HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM HEALTHCARE IMPROVEMENT SCOTLAND

Healthcare Improvement Scotland (HIS) is committed to supporting better quality health and social care for everyone in Scotland. We are working with communities, people who use services, clinical and care services, and leadership teams to develop and deliver improvements to services across a range of primary care supports and settings. During 2019-20 our work in primary care includes:

- Activities in support of quality improvement in primary care and specifically the delivery of the National Framework for Quality and GP Clusters in Scotland.
- The Scottish Patient Safety Programme in Primary Care (SPSP-PC) which aims to reduce the number of events which could cause avoidable harm from care delivered in any primary care setting.
- Supporting NHS boards and health and social care partnerships (HSCPs) to engage people and communities in the design and delivery of primary care services.
- Providing independent assurance of the quality of primary care services, including joint inspection of adult health and social care services, inspecting the care of older people in community hospitals and inspection of wholly private primary care medical and dental services.
- Running a number of national improvement programmes that support the implementation of new ways of working; further details on these are provided below.

We note the Committee’s report on the public panels on the future of primary care and have focused our response on the questions below and the areas of our work which are most relevant to these.

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?**

Healthcare Improvement Scotland undertakes a range of work to support the development and implementation of new models of care.

A key issue that is consistently highlighted through all of our work is the need to **build local capacity** to deliver service redesign and quality improvement activity in response to local population needs and local assets. We need individuals who have both the time and the skills to support the redesign and continuous improvement of primary care services. Healthcare Improvement Scotland is supporting that in a number of ways including:

- Through the development of good practice case studies and practical implementation guidance and tools.
• By supporting clinical and care delivery teams to develop their quality improvement knowledge and capability.
• Creating a network for those implementing changes to learn together about what is and isn’t working.
• Supporting services to take a user-centred approach to redesign which ensures all redesign work starts with understanding the needs and assets of the population served.

Engaging people and communities in the design and delivery of primary care services

The Scottish Health Council provides support from each of its 14 local offices to enable general practices to either establish a Patient Participation Group (PPG) or help existing groups develop. A PPG is a patient-led group, linked to a local general practice which works alongside GPs and practice staff to provide a patient perspective on healthcare services that are offered to the community.

During 2018-19 we supported 12 General Practices to set up a new PPG, and we refreshed our Start Up Guide for Patient Participation Groups in Scotland and PPG Development Tool. Scottish Health Council Local offices support PPGs to share practice and network with each other. The Scottish Health Council currently supports on average 20 PPGs per month.

Our aim is to support the framework that underpins the Scottish General Medical Services (GMS) contract which encourages an open and innovative approach to engaging and involving communities. The contract states that: “It is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. We will therefore ensure that engagement with patients, and professionals delivering primary care, is a key part of the development and delivery of any service redesign”.

In April 2019, the Scottish Health Council invited all general practices (944) across Scotland to take part in a survey about their existing public engagement activities. Some of the areas being surveyed include:

• How general practices currently engage and how.
• Whether practices currently engage volunteers and how.
• The difference their engagement has made to the practice and its services.
• Whether there is currently any engagement at cluster level.
• The diversity of their engagement activities.
• Whether any training is offered to people wishing to engage with the practice.
• Do general practices experience any barriers to engagement.
• Whether any general practices would like support from local offices to improve their engagement activities.
The survey response rate was 40% and a report of the results will be published. The Scottish Health Council plans to disseminate good practice emerging from the findings and evaluate new methods of engagement in primary care. This will enable the Scottish Health Council’s local offices to develop and deliver bespoke engagement improvement programmes to general practices where needed, share tools and resources to improve engagement activities and share good practice examples across Scotland.

**Redesign of Community Treatment and Care (CTAC) Services**

A key area of our work is supporting the redesign of Community Treatment and Care (CTAC) Services. These are a priority area for reconfiguration included in the 2018 General Medical Services (GMS) contract. Prior to the GMS contract, CTAC services had grown organically in some areas due to local population needs.

We carried out a 90 day learning cycle (which included the Scottish Health Council gathering views from patients) to pull together expert opinion and evidence to inform the future design and development of CTAC services. The outputs of the 90 day learning cycle included:

- A framework which identifies the key components which should be considered for CTAC services:

  **Framework for Planning CTAC Services**

  ![Framework Diagram](attachment:framework_diagram.png)

  - Identification of a number of different delivery models for CTAC services with advice that no one delivery model suits all contexts. The potential models we identified are:
    - centralised (for example as part of a hub of care services)
- peripatetic
- augmented community teams
- co-located within a GP practice
- mobile units

- We highlighted that HSCPs might want to consider a mixture of models to address their multiple demographic conditions and needs. More information on the models can be found in the report (link above).

