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RCGP Scotland welcomes the opportunity to respond to the Scottish Labour NHS and Social Care Workforce Commission’s consultation. Given the broad nature of the inquiry, we feel that it is not appropriate for the College to respond to every question in turn. The below response does, however, provide an overview of the College’s position on the areas outlined in the consultation.

1. Training for health and social care workers

Despite efforts by RCGP and NHS Education for Scotland to increase the number of GP trainees, in 2017 only 318 of the available 430 GP specialty training places were filled. In the February 2017 round of GP training, the Scottish Government increased the number of GP training places by 100. RCGP welcomes the Scottish Government’s recognition of the need to train more GPs, however, we are concerned that considerable numbers of training places remain unfilled. RCGP analysis shows that 856 Whole Time Equivalent (WTE) GPs are required by 2021 to rectify the projected shortfall of GPs (excluding registrars, retainers and locums), exemplifying the need for a continued focus on promoting GP training.

It is important to understand the reasons why medical graduates are not choosing a career in general practice. A recent report, jointly published by the RCGP and Medical Schools Council (MSC), entitled Destination GP found that medical school students are exposed to high levels of denigration of general practice during their undergraduate studies. The study, which was carried out in medical schools across the UK, shows that by their fifth year, 76% of medical school students had encountered negativity towards general practice from academics, clinicians or educational trainers. Such negativity ultimately serves to dissuade students from pursuing a career in general practice. As a means of tackling this negativity, RCGP Scotland has been leading on work to improve the ‘interface’ between primary and secondary care, which has a strong emphasis on rebuilding inter-professional relationships of trust, understanding, and support.

Destination GP also highlights the huge importance within universities of positive student placements in general practice with 81% of students reporting that GPs on placement had
most influenced their perceptions of general practice. RCGP Scotland, through our Chairmanship of the GP Recruitment and Retention Advisory Group, is working with key stakeholders, including the Scottish Government and Deans of Scottish Medical Schools, to reverse this trend and ensure that general practice is viewed as an attractive career path for medical students by enhancing the capacity of general practice to deliver more undergraduate training.

RCGP Scotland recognises the challenges that GPs face in providing work experience and practice-based training for medical schools and trainees; namely the time constraints placed on an already stretched GP workforce and the challenges of providing adequate and appropriate space in premises to accommodate trainees.

RCGP has consistently called for the GP postgraduate curriculum to be extended from three to four years, with the final year spent primarily in general practice. Exposing GP trainees to high quality, extended training in practice will help prepare them for the reality of general practice and smooth the transition between training and working practice. Extending the GP training curriculum in such a way would also help to ensure that GP workforce numbers are not adversely affected, as extra training would take place within practices. Phase one of the new General Medical Services Contract (nGMS) refocuses the role of the GP as the senior clinical leader in the community and generates a range of learning needs for general practitioners, for instance in leading a multi-disciplinary team and in quality improvement. RCGP Scotland believes that such key areas of training would be appropriate for incorporation within a four-year GP training programme.

Members of the wider Multi-Disciplinary Team (MDT) provide invaluable support to the GP workforce and also provide multi-faceted patient care for an aging population with increasingly complex health and social care needs. The success of the new GP contract is heavily dependent on being able to recruit into these extended teams and we have concerns that the extended workforce simply does not exist at the current time. For instance, workforce figures for key members of the MDT such as Practice Nurses, who are usually trained over many years by GPs within practices, are concerning as 72% of Senior General Practice Nurses are aged 50 or over. We are not aware of any formal schemes in place to address this workforce imbalance and ensure that numbers of these vital members of the MDT are not further diminished.

The nursing and midwifery profession, more broadly, are experiencing significant recruitment challenges, with the Royal College of Nursing (RCN) reporting nursing and midwifery vacancy rates of 4.1%. The new GP Contract describes enhancement of Advanced Nurse Practitioners (ANPs) within general practice, however there is considerable concern over the ability to recruit ANPs to fulfil these new commitments in the current climate. We are also concerned over the ability for GPs to train generalist ANPs, given the workload pressures that the GP profession are currently experiencing, with many GPs already working to capacity. GPs require appropriate and ongoing support to adequately train these key members of the MDT.

