Primary Care: People as Partners

Reflections on Emerging Models of Care and Support

An offer of a new contract for GPs in Scotland was agreed in January 2018 - this publication:

- Seeks to stimulate debate about the implications of the contract
- Describes opportunities to strengthen supported self management approaches for people who use support and services as a result of the contract
- Summarises how ALLIANCE programmes continue to work to strengthen and support the achievement of the ambitions of these new models of care and support across primary care.

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HEALTH AND SOCIAL CARE
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people at the centre

The new Scottish GP contract, what next for people with long term conditions?

GPs in Scotland have voted overwhelmingly to accept a new contract which will come into force in April 2018. It signals a departure from the boxed-in approach of the QOF (Quality and Outcomes Framework) to one that sets a foundation for the expansion and remodelling of primary care with GPs being seen as expert medical generalists, working collaboratively in clusters, sharing traditional workload with a wider base of skilled-up health and care professionals. It signals less micromanagement of GPs to a more mature relationship of trust, and peer-led, values-based professionalism. It hopes to improve the "mood music" in order to recruit and retain GPs; a bold ambition given the current famine. Also wider teams will pose challenges for joined up working and continuity.

What are the implications and opportunities for the care of people with long term conditions? Some may worry that the end of QOF will see a loss of focus given to the case management of people with chronic health conditions. Hopefully, it will be an opportunity to take a more "Realistic" personalised approach with a primary focus on people, and not simply their specific individual conditions. It should strive to identify and prioritise those with multimorbidity and frailty customising more time for those who need the most care and support and therefore addressing health inequalities. Hopefully, it will move us on from a model that turned our patients into passive recipients of surveillance to one that helps them to be more involved in decisions about their care and supports them to self manage.

The contract suggests that practice nurses will move from traditional "chronic disease management" approaches to one of proactive "care planning". This implies they will be less interrupted with the tasks of biometric measurement and recording, so they can spend more time helping their patients, identifying what matters most for them and planning care and support to help people achieve their personal outcomes. Care Planning approaches have been shown to be more wholesome and satisfying for patients and professionals alike and linked to better health outcomes and system performance. It is most effective when it is more nuanced by careful preparation of patients, with sharing of personalised information, ahead of a care planning conversation.

However, this will require new challenges, training and facilitation for practice teams. It will require different processes of care with health care assistants trained up to help in more of the measurement and recording tasks such as spirometry and foot screening. They will also be well placed to help prompt people to think of what they would wish to discuss at their Care Planning review. Admin teams will need to look differently at how they identify and plan appointments. Practice Nurses will need training to build on their communication and health coaching skills. Finally, when people do feel more more involved in their care, wider support needs often become apparent. To this end it will be crucial to see how community links workers are deployed as a resource for patients and practices, building connections with the valuable assets in the community that provide more than medicine. It will require recognising and resourcing the contribution of the voluntary and "third" sector.

These approaches are not new in Scotland but are yet to become widespread. Much can be learned about embedding care and support planning in practice from Scotland's House of Care Programme and building self management support through the Links Worker Programme. However, it will need to be seen as a priority for GP clusters, supported by Health & Social Care Partnerships and Chief Officers. There will need to be a commitment of resource for IT, training and facilitation within local primary care improvement plans backed up with primary care transformation funding. It will also require us to think differently about quality from not simply managing diseases according to medical targets. It will ask us to see how we are engaging and involving people in their care, responding to their health literacy needs and supporting them to address what matters most to them in life (and death) despite their conditions.

Dr Graham Kramer is a GP at Annat Bank Practice in Tayside, Chair of Scotland's House of Care Executive and an Executive Officer with RCGP (Scotland)'s Patient Partnership Group.

