HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM BMA SCOTLAND

BMA Scotland welcomes the opportunity to comment on the Health and Sport Committee’s consultation into Primary Care in Scotland.

A broad definition of Primary Care is that it includes care delivered by all of the professions that are signatories to the principles and includes both in- and out-of-hours care, both physical and mental health services, and services provided across all community-based settings.

*Primary Care is provided by generalist health professionals, working together in multidisciplinary and multiagency networks across sectors, with access to the expertise of specialist colleagues. All primary care professionals work flexibly using local knowledge, clinical expertise and a continuously supportive and enabling relationship with the person to make shared decisions about their care and help them to manage their own health and wellbeing.*

We are now well into the second year of implementing the new GP contract in Scotland and starting to look towards the development of Phase 2. At this stage it is encouraging to see that progress has been made in certain areas. We are very clear that the GP contract has set Scotland on the right direction of travel, however it is equally clear that there is still a lot of work to be done and the pace of change must increase over the next 20 months if we are to see a positive substantial shift and improvement in the way primary care is delivered in Scotland.

The Scottish Government and the health boards, along with Integration Joint Boards (IJBs) and partnerships, must work together to meet their commitments to the contract in full. The core aim of the contract was – and remains – to restore hope to the profession and make becoming a GP an attractive career choice for young doctors by lessening some of the burdens, such as inappropriate excessive workloads, responsibility for employing a large practice-based team, and the risks associated with owning practice premises. This goes for GPs right across Scotland, both urban and rural.

We are seeing some movement on this – with some areas beginning to feel the benefits of the work of multi-disciplinary teams which free up GPs time to spend with the patients who need them the most. But it is also true that we need greater efforts and clarity on how the extra staff to make this happen will be recruited and deployed by NHS boards. The Scottish Government’s forthcoming, but delayed workforce plan should address these issues and we look forward to it being published urgently.

Other positive developments include that from April 2019 a new minimum earnings expectation has been introduced which ensures that GPs in Scotland earn at least £84,630 (whole-time equivalent – and includes employers’ superannuation).
But of course, we cannot forget that there were huge challenges facing us when the contract was signed in 2018. Those deep-seated problems – such as there simply not being enough GPs – were never going to be solved quickly. So it is little surprise there is a mixed picture across Scotland, and varied progress. There is a lot of work to be done. We – BMA Scotland’s Scottish GP committee, the Scottish Government and health boards all have to play our part to the full to deliver our sides of the shared commitment.

As a result it is vital to appreciate the crucial period we are now entering with delivering the contract.

It is time to reduce the risks of general practice, and make becoming a GP a more attractive career choice again. It is only then – when we have enough GPs to deliver the work that is expected of them – can we really deliver the level and standard of primary care Scotland requires. Recruitment and retentions problems remain a real issue and they must be alleviated. Primary Care in Scotland will suffer greatly if they are not.

While of course, we must seek ongoing improvements and ensure the contract works well for all parts of Scotland, both rural and urban, equally it would dangerous to lose focus on the solutions and positive steps forward the GP contract has set in motion. The focus must be on implementation of the deal agreed, which would only be threatened by any dramatic changes in course. That does mean a renewed and clear focus on delivery of all parts of the contract from all partners. Only then will we achieve the kind of long-term stability in the GP workforce that will allow all partners to make progress on some of the more ambitious transformation that phase two of the contract has the potential to deliver. It is in this context that we have set out our answers to the questions posed below.

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.

BMA Scotland welcomes the opinion that primary care needs to be delivered in a way that focuses on the health and public health priorities of local communities.

Intelligence gathered points to a lack of engagement with local communities currently, so a new mechanism needs to be developed in order to create a more streamlined approach.

Public health priorities for local communities will vary and therefore it’s correct that these decisions are best taken at local level – we believe HSCPs are well placed to deliver on this but have often, to date, been limited by the resources available to communities.

The intention of the new contract is to develop GPs as clinical leaders allowing them to engage in assessing and developing services to meet the needs of local communities, informed by good quality and timely intelligence. To facilitate this, new structures have been developed; GP Clusters where GPs from every practice meet to discuss quality improvement, and the GP Tripartite group (made up of Cluster Quality Leads, GP
Subcommittee and HSCP Clinical Directors). These structures will not have capacity to engage directly with local communities but can consider reports or HSCP strategies developed as a result of community engagement and, crucially, will allow GPs to focus on outcomes of relevance for patients.

