HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM GLASGOW LOCAL MEDICAL COMMITTEE

Glasgow Local Medical Committee (LMC) is the representative body for all NHS Greater Glasgow & Clyde (NHSGGC) GPs. The LMC represents over 1,200 GPs working in GP practices and across primary care settings in GG&C. We work with the Health Board, Integrated Joint Boards and other local government and voluntary sector organisations interfacing with GPs in developing policies for general practice and patient care. We also work closely with the British Medical Association in forming national policies and liaising with the UK and devolved nations’ governments.

The LMC welcomes the opportunity to respond to the following questions-

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?

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

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?

Question 1

The H&SC Report identified the main areas that need a clear focussed approach to developing primary care services that is fit for the future. We agree that improving the use of technology to deliver primary care is key. We call for more investment in IT hardware and infrastructure for GP practices and the wider primary care team as well as a comprehensive strategy for eHealth in primary care. For too long, primary care services and GP practices have put up with out-dated IT equipment and software which hinders rather then enables good patient care. Safe and transparent sharing of patient information for care should be the norm. Electronic systems should be in place to allow patients and carers to opt out of sharing of their data for care if they wish and also be able to access the own data under the DPA without the need for time consuming and costly printing out of paper records.

Care needs be taken with roll out of electronic consultation models such as web or email consultations as well as wearable technology to ensure that only cost effective and evidence based solutions are implemented. In addition, there is an increasing evidence in England that the roll out of certain commercial online consultation services can destabilise general practice services and can disadvantage groups of patients are unable to access these new services.
We agree that the expanding access to the wider primary care team without the need for a GP referral is important. This is part of the implementation of the 2018 GP Contract in Scotland. Access to primary care staff via signposting and practice based triage by receptionists will streamline the care to patients. This includes practice based pharmacotherapy teams (pharmacists, pharmacy support technicians), community treatment and care services (phlebotomist, nurses), community vaccination teams, advanced practice physiotherapists, advanced nurse practitioners, and community links workers. Patients should be able to see the right health professional at the right time without the need for multiple consultations and the need for inter-professional referrals.

As the 2018 GP Contract is implemented GPs’ time will be freed up to allow them to re-focus their role as the leaders of the expanded primary care teams and the Expert Medical Generalist. GPs will be able to spend more of their time and expertise on the needs of patients with long term conditions and anticipatory care plans for those with multi-morbidity, chronic conditions, palliative care patients, with a focus on the right care to prevent frail elderly patients from being admitted to hospitals.

A concern that we have is the NHS taking over responsibility from local authority. The budgets for social care spending is always under considerable pressure and there is a risk that pooling of cost pressures from social care provision with the wider NHS financial challenges will destabilise services in primary care and GP practices. Any move of responsibility for delivery of social care from local authorities to the NHS needs to be carefully planned and transitional arrangements may be required.

Finally, workforce considerations along with comprehensive planning of the skills and numbers of primary care workers required to deliver the service is critical. A committed workforce in the community needs to be supported adequately in terms of career progression, effective management and pay structures as well as a working environment that is responsive to staff needs.

Question 2

Glasgow Local Medical Committee represents the GPs working in area of NHS Greater Glasgow and Clyde which is predominately an urban area with few areas of rurality. The main challenge for GPs in NHSGGC has been the lack of GP workforce. The reasons for this are multi-factorial and include fewer doctors choosing general practice as a career, an increasing number of trained GPs leaving the UK profession either retiring early or emigrating, more GPs working less than full time, the perceived increase in financial and personal risk for being a GP partner, and the intensity of current GP workload demoralising doctors. The Annual Appraisal system is another reason frequently cited by doctors as adding workload and bureaucracy to an already burdensome professional responsibility.

Also, we are increasingly hearing from doctors who are leaving the profession due to the negative financial impact arising from the Pensions reforms at UK level affecting doctors’ contribution rates and pension tax allowances.
The 2018 GP Contract aims to make general practices a more attractive career for doctors that will both attract doctors in the profession and better retain current GPs within the profession. It is vital for the future of primary care in Scotland that there is an environment for GPs that values their medical expertise, that reduces the current unsustainable workloads that many GPs face, that remunerates GPs adequately for their training and role within the NHS, and that reduces many of the financial and contractual risks facing GP partners.

