HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM NHS Greater Glasgow and Clyde

1. Considering the Health and Sport Committee’s report on the public panels, what changes are needed to ensure that primary care is delivered in a way that focuses on the health and public health priorities of local communities?

We welcome the report from the public panels and the focus on understanding how people want to be able to use and access services in future. We have commented below on some of the specific priorities identified in the report.

The response takes account of the experience and direction of travel across NHSGGC, including the Primary Care Improvement Plans being implemented across the six Health and Social Care Partnerships in the NHS Greater Glasgow and Clyde area, and the wider direction of travel as set out in Moving Forward Together, Greater Glasgow and Clyde’s vision for the future of health and social care.

We note the spread of views obtained through the public panels, survey and Scottish Youth Parliament engagement. Primary care is a universal service which has to work for everyone, and we would be keen to see such engagement continuing to ensure that the views and needs of those who are less likely to participate are included, and to fully represent the demographics of those accessing primary care in Scotland.

- **Use of technology.** We welcome the focus on use of technology and see real opportunities here. The Moving Forward Together programme recognises that digital technology will be central to delivering the transformational change that is necessary in order to support integrated health and social care teams in delivering new models of care, and focuses on
  - Improved communication and decision making support
  - Integrated comprehensive care plans
  - Integrated comprehensive health and care records

Use of technology underpins new ways of working across professions and agencies; however, models of care will also need to adapt to take advantage of that and there are some key enablers which are required to support this including robust information sharing agreements. Care should be taken not to skew priorities and to ensure that those who cannot access technology are not disadvantaged. We note the strong view that face to face contact with a trusted health professional who knows the individual remains important for diagnosis and ongoing care so it is important that technology is used to free up time for face to face contact for those who need it and for complex care; reviewing results or monitoring, video or telephone consultations all require time from health professionals and it is important that this is prioritised according to clinical need.

- **Community wide approach to well being.** We strongly support this and there have been some good examples across NHSGGC including the embedding of money advice workers in general practice, the development of Linkworkers and Community Connectors and Care and Support Planning (based on the House of Care model) which takes a ‘more than medicine’ approach to identifying the range of supports beyond
healthcare which an individual may need. The development of clusters of GP practices provides greater opportunities to understand the specific local needs and range of supports available in communities.

- **Patient centred approaches to accessing services.** We note the desire for extended access to primary care. Although the report focuses largely on ‘in hours’ primary care provision, it is important to develop this alongside the development of ‘Out of Hours’ services and to consider the network of services available over a 24 hour period including the use of technology as above. 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. The evidence of uptake of the existing extended hours enhanced service should be considered, alongside the evidence from extended access in England. The needs of all ages should be taken into account. We would support flexible local service planning based on an understanding of the needs of the specific practice or cluster populations and the full range of services available in the community.

- **Service / workforce planning.** We agree that service planning based on robust intelligence about the needs of the local population is essential. The development of extended multi-disciplinary teams requires robust long term workforce planning focused both on the numbers of staff available and the future skills requirements, as well as support for effective multi disciplinary team working. Improved data to support workforce planning, including independent contractors, is essential. At a patient level, Anticipatory Care Planning should increasingly be used to shape service requirements and access to appropriate supports. The model of General Practice where there is a registered patient list with care provided over the life course is a huge opportunity for population based service planning.

- **Health and Social Care.** The integration of community health and social care for children’s, adults and older people services through new Integration Joint Boards is a significant opportunity to improve how services work together around individual needs. The development of extended multi disciplinary teams around practices and clusters is a further opportunity to ensure that services are working effectively together around the patient. There have been good examples of this, for example through the Govan SHIP model developed in Glasgow. We agree that improving connectivity between IT systems and improvements in data sharing would improve the co-ordination of care and consequently provide substantial benefits to patients.

- **Finance.** There is strong international evidence that health systems with strong universal primary care services are associated with improved outcomes, equity and cost effectiveness. Investment and expansion in primary care is therefore key to effective use of public funding. The close alignment of primary care and third sector services is also vital especially if we are to further promote the preventative agenda and we support the priority of more sustainable funding for the third sector.

- **Prevention focus.** While we note the enthusiasm for health ‘MOTs’ and regular checks, any developments in this area should be strongly evidence based and there is very limited evidence of effectiveness and impact (see for example the evaluation of the
NHS England health checks programme). Primary care provides universal health coverage, and it therefore has a major part to play in the primary prevention of disease and the prevention-based management of people with establish long-term conditions. This should be responsive to the particular demographics and health needs of local populations. The health profile for NHSGGC shows, for example, higher rates of mental health disorders, substance use disorders and chronic liver disease as well as self harm and interpersonal violence. Much of this is explained by the age and deprivation profiles across GGC, and means that across primary care we need a stronger focus on mental health, mental wellbeing, substance misuse and interpersonal violence, blending prevention, treatment and support through more integrated working between GP practices, community services, patients and their families. We also need continued public health intelligence to understand the needs, experiences and assets of the population. And continued work with partners to tackle the fundamental causes of poor health and inequalities. This includes applying a life course approach, recognising the importance of a healthy start in life and the need to maximise opportunities for health and wellbeing at all life stages. Primary care continues to have a vital role in ensuring high levels of uptake for population wide screening and vaccination programmes which are key prevention measures.

