Fit for the Future

A challenge paper to revitalise general practice

Scottish Labour
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Executive Summary

General Practice in Scotland is in crisis. It appears harder than ever to see a family doctor in Scotland with practices struggling to fill vacancies, fewer medical students and more doctors looking to leave the country for a better work life balance.

Our practices are increasingly understaffed, under resourced and under too much strain.

These problems did not appear overnight but are the result of nearly a decade of negligence from the current Scottish Government who have failed to deliver proper workforce planning, dropped the share of investment for general practice by over £1 billion and cut funding for medical student numbers. They have done nothing to incentivise students to go into general practice.

As these problems did not appear overnight, neither can there be a quick fix, but action must be taken soon or the real pain will be felt in a decade, when Scotland will face an unsustainable shortage of family doctors.

This paper seeks consultation on a number of proposed immediate and medium term actions.

Immediate actions include:

1. Training more GPs

2. Cutting down red tape for substitute GPs.

3. Ensure practices notify Health Boards on unfilled posts.

It's known as primary care for a reason, it's the front line of our health service. Getting general practice right means other aspects of our NHS, for our A&E departments to our mental health services can function under less pressure and deliver better, faster care to patients across the country.

No party or organisation has a monopoly of wisdom. This paper seeks to start a discussion which will secure the future of general practice in this country, and ensure better care for Scots for decades to come.

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This paper is an initial one for consultation and draws on the material provided by a survey of GPs, and correspondence with patients and health staff.

Background

The background to this crisis lies in multiple factors.

The 2004 UK GP contract was negotiated with the BMA and in its first few years substantially enhanced general practice.

This new contract was the first to embody payment for quality across a broad spectrum of General Medical Services (GMS). This was the *Quality Outcomes Framework (QOF).*It was designed to reward those GPs who were providing a quality service. Within a very short period of years Scottish GPs were all rated close to maximum points. Some GPs were offered an alternative contract, in an intermediate model between independent *GMS* contract and fully salaried practices directly run by Health Boards *(2C* practices). Known as the *PMS* option, this was taken up only by a minority of practices. The 2c practices were always expected to be either temporary or in special circumstances; for example on the sudden death of a single handed practitioner or practices specifically for homeless people.

The GMS core contract was augmented by *National enhanced services (NES)* for those GPs who wished to undertake them; for example addiction services. There were also *Local enhanced services (LES)* where Health Boards sought additional support on areas of service.

At that time the removal of *GP Out of Hours* work, which had been increasingly organised in Scotland at least as cooperatives, transferred responsibility for GP out of hours services to the Health Boards.

GPs were encouraged to remain involved in out of hours by a payment for sessions undertaken and a financial penalty for non participation. However, the penalty was never onerous and especially not in the context of a substantial rise in GP net income resulting from the new contract. The out of hours GP service has suffered a slow but steady and continuous decline in participation rates. The per capita cost to the Health Boards was always variable with Highland costing 4-5 times Glasgow. This degradation has now reached tipping point with great difficulty in some areas in filling regular shifts, resulting in some out of hours centres closing (e.g. partly in Perth and fully Lanarkshire). This is the subject of a separate review by Sir Lewis Ritchie expected to report in October. However his findings will be of great import to the more general issue of the future of general practice.

The following are some of the issues that have been identified as contributing to the swing over a decade from competition for trainee places and partnerships in almost all bar remote and rural areas to one of unfilled vacancies.

1. ***Quality Outcomes Framework.***

The QOF, initially seen widely as a good thing has now become a bureaucratic imposition. The increasingly negative view of it has been compounded by UK and SNP Governments amending replacing and adding elements each year. The guidance in 2013 ran to 226 pages and even with the modest cuts this year is still 186 pages. Worse still, the new measures were almost routinely introduced without adequate notice and in the absence of the requisite computer software. Moreover the need to identify so called exemptions in order to modify the target percentages became burdensome. One example is the Hypertension QOF where a certain level of blood pressure had to be achieved. Many clinicians, faced with the holistic care of older patients, had to use exemptions in order not to treat patients inappropriately. Clinicians now regard the QOF as a top down, imposed 'tick box' medicine. We will return to proposals to modify the QOF later but the core principle should be that any recording should automatically transcribe from a clinical record including any decision not to treat.