- We identified the potential benefits that CTAC services could deliver as follows:

  **Benefits for patients**
  - Increased choice
  - Convenience
  - Clear patient pathways
  - Uniformity and consistency of services across Scotland
  - Continuity of care?
  - Right time / right place / right person

  **Benefits for staff**
  - Clear career pathways for nursing staff
  - Opportunities for staff to develop and become specialists
  - Free up time for staff to work on QI projects

  **Benefits for primary health care**
  - More capacity in GP practices
  - Opportunity to overhaul community and practice nursing
  - Strengthening of community resources
  - Potential for growing CTAC services to take on more secondary care work
  - GP practices more sustainable

- We identified the following concerns that currently exist around their implementation. We note that many of these concerns would be mitigated through good planning and effective mechanisms to implement.
Supporting reduction of GP workload

The General Medical Services Contract 2018 focuses on developing multi-disciplinary responses to better manage the challenges of increasing GP workload. In February 2018 we launched phase one of the Practice Administrative Staff Collaborative (PASC) which supported six Health and Social Care Partnerships (H&SCPs) to pilot approaches to:

- free up GP time from unnecessary documentation review (called workflow optimisation).
- directing patients to new multidisciplinary teams within GP practices and to health and care providers in the community (called care navigation).

The pilot work in relation to workflow optimisation within GP practices has succeeded in demonstrating an average 44% reduction in the number of documents handled by GPs in participating pilot sites. This impact has increased GP time for care and improved health staff work-life balance with one practice estimating an average of 5 GP hours per week saved. It has also been reported as a contributing factor to improved GP accuracy of decision-making when reviewing patient documentation.

The pilot work in relation to care navigation within GP practices has enabled practices to offer people options to access the care and information which best meets their health and social care needs; created opportunities for person-centred conversation; supported patients to be seen by the right person, at the right place, at the right time; make best use of appointments and resources; and increased health staff job satisfaction, morale and confidence.

Both toolkits are being shared with every GP practice in Scotland and are available on the PASC website. Phase 2 of PASC is currently recruiting up to 200 practices to spread the learning.
Enabling people with complex care needs to live well in their community for longer

We work with health and social care services in a number of ways to enable more people with complex care needs to live well in their community for longer.

The Living and Dying Well with Frailty Collaborative was launched in April 2019 and aims to improve outcomes for people with frailty through early identification, anticipatory care planning and community multidisciplinary team working. Anticipated benefits also include reduced unscheduled demand on GPs and acute services.

We are also supporting work to develop and test new models of providing post diagnostic support in primary care for individuals with dementia. Our Focus on Dementia project is working with three GP clusters across Scotland to test the relocation, or closer alignment, of post-diagnostic support (PDS) into primary care. This work involves 27 GP practices and each cluster has been encouraged to try new ways of working. This is enabling earlier diagnosis and timely support to people and their families and test sites are seeing a range of improvements. An external evaluation of this work will be carried out in 2020.

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

In May 2019 we published a rapid response review of evidence on models of rural primary care, in support of a Scottish Government convened task force led by Sir Lewis Ritchie. In particular, the group was interested in multidisciplinary team working in rural primary care.

The evidence suggested that decision makers should follow general principles of service design, adapting them to needs, as opposed to applying specific models to practice.

Based on our findings from the CTAC 90 day learning cycle detailed above, the main barriers to CTAC services across both rural and urban settings were:

- **IT systems** (the lack of shared IT systems and a single patient record – this hinders the ability of the multidisciplinary team to communicate effectively).
- **Workforce** (recruitment issues, destabilisation of the workforce, change management, etc).
- **Premises** (lack of premises to provide CTAC services, available locations might not be convenient to patients (especially in rural areas)).
- **Funding** (primary care funding not being enough and concerns about primary care money to be used to fund secondary care services).

These are similar barriers to those impacting on the implementation of other priority areas in the contract. Some also mentioned the lack of time to plan CTAC services properly given the pressures to implement the GMS contract within the timescales.
Similarly, the PASC Collaborative detailed above found a number of challenges when supporting practices to develop new ways of working, which applied to both urban and rural settings:

- Fear of change and time to engage in improvement activities due to ongoing pressures on the service.
- Identification and capacity of alternative local health and care providers.
- Availability of staff skilled in service redesign and improvement methodology to support improvement work.
- Ability to work with patients and their communities to support the development of new ways of working which meet their needs.

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?

In response to the Committee’s question, we can share the following learning in relation to measurement and evaluation from the initiatives described above.

As part of the CTAC 90 day learning cycle, we have seen examples of how people are using tools to assess practice activities and review what activities could be done by other members of the multidisciplinary teams, for example the Week of Care Audit. Doing this regularly could demonstrate a shift in roles, although the exercise is a manual process and time consuming.

We found an excellent example of an enhanced CTAC service in an area with high levels of deprivation in Aberdeen. A case study on the Healthy Hoose was developed to share how this service was created. The case study included quotes from patients that were interviewed. However, in common with many other areas, the impact of the service on outcomes, prevention and health inequalities had not been assessed. Indeed, based on the feedback we gathered, generally HSCPs were not evaluating the impact of CTAC services.

Through the use of quality improvement methodology the PASC Collaborative monitored a series of outcome measures to establish the impact of the changes introduced across the pilot sites including data collection on: the number of documents handled by GPs, the number of patients navigated to appropriate services and the number of inappropriate GP referrals.