

## **The Way Ahead -Introduction**

This consultation document represents the starting point of a process to define a long term vision for Scottish general practice. It seeks to stimulate debate and encourage discussion on long term solutions to some of the challenges facing general practice. The views expressed by the people of Scotland during the consultation period will inform the development of policy to underpin the long term strategy for Scottish general practice.

The document has been developed by the Scottish General Practitioners Committee (SGPC) of the British Medical Association. Six key areas of concern have been identified that, if effectively addressed, will ensure that high quality general practice is maintained and available when and where it is needed. It is our goal to create a high quality service which is responsive to patient needs and provided with equality across Scotland.

Many of the statements made in this document reflect discussions we have had with doctors working in general practice in Scotland who have day to day contact with patients. For each section, the document sets out the current position, where we want to be and the options of how to achieve this.

We want to hear what priorities the profession, patients and the public think are most important so that we can work together with government to develop policies for the future of general practice.

The consultation process will close on 12 June. Please send comments by email to: [info.thewayahead@bma.org.uk](mailto:info.thewayahead@bma.org.uk) or by post to: The Way Ahead, BMA Scotland, 14 Queen Street, Edinburgh EH2 1LL

## **Overview**

Six key areas have been identified where it is considered that positive improvements or changes can be made. Although they are described here separately, they are all inter-connected. Improving access arrangements for patients is, for example, dependent on ensuring that primary care has the right workforce and skill mix, and the right premises and facilities to support service delivery. General practice is a complex system and action in one area can affect many others. A co-ordinated approach is needed to develop general practice and deliver the best service for patients.

The essential foundation of a successful general practice system is:

- the right access for patients
- the right workforce with the right skill mix
- the right support for areas of greatest need
- the right balance between GP and hospital care
- the right support for care and treatment outside normal working hours
- the right infrastructure to deliver the highest quality service.

## **1. Improving access to services**

### **The position today**

Demand for GP services is increasing. Our ageing population, increasing availability of treatments and increasing public expectations result in increasing demand for GP services year on year. Similar pressures in hospitals, combined with improving technology and more advanced GP training, have also seen work move from specialist centres into the community. GP practices try to give priority to patients with the greatest clinical need, but this can lead to delays for other patients. Appointment systems are under constant review in an attempt to allow patients to book ahead at a time of their convenience while maintaining availability for those requiring more urgent attention.

The majority of practices are meeting Scottish Government targets for 48 hour and advanced access[5]. However some patients report problems in getting appointments that suit them. Patients tell us they find systems for 'same day'appointments frustrating. They often have to compete to get through to practices by telephone first thing in the morning. Difficulty in booking an appointment in advance can also cause issues with employers and childcare. On the other hand, advance booking can lead to non-urgent appointments being booked up for weeks ahead. Consequently, some patients believe that services are designed to suit the practice rather than them.

Extending practice opening hours has been proposed as a solution to access problems. This change was largely imposed on practices rather than allowing them to work with their NHS board and patients to develop services best suited to their local

circumstances. Early anecdotal evidence suggests that in some areas a significant number of these appointments are unused or taken up by people who could attend during regular hours. There are also concerns about increasing the length and intensity of the GP working day and the negative impact this may have in maintaining the quality of care.

## The focus for change

A good balance needs to be struck on access arrangements. The aim should be to provide the best and most appropriate level of access within available resources. Wherever possible, services should be organised to meet the preferences of patients. This may require some GP practices to be more 'customer' focussed and responsive to patient needs.

There is a difference between the *demands* of patients and the *needs* of patients, and this is the problem practices face in organising their appointments system. Practices need to involve their patients in determining the necessary balance between wants, needs and overall demand and provide services accordingly.

For example it may be agreed that all support services (such as laboratory and transport services) should be available during the hours practices are open. An increase in direct access to certain services such as self referral to physiotherapy would reduce the workload on GPs and thus free up appointments. Similarly, increased availability within practices of other health professionals such as psychologists and counsellors would free up GP time to see more patients.

## Options for the future

There is the potential for change at both national and local levels.

At national level, consideration should be given to:

- promoting realistic messages about what can be delivered within NHS resources
- sponsoring a public information campaign promoting responsible use of NHS services
- increasing the number of GPs, identifying funding for new practices and reducing average list sizes
- providing additional funding to allow other healthcare professionals to absorb some of the demand on GP services.

