HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM RCGP SCOTLAND (ROYAL COLLEGE OF GENERAL PRACTITIONERS)

1. Considering the Health and Sport Committee's report on the public panels, what changes are needed to ensure that primary care is delivered in a way that focuses on the health and public health priorities of local communities.

General practice is at the frontline of the NHS, playing a crucial role in providing primary care to patients in the heart of communities across Scotland. RCGP Scotland members have reported increasing workload pressures, rising patient demand and continued underinvestment in general practice are having a significant impact on them and their patients. Therefore, RCGP Scotland is calling for commitments to urgently bolster the GP workforce and increase the level of spending in general practice to 11% of the Scottish NHS budget. Appropriate resourcing will enable general practice to provide the high quality care that meets the current, and future needs of patients in Scotland.

- **Increase investment to general practice**
  The renewal of general practice must be underpinned by increased funding for service. General practice must receive 11% of the total NHS budget to enable an increased workforce with new roles that create sustainable workload levels, development of teaching and training for general practice, and digitally enabled care for patients.

- **Build a workforce to meet patient need**
  Planning the GP workforce using headcount numbers is not sufficient because it does not take into account the working patterns of GPs. In order to meet the current and future needs of patients in Scotland, general practice workforce planning must be realistic and reflect the differing needs of communities across Scotland.

- **Provide time to care**
  GPs must be given the time that they need to care for their patients. Increasingly, 10-minute appointments don’t work for patients or GPs. With minimum 15-minute appointments being provided as standard, patients would be given more choice over their care. To achieve this, more GPs must be introduced into the system.

- **Improve healthcare systems for the benefit of patients and GPs**
  Urgent investment in IT is required to ensure that systems work more effectively together, improving reliability for clinicians and patients. Before new digital services are rolled out, they must be fully evaluated to ensure that they improve patient safety and reduce health inequalities and clinician workload.

- **Tackle health inequalities**
  GPs play a vital role in tackling health inequalities. GPs serving areas with high socio-economic deprivation should have access to appropriately increased resource, to ensure that the NHS is at its best where patients need it most. Community Link Works should be rolled out to practices across Scotland, with practices in areas of high deprivation prioritised.

- **Promote Scottish general practice**
  Increased exposure to general practice during training encourages medical students to pursue a career in the profession. General practice should be supported through adequate investment to enable 25% of the undergraduate medical school curriculum to be delivered in primary care. GPs who wish to return to general practice in Scotland after moving abroad should be able to do so as easily as possible through adequately funded and publicised return-to-practice schemes.

- **Safeguard the future of the NHS in Scotland**
  We need a National Conversation, led jointly by politicians, healthcare professionals and patients, to promote sustainable use of the NHS and safeguard its future.

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

In RCGP Scotland’s recent national policy report, *From the Frontline*, 30 key recommendations were made to reflect the feedback that was received from GPs across Scotland during the report’s development. It is not an easy time to be a GP within Scotland’s primary care system, with workload rising and a diminishing
GP workforce. While *From the Frontline* explores many current barriers, and proposed solutions, in detail, the following will look at key policy areas where we believe change would result in a more sustainable primary care system for patients and clinicians.

**Workforce**

General practice in Scotland faces significant workforce challenges which must be tackled by policymakers if the future of the profession is to be secured. There are not currently enough GPs working in Scotland to meet rising patient demand. Many GPs are choosing to leave the profession, and we are not recruiting enough new GPs to meet the deficit.

The most recent figures from NHS National Services Scotland’s Primary Care Workforce Survey 2017 show that the estimated number of whole time equivalent (WTE) GPs working in Scotland has been steadily declining in recent years, with levels falling from 3,735 WTE GPs in 2013 to 3,645 in 2015, to 3,575 in 2017. This represents a decrease of more than 4% over the period.

In December 2017, the Scottish Government pledged to increase the GP workforce by 800 additional headcount GPs by 2027. Whilst this was welcomed by RCGP Scotland, no commitment was given however to how many sessions of time these GPs would be expected to provide, making this workforce planning less reliable in terms of accuracy. With increasing numbers of GPs choosing to work part-time, it is likely that these additional 800 GPs will represent a far smaller number of WTE GPs. While we recognise the impossibility of predicting individual GP working pattern intentions, we call for workforce planning to be based on aspirational WTE numbers rather than headcount numbers to ensure more accurate predictions and allow recruitment efforts to be adjusted accordingly.

Workforce challenges are felt particularly acutely in remote and rural areas and in the Out of Hours service, where a range of factors are culminating in a lower number of GPs. A concerning decrease in both headcount and WTE numbers for GP Out of Hours services is reported between 2015 to 2017.

