Modernising Primary Care: NHS Grampian & Community Renewal Report 2015-2017
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Community Renewal - Modernising Primary Care - NHS Grampian - 2015-17

164 GP PRACTICE STAFF SUPPORTED

SEVEN

65 THIRD SECTOR MEETINGS

FRONT OF HOUSE TRAINING SESSIONS

369 PATIENTS ENGAGED IN FOCUS GROUPS AND LISTENING SURVEY IN GP PRACTICE WAITING ROOMS

6 TRAINING SESSIONS FOR CLINICIANS
Executive Summary

Change in Scottish Primary Care is being shaped by a range of influential policies, strategies and examples of best practice including: 2020 Vision, NUKA, Health and Social Care Integration, the new GP Contract, The National Clinical Strategy and Realistic Medicine.

To be a success each of these policies calls for and requires that we engage people in a different way. Why?

Our Current Predicament

- General Practitioner stress and morale may be close to breaking point
- The Primary Care workforce is aging and recruitment is not keeping up
- Patients represent an aging population with increasingly complex needs

Searching for a Fifth Wave

In the seminal report, The Fifth Wave published by NHS Health Scotland, Andrew Lyon and Dr. David Reilly describe the British healthcare system over the last 200 years as having had four waves of development - each building on one another:

1. Civic works and sanitation
2. Emergence of medicine as a science
3. Social changes leading to the welfare state
4. Efforts to combat disease risk factors

Each wave has been succeeded by a new wave when its begins to yield diminishing returns. There is then a calling forth of a new wave, not to replace the proceeding waves but to stand on their shoulders. This would leave an emerging need for an additional fifth wave which can start to tackle our modern epidemics: depression, anxiety, dementia, obesity itself, drug use, alcohol dependency, diabetes, chronic illnesses, and a wide range of mental health issues.

In Scotland around 40% of adults are living with at least one long term condition. It is this that makes patient needs more complex.

If a GP traditionally has three options - prescribe, refer or do nothing - how many of these fifth wave needs can realistically be “fixed”?

Thinking in a Different Way

So how do we begin to think in a new way?

This has been a question explored by Community Renewal, a Scottish Charity which acts as a learning organisation - bringing innovation to intractable problems.
and experimenting with different ways of perceiving the problem and generating fresh solutions.

We bring in expertise from outside the medical community, from asset based community development and improving lives in deprived neighbourhoods.

Community Renewal was commissioned by NHS Grampian and the Scottish Government in March 2015 to begin an experimental process we called Deep Community Engagement. This piece of work took 2 years working in 6 GP practices in Grampian.

Our brief was experimental and we had the privilege of not having to work to fixed outcome targets but rather explore through dialogue and conversation with staff and patients, where community engagement principles might offer fresh vistas in the primary care predicament.

Three Core Principles
The core principles we started with were:

1. Exploring alternatives to a “fix it” approach for these fifth wave epidemics
2. Changing the balance of power between professionals and the people they serve
3. Creating conditions for patients to shape their own health

Testing new ideas

In primary care this has led to tests of new ideas across two, interlinked, strands of activities.

1. The first looks at the GP Practice as part of a wider community of health and building stronger connections to public health and third sector services
2. The second helps disentangle patients’ medical and social problems with a focus on finding the most appropriate support and activating self-care.

Looking at the GP as part of a wider community of health has meant Community Renewal working with a range of staff in individual GP Practices to work one local community at a time to consider:

• What services, groups, networks are already out there?
• Can we ensure there is an up to date mapping of all these assets?
• Can we invite these organisations into the GP Practice?
• Can we build relationships to develop mutual understanding and support paths?
We have sat in waiting rooms simply listening to patients needs and having a conversation with them about how they might get the best out of services offered at the GP Practice - do they really understand who to turn to?

We have spoken to patient representative groups or focus groups of people with shared needs. In particular, we have listened deeply to the needs and wants of patients who have been attending for appointments most frequently over a long period.

We have also looked at shifting Front of House staff from gatekeepers keeping patients out towards them being community navigators signposting people to effective support.

As an example of the power of such links to local community activities we use the example of an older man who had been attending one GP Practice weekly both to get a nurse to apply skin cream and for a GP appointment. When we opened a listening conversation with him he disclosed that the only conversation he had all week was to the nurse, the GP and to a photo of his deceased wife. He has now been connected to a men’s shed project where he enjoys the activities and the socialising. He no longer comes to the GP Practice for regular appointments or for the cream to be applied.

This example ties closely to the second strand of activities which is around disentangling medical and non-medical issues in the first place.

We have been developing training and tools with and for GPs and allied health professionals including what we call the Holistic Assessment. This 30 minute conversation covers patients social and family situation, their current level of self-care, work and finances, and critically their longer term hopes for wellbeing. This leads to a plan agreed and prioritised by the patient.

Even though this process takes a longer appointment which can be difficult to fit into the current triage system, we have found many GPs embrace this with enthusiasm as they can see the difference when a frequently attending patient significantly reduces their demand for appointments.

One female patient had accessed primary and secondary care 44 times over less than 5 weeks. A Holistic Assessment resulted in her developing a plan in which she aimed to spend more time with her sister and ensured she prioritised her own self-care. Over the following twelve weeks she did not attend any unscheduled appointments.

Clearly this interaction draws on the three principles of moving away from a medical “fix it” model and shift the balance of power and create conditions for patient to shape their own health. It was not a health interaction where another prescription or a referral within the health system could have fixed her needs.
Another question it raises is whether, when she walked in, the GP should have greeted this patient with the traditional line: “how can I help you?”, a question which goes against our new core principles. So perhaps an early indicator of embedding of the principles is when we hear GPs greeting patients with phrases such as “what would you like to get out of the appointment today?”.

**Learning Points from Deep Community Engagement**

This work by Community Renewal has been exploring and testing ideas and developing a theory of change and logic that can now be tested in a more formal manner.

We did not set out to prove impact - there was no control group or quantitative study. Instead a set of tools and approaches were tested, gathering learning and qualitative results which we hope can support the practical roll-out of Realistic Medicine values.

Some of our key learning points have been:

**Disentangling Medical and Non-Medical Issues**

- Training clinicians in a longer 30 minute holistic conversation was successful within a modest time investment of 3 half day training sessions
- Clinicians realised immediately the quality of their diagnosis was enhanced by learning more about their patient’s general life circumstances
- Following the training and some practical support on specific cases the clinicians were more confident about looking for non-medical solutions for people with complex problems
- There is resistance within GP practices to move away from the 10 minute appointment schedule and this creates logistical difficulties in setting aside the time for longer appointments
- One GP practice was prepared to make all GP appointments 15 minutes which made it easier for them to organise the 30 minute appointments
- In the absence of a Community Links Worker type role in a GP practice holistic assessments can be delivered by a range of clinical staff including GPs, Nurses and AHPs

**Connecting the GP Practice to a wider Community of Care**

- Many staff within the GP practice were unaware of the plethora of social, health promotion and third sector partners on their doorstep
INTRODUCTION

- Mapping these resources and using protected learning time to create networking opportunities was a quick win resulting in increased social prescribing with the confidence of having met the onward referral service provider.

Front of House Training

- Front of house staff are often confused about their role and over-emphasise the gate-keeping role to the detriment of their potential “community navigator role”

- When given training in customer care and signposting they were able to see a different angle to their role which was about helping the patient to get the right support both inside and outside the GP practice.

- There were some questions around increased remuneration for this enhanced role which was out with our scope but should be borne in mind.

Listening to Patients

- Through one-to-one conversations, focus groups and whole community events we were able to break down barriers of patient understanding e.g. when to go to the pharmacist rather than the GP

- Education took place for patients to better understand the referral process from Primary to Secondary care and back to Primary Care.

- Listening to patients has led to GP practices putting on themed health education workshops tailored to patient requests and delivered by new third sector partners.

- GP practices became the hub for bringing together third sector partners in lunchtime service exhibitions open to all patients.

- Working with patient participation groups (PPGs) led to greater empowerment of patients to represent the views of the GP practice at locality planning meetings.

Next Steps

Community Renewal would hope to use this report share learning within all the NHS Grampian practices.
PATIENT CASE STUDY 1

In one of the GP Practices supported by Community Renewal through Modernising Primary Care a routine case review by a District Nurse identified an elderly female patient who had made contact with Primary Care and Secondary Care services forty-four times in the previous five weeks.

Since this followed shortly after clinician training covering the use of Community Renewal’s Holistic Assessment (a 30 minute holistic conversation), the team decided to proactively contact this patient and invite her to an additional appointment.

In this additional appointment, the Holistic Assessment was used to carefully listen to need and reveal hidden priorities. The process helped to identify non-medical issues impacting on the patient: the patient’s isolation, lack of any physical activity, lack of understanding of her medical condition including appropriate medication and her reliance on the NHS rather than the support available from her family.

Following the Holistic Assessment process, the patient was aided to set her own goals. This included attending Moray Be Active Life Long (BALL) group where she would have the opportunity to socialise and undertake an appropriate level of physical activity. Following help to better understand her condition and the introduction of a box for her medication she then achieved her goal of explaining her health condition to her sister who in return worked with her towards her goal of accepting support from her family and break her overreliance on the NHS.

With this new family support the patient only attended appropriate medical appointments with no additional calls made for support (daytime/ out of hours) over the next twelve weeks. The patient has since continued to improve her level of fitness and family supported self-management.

“The Practice are delighted at the reduction of phone calls and appointments (booked and out of hours) as well as the clear improvement of the patient’s wellbeing. One longer appointment was worth it for the future time saved.”

Clinician at Moray GP Practice

44 UNSCHEDULED PRESENTATIONS IN FIVE WEEKS

0 IN TWELVE WEEKS AFTER HOLISTIC ASSESSMENT
Introduction

Community Renewal is a social enterprise (charity number: SC043684) working across Scotland in health, wellbeing, employability and community development. Our vision is one of resilient people and communities where there are better chances of securing and maintaining useful work and leading a healthy life and where families are lifted out of poverty.

In 2015 Community Renewal was contracted by NHS Grampian with funding from Scottish Government to deliver a project as part of NHS Grampian’s Modernising Primary Care initiative.

For this Community Renewal has been working in Grampian region within and around six GP Practices. This has involved support for and engagement with stakeholders including Health, Councils, Third Sector and patients. The GP Practices to support were identified through a call-out for Practices interested in being a pathfinder. This resulted in two identified in Moray (Elgin Community Practice and Maryhill), two in Aberdeenshire (Banchory and Aboyne) and two in Aberdeen (Danestone and Torry).