At local level, consideration should be given to GP practices:

- exploring more flexible access arrangements including telephone consultations, e-mail responses for routine requests and online bookable appointments
- sharing good practice to improve appointment systems
- actively involving patients in improving services
- engaging better with patients, possibly through patient participation groups
- supporting practices that are having difficulty in offering good access arrangements
- providing better information to patients on how the practice operates and its longer term goals
- transferring responsibility for routine repeat prescribing to pharmacists to free up GP time.

### Response

Our group of patients attending GP practices across South Edinburgh experience a variety of access arrangements. Not everyone is able to have an appointment within 48 hrs for example. In terms of extended opening hours, it was pointed out that not all GPs advertise the fact that there are early or late opening times – but this should be made clearer. And we noted that it was not helpful for anyone in the GP practice to make the judgement as to which patients can attend during “regular” hours. Patients have many and varied lives and responsibilities.

We welcome the aspiration to be more patient-focussed, and we recognise that in return patients cannot have 24 hour access to GPs and should be reasonable. However, to cover an extended opening, it may be possible to be more flexible at the beginning and/or end of a day – and even at weekends.

As regards options for the future, at national level, we agree with the general thrust of the points, with the following comments;

- it is important to target any public information campaigns at the correct target audience eg information re children’s services at clinics, nurseries, schools, parent groups etc.
- there is an expectation that patients should be given access to other healthcare professionals. Self referral to services such as physiotherapists, podiatrists (although we recognise the particular difficulties that may pose), and complementary therapists and counsellors would especially be welcome.

At local level, we thought the most important point was that there should be better engagement with patients, and that patient participation groups should be a matter of routine. Although we would welcome more flexible access arrangements, some people said they already have good access to telephone consultations. Some were concerned about the security issues surrounding e-mail responses. Online bookable appointments would be welcome, but we were concerned that this innovation might be seen as socially exclusive and not supporting equality of access. On the proposal to transfer responsibility for routine repeat prescribing, there were concerns about how exactly the system would work. For pharmacists themselves, we thought there would need to be some safeguard that they were prescribing medication that is still current for the patient (dosage comes to mind) and that would need to be built in to any system.

## **2. Developing the right workforce**

### **The position today**

Patients value the role of GPs. Research shows that while patients are happy to see a practice nurse or other healthcare professional for some aspects of their care, they want to see a GP when they are concerned about their health[6]. The skills of GPs in dealing with diagnostic uncertainty, balancing risk and ensuring the efficient and effective use of other services are immensely valuable to the NHS.

It is important that appropriate numbers of GPs are trained to meet current and future demands. The new GP contract initially had a positive impact on recruitment and retention. However, the lack of a clear vision on how general practice services will be delivered in future makes it difficult to plan the workforce.

Current short-term funding arrangements and the uncertainty they bring make it difficult for practices to increase the number of GPs and other members of the primary care team, thereby reducing the opportunity for trained GPs to make a full contribution to the NHS.

Despite a significant increase in workload in recent years, GPs have met targets which are making a positive impact on health improvement under their new contract. The increased workload has led to changing roles within the practice team to deliver the service. There are concerns however, that proposals made under the current review of nursing in the community have the potential to damage patient care and the delivery of primary care services by removing the close link between practices and the community nurses providing care to the GP practice population.

The introduction of the new pharmacy contract has increased the threat that some remote and rural GP practices will be forced to give up their dispensing service to patients. At present, patients are not consulted despite potential risks that loss of dispensing to a remote and rural practice could affect the services provided to patients and possibly the future sustainability of the practice.

### **The focus for change**

The goal is to provide consistently high quality GP services across Scotland. Patients should have the same level of service provision wherever they live in Scotland, including access to an appropriate professional within an appropriate timescale. There should be sufficient numbers of GPs to provide the longer consultations patients want and which are needed to address complex health issues. Good workforce planning is central to achieving this aim and will ensure that the right staff are available at the right time and in the right place.

This requires training appropriate numbers of GPs and promoting the profession positively to undergraduates to maintain recruitment. It needs development of a practice model that combines dynamism and innovation to make it attractive to the doctors of the future. Good quality training and development needs to be provided for all members of the primary care team.

Efficiency can be improved through co-operation and sharing of best practice and resources between practices. The appropriate use of skill mix can also assist in providing the most efficient and effective service to patients while retaining high quality standards.

