



MAKING the **CONNECTIONS**

DEVELOPING BEST PRACTICE INTO COMMON PRACTICE

Report from the Primary Care Modernisation Group

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Summary of Recommendations

The Primary Care Modernisation Group (PCMG) identified improving access, chronic disease management and mental health problems in the initial priorities to be addressed, together with a range of organisational support issues. Listed below is a summary of the recommendations of the PCMG; these are discussed in more detail in the main part of the report.

Improving Access to Primary Care Services

- Overall access to primary care services in each locality should be systematically audited and action plans developed to move towards the target of accessing a relevant member of the primary care team within 48 hours. In doing so, the specific needs of particular disadvantaged groups should be addressed;
- as part of local property strategies, an audit of primary care premises in each locality should be undertaken, identifying suitability for current and future use, including the standard of accommodation and location. This audit should cover the whole of primary care including dental, optical, pharmaceutical, and professions allied to medicine (PAM) services;
- the broader local community needs, as demonstrated through the community planning process, and the outcome of the premises audit should be used to develop a premises strategy which makes the most effective use of existing facilities and the various sources of funding available for primary and community care developments;
- to help people have access to the right member of primary care staff to meet their needs, there should be locally planned programmes which could include:
 - telephone triage systems
 - development and more effective use of the skills of all primary care staff
 - direct access to the full range of primary care staff
 - local protocols for inter-disciplinary referrals within primary care
 - information to local people about how to access and make the best use of services
 - use of NHS24

Service redesign approaches should be supported which:

- improve access to primary care (in particular, the Primary Care Collaborative approach should be adapted for, and tested out, in Scotland)
- improve referrals to, and discharges from, secondary care (this needs to include direct access from a wider range of primary care staff and be supported by improved information and communication technology).

Inappropriate use of clinical time should be tackled:

- locally by better use of support staff (clerical and technical)
- nationally by getting rid of unnecessary paperwork (e.g. form filling of various kinds).

Chronic Disease Management

To ensure high quality care and effective utilisation of the skills of the full range of staff (GPs, nurses, pharmacists, PAMs, etc.) there should be:

- a locally supported, systematic approach at LHCC level to
 - identify local needs
 - agree the contribution which each profession can make towards meeting those needs
 - use the nationally agreed standards and guidelines to agree the structure, process and organisation of care
 - monitor and review of the outcome of services delivered
 - ensure appropriate training, development, support and supervision to safely deliver services
 - a process for involving primary and secondary care professionals in designing services which are resourced to have an increasing focus within primary care.

Managing Mild to Moderate Mental Health Problems

- NHS Boards together with LHCCs and other local providers of mental health services should develop proposals to utilise the specific resources available to promote mental health and wellbeing;
- PCTs should support LHCCs in developing processes and structures to deliver national and local standards in mental health in primary care;
- to support integrated care, PCTs should strengthen the relationship between primary care services and specialist mental health services, with Community Mental Health Teams clearly focused at LHCC/locality level;
- in order to improve access to a full range of services, NHS Boards should support LHCC participation in the development of multi-agency, high quality, locally-based mental health services.

Organisational Support

LHCC Development

- NHS Boards should review with PCTs and LHCCs the organisational support needed for LHCCs to assume the growing responsibilities within the NHS and in partnership working. This should include developing and supporting the leadership needed within LHCCs;
- within NHS Board-wide plans, clear objectives should be agreed with each LHCC and performance monitored against these. This framework should clarify LHCCs' responsibilities and accountability for the services managed or delivered together with responsibilities in relation to joint planning of services with secondary care and local authorities;
- LHCCs should support the development of health and social care “co-operatives”, moving partnership working from pilots and projects to mainstream community care;
- NHS Boards should work with local authorities to develop joint plans to support staff and organisational development which will underpin joint service development at locality level.

Workforce

- The new Special Health Board for NHS Education in Scotland should ensure that there is an appropriate emphasis on the needs of primary care and on multidisciplinary working and learning;
- local HR Departments should actively support primary care, including independent contractor employers, in the recruitment and retention of staff, including family-friendly, flexible employment opportunities;
- within NHS Boards each area should develop local policies to ensure that all staff receive equal opportunities to access training and development, and that this supports both individual and team learning.

Service Redesign

- In order to provide integrated care for patients, it must be a core responsibility of NHS Boards to establish local mechanisms which bring together LHCCs and the specialist sector to develop strong collaborative arrangements to tackle issues of joint interest.

Premises

- The specific needs of primary and community care are recognised in the national and local premises investment plans;
- SEHD should review the funding arrangements for the provision of pharmacy and dental premises;
- with the involvement of the local community in the planning process, NHS Boards and LHCCs should investigate all possible partnership opportunities for funding where upgrading or new premises are required;
- SEHD should act as a resource to facilitate sharing of good practice in this area of service development.

IM & T

- As part of local IM & T strategies, NHS Boards should include all sectors of primary care in order to support electronic clinical communications within primary care and with other parts of the NHS and local authorities;
- relevant information is made available to primary care staff about those aspects of the national and local IM & T strategies which will impact on their work;
- to make the best use of the technology, NHS Boards should make available appropriate training and development support to all staff;
- clinical staff working from the same location should be encouraged to share technology as far as is practical.

Chapter 1

Background:

In June 2001, the Minister for Health and Community Care announced a “contract for change” with primary care in Scotland. This included:

- (a) a positive response to the report of the LHCC Best Practice Group “Connecting Communities with the NHS”. The policy paper *LHCC Development: The Next Steps* was published in July and set out how the new NHS Boards were expected to support and develop LHCCs in ways which empowered those in the frontline to plan and deliver services. LHCCs were to be given a voice in the strategic planning of change, with a formal advisory role. This greater responsibility was to be balanced with clearer and more robust accountability for resources and service improvement.
- (b) additional investment to strengthen the core capacity of LHCC-based primary care. In August 2001, a £30m investment package over three years was announced, with a requirement that the money should be spent in agreement with and through LHCCs. The funding was to be targeted at:
 - tackling access issues, e.g. by making access to the primary care team more flexible and quicker at meeting the needs of those who face barriers in accessing primary care;
 - developing and improving chronic disease management, delivering these services wherever possible in the community and achieving more effective partnerships with secondary care;
 - supporting improvements to services for children, older people, and other community care groups (e.g. those with mental health problems), with an emphasis on improving joint working;
 - tackling inequalities which exist in health and in the provision of health care services.
- (c) The establishment of a high level Primary Care Modernisation Group to drive the agenda for change.

The Primary Care Modernisation Group (PCMG) was established in August 2001 with a remit to:

- develop a coherent framework for primary care modernisation encompassing current developments and initiatives;
- develop a timetable for priorities for action over the next three years to deliver key aspects of primary care modernisation;
- advise on mechanisms for delivering the agreed change and developments taking account of the enhanced role of LHCCs.

