Royal College of General Practitioners

SCOTLAND

From the Frontline

The changing landscape of Scottish general practice

#RenewGP

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SCOTLAND

Foreword from

Dr Carey Lunan, Chair RCGP Scotland

I am proud to be a GP in Scotland. The longer I work in this specialty, the more I believe that being an excellent GP is one of the most intellectually rewarding roles in the NHS. We should never underestimate the skills it takes to do this incredible job well. We need to balance detail and nuance with bigger picture perspective, rapidly assimilate and make sense of unfiltered presentations in 10-minute consultations and manage the risk and tolerate the uncertainty that comes with a career in generalism. We need a wide and ever-expanding knowledge base, a commitment to life-long learning and an understanding of relationship-based care. We need to work, not just as clinicians, but often as educators, innovators, mentors, coordinators, advocates and leaders. We often journey with our patients and their families, providing contextual and holistic care in a way that no other speciality can. As the evidence-base for "continuity of care" in improving both morbidity and mortality grows, these valued relationships of trust that we build over time, through sickness and health, prove to be more valuable than any medicine.

But I am a realist as well as an idealist. It is not an easy time to be a GP and we are all aware of the challenges that we are facing in terms of rising workload and a diminishing workforce. Our primary care landscape is changing rapidly in response to these challenges. This report explores what we feel are the most important issues facing the profession and our patients today and makes a series of recommendations at the end of each chapter.

My personal priorities as Chair – building the GP workforce, improving the primary-secondary care interface, improving practitioner wellbeing, and leading on a National Conversation about sustainable NHS use – are included in this report. I am grateful to all the frontline GPs who fed into this report. I am also very grateful to those who responded to our Wellbeing Survey and to our Patient Partnership in Practice Group, P^3.

I am committed to continuing to work collaboratively and constructively with colleagues in the Scottish Government and in the BMA to make sure that the voice of general practice is heard and that together we build a primary care system that is fit for the future and able to address health inequalities, deliver realistic medicine, and offer high quality and safe patient care in every setting.

Thank you for reading.

Carey

Foreword from

Colin Angus, Chair Patient Partnership in Practice (P³)

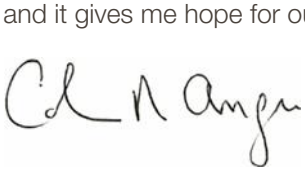
I am proud to be a patient in Scotland. My relatives, friends and I all have many positive experiences with the care that we receive from our healthcare professionals and in particular from our GPs. Had it not been for the professionalism and compassion of his doctor, my brother-in-law's cancer diagnosis could have been missed and he would not be with us today. His GP had the time to listen to him and start his care and treatment at an early stage, which saved his life. His GP knew from his body language that all was not right.

Had it not been for the expertise of my GP, a diagnosis of mine would have been delayed, with a possible life-threatening outcome. Had it not been for my niece's GP she would not have been able to cope with her diabetes. There are, however, many more challenges now, as we age and seem to gather more and more health conditions on our journey through life. Our longevity is a testimony to the success of our NHS. I now have two brothers-in-law over 80 and a brother-in-law aged 103, all in good health.

Timely access to our GP and members of their team is essential. As patients' demands change, with more reliance on medication and treatments, we need to take more control of our health and wellbeing and can only do this if we are better informed so that we can be more empowered to question our options by having a true and meaningful partnership with our healthcare professionals. We need to acknowledge that it may not always be our GP who sees us, but whoever it is, we need to be helped to understand why that is and be assured that our GP is still there to offer that continuity of care we value so dearly.

I am privileged to have chaired RCGP Scotland's lay patient group, P³, over the past 4 years. I and my fellow patients on P³ have ensured that our voice is not only heard in the College but at Scottish Government and Health Board level. Our agendas have helped to discuss the challenges that lie ahead for all of us.

I am heartened to note that more emphasis is now being placed on meaningful public engagement on all aspects of health and social care service planning, development and delivery. I'm delighted to note that a National Conversation about changes to the way our health services will be delivered in the future, and debate about sustainable use of our NHS in the 21st century is now being considered. I am, however, concerned that many members of the public are ill prepared to embrace new technology and models of care, and I am keen we ensure that nobody is left behind, especially in our more deprived communities, and our remote and rural ones. That's why this report is so important, and it gives me hope for our future.



Colin

Key Asks

THE ROLE OF THE GP

- RCGP continues to call for a minimum 4-year, competency-based GP training scheme, embedded within practice
- Postgraduate GP training opportunities should ideally enhance generalist, rather than specialist, skills
- The Scottish Government must continue to recognise and address the specific challenges faced by GPs working in Out of Hours, remote and rural and deprived settings
- All developments within general practice should enshrine the Core Values expressed by the College

WORKLOAD AND WELLBEING

- RCGP Scotland involvement in how workload is measured for Phase 2 of the 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
- A change in the focus of appraisal to prioritise wellbeing and minimise paperwork burden
- Development of dedicated healthcare services for doctors in Scotland

WORKFORCE, RECRUITMENT AND RETENTION

- 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, to be developed following the publication of the results of the next Primary Care Workforce Survey data
- Health Boards must proactively identify and support practices that are going into difficulty using predictive toolkits and local intelligence data

WORKFORCE, RECRUITMENT AND RETENTION cont.

- Research must be undertaken to better understand the reasons that GPs leave the profession at different points in their career
- Build the educational capacity of general practice to be able to deliver 25% of the undergraduate medical curriculum through adequate investment in infrastructure, clinical tutor time, and growth of the academic GP workforce
- Recognise general practice on the GMC speciality register
- Support the integration of members of the wider MDT through enhanced IT infrastructure, and the time and space to learn and build teams with the existing primary care team

QUALITY

- Clusters must have an agreed, equitable minimum level of resource which permits adequate supported time and appropriate administrative support for the Cluster Quality Leads to fulfil the role
- 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
- The Cluster model should be widened to include Out of Hours GP Clusters
- GPs and their practice teams must also be resourced to allow protected time within the working week to undertake Quality work together, to support their Practice Quality Leads

THE INTERFACE

- 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

Key Asks

HEALTH INEQUALITIES

- A more standardised and robust approach to addressing health inequalities through Primary Care Improvement Plans
- Community Link Workers should be initially prioritised for practices in areas of high deprivation
- Financial security is required for Third Sector organisations that have demonstrated value
- Improve the volume and quality of GP teaching (undergraduate) and training (postgraduate) delivered in areas of deprivation, through provision of adequate resource

THE PATIENT VOICE

- 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

FUNDING

- We continue to call on the Scottish Government to increase the proportion of NHS spending allocated to general practice to 11% to fully support the highest possible standards of patient care.

Introduction

The landscape of Scottish general practice has changed significantly in recent years. A new GP contract came into force in April 2018, which has the potential to mark a significant shift in the way general practitioners work in the future. Through the new GP contract, the way care is delivered will change. General practice across Scotland is therefore preparing for a significant expansion of the number of healthcare professionals working in primary care to complement the work of GPs. Scotland has rising numbers of people living longer, and with more than one long term condition.

We also have a desire from policy makers to move away from hospital-based care. The recent integration of health and social care in Scotland is being delivered alongside the Scottish Government's 2020 Vision[1] that, "everyone is able to live longer, healthier lives at home, or in a homely setting." We support this positive vision for the future of healthcare delivery. The importance of a joined-up, community-based approach in the delivery of care, and the benefits that that brings to patients, cannot be underestimated. General practice is vital to ensuring this community-based approach with a workforce that is motivated to make a difference to the health of Scotland's population.

