HEALTH AND SPORT COMMITTEE INQUIRY

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM THE PRIMARY CARE CLINICAL PROFESSIONS GROUP

August 2019

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We are grateful for the opportunity to provide evidence to the Committee's inquiry into the future of primary care.

Who we are

We are a group of professional organisations representing clinical staff. Formed in 2016, we came together to agree what we mean by 'primary care' and to set out shared principles which we believe should underpin the future for people in Scottish communities who need the support and expertise of generalist clinical staff. Between us we represent over 60,000 clinicians working across the length and breadth of Scotland. Together we are committed to working with the Scottish Government, with colleagues across health and social care, and with the public to turn this shared vision for the future of primary care into present-day reality. We hope this contribution will be helpful in shaping, and joining up, the many reforms underway.

We have a number of points we wish to make in a collective response to the call for evidence and the following underpin that response:

1. Our paper "The future of primary care in Scotland: a view from the professions" that contains the 21 principles with which any vision for primary care should accord (appended to this document).
2. Relatively recent (November 2018) correspondence with the Cabinet Secretary for Health and Sport, Jeane Freeman MSP, on 'Public engagement around the new GP contract' (appended to this document).
3. Our paper 'Principles for a technology-enabled health and social care service' submitted to the Committee in 2017 (appended to this document).

Many of the organisations that comprise our group will make separate submissions to the committee about the specific solutions and challenges relevant to their individual workforces.

Definition of primary care

An early goal of our group was to define what we mean by 'primary care'. We adhere to a broad definition that includes care delivered by all of the professions that are signatories to the principles and includes both in- and out-of-hours care, both physical and mental health services, and services provided across all community-based settings. We are pleased that the Scottish Government's vision for primary

[1] Allied Health Professions Federation Scotland, British Dental Association, Community Pharmacy Scotland, Royal College of General Practitioners, British Medical Association, Royal College of Nursing Scotland, Royal Pharmaceutical Society Scotland, Optometry Scotland, Queens Nursing Institute Scotland.

care reflects the key elements of our definition[2] and that SPICe[3] have accepted its utility.

> "Primary care is provided by generalist health professionals, working together in multidisciplinary and multiagency networks across sectors, with access to the expertise of specialist colleagues. All primary care professionals work flexibly using local knowledge, clinical expertise and a continuously supportive and enabling relationship with the person to make shared decisions about their care and help them to manage their own health and wellbeing."

1. What changes are needed to ensure that primary care is delivered in a way that focuses on the health and public health priorities of local communities?

Our principles document sets out our vision for how people should expect primary care to be delivered in all parts of Scotland. We welcome the results of the Health and Sport Committee's work with the public at phase 1 of its inquiry. The public's seven overarching priorities broadly accord with a significant number of our 21 principles. This should give the Committee confidence that the direction of travel envisaged by our professions is sufficiently in step with public priorities to allow for that journey to proceed in partnership.

The table is provided for the Committee's information and reference,

	Public Priority	**Our principles (no.)**
1	Use of technology	19, 20
2	Community wide approach to well being	2, 4, 7, 9, 10, 18
3	Patient-centred approaches to accessing services	1, 3, 4, 10, 17, 18
4	Service/workforce planning	3, 8, 11, 13, 14, 15
5	Health and social care	16
6	Finance	3, 18
7	Prevention focus	1, 9

Our approach also aligns with much of the Scottish Government's vision for primary care as set out in the 'Primary Care Outcomes Framework'.[4] For example, and in particular, it is clear that both we and the public are concerned to ensure that "We (i.e. care recipients) are more informed and empowered when using primary care" and that "Our primary care services better contribute to improving population health".

Scotland must accord equal priority and equitable resources to the primary prevention of illness, or harm and actions leading to good population health and individual wellbeing. This necessary foundation of a better future for primary care throughout Scotland simply cannot be achieved without long-term investments. Realistic healthcare will only happen as the result of realistic infusions of new human, technological and financial resources.

[2] https://www2.gov.scot/Topics/Health/Services/Primary-Care
[3] SPICe Briefing May 2019 'Primary Care in Scotland, SB 19-32'
https://digitalpublications.parliament.scot/ResearchBriefings/Report/2019/5/29/Primary-Care-in-Scotland
[4] https://www2.gov.scot/Topics/Health/Services/Primary-Care/PrimaryCare-Outcomes-Framework

We are committed to providing professional leadership to see our principles delivered in practice across all communities of Scotland and welcome further discussion on how we can best work in in partnership to support positive change.