The membership of the Group is shown in Appendix A.

Process:

The aim has been to develop a framework and action plan that reflect the requirements of patients and the public, staff and partner organisations.

In addition to seeking written input from a wide range of stakeholders across Scotland, meetings were held in Inverness, Glasgow and Dunfermline to discuss current issues, including aspects of the service which could be improved upon, and future priorities. It was clear that, for many staff, there are frustrations and irritations in the current system and current ways of working which prevent staff offering the best service to patients. It was equally clear that in many areas people have devised ways of tackling these concerns and making the system work better for patients. A summary of relevant “frustrations and irritations” is included at the beginning of each chapter, to reflect what the PCMG heard and what it has tried (at least in part) to address in the report and recommendations.

From the outset the PCMG was keen not to reinvent the wheel, but rather refer to evidence-based practice and standards, existing policies and strategies (e.g. for dental services, pharmaceutical care) and practical examples already happening in specific parts of Scotland. The PCMG wanted to highlight examples of what was already happening in parts of Scotland and which have been included in the report as “best practice”. There are, of course, many other examples but the key issue is making that “best practice” wherever it happens common practice across Scotland.

While reference is made in this report to current organisational arrangements, the PCMG is aware that work is being commissioned which may affect, in due course, the configuration of NHS organisations within NHSScotland. It is assumed that LHCCs will continue to play a key role in the future, and will need the support of whatever structures are in place to help deliver many of the recommendations.

Vision:

People live in communities, primary care has its roots in the community. People want to be supported to help stay well and if ill, cared for in, or near, their home.

Primary care is first contact, continuous, comprehensive and co-ordinated care to individuals and communities. If it can be done in primary care then it should be done in primary care. To help make this a reality, the ongoing development of primary care needs to be supported so that best practice becomes common practice across Scotland.

Primary care is central to the NHS and works in partnership with all other parts of the NHS and other agencies (particularly local authorities). It is uniquely placed to influence

and promote system-wide seamless care. It has enormous strengths on which to build in providing convenient, accessible and high quality care to people in their own communities. Primary care can and should:

- Focus on the individual and communities – ensuring a people-centred, enabling approach to health and healthcare;
- focus on improving health, and preventive care services for local people;
- provide comprehensive care;
- be based on partnership within and beyond the health and social care services;
- respect and value those who provide services;
- adopt a locality-based approach to needs assessment and service delivery;
- have a strong input from local people and communities;
- have clear, simple lines of accountability.

While much of the detail of this report concerns activity, capacity and support within primary care, it is essential that this is seen as a component of a well-connected overall NHS and social care system. Divisions between different parts of the system need to be tackled to produce a cohesive and integrated approach. NHS Boards have that overall responsibility and thus are uniquely placed to ensure implementation of the recommendations in this report.

Strategy for Primary Care Services

Our National Health provides a clear direction on the national priorities for health and health care. The PCMG recognised that it had to focus on a small number of priorities for primary care if real progress is to be made. For the reasons outlined later in this chapter the PCMG identified the initial priorities as:

- Improving Access to Primary Care Services;
- Meeting Specific Needs – Chronic Disease Management

Managing Mild to Moderate Mental Health Problems in
Primary Care.

The PCMG recognises that there is also a need to focus on promoting health and wellbeing and preventing ill-health, and would wish to tackle this in the next stage of its work. This would encompass activities undertaken with other agencies and local communities as well as the direct preventive services provided within primary care.

The PCMG also recognised that, in order to tackle the initial priorities, it was essential to look at the organisational support needed. This is done in the second half of the report. In particular, the PCMG is aware that, to enable LHCCs to truly influence changes in the health services and health status of their local communities as outlined in the “contract for change”, the devolved responsibilities and accountabilities and the capacity of LHCCs require to be enhanced. Organisational support also includes:

- workforce issues;
- redesign;
- premises;
- information management and technology.

Providing Services in the 21st Century:

Primary care (in common with other parts of the health and social care system) faces a range of challenges including:

- Demographic changes: 1998 population based projections suggest that by 2021 Scotland’s population will fall from 5.12 million (estimated as at June 2000) to 5.06 million, with a 15% fall in children aged under 15 and a 30% rise in the number of people aged over 75. Adding Life to Years (2001) noted that 81% of all coronary heart disease deaths occur in people aged 65 and over.

Tomorrow’s patient: The generation of older people who are alive in 20 years’ time will have lived very different lives to those of their parents. On a positive side, they are less likely to smoke, will have had access to health care throughout their lives thanks to the NHS and will be on average better off. On the negative side, they are more likely to be obese, have led sedentary lifestyles and lived in a society with greater income inequality.

(Wanless Review – 2001)

- Geographical and sociological variations across Scotland: Scottish mortality rates remain high relative to the rest of the UK. *Health in Scotland 2000* (2001) identified the clear association between deprivation and most cancers; there is a clear gradient of increasing incidence and mortality from coronary heart disease with increasing deprivation and the prevalence of common mental health disorders is significantly influenced by socio-economic factors. In addition to these “health variations”, there are major differences in the way in which services are and can be provided in different parts of Scotland – from the large urban settings to the remote and rural areas.

- **Increasing Incidence of Chronic Disease:** In the 21st century there are many aspects of the healthcare system in Scotland which are greatly influenced by acute disease while chronic disease has become the principal medical problem.
 - 30% of households contain at least one person with a long-standing limiting illness, health problem or disability
 - 20% of adults registered with a doctor visited their GP on 3-5 occasions in the last year, 13% visited more than 10 times.
- **Technology and medical advance:** Technology is one of the most important drivers of health spending and of changes in the way in which services are delivered. The advances in human genetics and the genome project will lead to a greater understanding of diseases and lead to significant advances in their treatment and prevention. Developments in technologies such as miniaturisation and electronic communications will shift certain diagnosis and treatment from hospitals to primary care.
- **The expectations of the public and patients:** The evidence behind *Our National Health* confirmed that people want to be more involved in decisions about their treatment and care. They want more information and to feel valued and enabled throughout their journey of care.

In the future the public will expect:

- a universal and fair service that contributes to social solidarity;
- fast access “waiting, but only within reason”;
- an integrated, joined-up system;
- comfortable accommodation;
- services that are designed around patients’ individual needs.

(*Wanless Review – 2001*)

Impact on NHSScotland

The changing profile of the population will not only have consequences in terms of the community to be served, but also how services are delivered and those available to work in NHSScotland. NHSScotland as a whole will need to consider new and innovative models of service delivery. The emphasis on improving access to services – at the outset and throughout the patient’s journey of care – means looking again at the traditional boundaries between the various health professionals, and using the development of services, such as NHS 24, to redesign how the public access and make the best use of primary care. The use of smarter technology, including information technology, will help to support the provision of seamless care within primary care and across the NHS. The correlation between deprivation and health status and the increasing demands on primary care reinforces the need to work in partnership with patients, carers and other agencies.

