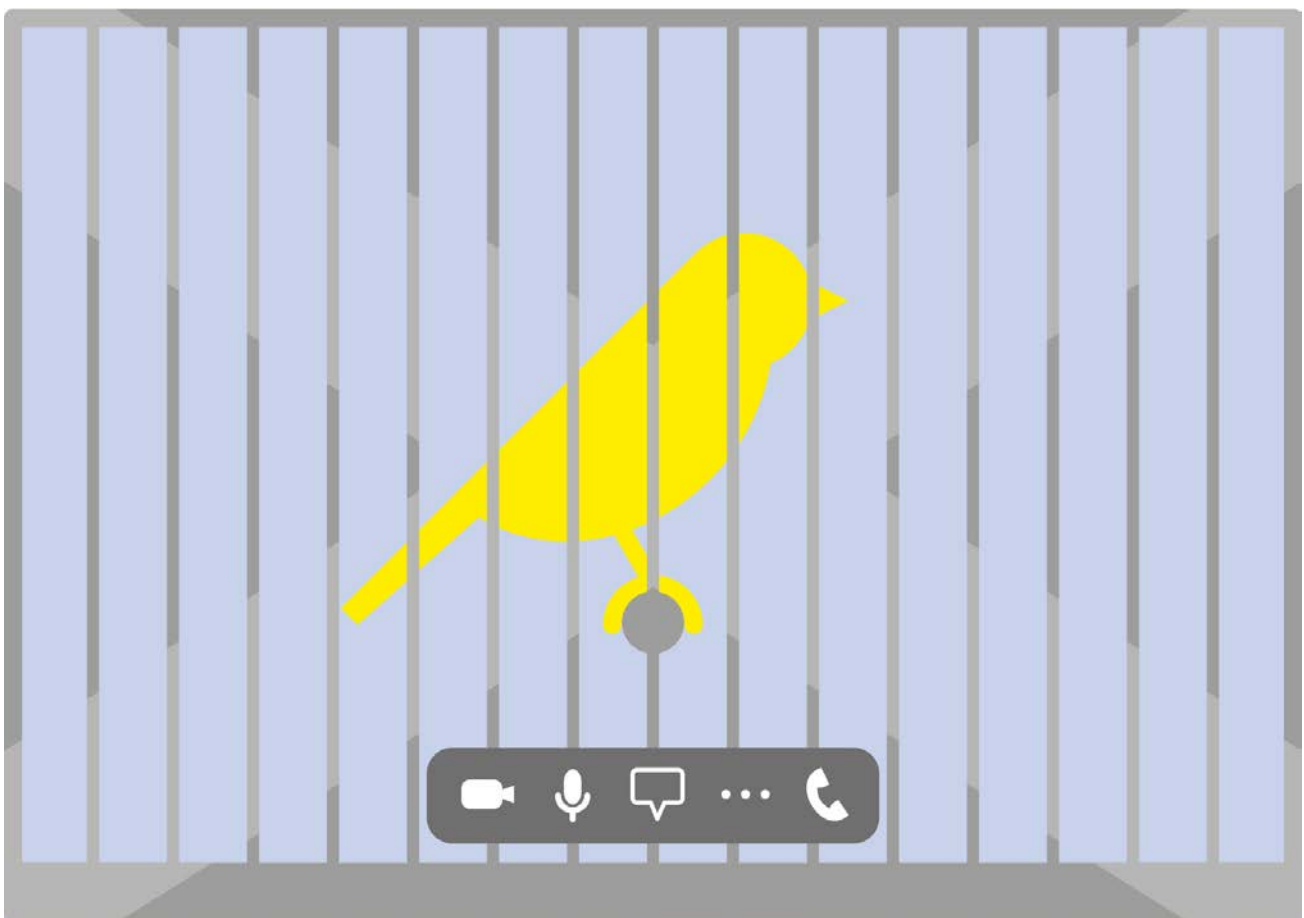


Is primary care the ‘canary in a coal mine’* of our health and social care system?

