HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM CURAM IS SLAINTE – WESTERN ISLES IJB

Our vision is that by 2021 the people of the Outer Hebrides will be living longer, healthier lives in a supportive community. We will have a well-resourced and sustainable primary care system delivered by a network of independent GP practices, which sit at the heart of our local health and social care system.

Integrated health and social care teams will be connected to our GP practices, which will collectively focus on preventing ill-health, tackling inequality, anticipating care needs and delivering coordinated care. We will offer a wider range of primary care services, developing the contributions of professionals like pharmacists and physiotherapists, alongside an advanced nursing workforce which will be able to provide a range of clinical services from initial assessment to completion of treatment.

We aim to address the greatest needs for health improvement in our communities. We will gather data to identify these needs and use GP quality clusters to help us develop strategies for addressing these needs.

GPs themselves will oversee the delivery of integrated care in community settings, providing clinical direction to the work of local teams and acting as experts in general medicine. In this role, the GP will focus on undifferentiated presentations and the most complex care so that our local system achieves the greatest benefit from their skills. This will also help to reduce GP workload.

GPs will also work together as a community of professionals to deliver whole system quality improvement through the work of Quality Clusters and by participating in Locality Planning Groups, bringing their influence to bear on the wider health and care system to embed new service arrangements which improve population health.

Care will be provided to the highest standards of quality and safety, with the person who uses our services at the centre of all decisions. We will seek to personalise support arrangements, to maximise people's ability to exercise choice and control over the lives they lead. We will build on the support arrangements and assets that people have in their lives. New peer-led support groups and informal community capacity will help support patients who do not need formal secondary care services but who would nonetheless benefit from additional support to manage their health and well-being.

We will prioritise support for people to stay in community settings for as long as this is safe and appropriate, and avoid the need for unplanned or emergency admission to hospital wherever possible. We will work with unpaid carers as equal partners, and include them in all planning and care management decisions.

Primary care services will be planned and delivered as locally as possible. This means the day-to-day services that people rely on to support their personal independence will be organised and coordinated within localities.
We need to make intelligent use of staff and their roles, so that one person can deliver more than one aim of the new contract. Initially we are seeking to bring together planning activity for vaccination transformation and community treatment. We therefore intend to build flexible, shareable and generic healthcare capacity wherever possible, to ensure that scarce resources are optimally deployed in our local system. This will mean in effect that our practices will share the added capacity provided by new Health Board employees and that these will be situated within localities. Our first areas of change will focus on integrating vaccination services and community treatment into local community nursing teams, ensuring there is an invisible line between Health Board employed community staff and practice employed staff. This innovative approach will overcome some of the difficulties of providing services across geographically dispersed populations.

For our vaccination program, we have developed a phased implementation schedule which focuses on the schools cohort and pregnant women in year one, which will extend to other vaccination categories in years two and three. Similarly, we are phasing in community treatment from 2019/20, to be deployed in accordance with practices’ community treatment priorities. As we develop this generic capacity over the four years, we would expect additional areas of work to emerge around the public health agenda: supporting people with alcohol and substance addictions and carrying forward health promotion work more generally.

In principle, this additional capacity should begin to liberate practice nurses to work to ANP level and take on some of the GP caseload. This in turn will free-up GP time to address workload issues and refocus the role on expert general medicine. The details of how this generic capacity will be deployed will be developed and agreed at local level, though we expect it to deliver against the principle of ‘fair share’ – the idea that each practice should benefit from the additional capacity in proportion to patient list size. We will also provide practices with the flexibility to meet national obligations while at the same time delivering a solution which sits comfortably within their local arrangements.

In respect of pharmacy, we are already investing £100k in primary care pharmacy advisors, and we are seeking to grow this by a further £60k over the course of 2018/19. Any underspend from the first half of the 2018/19 Primary Care Improvement Fund will be used to bolster investment in pharmacy in year two. This will boost the overall pharmacy support available to practices.

On the urgent care agenda, our plan is to streamline traditional management structures and build new clinical capacity capable of undertaking advanced clinical assessment in community settings – on a 24/7 basis. We anticipate this will support our strategic objectives to care for people at home in community settings and avoid hospital admission.