2. ***Population increase and change in demographics***

In 2002/3 the Registrar General for Scotland was making population predictions showing a continued decline from 5.025 million to around 4.75 million. The demographic changes predicted also showed an increase, especially in the over 75s. The Labour led Scottish Government noted this. But there were other challenges eg the impending introduction of the European Working Time Directive and the need to redesign services to shift the balance of care from hospital to primary care and from district hospitals to regional hospitals to achieve better outcomes. This led to the Calman & Poulson review of medical undergraduate numbers. At this time when Labour had announced the largest increase in NHS funding since 1948.

Despite the predicted reduction in population, Calman & Poulson recommended an increase in undergraduate places. This increase was partly in the clinical years only in order to accommodate preclinical students from St Andrews who had hitherto moved to Manchester for clinical years. Students completing their course fully in Scotland are more likely to remain in the Scottish NHS.

In fact the predicted population decline was wildly and unexpectedly inaccurate.

	Estimated Projected population at 30th June 2001(000's)					
Year	2001	2006	2011	2016	2021	2026
All ages	5,064	5,023	4,983	4,943	4,895	4,828

An increase of 10% in the birth rate, a decline in the death rate and a swing from net emigration to net immigration began an increase in population of 250,000 which reaching the highest Scottish population ever in 2015 [see graph 1-Register General]. However the projection on increasing numbers over 75 was exceeded [see table or figure 2] and research has shown that the numbers with multiple long term conditions has doubled.