Primary care, taking the next steps in a COVID world: virtual workshops

August 2020



* **Canary in a coal mine** refers to something whose sensitivity to adverse conditions makes it a useful early indicator of such conditions; something which warns of the coming of greater danger or trouble by a deterioration in its health or welfare. (Source: *Wiktionary*)

Foreword

Primary care, taking the next steps in a COVID world: virtual workshops was the first collaboration between the Chief Officer Group, **Health and Social Care Scotland** (HSC Scotland) and **BMA Scotland**; it was long overdue to organise a series of such collaborative events. Given the success and resounding appreciation expressed by colleagues, we fully intend that this first joint collaboration is the start of something bigger, enabling us to harness the power of partnership. It is critically important to colleagues that we have a forum where the collective voice of primary, community and social care can be heard and is able to influence the direction of policy development.

By gathering views from across Scotland, via the virtual workshops, we are enabling well informed strategic conversations at a national level, and supporting and reflecting positive engagement both regionally and locally.

Our world is changed by COVID19; we have responded with commitment, energy and focus. We hope this report reflects a moment in time when we paused and reflected on our successes and challenges; and as we highlight our needs and our aspirations, we look forward to being part of a future health and care system which recognises that the whole system is greater than the sum of its individual parts.

By **Val de Souza** (Chief Officer, South Lanarkshire Health and Social Care Partnership) and **Andrew Buist** (Chair, GP Committee, BMA Scotland)

10 August 2020

Anyone who would like to offer any comments on the report, offer any feedback, or be part of our national primary care conversations, please contact Eleanor McCallum (Eleanor.McCallum@sw.glasgow.gov.uk)

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N.B. The volume of inputs from the workshops was significant and the following pages attempt to give an overview without delving into detail. Additionally, all the quotes used within this document have been taken from participant feedback/scribed notes etc.

In this first collaboration between the Chief Officer Group, **Health and Social Care Scotland** (HSCScotland) and **BMA Scotland**, we are collectively harnessing the power of partnership. By gathering views from across Scotland, via virtual workshops, we will enable well informed strategic conversations at a national level, and support and reflect positive engagement both regionally and locally.

Background, purpose and aims

As the measures put in place to deal with the COVID pandemic over the last few months start to ease, and we start to return to pre-COVID work in the 'new normal', leaders within primary care acknowledged the need and welcomed the opportunity to reflect on learning and individual and shared experiences of colleagues in primary care and community settings.

A key work stream for all primary care colleagues is the implementation of the 2018 GP contract and the development of multi-disciplinary teams through the Primary Care Improvement Plan (PCIP). Moving forward, it is vital to consider our recent experiences and how we deliver community treatment and care in a COVID world. And as we move towards recovery, identify there are things we want to keep, things we want to leave behind, and things we want to improve.

Purpose

Three regional workshops were held.

Recognising the value of voices from across numerous disciplines within primary care, to create an opportunity with as wide an audience as possible, to hear voices, enable collaboration, and give recognition to common purpose from attendees.

The regional virtual workshops (23, 23 July and 5 August) were independently facilitated and attended by over 140 colleagues from East, West and North regions. Via 'breakout room listening spaces', health and social care staff, including clinical and non-clinical staff, reflected, listened and considered emerging themes, including:

1. Unscheduled care
2. Interface of care
3. Care home support including multi-disciplinary teams (MDT)
4. Digital working and data sharing
5. Inequalities
6. Public messaging including realistic medicine

Valuable conversations and was so good to meet new people and listen to their perspectives.

Invited attendees also included colleagues from Scottish Government Primary Care Division, chief executives from NHS boards (regional and national) and chief executives from local authorities. Pre-event questionnaires were issued to enable input by colleagues who were unable to attend, see **Appendix 1, Pre-event questionnaire comments**.

Aims

Through joint collaboration we aim to lead and positively progress a national conversation about the next steps for primary care.

By collectively harnessing the power of partnership and utilising our stronger unified voice and common purpose, we aim to ensure people in local communities receive the right care at the right time, in their own home or homely setting, whenever possible.