Aside from health and social care integration, modern day general practice in Scotland must also be considered within the context of the 2018 General Medical Services contract (the GP contract), negotiated in 2017 between the Scottish Government and British Medical Association (BMA) Scotland. The GP contract aims to improve the attractiveness of general practice as a career. It seeks to bolster GP Partnerships by reducing the risks associated with the independent GP contractor model (while also maintaining that model), reducing the workload pressures on GPs and increasing recruitment and retention rates within the profession. Crucially, the GP contract proposes a refocus of the role of the GP to that of an "expert medical generalist", with the aim of shifting some of a GP's workload to other members of the wider multidisciplinary team where it is safe and appropriate to do so.

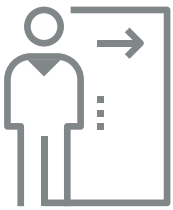
The Royal College of General Practitioners exists to encourage, foster and maintain the highest possible standards in general medical practice. In 2018 we surveyed,[2,3] members across Scotland. We wanted to know how they felt about working in general practice, what motivated them, what worried them, what impact working had on their wellbeing and their views on the future.

RCGP Scotland has analysed the health of general practice in Scotland today, examining challenges and proposing solutions. To provide a fair snapshot of the current state of general practice in Scotland, and to offer tangible solutions for the future, we need to understand the current Scottish model of healthcare delivery and how GPs working within this model feel.

The results made stark reading (see overleaf):

37%

feel so overwhelmed by their daily tasks that they feel they cannot cope at least once per week



26%

are unlikely to be working in general practice in five years' time

Most days, almost
ONE in **THREE**
GPs don't get a break of
10 MINUTES or more

38%

38% of GPs say it is financially unsustainable to run a practice (76% say that is due to insufficient core funding)

Almost 70% of GPs report[4] spending time face to face with patients, working as part of a team and improving patient outcomes as their primary motivations. At the same time however, GPs are telling us[5] that they are worried for the future, with 57% saying they think working in general practice will get worse over the next few years.

General practice plays a vital role in managing many patients with complex healthcare needs but the service is underfunded and overstretched. Of those questioned who thought general practice would get worse, 70% highlighted[6] workload and demand as one of the reasons and over 50% highlighted the lack of adequate funding for general practice as a reason.

Bolstering funding for community-based health and social care services is of course a key means of addressing many of the challenges identified in this survey. Improved funding is critical to supporting the Scottish Government's 2020 Vision and also to reducing unnecessary pressure on secondary care services, with a reduction in avoidable admissions and delayed discharges. This can, undoubtedly, also positively impact on waiting times, which is a key priority of the current Cabinet Secretary for Health and Sport, Jeane Freeman MSP.

Against the backdrop of this landscape this report further explores some of the key issues facing general practice in Scotland today and puts forward a series of positive solutions to safeguard the future of Scottish general practice for the benefit of patients, GPs and the wider NHS.

CHAPTER 1

The Role of the GP

Since the establishment of the NHS in 1948 what it means to be a GP has changed almost beyond recognition. With advancing medical technologies, new medicines, new medical knowledge and improvements in public health, life expectancy continues to rise. Many conditions that would previously have meant a terminal diagnosis or a hospital admission are now managed entirely in the community setting. While the role of the GP has adapted considerably to meet these challenges, there are also many fundamental aspects of what it means to be a GP that have not changed. These include the ability to provide contextual, person-centred care within communities, co-ordinate complex care and act as a patient advocate when needed. GPs often look after generations of the same family, providing continuity of care which can help build relationships of trust and shared understanding.

Since the establishment of the NHS in 1948, what it means to be a GP has changed, almost beyond recognition

It is these less measurable aspects of general practice care that allow GPs to hold clinical risk in a community setting, and to share and tolerate uncertainty with patients. These aspects of the GP role also support the principles of the Scottish Government's drive to deliver Realistic Medicine.[7] General practice is the obvious setting for early shared-decision making that is "as close as possible" to the patient, for helping to "de-medicalise" normal life experiences and manage unrealistic expectations, and to avoid over-investigation and over-referral.

The partnership model of general practice continues to be the principal way in which the large majority of GP care is delivered in the UK, and particularly in Scotland. Arguably, the cost-effectiveness of this model, with its ability to develop locally appropriate services according to population need and respond more quickly than salaried models of healthcare, is a key factor in the wider NHS' economically viability over the last 70 years.[8] To sustain this partnership model, we need an adequate GP workforce with sufficient GP trainees choosing to commit to partnership.

There is no doubt that some of the issues for which patients seek GP help could safely, and appropriately, be dealt with by other healthcare professionals. Although GPs have always worked as part of a team, new models of healthcare delivery are being developed to help widen the team of healthcare professionals working in general practice. These models are intended to allow GPs to focus their efforts on managing patients with the most complex health and social care needs. In Scotland, these new models will involve expanding the wider multidisciplinary team (MDT) to include nurses, paramedics and physiotherapists amongst others. The involvement of the MDT is intended to complement, not replace, GPs and to bring new experiences and skills into the primary care workforce.

The evolving role of the MDT is explored more fully in Chapter 3: Workforce, Recruitment and Retention, but it is important to note it here, also in relation to the future role of the GP.

Whilst recognising the valuable skills and expertise that colleagues in the wider primary care team bring, it is important not to lose sight of the unique and irreplaceable role of GPs. Due to their extensive undergraduate and postgraduate medical training, GPs play a crucial role at the centre of the wider primary care team. The medical generalist education and training that GPs receive, develops skilled diagnosticians who can rapidly assimilate and prioritise unfiltered information presented from patients. This rigorous education and training, culminating in the Member of the Royal College of General Practitioners (MRCGP)

examination, allows "expert medical generalism" (the term used in the new GP contract) to flourish and to provide real benefit to the whole system. Further, while specialist doctors often treat only one aspect of patients' health, GPs need to manage the complexity of patients with multiple conditions, and tailor care to patients as "whole" people, in their physical, psychological and social contexts. As advocates for their patients, GPs are often in the unique position to co-ordinate care across multiple health and social care providers and interfaces. They offer clinical leadership within the primary care teams they manage, and they often act as "boundary specialists" striving to manage patients within their communities where possible and, when not possible, helping to navigate patients' journeys between primary and secondary care.

Despite the increasing complexity of what it means to be a GP, the length of GP speciality training remains unchanged at three years. This stands in contrast to other medical speciality training of seven years. Current training arrangements are failing to adequately prepare many trainees for the demands of the evolving GP role. The RCGP Scotland Associates in Training and First5 committee (representing GP Trainees and those in the first five years post-qualifying) has called for improvements to the content and quality of this training. The training should be of sufficient length, and appropriately targeted, to equip the future GP workforce with the level and breadth of professional competence required to meet the changing landscape. There needs to be investment in training programmes so that an increased proportion of training time can be spent in general practice to enable and develop skills in relevant contexts. There also needs to be investment in the infrastructure that supports enhanced GP training, including GP premises, with enough capacity to deliver it. RCGP – and the BMA – continue to call for enhancement of the quality of competency-based GP training programmes. Training should be delivered over a minimum of four years, and embedded within practices, to allow for recognition of the changing, complex role of the modern GP as a leader, mentor, manager, teacher and clinician.[9,10]

One of the attractions of a career in general practice is the flexibility that it can offer in terms of career development

One of the attractions of a career in general practice is the flexibility that it can offer in terms of career development. RCGP Scotland aspires to a situation where core general practice is viewed as an attractive and sustainable career option so that increasing numbers of GP trainees choose to stay as expert medical generalists. At the same time many GPs, particularly younger GPs, are attracted to "portfolio careers", which combine clinical general practice with the development of more specialist clinical interests or other non-clinical roles in positions of leadership and management. It is also recognised that many GPs choose this way of working to avoid burnout as it helps with maintaining variety, managing intensity, and with taking on roles that could influence and change the wider system. We celebrate the diversity that a career in general practice can bring and we also acknowledge the potential risk of dilution of the generalist workforce if many GPs choose to specialise outside core general practice.

