HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM Dr Miles Mack

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?

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

General Practice has been critical to the excellent health outcome of the NHS in international comparisons yet GP numbers are static and in rural areas are facing recruitment crisis. Often traditional practices are being replaced by health board run practices with a mix of providers and at a much higher cost to the NHS. This is not surprising when one considers that the proportion of NHS Scotland expenditure has been falling form a high of 9.8% in 2008 to only 7.75% in 2017-2018.1 To focus on the health and public health priorities of local communities requires a number of considerations: -

a. **GP numbers need to increase**, Barbara Starfield showed a striking 6% fall in mortality with 15% increase in Primary Care physicians ii

    Starfield et al. “These three lines of evidence represent a progressively stronger demonstration that primary care improves health by showing, first, that health is better in areas with more primary care physicians; second, that people who receive care from primary care physicians are healthier; and, third, that the characteristics of primary care are associated with better health.”

b. **Distance to access care**, evidence from Norway/UK show that once the population are asked to travel more than about 40km to access care they will choose not to, even for severe and life threatening conditions.

    “The results confirm that increasing distance is associated with lower utilisation of out-of-hours services, even for the most acute cases. Extremely long distances might compromise patient safety. This must be taken into consideration when organising future out-of-hours”. iii

    “Each kilometre from the centres reduced the likelihood of seeing the GP (OR = 0.978, 95% CI = 0.976-0.979, P < 0.001).” iv

c. **Continuity** There is increasing and compelling evidence for the important of relationship continuity of care from academics such as Pereira Gray. “This review, finding that increased receipt of continuity of care is associated with reduced mortality, comes after it has been shown that continuity of care is associated with multiple benefits for patients.” v
This was clearly stated by the previous Cabinet Secretary in her address to the 2015 RCGP Annual Primary Care Conference who insisted upon the centrality of general practice in the NHS: - ‘From Cumbernauld to Cape Wrath, the services your community needs should be there for you, locally planned and locally delivered, reflecting the Four Cs of contact, comprehensiveness, continuity and co-ordination advocated by the RCGP.

The reality is that the present primary care reforms are in fact fragmenting care by separating off functions to new organisations such as Vaccination teams and community treatment rooms and to new staff who are separately employed and managed.

Solutions/Requests

1. Review of the suitability of WAF to distribute resources to GP practices across Scotland as it has effectively capped investment in rural general practice across Scotland for the foreseeable future.

2. Understand that a reliance on an urban model of hub based multidisciplinary teams will increase the likelihood of adverse mortality figures from: -

   a. Increased distances to travel and absent service in small remote locations
   
   b. Loss of continuity

3. That local, multi-purpose clinicians have been proven to be able to provide a sustainable and popular model. In all but the smallest communities, the GP is the best provider. In the most remote communities with very low populations, multi-purpose nurses would probably offer the best alternative, in close collaboration with visiting GPs.

4. Clinical autonomy and ability to shape local service provision is a requirement for ensuring retention and recruitment of GPs. Allocation of Health Board funding to local practices allowing greater freedom to deliver services and build teams is essential.

Summary

The issues in rural areas has been acknowledged to be a problem since at least 2012. Rather than ameliorating these issues there is increasing evidence that outcomes are worsening. General practice, with its long history of meeting needs in these areas, is being side-lined in expensive and unsatisfactory new models of care.

Much greater flexibility must be allowed to enable new resources to be used to invest in local practices so they can be assisted and enhanced in their ability to provide the cost-effective care that has been their trademark.

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?
Scottish School of Primary Care (SSPC) is a virtual school comprising all Scottish academic departments with significant primary care research output. It exists to facilitate collaboration between senior academics in primary care and key stakeholders involved in the development and implementation of integrated health and social care service policy.

It has a crucial role in building the evidence for primary care delivery. Not only that, but by building academic infrastructure it can do much to mitigate some of the negative and unhelpful stereotypes surrounding careers in general practice and create exciting opportunities for GPs in mid-career who might otherwise be lost to the profession.

SSPC was commissioned by the Scottish Government to carry out an independent evaluation of new models of primary care being tested in Scotland, including (but not limited to) those funded by the Primary Care Transformation Fund and the Primary Care Fund for Mental Health from April 2016 to March 2018. This was presented at their annual conference in May 2019. Unfortunately, they were only commissioned to “tell the story of primary care transformation in Scotland” to inform the learning related to implementing the changes. This has missed the opportunity to assess:

1. Economic analysis of cost effectiveness
2. Patient outcomes
3. Effect on continuity and comprehensiveness of the care provided
4. If in fact it has resulted in a benefit to GP workload.

I believe this a great omission and something that needs rectified urgently.

Scottish School of Primary Care should be independently funded to evaluate these outcomes which will also give the opportunity to build GP academic capacity and enhance GP career opportunities at all stages of a GPs career.

Dr Miles Mack MB ChB, FRCGP

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