We feel, and this report highlights that through relational and team working, appreciation and understanding, the enablers experienced in local systems due to the pandemic reflected by the strongly expressed views indicate that we “*can’t go back.*” to a pre-COVID world. And while we’re at the start of our joint journey, the workshops highlighted “*great enthusiasm and willingness to harness the good work that has happened quickly as we live with COVID.*” We have taken first steps. We have laid foundations to tackle some of the big issues being experienced by our communities and in primary care.

Reflections and insights

Three regional workshops with over 140 people, plus written questionnaires, produced a significant volume of material from which to gather reflections and insights, and an opportunity to listen to what matters to those working day by day in primary care and how the future can be shaped. The space was energetic, with ambitious collaborative discussions by enthusiastic participants – see **Appendix 2, Comments and chat from attendees during the virtual workshops.**

This is a brilliant step forward and if built upon will produce real gains for our citizens.

Each workshop covered the same six themes, and while regional differences were noted, such as poor internet and phone signals in rural areas, common themes came through across all events and within themed sessions; as one participant commented “*this session demonstrated we may not express / frame it the same way but actually we all have shared aims and honestly, other than joint working, what other way is there to achieve the changes needed?*” The majority of participants expounded the real benefits of integrated working and agreed that the pandemic response aptly illustrates that “*integrated care/collaborative working is the way forward!*” See **Appendix 3** for post-event evaluation.

The primary driver of the GP contract is to make general practice sustainable, however one participant posed a thought-provoking statement in an **Inequalities** session: “[We’re] supposed to be looking at the hardest problems and reducing inequalities ...” Across all workshops, participants agreed that cross boundary, collaborative agile working is needed to address whole system issues, such as inequalities and our response to COVID has illustrated the huge potential we have to succeed. Many also agreed that COVID has and will inevitably change our pre-COVID reform programmes for health and social care.

It must be recognised that some variation exists across the country: variation in culture, behaviours, approaches, and service delivery in localities and by partnership is at heart of primary care (and indeed a key driver for health and social care integration). Community based services continually adapt to meet the demands and needs presented by their local communities, and a one-size-fits-all approach is arguably not appropriate or realistic.

While the virtual sessions and questionnaires highlighted the numerous positive changes, along with palpable participant enthusiasm and ambition for the future of primary care, participants also expressed notes of caution, including, “*The speed has enabled changes*

that have been sought for years. Perhaps these have not been evaluated. We need to understand longer term impact.”

The ingathered reflections and insights have been distilled into high level themes and enablers, which we hope captures the essence of the forward looking, compassionate and “*very energizing*” discussions, and desire of participants to listen and learn from colleagues, while endorsing that, “*Change is difficult but can be very positive!*”

I've appreciated having an opportunity to reflect on what has been happening locally and nationally. I've also found it inspiring to think and talk about what our priorities should be in the near future, without feeling overwhelmed with the size of the job to be done, trying to develop a shared, inspiring vision.

Creating “*a shared, inspiring vision*”, (see above) was a participant suggestion as a next step for primary, community and social care. *Everyone Matters: 2020 Workforce Vision*, states that citizens should ‘live longer, healthier lives at home, or in a homely setting.’ Perhaps going one step further by adding ‘while receiving the right care at the right time’, could be our unified message?

Themes and enablers for the future

1. Unscheduled care – themes and enablers for the future

“... unscheduled care has changed, it has more than ever, highlighted the importance of the structures within the community. The response to Covid-19 has highlighted the efficiency of delivering care in the community and through teams that know the patient and are used to rapid and effective management of undifferentiated presentations.” How do we embed and build on new ways of working?

Our whole system response to COVID19 was responsible for breaking down barriers, forging new relationships, enabling direct and effective communication across the system, and appreciation and better understanding of colleagues’ roles and capabilities. Workshop participants whole heartedly agreed that we responded to the pandemic with common purpose, and while “*we’ll always have local variation [being] signed up to universal goals really helped.*”

We are all [primary and secondary care colleagues] on the same team.

