HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM CLACKMANNANSHIRE AND STIRLING HEALTH AND SOCIAL CARE PARTNERSHIP

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 development and sustainability of primary care requires significant refocus with enhanced prioritisation and investment. Current resourcing to effect sustainable change in community services is grossly inadequate.

Committee are keen to hear responses to the following questions:

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?

The public panels gave views on

Technology - Panel were largely in favour of improving / increased use of technology for single record shared across professionals
accessing primary care services (making appointments, contacting professionals, alternatives for face to face appointments)
Using technology to monitor health and share data with professionals

Our View

We would fully support all of the above views, we need to do more to improve digital access to health and care records, and to primary care services.

GP systems are not fit for current purpose, access to services via telephone remains the norm and likely the biggest source of dissatisfaction from people trying to access appointments and information.

People should have more access to their own information, the GP as the “information owner” is outdated.

Current systems are also a barrier to primary care modernisation – A single shared record rather than practice based records would enable practices to work better together and enable multidisciplinary health and care supports to design person centred models of care rather than practice based models of care.

The use of technology for monitoring in the community is currently growing positively from a telecare perspective but home and health monitoring is very limited, blood pressure monitoring is starting to be used but we have a long way to go, individuals are more likely to identify and use their own applications.

Local communities have discussed ideas on better use of telecare. We have been carrying out presentations within communities on how technology can be utilised to support adult’s
health and well-being at home and these have been positively received, we need to do more of the same. Increasing broadband coverage will also assist.

**Community Wide Approach to Wellbeing**

*The priorities from the panel are;*
- **Social prescribing** – support for physical activity & addressing loneliness e.g. promoting walking groups, active social groups, activities making better use of greenspace
- **Don't assume loneliness only affects older people. Use of neighbour networks.**
- **Co-location of facilities** – multi-use community facilities. Making use of community locations eg places of worship & social clubs, community hubs providing nutrition & cooking classes.
- **Teaching basic**
  - life skills in schools, & how to access/use health services.
- **School nurses integrated into community services**
- **Keeping people at home** – using voluntary support for home care – or collective care in homely settings (so that staff can care for more people)

Survey responses while not looking at the above areas exactly expressed a desire for services in primary care to be expanded, especially testing and diagnostics as well as pain and weight management clinics.

**Our View**

Future care will be dependent on educating the public on personal responsibility, co-production and the need to access services appropriately. Improved system navigation is important.

Co-location and collaborative working between practices and with other health and care services will be important to maximise the benefit of multidisciplinary working. Current GP Cluster structures and arrangements should be supported and allowed to evolve to enable quality improvement and shape service delivery. This needs to be stronger links with Locality Planning structures in order for professionals to be able to influence funding decisions.

We have been working to support the importance of informal supports rather than formal service provision being the only support. This has worked well in terms of community cafes; dementia initiatives including walks, activity based supports; using community venues and care homes for singing groups, befriending schemes and so on. It’s important that we link with wider place based initiatives in local areas. Dementia Friendly approaches have much to offer in terms of inclusive methodologies.

Volunteering will become increasingly important but there needs to be limits on expectations for volunteers and more flexible approaches and ideas. Volunteers could support with loneliness and isolation, volunteering within care at home more formally has significant challenge, especially where there are shortages in care at home staff as a workforce.

The role of a community link worker is critical in linking between formal and informal supports within a defined geographic area and oversight of what is working well and where the gaps are.
2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

Our view.....

Public expectations of health and social care services needs open discussion, we need to genuinely work together to create the change. Working extensively with a rural local reference group in Stirling on health and social care suggests this format, ie a local health and care group made up of local people and local services is helpful to discuss the ways in which services operate; levels of demand and realistic expectations of health and social care. Our key message is that we hope communities can work in partnership with services and develop the role of informal supports, most of which will be developed by communities themselves. We need to understand the needs of individual communities and accept the differences.

Lack of national resource and co-ordination around self / supported self -care. There is an appetite for better understanding of how care can be delivered more flexibly but adults tell us they find the system complicated.

Workforce Supply

That there is a need to provide support and resources to build a workforce with the right skills and capacity to deliver services in the community. Professionals must be supported and have adequate capacity to manage clinical care. Current recruitment, retention and sustainability issues make working in the community a difficult and unrewarding experience for many which impacts on future recruitment and retention.

Infrastructure /Technology /Lack of access to shared records

The Primary Care infrastructure requires to be robust. There needs to be prioritisation, focus and very significant capital investment to maintain and expand our primary care premises to make them fit for purpose and enabled to provide a base for an expanding multi-professional workforce.

Agile and interconnected efficient technology is essential to optimise service delivery. There is much to do to arrive at that position. A fit-for- purpose IT infrastructure that enables appropriate and effective information sharing to optimise patient care and safety must be developed and invested in.

Variation in approach, access and outcomes across multiple primary care systems.

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?

Reducing health inequalities must be at the heart of this

Primary care outcomes work does identify the key areas which we require to monitor.

- Outcomes for people both individuals and communities
- Outcomes for the workforce (retention, satisfaction etc)
- Outcomes for the system (e.g. are we reducing secondary care need by improving primary care?)
Our multi-disciplinary neighbourhood care team in rural South West Stirling have carried out evaluations within local communities.

The outcomes which represent the difference this team are in place to make are as follows:

- Peoples’ needs are met by the right person, first time, every time!
- People have improved health and wellbeing.
- People live at home independently for as long as possible with the right level of support.
- Staff are valued, motivated and empowered.

A snapshot of lessons learned reports indicate that the community know how we can all work together to support our health and wellbeing:

- The Community Reference Group consultation demonstrates that members have increased knowledge about their health and social services as well as informal support networks.
- “Regular meetings and updates which inform often about services which I wouldn't have known about”