HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM Glasgow City HSCP

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?

Introduction

We welcome the view of the participants who have clearly expressed their desires for a future primary care system. Despite the best efforts of the committee, it can be a challenge to hear the views of those living in very significant socio-economic deprivation, and those who are socially excluded. Furthermore, in addition to hearing what people want from primary care, it is important to explore what they need and to consider the health and care system as a whole rather than as a series of “asks” or specific issues. Only by considering how the system responds to health needs in our communities can true transformational change happen.

The recent Scottish Burden of Disease study brings into sharp perspective how people’s health needs have changed since the NHS started more than 70 years ago.

Since that time, infectious diseases have given way to chronic illness as populations’ age and their life circumstances change. Across the Scottish population as a whole, the largest groups in the overall burden of disease (this includes early deaths as well as years lived with chronic illness) were: heart disease, depression, low back pain, lung cancer and stroke. Looking specifically at premature deaths, the main causes were heart disease, lung cancer, stroke, airways disease and dementia. In terms of chronic illness across Scotland, the main causes were low back pain, depression, migraine, anxiety, and problems with hearing and vision.

The burden of disease experienced by the poorest group in society looks quite different to the pattern for Scotland as a whole. For those living in the poorest areas, the main overall causes were: heart disease, lung cancer, drug use, stroke, anxiety and alcohol dependence. The premature deaths in the poorest areas were caused by heart disease, lung cancer, chronic airways disease, drug use, stroke and chronic liver disease. The main causes of chronic illness and disability in the poorest areas were: depression, low back pain, anxiety, drug use and alcohol dependence.

Glasgow City contains a high proportion of people living in the poorest circumstances in Scotland. For too many of our population their lives are cut short, and they live many more years with chronic disability and illness, often caused by the so called diseases of despair: depression, anxiety, drug use, alcohol dependence, suicide, and chronic liver disease. Against this background, we need to consider how to reconfigure primary care in a way which better meets the healthcare needs of local people as well as taking account of their aspirations for a future primary care system. Two possible ways of improving the patient
care pathways could be the provision of specialist assessment of mental health at the primary care level, especially for people with co-morbid drug or alcohol problems and improvement in the interface between primary and specialist/secondary care services. We would welcome the opportunity to discuss the primary health and care needs with the committee.

**Reponses to some of the priorities highlighted by the participants**

**Flexible appointment systems – routine access to evening/weekend appointments to fit lifestyle/working hours – designed to serve public not professionals.**

We agree that promoting accessibility to primary care services for patients is a priority but we have a number of concerns about a blanket approach to providing appointments at evenings and/or weekends:

- This was undertaken in England but we understand that uptake was less than expected.
- Without considerable recruitment of new primary care practitioners extending hours will merely dilute the existing workforce providing “in hours” services.
- A recruitment campaign to increase the workforce to cover the extended hours would require additional funding and is unlikely to be successful given the current difficulties in recruiting GPs and other health professionals to provide the existing services.

**Use of technology - Ability to contact health professionals by email and schedule appointments online, hold consultations via video**

We agree that greater use of technology has the potential to promote improved access to services and health outcomes e.g. on-line appointments, medication ordering, remote consultation (video). We would stress, though, that caution needs to be exercised in relation to providing direct email access to health professionals, given the experience elsewhere with the volume of requests and amount of time that this takes professionals to respond to patients. Similar to our comments about extended hours for routine appointments, without an increase in practitioners we would be using a proportion of the currently available staff time in a different way.

There are other forms of digitally provided information and support (such as NHS Inform) that can be used to promote self-care and/or provide direction to other services and help that is available (and could be developed further).

**Social prescribing**

Whilst we support social prescribing approaches, we believe that these should be delivered in holistic ways that reflect the complexities and multiple dimensions of many patients’ lives.

**Health checks**
It is positive that the public saw a strong role for early years’ services and prevention but we have concerns about the efficacy of ‘health checks’ (MOTs). These have been tried before (such as Keep Well in Scotland and similar initiatives down in England) but have shown to be a relatively poor use of resources.

Within the NHS the approach to prevention falls into two main categories: conditions for which strict standards are met and screening programmes exist (examples include screening for breast, bowel and cervical cancer) and general wellbeing advice. Whilst the provision of wellbeing advice is well known, it is often the case that many patients do not follow up it up with life style changes, such as exercising more and reducing their intake of alcohol, salt and calories.

We would argue, therefore, that using professional time to tell people what they undoubtedly already know would not seem to be a good evidence based way to approach the prevention agenda; every professional contact will likely generate wellbeing advice opportunistically but prevention activities can be more effectively delivered elsewhere, such as through schools, in the workplace and through community initiatives.

**Triage/privacy at practice front desk**

The care navigation model does look very good in England; we are trying to emulate it in Scotland but that has implications for how we train our reception staff, where we might physically manage the triage (or more accurately ‘streaming’ of people to the right service first time) and what people are comfortable with and/or would need to expect to happen at the ‘front desk’ to deliver on this approach.

**Sustained relationships with health staff who know individuals**

There is a degree of tension between seeing a small number of people that form a small multi-disciplinary team (and who therefore know the patient quite well) but who might need to refer him/her a significant proportion of time to professionals elsewhere and a larger MDT, where they can access the right professional first time but who know the patient less well. However, patients have been accessing MDT members for years and normally realise that this means they do not always need to see the GP.

**GP at heart of hub but with shared responsibility with other professionals for care and sign-posting – connection between the different professionals**

We would agree that the relationships between the professionals are a vital aspect of patient care and we would highlight the importance of the relationship between primary and secondary care clinicians in this instance. Relationship-based care can often be undermined by overarching systems which return referrals without communication between the referrer and the secondary care clinician about why the referral was not accepted.

**Improved planning across health & social care, shared IT systems/ NHS to take over responsibility for social care from local authority**
In Glasgow we have integrated primary and community health care and social care for children’s adults and older people services within one partnership, to improve the planning and delivery of services. We are beginning to see evidence of improvements from these integration arrangements. We would not see any benefit from the NHS taking over social care because this would require considerable upheaval, without any evidence that it would improve outcomes for service users. We do agree that improving connectivity between IT systems and improvements in data sharing would enhance the co-ordination of care and consequently provide substantial benefits to patients.

Finance

The close alignment of primary care and third sector services are vital, especially if we are to further promote the preventative agenda and we support the priority of more sustainable funding for the third sector. We would argue that public sector funding that is invested in the third sector should be planned in close alignment with primary care health services to promote integration and to create more streamlined forms of support for patients.

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

- The availability of resources to meet the needs and demands of the population in Glasgow City to improve health and reduce health inequalities.
- The availability of suitably qualified and skilled staff, including general practitioners, nurses, MSK physiotherapists and pharmacists.
- Older age profile of the GP and nursing workforce.
- Scale of the workload for many practitioners working in primary care.
- There are widely known problems for the out of hours’ service because of the tax and superannuation arrangements that discourage medics from working additional hours.
- Transforming the system to meet the changing needs of our communities and their increasing diversity.

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

- A co-ordinated approach across Scotland with clear communication about roles and responsibilities for monitoring and evaluation of programmes.
- Tracking changes against the Burden of Disease framework.
- Shared / single IT system across primary care that provides a safe and effective care and provides the data for monitoring and evaluation.
- A standardised approach to record keeping.
- Approaches which track the health and care journey of patients and their experiences.
- Clarity about the resourcing for monitoring and evaluation.
- Incorporating questions into the national health and care experience survey to capture the changing views of the patients in a standardised way.