It was remarkable how general practice adapted overnight.

Participants highlighted many similar examples of primary care’s response, including, “*COVID Clinical Assessment Centres and Hubs showed the power of joint working and good links with secondary (easy access to specialists)*”; “*delivering services to Care Homes – supporting district nurses to have access to controlled drugs*”. Participants were keen to “*acknowledge the wider MDT, including – physios, occupational therapists and mental health workers who provided a lot of support remotely.*”

Participants also noted, “*If the system redesign ignores primary care, it risks not being designed to meet patient needs. We risk designing a system to solve a particular problem rather than thinking of the patient*” and again and again we heard a frustration

expressed that *“unscheduled care discussions usually focus around delayed discharges. We need to shift the discussion to one about patients being seen by the right person at the right time.”*

As you will read throughout this report, lack of data within primary care is a significant and recurring theme, and as stated by one colleague: *“We suffer from a lack of data, ED has data, acute has data, we don’t and we can’t keep discussions proportionate.”*

Participants also confirmed that *“SGPC has an important role in the contractual space”* while suggesting that wider policy could be discussed more widely, with recognition that *“practices are at such different stages in development.”* They confirmed that the *“GP contract is the right direction”* and noted that we now also *“need to be realistic about our goal setting”*.

Future enablers to improving outcomes for people noted, include:

- Changing the conversation to one about people being seen by the right person at the right time! Removing the focus on delayed discharge (seen as a negative culture that seeks to apportion blame)
- Creating and extending a common purpose / vision and enhancing joint working across all areas of unscheduled care for both patient and professional benefit, after all *“the majority of unscheduled care takes place in the community”*
- Clear public messaging about appropriate use of services, *“Please use the right part of the NHS wisely”* and let’s take realistic medicine seriously – or indeed realistic health and social care
- Sharing of data across health and social care system, as the *“contribution of primary care to unscheduled care needs to be made more visible with data”*
- Assessing the need to support access and the Expert Medical Generalist role with evidence-based actions to manage unscheduled care
- Continuing to embed and enhance a range of access options, including Attend Anywhere, Near Me, telephone triage, Pharmacy First, which have started to become commonplace since COVID
- Encouraging self-management and self-responsibility
- Increasing availability of the 111 service, in a context of continuous improvement
- Developing and rolling out electronic prescribing
- Continuing development of online resources – communication, engagement, consulting, training and education
- Continuing to upscale IT systems, paying particular attention to remote and rural coverage

There are going to be capacity limitations for both primary and secondary care ... Unscheduled care naturally falls as the priority so we may need to look at additional support within the community for more of the scheduled care aspects of the GMS contract ... more resource, both medical and nursing to deliver fully on unscheduled care.

Barriers to improving unscheduled care noted, include:

- Lack of action to build on the learning from the pandemic
- Lack of data (a recurring theme across all regional workshops and themed sessions)
- Access to patient records across transfers/interface of care
- Digital infrastructure being uneven and underdeveloped in areas
- Inequalities due to digital exclusion

2. Interface of care – themes and enablers for the future

The interdependencies between the hospital and community health services have never been so important and so visible across the whole system. We have been presented with a golden opportunity to effect a sea change with system-wide positive behaviours and single-system thinking.

Historic barriers slipped away as the system mobilised, as *“COVID rules applied to everything, so there was one singular focus”* and *“everyone was on the same journey.”* Participants highlighted again and again, throughout all the workshops, that relational working was at the heart of the system response to COVID19. Improving relationships and effective communication between primary, secondary, community and social care, including, the *“development of profession to profession care pathways”* was key to successful interface working. After all, *“an interface should merge, not collide!”*

COVID made way for pragmatism and it blew away bureaucracy!