Improving and increasing access

Moving from a medical model, which treats disease, to a society where people have a right to be supported to attain maximum health and wellbeing, will be central to how we access future care and support within primary care. The old adage, "If it aint broke, don't fix it" is evident. The present system was set up to try to "treat illness" rather than to "promote wellbeing". Additionally, the demands and expectations on modern GPs have mushroomed. It does need fixed.

Increasingly in some practice areas where GPs are struggling to meet demand, receptionists and staff are requesting that people only ask the GP about "one thing". This places further pressure on a system where people wanting a wider discussion with a GP have to come out from one consultation and make another appointment. Perhaps seen as a short-term fix, it simply serves to increase pressure in the longer term.

The ALLIANCE, working in partnership with Scottish Government facilitated engagement events in 2016 around the National Conversation on Health and Wellbeing in all new health and social care partnership areas. Common themes emerged in discussions with people with long term conditions, and Carers:

- The impact of 4-day local closures on person centred care
- Proximity of GP practices within communities and opportunities that can provide
- Pressures on GPs affecting the difficulty of obtaining appointments in some areas
- Appointment times that often promote a disease management, rather than, a person centred holistic, approach
- Difficulties of access in remote and rural areas.

Looking to how we deliver primary care services in the future, the new contract envisages that GPs will be general medical specialists supported by a range of staff operating within a multidisciplinary team. The intention is to complement changes on a phased basis overseen by an implementation advisory group.

The ALLIANCE, as part of the Our Voice partnership, is holding engagement events across Scotland to hear about what services could look like and to listen to the views of citizens on the future of primary care. We know that when we involve people themselves in decisions about their individual health and wellbeing, they are much more likely to experience positive outcomes.

Working together to improve health and social care

Our Voice

The Our Voice Framework is intended to operationalise the voice of lived experience at the individual, local and national levels.

Ensuring a strong voice for people with lived experience in the design of services, and on an ongoing basis in the delivery of services, is vital to our quality of service provision.

Initiatives such as "Hello my name is" that encourage clinicians to personalise interactions and "what matters to you?" that initiates constructive conversations based on what`s "important" rather than what's "wrong", moves us from deficit-based approaches focussed on medical models to a person centred framework that facilitates holistic approaches to wellbeing.

There are many members of the health disciplinary team equipped to take forward these initiatives thereby freeing up doctors for spending time on more complex issues. Primary care teams themselves are supported by innovative approaches to wellbeing piloted by NHS24 and NHS Inform: Breathing Space provides an alternative and easily accessible 'first stop' confidential service for those experiencing low mood or depression and is increasingly extending options. NHS24 helpline, operated in partnership with Macmillan, provides further options for those dealing with diagnosis and treatment of cancer.

Initiatives like these, supported by the third sector, have the potential to free up valuable resource and to increase options and improve access for people and communities 24/7 and 365 days a year.

Irene Oldfather is Director of Strategic Partnerships at the Health and Social Care Alliance Scotland (the ALLIANCE)

Relationship based care and more citizen governance

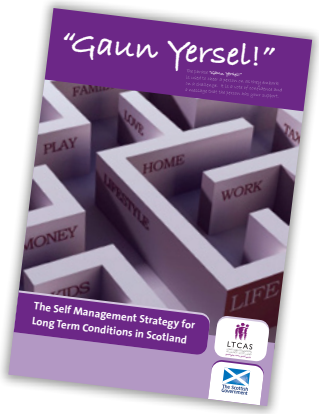
Having a general practice system that works for people and the workforce really matters. The agreed contract echoes the aims of Realistic Medicine with a will to develop a more equal relationship through personalised care and shared decision making. It's good to see that person centred care is prominent, the need for supported self management is acknowledged, and the importance of valuing relationship-based care features. All good and welcome statements of **what to do,** but it's the nature of the **how to do** and testing of the **want to do** that will unfold that will determine the success of that more collaborative ambition.