The project was called Deep Community Engagement, reflecting a desire to better engage GP Practices within their local communities to find opportunities to improve outcomes for patients and reduce pressures on Primary Care in the longer term. This name does not, however, reflect the broad range of activities and approaches that were delivered and tested: in each GP Practice different support was offered based on the identified needs and current pressures of that Practice.

This funded project ran from 2015 to April 2017 and this is the final report for that funding. However, this is not necessarily the end of the work. Realistically more time was needed to embed practices into each GP Practice and there are considerable opportunities to roll out successful approaches and learning to other Practices if this is done while there is still engagement and momentum behind this work. The work was never seeking a quick win or measuring short-term results. Modernising Primary Care is has considerable but long term ambitions. Techniques such as improving community connections, empowering patients as assets, or sharing skills/knowledge with clinicians / front of house staff will only yield results over a long period of time and once the approach is embedded into regular working.

This report considers the predicament that is being faced nationwide in Primary Care, then looks at the activities conducted which may address these linked to the long term transformative outcomes they seek to address. Throughout the report lessons are drawn through short examples or case studies. The concluding remarks seek to place the outputs and short term achievements in the context of the evolving health landscape and identify the potential for legacy of this project.
The Current Predicament in Primary Care

The delivery of high quality General Practice is absolutely central to patient care and the future of the NHS in Scotland. Around 90% of all NHS patient interaction in Scotland is with primary care services. Scottish GP surgery teams (approximately 3,735 whole time equivalent general practitioners (GPs) in 2013) carry out an estimated 24.2 million consultations each year — which represents an 11% rise over ten years. Increasing demand on Primary Care services is largely driven by an ageing population in which an increasing number of people have multiple long-term conditions — requiring complex medical care delivered in communities or homes.

With GPs facing increasing pressure due to rising workloads, constrained capacity and finances, morale in Scottish general practice is currently low. A 2015 survey of GPs found that over half (54%) feel their current workload is unmanageable or unsustainable.

INCREASED SERVICE DEMAND

Despite slow population wide growth, demographic factors are rapidly increasing demand on health services including Primary Care. The number of older patients has been steadily increasing: between 2002 to 2020 Scotland has gained an extra 6,600 people aged 75+ each year. The rate of change is increasing to become much faster placing ever more demand on services: between 2021 and 2039 Scotland will gain an extra 16,000 people aged 75+ each year. Older patients have more needs and more complex needs. These additional patients are entering secondary care through GPs and even in the community require higher levels of Primary Care services.

The proportion of NHS funding spent on General Practice in Scotland has reduced from 9.8% in 2005/06 to 7.8% in 2012/13. This reduction equates to a real term cumulative loss of £1.1 billion within Scottish general practice over this period.

WORKFORCE CHALLENGES

Challenges also exist concerning the capacity and sustainability of the current GP workforce in Scotland. GP recruitment and retention is low and the current GP workforce is aging. A fifth of GPs in Scotland are aged over 55. A 2015 British Medical Association survey, suggests that one in three Scottish GPs were hoping to retire within the next five years. Almost 50% of NHS community nurses in NHS Scotland are aged 50 years or older, with the Royal College of Nursing warning of an urgent need to safeguard against this community nursing retirement ‘cliff’.

Within the Grampian region there are approximately 500 GPs across 78 practices, with more than 2.5 million GP and practice nurse consultations occurring every year. Surveys indicate that in Aberdeen 32% of GPs are expect to retire by 2023; in Aberdeenshire this figure is 39% rising to 47% in Moray. GP recruitment is also slow in NHS Grampian, with many positions being vacant for more than six months and being advertised multiple times. GP locum availability is also a concern in Grampian. NHS Grampian has developed a range of responses to these demand and recruitment issues, including a General Practice Workforce Recruitment Summit in late 2014.

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1 British Medical Association (2015) GP Survey Omnibus report
2 Audit Scotland (2016) Changing Models of Health and Social Care
3 Royal College of General Practitioners (2015) Scotland, A blueprint for Scottish general practice
5 British Medical Association (2015) GP Survey Omnibus report
6 Royal College of Nursing. Safe staffing levels - a national imperative: The UK nursing labour market review
7 NHS Grampian (2015) The Development of General Practice in Grampian, Board Meeting 02 04 15, Open Session, Item 9.1
8 Workforce Directorate (2013) General Practice Workforce Survey, NHS Grampian
VISION 2020 AND SELF-MANAGEMENT

The Scottish Government’s 2020 Vision was first articulated in 2011. It is: “...that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting”.

At the heart of the 2020 Vision is an expanded role for general practice. Effective care, involving potentially a range of services and community support for patients with multiple and chronic conditions (or complex life circumstances) is emphasised as a key leadership role for primary care and general practice.

Informed by Christie Commission and the Marmot Review, the 2020 Vision route map has a focus on prevention and emphasises self-management as part of the future of health service delivery.

Prevention has long been part of public health and an ambition for healthcare, but a focus within the route map will help ensure that prevention remains part of modernisation efforts in health. Prevention has repeatedly been shown to be cost effective, especially community-level activities. Prevention is one of the four pillars of Modernising Primary Care and self-management is one of the pillars in the NHS Grampian Clinical Strategy.

Self-management ensures that the patient is part of both prevention efforts and their health care. As part of our work on MPC Community Renewal sat on the working group for the self-management strategy. Self-management is a move to collaboration between practitioners and patients, ensuring patients take ownership of their role in leading a healthy lifestyle and are an active part of their care; a range of tools have been developed that will help self-management support the overall 2020 Vision.

NUKA, MAKING EVERY OPPORTUNITY COUNT AND ASSET BASED COMMUNITY DEVELOPMENT

A key influence over MPC for NHS Grampian is Nuka, a whole health care system developed by South Central Foundation and owned by the Alaskan Native people from whom it was created. “Nuka” is an Alaskan Native work for strong giant structures and living things. The system considers spiritual and emotional wellness alongside physical and mental health.

It is based on relationships so informs MPC in terms of engaging patients and the community in transformative redesigns of primary care with a shift of power able to be made towards patients. One feature of Nuka is to move towards referring to patients as customers/owners to reflect this power shift. Proven benefits of the approach include a one quarter reduction in primary care visits and emergency room visits.

Other methodologies informing MPC include: Asset Based Community Development (ABCD), and Making Every Opportunity Count (MECC).

ABCD supports sustainable community development; in essence this involves assessing and utilising resources, skills and experience within communities, from residents or groups/organisations (“Community Connectors”).

Making Every Opportunity Count has been trialled by early adopters in NHS Grampian and builds on Make Every Contact Count from NHS East Midlands and the NHS England Five Year Forward Plan. It supports frontline staff to use more informal conversational approaches to change behaviours, encourage healthier lifestyle choices and

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9 e.g. The King’s Fund (2013) Transforming our healthcare system
signpost/support on wider social issues with every health contact.\textsuperscript{12}

**COMMUNITY LINKS WORKERS**

The inclusion of 250 new Community Links Workers by Scottish Government in the 2016/17 Programme for Government and 2016 Fairer Scotland Action Plan reflects a growing enthusiasm for this particular model of additional support within primary care. Community Link Workers or Link Workers can help the bridge between GPs and the Community, including local service and community groups. This link can help support non-clinical needs (e.g. debt or work), improve external referrals and link within the community to preventative support (e.g. healthy living activities). Many GPs report that “it is impossible to keep up to date with all that the third sector could provide”\textsuperscript{13}, so Link Workers assist when they are interested in referring people to wider support.

There are already a number of active examples of Link Workers across the country, indeed Community Renewal is one of Scotland’s biggest employers of Link Workers and has used the model for over ten years. Other examples include the Glasgow Links Worker Programme, Dundee Equally Well, and the EVOC pilot in Edinburgh.

It is important to note that Modernising Primary Care (MPC), including the role of Community Renewal in MPC, is far wider in scope than can be addressed by Links Workers. Throughout the work, the small but critical potential role that Link Workers can fulfil in supporting primary care has been considered at each step but as one aspect of a gradual bigger transformation in primary care sought under MPC. Community Renewal describe three types of Link Workers:

- **Bronze** - a intermediary well connected to community services who links patients to those services as part of social prescribing.
- **Silver** - a case manager who supports the patient set longer term wellbeing goals and supports the patient through a journey that brings in support agencies as required
- **Gold** - a case manager who also works at a whole system level building the network connections between the GP Practice and the wider community of care

**Realistic Medicine**

The Chief Medical Officer Catherine Calderwood has introduced new terminology and a new focus across healthcare and social care in Scotland in coining the term ‘realistic medicine’.\textsuperscript{14}

She is seeking to address the issue of ‘over reach’ by doctors who ‘over treat’ their patients, preferring a collaborative and de-medicalised approach. At the heart of this approach is having genuine discussion and shared decision-making with patients engaged in “Care and Support Planning Conversations”.

The Chief Medical Officer is emphasising an approach that seeks to reduce harm and waste across the spectrum of medicine and care, with a more consistent personalised approach improving outcomes.

The approach of Realistic Medicine, and learning how to implement this practically at a GP Practice level, has been at the core of Community Renewal’s work on Modernising Primary Care.

\textsuperscript{12} Lawrence W, Black C, Tinati T, Craddock S, Begum R, Jarman M, ..Cooper C. ‘Making every contact count’: evaluation of the impact of an intervention to train health and social care practitioners in skills to support health behaviour change. *Journal of health psychology* (2016); 21(2), 138-151
\textsuperscript{13} Carr Gomm (2016) An Intermediary Service for Primary Care in Edinburgh
\textsuperscript{14} Scottish Government and Chief Medical Officer (2014) Realistic Medicine
PATIENT CASE STUDY 2

At one of the Aberdeen Practices Community Renewal supported, an over 65-year-old male patient was attending every week. He had become accustomed to having a ten-minute appointment with the GP and an appointment with a nurse who would apply a skin cream to his back for which he had a repeat prescription. His was not able to apply the cream himself. He was a well-recognised face in the GP Practice, so when we were discussing with clinicians which patients may be helped by a new approach he was on the list.

A Holistic Assessment over 45 minutes was made by a recently trained GP. This uncovered that the man’s wife had recently passed away. He had her portrait over his fireplace and the only conversations he had in his week were with the portrait and with the clinicians.

