.

133. During oral evidence, Clare Morrison of the Royal Pharmaceutical Society advised "Like every profession, pharmacy has difficulties relating to total workforce capacity". Clare highlighted areas where improvements could be made which would result in increased capacity:

- Make processes more efficient in all settings;
- Improved information flow in and out of community pharmacy;
- Less variation in the availability of pharmacotherapy services in GP practices;
- Introducing an electronic single shared patient record;
- Improved skills mix by investing in more pharmacy technicians and support workers; and
- Modernise the dispensing process in pharmacy, including using digital tools, such as electronic prescribing.

134. The Committee heard there is a need for further investment to train pharmacists in independent prescribing. This is not available in all community pharmacies which can cause frustration for patients who are used to this service when they visit a pharmacy where the service is unavailable. The Committee heard evidence that training places for independent prescribing have increased but that courses remain significantly oversubscribed.

135. As part of the GP Contract, a pharmacotherapy service is now available in all but

seven GP practices in Scotland. However, the Committee heard evidence that pharmacists' clinical skills are not being utilised to their full extent in practices and a key reason for this is that pharmacy teams are overstretched due to insufficient workforce capacity. Clare Morrison advised:

> Pharmacy technicians and pharmacy support workers are needed to undertake the level 1 part of the service. If we had the right staff mix in place, pharmacists' clinical skills could be used more effectively at the higher level of the pharmacotherapy service—level 3— which is where they should be working. [16]

136. In relation to optometry, the Committee heard evidence that increased funding in the sector would allow optometrists to increase the range of work they undertook, including providing at home services across the country.

137. In its written submission to the Committee, Optometry Scotland stated:

> The greatest limitation on the optometry sector's ability to provide an increased role as an alternative pathway to healthcare is funding. With additional funding the sector will be able to offer an enhanced range of services and will be able to do even more to ease pressures on general practice.

It continued:

> ...as more and more optometrists become qualified as Independent Prescribers (currently 400), the burden on GPs will be reduced further.

138. During oral evidence, the Committee heard certain specialist optometrists offer a home care service. However, in 2019, out of 2.1 million eye exams conducted in Scotland, only 55,000 people accessed the home care service. The Committee heard the biggest barrier to wider availability of this service is cost and the need for additional funding to maintain its viability. [17]

139. Julie Mosgrove from Optometry Scotland told the Committee there is currently a good network of optometry services across Scotland, including in rural areas. At the same time, she emphasised the importance of maintaining a good supply of eye care professionals to fill emerging vacancies in community eye care services.

140. The Committee heard oral evidence that the most significant and most severe hearing problems occur in older age, with people over 80 more likely to have a hearing problem of greater severity. As such, much of the unmet need for home care audiology services is in care homes and in populations where people find it difficult to travel.

141. The Committee heard evidence in support of the development of a publicly available home care service, where people can receive hearing diagnostics, testing, care and aftercare at home. The Committee also heard evidence that home care services are currently only available at a cost from independent, private sector providers, resulting in an inequality of access that needs to be addressed. [18]

142. The Programme for Government 2021-2022 makes a commitment that: "We will support NHS Audiologists to work in a general practice and community settings, building on two pilots in NHS Tayside and NHS Ayrshire and Arran, freeing up capacity in acute settings".

143. The NHS recovery plan includes the following commitment in relation to audiology services:

> This year we are also investing £200,000 to pilot enhanced community audiology services, and we aim to develop community hearing services that are on a par with primary care services by the end of this parliament.

144. Harjit Sandhu of the NCHA told the Committee that for this evolution of service to be successful, access will need to be greatly expanded. He continued: "The current NHS workforce, which is predominantly hospital based, will not be able to meet that need but, fortunately, we can double the workforce by using other primary care professions in the same way as optometrists, GPs and pharmacists are using them.". [19] . He highlighted that many audiologists are already working in the same practices as optometrists and pharmacists.

145. In relation to psychiatry, whilst welcoming the expansion of link workers into primary care settings, Dr Jess Sussmann of the Royal College of Psychiatrists in Scotland noted there are "staffing crises in mental health services. That includes nursing staff and social workers—it is pretty much across the board. We have problems filling all the necessary roles." [20]

146. Dr Sussmann went on to note:

> We are concerned that, unless we have a real look at the workforce and how to plan for it, skilled staff from other settings will just be taken and moved across, which will create other gaps.

147. The Committee has been concerned to receive evidence that, in the short term, workforce constraints and delays to recruitment across a number of primary care professions other than GPs are likely to limit the capacity for a significant increase in referrals and self-referrals to alternative pathways to primary care.

148. In this context, the Committee believes urgent action is needed to accelerate planned recruitment and increase workforce capacity across the professions in question and warns that, until these issues have been resolved, the extent to which patients will be able to make use of alternative pathways to primary care, and can be actively encouraged to do so, will be limited.

149. The Committee recognises the significant progress made, under the new GP Contract, towards establishing pharmacotherapy services in GP practices throughout Scotland. At the same time, it has heard evidence that there continues to be substantial variability in the level of service available in individual practices and that workforce capacity and physical workplace capacity continue to constrain service provision in many cases. The Committee calls on the Scottish Government to set out what action it will take to improve workforce planning for pharmacists and pharmacy technicians and to overcome these continuing constraints on service provision.

150. The Committee is encouraged by evidence that optometrists have the potential to offer a wider range of services, including the provision of at-home services and diagnostic and treatment services, which would further ease pressure on GPs. It

further notes that Grampian already offers an example of best practice in this regard. The Committee therefore calls on the Scottish Government to assess whether optometry can be funded to fulfil this potential and how existing examples of best practice can be replicated more widely across Scotland.

151. As a first priority, the Committee calls on the Scottish Government to bring forward a targeted action plan to address current staffing challenges that avoids transferring mental health practitioners between settings in a way that only displaces staffing problems rather than sustainably resolving them.

## Workforce planning and recruitment issues

152. The Committee has heard evidence to suggest that sustainable long-term workforce planning will be a critical prerequisite for encouraging greater use of alternative pathways to primary care in the future. Evidence submitted to the inquiry suggests this needs to include consideration of how roles and skills requirements are likely to change over time as a result of advances in technology and the ongoing evolution of services and their delivery.

153. Alison Keir from the Allied Health Professions Federation Scotland (AHPFS) argued for a workforce planning approach that is focused on the underlying health needs of the population and is integrated across multiple professions:

> It is really important not to look at workforce planning around team members but to understand it from the point of view of population health need. We need to ask what it is that our population in Scotland needs and who can meet that need, and to plan the workforce from that point of view, rather than saying that we need X number of physiotherapists, occupational therapists and dieticians.[21]

154. The Chartered Society of Physiotherapy Scotland similarly argues for an integrated approach to workforce planning, stating that it:

> ...strongly promotes a 'whole systems' approach to health and wellbeing. Unless all primary care provision is expanded, (not just parts of the system) the transformation of primary care cannot transform health outcomes...integrated workforce planning remains an aspiration.

155. Several other witnesses equally supported integrated workforce planning rather than a piecemeal approach. The Committee heard evidence that such an integrated approach is particularly important if the aim is to ensure the creation of new staff capacity rather than redeploying staff from existing services.[22]

156. This was highlighted as an area in which the Scottish Government was working, with the Cabinet Secretary for Health and Sport advising "we must not, in creating multidisciplinary teams, merely take things away from other services in the community". He went on to note:

> We are confident that there is genuine additional capacity in primary care to complement existing teams. In the recruitment of MDTs, we are seeing much greater emphasis on training and on “growing your own". [23]

157. The Cabinet Secretary cited the example of pharmacotherapy where he argued the approach to workforce planning is helping to build a future workforce pipeline without cannibalising the existing workforce:

> The plans for years 1 and 2 were very pharmacist-heavy but recently the skills mix has been moving towards use of pharmacy technicians, with a projected 75 pharmacy technicians in post for every 100 pharmacists in 2023, compared with the current figure of 29 for every 1,000. [24]

158. As well as highlighting problems with workforce capacity, the Royal Pharmaceutical Society argued that physical workplace capacity can also create obstacles to recruitment. To address this issue, it called for investment in NHS premises to enable pharmacy teams to set up consulting space in GP practices and primary care hubs.

159. Julie Mosgrove from Optometry Scotland told the Committee that vacancies in more remote and rural areas can be more difficult to fill and that "...if you are looking at putting optometrists into more difficult locations where it is harder to fill posts, you will find that higher salaries help with that, which makes it more difficult to provide the service". [25]

160. The Committee is aware that the University of the Highlands and Islands (UHI) has recently joined Glasgow Caledonian University in offering an optometry course as part of its curriculum with the aim of alleviating existing workforce capacity issues, particularly in remote and rural areas.

161. The pandemic was highlighted in evidence as having an impact on workforce attitudes and approaches to matters such as work life balance and mental health support. Evidence suggests that a failure to respond effectively to the changing expectations of students and workers could result in reduced levels of recruitment, both at a university and college level and in the workplace.

162. The Committee heard evidence of a lack of awareness within multi-disciplinary teams of the value of the wide variety of professions within primary care. It was suggested that raising the profile of different professions within the MDT would help to make staff from across those professions feel more valued and could encourage them to pursue longer term careers as part of the MDT. Harjit Sandhu of the NCHA stated:

> The more we raise awareness, the more exciting and fulfilling the careers will seem, and we will not only attract people but, we hope, keep them in the professions for longer. That will help and be part of the solution.

163. The Committee heard from Wendy Panton of the Scottish General Practice Professional Nurse Leads Group about an issue relating to general practice nurses. She highlighted variations in remuneration of general practice nurses across GP practices, noting there is no established standard within the NHS agenda for change and no uniform pay and conditions or terms of employment and that this

discourages nurses from working in a GP practice. [26]

164. This issue was raised with the Cabinet Secretary for Health and Social Care during oral evidence. He was asked whether there was a need to standardise the starting salary level for allied health professionals. While acknowledging the issue as on the Scottish Government is exploring, the Cabinet Secretary noted the need to consider that workers in different practices will have different specialisms. He also argued that imposing a national structure would remove local flexibility, including in island and rural communities. [27]

165. The Committee heard extensive evidence of high staff turnover amongst Community Link Workers (CLWs), resulting in a loss of local relationships and knowledge. Rather than being a result of dissatisfaction with the job, The ALLIANCE attributed this to a widespread use of short-term employment contracts:

> …we are also aware of staff turnover as a direct result of short-term competitive funding models, which leave staff moving to other posts because they are employed on fixed term contracts, with no potential for longer-term stable employment as a CLP.[iv] This movement of staff who are otherwise satisfied by their role is inefficient – for individual CLPs, their employers, and for the people they support. It takes time to build trust within communities; that time is wasted when staff retention is adversely affected by short-term funding models.

It continued:

> While there are clear benefits to CLPs being embedded in general practice, in order to ensure the long-term sustainability of these systems there must be sustainable funding models and a review of current commissioning and procurement models.

