



Voluntary Health Scotland response to the Health and Sport Committee Inquiry: What should primary care look like for the next generation?

12th September 2019

Introduction

Voluntary Health Scotland (VHS) is the national intermediary and network for health charities and other third sector organisations with an active involvement in health. We work with our members and other partners to address health inequalities and to help people and communities live healthier and fairer lives. We are Secretariat to the Cross Party Group on Health Inequalities. Our vision for the future of primary care is for an effective, person centred and compassionate system that understands its role in addressing health inequalities, and that is confident and able to work with third sector partners.

Our response has been informed by our members' work, our involvement in the public health reform programme, and by three recent VHS reports:

- *Living in the Gap*, our 2015 study into the voluntary health sector's approach to health inequalities, with case studies that focused in particular on our sector's role in mitigating health inequalities.
- *Gold Star Exemplars*¹, our 2017 study commissioned by the Scottish Government to map the wide range of third sector initiatives across Scotland that deploy community link working approaches. Community link workers aim to tackle health inequalities and improve health and well-being, as well as reducing pressure on general practice, particularly in areas of deprivation.
- *The Zubairi Report*², our 2018 study into the lived experience of loneliness and social isolation. This was primary research that involved speaking to 57 individuals through 5 focus groups and 6 in-depth interviews. One of the major themes to emerge was the need for compassionate health and care services and the role of primary care in addressing loneliness and social isolation at a community level.

VHS is playing an active role in the public health reform programme, our role being to ensure the effective engagement of the third sector: for example, through the development and implementation of the six national public health priorities. By influencing the wider social and economic determinants of health, public health can play a role in supporting primary care to be as effective as possible.

Question 1: Considering the Health and Sport Committee's report on Public Panels, what changes are needed to ensure that primary care is delivered in a way that focusses on the health and public health priorities of local communities?

Operationalising Realistic Medicine

The Chief Medical Officer for Scotland, Catherine Calderwood, introduced the concept of Realistic Medicine³ in her 2016 Annual Report. The aim of realistic medicine is to put the

¹ [Gold Star Exemplars: Third Sector Approaches to Community Link Working Across Scotland](#)

² [The Zubairi Report: the lived experience of loneliness and social isolation in Scotland](#)

³ [Realising Realistic Medicine: Chief Medical Officer for Scotland annual report 2015-2016](#)

person receiving health and care at the centre of decision-making and create a personalised approach to their care. It does this by ensuring health professionals deliver healthcare that focuses on true value to the patient and where the patient is an equal partner in their own healthcare through shared-decision making.

It is clear that that moving away from a purely medical model to a more holistic approach to people's health and wellbeing would help to ensure a person centred approach and align with principles of realistic medicine. Maximising the roles of the current primary care workforce, including community link workers, and working in partnership with the third sector to engage effectively with people in local communities and support them to achieve positive health outcomes, can help to operationalise realistic medicine. This also resonates with many of the Inquiry's public panels' priorities: for example, sustained relationships with health staff who know individuals, greater engagement and consultation with patients about services, more effective triage and accessible information about referrals and signposting to services.

Compassionate Health and Care

VHS research into the lived experience of loneliness and social isolation, *The Zubairi Report*, found that, whilst NHS values are embedded in compassion, this is in practice not everyone's experience of primary care. What people want is to be listened to, understood and supported.

Participants in our study highlighted the time pressures that GPs were under, and understood that this was an underlying cause of what they experienced as a lack of compassion in the care they received. One participant commented that, "GPs are far too busy, they have 10 minutes to deal with you and they are looking for a physical health issue". Another participant with both physical and mental health issues felt constrained about discussing all of the issues affecting them with their GP: *"the GP has a 10 minute slot and a lot to fit in. So it becomes a case of we don't have time to discuss all of this today so we will make you another appointment in 4 weeks. Sometimes you are given a number for self-referral – and it feels like the doctor has taken it out of their own hands and made it your own responsibility. If you are depressed and lonely how can you go and phone that number or use a service – you will end up going back to that empty house and the same circumstances"*.

