HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM AHP Directors Scotland Group

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?

ADSG suggest the following changes to primary care delivery:

- Integrated IT - Across Primary, Secondary and Social Care which will:
  - Remove the duplication of referrals and possibly the need for referrals with staff being able to view involvement by other members of the wider multi professional/agency teams.
  - Awareness of/support for patients in their decision making about the care they receive and engagement in self-management activities. Allowing for conversations which may have been started by another professional to be continued providing consistent advice and discussions. Ongoing recognition of where a patient is within cycles of behaviour change and ensuring that opportunities to support self-management aren’t missed.
  - Awareness of person-centred goals/what matters to the person - with an opportunity for all professionals to be able to share this information.

- A once-for-Scotland approach to information governance - this is a significant barrier to multi-professional/agency working and the variation across boards and partnership areas is significant and needs to be resolved.

- Education of people in the roles/expertise/benefits of the different members of the Multi professional teams. Removing assumptions about what staff & public “think” a specific profession does, particularly as we extend traditional roles & expectations. Strong & clear communication about professions with the use of personal stories and media campaigns. Effectively supporting “gatekeepers” - Reception staff and first contact information services, to direct people to the most appropriate services and/or practitioners.

- Improving access - need to streamline access and broaden the range of services that people can access directly as first contact practitioners, building on the success of the Musculoskeletal (MSK) Physiotherapy model with other professions such as Occupational Therapy and Dietetics.

- Promoting the expert patient and peer support from people with lived experience of long-term conditions as being fundamental to how we truly co-produce primary care services.

- Education for the public that "see your GP" should mean "see your Primary Care Team" – multiagency/multi professional.

- People co-producing local Primary Care Teams - it is important that people consider themselves as part of their care teams and we co-create the condition for people in
communities to feel empowered to self-manage/self-refer, linked to the Realistic medicine agenda and developing a model of shared decision making.

- Promote the need to have honest and transparent conversations about the fundamental whole systems changes needed for sustainable service models and the key role people have in making best use of scarce resources.
- Strong Allied Health Professional presence & voice in the planning & development of the multiagency/professional teams within Primary Care and having Allied Health Professionals as core members of new primary care delivery models
- Ensure that whole systems pathways of care are simplified, and gate keeping referral process are minimised. For example, improved MSK Pathways.
- Change from ‘Referral To’ to a ‘Request for Assistance’ model of care. As used very successfully in Children and Young People’s Services (Refer to: Allied Health Professionals, Ready to Act Strategy).
- Fully utilise professionals such as Occupational Therapists, who are ideally suited help address the challenges in primary care. They are experts in assessing and uncovering a person’s barriers to participation. OTs can address a problem using a variety of interventions which can alter the person, the occupation or task and the environment or a combination of all three.
- Better meet the needs of people with mental health conditions by utilising the skills and competencies of a range of multi-professional roles for example Occupational Therapists (examples of which are given in Appendices A and B).

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

ADSG identified the following potential barriers to sustainable primary care:

- Staff recruitment & retention - availability of the workforce to expand into new and emerging roles - insufficient pipeline for some professions to meet predicted demand. Seeing the challenges of workforce planning as needing a whole systems approach
- Leadership and power base to move from a traditional medical model to a collaborative, co-produced model of primary care.
- Staff recruitment for the wider multi-professional roles without destabilising existing services. Particularly in remote and rural areas.
- Professional support for Allied Health Professional staff moving into Primary Care roles and ensuring robust governance arrangements to support and assure safe and effective practice. In remote and rural areas these professionals are often working as loan practitioners in small clusters and practices.
- Professional support for developing & evaluating evolving multi-professional roles within Primary Care - for example expanding non-medical prescribing and the capacity required to support the training and mentoring of staff developing new skills and competencies
- Limited QI capacity and skills within Primary Care to support improvements at scale and pace
• Some practical infrastructure considerations - having workplaces that support innovative MDT models of service delivery.