Improving Access to Primary Care Services

Frustrations and Irritations

Poor communication systems cause confusion for patients; need better information for staff and patients on “out of hours services”; too many referrals need to go through a GP for primary care, secondary care and social care services and equipment; primary care practitioners need better access to diagnostic services and rehabilitation; inappropriate triage by non-clinical staff in GP surgeries; increasing waiting times for, and cancellations of, hospital out-patient clinics creates additional workload for primary care.

The Scottish Consumer Council Report “Access to Primary Care Services in Scotland” (2001) demonstrates that this is a key issue for people. It does not matter how good a service is if those who need it are unable to access it. Access can be limited in a variety of ways – this may be related to where services are provided, how they are provided or when they are provided. But in promoting easier access to services, there are tensions which must be recognised. People value the length of time that they have with a GP or other primary care professional, and it is important that ready access and quality time is afforded first to those who need it most. In addition, those working in primary care can be frustrated when having seen people quickly, it is difficult for those patients to access secondary care.

Achieving Better, Fairer Access to Services

The PCMG, in focusing its main attention on primary care, recognises that, despite the efforts of many hard-pressed staff, access to primary care services is poorer in many of the most disadvantaged communities (*Poverty & Social Exclusion in Rural Scotland, 2000 and SCC Report*). Improved access, together with improved prevention and earlier intervention in health problems, is central to ensuring that primary care makes an optimal contribution to reducing health inequalities (*Fair for All: Working Together Towards Culturally-Competent Services, 2002*). Significant groups in the population who can be disadvantaged in seeking access to primary care services include homeless people, travelling people, people from ethnic and other minority groups. Chapter 3 seeks to address the difficulties experienced by individuals with mental health problems.

It is vital that individuals, including those with physical disabilities and other impairments, can gain access to the premises. While there has been a valuable programme of investment in upgrading and replacement of primary care premises, there is a recognition that more needs to be done, not least because of the importance of meeting the requirements of the Disability Discrimination Act 1995.

Access to Information and the Right Member of Staff

The public need ready access to information on health and how to access health services. In some parts of the country interpreting and translation services are being introduced to assist individuals with communication difficulties. The introduction of NHS 24 in 2002 will provide another way for the public to obtain information as well as providing opportunities to redesign the public's first point of contact with primary care.

Alongside the provision of information and support – encouraging individuals to take a more active role in managing their health – a challenge for NHSScotland is to reassure the public that “when you are unwell you don't always need to see a doctor”. In *Our National Health* the Government made a commitment to work with the professions to enable the public to access an appropriate member of the primary care team in no more than 48 hours. This reinforces the point that primary care is a team effort – with a range of complementary skills and roles, so that the right team member can provide the initial clinical assessment and onward access, where appropriate, to another professional.

Increased Flexibility

The development of the extended primary care team over recent years has provided an opportunity to utilise the skills of all disciplines more effectively – e.g. nurses providing chronic disease management and triage services, community pharmacists providing advice on health and treating common ailments. The traditional role of the GP as the gatekeeper into much of the rest of primary care and specialist services is changing. There will need to be changes in the system, together with a change of culture – both for professionals and the public – if the opportunities available are to be fully exploited, for example:

- There are over 1,150 community pharmacies in Scotland visited by one in ten of the population every day. Despite positive developments in recent years, community pharmacy still has significant untapped potential to expand its involvement in improving people's health and health care.
- Direct access by patients to physiotherapy can lead to a reduction in tertiary referrals, number and cost of prescriptions, number of X-rays carried out, in waiting times, and in the number of patients who fail to attend. Physiotherapists provide injection therapy as part of pain management, reducing unnecessary consultations with GPs.
- Nurse triage services in general practice, working within agreed protocols, provide an opportunity for speedy telephone advice or access to the appropriate member of the primary care team.

- Community optometrists are involved in co-managed care of individuals with diabetes and glaucoma and, by working closely with other members of the primary care team, this can reduce unnecessary referrals to secondary care.
- Multidisciplinary and multi-agency Rapid Response teams/Hospital at Home teams prevent admissions to hospital through fast intervention and rehabilitation in the home environment.

The PCMG believes that direct access by patients to the relevant primary care professional and from that professional direct to others in primary care and secondary care (when needed) is appropriate and all clinical staff should have ready access to relevant diagnostic facilities. The constraints which some perceive often turn out not to be real in practice.

For the small percentage (some 10%) of patients who present to primary care who require onward referral to secondary care, improving the referral and discharge systems and communications between primary care and secondary care is essential for better co-ordination of patient care.

Reducing Waiting Times and Improving the Patient's Journey

Evidence suggests (*Wanless Review – 2001*) that patient expectations are, and will be, for longer consultations with a GP or other health professional. Service redesign, new technologies, greater flexibility in roles and responsibilities of different staff groups and tackling bureaucracy can all create scope to increase the proportion of time health care professionals spend with patients. Better informed patients who take more responsibility for their health and care will change the nature of the relationship between patient and professional. There need to be well resourced approaches to helping LHCCs and primary care teams tackle these challenges, and the PCMG has noted the initial positive outcomes from the Primary Care Collaborative methodology developed in England.

Some new resources have already been invested. In September 2001 £30m over three years was allocated to develop primary care, through LHCCs. Across the country, LHCCs have allocated some of this funding to specific aspects of service access, as well as supporting and developing a range of clinical services in primary care. It is important that the opportunity is taken to make the most effective use of all the funding available – for premises improvements, IM & T, Health Improvement Fund, etc.

In the wider agenda of joint resourcing and joint management, LHCCs have a major role to play in helping to design services which make better use of skills and resources across the whole health/social care spectrum.

Developing Best Practice into Common Practice:

A “model pharmacy” has been developed in Possilpark, Glasgow providing a resource centre where other staff can work – complementing the core pharmaceutical services normally available. The local community can access a range of services from one convenient location.

