HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM NHS Education for Scotland

1. 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?

1.1 Primary care is the backbone of our healthcare systems – it is the key to continuity and integration, it is essential for patients, particularly those with complex needs. It has been proven to be highly effective and efficient way to address the main causes and risks of poor health and well-being as well as handling the emerging challenges that threaten health and well-being tomorrow. It addresses the health needs of all patients and improves the performance of health systems.

1.2 The training of general practitioners needs to continually evolve to reflect the changing needs of society, and to deliver the goal of the GP as the expert medical generalist at the centre of a multi-professional team working across an integrated health and care system which ensures that there is collaborative working between the public, voluntary and other sectors for the benefit of the local community.

1.3 Some of these changes are already in train – for example, the educational reforms set out by the UK Shape of Training Steering Group are guided by the principal that medical education and training must be configured to meet the needs of patients, while needing to ensure that medical careers remain sustainable and fulfilling, and that central to the delivery of high quality care are those who work and aspire to work in our healthcare services.

1.4 NES is already supporting these changes by delivering flexible training options for doctors in primary care, including a rural track training programme which delivers the UK GP curriculum in a remote and rural context, and developing a remote and rural credential to support trained GPs working in rural general hospitals. Alongside this, NES provides training fellowships, including in medical education, health inequalities, paediatrics and leadership training for GPs.

1.5 Although it takes 10 years to train a GP (5 years at medical school and 5 years in postgraduate training), it is recognised that this is the shortest training programme of any medical specialty in the UK. It will be essential, therefore, to ensure that resources continue to be available and refreshed to support the ongoing updating and continuous professional development of trained GPs, given the pace of change.

1.6 Whilst recognising the key role of the GP in the primary care team, there is a need to ensure the development of the whole team. This will include supporting career frameworks for nurses working in the community, in district nursing, public health, health protection, children’s nursing as well as general practice nursing.
Pharmacists, and pharmacy technicians working in primary care will also have a key role to play, as will practice managers[^11].

1.7 It is of note that a key priority to emerge from the committee’s report, and key message from the panels was the **development of appropriate technology in support of primary care**, including an electronic patient record, shared with all relevant professionals – a single set of records integrated across all care services – and a consistent platform, used for electronic test results, correspondence, etc.

1.8 In this context we would draw to the attention of the committee the development of the NES Digital Service – NDS[^12]. A key deliverable of the Digital Health and Care Strategy is a **national digital platform** which enables citizens and the workforce to easily access and understand the information they need, where and when they need it. NES has been requested by Scottish Government to lead development of the national digital platform to replace the current model of multiple systems which has led to duplication and placed limitations on our use of data.

1.9 The **National Digital Platform** will be developed with clinicians and the people who use services, to safely and securely deliver data to better support care, to allow for innovation and service development and to support research and the efficient use of services.’. The platform will be built, tested and rolled out through the development of products that improve the quality of patient care; and will connect to existing infrastructure to minimise disruption.

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

2.1 Central to the delivery of high-quality care are those who work and aspire to work in our healthcare services. **Supply** into the primary care workforce – across all professional groups – but particularly the medical workforce continues to present challenges.

2.2 The number of medical graduates coming out of UK medical schools is currently less than the number of year one specialty training posts which we are seeking to fill to deliver the projected requirement for consultants and general practitioners. Substantial **increases in medical undergraduate numbers** have been announced both in Scotland and the UK, which will significantly improve the position, but it will be some years before these increased undergraduate intakes enter specialty training, and it is likely that further increases will be required.

2.3 It is also the case that some specialties are more popular than others amongst medical graduates, although the service requires almost 1 in 2 graduates to work in general practice. Significant work is required, therefore, to **encourage a higher proportion of medical graduates to enter GP specialty training**. Initiatives which are planned or under way include (i) working with the Scottish Funding Council and Medical Schools to improve the image of general practice and to increase the
proportion of the undergraduate curriculum which is delivered in primary care, (ii) increasing the exposure of early years (foundation) postgraduate trainees to general practice and (iii) working with the service to support more flexible approaches to working and training – including less than full time working and career breaks.