Like many of the older men attending the practice the clinicians reflected that he was perhaps lonely and lacking contact more than ill and lacking medicine.

The practice had been improving not only their ability to disentangle medical from non-medical needs, but also enhance their options for referral routes into non-medical community services.

The man was put in contact with a Men’s Shed project which provides a space and activities for men of all ages to participate in. Critically it helps bring groups of people together in a social space. This has turned around the quality of life for this patient.

The patient no longer requires a prescription for the skin cream nor the weekly appointments for it to be applied.
Changing Primary Care - Our Logic Model

For this Modernising Primary Care work Community Renewal developed an ambitious theory of change. This showed three areas of input of activities:

- Engaging patients as assets
- Connecting with community groups and local services;
- Making better use of Front of House staff and getting the welcome right
- Support around Holistic Assessment and avoiding “fix it” model for clinical staff.

After a significant period at the start of the work to understand what activities were most important, the activities were designed around a number of long-term outcomes sought by the Modernising Primary Care programme in the context of Realistic Medicine, self-management, prevention, and Vision 2020 with learning from Nuka.

There was a focus on engaging leads from each of these different areas of policy and practice to ensure that this work was interdisciplinary and worked across any silos in developing outcomes and activities. The long term outcomes set at the heart of the project were:

- a paradigm shift in the relationship between patient and professional;
- to engage patients seeking care in a future-based conversation about transformation;
- move away from a “fix it” model of healthcare; and
- to disentangle medical need from non-medical need within a Primary Care setting.

Working back from these long-term outcomes, a series of shorter-term outcomes and inputs were determined that could start to support these changes. It was clear, for example, that the long term outcomes would require a greater understanding of local support services outside Primary Care available through public health teams, wider health services and third sector provision (including community groups and local activities).

The theory of change analysis resulted in three elements to the Deep Community Engagement project. This is set out in the theory of change diagram shown overleaf.
Disentangling medical and non-medical issues

“How can I help?”
“I’ve got a burst pipe.”
“You mean in your body somewhere?”
“No in the house. I don’t know who else to ask.”

- An account of consultation with patient by one of the supported GPs from Aberdeenshire.

CONTEXT

Health Scotland and the Scottish Government have been promoting copious evidence to demonstrate the link between social inequalities and poor health: “Income is strongly associated with some health risk factors, such as smoking, diet and obesity in women. For others (such as physical activity and alcohol) the association is more complex. People on low income (especially young adults) have poorer mental health, worse self-rated health and higher levels of mortality.”

Given the Scottish Government’s stated aim of addressing inequality in health this means that there are socio-economic factors that need to be dealt with in tandem with medical issues. Traditionally this would be tackled by hoping that initiatives with socio-economic focus (e.g. employability, regeneration, community development) can work in parallel with traditional health interventions to help close the inequality gap.

This approach lacks joining up and efficiencies. It also enables those in groups whose socio-economic determinants of health are not increasing their multi-morbidity to receive at least as good or better healthcare as those who require additional support alongside healthcare.

More immediately it means that those seeking Primary Care often bring a range of social-economic into the consultation room with them. These non-medical issues may be the highest priority to address or may prohibit health interventions. But having presented in a Primary Care setting, the clinical staff may not have the tools to identify or address such issues and basic signposting to alternate sources may result in a patient returning at a later date with more complex issues and still no non-medical support.

Realistic Medicine in practice

Through discussions with GPs and GP Practice staff about the context of their working environment and the focus of their efforts it was clear that there was an understanding of the mixing of medical and non-medical issues and the complex causes of health inequalities. Many were struck by the Chief Medical Officers Realistic Medicine report and agreed with the aims set out in it. However, translating this intent into practice can be daunting - where to start and how to ensure that immediate needs are still being met.

That isn’t to say that all GPs engaged in this work shared the same views and approaches. They were each at different stage of considering and implementing Realistic Medicine and other new initiatives. They also expressed a range

of views on issues such as what they felt their role should be for different groups of patients especially with non-medical issues, how the current predicament of overstretched services should be addressed.

Evidence on appointment length and providing GPs with self-management toolkits

Another area in which GPs frequently hold different views is on the desirability and efficacy of longer consultations. This reflects a range of experiences, different needs for different patients and a lack of evidence about a “silver bullet” solution to this issue.

Dr Stuart Mercer led research on the efficacy of longer GP consultations through a pilot and focus groups with patients, GPs and stakeholders. He concluded that:

“Participants endorsed the need for longer consultations, relational continuity and a holistic approach. All felt that training and support of the health care staff was important. Most participants welcomed the idea of additional self-management support, though some practitioners were dubious about whether patients would use it. The pilot study led to changes including a revised care plan, the inclusion of mindfulness-based stress reduction techniques in the support of practitioners and patients, and the stream-lining of the written self-management support material for patients.”

The GPs in this study rejected the offer of a standard toolkit to help them take a holistic view during consultations and instead co-designed an approach to pilot themselves (CARE Plus).

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This report was pertinent as it emerged in part in response to a previous research report which did not find that GP Practices trained “to enhance self-management support in routine primary care did not add noticeable value to existing care for long term conditions.”\textsuperscript{17} This research looked only at using basic training to embed self-management and did not consider more system wide changes such as increase appointment length. As the researchers noted: “The challenge is to show how a different intervention (for example, of greater intensity or duration) might enhance effectiveness without compromising reach.”

### Changing Practice Perspective on Current Fix It Paradigm

The “fix it” paradigm is the current status quo in medicine (and most other support services). It is the paradigm in which someone in need seeks the support of a professional who diagnoses the problem and seeks to mitigate or fix it for them. This relies on the professional providing the support themselves rather than empowering the individual. It also implies that problems are fixable - this has serious implications on expectations and wellbeing for the many people who are managing long-term / chronic conditions.

One of the principles that Community Renewal has adopted as a value for all the projects we deliver is that “people don't resist change, they resist being changed”: closely mirroring the Nuka system of healthcare delivery\textsuperscript{11}, Community Renewal places considerable emphasis on the ‘primacy of relationship’. On a practical level helping people to understand and implement the change they want to see and do it themselves links in the project’s logic model to reducing demand for GP consultations as people identify support themselves and better understand the limited role a GP can play in supporting them around an issue that does not lend itself to simply being fixed.

Dr David Reilly, in the support offered to GPs in this projects, described the impact that self-compassion can make on self-management. GPs attending such training themselves identified the benefits self-management would make on their practice.

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\textit{The Fifth Wave is a term introduces to health in Scotland by long-standing Community Renewal Chair, Andrew Lyon and his colleagues. The thinking revolves around the concept of a new wave of public health building on the previous four( clean water / sanitation, tackling infections, delivering universal health services, and reducing risk factors for disease).}

The fifth wave represents a shift towards personalisation, holistic approach, interconnectedness and local/personal solutions. This is a way to step back from a mechanical, clinical process of categorisation and reductionism within the existing “fix it” paradigm promoted in previous waves of healthcare reform.
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It is Community Renewal’s experience that this quality relationship building, which underpins integration and co-production across patients, GP surgery teams and community services and support, takes considerable time. The time spent at the outset in developing these relationships and in fostering these links is an organic and at times unpredictable process. But this time investment is profoundly worthwhile as it serves as a strong foundation from which more effective services can be delivered long term conditions in routine primary care settings, a cluster randomised controlled trial.
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\textsuperscript{17} Kennedy A, Bower P, Reeves D, et al. (2013) Implementation of self management support for
and services which are accessed rationally and proportionally by patients. Relationships and their quality are extremely challenging to quantify, monitor and report on; especially in quantitative terms.

One GP identified an elderly male patient with whom he had performed a Holistic Assessment. The GP had struggled to find something to meet the needs that the patient had been asking about. As a result of bringing together different staff members from within in the Practice team and listen to the patient’s non-medical needs it was found that a referral to the Men’s Shed in Aberdeen might be appropriate. This non-clinical context would be a place for the patient to improve wellbeing, avoid loneliness and maintain basic fitness.

One important aspect of the learning from the activities was that it was useful to include Practice Managers and other members of the GP team beyond the GPs themselves in support around disentangling medical and non-medical issues. This is because to effectively implement a new approach means new approaches and all the team need to a shared understanding of both the predicament and the potential gains of taking a new approach.

For example, we included Emergency Practice Nurses and Practice Managers in our Holistic Assessment training, even though they were unlikely to have any direct experience using the Holistic Assessment tool themselves.

In a Moray Practice, after putting their Holistic Assessment training into action, it was both GPs and Nurse Practitioners that wanted additional support to build on this training. Therefore an additional short practical introductory course was provided on how to use language across all Practice roles to motivate patients to self-activate their own self-care.

HOLISTIC ASSESSMENT TOOL AND TRAINING COURSE

Community Renewal staff led training in using our Holistic Assessment tool with GPs. This is a tool to establish a richer dialogue between GPs/clinicians and patients with complex conditions or difficult life circumstances who have very frequent GP appointments.

This training served the twin aims of enabling them to use the tool if they wished and providing the opportunity for a discussion about changing from a “fix it” paradigm that medicalises non-clinical issues.

Outside the GP consultation room actions may temporarily reduce demand on GP consultations, for example, more effective triage, patient referral to community services and empowering patients.

The aims is that this released GP capacity can be used to enable longer appointment times to complete a holistic assessment with complex, repeated appointment patients. A longer, more holistic, less clinical assessment can improve GP understanding of the wider social determinants of the patient’s condition including their circumstance, needs and aspirations. The Community Renewal Holistic Assessment tool is designed to generate solutions for patients and prioritise these. This can then be used for effective referral to community support and services - the practical step of literally making the referral to these external services/groups can be done by the GP or a more junior member of the team.
Features of the Holistic Assessment tool:

- A semi-structured conversation format which can be followed to really listen to a patient with brief notes and action points taken.

- Initial questions are intentionally easily accessible and open, e.g. “tell me about your typical week?”

- Details of current circumstances are explored in a systematic but open manner covering finance, housing, jobs, interests and family/friends.

- Self-care is explored in a jargon-free manner (e.g. “Do you feel you get time to look after yourself?”).

- The final section includes a forward looking open ended discussion imagining the future (e.g. “if your life had really improved in about 18 months’ time what would have changed?”).

- The main issues and priorities that arise in the assessment are scored to see how important they are to the patient to move towards setting an action plan. The actions should be focussed on self-management and should disentangle medical and social issues.