## Options for the future

Consideration should be given to:

- valuing and promoting the skills of GPs as clinical leaders
- promoting the value of integrated practice teams, led by GPs
- producing robust data to support accurate workforce planning
- ensuring best use of the trained workforce
- providing assurances on future funding to allow practices to expand and recruit newly qualified GPs
- assessing the advantages and disadvantages of various contractual models in general practice
- controlling overall workload, possibly by reducing the average number of patients per GP on practice lists.

### Response:

We were concerned that GPs' opinions of the review of community nursing is that there is the potential to damage patient care. However, in Lothian which was one of the pilot areas, the Herald article records that there has been a re-think following the issues raised by community nurses. See [http://www.theherald.co.uk/features/otherfeatures/display.var.2475469.0.Nursing\\_review\\_hits\\_new\\_setback.php](http://www.theherald.co.uk/features/otherfeatures/display.var.2475469.0.Nursing_review_hits_new_setback.php) Hopefully this will, in Lothian, remove GPs concerns.

We also noted that GPs wish to lead practice teams and to be valued and promoted as clinical leaders. Whilst most patients will be content with this model in many situations, we think that the way forward is for GPs to regard themselves as part of, but not necessarily the automatic leader of the integrated care team. Other professionals in medical centres will often have knowledge and expertise which complements the skills and conventional medical knowledge of a GP. Patients and taxpayers have an expectation that in modern primary care there will be a joined-up approach by all of those who are charged with the care of the patient.

As regards most of the options for the future, we note that the BMA is promoting the concerns of the GPs, but realistically the influencing of workforce planning, future funding and the contractual models, including the average size of the GP list, is financially and politically motivated. Patients simply want quality treatment, at a time they need it, delivered by a well-trained workforce.

## 3. Reducing health inequalities

### The position today

The Scottish Government's commitment to a publicly provided NHS provides greater opportunities to address health inequalities.

Improving the health of the most disadvantaged people in Scotland is one of our biggest challenges. GPs are already making an important contribution in helping to reduce health inequalities. However working in deprived, socially marginalised areas is very demanding. This needs to be recognised and positively resourced to attract more GPs to work in these areas.

Increasing resources to practices in deprived areas is desirable but this should not be at the expense of other practices. The GP Quality Outcomes Framework (QOF) has been shown to improve the care of marginalised and disadvantaged groups[7]. Recent changes to QOF payments are intended to improve funding for practices with the highest levels of disease prevalence.

### The focus for change

There is significant unmet need amongst the most vulnerable people in Scotland. Attempts should be made to identify the nature and extent of this need and a strategy developed to address it. As a minimum every member of the public should have the opportunity to be registered with a GP.

Special provision should be made to support services in areas with the highest need. That includes additional resources to GP practices based in deprived areas. This could involve an increase in support services. There should be robust analysis of the outcomes of projects designed to reduce health inequalities.

Support should be offered to encourage the better use of NHS facilities by disadvantaged or marginalised groups.

## Options for the future

Consideration should be given to:

- identifying and addressing unmet need and the workload arising from it
- providing additional resources to practices working in deprived areas
- ensuring that the progress made through the QOF is not lost
- increasing training opportunities within practices working in deprived areas for both undergraduate and postgraduate learning
- providing GP premises in areas of deprivation
- conducting research to identify the workload impact of disadvantaged and marginalised groups on general practice
- developing and funding services for minority groups.

### Response:

Generally speaking we were supportive of the proposals for reduction of health inequalities. Edinburgh would appear to be reasonably well covered already in this regard in that it has already a Unit for Ethnic Groups and it was pointed out that many areas of deprivation already have significant medical centre resources eg Craigmillar and Sighthill – and we welcome these facilities. The point was made however, that there are areas of Edinburgh which are asset-rich and cash-poor, where the population is ageing and which will need more in the way of resources in future. Fairmilehead, Morningside and Juniper Green are such areas.

## 4. Shifting the balance of care

### The position today

The NHS in Scotland aims to provide care to patients as close to their homes as possible. This has resulted in services that once were only available in hospital being provided in GP surgeries. This is a positive change that benefits patients. However, there has not been a corresponding rise in resources to primary care, leading to an unfunded increase in workload for GPs. Enhanced services, which are designed to offer a greater range of care in general practice, have made a positive impact but could be even more effective if they were funded more appropriately.

The ever rising cost of new drugs being used in hospitals makes it difficult to release funding to support developments in general practice. There are also emerging concerns that funding will be further squeezed because of ongoing and increasing pressure on hospital budgets.

