Royal College of General Practitioners
SCOTLAND

Mr Lewis Macdonald MSP
Convenor, Health and Sport Committee
T3.40
The Scottish Parliament,
Edinburgh
EH99 1SP

By email: healthandsport@parliament.scot

02 March 2020

Dear Mr Macdonald,

Thank you for your letter dated 17 February 2020 regarding the oral evidence that I provided to Committee members on 28 January on behalf of the Royal College of General Practitioners Scotland. This evidence formed part of the Committee's inquiry into the demand and supply of medicines.

I intend to respond to each of your points in turn:

10-minute appointments

In your letter you state that the Committee would like to understand the basis of the restriction to 10-minute appointments if this impedes a GP's ability to fully assess the treatment options available to patients.

The vast majority of GPs in Scotland – and indeed across the UK – offer 10-minute patient consultations as standard. The 10-minute model is not mandated to GPs, but is a timescale chosen as a result of the significant workforce and workload pressures that exist within general practice. Audit Scotland's recent report into Scotland's primary care workforce showed that even with the Scottish Government's commitment to deliver 800 additional headcount GPs by 2027, there will still be a GP shortfall of 661.5 GPs. These significant, national workforce challenges are reflected in the daily working lives of GPs. A recent ComRes survey of GPs in Scotland, carried out on behalf of RCGP, found that over a quarter of respondents said they were so stressed they felt they cannot cope at least once or twice per week. Furthermore, 81% of respondents said they work longer than their contracted hours every week. These significant pressures, coupled with increasing patient demand, mean that GPs are simply unable to offer longer appointment times as standard.

RCGP has consistently highlighted the need for longer consultation times within general practice. On average GPs consult for 9.2 minutes – this is one of the lowest consultation times in economically advanced countries in the world[1]. In Sweden for example patients will see their GP for on average of 22.5 minutes per appointment. RCGP would like to see appointments of at least 15-minutes offered to patients.

[1] G. Irving, A L Neves, H Dambha (2017) Miller, International variations in primary care physician consultation time: a systematic review of 67 countries BMJ Open

GPs are expertly trained to deliver truly patient-centred care and do their upmost to ensure that conversations in line with Realistic Medicine take place with patients in what are often difficult circumstances. However, with the increasingly complex presentations involving multimorbidity that we now see in an aging population, managing expectation and affording patients the time to explore all treatment options including those which do not involve a prescription within the confines of a 10-minute appointment basis is at times more than challenging for GPs.

Research

In relation to research, you asked what role RCGP can play in providing leadership on identifying and executing the research required and gathering information on unanswered questions.

RCGP actively promotes the highest standard of research through both its publication of the British Journal of General Practice (BJGP). BJGP is a monthly peer-reviewed journal expressly focussed on research pertaining to general practice and is sent to over 50,000 clinicians every month.

Beyond this RCGP specifically supports annual awards which focus on promoting high quality research and innovation in primary care.

RCGP Scotland will continue to promote high quality research through these mechanisms.

Curtailing the medicines budget

Your letter states that the Committee would appreciate further detail as to whether realistic conversations between patients and clinicians around medicines are a standard part of discussions between GP prescribers and patients. You have also welcomed further details on the role the RCGP can play in ensuring these conversations take place.

As previously stated, GPs are expertly trained – through both their time at medical school and their GP speciality training – to have meaningful conversations with patients, in keeping with the Realistic Medicine agenda. The College's curriculum and final exams (the MRCGP) which all GP trainees across the UK have to achieve in order to become fully qualified GPs, has the patient-doctor relationship at its heart and ensures that all GPs are fully qualified to carry out all aspects of general practice. Meaningful conversations with patients around medicines are of course part of standard discussions with GP prescribers and patients. Each consultation that a GP undertakes with a patient is unique and GPs are acutely aware of ensuring that information is communicated in a way that is appropriate and most useful for the patient sitting in front of them.

The RCGP's role in ensuring these meaningful conversations take place lies partly in the training and examinations that we provide for GPs. We also play a crucial role in championing the profession and as part of this, highlighting the benefit and need for longer consultation times with patients.

Non-medicines

Royal College of General Practitioners

SCOTLAND

You asked for detail on the governance role that the RCGP could play in ensuring that reviews of non-medicine prescriptions are taking place and detail of other mechanisms you believe could be utilised to achieve such improvements.

The prescribing of non-medicines is an area of challenge for GPs. Although GPs are the prescribers of non-medicines, there are not standardised quantities and formularies in all areas readily available to assure GPs that they are always providing the best value, most clinically appropriate item, in the same way that they are for medicines. Health Boards should look to ensure that there are checks and balances in place to support effective prescribing of non-medicines throughout Scotland. Although provision via a GP prescription might be a convenient method to provide a non-medicine, there are possible risks in asking GPs to do this when we are prescribing products we are not as familiar with. The current variation and growth in spending in non-medicines is not easy to rationally explain and provision by a non-expert may by contributing. New models could explore supply of non-medicines independently of GPs. Such a system can have review processes in place which are led by the experts in provision of these products. This could allow provision of the correctly chosen and clinically merited product, in a correct quantity and with ease of access to appropriate review from someone who understands the use of the product. This does not easily happen with GP provision. Such a system would free up GP time and improve the quality of prescribing. I am aware of several Health Boards looking into these issues, no less in Tayside where I lead the assurance group which has taken on responsibility for transforming all non-medicine provision as a single entity.

I trust that this information will be useful for Committee members. Should you require any further information, please do not hesitate to contact me.

Yours sincerely,

Dr Scott Jamieson

Dr Scott Jamieson
MBChB MRCGP DPD DRCOG
RCGP Scotland Executive Officer (Quality Improvement)