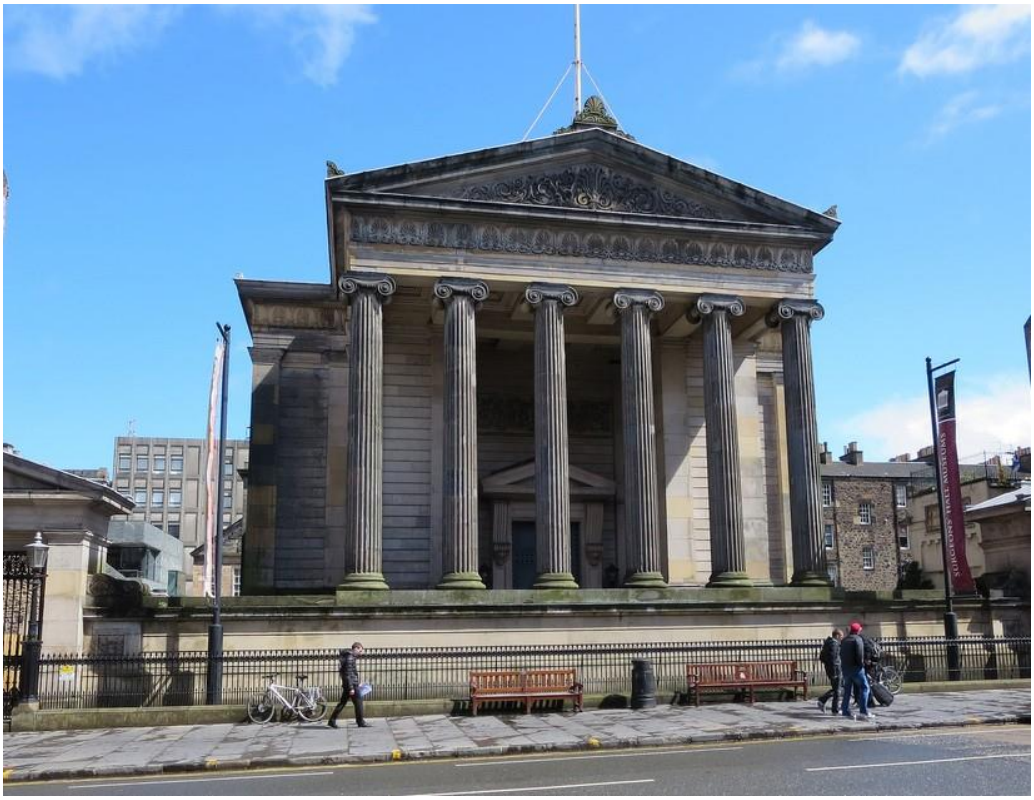
‘Learning Together’

Sharing international experience on new models of primary care; policy, delivery, and evaluation



Date: 17 May 2017

Venue: Royal College of Surgeons, Edinburgh

A workshop hosted by the:

Scottish School of Primary Care

Foreword

The Scottish School of Primary Care (SSPC) facilitates collaboration between primary care academics and key stakeholders involved in policy and integrated health and social care service developments in order to provide evidence-based solutions. Further information about the SSPC can be found at http://www.sspc.ac.uk/.

On 17 May 2017, SSPC hosted a workshop in Edinburgh to share international experience on new models of primary care in relation to policy, delivery and evaluation. External speakers included academic and primary care leaders from Australia, Canada, Denmark, Finland, the Netherlands, Norway and Wales. Those attending also included senior representatives from the Scottish Government, the Royal College of General Practitioners (Scotland), Health Improvement Scotland, NHS Health Scotland, NHS Services Scotland, and members of the SSPC Executive Management group. Details of attendees are listed in Appendix 1.

We are extremely grateful to all our speakers for their informative presentations and for allowing us to circulate their slides (available at http://sspc.ac.uk/presentations), and to our international guests and other attendees for helping to make this a thoughtful and positive meeting. We hope the Edinburgh Consensus Statement that emerged collectively from the meeting will serve as a useful benchmark for the development of new models of primary care in Scotland and other parts of the world.

We would also like to thank David Blane and Bridie Fitzpatrick for their help in recording essential information during the day and helping to write this report. Thanks also to Karen Penman for helping in the planning and organisation of this event. Finally, we wish to thank the Robert Wood Johnson Foundation for its support in enabling this meeting through an educational grant.