A further aspect to the Holistic Assessment tool, unlike other referral and non-clinical diagnosis tools, is to emphasise and develop the patient’s role in self-management. This is not a case of “how can I help you?” As one GP noted in Elgin, a whole new vocabulary is needed to ensure the response is self-management and sustained, else demand on GP consultations will not be reduced by Holistic Assessment.

Dr Mark Houliston (GP) recorded after the Holistic Assessment training that “It’s important that GP trainees learn the skills of the Holistic Assessment as part of their training”.

Some GPs started using Holistic Assessment in their consultations during the project. There was some anecdotal evidence of improved outcomes for individual patients and, critically, that some frequently attending patients were using services less frequently.

One of the practices supported has started performing Holistic Assessments but has done this by working overtime. That practice is now using some Protected Learning Time to explore new ways of integrating this into their normal working day.

As an overtime approach is not suitable in the long-term Community Renewal have adapted the training to include a workshop on how to integrate longer sessions into an existing workload.
PATIENT CASE STUDY 3

A male patient was attending one of the support GP Practices regularly for low mood and depression. He asked frequently for anti-depressants. Before making a new prescription the patient was invited by the GP to an holistic assessment session. The GP was using this to better understand the wider factors in this patient’s life.

The assessment highlighted issues in his marriage and lack of space in his home. The reality was that these two issues were linked due to his wife’s continuous need to hoard and this was impacting on his mental wellbeing. A further discussion was held between the GP, the patient and his wife (not a patient) where they came to an agreement to de-clutter one room at a time. The patient agreed to not using medication whilst they worked to address the issue and that he would return when they had de-cluttered one room.

The GP reported back to his Holistic Assessment trainer that he found the use of the assessment helpful towards finding out the real issues rather than writing a prescription and the ability to speak to the couple together over a social issue which so easily could have been medicalised.

PATIENT CASE STUDY 4

A patient who frequently attended an Aberdeen Practice who has a range of medical needs with complex physical symptoms and who has depression and anxiety was offered a holistic assessment. She reported that she was keen to participate. Through the process of the assessment four main non-medical priority needs were identified: welfare benefits; stuck in the house (“scared to go out”); limited social contact; and weight loss.

Having identified the severity of anxiety caused by the upcoming benefit appeal, the GP was able to send a letter that resulted in the patient getting three years grace from benefit reassessments.

With wider support, the patient started meeting friends for coffee as she became less anxious and joined a music group taking up the violin after many years of avoiding it. She felt greatly enthused by this.

Over time the patient has lost over 2 stone in weight and gets out walking more often. She has since stopped her course of anti-depressant medication and reports feeling well with a more positive outlook.

“The extended conversation allowed us to focus on her non medical issues and for us to discover possible routes to improving her general wellbeing. This led to a reduction in appointments with the doctor and when she does need to attend, it is in a much more positive way. The GP has one less ‘heart sink’ patient.”

Practice feedback
PATIENT CASE STUDY 5

A young male patient who was attending Primary Care as part of a methadone programme was offered a Holistic Assessment as the GP was aware that the patient was “stuck” in his situation. The GP had worked with this patient over a period of time with him having withdrawn from “hard” illegal drugs, to using methadone. The holistic assessment brought out his isolation due to having cut ties with his previous drug using social circle, his lack of confidence to see himself in employment in the future (due to other long-term non drug related) conditions his dissatisfaction with his living accommodation and the loss of connection with family members due to his previous drug use.

With the help of the GP he set his own goals to:
1. To reconnect to one of his brothers
2. Get support to look at pre-employment training / opportunities
3. Reduce his methadone use
4. Reassess / accept his present accommodation

With support, he sent a text message to his brother explaining his length of time off illegal drugs, the support he was getting from his GP and letting his brother know he had broken away from his drug using peers. The GP connected him with a third sector organisation for support regarding preparation for employment.

The biggest outcome for the patient was his reconnecting with his brother and a better understanding of his own achievement in moving away from illegal substances. The GP could see that the social issues were being resolved leaving him able to look at health.

"After the initial longer holistic assessment appointment the GP was able to support the patient with his goals during routine (normal length) methadone appointments."

Practice feedback
BUILDING ON COMMUNITY CONNECTIONS

CONTEXT

Having worked to disentangled patient’s medical and non-medical issues and promote where possible prevention and self-management approaches, GPs are faced with needing to link patients to support in the community. Furthermore, if Primary Care can help to improve connections between patients and community support out with the GP Practice then prevention, self-management, and non-medical issues may increasingly reduce pressure on demand for GP consultations.

Support in the community includes local provision of public or third sector services, local networks, local groups and community groups. It also includes community pharmacy, opticians, dentists and other provision around patient health. In Modernising Primary Care we have described these as “community connections”.

There are a number of barriers to Primary Care effectively using community connections and increasing links between services and groups outwith the GP Practice. Among these barriers are:

- The staff making up the GP team typically do not live within the local area in which they work - this may be even more of a barrier in GPs serving the most deprived communities.

In one supported GP Practice there is a Youth Centre that shares a car park with the GP Practice - they are 50m apart. When front of house staff were asked to describe community assets none knew what the Youth Centre offered as they had never entered or enquired. This is certainly not a criticism of those staff, but reinforces that even a basic understanding of community assets requires support and time. Each Practice engaged had at least some buildings and services around them of which they were unaware.

- Changes in local services and groups happen too quickly for staff to keep up to date. Project names, delivery locations, opening times, and contact details frequently change, especially for third sector organisations with precarious and shifting funding.

- Link workers can be seen as a silver bullet. Link workers are specific team members supplementing a GP team to link individual patients through community connections. While this may be effective for many, it can also result in duplication and in Edinburgh there is some evidence that GPs are now as confused by the Link Worker provision as well as they were by community connections. The risk is that Link Workers are seen as a silver bullet meaning that the rest of the team need not consider community connections. In fact the most effective Link Worker provision would require more widespread changes to the GP team.

- There is also some confusion over which programmes, support and policy areas community connections fall within. Is it part of Grampian Self Management Network’s work, part of the implementation of Realistic Medicine, a result of Link Worker proposals, part of Modernising Primary Care, or a way to reduce demand on GPs? It is, of course, part of all of these drivers, but the lack of clarity makes it harder to know who “owns” the transformation agenda in the GP Practice.
TAKING AN ASSET BASED APPROACH TO LOCAL COMMUNITY

Community Renewal activities around community connections for Modernising Primary Care started with a collaborative approach with one GP Practice to develop a shared language and approach that introduced elements of Asset Based Community Development (ABCD).

Developing ABCD as a tool in Practices

As a result of discussions with NHS Grampian Public Engagement Officer, Public Health Moray and TSIMoray, three ABCD workshops were delivered to around 60 clinical and non-clinical staff at Maryhill Practice. The workshops introduced the idea of doing things differently and recognised the skills, knowledge and “passions” of patients and staff alike. Understanding that patients are part of the community and can be viewed as assets rather than just having “problems that need to be fixed”

Having identified patients as part of the solution, staff at the workshop were asked to prioritise the non-medical issues that they found most difficult to support their patients with. As a result an ongoing series of information sessions was set up, which still continues, to which relevant community groups, organisations, the public and all Practice staff are always invited. This has served to introduce the idea of community connectors locally.

Community Asset Maps

A further step was to get the Primary Care team to develop a local community asset map. A series of facilitated meetings was used to systematically consider existing databases and maps which reference local services and community groups, for example ALISS. This information was compared with their personal knowledge of local groups and services and information they could find within the practice, for example on notice boards and leaflets. Patients were engaged to supplement the knowledge of the group with insights from local people about local groups and services that may not be represented in larger databases. Rather than create a new map or database, this mapping information was communicated to existing databases such as Grampian Care Data so they could be updated - therefore improving the resources available in the Practice and to others operating locally.

The process of mapping and checking for gaps creates a useful comprehensive tool but the process is also beneficial - helping them to consider what range of activities is relevant to patients and reinforcing the depth and breadth of support in the community just outside the GP Practice doors.

FORMING LINKS BETWEEN PRIMARY CARE AND COMMUNITY SUPPORT

Some of the GP Practices involved had some form of Link Workers (through Quarriers’ Carer Programme in Maryhill and Elgin Community Surgery). Most Practices did not. Almost all Practices supported asked Community Renewal for support around improving the link between the Practice and community connections although their requests and the support provided was in a variety of forms.

Information Stations

One example of this was Information Stations. An information station is an area of a GP Practice in which information about community connections is available.

In Aberdeen, Community Renewal supported staff with their idea to develop an information station in the patients’ waiting area. There were two tables with flyers and posters.

For one table, Community Renewal
worked with Active Aberdeen to identify all examples of physical activity opportunities form services and groups locally. Information about each was gathered in leaflets and posters, for example walking football. It was hoped that those represented would continue to man and update the information on this table. While Active Aberdeen hosted some meetings for this with the relevant organisations after six months the regular manning and updating of the table had come to a natural end.

The other table in the Information Station was for one community service to use for a week – a rota was used to ensure that groups that wanted to use this all had a turn. The group was asked to have a staff member of volunteer manning this station as much as possible during the week. This ran Wed-Wed so reception staff were available to welcome and support the group using the table when they arrived. While the aspiration was for the ongoing management of the rota and support for groups to become embedded within the receptionist role, this has not been sustained.

It was hoped that patients may have become involved in updating and working as regular volunteers to man the Information Station to proactively share information with other patients in the waiting room. This would have helped tackle some of the issues that were preventing organisations sending paid staff to perform this role.

The ideal impact of an information station is that patients can find for themselves support in the community more effectively. It also means that patients who are signposted to support by a clinician can pick up additional information about how to engage and understand what they are being signposted to. It is a source of information for staff so they can keep more up to date on new or changing community connections.

The findings from our work in Torry suggest that the ambitions for the impact of an information station need to limited. It takes a significant effort to keep it well maintained, it only impacts patients after they have entered the GP Practice (which may be too late to prevent a consultation) and it takes work from community organisations to keep it up to date.

In Banchory there was an existing signposting service facilitated by Aberdeenshire Signposting Project. It is a free and non-judgemental signposting service for people seeking support around mood and wellbeing. Following some changes the service was not well understood or used by staff within the Practice despite a clear need. Over the course of the support through Modernising Primary Care there was a chance for the Practice staff to reflect with Community Renewal on the value of this service. Subsequently they internally reviewed and improved the use of this service. It is reported that Signposting is now better used and more effective.

