HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP

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?

Dundee HSCP welcomes both the report itself and the opportunities to link with professionals locally and input to the Committees development process. There is obviously a significant level of change in primary care with the developments that are linked to the 2018 GMS contract for General Practice. Much of what is seen as a priority by the public is in line with changes being progressed as part of the local contract implementation.

Generally we endorse the priorities of the Public Panels, we have some additional comments about some of the priorities in some of the Themes which we recognise have gone further than Primary Care into reshaping Health and Social Care.

Use of technology: We would welcome one electronic record that could be shared by the multi-disciplinary team with permissions for access relevant to their needs. As the wider primary care team develops and takes on new roles, often as first point of contact with patients, it is vital that there is good access to up to date medical information so that patients can be managed comprehensively and safety. It is also vital that information collected by the team is available to the team, so there needs to be an ability to write into the GP record where appropriate. Shared access to electronic records has been an aspiration for some time nationally and has had limited progress. Consideration needs to be given to how this might be phased or prioritised and the infrastructure to work this. With the use of more technology there needs to be different investment, including for mobile working. Mobile working is key given the increasing number of frail elderly patients who may require care at home, and the use of a wider range of venues (including out with health premises) to deliver aspects of care.

We have already endorsed and encouraged use of technology through our Technology Enabled Care Strategy, annual local Smart Care Convention and Technology Enabled Care Social Media. In particular Attend Anywhere/ Near Me has been a focus within this.

The use of wearables and other home monitoring devices is also seen as advantageous. We would suggest that it is important that appropriate technical support is available at local level to avoid health professionals having to provide this. The focus of any wearables should be to encourage and support self-care, not necessarily to manage health conditions. The increased use of online resources for learning, self-care and self-management are recognised as important. In Dundee because of the significant inequalities in the city, this can be challenging, and the use of this may be lower than in some areas. However there is a lot of work to raise awareness of this and to support people to develop their skills.

Community Wide Approaches: Locally we have positive experience of Social Prescribing and will continue to provide this model and support development. The Dundee Green Health Partnership brings a focus to using green and outdoor spaces and outdoor gym
equipment has been a positive addition locally. We have a good network of local community centres which have provided opportunities for colocation and co-working particularly in areas of deprivation. Although community space is more of a challenge in other areas there is increasing inventiveness and use of the spaces that are available in communities.

Dundee is developing multi-use community facilities with “The Crescent” being a good example of general practice, health teams and arrange of community services, including a library, and cookery skills kitchen, being co-located. Longer term plans include the development of further buildings with a similar model to this, recognising the benefits to the services in these facilities and those in the local community. The panels noted a desire to have increased diagnostics in the community and the “hub” model described would allow more of this to shift form a secondary care setting to a local one, for some services.

In terms of collective care in homely settings we prefer the approach of supporting people to live independently in their own homes optimising the care provision available. The HSCP (including the third sector) is working along with housing colleagues and supporting people to live in their homes for life, while exploring new ways of providing an appropriate support, care and response services.

Patient-Centred approaches: We are in agreement that we want greater engagement and endorse the concept of co-production with the workforce and service users. We believe that this co-production will be essential in relation to developing more effective triage for primary care services which becomes ever more important when operating a GP at the heart of the hub model. In relation to flexible appointment systems we agree that appointments should be available at times that suit the service user, however this may not be possible given shortages of GP and others.

A positive relationship with a health professional is important for a range of reasons, including good patient outcomes, but in a climate where many staff, particularly in general practice, are choosing to have portfolio careers, or work part time because of other interests, this is challenging. Technology and a wider range of communication methods can support this.

Effective triage is seen as important given the changing context of health care delivery. There are a range of ways this can be done, with technology having a potential part to play in this. However it requires a culture shift from the public, many of whom do not understand the valuable role that reception staff have in this. A public campaign to support this would be welcome.

Professionals locally are unsure of the demand for evening and weekend appointments. Many practices will offer some evening appointments but these have not been well used in all practices. However recognition of local demand is important. Weekend clinics would be challenging particularly with GP staffing levels and there is likely to be a strong resistance to routinely offering weekend appointments for GP’s. However wider services are increasingly considering the delivery of services across the week.

Improvement and responsiveness is closely tied to technology developments, and to capacity. Professionals locally would have concerns about self-referral in some contexts, such as to specialist services, but a number of areas are currently being developed as part of the Primary Care Improvement Plans which will include self-referral, including for mental
health issues and musculoskeletal issues. There are other areas of care which can be developed in this way. Teams would welcome not only self-referral to the appropriate team, but also easier referral between teams so that GP’s do not have to act as the gatekeepers to services, but professionals who have seen and assessed a patient can refer.

One suggestion is that it may be worth exploring how to provide more effective support to people at high risk of not managing their health and wellbeing in their interactions with Primary Care to assist them to attend appointments and follow through with advice, treatment plans etc.

**Service and Workforce Planning:** We endorse the GP at the heart of the hub model. We need a good balance of professionals who share responsibilities as part of this and forward planning to ensure that the right workforce mix is available. We agree this will involve local strategic planning with expert analysis of data and evidence. This implies that we have enough GP’s to fulfil this role. Even with the evolving teams in primary care we face significant challenges in Dundee to have these skilled staff in post, including but not exclusively GP’s. National work to create attractive careers and a trained workforce feeding into the system is key. Tayside has developed a successful “career start” for young GP’s and this model is being considered for other professional groups such as pharmacy.

With respect to ‘taking into account workforce stress’ we prefer to take a proactive approach to workforce wellbeing and consider workforce capacity and capability. In addition to this we believe that a co-productive approach is needed which goes beyond just ‘listening to staff concerns before change’ and supports the workforce to be part of designing the future changes.

