HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM: NHS HEALTH SCOTLAND, INFORMATION SERVICES DIVISION AND HEALTH PROTECTION SCOTLAND

This submission is co-authored by the following NHSScotland organisations:

- NHS Health Scotland¹, which works to improve health and reduce health inequalities.
- Information Services Division² (part of NHS National Services Scotland), which provides health information, health intelligence, statistical services and advice.
- Health Protection Scotland³, (part of NHS National Services Scotland), which focuses on protecting the people of Scotland from infectious and environmental hazards.

We are submitting a single response because the three organisations above will become part of the new national public health agency in Scotland – Public Health Scotland – on 1 April 2020. Public Health Scotland’s remit will involve providing national leadership around realising Scotland’s new Public Health Priorities,⁴ including supporting primary care’s contribution to public health.

Contact details

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Response

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

Reducing health inequalities

1. There is evidence that making services universally available and accessible to all people in proportion to their need (proportionate universalism) helps to reduce health inequalities and improve the health of the whole population.⁵ This applies across

¹ https://www.healthscotland.scot/
² https://www.isdscotland.org/
³ https://www.hps.scot.nhs.uk/
⁵ The Institute of Health Equity. Fair Society, Healthy Lives: The Marmot Review. 2010
public services, including primary care, and is advocated for by the Deep End GPs. The idea is that:

“For those in the best circumstances, they and their communities need least support and intervention from public services. For those in the poorest circumstances, experience of poor health and its determinants is pervasive and leads to low-quality and reduced length of life. People in these circumstances, and in varying degrees, on the inequalities gradient, need support according to their need – an approach termed proportionate universalism.”

2. This approach would help tackle the Inverse Care Law, which states that “the availability of good medical care tends to vary inversely with the need for it in the population served.” The practical consequences of the Inverse Care Law limit the capacity and capability of practices operating in disadvantaged areas to address health inequalities and respond to public health challenges.

3. Health inequalities are the unfair differences in people’s health across social groups and between different population groups. There is a significant body of evidence that the fundamental causes of health inequalities are rooted in the political and social decisions and priorities that result in an unequal distribution of income, power and wealth across the population and between groups.

These fundamental causes influence the distribution of wider environmental influences on health, such as the availability of good quality housing, work, education and learning opportunities, as well as access to services, including GP services. Variations in access to primary care services experienced by different population groups can perpetuate and worsen inequalities.

4. To be effective at mitigating health inequalities, the way in which primary care services are delivered should be proportionate to need and also adaptable to the needs of people for whom standard pathways are not accessible. This may be due to, for example, socioeconomic constraints, low health literacy, language issues, or sensory impairment.

5. Together we lead the Scottish Public Health Observatory (ScotPHO), which published two reports earlier this year which show that health inequalities are worsening in Scotland and that socioeconomic position is increasingly impacting on

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how long we live for, and how long we live in good health. Life expectancy in Scotland has stalled and in our poorest areas, life expectancy has actually decreased. This underlines just how important it is that concerted action is taken to improve and protect health and people’s right to the highest attainable standard of health, and to reduce health inequalities.

6. The Royal College of General Practitioners (RCGP) recommends\textsuperscript{18} the following action to enhance the ability of general practice to respond to health inequalities and other public health challenges:

a. Increase the overall size of the GP workforce and use incentives to attract more GPs to under-doctored areas, particularly in areas where patient need is highest.

b. Rebalance resources towards general practice and wider primary care services, especially in those areas where health inequalities are worst.

c. Ensure new models of care tackle, rather than exacerbate, health inequalities.

d. Create a supportive environment for GPs and their teams to take a more proactive population based approach to preventing ill health.

e. Focus on continuity of care particularly in areas where a high number of patients are living with multiple morbidities.

f. Fund outreach programmes to help excluded groups such as those with mental health problems, learning disabilities and the homeless to access general practice.