**RCGP Scotland’s Key Asks on the topic of Workforce are:**

- Policy makers must ensure that workforce planning is based on WTE figures and not headcount to ensure accuracy around the planning and reporting of recruitment efforts
- RCGP Scotland calls for the establishment of a new target for the number of WTE GPs needed in the workforce by 2024/25 to meet growing demand

**Workload**

RCGP Scotland members report a rising workload along with rising patient expectations and demand. We are caring for an ageing population where more and more people are living with multiple long-term conditions. We are experiencing increasing fragmentation of community-based teams, challenges at the interface between primary and secondary care, entrenched health inequalities, continued funding pressures and a diminishing Whole Time Equivalent (WTE) GP workforce. All these factors impact the wellbeing of Scotland’s GPs.

The diversity of GP roles across the country makes workload all the more challenging to understand and measure. Understanding the reasons for poor practitioner wellbeing that stem from issues surrounding workload, and working with key partners to find solutions, is a key priority for RCGP Scotland. For example, the clinical breadth of workload in remote and rural settings, where the wider MDT is less available, can look and feel quite different to the high-volume workload of deprived urban settings, which will often have an element of social complexity. The second phase of the new GP contract (“Phase 2”) will specifically measure workforce, income and workload, encapsulating the range of clinical settings and their specific challenges, and crucially try to measure (and resource) workload based on patient need rather than demand.

RCGP Scotland would like to see moves to enable a “minimum of 15-minute consultation” as standard, because current 10-minute consultations do not afford GPs the time they need to care for increasingly complex care needs of patients, and more people who are living with multiple long-term conditions within communities. This will only be possible by increasing the number of GPs and reducing their current workload.

GPs are at the frontline of healthcare in our communities. We need to continue to address the multiple issues that are impacting our highly skilled, highly dedicated workforce so that they feel valued and can re-discover the joy of general practice.

**RCGP Scotland’s Key Asks on the topic of Workload are:**
• RCGP Scotland involvement in how workload is measured for Phase 2 of the GP contract, to capture and reflect the complexity and diversity of our workload challenges in different settings
• Longer consultation length as standard, allowing GPs to engage more meaningfully with their patients and their often-complex needs

The Interface
The “interface” as it relates to healthcare, is the point at which two systems come together, be it primary and secondary care, in-hours and Out of Hours care, health and social care, or within primary care itself across the multiple interfaces of extended multidisciplinary teams.

These systems are independently complex and do not always relate or communicate well with each other. Their different IT systems, cultures and priorities all contribute to this. Consequently, interfaces are points of high risk for patients accounting for 50% of all medical errors, with one third of those errors occurring at the primary-secondary care interface. On the other hand, a well-functioning interface impacts positively on patient safety, efficiency of systems, patient experience, interprofessional relationships and morale. This is what we should be striving for and has underpinned why improving the primary-secondary care interface has been a key priority area for RCGP Scotland over recent years.

Even though there is increasing recognition throughout all areas of health and social care, and among policy-makers, that efforts need to be focussed on improving our interfaces and promoting more collaborative ways of working, many significant barriers still exist. Inadequate IT systems, that do not allow reliable or efficient clinical information transfer across interfaces, are a frequently cited concern by the profession due to the detrimental impact on the quality and safety of patient care, and on wider system efficiency. These also limit the development of clinical decision support (for example, dedicated email advice lines) to enable management of increasingly complex patient needs within the community, with the potential to reduce unnecessary investigation, referral or admission.

Another barrier to improving interface working is the lack of opportunity for clinicians to come together across the interface. Joint learning events are now very rare, as clinician workload across the healthcare system has increased along with their tendency to work in silos. The new GP Contract has taken a small step forward in this regard, with the provision of one protected learning session per month, per practice. This is clearly welcome but is inadequate to allow GPs and other clinicians the time needed to undertake this interface work effectively. An increase in protected learning time will likely improve clinical care and Quality Improvement work, and indeed may help to achieve the aim of growing the GP workforce by building-in time to learn.

RCGP Scotland’s Key Asks on the topic of The Interface are:
• Dedicated interface groups in every Health Board area should be mandatory and not optional, with interface improvement included in the strategic plans of Integrated Joint Boards
• Urgent investment in IT infrastructure is required to improve interoperability, accessibility and the reliability of clinical systems
• Increase overall protected “time to learn” for GPs to allow more opportunity for joint learning and service development with hospital colleagues

The Patient Voice
RCGP Scotland has called for a National Conversation between clinicians, decision makers and the public. That conversation requires two layers. First and foremost is one concerning how society views future sustainable use of the NHS, more than seventy years after its inception and in the face of rising public expectations and demand. The second, and more specific issue for GPs at the current time, is how to engage and educate the public about the new models of primary care resulting from the GP contract in Scotland. These new models involve appropriate delegation of clinical work, traditionally undertaken by GPs, to other members of the wider MDT with receptionists (or “care coordinators”) playing an active role in non-clinical triage and “signposting” at the first point of contact. In addition to the feedback received from the ALLIANCE events, there is much anecdotal evidence from GPs that many patients are struggling to understand, accept and navigate these new systems. This is putting additional strain on practices. This evidence has been reinforced by the results of the latest RCGP annual tracking survey. Two questions were included for Scottish GPs to determine how patients were responding to these changes.