Getting Community Organisations connected to GPs

For Modernising Primary Care, Community Renewal staff worked hard to do the work required to better link the GP Practices being supported to individual community connections. This required work to understand the need and working of a practice. It then required meetings with many third sector and public sector services and local community groups/networks one by one. Where both parties were keen for a
stronger link between the community connection and the GP a plan of action could then be formed and tested.

**Moray Older People Champions** is a group that was identified and supported by the Public Health team in Moray. When Community Renewal was introduced to this community-led group, the group had already developed an excellent presentation about the impact of an aging population on health.

It was possible to enable the group to present this to the local GP Practice team. This was informative and cemented a strong link between the practice and this significant community asset. The group manages a walking group and provides support to people, diverting them from Primary Care.

Clearly meeting one group at a time is an intensive effort, but it tests the principles of forming better connections and ensures there are examples of improved connections that give a better understanding by both the community organisations and GP Practice in how connections in that locality could best be improved.

**Cash in your Pocket (CIYP)** is a service that offers financial education and case management for anyone with money issues in Aberdeen and Aberdeenshire. The Torry GP Practice and CIYP were brought together by Community Renewal to improve their connection. This resulted in a new bespoke leaflet being designed and a referral pathway being agreed.

CIYP report that, soon after, they got their “very first referral from the GP after the GP called while patient was still in the room”.

It was apparent from our conversations with GPs that they were not able to keep up with what third sector provision in the community looked like and how to make referrals to a wide range of community connections. For many, this was also too ambitious for them - they would prefer to understand how to separate medical and non-medical issues then pass on the responsibility for the connection to other staff. Given the workload and existing difficulty GPs have to keep track of developments in their own field these concerns are understandable.

Since 2012 every local authority area in Scotland has a Third Sector Interface to represent and support third sector service and groups. While the support they offer is varied one of their intended roles is to aid links to and between organisations.

None of the GPs asked about Third Sector Interfaces knew what a Third Sector Interface was. GPs have too many pressures to keep up with frequent changes in third sector provision, but it might be valuable for Primary Care if GPs drew on TSI support around community connections.

Those GPs that received the most support from Community Renewal generally did express that they understood the benefit of the overall GP Practice becoming better linked to community connections, even if this was to be implemented differently from Practice to Practice. A number of examples were identified where making these links immediately yielded results.

In Aboyne, Community Renewal staff identified and engaged a group of people who had suffered a stroke and were now supporting each. They met up to take a regular exercise class together. This is an excellent
example of self-management and preventative community support which may reduce pressure on health care.

Community Renewal were able to inform GP Practice staff about this community support. Now the GP team would be able to link other patients to the group and could support the group to sustain if necessary.

Role for patients as community connectors

It was discussed at various stages that there is scope for patients themselves to have a role in supporting connections between the GP Practice and community connections. For example, a group of patients could become responsible for updating a community notice board / information station. This remains an idea that could be tested but which none of the supported GPs Practices were able to test during this Modernising Primary Care programme.

CONNECTING PATIENTS AND COMMUNITY SUPPORT OUTWITH PRIMARY CARE

Community Renewal staff facilitated a range of network events among the practices; bringing GP surgery teams, local third sector organisations and community services together. On the one hand this has enhanced GP team awareness of local services in order to effectively signpost patients to a broader range of support including social activities, financial advice, housing repair, pharmacy and health promotion activity.

More importantly it has aimed to strengthen the promotion of community based support for patients without needing to engage Primary Care.

In 2016 Community Renewal with health and Council partners put on a “We Heart Torry” event. This was promoted as a fun day and had events including: information stands on health and wellbeing; music; taster sessions for a variety of including basketball; indoor football short tennis; face painting, story corner, visit from Fire engine; outdoor play and opportunities to connect with community and youth organisations.

Critically, at the event there were staff, stands and promotional materials from community services including Cash In Your Pocket; Fuel Poverty Advice; Benefit Advice; and Health checks.

The event was attended by 200 people, with many families attending with children.

Recognising the benefits of this approach, the event will be repeated in 2017 with a focus on reaching an even broader demographic and over 500 people.

Hosting or instigating events to create connections within the community takes expertise and time. Community Renewal was able to dedicate staff time to enabling this during the Modernising Primary Care project. There was also some development work with staff in GP teams to help them sustain or repeat this approach. In some areas, smaller events that are less complex to replicate or sustain were used to create connections in the community.

In Elgin the GP Practice, with support from Community Renewal, set up a new networking day. This was attended by dentists, opticians, community pharmacy and other community services.
Some patients attended and were shown the range of services available in the local area, understanding who to turn to, when and how. Links were made between the community services. We cannot measure whether this will divert patients from attending the GP, but the event was considered sufficiently successful yet easy to facilitate that it is becoming annual - it will be delivered by the HSCP, BID, GPs in partnership.

Involving the BID (Business Improvement District) was a significant step - findings a shared agenda with a local economic development group.

Better linking and supporting community support, groups, networks and services is not limited to events. The Community Renewal staff delivering Modernising Primary Care spent a lot of time working one to one with third sector groups to help them link to the Practices. Some third sector organisations felt that they would struggle to engage with Practices or could not retain relationships with all the Practices in an area without support. Similarly, some GP Practices would not initially see the relevance of some organisations or invest the time needed to explain how best to work alongside the GPs. The hard work was to identify groups that were relevant and work with them and with the Practice to find their shared goals, mutual benefits and easiest ways to remain engaged. Over time this can lead to improved relationships but the difficulty of this for Practices and third sector organisations to repeatedly do to link dozens of Practices to hundreds of organisations effectively.

In Torry, Community Renewal staff listened to a group of people with Dementia and their carers. While this was not the intention, this group continued to meet independently for a short period. Community Development is all about forming sustainable local activities and groups that can promote wellbeing. This example demonstrates the potential of bringing Community Development expertise into Primary Care.
Getting the Welcome Right and Opportunities to Better Use Front of House

CONTEXT

Front of house staff in a GP Practice include receptionists and administrators. Any consideration of transformation of primary care results in some debate about the role of these front of house staff members - they could have a smaller or greater role. Often front of house staff have taken on a gatekeeping role, there is always discussion and some disagreement as to whether this is done effectively, could be improved or should be completely changed.

This is not a new debate and there have been a number of efforts to experiment with the role of front of house staff. One notable example is in a Keep Well pilot in Wester Hailes where receptionists became more involved in care provision up to the point that their titles were changed to “Patient Assistants”.

Past examples and Community Renewal’s initial engagement of front of house staff in this project indicated that any change in front of house provision requires change in culture not just training or different processes. A discussion of the role of front of house staff inevitably also raises the discussion of pay - reception can be a very demanding job but is often considered an entry level role or is fulfilled by experienced staff without specific health or community development qualifications. Demanding a wider skill set and additional responsibilities is always likely to require additional pay to recruit or retain appropriate staff who are skilled, qualified and motivated for an expanded role.

OPPORTUNITIES AROUND FRONT OF HOUSE STAFF

Of the receptionists engaged by Community Renewal staff a number reflected on the scope of their role and recognised the number and breadth of community connections they could make. They came to realise that in general, GPs would be happy for their role to include community connecting. They raised concerns that patients may not want information from them and would prefer to speak to a clinician. Almost all were keen to explore further the possibility of developing their role.

Maryhill Practice, following support from Community Renewal, decided independently to make some changes in their triage system to include front of house input. They decided to include a receptionist in their “Virtual Ward” triage or “duty team” this allows the reception staff to take a more active role and when phoning patients back on behalf of a Clinician, (e.g. to arrange an appointment or referral identified by the Clinician) they can say that they are one of the Duty Team. This has the specific benefit of overcoming the need expressed by some patients to speak to a Clinician

By discussing with supported GP teams all aspects of their work across six different Practices, Community Renewal supported a number of discussions about changes and were involved to different extents in a number of tests at changing approaches.

Front of House training in an Aberdeen GP Practice highlighted the
Front of house staff could have a wider role in terms of community connections and signposting patients either before or after GP consultations to appropriate community services, community groups and networks. To support this wider role Community Renewal developed two training modules for front of house staff:

- Customer Care
- Introduction to Community Connecting

The introduction to Customer Care was tested on staff in five Practices and the Introduction to Community Connecting in three. All six Practices undertook at least one of the modules.

An example of the change in mindset was where one Receptionist identified several patients booked in for weight management. She then approached the Health Care Assistant to find out if it would be possible for the patients to attend the local Health Point weight management group as an alternative to appointments at the surgery.

To some extent this is an architectural issue and those involved in modernising primary care will have a greater capacity to inform the future design of health and community partnership buildings.

Community Renewal facilitated discussions in which GP teams simply reviewed what patients experience as they enter the existing Practice buildings. This helped catch issues that are obvious to patients but harder for staff to see, such as a Practice appearing “fortress
like” to community members seeking information rather than a GP consultation appointment.

As a result of a rethink, an additional board was added for community based information and community organisations have been informed that they can put posters directly onto the board.

One of the GP Practices supported has a large waiting room which had one large overused information board and a number of information / leaflet stands. There was no continuity in the upkeep of the notice board and the information displayed was overcrowded and confusing. After Community Renewal training, the front of house team became aware that no-one managed the notice board and that out of date information was not being removed.

The health information board is now divided into three sections:
- children & young people;
- adults & older people (both these sections being updated by Practice Staff and Allied Health Professionals);
- health promotion literature

The information is regularly updated by NHS Grampian’s Health Point staff who have taken on this responsibility.
Engaging Patients as Assets

CONTEXT

It is not intuitive to all in Primary Care that being more open to the community through more and better engagement may improve workload and working practices as well as patient outcomes. One GP Practice described this by saying that in response to the pressure for their services they have spent many years trying to keep patients out of the Practice. Some GP practices can feel like a fortress.

Community Renewal tried a “lunchtime learn” with an Elgin Practice about seeing patients as assets and things can be done with patients and staff together. A Practice Manager said “we have spent 20 years trying to keep patients out and that’s not worked, why not bring them in”.

Where this approach is in order to promote self-management and avoid dependency of GPs to “fix it”, this approach fits with current policy drivers. However, there is a disconnect where this isolates patients from informing the design of Primary Care and prevents information reaching patients that can be used to inform their self-management or preventative actions.

Some GPs of course are already very open to community engagement and use patients and community members as assets to support and inform the Practice.

Many GPs including those we supported operate Patient Participation Groups (PPGs). Inevitably there are both examples of best practice as well as PPGs that are not serving any useful purpose. More often than not Primary Care staff we engaged didn’t feel that a PPG was a beneficial investment of time and resource.