Under the nGMS the employment of the wider MDT, for example, ANPs, Advance Pharmacy Practitioners, paramedics, Musculoskeletal physiotherapists etc. has been transferred from the GP to the health board, however there has not yet been clarification provided on who will be ultimately responsible for delivering training to new members of the wider MDT. Training new staff members will have a considerable impact on GPs’ workload and this needs to be considered and clarified in any workforce planning undertaken. There is also, we feel, a case for the formulation of a ‘social contract’ between GPs and ANPs to ensure the retention of
ANPs within practices that have invested time and effort in their training. It is unclear how such a 'social contract' would apply under the conditions of the nGMS.

In order for the nGMS to be successful and to ensure the future stability of primary care in Scotland, all professions within the MDT must be adequately staffed, with training places available to reflect the respective needs of the profession. However, as the shortfall in uptake for general practice specialty training places demonstrates, it is not enough to simply increase the numbers of training places available; professions must be adequately resourced to ensure that they are attractive careers to attract sufficient numbers of candidates for the positions available.

In terms of additional data required for general practice, the Scottish Government and BMA have been clear that Phase One of the nGMS will focus on data collection to inform Phase Two of the contract. This information will specifically relate to GP workforce, workload and income. RCGP Scotland welcomes the recognition of the importance of such information, however the College is seeking further clarification on how this data, especially regarding workload, will be measured, as the process measures used by Deloitte when measuring workload for the Workload Allocation Formula as part of the new contract negotiations gave rise to significant concern from RCGP.

2. We would therefore welcome your views on what you consider are the barriers to a successful recruitment and retention strategy.

The findings of Destination GP highlight a concerning level of denigration of general practice within medical schools. To ensure that students are more likely to opt for general practice specialty training, this culture must be tackled by educational institutions and the health and social care sector more broadly. Tackling such a culture will also have future benefits for the profession as the interfaces and communication channels between different areas of the health and social care service will be improved.

In recent years, the problems facing general practice have been well publicised. Many of the challenges in recruiting and retaining GPs stem from the workload pressures that GPs experience in practice. A ComRes survey commissioned by RCGP and conducted last year showed that of those who responded, 49% said they were so stressed that they could not cope at least once or twice per month. RCGP Scotland has been clear that in order to relieve workload pressures on practicing GPs, more GPs have to be recruited into the profession and more funding needs to be directed towards general practice. We welcome the proposals in the new contract to shift appropriate work from GPs to the wider MDT to allow GPs more time to spend with patients with the most complex health and social care needs.

The Scottish Government and BMA have stated the need to reduce risk and stabilise the GP workforce as core aim of the nGMS. Given the problems of recruiting and retaining GPs within practice, RCGP Scotland is supportive of this stated priority. The College welcomed the Scottish Government’s announced aim of providing an additional 800 GPs by 2027, however we have been clear that in order to help rectify the predicted shortfall of GPs, these additional positions should represent Whole Time Equivalent (WTE) positions. The Primary Care Workforce Survey 2017 revealed that the WTE number of GPs has fallen below the level it was at four years previously. The findings showed that the estimated headcount number of GPs in Scotland has reduced from 4,465 in 2013 to 4,453 in 2017; with numbers of WTE GPs reducing from 3,735 in 2013 to 3,575 in 2017. The reduction in numbers of WTE GPs is of considerable concern for RCGP Scotland.
The number of sessions that GPs work across Scotland is highly variable, with some GPs working only one clinical session per week, and some working up to ten clinical sessions per week. A clinical session of GP time is generally recognised as 5 hours (compared with a session of consultants’ time at 4 hours). Thus, WTE is generally recognised as a minimum of 8 sessions per week (equating to a minimum of 40 hours per week). This wide variation underlines the importance of realistic workforce modelling in terms of sessional commitment, rather than based on absolute headcount figures. Only by ensuring that an increase in sessions worked in general practice is achieved, will meaningful improvements be achieved in relation to GP workforce stability.

Practitioner wellbeing is a priority area for RCGP Scotland. To ensure that GPs feel able to continue practicing and are confident that the care that they provide to patients is of the highest quality, practitioners must be able to have time to engage in Continuing Professional Development (CPD) activities. At present, the nGMS promises one session (5 hours) per month for the practice as protected time for CPD activities. While any protected time for CPD activities is to be welcomed, it is clear that GPs are experiencing considerable pressure and require more protected time for their own development and enhancement of wellbeing. RCGP Scotland would like to see enough time built in to a practitioner’s week to ensure that they can carry out all CPD activities and their appraisal requirement and paperwork within their working week. Additionally, we would like to see the appraisal process become less burdensome. GPs nearing retirement tell us that this is often a factor they consider when deciding whether to remain in general practice. We must therefore ensure that appropriate support is in place to make this process as easy as possible, to help encourage GPs to stay in practice.