7. Further, conducting Health Inequalities Impact Assessments (HIIAs) can help ensure that actions taken by general practice reduce, rather than exacerbate, health inequalities.\textsuperscript{19}

Integrating public health and primary care

8. A well-integrated health and social care system underpinned by a strong primary care infrastructure should be a sound basis for ensuring a focus on the health and public health priorities of local communities in Scotland. Further, there is evidence that such a system, incorporating a strong public health approach is necessary in order to achieve the optimum health of the population and individual patients.\textsuperscript{20, 21}

9. The World Health Organization (WHO) conducted a review of different approaches to integrating public health and primary care in particular and identified “five primary care strategies and operational changes needed to integrate public health actions into primary care”.ibid These are:

- Targeting health improvement actions and resources to the most disadvantaged areas.

\textsuperscript{18} Royal College of General Practitioners. Treating Access: a toolkit for GP practices to improve their patients’ access to primary care. 2014.

\textsuperscript{19} http://www.healthscotland.scot/tools-and-resources/health-inequalities-impact-assessment-hiia/what-is-an-hiia


\textsuperscript{21} World Health Organization. Primary health care: closing the gap between public health and primary care through integration. 2018.
- Building capacity in primary care to deliver proactive promotion and preventive care.

- Working beyond basic, essential and limited packages of care to a full range of services needed for first contact with the health system.

- Providing early interventions to prevent escalation of health care needs.

- Taking a broader perspective so that care for individuals is framed in the context of population outcomes (e.g. equity and social cohesion).

10. Further to these strategies, the WHO identified several possible models through which to achieve the integration, four of which are relevant for consideration and comment within the Scottish context:

a. Public health professionals integrated into primary care: in Scotland this could include alignment of local public health staff to GP clusters and support from the Local Intelligence Support Team (LIST) (see paras. 20 - 21 below).

b. Public health services and primary care providers working together: exploration of this is being taken forward by a group brought together by the Scottish Public Health Network (ScotPHN). A key recommendation emerging from the discussions is the creation of a national Primary Care Public Health Network. In addition to local and national public health leaders, this would include GPs, dieticians, district nurses, practice nurses, pharmacists, physiotherapists, and podiatrists. The idea is to create an environment within which general practice and wider primary care teams are supported and encouraged through data, skills and evidence provision to better address local and regional population health challenges through more effective planning.

c. Multidisciplinary training of primary care staff in public health: there is UK level evidence that many GPs lack the skills and knowledge to deliver effective public health interventions.\(^{22}\) In the future, Public Health Scotland will be well-placed to explore mechanisms for development of such skills and knowledge with NHS Education for Scotland.

d. Building public health incentives into primary care: consideration could be given to including actions relating to the Public Health Priorities in Phase 2 of the General Medical Services (GMS) contract negotiations and/or the next iteration of GP cluster guidance.

Prevention activity

11. There is evidence that appropriately targeted prevention activity, including ‘brief interventions’ by GPs, are effective at improving health and are economically cost effective.\(^{23, 24, 25}\) It is also acknowledged that the childhood and adult immunisation

\(^{22}\) The King’s Fund. Health Promotion and Ill-health prevention. 2011.


\(^{24}\) The King’s Fund. Transforming our health care system. 2015.

programmes, currently being revisited through the Vaccine Transformation Programme, continue to make significant contribution to vaccine preventable disease.

12. In addition to a lack of skills and knowledge, GPs identify lack of time, competing priorities, workforce shortages, lack of support systems, and remuneration issues as barriers to undertaking public and population health-focused activities, including the prevention and early detection of disease.27

13. Longer appointment times delivered through GMS contract changes should allow greater scope for such activity relating to smoking, weight, diet, exercise, alcohol and drugs. Primary and secondary prevention of cardiovascular, stroke and respiratory disease, diabetes, cancer and osteoporosis would be enhanced by such efforts.28

14. If GMS phase 1 changes are successful in delivering reduced workload for GPs and their teams, increased capacity may be available for population health approaches in key public health priority areas.

15. Ensuring equitable access to primary care is also central to delivering preventive medical interventions and providing a gateway to a health-care system that delivers effective interventions for the major causes of mortality, including cancer and cardiovascular disease.29

Enabling wider use of information and intelligence in primary care

16. To improve health and reduce inequalities it is necessary to understand the health of a local community and the factors that shape it. Access to good quality information and robust data is crucial to this. While there is a wide range of relevant data sources available already, more needs to be done to assist GP Clusters and others working in primary care to access and use the information and intelligence they offer.30

17. ScotPHO brings together a wide variety of high quality data, profiles and reports on the health of Scotland’s population. This includes online profiles which provide a wide variety of data for local areas.31 Greater use of this sort of information would help primary care to be delivered in a way that focuses on the health needs of local communities. A key part of our mission as we move towards Public Health Scotland is to continue to improve all the information tools and products we provide to make information more accessible and relevant.

