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Foreword

Working in partnership to achieve shared goals has been an approach that I have strongly favoured during my time as Chairman of the BMA’s Scottish General Practitioners Committee. I am therefore delighted to be publishing this document which reports on the progress towards achieving the recommendations set out in our original policy document General Practice in Scotland: The Way Ahead.

General Practice is complex and policy in one area often has an impact on another. It is therefore essential that progress is made in all areas featured in this report. For example, having the capacity to deliver on Scottish Government priorities such as improved access and shifting the balance of care may require more investment in the primary care workforce and GP premises. As a result of this connection between individual issues it is essential that the Scottish Government sets out a clear strategy describing its vision for general practice that we can all work towards.

The Scottish Government has recently announced plans to ‘repatriate’ parts of the GP contract to Scotland to help it achieve some of its priorities in tackling some of Scotland’s greatest public health challenges, but the contract alone will not solve Scotland’s health problems and it is vital that Ministers consider the role of general practice in the context of broader policy issues that contribute to the wellbeing of the nation.

The original report General Practice in Scotland: The Way Ahead was a policy document based on the views of the public, patients and the profession. This new report documents the progress made so far and I am pleased that so many of our recommendations have been taken forward. However, there is still more to do and I hope that we can continue to work with the Government and other stakeholders to achieve much more.

Dr Dean Marshall, Chairman, BMA Scottish General Practitioners Committee

Background

In February 2010, BMA Scotland published General Practice in Scotland: The Way Ahead. The report, based on an extensive public and professional consultation, provided analysis of six key areas of general practice and set out clear recommendations which, if implemented, would drive forward policy for Scottish general practice. The areas highlighted in the report were: access, out of hours, health inequalities, balance of care, workforce and infrastructure. This report outlines progress on the key recommendations for each area. It also sets out priority areas for action in the next 12 months.
Access

Recommendation
GP practices should engage directly with their patients on service and access preferences, and the extent and nature of services the practice is able to provide.

Progress to date:
SGPC (Scottish General Practitioners Committee) continues to promote the development of patient participation groups and the use of new techniques to engage with patients. The emergence of new technologies to engage patients and to promote themed discussions, for example, could be used as a simple and direct way to involve patients. Including patients in the planning of local GP services helps a practice to integrate into the heart of its community. Patient input can help inform practices of the services that their patients want and provides a forum to debate some of the more challenging issues that a practice needs to deal with, such as access. With the development of online and e-communication tools, there is scope to consider how these new technologies can be used to support greater public engagement. Mechanisms used by other public sector services such as schools, should be investigated for their appropriateness in general practice. SGPC also continues to explore, in negotiations with SGHD (Scottish Government Health Directorates), whether patient participation groups should be formally established under a contractual mechanism, such as a Directed Enhanced Service [as negotiated and implemented in England].

Case study: the Academy Practice in Forfar

The Academy Medical Practice in Forfar has established a patient group which has recently celebrated its first anniversary. Dr Andrew Thomson, a GP partner at the practice who developed the group, said: “There have certainly been some challenges along the way but there have also been some successes and it has engendered a feeling of working with the patients rather than a ‘them and us’ impression.

“We have opened a health information ‘shop’ in the practice which will be run by volunteers, giving self help advice and information on specific diseases to help involve people more in their own diagnosis and care.

“This has been a really positive experience for the practice and I would recommend establishing a patient group.”
Recommendation 2
The Scottish Government should re-engage GPs in the patient access agenda by removing the current link between patient perception and access and the resourcing of GP practices, and work with the profession to:

• Gain better understanding of the complexities and challenges of maintaining safe, high quality and effective patient services whilst also responding to the diversity of patient needs and preferences for access.
• Identify flexible solutions for optimising GP patient access which can be tailored to suit local circumstances.
• Develop mechanisms for locally based systems of support for GP practices experiencing difficulty in maintaining access for patients.

Progress to date
In 2010, SGHD introduced alternative arrangements for GP practices receiving Quality and Outcomes Framework (QOF) achievement payments relating to the GP access survey (PE7 and PE8). This has reduced the number of surveys being conducted and allowed practices achieving less than the maximum number of points to opt in to a 2010/11 survey or retain payments linked to their 2009/10 survey. Following agreement with SGPC, the Scottish Government used the savings released from conducting fewer patient surveys to provide funding to support GP practices having difficulty maintaining patient access. SGPC believes that ongoing support on access should be provided to practices where needed, however placing this duty on NHS Boards and Local Medical Committees would require additional resources.