The PCMG believes that the following actions should be largely focused at LHCC level, although it recognises that (depending on local circumstances) they will need varying levels of support from NHS Boards and PCTs to help them deliver: **It recommends that:**

- **overall access to primary care services in each locality should be systematically audited and action plans developed to move towards the target of accessing a relevant member of the primary care team within 48 hours. In doing so, the specific needs of particular disadvantaged groups should be addressed;**
- **as part of local property strategies, an audit of primary care premises in each locality should be undertaken, identifying suitability for current and future use, including the standard of accommodation and location. This audit should cover the whole of primary care including dental, optical, pharmaceutical, and professions allied to medicine (PAM) services;**
- **the broader local community needs, as demonstrated through the community planning process, and the outcome of the premises audit should be used to develop a premises strategy which makes the most effective use of existing facilities and the various sources of funding available for primary and community care developments.**
- **To help people have access to the right member of primary care staff to meet their needs, there should be locally planned programmes, underpinned by relevant training, which could include:**
 - **telephone triage systems**
 - **development and more effective use of the skills of all primary care staff**
 - **direct access to the full range of primary care staff**
 - **local protocols for inter-disciplinary referrals within primary care**
 - **information to local people about how to access and make the best use of services**
 - **use of NHS 24.**

- **Service redesign approaches should be supported which:**
 - **improve access to primary care (in particular, the Primary Care Collaborative approach should be adapted for, and tested out, in Scotland)**
 - **improve referrals to, and discharges from, secondary care (this needs to include direct access from a wider range of primary care staff and be supported by improved information and communication technology).**

- **Inappropriate use of clinical time should be tackled:**
 - **locally – by better use of support staff (clerical and technical)**
 - **nationally – by getting rid of unnecessary paperwork (e.g. form filling of various kinds).**

Meeting Specific Needs:

Chronic Disease Management:

Frustrations and Irritations

Need to extend role of GPs in pre-referral investigation; patients receiving secondary care and primary care at the same time with no co-ordination; inefficient and delayed communication from secondary care on (patient) discharge, including medication and follow-up; too many GP appointments used by patients for repeat prescriptions – need to review the role of community pharmacists; need to be innovative on public health message; need payment system for all independent contractors with the emphasis on health; need to invest in the future.

As demonstrated earlier, chronic disease is one of the major issues facing primary care in the 21st century. One of the strengths of primary care is its ability to provide a generic and holistic approach to care. This is particularly important in the management of chronic diseases as patients frequently present with multiple pathologies. A multifaceted approach to care is essential.

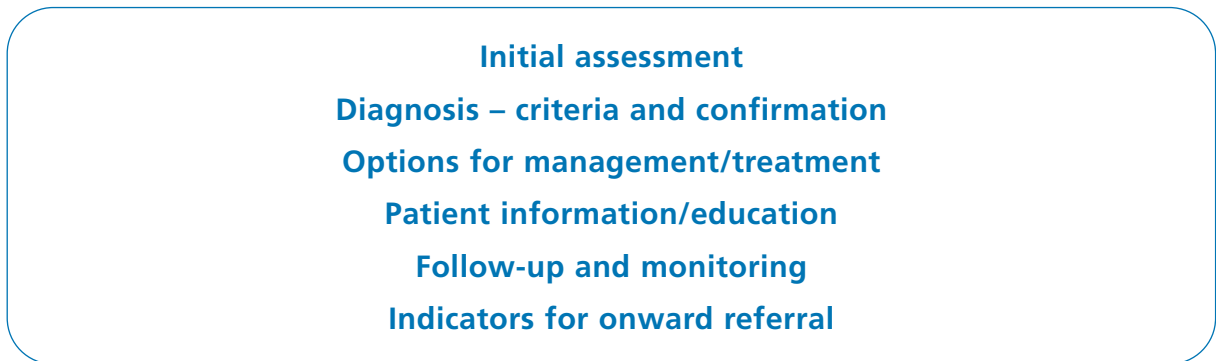
Effective Service Delivery

The key elements of effective chronic disease management comprise:

Prevention	Motivating individuals to think about and change their lifestyles – particularly in relation to diet, exercise and other health behaviours through public health interventions;
Information	For the public – which is easily accessible, understandable and up to date;
Partnership working	With patients – motivating and supporting individuals to take responsibility for managing aspects of their condition – lifestyle changes and concordance to drug protocols, etc.; With team members – health and social care systems, including treatment, joint training and development;
Clinical standards	Developing care pathways and protocols, with a holistic approach to care;
Assessment of clinical performance	Robust information systems, audit, appraisal, accreditation systems;
Support and development	Education and training (with protected time), organisational development.

Process of Care

The key elements of the process of care comprise:



The increasing incidence and range of chronic illnesses (including CHD, diabetes, asthma, epilepsy, mental illness, dental caries, etc.) is placing significant pressure upon the capacity of primary care to achieve models of “Best Practice” – such as the Scottish Diabetes Framework, the Clinical Standards Board for Scotland standards for the care of patients with schizophrenia and coronary heart disease and the CHD Taskforce Framework.

Primary care is the right place to focus the management of chronic disease, with referral on to specialist services only when appropriate and needed. But that requires staff with the right skills and support in primary care, thus seeking to reduce the demand on secondary care. This in turn requires secondary care to support the development of the capacity in primary care. NHS Boards need to ensure that local redesign programmes include both primary and secondary care perspectives.

A Partnership Approach to Care

The extent to which individuals are willing to take personal responsibility for their health may have a significant impact on health outcomes. A high percentage of chronic diseases are attributable to lifestyle (Davis *et al*, 1999). Prevention is therefore a major challenge for service providers and the public, and pharmacological developments may increasingly be focused on the treatment of risk rather than disease (in the way that statins have developed in recent years for treatment of risk in CHD).

The key to effective management is understanding the different trends in the illness patterns and their pace. A partnership between patients, clinicians and, where appropriate, carers is essential because:

- in developing good practice, patients should be partners in their own care;
- health care can be delivered more effectively and efficiently if patients are full partners in the process;

- carers require support both in adapting to their new role and also in understanding the patient's illness.

Collaboration between LHCCs and the acute sector will be necessary in developing disease management tools, jointly managing both the change in referrals and follow-up clinics, the information flow necessary for performance management, the expectations of patients and the public and the support required from secondary care to an expanded primary care capability and capacity. It will be necessary to develop liaison, planning and organisational development support at a variety of levels within the respective organisations.

Models of Care

In order to meet the differing clinical needs and individual circumstances of patients a range of models of care have been developed.

- Self management – self-management programmes can be designed to reduce the severity of symptoms and improve confidence, resourcefulness and self-efficacy. Education and training that addresses continuous use of medication, behaviour change, pain control, coping with emotional reactions and learning to interpret changes in the disease and its consequences enables patients to become key decision-makers in the treatment process. An important element is learning from others; supporting growth in confidence and the ability to cope with the disease (*The Expert Patient* DoH, 2001).
- Group/community fora – an extension of self management, where groups of patients and appropriate members of the primary care team meet. This experience can increase the quality of life; it demonstrates much lower decline in activities of daily living, reducing dependency on health services by accessing community and voluntary organisations able to meet the needs of individuals.
- Remote clinical management – for patients requiring greater support than provided in the models above. NHS 24 will provide an opportunity for people to talk directly to highly qualified and experienced nurse advisors, complementing the local health systems. The continuing development of telemedicine will provide particular benefits for individuals living in remote and rural areas.
- Direct Clinical Management – locally provided diagnosis, prognosis and treatment options.
- Managed Clinical Networks – the expertise available in all sectors working across traditional boundaries in primary, secondary, tertiary care and sectors outwith NHSScotland, ensuring a co-ordinated approach to care.
- Shared Care – co-ordinated care provided by primary care and secondary care. The balance of care provided by primary and secondary care is dependant on the patient's clinical needs.