An existing alternate to PPGs is exemplified by the Keith Friends of Practice Group a more engaging model with a bigger role in the Practice. This is not wide spread or widely understood.

The Banchory PPG have a level of authority to represent the Practice externally. The PPG represent the practice at Community Council and the Community Action Plan (Local authority and Community Council led forum). This ensures that the voice of the PPG is taken seriously and those engaged are making an impact.

HELPING PRACTICES UNDERSTAND VALUE OF PATIENTS AS ASSETS

Investing in community engagement isn’t going to create an instant return and there isn’t a single, definitive source of evidence to show the expected outcomes.

There are copious examples, including from our work, where community members engaged effectively and with authority to take action, can offer insights unseen to clinicians and other staff on how working practices can be improved and better link to existing community provision without clinicians needing to themselves become the experts in existing local provision.

In Banchory Community Renewal’s pilot community engagement identified from patients that signage
in surgery wasn’t clear to them and this could easily be resolved. It wasn’t obvious to staff members that this was the case. The surgery was easily able to respond by renumbering rooms.

There are engagement tools and techniques that Practice staff would not be typically expected to have a detailed knowledge of that can improve the number of patients engaged, how to get useful information form this and how to make changes as a result. At its most in depth this would represent an approach using community development.

In Elgin after some patient engagement activities, one engaged patient brought a friend who was interested. This presented an opportunity to gather a wider group together around these two enthusiastic patients. A facilitated discussion showed that the group. They want to become community connectors - more support would be needed to make this happen but the enthusiasm was already in the community for the Practice to tap into.

Community Renewal used Asset Based Community Development (ABCD) workshops in some Practices to encourage Practice staff to develop their understand of what community assets are and how this can include insights, skills and contribution from people living in the community including current patients.

During a Holistic Assessment training discussion in Danestone about moving towards an asset based approach to patients an example of an older person was identified who attends the practice each week and has ICT skills. Using him as the start of a new group, we have been asked to establish a new group of older people considering ways to reducing isolation, better engage the community and allow other patients to benefit from his skills.

In addition, conversations took place with front of house staff to see their perspective and understand any barriers to engaging the community. This accepts that it can be productive for front of house staff to increasingly see that community members and patients can be assets but there are practical barriers that can prevent this more nuanced form of engagement with the community (e.g. job descriptions, training, physical layout of the Practice, time demands). A key finding out of this was that more investment of time and training was needed and buy in from senior staff was needed in order for ideas to be tested that could demonstrate potential benefits to these front of house staff.

Good practice in engaging a patient group was identified in a Practice outwith the Modernising Primary Care project. This best practice was demonstrated to one of the supported Practices but the lead GP was not interested so change was blocked. This limited the opportunities to listen to the community during the project but also meant that the benefits of the model could not be experienced by staff who may have later changed to their own approach but maintained a shift in culture towards being more engaged with the community.

In a different Practice a Practice Manager has become convinced of the efficacy of an assets-based more open community engagement model as a result of successful local trials from
Community Renewal staff conducting listening exercises in the waiting room. As a result, she is going ahead organising four information sessions per year. This brings patients in who aren’t wanting an appointment but want to know more about a topic, or support for people with particular condition - e.g. diabetes.

LISTENING TO PATIENTS TO UNDERSTAND A PRACTICE AND SUGGEST CHANGES

To explore methodologies in each local Practice and to demonstrate quick-wins that can be made from engaging patients as assets, Community Renewal staff conducting their own listening exercise in each supported Practice.

In total the following numbers of patients were engaged in these listening exercises:

- Torry Medical Practice: 101 patients (60 face to face, 35 by telephone, 6 in a focus group)
- Aboyne Medical Practice: 85 patients (77 face to face, 8 in a focus group)
- Elgin Community Surgery: 63 patients (50 face to face, 2 by telephone, 11 in focus group)
- Maryhill Group Practice: 80 patients (52 face to face, 21 by telephone, 7 in a focus group)
- Banchory Group Practice: 118 patients (99 face to face, 19 in focus groups)

A listening exercise can be simple. Community Renewal staff just sat in the waiting room with a Listening Survey to complete with any patient willing to speak to them while they waited. The questions asked what patients thought about the Practice, what had brought them there, what else they might do about their health and what changes they would like to see for themselves or the Practice.

Insights, feedback and recommendations identified by patients can be cost neutral and very simple to respond to.

Young mums in Banchory - changed appointments systems. GP gives someone a card if they are allowed to make an appointment

In Aboyne a group wanted opportunities such as events to bring patients and practice together to share information and links to community supports.

There are more systematic ways to engage patients than sitting in the waiting room. For example, while this approach quickly reaches many patients including those who don’t have time to contribute more often, this approach doesn’t get views from people who don’t enter the Practice.

There are also better ways to keep a smaller number of patients engaged more deeply.

Good Practice (not us): Patient Tree implemented as a way to listen to listen in Elgin.
Following a number of focus groups and discussions which identified the route into and the route out of Secondary Care as an issue that patients wanted to understand more fully led to two workshops hosted by the Practice. The first one provided the GP perspective on the Route In to Secondary Care. The second workshop provided an opportunity for patients and Practice staff to discuss the Route out of Secondary Care with Dr Malcolm Metcalfe, Acute Associate Medical Director. The patients attending appreciated the opportunity to raise issues with Dr Metcalfe and for the Practice to hear their concerns.

A Moray Practice identified a list of what they called “Frequent Flyers”. Each patient was contacted. Eight became engaged by Community Renewal staff. Their perspective was different from anything the Practice staff had said, although the low numbers mean that this isn’t a robust scientific sample, these eight people were taking dozens of appointments each month. They reported that they didn’t want to waste appointments even though this list was a list of patients that staff informally indicated may be most likely to waste appointment. They reported wanted help around aspects of self-management and they were attending the GP as they felt they didn’t have any other option.

One approach is to work more intensively engaging patients who most frequently attend the Practice. This is an opportunity to understand why they are coming so often, link them into community groups or care outside the GP Practice, and to see their insights into the operating of the Practice.
Understanding the Landscape and Engaging Stakeholders

Before and during support for GP Practices around disentangling non-medical issues and better links to communities, it is important to consider the wider landscape of Primary Care, Secondary Care, Health Improvement, Public Health, Mental Health, and Social Care. There are further considerations around third sector policy, community development, and community engagement. The transformations sought in Modernising Primary Care particularly links agendas between Primary Care and Public Health.

The experience of this project is that stakeholders in each of these many areas of policy and practice need to be involved but also need to see that these sorts of changes to Primary Care do not

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National Community Engagement Standards present requirements for effective community engagement in seven stages. These principles have been widely adopted by practitioners in many different policy areas. Finding uniting approaches such as this helps link up different aspects of the health landscape around the transformations Community Renewal and NHS Grampian seek in Primary Care. Source: SCDC/VOICE (2005) National Community Engagement Standards
give a quick return, rather it is a slow transformation. A full system approach has proved necessary both:

- Within each GP Practice all aspects of deeper community engagement need considering - GP disentanglement of non-medical needs; listening to patients; taking an asset based approach; and getting the welcome right. All staff in the Practice need engaging.

- Engaging stakeholder from across many partners in many different policy areas with different relationships with Primary Care.

ENGAGING ALL STAFF IN PRACTICE

A consistent finding has been the benefit of engaging all staff in a GP Practice. It would be simpler to engage only clinical staff or only senior staff. This would completely miss the need to really understand all aspects of GP Practice and the influences/challenges they face. Each GP Practice is different - no two GP Practices Community Renewal engaged received the same support and none of the recommended changes would have worked in an alternate setting.

As transformation ideas are rolled out into other GP Practices, it may appear to be sensible to reach one type of staff over a wider geographic area - for example, a training course for all Front Of House GP staff across a local authority area. However, this would ignore the key finding that any training or support needs to be rooted in a deep system-wide understanding of the GP Practice.

Engaging all staff does not mean that there are not some that require closer engagement in the process - getting the buy in of the key decision makers is vital (normally the lead GP and Practice Manager). The difference between a Practice where a number of Modernising Primary Care trials could be taken forward during this project and a Practice was less interested in getting involved was consistently determined by how good relationships were with the key decision makers.

View of the Practice Manager

One important aspect of the Modernising Primary Care project was better understanding the perspective, role and potential of Practice Managers. Engaging them has been key. They have often proved to be a keystone in making change happen or seeing opportunities for improvements.

The Practice Manager roles vary depending on the size of the Practice and reflect the requirements of the GP partners. In some Practices the role may be split between more than one individual. The route to becoming a Practice Manager varies e.g. some have come through internal promotion from Reception / Admin roles up to Practice Manager, others have a business or nursing background. There is a vocational training for Practice Managers which is mainly taken up by Reception / Admin staff looking for career development into Practice Management. The role of Practice Manager itself also varies across Practices and can range from a high functioning administrative role, to a strategic manager.

For some Practice Managers, the volume of work was a strong motivation for them to change traditional ways of working and take a different approach whilst for others, the volume of work meant they felt there was no time to try out new ideas. This also reflected the type of role, size of Practice, level of confidence in making decisions, delegating and the dynamics within the Practice.

Examples of Practice Managers making a positive difference were seen most clearly in Practice where the Practice Manager was involved in the decision making process of the Practice. Examples include being able to adapt and change their appointment systems to allow longer appointments; agreeing different usage or layout of the waiting area to
promote involvement of patients in connecting to each other, other statutory services and the Third Sector as well as introducing new ideas or proposals and testing different approaches (e.g. Asset Based Community Development).

ENGAGING PARTNERS AND STAKEHOLDERS

The Community Renewal staff team also spent much time engaging and seeking to better understand the wider system outside the GP Practices. This included building relationships with partners and stakeholders such as the Third Sector Interfaces, Public Health Teams, Mental Health Teams, Community Development Teams, and major third sector partners.

“I really enjoyed working with this innovative project, exploring and being introduced into dynamic ways of working within the GP context.”

As a result of this the NHS Grampian Transforming Primary Care project could ensure that it was linked into the wider landscape and agendas. For example, the same team working on Modernising Primary Care were involved in developments around the Banchory Community Action Plan, the Grampian Self-Management Network, Torry Place Standard, Aberdeen Community Empowerment and Participation Strategy, and the tsiMORAY Health and Wellbeing Forum. More information on two of these is shown below:

“The Community Learning Team in Torry introduced the Place Standard Tool as part of their consultation with local residents. Community Renewal staff supported this process by providing facilitation at community events, allowing them to contribute to the overall consultation, learn more about other topics and issues affecting people and ensure the perspective of GP Practice was understood.

