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.

- What would be useful is consideration of ‘what is a community?’ The citizens of Edinburgh see themselves in c150 ‘natural communities’ ie one per 3000/4000 people. Only primary care provides a recognisable local service at that level. In contrast, we refer to ‘locality’ communities – populations of over 100,000 not recognised by the public – although helpfully now by all public services and the Third Sector (in Edinburgh).
- There is also need for clarity about the question posed; is Primary Care shorthand for GMS, for GMS + the attached and aligned healthcare teams, or non-hospital delivered healthcare.
- There may be merit in establishing sub cluster areas with interlocking practice boundaries as a meaningful way to engage the public about primary care, and in turn to start a long term dialogue about how to support better health and an adjusted relationship with services across the community. Local flexibility remains key in view of the long experience of initiatives to establish the required relationships; none of which have endured.
- 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.
- It is difficult for Primary Care to ‘engage’ with its local community – partly lack of capacity but also lack of an acknowledged and representative mechanism for doing so. GPs in particular, are more likely to trust the feedback they receive directly from c30 individual members of the public every working day.
- Early days!
- The major public health challenges facing local communities; poverty, alcohol, drugs, violence, antisocial behaviour, parenting, housing and social isolation, all require a much broader approach than primary care. This has been rehearsed for decades, but we don’t organise public services in a way which is coherent or effective for disadvantaged communities. ‘Failure demand’ remains a popular observation, rather than a stimulus for sustained change. Collaboration and integration are well recognised prerequisites, seldom supported by aligned resources, reporting and accountability frameworks.
- Any sustainable local partnership to address medium and long term priorities needs to be locally accountable and again, all parts of public service are resistant to the potential professional implications of this. Impasse.
- The report is useful in confirming the understanding that people are not resistant to seeing a broad range of healthcare professionals and making better use of technology.
- Many of the responses however, reflect the views of those who are able to make use of Primary Care as it is currently organised. There is challenge in how we capture the views of people who do not use Primary Care effectively and the reasons why.
- The development of a suite of potential quality markers which would allow us to assess long term changes in the health of economically deprived populations at a level relevant to primary schools (see below) and GP practices would be welcome. The potential sensitivity of some of this eg drug related deaths/domestic abuse/children under care system, being reported at a local level is understood. Nevertheless, unless we can make public health priorities and tackling inequalities a clear expectation at the service delivery level, we will not move beyond thoughtful observation to purposeful intervention.
- Quality markers seen as directly relevant to a broad section of public services/local communities would be welcome.

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

- Short and medium term shortages with particular staff groups are well rehearsed elsewhere and widely understood, particularly in the context of the implementation of the new GMS contract
- Rural and urban areas have inherently different challenges in the development of their workforces; opportunity of specialisation/segmentation and requirement for generalised skills for smaller populations.
- One of the significant barriers is the lack of investment in primary care premises and the physical condition of a sizeable proportion of current inner city premises
- NHS processes make securing available land on a commercial timescale very difficult, even when funding is available
- The separation of responsibility for sustained and large scale house-building from the provision of primary care premises is long overdue as a statutory amendment to Section 75 provision. Primary education, transportation and primary care are the front line of public service provision for expanding and new communities, yet Primary Care has no statutory provision.
- Several attempts have been made to establish this principle in Edinburgh, as part of the ‘Supplementary Guidance’ supported by Edinburgh Council Planners. To date Scottish Government has not permitted the adoption of this guidance.
- The balance between ‘local’ as understood by the public in urban areas ie one mile from where they live, and local as defined by public services can be very different (see previous comments)
- The issue of ‘access vs. continuity’ would benefit from sustained focus. Our local insight suggests that c30% of the population don’t use primary care in any given year, 60% make incidental use where access is paramount and 10% rely on sustained relationships (continuity) for effective care. The trick is how the balance between the two reconciles demand with need.
- The application of technology in primary care has progressed slowly, despite 20 years of ‘prioritisation’. This needs to move beyond exhortation and the focus on large scale systems, to the ongoing development of useful technology keeping pace with the prevalence of social media.
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?

- In Edinburgh we have defined our currency of augmentation to be in medical sessions eg a full time Primary Care Mental Health Nurse embedded in Primary Care team with prescribing qualifications will augment capacity by the equivalent of 4-5 medical sessions.
- This approach had allowed us to define/estimate the City wide capacity gap (c600 weekly sessions) and how our implementation of the New Contract resources relates to this (c200 sessions to date).
- GP Clusters continue to develop at different paces, mainly related to the experience of those who have been selected to participate by their practices. We are not sure whether the attempt to define outcomes for the clusters would add anything at this stage. Nevertheless, the thoughtful provision of practice and cluster information stimulates the debate, as does access to national data sets. Practices within the same cluster often serve populations with quite different populations and may not value the relevance of local averages. The unit of accountability in Primary Care firmly remains the individual practice.
- Although not directly related to evaluation of outcomes – the success of the new roles is highly reliant on effective evaluation and support. Any framework for this will naturally include assessment of both individual and collective MDT impact. This starts with the current focus on workload impact, but will develop into a broader assessment of what primary care can contribute including and beyond its established role in the treatment of ill health.
- The lack of any national benchmarks for primary care beyond comparative prescribing remains puzzling. This would be readily achieved and allow a stimulating dialogue to develop across and between systems. Placing this expectation vaguely with Clusters is almost guaranteed to frustrate all parties.
- In Edinburgh we have formed 5 ‘demand groupings’ based on age profile and deprivation. This allows our 70 practices to recognise other City practices which serve similar population types, facilitating more meaningful comparison and linkage across the City. This approach does not need to be confined to Edinburgh and would benefit from the addition of practices from other areas serving similar populations.
- Critical outcomes which are sought in Edinburgh are the continued absorption of new population despite ‘restricted’ lists, and the stability of the practice teams themselves.
- Admissions to hospital are already low per 1000 population, but we believe that steady progress is being made in understanding how further reductions might be made through the segmentation of the (admitted/at risk of admission) population. Asthma and falls prevention are obvious areas which lend themselves to a programme approach – already begun by our Long Term Conditions team.
- Health inequalities cannot be effectively tackled directly and solely by primary care – the insights of primary care are however vital to the multi-agency and multi-sector approach which is required for long term change in the health status of a population.
- Primary Care does a great deal to mitigate the effects of health inequality and has insight into the effective behavioural strategies which constitute effective preventative strategies.
- Making use of naturally occurring communities for health interventions may be a useful way forward. Using Place Making tools to explore the community assets within defined geographical areas - this would include access to transport, to shops; to greens spaces – factors we know that influence health behaviours,
- Primary Care together with Primary Schools (and to a lesser extent libraries), are perhaps the obvious public services with both the reach and local credibility, to lead (or better - to provide the public sector support to community leadership) the coherent and sustained change to public health outcomes which is required.
- It is instructive to compare the public sector focus on delayed discharges, with the focus on rising mortality in some sections of our population.

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