Re-imagining Primary and Community Care in Aberdeen

Introduction

This paper sets out a direction of travel for the future of primary and community care in Aberdeen City. It aims to provide the Integration Joint Board (IJB) with a vision and the overarching concepts for change that will support current developments in primary and community care (in the context of the current Transformation plan). It supports the longer term changes required to sustain good quality services for the people in Aberdeen.

The case for the wider transformation of health and social care has been driven by legislation and is set out in a number of related documents plans and papers; including the Aberdeen City Health and Social Care Partnership Strategic Plan and the Transformation Plan which should be read as a companion piece to this paper. All aspects of the partnerships Commissioning Implementation Plan have a direct or indirect impact on our ability to achieve our aspirations in respect of primary care. This document focusses on a specific part of our wider services – that of Primary and Community Care and in the context of our Locality Working and developments in the new (pending) GMS contract.

This paper builds on the work undertaken by the IJB membership at a workshop session which took place in November 2017. It signals the IJB's commitment to supporting longer term planning, innovation and new ways of working and in setting a clear articulation of future investment and resourcing aims toward that vision. It also signals the IJB's understanding of the complexity of tackling these specific challenges and an awareness of the partnerships need to be innovative in our thinking and bold in our actions.

We anticipate this being a 10 year + vision – and that many of the changes started under this plan will be completed or further developed over the course of that time. Within the complexity of the change required we know and understand that we need to make a start and set a direction – this paper sets out what we see as the main challenges and opportunities in order for us to be able to make that start.

Why Focus on Primary and Community Care?

While the national and local challenges to health and social care have been well articulated elsewhere there are specific issues that relate to primary and community care.

Overall the population of people over the age of 75 is expected to increase by 63% over the next 20 years. The case for integration has been set out in detail in the range of guidance and the economic case which accompany the Integration legislation. The national challenge is clear:

- 1 in 4 adults has a long-term illness or disability;
- Around 2 million people in Scotland have at least one long-term condition;
- People in Scotland are living longer, but more of those people over the age of 75 are living with a long-term condition and/or significant frailty;

- Overall the population of people over the age of 75 is expected to increase by 63% over the next 20 years;
- Over the next 15 years, alongside other pressures, we expect an increase of 12% in GP consultations – if nothing changes; and
- At the same time as we predict an increase in demand for consultations there will be a decrease in the number of GPs working – we anticipate vacancies in the city increasing.

The Scottish Government estimates that the need for health and care services will rise by between 18% and 29% between 2010 and 2030. Coupled with a shrinking working age population and the known workforce supply challenges, it is clear that the current model of health and social care cannot be sustained and that it must change. The emphasis of change is toward more preventative and anticipatory approaches and those that are community-based with acute services being used only when there is no alternative.

These pressures of demography and workforce are replicated across the UK, and we are not unique in seeking to ensure that we can continue to support people in our communities to stay well and receive the appropriate support in the right place and at the right time when required.

Primary and Community Care are crucial to our health and care system. The vast majority of healthcare interventions take place in Primary Care. It is seen as the first point of contact with NHS services – 90% of all patient interaction across the health care system is with primary care practitioners. Primary and Community Care are key services in relation to prevention and wellbeing and in maintaining people's independence at home and in the community. These are universal services that provide care across the lifespan and across physical and mental health, they are the first point of contact that many in our city have with formal health and care services. They provide long term continuity as well as single interventions. As such and given the expected increases in demand and ongoing challenges in workforce supply we must continue to think and act differently in our planning and delivery of these services – and hence the single focus of this work on this area of our health and care partnership. We also need to ensure that planning and delivery is designed alongside individuals and localities in order that we support them to act and think differently in their expectations of primary care services. This is not to suggest any lowering of quality, indeed to develop quality of experience and ability to manage health more independently.

Who is the Primary and Community Care Workforce?

Primary care is provided by a range of health and non-health professionals, working together in multidisciplinary and multiagency networks across localities, with access to the expertise of specialist colleagues. All primary care practitioners have developed working practices, using local knowledge, clinical expertise and an evolving supportive and enabling relationship with the person to make shared decisions about their care and help them to manage their own health and wellbeing.