Graph 1

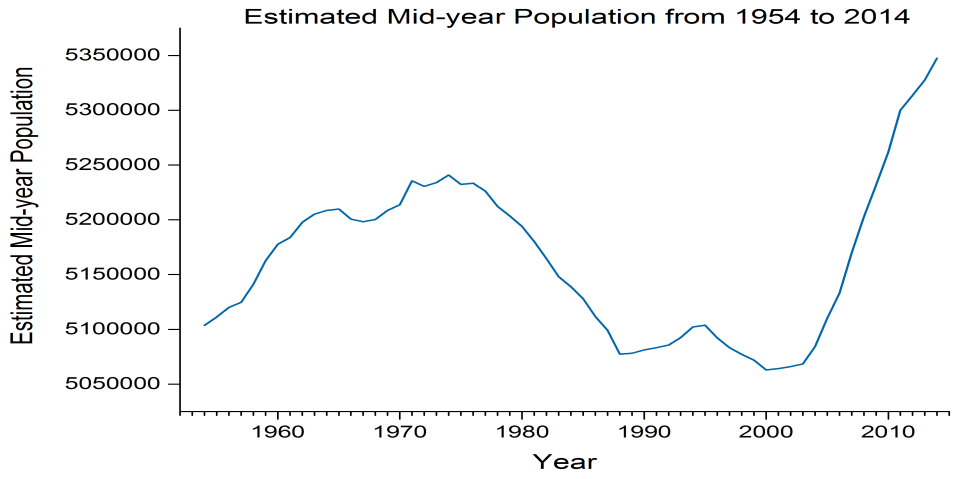


Figure 1

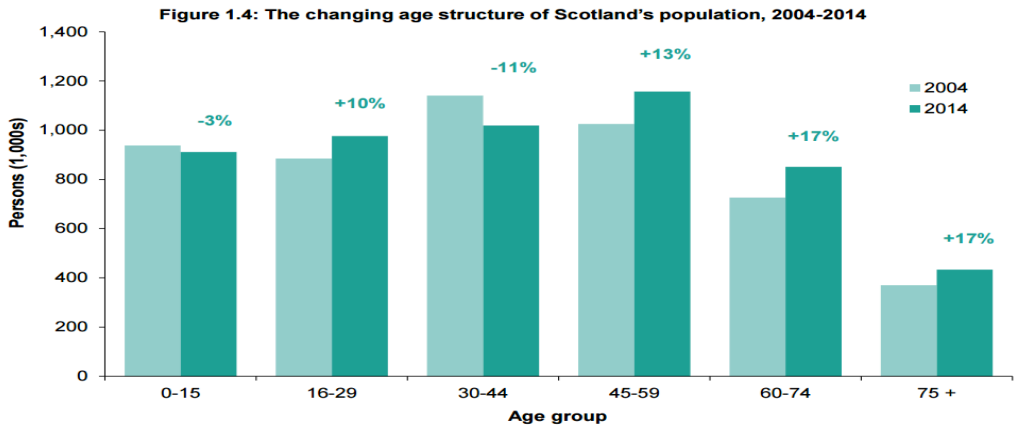
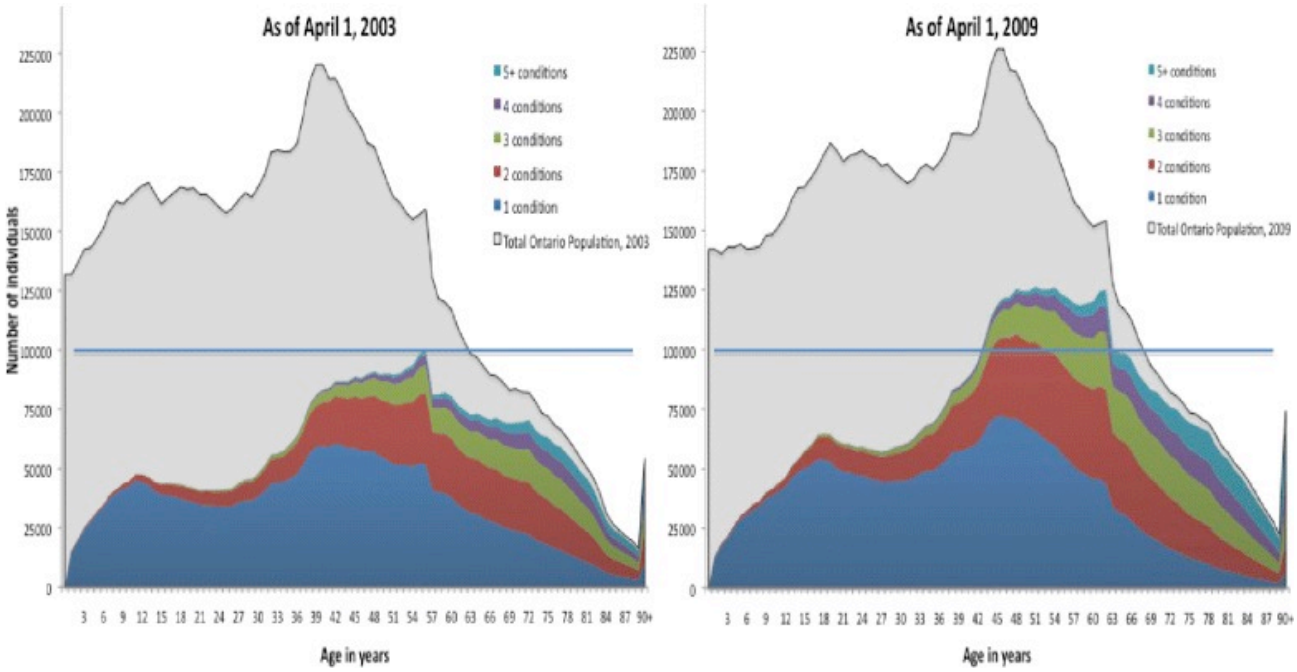


Figure 2- Numbers with multiple conditions by age



3. *Shift in Balance*

There has been a transfer of work over many years from secondary to primary care. This has not been accompanied by a corresponding transfer of resources. We also have transferred many patients with learning disability and mental health conditions from hospital to community care.

Resourcing primary care

The National Audit Office in its 'Four Countries Report' 2012 said:

> *"Since 2005-06, the proportion spent on health by each of the four nations has remained fairly constant. England has consistently devoted the highest proportion of total public spending to health services (22.0 per cent in 2010-11), with Northern Ireland the lowest."*
> *"In 2009-10, the average taxable income of GPs ranged from £89,500 in Scotland to £109,400 in England."*

This gap has remained largely unchanged, though increases in pension payments and pay freezes have reduced the net taxable income since 2010.