Professor Stewart Mercer, Director of SSPC

Professor John Gillies OBE, Deputy Director of SSPC

Dr Gregor Smith, Deputy Chief Medical Officer, Scotland

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Executive Summary

What do we mean by 'New Models of Primary Care'?

There is widespread recognition that health services across high-income countries face common challenges of ageing populations, health inequalities, and the multimorbidity that underpins both. The growing burden of care and the related escalating healthcare costs demand new approaches, particularly in primary care. 'New Models of Primary Care' refer to proposed solutions, some of which are currently being tested by Governments and health care systems. These include better integration between primary care and secondary care and between health care and social care; development of more multidisciplinary teams (MDTs); and General Practitioner (GP) Practices working collaboratively in clusters. This represents a major cultural shift.

What new ways of working are needed?

The need for Government policies and resource allocation to redress the imbalance between secondary care and primary care (and the inverse care law within primary care) in order to better meet the needs of patients was a recurrent theme across all countries. As New Models progress with the ambition to achieve better integration, there is a clear need to build and develop a different culture and new trusting relationships. Trusting relationships are required between the different GP practices within GP clusters; between different disciplines in MDTs; between health care, social care and the third sector; and at interfaces between primary care and secondary care. All of these require strong commitment by many different stakeholders including politicians, policy makers and those charged with the planning and provision of services.

What additional support is needed?

New models of working will need substantial local and central support to deliver high quality, integrated primary care. Primary care should have easy access to secondary care data and vice versa. This needs good national and local health service infrastructure, and training and support for all clinicians and support staff. Better and quicker linking of data from 'big data' sources to primary care data is urgently required. In Scotland, for example, data derived from the Scottish Primary Care Information Resource (SPIRE) will be essential to the development of New Models of Primary Care.

How do we know if the new models are working?

There is great scope for the development of 'Evidence-based Realistic Medicine' in primary care. There are numerous evidence gaps in areas such as multimorbidity, polypharmacy, use of digital health, treatment burden, and the early detection of cancer. Addressing these gaps will require innovative research methods. International research collaboration would be a useful way to pool resources to answer the 'big' issues in primary care transformation, producing findings that are robust within a shorter timeframe than usual. Scotland is well placed to lead such a collaborative effort.

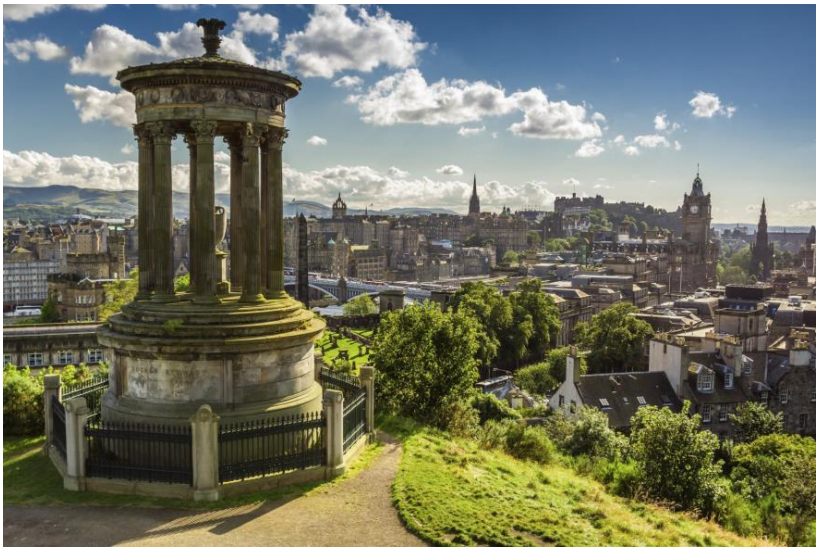
What are the key messages?

- The population challenges facing primary care require leaders who take a collaborative and collective approach, and who are willing to be proactive in terms of wider roles such as advocacy and social activism.

- As New Models of Primary Care develop and evolve, retaining and building on core values, such as mutuality, respect and compassion, is essential to staff and patients alike.
- Developing and maintaining trust among all involved is essential, and consideration for staff wellbeing must be evident. Generalism must remain at the heart of primary care as New Models develop.
- Rapid, real time access to high quality data to produce intelligence for transforming care is essential.
- Early collaboration between policy makers and academics in primary care research could quickly improve quality and value, achieving greater health gain for populations by filling in current evidence gaps and guiding the adoption and delivery of policy directives.

