Promoting general practice

A manifesto for the 2016 Scottish Parliamentary election
Over the next four years, Scottish Government has an opportunity to implement solutions and safeguard general practice for our patients in Scotland. It must do so if it is to deliver on the promises of the 2020 Vision. It is vital to secure GP led reform of primary care, backed by sustained, incremental increases in investment in general practice, and to work with the profession to direct such spending.

RCGP Scotland’s A blueprint for Scottish general practice (the Blueprint) clearly laid out, among many still necessary measures, how general practice is a cost-effective part of the healthcare system in which to invest and to improve patient outcomes more economically than other parts of the system.

This document covers the spectrum of Scottish general practice. Remote and rural practices and Deep End practices have been included through the broader picture, rather than explored individually. It should be clear to all that they have particular needs and the eradication of the inverse care law sits chief among these.

Promoting general practice is central to the future of the NHS in Scotland. The upcoming election is an opportunity to address urgently required commitments to political action. That urgency continues to intensify. Faced by the need for immediate action to safeguard general practice for the future, RCGP has and will continue to fulfil its role as guardian of standards for GPs in the UK, working to promote excellence in primary healthcare. We call on Scotland’s political representatives to fulfil theirs.

This manifesto shares pertinent quotations from the experiences of patients, families and carers (in blue) and general practitioners (in green), as relayed in writing to RCGP Scotland (please note: all experiences and opinions shared with RCGP Scotland have been anonymised). It also evidences the facts behind those experiences where necessary, and calls for appropriate actions to be taken by the next Scottish Government.
1. Grow the workforce

For two years, RCGP has been warning that rising workloads, a shortage of GPs and declining resources are putting intolerable pressure on local practices and posing a threat to patient care. Now, with vacancies in many practices, imminent large scale retirement, qualified GPs leaving to practice abroad, recruitment to general practice a major concern, and with universities not delivering sufficient numbers of doctors to GP specialty training, the profession is close to its tipping point.

CALLS FOR ACTION

1. Commit to a clear objective of recruiting an extra 740 GPs by 2020 and put an incentivised strategy in place to do so with measurable targets along the way.

2. Ensure medical students and trainees are regularly exposed to general practice each year throughout their learning, broadening their awareness of the great career available to them.

3. Expand the wider primary care workforce to support people’s needs. Numbers of Practice and Community Nurses particularly, should be increased, as should greater collaborative working with communities. All practice teams should include a Clinical Pharmacist.

4. Longer consultation times should be included in future workforce projections, especially when considering mental health, multimorbidity, and high deprivation.

5. Commit to ongoing, sustained increases in investment in general practice until it receives the necessary 11% of NHS Scotland spending. Publish regular statistics showing how this is being achieved.

6. Incentivise universities for each medical student they deliver to general practice training.

7. Support those considering retirement to remain in the profession. Approach those nearing retirement to understand how to delay it and look to ‘return’ those already lost to early retirement.

8. Enhance retention by actively supporting Continuing Professional Development.

9. Promote developments which ease workload intensity.

‘The biggest issue is a workload crisis colliding with a workforce shortage giving a sense the wheels are falling off general practice fast.’

‘His day begins at 7.30am and he leaves work at 7–7.30 at night. He also covers out-of-hour services at the weekends.’

‘We are approaching a tipping point... and without the appropriate funding being available, the service will be unmanned very soon.’

‘Patient safety is now being jeopardised by GPs working in a chronically under resourced and under funded service.’

‘The man seems to be there all day every day’

‘For patient safety we need more GPs. For that to happen we need better work life balance. More time and monetary investment in general practice.’

‘Average working day is now 12-14 hours long’

‘Three practices in our small area are without partners and we are feeling the strain of trying to avoid ill health as we could end up leaving the practice unmanned’

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2. Promote values based quality and leadership

The Quality and Outcomes Framework (QOF), implemented in 2004, adds administrative burdens on a GP workforce already at capacity. RCGP Scotland believes that the replacement of QOF is necessary and that a framework should be developed which will meet quality ambitions and ensure patient safety while minimising administrative duties. We can capitalise on our devolved system, and use these ideas to inform the way in which clusters of general practices could work together to enable a process that is peer led and values driven.

The guidance for QOF gives some indication of the administrative burden. The Scottish Quality and Outcomes Framework guidance for GMS contract 2013/14 ran to 224 pages. After reduction, in 2014/15, it runs to 186 pages.

One Tayside practice, with a list size of c. 6,000, has annually audited the amount of ‘paperwork’ managed through their electronic (Docman) filing system. They found a yearly increase, from an average of 1,389 items/month in 2006, to 3,424 items/month in 2013 - a 250% rise over just eight years.

A 2015 Scottish Liberal Democrat survey found that 91.9% of respondents thought that QOF should be abolished or reduced (with 54% for abolition and 38% for reduction).