In early 2011, UK negotiations between GPC and the Department of Health successfully removed the link between access survey results and practice funding.

To support appropriate and timely patient access, practices should regularly review their access arrangements to ensure they have the flexibility to respond to patient demands on access within the current contractual framework.

The SNP Government’s 2011 election manifesto included a commitment to increase the number of GP practices offering evening and weekend access. SGPC believes that extended access can be beneficial in some areas, for example higher density commuter areas, but is less relevant in others. Recent revisions to the extended hours enhanced service specification agreed between SGHD and SGPC have provided greater flexibility for practices wishing to provide extended hours. SGPC has suggested to SGHD that patient access could be improved through enhanced access rather than through extended hours. SGPC has presented a number of proposals to SGHD regarding enhanced access, especially relating to the period within core hours.

To support GP practices in the delivery of consistently high quality care while meeting increasing levels of demand and diverse expectations, RCGP has introduced the Productive General Practice programme which aims to release clinician and practice time by equipping practice team members with the tools to identify and prioritise areas for the improvement of general practice.
Recommendation 3
The Scottish Government should seek to make the best use of GP and other NHS services through:

- The promotion of appropriate self-care.
- Public education programmes on using and accessing NHS services and the consequences of inappropriate demand on services, possibly as part of the educational curriculum.

Progress to date
To gain greater insight into how the individual needs of patient groups with specific conditions can be incorporated into the work of general practice, SGPC negotiators have held discussions with representatives from various health charities (for example, Alzheimer Scotland, Asthma UK, National Osteoporosis Society and the British Heart Foundation).

Health and wellbeing is now a defined curricular area within Curriculum for Excellence. The Government’s policy intention is to ensure that children and young people develop the knowledge, understanding, skills/capabilities and attributes they need for mental, emotional, social and physical wellbeing now and in the future.

While school-based education programmes are being taken forward, SGPC believes there is still scope for the Scottish Government to improve how it raises public awareness about self care and the capacity of NHS services, including changes to service arrangements during public holidays.

Recommendation 4
The transfer of work from GPs to other health professionals should be evidence-based, monitored and evaluated to assess benefit.

This is an issue that should be assessed on a case by case basis, however the following examples demonstrate how transferring work may not always be appropriate or desirable for patients:

Case Study: Midwife-led Maternity Care

Dr Colette Maule, a GP in Lanarkshire, has raised concerns over continuity of care for her pregnant patients. She said: “In 2010, the NHS in Scotland introduced midwife-led maternity care where patients are encouraged to present directly to midwives for their first visit rather than to GPs. Essentially now I do not see patients for maternity care and unless the patient or midwife tells us of the pregnancy we may not hear about it until delivery. Recently I had a patient in the surgery who was 22 weeks pregnant and I knew nothing about it. This poses issues of governance over prescribing and treatment as patients expect us to have been informed.

“As well as the obvious risks, I worry that by losing this direct connection with my patients, I will lose my skills in providing maternity care and there is also a danger that future GPs will not see any routine pregnancy cases during their training and will not have the skills to treat them should the need arise.

“I’m not sure what benefit this service offers to my patients.”
Progress to date
Recent SGPC lobbying has secured agreement that midwives must inform the GP when a patient books in with them. The BMA remains concerned however, that there is no compelling evidence base for this service change. Recommendations for improved outcomes resulting from a review of maternal deaths suggests that GPs have an important role in providing advice and treatment to pregnant women with pre-existing illness and those at risk of genito-urinary infection and sepsis. The same review recommends improvements in training for service providers, integration of services for pregnant women and communication between healthcare professionals. More recently, Scottish population-based research has identified specific categories of women at increased risk of sepsis during pregnancy, creating an opportunity for fresh consideration of how maternity care should be organised on an inter-professional basis in Scotland.

Case Study: Chronic Medication Service

Dr Bob Mack, a GP in Dumfries and Galloway is taking part in the Chronic Medication Service (CMS) scheme. This scheme merges two previous policy initiatives: serial dispensing and the pharmaceutical care model schemes. He said:

“There can be benefits in pharmacists being involved in a patient’s repeat medicines, particularly in relation to identifying redundant medicines and assisting patients who are struggling to comply with their regimes. However, while CMS seems to be fine for patients on one or two regular drugs, it is not so useful for those on a more complicated regime as the scheme is too inflexible. The result could be that some drugs are on CMS and others are not which means that the patient does not benefit from a complete review and it is these patients who would be most likely to benefit from such a service.