Changes in expenditure reported by the Institute for Fiscal Studies are seen in table 1- Institute for Fiscal Studies

Overall and health budgets (£ billion, 2013–14 prices) England and Scotland

	2009–10 spend	Planned 2015–16 spend	% change
UK Government			
Overall "English" departments	278.4	240.4	-13.7%
Health	106.8	112.4	5.2%
Scotland			
Overall Scottish Government	33.0	30.2	-8.4%
Health	11.8	11.9	0.2%

Source: SPICe calculations based on IFS methodology

Notes: 'English' Departments are defined as those where the bulk of that department's work is devolved to the Scottish Government. English departmental spend includes Departmental Expenditure Limits (DEL) only, with the exception of the Department for Communities and Local Government where an adjustment has been made to account for the localisation of council tax benefit and business rates. Scotland spend includes the Scotland DEL (i.e. the block grant) and business rates revenues. Business rates revenues are added to

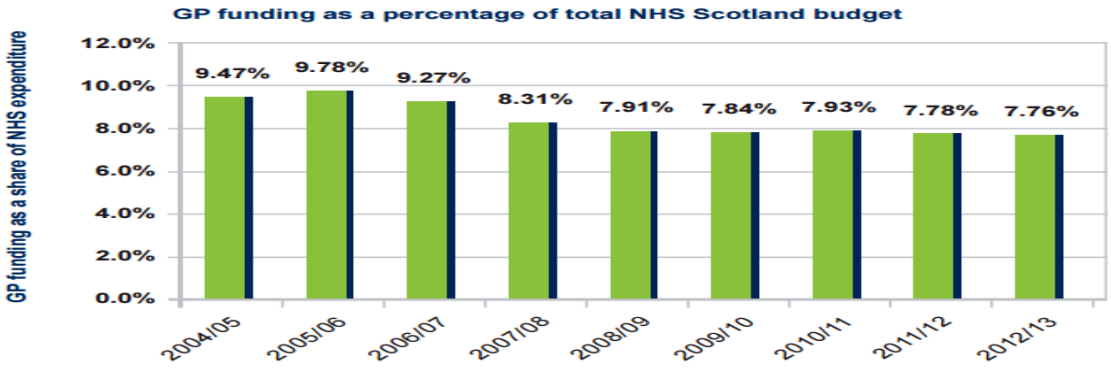
the Scottish DEL to ensure greater comparability with figures for “English” departments (business rates revenues are counted as part of English DEL but as a separate item for Scotland). .

The Scottish Information Services Division of NHS Scotland in its 'Cost Report' stated that:

> *"Family health sector expenditure, which includes the cost of running local GP practices as well as local pharmacy, dental and ophthalmic services, amounted to just under £2.4bn in 2014, a cash terms increase of 1.2% but a real terms decrease of 0.5 % compared to 2013."*

	Cash Terms					Real Terms			
Operating Costs (£bn)	2011	2012	2013	2014		2011	2012	2013	2014
Family Health	2.38	2.42	2.37	2.40		2.50	2.48	2.42	2.40

This was compared to a real terms increase in Acute spend.
Table 2 from https://t.co/OhmE0HEKsF



This is a pattern which has been recurring over the last decade.

The Royal College of General Practitioners in Scotland reported, that as a share of overall budget, there has been a decline from 9.78% to 7.76% representing a cumulative loss to primary care of £1 billion.

The Growing Crisis

In 2010 we warned that there was little competition for general practice partnerships. There were anecdotal reports of increasing difficulties in obtaining the services of locums.

The trend for seeking both sessional work and part time partnerships was increasing. The previous stability of GPs who in the period from 1948-2000 often entered a partnership in their early thirties and remained in that practice for the next 30 or more years was eroding. The early retirement of GPs was increasing.

All of this, together with the increasing differentiation in the strategic approach to the NHS in Scotland and England led Scottish Labour to call for a separate and distinct contract for Scottish GPs. Unfortunately this was rejected by the SNP Government and the BMA.

