CHARTERED SOCIETY OF PHYSIOTHERAPY

Meeting the challenges in primary care:

ROUNDTABLE DISCUSSION

CONSERVATIVE PARTY CONFERENCE 2015

On Monday 5th October 2015 at the Conservative party conference in Manchester the Chartered Society of Physiotherapy (CSP) in conjunction with the National Association of Primary Care and NHS Confederation held a roundtable discussion on Meeting the challenges in primary care.

The event was chaired by Rob Webster, CEO of the NHS Confederation and brought together leading experts and health professionals to explore new approaches to workforce and models of care as we sought to develop clinically effective, value for money solutions within primary care.

Consensus for change

The discussion illustrated the high levels of consensus across professions, politicians, health research bodies and voluntary sector organisations around the shifts required in primary care in order to meet demand and be sustainable. Maggie Throup MP lead off the conversation by setting out how the current Health Select Committee inquiry into primary care is seeking to identify what needs to happen to enable these shifts to take place.

Collaboration for excellence

Maggie Throup MP introduced the discussion by setting out the terms of the Health Select Committee inquiry into Primary Care.

There was universal agreement around the necessity to expand and remodel the primary care team, with the skill mix to match population need.

While the catalyst for innovation in primary care has often been the mismatch between GP capacity and demand, the discussion concentrated far more on quality improvements. A significant opportunity now exists to deal both with supply and the use of a broader set of skills to make care better.

The meeting identified a number of necessary building blocks: investment in time to construct new teams and make them work; retraining existing practice teams; working to shared goals for patient outcomes; establishing lines of accountability and professional support aligned to new teams' structures; managing the trade-off between continuity of care for patients with a single point of contact and patients empowered to choose what they need from different members of an extended team.

There was optimism about the potential for the Rowland Review to start this process and some frustration at the loss of momentum.

Shifting power

The conversation with patients and the power balance between patients with professionals needs to move away from a paternalistic relationship. The role of patients and carers in their own disease management, and their unique overview, needs to be understood and used by clinicians.

A wider discussion across society also needs to shift discourse from a deficit model, dominated by a fear of losing services, to a fresh view of what better possibilities a modern health services could offer.

Supporting self-management should not be seen as a means to reduce personal services but the opposite. Self-management is enabled by services being tailored to the context of individuals' lives and the wider assets available to them. These assets include the expertise of patients and carers and the four to six hundred voluntary groups accessible within the average GP catchment area.

Democratising health

Services are catching up with the use of digital technology, now part of everyday lives. How we all use technology is already revolutionising how we manage our own health.

Technology may also help patients and carers to navigate the health and care system, making it easier to access the advice, information and services they need. The advent of shared records, owned by patients, accessible online, will inevitably shift the power balance in a positive direction.

Data and data technology is underutilised. Far more could be done to segment populations and stratify risk, making it possible to tailor services – for example to judge if someone needs a longer face-to-face assessment or a quick phone conversation with a specialist.

The elephant in the room

Professional identity, its value as well as possible rivalries between professional tribes, was raised. There are genuine fears about dilution of professional expertise and a lack of clarity about accountability. Both issues need to be addressed as change occurs.

The discussion was clear regarding how essential professional identity is to leadership – and how essential professional leadership is to positively changing the system as well as developing roles that ensure professionals work to their full capability.

Protectionism can stem from feeling that your profession is under threat. But reducing protectionism shouldn't mean undermining professional identity but rather the opposite. Skilled professionals do not just know why services should be integrated and reorganised, but are also best place to know how.

Participants:

Dr Adrian James, Royal College of Psychiatrists
Andrew Walton, Connect
Ann Marie Morris, MP for Newton Abbot
Candace Imison, Nuffield Trust
Dr Chaand Nagpaul, BMA
David Sinclair, International Longevity Centre
Don Redding, National Voices
Jeremy Hughes, Alzheimer's Society
Joanna Brown, Society of Chiropodists and Podiatrists
Karen Middleton, The Chartered Society of Physiotherapy
Dr Liam O'Toole, Arthritis Research UK
Linda Cuthbertson, Royal College of Physicians
Maggie Throup, MP for Erewash
Mark Thomas, Royal College of General Practitioners
Dr Neil Langridge, Arnewood Practice and Milton Medical Centre
Nigel Edwards, Nuffield Trust
Rachel Newton, The Chartered Society of Physiotherapy
Rob Webster, NHS Confederation
Stephen Cannon, Royal College of Surgeons
Sue Rees, The Chartered Society of Physiotherapy
Tim Ballard, Royal College of General Practitioners
Tom Wright, CBE Age UK
Vicky McDermott, Care and Support Alliance

The continued reliance on incentives to change the behaviour of practitioners was noted. It was felt that this discussion needs to move on and that change needs to be based on professionalism and professional leadership.

Will a permissive approach achieve sufficient scale?

It was recognised that the Five Year Forward View implementation plan is largely permissive – allowing local clinical leaderships to design and try out new models of care. The shortage of GPs in many areas has also driven change from the bottom through necessity.

This has produced many examples of change – including new organisational partnerships, pharmacists and physiotherapists working alongside GPs in practices, podiatrists and nurses working together on diabetes foot screening, voluntary sector care navigators and paramedics making home assessments.

However, there doesn't appear to be any area where all the new potential roles in an expanded primary care team are in operation.

There is also a fear that the learning and analysis from new models of care isn't happening sufficiently to provide the surety needed to deliver change on a larger scale.

Permission to 'get on with it' is recognised and valued. But there were significant concerns that there will not be enough dynamism or resource in the system to allow large-scale change.

Key areas of concern included investment in the workforce: the shortage of GPs; supply not keeping up with demand for physiotherapists and other allied health professionals; chronic underinvestment in community nursing.

The current crisis of capacity and funding is both driving changes and is a factor in holding it back, as professionals lack the time and space to learn, think and develop. For GPs there was the recognition that reallocating the proportion of their workload that can be carried out by other professionals could help create this space; essential given their role in leading change in primary care.

Working together – next steps

Throughout our discussion professional leadership was proposed as the key to change, the next step in the reassertion of professional leadership of the health and care system of recent years.

This includes professions looking to themselves to change, to challenge their own sacred cows. It also involves working across professions to collaborate in new ways, and work collectively to shape policy and maintain the momentum for change.

"Allowing people direct access to the right clinician in primary care prevents needless debilitation."

"Surely we've reached the end of trying to micromanage GP's through incentives – it's is like designing neuro-surgery with oven gloves."

"What we have are micro-packages of change in primary care with no analytical capacity. What we need is investment in improvement activity to scale up."

"Let's look at the whole household, not individuals and their single episode of need."

"GP lack of capacity means professional barriers are coming down – but it requires us to invest time in building relationships."

"Better data has enhanced my knowledge of the population I am serving."

"The standard few minutes with GPs is not going to work for the 50% of patients 65+ with 2 or more long-term conditions."

"GPs are recognising the benefits to them and their patients to working in extended, more horizontal teams."

"We need to change the dialogue about community services from one of loss to what people are gaining instead of hospitals."

"Change in primary care will occur through the pull of patient expectation."

"Expanding teams in primary care needs to be collaboration for excellence not a sticking plaster."

"Transforming primary care for patients depends on professions working to their full capability."

"Digital tools should be used to make the health system simpler for patients."

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