2.4 The committee will be aware that following an announcement by the First Minster of a 30% increase in GP training places in 2016, NES has substantially re-worked GP training programmes across Scotland, to both increase the number of programmes offered, and to improve their attractiveness. This has resulted in improved fill rates, and we expect to see almost a 30% increase in doctors completing GP training over the next 2 years.

2.5 In addition to improving the supply into the GP workforce, a number of approaches to retaining the existing workforce are essential – including supporting existing doctors through providing coaching, supporting GPs to stay in practice through the ‘Stay In Practice Scheme’\(^\text{13}\), supporting doctors who have left clinical practice to return\(^\text{14}\), supporting those who (for personal reasons) reduce their hours to retain\(^\text{15}\) their skills, and supporting overseas\(^\text{16}\) graduates who come to work in the UK to make a smooth transition into UK practice.

2.6 All of these initiatives, as well as those aimed at increasing the supply of the non-medical primary care workforce, will require a substantial increase in the available educational capacity in primary care. For example, currently, only 9% of undergraduate medical education takes place in general practice – so the ambition to increase this to 25% will require considerable investment in additional teaching capacity.

2.7 Similarly, there are substantial pressures on the available educational capacity for postgraduate training – of the 944 GP practices in Scotland, only 337 support the training of GPs, and only 105 support the training of early years (foundation) postgraduate trainees in a primary care setting. An education capacity group is currently exploring the capacity to deliver training of other health professionals within primary care, the role of clusters in teaching/training, and hub and spoke models to encourage non-training practices.

2.8 The delivery of a primary care workforce for remote and rural Scotland is a key priority. We know from the extensive research into workforce development conducted and commissioned by NES\(^\text{17}\) that ‘location’ is a key driver of the choices doctors make about where they aspire to live, work and train. In short – doctors commonly aspire to live and work ‘where they came from’, and so the process of selection into undergraduate medical education is critical – not only in terms of widening access generally, but also in terms of ensuring access from a wide geographical area.

2.9 NES has invested in education and training to support the remote and rural health and care workforce, through the Remote and Rural Health Education Alliance (RRHEAL)\(^\text{18}\) supporting inclusive access and at distance educational engagement.
RRHEAL develops educational tools and links to material specifically relevant to teams supporting health and social care for remote, rural and island populations of Scotland.

2.10 For the medical workforce in rural areas, NES has put in place a dedicated (and popular) rural-track training programme, provides bursary support for training programmes in hard-to-fill areas, developed rural fellowships for GP’s following the completion of training, and is working with the service and the General Medical Council to develop a remote and rural credential as part of the ‘Shape of Training’ project.

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?**

3.1 Although primarily an area for the collection and analysis of data by NHS Boards, NES can support this area by building capacity and capability for Quality Improvement\(^1\) across the public service through a range of educational programmes and resources. NES has developed a range of training materials and tools to help individuals and organisations improve their understanding and knowledge of Quality Improvement. Formal face-to-face Quality Improvement education programmes available include the Scottish Quality & Safety Fellowship, the Scottish Improvement Leader (ScIL) programme and the Scottish Improvement (SIS) programme.

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2. WHO Primary Health Care, February 2019. (Link)
3. Van Weel C and Kidd MR Why strengthening primary health care is essential to achieving universal health coverage, CMAJ, 2018, 190, E463-E466 (Link)
5. Report from the UK Shape of Training Steering Group (UKSTSG) 2017. (Link)
7. GMC Credentialing, 2019. (Link)
8. NES GP Fellowships. (Link)
9. Continuing Professional Development – CPD Connect (Link)
10. Career development frameworks for nurses working in the community. (Link)
11. Practice Manager Development (Link)
12. NES Digital Service (Link)
13. GP Stay In Practice Scheme (Link)
14. Scotland GP Returner Programme (Link)
15. Scotland GP Retainer Programme (Link)
16. Scotland GP Enhanced Induction Programme (Link)
17. NER Medical Directorate Education Research and Innovation Annual Report 2019 (Link)
18. The Remote and Rural Healthcare Education Alliance (Link)
19. Safety and Improvement Resources (Link)