GP Clusters and the GP Tripartite group will then be able to use their generalist medical knowledge and experience as clinical leaders of teams to comment on quality of services and to inform commissioning decisions of HSCPs. That should be mostly informed by clinical need and priorities, and we appreciate that this may, at times, need to be reconciled with public demand to make best use of clinical resources.

In addition to this, GPs need to be invested in to give them the protected time required to contribute effectively to these structures: they require a workload shift, with an increased number of GPs to backfill other GPs taking time out of clinical work. HSCPs need to engage more effectively, and directly, with local communities and feed that back to the GP structures.

It is also important to note that the priorities of local communities need to be framed in the realities of a system which is not able to provide everything that may be asked of it. This is the national conversation that BMA Scotland and the SGPC have been asking for.

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

The primary care system currently faces a number of barriers. Workforce supplies are a significant sustainability issue. The Scottish Government’s National Clinical Strategy wants to deliver more care at home or in a homely setting – but in order to deliver this effectively an increased workforce capacity is required: it simply cannot be done properly with the current numbers.

The current workforce within the primary care sector is aging: fewer people are coming in, and more people are going out. Transformation of the primary care sector requires a new workforce in addition to replacing those who leave and retire.

Clinical professionals are committed to helping people understand how they will benefit from new ways of offering primary care, and to listening respectfully to concerns and preferences, but progress can often be slow, and change resisted. Ensuring the best outcomes for people using primary care services requires the full clinical team to work together with patients and families, using the full range of face-to-face and technological options, to address health needs collaboratively. This can mean, for example, convincing someone that an appropriate, direct referral to a nurse, physiotherapist or other clinician is enhancing the service primary care provides, not diminishing it.
However, there is a lack of investment in infrastructure to accommodate community care staff – who require good IT connectivity between them – and replace facilities that have outlived their use.

The lack of a national conversation about what kind of health service the public really wants is also a major barrier to delivering a sustainable primary care system. We need to know what is important to them, whilst ensuring they appreciate that there are limits on total expenditure and some things will need to be either/or. Primary care is always expected to be there, and accessible at all times: however, when waiting to see a GP are too long, sometimes the view is that this is because the service is inefficient rather than they simply lack capacity.

Another barrier is that often issues are approached from the wrong side: instead of looking at current hospital workloads and asking what are we doing in hospital which could be done by GPs/Primary Care we should be asking what is going on in General Practice and the community which really needs the involvement, expertise and facilities of secondary care, and what would the most effective patient pathways be, taking account of the use of both secondary and primary care resources?

Finally, a major barrier for primary care – in both urban and rural areas – is the lack of young GPs who have the confidence to take on partnerships, which are the basis of sustainable general practice across the country.

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

BMA Scotland believes General Practitioners require better intelligence and data on what they are doing and the health outcomes: referrals, A&E attendances, unscheduled care admissions, days occupancy. Prescription costs adjusted for age and sex need real-time data to build the case for improvement and, in some cases, additional investment. GP Clusters working with Public Health and the LIST analysts from NSS will also determine what intelligence is most useful to them, allowing them to improve quality outcomes.

GPs and primary care workforce also need to be aware of the number of children on ‘at-risk’ registers, numbers of suicides, numbers of drug-related harm in order to identify areas that require increased support for these issues.

Data must be gathered in a consistent way across Scotland and across different members of the service. The IT used by the MDT needs to be able to be integrated – this issue is central to what we seek to achieve through Phase 2 of the Scottish GMS contract, whereby in future the case for additional health resources, including additional GP time, additional
health visitors, district nurses, mental health workers, drug and alcohol counsellors, needs to be based on needs and activity.

It is also important that this intelligence is delivered in a positive manner in order to encourage reflection and improvement.

GPs within the GP Clusters and GP Tripartite group will, as senior clinical decision makers, be responsible for assessing performance of their own practices and that of the wider community team, and will evaluate change through considering quality outcome measures. HSCPs and Public Health, along with the Scottish School of Primary Care will have a role also in evaluating the effectiveness of MDT and GP Cluster working – much of which will require long-term studies to capture changes in clinical outcomes which will only become apparent over years.