18. An important asset available locally are ISD’s Local Intelligence Support Team analysts (LIST). This dispersed team offer analytical capacity and capability to Health and Social Care Partnerships and to GP clusters in particular. They offer access support in the use of a wide range of data, drawing on national and local sources as appropriate. Examples might be profiling local populations, projecting

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26 http://www.healthscotland.scot/health-topics/immunisation/vaccination-transformation-programme
27 The King’s Fund. Health Promotion and Ill-health prevention. 2011.
28 The King’s Fund. Transforming our health care system. 2015.
30 ISD Scotland. A Guide to Primary Care Data Sources. April 2018.
31 https://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool
future demand and looking at alternative models of service delivery and care – information that can help find potential answers to complex problems.32

19. LIST works with GP Clusters across Scotland to support Cluster Quality working, in particular intelligence-led influence and decision making. For example, GP Cluster intelligence profiles using ISD data are being piloted by senior public health staff in NHS Greater Glasgow and Clyde to act as a catalyst for data quality discussions and agreed approaches to improving local population health.

20. There already exists a range of different insights drawn from national data that are potentially important locally. Examples include the Burden of disease data33 and infectious disease burden data which can also be used to model current and future demand related to public health priority areas. Using standardised disease prevalence rates could help partnerships and clusters to understand local population health priorities, gaps in service provision and priorities for service development.

21. Among other relevant initiatives that are underway, we are developing public health intelligence systems for measuring inequalities in access to health and social care services, quality of care and treatment received, and health and social care service outcomes by area-based deprivation classification. These could be used by Health and Social Care Partnerships and GP clusters to aid the mitigation of health inequalities using locally targeted service developments and interventions.

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

22. The barriers to delivering a sustainable primary care system in both urban and rural areas are acknowledged to be complex and multifactorial. The barriers cross over into issues for other sectors, including third sector sustainability generally and also specific issues facing the sector in remote and rural areas.34

23. There is significant overlap between the changes needed to ensure that primary care is delivered in a way that focuses on the health and public health priorities of local communities highlighted in our answer to question one above, and the barriers to delivering a sustainable primary care system. For example the Inverse Care Law (see para. 4 above) and the barriers to undertaking public and population health-focused activities identified by GPs (see para. 14 above) are significant barriers.

24. A greater focus on prevention activities across the wider public health system could 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.”35 The ambition is 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

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32 https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Local-Intelligence-Support-Team/GP-Clusters/
health and care, within an enabling environment that makes it possible for them to do so.” Public health Scotland will have a crucial role in supporting the public health system, of which GPs are a vital part, to work collaboratively to realise this shift to prevention.

25. A number of briefings and reports from the Royal College of General Physicians and the British Medical Association outline the issues from the perspective of the profession and made recommendations. This includes the policy paper from the Royal College of General Physicians Being Rural: exploring sustainable solutions for remote and rural healthcare36 and the British Medical Association’s “urgent prescription for general practice.”37

26. The Scottish Government established a short-life working group in 2016 in recognition of the sustainability challenges facing practices across Scotland. The Improving Practice Sustainability Group made recommendations in November 201638 and provided an update on progress towards implementation of the recommendations in November 2019.39

27. With the majority of patient contact with the NHS occurring in primary care, general practice is central to the delivery of effective public health interventions. Issues of capacity and resource giving rise to current concerns regarding the sustainability of general practice services are likely to have a direct bearing on the ability of primary care to engage in the delivery of effective population health improvements over time.40

Lack of reliable data

28. There has been a lack of reliable data on workforce and workload capacity at a primary care level, which is a potential barrier to delivering a sustainable primary care system in both urban and rural areas. This may be remedied, at least partially, by means of a new initiative (involving ISD) that is currently underway to gather data from general practices.