In terms of the impact of leaving the EU on the health and social care workforce, RCGP Scotland provided a detailed response outlining our thoughts on this to the Scottish Parliament’s Health and Sport Committee as part of their recent inquiry. This response is attached as Annexe A.

We are clear throughout our response to the Health and Sport Committee, that given the workforce challenges already facing general practice, we are concerned that a complex and overly-bureaucratic recruitment process post-Brexit will further exacerbate these problems. We must be able to recruit GPs from Europe as easily as can be made possible in a post-Brexit healthcare system, to ensure that patients in the UK have sufficient access to healthcare. This system needs to be transparent and involve only the minimum necessary bureaucracy.

RCGP would have concerns about the impact on GP workload, and therefore on patient care and safety, if there were significant insurance implications for patients travelling regularly in a post-Brexit environment. The primary concern of GPs is delivering high quality care to their patients. If practices themselves were required to spend time recovering charges to patients they would have to be appropriately supported to do so. This type of work is also a non-NHS service and is not a mandatory part of the GP’s role. As the mandatory workload of GPs becomes more intense, many GPs may simply opt out of providing these services.

When considering the health and social care workforce, it has been widely reported that many professions are seriously understaffed and struggling to recruit. For instance, community nursing, physiotherapy and community psychiatric nursing are reporting significant vacancies. Each of these professions plays a crucial role in the effective functioning of primary care and problems in recruiting within these professions has an impact on general practice.
An area of considerable concern for RCGP Scotland is the absence of career pathways for carers. Carers play a hugely important role in the functioning of the NHS and given the changing demographics of the population of Scotland, will likely play an ever-increasing role in years to come. The lack of career structure, the lack of value placed on their role by society, the intensity of the workload, low wages and low morale all have an impact on the retention of carers within the profession. Different employment options for carers should be explored, including the possibility of employing carers through the NHS and providing a carer with their own caseload for which they are responsible. There appears to be a great deal of potential development within the role which has not yet been implemented, for instance in offering qualifications and establishing a clear career path. RCGP Scotland is pleased that this has been explored in the Scottish Government’s National Health and Social Care Workforce Plan Part 2 and we would urge action to be taken in this area.

Funding cycles for Third Sector organisations

Third sector organisations provide a huge source of support for many patients and clinicians alike, particularly those working in deprived areas, yet their funding is often not sustained over time. The inverse care law means that those living in higher levels of deprivation are less likely to be able to access the health care that they require. RCGP Scotland is committed to tackling the inverse care law and has consistently called for practices serving populations with higher levels of deprivation to be provided with proportionately higher funding. However, we also recognise that GPs alone cannot provide the solution to tackling burgeoning health inequalities, and that we are heavily reliant on our third sector colleagues to provide support to our patients, particularly around issues such as literacy; debt and employment advice; benefit appeals; counselling services and many more crucial areas.

We therefore strongly agree that the funding cycles of third sector organisations should be reviewed to ensure that these organisations are put on a more financially stable footing, allowing them to more easily recruit and retain staff, and build on the often long-established relationships of trust within marginalised communities.

A thriving third sector provides a lifeline to many GPs who are already working to capacity, as they are able to confidently signpost patients to local organisations who can provide expert care and advice. This sector helps to ensure that GPs can provide truly patient-centric care and is also crucial to tackling the health inequalities which exist in Scotland today.

5. Demographic changes are going to have an impact on future workforce requirements. We are seeking your views on this issue and whether the current workforce planning arrangements take this sufficiently into account and what more could be done to plan for this.

RCGP Scotland recognises the considerable challenge that comes with workforce planning, however we believe that the most effective way to understand the challenges facing health and social care ‘on the ground’ is to consult with those professions during the workforce planning process. At present, the process of workforce planning feels rather unsettled, with limited opportunities for professions to voice their needs during the process. A robust and transparent consultation period may help to alleviate these concerns and ensure greater buy in from the sector to the workforce planning process.

The Scottish Government recognises that there are significant gaps in the workforce data of primary care. At present, the voluntary Primary Care Workforce Survey which is carried out every two years provides the most comprehensive data for the general practice workforce.
However, this is unable to adequately detect trends in important elements of general practice such as workload. This type of data is vital to accurate workforce planning and although we are pleased that it will be collected to inform Phase Two of nGMS we await details on how this will be measured.

