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Health and Sport Committee

What should Primary Care look like for the next generation? Phase II

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Introduction

1. Primary Care is usually a person's first point of contact with the NHS and tends to be associated with the physical premises from which care is provided. Recognising there has been multiple developments within Primary Care Services in recent times we agreed it was appropriate we should look at the provision of services and approaches. Our principal aims being to consider whether they were meeting current needs and how they should be provided in future.

2. Given the aims, we considered it important and appropriate to listen to the views of the public, the service users. Accordingly we commenced our inquiry by asking the public how they wished to see their primary care services organised and delivered in the future. Their views were reported in our July 2019 report " What should Primary Care look like for the next generation? – Phase I ".

3. This report briefly summarises the findings from the public we received and reported in Part 1 of the inquiry and uses those findings to consider the extent to which they align with the Scottish Government vision and the reality of delivery. Our report considers the role of the Integrated Joint Boards (IJBs) and their Health and Social Care Partnerships (HSCPs) within Primary Care, looks at their governance and considers how their influence on delivery and outcomes is or should be exercised.

4. The report then considers and recognises the crucial delivery role of GPs and the primary care workforce along with the contribution and input from the third sector and how that should be developing in line with current policies and vision and the findings from Part 1. The report looks at what is required to meet the public visions of a patient-centred approach with an increased focus on preventative working and well-being. Finally, consideration is given to the role technology and data sharing require to play if the vision of the Scottish Government, patients and the wider workforce are to be met.

5. Throughout the report the original material gathered, and evidence received, is considered against the significant impacts and changes brought about as a consequence of the Covid-19 pandemic.

6. During the initial phase, the public told us they wanted to see change in how their primary care service was delivered, including to experience and receive the benefits of technology. They wanted solutions to a number of areas covering access, speed of service, a more person-centred approach with a preventative focus and an increasing use of technology. They did not view the status quo as an option.

7. In Part 2, we have taken the views of the public and using those views taken evidence from a wide range of health professionals involved in primary care, asking how they considered services could evolve in line with the needs and wishes of the users.

8. This report builds upon our July 2019 report, considers the current Scottish Government vision for Primary Care, reflects upon the evidence we received in this part of our inquiry and sets out our conclusions on what we consider are the need for radical changes in the way services are delivered and consumed. Our report endeavours to take account of the impacts Covid-19 have had on ways of working

across the health service. The report also considers and incorporates our work on our inquiry into the Supply and Demand for Medicines including consideration of aspects of the Scottish Government response to that report.

9. Our report has been significantly delayed as a consequence of the arrival of Covid-19 and then the consequential changes in ways of working and delivery of care that occurred. While we apologise for this delay, particularly to those who contributed to this inquiry at Part 1 and Part 2, we hope they will recognise the desirability of the delay in our reporting to reflect as far as is possible the impacts arising from the pandemic.

10. The Committee would like to thank all of those who participated in our public forums including those who responded to our online survey and young people from the Scottish Youth Parliament who ensured the voice of the next generation was heard. Particular thanks go to those who participated in the three regional meetings. We all express our thanks to all who have contributed to Part 2 of this inquiry and our other recent inquiries from which material in this report has been drawn.

11. Without the support of the public and health professionals who have assisted us it would not be possible for us to undertake our work and we are grateful to all who assisted us.

What is Primary Care?

12. Primary Care is where most people generally experience NHS services outside of a hospital setting. Around 90% of all health contacts take place in Primary Care [1] which people tend to associate with the physical premises from which care is dispensed. Typically, primary care is provided by generalist health professionals including GPs, Nurses, Dentists, Pharmacists, Optometrists and Allied Health Professionals (AHPs) such as podiatrists and physiotherapists. The primary care team also includes non-clinical personnel such as administration staff, managers and receptionists.

13. The Scottish Government's vision for the future of primary care services is of

> "general practice and primary care at the heart of the healthcare system. People who need care will be more informed and empowered, will access the right professional at the right time and will remain at or near home wherever possible. Multidisciplinary teams (MDTs) will deliver care in our communities and be involved in the strategic planning of our services".

We endorse that vision.

14. The need for change is compelling, as demands and costs are predicted to grow sharply. Scotland has an ageing population, with the over 75s projected to be the fastest growing age group in the ten years to 2026. This older population are living longer, some with more complex health issues and co-morbidities (e.g. increasing incidences of dementia). There is an obesity epidemic and health inequalities are striking in the most deprived areas of Scotland. Audit Scotland indicated the average healthy life expectancy of people living in the least deprived areas in 2009-10 was around 18 years higher than people living in the most deprived areas. [2]

15. The overall health and social care budget in Scotland in 2020-21 exceeded £15 billion and exceeding for the first time 50% of the entire Scottish budget, having increased from over £12bn – 40% – in 2015. We are clear this trajectory for increased resources cannot continue indefinitely. The questions are what needs to change, and what impact this will have on costs while continuing to provide the care from cradle to grave we have all come to expect.

Part I of our Inquiry

16. This part of our report looks back at the findings and report of our public panels. These were crucial to the approach taken in Part 2, when we used and tested their findings with those responsible for the delivery of Primary Care.

17. We agreed in 2019 to conduct an Inquiry into 'Primary Care for the next generation' against the backdrop of a changing demographic in Scotland (an older population) with increasingly more complex conditions, challenging health problems, and significant changes within the governance procedures (health and social integration; new GP contract; realistic medicine; national transformation plan).

18. Our initial phase focussed on gathering information, primarily information from the public. We wanted this work to focus on the needs of users and to hear directly from them the extent to which the current delivery of services was working for them, and how they wanted their future primary care services to look.

19. We agreed this should attempt to move the debate on from the ideal local scenario for each individual, to one which reflects the reality of cost, impact and accessibility for all. The intent of this approach was to acknowledge and illustrate that no government, local authority or health board starts with a 'clean slate' and has to plan in the context of existing policy, legislation and societal circumstances.

20. The deliberative aspect of this phase was the establishment of three randomly selected panels in East, West and North of Scotland populated by randomly selected members of the public. Participants were provided with information on how primary care is organised in Scotland, including what has changed in NHS Scotland and the social care landscape over recent years. They also received information on what changes are scheduled to take place in the next few years. This gave the panel members an informed perspective for their deliberations as to how, where, when, and by whom they would like to see primary care services in Scotland delivered.

21. In addition to the three public panels, we conducted an online survey to gather further information, resulting in over 2,500 responses. We also took views from the Scottish Youth Parliament to ensure the inquiry considered the views of the those between ages of 12-25 - the future generation.

22. The responses from the public disclosed an appetite, as well as an expectation, for change in the way primary care was delivered. A number of common themes emerged which are fully set out in our Part 1 report. The following is a brief summation of what we were told:

Workforce and ways of working

23. Workforce and ways of working were common themes. There was a strong desire for GPs to remain at the heart of the medical hub, sharing responsibility with other professionals, e.g. pharmacists and AHPs. Also, strong support for improved sharing of information among professionals, including having the ability to access and input to patient records. Respondents sought better management of the primary care workforce to help ensure supply could meet demand and allow

professionals to develop their careers, all of which was seen as ways to help retain staff. More innovative approaches, it was suggested, were required to attract professionals to rural practices, where it was more difficult to recruit.

24. The approach taken to this part of the inquiry was very distinct. Parliamentary Committees have not typically taken the approach of reaching out to the public, in person, to hear their concerns before undertaking an inquiry. Part I was thus rather unique. But productive, as the information gained by us is of huge value. It highlighted areas for focus and shaped the questions we asked health care professionals in Part II.

A Patient-Centred Approach

25. We were told primary care should take on a more patient-centred approach, e.g. having more flexible appointment systems for working people (evening/weekend appointments). There was some frustration that the current service delivery model seems more to serve the health professionals rather than the services users, and adverse comparisons were made with virtually every other service sector.

26. Easy and accessible signposting about other services that might be available as opposed to always having to visit their GP was also suggested. More personalised relationships with healthcare professionals were preferable as was a better triage system to direct service users – there was however reservations with some concerns about having to divulge personal medical information to non-clinician staff such as receptionists.

Preventative Focus

27. There is an appetite for primary care to have a preventative focus, including encouragement for healthy eating (increasing understanding of food and nutrition) and physical activity – especially in more deprived areas where financial barriers often stop people from participating in sports or having healthier lifestyle, e.g. buying healthier food. It was felt education on this should start in the early years.

28. There was strong support for increasing mental health services including wellbeing spaces in schools and work places. There were suggestions that a more holistic policy approach needs to be taken to health issues, e.g. education (teaching about health and nutrition and resilience), urban planning (green spaces, cycle lanes), infrastructure (building multi-functional hubs). Overall the public message was they wanted to avoid becoming unwell and requiring treatment.

Community wide approach to Wellbeing

29. Linked to the preventative agenda there was a desire for a community wide approach to wellbeing. Making better use of community facilities such as community centres, schools and places of worship for multi-functional purposes. Bringing communities together, it was suggested, could help address issues such as

loneliness, thereby reducing mental health issues. A wider use of community facilities would also minimise costs of access, therefore making initiatives more accessible to all communities, including those in deprived areas.

Use of data and Technology

30. Frustration around the lack of use of technology and data was common**.** Feedback demonstrated a desire to embrace technology particularly to make it easier for service users. There was frustration at a paper-based system. Phone calls still being required to make appointments with GPs, to order repeat prescriptions and correspondence generally all on paper issued by post. There was a desire for change, including scheduling appointments, receiving results and generally corresponding with medical professionals by email; with an option to conduct appointments via video.

31. Frustration was also expressed with the necessity to repeat medical history/ conditions many times to each health professional involved (GPs, different consultants/specialists, pharmacist, community nurse etc). There was a desire for an electronic patient record shared with all relevant health professionals.

32. Current data difficulties centring around control were neither understood nor accepted, patients were clear data should be owned by the individual and patient data owned by the patient. Service users also raised a desire for greater use of technology/wearables to monitor health e.g. blood pressure and diabetes with automatic submission of results to relevant health professionals.

Thoughts on Part 1

33. We took a new and innovative approach to Part 1 of this inquiry which with hindsight still appears to be both desirable and appropriate. Primary Care is for the public, and it should be the public who drive the approach to its delivery. Thus, our first phase of the inquiry was fully focused on gathering views and experiences mostly from the public, and especially people who use primary care services across Scotland. We wanted people to tell us what they think primary care should look like to best serve their needs, how it can be accessible for all and how the reality of cost impact can be managed. We asked and received thoughts on current services and how they could be improved and sustained in the future.

34. From the surveys and the deliberations of the public panels it was made clear to us the public support change in the way Primary Care is accessed and delivered. We were told the public wanted change and to experience the benefits of technology. The public have universally indicated they want solutions and that the status quo is not considered an option.[i]

35. We commend this approach to future Committees of the Parliament and more generally to policy makers and we again thank all who contributed for their time,

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[i] Health and Sport Committee, 9th Report, 2019: What should primary care look like for the next generation?, Paragraphs 50-51

insight, honesty and foresight. The findings and recommendations of this second report are our own, but without the input we received it would not have been as possible to be as confident in the need for significant change.

Part 2 of our inquiry

36. In this, the main part of the report, we look at existing Scottish Government policies and the structure of Primary Care, taking account of legislative changes introducing the role of the Integration Joint Boards (IJBs) and the requirement it imposes for localities. We look at the role of the GP and the proposed impact of the new GP contract. We consider the role of other healthcare professionals and other members of the multi-disciplinary teams and the role of the third sector in delivery. We consider all of this against the views of the public earlier provided to us, and all against the backdrop of the impact of the Covid-19 pandemic.

Scottish Government Vision for Primary Care

37. The Scottish Government's vision for the future of primary care services [3] is of:

> general practice and primary care at the heart of the healthcare system. People who need care will be more informed and empowered, will access the right professional at the right time and will remain at or near home wherever possible. Multidisciplinary teams (MDTs) will deliver care in our communities and be involved in the strategic planning of our services.