Others spoke of their experiences of compassionate health staff elsewhere in the system. A recently bereaved carer recounted that it was her gynaecologist who picked up on her situation. She said, *"the gynaecologist was the only one to ask me about myself and how I was doing – she looked at me as a person and actively listened and recognised the issue."*

Our research found that it is important for primary care to do more to understand the nature and importance of compassion, in order to improve people's experiences of its services. The Chief Medical Officer for Scotland has also recognised the importance of compassionate health and care services, and the Royal College of Physicians of Edinburgh dedicated a conference to discussing, 'How compassionate is our NHS?'⁴.

Multidisciplinary teams and holistic support

Deployment of multidisciplinary teams should help to alleviate the time pressures that the primary care work force faces, maximise best use of available resources, and help to provide

⁴ [Royal College of Physicians of Edinburgh conference *A Patient's Tale*](#)

more holistic and joined up support to patients. It should help shift the focus of primary care towards prevention and early intervention by ensuring patients can get the right support at the right time. Some participants in *The Zubairi Report* research said they wanted to see more prevention, “*NHS has to shift from being about fixing people to being about preventing people from becoming broken*”.

Currently a barrier to voluntary organisations being an effective community resource and partner with primary care, i.e. to assist in providing joined up support to people in the community, is the complexity of local geographic infrastructures as they are not aligned. Health and social care localities. GP clusters and community planning partnership localities all comprise different geographic areas. This can cause difficulties for voluntary organisations receiving funding to provide a service in a particular locality, community and/or postcode area but not others.

Community Link Workers

The Scottish Government is committed to creating an additional 250 community link workers (CLW) during the current Parliamentary session. The stated aim is to provide additional support to primary care in Scotland’s most deprived areas (SNP Manifesto 2016). The University of Glasgow’s evaluation of the Deep End Link Worker Programme in 2017 (commissioned by the Scottish Government) showed that patients referred to a CLW experienced a range of positive ‘soft’ outcomes such as improved mental wellbeing and increased confidence. While the number of GP appointments with patients using CLW services did not necessarily reduce, the quality of conversations with the GP did improve.

The new CLW roles are designed, planned and commissioned by Health and Social Care Partnerships (HSCP), based on assessment of local need, and through discussion with local GP’s, patients and local community based organisations. An unknown number of these posts have been provided within the third sector. CLWs need to have strong local knowledge and relationships with local services and resources if people are to be successfully linked into them.

A new briefing⁵ by the Scottish Public Health Network (ScotPHN) draws attention to a number of challenges. Whilst the manifesto commitment focussed on additional CLW support being provided to ‘*Scotland’s most deprived communities*’, the funding allocation for CLW has been distributed via the NHS Scotland Resource Allocation Committee (NRAC) formula which is adjusted for, rather than based on deprivation. Given the pressures facing HSCPs, ScotPHN say that it is unclear whether or not they will all prioritise the CLW resource to working with GP practices in their most deprived communities. This is a question the Inquiry might usefully seek an answer to. There is anecdotal evidence that austerity and ongoing cuts to funding third sector and community based organisations are constraining their ability to provide support and services to people ‘linked’ to them. The capacity of CLW to respond to new referrals is in turn being constrained, as they need to provide ongoing support to people until appropriate community based support and services become available. Like ScotPHN, VHS would call for robust monitoring and reporting of how CLW resources are being used, so that their impact on reducing health inequalities can be assessed.

⁵ <https://vhscotland.org.uk/kates-blog-rights-of-way-what-affects-older-adults-walking-to-stay-healthy-and-happy/>

Recognising socio-economic circumstances

Primary care, with its local knowledge of patients and communities, has a role to play in helping to identify and highlight the wider socio-economic determinants of health in their own area. That intelligence should be informing how primary care works in partnership with others across the community to plan services, and in how they engage and support patients.

The impact of deprivation on people's agency is well known, so primary care should look beyond bio-medical issues and try to better understand how the wider determinants of health impact on people's ability to make decisions about their own health and wellbeing. Professor Sir Michael Marmot has described the 30-70 split whereby 30% of health issues are caused by disease, genetic factors or medicalised issues and the remaining 70% are due to social, environmental and economic circumstances.