It is this ethos that supports our ability to develop a future vision and to start creating concepts that we know we will be able to implement.

This is a broad and diverse workforce and is provided under different contractual mechanisms. For the purposes of this paper it includes:

- General Medical Services – under an independent contractor model for the most part in Aberdeen
- Staff working in GMS services include – General Practitioners, Practice Nursing staff, ANPs, Pharmacists, General Dental Practitioners and Community Optometrist.
- Services working alongside but under contract to the HSCP – District Nursing, Community AHPs, Community Pharmacists, Mental Healthcare Workers, Health Visitors. LD Nursing etc.

There are a number of challenges within this workforce. A survey undertaken by ISD in 2015 and reported in 2016 concluded the following main points (Survey covers 2013 -2015):

- The estimated whole time equivalent (WTE) of GPs declined by 2% between 2013 and 2015 (from 3,735 to 3,645).
- The estimated WTE of registered nurses and Health Care Support Workers employed by general practice however increased by 2%.
- There was a decrease in the proportion of GPs working 8 or more sessions from 51% of GPs in 2013 to 43% in 2015.
- Nearly 9 out of 10 practices reported using GP locums. The estimated GP locum input was 350 WTE for the year ending 31 August 2015. This was an increase from an estimate of 290 WTE GP locum input reported by the survey in 2013.
- The majority of practices also reported difficulties in recruiting locums, with 60% of practices regularly unable to recruit locums for unplanned absences.
- One in five (22%) responding GP practices reported current GP vacancies at 31 August 2015. This is an increase from 9% of practices reporting current vacancies in 2013.
- In 2015, half of the vacancies reported had been vacant for over 6 months. In contrast, a much smaller percentage of practices reported vacancies amongst nurses, with 1% reporting vacancies for nurse practitioners/advanced nurse practitioners, and 4% reported vacancies for general practice/treatment room nurses.
- Over a third of GPs working in Scottish general practice are aged 50 years old or over. Among male GPs this proportion is higher, with nearly half (47%) aged 50 years old or over,
- Among registered nurses in Scottish general practice over half (53%) are aged 50 years or over.

Our experience and data is telling us this is not merely a recruitment issue but one about supply. Our aging population is playing out in our workforce as well as in increased demand on services. The majority of our nursing workforce being 50 years plus.

We have had clear changes to the demographics of our GP population – a huge shift in to a predominantly female workforce, with the majority of GPs now working part time.

So it is not about merely a financial solution, it's about being intelligent with what we have got – in thinking differently about how to maintain a level of GP availability for those that need the range of skills of a GP, and how we support the role by developing a range of allied health professionals working side by side with General Practitioners and their teams. Some of this work is already underway within our Transformation programme where we are already investing in Community Nursing succession planning, and putting resource into the development of a range of practitioners

to support our future primary care services such as Link workers and an increase in Pharmacy support in General Practice.

The Case for Change

Our Transformation Plan clearly articulates the wide range of pressures facing health and social care. Developing a resilient primary care service will be critical in ensuring safe, appropriate and sustainable services being able to meet the needs of future generations of people working and living in Aberdeen City. Building such resilience will take time. We need to start with our known pressure points and take the opportunity to think differently and not burden ourselves with trying to create more of the same – we can't. The current system isn't working in respect of being able to absorb the current increase in demand; it is not working well for GPs either. The BMA surveyed one thousand, eight hundred GPs in Scotland (2015) and from this survey; a quarter of GPs stated that their workload was unmanageable. Sixty-nine per cent also advised that their workload was having a negative impact on their personal commitment to their career.

Workforce issues

As stated there is a need to change the relationship with the public in their expectations of all health and social care services. Audit Scotland in their recent report, NHS in Scotland 2017 recommends that;

> ***"The Scottish Government, NHS boards and integration authorities, should continue to work with the public, local communities and staff to develop a shared understanding and agreement on ways to provide and access services differently…."***

And:

> ***" continue to develop a comprehensive approach to workforce planning that: reflects forecast of future staffing and skills requirements to deliver changing models of healthcare provision at regional, local and community level."***

ACHSCP recognises it needs significant change and this vision sets out some of the things we **could and should** be doing and building now to help achieve the resilient primary care that we aspire to.

