HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM PENUMBRA

We welcome the opportunity to submit evidence to the Committee's inquiry.

The role of the third sector in primary care.

Penumbra is a leading mental health organisation providing a range of recovery focussed support services to around 1800 adults and young people each week and 4500 people each year. We work with partners across seventeen local authority areas to provide innovative mental health support in a community setting. Our compassionate and highly skilled recovery teams work with the people we support to create tailored and person focussed strategies that give practical steps towards recovery. Using our I.ROC and HOPE toolkits, our whole person approach is based on the rights of the people we support through choice, dignity and the expectation of recovery.

We believe that the 3rd sector has a significant role to play in delivering key public health priorities.

Question 1

Considering the Health and Sport Committee's Report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities?

a) Language. It is interesting to note that many GP practices are called either medical centres or health centres. Given the desire to move to earlier intervention and prevention we would suggest that practices could be called health and wellbeing centres, this reflects the fact that you do not need to be 'ill' to attend. There is a clear need to shift public expectation of what a GP practice is and can offer. Increasingly they are places where many different disciplines work together from medical staff to voluntary/3rd sector organisations.

b) Digital. We agree with the public panels that use of digital services and sharing of data (where required and appropriate) would modernise the way the public interacts with primary care. In a number of situations, we are told it is not possible to receive emailed/electronic referrals for our services due to confidentiality and security worries. This means that referrals are made by phone or letter which is not always the best or most timely way to pass information. The use of online scheduling of appointments (including after 5pm and weekends) and text reminders would bring the NHS in line with many other services (e.g. dentists and optometrists etc). Self-management using digital technology such as wearables or online accredited websites (e.g. living life to the full) and the use of *Attend Anywhere* for secure online video appointments would greatly increase the interaction between the public and health professionals.

ALISS is a community health and wellbeing portal that offers an online directory of local community services. Currently it is difficult to ensure the information it contains is up to date and still valid, due to agencies being responsible for keeping their own information up to date. However, it has the potential to be a trusted aggregator platform of community health and wellbeing resources fulfilling a role that would complement *NHS Inform*.

There needs to be an increased connectedness of GP practices to the wider health and social care strategy and commissioning to ensure an integrated response to the health and wellbeing needs of communities. There also needs to be a greater awareness within primary care of alternative sources of support, for example through 3rd sector services and community resources.

c) There should be a greater focus on community wellness, and a promotion of the idea of wellbeing and maintaining good mental health as opposed to individual illness.

d) Primary care teams to include quick response to emerging health and mental health needs e.g. having wellbeing practitioners/peer workers that are able to respond quickly to mental health needs as a 1st response. In parts of Angus, Penumbra has Peer Support workers (people who use their own lived experience of mental ill health and recovery) working within practices to offer practical support to develop self-management techniques or to connect to local community resources. In many parts of the North East of Scotland we have developed 1st Response services where people can walk in and see a Penumbra worker. In Elgin for example over 1500 have accessed this service in the last year. Many are looking for information, guidance and some support to overcome emerging challenges to their mental health and wellbeing. This form of early intervention has worked well and people have positively rated this support.

We have some concerns about the term *'social prescribing'* as it still positions the work within a medical model by virtue of the word prescribe. This is because the public connect the term prescribe/prescription with doctors and ill health. Often people require support to 'connect' with local community resources and do not have illnesses or symptoms that require medical intervention. We prefer terms like community connectors or wellbeing practitioners etc.

Question 2

What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

a) Recruitment. We often face challenges to recruit skilled staff for some of the emerging roles for 3rd sector workers in primary care. Particularly if funding is only awarded on an annual basis as we cannot offer medium to long term job security and personal development opportunities.

b) Procurement and commissioning of the 3rd sector. Often this is carried out via competitive tender and is for a 3-year contract or shorter. If it is a spot purchase or 1-year contract this does not provide the security and sustainability we need to offer good quality services. Often tenders for work are heavily specified which also hampers or restricts innovation and the opportunity to put emerging practices into effect.

c) Health priorities. We believe that primary care is vital to assessing the health and public health needs of local communities. Clear links between primary care and local strategic planning groups should be supported and maintained so that data and information can be shared to ensure that locality plans and commissioning strategies meet the Health needs of local populations.

d) Access. Opening hours and travel distances can be a deterrent to people to access primary care in a timely manner, particularly in rural areas. People often feel they have to be 'really unwell' before 'seeing the doctor'. We need to think more clearly about how we market primary care as a wellbeing service, not just an illness service. As mentioned earlier alternatives such as video links and more use of online tools could help here.

e) We feel that more use can be made of the third sector in providing walk-in services that give support and information along with the ability to connect people to local community resources.

Question 3

How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?

a) Clearly defined expected outcomes for MDTs/GP clusters. A lot of data is collected for secondary care services which reflects use of hospitals and out-patients. We need to be clear what health and wellbeing outcomes we want for primary care and identify clear measures and datasets for this. We already have the Scottish Public Health Observatory which produces locality profiles, and more use should be made of this data when looking at setting objectives and outcomes for an area.

b) Involve people who use the service in identifying clear outcomes for a locality.

c) Less focus on clinical outputs and more focus on people outcomes. Traditionally, we have measured and counted systems outputs. We believe more work can be done to identify outcomes for people.

Penumbra
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