The majority of respondents stated that significant levels of clinical time were being spent educating patients, and that significant numbers of patients were expressing distress, anger or confusion at being asked for additional information by receptionist colleagues when contacting the practice. This has provided
a useful evidence base on the critical need for any local education to be supplemented and supported by a national information campaign, whilst considering the highly variable levels of health literacy across our country.

The voice of the modern patient is increasingly a digital one. As technology continues to create new ways of accessing care, patients and clinicians will need support in using these new systems. There is concern that without adequate digital infrastructure to support these new models, particularly in remote and rural areas where broadband speed and mobile signal may be poor, this may result in a new “digital Inverse Care Law” with the use of such services dominated by those with least medical need. RCGP Scotland calls for Health Equity Impact Assessments where each new implementation is evaluated for its impact on practices and patients in more deprived and remote areas. Further research is also needed to fully assess the impact and potential unintended consequences of new technology on both patient safety and GP workload.

RCGP Scotland’s Key Asks on the topic of The Patient Voice are:

- Work collaboratively with Scottish Government and Health Boards to develop a public education campaign about the changing models of care in general practice to support GPs and their wider primary care teams
- Gain public agreement on how to use the NHS sustainably through a cross-party National Conversation, led jointly with healthcare professionals and patient groups
- Before wider adoption, all new digital services should be fully evaluated in terms of impact on patient safety, health inequalities and clinician workload

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

The Multi-Disciplinary Team (MDT)

Under the terms of the new GP Contract, the Scottish Government aims to expand the number of other healthcare professionals working with GPs within a wider primary care MDT. For a number of less complex medical issues it makes sense that patients can be seen by an alternative healthcare professional, such as a Mental Health Nurse, Pharmacist, Physiotherapist or Advanced Nurse Practitioner, when it is safe and appropriate for them to do so. This enables the GP to have additional time to see patients presenting with more complex or multiple problems, which is when the GP’s medical expertise is most needed. There is a significant need for more local flexibility to enable safe and efficient patient care with co-ordinated services led by GPs as expert medical generalists.

RCGP Scotland supports the valuable role other healthcare professionals can bring to patient care in general practice and regards these as safe and effective clinicians who form an integral part of the wider enhanced team, both in-hours and Out of Hours. However, we must ensure that these important primary care professionals will complement and bolster the role of the GP, not substitute it. Nor must it be viewed as a “sticking plaster” for difficulties in retaining and recruiting GPs, by simply moving workload elsewhere.

As teams expand, we must remain mindful of the potential risk of fragmentation of care. Expansion of the MDT must be complemented by improvements in IT systems to facilitate safe and reliable communication, and access to clinical information, to ensure the continuity of care that patients value so highly. We must also protect time within the working week for the new members of the wider team to both learn together and build these new teams. Essential ingredients for any successful change management include establishing relationships of trust, having clarity and respect for each other’s roles and limitations, and having a shared purpose and goal around patient care.

Clusters

RCGP Scotland wishes to see implementation of the national guidance for Clusters, co-written with SGPC and Scottish Government, with input from key stakeholders, to allow Clusters to focus on local quality work as intended. Clusters offer huge potential to share best practice and learning as they mature, but this will require adequate and consistent resourcing. It is also crucial that high quality primary care data is available to all Clusters across the country to inform local decision making and measure outcomes. This in turn is dependent on adequate IT systems to support schemes such as Scottish Primary Care Information Resource (SPIRE) and the Primary Care Clinical Dashboards, together with local data analyst support.

Health Inequalities
The mechanisms for addressing health inequalities, within existing allocated budget, sit at a local level through local structures (Health & Social Care Partnerships, Integration Joint Boards) and Primary Care Improvement Plans (PCIPs). There is significant variation in how health inequalities are being approached locally within PCIPs and there are varying levels of interest and commitment to address these inequalities in different Health Board areas. There needs to be a more robust and standardised approach, and a better understanding of where the responsibility lies, to address this important issue, be it at a central or a local level.

**Monitoring and Evaluation**

With new models of care proliferating across Scotland, there is a need to develop a robust evidence base to support policy and funding decisions at a local and national level. The Scottish School of Primary Care is a well-respected and valued organisation which is well placed to add value to the current climate of primary care reform, as evidenced in the recent report entitled *National Evaluation of New Models of Primary Care in Scotland*. 