

# Health and Social Care Alliance Scotland



## Consultation Response: What should primary care look like for the next generation? Phase Two

11 September 2019

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The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector intermediary for a range of health and social care organisations. It brings together over 2,700 members, including a large network of national and local third sector organisations, associates in the statutory and private sectors, and individuals.

### Responses to Consultation Questions

#### **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?**

Primary care encompasses the whole range of multi-disciplinary roles which occur in both primary care buildings (e.g. GP surgeries) and in the local community. The latest GMS contract envisages that GPs will be general medical specialists supported by a range of staff operating within a multidisciplinary team<sup>1</sup>. In our view, this change can only be achieved if all staff involved are “bought into” a truly multidisciplinary and non-hierarchical approach to delivery of services across the local community. General Practitioners comprise just one of these roles, but there are many other staff members, for instance Allied Health Practitioners such as physiotherapists, podiatrists and speech and language therapists, who are equally critical in ensuring that a sustainable model of primary care is delivered. It is vital trust is nurtured across professional boundaries and that frontline staff are empowered with the autonomy to do whatever is relevant to meet people’s outcomes.

The investment in Community Link Practitioners/Workers, in various forms communities across Scotland, is an example of how an ambitious multidisciplinary approach can work in practice and how the third sector can play a critical role in developing and embedding new roles and ways of working, supporting the delivery of a new vision of primary care which aligns with the priorities described by the public in the Committee’s public panels. Community Link Practitioners support people to build

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<sup>1</sup> <https://www.gov.scot/publications/gms-contract-scotland/>

self-efficacy and self-determination and find things in their community that can help them to live well. This is focused on creating better health and wellbeing outcomes for the individual and not simply driving down pressure on primary care.

### **The ALLIANCE's Links Worker Programme<sup>2</sup>**

- Originally delivered in seven 'Deep End' GP in Glasgow practices since 2014, soon to expand into at least 27 practices by the end of 2019
- The Community Links Practitioners (CLPs) have worked with around 10,000 people to date
- Most people who see a CLP work with them to address at least 2 or 3 different issues. More than half of these issues are either related to physical, mental and social issues.
- Community resources in the localities where the programme is active have reported an increase in the number of referrals they receive from General Practice
- Importantly, these community resources report that these referrals are now more relevant to the services that they offer, compared to before the Links Worker Programme intervention.

### **ALISS (A Local Information System for Scotland)**

The ALLIANCE manages the ALISS programme, which exists to increase the availability of health and wellbeing information, supporting the wider social determinants of health. Within the wide scope of the Committee's inquiry, ALISS supports the sharing of information on easily accessible and 'entry-level' sports and activities (as opposed to high-performance sports). ALISS is a free to use online platform which helps people find and share services and activities which support health and wellbeing. It can be used by people accessing services and social prescribers alike.

Integration between all forms of primary care and the third sector (and notably the significant level of innovation from the private sector in this area) is key to achieving a sustainable primary care system that meets the needs of people who use support and services. Where it is successfully achieved, such integration has the potential to free up valuable resource across the multi-disciplinary team and to increase options and improve access for people and communities.

Other examples of this integration include the relationship between NHS24/NHS Inform and Breathing Space to provide an alternative and easily accessible 'first stop'

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<sup>2</sup> <https://www.alliance-scotland.org.uk/in-the-community/national-link-programme/>

confidential service for those experiencing low mood or depression and the NHS24 helpline, operated in partnership with Macmillan, which provides further options for those dealing with diagnosis and treatment of cancer.

As recognised by the Committee's public panels, longer term funding for third sector services is necessary to enable primary care teams to take advantage of the value that it brings. The funding of third sector services, largely not by the NHS but by HSCPs or local authorities, is often under threat and removal of these services does not necessarily consider the wider impact this may have in supporting the primary care sector through referrals and prevention.

Transformation is also required in the involvement of people with long term conditions in planning for their care – a key component of the self management approach around which the ALLIANCE was founded. In keeping with other societal shifts, people expect to have more say now than ever before on how they will be treated and to be equal partners in decision making about care and treatment. The House of Care model is an example of this, underpinned by the principles of person-centred care and rooted in the assets of local communities. Healthcare professionals together with people who are living with one or more long-term conditions, work as equal partners, to engage in a care and support planning conversation addressing the needs of the individual, and to develop a care plan if appropriate. This conversation draws on the expertise of the individual living with their condition, taking into account their own health needs, personal goals and their limitations.