38. The above is closely aligned with the priorities identified during the Committee's interaction with the public.

The Scottish Government has produced a number of polices which signal its desire to move care out of hospital and into the community. In 2011, they published a strategic vision for achieving sustainable quality in the delivery of healthcare services across Scotland. The ambition set out is that:

> by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

39. The National Clinical Strategy for Scotland, published in 2016, contains proposals for change to provide sustainable health and social care services. It notes that:

> effective primary care, with universal coverage, can significantly improve outcomes for patients, and deliver the most cost-effective healthcare system.

The strategy signalled a transformation in primary care. The vision being to bolster local primary care services to deliver a wider range of services, ensuring patients received the right care from the right health care professional and at the right time. This approach was in acknowledgement of the changing and complex needs in communities and the need for better integration between various parts of the health and social care system.

40. The National Clinical Strategy states that:

> increased investment in primary care will ensure the sustainability of secondary care services by allowing an increasingly elderly population with multi-morbidity to be treated more appropriately in primary care.

41. The 2017 National Clinical Strategy for Scotland also introduced the concept of

"realistic medicine". Realistic medicine aims to put the person receiving health and social care at the centre of decisions made about their care, and aims to encourage shared decision making. This sets out the aim that, by 2025, anyone providing healthcare in Scotland will take a realistic medicine approach.

42. The Scottish Government developed six national indicators for Primary Care as part of the Outcomes Framework. These set out how the Scottish Government expect to evaluate progress under the Primary Care vision:

- we are more informed and empowered when using primary care;
- our primary care workforce is expanded, more integrated and more coordinated with community and secondary care;
- our primary care services better contribute to improving the population's health;
- our primary care infrastructure – physical and digital – is improved;
- our experience as patients in primary care is enhanced;
- primary care better addresses health inequalities.

43. The cost of primary care is already significant. According to the ISD 2018-19 cost book, primary and community care services account for 37% of the total health and social care budget (£5.8 billion) while hospital care costs are 42% at £6.6 billion and social care accounts for £3.25 billion.

44. GPs, dentists, ophthalmic services and local pharmacy cost £2.6 billion. GP prescribing, part of the pharmaceutical services budget accounted for over £1 billion of that £2.6 billion. Slightly less than this, £2.4 billion was spent on some elements of community services covered by primary care such as district nursing, home dialysis, screening programmes and health promotion. Some members of the MDT will not be counted in the last figure as they will be employed directly by the GP practice, however more are included as they are employed by the health board, such as AHPs, community nursing teams and Out of Hours services.

The Increasing Role of the HSCP in Primary Care

45. The Public Bodies (Joint Working) (Scotland) Act, 2014 (the Act) is intended to ensure that health and social care services are well integrated, so that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care. The reforms affect everyone who receives, delivers and plans health and care services in Scotland. The Act requires councils and NHS boards to work together to form new partnerships, known as Health and Social Care Partnerships (HSCPs). In 30 of the 31 areas the HSCP is run by a body corporate known as an Integration Joint Board (IJB) or Integration Authority (IAs). There are 30 IAs, established through partnerships between the 14 NHS boards and 31 councils in Scotland. [4]

46. Highland adopted a different model the **lead agency** arrangement. In this arrangement, the chief executive of the lead agency has responsibility to develop the strategic plan. NHS Highland has responsibility for adult health and social care

services and Highland Council has responsibility for children's health and social care services. In the Council area of Argyll and Bute, Highland have however adopted the more usual IJB route.

47. Each HSCP has been required to establish at least two localities. These are intended to provide an organisational mechanism for local leadership of service planning, to be fed upwards into the integration authority's strategic commissioning plan.

48. Localities are intended to have real influence on how resources are spent in their area. Localities bring together representatives of the third and independent sectors, carers' and patients' representatives and people managing services, local GPs and other health and care professionals, representatives of the housing sector.

49. The Scottish Government's guidance on localities notes they must:

- Support the principles that underpin collaborative working to ensure a strong vision for service delivery is achieved. Robust communication and engagement methods will be required to assure the effectiveness of locality arrangements.";
- Support GPs to play a central role in providing and co-ordinating care to local communities, and, by working more closely with a range of others – including the wider primary care team, secondary care and social care colleagues, and third sector providers – help improve outcomes for local people.";
- Support a proactive approach to capacity building in communities, by forging the connections necessary for participation, and help to GP Clusters. [5]

50. It is clear from submissions, as integration becomes better embedded, HSCPs are becoming clearer and more confident about their role and direction. The IAs have all developed Primary Care Improvement Plans. It is also becoming clearer to HSCPs that primary care sits within a much broader public health context in communities.

51. Primary Care Improvement Plans outline how new funding will be used to establish an effective multidisciplinary team (MDT) model at Practice and Cluster level by March 2021.

52. The Plans were required to be developed in collaboration with a range of stakeholders in line with IJB strategic planning responsibilities. The plans should be designed to reflect local needs and priorities and set out:

- How the multi-disciplinary team will be developed and will function at practice level and at cluster level;
- Available resources and spending plans;
- Assurance, accountability and dispute mechanisms;
- How the new delivery model will align with wider community services;
- How funding will enable the shift of work and responsibility from GPs to the wider MDT, with clear milestones for progress/delivery.

53. However as David White, Edinburgh HSCP submission told us:

> Primary care is not established to focus on the priorities of local communities – its priority is the (ill) health needs of individuals, and before clusters, no consistent capacity or encouragement was given for this.

54. This highlights some of the ambiguity of the current changes: GPs are trained to diagnose and manage illness but are confronted by the frequent presentation of the effects, such as poor mental health and obesity, of bigger societal issues such as poverty, deprivation and poor nutrition.

55. Many of the practical changes, challenges and innovations in primary care are 'behind the scenes', coming from the GP contract and/or the primary care vision:

- a change of emphasis for GPs towards complex care, some of their tasks/roles being transferred to MDT, and less risk associated with their premises;
- HSCPs having the main co-ordinating role for community healthcare but with a significant role for GPs;
- an expanded and visible multi-disciplinary team working mainly in the community and under the control of the HSCP;
- teams will be working with a potentially more dependent and dispersed population given the changing policy, the changing demographics and the rise in certain long-term conditions and multi-morbidities.

56. Nothing in the primary care vision, or the new GP contract presents anything radically new to the public, except that they might be signposted directly, by reception staff, or they might self-refer more frequently to other health professionals.

57. However, as shown in the submissions and oral evidence we received, there is an increasing presumption of 'self-management' and self-care. This often sits in the same sentence as the need to focus on personal outcomes for people. For many it needs to be made clear where the role of statutory services and the responsibility of the individual begins and ends.

58. **We ask the Scottish Government if it accepts the need for a shift in Primary Care to focus more on the needs of local communities and less on ill-health?**

59. **We are concerned the guidance on localities could be too narrow and overly focus on the role of the GP. We consider the guidance should be strengthened and take account of the National Clinical Strategy aims to move away from a clinical model and widen locality aims to have more of a prevention focus, and thus seek deliverables before involvement with GPs. The work of the third sector and others in supporting residents must be fully integrated and incorporated into locality planning.**

60. The cost of the GMS contract exceeds £1 Billion [6] and makes up approximately half of the total Community Health Service Budget of £2.109 Billion all of which is controlled by the HSCPs [7] an increase from 39% in 2016/17. It is therefore clearly essential the HSCP are able to use their influence, drive and monitor closely the workings and effectiveness of community healthcare including the work of GPs through their strategic commissioning plans and the localities they have established.

61. **We ask the Scottish Government how this monitoring of community healthcare is achieved and reported.**

GPs and the Primary Care Workforce

GPs

62. General Practitioners (GPs) are doctors, based in the community and specialising in primary care. Consultations with a GP remains the core of general practice; diagnosing a presenting condition or managing an existing one through giving advice, prescribing medication, treating a patient, or referring them to a specialist or another service. They are the lynchpins of primary care and historically have been the gatekeepers to all other Primary Care services.

63. The Scottish Government's National Clinical Strategy for Scotland signalled there is a need to move away from the traditional model. The new vision continues to see the GP as the lynchpin to the primary care team, but other services would be:

> delivered by increasingly multidisciplinary teams, with stronger integration (and where possible, co-location) with local authority (social) services, as well as independent and third sector providers.

64. GPs, like dentists, pharmacists and ophthalmologists, are mostly independent contractors. This means they are financially responsible for the business affairs of the practice and are independent of the NHS. They are however contracted by NHS Health Boards to provide services on their behalf.

65. NHS Boards can contract with a practice, run their own practices or negotiate a local contract. The Primary Medical Services (Scotland) Act 2004, established three types of general practice contracts in Scotland:

- 17J: A General Medical Service (GMS) practice is GP run and has a standard, nationally negotiated contract in place. The majority (84%) of practices in Scotland are run by GPs with a GMS/17J contract in place;
- 17C: These practices (around 8%) are GP run and have a locally negotiated agreement between the HSCP and the practice. This enables, for example, flexible provision of services in accordance with specific local circumstances;
- 2C: An NHS Board run practice (around 4%) where all GPs and practice staff are salaried to the local NHS Board.

66. GP clusters were introduced in 2016/17 as a way of improving integration and quality of care within and across practices. They are small groups of GP practices within a locality who work with local partners to improve quality in the care of the local population. Each GP practice has a Practice Quality Lead who engages with the local cluster, and each cluster has a GP designated as a Cluster Quality Lead.

The 2018 Scottish General Medical Services (GMS) Contract

67. The GMS contract further embeds the cluster quality approach. Improving together: A National Framework for Quality and GP Clusters in Scotland sets out the role of clusters and the national support available for improving quality in GP clusters through quality planning, quality improvement and quality control.

68. The 2018 Scottish General Medical Services Contract Offer was agreed in January 2018 and is supported by a Memorandum of Understanding between the Scottish Government, the British Medical Association (BMA), Integration Authorities and NHS Boards.

69. The contract sees GPs fulfilling roles to support a wide range of other clinical professionals and working as an expert medical generalist and senior clinical decision maker within multi-disciplinary community teams. It notes that the key contribution of GPs in this role will be in:

- undifferentiated presentations;
- complex care in the community;
- whole system quality improvement and clinical leadership (assessing and developing services intended to meet the needs of their patients and local communities).

70. Some of the aims of the contract are for general practice in Scotland to improve access for patients, address health inequalities and improve population health including mental health.

71. With a wider team available, general practice nursing is also expected to change, allowing practice nurses to become expert nursing generalists, managing acute and chronic disease and supporting self-management of conditions.

The Multi-Disciplinary Team (MDT)

72. Throughout our inquiry we have heard references to the MDT and its value, while at the same time becoming aware of misunderstandings about their role and competencies. We discussed this with a variety of witnesses at our session on 24 September 2019.

73. We heard the MDT needs to involve not only the GPs, the nurses, occupational therapists and physiotherapists but also extend to include speech and language therapists, art therapists, dieticians and the 14 professions that compose the AHPs. [8]

74. As was succinctly put to us it must “include everyone who can make a difference to patients." [9] It is essential it cover everybody “needed to make sure that the patient has a good experience and has their needs met.” [10] It also requires to be “centred around giving personalised care to the patient and achieving the outcomes that the patient wants and that are relevant to them.” [11]

75. As Theresa Fyffe (Royal College of Nursing Scotland) said:

> When done well, multidisciplinary team working is about getting the right resources, planning and care for people and utilising the best of individual professions. The unique contribution of professionals is critical to MDTs.” Adding “One of our frustrations is that, sometimes, when people talk about multidisciplinary team working, they say that everyone does everything as one whole team. MDT working is about planning care, making decisions on care, assessing and evaluating that care and then focusing on outcomes for people, but each of the professions makes its own unique contribution to that care. [12]

76. We recognise and understand the range of skills physiotherapists have enabling them to do much more than Musculoskeletal (MSK), equally that Occupational Therapists have a vital role much wider than merely mental health, and that speech and language therapists work across all sectors of society despite perhaps a perception they only work with children.