166. The Committee firmly believes that better recruitment and retention of workforce across MDTs are crucial to success in promoting greater use of alternative pathways to primary care. To address this, the Committee calls on the Scottish Government to set out what it is doing to assist health boards to develop an integrated approach to workforce planning across professions in the multi-disciplinary team and to overcome key obstacles to recruitment and retention within these professions, including:

- Addressing variable salary structures and terms and conditions, for example for general practice nurses;
- Resolving particular recruitment challenges in remote and rural areas while maintaining viability of services;
- Employing Community Link Workers on more stable, long-term terms of employment;
- Addressing revised expectations of employees around flexible working

---

iv Alternative name for a CLW

resulting from the experience of the pandemic;

- Improving recognition of the distinct role of different professions within the multi-disciplinary team;
- Increasing and improving capacity for non-GP health practitioners to co-locate in GP practices and primary care hubs;
- Ensuring that recruitment plans are successful in creating additional capacity rather than simply displacing workforce capacity issues from one area to another.

## Signposting and the role of GP receptionists

167. The Committee has heard evidence that effective signposting of alternative pathways is a critical stage in ensuring patients can get the right care to meet their needs.

168. In its written submission, RCGP Scotland states that, for signposting to be effective, it needs to be "done well at the first point of contact, usually with the practice receptionist. That requires not only training, confidence and skills, but also having up-to-date information".

169. Dr Anurag Yadav of BAPIO highlighted three specific measures he believed would help to improve signposting and uptake of alternative pathways to primary care:

> First, we need more information for GP practices about the available resources. Secondly, we need more training for staff on signposting as well as more funding for it. More time should be dedicated to it, and there should be NHS 24 cover during training time.
>
> Thirdly, I would emphasise the need for increased public communication to give people more confidence in taking up those services. If there is an easy way for patients to access those services, or to self refer, and if the information is out there, that will be a step forward with regard to signposting. [28]

170. In its written submission, the NHS Scotland Primary Care Leads Group said it believes signposting to be good and noted there was evidence of the benefit of a national directory system. In particular, it made the following observations:

- reception signposting works well at checking in and well-evidenced;
- care navigation training should be available;
- may be seen as refusal to see in times of extreme pressure which is not intention;
- lot of work on this but requires consistency across all system touchpoints;

- good directory system would assist;
- works well but services need to be consistent; and
- gaps in recruitment make signposting difficult.

171. The Committee has heard evidence that a key prerequisite for promoting greater use of alternative pathways and providing proper signposting to services is to ensure GP staff and members of the non-GP primary care team have access to proper training and time for continuous professional development.

172. HIS published a 10-step guide to care navigation in general practice which notes that improved care navigation can deliver benefits including:

- increased GP practice administrative staff job satisfaction, morale and confidence.
- patients can be seen by the most appropriate practitioner or service at the right time.
- builds and strengthens relationships between GP practices and other organisations and services.

173. Witnesses giving evidence to the Committee highlighted the challenge GP practices face in finding time and capacity to undertake training. To be done properly, this requires the practice to close its doors to everything but emergencies for the duration of the training. Whereas NHS24 has previously supported this by covering telephone lines during the closure, the Committee heard that this service has been progressively withdrawn. Dr Anurag Yadav of BAPIO noted: "We find it quite difficult to get training sessions for the practice and even for the GPs because of a lack of NHS 24 cover". [29]

174. In its written evidence to the Committee, RCGP Scotland noted that encouraging greater use of alternative pathways to primary care relies heavily on receptionists effectively fulfilling their signposting role. It added that "…there is constant time pressure on receptionists, with demand rising and sadly also episodes of denigration and abuse from patients, and unrealistic expectations. Like all frontline members of the practice team, they work fast because of the high work volumes experienced by general practice", and that "much better public recognition of their increasingly complex role, [is] long overdue".

175. The perceived role of the general practice receptionist in controlling access to GP appointments emerged as an area of concern for many respondents to the public survey. The Scottish Government has undertaken qualitative research into patients' attitudes towards general practice receptionists. Issues raised included:

- receptionists are perceived as gatekeepers, and more of a block than a helpful guide/navigator.
- confidentiality concerns when asked personal health questions.
- receptionists are considered to be nosey, invasive, unprofessional and accusatory.

- receptionists are perceived to lack empathy, sympathy, patience and training.

176. Dr Chris Williams of the RCGP Scotland argued during oral evidence that receptionists should be seen as "...care navigators, recognising that we have equipped them with knowledge of the healthcare system and have tried to give them enough knowledge to help them to direct someone who is describing a certain set of symptoms to a place where they can be seen quickly". [30]

177. The Committee heard the key importance of including practice receptionists in signposting training and that this would have the additional benefit of reinforcing their role as a key member of the primary care MDT as well as supporting their wellbeing by making them feel valued and supported.

178. Hannah Tweed from the ALLIANCE highlighted the importance of giving patients a clear understanding of the receptionist's role as a facilitator rather than a gatekeeper. At the same time, she argued this must be "followed through with meaningful support for those staff...Staff need to be supported and enabled to signpost people effectively". [31]

179. HIS advised in its written submission that while such resources are available, the onus is on leads (in health boards/HSCPs, general practice and wider services) to implement and promote them effectively. It advises a key barrier to full implementation of effective care navigation is the availability of specific training packages, particularly for practice administrative staff around the cultural and behavioural aspect of care navigation (i.e. managing and dealing with change, customer care and support, patient engagement, behavioural support and de-escalation strategies).

180. The Committee heard receptionists being described as being in a "no-win" situation where they are often forced by time pressures on GPs into a gatekeeping role. Margaret McKay, representing Riverside Medical Practice Patient Participation Group, noted the issues people have with receptionists are actually to do with access to the GP Practice:

> The medical care in our practice is highly respected and commented on, but most patients would say that access to the practice is devastatingly poor. If we do not tackle that issue, receptionists are put in a very difficult position, because they are having to give that message, which is unfair on them and on patients. The mechanisms for getting through to the practice need to be looked at. [32]

181. The Royal Pharmaceutical Society told the Committee that work undertaken by the Practice Administrative Staff Collaborative has significantly improved triaging and referral to the appropriate professional, including pharmacists in practices and in community pharmacy. However, it also advised that this has not been replicated across all practices which has resulted in variation in signposting. RPS advises "Training and development for administrative staff based on the Collaborative's outcomes would be beneficial".

182. Health Improvement Scotland's (HIS) Practice Administrative Staff Collaborative was launched in February 2018 with the aim of supporting practice administrative staff to develop their quality improvement skills while improving key GP practice

processes and outcomes and care experience for people, families and staff.

183. Multiple witnesses noted that the signposting information available to GP receptionists and health practitioners could be improved. The following issues were raised:

- Constantly changing landscape of service providers means that information rapidly goes out of date.
- Volume of information can be overwhelming.
- Collation at local, regional and national levels is required.
- Format needs to facilitate rapid assessment of the options.

184. The Committee heard of a range of national and local initiatives providing information about what alternative pathways to primary care are available. These include:

- NHS Scotland's Pharmacy First service
- NHS Grampian's Know Who To Turn To
- NHS Greater Glasgow and Clyde's Right Care, Right Place
- NHS Inform's Scotland's Service Directory : details of health and wellbeing services in Scotland, including GP practices, dental services, and support groups.
- Signpost guides on some GP practice websites, e.g. Leith Mount Surgery signpost guide
- The ALISS database (A Local Information System for Scotland) maintains information about services, groups and activities in local communities. ALISS is funded by the Scottish Government and delivered by the ALLIANCE.

185. The Cabinet Secretary for Health and Social Care acknowledged the pressure felt both by receptionists and by patients as a result of the daily rush to get through to the GP practice when it opens each morning in order to get an appointment over the telephone. As well as providing health boards with around £2 million to invest in telephony systems, he argued that developing a "digital front door" to GP practices could further help to alleviate that pressure:

> That is frustrating for everybody: it is frustrating for the receptionists, who I expect are feeling quite anxious at 7:59 am, and I suspect that it is pretty frustrating for the individuals at the other end. Digital will have a real role to play in that. [33]

186. The need for awareness-raising of the signposting role of GP receptionists was highlighted by a number of written submissions to the inquiry. Audit Scotland argued a national campaign is needed to ensure members of the public understand why they may be asked more questions than before when they contact the GP practice to make an appointment, and why their default pathway to primary care may not necessarily be to see a GP.

187. In March 2022, the Scottish Government launched its Right Care Right Place – Receptionist Campaign on TV, radio, press, and social media . The aim of the campaign is to improve patients' understanding of the GP receptionist's role in signposting access to care, and to reduce public frustration in their interaction with receptionists. The short video clip explains:

> A general practice receptionist is much more than a receptionist. By asking a few simple questions in complete confidence they are trained to guide you to the right care in the right place. So you get the help you need delivered by one of a range of expert health care professionals. Which is the outcome we all want.

188. The Cabinet Secretary for Health and Social Care told the Committee the purpose of the advert was to:

> ...explain that when receptionists redirect patients it is being done because that is in the best interests of the person's clinical care. There may be others who can see the person and that will allow the GP, as an expert general medical practitioner, to focus on complex cases. I hope that will result in a better experience for the GP and, most importantly, a better experience for the people we are looking to serve. [34]

189. The Committee understands that the Scottish Government is restarting a short-life working group (SLWG) that will focus on the role of GP receptionists. It was due to meet in April 2022 for the first time since the pandemic and is chaired by Fiona Duff, senior adviser to the primary care directorate. The SLWG will focus on development and the future needs of GP practice managers and administrative staff, including their development and training.

190. Citizen's Advice Scotland's patient advice and support service was highlighted to the Committee as an additional source of signposting information and support for patients. Val Costello from Citizens' Advice Scotland advised:

> The Scottish Government already has a contract with CAS for the patient advice and support service...Should any patients need access to digital services, they can get it via their patient advice and support service. There is one worker, and sometimes two, in each local authority, and those workers can help patients...We have local and national knowledge. We have extensive knowledge of how the NHS works and of each of our local GP practices. [35]

191. The Committee recognises the importance of effective signposting in helping to reduce the burden on GPs and allow them to fulfil their role as expert medical generalists. At the same time, it recognises that inappropriate signposting could result in poorer outcomes for patients and the need for them subsequently to return to their GP.

192. With a view to further improving signposting practice across the country, the Committee calls on the Scottish Government to make additional efforts to ensure Healthcare Improvement Scotland's 10-step guide and other key learnings from the Practice Administrative Staff Collaborative are systematically disseminated to all GP Practices.

193. The Committee recognises the critically important role GP receptionists have to play as part of the planned transformation of primary care, particularly in effectively signposting patients. Working in conjunction with frontline staff, the Committee suggests it should be possible to define a more appropriate job title that better reflects their role.

