HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM NHS NSS

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?

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

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

Contact details

If you have any questions or require further clarification on any point, please contact:

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Overall:

National Services Scotland (NSS) welcomes the opportunity to contribute to this crucial conversation regarding the future of Primary Care. NSS deliver or support numerous activities across the breadth of Primary Care service delivery and so have only presented a selection of our thoughts, but would be happy to engage in more detailed discussions as relevant.

The bulk of the report referenced refers to Primary Care in the sense of that which has been traditionally provided by General Medical Practices and community nursing. It is important to remember other aspects of primary care; community pharmacy, optometry and General Dental practice, including how these areas could potentially work differently to relieve some workload in General Practice. Comments below are mainly about the former given the content of the report.

Question 1 – Health and Public Health of Local Communities
In line with Realistic Medicine, there is opportunity to de-medicalise many of the problems which people who attend their GP present with, for example, low mood due to loneliness, benefits issues, and acute distress and lifestyle problems. A sense of belonging to a community and taking part in community activities e.g. ParkRun can reduce loneliness and increase wellbeing without recourse to prescription medicines or medical intervention. This is a simple example of something which increases health and wellbeing for the long term and empowers and enables people. Healthcare provision should be part of a community but not central to it and alternatives to medicalization should be created, supported and sustained. Thus link workers, benefits advisors, brief interventions for distress, counselling, social care, alcohol and drug interventions and exercise and weight loss interventions are key. These should be visibly available in communities in line with the needs of communities and not require referral by a health care professional. Variable access to such services can act as a barrier to people using them, changing referral criteria and the financial ups and downs of third sector organisations can act as a barrier to referral by GPs.

Primary ‘health’ care should be provided by a multi-disciplinary team (MDT). It is wasteful for a patient not to see the right care provider first time where that is possible. This does not mean that every request has to be triaged. People often know who they need to see, for example, most people know they wish to see a physio with a musculoskeletal problem but do not always have the option to self-refer in a timely manner thus a GP appointment can be lost to someone else who needs to see a GP. This will enable MDTs to be shaped in line with local needs, enabling peoples wellbeing to be addressed by the right professionals.

It is not necessary to know a patient for 20 years to provide continuity of care however where there is significant complexity and at the end of life continuity has been shown to be of greatest benefit. Continuity does not always have to mean seeing just one clinician rather that a team are communicating and supporting a direction of travel and that anyone outside that team who sees a patient behaves in a way that is consistent with the team approach and patient wishes.

The practical availability of the extended multi-disciplinary team is an issue in both rural and urban areas however the problems of recruitment and reaching a balance between workforce and population numbers may be more extreme in more rural areas.

Multi Disciplinary Teams can provide many benefits to local communities and patient care, however ensuring the conditions for their effectiveness is key. This includes having the right mix of clinical professionals and skills in place, having the means for effective information sharing across the team, having the physical environment for MDT working and technology in place to support collaborative working and work from different locations. This will need to include mobile technology to enable care in community settings.

NSS have recently undertaken discovery workshops with a range of Primary Care health carers to consider how to better digitally support MDTs, and this surfaced key pain points of time wasted accessing multiple systems to rekey or locate information and some reliance still on paper records particularly for home visits. Using this intelligence NSS are now
working to identify Proofs of Concept with Board partners to determine how to best address these challenges utilising current technologies. For example, how robotic processing could be utilised to automate process which are currently manually intensive, thereby freeing time of practice staff to focus on the needs of patients within their community. A report summarising the discovery work and recommendations is currently being finalised.

Primary care should be available 24/7. This should be appropriate availability, that is to say, people should receive care in a timely manner for their need whether for urgent or routine matters. This shouldn’t be taken to mean that ‘routine’ primary care should be available 24/7 as that could be impractical and potentially unnecessary. Primary care should be delivered by multi-disciplinary teams and not be as doctor–dependant as it is currently. There should continuity of teams.

With care models evolving through for example the use of MDTs, online advice from NHS Inform and potential developments regarding how patients could communicate with professionals, this is obviously a cultural shift in the mind-set of care being a face to face appointment with a GP. As such awareness is required both locally and Scotland wide to ensure the public recognise these new models as improving care and support for communities.

**Chronic conditions**

Chronic diseases are part of life for many people in Scotland and living with a chronic disease should be, as far as possible, de-medicalised. People should receive the support they need to manage their own condition and be empowered to do so, this should include digital support and where appropriate support to stay at work. Work is good for health and wellbeing as well as the economy. Over reliance on medicalization because that is how our system has been created does not always help people to stay at work. It should be remembered that people often have two or more long term conditions and apps for single conditions will not be appropriate for those people. Health literacy is a key enabler for self-management of chronic diseases. Promoting health literacy in communities and for individuals should be a priority. Digital tools could be used to help people manage their own conditions but caution must be applied due the context of multiple morbidity, for example, it is likely to be unrealistic for someone who has diabetes, cardiovascular disease and asthma to use three different tools unless they are very health literate. Arguably to reduce inequalities those with poorer health literacy should receive more support in these matters.