What this Vision is and what it is not

This is not a step by step plan but a vision towards a changing model of health and social care in Aberdeen City with a specific focus on Primary Care in our localities. It should be read alongside our Transformation Plan and Commissioning Implementation plan and is one of our big ticket change items.

We aim to set out a broad framework for these work streams that will help us focus on what we believe are the main platforms for change.

The plan has been developed with the IJB following a 2 day workshop - the ideas and proposals set out here have been checked against the aspirations and ambitions of our Strategic Plan and will

inform the work that we will undertake to deliver our Primary Care Transformation plan as required by the new GMS contract (**pending this being agreed).**

What are we seeking to achieve

As an IJB we want to ensure the sustainability and development of good health and wellbeing for the population of the City. We want people to be well and do well and we want them to be able to access the right advice and service at the right time, from the right person. Doing more of the same isn't sustainable – as set out above – and we have an opportunity to change. While we acknowledge we do not have a complete blueprint for change we want to see change deliver the following:

- People in Aberdeen can access the right advice and act on it when they need. We will change the relationship with people and more people will seek advice and treatment from the wider healthcare system;
- The first point of contact for many will be widened to include Community Pharmacists, online or phone advice;
- People will have appropriate triage and be guided to the most appropriate professional – in time we will shift thinking from 'going to see the GP' to 'going to get advice to support me to manage this myself'
- GPs will increasingly become 'specialist generalists' and we will support them in undertaking this role – focusing their skills and training on areas of complexity and continuity for those patients with most need for their skills;
- We will broaden further the skill set in primary and community care.

Main Areas for Change

In order to achieve our ambitions we believe that the evidence and data supports a focussed, long term programme that supports transformation in:

- **Our Relationships with people and communities**
- **The Workforce**
- **New Practice Models**
- **Estate and Premises**
- **Technology**
- **Prevention and Public Health (a future vision)**

Our IJB Commitment to a Long Term Plan

The Aberdeen IJB has recognised since it came into being, that given the scale of the challenge facing health and social care that the work to transform our system would involve us working across a long term vision. That is not to say that we will **only** see change in the longer term, but it recognises that there is a need to work actively to a longer term aim over a number of years. Our plan will set out that vision acknowledging that some of the work won't potentially be completed within a 5 year programme but will go beyond this. We will set out short and medium term concrete plans, but our vision is one that allows for a longer term view and the art of the possible. We also recognise our approach needs to be agile as some of the complexities of challenge are not easily in our gift to

change, e.g. the complexity around GPs owning their buildings and this being part of their pension planning.

An **example** of this might include the following in relation to accessing information:

Vision

We aim to transform the way the people access information, self-care and health and care services. We can envisage moving toward a hub and spoke model with a transformed estate and modernisation of assets, including premises, equipment, ICT and a transport structure. This might include larger, multi-functional buildings in which a wide range of professionals work flexibly over the day and week. People will access these buildings for health and care information, by phone and VC/Skype and will access both partnership and 3rd sector services in one place but accessible to the wider community. General practice will remain the gateway to primary care, with individuals still being registered to practices. However, we aim to shift expectation and behaviour toward people thinking about *going to the health and wellbeing service* rather than *going to see their GP.* People will get the right information or be directed to the right person to meet their needs and our professionals will be utilising the full extent of their skills where they are most needed at the earliest opportunity.

This is a long term vision because:

Shifting toward a hub and spoke model will mean big changes to the way that we use buildings we have and those that are owned by others. We will need to make strategic investments of IJB/Public Sector Budget to achieve this and the formal planning for new premises can take 5-10 years to complete. This will also involve us working with universities and other education providers to develop new roles and prepare the professionals of the future in new approaches. This can take time. Training a GP can take up to 10 years, training District Nurses 5-7years and Physician Associates 2 years following a first degree and 2 years preparation in work. This shouldn't daunt us but we do recognise that what we initiate now we may not see the fruits of for 5-10 years.