Community Renewal staff linked with the Grampian Self-Management Network and contributed to the development of the framework for supported self management, ensuring the six MPC practices were aware of the role of the network and the need for actively supporting and promoting self management.
Legacy, Learning and Next Steps

CONCLUSIONS
This project has led to some Practices changing their ways of working in steps to Transform Primary Care to embed deep community engagement and use techniques building on prevention, self-management and using community assets.

Even where many positive steps have been taken a central piece of learning has been that investing in community engagement doesn’t give an instant return even when it represents best practice.

On the other hand, the work has also shown that some easy to implement short term positive changes can emerge from community engagement, even if it is as simple as responding to patients who are confused by the welcome to the surgery.

It was only by sticking with the project through difficult periods, improving individual relationships, and starting to see people pick up the language asset based community development within the Practices that the potential of the project started to be realised.

There were significant challenges. This was inevitable given scale of the cultural changes sought compared to only 0.25FTE Community Renewal staff per Practice and some Practices being 75 miles apart. The project suffered some practical difficulties with a three-month delay over contractual issues and some changes of key NHS Grampian staff.

The project didn’t have clearly articulated outcomes during delivery and it was not easy to communicate the nature and benefits of the front of house or holistic assessment training. It wasn’t until GPs, nurses and front of house staff had been through the training that it was clear to them which bits related to ways they already work and which were less familiar. For example, in describing Holistic Assessment it can sound like a slower version of the diagnostic process and social prescribing that GPs already understand. It was important to learn that very clear and tailored communication and tight organisation is required to work effectively in this setting.

Change needs to be considered system-wide, engaging many different external stakeholders across different policy agendas and ensuring all staff in the GP Practice were engaged were critical. Each GP Practice has its own landscape of provision around it and its own distinct operational considerations. To recommending actions and facilitate change management means the whole system needs to be understood from many perspectives in advance (clinical, front of house, patient, external stakeholders). This in itself takes time.

Throughout this report have been given many examples of the GP Practices changing the way they work:

EVIDENCE OF CHANGED WORKING: DISENTANGLING MEDICAL AND NON-MEDICAL ISSUES
There are examples of GPs and other clinicians using Holistic Assessment effectively following training in the Community Renewal toolkit. Case studies show that this has had a transformative impact on some patients. In some cases, patients that were frequently using Primary Care have drastically reduced the number of appointments and amount of health care support they have individually been seeking.
It was vital that Practice Managers and clinical staff including but not limited to GPs were involved in training around Holistic Assessments. Only once they can all understand the techniques can they work together as a team on non-clinical issues and share a language (for example, needing to stop saying “how can I help you” as this undermines self-management of non-medical issues).

**EVIDENCE OF CHANGED WORKING: BUILDING ON COMMUNITY CONNECTIONS**
A number of community groups and networks became better engaged with GP Practices directly as a result of the work. This includes Moray Older People’s Network and Cash In Your Pocket. Positive examples of this were seen in most Practices. Importantly there was a wide range of types of Community Connections that were improved from unconstituted community groups to public services to national providers.

Unlike with simple a Link Worker referral system, it proved difficult to gather any evidence that these improved Community Connections result in better use of community resources by patients self-managing in the community. But if the connections did not exist it is not feasible that these community resources could have been used at all. There were enough examples where GP Practice staff were found to be very disengaged from the local community resources that it is reasonable to expect the project to have enabled patients to have better routes into a wider range of community support.

The really promising examples were where multiple Practices have subsequently chosen to maintain networking events (or similar) to keep Practice staff better engaged with community services/groups/networks and to allow patients to directly engage these community resources outside the Practice. Embedding such networking at events or one to one is the way that improved community connections can continue to develop and new connections form outside Modernising Primary Care.

**EVIDENCE OF CHANGED WORKING: GETTING THE WELCOME RIGHT AND OPPORTUNITIES TO BETTER USE FRONT OF HOUSE**
Across a number of the GP Practices trials in changing the role of front of house staff and the welcome were tested. This tended to happen where the key decision makers (GP lead / Practice Manager) were really bought into the wider goals of the project, understood that change needed to be system-wide and the front of house staff could be effectively engaged (e.g. during Protected Learning Time).

It is clear that there isn’t a single correct answer for how to get the welcome right and how to involve front of house staff in this. It is also clear that change requires resource to sustain new practices and the impact may take a long time (e.g. if patients get better signposting in the waiting room, it won’t stop them having the appointment today).

Any ambition for taking advantage of opportunities with front of house needs to recognise that reception staff are recruited and paid to perform reception tasks - if the role changes, receptionists cannot be expected to just take on more work.

Consulting patients on the change they would like to see front of house is an effective way of spotting some quick wins for signposting or making it clearer how to best engage the Practice for support without simply booking GP appointments. Patients can feel like a Practice is a fortress wanting them to stay away but without there being an alternate.

**EVIDENCE OF CHANGED WORKING: ENGAGING PATIENTS AS ASSETS**
Community Renewal supported many GP Practice staff whose eyes were really opened through workshops or training that encouraged them to see patients as assets. This can be
a significant change in perspective after years working under pressure and working in a “fix it paradigm” of health. For example, the Practice Manager who told us they had “spent years trying to keep patients out”.

There were examples where the role of patients was improved in informing the working of the Practice or in improving Community Connections. Promisingly these changes were often made outside of the direct support from Community Renewal - by Practice Managers seeking to make their own changes. The positive impact of patient engagement will only be achieved through GP Practice staff themselves identifying and making the most of opportunities to do this, having recognised the potential of engaging patients as assets.

With the exception of some case studies (such as a group of carers and people with dementia forming a short term self-support group), the evidence is not available yet to suggest that this makes a day to day impact on demand for appointments or patient outcomes. On the other hand, the case studies and logic model suggest that we should see this as these behaviours become routine.

**NEXT STEPS: INFORMING LINK WORKER ROLE AND FURTHER EMBEDDING**

The role of the Modernising Primary Care project has not ended in April 2017. The principles are being taken forward by Community Renewal to inform their delivery of the six new Mental Health Link Workers in Moray. It may also inform the development and delivery of the twenty new Link Workers expected in Aberdeen.

Community Renewal recognised that one of the shortcomings of the change management project has been that there is no longer clear leadership on this agenda from single public body (following integration of health and social care). This means that there is a gap in supporting ongoing work to help embed change into the supported Practices. There is also a gap in terms of how to roll out learning and resources to other GP Practices in Grampian.
WHAT MODERNISING PRIMARY CARE ISSUES WERE SUPPORTED WITH EACH GP PRACTICE INVOLVED?

- **Torry**
  - Front of house training
  - Listening exercise with patients
  - Getting the welcome right
  - Better engaging patients
  - Building on community connections
  - Dis-entangling non-medical issues

- **Danestone**
  - Front of house training
  - Better engaging patients
  - Dis-entangling non-medical issues

- **Banchory**
  - Front of house training
  - Listening exercise with patients
  - Getting the welcome right
  - Dis-entangling non-medical issues
  - Better engaging patients
  - Building on community connections

- **Aboyne**
  - Front of house training
  - Listening exercise with patients
  - Dis-entangling non-medical issues
  - Building on community connections

- **Elgin**
  - Front of house training
  - Listening exercise with patients
  - Dis-entangling non-medical issues
  - Better engaging patients
  - Building on community connections

- **Maryhill**
  - Front of house training
  - Listening exercise with patients
  - Getting the welcome right
  - Dis-entangling non-medical issues
  - Better engaging patients
  - Building on community connections
Appendix: Strategic Context and Policy Overview

There is constant evolution of health policy and the research that informs it. A number of policy documents from Scottish Government and NHS have informed the role of Community Renewal within this Modernising Primary Care exercise. This section introduces some of the key policy documents and the changing strategic landscape for primary care during 2015-2017.

VISION 2020

The Scottish Government’s 2020 Vision was first articulated in 2011. It is: “…that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting”.

The ‘Route Map’ to the 2020 Vision for Health and Social Care in Scotland\(^{18}\) sets out a continued focus on improving quality in Scotland’s health and care services. The vision emphasises a commitment to pursuing safe, effective and person-centred care. These ambitions are embedded across the ‘triple aim’ and twelve priority areas for improvement:

<table>
<thead>
<tr>
<th>Triple aim 12 Priority Areas</th>
<th>Quality of care</th>
<th>Health of the population</th>
<th>Value and sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Safety in all healthcare settings</td>
<td>8. Reducing health inequalities</td>
<td>11. Increase investment in innovation to increase quality of care and reduce costs</td>
<td></td>
</tr>
</tbody>
</table>

At the heart of the 2020 Vision is an expanded role for general practice in delivering innovative unified, local approaches to more effectively deliver person-centred care within communities; to reduce the levels of unscheduled care. Indeed primary care and general practice are central to almost all of the twelve priority areas for improvement. Effective care, involving potentially a range of services and community support for patients with multiple and chronic conditions (or complex life circumstances) is emphasised as a key leadership role for primary care and general practice.

GROWING FOCUS ON SELF-MANAGEMENT, PREVENTION AND INEQUALITIES

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\(^{18}\) Scottish Government and NHS Scotland (2012) Route Map to 2020 Vision for Health and Social Care
The Christie Commission\(^{19}\) set the Scottish Government agenda towards inequalities, partnership working and preventative actions. The commission report found that “some estimates suggest more than 40 per cent of local public service spending is attributable to ‘failure demand’. It is clear that substantial savings to public service costs are achievable by prioritising preventative services addressing generational inequalities.” Social and economic factors have been shown to represent the majority of inequality in health outcomes.\(^{20}\)

In this health context, inequalities are defined as “the preventable and unfair differences in health status between communities, groups, or individuals. They exist because of unequal distributions of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent illness, or opportunities to gain access to the right treatments.”\(^{21}\) Tackling health inequalities has meant services taking more consideration of accessibility, holistic actions, integration with partners working in the same community and seeking a system-wide approach.

