HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM Dr Alastair L Noble MBE

Question 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?

This is the fundamental question that I have been working on for the 30 years.

In particular, the work we did in Nairn on Total Fundholding became the basis for the Highland Cost Cube and then the Integrated Resource Framework. We were evaluated by the King’s Fund to be one of the top 5 Total Purchasing sites in United Kingdom. We also commissioned/contracted for Intermediate care in a unique way and had to use our DATA set to justify our contracting agreements.

The Clinical Decision is the Purchasing Decision became our fundamental action point. It is essential that Localities understand this and become accountable and responsible for all their Clinical Activity.

We need to use the Integration of Health and Social Care to prioritise Community Care and right size Secondary care. This will only happen if we move to rewarding high quality intermediate care in the community as our number one priority. We have the best DATA sets in the world aligning health and social care both clinically and financially.

This however will only work if we allocate a Fair Share Total Budget for Health and Social care to each locality. Therefore, they (the locality) are accountable and responsible for the total clinical and financial activity. From an Audit position the same patient’s episode of care cannot then be paid for twice. At present we are often double funding the same patient’s episodes of care.

As we move to understanding the vital importance of the GP as the Clinical Lead both for all the Integrated Community Care Teams but also as an Equal Clinical Input into deciding who will benefit from Consultant Care and when that benefit ceases, then we can see how important a role this is and how we must understand and support the GP in this pivotal role.

I think Scotland is in a very strong position to deliver this world class service in the future.

We need to find a common language /understanding for Clinicians, Management and Finance to understand what is best clinically and can remain within a Fair share budget heading.

In business terms our biggest cost expenditure is on the over 75 unscheduled admissions to hospital and the community care costs of this group. Hard experience tells us that providers use complex coding and tariffs to maximise their income. Therefore, I like the
What bed did you sleep in coding? If we apply it to the over 65 population in each locality, we see clearly the variation we found in the MAISOP (Multi-Agency Inspection of services for older people) and again in all of Helene Irvine’s West of Scotland work. Working closely with Perth and Kinross we developed the Perfect Equation. This to me is as close as we can get to answering your question. If the locality and most importantly the people living in it are getting really good, joined up team working for their elderly population then it is very likely it will be working for all age groups and diagnoses.

If the locality is looking after 99+% of their over 65 population in their own locality at home, nursing home, community hospital/hospice then they are working in the best integrated manner both in the locality but also with their Consultant Teams. This the best outcome for the individual patient and their carers, but also best for the Consultant team who can concentrate on what they do best - looking after the patients who will benefit from their specialist care and in some ways as important when they will not. This is Realistic Medicine in action.

We now must look at the next stage of contracting for intermediate care in each locality. The GMS contract applies throughout Scotland. The next priority must be to have the same Intermediate Care Contracts available for all our patients throughout Scotland. This at present is being taken forward by Sir Lewis Ritchie’s Working group.

Audit Scotland, Health Improvement Scotland and the Care Inspectorate have long been interested in using this Clinical DATA set to allow value for money as well as clinical best care to monitored and used to quality assure the Integrated Model.

All of this must also be seen in the context of Scottish Government policy as regards Community Empowerment, Locality planning for both Spatial and Community plans and above all delivering a green sustainable future for the Scottish people within a defined budget. It also fits well with Audit Scotland’s Planning for outcomes.

I think this is the right time to prioritise Integrated Community Care and I detect a real willingness among the GP work force to deliver this very satisfying Career and above all balance the importance of the Generalist to match the Specialist.