Elements we'll begin to deliver in the short term are:

We will begin working with premises that we have across the city and look for immediate opportunities to work differently where we are now. We will look at technology and opportunities to develop new forms of triage and access that uses such technology. We are already investing in new ways of delivering new roles – Link Workers, INCA, West Visiting and Acute Care at Home, Pharmacists, Mental Health workers in Primary Care. Our plans will continue to be tested and evaluated and we will create the building blocks from these toward the longer term vision.

Elements we'll begin to deliver in the medium terms are:
We will begin conversations with the Universities and workforce regulatory bodies on how we development the necessary academic support and meet ongoing registration requirements for the new roles we envisage for future workforce. We will also consider how we offer transitional support for practitioners working in these new service delivery models. We are looking at what investment is required to mainstream further the role of Physician Associate, achieve robust nursing succession planning and revisit our ideas on how we develop a care centre of excellence in one of our care facilities.

Elements we'll deliver in the longer term are:

We need to support individuals, communities and our workforce in being confident in the use of technology, using it as the norm in supporting people in managing their long term health conditions, accessing mainstream support and in feeling safe within their own homes. Our Tech Enabled Care work stream and like-minded partners will work to develop the most up to date health and care navigation system. Technology is a fast moving industry and we will need to ascertain good advice on how we ensure we are always using and investing in the safest and effective technology solutions.

Describing the possible future state

There are a number of future scenarios and the following section tries to set out the potential future for a number of elements of the system – for different types of patients, for members of the Primary Care Team and for the future of our premises across the city. These are given for illustrative purposes only.

Who /What?	Current	Future
Patient with short term, self-limiting condition	• Appointment to see GP • Sees GP in practice premises • Face to face appointment with GP	• Central Triage and signposted to right advice or professional • Registered with a practice but can access advice and services in a range of access points across the city • Increasing use of phone /VC advice and contact
Patient with Long Term Condition(s) / Complex Needs	• Sees GP or range of GPs depending on availability • May require frequent, short appointments • Care largely led by GP • Limited access to self-monitoring	• Increased continuity of practitioner with more practitioner time freed up to support 'expert generalist' role • Less frequent but longer appointments • Care co-ordinated by GP with more input from wider range of expert practitioners depending on need • Greater availability of self-monitoring supported by single point of access = greater self-management and independence in the community
Primary Care Professionals	• Practice based • IT challenges	• Increased potential to be agile and work across a range of high quality hubs • Increasing connectivity and

Who /What?	Current	Future
	• Referral to secondary care for testing/imagining • Individual/isolated practice • Fairly rigid career pathway for GPs • Limited access to wider roles in team	ability to access patient information across the estate • Increased access to imaging and testing in primary care • Increasing multi-disciplinary team approach to complex patient care • Diverse career pathways that enable wider range of employment opportunities without need to 'buy in' to premises • Increased range of extended practice roles in wider team – Advanced Nurse Practitioner, Physician Associates, Link Worker, Mental Health Worker
Estate and Premises	• Range of buildings and premises not all fit for future purpose • 30 separate practice buildings and teams across the city • Patient access largely limited to own practice premises	• Clear estate / premises plan that reflects wider primary care vision • Vision rationalises this without loss of income to GPs • Patients can access range of services to meet needs across the city
Prevention and Public Health	• Range of prevention and wellbeing initiatives across the Partnership	• IJB has an agreed vision and plan to address its preventative and public health ambitions. • Plan is linked to delivery at a locality and community level and this is set out in the context with the Community Planning Aberdeen agenda and the Local Outcome Improvement Plan

Conclusion

At the workshop help in November 2017 we considered our 'pathway' to the future primary care services. A pathway starts with thinking about the long term vision which this paper has endeavoured to articulate. It also considers some of the short, medium and long terms goals which

are beginning to be fleshed out in the Blue Print – Appendix A. These as stated will be agile, as we learn from our own and others experience

Another consideration was thinking about - who do we need to enrol? This isn't just about thinking about who is going to help us achieve our aspirations – it's about identifying who might be challenging of our aspirations. The challenge is welcomed and necessary to provide the friction for action and for stimulating thinking that there might be other solutions etc. It is essential for us to engage in our work going forward with;