In my role as ALLIANCE lead for the national House of Care programme, I've met many committed staff who already understand that it's about changing the nature of the conversation at the heart of the house. In primary care teams in adopter sites across Scotland there are GPs, Practice Nurses, Health Care Assistants and Pharmacists who have been trained in using a clinical method of care and support planning that supports staff to be prepared for that different kind of conversation, where the person is supported and prepared to engage in a more collaborative way. The learning from this work will provide valuable intelligence to Health Boards, Health and Social Care Partnerships and Quality Clusters as the contract Implementation planning gets under way.

Scotland's House of Care

The aim is to make care and support planning conversations routine for people living with long term conditions, with supported self management at the heart.

…**focussing on people** not their condition.



Within the context of Health and Social Care Integration, we increasingly share a common language around person centred care and supported self management, but it's become clear to me that we often mean different things. If we see this as a continuum, then at one end self management can be seen as supporting a person to manage their condition, but at the other end it's much more about creating the conditions so that the person has what they need to live, and die, well with their condition. What is rarely talked about however, is the imbalance of power in those relationships and the importance of ceding power.

The nature of power was the focus of a recent Glasgow Centre for Population Health (GCPH) hosted Glasgow Healthier Futures Forum where we were reminded of how power doesn't belong to any one person, but exists in the relationship between people. It's given me pause to reflect on how traditional primary care models might be described in terms of power:

- *Power Over*: the prevailing fix it model
- *Power To* and *Power Within*: might describe those empowerment aspirations of supported self management approaches
- *Power With*: collective power of communities or organisations.

Ultimately I believe that within a new model in primary care, we're aiming for a more empowering approach, with people being valued for their own expertise in their long term conditions and working alongside and supported by the wider Multi Disciplinary Team who themselves feel valued, prepared and supported to work in this way – every day and with every person they meet. The new contract emphasis on the MDT role is key to this.

The additional time that will be offered within the contract for consultations with people living with multiple conditions is welcome, but the nature of those conversations will be key. The first important step for the person is to be included and in the room, but moving to the next step of inclusion is about being able to contribute and

shape the conversation. This is the vital step in building that shared decision making approach.

Rebuilding trust with people and communities is necessary if new models of care are to be valued and understood by people. I was reminded of this at a recent HoC Lothian /Thistle GP Practice Learning session, where staff described how a woman reacted to the news about having a different kind of collaborative care and support conversation with a member of the Practice Team.

"I had one patient who said she hated being here but had changed her mind by the end of the conversation."

"Newer patients tend to say 'this is fantastic' while ones who have been with the practice for years don't like change."

In the world of financial constraints, decisions about what to support and implement in health and social care are pressured and complex, but involving people with lived experience and the third sector fully in the detail of implementation is vital to achieving a transformational, third era change. We need greater recognition and sustainable resourcing of the third sector that strengthens the 'more than medicine' of health and social care.

I've been heartened to hear echoes of this recognition from health and social care leaders at recent national conferences on priorities for the NHS in Scotland:

"We need more relationship based care in a future primary care system... we also need more citizen governance."

Following the ALLIANCE led community engagement events across Scotland, I look forward to hearing how citizens will be included as partners in shaping the **how to do** and **want to do** of emerging models of general practice and the wider primary care landscape.

Cath Cooney is Director of Development and Improvement at the Health and Social Care Alliance Scotland (the ALLIANCE).

Self Management and Coproduction Hub

The ALLIANCE Self Management and Co-production Hub contributes to the delivery of health and social care integration and transformation of primary care.

Transforming Self Management in Scotland

Since 2009, the Fund has continued to support funded projects, while evaluating the wide-ranging impact of the Fund.

Self Management Programme

Aims to ensure the voice and assets of the self management network continue to be at the heart of our work.

Co-production

The principles of co-production based on valuing and empowering people remain central to the philosophy of the ALLIANCE and all its programmes.

Scotland's House of Care

Scotland's **House of Care** works to make care and support planning conversations routine for people living with long term conditions.