Difficulties also arise from the lack of agreed definitions for key elements of workforce planning, such as the length of time that clinical sessions equate to. It is generally agreed that a ‘session’ of general practice equates to 5 hours however this needs to be formally acknowledged and universally agreed. Only then will effective comparisons be drawn among the health and social care workforce.

From a general practice perspective, alongside collecting data on workforce, it is also important that data on the prevalence of multi-morbidities, frailty and chronic conditions is widely and regularly collected. Under the terms of nGMS, GPs will be primarily responsible for these conditions and as such, their future prevalence is likely to have the biggest impact on GPs’ workloads and therefore workforce planning.

The Scottish Government’s 2020 Vision states, ‘...that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.’ As part of achieving this vision, patients are placed at the centre of all decisions and more care is delivered in the community. This vision complements the Chief Medical Officer’s (CMO) emphasis on Realistic Medicine, which aims to match the care offered to individual patients to their personal circumstances. RCGP Scotland are supportive of both the 2020 Vision and Realistic Medicine, however in order to achieve these aims, more resources must be directed into the community setting with greater resource provided for Anticipatory Care Planning (ACP), multi-morbidity and frailty. GPs must also be supported to have meaningful conversations with their patients, which the current standard 10-minute consultations do not allow for. We believe that workforce arrangements should mirror more closely the Scottish Government’s own aspirations.

As has previously been stated, the demographic challenges of the workforce itself are considerable. The Scottish Government’s Primary Care Workforce Survey findings showed that over a third (36%) of all GPs are aged 50 years or over and a recent Audit Scotland Report has shown that more than a third of the nursing and midwifery workforce is also over 50 years old. District nurses play a vital role in being able to care for elderly people unable to leave their homes and will play a pivotal role in helping to achieve the 2020 Vision. However, if these professions continue to experience workforce challenges, it is difficult to imagine how this will be achieved.

6. We are keen to understand what you consider could be the additional frameworks, regulations or legislation that would best support the health and social care workforce.

Under the nGMS, health boards will be responsible for the employment of members of the MDT and will therefore have a considerable impact on the daily functioning of general practice. Currently, although there is GP representation on Integrated Authorities, it is unclear what process is undertaken to appoint these members. We would like to see greater transparency built into this process, given the importance of these bodies to the functioning of general practice.
In order to avoid duplication of work, we have attached in Annexe B our recent response to the Scottish Government’s Safe Staffing Bill. This represents the College’s position on this piece of legislation.

Dr Alasdair Forbes, Deputy Chair (Policy)
RCGP Scotland
May 2018
Health and Sport Committee Inquiry into the impact of leaving the EU on health and social care in Scotland

The Royal College of General Practitioners (RCGP) is the professional membership body for family doctors in the UK and overseas. We are committed to improving patient care, clinical standards and GP training. Its objectives, in concern for care for patients, are to shape the future of general practice, ensure GP education meets the changing needs of primary care throughout the UK, grow and support a strong, engaged membership and to be the voice of the GP.

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RCGP Scotland welcomes the opportunity to respond to the Scottish Parliament’s Health and Sport Committee’s inquiry into the impact of leaving the EU on health and social care in Scotland. Given the nature of the individual questions set out by the Committee, we feel that it is not appropriate for the College to respond to every question. The below statement sets out RCGP Scotland’s position on Brexit and seeks to aid the Committee’s inquiry.

The impact of EEA migration trends on general practice in Scotland

In terms of the impact of Brexit on health and social care in Scotland, it is helpful to firstly ascertain the number of doctors from EU countries currently working in the UK. Although the RCGP is unaware of any public data that quantifies this number in its entirety, there are some sources for the number of doctors from the European Economic Area (EEA). However, this is not a perfect proxy for doctors from the EU for the following reasons:

- A doctor from the EU could obtain their Primary Medical Qualification (PMQ) at a British institution (and therefore not be counted).
- A doctor from the UK could obtain their PMQ at an institution in the EEA that isn’t the UK (and therefore be counted).
- The EEA includes the non-EU countries Iceland, Liechtenstein and Norway, and numbers in these instances also include those from Switzerland.