Many of these career development opportunities occur for GPs after completion of their speciality training, through mechanisms such as postgraduate Fellowships. RCGP Scotland is therefore concerned to see the rise of proposed postgraduate schemes such as "3+1", which previously have largely focused on a 1-year development of specialist skills following completion of 3-year training, in areas such as paediatrics and mental health.

We would instead prefer to see any training needs in these clinical areas met through expansion of the GP training scheme, so that all GPs stand to benefit from the additional skills and knowledge. Our preference is that these postgraduate schemes prioritise the development of generalist skills which enhance the primary care workforce and the expert medical generalist role – such as leadership, preparedness for partnership, management of extended teams, and quality improvement.

As the landscape within which GPs deliver care continues to evolve rapidly, RCGP Scotland has articulated what it understands to be the Core Values of general practice and which we strongly recommend are maintained in any new models of care.[11] We recognise and celebrate the diversity of our profession in terms of the settings within which we deliver patient care, and in the flexible and locally-appropriate ways in which we achieve this.

From remote and rural communities to densely populated urban areas, from affluent to poor areas, and from in-hours to out-of-hours – these core values hold.

We recognise that there are challenges common to all types of general practice irrespective of the population or geography served, but it is also important to recognise that there are very specific challenges that come with certain settings. For example, in remote and rural settings, a wider breadth of GP-delivered clinical services is often required, and the flexibility of being able to delegate these to a wider MDT is not always possible. In deprived settings, social complexity adds to the workload of managing patients who develop multimorbidity at a younger age and are also more likely to have co-existing mental health issues. In the Out of Hours setting, the workload challenges are largely related to worsening recruitment issues as fewer GPs feel able to undertake Out of Hours work due to daytime commitments.

We recognise that there are challenges common to all types of general practice irrespective of the population or geography served

RCGP Scotland, with its diverse membership, has a key role in understanding and supporting all of these groups in addition to ensuring that the voices of salaried GPs and sessional GPs are heard. This allows us to work collaboratively with colleagues in Scottish Government and the BMA to ensure that concerns are heard and addressed and to ensure that patient care does not suffer in these areas.

KEY ASKS

- RCGP continues to call for a minimum 4-year, competency-based GP training scheme, embedded within practice
- Postgraduate GP training opportunities should ideally enhance generalist, rather than specialist, skills
- The Scottish Government must continue to recognise and address the specific challenges faced by GPs working in Out of Hours, remote and rural and deprived settings
- All developments within general practice should enshrine the Core Values[12] expressed by the College

CHAPTER 2

Workload and Wellbeing

Being a GP is an incredibly rewarding career, but it can also be a challenging one. 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.

Being a GP is an incredibly rewarding career, but it can also be a challenging one

37% of respondents to our wellbeing survey[13] indicated that they feel so overwhelmed at least once a week that that they cannot cope. 35% of respondents also report that their stress levels impact their ability to make decisions. This can affect patient experiences and patient safety.

Our findings highlight the fact that much of the stress experienced by GPs is generated by the sheer intensity of their workload, but a significant proportion is also generated by the often unrecognised "emotional labour" of the jobs that GPs do. GPs are often the first point of contact for patients and their families at times of distress and at least a third of GP consultations have a mental health component within them.[14] Without a forum for processing, sharing and understanding some of the difficult emotions and frustrations that can arise within these types of consultation, the effects can be damaging on the individual GP.

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 and RCGP Scotland is keen to work with the BMA's Scottish General Practitioners' Committee (SGPC) to ensure that workload is measured in a meaningful and flexible way. This should encapsulate the range of clinical settings and their specific challenges, and crucially try to measure (and resource) workload based on patient need rather than demand. This important aspect of tackling health inequalities is explored more fully in Chapter 6.

"I have reduced my clinical commitment in [the] past three years from being a partner to salaried GP, to locum/Out of Hours, to manage my own workload and stress levels"

The increasing inadequacy of the standard 10-minute appointment to meet patient needs was also identified, with 86% of respondents reporting that they feel stressed about the level of risk and uncertainty in their clinical workload. RCGP Scotland would like to see moves to enable a "minimum of 15-minute consultation" as standard. This will only be possible by increasing the number of GPs and reducing their current workload.

"Meeting the demands of the complex patient in a 10-minute appointment! The vast majority of our patients (the ones we actually see) have increasing multi-morbidities and it is simply not sustainable to meet these needs in a 10-minute consultation – yet to give them the time they need means running over time which adds to stress"

Throughout the survey there were also many comments about the unsustainability of rising public expectation as a contributor to stress, and what GPs felt was needed to address this:

"Education around appropriate use of services at national level"

"Leadership around what the NHS is and isn't for"

RCGP Scotland has led a call to Scottish Government to work jointly with healthcare professionals and engage the public in a "National Conversation" about sustainable use of the modern NHS. This is discussed later in Chapter 7 on The Patient Voice.

The survey findings also articulated the effects that stress have on patient care, team working, and personal wellbeing:

> "I have become less tolerant of colleagues … I am probably less patient-centred than I was five years ago"
>
> "I am irritable when I get home with my family. I feel stressed and unhappy. I hate not being able to deliver the care that I want to"

The role of Scottish Government in addressing the concerns around workload and workforce planning attracted many suggestions from our members:

> "Recognition of the differing demands of urban and rural GP practice and resourcing for each adequately"
>
> "Evidence based policy and strategy based on cost benefit and cost effectiveness analyses"
>
> "Adequate resourcing and meaningful investment"
>
> "Honesty from politicians around what is possible and achievable with the funding that there is"

Other key themes identified in the Wellbeing Survey included the interface between primary and secondary care (discussed in Chapter 5 on The Interface) and annual appraisals. Appraisal discussions have the potential to shift what is currently often perceived and experienced by GPs as an "assessment" and "tick-box exercise" towards a discussion with GPs on their perceived ability to influence change, to escalate concerns, and develop their leadership skills, and towards a discussion of practical

ways to enhance these aspects of their work as appropriate. 70% of respondents stated that preparation for their appraisal was undertaken in their personal time. While we recognise and support the role that annual appraisal has in reassuring the public that GPs are objectively assessed, RCGP Scotland wishes to see the focus of appraisal change towards one of support for practitioner wellbeing. This also recognises the impact that poor practitioner wellbeing and burnout can have on patient safety.

RCGP Scotland has recently recruited a Clinical Lead for Wellbeing to our team. The remit of this Clinical Lead will be to continue our collaborative work with key partners (including the BMA, Scottish Government, General Medical Council, and NHS Education for Scotland) to help improve wellbeing within our spheres of influence be they contractual, practical or cultural. This recognises that workload and wellbeing form a very regular part of the conversations that RCGP has with these organisations. The Clinical Lead will also scope the availability and acceptability of existing wellbeing resources.