From the themes raised and discussed, and the key messages, a consensus statement was written:

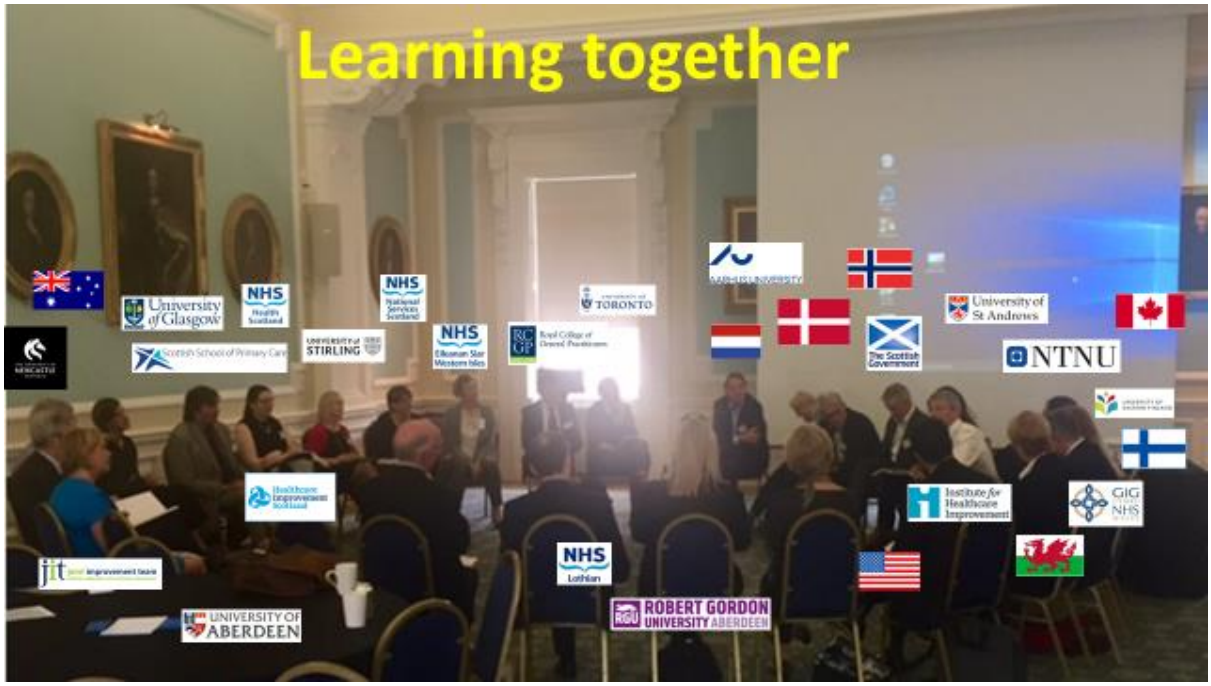
The Edinburgh Consensus Statement

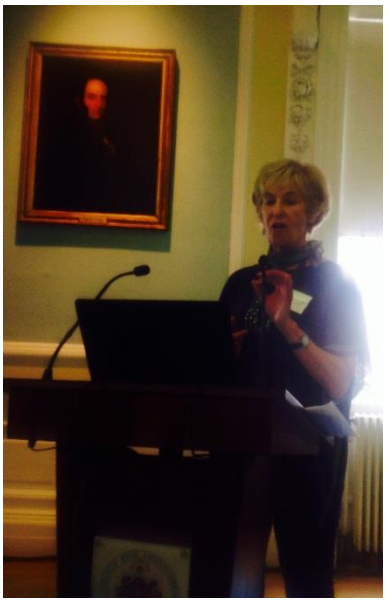


"The population challenges facing primary care in Scotland and other countries will require leaders who take a collaborative approach, and who are proactive in wider roles such as advocacy and social activism. General practitioners will work closely with other health and social care professionals in multidisciplinary teams where roles and contributions are understood and respected. Patients' goals and preferences elicited through shared decision -making will guide the direction and amount of their healthcare. The resourcing of primary care will reflect the growing needs of older people and those with premature multimorbidity in deprived communities. These represent major cultural shifts. As New Models of Primary Care develop and evolve, retaining and building on core values, such as mutuality, respect and compassion, will be essential to staff and patients alike. A strong focus on developing and maintaining trust among all involved is essential, and consideration for staff wellbeing must be evident. Generalism will remain at the heart of primary care. Rapid access to high quality data to produce intelligence for transforming care will be essential. Collaboration between policy makers and academics in primary care research could quickly improve quality and value, achieving greater health gain for citizens, by filling in current evidence gaps and guiding the adoption and delivery of policy directives."