“I have not noticed any significant reduction in the practice workload as a result of this new service and I have not yet seen any obvious benefits for my patients.”

Progress to date:
Again, the SGPC has not seen the evidence base that has led to the development of this service. SGPC believes that an urgent review of the scheme, with input from the GP and pharmacist representative bodies, should be undertaken.

Priorities for action
A sensible and evidence-based approach to access in primary care remains a priority for SGPC.

SGHD and SGPC should explore the use of technology to develop new ways to engage with patient groups at practice level.

SGHD, in consultation with NES and RCGP should consider and if necessary address, SGPC concerns about GP training gaps caused by community maternity service changes.

There should be an urgent review of CMS [with input from the GP and pharmacist representative bodies] to clearly identify the best way of delivering benefits for patients and health care professionals.

Out of Hours

**Recommendation 1**
The Scottish Government and NHS Scotland should do more to raise awareness and increase public understanding of the role of NHS24 as the initial point of contact for out of hours services.

**Progress to date**
The Scottish Government has worked with NHS24 and a small group of NHS Board representatives to turn the ‘Know who to turn to’ campaign marketing toolkit into a universally branded resource available on the NHSinform website [www.nhsinform.co.uk/]. The intention is to develop this website to act as a portal for users to be directed to all appropriate unscheduled care services in their locality and to other aspects of patient information such as local authority social care services.

The Scottish Government has also established three national groups to oversee development and delivery of unscheduled care services. A multi-agency National Unscheduled Care Group will provide Government with expert advice and guidance on how unscheduled care services across Scotland could be better developed. A national Emergency Access Delivery Team will work with NHS Boards and relevant stakeholders to improve patient access to appropriate care. In addition, a group has been established to consider messages conveyed by professionals to patients relating to unscheduled care.

**Recommendation 2**
As part of a public debate on the range and availability of services out of hours, the Scottish Government should commission research on the beliefs that underpin decisions to contact out of hours services and why demand is rising.

No progress to date.

**Recommendation 3**
NHS24 should focus on improving call triage and integration with local services rather than planning further service expansion.

**Progress to date**
SGPC now has membership of NHS24’s Core Clinical Group which has a remit to oversee all decision support, nurse practitioner algorithms, call handler advice and refer and discharge protocols.

NHS24 continues, however, to expand its range of services despite repeated concerns raised by doctors locally and the BMA centrally about the quality of its call handling services. As its remit grows it is important that NHS24 prioritises its primary function of out of hours call handling to maintain and improve the delivery of high quality out of hours services that meet public expectations.

Nevertheless, there have been some improvements to the service since the publication of General Practice in Scotland: The Way Ahead. NHS24 has made significant progress in reducing the number of one hour triages for urgent home visits from 22% to around 12% with the introduction of a “team leader” intervention and an algorithm. This reduction has been sustained for a number of months and the service believes it to be secure. This change appears to have reduced demand without any negative consequences for patient care. SGPC hopes to continue to work with NHS24 on service improvements.

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3 Source: Report to BMA Scotland from Dr M Alexander, Associate Medical Director, NHS24. NHS24 Home Visit Project 3 November 2011
As well as providing out of hours call handling services, NHS24 currently runs the following services: website (health information service), breathing space, living life, supporting GP services, emergency dental service and the Scottish Centre for Telehealth. Towards the end of 2011, NHS24 also launched a digital TV channel and a National Musculoskeletal Service which is a telephone and web based advice facility for NHS Scotland. The aim is also to develop tele-rehabilitation opportunities as well as specific web based rehabilitation resources.

Recommendation 4
The current NHS Quality Improvement Scotland national core standards for out of hours services should be reviewed using the principles and methodology of the Quality Strategy.

Progress to date
SGPC had input to a 2010/11 review by NHS Health Improvement Scotland of the original 2004 Quality Improvement Standards for the delivery of safe and effective out of hours services which has resulted in a newly developed package of quality indicators. The new indicators, which also apply to NHS24, retain the validity of the original standards (relating to infrastructure required for safe and effective services), but align to the aims and ambitions of the Healthcare Quality Strategy for NHS Scotland. The indicators, which are being piloted in NHS Greater Glasgow and Clyde and NHS Highland, are designed to support the delivery of consistent care and enable continuous improvement within local services. They cover access, triage, clinical assessment and management (including antimicrobial prescribing), continuity of care, use of Emergency Care Summary (ECS) and Emergency Palliative Care Summary (ePCS), communication with daytime GP and communication with hospital on admission, and patient experience.