Nonetheless, given the paucity of reliable nationality data, this is the best proxy that the RCGP is aware of.
The General Medical Council (GMC) published a report in February 2017 about their data on doctors who obtained their PMQ in the EEA. This focuses on doctors with a licence to practise in the UK (which does not mean they are currently doing so). The GMC’s analysis indicates the following number and proportion of licensed EEA graduates who were GPs in the UK (excluding those who are on both the GP and specialist register) in 2015. There are a further 191 GPs whose location is not known.

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>1,742</td>
<td>5%</td>
</tr>
<tr>
<td>Scotland</td>
<td>172</td>
<td>4%</td>
</tr>
<tr>
<td>Wales</td>
<td>80</td>
<td>4%</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>143</td>
<td>11%</td>
</tr>
</tbody>
</table>

In an attempt to quantify the impact of EU GPs, the RCGP used this information in conjunction with the number of GPs working in each nation. Although only an approximation, this indicated that 2,137 GPs working in the UK obtained their PMQ in the EEA, serving almost 3.5 million patients. This information was published by the RCGP in May 2017.

<table>
<thead>
<tr>
<th></th>
<th>Number of EEA GPs (excluding registrars, retainers and locums)</th>
<th>Number of patients served by EEA GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>1,742</td>
<td>2,892,367</td>
</tr>
<tr>
<td>Scotland</td>
<td>172</td>
<td>226,539</td>
</tr>
<tr>
<td>Wales</td>
<td>80</td>
<td>127,905</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>143</td>
<td>214,309</td>
</tr>
</tbody>
</table>

RCGP analysis predicts that Scotland needs to increase the number of Whole Time Equivalent (WTE) GPs by 856 across Scotland by 2021. The problems facing general practice in recent years have been well-documented, with increasing numbers of GP practices going ‘2C’ and handing their contracts back to their health board at an increased cost to the tax payer and to the detriment of the continuity of care.

Indeed, the Scottish Government and BMA have recognised the serious concerns facing the GP workforce and have stated the need to reduce risk and stabilise the GP workforce within general practice as a core aim of phase one of the proposed General Medical Services Contract 2018 (nGMS). RCGP Scotland agree that this should be a clear priority for policy making in general practice to help stabilise the profession and increase the GP workforce numbers. The College has welcomed Scottish Government’s announced aim of providing an additional 800 GPs by 2027, while advising that that aim should stipulate these be 800 WTE GP numbers.

With such considerable workforce challenges facing the profession it is vital that measures are put in place to retain the current GP workforce, whilst simultaneously improving the recruitment of GPs to ensure that a sustainable workforce level can be reached as quickly as possible. We must therefore...
be able to recruit GPs from Europe as easily as can be made possible in a post-Brexit healthcare system, to ensure patients in the UK have sufficient access to healthcare. This system needs to be transparent and involve only the minimum necessary bureaucracy.

To assist the mitigation of any potential risks of Brexit on the general practice workforce across the UK, the RCGP has called for the Performers List processes to be significantly reviewed in the light of any changes to the approach to overseas doctors applying to join in the UK.

RCGP would have concerns about the impact on GP workload, and therefore on patient care and safety, if there were significant insurance implications for patients travelling regularly in a post-Brexit environment. The primary concern of GPs is delivering high quality care to their patients. if practices themselves were to have to spend time recovering charges to patients they would have to be appropriately supported to do so. The RCGP would also have serious concerns if those travelling into the UK from the EU are required to pay or provide insurance for medical treatment as an unintended consequence of this may be a greater workload put upon general practice. Ultimately, RCGP would advocate for broadly the same arrangements for incoming doctors and the equivalent for medical staff wishing to work in other European countries.

The view from the professionals in relation to the decision to leave the EU

In a recent ComRes survey commissioned by RCGP, ii 74% of respondents in Scotland said that they were concerned about the impact of leaving the EU on recruitment and retention of GPs. 60% of respondents believed that Brexit was likely to impact their GP practice negatively.

It should also be noted, that after the Brexit vote, many RCGP members from EU countries raised concerns about the emotional impact of the uncertainty that they felt over their future following Brexit. In an already demoralised workforce, where 49% of respondents to the ComRes survey told us that they were so stressed they feel that they cannot cope at least once or twice per month, we must do all that we can to minimise the stress and uncertainty on the GP workforce. Only in doing so will we help build morale amongst the GP workforce to help deal with the retention problems facing general practice. Following the Brexit vote, RCGP was clear in calling for a unilateral promise for all EU citizens working in the NHS that their position would be secured as a result of the Brexit negotiations. This assurance has now been provided by the Government and the focus now must be on ensuring that GPs continue to be able to come to Scotland to practise from around the world, with as little bureaucracy as possible, while of course continuing to uphold safety standards.