Learning Together: Sharing International Experience on New Models of Primary Care.

Policy, delivery and evaluation





Introduction

The aim of the meeting was to bring together key stakeholders from eight countries to share experiences of New Models of Primary Care. The number attending was limited, and those attending included international and national primary care academics and leaders; senior representatives from the Scottish Government, the Royal College of General Practitioners (Scotland), Health Improvement Scotland, National Health Service (NHS) Health Scotland, NHS National Services Scotland; and members of the Scottish School of Primary Care (SSPC) Executive Management group. Details of attendees are listed in Appendix 1.

Speakers from Scotland, Australia, Canada, Denmark, Finland, the Netherlands, Norway and Wales presented an overview of the current situation in primary care in each of their countries. There were three workgroup discussions on Policy, Delivery and Evaluation (see Appendices 2 to 4 for summary notes of these). In keeping with previous SSPC meetings, ground rules were agreed to encourage open and frank discussion. This was achieved, and discussion and debate throughout the day remained lively, informative and exploratory.

There were remarkable similarities between countries not only on the common challenges faced (ageing population, health inequalities, multimorbidity, escalating healthcare costs) but also in the proposed solutions that are currently being enacted or suggested by Governments and health care systems. These solutions included better integration between primary care and secondary care and between health care and social care; more multidisciplinary teams; and the move towards General Practitioner (GP) Practices working collaboratively in clusters.

Throughout the day, there were references to meeting the needs of the populations served and the importance of integration. However, there were also references to tensions between 'traditional general practice' and 'New Models of Primary Care'. Although better integration of health care (and social care in some countries) was regarded as essential, there were concerns about losing the essence of general practice ('throwing the baby out with the bath water'). Moreover, whilst multidisciplinary teams (MDTs) offer great potential, there is still a need to develop evidence to demonstrate their effectiveness, safety and value.

The need for clear Government policy and funding to redress the imbalance between secondary care and primary care (and the inverse care law within primary care) in order to better meet the needs of patients was a recurrent discourse. There is a resounding message that we have an opportunity for pro-active, collaborative leadership from general practice and primary care, moving towards long - term systemic change.

Five key themes emerged from presentations and discussions throughout the day. These were Leadership; Values; Roles, Relationships and Ways of Working, Data and IT systems; and Research and Evaluation.

Key Themes and Messages

Theme 1: Leadership

The need for leadership was raised many times during the day. It was widely agreed that collaborative leadership was required to meet the dual challenges of improving population health as well as integration and quality improvement in primary care, particularly for patients with complex care needs. This requires flexible and transparent leaders who are resolute in their focus on vision and strategy, and capable of working across traditional professional boundaries and with multidisciplinary teams and networks. Critically, all of this must be achieved with people and person-centred care at the heart of every discussion or action. In Scotland, it is vital to build on the current Leadership for Integration scheme [NHS Educational for Scotland (NES)/ Royal College of General Practitioners (RCGP) Scotland/ Scottish Social Services Council (SSSC)] in order to produce confident, collaborative leadership not just *in* but *from* primary care. This will require ongoing support and training for GPs and GPs in training, as well as other core members of the integrated primary care team. There is a need to enhance training in leadership and strategic thinking. Academic primary care leadership is also under-valued and under-resourced. Leadership is important in all areas of Scotland, including remote and rural, areas of high deprivation (the Deep End), and in out-of-hours care.

Key Message 1: *The population challenges facing primary care require leaders who take a collaborative and collective approach, and who are willing to be proactive in terms of wider roles such as advocacy and social activism.*

Theme 2: Values

The importance of core values that underpin the health and social care systems in the different countries represented at the meeting was discussed at length during the day. These core values included integrity, altruism, mutuality, respect, empathy and compassion. These need to be shared and demonstrated to all staff throughout health and social care, as well as to the people (patients) using the services. Clearly, the enactment of these values requires committed leadership and collaborative working. For primary care, this means maintaining and building on the essence of general practice, recognising clinicians as human beings and human beings as clinicians, and making care truly 'person-centred'. Caring for ourselves, for each other, and for the people we serve are not mutually exclusive activities; compassion is essential for everyone.