Recommendation 5
Health Boards should establish a local-multidisciplinary strategic group to review out of hours activity data and gather evidence of successful delivery models to improve current out of hours patient care pathways.
Case Study: Out of Hours Quality Assurance Committee in Glasgow

Glasgow Local Medical Committee, representatives from NHS Greater Glasgow & Clyde, NHS24 and Glasgow Emergency Medical Service (GEMS) set up the Quality Assurance Committee (QAC) a number of years ago to monitor out of hours services. The group also includes two lay members of the public, invited by the NHS Board to sit on the committee.

The Committee, chaired by a local GP, meets quarterly and the committee considers the quarterly performance data from NHS24 and GEMS. This includes call rates from the public, response times for Primary Care Emergency Centre attendances and home visit statistics.

In addition to the service performance, the Committee also scrutinises all patient complaints. Any recurrent themes are discussed and solutions sought.

The QAC is able to plan in advance collectively for public holiday periods at Christmas, New Year and Easter.

Dr Douglas Colville, Chair of the Committee said: “I think the QAC has proved to be immensely valuable to all concerned working in out of hours services, and definitely to members of the public. The multidisciplinary nature of the Committee ensures that all voices are heard and that a balanced view is taken.”

Priority for action
Continued improvement of unscheduled triage underpinned by research and evidence on patient decision-making during the out of hours period and the reasons for increasing demand.
Health Inequalities

Recommendation 1
Health Boards should encourage greater joint working between health and social care to address health inequalities.

Progress to date
In September 2011 the Cabinet Secretary for Health and Wellbeing and Cities Strategy announced her strategy and vision for achieving sustainable quality in the delivery of healthcare services across Scotland. At that time, the Scottish Government said that: “The aim is that by 2020 everyone will be able to live longer healthier lives at home, or in a homely setting, and that Scotland will have a healthcare system where there is integrated health and social care, and a focus on prevention, anticipation and supported self management.”

Legislation to create health and social care partnerships is expected later this year.

Recommendation 2
The Scottish Government should provide additional support for GP practices in areas with highest need.

Progress to date
SGPC and SGHD continue to discuss how additional support, for example on site social work and alcohol counselling, could be provided to GP practices in areas with the highest need, particularly given the implications for health and wellbeing of the current economic climate.

Recommendation 3
RCGP should consider conducting further research to quantify the increased workload and needs impact in areas of deprivation.

Progress to date
In 2010, RCGP Scotland produced a report on health inequalities for the Scottish Government. This is a comprehensive evidence based position paper addressing Scotland’s continuing problem of inequalities in health and makes a series of recommendations to policy makers.

The “Deep End Project” a group of GPs from the 100 most deprived practices in Scotland has been successful in raising the profile of general practice serving deprived communities, boosting the identity and morale of Deep End practitioners and generating support and interest from NHS organisations. The Project has also been looking at alternative ways to provide services and to better engage with the population within the current terms of the GMS contract.

From a wider perspective, the BMA has established policies that seek to address the social determinants of health inequalities.

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4. Royal College of General Practitioners (Scotland) Time to Care: Health Inequalities, Deprivation and General Practice in Scotland, 2010
5. British Medical Association Board of Science Social Determinants of Health: what doctors can do, October 2011
Fair society, healthy lives: framework for action:

Professor Sir Michael Marmot, former President of the BMA has identified six key policy objectives where action is required:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention


Recommendation 4

Health Boards should focus on a preventative approach to health with the development of evidence based, local enhanced services appropriate to the area’s health needs.

Scottish general practice is at the forefront of delivering preventative healthcare. The Quality and Outcomes Framework (QOF) has ensured that patients with long term conditions such as diabetes, CHD, or depression receive evidence based care that improves the management of their condition. Evidence suggests that the introduction of QOF has reduced the need for hospital admissions amongst some patient groups.

Figures published last year show that Scotland’s GPs are delivering high quality care to their patients, achieving 97.6% of all targets set out in the Quality and Outcomes Framework (QOF), an improvement on the previous year’s achievement.

Health Boards can develop and fund services locally to meet the health needs of the community. However, recent moves by some NHS Boards to achieve efficiency savings have resulted in decisions to cap payments for some services (for example diabetes), and GP practices are expected to deliver the same level of service for less funding. This could have consequences for patient access to primary care services.

