HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM South Lanarkshire Health and Social Care partnership

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.

Primary Care

It should be acknowledged that Primary Care refers not only to GP and the teams surrounding them but to the 4 independent contractor groups, namely General Practice, General Dentistry, Community Pharmacy and Optometry. Greater coordination and understanding of what each of these groups can offer around the health agenda in terms of prevention and treatment should and is be further explored.

Primary Care should be 24/7 and easily accessible, (even and perhaps especially for marginalised groups such as those affected by homelessness) within hours routine and urgent care and out of hours urgent care. It should be delivered by staff (clinical and non-clinical) who are best placed to meet the need. It should be clear to people who those staff are. Where at all possible illnesses should be managed in a planned way (e.g. Long Term Conditions) allowing the individual to have more control over their health and social care choices with less reliance on urgent care.

Technology

IT systems in primary care and indeed into secondary care should be reliable, better connected and faster, ensuring the necessary details are with whatever member of the team will provide the care episode.

V/C etc should be available and is in many areas (e.g. Attend Anywhere) but staff may need additional training to improve their confidence in managing patients using this technology. It should also be remembered that a substantial minority of patients prefer face to face consultations. We need to be mindful that one of the key priorities for General practice is “humaneness” and technology should not detract from this.

Health Home Monitoring is expanding and this should be further encouraged as it empowers people to better manage their own health and be more involved in decisions. It also reduces appointment volume which in turn frees up time that health care professionals can spend with those with the most complex conditions.

Digital resources should be further invested in to aid self-care.
Community Wide Approach to Wellbeing

This is the essence of integration. There should be a focus on community connectedness, communities being supported to do things for themselves and further work on supporting community asset building. For too long the focus of the NHS has been on illness with a tendency to over medicalise rather than wellness and a shift in focus is to be welcomed, especially as we tackle the growing challenges of frailty. Increased social support and networks should be developed and communities encouraged to support each other so that the tendency for social and societal issues to be medicalised is reversed.

Social inequalities and especially poverty is one of the largest determinant of health. The primary care system of the future must be cognisant of this to ensure our most vulnerable are supported to expect and attain the levels of health enjoyed by those who are not disadvantaged in this way.

Patient Centred Approaches to Accessing Services

The focus should be person centred approaches to accessing services, (especially if we are acknowledging the need for a wellness focus) with a balance between continuity and access. For those with short term issues who contact services infrequently continuity is likely to be less important where as those with Long Term Conditions which are complex are likely to value continuity. This is where the management of Long Term Conditions in a planned way, reducing the need for regular urgent intervention will help balance the tensions.

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

The main barriers to sustainable change can be broadly described as

- Workforce – recruiting and retaining suitably qualified practitioners
- Finance – although the new GP contract sees considerable investment in Primary Care, there is a risk that this is underfunded, causing challenge when implementing the contract.
- Infrastructure both IM&T and Premises
- Capacity for change within the work force and also the wider population. Capacity for change is the ability of people to provide and use services in a different way to that previously. The change within the new GP contract is arguably the biggest in the health service since 1948 because it invites staff to deliver and the public to use primary care in a very different way than they have historically. GPs other primary care clinicians and secondary care clinicians need to be willing to give up the familiar and embrace new ways of working, they will require support to do this as they develop their existing skills in team working, and leadership. Similarly members of the public need to be helped to understand the need for change, and their role in helping us to realise it.
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 answering I have assumed that the multidisciplinary team referred to is the new PC MDT envisaged by the GMS 2018 contract. Evaluation of the PCMDT should be built into the implementation of the new contract, covering all of the above.

The monitoring of GP cluster working and its contribution to intrinsic and extrinsic quality is more difficult to evaluate but linking clusters to the wider system structures would assist with reporting. SPIRE can also be used by GPs and Clusters but this data is not made available to Boards.

The type of change described will realise benefits over 5-10 years and any evaluation must be cognisant of this. The Primary care: national monitoring and evaluation strategy sets the trajectory for this work between now and 2028.

There is a need for central (national) work and support offers to be more coordinated, this will allow similar pieces of work to be coordinated at a local level, e.g. better joining and coordination of the PCIP and Action 15 or linking modernising outpatients with the RCGP work on the primary and secondary care interface. More coordinated central working would support more coordinated local working and lead to better outcomes for people.