Key Message 2: *As New Models of Primary Care develop and evolve, retaining and building on core values, such as mutuality, respect and compassion, is essential to staff and patients alike.*

Theme 3: Roles, Relationships and Ways of Working

A great deal of the discussion during the day concerned the importance of roles and relationships. As new models progress with the ambition to achieve better integration, there is a clear need to build and develop a different culture and new trusting relationships. Trusting relationships are required between the different GP practices within GP clusters; between different disciplines in MDTs; between health care, social care and the third sector; and at interfaces between primary care

and secondary care. All of these require strong commitment by many different stakeholders including politicians, policy makers and those charged with the planning and provision of services. Staff wellbeing will need much more attention than has been evident in the past. Humane working conditions must be prioritised to deliver better services for patients as well as to increase recruitment and to avoid burnout and early retirement. New ways of working need to retain generalism at the heart of primary care if the needs of patients with multiple complex problems are to be met and the ambitions of 'Realistic Medicine' are to be achieved.

Key Message 3: *Developing and maintaining trust among all involved is essential and consideration for staff wellbeing must be evident. Generalism must remain at the heart of primary care as new models develop.*

Theme 4: Data and IT Systems

Data and IT systems were also much discussed throughout the meeting. No country had an ideal IT system though some were much more advanced than others. It was widely agreed that high quality, real-time patient data, which are readily accessible will be essential to support the delivery of high quality, integrated primary care. Primary care should have easy access to secondary care data and vice versa. This needs good health system infrastructure, training and support for all clinicians and support staff. Better and quicker linking of data from 'big data' sources to primary care data is urgently required. In Scotland, for example, data derived from the Scottish Primary Care Information Resource (SPIRE) will be essential to the development of New Models of Primary Care.

Key Message 4*: Rapid, real time access to high quality data to produce intelligence for transforming care will be essential.*

Theme 5: Innovative Research and Evaluation

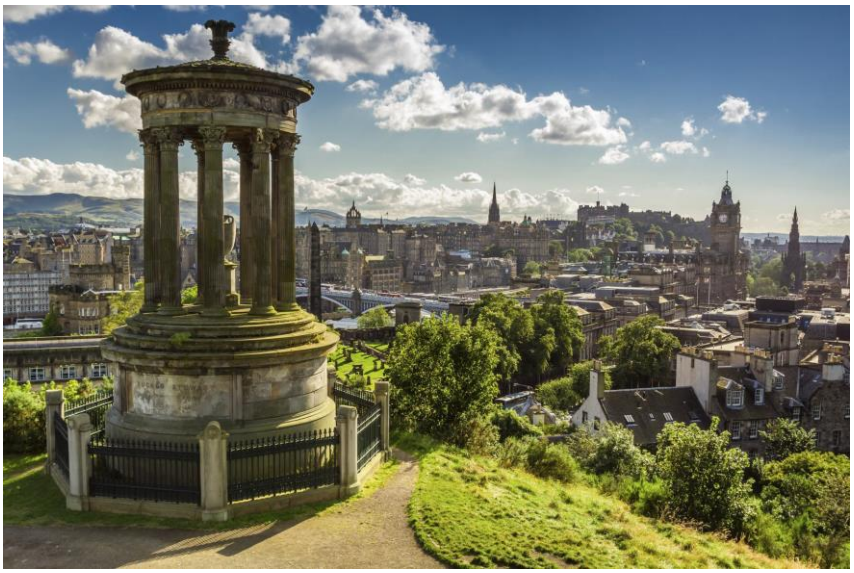
It was felt that there is great scope for the development of 'evidence based Realistic Medicine' in primary care. Much remains to be understood in areas such as multimorbidity, polypharmacy, digital health, treatment burden, and the early detection of cancer. Innovative research is required in the 'middle-ground' between large definitive randomised controlled trials and small-scale evaluations. This requires innovative research methods. International research collaboration would be a useful way to pool resources to answer the 'big' issues in primary care transformation, producing findings that are robust within a shorter timeframe than usual. Scotland is well placed to lead such a collaborative effort.

