**RCN Scotland Response to Health, Social Care & Sport Committee Inquiry into Alternative Pathways**

*Inquiry context: When a person seeks healthcare their first point of contact is usually with a general practitioner (a GP, or family doctor). Our inquiry, however, is focused on other sources of healthcare that exist in the community, which we term 'alternative' pathways.*

*The aim of the inquiry is to explore how alternative pathways are being accessed and used in primary care, and to identify key issues and opportunities for improvement.*

**The Committee would like to hear stakeholders views on the following seven questions:**

**1) What is the current level of awareness amongst health practitioners and patients of the availability of alternative pathways to healthcare services other than seeing a GP?**

RCN members, from a range of settings, display a high level of awareness about the availability of alternative pathways. Awareness is especially high for staff working in for example in Deep End practices, such as in Craigmillar in Edinburgh and for staff whose roles have changed or been affected by the creation of new pathways or structural reorganisations. The limitation on practitioners' ability to access alternative pathways is often down to a lack of support or local structures, rather than a lack of awareness.

The RCN's General Practice Nursing Forum has developed a range of resources [https://www.rcn.org.uk/clinical-topics/public-health/self-care/social-prescribing] for members from primary care teams and others to raise awareness of the benefits of social prescribing. These resources include guidance, models and case studies of social prescribing in action.

Additionally, a considerable amount of work has been carried out recently, before and during the pandemic, to make the public aware of pathways available with a focus on seeking to divert people away from GPs and A&E (such as NHS Pharmacy First, or 'Should you go to A&E [https://www.gov.scot/news/getting-the-right-care-in-the-right-place/]'). The impact of these campaigns on how the public access different pathways should be analysed but that would require better data on how many people are accessing different pathways, beyond seeing a GP.

Relevant to this question is the issue of health literacy, which is discussed in response to question 5, below.

**2) How good is the signposting between general practice and other primary healthcare professionals? To what extent are GPs equipped with the information they need to make onward referrals? To what extent are GP practice receptionists equipped to signpost patients to the most appropriate service?**

The RCN is not in a position to comment on how well equipped GPs and receptionists are to signpost patients, though we have no evidence to suggest a lack of knowledge or understanding amongst primary care health professionals around referrals and alternative services. A longstanding challenge, which has been highlighted by the pandemic, is a need to recognise the breadth of provision in primary care and focus on joining it up to enable multidisciplinary working and clear pathways for patients. There is a clear need to recognise the role and unique set of professional attributes contributed by every clinician in the multidisciplinary primary care team and the role they play in improving health outcomes.

**3) What is the level of public awareness of options to self-refer to alternative pathways to healthcare? What is the current extent of self-referrals? How could this be improved?**

The RCN would not wish to comment on the level of public awareness, however data on this would be useful, as would analysis of the impact of campaigns to raise public awareness about pathways more widely (see above).

**4) To what extent is there available capacity amongst other primary healthcare professionals to take on more patients if there was an increase in referrals from GPs / self-referral by patients?**

Put simply, in terms of nursing, there is no available capacity in primary healthcare to take on more patients if there was an increase in referrals.

RCN members working in community nursing are short-staffed while being asked to take on more and more, including expanded vaccination delivery, increased support for care homes, and the increased workload caused by emphasis on swifter hospital discharge and changes to unscheduled care access.

NHS Education for Scotland (NES) NHS workforce statistics [https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/all-official-statistics-publications/07-december-2021-workforce/dashboards/nhsscotland-workforce/?pageid=5982] show that, as of September 2021, District Nursing vacancies were at a record high of 837 WTE, a vacancy rate of 18%. Vacancies in district nursing have been rising steadily since 2015 and more significantly since the pandemic. Sustained pressure from the RCN led to a Scottish Government commitment for a 12% increase in the district nursing workforce by 2024. This is what is required to deliver existing workloads, not cover extra demands.

This serves only to exacerbate pressure stemming from current shortages in the General Practice Nursing workforce. Although it is not as straightforward to gather data on this workforce as on the NHS workforce, Public Health Scotland's most recent figures [https://publichealthscotland.scot/media/9866/2021-10-26-gpworkforcesurvey2021-report.pdf], published in December 2021 put the Scotland wide vacancy rate for nurses at 7.4% (based on a calculation of vacant hours per week from practices that responded). This is comparable with the latest NES figures for the overall vacancy rates for all nursing and midwifery WTE in the NHS, of 8.2% WTE, as shown here [https://turasdata.nes.nhs.scot/data-and-reports/official-

workforce-statistics/all-official-statistics-publications/07-december-2021-workforce/dashboards/nhsscotland-workforce/?pageid=5982].