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

Public Understanding of Change
In our experience - and notwithstanding the very encouraging results of the Committees phase 1 work - many members of the public still hold a broadly 'traditional model' of primary care and can become anxious, confused, frustrated and sometimes even angry at the introduction of new approaches. We know that individual practices work hard to explain these changes every day. Clinical professionals are committed to helping people understand how they will benefit from new ways of offering primary care, and to listening respectfully to concerns and preferences, but progress can sometimes be slow and change is often resisted. As a group, we are clear: ensuring the best outcomes for people using primary care services requires the full clinical team to work together with patients and families, using the full range of face-to-face and technological options, to address health needs collaboratively. In reality this can mean, for example, convincing someone that that an appropriate, direct referral to a nurse, physiotherapist or other clinician is not a diminution, but an enhancement of service.

The Cabinet Secretary has made it clear to us that her aspiration is for the public to come to understand changes to primary care through the 'public engagement' duties held by Integration Authorities, Health Boards and Local Authorities and further work being undertaken by NHS 24 via NHS Inform. She has also recognised 'the value of conversations happening at a practice level to help people navigate new and modified services'. Discussions with Scottish Government are ongoing, but we remain concerned that the onus for engaging with and educating the public about change will continue to rest on local clinical practitioners in the field. We believe it would be enormously beneficial and supportive if this engagement and education were delivered through a national drive to develop and share key messages with the public about change focused on improvement, enhancement and gain.

Information Technology and Data Sharing
It is clear to us that the transformation of primary care with a wider primary care team cannot be achieved without the sharing of information amongst health and social care professionals and their teams. We refer to the paper previously submitted to the Committee (referenced above) which set out our jointly agreed principles and requirements for any successful technology-enabled health and care service.

Our joint commitments to improving technology enabled care include calls for the true co-production of new systems, rigorous governance of information, improved access to technology for staff and appropriate read and write access to health records for all professions in order to improve the patient journey and minimise duplication of resources. We are also clear that ownership of a record should be with the patient, stating: "Health records belong to an individual and as such, that individual gives consent to sharing of information within their level of capacity or in line with guidelines set out in The Adults with Incapacity (Scotland) Act 2000."

Adapting communication
Twenty percent of the population will experience communication support needs at some time in their lives. For example, over fifty percent of children from socioeconomically deprived communities in Scotland start primary school with under developed speech, language and communication skills and more people are living with the effects of conditions such as stroke and dementia. Primary care must be provided in ways that people who have difficulties in communicating can receive information, including all written information, and express themselves in the ways that they find easiest. We note that the new Social Security Act has, for the first time, defined in law what "Communicating in an inclusive way" means.

Workforce
The primary care MDT must have the necessary infrastructure to support safe, quality care, including suitable and sustainable staffing levels and skill mixes in all settings. This is not yet reality in many parts of the country. Recruitment, retention and long-term workforce planning for service changes are ongoing issues across our professions. We note that we are still awaiting publication of the Scottish Government's Integrated Workforce Plan.

A concern raised across the members of our group is the impact of displacement of care and/or staff across acute and community services, or between NHS and non-NHS services, where reforms are made in one part of the system with too little consideration of their impact on other parts. For example, as our balance of use between care homes and hospitals change, the clinical acuity of care home residents has also changed, impacting on the workforce required by both direct employees of care homes and wider members of the MDT providing wrap-around services. New models for the provision of primary care must take better account of this substantial (and increasing) shift in where clinical care takes place.

In addition, it is imperative that national government, and local commissioners and providers ensure protected time and adequate resources for primary care professionals to: design and deliver new models of care; plan and manage their work together; build new relationships; promote positive ways of working to their service user groups, and engage in evaluation of new ways of working to evidence outcomes. Positive, respectful and collaborative relationships are at the heart of primary care, both between professions and between professionals, service users and families. This takes time and support to nurture.

3. How can the effectiveness of MDTs and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?

There is broad acceptance that timely change can be necessary without pre-existing evidence being available. If this drives progress, then it is to be welcomed, but must be followed by robust evaluation in such cases. That being said, there is far more to be done in Scotland to create a robust new evidence base to support the roll out of improved models of care which address national and local priorities, such as preventative interventions and persistent health inequalities. We would direct the Committee to the Scottish School of Primary Care's (SSPC) recent report 'National Evaluation of New Models of Primary Care in Scotland'.[5] Given how precious

[5] http://www.sspc.ac.uk/reports/

investment in tests of change are in the current climate, the lessons set out in this evaluation must be learned. In our principles document, we noted: “When there are so many routes to improvement and sustainability, it is ever more important to ensure that we are all signed up to the same understanding of what we are trying to achieve. Without this, we risk fragmentation, misunderstanding and conflict.”

We are now keen to see how the Scottish Government’s ‘National Monitoring and Evaluation Strategy for Primary Care in Scotland’[6] can support improved monitoring and evaluation as the urgent need for primary care reform is addressed.

[6] https://www.gov.scot/publications/national-monitoring-evaluation-strategy-primary-care-scotland/pages/5/