The inverse care law is an established terminology for describing the higher level of care provided to those who need it less. This is a mechanism by which health care can entrench and not tackle inequalities. The inverse care law is often described with relation to elective care and prescription; work by Dr Stuart Mercer from the Deep End GPs groups has described a more general applicability of this inverse care law across primary care which needs to be addressed before primary care can integrate with wider efforts to reduce inequality across health outcomes and their socio-economic causes:

“Primary care has a central role in the management of multimorbidity, but the continuing existence of the ‘inverse care law’ limits this potential in the deprived areas due to the mismatch between patients’ needs and primary care capacity. Consultations in the deprived areas are shorter than in more affluent areas yet patients have more complex problems to discuss due to more mental, physical and social problems. The GPs working in the deprived areas suffer more burn-out and feel more stressed in the consultations. Patients with complex problems are less enabled by these consultations compared with their counterparts in more affluent areas and have worse outcomes.”

Informed by Christie Commission and the Marmot Review, the 2020 Vision route map has a focus on prevention and emphasises self-management as part of the future of health service delivery.

Prevention has long been part of public health and an ambition for health care, but a focus within the route map will help ensure that prevention remains part of modernisation efforts in health. Primary prevention reduces the incidence of health problems and is often delivered through “Tier 1” provision, which includes third sector led activities, public health programmes, and wellbeing activities; secondary prevention and “Tier 2” prevention tends to be seen within GP practices where practitioners identify emerging symptoms and take steps to manage health problems, but this can include referral to wellbeing activities, peer support and community-level programmes\(^{22}\). Prevention has repeatedly been shown to be cost effective, especially community-level activities\(^{23}\).

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\(^{19}\) Scottish Government (2011) Commission on the future delivery of public services  
\(^{20}\) University College London (2010) Fair Society Healthy Lives  
\(^{21}\) EVOC and Carr Gomm (2016) An Intermediary Service for Primary Care in Edinburgh  
\(^{22}\) Terminology taken from NHS Grampian reports e.g. NHS Grampian (2014) Local Delivery Plan  
\(^{23}\) e.g. The King’s Fund (2013) Transforming our healthcare system
Prevention is one of the four pillars of Modernising Primary Care and self-management is one of the pillars in the NHS Grampian Clinical Strategy. Self-management ensures that the patient is part of both prevention efforts and their health care. As part of our work on MPC Community Renewal sat on the working group for the self-management strategy. Self-management is a move to collaboration between practitioners and patients, ensuring patients take ownership of their role in leading a healthy lifestyle and are an active part of their care; a range of tools have been developed that will help self-management support the overall 2020 Vision.

ROYAL COLLEGE OF GENERAL PRACTITIONERS: A VISION FOR GENERAL PRACTICE IN THE FUTURE NHS

The Royal College of General Practitioners (RCGP) publication - A Vision for General Practice in the future NHS - the 2022 GP\textsuperscript{24} outlines six areas of development (outlined in table 2, overleaf) which would enable GP surgery teams to more effectively meet these challenges alongside an urgent increase in Governmental investment in primary care. Organisational development and expanding the capacity, skills and flexibility of the general practice workforce is at the core of the RCGP vision; as is a focus on utilising community-based resource and generating evidence as to best practice in community integration. The six themes of the action plan emerging form the vision are:

- Promote greater understanding of the value that generalist care brings to the health service.
- Develop new generalist-led integrated services to deliver personalised, cost-effective care.
- Expand the capacity of the general practice workforce to meet population and service needs.
- Enhance the skills and flexibility of the general practice workforce to provide complex care.
- Support the organisational development of community-based practices, teams and networks.
- Increase community-based academic activity to improve effectiveness, research and quality.

INTEGRATION OF HEALTH AND CARE

Part of the 2020 Vision is for integrated health and social care. On 1 April 2016 the Public Bodies (Joint Working) (Scotland) Act 2014 came into force. This Act provided the legislative framework and empowered both NHS and local authorities to work through 31 new Health and Social Care Partnerships. Integration of health and social care in practice is intended to support and enable community participation within service planning and delivery.

\textsuperscript{24} Royal College of General Practitioners (2013) The 2022 GP: A Vision for General Practice in the future NHS
MODERNISING PRIMARY CARE

Modernising Primary Care (MPC) is a Scottish Government sponsored national initiative which aims to develop and assess new ways of working and skills development within general practice. MPC also aims to illuminate how practices can be more effective in utilising local community-based services, resources and assets in patient care and to pilot methods of engaging and empowering practice populations.

NUKA, MAKING EVERY OPPORTUNITY COUNT AND ASSET BASED COMMUNITY DEVELOPMENT

A key influence over MPC for NHS Grampian is Nuka, a whole health care system developed by South Central Foundation and owned by the Alaskan Native people from whom it was created.25 “Nuka” is an Alaskan Native work for strong giant structures and living things. The system considers spiritual and emotional wellness alongside physical and mental health.

It is based on relationships so informs MPC in terms of engaging patients and the community in transformative redesigns of primary care with a shift of power able to be made towards patients. One feature of Nuka is to move towards referring to patients as customers/owners to reflect this power shift. Proven benefits of the approach include a one quarter reduction in primary care visits and emergency room visits.

Other methodologies informing MPC include: Asset Based Community Development (ABCD), and Making Every Opportunity Count (MECC).

ABCD supports sustainable community development; in essence this involves assessing and utilising resources, skills and experience within communities, from residents or groups/organisations (“Community Connectors”).26

Making Every Opportunity Count has been trialled by early adopters in NHS Grampian and builds on Make Every Contact Count from NHS East Midlands and the NHS England Five Year Forward Plan.14 It supports frontline staff to use more informal conversational approaches to change behaviours, encourage healthier lifestyle choices and signpost/support on wider social issues with every health contact.27

SCOTTISH GOVERNMENT PROGRAMME FOR GOVERNMENT

The Scottish Government Programme for Government 2016/17 sets out “four underpinning priorities for our actions in the coming year that will help bring about long-term improvements to our population’s health:

- empowering a truly community health service - working with integrated authorities, social care, community care, primary care, and general practice to deliver the reforms needed for successful community health services

27 Lawrence W, Black C, Tinati T, Cradock S, Begum R, Jarman M, ..Cooper C. ‘Making every contact count’: evaluation of the impact of an intervention to train health and social care practitioners in skills to support health behaviour change. Journal of health psychology (2016);., 21(2), 138-151
• enhancing mental health - improving mental health services through investments in more effective and accessible treatment

• improving population health - working across government to help raise attainment, promote inclusive growth, and progressive human rights. These can all contribute towards improving the health of the people of Scotland

• supporting clinical leadership of transformation - acting on the principles of the National Clinical Strategy and Chief Medical Officer's aims of ‘Realistic Medicine’

The following intents and commitments were also agreed by Scottish Government:

• “To support the shift in the balance of care away from acute settings towards primary and community settings we will support more multi-disciplinary teams working with GPs.

• In 2017 we will be working with the British Medical Association to bring forward a new GP contract to support our efforts to reshape primary care and improve accessibility to GP services. We will also continue to invest significantly in primary care transformation, investing £85 million over the next three years and working across Scotland to deliver new patient-centred models of care.

• During the lifetime of this Parliament we will recruit up to 250 community link workers to work in GP surgeries, with at least 40 being recruited in the coming year.

• In the coming year we will continue our three year programme to recruit up to 140 full time equivalent additional pharmacists with advanced clinical skills training to work in general practice settings. By the end of this Parliament all GP practices will have access to a pharmacist with these skills.

• £10 million will be invested this year to implement the recommendations of the National Review of Primary Care Out-of-Hours Services.”

FAIRER SCOTLAND ACTION PLAN

Scottish Government has set aside actions that it feels are critical to improving “fairness” across Scotland: ending poverty for children, improving young people’s life chances, fairer working lives and then a thriving third age.

One of the pillars of the approach is to increasingly “listen to and involve service users at the design stage so that any new service ‘fits’ the needs of people as best it can. This point was made in particular about integrated health services, education and transport.”

Of all the Scottish Government activities, the two areas that were highlighted from health as meeting these needs were changes to primary care and a new mental health strategy.

Around primary care they highlighted the roll out of Community Link Workers and picked out an example of better joined up services to address inequalities through an example related to the complex needs of homelessness: And we will strengthen links between homelessness services and health services, including mental health and primary care services, so that the effects of homelessness on health are better understood and addressed and so that those facing homelessness combined with multiple exclusion get joined up support.”
COMMUNITY LINKS WORKERS

The inclusion of 250 new Community Links Workers by Scottish Government in the 2016/17 Programme for Government and 2016 Fairer Scotland Action Plan reflects a growing enthusiasm for this particular model of additional support within primary care. Community Link Workers or Link Workers can help the bridge between GPs and the Community, including local service and community groups. This link can help support non-clinical needs (e.g. debt or work), improve external referrals and link within the community to preventative support (e.g. healthy living activities). Many GPs report that “it is impossible to keep up to date with all that the third sector could provide”, so Link Workers assist when they are interested in referring people to wider support.

There are already a number of active examples of Link Workers across the country, indeed Community Renewal is one of Scotland’s biggest employers of Link Workers and has used the model for over ten years. Other examples include the Glasgow Links Worker Programme, Dundee Equally Well, and the EVOC pilot in Edinburgh.

It is important to note that Modernising Primary Care (MPC), including the role of Community Renewal in MPC, is far wider in scope than can be addressed by Links Workers. Throughout the work, the small but critical potential role that Link Workers can fulfil in supporting primary care has been considered at each step but as one aspect of a gradual bigger transformation in primary care sought under MPC.

Community Renewal describe three types of Link Workers:

- **Bronze** - a intermediary well connected to community services who links GPs to those services as part of social prescribing.

- **Silver** - an intermediary to a GP Practice who listens, assesses and makes introductions through a flexible, open ended relationship to address any non-clinical support.

- **Gold** - a worker within an open, flexible GP Practice well connected to community services which listens, assesses and makes introductions through an open ended relationship to address any non-clinical support desired.

REALISTIC MEDICINE

The Chief Medical Officer Catherine Calderwood has introduced new terminology and a new focus across healthcare and social care in Scotland in coining the term ‘realistic medicine’. She is seeking to address the issue of ‘over reach’ by doctors who ‘over treat’ their patients, preferring a collaborative and de-medicalised approach. At the heart of this approach is having genuine discussion and shared decision-making with patients engaged in “Care and Support Planning Conversations”. The Chief Medical Officer is emphasising an approach that seeks to reduce harm and waste across the spectrum of medicine and care, with a more consistent personalised approach improving outcomes.

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28 Carr Gomm (2016) An Intermediary Service for Primary Care in Edinburgh
29 Scottish Government and Chief Medical Officer (2014) Realistic Medicine