77. It was interesting to hear from Dr Chung, a consultant Emergency Doctor, that his immediate thoughts about MDT was to consider child protection and adult support and protection. Adding he would include the local authority and other agencies within the description. Before noting that he has become aware of the availability of services that, previously, he had no idea about. This [understanding the breadth of MDT services available], being as much of a challenge for healthcare workers as it may be for the public. [13]

78. We were also told it was important to be clear that members of the MDT are invariably able to make independent decisions enabling their patients to live the lives that they want to live. [14]

79. It was heartening that our public panels had no such preconceptions, recognising they would be happy to see the person best equipped to address their problems as a first point of contact.

The role of the GP and the Multi-Disciplinary Team

80. Part of the Scottish Government’s long-term vision for health and social care in Scotland is to shift the balance of care, giving a greater focus on keeping people well in their own homes and the community. To achieve this there is acceptance of the need to change the way primary care is delivered. The government plans to expand the primary care workforce, with care provided by a wide range of professionals working together in multidisciplinary teams. Care would then be delivered by the most appropriate member of the MDT.

81. Under the new contract the GP remains as the lynchpin to the primary care team, a

team which can also include nurses, physiotherapists, pharmacists and occupational therapists with the exact composition depending on local needs. Where possible they would be physically co-located, and increasingly include non-clinical members such as social services and Community Link Workers.

82. A similar vision was by and large reached by the public who participated in our forums, they want GPs to share responsibility with other health professionals.

83. It is recognised pressure will increase on primary care services as the population lives longer, often with multiple long-term conditions. The change in delivery model to MDTs is aimed at directing patients to the most appropriate healthcare professionals. This in many instances will not be the GPs and will consequentially allow GP to focus their time on patients who require their expertise. In areas as set out in the contract (see above) such as undifferentiated consultations and complex care in the community.

84. Work is required to ensure the vision above translates into practice across the board with a variety of issues requiring to be addressed. Kim Hartley Kean (Allied Health Professionals Scotland) suggested the definition of MDTs should be widened to include others such as speech and language therapists, art therapists, dieticians and the many other professions that compose the Allied Health Professionals (AHPs). In effect to include all who can provide help and support.

85. We heard frustration that the focus of attention and narrative of crisis espoused in public by the media or government was only on the number of GPs, when there are similar issues hitting recruitment and retention targets amongst all the MDT professions.

86. As indicated, our public panels were clear they wanted to see the right person to address their symptoms at the right time and were not concerned about job titles.

87. We agree with Kim Hartley Kean when she summarised the frustrations many AHPs feel telling us:

> We also need to stop the narrative in the public sphere that leads people to say that if they have not seen their GP, they have not received primary care. We must start changing how we talk about this and, on this stage in the Parliament, in the media and in boardrooms, we need to start breaking down those misbeliefs. [15]

88. **The impression given from the evidence we heard that the AHPs and others are not part of the MDT requires to be addressed. We are clear AHPs, and others, play an invaluable role in enabling people to live an active life and encourage the Scottish Government to include the full range of staff involved in supporting health care when planning future workforce.**

89. **Work needs to be undertaken to ensure all, including the public and members of the MDT, recognise other clinicians are able to make independent decisions. And they all share concerns and an interest to identify what matters to patients and crucially what is required to enable**

them to live the lives that they want to live.

90. **We note the wider role given to GPs in relation to the management of the MDT within clusters, and are concerned to ensure appropriate training and skills are provided to them to allow this to be achieved to maximum advantage.**

91. **We recommend a clear set of performance and improvement indicators are identified for universal use within the national monitoring and evaluation strategy [16] with the results published regularly. We also ask how benchmarking across clusters is to be undertaken, and how learning and improvement is to be disseminated across the country.**

92. **We recommend the national monitoring and evaluation strategy make clear the linkages between the MDT and clusters and identifies ways in which the effectiveness of the MDT can be assessed.**

93. **We also repeat the question posed in our report on the supply and use of Medicines and ask when all GP practices will include pharmacy staff. [17] And we seek confirmation appropriate adjustments have been made to the number of pharmacy training places to allow this to be realised and maintained.**

Are there enough GPs?

94. The Scottish Government told us:

> We have a record number of GPs working in Scotland and we are committed to increasing numbers by at least 800 in the next ten years. We are also investing an additional £250 million in direct support of general practice by 2021 [18]

95. We were interested to understand how this number was reached and what services the additional GPs would be involved in delivering.

96. We heard the figure was reached without consultation with RCGP, BMA or any other medical association. The Cabinet Secretary clarified that the figure was based on estimating work force trends for the period up until 2027 and estimating future demand for GP surgeries.

97. We also note the absence of current data in the estimates covering GP activity. Between 2004 and 2018, GP practices were not obliged to provide data on staff employed by the practice. This lack of data on practice-employed staff means that

there are no accurate figures on the size and make-up of the primary care workforce.

98. Within the new GMS contract, practices are required to provide data on income and expenses and on practice-employed staff. Despite the IT system SPIRE[ii] being provided to assist with this data collection at 96% of practices [19] information is still lacking, and we heard about a reluctance by GP's to provide such information.

99. Dr Carey Lunan (Royal College of General Practitioners Scotland), when acknowledging this lack of data, noted this made it impossible to show what work is being undertaken and crucially to identify areas for improvement.

100. Regardless of the contractual status of most GPs, they are remunerated from public funds with the GMS receiving £ 1.0358 Billion in the current financial year [20] . We agree with Audit Scotland who suggest there is an obligation for a clear and transparent audit trail making it possible to follow in every case the 'public pound'.

101. Support for this approach comes from the Office for Statistical Regulation who state, "primary care statistics do not currently deliver public value". They note there is limited information currently available about when new primary care statistics will be delivered and what they might look like. The Royal Society of Edinburgh indicated benefits from such transparency noting:

> Primary care will not develop satisfactorily, nor achieve its full potential, without a substantially re-configured system for the collection and use of data to measure performance, share learning and support decision-making.

102. We heard there were historical concerns about data usage despite the purpose of this being to enable GPs to fulfil their role more effectively.

103. We pursued the absence of data collection with the Cabinet Secretary, asking when national data on clinical activity and demand in primary care will be available.

104. In a written reply we were told the need to gather activity and capacity data had been agreed as part of the 2018 GP Contract. This to be collected using the SPIRE data extraction tool currently being rolled out, although the specifications were still being developed. The intention being to provide Scotland-wide statistics and indicators capable of being interrogated to Board level. Work was to be completed by Spring 2020. [21] As of February 2020 5 Boards had completed training of all GPs and installed systems while for the remainder this was ongoing.[iii]

105. All of this means the size of the GP staff is unknown, and there is a lack of data identifying the activities of MDTs. As a consequence it is currently impossible to assess the returns on this public spending.

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ii SPIRE is the Scottish Primary Care Information Resource. It is a service which allows information to be requested from GP practice records and collected centrally to produce statistics for Scotland as a whole. SPIRE also provides a platform for practices to see information about their patients, through report on topics such as practice activity, vaccination uptake and multimorbidity.

iii Scottish Primary Care Information Resource (SPIRE)

106. **We note information to be collected under SPIRE goes some way to allowing MDT output and outcomes to be assessed, but ask the Scottish Government when this will be available and whether it will be available to practice level thus allowing learning from best practice areas to be identified. As part of phase 2 of the GP contract it is essential there is a requirement on the MDT to provide data on activity, salaries and other costs.**

107. **We also recommend all HSCP primary care improvement plans make clear the role of all staff within the MDT. We would also like to see more plans giving lead roles to other members of the MDT and the wider community including third sector representatives.**

108. **We recommend the Scottish Government review annex 3 of the national monitoring and evaluation strategy [22] to widen those who are responsible for contributing evidence, to include those practising within and supporting the MDTs.**

109. **We were also told the Scottish Government had agreed with the BMA the need for practices, clusters and HSCP's to have available activity information. We ask the Scottish Government what information this will contain, when it will be available and how it will be made available in the public domain.**

110. The Scottish Government also told us the "new GP contract and investment in multi-disciplinary teams will increase capacity in primary care allowing patients to be seen at the right time by the right person. It will help reduce GP workload, making the career even more attractive to new doctors. [23]

111. We have seen reports from two IJBs evaluating local initiatives to release GP resources through work being undertaken by other members of the MDT. In Lanarkshire [24] by advanced nurse practitioners in relation to unscheduled care presentations and in Edinburgh [25] by practice-embedded Primary Care Mental Health Nurses, Link Workers and Physiotherapists.

112. it is imperative that under the new GP contract the government must receive information recording activity across the MDT which will assist in national workforce planning, not only for GPs but also for other health care professionals.

113. Such data will enable better future workforce planning leading to more accurate forecasting, which in turn should result in GPs being available to focus on caring for those who most need their specialist expertise. Enhancing their role in this way may also positively impact on the number of medical students pursuing a career in General Practice.

114. **We acknowledge the Government's commitment to increase GP numbers is intended to strengthen primary care, but it appears to reflect the position before agreement on the new contract, with its much greater emphasis on the Multi-Disciplinary Team. We recommend this commitment is recast, to commit to an appropriate number of MDT professional staff, including both GPs and other professions, which can deliver the intended benefits to primary care as a whole.**

Community Hubs

115. At the outset of lockdown, a network of new Community Hub's was established across the country to help reduce pressures on GP practices and hospitals amid the coronavirus (COVID-19) outbreak.

116. Hubs are staffed by a mixture of nurses and doctors. They handle calls from the public who may be experiencing symptoms of coronavirus (COVID-19) and who may need further assessment and advice. The Hubs provide face to face scheduled appointments for those who may need further clinical assessment short of emergency care.

117. The idea being to ease some of the pressure on GP practices and NHS24 as a result of coronavirus (COVID-19). The intention was to better manage demand, provide information, advice and clinical assessment, allowing GP and hospital resources to focus on patients with other conditions.

118. During our budget evidence sessions we heard more about the impact and future of the hubs and whether the approach could be mirrored in other areas of the NHS that are looking for efficiencies, and whether there were any lessons to be learned from their use.

119. On 11 August, Elinor Mitchell (interim Director-General Health and Social Care) told us Hubs have been considered a success and they would expect to continue to run the hubs for as long as we need to. Also, that they fit with aspirations around phase 1 of the GP contract, ensuring GPs see a greater acuity of patients.

120. She noted the work of the hubs helps make use of the multidisciplinary teams in primary care, ensuring all that can possibly be done in primary and community settings is done. They were considering them with regard to the patient pathway including avoiding patients turning up to A & E when there are perhaps better ways of caring for them. [26]

121. The Cabinet Secretary confirmed this approach and that the Scottish Government are actively considering how to use the community hub and assessment centre infrastructure to help to redesign urgent care. [27]

122. We discussed the cost of the hubs, £35m was allocated to them in the Autumn budget revision, and were told it was more than just a question of whether it is cheaper or more expensive. It allowed consideration of how funding flows and follows people in the best way, which could impact on shifting the balance of spend

to the most effective ways. [28]

123. **We ask the Scottish Government to provide the updated costs of the hubs and indicate the numbers of patients they have seen and detail how the impact this has had on primary care and A&E services are being monitored.**

Role of voluntary sector in Primary Care and local planning

124. Having accurate workforce data is essential to all areas of effective workforce planning. Without a clear picture of the size and make-up of the primary care workforce, it must be impossible to accurately plan for a future workforce that will be both the appropriate size and appropriately equipped.

125. In considering future workforce planning we consider there is also a strong case to include sections of the third sector. The Scottish Government has already indicated they are open to this type of initiative, indicating how essential the third sector has become:

> The third sector, which includes charities, social enterprises and voluntary groups, delivers essential services, helps to improve people's wellbeing and contributes to economic growth. It plays a vital role in supporting communities at a local level.