A 2007 large-scale study by Campbell et al could not identify a difference in improvement trend between incentivised and non-incentivised clinical indicators.

A 2010 study by Howie explored the complexity of diagnosis in general practice and concluded that current incentives veer healthcare away from what both patients and clinicians want.

CALLS FOR ACTION

1. QOF should be replaced with a system of professional, peer led, values driven governance to better meet the local needs of patients and the health care service, and allow skills and expertise to be shared across practice clusters.

2. Clusters of GPs should be formed, defined as groups of GP practices within a geographic locality (community), covering between c. 20-50,000 patients.

3. Practices should then be asked to agree to the shared values that are of greatest importance in their locality. Practices must then have the time and resources to undertake audit and quality improvement work to show that what they are delivering is congruent with those values.

4. Trials should be undertaken urgently whereby practices pilot this model of governance through the clusters approach. Funding equivalent to QOF payment should be guaranteed to participating practices while trials are underway.

‘[QOF] takes the heart out of the job we are trained to do which is about listening to patients and their needs and helping them to find wellness … it shifts the way we view ourselves, as professionals who are highly trained and skilled at treating people, to number crunchers.’

‘The GPs have changed over the years for various reasons but the ethos of the practice has not changed.’

‘Let us look after our patients and not “the books”!’

‘There is a very basic lesson taught in management circles; do not attempt to incentivise already incentivised individuals. The result is you corrupt their core values; generally caring for others (not money) was the reason they became doctors/GPs in the first place.’

‘Until this fundamental change is made you will continue to lose doctors abroad once trained and discourage people from a career in general practice.’

‘As it stands GPs do a large proportion of their administrative work in their own time. This results in 13 hour working days and working at weekends and during annual leave’

‘I am saddened to see my younger partners exhausted and dispirited due to … the overwhelming burden of administrative and quasi-clinical work … We need to aim to reduce this burden which is NOT the type of work that GPs entered the profession to practice.’

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Supporting statements

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3. Promote the interface

Interface is the point of interaction between different systems. In healthcare, interfaces exist where a patient journey crosses from one area of care into another – such as between primary and secondary care or between health and social care. General practice is the hub of the NHS because of the multiple interfaces it works across to provide co-ordinated patient care. Due to the individual complexity of these different systems, interfaces are recognised as areas of potentially high risk with factors including different cultures, different professional boundaries, different governance systems, different performance targets and different IT systems.

Calls for Action

1. Health boards require dedicated primary and secondary care clinical ‘interface leads’, recognised and resourced within job plans to allow autonomy and to become involved in system change.

2. Specific endorsement is required of the key role of GPs as equal partners to secondary care in any key policy statements affecting the wider NHS, and in NHS processes such as Significant Event Analysis.

3. Increase resourcing of existing IT structures to enable safe and efficient communication across the interfaces, especially that between primary and secondary care and with Out of Hours care.

4. Improve integrated patient records and care plans to ensure they are available to all clinicians looking after patients in the Out of Hours period.

5. Provide appropriate broadband and mobile coverage across Scotland to ensure adequate interface with and within remote and rural practice.

6. Extend, further develop, and maintain existing systems of, clinical decision support. For example, establish dedicated emails and phone lines.

The United States’ National Center for Biotechnology Information reported in 2009 that, in the UK, 55% of Significant Event Analysis reports described the direct or indirect involvement of other health and social care agencies in the significant event with secondary care making up 30% of those.

A RCGP Scotland survey of members found that an average of 71% of respondents across 12 of Scotland’s Health Boards felt they lacked a recognised system through which to feedback issues relevant to secondary care, with a profound sense of disconnect between primary and secondary care.

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The Lack of appropriate structures significantly impacts on two-way feedback processes relating to concerns or suggestions for change, and thus hinders improvements in processes or systems.

The Health Foundation reported in 2011 that a review mapping out the medication system in UK primary care demonstrated that error rates are high. Several stages of the process had error rates of 50% or more, interface prescribing among them.

The same report concluded that “key areas with heightened risk include … the interface between primary and secondary care”.

Existing IT systems are currently not considered fit for purpose; they are unreliable, inflexible, incompatible and limited in their functionality. This significantly impacts on safety and efficiency of clinical data sharing.

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Out of Hours services (OOH) are a crucial part of primary care, used by those in need of care once their usual practice has closed. Yet OOH services have seen a 3.3% drop in funding in real terms since 2004. RCGP Scotland welcomed, and has participated fully in, the Scottish Government’s National Review of Primary Care Out of Hours Services in Scotland. It is a core professional value of general practice that GP driven care in the community is available at any time. The College sees it as essential that GPs remain a central part of the OOH service to ensure holistic, co-ordinated patient care and that In Hours and OOH should be linked up.