194. The Committee pays tribute to the vital role of GP receptionists and has therefore been concerned to hear evidence of public frustration with them, sometimes resulting in aggressive or abusive behaviour by patients, and a common misconception that their principal role is to act as gatekeepers who control access to GP appointments. The Committee is strongly of the view that such behaviour is never acceptable and supports any measures that can be taken to improve patients' understanding of the GP receptionist's role as well as the significant pressure they are often under.

195. The Committee welcomes recent efforts by the Scottish Government, notably through the Right Care Right Place - Receptionist Campaign, to improve patient awareness and understanding of the expanded role of GP receptionists in the context of the Scottish Government's planned primary care reforms.

196. In recognising how the role of receptionists has developed, the Committee highlights the need for receptionist-patient interactions to be improved from both sides and calls for a greater focus on actions to achieve this. Following completion of the Right Care Right Place Campaign, the Committee calls on the Scottish Government to provide an evaluation of its impact and to set out any further measures it plans to take to improve receptionist-patient interactions.

197. The Committee calls on the Scottish Government to provide an update on the work of the Short Life Working Group on the role of GP receptionists. On the back of that, it further calls on the Scottish Government to work with NHS Education Scotland and the RCGP to develop additional best practice guidance that will support GP practices to prioritise ongoing development and training of GP receptionists that assists them in fulfilling their signposting role and makes them feel suitably valued as an integral part of the multi-disciplinary team.

## The role of community link workers

198. The Scottish Government describes a Community Link Worker (CLW) as a:

> generalist social practitioner based in a GP practice serving a socio-economically deprived community, addressing the problems and issues that the individual brings to the consultation, rather than a worker whose domain is limited to a specified range of conditions or illnesses, or one who is based elsewhere within health, social care or other services. They offer non clinical support to patients, enabling them to set goals and overcome barriers, in order that they can take greater control of their health and well-being. [36]

199. A CLW is a non-clinical practitioner who is trained to help people access local sources of support. Whilst GP receptionists can help signpost to non-GP primary care services, a CLW is there to help signpost to community, non-clinical services

which can help individuals with issues that affect their health and wellbeing, such as money advice services, social groups to help isolation and fitness classes.

200. In 2016, the Scottish Government made a manifesto commitment to recruit at least 250 CLWs to work in GP surgeries in Scotland's most deprived communities by the end of the parliamentary term that ended in March 2021. By that point, 218 CLWs had been employed (189.3 full time equivalents). [37]

201. Glasgow City HSCP highlighted the important role of Community Link Workers (CLWs) and their ability to develop a good knowledge of local services where patients could be signposted:

> The introduction of Community Link Workers has been welcomed in Glasgow City because they are able to help patients find the most appropriate service and, unlike GPs, have the time to develop a detailed knowledge of the non-NHS services that are available in a patient's neighbourhood/locality and to support the patient to access them.

202. The National Association of Link Workers (NALW) explained the role CLWs can fulfil in empowering individuals through their holistic approach to health and wellbeing:

> LWs [Link Workers] play a pivotal role across the UK, enabling and empowering individuals to proactively take control of their lives by understanding the contexts in which illness occurs.

203. CLWs have also been able to develop good knowledge of local services, as explained by the written submission from the ALLIANCE :

> In practices where a Community Links Practitioner (CLP) has been embedded within the practice and community and been able to build up trust with the people who access and deliver services, the ALLIANCE has seen high levels of awareness and appreciation.

204. Comments from the Deep End GPs [38] (100 GP practices in the most socio-economically deprived areas in Scotland) demonstrate how CLWs have contributed to improved outcomes for patients during the period of the pandemic:

> Community link workers have been invaluable in contacting vulnerable patients, meeting their needs and making connections with community resources for health.

> How do practices in areas of deprivation manage without a Link Worker when so many patients are struggling with mental health and isolation issues? Link Workers are better placed to connect with community organisations that have quickly adapted to offer support with food and prescription delivery, and activities to counter isolation and mental health problems during lockdown.

205. During oral evidence, Hannah Tweed from the ALLIANCE argued CLWs provide an important link to local community organisations for social prescribing and that the CLW programme should be expanded to become the norm (in terms of being made available in all GP practices). [39] She also highlighted that:

> We have seen a real increase in people seeking support from links practitioners. Between 2019 and 2020, we had a 74 per cent increase in referrals, which was huge. Even allowing for the fact that we had a staff increase, it was still a really substantial increase. In 2020-21, there was a 60 per cent rise. It is partially a consequence of word of mouth. [40]

206. The limited provision of CLWs was also noted by [Glasgow City HSCP] in its written submission:

> In Glasgow City we are keen to see CLWs being available to all 143 practices but our ability to do this has been constrained by funding limits. Currently around 40 practices have recurring funding for a CLW and this has been extended to another 40 on a two year fixed term basis, therefore, a significant number of practices in the city (with some located in deprived communities) do not have any CLW help for their patients.

207. The Committee questioned witnesses on whether too much of CLWs' time is currently taken up dealing with financial issues, such as providing help with benefits applications. Witnesses were asked if this could be resolved by employing more links workers or whether that part of their role should be separated out and allocated to, for example, welfare rights advisers.

208. Wendy Panton from the Scottish General Practice Professional Nurse Leads Group responded that a financial adviser might be a better option than a CLW for some patients, but that this would "be yet another person that the patient would have to see. The patient or service user might feel that they were being pushed from pillar to post". [41]

209. Dr Chris Williams from the RCGP Scotland expressed his support for making financial advice services available in GP surgeries but highlighted many GP practices are constricted by how much space they have on offer and that much of the general practice estate is already fully utilised. [42]

210. Another area of concern raised with the Committee was the training and education needs of CLWs. The Committee heard evidence that the NALW has a voluntary code of practice that members sign up to and a continuing professional development network but that these should be placed on a more formal footing. The Committee was advised that discussions have begun with a view to NHS Education for Scotland (NES) taking the matter forward. The Committee also heard evidence that, in other nations of the UK, such matters are overseen by statutory education bodies.

211. Christina Melam from NALW advised:

> We cannot have a cycle of bringing people in but not having plans or standards, with workers getting burned out and nobody looking at their career progression, education needs and so on. That makes the job unattractive. [43]

212. A NALW survey showed over 70 per cent of CLWs are in favour of a professional register to overcome challenges they currently face in not being seen as professionals and to address issues around pay and conditions, poor availability of training and educational opportunities, and the prevalence of short-term

employment contracts.

213. The Committee has learned that the Scottish Government has now commissioned Voluntary Health Scotland to develop a national network of community link workers to enable sharing of best practice and the provision of peer-to-peer support. Voluntary Health Scotland is also undertaking a review of the support and training needs of link workers, and will build on the findings of that review. [44]

214. In its written submission, Healthcare Improvement Scotland advised there is significant potential for greater use of alternative pathways but this remains dependent on various factors, one being continuous local monitoring and updating of service information. In relation to link workers, the Cabinet Secretary expressed his view that the Scottish Government should:

> ...leave how local community link workers work and interact with the third sector and community groups to the link workers themselves and their expertise, as well as to the general practice that they work in and the other members of the multidisciplinary team whom they work with. There is not some kind of standardised, one-size-fits-all top-down approach...We have to have that local flexibility... [45]

215. At the same time, the Cabinet Secretary acknowledged there is an expectation that the Scottish Government should set out how it is monitoring the impact of link workers on encouraging greater use of alternative pathways and the need to do more work at a "national level on monitoring that impact in greater detail".

216. The Committee heard substantial evidence on the positive role CLWs play in communities where they work, and how they enable and empower individuals to proactively take control of their lives, as well as the particularly valuable role they fulfilled during the pandemic.

217. The Committee notes that, as of October 2021, the Scottish Government had yet to meet its target to recruit at least 250 CLWs to work in GP surgeries in Scotland's most deprived communities. [46] Given the extensive evidence it has heard of the positive role CLWs have to play in facilitating access to alternative pathways to primary care, the Committee calls on the Scottish Government to evaluate each health board's progress in bringing forward updated recruitment plans with a view to expanding the provision of CLWs to every GP practice in Scotland.

218. The Committee highlights the work being undertaken by Voluntary Health Scotland to review the support and training needs of CLWs and to develop a national network of CLWs to enable sharing of best practice and peer-to-peer support. The Committee calls on the Scottish Government to review any additional funding it can make available to support this work.

## ALISS (A Local Information System for Scotland)

219. Many witnesses have noted that reliable, comprehensive, and up-to-date

information about local and national services would greatly assist signposting of patients. A source of digital health and care information the Committee heard about is the ALISS (A Local Information System for Scotland) database, which is run by the Health and Social Care Alliance (the ALLIANCE) and funded by the Scottish Government. The ALLIANCE is the national third sector intermediary for a range of health and social care organisations.

220. In its written submission to the Committee the ALLIANCE described ALISS as follows :

> ALISS helps people in Scotland find and share information about services, groups, activities and resources that help them live well... Organisations and local groups can share information about what they offer, and people – including health and social care professionals and the general public – can find information about what is available near them.

221. The ALLIANCE provided the Committee with ALISS usage statistics, which suggest use of the database is increasing. In 2021, 84,326 people accessed ALISS directly (238,253 page views), representing a 34% increase on 2020. There were 59,740 ALISS hits from NHS Inform's Scotland's Service Directory in 2021, a four-fold increase compared with 2020. Presenting these statistics to the Committee, the ALLIANCE concluded: "This increased engagement is welcome and demonstrates the position of ALISS as a useful tool to enable people to manage their own health, care and wellbeing".

222. Referencing the potential use of ALISS to help signpost alternative pathways to primary care, the ALLIANCE suggests:

> ...that Scottish Government should recognise the value of ALISS, as a co-produced, crowdsourced information resource for community assets across Scotland, utilising open source, open data, and open referral standards. This recognition should include financial and political support across government, acknowledging that ALISS is specifically tailored to allow people to locate alternative pathways to health and wellbeing.

223. However, the Committee also heard evidence that the constantly changing landscape of providers of non-GP primary care services limits the reliability of the information within ALISS. Multiple witnesses suggested that the signposting information available through ALISS could be improved. In its written submission, the Royal College of General Practitioners Scotland commented:

> Communication about new services is key, but is often piecemeal, and when it does happen then adds to an existing information overload. National systems such as ALISS do not always link to very specific localities nor always kept up to date.

224. Written evidence to the inquiry has noted that the co-produced and crowdsourced nature of ALISS affects its reliability and completeness:

"ALISS is a useful resource but is hampered by its' accuracy – entries rely on service provider input". [47]

"Currently, the national platforms such as NHS Inform's Scotland's Service Directory

and ALISS only reflect what should be available from a national perspective or are reliant on local services uploading their details independently". [48]

225. Dr Chris Williams from RCGP Scotland spoke positively about ALISS's "very useful interface" and its search function. At the same time, he noted the importance of keeping information in ALISS up-to-date. He concluded by suggesting ALISS is a "superb and underused resource", arguing: "If some resource were to be injected into it or if we were able to make more people aware of its existence and what it can be used for, that would, I think, be a very helpful step". [49]

226. At the same time, the Committee heard evidence that the existence of a national directory such as ALISS would not necessarily remove the need for local information databases such as Dumfries and Galloway's DG Locator. The Committee heard that a number of local authorities have invested in setting up their own, localised online information resources. For instance, in Edinburgh, CLWs use four different directories to access information about local community services. These are: ALISS, the Red Book, the iThrive directory and the long-term conditions directory.