126. The Scottish Government published a Third Sector Interface (TSIs) Outcome Framework (September 2018) to support TSIs in ensuring that the third sector becomes embedded in local planning. This will require to be aligned with the National Performance Framework.

127. However, there is some doubts as to the role and status of the third sector (and the private sector), as fully acknowledged partners in the integration of health and social care, including delivery of primary care services in relation to statutory services. The ALLIANCE told us:

> As recognised by the Committee's public panels, longer term funding for third sector services is necessary to enable primary care teams to take advantage of the value that it brings. The funding of third sector services, largely not by the NHS but by HSCPs or local authorities, is often under threat and removal of these services does not necessarily consider the wider impact this may have in supporting the primary care sector through referrals and prevention.

128. In relation to funding, third sector organisations told us they face great uncertainty. Inevitably, twelve-month funding cycles result in difficulty in setting and implementing long-term strategic plans, with resulting consequences on impact. Lack of funding certainty also leads to job insecurity with many experts who could make impacts being lost. The third sector could be an enabler to provide patients a service that cannot be done through a GP, e.g. access to mental health specialists.

129. **The Committee believe in future workforce planning within primary care,**

must also take account of the third sector.

Patient-centred approach

130. From our public panels and the online surveys came a strong desire for a more patient-centred approach to primary care services. This included making it easier for users to access services, with for example GP surgeries being open and available in the evenings and at weekends. There was a strong message that many view the current service as being designed to meet the needs primarily of practitioners rather than service users.

131. During phase II of the inquiry we heard examples where health practitioners provide a patient-centred approach. Community Pharmacy Scotland's written submission noted:

> Almost all Community Pharmacies are open 6 days a week, with some being open 7, and cover more hours than a traditional working day.

It was also possible to access community pharmacy without an appointment. These examples are closer to meeting the public appetite for a far stronger patient-centred approach.

132. In other services, such as physiotherapy and optometry, it was also common practice for services to be offered six or seven days a week. With appointments routinely available in the evenings. In some places an appointment is not necessary.

133. It was in GP surgeries that patient-centred approaches were used least, with historical based 9-5, 5 days per week being most comment common. NHS Greater Glasgow and Clyde envisaged difficulty in addressing this noting that:

> simply extending the opening of practices under the existing model would require considerable additional primary care practitioners at a time when recruitment is already challenging and may impact on the core services already being provided. [29]

134. In the final session of our inquiry, we engaged directly with members of the public panels from phase 1. We heard frustration, and the strong observation, that many of the services and service delivery models offered by GP practices (paper correspondence, no online booking facility, no online consultation, 9-5 appointments only) would not be acceptable from any other service provider. The panels questioned why it was deemed acceptable from GPs who are delivering a publicly funded service.

The use of technology within Primary Care is further considered further in a later section of this report.

135. Having continuity in relation to the Primary Care professional you see was also highlighted in responses. The desire to build relationships and trust with healthcare professionals, were viewed as important. However, with fewer full-time GPs this we

were told was inevitably happening less often.

136. **Although we acknowledge continuity of care is a challenge for GPs, by better utilisation of the other healthcare professionals, including AHPs, we consider increased continuity of care should be achievable and so recommend.**

137. There was concern expressed about the role of the non-clinician staff in GP practices, and how they are increasingly being used for triage purposes. For many service users this was an uncomfortable experience, with concerns expressed generally about the level of knowledge and training such staff had. A specific concern over confidentiality of information existed particularly in small and rural communities.

138. **We accept change will be difficult, nevertheless we consider the move to multi-disciplinary teams must be accompanied by a radical change in how services are presented. We expect health leaders to be ambitious, and to give primary consideration to the needs and impacts on patients. We expect them to identify innovative ways in which the delivery of primary care can be remodelled, putting the needs of the patient at its heart.**

139. **We recognise addressing this lies principally with Health and Social Care Partnerships and we would urge them to lead the design of more holistic and seamless primary care services with the primary focus on patient needs. There is an opportunity for HSCPs to incorporate innovative design thinking into PC Improvement Plans. Designs that include consideration of all aspects and representatives of the wider primary care team, hubs, out of hours services, and including third sector partners and essentially with public involvement in the design.**

Preventative working

140. In phase one of the inquiry the public expressed a desire for a more preventative approach to be taken in primary care. The clear preference was to avoid illness and prevent or reduce the need for treatment. Many health and social practitioners agreed a preventative focus should be a priority.

141. Glasgow City described how prevention is traditionally approached within the NHS in Scotland, indicating the approach to prevention falls into two main categories: conditions for which strict standards are met and screening programmes exist (examples include screening for breast, bowel and cervical cancer) and general wellbeing advice.

142. The first category is not what we view as examples of a primary preventative focussed model as the focus is on identifying harm early to reduce or minimise impact. Primary prevention is, we consider, designed to prevent any impact.

143. Other comments closer reflect our earlier work on the preventative agenda Preventative Action and Public Health in 2018 when we concluded:

> As the population ages it is imperative greater focus is given to address primary prevention, prevent people becoming ill with known preventable diseases, to lengthen peoples' healthy lifespan and reduce the time they spend in ill health. [30]

144. For example the Primary Care Clinical Professions Group, indicated:

> Scotland must accord equal priority and equitable resources to the primary prevention of illness, or harm and actions leading to good population health and individual wellbeing.

145. The Queen's Nursing Institute went a step further stating that "at the heart of a sustainable primary care system is a deep-rooted emphasis on primary prevention".

146. Many comments aligned with what we heard from the public during this inquiry, with NHS Arran and Arran and East, North and South Ayrshire Health and Social Care Partnerships welcoming the view that resources:

> should be shifted from secondary care into primary care and noted they would "also welcome action to shift resources even further into prevention as this will undoubtedly have a positive impact in the longer term on primary care.

147. We also agree with Marie Curie who indicated in their written submission that:

> preventative action should be focused on making processes, and the co-ordination and integration of care easier for individuals to navigate". In addition to easing pressure on primary and acute services this approach enables people to live with their conditions, self-manage to become self-reliant and be able to contact the right services when they require specialist support. This should become the most important public health priority and public campaign in Scotland.

148. We heard the ability to fully embed a preventative agenda is not possible within the confines of the current system. GPs told us during our inquiry into the Supply and Demand for Medicines they do not currently have the time to sit with patients and discuss with them how they need to change their lifestyle habits. Such time is crucial to addressing what can often be deep rooted issues and can prevent other episodes that would require future GP time.

149. However,if not GPs then who should be providing this service, should it be a member of the multi-disciplinary team? Many issues brought to GPs are not things they are specialists in, e.g. mental health problems. And in some cases the real issue is about something completely unrelated to health, e.g. financial problems. Fully utilising the MDT allows GPs to focus on patients who need them the most, whilst at the same time allowing the most appropriate support and assistance to be provided to others with the aim to prevent crises before they happen.

150. Dr Carey Lunan, RCGP also made the point about time:

> Extra time for us is crucial, because it allows GP practices, and whoever else has pressures because of patients' complex needs, to provide empathetic care. Such care can prevent unscheduled admissions and pull fragmented systems together.

151. The idea that health professionals are not always the most appropriate conduit was raised by Jane Cumming from Penumbra who said:

> Although primary care is a gateway, it is often not the first port of call for people…People have often sought more informal means of support so they will arrive at primary care after they have clearly identified that there is an issue.

In this sense, medical intervention is too late for primary prevention to be effective.

152. The Scottish Government are aware of this and have stressed the need "to increasingly move towards the prevention of illness" as they aim to create:

> a genuine 'culture for health' where citizens achieve the highest attainable standard of health by both taking - and being empowered to take - responsibility for their own health and care, within an enabling environment that makes it possible for them to do so.

153. The creation of Public Health Scotland, which came into being in April 2020, will play a crucial role in supporting the public health system, including GPs, to work collaboratively to realise this shift to prevention. This new body, a partnership between national and local government, is intended to improve and protect Scotland's health and wellbeing and reduce health inequalities around the country.

154. We will watch closely how well Public Health Scotland focuses on developing a focus on primary prevention and how this meets Government ambitions for a significant shift at a strategic level.

155. Undertaking a preventative approach in a serious and sustainable way will require contribution across the whole of government . In Education, introducing healthy lifestyle and knowledge of food and nutrition into the curriculum. In Local Government, to allow planning for cycle tracks in villages, towns and cities, allowing communities to utilise schools, places of worship and community centres as places where to exercise. In Infrastructure, to ensure new initiatives do not reduce green spaces. Without a healthy population who can be an effective and efficient workforce, Scotland's economy is at risk.

156. It is of course right that GPs and other healthcare professionals offer lifestyle advice during every professional contact, but the challenge lies in finding adequate time and having the ability to follow up. Realistically this is not feasible in the current structure.

157. **We consider prevention activities should also be delivered elsewhere, such as through schools, in the workplace and through community initiatives. We look forward to seeing how this will be encouraged by Public Health Scotland working with GPs and other public agencies..**

158. Building citizens knowledge and understanding can empower citizens, allowing them to be able to self-manage their own health. Gaining awareness/knowledge of what services are available enables them to make choices that work best for them as well as going directly to the health professional most suited to treating them. This should also have the effect of reducing demand on GPs times.

159. A greater focus on prevention activities across the wider public health system will help with sustainability of the primary care system in both urban and rural areas. Through public health reform, the Scottish Government has stressed the need to tackle the social and economic determinants of health “and the need to increasingly move towards the prevention of illness."

160. Like the public, the Scottish Government want to move to a preventative model. They have stressed the need “to increasingly move towards the prevention of illness”, as they aim to create “a genuine ‘culture for health’. One in which citizens achieve the highest attainable standard of health by both taking - and being empowered to take - responsibility for their own health and care, within an enabling environment that makes it possible for them to do so.”

161. **We agree with the Scottish Government on all of this, and ask for detail as to how a move towards the prevention of illness is going to be enabled and by whom. Also, how are the public are to be empowered to take more responsibility for their own health and within what timescale all of this will take place.**

Wellbeing (community)

162. Building on the suggested preventative model and patient-centred approach, respondents also said they want services to have a community wide approach to well-being. This includes clinical services, but also encompasses non-clinical services that impact on people’s health and welfare.

163. The Scottish Community Development Centre described this in their written submission:

> We believe that in order to be more preventative, primary care needs to invest in and harness the potential of community-led health. Community-led health is a way of improving health and wellbeing that starts with what people say is important to them. It follows the social model of health which recognises that our health and wellbeing results from factors including work, education, housing, leisure and the way we organise ourselves as a society. Community-led health organisations are focused on tackling inequality in all its forms. They involve people experiencing poverty as well as disabled, BME, LGBTQ people and others. [31]

164. To achieve this goal the Scottish Government are expanding the role of Community Link Workers (CLWs). CLWs have a role in assisting and directing individuals from clinical services into mainly non-statutory and voluntary services. CLWs are allocated to GP practices based on an assessment of local need and in line with

strategic priorities. It is for HSCPs in consultation with local partners to determine where CLWs should be placed, their key deliverables, and how many are required.

165. Within primary care there are high expectations of these new resources once deployed in areas of socio-economic depravation. The Alliance says:

> the investment in Community Link Workers is an example of how an ambitious multidisciplinary approach can work in practice and how the third sector can play a critical role in developing new roles and ways of working, supporting the delivery of a new vision of primary care'…(they) support people to build self-efficacy and self-determination and find things in their community that can help them to live well.

166. Some Health Boards have devised similar roles to CLWs in order to bolster their locally delivered services. For example, NHS Fife have introduced local area coordinators (LACs) in their more deprived communities to help redress health inequalities. They are employed by a local voluntary sector organisation and work collaboratively not just with the GPs surgery but across the whole Primary Care spectrum, identifying needs and referring people to the most appropriate support service.