"My GP is now retired; the service, although changing, continues to be delivered locally 24 hours a day – out-of-hours too – by our local GPs and primary team."

"I regularly work in _______ OOH as well as full time as a partner in GP and OOH needs urgent investment/overhaul before complete meltdown occurs."

"I regularly get job offers from Australia or the USA with offers of at least double my salary and if OOH workload is not addressed I may leave."

"The only GP covering for an extensive region in chronically short staffed rotas is not a desirable job."

"My GP is now retired; the service, although changing, continues to be delivered locally 24 hours a day – out-of-hours too – by our local GPs and primary team."

"OOH is in meltdown."

"She visited us, often twice a week during the last months before he died. She also put on his notes that he was not to be taken to hospital if we needed a doctor at the weekend."

"The service must be integrated within the wider health and social care service and adequately funded to allow the fulfilment of its objectives."

"We need] more secure arrangements for OOH"
5. Promote Mental Health

The Scottish Government’s Mental Health Strategy for Scotland: 2012-2015 is now due to be replaced. RCGP Scotland believes that mental and physical health need to be given equal standing. We welcome intimations of increased funding to prevent mental health distress and to care for those in distress.

**CALLS FOR ACTION**

1. Mental health should be given parity with physical health, erasing the barrier between the two terms.
2. Adequate consultation time must be available to safely care for those suffering mental distress.

‘I was feeling suicidal and had went to the Forth Road Bridge with the intent to jump off it. Dr ____ spoke with me and spoke me down enough for me to turn around and go home to keep myself safe till I seen him the next day. I think it was. This is just one of many incidents Dr ____ has enabled me to continue the fight for life. Dr ____ has gotten to know myself pretty well over the last seven years and I can see he believes I can manage my mental ill health rather than it managing me.’

‘Dr ____ continued to see me at least every few weeks even during good periods even if it was just to “check in”. I really appreciated her doing this as it allowed her to remain up to date and me to develop a trusting and good, strong therapeutic relationship, vital for identifying and stopping any relapse early.’

6. Promote GPs in Integration and the 2020 Vision

The Integration of Health and Social Care has been one of the main objectives of Scottish Government since the establishment of the 2020 Vision. Delivering care at home or in a homely setting, will rely absolutely upon the work of GPs. To date, despite clear and evidenced willingness on its part, general practice’s involvement in the establishment of Integration has been limited. RCGP Scotland recognises the efforts of Scottish Government to encourage Integration Joint Boards (IJBs) to engage. Timescales are now such that more than encouragement is required.

**CALLS FOR ACTION**

1. Integration Joint Boards must initiate urgent and adequate engagement with general practice, beginning with the development of specific planning groups.
2. Integration should seek to utilise the developing structure of GP clusters within localities.
3. Appropriate time and funding must be made available for GPs involved in this process and in the subsequent work of providing satisfactory integrated care.
4. Social prescribing development, such as that provided by Links practitioners, must be resourced to allow people to access non-pharmacological services where these would be beneficial to their wellbeing.

‘Time to allow the primary care team to contribute meaningfully with the integration agenda will be essential. If colleagues cannot leave their practices to engage with partners there will be a serious risk that the changes will flop.’

‘[We need] funded time for grass roots GPs to contribute and influence strategic planning by IJBs. If integration is to succeed the voice of GPs working at the ‘coal face’ and struggling to meet increasing demand is essential.’

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The perceived lack of a political strategy for primary care has encumbered its development. Current, long-term funding trends could be interpreted as a strategy of a deliberate reduction of general practice for Scotland. The Primary Care Fund, announced by Scottish Government in June 2015, is a welcome beginning towards addressing problems but is very clearly far from enough. A much larger, strategic financial response is called for. With the Scottish Government committing to the trial of new models of primary care in the development of the planned 2017 General Medical Services contract, it must be acknowledged that any new model can only be made fit for purpose with the full engagement of the profession. As a minimum requirement, we need a clear political strategy for general practice, allowing delivery of safe, person-centred care, underpinned by the ‘Four Cs’ of general practice (see below), in an adequately resourced and empowered environment.

RCGP Scotland believes that high quality GP consultations are the key focal point for enabling patient centred care and patient safety in the future.

**The ‘Four Cs’ of general practice**

**Contact:** General practice is the default place, the first point of contact, for the vast majority of patients seeking access to healthcare for the first time.

**Comprehensiveness:** It’s not just about seeing the person and their presenting complaint. GPs see people in their holistic lived experience. GPs are uniquely placed to deal with aspects of medical, social, and psychological factors. GPs ask people about something they didn’t come in for and take the time to listen, identifying major issues.

**Continuity:** GPs are there from cradle to grave, with care benefitting from long-term relationships with patients.

**Co-ordination:** Critically, GPs are able to oversee care from multiple providers and 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 services provision and the health system as a whole.

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