HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM Clinical Primary Care Lead Group

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?

Response collated on behalf of Scottish Primary Care Clinical Leads Group

1. 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?

The development and sustainability of primary care requires significant review at national level and by host organisations recognising a need for a strong focus on enhanced prioritisation and investment in community based services and a recognition of the value of primary care within our healthcare system.

To date there has been, and there continues to be, a disproportionate focus of attention and resourcing of acute services to the detriment of other parts of the system.

Current resourcing to deliver sustainable change and ongoing delivery of high quality primary and community services is grossly inadequate, and will be further challenged by increasing indices of chronic diseases. Consequently the healthcare system is at significant risk of becoming destabilised.

Often primary care is considered synonymous with services that are traditionally provided by General Medical Practices and community nursing. However it is important to remember other aspects of primary care: community pharmacy, optometry and General Dental practice and the contribution made by social care services, the third sector and by carers and communities. Communities in particular have an important role to play and should be at the centre of creating, shaping, changing primary care services.

Modern Primary Care needs to be celebrated and assured of the highest visibility and profile at national and organisational level. This should recognise and appreciate the capability of primary care services in delivering the very significant majority of holistic care for a population that is ageing and has increasingly complex needs and expectations.
The supporting Primary Care infrastructure requires to be made more robust. To achieve that, there is a need to provide appropriate support and resources to build a workforce with the right skills and capacity to deliver services in the community and manage increasing demand and expectation. Professionals must feel supported and have adequate capacity to deliver and manage clinical care.

Currently recruitment, retention and sustainability issues make working in the community a less rewarding experience with subsequent impact on future recruitment and retention.

In recent years our culture and our society has changed, with a relative reduction in support networks in communities, while public expectations have risen exponentially. There has been a medicalisation of many social and life issues all of which have increased demand on all our healthcare services.

Future care will be dependent on improving health literacy, educating the public on personal responsibility for their health status, co-production and the need to access services appropriately. Improved system navigation and enhanced visibility of all community services requires to be prioritised.

In line with Realistic Medicine, there is an 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.

Alternatives to medical prescribing should be created, supported and sustained to provide additional support and effective long term behavioural change and lifestyle choice. This should include exercise and weight loss interventions, benefits advisors, counselling support, benefits advisors, facilitated social care access and services to support alcohol and drug related behaviours.

A sense of belonging to a community and taking part in community activities can reduce loneliness and increase wellbeing without recourse to prescription medicines or medical intervention. More than improving health literacy, involving people with lived experience in the team could provide further support to those with long term conditions. There could be more focus on networks of support to individuals to involve such patient experts to deliver 1:1 and groups on chronic pain, mental distress, addiction as well as training.

There is therefore a need for increased focus on using community resources, working with the third sector and enabling positive lifestyle changes with green prescription supported by organisations and by professionals. All appropriate services should be visibly available in communities in line with the needs of communities and not require referral by a health care professional. Moving the focus to development of community based resources as a first line of access to all and strengthening the support around the social aspects of peoples' lives e.g. loneliness, housing, financial difficulties, isolation and a lack of
relationships. This would mean that health would remain accessible to all however would not be the only “open door” and would be part of a suite of services available.

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

The barriers and risks to delivering a sustainable primary care system in urban and rural areas have been well recognised for some time but unfortunately a chronic lack of action has resulted in a threat to service sustainability.

The main challenges are:

- workforce recruitment and retention;
- adequate community and primary care funding to match expectation, need and demand;
- inadequate primary care premises;
- inadequate IT infrastructure.

Recruitment and Retention

Funding levels for primary care services continue to be set at a very small percentage of the overall health budget. There are significant concerns about the resource available to recruit professionals to deliver services in the community (as evidenced by current concerns relating to the Primary Care Improvement Plans) compounded by additional issues with sufficient availability of a potential workforce. There is significant concern that the national workforce plan is not going to deliver the multidisciplinary workforce required to sustain primary care.

Positive messaging and communication of the value of primary care needs to be improved with continued focus on improving access to careers in primary care that are seen to be sufficiently attractive. There should be more investment in early introduction in schools to promote and support people to work in primary care roles.

Workforce Planning requires prioritisation of community-based recruitment and acknowledgment of the interplay between salaried staff, independent contractors and health and social care systems. Current failure to manage this in a co-ordinated way reduces the effectiveness, efficiency and co-ordination of care.

The impact of pensions and tax rules must be considered as a key concern for future recruitment and retention for GPs.

Premises

There is a need to ensure that primary care and community premises are fit for purpose and are well maintained, appropriately equipped and have capacity for an increasing community workload. There is a requirement for significant capital investment to maintain
and expand our primary care premises to provide a base for an expanding multi-professional and multi-agency workforce.

**Information Technology**

An agile and interconnected IT infrastructure is essential to optimise service delivery, reduces the issue of professional isolation and a sense of sole responsibility. This is currently not in place and is a barrier to reform and efficacy of service delivery. A fit-for-purpose IT infrastructure that allows appropriate and effective information sharing to optimise patient care and safety must be developed and invested in.

Primary care has outgrown its current IT systems. IT systems in primary care need to be reliable, accessible and fit for the future including appropriate interface with social care, secondary care, tertiary care and other independent contractors, so that services can be provided remotely when appropriate and helpful. Many of our services can benefit from this (triage, mental health support, pharmacotherapy, support for smaller practices). In particular, the following issues should be considered:

- Transactions currently undertaken by paper should be reviewed and redesigned to be digitally enabled. e.g. repeat prescribing.
- NHS NearMe should be an option for remote and rural locations in particular when appropriate but recognising the limitations of virtual consultation.
- Decision aids are useful and there should be 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 specialities. Decision aids should be used to support shared decision making and should be citizen facing.
- Services like Order Comms should be of a consistent standard across Scotland and provide functionality which supports patient safety at a GP practice level and GDP 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.

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**

General Practice will increasingly be supported by multi-professional teams working collaboratively to deliver care.

Access to Primary Care and levels of satisfaction with access vary enormously and mirror the inverse care law. The two yearly Health and Social Care Experience Survey illustrates this repeatedly. Insufficient attention to this issue perpetuates and magnifies health inequalities, and funding formulae fail to recognise this issue sufficiently.
Co-location and collaborative working between practices and with other health and care services will be important to maximise the benefit of multidisciplinary working. Real integration between services requires a significant investment of time to be able to start to understand various roles and responsibilities and identify the gaps between these, allowing a collaborative approach to how these are managed. Time to develop trust and relationships is crucial and will be what determines success and failure.

Primary healthcare should be provided by a multi-disciplinary team and built on the Right Person, Right Place, Right Time approach.

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. This can also be supported by good IT connectivity as above.

Primary care should be available 24/7. This should be appropriate availability and people should receive care in a timely manner for their need whether for urgent or routine matters.

Holistic Care

Holistic care is the cornerstone of primary care particularly for individuals with complex, chronic or palliative care needs. This should be enabled on a 24/7 model. There is a need to consider ways to ensure the sustainability of primary care Out of Hours services.

GP Clusters and Locality Planning

Cluster structures and arrangements should be supported and allowed to evolve to enable quality improvement and shape service delivery. There needs to be stronger links with Locality Planning structures in order for professionals to be able to influence funding decisions.

Ownership of quality improvement, effectiveness, prevention and tackling health inequalities should be managed by all professional groups and agencies working in collaboration. This requires an effective HSCP infrastructure.

Effectiveness could be best measured by patient reported outcomes with a suite of indicators 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.