Future enablers to improving outcomes for people noted, include:

- Creating a universal and robust streamlined communication method across interfaces, which seamlessly integrates with existing systems
- Recognising common purpose and parity across primary, community and secondary care with better understanding of primary and community care capabilities
- Data sharing and data collection to illustrate primary care capacity and capabilities
- Continuation of direct primary-care-to-clinician contact, established via COVID19, as required to discuss patient management or appropriate, timely transfer of care
- Importance of Third Sector support in and for our communities
- Streamlining the process via digital enablers, aligned with reduction in bureaucracy, including use of SCI Gateway advice referrals
- Changing the narrative to outcome focused, person-centred care with community-based targets and measures that include qualitative and quantitative elements: people’s stories are key!

Barriers to improving the interface of care noted, include:

- Different definitions of whole system working
- Slipping into pre-COVID19 behaviours, including moving back into silo working
- Continued national focus on acute services and hospital as the default, including perceived NHS centric mobilisation planning
- Target and number driven messaging i.e. waiting times, delayed discharge, attendances at A&E

3. Care Home support including multidisciplinary team (MDT) working

The care of the frail elderly population in Care Homes and local communities has come to the forefront of our primary care response and national priorities. We now have better understanding and appreciation of the work of our care staff and the valuable and valued support they give to residents in their own home; participants were clear, Care Homes *“need to be viewed as part of the wider primary care team.”*

While there have been significant pressures in our Care Homes, participants were quick to acknowledge the pace and scale of positive change, and the culture shift, with Care Homes, care staff and primary care staff working as teams, one participant said, “[I was] struck by willingness to change” and “[we] can’t go back.” Key enablers in this culture shift, included information sharing, remote working, teamwork and locality approaches, planning with secondary care, workforce utilisation and leaning across traditional boundaries to provide support. One participant said, “Previously Care Homes sat separately, [they] didn’t have access to specialist advice”, with another stating, “Care Homes were able to utilise specialists therefore not all [work was] falling on GPs.”

Future possible and proposed enablers to improving resident outcomes, include:

- Accelerating the creation of multidisciplinary teams with core values and common purpose, and transfer of associated services
- Aligning Care Homes to a single general practice, for patient safety purposes
- Aligning ANPs to Care Homes to undertake assessments and support nursing and care teams
- Changing delivery of care via digital working, including virtual ward rounds as a multidisciplinary team
- Ensuring end of life planning is a normal conversation – ACPs
- Upskilling care workers and moving to parity of pay with statutory sector to address the high turnover of staff

Barriers to MDTs supporting Care Homes noted, include:

- Slipping into pre-COVID19 behaviours, including moving back into silo working
- A perceived and felt search for blame – numerous participants mentioned the Lord Advocate’s decision to enable Police Scotland investigations into deaths in Care Homes. While acknowledging the need to assess what went wrong, participants expressed that this approach is substantially increasing the very high levels of anxiety being experienced by professional, skilled staff who support and care for the most frail and vulnerable people in our society
- The sustainability of the Care Home sector
- Finances to address and continue new and improved ways of working

4. Digital working – themes and enablers for the future

Access to primary care services via digital methods can make the patient journey easier and help ensure patient safety, including in Care Homes where the digital approach “saves unnecessary visits/risk” and “can help patients keep in touch with families, carers, support network, [which] helps with mental health.”

Digital working is great for people who are able to use it. Challenge is those who can’t learn how to use it.

Participants agreed that the pandemic has enabled a swift introduction of new technology and adoption of digital working, including expansion of telephone triage and Near Me/Attend Anywhere video consultations for patients. Video consultations were reported as not being as impersonal as perhaps feared and helped improve continuity of care and build a different kind of relationship, more than is really

possible by telephone. Additionally, use of Microsoft Teams (and other platforms such as Zoom) by colleagues within primary care has been highly successful; “*This fits well with supporting the increased and integrated multi-disciplinary team with unified communication solutions*”, reduces travel time, enables timeous meetings and is “*great for communications and building relationships.*”

*Information sharing
is vital for effective
MDT working!*

There have been significant cross-service benefits arising from an increased use of Key Information Summaries (KIS) and Anticipatory Care Plans (ACP) throughout the system’s response to the pandemic. This has been a key part of COVID19 working in Primary Care and has been especially valuable to partners working in out of hours, the Scottish Ambulance Service and NHS 24. Practical benefits have included better availability of palliative care medication out of hours, together with updates of KIS records consistent with Realistic Medicine, which have in turn facilitated greater care at home in preference to referral to acute services.