To date, there has been limited GP input into the planning of this shift in the balance of care. This may change under the *Better Working* programme[8] which has allocated funding to NHS boards to increase GP involvement in this process. The work around achieving the 18 week referral to treatment target has also led to a greater recognition of the important role that GPs play and this needs to be developed further.

### The focus for change

General practice potentially could deliver the shift in care if appropriate funding and increased access to diagnostic tests are made available. This will require investment in primary care premises, including the development of community hospitals. It will also require improved access to allied health professionals in primary care.

The role of GPs who take a special interest in specific clinical areas is important for the expansion of NHS services. Reducing the average GP list size would allow more opportunities for GPs to develop skills in specific clinical areas and would also help to meet the demands arising from increased workload. There should also be a mechanism to allow practices to recruit extra staff to cope with workload demands without this negatively affecting practice funding.

## Options for the future

Consideration should be given to:

- directing NHS boards to increase resources to primary care and ensuring resources are ring-fenced for new work
- ensuring that NHS board managers are aware of the benefits of transferring work from hospitals to primary care
- developing the concept of virtual diagnostic and treatment centres where control of the management of the patient remains in primary care
- ensuring GPs are involved in planning service changes that shift the balance of care
- providing sufficient resources for both hospital and GP services to enable effective transfer of workload
- acknowledging there is a limit to how much new work can be taken on by the current GP workforce
- supporting practices to investigate the variation in hospital referrals between different GPs.

### **Response:**

We had some difficulty in unravelling the options for the future. We would have found it helpful to have a definition of primary care and of GP services, since the terms seemed to be used interchangeably. We also found some difficulty with the proposal to increase resources to primary care (with suitable ring fencing) and at the same time providing sufficient resources for both hospital and GP services. While we would expect there to be GP representation in planning service changes that may shift the balance of care (presumably between hospital and GP), we would see this as a main task for the CHP and the Area Health Board.

## 5. Providing care outside normal working hours (out of hours care)

### The position today

Out of hours (OOH) care at night and weekends has undergone a number of changes in recent years. GPs no longer have 24 hour responsibility for their patients although GPs continue to work in OOH services. With the introduction of the new GP contract, NHS boards were obliged to accept NHS 24 although many already had excellent call handling and triage services in place. This resulted in challenges as services adapted to the new way of working.

From the outset, NHS 24 struggled to cope with the volume of calls and the slow triage process used by call handlers. Following significant public and professional dissatisfaction with the service an independent review of the service was undertaken in 2005. The resulting interim[9] and final reports[10] made a number of recommendations to enhance the service which have been progressively implemented.

NHS 24's costs have risen substantially since it was first introduced[11]. Many GPs continue to believe that ongoing difficulties such as meeting demand at peak times, and inappropriate referral to accident and emergency departments and use of the 999 service, need to be addressed.

It is acknowledged that some patients feel let down by GPs giving up 24 hour responsibility but delivering the service was becoming an increasing burden for doctors across Scotland and the previous arrangements were unsustainable in the long term. NHS 24's difficulties demonstrate the challenges of delivering a service out of hours.

### The focus for change

Patients in Scotland should receive a high quality, seamless OOH service that is safe, reliable and efficient. They should experience good continuity of care through close co-operation between different service providers. One size does not fit all in a country with the geography of Scotland and, consequently, the service should be delivered as locally as possible to ensure it is responsive to local issues. GPs should be closely involved in the planning, commissioning and delivery of the service. Such a system could allow better use of resources by, for example, reducing unnecessary use of ambulances and attendances at hospital.

## Options for the future

Consideration should be given to three main options:

maintaining the current NHS 24 system but increasing GP involvement in providing the OOH service

retaining NHS 24 as a telephone answering service but devolving funding to NHS boards to provide the service which would promote local flexibility and ownership

dismantling NHS 24 and transferring responsibility for the service to NHS boards.

A locally run service could be managed by OOH organisations made up of GPs, the NHS board and the Scottish Ambulance Service. This would improve local co-ordination, integration, responsiveness and ownership.

The loss of GP leadership and involvement in OOH care has led to reduced confidence and satisfaction in the service. This could be addressed by increasing GP involvement by, for example, creating opportunities for GPs to be involved in the commissioning and delivery of OOH services.