167. A related point in relation to the necessity of the wider community role in addressing inequality was made by Dr Anderson (NHS Health Scotland) who told us that health inequalities:

> arise from unequal distribution of power, wealth and resource across communities and populations. Such differences give rise to differential experiences of the wide range of social determinants of health, including education, housing, employment, income and access to services. Those differential experiences underpin the differences in health among the population and individuals as well as giving rise to health inequalities. Primary care's ability to reduce health inequalities lies mainly at the mitigation end of the spectrum and is therefore limited. [32]

168. Other areas, highlighted to us in phase 1, emphasise greater use of community facilities and other community locations, with services being co-located and becoming multi-use. Examples were given of community hubs providing nutrition and cooking classes. Panels stressed the wider value of community places and neighbour networks making the point that loneliness does not only affect older people. All of these issues have increasingly come to the fore since the arrival of the pandemic.

Social Prescribing

169. We recognised that social prescribing is, in essence, a way in which people can receive non-medical support. We undertook a short piece of work in this area to complement this inquiry in the Autumn of 2019 and published our report "Social Prescribing: physical activity is an investment, not a cost" on 4 December 2019.

170. The report made clear our view that social prescribing has the potential to ease the current pressures on health and social care services, as well as reducing waiting

times, unplanned hospital admissions and delayed discharges. The report was debated [33] by Parliament on 18 February 2020.

171. In the Government's response to the first conclusion of our report, which stated "We are agreed and are clear that we do not require any further evidence in relation to the efficacy of physical activity on improving health and wellbeing. Direct correlation and causation has been proven and should be accepted by all sectors."

> The Scottish Government stated they "share[s] the Committee's view that evidence of the benefits of physical activity is abundantly clear. Being physically active is one of the best things we can do for our physical and mental health, helping to protect us from many of the most serious long-term health conditions, and contributing significantly to physical and mental wellbeing. [34]

172. In our subsequent report Supply and Demand for Medicines, published on 30 June 2020, we reiterated our position in relation to social prescribing, making a series of recommendations and requests of the Scottish Government.

173. Social Prescribing is a means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker - to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalised solutions, i.e. 'co-produce' their 'social prescription'. Thus, allowing people with social, emotional or practical needs to be empowered to find solutions which will improve their health and wellbeing, often using services provided by the voluntary and community sector. It is an innovative and growing movement, with the potential to reduce the financial burden on the NHS and particularly on primary care.

174. A key in improving the people of Scotland's physical and mental health and wellbeing is creating conditions for them to live healthy, active and independent lives in their local communities. The Scottish Government's National Performance Framework recognises health is dependent on a number of factors advocating a whole system approach to promoting good health. Increased wellbeing is central to the national outcomes in the framework. We observe this as a shift towards measures of social progress.

175. On 19 November 2019 we heard strong support for social prescription. It supports an active lifestyle, as well as having a positive impact on reducing mental health issues, e.g. by addressing loneliness. We heard about barriers to people interacting in localities and participating in community activities, especially for those from disadvantaged areas often relating to cost and access.

176. There are many organisations already operating in and around the primary care sector. ALISS (A Local Information System for Scotland funded by the Scottish Government) is intended to be the online database to enable organisations, communities and individuals to view services available in local areas. However, awareness of ALISS is poor and it is not kept updated. Either ALISS needs to be better deployed, or a new system to record and track third sector organisations needs to be devised. Without a verified list, it is understandable why GPs and other health professionals would be reluctant to recommend organisations to patients.

177. There were some positive examples where Integration Authorities are investing in physical activity programmes and working with local communities. For example,

Moray Health & Social Care Partnership have a range of initiatives aimed at increasing physical activity, including Be Active Life Long (BALL) Groups, created to improve mental and physical wellbeing in people over 60. Over 780 people attend BALL Groups on a weekly basis.

178. **Efforts must be made to make social prescription accessible to all, including making better use of existing community facilities (places of worship, school, community centres). We reiterate the recommendation made in our December 2019 report, Social Prescription, an investment, not a cost, that 5% of Integrated Authority budgets should be allocated for social prescription.**

179. The Scottish Government subsequently responded to the Supply and Demand for Medicines report on 23 November 2020 [35] including covering the questions we asked in relation to Social Prescribing. Unfortunately, many of the answers given in this area did not address the questions we posed and those that did provided vague or imprecise information.

180. **We ask the Scottish Government to revisit their responses to the questions posed and provide updated information covering, in particular to the issues set out in annex A of this report.**

Taking the public with the changes

181. In making such radical changes to the primary care offer as has been suggested – which marks a real cultural shift, for both professionals and the public – a national information campaign will be required. This will help in managing the expectation from the public on what can realistically be delivered. It should also provide health care professionals information on what is available to them in terms of assistance from AHPs and the third sector.

182. The ‘conversation’ must highlight the role of MDTs, that many AHPs can be used for self-referral and that not everything needs to be through or by the GP. We agree with Audit Scotland that the Scottish Government should "work with primary care professionals to develop a coordinated national approach to engaging with the public about the changes to how primary care services are delivered."

183. Without this type of campaign, the required transformation is unlikely to be successful. The BMA told us, without this type of campaign, the required transformation is unlikely to be successful "the lack of a national conversation about what kind of health service the public really wants is also a major barrier to delivering a sustainable primary care system."

184. The RCGP also comment that "we need a National Conversation, led jointly by politicians, healthcare professionals and patients, to promote sustainable use of the NHS. This urgently needs to happen followed by a public campaign to inform public."

185. **We recommend the Government lead work with GPs, HSCPs, Health Boards and the NHS on devising an information campaign to inform the public on what their primary care service will look like, what they can expect and when, consult them on their priorities and bring them along with the required transformation.**

Technology & Data Sharing

Phase 1 views

186. In Phase 1 the Committee heard many frustrations over a lack of modern technological systems, particularly the ability to record and share data. The public respondents felt strongly that technology needs to be better embraced to make it easier for primary care services users to utilise. They also saw advantages for health professionals in working more efficiently across and between teams to provide person-centred care.

187. Just over 75% of our survey responses said they would be happy for their data to be shared electronically, slightly more would use wearable devices to monitor activity levels and blood pressures, allowing information to be transmitted directly to GPs. More than 85% would be happy for their medical notes to be shared across the primary care team. 90% of respondents would be happy to use technology to order repeat prescriptions, and similarly high numbers would like to receive texts or email reminders of appointments.

188. One member of our panels summed up general frustrations of panel members and the public when asking why other sectors, such as banking, could effectively embrace technology, but the NHS could not?

189. Our phase 1 report summarised the priorities in this area from the panels as follows:

- Electronic patient record, shared with all relevant professionals – a single set of records integrated across all care services – consistent platform, used for electronic test results, correspondence, etc;
- Ability to contact health professionals by email and schedule appointments online, hold consultations via video;
- Using technology/wearables to monitor health e.g. blood pressure, diabetes and sharing information with relevant professionals.

Background and previous committee activity

190. Throughout every inquiry we have undertaken this session we have considered technology, and its ability to be a game-changer within primary care, and the failure to deliver this has been a critical issue delaying progress.

2017 Committee Inquiry

191. There has been much discussion and debate about the role digital technology could and should play in health and social care and in furthering the preventative agenda. In 2017, we undertook an inquiry into Technology and Innovation in Health and Social Care.

192. As part of that work we heard about a number of potential opportunities for the use

of technology in health and social care such as remote and self-monitoring, the use of analytics and artificial intelligence, access to information and the development of telehealth and video consultations. Key issues for primary care included data sharing, communication, access to patient records and the development of an electronic patient record.

193. In our report we noted that “Probably without exception in every inquiry and piece of work we have undertaken the sharing of data has been raised as both a barrier and an impediment. From prisons to pharmacists, from GPs to emergency care we have heard about the inability to share data”.

Similarly our recent report on medicines noted significant concerns about the lack of collection of data and the inability to utilise and share information.

194. Further we noted “a disconnect between Scottish Government strategies and local delivery and unwanted variation between NHS boards.”

195. We recommended the Scottish Government takes a "once for Scotland" approach to the implementation of its forthcoming Digital Health and Social Care Strategy. Adding that “the responsibility for the success of this Strategy lies with the Scottish Government and as such they must take the lead strategic role in its delivery."

196. We were also clear more was required to be done by the Scottish Government to increase the use of technology across NHS boards and social care. Adding “this cannot be left to be agreed on a board by board basis. Such a piecemeal process leads to increased variation in health outcomes across Scotland."

197. Our 2017 report also noted:

> It is no longer acceptable in this age that our health service is still using multiple, incompatible systems and various platforms. In all our work we have heard repeated concerns around data sharing and interoperability. Nurses, pharmacists, allied health professionals, social care services, primary care services, prison health services and more all highlighting the fact they do not have timely access to relevant health records. This is an area the Scottish Government must tackle urgently to ensure appropriate medical care can be given in the right place at the right time. Work must be done to update systems so they can interact, whilst work must also be carried out to ensure data protection requirements and opportunities to share data are better understood.

198. Many of the barriers identified as part of the Technology and Innovation Inquiry persist and have been raised in written submissions to the Primary Care Inquiry.

Scottish Government activity

199. In response to our call for evidence on our technology inquiry a joint submission was made by the health professions working in primary care. “Principles for a technology-enabled health and social care service: A view from the health professions working in primary care”. This stated that:

> It is clear to us that the transformation of primary care with a wider primary care team cannot be achieved without the sharing of information amongst health and social care professionals and their teams.

200. It went on to say that a number of key areas need to be addressed. Namely, the need for a collaborative approach, the importance of confidentiality and consent, improving patient outcomes, the importance of a "once for Scotland" approach and the role of information governance.

201. In April 2018, the Scottish Government published its Digital Health and Care Strategy. This strategy proposed six priority areas of work:

- National direction – establishing a joint decision-making Board from national and local government and the NHS, supported and advised by industry, academia and the third sector to achieve greater consistency, clarity and accountability;
- Information governance, assurance and cyber security – ensuring appropriate safeguards are in place for the management of data and ensuring consistency in decision-making about sharing information;
- Service transformation – a clear, national approach to service redesign and the scaled-up adoption of successful models such as home and mobile health and care monitoring;
- Workforce capability – recognition that leadership and workforce development in digital skills and capability underpin successful uptake and use of digital technology;
- National digital platform – commitment to the interoperability of systems by developing a national Health and Social Care services digital platform through which real-time data and information from health and care records is available to those who need it, when they need it, wherever they are, in a secure and safe way;
- Transition process – a recognition of the need to improve and upgrade existing systems to contribute to future developments, with a joint approach required between NHS National Services Scotland and the Local Government Digital Office to ensure that existing systems continue to work effectively. (eHealth website).

202. In April 2018, the Scottish Government also published the Report of the independent external expert panel, which informed the Digital Health and Care in Scotland strategy. The independent panel of UK and international experts was asked to advise the Scottish Government on how digital technology can support Scotland's aim for high quality health and social care services with a particular focus on prevention, early intervention and supported self-management.

203. Amongst its findings the expert panel noted on governance that “the current approach has led to a great deal of variation across Scotland which creates a number of issues, in particular impeding interoperability and data exchange”.

204. That report of the independent expert panel further stated, ‘having a robust

information governance structure is of central importance for both achieving transformational change and maintaining citizen trust'. It should be an enabler to a more effective PC system.

205. The External Expert Panel recommended the following actions:-

Within a year, the Panel proposes that the following actions could be taken:

- Appointment of a national Chief Clinical Information Officer (CCIO), Chief Technology Officer (CTO) and local CCIOs;
- National approach agreed in regards to Information Governance;
- A national financial plan for IT in health and social care will have been developed;
- Infrastructure plan in place looking at key infrastructure developments to aid implementation;
- The CHI number to be standardised across Scotland;
- Digital maturity assessment completed across health and social care services;
- Develop a public awareness plan as well as a short summary of the strategy targeted to people who are not fully aware of the on-going work.