### **House of Care**

House of Care involves redesigning systems to deliver person-centred care, as opposed to system-driven care based on single disease clinics and services. As well as attending to patient activation<sup>3</sup> and health literacy<sup>4</sup> the process involves:<sup>5</sup>

- A preparatory meeting with a healthcare assistant to collate required information and discuss how a person-centre 'care and support planning appointment' works.
- Materials including test results to be sent with short explanation to the person in advance of their appointment.
- Significantly extended appointments that use a collaborative conversation to develop a shared agenda that reflects both patient and professional concerns.
- Proactive linking of patients to sources of help and support that they value.

<sup>3</sup> [www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/supporting-people-manage-health-patient-activation-may14.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf)

<sup>4</sup> [www.healthliteracyplace.org.uk](http://www.healthliteracyplace.org.uk)

<sup>5</sup> [www.yearofcare.co.uk/process](http://www.yearofcare.co.uk/process)

The House of Care approach helps people be more involved in decisions about their care and to identify what matters most to them. It also helps people to identify the resources within their communities which can support them in achieving their goals. This approach, now been adopted by 10% of GP Practices in Scotland having been developed in partnership with the ALLIANCE and the Scottish Government<sup>6</sup>.

This approach, now included in the RCGP curriculum for trainee GP's, should be widely adopted across the country and learning from its implementation could be shared with other similar service redesign processes.

### **Implementing primary care digital transformation that is person centred**

Digital technology is often seen as a helpful solution for some people to access services. The public panels recommended the use of “email, text and social media for appointments and prescriptions... (and) Skype or FaceTime appointments with GPs in particular for those in rural/remote areas and with disabilities.”<sup>7</sup>

The Scottish Government's eHealth Strategy suggested a series of measures that sought to utilize digital technology and whilst progress is being made in some areas, for example the increasing use of video consultations, in others there has been less action. For example, the strategy aimed for at least 90 per cent of GP practices to offer online booking of appointments and repeat prescription ordering by 2017 – however, with no detailed action plan to accompany this, we understand this target has still not been met. Further consideration of why these measures have failed to be implemented to date is required.

Furthermore, we note that Scotland's ambitious Digital Health and Care Strategy - launched well over a year ago - doesn't contain any timescales for delivering digital services to the public, including those linked to primary care. We believe there is a clear need for commitments and an associated delivery plan for citizen-facing digital health and care in Scotland, to spur delivery as well as accountability. This includes clarifying whether and when Scots will get online access to their health records, as well as various other digital tools that could potentially support shared decision making, care and support planning as well as self-management.

### **Electronic patient records**

The public panels noted that electronic patient record, shared with all relevant professionals were a priority for them. The technology exists for there to be live systems that, in real time, links, collates and analyses data collected by front line

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<sup>6</sup> [www.alliance-scotland.org.uk/what-we-do/our-work/primary-care/scotlands-house-of-care](http://www.alliance-scotland.org.uk/what-we-do/our-work/primary-care/scotlands-house-of-care)

<sup>7</sup> <https://sp-bpr-en-prod-cdnep.azureedge.net/published/HS/2019/7/3/What-should-primary-care-look-like-for-the-next-generation-/HSS052019R9.pdf>

health professionals in a secure manner. Scotland should seek to be a world leader in developing this and leveraging the potential of contemporary computer science.

We believe that if they are to attain near universal population coverage they must incorporate information on the social determinants of health and be designed in a way that can lead to greater analysis of the relationships between social and biological indicators and outcomes. This could assist in combating challenge of recruitment of people from disadvantaged communities into clinical trials/public health studies and other limitations of the traditional evidence based approach when it comes to tackling health inequalities.

## **Out of Hours**

The public panels noted the future importance of out of hours (OOH) services and how they could be improved in the future. We believe that changes are necessary that enable better shared access to Key Information Summary between professionals, customer service training for OOH staff and improved signposting to services which open outside of GP hours.

## **Health and Social Care Integration**

Primary care is a key function of integrated health and social care activity across Scotland following the Public Bodies (Joint Working) (Scotland) Act 2014. Governance, planning and resourcing are overseen by Scotland's integrated joint boards, which bring together representatives of both the NHS and the local authority. Some public panel members recommended that the NHS should take over responsibility for social care from the local authority. We don't agree with this recommendation. The vast majority of social care, and support for good health/wellbeing, is delivered not by statutory services but by individuals themselves, families, unpaid carers, peer and community-based support and the third sector. Integration itself should be offering important opportunity to improve connections between these types of support and statutory services, including primary care.

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

Additionally, whilst, in our experience, community engagement tends to be better in rural areas, often the level of community assets, peer support and choice over services are limited. Additionally, primary care services are often not well appraised of the community assets in their local area. This restricts primary care's ability to refer or signpost to relevant and helpful local services.

Travel distances, travel costs and work commitments work against people's ability, or

willingness, to access the range of services offered within primary care. These issues are often exacerbated for people who live with long term conditions and disabled people who often experience additional inequalities in each of these areas. For example, participants in the ALLIANCE's recent work on the Grampian System wide Mental Health and Learning Disability Services Review<sup>8</sup> "...transport to appointments or support groups (is difficult) and if you live in a rural area and public transport is poor - you can't drive if you are medicated."

In urban settings, such as those within which we deliver the Links Worker Programme, some of the key challenges are around the volume and diversity of social determinants of health and people living with multiple conditions encountered. This presents challenges for health professionals across roles in that it is seldom one role that can address all of an individual's requirements.

Building capacity within workforce development schemes for ensuring interconnectedness of services and reducing prevalence of complex exclusion/inclusion criteria is absolutely critical to addressing these issues. Services must be empowered to work together in a more open, coherent manner, if we are to meet complex needs of the population. To achieve this, as aforementioned, it is imperative that a less hierarchical culture, and more autonomous, trusted, frontline workforce must be fostered. Superfluous, risk averse, bureaucratic processes must become a thing of the past.

### **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?**

As noted in Sir Harry Burns' Review of Targets and Indicators in Health and Social Care in Scotland, "The lack of robust primary care data has been a significant challenge in the drive towards intelligence-led primary healthcare." Recent developments such as the Scottish Primary Care Information Resource (SPIRE) enables GP practices to use data for approved purposes but this is limited in terms of the scope of effective monitoring and evaluation of new approaches to work. Developing a variety of qualitative and quantitative means of identifying these impacts should be a key priority for the implementation of any proposed changes.

The effectiveness of any intervention can only be suitably identified if it adequately assesses the impact on the individual and their experience. Often data is collected on service change that reflects too much on information that can be too easily collected by the existing system (often quantitative) and does not prioritise people's experiences. One example of this in the health and social care system has been the

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<sup>8</sup> <https://www.alliance-scotland.org.uk/wp-content/uploads/2019/06/ALLIANCE-Grampian-Final-Report.pdf>

roll out of self-directed support in Scotland, where data is currently collected on the number of people who use social care who have been given a choice but not on their experiences<sup>9</sup>. This is why the ALLIANCE and Self Directed Support Scotland are running the My Support My Choice research project focussed on service users' experiences of self-directed support<sup>10</sup>.

At the same time ISD Scotland should be encouraged to consider operational measures which can appropriately evaluate the value of multi disciplinary, both to the health and social care system and the wider community. Often this misses out key local data from the third sector – this should be addressed.

### For more information

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### About the ALLIANCE

The ALLIANCE's 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.

The ALLIANCE has three core aims; we seek to:

- Ensure people are at the centre, that their voices, expertise and rights drive policy and sit at the heart of design, delivery and improvement of support and services.
- Support transformational change, towards approaches that work with individual and community assets, helping people to stay well, supporting human rights, self management, co-production and independent living.
- Champion and support the third sector as a vital strategic and delivery partner and foster better cross-sector understanding and partnership.

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<sup>9</sup> <https://www.gov.scot/binaries/content/documents/govscot/publications/statistics/2018/08/self-directed-support-scotland-2016-17/documents/00539169-pdf/00539169-pdf/govscot%3Adocument/00539169.pdf>

<sup>10</sup> <https://www.alliance-scotland.org.uk/blog/news/my-support-my-choice-sds-research-project/>