- Public – there was an element of fear of backlash discussed. As already said in this paper we need to be having very honest conversation with the public and indeed all stakeholders.
- Community pharmacist.
- Dentist
- Optometrists
- GP Practices
- All other primary care and community based staff
- Scottish Government
- NHS Board – in patient/ elective and acute care
- IT departments
- Local Leaders
- Different patient groups – LTC's

This is a complex and long term piece of work, which will continually provide us with challenges and opportunities. By starting to plan for achieving our vision we need to look at what strengths will help us initiate and continue developing the vision and achieving the steps on the way. Some important strengths have been identified as;

- Involving the public – it was felt essential that this was a continual piece of collaborative work to support proper design, achieve 'buy in' and shared ownership.
- To continue to develop the positive culture of the partnership to ensure resilience and good management of risk enablement.
- We have already done some really good early work with localities and this is a good foundation for future work.
- Showing our innovation and our ability to roll things out when they work and having the confidence to stop doing stuff that doesn't work.

This work is not just being driven by resource constraints and rising demand it is about what we think will be better for those who live and work in Aberdeen City over the next generations.

It will clearly need a shift in focus in respect of the culture of both how services are design and delivered and a change in expectations. We want individuals to stop thinking, 'I need to see my GP' but instead for them to think, 'I need to access primary care/the right service'. In order to do this we need to rebuild this primary care service and make it easy to access and navigate.

It is about less primary care services being provided in buildings but more being delivered at home, closer to home and being more affordable.

Our future model will have aspects of co-location where there is a clear rationale for this but will also see an increased remote workforce that is trained and supported to fully undertake this type of working and new roles. Our models will attract the workforce of our future primary care.

It will have IT and tech enable care as a main resource in providing the primary and community care of the future. This is to support staff, data sharing and bringing diagnostics into the community.

In conclusion, this paper is about the necessity for us to do all of this and setting that into the current context. If we are to do this we all need to prepared to;

- Do – we need to keep a momentum going, in building a resilient Primary Care fit for our future generations we need continual drive. We expect and welcome challenge.
- Unpick – what we are doing now, to work around sensitivities and release our imaginations.
- Lobby for – this might be locally and nationally, but we will certainly need this support.
- Investment – in staff in new buildings and of people's time.
- Disinvestment – in all that isn't going to help us achieve in achieving our aspirations.
- Be bold – let's do the right thing for the people of Aberdeen City and our future generations.

We will design an incremental programme plan which will give full consideration to;

- What feasibility studies we may undertake in order to establish our preferred options going forward.
  - This may also mean looking at success achieved elsewhere and analysing how this may be used in some or all of our localities in Aberdeen.
  - Looking at what initiatives could be planned in localities or city wide. E.g. triage
  - How we may develop better use and closer availability of such things as diagnostics
  - Developing and sustaining roles such as Physician Associates, Advanced Nurse Practitioners and practice based Pharmacists.
  - Identify current practices and the model they operate and forecast the end date of that provision.
  - Maximising the use of shared space and work environment that promotes multidisciplinary working.
- Identifying what's in our gift.
  - Looking at opportunities of change being offered by current practices undergoing change.
  - Rollout of West Visiting service (after evaluation)
  - Developing link Workers
- Expansion
  - Describing how we will plan, prepare and implement roll out of those projects that have proven successful in delivering measureable benefits.

Appendix A - Blue Print

Change Theme	Vision	Short Term	Medium Term	Long Term
Our Relationships with people and communities	The relationship we have with people and communities will be built on trust and honesty. It will increasingly support self-management and self-determination. It will put individuals and the localities they live in at the heart of designing and delivering our future primary care services.	We will host a series of city wide and locality based workshops to explore the suite of challenges we face and the inability to sustain current models. We need to be very clear about the risk of not moving and not moving quickly. We will share what is working locally across localities and also success stories external to Aberdeen City – we will develop thinking of the possible for individual localities on a short, medium and long term basis. Locality leadership will support wider primary and community care planning in alignment with Locality Plans and this vision	Continue to introduce individuals and communities to alternative models support implementation locally.	Community members in our localities will be identified as contributing and participating assets of our primary care system.
The Workforce	ACHSCP will be a partnership of choice, attracting future	Conduct a full workforce survey to highlight current gaps and risk in respect of	Examine the need and practical issues of impact on further and higher education	Development of a suite of formalised training that continues to support and