There are many examples of good practice across Scotland in the management of chronic diseases within primary care, with high quality structured care in which:

- local needs are identified at micro (patient) level and macro (LHCC) level – identifying patients “at risk” and informing public health planning;
- patients perceive they are involved in decisions regarding their care;
- there is an improved quality of life for patients; ensuring chronic illness is appropriately treated and monitored;
- there is accessible information, readily available in a range of public places including libraries, community schools, GP surgeries, pharmacies, social work and housing offices;
- national standards are delivered with:
 - practices having working protocols for assessment, diagnosis, treatment and onward referral
 - comprehensive, easily accessible patient records
 - development of registers and review/recall systems
- integration of service delivery within primary care and between primary care and secondary care and other agencies, ensures continuity of care and teamwork;
- there is ready access to training and availability of equipment for specific GPs and other members of the primary care sector with a special interest in chronic disease management;
- performance management systems are in place to support clinical governance, providing opportunities for continuous learning and development.

Developing Best Practice into Common Practice:

Dumfries and Galloway CHD: The Coronary Heart Disease Task Force has developed a Managed Clinical Network, providing care pathways for all health professionals identifying what is required at each stage of a patient’s care, ensuring a uniform approach across the region. The project is developing a patient-held record for cardiac disease – designed to facilitate continuity of care between primary care and secondary care and increase patient involvement in their own care.

The PCMG recommends that, to ensure high quality care and effective utilisation of the skills of the full range of staff (GPs, nurses, pharmacists, PAMs, etc.) there should be:

- a locally supported, systematic approach at LHCC level to:
 - identifying local needs
 - agreeing the contribution which each profession can make towards meeting those needs
 - monitoring and review of the outcome of services delivered
 - using the nationally agreed standards and guidelines to agree the structure, process and organisation of care
 - ensuring appropriate training, development, support and supervision to safely deliver services
 - a process for involving primary and secondary care professionals in designing services which are resourced to have an increasing focus within primary care.

Meeting Specific Needs:

Managing Mild to Moderate Mental Health Problems in Primary Care

Frustrations and Irritations

Need to develop inter-agency referral systems; need to integrate service delivery bringing local agencies together; need to extend the community service beyond 9-5.

Mental Health is one of the three clinical priorities for NHSScotland. The majority of mental health problems are treated in primary care, and indeed constitute one of the most frequent reasons for visits to GPs – 300 consultations for mental health problems for every 1,000 people in a general practice during a year. (CMR July 2001)

Developments to Date

Despite the impetus of the Framework for Mental Health Services in Scotland (1997), the work of Scottish Health Advisory Service and the Mental Welfare Commission, the development of clinical standards for patients with schizophrenia (CSBS 2000) and other initiatives to improve the care of individuals living in the community with mental health problems, there is still significant variation in service provision across Scotland. To date many community developments have been particularly targeted at those with severe and enduring mental health problems. A parallel agenda is now required in primary care to address the needs of individuals with mild to moderate mental health problems. There is a need to build on good practice in evidence in some parts of the

country with developments including practice attachment of mental health workers, dedicated primary and mental health care teams and CPN services targeted at the primary care mental health population. In addition, a number of developments have set out to build clearer links between primary care and social care services including the voluntary sector employment and volunteering services.

Deficiencies and impediments to effective service delivery in some areas requiring to be addressed include:

- people having better access to information to help support self-management of their illness or how to access available services;
- tackling the continuing stigma of mental illness among sections of the public;
- better co-ordination between primary care teams, mental health teams and specialist services;
- better integration and co-ordination of health, local authority and voluntary sector services;
- improving the consistency in the services provided;
- better support and training for primary care teams in diagnosis and treatment of mental health problems.

Effective Service Delivery

Our National Health explicitly acknowledged “poor mental health can come at any time and affect anyone”. People want effective mental health services that make a difference by improving the speed, responsiveness and quality of care. Severe and enduring mental illness is only the tip of the iceberg. Anxiety and depression contribute to much wider community health problems which need the support of extended mental health services in primary care settings.

The outcome of less severe mental health problems could be improved if recognised and dealt with by a multi-faceted approach at an earlier stage. Evidence suggests (Mental Health Reference Group, 2001) a correlation between higher incidence of mental illness and social exclusion – e.g. poor housing and low employment opportunities leading to a lack of motivation and self-worth. Addressing issues leading to social exclusion may prevent recent onset mild and moderate depression becoming chronic. Interventions include a range of psychological and pharmaceutical treatments and patients with chaotic lifestyles require support with compliance.

The main focus in primary care is on individuals with mild to moderate mental health problems, and they can experience particular difficulties in gaining access to services and then in receiving a consistent standard of service. There is further work to be done to consider the implications for the roles and functions of primary care workers in

enabling and supporting self help and self management among individuals and patient groups.

The provision of services needs to be designed locally to:

- Encourage and support lifestyle changes.
- Give information and support to patients, carers and communities.
- Promote a change of public attitudes regarding mental illness.
- Improve the quality and consistency of services provided to patients and carers.
- Ensure that integrated services are provided within primary care and between primary care and secondary care.

The characteristics of high quality community-based mental health services include: (*Framework for Mental Health Services in Scotland; Mental Health Reference Group.*)

- Development of multi-disciplinary and multi-agency teams – services provided by NHS and local authorities, voluntary organisations and self help groups.
- Review of continuing appropriateness of treatment – pharmaceutical and psychological.
- Multi-disciplinary/multi-agency care planning for patients with chronic mental illness (modelled on Care Programme Approach and CSBS standards for schizophrenia).
- Regular training programmes on “frequently met issues” for members of the primary care team.
- Managing crisis in the community, hence avoiding hospital admissions.
- Reduction in waiting times for psychological and psychiatric services.
- NHS Boards and Local Authorities supporting “accredited” voluntary organisations within their area.

Developing Best Practice into Common Practice:

Greater Glasgow: Having identified that less severe, common mental illnesses form the single biggest reason for patients presenting to the primary care team, the PCT and Health Board have developed a framework for the development of primary care mental health services, provided by a range of agencies and co-ordinated through LHCCs.