Key Message 5: *Early collaboration between policy makers and academics in primary care research could quickly improve quality and value, achieving greater health gain for populations by filling in current evidence gaps and guiding the adoption and delivery of policy directives.*

Conclusion

The challenges facing primary care and the proposed solutions are very similar across the eight countries involved in this workshop. All countries face the challenge of ageing populations, multimorbidity and health inequalities. Primary care is seen as key to the solution, and new models of care are being developed and tested within a landscape of integration. Care must be taken not to re-invent the wheel, and to retain the best of general practice in terms of its traditional values and holistic approach. A consensus statement has been generated from the meeting, which all participants have endorsed.

The Edinburgh Consensus Statement



"The population challenges facing primary care in Scotland and other countries will require leaders who take a collaborative approach, and who are proactive in wider roles such as advocacy and social activism. General practitioners will work closely with other health and social care professionals in multidisciplinary teams where roles and contributions are understood and respected. Patients' goals and preferences elicited through shared decision -making will guide the direction and amount of their healthcare. The resourcing of primary care will reflect the growing needs of older people and those with premature multimorbidity in deprived communities. These represent major cultural shifts. As New Models of Primary Care develop and evolve, retaining and building on core values, such as mutuality, respect and compassion, will be essential to staff and patients alike. A strong focus on developing and maintaining trust among all involved is essential, and consideration for staff wellbeing must be evident. Generalism will remain at the heart of primary care. Rapid access to high quality data to produce intelligence for transforming care will be essential. Collaboration between policy makers and academics in primary care research could quickly improve quality and value, achieving greater health gain for citizens, by filling in current evidence gaps and guiding the adoption and delivery of policy directives."

Appendix 1

Workshop Attendees

Scotland

Stewart Mercer	SSPC Director	Scotland
John Gillies	SSPC Deputy Director	Scotland
Margaret Maxwell	SSPC Executive	Scotland
Frank Sullivan	SSPC Executive	Scotland
Bridie Fitzpatrick	SSPC Operational Team	Scotland
Gregor Smith	Scottish Government	Scotland
Ali Azhar	Middle East & Asia Pacific Institute for Health Care Improvement	Scotland
Jan Beattie	Scottish Government	Scotland
Gordon Black	Scottish Government	Scotland
David Blane	University of Glasgow	Scotland
Kirsty Brightwell	NHS Western Isles	Scotland
Ruth Dryden	Health Scotland	Scotland
Anne Hendry	NHS Lanarkshire	Scotland
Carey Lunan	RCGP Scotland	Scotland
Miles Mack	RCGP Scotland	Scotland
Lucy Munro	NHS National Services Scotland	Scotland
Brian Robson	Healthcare Improvement Scotland	Scotland
Alison Strath	Robert Gordon University	Scotland
Andrew Scott	Scottish Government	Scotland
Sian Tucker	NHS Lothian	Scotland
Jennifer Wilson	Scottish Government	Scotland

International

Joseph Dahine	Healthcare Improvement Scotland/NHS Lothian	Canada
Christian Freitag	Organisation of GPs Denmark	Denmark
Anders Grimsmo	Norwegian University of Science and Technology	Norwegian
Trine Jeppesen	Organisation of GPs Denmark	Denmark
Tiina Laatikainen	Aalto University	Finland
Richard Lewis	NHS Wales	Wales
Sally Lewis	NHS Wales	Wales
Renee Lyons	University of Toronto	Canada
Frede Olesen	Aarhus University	Denmark
David Perkins	University of Newcastle	Australia
Niek de Wit	UMC Utrecht	Netherlands

Workgroup 1: Policy
Summary of Key Points

Policy vision and direction

- **Turnover of governments** with political election cycles can be an issue, though, even when there is relative stability, some Ministers can be reluctant to reverse previous policy without compelling evidence of inappropriate effect.
- The challenge is to move beyond short-term fixes for 'crises' (for political comfort) when **longer-term strategic** planning is required.
- **Think tactically** – the work of Professor Scott Greer on the three Ps of Problem, Policy and Politics is helpful (see https://academic.oup.com/bmb/article-lookup/doi/10.1093/bmb/ldw013). In short, think about how people (**general public/ media**) will react to your proposed policy solution – because that is a critical consideration for politicians.
- A focus on **person-centred outcomes** (with supporting evidence) is appealing. Social prescribing approaches were particularly 'in favour' at the moment, reinforcing the idea that timing is important.
- Some things cannot be implemented as traditional policy – e.g. 'Realistic Medicine' is more about a **shift in culture** than specific policy prescriptions (although these may follow). [Remember that "culture eats strategy for breakfast"!]
- It is important to think ahead in terms of **succession planning** (e.g. think of the next generation of clinical leaders). Clinical fellowship posts can help with this capacity building (see below).