Integration Support

The **Integration Support Team** provides guidance, training and support through the evolving landscape of health and social care integration.

Signed, Healed, Delivered

When the fictional Dr Finlay cared for the population of Tannochbrae in the 1920s, he did so under a General Medical Services contract. The Links team has worked with 3,000 people in 15 Deep End Practices across Glasgow with eight Community Links Practitioners. This contract has always guided what services are provided by GP teams and sets out the terms of their remuneration.

With the approval of the new contract, April 2018 will mark the beginning of a three-year transition period which will see arguably the biggest transformation of General Practice since the Thatcher-imposed contract of 1990.

This new contract, is ambitious. It aims to improve access to GPs, address health inequalities, and improve population health (with mental health gaining a specific mention). Alongside these benefits for the general population, it aims to offer benefits to GPs, including providing financial stability, reducing GP workload, reducing financial risk, and an increase in peer support in quality assurance activities.

Links Worker Programme

National Links Worker Programme

The Links team has worked with 3,000 people in 15 Deep End Practices across Glasgow with eight Community Links Practitioners.

"Can I have an appointment with that person in here who helps you turn your life around?"

Person to receptionist at participating GP practice

Alongside additional financial investment, the reorganisation of multidisciplinary teams aims to ensure that people receive care and services from the professional most suited to meeting their needs, no longer will the GP be the main provider of all general medical care. For example, by the end of the transition period all acute and repeat prescriptions will be undertaken by a General Practice pharmacist. 'Additional services' will also be provided by the expanded general practice team. These include acute musculoskeletal physiotherapy services, community mental health services, and community link worker services. It's ambitious and appears to be very positive. I do have a couple of anxieties though.

Just as the 2004 contract was seen by many to improve clinical care, the side effects outweighed the benefits and the letter of the contract became more important than its spirit. I fear that the same mistakes could be repeated here.

The aim of the 2018 contract is to 'provide the very best of care', and the intention is for this care to be person centred, holistic, and co-produced. Our experience in co-producing and delivering the National Links Worker Programme at the ALLIANCE has been that finding the balance between delivering an enhanced person centred relationship-based service that can also meet the demand created by being part of a general practice team is incredibly nuanced. It's possible but there are barriers that will need to be overcome:

Staff delivering new services will need to quickly establish relationships of trust with their new colleagues. Establishing successful relationships between new staff (in our case Community Links practitioners) and existing practice staff is critical in embedding new roles, and the ALLIANCE's 2015 research showed that this has a direct impact in how much new staff members are utilised by patients.

The physical space required to host the expanded team. GP premises are notoriously struggling for space but for the above relationships to be created, colocation is critical. Colocation also aids sharing of information and access to medical systems.

In terms of sharing of information, staff are increasingly aware of data protection issues, and the new GDPR legislation could present further challenges to this. Where information sharing is legally possible, there are often other barriers, and people are already having to repeat their story with their existing care providers and pertinent information isn't always shared. Increasing the number of providers could exacerbate this existing issue.

Public perception? For the expanded team to be most efficiently used, people presenting to primary care will need to be triaged by reception staff and *they* will identify the most appropriate professional. Will people be happy to share this information with reception staff, in the waiting area and will they understand the reason for asking?

Will GP practices in the future operate as mini hospitals. Some of the services being brought in to General Practice are currently based in secondary care. And here's my main anxiety - I don't see hospitals as providers of relationship-based care. Don't get me wrong, the individual staff that work within each department do an amazing job and aim to treat 'the whole person', but they are based within their specialist department. My bones are cared for in a separate part of the hospital to my eyes. My acute ill health as an infant is managed by a different team to my health as an older person. General Practice is the last part of the NHS that takes all comers and this enables a depth and duration of relationship that secondary care cannot replicate.