The PCMG recommends that:

- **NHS Boards, together with LHCCs and other local providers of mental health services, should develop proposals to utilise the specific resources available to promote mental health and wellbeing**
- **PCTs should support LHCCs in developing processes and structures to deliver national and local standards in mental health in primary care**
- **to support integrated care, PCTs should strengthen the relationship between primary care services and specialist mental health services, with Community Mental Health Teams clearly focused at LHCC/locality level**
- **in order to improve access to a full range of services, NHS Boards should support LHCC participation in the development of multi-agency, high quality, locally-based mental health services.**

Organisational Support

As indicated in Chapter 1, if primary care is to tackle these priorities effectively, it needs to have the capacity and organisational support. The development of LHCCs is a vital component in this, but equally important are:

Workforce issues

Service redesign

Premises

Information management and technology

and the PCMG recommendations on each of the above are discussed in this chapter of the report.

Partnerships

The organisational support which primary care (particularly LHCCs) requires in order to deliver the recommendations in this report need to take account of the changing and developing needs in the community and these require to be seen in the broader context of partnership working.

The “Joint Future” (2000) agenda, is perhaps the most challenging aspect of partnership working. While there are already examples of joint management and resourcing of health and social care for mental health, older people’s and learning disabilities services, the introduction of such arrangements means new ways of working for many staff and the need for support during the change.

Community planning is now the vehicle through which local planning is co-ordinated by local authorities, and LHCCs have a key role to play in ensuring that the health input reflects the local needs which they have identified.

LHCC Development

Frustrations and Irritations

Need to have more devolved power: decision-making, planning, service delivery and resource allocation; involving the local community in planning services has raised expectations about what the LHCC can deliver; LHCCs need to agree priorities with local authority if they are to be portrayed as multi-agency; local responsibility will allow local solutions.

The PCMG is very conscious that LHCCs are being invited to take on an enhanced role both within the local health care system, and in the developing partnership arrangements. The PCMG recognises that organisational development support will be required to help deliver this challenging agenda.

At the outset, structures and responsibilities for LHCCs were intentionally not prescribed, encouraging local ownership and commitment. During the last two years many LHCCs have evolved into multi-professional, and in some cases, multi-agency organisations. Some have active community involvement. However, the PCMG recognises that the lack of standards presents difficulties around responsibility and accountability. In order to fulfil their role in the future NHSScotland (whatever its final shape) LHCCs must be able to demonstrate consistent and coherent standards and added value (as detailed in “Connecting Communities with the NHS”). In taking forward the good practice in evidence in some parts of the country, there is a need to support NHS professionals to develop their role within LHCCs. LHCCs need to demonstrate inclusiveness (by bringing together **all** who work in primary care settings as full members) and support all constituents in planning and priority setting, and delivering services within a culture of teamworking.

Accountability for LHCC Development

While the diversity in the development of LHCCs across Scotland has had its benefits, the PCMG believes that the relevant section of the performance assessment framework (PAF) on LHCC development provides an opportunity to measure more systematically the development of LHCCs as key players in the local NHS and joint systems.

The challenges for NHS Boards (while recognising that not all LHCCs can or need to do everything themselves) will be:

- to support LHCCs to improve the health status of the local community, through multidisciplinary and multi-agency partnership working;
- to develop the capacity and capabilities within LHCCs to manage an evolving organisation;
- to take action where LHCCs are not progressing the health agenda in their locality, as outlined in locally agreed objectives.

Key Roles within LHCCs

The role of the LHCC Lead and Manager will be crucial to the ongoing development of LHCCs. For many LHCC leads the position is undertaken on a part-time basis with competing pressures on their time. There is a diversity of role, reward and support available. The extent to which they believe the LHCC is genuinely in a position to make

change and be involved in strategic decisions within the local health system will influence their desire to remain in the position. Similarly, there are wide variations in the role, responsibility and reward for LHCC Managers.

Looking to the future, the PCMG suggests that NHS Boards should seek to identify clinicians in primary care with the potential to become LHCC leads and provide training and development opportunities.

Developing Best Practice into Common Practice:

Perth & Kinross – Care Together: Care Together has a budget of approximately £50m, with responsibility for the provision of a range of health and social care services. The organisational mechanism is set around locality-based teams. Care Together has invested time in the development of an organisational framework, including a human resources implementation plan, the development of financial and information systems.

The PCMG recommends that:

- NHS Boards should review with PCTs and LHCCs the organisational support needed for LHCCs to assume the growing responsibilities within the NHS and in partnership working. This should include developing and supporting the leadership needed within LHCCs
- within NHS Board-wide plans, clear objectives should be agreed with each LHCC and performance monitored against these. This framework should clarify LHCCs' responsibilities and accountability for the services managed or delivered together with responsibilities in relation to joint planning of services with secondary care and local authorities
- LHCCs should support the development of health and social care "co-operatives", moving partnership working from pilots and projects to mainstream community care
- NHS Boards should work with local authorities to develop joint plans to support staff and organisational development which will underpin joint service development at locality level.

Workforce

Frustrations and Irritations

Morale affected by too many changes, too quickly; staff at the “sharp end” need to be able to make decisions; need Scotland-wide agreement on current best practice on extended roles; need dedicated time for clinical staff to meet to discuss clinical patient issues; all staff need time for training.

Professional Roles and Responsibilities

While the increasing emphasis within primary care is on greater team working, each of the professions faces specific challenges in its contribution to the effectiveness and efficiency of service delivery, e.g.:

- GPs developing areas of special interest as well as retaining their generalist skills;
- the development of nurse “consultants”, nurse “practitioners” (and the need to define those terms), nurse prescribing (both independent and supplementary);
- pharmacists as first contact for NHS treatment of minor ailments and chronic disease management through repeat dispensing schemes and extensions of their prescribing role within GP practices and community pharmacy;
- primary care dental services being delivered by independent contractors, salaried GDPs and community dental staff with the need to ensure that their roles complement each other;
- dental therapists developing skills in oral hygiene and health education provided to patients and parents of children;
- increasing specialisation in some of the professions allied to medicine;
- generic health care support workers, supporting the specialist skills of health care professionals, reducing the number of health care staff each patient has contact with.

It is important that both the undergraduate and postgraduate education systems recognise and respond to the changing professional and service needs. In particular there is an opportunity for the new Special Health Board for NHS Education in Scotland to focus on both the individual and collective needs of the professions in primary care.

Recruitment and Retention

Primary care services face similar challenges to the rest of the NHS in recruiting and retaining staff, although there are greater problems in some remote and rural and deprived areas. RARARI is actively exploring possible solutions for the former, and incentives are also planned or being considered for specific professional groups. It is important that independent contractors (and the staff employed by them) are regarded as part of the wider “NHS family” and that recruitment and retention action plans (such as that being developed under “Facing the Future”) encompass all staff, not just those directly employed by the NHS.

Making Best Use of Skills

It is important to utilise the skills of existing staff to their full potential. This is already happening in specific professions and teams in primary care e.g.:

- nurses and pharmacists supporting the management of chronic diseases;
- professions complementary to dentistry (e.g. hygienists) playing an increasing role in oral health promotion and dental care;
- pharmacists undertaking medication reviews for individual patients as part of the Scottish Executive’s agenda for pharmaceutical care.