At the time of the Scottish election in 2011, Scottish Labour was of the view that the very future of the NHS was at risk in the medium [5years] to long term [15 years] and that a full scale review of both the 'free at the point of need' NHS and the means tested Social Care system was needed. This too was rejected by all the other Scottish Parties including the SNP Government on the grounds that 'it would take too long'.

The most recent attempt at all party approach has been overtaken by the unilateral announcement in August 2015, after pressure from the BMA, the medical and nursing Royal Colleges and the media combined with continuing failures to meet most of the NHS targets, of a 'National Conversation' by the SNP government which they previously rejected. The President of the Scottish RCGP welcomed this but said 'it had better be a short conversation".

Meantime Scottish Labour having had its proposal and offer of an all-party supported independent review rejected, established commissions to study two of the core areas where successive governments had failed: 'Health Inequalities' and 'Sustainable Funding in Social Care'. These will report shortly.

In Scotland, meantime, we have experienced:

- an increasing population (150,000 during the current SNP Government),
- an increased birth rate,
- an increasing number of over 75 year olds with multiple and complex conditions,

- an increasing demand as evidenced by a growth year on year in GP consultations and a largely un-resourced transfer of work from secondary hospital based care to GPs,
- a bureaucratic quality outcomes framework and
- a new revalidation system and
- a largely inadequate outdated infrastructure.

The response of the SNP has been to cut nursing student intake, cut the midwifery student intake (at one point by 40% with the closure of three University midwifery departments). Not only did they cut Scottish medical student intake by 67 and total student intake, since 2011/12, by 200; further they presided over a reduction in the proportion of domiciled Scottish graduates from 60% under Labour to 54% last year.

The nature of the work delivered in primary care is changing and must continue to change. A starting point which is agreed in all-party support for the 20-20 Vision is that we want to enable people to live at home independently or with their families, in their communities, for as long as possible. But this will require proactive re-designed service models with a strong focus on function rather than form.

A fundamental aspect of a new strategy must be to identify those services which should in future be delivered in community settings by a range of organisations and professionals. This requires service redesign across the integrated system, away from models of care centered on hospital-based services which treat single conditions, to a population-based approach with much greater emphasis on managing co-morbidity.

At the core of the redesign has to be co-production with increased enablement of self-management. It will also mean challenging historic boundaries between organisations and sectors to identify those areas where greater flexibility or new roles and accreditations can make a difference, or where new ways of working can be developed which create better integration between professions.

Health and Social Care integration which has long been the failed ambition of successive Scottish Governments will not succeed unless there is ownership at the frontline. This requires both a revival of general practice but also its integration with other previously separate organisational and management structures.

If we look to the Labour led Welsh Government, it did set up the 'Bevan Commission' years ago. This was an independent commission charged by the

Welsh Assembly to engage with all stakeholders. As a result in Wales action has been taken under the banner of 'Prudent Medicine'. The actions in the primary and community care field include, amongst a raft of measures, GP practices being organised into 64 funded clusters.

These are supported by effective management. They have incentivised doctors to enter GP training and move to areas of need. They have substantially cut the bureaucracy for GPs. Morale is already improving and the numbers of GPs per head of population has begun to improve.

The system of clusters was advocated by the Royal College nine years ago [federated practices] and has been endorsed by the Kings Fund [family care partnerships] as essential. There were 88 locality groups of GPs in Scotland at one point in the 1990s.

Crisis, what crisis?

By May 2015 the correspondence being received from GPs indicated a deterioration in GMS practices. The SNP government could provide no details, persisted in referring to the numbers of GPs rather than defining the problems.

They had announced in November 2014 an additional £40 million over three years for primary care in support of the integration programme. But again no details were available.

The BBC and Dr Simpson independently undertook surveys of general practices - 330 out of 990 practices responded, with many more GPs writing in with detailed comments on the challenges being faced. A further 49 responses were received too late for analysis but confirmed the general picture.