Future enablers to improving outcomes for people noted, include:

- Adopting a Once for Scotland approach for resources and support, including infrastructure, connectivity and access to hardware
- Scoping a single IT system for use in community settings
- Ensuring more effective use of data and data collection to assess workload/impact in primary care and to build a more strategic approach to the future of primary and community care
- Improving data sharing across partner organisations
- Investing in e-prescribing, and e-consulting solutions for 24/7 patient access
- Promoting self-management and chronic disease monitoring via digital solutions

Barriers to digital working noted, include:

- Digital consultation is not a replacement for face to face engagement and the impact on inequalities needs to be carefully considered, in particular for people with disabilities, some non-native English speakers, and those living in poverty
- Access (including hardware and connectivity) and ability to effectively use digital solutions should not be assumed and support for alternative routes into primary care should be available

5. Inequalities – themes and enablers for the future

Primary care strategy, policy and working practice has a “*pivotal role in tackling inequalities in our communities.*” We have a responsibility to ensure parity of access and information across patient groups, including people with disabilities, non-native English speakers, people in the justice system and those living in poverty and deprivation. “*Remember, one size does not fit all!*”

Inequalities was a recurring theme across all six breakout sessions, across all three regional workshops, and participants highlighted how quickly the system came together, supporting those at risk, particularly those in the shielded categories and responded as, “*many of the old ways were stood down*”. Participants felt it “*was liberating to not need permission to do some things*” as “*laying down bureaucracy really empowered things.*”

Participants were passionate about the need for parity, especially as some of the work during the COVID19 response did not meet needs and, *“created and perpetuated inequalities e.g. asylum seekers, Care Homes, people with mental ill-health.”* Digital engagement was both an enabler and a barrier, depending on circumstances. However, many participants felt that the role of the Third Sector was crucial and the *“role of volunteers supporting vulnerable patients was phenomenal.”* Communities responded and stepped forward to support their own.

The need to ensure readily available and accessible mental health services in primary care was highlighted during the virtual sessions and via the submitted questionnaires. Participants shared examples such as, *“mobile outreach models via the use of a bus to support addictions service delivery”* and the need for the whole system to manage pathways for people with chronic severe enduring mental health issues in a different way by making sure they are *“always on the books and not immediately discharged if stable or DNA as this often leads to crisis and frequently a poorer standard of care due to the delay in re-access rather than preventive and holistic patient centred care.”* One contributor also stated: *“Recognise and promote spending to embed mental health in practices. Most Action 15 funding has remained in outreach arrangements. The actual mental health support within primary care is very limited indeed. This is about more than money. It is about resistance to change.”*

Future enablers to improving outcomes for people noted, include:

- Service redesign that ensures the inequality gap is addressed and not widened, and accessibility of the MDT to all primary care patients
- Collaboration with Third Sector and devolving power and trust to people in our communities – community asset building
- Public information/national conversation to inform people how they can achieve wellness and better contribute to decisions about their own health and wellbeing
- Ensuring social prescribing is a priority and available across all localities
- Collaboration with community planning and public health colleagues in localities to address the health needs of the whole population, including health promotion and empowering people to actively pursue better lifestyle and health choices
- Expanding of the Community Link Workers role
- Creative links with local authority community engagement activity, particularly those linked into Community Planning Partnership and neighbourhood priorities
- Embedding mental health supports, which are easily and directly accessible, within primary care services
- Ensuring attention to vulnerable people, health and homelessness, drug and alcohol use, drug related deaths and suicide prevention
- Enabling equitable access to digital technology and information
- Ensuring information is available in all formats/languages/methods
- Data sharing and analysis to highlight and quantify work undertaken in primary care

Barriers to improving inequalities noted, include:

- The impact over the long term of standing down services such as screening services, dentistry and optometry, and acute-based interventions
- Digital access (including hardware and connectivity) and ability to effectively use digital solutions should not be assumed and support for alternative routes into primary care should be available.

