HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM NHS AYRSHIRE AND ARRAN AND EAST, NORTH AND SOUTH AYRSHIRE HEALTH AND SOCIAL CARE PARTNERSHIPS

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.

In line with the National Clinical Strategy, new GMS contract and the national primary care outcomes, Ayrshire and Arran is working collaboratively to achieve the following principles as set out in our Primary Care Improvement Plan. These appear to align well with the priorities reported from the public panels.

1. We will encourage and empower our citizens and carers to take control of their own health and wellbeing within our communities and services.
2. We aim to deliver outcome-focused and responsive services for the population of Ayrshire and Arran.
3. Service developments will aim to improve patient health and the patient journey aligned with the goal of supporting the continuous improvement and sustainability of Primary Care.
4. Seek to ensure a balance between operating as a consistent, equitable service across Ayrshire and Arran alongside appropriate local flexibility to include the aspirations of local communities and professionals.

We have some concern, however, that some of the more vulnerable people in our communities, who may not be users of primary care services, may not have been engaged in this consultation process so far therefore their views are not being heard. Given this we would suggest:

- Engagement with those who may not currently use primary care services (for example, men, those who are experiencing homelessness) and also those who may be less likely to participate in online surveys and public panel discussions. In doing this some of the language used might require clarification.
- Consideration of both universal and targeted provision, delivered proportionately or it will be unsustainable and may even increase inequalities in health. For example, MOT/health check for all is universal however, evidence demonstrates that this may encourage “the worried well” and is unlikely to reach some of Scotland’s most vulnerable.
- Reference is made throughout the document to mental health, we would encourage further work to consider the contribution of primary care to supporting mental health and wellbeing (rather than focus on preventing mental health problems).
- Communication with patients, public and staff is vital; they must be consulted and informed each step of the way. For this to work, funding directed to Health and Social Care Partnerships and Primary Care to support this is required. A public health and health improving approach delivered in true partnership is important with a clear focus on the wider determinants of health to deliver on the public health priorities.
NHS Ayrshire and Arran is undertaking a programme of significant transformational change and, as part of this, with the three Ayrshire Health and Social Care Partnerships (HSCPs) has defined a model for delivering an Integrated Health and Care System as set out below:

This model starts with individuals, families and communities with general practice and primary care providing holistic, accessible, continuing and co-ordinated care. The aim is to empower people to take control of their own health and care as far as possible, enabling self-management, promotion of wellbeing and prevention of ill health, use of telecare and telehealth and maximising care provided in and around communities, general practices, community optometrists and community pharmacists. There is an increasing evidence base that such a model can lessen growth in demand on acute services.

Primary care should continue to provide a clear and easy to navigate generalist contact point for the public seeking health and care. Heath and social care provision is currently complex with numerous access points. Primary care in conjunction with services such as NHS inform needs to provide an accessible and supportive partnership with patients and carers as well as an effective route into social and third sector services and assets.

To achieve this model continued increased investment is required in general practice and other community health, primary care and other care services. This should reflect the need for enhanced provision relating to the social and economic and other wider determinants of health, evidence from the “Deep End” practices demonstrated clearly the impact of this. General practices which are based on a patient list and geographic area provide an effective unit of delivery which can integrate well with wider service and community assets.

Within this model general practices should provide co-located, multi-disciplinary teams providing ‘the right care, at the right time, in the right place and by the right person’. The new GMS contract provides the basis of this (with expertise joining practices from
pharmacists, mental health workers, physiotherapists and linkworkers as well as redirection of patients, where appropriate, to other primary healthcare professional within the community. These new roles will enable GPs to adopt their new role as Expert Medical Generalist, focusing on complex care. These primary care teams should continue to grow enabling individuals to access the right care at the right time, this should include community nursing and social care with the aim minimising transitions or transactional referrals processes in care. In choosing what additional roles to add to the team, it is essential that practices with their Clusters and HSCP localities have a detailed understanding of the needs of the population they serve and employ/train the right professionals with the right skills, supported by appropriate governance structures, to provide that care.

There should be a long-term commitment to Clusters and their development as a means for teams of practices to come together to improve quality of care and to influence locality planning for service developments and to improve population health by tacking the wider determinants of health.

For care to be accessible and coordinated wider locality resources should be built round these practices teams in HSCPs localities this includes maternity, specialist child and adult mental health services and re-enablement care for older people.

Community pharmacists, general dentists and optometrists practices contracts should similarly continue to be transformed to a first contact point for wellbeing, prevention of ill health and frontline delivery of appropriate healthcare. For community pharmacists this should maximise their delivery of urgent and common clinical condition care, long term conditions clinics and serial prescribing. Dentistry can build on the preventative focus of the Scottish Government’s Oral Health Improvement Plan, by developing a coherent message for people’s diet and nutrition, while ensuring that oral health is a fundamental part of people’s general health and wellbeing. This can be progressed by embedding the proposed Oral Health Risk Assessment. For community optometrists this should maximise the use of their skill set (especially independent prescribers), to encourage and further develop shared care pathways.

Linkwork as well as practice administrators should continue to develop their roles of both signposting and maximising local assets including social assets (relationships), community assets (e.g. third sector) and neighbourhood assets (e.g. physical spaces).

There is the potential for acute specialists to work more closely with general practice including relocating specialist clinics into a general practice setting and mechanisms to provide primary care with easy access to advice, investigations and providing outpatient services jointly as part of practices multidisciplinary teams. The aim of this should be to reduce patients’ waiting times.

