HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

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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.

A focus on shared decision making at all levels of the health care system will enable the health and public health priorities of local communities to be realised. The panel findings are a welcome example of co-producing health policy involving the public and politicians. The report outlines what the public have asked for. This now need to aligned with the best evidence of effectiveness, availability of infrastructure to support, workforce availability and financial considerations regarding the fair and best value allocation of limited resources.

Use of technology

There would be benefits of an electronic patient record of patient-centred care, cost-efficient systems, efficient use of workforce, improved data security, improved communication and improved patient safety. This should therefore be prioritised as having whole system benefits and is considered the most important intervention required by the partnership. In order to deliver improved access to technology, the investment in IT infrastructure within primary care will require to be prioritised at a national level. Clear direction to health boards with a specified level of funds in this area would assist local prioritisation. Implementation of technology, while desirable, needs to be subject to rigorous evaluation around the evidence. Conflicts of interest within the technology industry should be explicit as would be expected of the pharmacology industry, with new technology subject to a similar level of evaluation to that of new drugs in order to avoid low value investment. Digital resources should be intuitive for both patients and clinicians to access, considering the constraints of current working environments. They should therefore be developed with patients and front-line clinicians involved in their design from the outset. This will require adequate resource to support people to be involved in the design process. Members of the multi-disciplinary team being able to input clinical entries directly into the GP record is seen as essential to effective working and this should be considered a core provision of IT to enable the nGMS contract. A federated IT system as in the Letham Health and Wellbeing Centre in Angus is a possible solution that should be considered for wider roll out due to its success.

Community wide approach to wellbeing

This needs to consider the best evidence of what is effective, and where such evidence is not currently available, it should be evaluated with learning shared across Scotland. Clinicians and public health in particular, should be explicitly involved in strategic commissioning within the HSCPs. Community planning partnerships and the strategic commissioning plans of the HSCPs needs to be aligned as they work on similar areas within the same communities. Consideration may be given to the structure of planning
within communities to avoid duplication, particularly around community engagement. A co-production approach which combines the expertise of professionals and the experiences of the population, as has taken place in Angus through our ‘continuing the conversation’ events, may be considered an example for learning across Scotland. These have included work on primary care development, mental health and various other topics related to wellbeing. In order to resource access to classes in primary care, e.g. weight management and pain management, a method of moving financial resources between different budgets would be helpful, e.g. spend on diabetes clinics towards weight management clinics in practices. Greater support and national guidance for HSCPs and health boards on transfer of resource between budgets in the interests of better value to the whole system is required, particularly taking into account the whole system benefits of social prescribing. National work currently underway looking at disease mapping and programme budgeting should be progressed as a priority.

Patient-centred approaches to accessing services

The traditional role of General Practice as a ‘gatekeeper’ will require to be reversed in the public mind if we are to increase self management and ability to self navigate resources. This change in culture requires to be supported at all levels. IT and co-location of services both benefit patient access. Support for such infrastructure requires to be prioritised, ring-fenced resource to support premises development in the community would be beneficial. Continuity is important for both health staff and patients, however is restricted due to workforce pressures. A further conversation is needed around which patients require to be prioritised for continuity of care, particularly where investment in continuity supports longer term benefits in outcomes and cost-effectiveness in the wider system (e.g. reduced rates to secondary care). Patient participation groups within General Practice are one way of gaining a shared understanding of current challenges regarding access and coming to local solutions which maximise access and make best use of the multi-disciplinary team. Further support should be offered to practices for patient involvement in quality improvement activities, including access. The role of self-referral to secondary care should be explored within the context of involving patients in pathway design to maximise opportunities for better patient outcomes. There should be a requirement for health services to be designed with patients with a move towards co-production with people from the outset of service redesign. The process for consultation within partnerships has allowed for a co-production approach and learning may be applied to the process for NHS boards.

Service/workforce planning

In order to enable improvements in this area improvement in the IT infrastructure should be prioritised as above. An ethos of shared decision making with patients requires greater time in appointments, but there are additional ways of supporting this with greater access to information outside the appointment. Involvement of all stakeholders including patients and front-line staff in service/workforce planning will have benefits in improving outcomes and reducing the stress involved in implementation of change.

Health and Social Care

Health and social care integration offers an opportunity to maximise the value of professional input into decisions around social care. Clarity is needed regarding what is
intended by the NHS taking over social care from the local authority due to funding implications as NHS care is free at the point of delivery. Regardless of funding, more needs to be done to ensure the various professionals work in an integrated way, respectful of everyone’s roles. This may be achieved by greater devolution of decision making to front-line leadership within integrated teams. For example the Buurtzorg model of care which is successful within an area of Angus should be prioritised for evaluation and roll out. It offers opportunity to remove barriers related to which body has the overall authority in decision making.