But there is more to be done in using technical and support staff to free up the time of more highly skilled professionals.

Developing the Team

While in most parts of Scotland, much has been done to support and develop the primary care team (GPs, practice nurses, community nurses, etc.), the challenge now is to build on that to encompass the wider team and ensure that all the professionals in primary care are seen as valued members. The development of the Public Health Practitioner posts in LHCCs has created an opportunity to co-ordinate activities focusing on promoting health and wellbeing, developing partnerships with other agencies and local communities. The Joint Future agenda, including, for example, the introduction of single-shared assessment of older people from April 2002, further demonstrates the need to extend the team beyond health and into social care and other community-based services. This will not happen without dedicated training and development support, and this needs to include, as equal participants, independent contractors and their staff, as well as direct NHS employees. With increasing emphasis on working in partnership with other agencies, local healthcare systems need to ensure that the resources available are utilised in the most effective way. The “best person” need not be a healthcare professional. For teams to work effectively, they also need the right premises to work from, the information (and information technology) which supports effective communication, and the management and clerical support which allows clinical staff to concentrate on their core activities.

Developing Best Practice into Common Practice:

The introduction of model schemes for pharmaceutical care has provided an opportunity for community pharmacists to complement existing services in primary care and recognise the specific skills of community pharmacists in improving care in the community. Model schemes developed to date include patients requiring palliative care, patients with severe and enduring mental illness and support to frail, elderly patients living at home.

The PCMG recommends that:

- **the new Special Health Board for NHS Education in Scotland should ensure that there is an appropriate emphasis on the needs of primary care and on multidisciplinary working and learning**
- **local HR Departments should actively support primary care, including independent contractor employers, in the recruitment and retention of staff, including family-friendly, flexible employment opportunities**
- **within NHS Boards each area should develop local policies to ensure that all staff receive equal opportunities to access training and development, and that this supports both individual and team learning.**

Supporting Service Provision

Quality

An overall framework is needed to support development, accountability and continuous improvement. This should support the growing clinical governance agenda (with an increasingly multi-professional focus) and be underpinned by research (using for example, the resources of the Scottish School of Primary Care). The review of national organisations with an interest in clinical quality (CSBS, HTBS, CRAG, etc.) gives the opportunity to build on, in a co-ordinated and inclusive way, initiatives already in place in primary care e.g. the RCGP practice accreditation scheme. Again, getting the right balance between the requirements of individual professionals, of the different teams, and of corporate accountability will be a challenge.

Redesigning Services

Frustrations and Irritations

Patients discharged home without GP being notified; beds blocked due to lack of primary care and social care services; too many short-term pots of money for projects and funding “gets lost in the system”; too many requests for the same, or similar, information from different parts of the system; not clear how decisions are made; clinicians and managers in primary care and secondary care need to meet to discuss proposed change in services and identify knock-on effects; staff in primary care do not understand secondary care and vice versa; insufficient trained staff to make changes happen.

In the comments received from stakeholders a significant number of “frustrations and irritations” voiced were in relation to the interface between primary care and secondary care (acute services, psychiatric services and specialist older people’s services). The present way of working is not resolving these problems as organisational boundaries do not encourage staff to see the problem from the point of view of patients moving through the whole system. LHCCs need to work in collaboration with specialist services to develop the most appropriate models of care, with shared protocols and integrated communication systems. It is only through a genuine collaborative process that redesign of services will be successful.

Redesigning services is fundamentally about rethinking how services are provided, focusing on areas for improvement in service quality and access to care by patients. The process is based on effective teamwork across all sectors and the greatest leverage lies in changing patterns of interaction – removing those steps which provide no added value to the patient. Redesigning services may impact on how staff work and where they work – seeking to make the best use of their skills and knowledge.

Vehicles which may help to facilitate redesign include the “Collaboratives” approach which involves identifying and implementing innovative and successful practices that create fundamental improvements in service utilisation, patient satisfaction and clinical outcomes. Personal Medical Services (PMS) is also giving some LHCCs the opportunity to look at how services can be delivered in a different way.

Developing Best Practice into Common Practice:

Within NHS Forth Valley a number of service redesign projects have led to significant benefits for patients, including:

Redesign of acute emergency medical admission and discharge practices to ensure a patient focus, improving clinical effectiveness. The project aims include addressing unacceptable practice, such as frequent decanting, long patient waits on trolleys and unplanned discharge and to develop acute/elective admission care pathways.

The PCMG recommends that:

- in order to provide integrated care for patients, it must be a core responsibility of NHS Boards to establish local mechanisms which bring together LHCCs and the specialist sector to develop strong collaborative arrangements to tackle issues of joint interest.

Premises

Frustrations and Irritations

Lack of community-focused health care centres which could meet the needs of all aspects of patient/client care; need more funding to upgrade premises to accommodate the primary care team; need to improve transport systems – particularly in remote and rural areas.

Developments to Date

The expansion of the level and range of services provided in primary care and community settings, the wish to improve access to services by patients and the requirements for continuous improvements in the quality of services has led to increasing pressures on primary care premises. The Modernisation Programme, in addition to the traditional funding sources, has produced some important development models but it is acknowledged that there is still much to be done. The earlier chapter on “Access” lists some specific action on the overall planning and provision of premises. There are also specific aspects which need to be considered:

Community Pharmacy Services

- Many people visit the local pharmacy more often than their GP. Community pharmacists have a key role to play in addressing health and health care issues for local populations. Over the last two years there has been investment in discrete consultation areas, where advice and support can be provided to people in a confidential environment. As detailed in *The Right Medicine (2002)* pharmacies also have the potential to become walk-in resource centres where other staff from the health service and other agencies can provide additional services, and the most recent Modernisation Programme has supported some specific developments.

Dental Services

- Scotland has a poor record in oral health with levels of dental decay strongly related to deprivation. There is a commitment to improving access to dental services for those who need them most, and this includes the premises from which services can be provided. Dental Access Grants, the inclusion of NHS dentistry in the Modernisation Programme, and the investment in the last two years in dental practice improvements have provided some support.

In both services, however, it is clear that the traditional funding methods, whereby individual contractors/bodies undertook the whole capital investment, need to be reviewed.

Opportunities for Further Development

It is important that there continues to be an overall programme to develop the capacity of premises to support:

- closer working for primary care teams – with community nursing, professions allied to medicine and other staff working in the same building as GPs;
- integrated health and social services in the community, together with services provided by the voluntary sector;
- integrated working between community pharmacists with GP practices;
- out-patient and day care services in community settings, reducing the need for patients to travel to hospital;
- multi-purpose community resource centres integrating primary healthcare with leisure, retail and community service developments.

