HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM CHEST HEART & STROKE SCOTLAND

1. Considering the Health and Sport Committee’s report on the public panels, what changes are needed to ensure that primary care is delivered in a way that focuses on the health and public health priorities of local communities?

There are a number of priorities which the public panels identified that reflect our focus as a charity, in particular:

- The importance of keeping people at home;
- The value of social prescribing, support for physical activity and addressing loneliness;
- Easily accessible information about and referral or signposting to services such as community opportunities;
- Prevention and health behaviour change, particularly in more deprived communities;
- Co-location of facilities such as community hubs.

Keeping people at home

The Scottish Health Survey 2017 highlights that people are increasingly living longer but often with multiple long-term conditions and more complex needs. Long-term conditions such as chest and heart disease, or the effects of a stroke, account for 80% of all GP consultations and for 60% of all deaths in Scotland. Older people are more likely to have multiple long-term conditions, and with our ageing population the demand for ongoing care will increase.

Primary care services are key to people being best supported to self-manage their conditions, remain at home, and optimise their physical and mental health. GPs have a crucial role in treating and supporting people living with long-term conditions; they are not only often the points of onward referral to specialist consultants, but also the first point of call thereafter for what might be many years, through to palliation.

The wider Primary Care Team is also hugely important and the move towards multi-disciplinary teams in the primary care setting is therefore very welcome. But this needs to be matched by appropriate workforce planning and resources, and ensured that acute services are not adversely affected.

The people we support tell us that it is community-based rehabilitation where the gaps often lie. Whereas allied health professionals such as physiotherapists might be easily accessed whilst someone is in hospital, on return home people often feel abandoned by the system. They experience long waiting times to see specialists in the community such as speech and language therapists, occupational therapists, or physiotherapists. And then those services are so stretched that the time they can provide people is often minimal.

Social prescribing, physical activity and signposting

Improving people’s health and their overall wellbeing does not just lie with a purely medical model of disease control, but also with broader psychosocial support and physical activity. The response from the Committee’s public panels highlights the importance that people place on social prescribing, being physically active, and signposting. We strongly agree that these are vital, particularly for people who are living with long-term conditions such as chest and heart disease, or the effects of a stroke.

Chest Heart & Stroke Scotland has a network of 150 peer support groups across Scotland which are run by members, providing support in whatever form members’ require such as physical activity, social activities, walking, or singing. The social element of such groups is often the ‘glue’ that sustains them and retains members.

Physical activity is important in preventing disease, but also in the secondary prevention of stroke, heart disease and exacerbations of lung disease. It helps people to self-manage their conditions, live independently, and reduce the risk of isolation. It is a core component of NHS rehabilitation programmes, and needs to be sustained in the long-term to maintain the benefits of that rehabilitation.

The findings of Chest Heart & Stroke Scotland’s One in Five Report\(^2\) reflect the panels’ priorities, and are similarly based on the lived experience of people with our conditions;

- 65% of people with chest conditions or after a stroke told us their ability to be physically active was affected, and 54% of people with heart conditions.
- Almost one in five people are not accessing support or services because they don’t know what is available to them in their communities.
- At least half of people rely on their family or friends for information, advice and support, and this figure rises for people after a stroke or with multiple health conditions
- Two-thirds of people after a stroke experience enormous loss of confidence and independence, many struggle to leave to house, or to see their family and friends.

In response to those, one of the recommendations we make in the One in Five Report is for Integrated Joint Boards to ensure that their health and social care professionals are able to easily signpost people to the support and services available, including rehabilitation

programmes, and community and formal support. Professionals in primary care need to be proactive in signposting people towards broader opportunities to be physically active, particularly as the time when someone is most receptive to those messages is often not at the point of diagnosis or when receiving acute care, but once someone has returned home and come to terms with their changed health.

**Health behaviour change, and community hubs**

Primary care cannot work in isolation, and needs to take a whole-system approach through joining up services and local partnerships. At Chest Heart & Stroke Scotland, our Health Defence team work through our Community Hub in Drumchapel to provide some of those connections within a non-traditional model of primary care services. We offer a preventative programme directly in the community including screening for cardiovascular disease, health checks and health promotion, and have built a partnership with the local Deep End practice and their Links Workers to ensure the Health Defence work complements their pathways.

In addition, our Community Hub in Drumchapel, where the Health Defence team are based, supports a wide range of local community programmes and initiatives delivered by other partners which Links Workers can signpost people to. The Hub is based around the traditional charity retail model, but with the addition of free-to-use community space, free wi-fi, coffee and tea with a café space to encourage people to visit. It not only relies on local volunteers to run it, but has successfully become a key part of the local community and is currently working with 35 groups or organisations based in Drumchapel.

Much of that success is due to letting the community lead – rather than be led by us. We have also not limited the partnerships and services at the Hub to purely health-related issues, incorporating the physical, mental, financial, social and nutritional, in recognition of the wide causes of health inequalities. We provide Thriving Places with a free office in the Hub, and sessions available include IT, cookery demos, Zumba, a Men Matter Support Group, a conversation café, and a Drink Wise Age Well drop-in. We now have five Community Hubs across Scotland, targeting areas of most need.

Primary care delivery needs to be better informed by the local community, and the third sector is ideally placed to gather the voice of people not usually reached by traditional healthcare – such as with our partnership work in Drumchapel with organisations such as AddAction and Cope.

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

Short-term third sector funding for projects presents a barrier to the collaborative primary care model which is needed. Without sustainable and equitable funding being in place, interventions are limited, and the ability to build on momentum and impact is limited.
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?

Robust data collection systems need to be embedded into clinical practice in order to capture this at the point of contact – for example the Allied Health Professionals Operational Measures Project.³