Finance
One way to effectively manage care at local level without over-reliance on managers is to consider the Buurtzorg model care as above, extended to include a multi-disciplinary team based around General Practice. Professional leadership, starting at a national level, will be essential to devolve leadership to the front-line, including the requirement for individual professions to be supported to work in an inter-disciplinary fashion with the third sector. There also needs to be a mechanism to move from short-term funding of the third sector to longer-term commissioning which provides sustainability to local teams. Note the comment on programme budgeting under community approach to wellbeing above.

Prevention Focus
As prevention has been identified as a priority for the public, so should it be a priority within national indicators for Health and Social Care partnerships. While an ‘MOT’ for everyone may seem desirable from the public perspective, there are risks of harm associated with screening. There are also risks of exploitation by drug companies keen to support screening for conditions which may result in prescribing of their drug. Therefore any plan to roll out screening should be considered through the National Screening Committee. Priority may be given to groups where there is best evidence of an annual ‘MOT’ which may include people with one or more chronic conditions, frailty, or polypharmacy. DNA profiling is as yet poorly understood therefore should perhaps take less priority until further clarity is achieved. Resources should be prioritised towards mental health and wellbeing within General Practice, with the availability and access within GP populations to mental health and wellbeing services considered as an outcome measure for HSCPs. A system of locality improvement bids is a method of encouraging clusters to obtain money for projects which place a focus on priority areas for communities which has been particularly successful in Angus. These may be open to all members of the local area, and may attract clusters to apply for funding for quality improvement which addresses local need. For example a quality improvement project around third sector support for mental health within an Angus General Practice cluster, supported by the HSCP, has recently won a national quality award.

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

The workforce within rural areas may be more difficult to recruit to due to a limited pool of people who wish to live in that area.

The IT infrastructure available to support General Practice is a major barrier to effective working at present, particularly around mobile working which may be more relevant within
rural communities, which does require to be addressed as a priority. This is important to enable staff to support multiple sites while maintaining a high standard of both information governance and patient safety. It also would allow multiple practices to use one centre as part of locality treatment services within urban areas, thus achieving economies of scale. Adequate premises are essential for the provision of a greater proportion of care in the community rather than within hospitals. NHS boards have no clear directives or ring-fenced resource to ensure they are able to prioritise the provision of premises for General Practice. With no clear resource allocated there is a risk of over ambitious planning which cannot be realised within resource, less ambitious planning which is unable to meet the requirements for shifting care into the community.

One specific barrier is the inability to pay practices under a service level agreement to carry out community care and treatment services. This has not been popular with our General Practices in less central locations who remain concerned that patients will have to travel to receive items of care such as ECGs, phlebotomy and suture removal. Furthermore it is of greater cost to the whole system to employ additional staff through the HSCP. These services require to be carried out as the need arises. This would result in GPs continuing to provide services in small communities to avoid the need for patients to travel which is not equitable.

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?**

Multi-disciplinary teams within General Practice are employed by HSCPs. Quality of care is a shared role of the GP cluster and HSCP multi-disciplinary teams. In order to ensure a focus on outcomes, prevention and health inequalities, monitoring and evaluation requires to be prioritised towards these areas. National indicators for performance reporting within HSCPs currently have a heavy focus on performance related to hospital admissions, which may remain a priority in some areas, but as models of care change towards community provision, the indicators may change to reflect this.

There has been a move away from a target driven culture in General Practice in order to focus on quality improvement. Thus it is at HSCP level that outcomes may be best monitored. This places the responsibility on HSCPs to support clusters in order to achieve person-relevant outcomes which focus on prevention and addressing health inequalities through quality improvement support and resource being in place to support the multi-disciplinary team in the right areas.

There is a need for greater connection between GP clusters and the HSCP strategic commissioning plans in order for quality improvement at a local level to be translated into population level improved outcomes. This may be achieved by the requirement for shared agreement of priority areas for resource allocation for quality improvement work rather than this being completely decided by clusters as it is at present. There should be a natural link between community planning partnerships, HSCP strategic planning within communities and GP clusters. One way of achieving this is a move towards a geographical alignment of GP clusters, local planning and finance allocation. This would enable more joined up monitoring and evaluation of outcomes across the whole system.