One of the main pressures on general practice and primary care affecting NGSGGC is the issue of deprivation. The area of NHSGGC has many of the most deprived communities in Scotland and in the UK. Deprivation brings significant challenges for delivery of GP services and primary care. Mental health and addiction as well as earlier onset of almost all the chronic diseases such as ischaemic heart disease, stroke disease, general frailty, diabetic complications, etc puts significant pressures on services. Planning of service delivery must take into account the additional needs of deprived communities and the need for investment in services and education to minimise the gap in health outcomes and to mitigate the increasingly recognised impact of early years childhood adversity.

Question 3

We are approaching 18 months since the start of the implementation of the 2018 GP Contract. Whilst key priorities such as the Vaccination Transformation Programme (VTP) and Pharmacotherapy service is now underway in GGC, there is still much work to be done for full implementation of the GP Contract. In GGC there is delivery of the Pre-5 Immunisations by HSCP teams. The part of the national flu immunisation programme will be piloted in 2019/20. Work is ongoing to scope out the requirements of other aspects of the VTP and we are working closely with NHSGGC in this work. Other contract areas such as Pharmacotherapy that is bringing pharmacists and pharmacy support staff into general practice are being implemented.

A key challenge is the availability of the pharmacy workforce. Community care and treatment will deliver phlebotomy and community nursing and treatment services such as wound care, dressings and chronic disease monitoring, taking this workload away from GP practice staff.

Implementation of these services in GGC, including community links workers, advance nurse practitioner and also advanced practice physiotherapists is overseen by the Primary Care Programme Board (PCPB) which has input from Board leads, HSCP leads, GPs leads, nursing leads and other professional leads. The PCPB meets monthly and overseas and advises HSCPs on the implementation of these new services and staff. We feel that this group functions well. Development of the new teams and effective working by the new team members has been a focus of the PCPB and a sub group has been formed focusing exclusively on the development and training requirements of the team members.
The PCPB has involved expertise from the Public Health department of NHSGGC to conduct an evaluation of the implementation of the 2018 GP Contract and its impact on workload on general practice and the outcomes for patients. The expertise of the analysts from the Local Intelligence Support Teams (LIST) will assist in this work. The implementation timescale is 3 years and we expect the Public Health evaluation work to report by Year 3.

In terms of GP Cluster working, the national guidance for GP Clusters was published recently by the Scottish Government1. This document sets out the direction for GP cluster development outlining the intrinsic and extrinsic roles of the clusters.

GP Clusters are not delivery organisations. They are groups of GPs- Practice quality leads from each practice lead by a Cluster quality lead, who met to discuss clinical quality of services and to form a quality agenda for the cluster to take forward. This is in keeping with the GP Contract which will refocus the GP role to being the clinical leaders of the expanded multi-disciplinary primary care teams in the community.

GP Clusters are still developing and as more GP time is freed up as part of the 2018 GP Contract implementation, we hope that GP Clusters will be able to take on more work as part of the quality improvement agenda that will both improve the quality of NHS services, and also to advise on how to spend NHS resources effectively to get the best health outcomes for patients.

As part of the GP Contract implementation, the Tripartite group will be developed in each Health Board area which will bring together the expertise of GP Subcommittees, Cluster Quality Leads and Clinical Directors of HSCPs to articulate a unified GP clinical voice giving advice to Health Boards and HSCPs on clinical pathway redesign and the efficiency of services, and also ensuring that commissioning of new services is clinically lead. This vital clinical advisory link for HSCPs, which are the community health service delivery organisations and service commissioners in Scotland, has been missing for some time. We remain concerned that HSCPs as they are currently configured may lack the necessary infrastructure to undertake an effective commissioning role that is required to develop primary and secondary care services.

Glasgow Local Medical Committee

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