In addition, consideration should be given to:

- developing closer integration between GP services and accident and emergency care. Where possible, OOH centres and A&E departments should be located next to each other
- improving information sharing
- reviewing the standards of care and training for health professionals working in OOH
- ensuring that patients have access to a fully trained GP during OOH periods
- improving public information about the availability and appropriate use of OOH services
- promoting a public debate on the level of service that should be provided outwith normal working hours.

### **Response:**

This section provoked much discussion. There was a recognition that some (maybe a majority) of the patients would like to return to their GP being in charge of care 24/7. However there was also a recognition that given the resources allocated to NHS 24, it was unlikely that Boards would wish to return to the previous system, and arguably would not wish to pay for it. We as patients would particularly welcome the opportunity to have access to a fully trained GP during OOH periods. It would be helpful if this was face to face rather than by phone – where the articulacy of both doctor and patient are key. We would suggest that it would be helpful if the Scottish Government promoted a public debate on the level of service to be provided in OOH service.

## 6. Improving premises and information technology

### **The position today**

Many existing GP premises are in need of replacement or re-development. In addition, Scotland needs more GP practices which will involve building new premises[12]. However, there are shortcomings in the current system for building or improving GP premises. NHS boards have to build new premises from their existing funding which puts pressure on current services. In addition, there has effectively been a halt on the development of practice premises in recent years because of funding issues. This has had a negative effect on service development.

The HUB initiative, which is based on public private partnerships, has resulted in the development of very few premises. Third party developer-led schemes have suffered a similar fate. Priority has also been given in recent years to joint health and social work projects but this has led to longer completion times. Some GPs own their own premises under the cost rent scheme. However, as premises become larger, more complex and specialised, they become more expensive and less able to be converted to other uses. Many young GPs are reluctant to take on the additional burden associated with owning their own premises.

Some NHS boards are recognising the importance of investing in practice premises due to the need to redesign services and meet the 18 week referral to treatment targets. However, progress is slow.

Information technology (IT) is crucial for effective patient management. GPASS (the current computer system used by the majority of GPs) is being phased out but a lack of clear information from the Scottish Government Health Directorate is preventing appropriate planning for its replacement. There is also a lack of sufficient development of wider primary care systems such as pharmacy, dentistry and optometry.

There are problems with the inability of computers in primary and secondary care to “talk” to each other. Information such as discharge letters cannot be passed electronically between hospitals and GP practices. There is little or no involvement of GPs in the procurement of hospital patient management systems.

## The focus for change

Fit for purpose premises are a vital component in the provision of high quality patient care and in the training of new GPs. Greater priority needs to be given to the development of premises. Funding should be increased significantly and clarity provided to NHS boards on how premises are to be funded.

Arrangements should be made to make it easier to build premises in areas where the population is expanding or where extra doctors are needed. Finance needs to be available more quickly to enable premises to be altered in response to demand. The priority given to joint health and social care premises needs to be reconsidered as this is inhibiting the ability of practices to develop premises.

All practices should have an appropriate level of IT to ensure the most efficient service can be provided. It should be flexible, secure, fit for purpose and capable of linking with secondary care and OOH organisations. It should allow for the complete, secure exchange of patient information, with explicit patient consent. The aim should be to have at least two GP systems to ensure a monopoly is not created. GPs must retain their role as data controllers for the GP record and continue to control access to writing the patient record.

## Options for the future

Consideration should be given to:

- ensuring investment in premises and IT is given greater priority
- providing direct capital investment from ring fenced central funding
- examining direct funding from NHS boards as the preferred method
- ending the preference given to joint health and social care projects as the primary vehicle for GP premises development
- providing clear guidance to NHS boards on plans for future IT provision
- developing an improved strategic vision for the future of eHealth in Scotland
- providing appropriate funding to allow GPASS to be replaced urgently
- ensuring full integration of secondary care patient managements systems, currently under procurement, with GP clinical systems
- valuing clinical leadership and ensuring doctors continue to be involved in developing eHealth policy.

### Response

In Edinburgh we are seeing proposed investment in new or revamped premises. However in the present financial climate patients recognise that it is not always possible to implement such plans as quickly as we would like.

We do recognise the wish for GPs to have better IT systems which ideally “talk” between primary and secondary care. But we need to make sure that procurement of IT systems involves less bespoke software – the more bespoke it is the more expensive. Patients themselves are also becoming more IT skilled and the expectations are that there will be on-line appointment systems, access to their own patient record, advice and information easily available to them. We also recognise the difficulties in Government and Health Boards providing public funding for the independent sub-contractors which GPs are.