Within three to five years, the Panel proposed that the following actions could be taken:

- Every Scottish citizen will have a near real-time personalised view of their information to which they can contribute;
- Online booking of appointments should be in place;
- All primary, community, hospital, and social services should offer access a citizen facing services platform which is underpinned by a common approach to data integration/ sharing;
- All CCIOs will have had specific digital training.
- Standards will be in place for all key types of health data;
- There will be agreement around a clinical data summary which can be exchanged among Health Boards and IJBs;
- Half of encounters for chronic conditions and acute complaints in the outpatient setting will be, if the patients so desire this, virtual;
- Multiple digital innovation centres will be in place in Scotland with clear evidence that innovation has been catalysed;
- A Scotland-wide infrastructure for research will be in place that is closely aligned with the needs of the NHS, social care and public health, and which will enable researchers to make queries across the entire Scottish population among those who have opted to participate in near real-time.

206. **While we recognise some actions will have been completed, and the following section of this report will update with information we have received since Covid struck, we ask the Scottish Government for an update on each of the above recommendations. For each of those which have not been implemented and/or are not fully functioning, the update should detail the reasons and provide the expected date when implementation will have been completed.**

What we heard in part 2 of this inquiry

207. We received a number of submissions commenting on this area and heard directly from witnesses on 5 November 2019. We heard detail of development activities taken place and plans and proposals to deliver change. We also heard quite forcibly that transformational change is required which can in the health service take from 5 to 10 years, with much of that period spent on taking people with the change.

208. A number of obstacles were highlighted to us. QNIS suggested "current IT systems are obstructive in moving forward with integrated ways of working, particularly around shared access to relevant information' with 'multiple records held by different agencies having an impact on patient safety and staff agility in rural and urban areas."

209. NHS Greater Glasgow and Clyde made the obvious point of the need for a "shared /single IT system across primary care including links to other systems, that provides safe and effective care and provides data for monitoring and evaluation."

210. The public responses clearly highlighted the public is largely comfortable with a more digitised approach, including sharing of data amongst healthcare professionals. The question the public are asking is, - why is the health sector, including primary care, so slow in making its services more accessible for its 21st century citizens?

211. In its submission, NHS24 referred to 'Primary Care Digital Services', which it hopes will provide a nationally assured consistent 'digital front door' to (as part of a test of change) a number of practices with the intention of scale-up to a nationally consistent approach. The NHS 24 Digital Strategy: 2019/20 – 2021/22 states that it is:

> aspiring to deliver a 'front door' into health and care services in Scotland, through a future version of NHS inform. This also would align with the development of GP websites, which NHS 24 is taking forward. Enabling consistent access to services at a local (GP practice) and national (NHS Inform) level, ensuring inter-operability with the national digital platform.

212. There is a recognition of the need to improve and upgrade existing systems to contribute to future developments. This requires a joint approach between NHS National Services Scotland and the Local Government Digital Office to ensure that existing systems continue to work effectively. (eHealth website).

213. As indicated elsewhere in this report, there also needs to be a cultural shift in how to deliver primary care services online. The Digital Health and Care Institute (DHI) submission commented that:

> to create a more sustainable system, the NHS must move from a role in implementing these technologies to instead fulfil a role that stimulates and then assures a marketplace of technology providers and community carers.

214. DHI noted this would require "The NHS to provide a 'digital front door' to these actors, allowing them to integrate their technologies with clinical systems. The National Digital Platform, developed by NES Digital Service, could provide this service."

215. The DHI submission notes that:

> overall Home and Mobile Health Monitoring technologies are not being fully capitalised upon" and that "Focusing further on the use of digital technologies in the remote monitoring of long-term conditions, there are opportunities to engender multi-disciplinary team working while moving to an outcomes-based service and business model.

216. We heard a lack of strategic investment in IT appears to be one of the factors behind the lag in modernising IT infrastructure, with only 1-3% of the health budget being allocated for IT. As a comparator, countries such as Estonia and Finland are spending between 5-7% of health budgets on IT. As Chaloner Chute from DHI commented:

> we are paying for information technology support but not digital development. 36

217. **We ask the Scottish Government to set out its expectations of the role of Health Boards and the IJB's in developing and implementing new IT systems and ways of working and how consistency across the country can be assured.**

218. **We ask the Scottish Government and Health Boards if they believe their current IT investments are adequate for the services they aspire to provide? And we ask them to indicate how they evaluate and measure the strategic value received from digital investment and how they will ensure IT spending on IT infrastructure increases to at least 4%.**

219. **We also request the Scottish Government to provide a clear timeline on when they expect the "One for Scotland" approach to be fully operational.**

220. The NHS in Scotland 2019 report recommended the Scottish Government, in partnership with NHS boards and integration authorities, should "develop a new national health and social care strategy to run from 2020 that supports large-scale, system-wide reform, with clear priorities identifying the improvement activities most

likely to achieve the reform needed". We asked the Cabinet Secretary what steps the Government are taking to meet this recommendation, and what are the anticipated timescales for this?

221. In a follow up letter to the Committee [37] the Cabinet Secretary indicated the Scottish Government had work underway and would "set out our next steps in due course" indicating "We are also currently finalising a review of our progress against the delivery plan, and we will communicate this in due course."

222. **We ask the Scottish Government when the new strategy will be published and what evaluation of success of the 2020 strategy has been undertaken. We also seek an indication of when the strategy will be delivering outcome data relating to the use of medicines.** [38]

223. We also asked the Scottish Government what steps are being taken to ensure developments in technology are accessible to everyone in the country. And we were advised that the:

> "Digital Health and Care Strategy highlights the opportunities that technology offers to empower citizens to better manage their health and wellbeing, support independent living and gain access to services through digital means, and to support a shift in the balance of care. The Scottish approach to Service Design is being adopted for services, with citizen engagement that enables the co-design of products and services that meet their needs and delivers sustainable, fit for purpose service models.

224. **We ask the Scottish Government to update progress on this empowerment and indicate when the new service delivery models referred to will be delivered and available to the public?**

225. At various times during our work this session we have heard about a tension between ensuring patient data protection security and IT was butting against ease of working and sharing of data between professionals.

226. **We ask the Scottish Government the extent to which this remains the position and how such tensions are being addressed.**

Impact of Covid-19 on Data and Technology

227. On 6 July the Cabinet Secretary wrote to us with an update on the use of digital in response to Covid-19. Her letter said digital was a key priority moving forward, to build on the rapid implementation of video consultations and remote working. The letter indicated the introduction of *Near Me* consultations had transformed how many services are delivered, with an initial increase from 300 patient consultations per week pre-Covid to close to 17,000 per week. Also noting a shift in traditional acute sector care and treatment into community settings. We agreed within this report it was necessary for us to consider evidence received as part of work we

undertook during the first lockdown which reflects the significant changes in the use of data and technology that occurred.

228. We took evidence from Elinor Mitchell, Interim Director General of Health and Sport as part of our budget 21/22 inquiry on 11 August 2020. In a written response following that meeting, she told us "A shift to virtual appointments in recent months has allowed us to maintain services while supporting people in their homes." Adding the use of *Near Me* along with telephone consultations "will continue to be a core component in delivering modern health and care services going forward."

229. In a wider vein we were told in the above reply "Our digital response to Covid-19 has also included supporting changes to the way our health and care staff work. We were able to quickly roll-out Microsoft Teams across our entire NHS workforce which has supported people to work remotely from home and has allowed for greater collaboration across organisations." [39]

230. We heard from a number of witnesses that in Primary Care, *Near Me* enabled video consulting to be available in nearly every GP practice as well as social work teams and care homes across Scotland.

231. The report “Scotland’s digital health and care response to Covid-19" [40] details progress made enabling people to access secondary care services remotely in areas such as haematology, oncology, mental health, obstetrics, paediatrics and respiratory.

232. We heard from the then Minister from Public Health [41] about resistance to moving to some new ways of working prior to the pandemic, such as *Near Me*, not just by patients but by service providers. With some indicating “That won’t work. I need to see all my patients face to face” or “No, I need to see the doctor directly.”

233. But, because of the pandemic, people started to realise the real potential of the new ways of working. The Minister also gave the example of *Near Me* to highlight a dramatic speeding up of the roll out of technology; changes had been planned with the expectation of taking around two years to deliver. Because of the pandemic, this was delivered in six weeks.

234. The Minister added he did not think people will want to go back from the range of benefits discovered. With patients being seen more efficiently and spending 15 minutes on a 15-minute appointment without having to travel to a surgery, wait and then return to work.

235. The Cabinet Secretary agreed [42] pointing to a survey with clinicians who had used the *Near Me* service, primarily in primary care, showing patients overwhelmingly preferred that way of consulting their clinician or GP.

236. **We applaud the widespread adoption of Near Me and ask the Scottish Government to indicate how this is being monitored and evaluated. In particular, what steps are being taken to ensure its use is patient-centred and not simply being adopted to meet the needs of clinicians? We recognise the significant benefits that can accrue from its use as a triage tool but have reservations that a default use may widen health inequalities**

and ask the Scottish Government how this potential problem is being addressed.

Health Boards

237. We also heard directly from Health Boards about the use and benefits of *Near Me*. Jane Grant from Greater Glasgow and Clyde (GGC) told us they had moved a lot of services across the Board area onto the digital *Near Me* facility, receiving good feedback from patients. They were looking to further increase capacity and maximise its huge potential, across all specialties, including mental health and allied health professional services. She also referred to *consultant connect*, which allows GPs to talk directly to consultants within the hospital. Indicating this “has proven to be a positive direct access route for GPs and primary care colleagues.” She indicated a desire to augment some of the remote monitoring processes, stating there was much to do in that arena as well. [43]

238. In other areas GGC, because a lot of out-patient activity requires phlebotomy and blood tests, had set up acute phlebotomy hubs. This was giving patients the opportunity to go to a range of acute sites to have their blood taken along with a virtual consultation. They were looking to take that approach into the community. [44]

239. Alternatives to endoscopy were being looked at to provide additional options for patients. They told us they have established two mental health assessment units, to which people access directly.

240. Jane Grant also indicated a need for more e-health resource in order to move increasingly into the digital world. Although she sounded a note of caution about assuming such an approach suits everyone. [45]

241. NHS Lothian also indicated they have used *Near Me*, with Calum Campbell, chief executive, giving the example of increasing use in nursing homes allowing patients to be maintained there instead of moving in and out of the acute sector. He also indicated an increasing use of remote monitoring, also reducing the need for some patients to attend hospital.

242. Like GGC, Lothian noted the need to spend more money on information technology and the need for care around digital exclusion. Indicating "as we invest in the health service, we have to be aware that we do not drive inequalities in a different way." [46] On evaluation of new technology Lothian indicated a need to use it at a regional or national scale in order to drive the biggest benefits, flexibility and standardisation and to avoid confusion for patients moving between Boards.

243. The benefits for patients from using *Near Me* consultations were explained by Hazel Borland of NHS Ayrshire and Arran, who having told us of an increase in usage added it will continue to be used. Patients have responded positively, liking the ability to have a telephone consultation or an NHS Near Me consultation. Benefits reported included removal of the stress of driving to and parking at the facility. For a number of patients and families this had reduced anxiety and having a consultation

from the safety of their living room was welcomed. [47]

244. The use of virtual and digital ways of connecting with patients was also reported by NHS Ayrshire and Arran as one releasing clinical time. In addition, staff found some virtual consultations, allowed the patient and their clinical team to interact differently, resulted in some having more time dedicated to them, which was valued by patients. *Near Me* had also proved successful for mental health specialties enabling mental health community teams and specialties to stay in touch with patients. Equally, we were told, the benefits had been felt by surgical and medical specialties, while clinical nurse specialists and allied health professions have also found it to be valuable.

245. Hazel Borland told us "There is no doubt that the reduction of travel, mileage and travel expenses will have an impact, and we will be able to measure the difference that that is making for our clinical teams and patients." [48]

246. In response to our report into the Supply and Demand for Medicines the Scottish Government indicated Remote Blood Pressure Monitoring (tele-monitoring) remains a priority. It having been extremely popular with practices, particularly during the pandemic where it is seen as the means of managing the condition remotely.