Developing Best Practice into Common Practice:

Opened in 2001, the Dalmellington Area Centre developed to serve a largely rural community and is a prime example of joint partnership planning. The Centre provides a wide range of primary health care and social work services, together with police services and a business technology and training centre. The local community are involved in the planning and provision of services through the Centre User Group. Visitors to the Centre and service providers are already seeing the advantages of co-location. Funding for the project was secured through a range of sources including the Primary and Community Care Premises Modernisation Programme.

The PCMG recommends that:

- the specific needs of primary and community care are recognised in the national and local premises investment plans
- SEHD should review the funding arrangements for the provision of pharmacy and dental premises
- with the involvement of the local community in the planning process, NHS Boards and LHCCs should investigate all possible partnership opportunities for funding where upgrading or new premises are required
- SEHD should act as a resource to facilitate sharing of good practice in this area of service development.

Information Management and Technology

Frustrations and Irritations

Common databases and registers would improve efficiency in all sectors – avoiding duplications and gaps in service provision; too many delays in receiving results on diagnostic tests; software packages cannot deliver requirements of primary care team; not all members of the primary care team have access to a PC; systems do not link across the various interfaces; not enough training.

Demands for Information

Capitalising on the potential of clinically-focused information technology will be a key factor in improving access to services, integrated service delivery, the management of chronic diseases and continuous quality improvement. IM & T developments need to encompass links within the primary care team and with other sectors – most noticeably secondary care and social work. At the same time, there are important issues of patient confidentiality and access to information which need to be taken into account.

It is important that those working in the service have a clear understanding of the overall IM & T strategy for NHSScotland and its implications for how they may work now and in the future.

Investment in Primary Care IM & T

Historically the various professions in primary and secondary care have developed information systems independent of each other, presenting many challenges for team working. The creation of LHCCs has added an impetus for integrated information systems. There has been significant investment in IM & T infrastructure over recent years which provides a basis on which integration of systems can begin to take place.

The enhancement of practice-based systems provides an opportunity for GPs, their staff and practice-attached community staff to make use of the technology as an integral part of their work, to support clinical care. Progress is being made to fulfil the Programme for Government commitment to link community pharmacists to NHSnet and parallel development work is underway to create the capability to transfer prescriptions electronically and exchange appropriate clinical information between GPs and community pharmacists. Similar links to NHSnet for dentists are under active consideration.

It is recognised that further resources will be required on a recurring basis to meet clinical information requirements and keep pace with technological developments. It is equally important to ensure that value for money is being obtained from the technology available e.g. better sharing of access to facilities, staff appropriately trained. NHS Boards should ensure that the infrastructure is robust and has the capacity to perform the task of supporting clinical practice.

Partnership Working

With the emphasis on improving the patient's journey, information and IT developments need to encompass links with other sectors – including:

- Secondary Care: ECCI – the national programme to implement electronic clinical communication between primary care and secondary care – will underpin
 - Co-ordinated referral information
 - Investigative test/requests and results

- Electronic booking – protocol-based where appropriate
 - Discharge letters and summaries
 - Information in support of shared care
- Social Work: Interagency IM & T is evolving. The Joint Future agenda, aimed at improving partnership working between agencies to secure better outcomes for patients and carers, will need greater integration of information systems, with agreed protocols.

Future Developments

Developments include:

- Electronic patient records – these will provide comprehensive organisation-based information on individual patients, to support clinicians treating the patient at each stage of their journey. Within agreed protocols on patient confidentiality, health care practitioners in primary care and secondary care will be able to access information on individual patients to enable them to make informed decisions about the patient's care.
- Electronic health records – patient-focused and containing lifelong core/summarised information. The record will be owned by the individual, available for use at each contact with health care practitioners.
- “Smart cards” – patient-held records which promote patient involvement and better co-ordination of care.

In future developments, it is important that NHS Boards adopt a balanced approach to investment. The desire to invest in innovative projects should not be to the detriment of the infrastructure needed for basic electronic communications which some clinical staff (e.g. many PAMs and dentists) do not yet have.

NHS Boards are accountable for developing a local IM & T strategy, with progress being monitored through the PAF. It is essential that implementation plans build in resources for training and support for users – directly employed staff, independent contractors and their staff.

Developing Best Practice into Common Practice:

Sponsored by the Modernising Government Fund the e-Care project is being developed in Lanarkshire and other parts of the country to support more effective and efficient joint working – based on a person-centred approach, the project is developing new approaches to the management and delivery of health and social services.

The PCMG recommends:

- **as part of local IM & T strategies, NHS Boards should include all sectors of primary care in order to support electronic clinical communications within primary care and with other parts of the NHS and local authorities**
- **relevant information is made available to primary care staff about those aspects of the national and local IM & T strategies which will impact on their work**
- **to make the best use of the technology, NHS Boards should make available appropriate training and development support to all staff**
- **clinical staff working from the same location should be encouraged to share technology as far as is practical.**

Implementation

Many of the recommendations in this report are directed towards NHS Boards which encompass Chairs and Chief Executives from across local health systems. It is expected that NHS Boards will assume leadership of this agenda which will require changes to be made within local ways of working.

The PCMG recognises that the actions proposed in this report will require local health systems to develop implementation plans which reflect their own local circumstances. There are also some actions which are for SEHD to pursue; it is also hoped that SEHD will consider the support which local areas will need to deliver this programme. The implementation programme will not only strengthen primary care but make a major contribution to improving the working of the whole NHS and social care system.

The PCMG would wish to see monitoring of implementation become part of the overall PAF process whereby NHS Boards demonstrate progress towards delivering the recommendations contained in this report.

Membership of PCMG

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Glossary and Definitions

CHD	Coronary Heart Disease
CRAG	Clinical Research and Audit Group
CSBS	Clinical Standards Board for Scotland
ECCI	Electronic Clinical Communications Implementation
HTBS	Health Technology Board for Scotland
IM & T	Information Management and Technology
NHS 24	National, nurse-led, triage and health information service
PAF	Performance Assessment Framework
PAM Services	Professions Allied to Medicine: for example chiropody/podiatry, dietetics, occupational therapy, physiotherapy and speech and language therapy
PCT	Primary Care Trust
Primary Care Team	Traditionally the team directly attached to the GP practice (GP, practice nurse, community nurses), this is now extending to other professionals e.g. pharmacists, PAMs, etc.
RARARI	Remote and Rural Areas Resource Initiative
RCGP	Royal College of General Practitioners
SEHD	Scottish Executive Health Department
Staff	Individuals who are direct employees of NHSScotland, independent contractors and their staff

Key Documents

Access to Primary Care Services in Scotland – Scottish Consumer Council	2001
An Action Plan for Dental Services in Scotland	2000
Adding Life to Years	2001
CHD Taskforce	2001
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Clinical Standards for Schizophrenia	2000
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