There also needs to be a more sophisticated approach to deprivation so that investment is directed accordingly. Local Authorities with low SIMD levels overall nonetheless all contain multiple pockets of deprivation. Whilst we are not in a position to comment on how this affects investment in primary care, we do know that voluntary health organisations operating in what may be deemed more affluent areas typically have less funding options, which impacts on the services they are able to provide and reduces community capacity.

Working with the third sector

The strength of third sector organisations is their ability to engage and develop the trust of vulnerable people in a way that statutory services sometimes find hard to do. There is significant scope for our sector to be a much stronger partner for primary care in the future. VHS's report, *Living in the Gap: A voluntary sector perspective on health inequalities in Scotland*, drew attention to this. One charity commented, "often the individuals who are most in need are not accessing statutory services, and therefore remain in the shadows of service provision". Another charity commented, "The relationship that (the) voluntary sector develops with individuals in the community is the start of a health behaviour change." Third sector organisations can act as a lynchpin or conduit between public services and services users. The charity CIRCLE⁶ talked about providing "information and support to help people engage with health services...including support for families to register with the local GP...encouraging someone to engage with mental health services...or building confidence so that an individual is more likely to participate in medical interventions".

An example of successful cross-sectoral collaboration is the Jigsaw Project⁷ which involves a local charity Cope Scotland⁸ and the Drumchapel and Yoker GP cluster, comprising seven GP practices. The project developed a whole system learning programme, led by the third sector and GP cluster, in order to better understand and help to find solutions for people who experience long term or recurring mental health difficulties and who also face barriers to accessing and using existing services. The project has identified and sought to correct the barriers and disruptions at the interfaces between statutory services, third sector, communities and GP practices.

⁶ <http://circle.scot/>

⁷ <https://vhscotland.org.uk/hildas-blog/>

⁸ <https://www.cope-scotland.org/>

The outcomes of the project include:

- (1) The GP cluster has prioritised wellbeing and prevention of burnout as a quality improvement topic.
- (2) Steps have been taken to improve communication between GP practices and NHS mental health services.
- (3) The availability of community-based resources has been strengthened through seed funding.
- (4) Awareness by GPs of community based resources and alternative sources of support for patients has been improved.
- (5) The problems and possible solutions have been more clearly defined from a variety of perspectives, reflecting a 'whole system' ethos.
- (6) The Jigsaw steering group has become a useful forum for bringing together the GP cluster leadership with NHS managers, third sector leaders and community planning processes.

Question 2: Barriers to sustainable primary care system in both urban and rural areas

We support the use of technology for self-management of conditions and understand that it has particular efficacy in rural areas. However, we point out that this must not become a 'one size fits all' approach, as technology is not always either accessible or welcomed by everyone. Greater awareness of and involvement of the third sector in supporting patient's self-management is also important. We need a shift in primary care to become a community hub for social health that develops capacity and connects people with the support they need.

One example of this is the Edinburgh voluntary organisation Wester Hailes Health Agency⁹. They play a key role in tackling health inequalities in their local area, using community development approaches that aim to empower people, individually and collectively, to identify and address the issues that confront their lives. They work collaboratively with other voluntary and statutory services and are based in NHS Lothian premises alongside community health, social care and family support services. They take a holistic approach to supporting people, with a wide range of services including counselling, complementary therapies, carers groups, social groups and physical health classes. They are also connected with the Wester Hailes Health Practice community link worker.

⁹ <https://sites.google.com/a/whhealthagency.org.uk/home/>

3. How can the effectiveness of multidisciplinary teams and GP Cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?

The third sector is a rich source of data for communities throughout Scotland, particularly qualitative data about people's needs and lived experience and data on innovative and effective interventions. It already contributes valuable data to health and social care partnerships and there is considerable scope for greater recognition of and use of third sector data. Our sector has the trust of vulnerable and seldom-heard groups, supports and empowers people to voice their own stories and be heard, and has local intelligence that can help to create a detailed and nuanced representation of Scotland's health, alongside clinical and statistical data.

For further information, please contact: Kiren Zubairi, Policy Engagement Officer:
kiren.zubairi@vhscotland.org.uk



Mansfield Traquair Centre
15 Mansfield Place Edinburgh EH3 6BB
0131 474 6189 mail@vhscotland.org.uk
www.vhscotland.org.uk @VHSComms
Registered Scottish Charity SC035482
Company limited by guarantee SC267315