

HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM THE QUEEN'S NURSING INSTITUTE SCOTLAND (QNIS)

For 130 years, QNIS has provided education, training and support to nurses working in primary care. This [three minute animation](#) provides a brief history of Scotland's Queen's Nurses and our work today.

In 2019, Queen's Nurses (QNs) work in communities across Scotland as role models for high quality, compassionate care. They are employed in the NHS, the independent and voluntary sectors and undertake a nine-month leadership programme funded by QNIS, and other grant making trusts.

QNIS is a member of Scotland's Primary Care Clinical Professions Group (PCCPG). Our 2016 collective statement 'The future of primary care in Scotland: a view from the professions' – defines our vision. We were pleased that SPICe and the Committee have accepted and shared the 21 fundamental principles contained in that statement. QNIS contributed to, and fully endorses, PCCPG's recent submission to this Committee's inquiry. We welcome the opportunity to submit our own supplementary evidence.

Q1. 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?

Further developing multi-disciplinary teams (MDTs)

Bringing together a range of clinical expertise to plan an individual's care is increasingly the norm in primary care. However, there is work still to do. We asked contemporary Queen's Nurses for their views and a theme emerged around a desire for genuine integration and connected working practices. In the words of one QN health visitor: *At present, we are very much separate services. We make referrals to each other and give feedback instead of joining forces and providing a more holistic approach. That would give people the benefit of our collective experience in one space.*

Strong links are being made across the different parts of the health and care system and this needs to be accelerated. We need to relax the hierarchical approaches and take steps towards realistic healthcare that invests in communities and supporting them to work together to rebuild community networks which support health and wellbeing. As swiftly as feasible, Scottish primary care must move beyond the remaining vestiges of siloed service provision, IT systems, resource allocation, training, and CPD. **The challenge is to go beyond cooperation toward genuine collaboration and integration.**

As detailed in the PCCPG response, the public understanding of these changes needs to be supported. While there is increasing awareness of the different roles within the MDT, the general public can be reluctant to access new services and will seek the GP as a first point of contact. There is a need for continued education about how to access the best possible member of the MDT in a timely way.

Community nursing in Scotland's primary care landscape

Nurses will always be central to achieving excellent primary care, making up by far the largest group in the workforce. The number of nurses, midwives and health visitors in Scotland's communities is approximately 14,000, with an additional 2,300 working in general practice. These practitioners have a huge range of knowledge and expertise and cannot be regarded as a homogeneous group. The figures above are for NHS staff. There are many others who work in the independent and voluntary sector e.g. 4,500 nurses in care homes. There are places in Scotland, for example remote islands and oil rigs, where nurses are the only resident primary care providers.

These roles include (but are not limited to):

- Community mental health nurses working across the age spectrum;
- Health visitors enabling young children and their families to prevent and overcome adversity, develop resilience, and flourish;
- Occupational health nurses who provide advice and care in Scotland's workplaces, preventing injury and supporting workers with health challenges;
- Prison nurses providing primary care and mental health support to those in the prison estate;
- Community children's nurses caring for children and families with complex health needs in their homes and communities; and,
- Learning disability nurses as they support people to navigate health and care systems and lead healthy lives.

Investing in integrated workforce planning, recognising the expertise of the full range of clinical professions is essential. This must be focussed on community need (robust scoping of demand), across the lifespan.

The central role of district nurses

District nurses undertake postgraduate training that equips them with high level clinical skills to deliver expert 24/7 primary care. They have a leadership role in coordinating complex care for those at home through injury, illness, frailty, or long-term conditions. They are also experts in end-of-life care. There is a need to grow the district nursing workforce to support an ageing population, in and out of hours, at a time when many DNs are approaching retirement. **The district nursing workforce is central to delivering both high-quality, next generation primary care and the Government's 2020 Vision. Ensuring there are sufficient numbers of educated, skilled and properly resourced district nurses is both important and urgent.**

Addressing health inequalities

Primary care workforce planning must be accurately adjusted for deprivation, so that health visitors, school nurses, community midwives and others working in areas of high deprivation are adequately resourced to make a real difference when and where support is needed most. When nurses are given permission and resource to make a difference in communities, they are well placed to co-produce creative solutions with marginalised groups. The QNIS [Catalysts for Change](#) Programme is an illustration of the ways in which community nurse-led projects can make a lasting, positive difference - not only for individuals, but also for the communities of which they are a part.

Q2 What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

The most significant barrier to delivering a sustainable primary care system is the need to invest in a skilled and highly valued workforce and this has been discussed above.

Primary care as primary prevention

At the heart of a sustainable primary care system is a deep-rooted emphasis on primary prevention. There has long been a tension within primary care between the need to respond swiftly to illness, injury or adversity and the potential to act as a powerful force for promoting good health and wellbeing, preventing some of the issues which dominate primary care.

It is a question of balance which has not yet been reached. The widespread endorsement of the value of prevention has not been matched by major shifts in resource allocation and governmental actions.

Primary care for the next generation will have a dramatically greater chance of meeting Scotland's needs, if there is a profound shift of priorities, resources and actions in favour of primary prevention.

The role of technology

Feedback from QNs indicates that current IT systems are obstructive in moving forward with integrated ways of working, particularly around shared access to relevant information. Multiple records held by different agencies has an impact on patient safety and staff agility in rural and urban areas. Greater access to the right mobile technology would reduce unnecessary hospital appointments, house visits and support self-management.

There is a myth that one benefit of investing in technology is that this will free up clinical time, so that the number of posts can be reduced. Any time that is liberated needs to be prioritised to further opportunities to listen deeply, and respond meaningfully, to what people are saying about themselves, their families and their communities. As we move into the next generation of primary care in Scotland, the emphasis will be on having more

important conversations about living well, as well as much-needed anticipatory care discussions with all those affected by long-term conditions or moving toward palliative and end of life care.

To enable primary care clinical professionals to work effectively, we must invest in the right digital and mobile systems to support agile, integrated working.

Transport as a barrier

Transport is a big issue in urban and rural areas. This is especially important for patients who do not drive. As one rural Queen's Nurse explains: *patients rely on 1 bus a day leaving early morning and returning later evening requiring them to travel in excess of 70 miles each way to attend optician, dental appointments or for minor injury.* Poor public transport links (and the lack of cars among people with the greatest needs) make it more difficult for people to access immunisations, counselling and other primary care services. Another health visitor QN adds: *The introduction of two-year nursery provision does help to support our most vulnerable families, but accessing a place in the family's catchment area is not always possible, especially in our more rural locations.* In addition, there remains an over reliance on hospital appointments for consultations which could more appropriately be provided locally.

Q3. How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?

In relation to the monitoring of outcomes and impacts, QNIS endorses a clear, consistent and candid focus on what primary care is, and is not, achieving. This needs to focus on improvement as opposed to monitoring. Preventing harm, promoting good health (physical and mental), as well as achieving greater equity are Scotland's goals. We need to explore creative and integrated ways of capturing progress towards these goals as a whole system rather than trying to extricate the impact of only one part. QNs have reported powerful examples of patient and staff collective stories, sharing successful projects in communities, like engagement events to increase screening uptake or building peer support networks for self-management.

The shift in priorities essential to reducing health inequalities is not a task for primary care professionals alone. **QNIS recommends that the evaluation of primary care not be undertaken in isolation from the larger societal context within which it increasingly works collaboratively.** It would be unwise to separate entirely the consideration of what works within primary care from assessments of the local, regional and national efforts underway to transform the health of Scotland's people and the wellbeing of its communities.