- Lack of face-to-face engagement with individuals and communities furthest from services
- Poverty and increasing levels of deprivation due to unemployment, shrinking economy etc with associated impact and increased use of services. There was a sense and a sentiment expressed that *“we ain’t seen nothing yet!”*

6. Public messaging, including realistic medicine – themes and enablers for the future

Strong, consistent, simple messaging about the risks associated with COVID19 and the resulting ask of the public, **Stay home, stay safe / Stay safe, protect others, save lives** was undoubtedly one of the successes of the national response to the pandemic. Workshop participants did express some concerns that *“the primary care voice [was] lost in the secondary care perspective”* and *“frustration at the message ... nothing has closed – we needed to say [we’re] open, just doing things differently.”*

Did we optimise messaging fully at all levels?

One participant stated that *“we have empowered people to treat themselves, [an] important step in realistic medicine”* and many recognised there is much to do to improve understanding of ACPs and *“DNACPR/levels of frailty amongst Care Home residents and their families”* guardians and powers of attorney.

Managing public expectation is going to be crucial in the coming months; how can the message of realistic health and care best be communicated to the public, as well as the whole health and care system? How can we change expectation, with digital methods as the new norm, and *“shift from a wants-based system to a needs-based system?”* *“The messaging now needs to be more nuanced – we can help with this.”*

This is an opportune time to engage with communities who have seen the real value of services and key workers ... utilise local networks and communications to tailor local messages in relation to services, access and what to expect.

Future enablers to improving outcomes for people noted, include:

- National primary care campaign, linking into a national primary care strategy, articulating primary care working, including mental health services, realistic medicine and self-management
- Building trust with consistent unambiguous messaging including *“seeing your primary care professional/health and care team (as opposed to GP)”*
- Realising the importance and effectiveness of ‘designed with’ rather than ‘communicated to’ messaging
- Creating person-centred, person-led and strengths based public messages
- Utilising the national public communications approach as a basis for consistent local messaging, across multiple channels in various formats

- Enabling and developing our staff to have realistic medicine and palliative care conversations; “good life, good death”
- Building on the benefits realised and resetting relationships between colleagues, “*secondary care came closer to primary care – far more collaborative and integrated*” – the way ahead!

Barriers to effective public messaging, including realistic medicine, noted, include:

- Lack of messaging, which can be as detrimental as unclear, cluttered, mixed messages
- Target driven messaging: Were some of the targets right in the first place? Is now the right time to say that some things in the past were unrealistic?
- Taking a digital only approach: we must consistently try to engage with people who are furthest away from services and reduce inequalities
- Inappropriate political distraction: “*There needs to be cross party support. Politicians and professionals need to stand shoulder to shoulder.*”

“To walk and not look back” – opportunities for next steps

We have a system-wide duty of care to work together, with common purpose and vision across the **whole health and social care system**, providing realistic health and care and meeting the needs of our citizens.

Primary care colleagues joined together in our workshops with common focus. Their commitment and drive to deliver exemplary services, their compassion, positivity and belief in a community-first approach, and their understanding that relational working is at the heart of the matter created future focussed virtual conversations in safe spaces.

To ensure 21st century primary care services in local communities can continue to support our citizens, workshop participants suggested the following opportunities for next steps should include:

- Developing a national Primary Care strategy
- Utilising whole system planning and modelling for whole community needs
- Mobilising general practice by identifying priorities and moving forward with contract implementation, including support for PCIP and aligning to strategic planning with HSCPs and NHS Boards
- Addressing health inequalities via realigning of existing primary care roles
- Public messaging informing people how to use primary care services and how they can better contribute to decisions about their own health and wellbeing (physical and mental)
- Improving IT infrastructure and sharing of data
- Seasonal vaccination discussions: learning and sharing how practices can contribute to this, in preparation for future COVID19 vaccine
- Enhancing multidisciplinary support within Care Homes including exploring staffing models with HSCP staff/NHS staff as ‘the norm’

[We] need a public conversation about realistic medicine.