227. The ALLIANCE told the Committee it is currently exploring opportunities to form partnerships with local directories with a view to aggregating their data and incorporating it into the ALISS platform. It is also seeking to improve accessibility beyond the www.aliss.org website, for instance by partnering with NHS 24 to enable ALISS data to be searched on NHS inform.

228. The Committee heard evidence that it is often unclear who should be responsible for updating information directories of community services and that this has an impact on the quality and reliability of the information and, consequently, on effective signposting of patients to alternative pathways to primary care.

229. Christ Mackie from the ALLIANCE advised:

> We need to continue with the crowd-sourcing approach but also to redirect some of our attention to specifically addressing the data quality issue. We plan to address that with staff time, but we also have plans on the technological aspect, such as giving people reminders to keep things up to date. We can do that through automatic means on the platform. [50]

230. The Cabinet Secretary for Health and Social Care advised the Committee that "Work to enhance the performance and accessibility of ALISS is being undertaken by the ALLIANCE, and we hope that that will be finished this summer." [51]

231. The target audience of ALISS was noted on several occasions, with an understanding that when it was originally launched, GP practices were not the target audience. Given the shift in focus towards multi-disciplinary teams and greater use of alternative pathways to primary care, some witnesses argued there may be a need to refocus and to promote ALISS more widely.

232. The Committee acknowledges the critical importance of reliable, up-to-date information about locally availably community services for effective signposting to

alternative pathways to primary care as well as improving patient and practitioner trust and confidence in these pathways. It recognises the important role ALISS could play in this regard.

233. Evidence has shown that, although a useful resource, the constantly changing landscape of non-GP primary care services in local communities can result in ALISS being unreliable and often out of date. The Committee welcomes the ALLIANCE's acknowledgement that issues around data quality need to be systematically addressed. Once completed, the Committee looks forward to receiving an update from the ALLIANCE on ongoing work to improve the performance and accessibility of ALISS.

234. The Committee believes that significantly improving general awareness of ALISS and the accuracy, reliability and comprehensiveness of information available through the ALISS database are fundamental prerequisites for it to become an authoritative source of data for those seeking to signpost patients towards alternative pathways to primary care. The Committee therefore calls on the Scottish Government, working in partnership with the ALLIANCE, to undertake an assessment of the actions and associated funding required to achieve this.

# Role of alternative pathways in preventative primary care

235. As part of its inquiry, the Committee wanted to understand the extent to which alternative pathways to primary care could have a role in a more preventative approach to healthcare.

236. The Scottish Government's Route Map to the 2020 Vision for Health and Social Care stated:

> We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management.

237. The 2018 National Health and Social Care Workforce Plan: part 3 set out evidence of the significant benefits that will be delivered through focusing the primary care workforce on prevention and supporting self-management, and stated:

> We will see a developed and enhanced role for allied health professionals in supporting patients' needs, including promoting prevention and self-management with improved access.

238. Many of the non-GP primary care professions identified within this report highlight the preventative role of the services they provide. For example, pharmacy services such as sexual health, smoking cessation, and providing injecting equipment were all highlighted as having a preventative role. Audiology practitioners noted that, by limiting the impact of hearing loss on communication, their services will play a preventative role in reducing the risk of social isolation and mental ill health.

239. Several submissions to the Committee, such as those outlined below, gave specific examples of how greater use of alternative pathways to primary care could help to deliver a more holistic and preventative approach to healthcare that helps to keep people well and, in so doing, eases pressures on GPs and GP practices.

## Screening and early identification

240. Disparities in health-related screening uptake between people in the least and most deprived areas were raised during the inquiry as an area of concern. Some contributions to the inquiry raised concerns that increased use of alternative pathways to primary care could exacerbate this issue.

241. The Cabinet Secretary told the Committee the Scottish Government has a focus on increasing levels of uptake in health-related screening in areas of deprivation. As an example, he highlighted recent work to explore the use of mobile units to increase rates of breast cancer screening in areas of higher deprivation. More broadly, he outlined the importance of effective targeting of communications about screening towards disadvantaged groups including ethnic minorities:

> How do we use voices from minority communities—as opposed to a middle aged white male doctor, for example, who of course has great clinical expertise but might not be as impactful as a female doctor from an Asian background, for instance—in speaking about the importance of going to screening appointments? There is a lot of effort and work going into that, as we recognise the disparities that exist. [52]

242. Giving oral evidence to the Committee, Christiana Melam from NALW made the case for a preventative approach to be mainstreamed into primary care. She argued: "...general practice is at risk of becoming a crisis service— everybody is chasing, or treating, the symptoms. If we are not going to intervene to address vulnerabilities and get at the root causes, we will have a healthcare system that is all about illness". [53]

243. Early identification of diabetes was highlighted to the Committee as one specific area where optometrists can specifically add value in the area of preventative healthcare. At the same time, the Committee heard that, once identified, patients are still required to attend their GP to have an optometrist's diagnosis of diabetes confirmed. The Committee also heard that optometrists can fulfil a role in providing ongoing care to patients diagnosed with diabetes via regular eye exams. In such cases, Julie Mosgrove of Optometry Scotland said: "with additional training... the optometrist can monitor their condition and look for changes. It requires a bit more equipment and training, but it is something that is happening in pockets across Scotland". [54]

244. Optometry Scotland cited evidence that older people with eye diseases are three times more likely to limit their activities due to fear of falling, compared with those who have good vision, highlighting the broader preventative benefits of treating these conditions. It stated: "The collateral benefits of addressing visual impairment on fall prevention, dementia, and other mental illnesses are already documented".

245. The Royal College of Psychiatrists in Scotland also highlighted the broader benefits to physical health of enabling easier access to care via alternative pathways for patients suffering from mental ill health:

> We know from previous studies the lifestyles of those with severe mental ill health are likelier to feature weight gain, risk of diabetes and increased smoking prevalence. This is one of the critical reasons their life expectancy is 20 years less than the rest of the population. This makes this group a priority one for engagement as part of the design of these alternate pathways.

246. The NCHA Scotland noted the high prevalence of unaddressed hearing loss in Scotland and that this can increase health and care costs due to an increased risk of depression, dementia, social isolation and loneliness, unemployment and wage inequalities, and premature retirement. The NCHA adds:

> In context, this Health, Social Care and Sport Committee inquiry into alternative pathways to healthcare is essential for tackling inequalities in access and outcomes, and the overall sustainability of the NHS and care system. Put simply, making the best use of wider primary care services will help keep people well for longer, reducing the overall cost for health and care.

247. The Chartered Society of Physiotherapy Scotland highlighted the benefits of early access to rehabilitation, arguing that this:

> ...reduces the number of people becoming needlessly disabled and prevented from leading active lives. It also reduces pressures on secondary care. Too often people receive intensive rehabilitation in hospital but then face long waits when they get home, if it's available at all...in managing long term conditions, the role of the third sector and local authority provision must not be underestimated. Intervention by health professionals is often targeted and limited, and ongoing self-management in the community requires complimentary provision, such as rehabilitation groups, walking groups, exercise classes and other ways for people to remain active and feel supported with their conditions. Without this provision, more pressure is placed on primary and acute health services.

248. Evidence submitted to the inquiry suggests many of the individual primary care professions support a preventative and holistic approach to healthcare and, as alternative pathways, can help support early identification and diagnosis of a range of medical conditions. At the same time, many contributors to the inquiry highlighted the need for a more joined-up, integrated approach to service planning and delivery and improved inter-professional communication to maximise the contribution alternative pathways can make to that more preventative approach.

249. In this context, the Committee has heard evidence that the joint Scottish Government and COSLA Integrated Health and Social Care Workforce Plan could help to realise the benefits of a preventative approach.

250. As part of that preventative approach, Harjit Sandhu of the NCHA made the case for an active ageing strategy designed to help the population to age well. He suggested alternative pathways such as audiology could play an important role as part of such a strategy. [55]

251. The Scottish Government began consulting on a Health and Social Care Strategy for Older People on 8 March 2022. The consultation document notes "Scotland must adapt to our increasingly older population and ensure that older people are afforded the opportunity to age well and be resilient".

252. The Committee has heard encouraging evidence of the important contribution non-GP primary healthcare practitioners can make towards a more holistic and preventative approach to healthcare, particularly in relation to the early diagnosis and ongoing monitoring of a range of health conditions.

253. To realise the full potential greater use of alternative pathways to primary care offers in achieving a more preventative approach to healthcare, the Committee calls on the Scottish Government to work with health boards and health and social care partnerships to develop a strategy for improved collaboration on service planning and delivery between different primary healthcare professions.

254. In responding to this report, the Committee calls on the Scottish Government to set out what steps it intends to take, as part of its Health and Social Care Strategy for Older People, to encourage active ageing and, in particular, what role

it expects the promotion of alternative pathways to primary care to play in this regard.

# Social prescribing

255. As part of the inquiry, the Committee was interested to understand levels of awareness of social prescribing amongst both patients and health practitioners and to what extent effective use is currently being made of social prescribing.

256. The King's Fund describes social prescribing as follows:

"Social prescribing, also sometimes known as community referral, is a means of enabling health professionals to refer people to a range of local, non-clinical services".

257. In its written submission to the inquiry, the NALW described social prescribing as "a non-medical treatment for non-medical determinants of health". These non-medical determinants of health include social, economic and environmental factors. By looking at these wider determinants, social prescribing is characterised by a holistic, "whole-person" approach to health and wellbeing.

258. In its National Clinical Strategy for Scotland (2016), the Scottish Government noted that multiple long-term health conditions can result in complex needs, many of which would be best addressed by social rather than medical interventions.

259. To deliver the vision that "People are able to live more years in good health, and that we reduce the inequalities in healthy life expectancy", the Scottish Government argues "Our efforts need to shift towards even greater prevention and early intervention and to local, community-based support across Scotland" [56]

260. In 2019 the Session 5 Health and Sport Committee published its inquiry report Social Prescribing: physical activity is an investment, not a cost. The report explored opportunities and challenges for social prescribing in Scotland, with a focus on physical activity.

261. This report concluded that social prescribing has clear benefits for the Scottish population and health services:

> Social prescribing and primary prevention approaches can help in preventing long term conditions and dependence on pharmaceutical prescriptions. They also have the potential to ease the pressure on existing health and social care services, as well as reducing waiting times, unplanned admissions to hospital and delayed discharges.