The 2018 contract aims to provide the very best of care for the people of Scotland, but does it take away our ability to actually *care?* Can 10 highly-skilled staff caring for one person offer the same level of care as one generalist practitioner who, like Dr Finlay, has been a person's GP from cradle to grave? Is it possible to contract for care, and if it is, does the latest GMS contract cut it?

Mark Kelvin is Programme Director at the Health and Social Care Alliance Scotland (the ALLIANCE)

ALISS

A Local Information System for Scotland (ALISS) has its origins in the premise; "what is in my local community that can help me to live well?" Communities are often full of resources that can support people to live well but information about these resources is often invisible, inaccurate, or stored only in one place. If this information is findable, accurate, and relevant, people are more likely to receive the right support, in the right place, at the right time.

ALISS is the system that facilitates the aggregation and dissemination of health and wellbeing information across Scotland.

Timely access to accurate information about services and support that can help people to live well is vital for good health and wellbeing. ALISS engages and empowers communities to find and share what matters to them. Communities are often full of resources that support people to live well and the ALISS team have a renewed focus on community engagement. We also continue to support other staff across Scotland, such as Links Workers, to enable them to find and share information about their communities.

ALISS is also partnering with NHS 24 to support the new National Support Services Directory. This will make information about community health and wellbeing services available through NHS Inform and other channels. NHS 24 will be working with GPs and primary care information systems providers to develop the practical application of the directory. ALISS is referenced as a useful resource in the current Anticipatory Care Plan which will be used by GPs across Scotland. ALISS will continue to support the House of Care "more than medicine" foundation through the continued partnership working with the House of Care practices.

The foundation of using and accessing good information is that people "trust" the information that is in front of them. The ALISS technical infrastructure has been developed to ensure the robust collection and management of high quality information, using common information management standards.

With ALISS being able to support the generalist nature of primary care and provide people with the ability to access support that's relevant to them, ALISS continues to support the critical work of primary care in Scotland.

Our GP is a Scottish Government funded project managed by the ALLIANCE, working with mHabitat. Its vision is to co-design an innovative GP digital service with the potential to transform and enable better care for all, by collaborating with people and professionals across Scotland.

Ground-breaking in its approach to public and digital service design, over 1,000 citizens and practice staff participated, helping to define three new ideas for digital solutions to meet their needs.

A wide range of research and activity was undertaken, working with a representative group of citizens and professionals across urban and rural areas of Scotland. This included co-design workshops where people generated their ideas for digitally enabled improvements to care, roadshow events and then an online feedback/iteration phase of three feasible people-led ideas

Our GP

Designing GP Digital Services, Together

(see http://dhcscot.alliance-scotland.org.uk/ideas) that showed that these innovations were potentially valuable to the public and GP staff.

This value has been recognised and Our GP has recently been awarded £100k to further develop these co-designed solutions:

- The 'Personal Profile' (an online summary of non-medical information important to an individual which they can create/share with healthcare professionals, to facilitate more person centred care) will be included in the developing national health and social care portal
- The 'Advice and Information tool' (allowing people, after a GP consultation, to receive details about relevant online health information and support services, to help facilitate self management) will be developed by NHS24 drawing, for example, on NHS Inform content.

A third solution 'Digital Photo Triage' (a tool for people to send images of minor skin conditions/injuries to their GP for feedback) is also being discussed with public sector partners to see how this can link up with other ongoing digital health and care innovations.

Through Our GP, people have shown their willingness to participate in service design as well as the creativity and real value they can bring to help shape new ways to deliver care. We hope the project's success will encourage more co-design and public participation in primary care and other public services.

About the ALLIANCE

The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector intermediary for a range of health and social care organisations. We bring together over 2,200 members, including a large network of national and local third sector organisations, associates in the statutory and private sectors and individuals.

Our vision is for a Scotland where people of all ages who are disabled or living with long term conditions, and unpaid carers, have a strong voice and enjoy their right to live well, as equal and active citizens, free from discrimination, with support and services that put them at the centre.

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