Participants also asked some big questions, which should be addressed by primary care colleagues, health and social care leaders and the wider system:

1. Are we actually addressing health inequalities through the PCIPs and GP contract?
2. How can primary care better lead and drive improved care interfaces and behaviours to enable improved outcomes for people?
3. What does good look like and how do we share good practice* more effectively? (Including partnership working with the third and independent sectors.)

This report will be provided initially to:

- Workshop participants and colleagues in primary care
- The Primary Care GMS Oversight Group, including NHS Board chief executives, BMA Scotland, the HSC Scotland Chief Officer Group and SGPC
- The Mobilisation Recovery Group (MRG), which is chaired by the Cabinet Secretary for Health and Sport, THE MRG subgroup on Primary Care.

*Good practice will be identified and linked into the *Framework for Community Health and Social Care Integrated Services* and made available online.

Future joint working between HSCScotland and BMA Scotland

Via the post event evaluation, participants were asked, ‘Would you be keen on a follow up session?’ 95% of respondents answered positively.

One participant stated, “Joint working between the Chief Officer Group and BMA means being better informed to create the strategic vision needed at a regional and national level. Events such as this will support this joint working by bringing real experiences, information and creative thinking to the table for the chief officers and BMA to develop strategy.”

Co-chairs of this joint collaborative work, Val de Souza and Andrew Buist, would be particularly interested in hosting discussions about primary care’s role within the mental health and wellbeing landscape.

In addition, participants suggested themes for more detailed exploration, including: unscheduled care, delayed discharge, public engagement, health inequalities, Care Homes, anticipatory care planning, social care/primary care interface, workforce planning, community assets, interface between third sector, social and health care, preparing for EU Exit and potential impact on workforce and supplies.

Additional endorsements for the virtual workshops, included “more of this connectivity is needed” and “I believe that it is an area ripe for development. HSCPs and general practice need to work more closely together to provide a strength of voice that shifts the narrative away from constantly discussing acute service based targets.”

I liked this approach; it was useful to hear about the experiences of colleagues. This format could be used to gather information for other knotty problems.

Our contributors

Our thanks to colleagues across all regions for their support in attending and contributing to the virtual workshops, including colleagues who scribed and those who fulfilled roles as facilitator/timekeepers in the breakout rooms (see **Appendix 4.**) Thank you also to those who submitted feedback via the pre-event questionnaire. We hope this report expresses your reflections and hopes for the future of primary care.

Gratitude also goes to Mairi McTaggart from Animate Consulting, our virtual workshop facilitator for her expert, relaxed and skilled assistance in ensuring participants knew what was happening and how to approach the conversations in our virtual listening spaces. And for keeping everything running to time!

A special note of thanks to event organisers, Claire Maclachlan and Eleanor McCallum from Health and Social Care Scotland. As enablers for our virtual conversations they became Zoom experts overnight!

Thank you to everyone involved – organisers and participants – really welcomed this opportunity to come together.

Finally, thanks to the **Chief Officer Group, Health and Social Care Scotland** and colleagues from **SGPC, BMA Scotland** for their leadership and foresight, and for their belief and commitment in pursuing this collaborative piece of partnership working. We hope

that together we can ensure primary care, as the healthcare service at the heart of local communities, is no longer the 'canary in the coal mine', but can be supported and enabled to be at the front and centre of our 21st century healthcare system, ensuring people receive the right care at the right time, in their own home or homely setting, whenever possible.

We anticipate holding more joint events to explore next steps in primary care. We hope to see you then.

If you'd like your own copy of this report, please contact Claire Maclachlan (Claire.Maclachlan@glasgow.gov.uk)

Appendices

Appendix 1: Pre-event questionnaire comments

Appendix 2: Comments and chat from attendees during the virtual workshops

Appendix 3: Post-event evaluation from virtual workshop attendees

Appendix 4: Attendee list by region

Appendix content can be provided by emailing Claire.Maclachlan@glasgow.gov.uk