We note that on average 90% of people contact their GP practice over the course of a year. Dentists, optometrists, community pharmacists and, increasingly, other members of the wider multidisciplinary team offer direct access for a range of conditions and for supported self care. This network provides an opportunity to support population health including the challenge of multimorbidity using the ‘Four Cs’ framework:

- Contact – accessible care for individuals and communities
- Comprehensiveness – holistic care of people – physical and mental health
- Continuity – long term continuity of care enabling an effective therapeutic relationship
- Coordination – overseeing care from a range of service providers.

The NHSGGC Moving Forward Together vision for primary care and community services is that we should develop services which:

- Have a focus on the GP in their expert medical generalist role and the development of multidisciplinary teams working together with GP practice populations, building on the list based system of primary care, to ensure that people can access the right professional at the right time and to have more time with that professional when necessary
- Ensure the ability of the integrated community network to take a coordinated approach to supporting people with complex needs, through stronger links with all care groups to support individuals with multiple and enduring complex needs across our services. People with complex needs can have multiple areas of need such as mental health, physical health and disability, learning disability and alcohol and or substance misuse or dependency issues
- Recognise that people with complex needs present with a range of issues and will require varying levels of support. Effective support for people with complex needs should offer trauma informed approaches with emotional support or assistance to access care appointments, care management and referral or signposting to community supports
In each HSCP and locality bring services together in a virtual network or in some places a single physical hub from which services reach out.

- Have a clear strategy for the development of community-based premises and accommodation to ensure that premises are fit-for-purpose and support the new models of working at practice, cluster, health and care centre or community network levels.
- Balance local accessibility with co-location to meet need and provide safe and effective delivery of services.
- Support people to access additional support if their needs are increasing with timely referral to the appropriate primary or community services, or other appropriate support at point of crisis as well as support to engage with training and employment opportunities when ready.

2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

NHSGGC’s *Moving Forward Together* strategy identified the drivers for change for primary and community services which reflect some of the barriers and challenges. These include:

- Demand associated with the changing demographic profile with age and deprivation key drivers of demand in primary care and community services. As well as an ageing population there has been an increase in multimorbidity across all age groups and therefore an increase in the complexity of care required, which necessitates different ways of working.
- Service sustainability. A number of services have experienced specific issues with recruitment and retention. Within primary care, the new GP contract has in part been driven by a recognition of the pressures on service sustainability in general practice and the need to develop a wider team to deliver services. Recruitment and retention retain a challenge, and there is a specific need to support GPs in partnership to maintain access to local general practice.
- Financial environment. Over recent years there has been pressure on the delivery of community-based services and there must be a focus on developing sustainable and efficient service models which are appropriately resourced.
- Community infrastructure. There have been several innovative health and social care centre developments in recent years which have created high quality accommodation in communities and enabled co-location and supported joint working. Technology enabled networking of teams provides opportunities for virtual co-location without the need for physical co-location. Across the community there is a need to invest in infrastructure to ensure the capacity for the sustainable high quality community based care we are seeking to deliver.

Specific challenges identified during the development and implementation of the Primary Care Improvement Plans include:

- The availability of suitably qualified and skilled staff, including general practitioners, nurses, MSK physiotherapists and pharmacists.
- Age profile of the GP and nursing workforce.
- Scale of the workload for many practitioners working in primary care.
- Challenges in sustaining out of hours provision under the existing model.
- Shared / single IT system across primary care including links to other systems, that provides safe and effective care and provides the data for monitoring and evaluation
- Availability and suitability of premises across the primary care estate, to meet new models
- The scale of change required and the skills to support that.
- The changing nature of the population and needs as described in the first section, and the need for local flexibility to identify and respond to those needs including greater complexity, needs associated with concentrations of deprivation in urban areas and the specific health profile in GGC.

3. How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?

A local evaluation framework has been agreed within NHSGGC which is seeking to answer a number of key questions on the implementation and impact of the new contract and establishment of the multi disciplinary team. Baseline measures are currently being established and the next phase of evaluation will focus on outcomes at patient, practice and wider system level. This will be informed by improved data available nationally on activity and quality indicators. The key questions for the evaluation are:
- Have we shifted non-complex work to the wider MDT and concentrated complexity on GP resource?
- Are the new ways of working improving professional satisfaction and sustainability in primary care?
- Are patients confident and satisfied in their use of the new primary care system?
- Are patient outcomes and safety sustained and improved under the new system?
- What are the impacts of the new GP contract on the wider health system (not just healthcare)?

The development of GP clusters has been welcomed and enables peer review and support for locally relevant quality improvement activities, supported by tailored data and intelligence on practice and outcomes. Greater transparency of outcomes and quality indicators would be helpful to provide assurance about quality and the impact of changes. Existing mechanisms, such as the Health and Care Experience survey, should be reviewed as changes take place across primary care to add to understanding of the impact and effectiveness.