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

ADSG suggestions for monitoring and evaluation:

• Practice(s)/Clusters can monitor and evaluate their Practice population health and social care needs, along with social deprivation and within that identify:
  
  o Who are seeking services from Primary Care and which services they are accessing at First Point of Contact.
  o Who isn't engaging with Primary Care services for example non uptake of Long-Term Condition reviews. This has the potential to offer opportunities to work differently
  o Growth in the First Point of Contact uptake
  o Conversion to self-management rates and onward pathway outcomes
  o GP Practice Clusters and wider community interface groups at a locality or community level working collaboratively to use local data and understand what matters to people to agree priorities and how they will be evaluated

• The use of the LifeCurve & Pre-LifeCurve as holistic outcome measure which could be used across health, social care, 3rd sector and particularly by people themselves.
• Case Studies of peoples’ stories/journeys
• Staff experience, retention and recruitment levels, and stress surveys
• The diversity of primary care teams
As part of NHS Lanarkshire’s GMS/Primary Care Improvement Plan, Occupational Therapists (OTs) working in two GP practices are developing a service model which will be integrated into multidisciplinary primary care teams across Lanarkshire. The model offers occupational therapy assessment and intervention to a diverse range of patients aged 16+ and focuses on identifying what matters to patients in their day-to-day activities and roles. It aims to maximise patients’ ability to live well at home, in the workplace and in their community through increased access to prevention, early intervention and condition management support.

Key Learning

Occupational Therapy adds value by:
- Addressing the needs of people with multiple, physical and mental health conditions thereby reducing the need for referrals to multiple condition specialist services
- Delivering early intervention, leading to shorter interventions, better patient engagement & improved long term functional outcomes & quality of life
- Offering interventions aimed at preventing functional decline, building resilience & keeping people safe. This has resulted in reductions in:
  * need for homecare & social services input for older adults
  * use of medication for individuals with LTCs
  * sickness absence & reliance on sickness benefits for people in work

Integration of OT clinicians with GP teams is important to:
- Promote GP learning about breadth of OT role
- Improve communication & partnership working
- Increase understanding of wider referral pathway

Referral data (November ’17 to January ’18)
- 282 referrals received
- 63% of referrals taken onto OT caseload after triage
- 14% signposted/referred on
- Age range 16 to 89

Patient goals themes

Outcomes

Patient rated outcome measures, the Canadian Occupational Performance Measure (COPM) & the World Health Organisation Quality of Life Scale (WHOQOL), are used at assessment & discharge to measure changes in functioning and quality of life.

Of patients completing OT intervention:
- 88% report improvement in performance of named occupations
- 96% report improvement in satisfaction of named occupations
- 97% report improved Quality of Life

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Next Steps
- Continuation & further testing of current service
- Scale and spread of OT service within NHS Lanarkshire Primary Care MDT Team model
- Networking and sharing of learning across Scotland to inform wider service development

Patient and GP feedback

Responsiveness:
- Patients like that its in house...part of the practice team
- The door was left open for me to contact her again

Flexibility:
- Following OT input, she’s been transformed & everything's much more positive
- ..more of a discussion, like what about this? Could you try that? Have you thought of this?

Person-centred:
- She's gone to some of the local groups... willingmess between NHS & local groups is a helpful thing, then you can start to build links that allow you to have dialogue

Informed/Integrated:
- She’s gone to some of the local groups... willingness between NHS & local groups is a helpful thing, then you can start to build links that allow you to have dialogue

ABOUT THE TEST OF CHANGE
Jacqueline Terrance (Lead OT for Mental Health) summarised this test of change as:

‘Behavioural Activation (BA) is a low intensity, evidence based psychological intervention for the treatment and management of mild to moderate depression. It emphasises the link between behaviour and mood using a problem solving approach, exploring the function and impact of current behavioural patterns. BA in Primary Care offers an opportunity for early intervention and enables the individual to develop self-management skills to improve mental health & well-being.

‘This test of change sought to align Occupation Therapists (OT) GP practices (or clusters) to deliver a structured 8 session programme to patients referred by their GPs. The OTs would need to liaise with GP practices to ensure they understood the BA program and to establish good working relationships.’

ABOUT THIS REPORT
As this test of change was not successful at this time, it was felt to be important to fully extract the learning for future reference. An interview was held with Jacqueline Terrance, who was the main sponsor, because she had maintained an overview of progress at each stage. The interview was digitally recorded and reviewed to identify the main themes. These are illustrated below, with relevant quotes, where possible.