262. The report also noted there were costs involved, that should be considered as an investment:

> However, social prescribing cannot be seen as a cost-free alternative. Sport and physical activity is an investment, not a cost. Systems and processes need to effectively support people to participate in and organisations to deliver this essential preventative action. Upstream funding for infrastructure, utilisation of community spaces and support for organisations to deliver prevention activities highlighted in this report is required. Cost benefits of social prescribing are not in dispute and we are unclear why if the Cabinet Secretary for Health and Sport is convinced of the need for such initiatives, this is not being delivered at scale across all NHS boards and Integration Authorities.

# Potential for social prescribing

263. Many of the witnesses contributing to this inquiry identified significant potential for social prescribing to patients, particularly for those presenting problems that are rooted in non-medical issues.

264. In its written submission, Audit Scotland provided an example of the positive outcomes of the 'Sources of Support' social prescribing project in Dundee. As part of this project, GP practice Link Workers supported patients with poor mental health and wellbeing to access appropriate non-medical services and activities. An external evaluation found the project had positive impacts:

- For clients: decreased social isolation, improved/new housing, financial and benefits issues being addressed, and increased confidence, awareness and self-esteem.
- For GPs: reduced patient contact with medical services, providing more options for patients, raising awareness of non-clinical services, and increased GP productivity.

265. In oral evidence, Clare Cook from SPRING Social Prescribing/Scottish Social Prescribing Network argued there should not be a "one-size-fits-all" approach to social prescribing. She highlighted the importance of recognising that "throughout Scotland, there are lots of different models and lots of experienced and professional organisations that run them". [57]

266. The Committee heard evidence that mapping work currently being undertaken by social prescribing networks would provide a clearer overview of social prescribing provision across the country and enable improved sharing of knowledge and best practice.

267. Giving oral evidence, Alison Leitch from Edinburgh Voluntary Organisations Council/Scottish Social Prescribing Network (EVOC/SSPN) argued that the lack of a clear overall lead on social prescribing is currently hampering efforts to promote it:

> That is where Scotland falls down. In England, there is a head of social prescribing in the NHS; in Wales, that is dealt with through public health... There is also the All Ireland Social Prescribing Network. The Government is aware of the issue—it falls within the portfolio of two ministers. [58]

268. Elemental Core, a social prescribing management tool that talks to the GP's Vision system, was highlighted to the Committee as a system which will provide evaluation

opportunities. The Committee heard that Edinburgh health and social care partnership has invested in this system and that health and social care partnerships in West Lothian and the Highlands are considering it. Alison Leitch from EVOC/SSPN advised "Perhaps we could implement that on a national scale, so that we all undertake evaluation that proves that what we do is worthwhile, meaningful and worth future investment". [59]

# Public attitudes to social prescribing

269. The public survey conducted as part of the Committee's inquiry asked about patients' experiences of social prescribing. Referrals that could be termed 'social prescribing' were reported by 22% of respondents.

270. Respondents' ratings of their experiences of social prescribing were evenly split: one third rated the experience as bad or very bad, one third rated it as OK, and one third rated it as good or very good.

271. Only 3% of respondents to the public survey reported having been helped to access social prescribing by CLWs, and these reported both positive and negative experiences from their interaction.

272. Respondents to the public survey also expressed a wide diversity of attitudes to social prescribing. Some respondents commented that this was not the type of care they wanted or expected to be offered when seeking help from their GP. One noted they would feel insulted if directed to social prescribing, while another felt referral to social prescribing represented an "easy way out for [the] GP".

273. Some respondents with experience of being referred to social prescribing services said they did not find these services helpful, and that they could have found the same or better information themselves. Another expressed the view that, as someone with a health need, they did not feel that the personnel offering social prescribing services were suitably equipped to help them.

274. Several respondents reported positive experiences of social prescribing, with the services rated as "very good", "excellent", and "great". Amongst the specific benefits they had derived from this experience, these respondents highlighted meeting other people, being supported and feeling listened to.

275. During oral evidence, the Committee heard that the pandemic has given many people an increased understanding of social prescribing and that this has manifested itself, for example, in the form of greater recourse to online befriending services and other forms of community-based support. However, Val Costello from Citizens' Advice Scotland cautioned:

> That has happened during the pandemic, but I think that people now think that things have gone back to normal, that they have tended to fall away a bit from that and that they are going back to their old and trusted method, which is contacting their GP practice. [60]

276. Hannah Tweed from the ALLIANCE suggested there is evidence that attitudes to social prescribing have improved during the course of the pandemic as a result of

positive experiences from using these services. She said: "People are reporting that they do not want to access GP services as often but are getting other services involved, experiencing better outcomes for themselves and feeling better in themselves". [61]

277. Hannah Tweed also emphasised the importance of word-of-mouth in promoting use of social prescribing, particularly in more deprived communities:

> Within the areas that I referred to, people are beginning to talk about social prescribing and are saying that it worked for them, so we see a knock-on effect from that. That cannot happen instantly. It is slow but, as it builds, we get momentum.

278. Certain contributions to the inquiry suggested that clinicians should be doing more to champion social prescribing, while the Royal College of General Practitioners Scotland could do more to raise the profile of social prescribing among their members.

279. The Cabinet Secretary for Health and Sport advised he is "a real believer in the ability of social prescribing to have a positive impact on people" but highlighted there may be a need for "Social messaging...perhaps the Government needs to think about how we can articulate the virtues of social prescribing". [62] He also expressed a hope that the more people access social prescribing, the more they will see its value and promote its benefits to others.

# Barriers to greater uptake

280. The Session 5 Health and Sport Committee identified a number of barriers to health practitioners' use of social prescribing as an alternative pathway to primary care. In brief these were:

- Mixed enthusiasm for and knowledge and understanding of social prescribing among GPs.
- Lack of strong evidence for the long-term effectiveness of social prescribing.
- Time constraints within consultations.
- Lack of awareness of which services are available.
- Quality assurance: GPs' reluctance to refer to the third sector.

281. Evidence to this inquiry suggests that at least some of these barriers to greater use of social prescribing remain.

282. Val Costello from Citizens Advice Scotland highlighted a lack of public awareness as a continuing barrier:

> Social prescribing is beneficial for a certain group— the "savvy" group, which is the group that is aware that self-care works and that social activities can help and can alleviate issues—but it does not seem to work for the other groups. That is down to a lack of public awareness. We have talked about that on the national level, but, at local authority level, if people knew what was available to them, what they could join and what the process would be for joining it, it might increase the uptake and, therefore, reduce the need for them to see the GP. [63]

283. Alison Leitch from EVOC/SSPN sounded a note of caution on the question of patients self-referring to social prescribing services:

> We do not take self-referrals— the referral has to come from somebody in the practice team. That decision was made because of risk...
>
> We also have an obligation to assess risk before referring people on to community organisations. We do not have posters or leaflets in practices; we rely on GPs. It is all about having a trusting relationship. [64]

284. The Committee heard social prescribing described as the "biggest cultural shift in healthcare and medicine that we have had". [65] At the same time, witnesses felt this had been poorly communicated at a national level and argued in favour of a national campaign to promote awareness and use of social prescribing. At the same time, they acknowledged that these services are not universally available throughout the country and this is a further barrier to promoting them at a national level.

285. As well as supporting a national campaign on social prescribing, Christiana Melam from NALW highlighted the crucial role of link workers:

> On how we raise awareness, we need to get political buy-in. We need to have a national campaign to raise buy-in, and we also need to have campaigns that embed and embrace social prescribing link workers' role as part of the team. [66]

286. While acknowledging the need for improved communication about social prescribing and its benefits, the Cabinet Secretary for Health and Sport equally expressed his hope that the further roll-out of Multi-Disciplinary Teams would give GPs greater time and capacity to explain these benefits to patients:

> I hope that, as the expansion of the MDTs eases the workload pressures on GPs, they will have the time to explain to individuals that social prescribing is not about being fobbed off or passed on but that there is real value in what a community links worker can do. [67]

287. SAMH explained that GPs do not always recognise the value of Community Link Workers (CLWs) in promoting social prescribing pathways and that this acts as a further barrier to increased uptake:

> There is however some work to be done to convince some GPs practices of the value of Link Workers. It has been our experience that if GPs in an area have not engaged with a service, it puts pressure back on the third sector provider to change and adapt because of the lack of buy in.

288. In its written submission, the NALW reported a lack of understanding of the role and role boundary of link workers as a continuing barrier to wider uptake of social prescribing, concluding: "Everyone in the GP practice should buy into the vision of social prescribing and understand it".

289. Community Pharmacy Scotland highlighted the importance of training and information for health practitioners to give them a full understanding of locally available social prescribing services and enable them to effectively signpost patients.

290. A lack of knowledge and awareness in GP practices was also highlighted to the Committee as a barrier to greater uptake of social prescribing during oral evidence. When asked what the main barriers to GPs engaging with social prescribing were, Dr Chris Williams of RCGP Scotland cited "a lack of time and available capacity as being high on the list, but I would also highlight a lack of knowledge of the services that are available". [68]

291. Some respondents to the Committee's public survey mentioned additional barriers to accessing social prescribing services. These included being charged to use them, a lack of reliability and a lack of local provision, particularly in remote and rural areas.

292. The ALLIANCE highlighted cost as a critical barrier to longer term participation in social prescribing for those on lower incomes:

> It is also worth noting that while CLPs and community referrals can have clear positive impacts on people, not all resources are open to all groups of people who require support. To give one example, CLPs in Glasgow routinely help people in Deep End practices to access cards for Glasgow Life. These cards provide holders with six weeks of free entry to any of the Glasgow City Council sport centres, gyms, and swimming pools. Many people have welcomed these cards, and the access to sports facilities and improved health as a result. However, while people have the option to continue membership after six weeks, the subsequent fee – £15 a month – is far too high for most people accessing these services via CLP referral to continue, and the health benefits are then lost.

293. The social prescribing inquiry conducted by the Committee's predecessor in 2019 noted: "Regardless of referrer, social prescribing schemes nearly always rely on the availability, capacity and readiness of third sector organisations and sports clubs."

294. Public Health Scotland's evaluation of early adopters of CLWs concluded:

> The CLW role cannot be seen in isolation and the sustainability and potential for a CLW programme to succeed will be dependent on the availability of sufficiently resourced services and support to refer patients to in the local area.

295. In its written submission SAMH notes that short-term funding leads to unhelpful uncertainties for health practitioners:

> The short term nature of tenders and changing providers make it harder for GPs and other health professionals to know what services are available and who is providing them.

296. The Committee welcomes the increased uptake of social prescribing witnessed during the course of the pandemic and those positive experiences patients have reported with social prescribing during this period. It is concerned by evidence that, during Covid recovery, patients who used social prescribing during the pandemic are reverting back to contacting their GP in the first instance when ongoing use of social prescribing as an alternative pathway to primary care could offer quicker and better health outcomes for them.