Change Theme	Vision	Short Term	Medium Term	Long Term
	practitioners with varied and interchangeable skills. We will offer good career and progression opportunities affording our staff varied portfolios and ability to work across health and social care.	building our new models. Feasibility study into what a mixed economy of GP (independent and salaried) looks like and any contract implementation issues. Revisit and develop further our aspiration of creating a Centre of Excellence.	with colleges and universities. Representation from workforce registration bodies need to be included. Develop ACHSCP Workforce Plan in alignment with new GMS contract and National requirements.	further develops our primary and community care workforce.
New Practice Models	The structure of our specialist primary care services will be informed by evidence and responsive to the assessed population. It will be shaped by those living within localities. Primary care will be designed individually to these localities and will not be a one size fits all.	Evaluate the impact of; • Link Workers • INCA • Acute Care at Home • Visiting Service Evaluation will be about improved outcomes for individuals but also about whole system impacts. Consider what is working well – triage models etc. and develop across the localities.	Evaluated and roll out of all intiatives City wide Further develop the 'Healthy Hoose' model. Develop further the collaborative working across practices. Wider MDT as first contact Have options appraisals identified and developed with localities and wider	Developed hub and spoke model. Extended and integrated teams. Single locality triage. Extend availability of testing and imaging in primary care Maximise potential in new developments for mixed models and increasing use of technology

Change Theme	Vision	Short Term	Medium Term	Long Term
		Look at opportunities and barriers to working in GP clusters. Identify with current practices what their future intent is, in respect of retirement etc. and establish timelines for this.	stakeholders to maximise the best practice outcomes from these opportunities. Develop model for remote health monitoring in certain conditions – e.g. Respiratory Illness	Following evaluation roll out wider access to remote monitoring for self-management and prevention
Estate and Premises	By using a locality asset based approach to evolving our primary care services we will become less reliant on specific buildings. Our future primary care should not be about buildings – it should be about a collective use of skills to prevent, maintain and improve the health and well-being of our citizens, in the most appropriate place for them by the most appropriate practitioner.	Review the full estate and premises, looking at identifying maintenance cost and capacity issues. Identify what capacity for 'space' we have in existing buildings within our localities.	Develop a disinvestment strategy in to potentially costly and non-fit for purpose buildings. Have a clear plan of what will be required across our localities in terms of functional buildings or spaces.	Have developed one-stop, multi-functional buildings
IT & Technology	To support the increased confidence of staff, people and communities in the use of technological enabled care and support systems. For those with long term health conditions to use	Identify IT and tech issues that need to be addressed to support our increased provision of service in peoples own homes and community based buildings.	Develop a clear IT and Tech policy Develop training plans for both practitioners and individuals in use of technological solutions.	Practitioners and individuals will be confident in using technology as a safe and effective means of supporting the self-management of long term conditions.

Change Theme	Vision	Short Term	Medium Term	Long Term
	technology to support both the management of their condition and ability to respond confidently to fluctuations in their conditions, hence seeking specialist primary care when absolutely required.	Review the ability of or gaps in the ability of current IT and tech systems for supporting our current transformation initiatives – INCA, Care @ Home etc. Consider the range of data protection issues currently encountered within our integrated teams.	Review our data protection policy and ensure we are maximising currently legislation in terms of supporting us to share information safely, not restricting are ability to do so. Identify on-going issues that are causing real barriers and seek to develop a plan of lobbying for any necessary legislative change. Would be more effective if we gathered this information across all IJB partnerships.	Increased and developed diagnostics within the community. Effect legislative change.
Prevention and Public Health (a future vision)	Primary care is about the use of both clinical and social approaches in supporting individuals and localities providing a whole range of preventative support to achieve their individual and collective	We will develop a Prevention and Public Health Strategy which the principles of will thread through all of our redesign and transformation Identify community		Good health is achieved through a holistic/ social/ community based approach.

Change Theme	Vision	Short Term	Medium Term	Long Term
	outcomes. Primary care will be designed and resourced taking into recognition the needs of those people who are negatively affected by inequalities, social isolation or other wider social determinants of health.	resources to enable effective social prescribing		