This showed:

- a growing level of practises being taken over by Health Boards as GP partner vacancies remained unfilled and GMS practices [42 2c practices in all with more expected e.g. Brechin and a practice in Fife]
- a growing number of vacancies for GP partners [92/330]
- a growing number of vacancies for sessional doctors [68/330]
- a number of practices who had asked the Health Board to remove thousands of patients from their list as an alternative to seeking direct Board control
- a growing number of practices who were restricting new patient registrations either to a specific number weekly or to members of existing registered households. This on top of more restrictive geographical practice boundaries. E.g. 23 Edinburgh City practices operating restrictions had introduced these since 2014.
- Increasing difficulties in obtaining both long term and short term locums. This was reported as causing difficulties in covering sickness and maternity leave and in providing cover for training sessions.
- 25% of GPs in the practices were reported as being five years or less from retirement.
- a declining number of doctors willing to participate in GP 'out of hours' with sessions unfilled.

Possible Actions

The actions we urgently need to consult on and which have been suggested to us are laid out below. They are not exclusive and we hope that we will get responses from GPs, primary care staff and others in social care at the frontline, together with patient groups and voluntary organisations:

Note: *italics* indicate the possible responsible organisation

Immediate

1. *NSS Scotland* -
   to establish A 'national performers' list to allow locum doctors to be employed in any area replacing the localised system which requires multiple applications.
2. *Health Boards*-
   to contract retained banks of GP locums, retainer doctors and other primary care staff.
3. *GP practices*-
   An immediate requirement on all practices to advise their Board if a vacancy for a partner a
   sessional doctor or a locum for maternity leave remains unfilled.
4. *Health Boards*-
   To draw up an at risk register if they have not already done so
5. *GP* practices-
   All practices required to have a Patient Participation Group with a representation from the community council.
6. *Government with RCGP*-
   A review of and significant reduction in QOF with eradication of any QOF which does not either fall out of day to day clinical recording or is associated with patient access to GP services.
7. *Government*-
   A moratorium on new community pharmacy licenses agreed by the community council or patient participation group.
8. *Government*-
   To offer favourable terms to retiring doctors to undertake locums for Health Boards who should pay for Medical insurance cover.
9. *Government*-
   All undergraduates entering final year bonded to practice full or part time in medicine in UK or in an approved overseas post for a specific number of years.

Immediate to medium term

Structure

1. *Government and Boards working with Local Medical Committees-*
   To introduce incentives for GP practices to form into groups known variously as networks/clusters/federated practices/family care partnerships/ localities.(see Royal College paper, Kings Fund paper , the 64 Clusters project in Wales and the Tower Hamlets system). Establishment of such groups of practices will restore the locality groups of which there were 88 in the 90's. These clusters should cover approximately 30,000 to 50,000 patients with aligned social work and social care teams. Practice locality groups should be supported by professional management, specialist nurses, advanced nurse practitioners, physician assistants, allied health practitioners and pharmacists. Support staff to be repeat prescribers for chronic conditions. Every cluster backed by a patient participation group.

   *Audit Scotland in its report on GP prescribing notes:
   "Over 900,000 people in Scotland over the age of 50 are taking four or more different drugs. People taking many drugs have an increased risk of side effects from their drugs and, in some patients; the combination of drugs could have an adverse effect on their quality of life. GP practices serving the most deprived areas prescribe on average 46 per cent more drugs per head of population than those in the least deprived areas." Pharmacists have a key role to play in support of GP chronic prescribing and a number of Boards have linked pharmacists.

2. *Integrated Joint Boards or Lead Authority-*
   All locality clusters to be coterminous with Social work and social care teams.

3. *Integrated Joint Boards or lead Authority*
   All care homes to be supported by an integrated team including geriatrician nurse and AHPs linked to clusters and to cluster specialist nurses

4. *Government and Department for rural affairs Aberdeen University-*
   Through a revitalised Remote and Rural workstream to construct a new contract for remote and rural practices which recognises the benefits and damage to GMS through community Pharmacy contracts. Revise the contract for remote and rural community pharmacies to require

pharmacists to be engaged within the practice.

5. *Government and Health Boards-*
   All practices to be assisted to achieve paper free status with established websites with access for appointments and repeat prescribing.

6. *Government, RCGP and Community Pharmacy Scotland-*
   KIS/Anticipatory electronic care summary to be accessible to pharmacists with consent from the patient. This should lead on to a review of the linkage of primary and secondary care records and address the security issues involved.