297. The Committee notes there is no single national lead on social prescribing, given that responsibility for it is shared between two Scottish Government ministerial portfolios. The Committee would appreciate a response on the rationale for sharing this responsibility, and whether the Scottish Government has considered following other models from other countries in the UK, and beyond, on having one national lead to develop social prescribing policy.

298. The Committee commends work currently being undertaken by CLWs and social prescribing networks to map the availability of social prescribing pathways across the country. Once complete, the Committee calls on the Scottish Government to work with CLWs and these networks to ensure this information is widely disseminated to those responsible for signposting patients to alternative pathways and directly to patients looking to self-refer.

299. The Committee recognises the importance of word of mouth within local communities in promoting greater uptake of social prescribing. At the same time, the Committee has heard evidence that clinicians should be doing more to champion social prescribing as an alternative pathway to primary care and that the RCGP in Scotland should be more actively promoting its benefits to its membership. The Committee calls on the Scottish Government to work with partners to bring forward a targeted communications plan with the aim of raising awareness of social prescribing and its benefits amongst patients and health practitioners and encouraging greater and more effective use of social prescribing as an alternative pathway to primary care.

300. The Committee has been particularly concerned to hear evidence that cost is a critical barrier to access to social prescribing pathways for people on low incomes. The Committee is therefore keen to understand what measures the Scottish Government will take to address this specific issue.

301. The Committee has heard extensive evidence of the essential role played by the voluntary sector in providing many social prescribing services. The Committee calls on the Scottish Government, in responding to this report, to set out what measures it can take to improve the long-term financial viability of these voluntary sector providers and thereby improve the reliability and uptake of social prescribing as an alternative pathway to primary care.

# Role of digital health and care

302. As part of the inquiry, the Committee also wanted to examine the role of digital services as another alternative pathway to primary care, particularly as the use of these services continues to grow.

303. Digital sources of health information or services include:

- Information sites like NHS Inform, GP practice website, Care Information Scotland, mental health tools, and other health and wellbeing websites.
- Online portals for ordering repeat prescriptions or making appointments.
- Remote ways of receiving individual care, such as NHS24 (111 phoneline), video or telephone appointments, online therapy, and remote monitoring of health conditions.

304. In its 2021-22 Programme for Government , the Scottish Government recognised the impetus for improvement in digital health and care services brought about by the COVID-19 pandemic:

> The need to deliver services in new ways during COVID‑19 has demonstrated the range of alternatives available, in addition to traditional face‑to‑face care. Building on the desire of many to access care and support in new ways and underpinning our commitment to offer flexible access to care, we will scale up digital care.

305. The Programme for Government commits the Scottish Government to a number of actions designed to "scale up digital care":

- Video consulting: We will continue to increase the use of Near Me, the video consulting service, backed by £3.4 million a year. The service was rolled out to GP surgeries and community pharmacies in response to the pandemic and has now provided over 1 million consultations across all services.
- Digital app for information and services: We will develop a safe and secure digital app that will support people to access information and services directly, self‑manage, and access and contribute to their own health and care information. It will be introduced by the end of this Parliament, following public consultation and engagement.
- Digital prescriptions: We will also develop a digital prescription service freeing up capacity for healthcare professionals to see more patients and making it easier for patients to access their medicines quickly and safely.
- Digital mental health: Over the next year, we will begin work on an expanded Digital Mental Health Programme, that will increase self‑referral to online treatments, establish a Mental Health Innovation Hub and explore options for an online national psychology service.

306. In October 2021, the Scottish Government and COSLA published a joint Digital Health and Care Strategy for Scotland: Enabling, Connecting and Empowering:

Care in the Digital Age . The vision of the Strategy is "To improve the care and wellbeing of people in Scotland by making best use of digital technologies in the design and delivery of services". The strategy includes two key aims of relevance to the Committee's inquiry, namely:

- Aim 1: Citizens have access to, and greater control over, their own health and care data – as well as access to the digital information, tools and services they need to help maintain and improve their health and wellbeing.
- Aim 2: Health and care services are built on people-centred, safe, secure and ethical digital foundations which allow staff to record, access and share relevant information across the health and care system, and feel confident in their use of digital technology, in order to improve the delivery of care.

307. In addition to commitments already made in the 2021-22 Programme for Government, the Digital Health and Care Strategy states that COSLA and the Scottish Government will:

- Provide 24-hour digital access to services through asynchronous communication (the ability to 'chat' with services any time, when an instant response is not required, such as via email and online).
- Further develop and implement online triage so that people can be better supported/directed to information that allows them to access the most appropriate service depending on their needs, including self-service, Pharmacy First and others.

308. The Scottish Government's Digital Health & Care Directorate works "to ensure that the health and care needs of the people of Scotland benefit fully from digital and data developments and innovation." The Directorate's work includes the Technology-Enabled Care (TEC) programme, which focuses on citizen-facing digital solutions.

309. To enable the development of digital technology for health and social care, the Cabinet Secretary highlighted a need to upskill and increase the size of the Scottish Government digital team. He told the Committee: "The digital team in the Government will be appropriately resourced, and that resource will undoubtedly have to increase to meet our ambitions." He also acknowledged the importance of giving an equal focus to investing in digital infrastructure as for physical infrastructure. [69]

310. Public awareness and use of digital sources of health and care were assessed in the public survey for the current inquiry. Comparison with data from 2017 showed that awareness and use of most sources was higher in 2022. In particular:

- NHS Inform website: awareness more than doubled, and use was five times higher in 2022.
- Video access to services (e.g., appointments): awareness tripled, and use of these services increased by over 12 times between 2017 and 2022.
- Online services: a much higher proportion of respondents in 2022 reported using their GP surgery website and getting repeat prescriptions online.

311. Although the Committee's public survey suggests that awareness of digital health and care resources is increasing, NHS24 argues that further increasing awareness would help people use alternative pathways more readily:

> We recognise, people cannot predict when and what they can access, for acute healthcare matters. In that stressful moment, figuring out how and what is available, can be a new pressure, which results often in reverting to use of 'usual' access points e.g. General Practice or Emergency Departments where that is avoidable… For example, people cannot anticipate a sudden onset of a sore back but could self-refer to local back pain services if that awareness was prominent

312. Adam Stachura of Age Scotland highlighted that, during the past two years, people have become more aware than ever of digital services and digital access to medical services. He attributed this trend to the reality that, for many, this was the only way that they could access such services during the pandemic.

# Risks and benefits of greater use of digital

313. In its written submission, the Royal College of Physicians and Surgeons of Glasgow emphasised the growth in usage of digital health and care resources that has occurred during the course of the pandemic: "The pandemic has undoubtedly resulted in a rapid expansion in the use of alternative sources of health and wellbeing information and advice…".

314. NHS 24 also saw a significant increase in demand over the past year as a consequence of COVID-19, the expansion of mental health hubs, and access through 111 to the national redesign of urgent care, all delivered 24/7, where previously NHS 24 operated largely out of hours.

315. The Royal College of Physicians and Surgeons of Glasgow emphasised the importance of ensuring digital technologies are used appropriately and ensuring "patients do not 'fall between the gaps' and are signposted back into a medical pathway if necessary".

316. The Committee heard evidence of an increased reliance on remote consultations during the COVID-19 pandemic, but witnesses argued that face to face appointments continue to offer clear advantages in terms of accuracy of diagnosis, preventative care and relationship building with patients. [70]

317. The Committee heard the roll-out of the NHS Near Me video consultation service was significantly scaled up during the pandemic. While, this was seen as beneficial to many, the Committee heard evidence that such digital solutions are not necessarily suitable for everyone. The Committee heard particular concerns around the use of NHS Near Me for patients with serious mental health conditions.

318. Dr Jess Sussmann of the Royal College of Psychiatrists, who has extensive experience of treating patients with chronic schizophrenia, noted:

> I cannot think of one patient in my rehabilitation service who would feel comfortable using an online service to access any support. All the way through the pandemic, they have chosen to have face-to-face contact, and those who have chosen not to have it, because of anxiety about COVID, have become unwell, so we have had to reinstate face-to-face contact. [71]

319. Giving evidence to the Committee, the Cabinet Secretary for Health and Social Care pointed out that remote consultations were already an integral part of care delivery in general practice prior to the pandemic and went on to say:

> Over time, as restrictions ease, the balance will shift towards more face-to-face appointments—as it should— but a mixture of appointment types will remain a core part of general practice, as we know that it suits many patients to have consultations with their GP over the telephone or over video. [72]

320. During the inquiry, the Committee has learned the Scottish Government is exploring the use of online triage systems for GP practices, known as GP DACS ( General Practice Digital Asynchronous Consultation Systems ). These digital tools support clinical triage and remote consultations that can occur 'asynchronously' (i.e., the patient and health practitioner are not necessarily present at the same time). The Scottish Government's intention is that non-urgent health issues could be triaged in this way, and would be directed to the right source of care first time.

321. The ALLIANCE told the Committee it has conducted a Digital Citizen Panel about GP DACS. This found that, while some people viewed it positively, others were concerned it will create additional barriers to accessing the help they need. The Committee understands some GP practices are already using online triage and experiences vary here too: In a regular newsletter updating GP practices on the implementation of GP DACS published in February 2022, the Scottish Government reports that, while some practices report significant benefits, others report significant disbenefits. [73]

322. Written evidence to the Committee considered digital sources of health and care to be potentially useful tools in primary care, not least because: "Self management is often entirely appropriate given many conditions are non-serious and self-limiting" [74]

323. Further to this, BMA Scotland similarly recognised the increasingly important role fulfilled by digital resources in facilitating patient access to healthcare:

> NHS24 and NHS Inform are vital tools nowadays either as an alternative to a consultation or to allow the patient to access further information for decision making or self-help advice. It suits a lot of patients who want information or simple advice on certain issues. There is too much misinformation on the internet so it is essential that we have an authoritative source of health-related information to direct patients.

324. During oral evidence, the Cabinet Secretary for Health and Social Care was asked about a digital app already available through NHS England which allows patients to access test results and make appointments among other things and why a similar app was not currently available in Scotland. The Cabinet Secretary responded:

> One of the SNP's manifesto commitments is to develop an NHS app, which will be a digital front door. We are working on that. Where it is sensible to have that discussion with other parts of the UK, we are doing—and will do— that. There is no point in reinventing the wheel if something already works particularly well... but we might not just be able to pluck an app from one part of the UK and transplant it here. [75]

325. Witnesses also raised concerns about the variable quality of digital health and care resources. The Scottish General Practice Professional Nurse Leads Group cautioned that, if relied upon by patients, less authoritative digital sources could be unhelpful and counter-productive.

326. In its written submission, NHS24 described its approach to ensuring reliable content and guidance, with signposting to appropriate practitioners if required:

"NHS 24 continuously updates NHS inform content, via a governed process which involves external subject matter experts on a regular basis. These also direct patients to other pathways and services and promote self-care".

"NHS 24's clinical team has developed a range of care guides and symptom checkers covering a range of physical and mental health and wellbeing conditions...These guides have been created by clinicians and subject matter experts using NHS 24's robust triage technology and reflect exactly the same patient journeys offered to those who call 111."