29. There is also a lack of geographical analyses of data on the need for and supply of primary care services. Such data could be used to reveal variation, desirable or not, across similar or diverse environments and specifically contrast needs and supply of primary care in urban and rural areas.

30. Geospatial analyses could help ensure appropriate access to services wherever they are based; identify variation in need and capacity by geography; and support joint planning of community functions and delivery of integrated services in both urban and rural settings.

31. Much of the health and social care data about people held nationally carries postcodes of residence and Community Health Index (CHI) numbers. In some cases (such as hospital admission) the data explicitly identifies the general practice of the patient. These data can then be appropriately analysed at different geographical and administrative levels for a variety of purposes. Equally importantly is that a much broader account of the patient experience and the whole system can be described through data linkage (where summary records on health and social care events for individuals are linked across multiple sources and over time). This well established process, with its appropriate safeguards in place, enhances understanding of the health and care system and local populations.

32. The on-going development of the Scottish Primary Care Information Resource (SPIRE)\(^4\) should, over time, contribute more and more to the intelligence available to primary care. SPIRE provides a tool for GPs to build their own reports from the patient information collected within the practices. In the future it will also allow extracts of summary information for use at cluster and national level for a variety of statistical and research purposes including geospatial analyses as required. SPIRE data will enable greater geospatial analyses thus adding to our understanding of variation geographically.

33. The creation of Public Health Scotland in April 2020 will also help to tackle this barrier by bringing together the skills and expertise of Information Services Division, Health Protection Scotland and NHS Health Scotland. Through evaluation of primary care health service data and its relationship to the patient journey in secondary care, PHS will demonstrate the public health impact of treatment and prevention allowing refinement of patient management at local and national level.

**Question 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?**

34. NHS Health Scotland worked closely with the Scotland Government in the development of the ten year monitoring and evaluation strategy\(^4\) for primary care. The strategy spans a decade so as to allow sufficient time for the full effect of changes instigated through primary care reform to be seen throughout the system. However, while it may take at least ten years to fully achieve the primary care vision and outcomes,\(^4\) the strategy recognises the importance of monitoring the progress of implementation and evaluating the impact on outcomes in the short and medium term. We are currently developing a report on the ‘State of Primary Care in Scotland’ which will pull together existing primary care data sources as a baseline for the strategy, and identify data gaps.

35. The Primary Care Evidence Collaborative supports this work by exploring ways to generate, coordinate and share primary care evidence on a ‘once for Scotland’

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\(^4\) [https://spire.scot/](https://spire.scot/)


basis’ and develop the primary care data landscape. The collaborative co-produced a detailed outcomes framework\textsuperscript{44} which maps out the changes that need to happen to realise the Scottish Government’s vision for primary care over the next ten years. The framework sets out intermediate outcomes for people, the workforce and the system.

36. In order to develop an effective monitoring strategy the desired outcomes of any primary care reforms need to be articulated first. For instance in order to understand if primary care is better addressing health inequalities in the long-term we would need to collect data on the impact of the new models of care on different population groups, such as those experiencing deprivation, people living in urban and rural settings, and those with protected characteristics.

37. Change in one area will affect other areas and therefore we would caution against monitoring and evaluating specific areas of primary care reform, such as the effectiveness of multi-disciplinary teams and GP cluster working, in isolation. Our recommendation is an approach that looks at individual areas of change in addition to, and embedded in, a ‘whole system’ approach to the evaluation of primary care reform.

38. The monitoring and evaluation strategy for primary care is in the process of being operationalised into a practical evaluation plan. Our recommendation is that this is done over the next twelve months and that the focus is on evaluating outcomes based on the GMS Contract and accompanying Memorandum of Understanding (MoU)\textsuperscript{45} in the first instance.

39. The MoU sets out six priority areas for development of services: the Vaccination Transformation Programme, pharmacotherapy services, community treatment and care services, urgent care, additional professional roles and Community Links Workers. Core evaluation questions could be identified that apply to all six of the priority areas also in addition to questions that are unique to specific professions or interventions. The evaluation plan should clearly articulate the desired outcomes for each of the priority areas (including multi-disciplinary teams and cluster working), the monitoring data required and the resources that would be needed to conduct this work.