7. *Health Boards-*
   All clusters will have a patient participation group *(PPG)*. Individual practices may choose to have their own group.The PPG will review access, support the cluster in ensuring adequate resources and provide support to associated volunteer groups

8. *Health Boards-*
   Each cluster should have both attached volunteers providing a variety of functions linked to the cluster and to the community. Some of these may be part of formal third sector organisations.

9. *Health Board and Local Authority-*
   A review of the estate should be undertaken as a priority task for the new Integrated Joint Boards in conjunction with the Health Boards. A top priority must be those practices within areas of deprivation with a secondary priority for areas where there is substantial new housing [though this latter area should have been part of routine work for the Community Planning Partnerships involving the Local Authorities and Health Boards].

Staffing

1. All practices to have an input from a pharmacist with the immediate objectives of
    a. Implementing fully appropriate chronic prescribing registers.
    b. Ensuring safe polypharmacy and in the longer term to be non-medical prescribers for chronic conditions.

2. Recruitment a) introduce a Scottish Medical Graduate entry scheme b) undertake research to understand both the failure to recruit and the increasing emigration.

3. To increase the entry to Advanced Nurse Practitioner course specifically to provide support to both in hours and out of hours primary care work.

4. To increase the numbers of specialist nurses who are community based or in outreach teams for diabetes, asthma, heart Failure, mental health and palliative/end of life care. Specialist staff to be attached to practice clusters. These specialist nurses could be prescribers.

5. All clusters to have additional support from Allied Health Professionals (AHP).

6. The clusters will have management support and engage sessional doctors, bank locums and retained doctors.

7. School nurses to be aligned with an integrated with clusters.

8. Family nurse practitioners to be aligned with clusters.

Workforce

1. The cut in medical student intake to be reversed immediately increasing Scottish domiciled entry.

2. The cuts in nursing and midwifery student intake to be reversed immediately.

3. AHP student intake to be set by Scottish Government with a guarantee of one year post registration employment.

4. Health visitor entry to be determined and funded nationally and expanded to meet Family Nurse practitioner workforce and additional responsibilities under GIRFEC.

5. Courses for physician assistants to be expanded.

6. Super paramedics to be established to provide both mobile out of hours cover and support especially in remote and rural communities.
7. An independent review to be established to determine future intake of medical students, nurses, midwives and AHPs. [updating the Calman Poulson review of 2004]
    a. whilst moving to establish a Scottish graduate entry medical course in the meantime pay tuition fees for successful applicants to existing English graduate entry courses
    b. consider offering tuition fees for Scottish entrants to English Welsh and Northern Ireland medical schools provided they return to Scotland within ten years for at least five years.

8. Provide support in paying of all or part of the tuition fees for rest of UK and overseas non EU medical graduates in return for training and a minimum of five years (or equivalent part time) in general practice in Scotland. Note that rUK and overseas undergraduates pay £9k each of five years but the cost of training a doctor is around £250K. Two further options are to provide an incentive against student debt or to require bond against part of the costs which are in excess of other courses.

9. Follow all GPs completing training and emigrating or leaving the profession to invite them to make contact with NHS Scotland to make it easy to return.

10. Revitalise the retainer scheme (where there has been a 40% decline). Part of this has to be a recognition that the gender balance in general practice has changed radically in the past 15 years since the Parliament was founded. The number of women is now over 60%. It is not only women who wish to either take time off for family or work sessionally for a better work life balance. This poses major challenges which have not been recognised sufficiently.

11. Increased training places for returnees, doctors, nurses and AHPs with additional support, e.g. child care.

12. Increase postgraduate Advanced Nursing Practitioner courses.

13. A negotiation to incentivise senior GPs not to retire, or to retire and return as bank locums.

14. A volunteer cadre to be developed for each cluster of practices.

Support

1. To provide increased courses for practice management and reception staff qualification courses and in service training.