327. Witnesses also cautioned that digital health and care would not be suitable for all patients. The NHS Scotland Primary Care Leads Group noted that effective use of these services was predicated on an absence of digital poverty, and a motivated, inquisitive recipient. The Royal College of General Practitioners Scotland said:

> Such resources can be a useful adjunct and are better suited for confident patients with higher literacy levels, but many of the reasons people are looking for assistance are also associated with factors which make it difficult to access self-directed help.

328. In considering the potential for digital health and care resources to enable access to alternative pathways to primary care, the Committee heard evidence of the critical importance of considering the 'digitally excluded' (that is, people who are not able to use the internet) and that people may be digitally excluded for a variety of reasons, including a lack of skills, confidence, interest, internet connection, or suitable devices. [76]

329. In its written submission, the Office for National Statistics highlighted the negative impact of the digital divide on societal inequalities:

> In an increasingly digital age, those who are not engaging effectively with the digital world are at risk of being left behind. Technological change means that digital skills are increasingly important for connecting with others, accessing information and services and meeting the changing demands of the workplace and economy. This is leading to a digital divide between those who have access to information and communications technology and those who do not, giving rise to inequalities in access to opportunities, knowledge, services and goods.

330. According to the Scottish Household Survey 2020 , while 93% of Scottish households were recorded as having internet access, the groups most likely to remain disconnected were people in deprived areas, older generations, and people living in social housing.

331. Adam Stachura from Age Scotland told the Committee about half a million over-60s do not use the internet, and 600,000 over-60s do not have access to the internet via a smartphone.

332. Several organisations raised the issue of digital exclusion in their written submissions to the Committee. NHS24 acknowledged the issue:

> NHS 24 recognise that… citizens will have preferences and have specific requirements we need to address to ensure equitable access, that exclude no one. Digital consultations and interactions are not a choice for everyone.

333. Local examples of barriers to digital inclusion were provided by Glasgow City HSCP in its written submission:

> ...social and economic inequalities are likely to be a major factor in the awareness and uptake of self-referral to alternative health care. In particular, with more services moving to digital platforms there is the potential for this to create further barriers to access for many people. It is quite common in Glasgow for patients to not have suitable IT equipment and/or to be unable to afford broadband charges. Continued support to reduce digital exclusion will be an important action to increase self-referral to health care, health care advice and self-management support.

334. The Riverside Patient Participation Group argued that those most likely to be digitally excluded were equally likely to have significant health needs and concluded:

> Their route into primary healthcare must be protected.

335. In the 2021-22 Programme for Government , the Scottish Government notes that it has ambitions to "make Scotland a digitally inclusive and connected country" and is doing "significant work to help get more people online through Connecting Scotland." It states:

> Over the past 18 months, the coronavirus crisis has … demonstrated the problems that come from digital exclusion. It has reminded us all that whilst technology can transform lives for the better, it is essential we ensure no one is left behind. We will ensure everyone – regardless of where they live – has an acceptable level of connectivity so they can be a part of the digital world. That is particularly acute in our rural communities, and our Reaching 100% (R100) contracts are continuing to deliver broadband across Scotland.

336. Connecting Scotland is a Scottish Government initiative set up in response to Coronavirus. It aims to help every citizen in Scotland get online. Scott Henderson from Technology Enabled Care Scotland (TECS) advised that throughout the pandemic, TECS has relied on the Connecting Scotland programme to facilitate access to devices as well as to upskill people where required.

337. To ensure everyone's route into primary care is protected, NHS24 argued:

> NHS Scotland must reflect how all services including NHS24 can put accessibility and user-centred need at the heart of developments to ensure nobody is excluded and everyone has access to equitable, high quality, safe services.

338. The principle of 'Digital as ongoing choice' was raised by the ALLIANCE during oral evidence. Chris Mackie of the ALLIANCE advised: "…it should not be digital first. Instead, we must have digital choice to give people a range of access points". [77] Chris Mackie continued:

> We need to open up complementary approaches to ensure that those who do not have devices, data, or the skills and confidence to use them can still access health and social care services....We should make progress and exploit technological advances, but we need to bear in mind that we have a diverse and ageing population, and that lots of factors will play in to whether people can use digital options. Lots of people will not or cannot use those digital options, so we must not close down the other avenues. [78]

339. The Scottish Government and COSLA's Digital Health and Care Strategy for Scotland aims to "improve the care and wellbeing of people in Scotland by making best use of digital technologies in the design and delivery of services". The strategy aims to both "bridge the digital divide" and "improve digital health literacy".

340. The Cabinet Secretary for Health and Social Care advised during oral evidence that:

> ...anything that we do in the digital space, we have to ensure not just that we are aware of and acknowledge digital exclusion, but that there is an alternative pathway for people who just do not have access digitally. [79]

341. In 2020, the Scottish Government established a Short Life Working Group (SLWG) to look at Primary Care Health Inequalities . The group reported in March 2022 and recognised: "Access to health care is itself a social determinant of health. As a result, inequitable access to effective health care is an inadvertent yet powerful driver of health inequalities."

342. The SLWG made 23 recommendations for actions to be taken to reduce health inequalities and improve health equity in Scotland. Key recommendations related to digital exclusion were:

- Recognise digital as a social determinant of health: Technology should be understood and recognised as a determinant of health inequalities and outcomes alongside other socio-economic and environmental determinants. The Scottish Government and Public Health Scotland should look at ways to incorporate digital access and skills into their analysis of inequalities.

- Pilot and implement a national programme of digital empowerment for health through community-based peer-supported learning programmes to enable patients who are digitally excluded to safely use digital networks for peer support, access health resources on-line, and gain hands-on experience in using NHS remote consulting technology.

343. Lack of access to digital devices is not the only cause of digital exclusion. The Committee heard it can be difficult for people to navigate the web and access services, especially if they are living with certain conditions such as arthritis, Parkinson's or sight loss.

344. Dr Paul Perry from NHS24 highlighted language as another potential barrier to the use of digital services and outlined the work it has undertaken to design the NHS Inform platform in a way that can be used in multiple different languages as well as its use of the LanguageLine system to make its NHS 24 111 telephony service accessible for people who do not have English as their first language. [80]

345. The Royal College of Nursing commented in its written submission that digital services are harder to access for certain groups:

> There are also obvious limitations in terms of availability to and ability to access alternative pathways in rural areas or even in urban areas with higher social deprivation where barriers exist in terms of transport infrastructure and proximity of services.

346. The Committee acknowledges the increasing role of digital health and care and notes its wider use has been accelerated as a result of the pandemic.

347. The Committee believes digital health and care has an important role to play in the future delivery of primary care services in Scotland. However, the Committee recognises such services are not suitable for all patients, all cases or the digitally excluded. It therefore takes the view that other routes to primary care need to be safeguarded in that context. The Committee calls on the Scottish Government, in responding to this report, to set out what measures it will take, as it continues to extend the availability of digital health and care services, to encourage frontline practitioners to safeguard primary care access for the digitally excluded and other categories of patients who struggle to access digital services.

348. The Committee welcomes the Scottish Government's commitment to introducing a Digital app which would work as a front door for access to a range of information and services including booking appointments and receiving results. To enable greater use of digital services as an alternative pathway to primary

care, the Committee believes the Scottish Government needs to accelerate this commitment and would welcome an update on when such a service is likely to be available and how it will be rolled-out to GP practices across the whole of Scotland.

## Single electronic patient record

349. The Committee has heard throughout this inquiry, and in Session 5 inquiries, that access to data across different health specialities is very patchy, which leads to frustration for both practitioners and patients. There was broad agreement amongst many contributing to the inquiry on the need for better integration and coordination of health and care information.

350. A single patient electronic record was seen by many witnesses as being transformational in enabling multidisciplinary team working and helping to ensure people consistently get the best care by allowing seamless access between services.

351. In its written submission, the Royal Pharmaceutical Society outlined what it saw as some of the key benefits of developing a single patient electronic record:

> ...improve capacity, quality and safety; and to underpin referrals. This would release capacity for both community pharmacists (improved communication) and in general practice (reduced time spent on medicines reconciliation). Pharmacy teams in all settings would require read/write access to this record to allow the maximum positive impact.

It went on to state:

> An embedded direct referral mechanism would ensure that time or difficulty is not added to the patient's journey. It must be enabled with a reliable mechanism for the pharmacist to provide relevant clinical information to the GP. An obvious solution is a single shared patient record, to which pharmacists have read/write access, which would underpin the sharing of information between professionals.

352. Glasgow City HSCP also made the case for "the importance and value of a comprehensive patient record", arguing "it is critical that there are further developments with shared records, communication back to practices and clear governance about responsibility for following up issues and results".

353. The Scottish Government's 2021 Digital Health and Care Strategy recognises the frustrations associated with the current lack of a single electronic patient record:

> People wonder why their health and care records don't move with them when they move. They are surprised that hospitals and GPs can't share medication lists, or that their doctor doesn't link with their care support worker to coordinate support. They get frustrated that they are asked the same questions at every appointment with different workers in different parts of the health and care system. Data about an individual is often held in multiple different places, making it difficult for people providing support across health and care to access the most relevant, up-to-date information. This makes effective delivery of care, and continuity of care across different service providers and over time as care needs change, more challenging than it needs to be.

354. Key challenges associated with producing a single electronic patient record were explored during oral evidence. Dr Paul Perry of NHS24 advised that the multiplicity of clinical systems in the NHS creates barriers to data interoperability and data sharing. He went on to advise "to overcome that barrier, we need a central cloud-based platform". [81]

355. When asked in December 2021 whether the Scottish Government "plans to invest in the introduction of an electronic single patient record across Scotland, in order to save time and improve patient safety" [82] , the Cabinet Secretary for Health and Social Care responded :

> It is our intention to make it easier for health and care professionals to access relevant information about the person being cared for, regardless of organisational boundaries... The ambition is to enhance and improve existing investments in technology to provide digital views on patient records for both clinicians and citizens to access relevant information when and where they need it. This will support urgent care, decision making and improve patient safety.

356. While giving oral evidence to this inquiry, the Cabinet Secretary expanded further on this commitment:

> There is recognition that the sharing of information and data is crucial to ensure that people are not passed from pillar to post...It is the integrated approach to cloudbased digital components and capabilities that will play an important and significant role in the data sharing...Some of the work is already under way, but it is incumbent on me, in my role, and the Government to accelerate that work. [83]

357. While accepting that the COVID-19 pandemic will have caused understandable delays to progress, the Committee is concerned that the lack of a single electronic patient record is a major barrier to increased use of alternative pathways to primary care. Until this issue is resolved, it believes expanded use of these pathways will be limited because they will continue to be difficult for patients to navigate, resulting in patients reverting to their GP as a first port of call and in turn placing GP practices under continued strain.