247. We were advised, that to date, the programme has supported the remote diagnosis and management of hypertension for over 13,000 patients, with 423 GP practices offering remote hypertension management available across 13 Health Boards. As well as proving effective in reducing blood pressure it was also reducing workload on GP's and nurses with scope for this to be utilised even further.

Data ownership

248. The issue of data ownership featured prominently in the inquiry. The public's desire for this was to curb the need for patients to explain to each and every health professional what their problem is.

249. Out of all the sessions we held the GP panel was the only one which questioned whether individuals should have sole ownership, with Dr Andrew Buist from the BMA suggesting "it is the patient's data, but GPs and boards are the joint data controllers."

250. The public were very clear in their assertion they should be the sole owner of their personal medical data. Hugh Dunn, from the Cambuslang panel suggested data was the patient's and it was their decision on who they wanted to share it with. Geoff Huggins, NES Digital Service agreed "data relating to the citizen and the individual is the citizen's data." [49]

251. This view was echoed by the Cabinet Secretary "My view is that the ownership of the data should absolutely be with the patient."

252. The Information Commissioner's Office (ICO) has issued a statement that whilst they had previously considered GPs to be sole data controllers of their patient records; they now accept that GPs and their contracting Health Boards have joint data controller processing responsibilities towards the GP patient record.

253. We were also advised the new GMS contractual provisions in Scotland supports ICO's position that GPs are not the sole data controllers of the GP patient records but are joint data controllers along with their contracting NHS Board.

> The contract will clarify the limits of GPs' responsibilities and GPs will not be exposed to liabilities relating to data outwith their meaningful control.

254. **We recommend the Scottish Government take steps to ensure the Cabinet Secretary's view on the question of data ownership is reflected in reality, either in terms of the second stage of the GMS contract or in the roll-out of the Government's e-health plans.**

Conclusions

255. Our inquiry has been driven by our work in hearing from the public what primary care services they want, need and require. During the course of our inquiry the delivery of Primary Care has been significantly affected by COVID-19 both constructively and negatively.

256. Current delivery methods and models are financially unsustainable, they have not kept pace with modern living. Primary Care requires radical revision to ensure our citizens receive the primary care they want, need and require for the next generation and beyond.

257. A focus on prevention needs to be prioritised and mainstreamed across all areas of the health service and indeed beyond.

258. Place is central to the delivery of good health. There is a clear need and desire for connected communities, with spaces that give people opportunities to become active and socialise, where people are connected to others and to the local natural environment. The role of the HSCP is central to this and their locality planning is an essential element which requires to meaningfully involve the public at large and drive this change.

259. Undertaking a preventative approach in a serious and sustainable way will require the whole of government to contribute. We recognise work is needed to invest in local environments to create the essential conditions needed for people to live healthy lives and that this is not solely a health service issue. The public were clear of the need for a cross government approach; In Education, introducing healthy lifestyle and knowledge of food and nutrition into the curriculum. In Local Government to allow planning for cycle tracks in villages, towns and cities, allowing communities to utilise schools, places of worship and community centres as places in which all can exercise. In Infrastructure, to ensure new initiatives do not impinge on and reduce green spaces.

260. A fundamental shift is required in General Practice. As set out in the new contract, GPs require to relinquish their role as the deliverer of all services with recognition other health professionals will be better placed and equipped to help and support people. GP practices, clusters and hubs should be required to meet the needs of their patients at a time and place that suits them. It is essential that the value obtained through GP services is measured.

261. The days of the 9-5 service, 5 days a week in primary care should be consigned to history.

262. Focus should shift towards prevention and away from the automatic provision of a prescription. Patients must however be required to take more responsibility for their own health, with social prescribing becoming much more of the norm across the board.

263. We acknowledge the Government's commitment to increase GP numbers is intended to strengthen primary care, but it appears to reflect the position before agreement on the new contract, with its much greater emphasis on the Multi-Disciplinary Team. We recommend this commitment is recast, to commit to an

appropriate number of MDT professional staff, including both GPs and other professions, which can deliver the intended benefits to primary care as a whole.

264. The health service must now embrace new technology, stop talking about what they are going to do and start delivering a 21st century system to patients. Historical divisions between areas, specialities and divisions must be removed, patient records shared with all health professionals. Technology should be available for use by the public, should they choose to utilise it, in as many areas as possible giving patients the opportunity to be seen and monitored remotely. The default option should always be the availability of remote monitoring. Appropriately levels of funding should be made available to enable the delivery of these services on a once for Scotland basis.

265. The public do not distinguish between different professionals when receiving care and rightly expect all to have up to date information available covering their conditions, treatment and medicines.

266. The public have no interest in the division of services between primary and secondary care, indeed many were unaware of what seems to be an artificial, historical and unnecessary construct. Their interest lies in the results and improvements delivered to their health, by whichever people are delivering care and support.

Annexe A

Follow up questions on social prescribing

267. We ask the Scottish Government to provide further information on its response dated 23 November 2020 to our report on the Supply and Demand for Medicines. In particular we ask for answers to the following questions we originally asked in relation to social prescribing.

- **Progress in establishing the short life working group to examine social prescribing of physical activity, its remit, membership and deadline for completion of its work;**
- **Progress in establishing tracking monitoring arrangements for the new pharmacotherapy service introduced as part of the 2018 GMS contract and when the first report on this will be available**;
- **How many Community Link Workers are now in post**;
- **Details of the process under which Link Workers have been allocated and which practices they have each been associated with;**
- **When the first monitoring report of the new GMS contract will be available showing progress in this area;**
- **What training is provided to health professionals including specifically GPs to ensure they are competent in the areas set out in the WHO Global Action Plan for Physical Activity**;
- **What evidence they base the statement upon that "We believe that we continue to make progress on social prescribing and changing the culture of the way healthcare is practised in Scotland" with specific reference to social prescribing;**
- **Where the data required under National Physical Activity Pathway guidance is reported and published in line with the guidance produced by NHS Health Scotland and how the results are being monitored and compared across Health Boards**;
- **Confirmation the e-learning module "Encouraging and Enabling Physical Activity" which supersedes the e-learning module "Raising the issue of Physical Activity has been launched and details of usage to date;**
- **When production of the delayed Quality Standards for Physical Activity Referrals will be completed and published**;
- **When the evaluation of mPower designed to create cross-border services for older people living with long term conditions will be concluded and reported**;
- **When the blood pressure taskforce will report its findings and when the various evaluation studies in progress will be reported;**

- **What targets have been set for the various programmes established to support and build capacity among community organisations who are contributing to improve the health and wellbeing of people in Scotland, what monitoring and evaluation is taking place and what progress has been made since the targets were established;**

- **When ALISS will be brought up to date**;

- **While recognising it takes time for the impact of interventions under the healthy living strategy to prevent ill health and reduce health inequalities to be realised, what measures have been established to enable this to be undertaken and when does the Scottish Government expect information to be reported. In particular, when will the effects of the current pandemic in these areas be reported;**

- **When the 2013 audit of school sport facilities will be updated and what progress has been made since that audit in widening access to school facilities**;

- **Having recognised the importance of long-term funding stability for the third sector when will the Scottish Government start allocating them three-year contracts**;

- **When Integration Authority strategic plans covering social prescribing will be reviewed.**

Annexe B

Extracts from the Minutes of the Health and Sport Committee Meetings

21st Meeting, 2019 (Session 5) Tuesday 24 September 2019

1. Primary Care Inquiry - Phase Two: The Committee took evidence from—

- Kim Hartley Kean, Head of the Royal College of Speech and Language Therapists' Scotland office, representing the Allied Health Professions Federation Scotland;
- Sara Conroy, Professional Adviser, The Chartered Society of Physiotherapy;
- Alison Keir, Policy Officer Scotland, Royal College of Occupational Therapists;
- Joanna Instone, Head of External Affairs, British Dietetic Association;

and then from—

- Theresa Fyffe, Director, Royal College of Nursing Scotland;
- Dr David Chung, Vice President, Royal College of Emergency Medicine Scotland;
- Clare Cable, Chief Executive and Nurse Director, The Queen's Nursing Institute Scotland.

3. Primary Care Inquiry - Phase Two (in private): The Committee considered the evidence heard earlier in the meeting.

22nd Meeting, 2019 (Session 5) Tuesday 1 October 2019

2. Primary Care Inquiry - Phase Two: The Committee took evidence from—

- Jonathan Burton, Chair, Scottish Pharmacy Board, Royal Pharmaceutical Society;
- Matt Barclay, Director of Operations, Community Pharmacy Scotland;
- David McColl, Chair of the Scottish Dental Practice Committee, British Dental Association;
- David Quigley, Chair, Optometry Scotland;

and then from—

- Dr Andrew Buist, Chair of the Scottish GP Committee, BMA Scotland;
- Dr Carey Lunan, Chair, the Royal College of General Practitioners Scotland;
- Dr David Hogg, Portfolio GP, the Rural GP Association of Scotland;
- Karen Murphy, member of the Rural and Remote Patients Group, and signatory on Petition PE01698, Medical Care in Rural Areas;

- Dr Anne Mullin, Chair, The Deep End GP Group;
- Dr Amjad Khan, Director of Postgraduate General Practice Education, Scotland Deanery, NHS Education for Scotland.

3. Primary Care Inquiry - Phase Two (in private): The Committee considered the evidence heard earlier in the meeting.

23rd Meeting, 2019 (Session 5) Tuesday 8 October 2019

1. Primary Care Inquiry - Phase Two: The Committee took evidence from—

- Ainsley Dryburgh, Local Area Co-ordinator, Fife Forum, Fife Health and Social Care Partnership;
- Caroline Cherry, Service Manager, Adult Assessment & Partnership, Communities and People, Clackmannanshire and Stirling Health and Social Care Partnership;
- Gerry Power, Director of Integration, the ALLIANCE;
- Dr John Anderson, Organisational Lead for Primary Care, NHS Health Scotland;
- Anne Crandles, Social Prescribing/Community Link Worker Network Manager, NHS Lothian;

and then from—

- Claire Stevens, Chief Executive, Voluntary Health Scotland;
- Susan Paxton, Head of Programmes, Scottish Community Development Centre;
- Gail Anderson, Chief Executive, Voluntary Action Orkney;
- Suzanne Martin, Senior Public Affairs Officer, SAMH (Scottish Association for Mental Health);
- Jane Cumming, Director of Services and Innovation, Penumbra.

5. Primary Care Inquiry - Phase Two (in private): The Committee agreed to defer consideration of evidence heard earlier in the meeting, and from its meeting on 1 October, to the next meeting scheduled for 29 October.

24th Meeting, 2019 (Session 5) Tuesday 29 October 2019

8. Primary Care Inquiry - Phase Two (in private): The Committee considered evidence heard on the 1 and 8 October 2019 on its Primary Care Inquiry - Phase Two.

25th Meeting, 2019 (Session 5) Tuesday 5 November 2019

1. Primary Care Inquiry - Phase Two: The Committee took evidence from—

- Scott Heald, Associate Director (Data Management & Strategic Development), Information Services Division Scotland, NHS National Services Scotland;
- Lynne Huckerby, Director of Service Development, NHS24;

- Geoff Huggins, Director, NES Digital Service;
- Chaloner Chute, Chief Technology Officer, Digital Health and Care Institute;
- William Edwards, eHealth Director, NHS Greater Glasgow and Clyde;

and then from—

- Jeane Freeman, Cabinet Secretary for Health and Sport;
- Aidan Grisewood, Deputy Director, Primary Care;
- Naureen Ahmad, Head of GP Contract and Implementation; and
- Phillip McLean, Patient Engagement/Health Inequalities Team Leader, all Scottish Government.

2. Primary Care Inquiry - Phase Two (in private): The Committee considered the evidence heard earlier in the meeting.

27th Meeting, 2019 (Session 5) Tuesday 19 November 2019

5. Primary Care Inquiry - Phase Two: The Committee took evidence, in a roundtable format, from—

- George Burton, Healthcare user;
- Stacey Smith, Healthcare user;
- Iain Laing, Healthcare user;
- Adedokun Adenipekun, Healthcare user;
- Martin Misovic, Healthcare user;
- Craig Henderson, Healthcare user; Hugh Dunn, Healthcare user.