In addition to these existing staffing pressures, the pandemic is expected to result in extra demands on primary healthcare professionals. As is widely recognised, the reduction in services, which continues almost two years into the pandemic, is resulting in people not getting the preventative or initial care that they need and is resulting in patients presenting with increased acuity, particularly in primary services. ONS estimates [https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/alldatarelatingtoprevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk] also suggest that around 100,000 people in Scotland are currently suffering from long-Covid, which will also put additional pressure on primary health teams.

Nursing staff in community services are therefore already under sustained pressure and this will be exacerbated by the pandemic. Any policies which would divert pressure away from general practice, can only be achieved with additional resourcing for other primary healthcare teams, rather than relying on a redistribution of existing staff.

**5) What potential is there for greater use of alternative pathways to healthcare to ease current pressures on general practice? What are the potential limitations?**

There are a variety of potential models of alternative pathways which could be adopted or further developed to ease pressures on general practice. The hospital at home model, although primarily designed to relieve pressures on secondary services and reduce delayed discharge, may also ease pressures on general practice. Other models such as health monitoring pathways (such as Connect Me), community response pathways (such as respiratory pathways involving nurse specialists and AHPs) and community pharmacy services are existing models which could be developed.

The greatest limitation around the development of these pathways relates to workforce, as without significant investment and workforce planning, the development of these pathways would simply move the same staff from services which are already under pressure.

The issue of inequalities of health literacy is a further limitation to service redesign. Health literacy is about “people having enough knowledge, understanding, skills and confidence to use health information, to be more active partners in their care, and to navigate health and social care systems”[1]. Those with poor health literacy are less able to identify or ‘label’ what is wrong with them and therefore less able to identify and self-refer to alternative pathways. A greater use of alternative pathways, without acknowledgement of this and steps to mitigate against this risk, would only increase health inequalities.

[1] https://www.gov.scot/publications/making-easy/

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

**6) What scope is there for greater use of social prescribing to ease current pressures on general practice and to achieve similar or even better health outcomes?**

GPs, nurses and other members of the primary care team are able to refer people to a range of local, non-clinical services often provided by the voluntary sector. It can help individuals to experience a better quality of life, improved mental and emotional wellbeing, and lower levels of depression and anxiety.

Social prescribing therefore has the potential to become an integral part of the personalised care agenda and nurse prescribers are in a unique position to ensure that social prescription is fully embedded into the non-medical prescribing programme to meet the changing needs of the population.

However, the impact on health outcomes of social prescribing is unclear. A recent journal article entitled 'Social prescribing: the whys, wherefores and implications' [https://www.magonlinelibrary.com/doi/abs/10.12968/jprp.2019.1.2.94#:~:text=Social%20prescribing%20is%20an%20integral,support%20both%20individuals%20and%20communities.&text=It%20presents%20an%20opportunity%20for,to%20a%20non%2Dmedical%20service.] which was co-authored by RCN member Dr Michelle Howarth, an academic senior lecturer at Salford University, and Helen Donovan who is RCN UK Professional Lead for Public Health considers the evidence on the effectiveness of social prescribing. The most recent reviews concludes that while the evidence around impact of social prescriptions on communities, groups and services is sporadic there is now "acceptance that social prescribing works, but the how and why requires further research."

It is also important to note that social prescribing doesn't not mean that care is simply handed over to the relevant service, primary care teams and prescribers retain a responsibility for supporting patients to access these services and to evaluate their impact and the ongoing need for other medical and non-medical interventions. This point has to be understood when considering the ability of social prescribing to ease current pressures on general practice.

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

The Covid-19 pandemic has required many services being provided via alternative sources and for these systems to be developed at a pace not seen before. There is now a debate to be had around what alternative sources could become 'the norm' and what still requires traditional face-to-face appointments with healthcare professionals.

RCN Scotland is concerned that a tendency is emerging amongst decision makers to presume that just because a service has been successfully provided in a way during the pandemic that this can continue to be the case, without any analysis of the impact on health outcomes and access to services. Clearly, alternatives to patients making an appointment and accessing advice and information online is preferred by some people and offers flexibility and can reduce workload on traditional services. However, appointments with primary care teams, particularly face to face appointments, have clear advantages in terms of accuracy of diagnosis, preventative care and relationship building with patients.

An important point is that the right workforce is required regardless of what alternative sources of health and wellbeing information exists. Trained staff are still required to answer phones, monitor and update websites and provide online therapy. Too often these alternatives are viewed as ways to solve workforce pressures elsewhere, when in reality, they still require staff with the rights skills, often recruited from the very services you are trying to reduce pressure on.