358. The Committee acknowledges the Cabinet Secretary's commitment to accelerate introduction of a single electronic patient record but remains concerned that, until

this is realised, it will be impossible to fully embrace opportunities for quicker treatment and better outcomes for patients through the greater use of alternative pathways to primary care. The Committee therefore calls on the Scottish Government, in responding to this report, to provide regular updates on progress and to set out a timetable for the introduction of a single electronic patient record.

# Annexe A - Note from private informal engagement session

**Health, Social Care and Sport Committee, Alternative Pathways into Primary Care Inquiry – Engagement session**

On Monday 7 March the Committee held an informal engagement session to hear the patient perspective and the lived experience of people who access primary care services as part of their inquiry into Alternative Pathways into Primary Care.

The people who attended were identified by the ALLIANCE and Spring Social Prescribing .

Below is a summary of the key points raised during the discussion.

**Awareness of Alternative Pathways**

- Awareness seemed to vary depending on the GP practice.
- Participants from smaller rural communities had a better experience and were more aware of what was available in their area.
- Others mentioned that GP practices who worked in Clusters were better placed to be able to share resources.
- Most people who had accessed alternative pathways had done so via their GP practice in the first instance.
- Many people reported that there are posters and leaflets available within GP surgeries, but you will only see those when you are already there waiting for an appointment.
- GP receptionist are perceived as being a barrier. Some participants felt they are trying to keep them away from a GP and others felt they lacked knowledge of what alternatives are available.
- Waiting times were seen as a barrier once patients were referred on to alternative pathways. They felt abandoned.

**Signposting and self-referral**

- Similar to above there seemed to be better signposting and opportunities for self-referral in smaller communities but then there is often travel involved to access alternative pathways with services being out of town.
- One participant noted that after speaking to a GP receptionist she then gets a call back from the practice nurse who acts as a triage to signpost her on to the most appropriate professional. Often doesn't have to see a GP and feels that works well.
- Others reported a similar system with e-consultation working well. You complete the e-consultation and then receive a call back to be triaged.
- Additional support needs like autism aren't flagged when someone has to contact a

GP receptionist and therefore the communication isn't appropriate for that person. They will rely on family support to access health care. Being offered things like telephone consultations are not appropriate.

- Waiting times were again flagged as a barrier with people feeling it was quicker and easier to see a GP than be placed on a waiting list to access alternative practitioners.

### Social Prescribing

- There were mixed opinions on social prescribing with some people saying it had worked really well for them and others being sceptical about it being a way for GPs to just dismiss you and pass you on to someone else.
- Awareness of what is available has to be better – There was limited awareness of ALISS and a feeling that there are services not listed on it that could help people.
- Some patients who had found community-based health support had done so themselves and felt that their GP surgery should've been aware of it and made the process easier.
- Others who had been referred to community support had found it to be ineffective with the people running it not fully aware of how to support people with certain health conditions.
- There was a feeling that many health professionals viewed social prescribing as less valuable than traditional health care.

### Alternative sources of health information

- There was knowledge of services like NHS inform and online repeat prescription services.
- Some patients had accessed information online after feeling they were not getting the support they needed through their GP.
- Digital exclusion and additional support needs were flagged as barriers to accessing health information online.

### Other key points

- Recruitment and training were mentioned as being key issues to ensure that these alternative pathways can be effective.
- The role of Link workers seemed to vary depending on where people lived with some patients raising concerns that they don't have a medical background and aren't fully aware of what is available.

# Annexe B -Extracts from the Minutes of the Health, Social Care and Sport Committee Meetings

10th meeting, 2022 (Session 6) Tuesday 8 March 2022

**2. Alternative Pathways to Primary Care:** The Committee took evidence from—

- Dr Hannah Tweed, Senior Policy Officer, Alliance Scotland;
- Margaret McKay, Chair, Riverside Patient Participation Group;
- Val Costello, Patient Adviser, Citizens Advice Scotland Patient Advice and Support Service;

*and then from*

- Dr Chris Williams, Joint Chair, Royal College of General Practitioners Scotland;
- Wendy Panton, Senior Nurse, NHS Lanarkshire, Scottish GP Professional Nurse Leads Group;
- Dr Anurag Yadav, General Practitioner, British Association of Physicians of Indian Origin.

**3. Alternative Pathways to Primary Care:** The Committee considered the evidence it heard earlier under agenda item 2.

11th meeting, 2022 (Session 6), Tuesday 15 March 2022

**2. Alternative Pathways to Primary Care:** The Committee took evidence from—

- Clare Morrison, RPS Director for Scotland, Royal Pharmaceutical Society;
- Harjit Sandhu, Managing Director, National Community Hearing Association Scotland (NCHA);
- Jess Sussmann, Policy Lead, Royal College of Psychiatrists in Scotland;
- Julie Mosgrove, Vice Chair, Optometry Scotland;

*and then from—*

- Alison Keir, Chair, Allied Health Professions Federation Scotland;
- Dr Graeme Marshall, Clinical Director, Glasgow City Health and Social Care Partners.

**3. Alternative Pathways to Primary Care:** The Committee considered the evidence it heard earlier under agenda item 2.

12th meeting, 2022 (Session 6), Tuesday 22 March 2022

**2. Alternative Pathways to Primary Care:** The Committee took evidence from—

- Clare Cook, Regional Manager and Co Chair of the Scottish Social Prescribing Network (SSPN), SPRING Social Prescribing;
- Alison Leitch, Community Link Worker Area Lead and Co-Chair of Scottish Social Prescribing Network, EVOC (Edinburgh Voluntary Organisations' Council);
- Roseann Logan, Links Programme Manager, The Health and Social Care Alliance;
- Christiana Melam, Chief Executive Officer, National Association of Link Workers;

*and then from—*

- Chris Mackie, Digital Hub and ALISS Programme Manager, The Health and Social Care Alliance;
- Dr Paul Perry, Associate Medical Director, NHS24;
- Scott Henderson, Head of Programme - Digital Front Door, Technology Enabled Care;
- Adam Stachura, Head of Policy and Communications, Age Scotland.

**4. Alternative Pathways to Primary Care**: The Committee considered the evidence it heard earlier under agenda item 2.

13th meeting, 2022 (Session 6), Tuesday 29 March 2022

**2. Alternative Pathways to Primary Care:** The Committee took evidence from—

- Humza Yousaf, Cabinet Secretary for Health and Social Care;
- Naureen Ahmad, Head of General Practice Policy Division;
- Tom Ferris, Chief Dental Officer;
- Alison Strath, Chief Pharmaceutical Officer; and
- Michelle Watts, Senior Medical Advisor, Scottish Government.

**5. Alternative Pathways to Primary Care:** The Committee considered the evidence it heard earlier under item 2.

# Annexe C - Evidence

## Official Reports of meetings of the Health, Social Care and Sport Committee

- 8 March 2022 - evidence from stakeholders
- 15 March 2022 - evidence from stakeholders
- 22 March 2022 - evidence from stakeholders
- 29 March 2022 - evidence from the Cabinet Secretary for Health and Social Care

## Written evidence

Responses received to the Committee's call for views

SPICe summary of responses to the public survey

1 Information regarding community link workers: FOI release

2 Scottish School of Primary Care, 2019

3 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL32

4 Health, Social Care and Sport Committee, Official Report 15 March 2022, COL44

5 Health, Social Care and Sport Committee Official Report, 8 March 2022, COL 5

6 Health, Social Care and Sport Committee Official Report, 8 March 2022, COL 29

7 Health, Social Care and Sport Committee Official Report, 8 March 2022, COL 12

8 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL5

9 Health, Social Care and Sport Committee, Official Report 15 March 2022, COL11

10 Health, Social Care and Sport Committee, Official Report 15 March 2022, COL25

11 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL33

12 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL2

13 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL6

14 Audit Scotland: NHS workforce planning part 2

15 Health, Social Care and Sport Committee, Official Report 8 Mar 2022, COL 5 & 11

16 Health, Social Care and Sport Committee, Official Report 15 March 2022, COL24

17 Health, Social Care and Sport Committee, Official Report 15 March 2022, COL7

18 Health, Social Care and Sport Committee, Official Report 15 March 2022, COL6

19 Health, Social Care and Sport Committee, Official Report 15 March 2022, COL14

20 Health, Social Care and Sport Committee, Official Report 15 March 2022, COL14

21 Health, Social Care and Sport Committee, Official Report 15 March 2022, COL41

22 Royal College of Psychiatrists in Scotland written submission

23 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL7

24 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL9

25 Health, Social Care and Sport Committee, Official Report 15 March 2022, COL7

26 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL36

27 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL31

28 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL46

29 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL38

30 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL37

31 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL7

32 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL8

33 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL15

34 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL6

35 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL27

36 Scottish Government 's Community Link Worker Programme, VHS

37 Primary Care Improvement Plan Summary of implementation progress at March 2021

38 Deep End Report 36, 2020

39 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL 16

40 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL14

41 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL42

42 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL42

43 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL22

44 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL17

45 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL17

46 Information regarding community link workers: FOI release

47 Community Pharmacy Scotland

48 Healthcare Improvement Scotland

49 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL41

50 Health, Social Care and Sport Committee, Official Report 22 March 2022, COL51

51 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL19

52 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL28

53 Health, Social Care and Sport Committee, Official Report 22 March 2022, COL5

54 Health, Social Care and Sport Committee, Official Report 15 March 2022, COL8

55 Health, Social Care and Sport Committee, Official Report 15 March 2022, COL20

56 Health and Social Care: National Workforce Strategy, 2022

57 Health, Social Care and Sport Committee, Official Report 22 March 2022, COL3

58 Health, Social Care and Sport Committee, Official Report 22 March 2022, COL9

59 Health, Social Care and Sport Committee, Official Report 22 March 2022, COL9

60 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL15

61 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL14

62 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL17

63 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL13

64 Health, Social Care and Sport Committee, Official Report 22 March 2022, COL11

65 Health, Social Care and Sport Committee, Official Report 22 March 2022, COL12

66 Health, Social Care and Sport Committee, Official Report 22 March 2022, COL18

67 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL18

68 Health, Social Care and Sport Committee, Official Report 8 March 2022, COL41

69 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL23

70 Royal College of Nursing Scotland , and Scottish General Practice Professional Nurse Leads Group

71 Health, Social Care and Sport Committee, Official Report 15 March 2022, COL12

72 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL3

73 GP DACS Newsletter 2022

74 Scottish General Practice Professional Nurse Leads Group

75 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL22

76 Scotland's Census 2020

77 Health, Social Care and Sport Committee Official Report, 8 March 2022, COL 4

78 Health, Social Care and Sport Committee, Official Report 22 March 2022, COL38

79 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL20

80 Health, Social Care and Sport Committee, Official Report 22 March 2022, COL37

81 Health, Social Care and Sport Committee, Official Report 22 March 2022, COL55

82 Written question to the Scottish Government, S6W-05131

83 Health, Social Care and Sport Committee, Official Report 29 March 2022, COL25