40. Based on our extensive experience in both the fields of primary care and evaluation, we have found that working together with those who are responsible for developing and implementing the policy is essential. Therefore we recommend that evaluation plans are drawn up in conjunction with the relevant primary care workforce, patient groups, service planners and policy makers. An example of how this might be achieved is provided in Appendix A.

\textsuperscript{44} Primary Care Evidence Collaborative. Outcomes Framework for Primary Care. 2018.

Appendix A: An example of how the effectiveness of multi-disciplinary teams could be evaluated

**Purpose:** To identify the most appropriate methods to help us understand how multi-disciplinary teams (MDTs) are being implemented and what difference they are making in primary care settings across Scotland.

**Suggested approach:** Work with stakeholders and subject experts to:

- Establish appropriate short and medium term outcomes which contribute to the existing long term outcomes for primary care reform articulated by the strategy.

- Explore existing evidence – what do we already know about how MDTs are working in primary care in Scotland?

- Identify evaluation questions – what do we need to know and how would we measure achievement of goals?

- Identify and prioritise evidence gaps

- Scope and review data sources for validity, reliability and acceptability

- Develop, test and evaluate proof of concepts to fill evidence gaps with appropriate methods and data sources

**Areas to explore could include:**

- What data sources/methods could help to answer questions based on the primary care outcomes framework about what impact the MDT had on outcomes for:
  - people/patients, e.g. health and wellbeing, patient experience, patient satisfaction?
  - the workforce, e.g. health and wellbeing, staff experience, staff satisfaction, recruitment and retention?
  - the system, e.g. equality of access, demand, sustainability, efficiency, (cost) effectiveness, safety and quality?

- The potential of SPIRE, data linkage, experimental studies, statistical modelling, health economics to inform learning and service development

- How NHS Health Scotland and Public Health and Intelligence (and from 1 April 2020, Public Health Scotland) can work with the wider Primary Care Evidence Collaborative to complete the knowledge into action cycle and support primary care improvement plans.
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<th>Potential evaluation questions</th>
<th>Approach/ measures</th>
<th>Data sources</th>
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<td>□ What do Primary Care MDTs look like across Scotland?  □ How are recruitment and retention rates changing over time?</td>
<td>□ Secondary analysis of specified data sources to better understand the shape and size of MDTs by practice characteristics over time  □ Description of size (headcount and whole time equivalents), shape (profession type, skill mix), governance arrangements, where are they based etc.</td>
<td>□ Primary Care Workforce Survey (2009-2017)  □ Workforce data extract (2019 onwards)  □ Primary Care Improvement Plans</td>
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<td>□ What do we know about the roles undertaken by different professions within MDTs?  □ Is everyone working to the top of their licence?</td>
<td>□ Documentary analysis  □ Primary qualitative research</td>
<td>□ Scottish School of Primary Care –National Evaluation of New Models of Primary Care in Scotland  □ University of Strathclyde Evaluation of Pharmacy Teams in GP Practice  □ Local evaluations  □ In-depth case studies</td>
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<td>□ What is the impact of the MDT on GP workload?</td>
<td>□ Data linkage</td>
<td>□ SPIRE  □ Manual data collection, e.g. week of care audit  □ Appointment book</td>
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<td>□ What impact does the MDT have on patient outcomes?  □ Are patients seeing the right person at the right time?</td>
<td>□ Analysis of the following by demographic:  □ Consultation rates  □ Waiting times  □ Activity data</td>
<td>□ Source  □ SPIRE</td>
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<td>How are population health needs assessments and burden of disease data currently used in workforce planning and what is the potential to expand this?</td>
<td>Documentary analysis, Primary qualitative research</td>
<td>Primary Care Improvement Plans, Interviews/ focus groups with LIST analysts, GP Clusters and Health and Social Care Partnership Chief Officers</td>
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<td>Does the GP footprint change over time?</td>
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<td>Secondary analysis – do the responses differ by demographics?</td>
<td>Our Voice – Third Citizen's Panel Survey on access to healthcare professionals other than doctors, Health and Care Experience Survey responses to questions around new models of care</td>
</tr>
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50 [https://www2.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey](https://www2.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey)