Clinical Services Fit for the Future

Primary Care and Community Services and the Hospital Interface

Event Report: Wednesday 12 December 2012

1. Introduction

80 people from across primary care, community services and acute services came together at Maryhill Burgh Halls to discuss the emerging issues from the clinical services review, and how services need to change across primary care and community services, and at the interface with hospitals.

A wide range of proposals for change came out of the meeting. Some of these will impact on the long term strategic direction set by the Clinical Services Review; others reflect more short to medium term priorities which could begin to be addressed now. This paper sets out the key issues raised on the day and proposed some next steps.

2. Presentations

The morning focused on the themes emerging from the Case for Change and an overview of primary care in NHSGGC. The afternoon focused on models from elsewhere in the world, introduced by McKinsey.

Presentations were made on the following topics.

- Clinical Services Review – emerging issues (Jennifer Armstrong)
- Primary Care in NHSGGC (John Nugent)
- LMC perspective (John Ip)
- Ribera Salud health system in Spain (McKinsey & colleagues)
- North West London integrated care pilot (McKinsey & colleagues)

3. Group discussion

Groups were asked to reflect on the presentations and consider the areas with the greatest potential for change in NHSGGC, particularly looking at different models of working across primary, community and secondary care boundaries.

A full note of each of the group discussions is available from lorna.kelly@ggc.scot.nhs.uk

A summary of the main issues from the discussion is attached.

4. Emerging themes and challenges

A range of longstanding frustrations and challenges were aired, both around the services we provide and our ability to make change happen across the primary secondary care interface. These included:

- There is shared understanding of the need for primary and secondary care to plan and deliver change together but mechanisms don't seem to be in place to do that;
- Demand management with tight resources is a major issue for hospitals and for primary care and needs to be addressed together to avoid unplanned workload shifts.
- Lack of systems and infrastructure to support care co-ordination and navigation: GPs often have that role by default without support to do it properly.
- Co-ordinating patient care often seems to fall down on basic communications and administration issues.
- Our HIT investment has delivered a platform for substantial change but we need to plan together how to use it to share information and manage patients better, including social care information and real time communications.
- There is a real challenge of delivering change across a large and complex system even where we can agree what needs to be done: e.g. remaining variation in practice in acute services and the even bigger challenge of agreeing and delivering change across hundreds of individual GP practices. The GMS contract has benefits but also constrains what we are able to do at a local level.
- We need to move away from describing the problem to defining the outcomes and what a different solution would look like.
- How do we take forward the theme of practices working more in clusters or groups?

5. Next Steps

It is proposed that these issues are taken forward in the following ways:

- Clinical Services Review models: the output from the event will be shared with CSR groups to inform the service models and development of more detailed description of what needs to happen in each part of the system.

- We need to review how we our GP forums and locality groups are working to support joint problem solving and progress on service delivery, including group / cluster arrangements.

- Establishing and Interface group to work on the shirt and longer term issues which we need to address together. Initial priorities could include:

    - Mapping out what is happening now, e.g. through referral management and guideline groups, action to follow up the QOF

event, ongoing work on discharge information and appointments systems.

- Systematically reviewing communication and information arrangements to look at what the core elements of shared information should be and ensure that appropriate communication routes exist and are used.
- Scrutiny of variation in practice and targets to reduce this.
- Arrangements for taking bloods in a community setting.
- Prescribing issues including secondary / primary care initiation and reviewing range of over the counter medications on the formulary.
- Develop a consistent model of one stop clinics which could be rolled out across NHSGGC.

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APPENDIX 1

Primary Care Event 12 December 2012

Key Themes from Group Discussions

Shared Information Systems

- Single patient record as platform
- GPs have information to be actively involved in the patient's pathway
- Patient access to test results
- Opportunity for single person to co-ordinate caare

Groups / Clusters of Practices

- Making best use of different GPs' skills and expertise across a cluster
- Specialist services could be aligned with groups / clusters for service delivery and focus for communications
- Principle of polyclinics is good – could clusters of practices based round a community facility enable more joint working and outreach from acute
- 50,000 population for clusters?
- Opportunities of new health centres as focus for services for a group of practices

Risk Stratification

- Need to be clearer what risks we are stratifying for, and include the second tier of risk as well as those at the very top.
- How can we apply this beyond older people / chronic disease – e.g. to children.

Demand management across the system

- Develop better more consistent approaches to triage and skill mix within practices
- 1 admission per month / one attendance per day adds up to a big impact across 240 practices. More 'in hours' unscheduled care in practices?
- Focus GP role on making diagnoses and managing risk rather than delivering screening programme
- GPs having same access to investigations as hospital specialists

Communications

- Ability to discuss / seek advice rather than refer
- Instant messaging and individual response
- Integrate into governance, patient records and activity monitoring
- More virtual / digital alternatives (example of Kaiser Permanente 30% of interactions are not face to face)

Services designed around the patient

- Define clear model of 1 stop clinics and critical services where this should be in place
- Consistent access to treatment room type facilities to support more services in the community, e.g. bloods.

More multi-disciplinary team based care

- Within primary care
- Working across primary / secondary (e.g. Diabetes foot care team)

Shared ownership of patient journey

- GP / community services involvement in treatment plan and discharge plan in hospital
- Acute specialist ‘outreach’ to community e.g. for MD care planning for individuals

Leadership and joint planning

- Cross system clinical engagement to design and deliver change across services is essential – how do we strengthen that.