For many doctors in the NHS, wellbeing issues move beyond that of situational stress occurring in the workplace. Doctors across the NHS are known to be at higher risk of mental health problems than the average population and they face a number of barriers in accessing care,[15] being much less likely to seek professional help or take time off work.[16] In addition to the significant impact that this has on individual practitioners and their families, continuing to work when unwell introduces safety risks for patients. Studies of thousands of doctors and nurses have consistently found that engaged staff are associated with improved patient outcomes and are significantly less likely to make mistakes,[17,18,19] whereas one study found that depressed doctors made six times as many mistakes in a month as their peers.[20] RCGP supports the call for the establishment of dedicated health services for doctors in Scotland, similar to the Practitioner Health Programme in England, to help address some of these issues of access and stigma.

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.

KEY ASKS

- RCGP Scotland involvement in how workload is measured for Phase 2 of the 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
- A change in the focus of appraisal to prioritise wellbeing and minimise paperwork burden
- Development of dedicated healthcare services for doctors in Scotland

CHAPTER 3

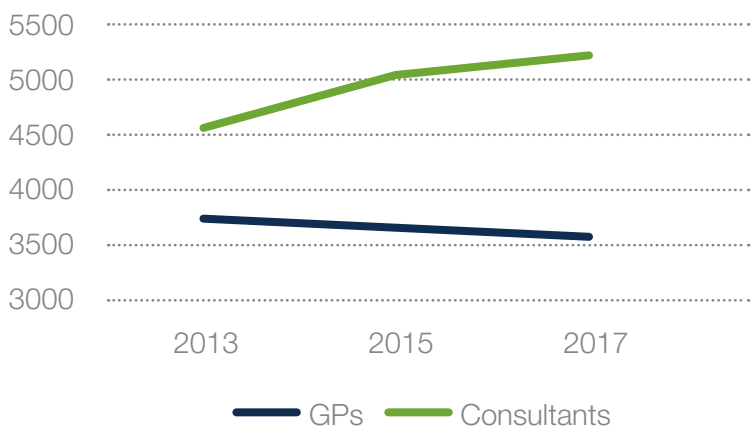
Workforce, Recruitment and Retention

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. As one respondent in our survey notes:

> "There are too few GPs. To provide a reasonable service, it is necessary to work very significantly in excess of a manageable working day. Without more doctors to share the work load it seems unlikely to improve"

The most recent figures from NHS National Services Scotland's Primary Care Workforce Survey 2017[21] 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 that same period, the number of WTE Consultant grade posts in Scotland rose from 4559 in 2013, to 5044 in 2015, to 5232 in 2017. This represents an increase of almost 15%.[22] This trend would appear to be at odds with achieving the aims of Scottish Government to deliver more healthcare in the community setting.

Changes in WTE GPs and Consultants in Scotland 2013-2017



For meaningful workforce planning, we need to have both a better understanding of our existing workforce numbers in addition to the predicted deficit over time, based on current trends. There is currently a lack of accurate baseline data around this and a lack of consistency in how future workforce figures are being calculated.

A major challenge in measuring and planning the GP workforce is the variation in working patterns across the profession. A session of GP time is generally understood to be a minimum of five hours, and therefore any GP working eight sessions or more in a practice is considered whole time. In secondary care, workload is measured in units of "professional activity" or PAs rather than sessions. A PA is four hours in length, with this inconsistency adding further confusion in measuring doctor workload across the wider NHS.

A major challenge in measuring and planning the GP workforce is the variation in working patterns across the profession

In December 2017, the Scottish Government pledged[23] 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. 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) to be developed following the publication of the results of the next Primary Care Workforce Survey.

The next phase of the contract includes collecting accurate data about the current GP workforce, which will allow more accurate workforce planning, and it is hoped that one of the roles of the national oversight group of the new GP contract will be to monitor the growth of the GP workforce.

A 2018 Audit Scotland report on the Scottish NHS reported that 24% of practices had a GP vacancy,[24] with more than a quarter of those vacancies taking more than six months to fill. As this workforce crisis deepens, the number of practices in Scotland has fallen, and there has also been an increase in the number of practices handing back their GMS contracts and being taken over by their local Health Board (a process known as becoming 2C). This can have a direct effect on the capacity to train future GPs (and indeed other professionals) as 2C practices are often unable to maintain their training status. All possible efforts must be taken at a Health Board level to proactively ensure that practices are identified at the point of difficulty rather than crisis and are provided with the support and assistance they require, earlier than at present. Scottish Government figures show that, between June 2017 and June 2018, 17 practices gave notice to terminate their contracts, bringing the total number of Health Board-run practices in Scotland to 52, which represents 5.6% of the total number of GP practices in Scotland.

RCGP Scotland has worked closely with the Scottish Government, SGPC and Health Boards through the Improving Practice Sustainability Group to develop a predictive toolkit for Health

Boards. This toolkit is intended to be used, in conjunction with local intelligence data, to identify practices at risk of returning their contracts and thus allow earlier intervention and support to be offered.

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.[25]

Consideration must also be given to the impact that Brexit could have on GP workforce levels in Scotland. A 2017 ComRes survey[26] commissioned by RCGP showed that 74% of respondents in Scotland were concerned about the impact of leaving the EU on recruitment and retention of GPs, with 60% of respondents stating that they believed Brexit was likely to impact their GP practice negatively. Given the levels of concern among the GP workforce, and existing workforce challenges across the wider health and social care system, RCGP Scotland welcomed the approach taken by the Scottish Government to actively reassure NHS and social care colleagues from European Economic Area (EEA) countries that their contribution to Scotland is hugely valued. We support all action taken to mitigate against workforce loss associated with Brexit.

Building the GP workforce requires a focus on both retention of existing GPs and recruitment of new GPs, in addition to close collaboration between universities, Scottish Government, NES and other key partners. The RCGP Recruitment and Retention Advisory Group, established in 2017, has provided a vital forum for that multi-professional discussion.

With respect to retention, it is important to understand the different factors that impact a GP's decision to leave the profession as these factors can change across a GP's career, be it early career (the "First5"), mid-career, or late career (the "Wise5"). The solutions needed are different for each stage.

The current age demographic of GPs gives cause for concern, with over a third (36%) of all GPs working in Scotland aged 50 years or over.[27] This means we potentially face a third of our "Wise5" workforce retiring in the next five to ten years. Reasons for the decision to leave general practice at this career stage include intensity of clinical workload, perceived burden of appraisal and revalidation, and financial disincentives around existing pension arrangements.

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 report for the RCGP Scotland Recruitment and Retention Advisory Group also noted an alarming number of GPs in their mid-career leaving the profession. There is a lack of current data available to understand the factors behind mid-career loss, and RCGP Scotland recommends fuller investigation to explore this, so that targeted solutions may be offered.

There are also specific retention challenges for those starting out on a career in general practice, the group we refer to as the "First5". Challenges can relate to the intensity of clinical practice on completion of GP training, desire to sustain a work-life balance, concerns about preparedness for some of the roles of the "modern" GP around

leadership, management of teams, and quality improvement (not fully addressed in the current 3-year curriculum) and the attractiveness of medical work outside the UK. In recognition of this, RCGP Scotland has promoted the development of mentoring schemes for newly qualified GPs by end-career GPs, to increase retention at both ends of the career spectrum.