**Health and Social Care:** In relation to the priority that the NHS take over social care we have concerns about the need to continue the relatively recent change which created Health and Social Care Partnerships. There is a need for colleagues to work in an integrated way as partners in delivery and this may not be effectively achieved if one partner “took over” another.

**Finance:** The short term nature of funding to the third sector is difficult and longer term security would allow them to have a stable workforce to meet the increasing demands of service delivery for health placed on them.

General practices locally have varying views on their independent status. We had limited responses for practices but know that many GPs value their independence. However we have local experience that with the increasing financial pressures, and issues with managing more and more complex businesses, at a time when there are many unfilled GP posts, it is not sustainable for some practices. We are seeing an interest in salaried and portfolio posts, particularly for GP’s. We need to strive to find a model which can support both the existing partnership model and evolving salaried models. We are unclear locally what this should look like. It is an area that there is a lot of national work and would await that.

**Prevention Focus:** with respect to this area we endorse the need for this focus and our work relating to reducing Health Inequalities is contributing to this. This is an area where co-production and supporting service users and the workforce to find the best ways forward is essential. It is also important that clinical evidence is taken into account e.g., in respect to the
prevention / early detection of dementia. We would be keen that there should be solid clinical evidence collected and shared prior to making decisions about initiatives - the screening at medical practices in England has failed to give us this evidence.

Prevention is a complex area and requires many levels of support and development across wide partnerships, including people being proactive in maintaining their own health. There continues to be limited resource to support this agenda, and we would welcome an increased resource on upstream prevention.

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

There is a significant degree of change underway with the implementation of the new GMS contract and the focus on wider teams working in primary care. However the scale and pace of this change is relatively slow currently. This is frustrating for the teams involved and for the public who feel they are not receiving the care they require. Longer term planning for the agenda is key to ensuring progress towards this new model of care.

We have 3 key barriers to a sustainable primary care: IT, premises and workforce. The criticality of these is described in the responses above. In summary, the substantial changes in service disposition called for by the new GMS contract require staff with new skills not available at present within our current workforce. This requires a significant investment in training and development, as well as targeted recruitment. There is limited local capacity to provide this at scale. The legacy premises that we currently control are not configured for the new primary care, and there is limited capital available to either invest in new premises, or reconfigure old ones. In order for the primary care team to fulfil its potential as being an effective, patient focussed, locally accessible team working seamlessly with General Practice, there needs to be immediate electronic read/write access to relevant aspects of the primary care record.

A major workforce concern is the availability of GPs. We would suggest there needs to be an increasingly rapid increase in the level of support from other parts of primary care to create that balance.

Proposed solutions like extending appointments to suit service users seem impossible without enough GP cover. Doing this would also increase the demand on support services and other parts of the multi-disciplinary team to match these appointment times, potentially making them more stretched in supporting the Hub system.

With reference to improved reception staff triage this would be a change process that should be led by the Reception workforce and the service users to avoid a misinterpretation that Receptionist are trying to put barriers in the way of effective medical care. Upskilling and training related to this could benefit from being supported by centralised training being made available for some staff to cascade knowledge to colleagues.

A workforce targeted at reducing inequalities is not a concept that is universally accepted given we work in a system what has equal access as a focus rather than equity of outcomes. For teams in primary care this creates a particular challenge as we change systems, particularly where systems like self-referral are used, as these can become demand led, rather than based on need or outcome, and can skew where resources are focussed.
There are particular issues as to how multi-disciplinary teams work in Dundee as practices do not have a concentrated catchment area that supports local working. However teams are finding ways around this and this is a specific issue to Dundee.

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?

Clusters have been in place for some time in Dundee and have become accepted as the norm for much of local focus. However given the geography of Dundee this creates a tension as to how to have close links with communities locally, given that most practices cover most of the city and so people have a wide choice of practice. With integration we are increasingly focusing on delivering services locally, but that is not feasible when linked to practice based teams. We need to consider this impact as we develop a new primary care. There are local discussions on the recent cluster guidance from the Scottish Government. The aspirations it contains are generally positively received. However in the current environment with GP’s still being understaffed it is difficult to create capacity to support this. The cluster leads leadership in the change process is however critical and we need to find solutions to this issue.

It is recognised by Medical Practices locally that LIST (NHS Information Services Division) is a helpful resource. A number of tools have been developed by ISD and others to support data, but are not at the stage of being refined enough to meet all of the needs for looking at impact and outcome.

Practitioners have expressed concerns that monitoring and evaluation should not add to the existing Primary care workload. It is challenging to get the right balance between evaluating the impact of change and the demands that can place on systems. Many of the changes being progressed currently are small tests of change which are then scaled and professional and patient views are a key part of that.

The DHSCP is currently working with Dundee Partnership regarding participation and engagement across the city. We believe that it is important to involve services users and the workforce at an early stage in making decisions about what and how to evaluate and in identifying what matters to them. We have shared this request for views across the Health and Social Care Workforce (directly employed by NHS Tayside and Dundee City Council) inviting them to respond to the submission request and to send their views to shape our submission.

4. Additional comments

DHSCP are keen to learn from what is working well in terms of multi-disciplinary working across our city and elsewhere in Scotland and would welcome any additional support to do this. There is currently no clear platform to share knowledge, in reality or virtually, for this at HSCP level where most of the change is happening.

Primary care is critical to the future of a healthy population in Dundee. Having a sustainable fit for purpose model is key to this. It is not a simple change but multifaceted and needs significant resource to ensure it is delivered. There is a huge breadth and depth of
experience, and a willingness to embrace change, that ensures that the current primary care workforce will work to achieve this challenge.

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