RCGP commissioned ComRes to run an online survey among its members in Scotland. It was in field and ran between 03 August to 17 September 2017, with 208 respondents.

Annexe B

Scottish Government Consultation on the ‘Safe Staffing’ Bill

Response from RCGP Scotland

The Royal College of General Practitioners (RCGP) is the professional membership body for family doctors in the UK and overseas. It is committed to improving patient care, clinical standards and GP training. Its objectives, in concern for care for patients, are to shape the future of general practice, ensure GP education meets the changing needs of primary care throughout the UK, grow and support a strong, engaged membership, and to be the voice of the GP.

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This response was entered through the Scottish Government’s online consultation survey portal and is saved as a record of entered responses only. RCGP Scotland choices and text responses have been saved here in blue.

Question 1

**Question 1a:** Do you think it is important to have a coherent legislative framework across health and social care to underpin workforce planning and appropriate staffing in health and social care? [Yes/No]

If you answered yes, how important

1 = extremely important,
2 = very important,
3 = moderately important,
4 = slightly important,
5 = not at all important
Question 1b: How should organisations’ progress in meeting requirements be monitored and facilitated, taking account of what currently works well?

Monitoring of progress towards fulfilling statutory obligations on workforce recruitment should be done by an organisation with robust structures and experience, external to territorial Health Boards, as Healthcare Improvement Scotland. Appropriate sanction should be available to ensure compliance.

Question 1c: Please provide any other comments you may have. [Text box]

In the case of healthcare professional workforce planning, the workforce’s professional bodies should be intimately involved in the informing and setting of workforce plans and supported to play an advisory and active role in efforts to attract appropriate staffing numbers. Existing experience and expertise surrounding staffing requirements should be sought wherever it may originate from. GP Practice Managers, for example, may be used to further inform the principles of the Bill’s requirements.

From a general practice perspective, it is clear that, under the proposed new General Medical Services contract (nGMS), patient safety, practitioner workload and the further transformation of primary care will rely heavily upon successful recruitment and retention of significant numbers of a wide range of healthcare professionals. Failure to attract and maintain sufficient workforce numbers will have a potentially serious and detrimental effect on patient safety, the quality of care, practitioner wellbeing, GP workforce levels and the success or failure of the new models of care the contract outlines.

The inclusion of the word ‘safe’ within the Bill would give RCGP Scotland concern unless it were rigorously defined upon publication of the Bill. Without such clear and absolute definition, the meaning of ‘safe’ and the provision of ‘safe staffing’ would likely be decided by test case. Given that such a test case could potentially be pursued against a general practitioner, the College would have difficulty supporting its use should it feature without such rigorous definition.

Question 2

Question 2a: What is your view of the proposal that there should be guiding principles for workforce planning to provide NHS Boards and care service providers with a foundation on which to base their staffing considerations?

Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree

**Question 2b:**
Do you have a view on whether/how application of these principles should be monitored?

Yes, these principles should be monitored.

**Question 2c:**
Please rate the following examples of potential principles on a scale of 1 to 4, where 1 is very important, 2=important, 3=not very important, 4=not important at all (note that the following do not represent draft wording for the principles to be included in legislation).

i. Workforce planning must ensure an appropriate number and mix of staff to provide high quality services.

1

ii. Workforce planning must ensure an appropriate number and mix of staff to provide effective and efficient use of resources.

2

iii. Workforce planning must ensure an appropriate number and mix of staff to provide services that meet service user needs.

1

iv. Workforce planning must ensure an appropriate number and mix of staff to provide services that respect the dignity and rights of service users.

1

**Question 2d:**
Are there other principles you think should be included?

Workforce planning must ensure an appropriate number and mix of staff to protect the health and wellbeing of the workforce.

Workforce planning must ensure an appropriate number and mix of staff to protect the legal standing and professional reputation of the workforce.

Importantly, any work towards recognition of ‘safe staffing’ should encompass the need to provide effective levels of support for induction and orientation of
new or returning staff. These individuals should not be expected to work without appropriate support.

Question 3

Question 3a:
What is your view on the proposed requirements for Health Boards?
[These are available in the link above, from the Discussion Paper (DW)]
Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree

Question 3b:
Are there any other requirements you think should be included?