Understanding Behavioural Activation Therapy (BAT)
One of the main issues with BAT was that although it had a strong evidence base and worked well in our Community Mental Health Teams, there was relatively little understanding of it in Primary Care (see Quote no. 1).

But there was also a sense that Primary Care did not feel the need to know about the full range of mental health services and possible interventions. The practices that initially expressed an interest in hearing more about the project were unsure about changes to mental health services and the single point of access arrangements within mental health teams.

Occupational Therapists delivering a psychological intervention
In Primary Care there is a perception that Occupational Therapy is about ‘lifts, rails and ramps’, so the idea of OTs delivering a therapeutic intervention is not within the frame of reference. Not only was this aspect of the project not able to be fully explained in advance (see Quote no. 1), but it caused some confusion in follow-on discussions with individual GPs (see Quote no. 2).

Some of this may be related to the fact that it was Practice Managers who initially submitted notes of interest, so the GPs themselves did not directly request this test of change. Not only was the proposal for something that was new to Primary Care, but it involved a different role i.e. psychological therapy to the one they associated with OTs.

Timing
In line with the processes around applying for and being awarded Primary Care & Mental Health Transformation funding, this project was ready to begin at a difficult time of year. Not only are December and January busy months due to winter pressures, but GPs are involved in job appraisals and this year the new General Medical Services contract was released. There was less capacity at this time to fully consider any proposed changes than there might have been at a later date.

Developing working relationships in GP surgeries
The model that was designed to deliver BAT in Primary Care involved two OTs in North Lanarkshire and another two in the South. The referrals they received would be added to a list of potential
participants in this group intervention. BAT could be offered at different times, days, and venues to suit each group, and everything was put in place for things to start. However, when referrals did not materialise, it was realised that the model was missing the necessary working relationships between the GPs (who would generate referrals) and the OTs (who would be delivering the intervention). It was clear that, ‘because there was no visibility, there was no relationship’ and this was felt to be due to the OTs not being based in the GP surgeries.

**An alternative referral route**

Rather than add any more pressure to the GPs at this time, it was suggested that referrals could be generated from elsewhere. The new Mental Health Liaison Nursing service, which was based in a number of GP surgeries, agreed to explore this. However, they found that three referrals was the most that any one area could find, so this service did not have enough patients to generate a full group. They also encountered difficulty selling the concept to patients (see Quote no. 3).

**Group versus individual therapy**

The Mental Health Liaison Nurses were also able to explore the views of the people they were offering BAT to and the potential participants were quite clear that they did not wish to join a group. Although this is the normal mode of delivery in some other settings e.g. secondary care, there was a sense from these patients that they were less inclined to surrender control for their health and wellbeing to a group leader. The other consideration was their resistance to being in a group in their own locality with other people who had mental health issues. The usual mode of Primary Care service delivery allows people to retain responsibility for who they choose to share health issues with, especially in relation to sensitive aspects such as mental health. However, this reluctance meant they missed out on something that has been successful with other BA groups, which is the learning from other participants around how to apply the principles and techniques being taught.

**Potentially adding to Primary Care pressures**

Part of the impetus for testing BAT in Primary Care was being able to offer a treatment intervention that could prevent onward referral to secondary care, and avoid people having a history of mental health issues (see Quote no. 4). However, because this was an intervention that required a referral, rather than simply signposting to another service, it was perceived as requiring more work from the GP. Whilst the OT would be gathering robust data on the outcomes and potentially suggesting onward referral to other services that could improve the outcomes for patients, it was not seen in that light by those being asked to refer in.

Nonetheless, the current pressures on Primary Care were perhaps not fully appreciated when this test of change was proposed. Part of the learning for those leading it was that many GPs do not have the capacity at present to give full consideration to new ways of working.

**Possible future fit**

It was recognised that this may simply not be the right time for introducing BAT into Primary Care. If hubs led by GPs develop, with a number of different professionals seeing patients, then it should be possible to include Mental Health OTs delivering psychological interventions. This would have the added advantage of avoiding any mental health stigma for everyone involved. However, a lot of learning is required before this point can be reached.