2. Boards to provide where asked HR functions and to support practices with recruitment and retention difficulties.

3. Staff payment support for agreed levels of staff to be increased in 15% most deprived practices.

4. In remote and rural areas ensuring the Board provides locums and charges a fixed rate against independent GP funds to ameliorate market difficulties

Governance

1. The QOF should be terminated completely. The governance arrangements should move to an *outcome based approach* where each cluster and practice within the cluster and each GP and speciality health professional is provided with data feedback. A model for this can be seen in Tower Hamlets and can be based on both SMR data and the Integrated Resources Framework data set. The cluster and individual practices should be subject to an patient and peer led inspection review. This should be run by Health Improvement Scotland and involve the Royal Colleges of General Practitioners and Nursing, AHP representatives and the public. The system currently used in England should be examined closely.

2. A review to achieve a moderation in the bureaucratic *revalidation* scheme especially for GPs approaching retirement.

Other issues

1. Increased support and opportunities for part time *academic* work. Scotland needs to up its game to match recent developments in England.

2. Increased opportunities for *GPs with a special interest (GPsWI)* GPs with a special interest in supporting Practice Clusters.

3. Aligned post graduate and *continuing professional development* for all primary care health and social care staff.

4. More urgency in considering the *Greenaway Review* of medical education alongside a review of GP training.

5. A full review of both *IT and data collection*. Improved IT linked to pharmacy, optometrists and integrated with secondary and social care (clusters), Enhanced e-health support and good data. Research into why almost one in four training places are empty and there has been an increase in emigration.

6. Support for primary care based research where we have fallen way behind England.

All these measures and more are required to save primary care and reverse the trend in the health inequality gap between richest and poorest areas which have worsened over the last decade. Two more years of a 'Conversation' until a new GP contract emerges is too slow, but at least it is the dawning of a reality too long denied.

The objective will be to ensure a revitalisation of primary care with a fully resourced further shift in the balance of care from acute hospital services to a modernised integrated community health and social care service fit for the 21st century.

This vision needs urgent actions.
The Health Boards are being required to produce efficiency savings every year for reinvestment but there has been no direction from the Government that at least part of the recurrent funds released every year should be applied to reversing the £150 million annualised reduction in the primary care share of overall funds which has developed over the past decade, £1 billion overall.

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GLOSSARY

AHP: Allied Health Professionals including Physiotherapists, Speech and Language Therapists, Chiropodists/podiatrists and occupational therapists.

BMA: British Medical Association

Deprived Practices: Practices which have a significant proportion of patients from deprived areas. The 'Deep End' practices are a loose collective representing the 100 most deprived practices.

Family Nurse Practitioner: Nurses intensively supporting teenage mothers from pregnancy until the child is two years old.

GMS: General Medical Services (17c. this is the most common contract with practices run by GP partners with or without them sub-contracting to salaried sessional doctors).

GP: General Practitioner

GPwSI: GPs with a Special Interest who are accredited in a variety of areas [Pharmacists may also be accredited for some of these areas].

Hypertension: Raised blood pressure

Integrated Joint Board (IJB) or Lead Authority: The new Boards combining Local Authority and Health Boards to provide integrated Health and Social Care.

ISD: Information Services Division

LES: Local enhanced services

Local Medical Committee: GP committee

NES: National enhanced services

NSS Scotland: National Services Scotland

PMS: Personal medical Services (17j. a local contract for specified health services which is underpinned by and MPIG Minimum practice income guarantee.

QOF: Quality Outcomes Framework

RCGP: Royal college of General Practitioners Sessional doctors: undertake a specified number of sessions half days or surgeries each week on an annual contract Locums Doctors: accredited on the Health Board 'performers list' as being competent to undertake GP work can be employed for occasional surgeries or sessions or on a longer term basis

Retainer Doctors: Doctors taking a career break but wishing to retain General Medical licence/registration

Revalidation scheme: A GMC system for ensuring the GPs are up to date NHS targets: such as Accident and Emergency, Cancer, Child and Adolescent mental health and Diagnostic Test, and treatment time waiting times, and the 12 week legal guarantee from diagnosis to inpatient and day case treatment.

20-20 Vision: Scottish Government report on the future NHS GIRFEC getting it right for every child, now embodied in Law with a named person for every child.