Efforts to improve recruitment into general practice are equally important to retaining the existing workforce. Similarly, it is important to understand the different factors that influence the career choices of medical students, and what would make them more likely to choose general practice.

There were several key findings from a joint report published by the RCGP and Medical Schools Council, "Destination GP",[28] looking into factors influencing career choice. Unsurprisingly, students were more likely to choose general practice as a career if they had early exposure to general practice placements in their undergraduate years or were inspired by positive role models within general practice. Negative perceptions and narrative from peers, academics and secondary care clinicians about choosing general practice as a career also had a negative impact.

A number of Scottish Government initiatives have focused on improving recruitment into general practice through improved undergraduate exposure. In 2017, the Scottish Graduate Entry Medicine Programme (ScotGEM) was established. This has been particularly welcomed by RCGP Scotland as the programme is specifically designed to develop doctors interested in a career within Scottish general practice and with a particular focus on rural medicine and healthcare improvement. In 2018, the Scottish Government announced[29] an additional 85 medical school places in Aberdeen, Glasgow and Edinburgh, again with an emphasis on general practice. The aim is to significantly increase the percentage of the undergraduate curriculum delivered within the primary care setting from its current level of approximately 8% to an ambitious 25%. To progress this, the "Increasing Medical Education in Primary Care Group", (chaired by Professor John Gillies and including representation from RCGP Scotland) was established in March 2018, with a view to making recommendations on how to build additional educational capacity in general practice and primary care. Building this capacity will require adequate investment in infrastructure, clinical tutor time, and reversal of the significant decline in the academic GP workforce. GP academics are well placed to promote our specialty within medical schools, act as role models for aspiring GPs, and conduct much-needed research into primary care for the rapidly changing and ageing population of Scotland. The recommendations of Sir Lewis Ritchie's 2009 RCGP Scotland strategic report on academic careers, "Securing the Future"[30] should be re-examined in light of this decline.

> Changing the culture of negativity towards general practice in medical schools is a significant challenge

Changing the culture of negativity towards general practice in medical schools is a significant challenge with report findings revealing that 76% of the medical students surveyed for "Destination GP",[31] had encountered negativity towards general practice by their fifth year.[32] Much of this cultural change needs to be addressed by universities but we also believe that these negative perceptions can partly be addressed by improving interprofessional relationships and understanding across the primary-secondary care interface. This topic is discussed further in Chapter 5. Inclusion of general practice on the GMC speciality register would also help to improve parity of esteem between consultants and GPs and challenge the negative attitudes about being "just a GP".

For foundation stage doctors, NES is working in conjunction with the Scottish Government to increase the number of general practice speciality training places available and to improve the fill rate. RCGP Scotland is monitoring this closely and is committed to supporting this work, in addition to actively encouraging previously practising GPs to consider a return to practice through NES schemes such as the GP Retainer Scheme[33] and the GP Returner Programme,[34] both of which are currently under-filled.

We also need to ensure that Scottish general practice is viewed as an attractive career option by already qualified family doctors from outside Scotland (or by those who qualified in the UK and left to pursue GP training and work overseas). There is considerable work being undertaken by RCGP to facilitate this.

To aid these recruitment efforts, we warmly welcomed the launch of the Scottish Government's www.gpjobs.scot website as a much-needed resource.

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.

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.

RCGP Scotland supports the valuable role other healthcare professionals can bring to patient care in general practice

Through their undergraduate and postgraduate medical training, it takes a minimum of 10 years to become a GP. This training is what allows GPs to manage the complexity, uncertainty and risk associated with all types of general practice. The expansion of the MDT workforce should only happen in tandem with expansion of the GP workforce as the skills acquired during training become ever more important to protect as our population ages, and as we strive to provide more care in a community setting. The role of the GP is also vital in providing training, mentorship and clinical decision support for our new colleagues in primary care. This is only possible with a flourishing GP workforce.

KEY ASKS

- 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, to be developed following the publication of the results of the next Primary Care Workforce Survey data.
- Health Boards must proactively identify and support practices that are going into difficulty using predictive toolkits and local intelligence data
- Research must be undertaken to better understand the reasons that GPs leave the profession at different points in their career
- Build the educational capacity of general practice to be able to deliver 25% of the undergraduate medical curriculum through adequate investment in infrastructure, clinical tutor time, and growth of the academic GP workforce
- Recognise general practice on the GMC speciality register
- Support the integration of members of the wider MDT through enhanced IT infrastructure, and the time and space to learn and build teams with the existing primary care team

CHAPTER 4

Quality

GPs strive to provide the best possible care for patients, families and communities. Improving the quality of general practice care for patients has always been at the heart of the College's mission.[35] In the midst of the current workload and workforce crisis, RCGP Scotland is keen to ensure that Quality Improvement work is able to thrive. In 2016, the College released "Setting the strategy for Quality in Scotland's General Practices" to guide quality development.[36] Although this chapter focuses largely on the work of GP Clusters, it recognises that Quality Improvement happens at all levels of professional practice by all types of working GPs and their practice teams. This includes Quality Improvement activities that are undertaken for annual appraisals, projects undertaken within practices or in the Out of Hours setting, the work of GP Clusters, and contributions to national Quality Improvement work.

The removal of the Quality Outcomes Framework (QOF) in 2016 provided the opportunity to re-energise Quality Improvement work, with an emphasis on local prioritisation by the profession according to the needs of the local population. This has been largely welcomed by GPs, as has the establishment of Clusters of GP practices across Scotland. Clusters describe a small group of practices in the same geographical area coming together to undertake both local quality work and influence wider systems. They are designed to have both intrinsic and extrinsic functions, which are summarised in Table 1 below:

Table 1: Intrinsic and Extrinsic Functions of Clusters

INTRINSIC	EXTRINSIC
• Learning network, local solutions, peer support • Consider clinical priorities for collective population • Transparent use of data, techniques and tools to drive quality improvement – will, ideas, execution • Improve wellbeing, health and reduce health inequalities	• Collaboration and practice systems working with Community MDT and third sector partners • Participate in and influence priorities and strategic plans of Integration Authorities • Provide critical opinion to aid transparency and oversight of managed services • Ensure relentless focus on improving clinical outcomes and addressing health inequalities

[37]

In general, although the intrinsic functions of Clusters are working well (shared learning, relationship-building, peer support, prioritisation of local needs), their extrinsic functions, designed to influence the development of the wider health and social care system by providing frontline intelligence and expertise from the general practice setting within communities, are proving more challenging to achieve. RCGP Scotland has created new "Local Advocate" roles within its team. These are GPs who have visited and consulted widely with Clusters to better understand the challenges that they face, in addition to raising awareness of the support that RCGP can offer in their development. Based on anecdotal feedback from the Local Advocates it appears that Cluster Quality Leads (CQL) do not routinely have access to those important strategic bodies within the health and social care system that have decision-making and funding responsibility (for example, Integrated Joint Boards). This needs to be addressed if we wish Cluster working to have a meaningful impact on the wider system.

Currently, Cluster working only exists for in-hours general practice, with the Practice Quality Lead (PQL) usually a GP partner or salaried GP within the practice. It is important that PQLs also seek to represent the views of their sessional GPs where possible. Cluster working needs to develop further to incorporate Out of Hours GP working, which covers 70% of the working week. This would allow GPs working in this setting to have the same opportunities for learning, peer support, quality work and to influence wider service developments that are possible from in-hours Clusters.