The development of community link workers will be developed from initial pilot work being undertaken locally to tackle social isolation. This pilot is currently operating in Uist, Harris and Rural Lewis and is designed to ensure people using primary care services are better connected to other social supports. We will explore whether additional specialist community link worker capacity could benefit the local population.
We are also thoughtful about the changes that are needed to ensure that primary care is delivered in a way that focuses on the health and public health priorities of local communities. Within this context, there is a tension to manage between what some members of the public want from services, as against how we design a primary care system capable of optimally meeting need into the future. While the Health and Sport Committee’s panels offer some encouragement about members of the public evolving their views around primary care away from a traditional model (GP as gatekeeper) to a new model within which they access the most appropriate healthcare professional (or indeed other advisor), our sense is that there is a long way to go to effect the transition outline below:

<table>
<thead>
<tr>
<th>Old model</th>
<th>New model</th>
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<tbody>
<tr>
<td>Target based medicine</td>
<td>Holistic medicine</td>
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<tr>
<td>GP as gatekeeper</td>
<td>GP as clinical leader</td>
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<td>GP-led service</td>
<td>Multi-professional team</td>
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<td>Practice Nursing as Support</td>
<td>Practice Nursing as Empowered Practitioners</td>
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<td>Services accessed at practice</td>
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<td>Referral based onward care</td>
<td>Actively coordinated onward care</td>
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<td>Focus on access times</td>
<td>Focus on convenience</td>
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Community engagement is therefore of primary importance. While we have undertaken some limited work in this area locally, ostensibly through Locality Planning Groups, which include various community representatives, we need to be able to impact on behavioural changes within the population at large to optimise how we access and use generic and specialist healthcare professionals within the primary care system.

We also need to recognise that primary care has a crucial role to play in supporting the public health agenda. It has a well-established role in supporting health improvement work, particularly around smoking cessation, screening programmes including for alcohol, recovery programmes for people who use drugs, mental health and well-being programmes and healthy weight services. It will be important that as we transition away from the old Quality Outcomes Framework, that this public health agenda continues to be supported. Just as important, however, is engaging in wider challenges around the impact of deprivation and inequality and support people with chaotic lives to find viable support mechanisms outside of the primary care system.

As the reforms become more embedded, some of our practices have highlighted opportunities to become more proactive on the public health front, especially if there is latent capacity within practices liberated from the reforms.

**In terms of the barriers to delivering a sustainable primary care system in rural areas,** we are focused on making a success of the reforms. While the concerns about the new contract within rural settings have been well-trailed, our view is that many of these concerns will prove to be unfounded. For example, our early data suggests an uptake in vaccinations rather than a decline (as some predicted). However, that is not to say that the underlying challenges around the financing of primary care in rural Scotland are immaterial: our practices continue to express concern about the political security of the practice income.
guarantee, brought in to guard against the new formula eroding practice sustainability in rural locations. This needs to be permanently secured to ensure the ongoing viability of rural practice.

We also need to give thought to the wider financial challenge facing Health and Social Care Partnerships. While the primary care budget will grow by circa £1m by the end of the four year transition period, other services will have to make substantial financial savings over the same period: our three year financial plan indicates that we need to make over £5m of recurring savings within our £60m budget by 2021/22. There is a danger this could create an empowered primary care system at the expense of an under-resourced community care system. We cannot over-emphasise the challenges this creates.

There also continues to be locally significant themes around practice sustainability, not just in respect of finance but more directly in relation to workforce. Every practice in the Hebrides has experienced sustained challenges around the recruitment of staff, and not just medical staff. For instance, the continuing focus on building ANP capacity is creating similar recruitment challenges (although at least in that area we can grow our own local supply). That said, we are working with the other island partnerships to deliver innovative approaches to GP recruitment. For example, together with Orkney and Shetland, we have promoted a Scottish Government funded arrangement (Project Joy) which provides opportunities for GPs to work on the islands as part of a short-term, intensive placement. This sort of model can complement substantive posts and help deliver continuity of service.

**In terms of how we monitor and evaluate the effectiveness of multi-disciplinary teams and GP cluster working**, we are working with our local clinical governance team to build a system of quality assurance, using an improvement science approach. This will help us to monitor core deliverables (e.g. vaccination rates) as well as softer outcomes like the benefits accruing from multi-disciplinary working. However, we recognise that this is an area that deserves more thought both nationally and locally.