HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM THE DIGITAL HEALTH & CARE INSTITUTE (DHI)

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?

GPs and primary care often form a first point of call for patients. They are faced with the challenge of keeping up to date with large numbers of pathways and guidelines and associated updates. There is good quality support for patients from NHS and third sector however GPs do not have a consistent route to access assured quality advice. In the future IT support systems could offer GPs:

- A bank of quality assured support materials
- Up to date pathways and national guidelines
- Support for referrals including seeking advice from secondary care
- Decision support, moving towards AI in support of referrals
- A bank of available local community referral options

These services must go beyond a website with downloadable PDF documents, and instead adopt modern, modular and open platform approach to allow the NHS’s knowledge to be properly curated and cascaded to a range of websites, apps and devices.

Referrals will not always be for secondary care. For example, where dietary and exercise advice and support are necessary there is a need for good quality community-based services.

There could be support and guidance for patients to access services such as exercises to try (for hip or knee pain for example) before presenting to primary care. For this to work there would need to be investment in these services such that they became the default first step.

DHI’s co-design work supporting the Scottish Access Collaborative has shown that this lack of guidance, in addition to adversely affecting primary care practice, creates a large amount of unnecessary attendance across outpatient services. This also often results in poor patient experience and an increased burden on primary care as patients are repeatedly referred back and forth across the system.

DHI is supporting the Scottish Government eHealth Clinical Decision Support Programme that is developing these kinds of ICT infrastructures. A case for further investment to progress this programme is currently in development.

When looking at primary care there needs to be an increased recognition that current and in particular future challenges do not simply sit at the door of general practice and general
practitioners. All the key agencies and players across the primary care landscape need to reassess their current working practices and determine how in the future they can add the greatest value to our populations health and wellbeing at a time when the way our citizens live and coordinate their day to day lives is rapidly changing through the availability and use of technologies. For example, it is likely that over the next 5 to 10 years the supply of medicines will become less likely the exclusive preserve of community pharmacy but will be delivered by logistic companies or even direct from the manufacturer using Industry 4.0 techniques. Rather than threatening community pharmacy this could create significant opportunities for pharmacy to become a major player in supporting individuals to make better informed health and lifestyle choices and to monitor and support people to deliver more of their own health and care services (for example manage their long-term conditions) empowered by technology. DHI is already working with Community Pharmacy Scotland to develop a technology supported future service offering that will look to secure a sustainable future for community pharmacy services with the pharmacy playing a more prominent role as a health and care hub for a community. This type of programme requires dedicated time and funding to secure real impact in the desired timescales.

This type of thinking needs to be progressed across the other disciplines within primary care looking to step down care by activating and empowering people to do more for themselves, their families and their communities and by so doing create space and time for health care professionals to do more complex activities embedded within the community rather than defaulting to hospital supported care.

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

Despite recent increases in the use of remote blood pressure monitoring at scale in some parts of Scotland, overall Home and Mobile Health Monitoring technologies are not being fully capitalised upon.

Current efforts are driven by the NHS and focused on procurement of devices and capacity building for doctors and nurses to distribute, troubleshoot and monitor the data from these devices as patients use them.

The issue with this approach is that it is entirely dependent on top-down funding and implementation by the NHS and does not leverage the broader set of assets and capabilities in the community. It does not recognise that if remote monitoring continues to be based in GP practices, and is then scaled further through this model, that this will exacerbate the current sustainability issues. For example, detecting and treating the undetected hypertensive population in Scotland could double the related appointment load, adding 1.3 million extra appointments per year.
It also largely ignores the fact that people can purchase their own technologies, or that other care professionals or organisations can be better placed to support a remote monitoring method.

To create a more sustainable system, the NHS must move from a role in implementing these technologies to instead fulfil a role that stimulates and then assures a marketplace of technology providers and community carers. This would require:

1) Capacity building with service users, informal carers, community care organisations, pharmacies, leisure centres, etc. to have both the infrastructure, skills and business / service model to play a role in this system.

2) The NHS to provide a 'digital front door' to these actors, allowing them to integrate their technologies with clinical systems. The National Digital Platform, developed by NES Digital Service, could provide this service, and this can be prototyped quickly within existing resources by DHI and partners over the next two years.

3) An understanding of a reimbursement model, that focuses on outcomes, and the use of modern technologies to automate and reduce the cost model of the information, clinical and financial governance of this kind of distributed approach.

4) An understanding of how to stratify the remotely monitored population, and create a responsive service based on risk and need. This would mean moving large numbers of people consuming routine appointments to a lighter touch model (for example pharmacy drop in only when needed) and focusing GP time on complex care.

In addition, this approach must be considered on a networked / regional / national basis, working with organisations that can risk and resource pool across geographies. This is because, much like internet access and other basic utilities, big pharmacy chains, insurers, digital tech companies, etc. will focus their efforts and build digital capacity in urban environments where the economies of scale can help to sustain their business model.

The public sector can incentivise and regulate this market in a way that allows groups of organisations and people to use common assets that are funded once for Scotland, reducing the inequality between urban and rural environments.

The Scottish Government is already doing this through initiatives such as the Low Powered Wide Area Network contract it awarded recently. The issue, however, is that without coordination and capacity building, many rural organisations are not yet shouting loud enough for this kind of technology to be made available through the contract in their area.

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?
Focusing further on the use of digital technologies in the remote monitoring of long-term conditions, there are opportunities to engender multi-disciplinary team working while moving to an outcomes-based service and business model.

Modern technologies can automate many of the governance mechanisms necessary to assure quality of service and prove it has been delivered. It is possible to allow a person or organisation outside of the immediate NHS governance to cheaply gather long term condition data while simultaneously proving its provenance and relevance, and this can be used to construct smart contracts that allow GPs to much more effectively and dynamically activate other community resources.

For example, a blood pressure reading, submitted by a user from their own device, can be accompanied by proof that the device is regulated appropriately, that the person is competent in collecting the data, and that the data has been collected in compliance with SIGN/NICE guidelines. Further, that data could be accompanied by dynamically updated family history and demographic factors that would support risk stratification of remotely monitored populations. Then incentives can be introduced to third party services such as pharmacies to responsively titrate medications for ‘medium risk’ patients and enrol them in lifestyle change services (for example in conjunction with leisure centres) for top up payments.

These sorts of methods are common place in many other sectors, and it is recommended that when service transformation is considered that we spend as much time thinking about the business model of a sustainable, distributed community service, as we do thinking about the clinical and technical components.