The potential of Clusters to deliver Quality Improvement through their intrinsic and extrinsic functions is enormous. Consequently, Clusters have become the target of much excitement among healthcare planners, not just in Scotland but across the UK and further afield, and are viewed as a possible, professionally-led solution to many difficulties. When Clusters were first introduced, their role and remit were deliberately wide to allow flexibility of development in accordance with local need, to protect professional autonomy, to allow local quality work to be peer-led and values-driven, and to not be too prescriptive. Now however, there are an increasing number of requests being made of Clusters to address the challenges being faced across the health and social care system. There is also a real risk that Clusters will become overwhelmed, fragmented and demoralised if a more strategic and supportive approach to their work is not adopted. The role of Clusters must be more clearly defined and protected so it is clear that they are, first and foremost, responsible for the development of quality work within their localities according to what they perceive as priority areas. Clusters are specifically not an operational group for other parts of the health and social care system.

One of the significant challenges faced by Clusters is the wide variation in resource that they receive across the country

One of the significant challenges faced by Clusters is the wide variation in resources that they receive across the country, with some CQLs funded to provide one session per week for Cluster working and some funded to provide one session per month. In addition to this discrepancy in funding, which is decided at health board level rather than at national level, Clusters currently receive minimal practical support to undertake their quality work. Clusters should have access to a local data analyst, but very few Clusters (if any) have project support or administrative support. Such discrepancies in resource significantly impact on equity and the work that Clusters can undertake. If we wish Clusters to provide meaningful and sustainable quality work in place of QOF then they need to be adequately resourced.

There are many organisations in Scotland keen to see Clusters better supported to allow their work and learning to be shared. RCGP Scotland, Scottish Government, SGPC, NES, Scottish School of Primary Care (SSPC), NHS National Services Scotland Information Services Division (ISD) and Healthcare Improvement Scotland (HIS) have all stated their intention to work collaboratively to develop resources and national guidance for Cluster working and to achieve what is necessary to make a success of a core offering of general practice. The Improving Together Interactive[38] toolkit brings resources together from all the above organisations for GP Clusters.

With the removal of QOF, the quality of care for long-term conditions and overall healthcare must continue to be assured by Clusters. Work is ongoing about how best to monitor and improve quality while incorporating the principles of person-centred Realistic Medicine.[39]

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)[40] and the Primary Care Clinical Dashboards, together with local data analyst support.

KEY ASKS

- Clusters must have an agreed, equitable minimum level of resource which permits adequate supported time and appropriate administrative support for the Cluster Quality Leads to fulfil the role
- 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
- The Cluster model should be widened to include Out of Hours GP Clusters
- GPs and their practice teams must also be resourced to allow protected time within the working week to undertake Quality work together, to support their Practice Quality Leads

CHAPTER 5

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.[41] On the other hand, a well-functioning interface impacts positively on patient safety, efficiency of systems, patient experience, inter-professional relationships and morale. This is what we should be striving for.

In recent years, improving the primary-secondary care interface has been a key priority area for RCGP Scotland

In recent years, improving the primary-secondary care interface has been a key priority area for RCGP Scotland, and more recently for RCGP UK-wide. Over the last five years RCGP Scotland has developed an Executive Officer for Interface role, recruited a Clinical Lead for Interface work and has established a cross-College Interface Group. Our work and recommendations have been based on the findings from membership surveys, thematic analysis of multiple significant events involving dysfunctional interfaces and the work of our cross-College Interface Group. We have focused on developing "best practice" guidance from areas of high quality interface working across the country. Our key recommendations, published previously through "Promoting General Practice"[42] and shared with key Scottish Government working groups (such as the Improving Practice Sustainability Group, the Modern Outpatient group and the Access Collaborative) have been highly influential, and the new GP contract makes specific reference to the promotion of dedicated local interface groups.

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. Our newly recruited Clinical Lead for IT jointly chairs, with SGPC, the recently established Scottish Joint GP IT Group. This important group provides a more coordinated approach and acts as a professional advisory forum.

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.

Countering the denigration of general practice by peers, secondary care and academics, as noted in Chapter 3, is key to improving the interface and requires a concerted effort among all clinicians. We must work to better understand and respect each other's roles, remits and challenges, work collaboratively to achieve common goals, and rebuild relationships that have broken down as NHS care has become more specialised and fragmented. Joint learning, interface groups and work-shadowing opportunities are potential ways of addressing this issue. RCGP will continue to promote general practice as a positive career and address the negative views that have been expressed about the profession.

The work of RCGP Scotland in better understanding the challenges that exist at the interfaces of care has allowed the development of key resources and recommendations in this area. The two key workstreams have been the development and roll-out of an interface quality improvement module, and the support offered to Health Boards across Scotland to establish dedicated interface working groups by the RCGP Clinical Lead for Interface.

The "Effective Interface" is a facilitated Quality Improvement module for primary and secondary care clinicians, with the aim of building relationships and improving local systems across the primary-secondary care interface.[43]

Our Clinical Lead for Interface was recruited in 2018 following a successful bid for three-year funding from Scottish Government. Initial scoping has shown high variance in the existence and effectiveness of interface working across Boards. Key aims of this role are to support the establishment of dedicated interface groups (comprised of GPs and consultants) and to provide a forum to address and improve interface working, prioritised for local needs and issues. These interface groups have enormous potential to improve the primary-secondary care interface. They can facilitate joint learning from adverse or positive events occurring at the interface; offer a sense-checking function for any new processes being rolled out that may affect the other side of the interface; enable the development of clinical decision support systems within Boards; and make specific recommendations for improvement in their local areas. They can also facilitate opportunities for clinicians to come together through joint learning or work shadowing, thus improving inter-professional relationships and the understanding of each other's roles and systems. This is crucial to improving the interfaces of care.

KEY ASKS

- 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

CHAPTER 6

Health Inequalities

Scotland still has one of the lowest life expectancies in Western Europe.[44] Patients living in areas of inequality develop chronic diseases earlier in life, live with ill health for longer, and die younger than those living in the most affluent areas. For instance, in the most deprived areas people aged between 45 and 74 are more than twice as likely to die of cancer than those living in the least deprived areas. 49% of people living in deprived areas report that they have a limiting long-term condition compared to only 20% of those in more affluent areas.[45] For those living in deprived areas throughout Scotland – both in rural and urban areas – multimorbidity (experiencing two or more concurrent health conditions) occurs more frequently, and between 10-15 years earlier, than for those living in more affluent areas.[46]

Reducing health inequalities is a key priority area for the Scottish Government, with the Government's 2018 Programme for Government stating that, for Scotland to be a more successful country, "we need to see an overall improvement in our population health, and we need to close the gap between the health of our wealthiest communities and the health of our poorest."[47] RCGP Scotland strongly supports this ambition. It views general practitioners and their teams as vital to achieving this ambition and to addressing the "inverse care law", a concept first described by the pioneering and highly influential GP, Dr Julian Tudor Hart, who stated that:

> "The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so when such exposure is reduced"

The inverse care law in the modern NHS is not so much about the difference between "good" or "bad" medical care, but the difference between what GPs can do – and what they would be able to do – if resourced according to the health needs of their practice populations.[48]

There is now increasing evidence to show that access to general practice reduces morbidity and mortality rates in areas of high deprivation,[49] thus reinforcing the argument that general practice needs to be at its best where it is needed the most. There is also increasing evidence that the current models of health service funding are resulting in the unintended consequence of worsening health inequalities.[50]

There are many aspects of the GP role in areas of high socio-economic deprivation that make GPs uniquely placed to address persisting health inequalities.