Engaging with policy makers

- Good relationships between policy makers and healthcare professionals are key, and depend on **mutual respect** and **trust** as well as **professional integrity and humility**.
- Trust between politicians and the clinical professions has been successfully **developed over time** in Scotland.
- There is a need to **present solutions that resonate and make sense**, i.e. easy to understand and communicate. Everyone wants to be associated with success.
- **Timing is important**. "In dark days, the light shines brighter" – e.g. at a time of increasing public dissatisfaction with increasing waiting times, it was easier to promote some of the more radical proposals in one country's primary care reforms.
- The Deep End GP group is one example of successful engagement with the political process. It **took time** (started in 2009 with sharing experience, collective identity); a **consistent message** (inverse care law, NHS should be at its best where it is needed most) with a **recognisable brand** (Deep End logo); and **academic input** helped, with Professor Graham Watt as a **unique driving force**.

Support for leadership

- There is a need to support the translation of policy into implementation. For instance, Cluster Leads need **administrative and managerial support** to implement changes. The implementation staff **need training also** (e.g. receptionists being trained to be 'care navigators'). This **public-practice interface is crucial**.
- A broader discussion of the **limitations of general practice training** followed. There is limited training in leadership and strategic thinking, and academic general practice is under-valued and under-resourced. This combined with **sub-optimal use of general practice data** (and lack of analytic support) results in a lack of confidence in primary care to challenge specialist colleagues (e.g. why has shifting the balance of care been so unsuccessful?). There are also wider issues of the denigration of general practice throughout undergraduate medical training and lower pay structures compared to hospital colleagues.
- Primary care needs to think carefully about the **infrastructure required to collect data**, what data to collect, and how to use it. **Practitioners need protected time and space** to work on service development. Innovative educational developments like the pioneer scheme supporting GPs at the Deep End is a positive example of how this can be achieved.

Funding mechanisms

- Related to funding, and reinforcing the need to support implementation, it was noted that some GP clusters were unclear how to direct their activity when setting out. They would benefit from training/support with regard to proposal writing and project planning (i.e. getting ideas into practice).
- Another issue raised was that of financial systems that direct money out in silos. One recent exception has been the Scottish Government's Primary Care Transformation Fund, which has changed its approach to funding for Health Boards involved in the Fund, by **allowing more flexibility**, rather than ring-fencing budget for prescribed purposes.
- Regarding GP pay, there is a misconception that GPs can afford to pay for extra staff from their own pockets, and it is harder to make the case for funding via General Medical services rather than via other primary care services. It is, however, possible to challenge this narrative – in one country it is considered as "just a way of paying people".

Workgroup 2: Delivery
Summary of Key Points

Skills, tools and training

- This workshop highlighted the need to make **best use of existing assets in relation to service delivery** across Scotland, including the skills of Scottish Quality and Safety Fellows and Clinical Leadership Fellows. Positive initiatives (e.g. the Quality Academy in NHS Lothian) were highlighted.
- **Current barriers to skills development** across primary care were identified. These included a lack of study leave budgets for some urgent Out-of-Hours (OOH) care service clinicians, the lack of opportunity for them to become involved in the new GP clusters, and the reduction in clinical cover for protected learning time for many GPs and practice teams. There were perceived differences relating to all of these across localities. These could be addressed in rolling out new models of care.
- Although there were opportunities to undertake some training on-line for clinicians unable to take study leave (lack of budget or unable to backfill absence), this generally meant undertaking this in 'own time', which negatively impacted on morale as well as perceived value of the training.
- Future developments need to have much more **focus on practitioner wellbeing**, **confident collaborative leadership** and **reflective practice**.
- The generalist approach must be maintained in all aspects of training.
- The planned expansion of the primary care team to include Allied Health Professionals (e.g. Musculoskeletal Physiotherapist) and Advanced Nurse Practitioners was discussed. The need for both training in primary care and evaluation of outcomes was welcomed.
- In practice, both are resource intensive in terms of GPs in delivering the required training and mentorship (for Advanced Nurse Practitioners the academic requirements for GPs to provide mentorship, and for Musculoskeletal Physiotherapist the requirement to locate practitioner training in a primary care setting). Further discussion is needed on how Higher Education Institutes (HEI) / NHS Education for Scotland (NES) can sustainably achieve autonomous generalist advanced practitioners, possibly through the expansion of peer mentorship and support.
- There was discussion around the need for a "*social contract"* to ensure that the patients of Practices investing in advanced practitioner training would benefit from such investment for a defined period of time upon completion of training, but how this could be enforced was not clear.