Studies show that relational continuity (ongoing therapeutic relationship between a patient and health professionals that bridges episodes of care) is key. As practices grow and with wider community and specialist resources there will be an increasing need to co-ordinate care properly. The GP practice has a key role in co-ordinating this care, and helping patients navigate their path through the system. The ability to share clinical records electronically will be essential to achieve continuity of care as well as digital technology providing a network enabling shared care between GP practices, community pharmacists and acute services supported by care pathways.
To achieve this digital systems must be more joined up, faster, accessible at the right time to professionals providing care and more reliable. Digital innovation should be maximised enabling improvements in access (teleconsultation, Attend Anywhere) as well as self-care technology allowing people to monitor and share information about their health remotely between consultations.

In the longer term a connected, network of services should be in place to respond to acute health needs enabling a wider range of urgent care to be delivered to people in their homes or communities, avoiding hospital admission or enabling early discharge from the emergency department or medical or surgical assessment units. To achieve this GPs need to have easy access to and influence over the provision of rapid-response community nursing, community observation beds, hospital-based specialist advice and rapid diagnostic tests. This should be complemented by community rehabilitation re-enablement. While to maximise eye care within community optometry practices improved connectivity with acute care colleagues is desirable. This should realise huge potential to expand the scope of eye care services within the community setting.

Primary care should be a 24/7, easily accessible for in-hours routine and urgent care and out of hours for urgent care. In line with *Pulling together: transforming urgent care for the people of Scotland* out of hours services should continue to be enhanced to be able to provide a more interventionist support out of hours including access to electronic shared records and diagnostic tests as well as integrated working with mental health and social care.

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

Delivering transformation in primary care is complex and takes time, leadership, resources change management, support and clear and consistent vision. It is essential to continue to build local relationships and work with HSCPs to engage local community.

We welcome the view that resources should shifted from secondary care into primary care (page 26). We would also welcome action to shift resources even further into prevention as this will undoubtedly have a positive impact in the longer-term on primary care.

Ensuring a sustainable workforce is a key barrier to delivering a sustainable primary care system and there is a need to continue to make careers in primary care attractive, reflecting changing work preferences among professionals, for example a desire for flexible working, for portfolio careers and for work life balance living and working in rural communities. In addition to our GP workforce, we know that this is a significant challenge for other professional groups and in particular community nursing where the situation is rapidly becoming unsustainable.

Effective team working will be essential to smooth people’s pathways to care but also to create effective, efficient and enjoyable work for professionals and support staff. Research¹ shows that a number of elements are required for successful team working in primary care including:

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¹ Innovative Models of General Practice, King’s Fund, June 2018
• building relationships and trust within the team
• being located in the same place
• a stable organisational structure
• a culture shift from doctor-driven to team-based care
• defined roles and workflow
• good communication through ‘huddles’ (very short daily team meetings)

A move to technology enabled and delivered care will need to take place particular when working across rural communities however there is a need to support some marginalised groups who are likely to find it more challenging to access digital models of care because they experience barriers to using online services. Consideration should be given to development of programmes underpinned by targeting and support for those who may not be able to access and use technology.

There are financial barriers, however, an evidence based Public Health, health promoting, partnership approach would in time improve population health and reduce the necessity for treatment and care, and we would urge considerable change to make this a reality.

Action is required to address GP premises as a barrier to change in the medium and longer term. In the medium term the risk of premises ownership continues to cause instability for practices and as more staff are based in practices there is cost pressure related to accommodation for Boards and HSCPs. In the longer term providing primary care in modern, fit for purpose premises will require a solution to compensating independent contractors when the value of GP premises buildings is significantly higher as a functioning practice compared to the building and land value.

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?**

Monitoring and evaluation in terms of outcomes, prevention and health inequalities for primary care multi-disciplinary teams and GP Clusters should be integrated with wider HSCPs measurement and performance reporting.

National Performance Framework Outcome ‘We are healthy and active’ which underpins the Primary Care Vision, provides a good basis and it is important that measurement and evaluation is robust using both quantitative and qualitative information as experiences are key.

The Canterbury Health System Outcomes Framework may provide a useful model of whole system monitoring as below:


The Canterbury health system recognises that outcomes are achieved through a range of integrated activity which collectively contributes to progress. From this key primary care outcome measures could be:

- Delayed / avoided burden of disease and long term conditions
- Reduced demand on acute primary care
• Access to 24 hour primary care intervention
• At risk population identified and supported
• Community access enhanced
• Timely access to specialist intervention
• Decrease acute care rate
• Reduced falls
• Reduced pressure injuries
• Timely access to community supports
• Anticipatory and advanced plans in place

Process measures might include:
• Full complement of multi-disciplinary teams
• Active Clusters progressing quality improvement initiatives
• Effective and efficient prescribing
• Care in line with key patient pathways
• Patient experience
• Team experience

However, in the longer term there should be measurable differences in morbidity and mortality if changes have a public health, health improving focus although the complexity of health and therefore robust evidence and measurement is recognised to be challenging. It may be novel to focus on “whose outcomes” are important and if this encourages a community empowering approach then perhaps, we need to consider some alternatives such as the [World Health Organisations](https://www.who.int/bulletin/volumes/95/5/16-179309.pdf) methods of monitoring effectiveness.

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2 [https://www.who.int/bulletin/volumes/95/5/16-179309.pdf](https://www.who.int/bulletin/volumes/95/5/16-179309.pdf)