- A report by the King's Fund in relation to NHS England showed that overall consultations, per registered patient per year, rose from 4.29 in 2010/2011 to 4.91 in 2013/2014. Consultation rates in deprived areas are generally understood to be higher, thus offering significant population coverage and opportunity for both planned and opportunistic care to enable a more preventative approach to health.[51]

- Levels of uptake of screening programmes are typically lower in areas of higher deprivation,[52] so opportunistic care becomes even more important to address the shortfall.

- Whole-person, generalist medicine addresses the medical, social and psychological needs of patients within the context of their families and their communities. This happens in general practice in a way that does not happen in any other part of the NHS and it is vital to understanding the challenges faced by patients living in socio-economically deprived areas to address their healthcare needs.

- Continuity of care saves lives[53] through building relationships of trust, based on serial encounters, often over many years. It enables a better understanding of challenges faced by patients, earlier disclosure of potentially serious medical problems, and more shared decision making, supporting the principles of Realistic Medicine.[54] This is supported by research[55] from the Deep End.[56,57]

- The co-ordination role provided by GPs oversees care from multiple providers. This can be especially important for those patients without other sources of support. GPs also act as a "system failure service" for the NHS. When anything goes wrong, GPs are usually the ones to hear about it. The co-ordination of services at primary care level is an important determining element in the responsiveness of health service provision and the health system "as a whole".

- The advocacy role that GPs and their teams play is crucial, though often unrecognised. GPs often advocate on behalf of their patients when they feel patients are being disadvantaged. That advocacy may be on an individual or community basis.

GPs and their teams struggle to adequately address the health inequalities that persist within their communities. There are many reasons for this, largely related to higher volumes and levels of complex patient need, lower levels of health literacy, and lower levels of patient confidence and ability to address health issues (often presenting to clinicians as the "unworried unwell"). The "emotional labour" required to work in areas of high socio-economic deprivation, alongside the intensity of the clinical workload, make recruitment and retention of the GP workforce in these areas particularly problematic.

Addressing health inequalities has also been a key priority area for RCGP Scotland for many years. In 2009, the RCGP Scotland working group on Health Inequalities helped to establish the Deep End group with funding from Scottish Government. This is a network of GP surgeries in Scotland which cover the 100 most deprived patient populations and almost 80% of the participating practices are in Glasgow. For the first time this enabled GPs to share their experiences of the challenges they face in dealing with some of the most deprived sectors of society. The Deep End group has enabled an identity, profile, collective voice and forum to share activity and learning. They have undertaken a number of highly successful projects and developed models of care, such as the Govan SHIP,[58] the Pioneer Scheme,[59] the Link Worker Programme, and the establishment of Financial Advisors in practices. The group has

also produced 33 reports and two manifestos on the key issues affecting Deep End practices.[60]

A landmark conference was held in Glasgow in February 2019 celebrating the "Exceptional Potential of General Practice"[61] and the life and work of the pioneer GP, Dr Julian Tudor Hart. This was an opportunity for Deep End groups across the world to come together and share learning. There were two important commitments from this meeting. The first was to distil the learning from Deep End practices and consider how it could apply more widely and inclusively, to "deep end patients", in recognition of the fact that health inequalities exist in every general practice in Scotland to a greater or lesser extent (be they in remote and rural settings, affluent settings, or in the more traditional areas of urban poverty). The second commitment was to convene a meeting of key stakeholders to tackle persisting health inequalities and identify where the responsibility lies to address this. This meeting includes frontline GPs representing the diversity of general practice, GP academics, public health clinicians, policy makers, BMA negotiators and representatives from local integration authorities. It will be chaired by RCGP Scotland.

Although many GPs were disappointed that the new GP Contract in Scotland did not allocate additional funding to practices in the most deprived areas, it is recognised that a capitation-based allocation formula will never be an appropriate way to address health inequalities. In reality, the persistently low percentage spend on general practice, as part of the overall NHS budget, is what is limiting ability to tackle health inequalities within communities.

Until this is addressed 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 are however challenges around this also. 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.

Building the appropriate wider workforce in practices within areas experiencing health inequality is vital. The introduction of Community Link Workers (CLW) in practices situated in communities with high levels of deprivation across Scotland has been hugely beneficial for both patients and GPs working in these areas. Link Workers provide non-clinical support to patients, providing a social prescribing function within the practice. The type of support that they provide to a patient varies depending on the patient's own goals and wishes. Being able to spend extended lengths of time with patients, CLWs can foster relationships of trust and help to address issues of social isolation, identified as a key issue in the pilot[62] managed by the Health and Social Care Alliance Scotland (the ALLIANCE). CLWs also facilitate connection with local non-NHS services as appropriate to patient need. Evaluation[63] of the programme by NHS Health Scotland in 2016 found that CLWs were an asset to practitioners and to the most vulnerable patients. RCGP Scotland welcomes the Scottish Government's pledge to deliver at least 250 CLWs by 2021 and would recommend that initial priority be given to areas of high health inequality.

Similar analysis has shown the important role of embedded financial advisors improving patients' access to welfare benefits.[64] Third sector services based in communities across Scotland provide vital support for both patients and clinicians, particularly when based in areas of high socio-economic deprivation. They often provide a wide

range of support services, from improving literacy, to debt management and employment advice. Far too often however their funding is short-term, and vital services can be withdrawn from communities.

Recruitment and retention of the GP workforce, a key priority area for RCGP Scotland, is more acutely felt in areas of high deprivation. Much of this relates to the intensity of the workload as described above, but there are other important factors to consider across the spectrum of recruitment. One is the need to widen access to medical schools to include students from more deprived backgrounds; the other is to enable more practices in deprived areas to become involved in both undergraduate teaching and postgraduate GP training.

All RCGP local faculties in Scotland now have recruitment ambassadors who work closely with local organisations such as Reach. Through Reach, universities have increased the number of medical students from Scotland's poorest areas by 50%.[65]

In 2016, all the medical and nursing Royal Colleges signed up to a joint statement with the Faculty for Homeless and Inclusion Health to include health inequalities in the medical curriculum to equip practitioners with the knowledge, confidence and skills required to work in areas of high deprivation.[66]

RCGP Scotland is committed to working with this Faculty to develop these resources for universities and, in association with key partners such as the GMC and NES, to address any gaps in the current RCGP training curriculum.

It is also crucial that deprived area practices are adequately represented in the undergraduate teaching and the postgraduate GP training landscape. High workload and low workforce numbers have meant that there are lower numbers of training practices in deprived areas, resulting in an "inverse training law".[67] This is important to address because it means that GPs are less exposed to the skills and experience needed to work in these areas during their training. There is also evidence[68] that recently-qualified GPs are more likely to join practices in areas where they have trained, which further reinforces the need to encourage and enable GP training in deprived areas if we are to address the persisting recruitment challenges.

Increasing investment in primary care allows many of the root causes of health inequalities to be more adequately addressed and has been shown to reduce the pressure on secondary care services. If the NHS is not at its best where needs are greatest, inequalities in health will worsen.