Infrastructure

- Infrastructure issues for new models of primary care are **not just about health policies**, as they are affected by national digital infrastructure, health and social care integration policies and Council (or municipality) planning policies.
- **Poor mobile and broadband infrastructure** limit communications in remote and rural areas in Scotland and other countries; there are issues for the response from emergency services as well as day-to-day communication across health systems. This also adversely affects

recruitment of staff; good quality broadband is now essential for family education as well as health and social care.

- On premises, there are some excellent new builds that include both health and social care provision, but **inadequate GP premises** limit development in many areas. Health infrastructure is not fully taken into account in local planning decisions and policies.
- On Digital Health, there is a great deal of concern about the risks of data sharing, and not enough focus on the **need for good practice/cluster/population data as essential for high quality clinical care as well as planning for the future.**
- There are now patient portals for individual conditions like diabetes, kidney failure and inflammatory bowel disease. **The development of patient portals for primary care patients could offer a great deal.**
- There is a need to better understand and define the roles, reporting structures and interfaces of the various new organisational structures that will be key to delivery – such as Health & Social Care Partnerships, Integrated Joint Boards, Clusters, Interface Groups etc and how these should link in to the previously existing structures to complement their roles.

Workgroup 3: Evaluation
Summary of Key Points

Evidence base

- There is a lack of evidence in areas such as multimorbidity, polypharmacy, digital health, treatment burden, and the early detection of cancer, with much still to be understood. There is great scope for the development of **'evidence based realistic medicine'** in primary care.
- **International research collaboration** would be a useful way to pool resources to answer the 'big' issues in primary care transformation, producing findings that are robust within a shorter timeframe than usual. Scotland is well placed to lead such a collaborative effort.
- There is a **need for innovative research** in the 'middle-ground' between large definitive randomised controlled trials and small scale evaluations. Innovative research designs such as stepped wedge trials can be helpful.
- Examples were cited from Canada of **early investment** in complex evaluation using realistic approach. Time is important and sharing of learning is not black and white.
- Early **collaboration between policy makers and academics** in primary care research could quickly improve quality and cost effectiveness by filling in current evidence gaps and guiding the adoption and delivery of policy directives.

Research challenges

- There are several challenges related to data, including **access to high quality data** and data privacy/patient confidentiality. Organisation of data is particularly difficult when different regions within a country are each using different systems. In Scotland, the new Scottish Primary Care Information Resource (SPIRE, www.spire.scot) should help provide meaningful information at primary care and GP Practice levels.
- The integration of data between health and social care (where data are often lower quality) is another significant challenge.
- A further challenge is to agree on **what outcomes are most important**. Once these are agreed, work on form and function can start. The only way to improve the data is to use them (which will illustrate their shortcomings).
- Clinicians should be involved in research implementation, with early input from policy makers as well – the '*arm's length'* model is no longer fit for purpose.
- There is a need for funding boards to change their focus, from competition to collaboration. The Centres for Research Excellence in Australia set a good example.

Appendix 5

Speakers Presentations

Powerpoint files for each speaker are available to download below, please click on the link below to view.

Gregor Smith: Learning Together

Niek De Wit: Primary Care in the Netherlands

Anders Grimsmo: Primary Care in Norway

Tiina Laatikainen: Primary Care in Finland

David Perkins: Integrated Primary Care - the news from Australia

Renee Lyons: Canada's Primary Care: Models, Innovation & Research

Richard Lewis: An overview of cluster development in Wales

Sally Lewis: Enhancing Primary Care

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