Where the requirements propose a common methodology on ‘Consideration of staff and service user views’, it should be made clear that that ‘consideration of staff’ should include relevant and appropriate staff from any affected multidisciplinary team professionals.

Safe staffing should include avoidance of lone working where feasible. Where avoidance is not feasible, secure premises and good communications should be available. GPs and community nurses are often alone in houses and other premises, whether during practice opening hours or delivering Out of Hours care, and, though that attendance is part of their professional requirement, risk mitigation should be in place.

Question 3c:
Please provide any other comments on the proposed requirements set out in section 3.

No safe staffing tools are available currently for general practice. Developing appropriately robust tools for general practice would be an academic challenge and present real risks of unintended consequences.

Question 4

Question 4a:
Do you agree with the proposed role for the Care Inspectorate in leading work, with the social care sector, to develop workforce planning tools for application in specified settings, where there is an identified need?
Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
If you answered Disagree/Strongly disagree, who else do you think should lead this work?

**Question 4b:**
Do you think that social work should be included within the scope of this legislation (while there is currently no proposal to include social work, this could be considered for inclusion at a later stage).
Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree

**Question 4c:**
Please provide any other comments on the inclusion of social work within the scope of the legislation.

No response.

**Question 5**

**Question 5a:**
In delivering the function described under 3 above, the Care Inspectorate could be required:

i. To work with employers/service providers and commissioners from the sector to identify and agree specified settings where there is a need for the development of workforce planning tools and methodologies

ii. To work with service providers and commissioners from the appropriate parts of the sector to develop and validate workforce planning tools and methodologies to demonstrate that they are practicable and beneficial for specific settings

iii. To consult with the sector before a requirement to use validated workforce planning tools and methodologies is confirmed in regulations.
How important do you consider the suggestions above are in providing possible routes for the sector to be fully engaged in the development and validation of approaches appropriate for a specified setting? Mark each requirement on a scale of 1 to 4, where 1 is very important, 2=important, 3=not very important, 4=not important at all, 5= not desirable

**Question 5b:**
Are there any other routes you think should be considered to ensure appropriate engagement with the sector? [text box] **Question 5c:** Please identify any settings where you think the development of appropriate workload and workforce planning tool or methodology is most important; and any care settings where you think this is not relevant or required. [text box] No response.

**Question 6**

**Question 6:** What support do you think will be required / most useful to enable the development of validated tools and methodologies for the social care sector? Please mark each suggestion on a scale of 1 to 4, where 1 is very important, 2=important, 3=not very important, 4=not important at all
i. Dedicated central expertise for the identification of specified settings where the development of workload and workforce planning tools and methodologies would be practicable and beneficial.
ii. Additional resource for the Care Inspectorate to enable the proposed functions
iii. Training for key personnel in the sector in the development of workforce planning approaches.
iv. Dedicated resource for service providers who engage in the development and validation of approaches, tools and methodologies.
v. Training for key personnel in specified services once validated tools and methodologies are confirmed through regulations.
vi. Other [please specify – large text box]

No response.

**Question 7**

**Question 7a:** What risks or unintended consequences might arise as a result of the proposed legislation and potential requirements? [text box]
As noted in answer to Question 3c (above) ‘no safe staffing tools are available currently for general practice. Developing appropriately robust tools would be an academic challenge and present real risks of unintended consequences.’ For an example, the alteration planned to the formula through which to calculate funding for general practice has acknowledged challenges due to factors such as the variety and differences in ways of working within general practice across Scotland. Designing a suitable safe staffing tool could produce similar unintended effects and must be undertaken with the utmost care.

**Question 7b: What steps could be taken to deal with these consequences?**

Much more work would be required to provide a satisfactory answer to this question than can be carried out in preparation towards supplying a response to this consultation.

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i NHS Education for Scotland, ‘General Practice ST1 recruitment figures 2017’ available at: https://gprecruitment.hee.nhs.uk/Portals/8/Documents/Annual%20Reports/GP%20ST1%20Recruitment%20Figures%202017.pdf


v National Services Scotland, Information Services Division (ISD) ‘Primary Care Workforce Survey Scotland 2017 – A Survey of Scottish General Practices and General Practice Out of Hours Services (2018) available at:


vi Scottish Government ‘2020 Vision’ available at:

http://www.gov.scot/Topics/Health/Policy/2020-Vision