KEY ASKS

- A more standardised and robust approach to addressing health inequalities through Primary Care Improvement Plans
- Community Link Workers should be initially prioritised for practices in areas of high deprivation
- Financial security is required for Third Sector organisations that have demonstrated value
- Improve the volume and quality of GP teaching (undergraduate) and training (postgraduate) delivered in areas of deprivation, through provision of adequate resource

CHAPTER 7

The Patient Voice

The patient voice is vital to the development of a health service that is fit for purpose and meets the needs of patients. RCGP Scotland is committed to encompassing the patient voice in the work of the College and has a patient group, P[3], within its constitution, for this purpose. Incorporating the views of patients into every stage of health care delivery development, and ensuring that changes to models of health care delivery are communicated in a way that resonates clearly with the public, should be at the forefront of healthcare delivery in Scotland.

Patients place a huge amount of trust in their GP and the service that their GP practice provides. The 2017/18 Scottish Government Health and Care Experience Survey showed that 86% of people rated the overall care provided by their GP practice positively.[69] For the Out of Hours service, 83% of respondents to the same survey positively rated the overall care that they received. The relationships that GPs and their teams can build with their patients, often over a long period of time, are unique within the health service and should be further developed wherever possible.

Patients place a huge amount of trust in their GP and the service that their GP practice provides

Following agreement by the profession on the new GP contract, the Health and Social Alliance Scotland (the ALLIANCE) carried out a series of public engagement roadshows[70] with the intention of ensuring that the public priorities for general practice be reflected in the implementation of the contract. The feedback received from these engagement events provided valuable insights into patients' priorities across a range of issues relevant to general practice. Of note is a finding regarding the lack of information availability, which states, "there is a large appetite for a public awareness campaign that incorporates broadcast and print media."

Earlier in this report, RCGP Scotland detailed its call 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 co-ordinators") 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.[71] 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.

Following a formal letter of request for such a campaign (co-signed by RCGP, SGPC, P[3], and the multidisciplinary Primary Care Clinical Professionals Group), the Cabinet Secretary for Health and Sport announced her commitment to providing national leadership on this at the 2018 Local Medical Committees Conference, and to working closely with healthcare professionals to develop public messaging.[72]

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.

KEY ASKS

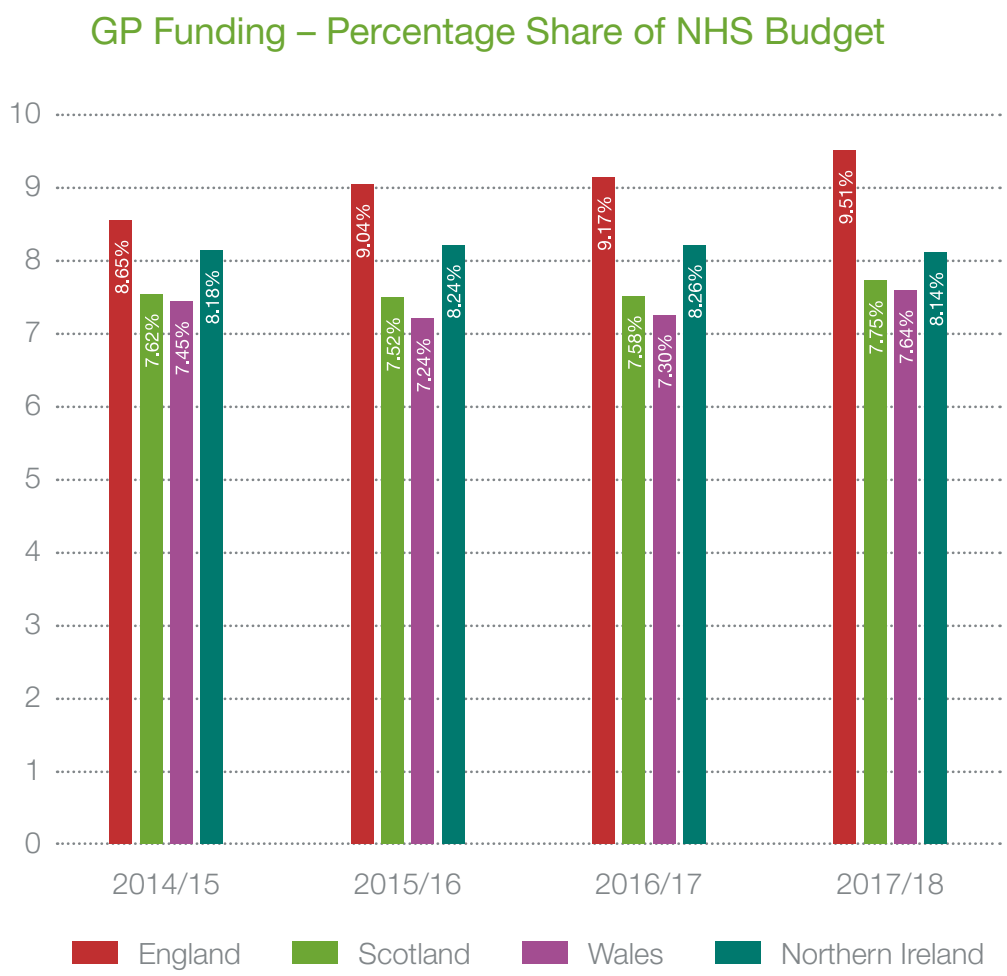
- Work collaboratively with Scottish Government and Health Boards to develop a public education campaign about the changing models of care in general practice to support GPs and their wider primary care teams
- Gain public agreement on how to use the NHS sustainably through a cross-party National Conversation, 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

CHAPTER 8

Funding makes the world go round

Throughout this report we have highlighted both the exceptional potential of general practice and the very significant challenges it is facing. The urgent and ongoing reform needed to support Scottish general practice must continue to be underpinned by a step change in funding. We warmly welcome the Scottish Government's commitment to invest £250m in direct support of Scottish general practice and a further £250m in support of primary care. We are closely following work being undertaken by the BMA in Scotland to ensure this money is being delivered effectively to the frontline.

RCGP Scotland's analysis of the most recently published data shows that, while there was a very modest increase in the percentage of NHS funding spent on general practice, Scotland still lags far behind England and Northern Ireland in this measure.



The effect of underinvestment is felt most acutely at the frontline of general practice service delivery. 38% of GPs[73] believe that it is currently financially unsustainable to run a practice, with 76% of those respondents citing insufficient core funding as the reason. If we are to protect the partnership model of general practice, with its ability to develop services and teams according to local population needs in a highly cost-effective way, and if we are to recognise the potential of general practice to support and enhance the wider NHS, then we need to ensure that the funding to support general practice in Scotland is sufficient. This is specifically not a request for higher take-home pay for individual GPs. It is a request to invest in Scottish general practice to ensure that our patients continue to receive the highest quality and most appropriate care. RCGP Scotland needs our members to feel secure and confident that the funding being promised is making a tangible difference to their working lives and their ability to design and develop locally tailored services, to achieve the highest standards of care for their patients.

Continued increases in funding for general practice support and underpin the key asks in our report, namely retaining and recruiting more GPs; building resilient wider teams that can support more care in our communities; supporting interface working and local quality improvement work; improving practitioner wellbeing; and ending 10-minute consultations. This will give patients the time they need to tell their health story, explain what matters to them, understand their options and share in decision making regarding their treatment.

KEY ASKS

- We continue to call on the Scottish Government to increase the proportion of NHS spending allocated to general practice to 11% to fully support the highest possible standards of patient care.

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