7. Primary Care Inquiry - Phase Two (in private): The Committee deferred consideration of the evidence heard earlier in the meeting.

Annexe C

Written evidence

- HS/S5/19/PC/1 Dr Richard Weekes, Ullapool Medical Practice
- HS/S5/19/PC/2 Dr Miles Mack
- HS/S5/19/PC/3 Sue Ryder
- HS/S5/19/PC/4 East Dunbartonshire Health and Social Care Partnership
- HS/S5/19/PC/5 Western Isles Integration Joint Board
- HS/S5/19/PC/6 British Dental Association Scotland
- HS/S5/19/PC/7 Deep End GP Group, Scotland
- HS/S5/19/PC/8 Community Pharmacy Scotland
- HS/S5/19/PC/9 The Royal College of Emergency Medicine Scotland
- HS/S5/19/PC/10 Philip Wilson, Professor of Primary Care and Rural Health, University of Aberdeen
- HS/S5/19/PC/11 Ascensia Diabetes Care
- HS/S5/19/PC/12 Allied Health Professional Directors Scotland Group
- HS/S5/19/PC/13 Glasgow City Health and Social Care Partnership
- HS/S5/19/PC/14 NHS Orkney
- HS/S5/19/PC/15 NHS Grampian, Optometry perspective
- HS/S5/19/PC/16 Optometry Scotland
- HS/S5/19/PC/17 BMA Scotland
- HS/S5/19/PC/18 Renfrewshire Health and Social Care Partnership
- HS/S5/19/PC/19 NHS Near Me, NHS Highland
- HS/S5/19/PC/20 Dundee Health and Social Care Partnership
- HS/S5/19/PC/21 deafscotland
- HS/S5/19/PC/22 Royal College of Physicians of Edinburgh
- HS/S5/19/PC/23 Chest Heart & Stroke Scotland
- HS/S5/19/PC/24 Clackmannanshire and Stirling Health and Social Care Partnership
- HS/S5/19/PC/25 Royal College of General Practitioners Scotland (RCGP Scotland)

- HS/S5/19/PC/26 British Dietetic Association (BDA) Scotland Board
- HS/S5/19/PC/27 NHS Ayrshire and Arran and East, North and South Ayrshire Health and Social Care Partnerships
- HS/S5/19/PC/28 Faculty of Sexual and Reproductive Healthcare (Scotland Committee)
- HS/S5/19/PC/29 The Royal College of Speech and Language Therapists
- HS/S5/19/PC/30 NHS Grampian, Health and Social Care Moray, Aberdeen City and Aberdeenshire Health and Social Care Partnerships
- HS/S5/19/PC/31 Healthcare Improvement Scotland
- HS/S5/19/PC/32 The College of Podiatry
- HS/S5/19/PC/33 The Company Chemists' Association
- HS/S5/19/PC/34 Royal Blind and Scottish War Blinded
- HS/S5/19/PC/35 NHS Education for Scotland
- HS/S5/19/PC/36 Marie Curie
- HS/S5/19/PC/37 Dr Helene Irvine
- HS/S5/19/PC/38 Glasgow Local Medical Committee
- HS/S5/19/PC/39 Dr Alison Clement, Angus Health and Social Care Partnership
- HS/S5/19/PC/40 South Lanarkshire Health and Social Care Partnership
- HS/S5/19/PC/41 Diabetes Scotland
- HS/S5/19/PC/42 Dr Stephen McCabe
- HS/S5/19/PC/43 General Medical Council
- HS/S5/19/PC/44 Hospice UK
- HS/S5/19/PC/45 MS Society
- HS/S5/19/PC/46 NHS 24
- HS/S5/19/PC/47 NHS Greater Glasgow and Clyde
- HS/S5/19/PC/48 NHS Health Scotland, Information Services Division and Health Protection Scotland
- HS/S5/19/PC/49 NHS NSS
- HS/S5/19/PC/50 NHS Scotland Directors of Pharmacy Group
- HS/S5/19/PC/51 Office for Statistics Regulation

- HS/S5/19/PC/52 Primary Care Clinical Professions Group
- HS/S5/19/PC/53 Royal Pharmaceutical Society in Scotland
- HS/S5/19/PC/54 Scottish Ambulance Service
- HS/S5/19/PC/55 Scottish Care
- HS/S5/19/PC/56 Scottish Partnership for Palliative Care
- HS/S5/19/PC/57 Scottish Public Services Ombudsman
- HS/S5/19/PC/58 Aberdeen City Health and Social Care Partnership
- HS/S5/19/PC/59 British Healthcare Trades Association
- HS/S5/19/PC/60 Edinburgh Health and Social Care Partnership
- HS/S5/19/PC/61 Dr Alastair Noble
- HS/S5/19/PC/62 Macmillan Cancer Support
- HS/S5/19/PC/63 Chartered Society of Physiotherapy Scotland
- HS/S5/19/PC/64 Clinical Primary Care Lead Group
- HS/S5/19/PC/65 National Pharmacy Association
- HS/S5/19/PC/66 RCN Scotland
- HS/S5/19/PC/67 Royal College of Paediatrics and Child Health Scotland
- HS/S5/19/PC/68 Royal College of Occupational Therapists
- HS/S5/19/PC/69 Royal Society of Edinburgh
- HS/S5/19/PC/70 COSLA
- HS/S5/19/PC/71 Scottish Directors of Public Health
- HS/S5/19/PC/72 Penumbra
- HS/S5/19/PC/73 SAMH (Scottish Association for Mental Health)
- HS/S5/19/PC/74 Health and Social Care Alliance Scotland (the ALLIANCE)
- HS/S5/19/PC/75 NHS Fife
- HS/S5/19/PC/76 Voluntary Health Scotland
- HS/S5/19/PC/77 The Queen's Nursing Institute Scotland
- HS/S5/19/PC/78 Voluntary Action Orkney
- HS/S5/19/PC/79 Scottish Community Development Centre (SCDC)
- HS/S5/19/PC/80 Digital Health and Care Institute

- HS/S5/19/PC/81 Scottish Communities for Health and Wellbeing

Annexe D

Supplementary written evidence

Additional information received following the evidence session on 8 October 2019:

- Voluntary Health Scotland - Additional information 11 October 2019

Additional information received following the evidence session on 5 November 2019:

- Information Services Division, NHS National Services Scotland
- NES Digital Service
- Digital Health and Care Institute

Annexe E

Correspondence

The Auditor General for Scotland published the following report on 29 August 2019:

- NHS workforce planning - part 2: The clinical workforce in general practice

The Public Audit and Post-Legislative Scrutiny (PAPLS) Committee considered the report at its meeting on 12 September 2019. Following consideration of the report, the Convener of the PAPLS Committee wrote to the Health and Sport Committee to highlight key issues arising from its scrutiny to help inform Phase 2 of its Primary Care inquiry:

- Letter from Jenny Marra MSP, Convener of the PAPLS Committee to Lewis Macdonald MSP, Convener of the Health and Sport Committee - 7 October 2019

Further to the Cabinet Secretary for Health and Sport's evidence session on 5 November 2019, the Convener issued a letter following up on a number of points raised during the meeting:

- Letter to the Cabinet Secretary for Health and Sport from Lewis Macdonald MSP, Convener of the Health and Sport Committee - 12 November 2019

On 26 November 2019 the Cabinet Secretary for Health and Sport responded to the Convener's letter of 12 November:

- Letter from the Cabinet Secretary for Health and Sport to Lewis Macdonald MSP, Convener of the Health and Sport Committee - 26 November 2019

Annexe F

Official Reports of meetings of the Health and Sport Committee

- Tuesday 24 September 2019 - evidence from stakeholders
- Tuesday 1 October 2019- evidence from stakeholders
- Tuesday 8 October 2019 - evidence from stakeholders
- Tuesday 5 November 2019 - evidence from stakeholders and Scottish Government
- Tuesday 19 November 2019 - evidence from public panel participants

1 https://www.nhsresearchscotland.org.uk/research-areas/primary-care

2 Audit Scotland health inequalities Report page 10 https://www.audit-scotland.gov.uk/uploads/docs/report/2012/nr_121213_health_inequalities_0.pdf

3 Scottish Government's vision for the future of primary care services

4 Audit Scotland Report November 2018: Health and social care integration, Update on progress

5 SPICe Briefing: Primary Care in Scotland

6 £1.0358 Billion

7 Scottish Government response to the Supply and Demand for Medicines report, 23 November 2020, paragraph 51

8 Health and Sport Committee, Official Report, 24 September 2019, Col 1

9 Health and Sport Committee, Official Report, 24 September 2019, Col 2

10 Health and Sport Committee, Official Report, 24 September 2019, Col 2

11 Health and Sport Committee, Official Report, 24 September 2019, Col 3

12 Health and Sport Committee, Official Report, 24 September 2019, Col 27

13 Health and Sport Committee, Official Report, 24 September 2019, Col 29

14 Health and Sport Committee, Official Report, 24 September 2019, Col 8

15 Health and Sport Committee, Official Report, 24 September 2019, Col 14

16 Scottish Government publication: Primary care: national monitoring and evaluation strategy, March 2019

17 Health and Sport Committee, 6th Report, 2020 (Session 5), 30 June 2020, paragraph 368

18 Letter from the Cabinet Secretary for Health and Sport, 26 November 2019

19 Scott Heald, Health and Sport Committee, Official Report, 5 November 2019, Col 19

20 Scottish Government publication: Scottish Budget 2020-2021, 6 February 2020

21 Scottish Government publication: Scottish Budget 2020-2021, 6 February 2020

22 Scottish Government publication: Primary care: national monitoring and evaluation strategy, 27 March 2019

23 Scottish Government publication: Primary care: national monitoring and evaluation strategy, 27 March 2019

24 North Lanarkshire Health and Social Care Partnership, Report, 12 September 2019

25 Edinburgh Integration Joint Board, Edinburgh Primary Care Improvement Plan Update, 27 October 2020

26 Health and Sport Committee, Official Report, 11 August 2020, Col 19

27 Health and Sport Committee, Official Report, 29 September 2020, Col 37

28 Health and Sport Committee, Official Report, 11 August 2020, Col 24

29 NHS Greater Glasgow and Clyde written submission

30 Health and Sport Committee, 10th Report, 2018, (Session 5)

31 Scottish Community Development Centre written submission

32 Health and Sport Committee, Official Report, 8 October 2019, Col 14

33 Meeting of the Parliament, Official Report, 18 February 2020

34 Scottish Government response to the Social Prescribing: "physical activity is an investment, not a cost" report, 4 February 2020

35 Scottish Government response to the Supply and Demand for Medicines report, 23 November 2020, pages 34- 47

36 Health and Sport Committee, Official Report, 5 November 2019, Col 21

37 Letter from the Cabinet Secretary for Health and Sport, 26 November 2019

38 Scottish Government response to the Supply and Demand for Medicines report, 23 November 2020, answer 34

39 Letter from Elinor Mitchell, Director General Health and Social Care, 1 September 2020, page 5

40 Digital Health and Care Scotland publication: Scotland's digital health and care response to Covid-19

41 Health and Sport Committee, Official Report, 22 September 2020, Col 25

42 Health and Sport Commitee, Official Report, 29 September 2020, Col 43

43 Health and Sport Committee, Official Report, 15 September 2020, Col 16

44 Health and Sport Committee, Official Report, 15 September 2020, Col 9

45 Health and Sport Committee, Official Report, 15 September 2020, Col 17

46 Health and Sport Committee, Official Report, 15 September 2020, Col 36

47 Health and Sport Committee, Official Report, 1 September 2020, Col 10

48 Health and Sport Committee, Official Report, 1 September 2020, Col 11

49 Health and Sport Committee, Official Report, 5 November 2019, Col 12