**GP Clusters**

Ownership of quality improvement, effectiveness, prevention and tackling health inequalities should be the whole team not just GPs thus GP clusters should be re-thought in that light. Effectiveness would be best measured by patient reported outcomes and a suite of these could be developed at a micro and macro level. Health inequalities are largely determined by social determinants thus areas of social deprivation are likely to benefit from more focus on community interventions than sole focus on health care, this cannot be overstated. While providing primary care in an affluent area will feel different to doing so in
In a socially deprived area, the principles of the expert medical generalist and demedicalization remain important. Prevention may be best managed by HSCPs with GP practices (not necessarily GPs themselves). The appropriateness and cost-effectiveness of GP practices and GPs being ‘go to’ places in a community for public health interventions should be investigated.

**Question 2 - Barriers**

**Technology – this is a barrier to primary care reform and the efficacy of primary care**

IT infrastructure needs to be robust and consistent. Primary care has outgrown its current IT. IT systems in primary care need to be reliable, accessible and fit for the future including appropriate (not wholesale) join up with social care, secondary care, tertiary care and other independent contractors. There should be appropriate patient-facing elements. There should be role-specific views, much less variance in IT systems and a single source of truth.

Transactions currently undertaken by paper should be reviewed end to end via redesign methodologies to enable redesign and digitally enablement. For example, repeat prescribing; indeed digital prescribing offers significant benefits to healthcare professionals, allowing medicine to be prescribed in a wide variety of primary and community care settings but also direct to the patients’ smart device or a secure accessible portal. This will allow ease and convenience for their collection at a pharmacy of choice, or in time delivered to their door. This would save time for professional providers, carers and patients themselves.

NHS NearMe should be an option for remote and rural locations in particular but applied with caution. People often need to be examined, VC may take longer than face to face, the consultation may need to be stored and so safe storage mechanisms require to be considered. The empathy and rapport built up through direct contact, including the power of touch, should not be dismissed completely, but utilised where required. All consultations may not be easily replicable by VC so consideration should be given to those where VC is appropriate rather than assuming one size fits all.

Decision aids are useful and there should be a digital repository for these with easy access for people and health care professionals in primary care in one place rather than held in multiple different places because they are created by multiple different specialties. Decision aids should be used to support shared decision making and should be citizen-facing.

Online triage does not currently have the acuity for wide scale use and should not be implemented until it is proven to be safe.

Order comms should be of a consistent standard across Scotland and provide functionality which supports patient safety at a GP practice level, similarly with GDP practices. Order comms support laboratories in some places rather than GP practices.

Electronic referrals pathways should be consistent and easy to navigate such that a clinician new to the area could easily access referral guidance and pathways. There should be a reduction in the need for re-keying of information from external sources.
variance in IT systems simple access to relevant patient data continues to be a barrier to better care, with challenges to effective information sharing continuing – both in terms of technical infrastructure and information governance.

Time being taken up with activities which could be better automated or digitally enabled such as prescribing and in particular managing repeat prescribing needs to be further considered. NSS are currently starting discovery work in this area with users to determine any potential for redesign of services with the view of releasing clinical time for other purposes.

Anticipatory Care Planning

Holistic palliative care is essential to dying with dignity. Palliative care must be delivered with a team approach including health and social care 24/7. Communication must be digitally enabled and a new system developed for this that can be used both in palliative care and for information sharing in a non-palliative situations. All professional and patients should be enabled to contribute to this. It should be easily available in every appropriate circumstance. It is not sensible to have multiple systems, ePCS, eKIS and RESPECT forms as that becomes unmanageable and confusing in emergency situation. These types of systems should be created with the end user and person to whom they pertain in mind, their environment and when/where they are most likely to consult. Increasingly, that will be in the person’s own home where there may be no access to a reliable digital solution.

Workforce

Everyone in primary care should feel valued and feel part of a team. Teams are of enormous importance in primary care.

The impact of pensions and tax rules should be considered on recruitment and retention for GPs.

In an ideal world the issue of contractor/employee managed service should not matter, however it is widely acknowledged that, despite its problems, the contractor model is value for money for the use of public funds. It may be that future GPs may not wish to continue this tradition and the risks of property ownership becomes too onerous. The nation should prepare itself for this.

Recruitment challenges evidently continue, particularly in rural areas, and therefore measures to attract professionals to work in Scotland are urgently required. This should not simply focus on having people in one specific location, consideration of different models to provide care to patients and support to professionals in rural areas should also be considered, along with the infrastructure required to make this effective.
Premises

Ageing premises with limited collaborative/ team space are common across Primary Care, so consideration is required as to how to address this. Health Facilities Scotland have recently completed surveys of GP premises to allow NHS Boards to better understand what is in place/ what is needed/ what is the gap.

Harnessing Big Data

There is much that could be achieved in targeting appropriate healthcare solutions to the population need if there was better / more harnessing of existing data-sets. Predictive analytics and / or Artificial Intelligence options could quickly identify unwarranted variation and allow improved decision making through visual decision support tools. This technology applies to data across all primary and community care, but in particular medical, ophthalmic, dental and pharmacy data-sets. Community health and social care, e.g. care homes, data could be explored as well to improve integration of service provision.