Case study: Withdrawal in Lanarkshire of the IUCD enhanced service

An example of NHS Board “efficiency savings” relates to the withdrawal in Lanarkshire of the Intrauterine Contraceptive Device (IUCD) enhanced service. This service change has resulted in many patients having a longer commute to access this contraceptive service and reduced patient access due to long Family Planning waiting lists. A further consequence is the de-skilling of GPs in providing this type of service.

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7 ISD Scotland Quality & Outcomes Framework (QOF) of the new GMS contract – achievement, prevalence and exception reporting data 2010/11 September 2011
Recommendation 5
The Scottish Government and NHS Health Improvement Scotland should ensure that the Quality and Outcomes Framework is supported by adequate and consistent funding and remains comprehensive and evidence based.

Progress to date
SGPC continues to promote these principles during negotiating discussions with the Scottish Government.

Recommendation 6
The Scottish Government should develop measures to improve recruitment and retention of GPs in areas with the poorest health outcomes.

Progress to date
To assist GP practices in managing the multiple health needs of patients in areas with the poorest health outcomes, resources should support an increase to the average consultation time for GPs. This would have implications for GP workforce planning. Support would not necessarily need to come from increased practice funding but could take the form of more support from, for example, salaried GPs, community nurses, social work services and counsellors. The usual focus on health inequalities as an urban problem obscures the reality that rural deprivation is also a significant problem in Scotland. The workforce section of this document highlights and discusses current concerns about the ability of GP practices in isolated communities to recruit and retain GPs.

Priority for Action
SGHD should provide sufficient support to GP practices, particularly those in areas of high deprivation, to allow longer GP appointment times to address the needs of patients with complex conditions.
Balance of Care

**Recommendation 1**
The Scottish Government and NHS Scotland should promote clinical leadership in the redesign of services.

**Progress to date**
In 2010, the BMA published a set of key principles against which reconfiguration proposals might be assessed. These emphasise the need for reconfiguration decisions to be based on evidence, clinical need and patient safety.

The Scottish Government has clearly stated that clinical leadership in the design and delivery of local services and patient pathways is essential to ensure that they are safe, effective and person centred. The Government is currently engaging with the BMA and other stakeholders including GPs from across Scotland, to inform the development of Community Health Partnerships (CHPs) and the integration of health and social care. The Government has given SGPC and the BMA a commitment that clinicians will sit at the operational heart of service planning as part of its announcement [in December 2011] to review Health and Social care.

The SGPC has welcomed news that the RCGP Scotland has received funding from the Scottish Government to support a Developing Leadership programme for GPs.

**Recommendation 2**
The Scottish Government and NHS should encourage and support joint working between primary and secondary healthcare professionals on the redesign of patient pathways to achieve the optimum balance of care.

The BMA in Scotland is against the reform agenda for the NHS in England and is keen to support and promote a model of care that encourages collaborative working between doctors working in both primary and secondary care to try to break down the barriers between the two service sectors.

Changes to the GMS contract in 2011/12 introduced new Quality and Outcome Framework indicators to support Quality, Innovation, Prevention and Productivity (QIPP). These include indicators specifically developed to support referral management, care pathway design and to review emergency admissions.

**Recommendation 3**
The impact of shifting the balance of care developments on primary care services should be anticipated and monitored by the Scottish Government and NHS Scotland to assess the quality and benefit to patients and ensure that the necessary capacity and resources are available.

**Progress to date**
The Scottish Government has indicated that it is the responsibility of NHS Boards to ensure that the services they develop within the community benefit patients and are suitably resourced. The integration of health and social care agenda will add impetus to the requirement for NHS Boards to continue to shift resource from institutional care to packages of care and support provided within a community setting.

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8  BMA Scotland Hospital reconfiguration in Scotland: Key Principles, November 2010
Case study

A 90 year old man with metastatic prostate cancer presented at his GP practice with a suspected Deep Vein Thrombosis (DVT). The GP referred the patient to Aberdeen Royal Infirmary’s Acute Medical Assessment Unit (AMAU). Due to the patient’s malignant cancer, he did not meet the criteria for referral to the local ambulatory DVT clinic. Although a junior doctor at the AMAU accepted the referral, a relative later called the GP practice in some confusion having been advised not to take the patient to the AMAU. The doctor from the AMAU then called the GP practice to say the patient would instead be dealt with through the ‘DVT Clinic’. The GP sought clarification from the AMAU and was advised by the Registrar on duty that the patient was at ‘moderate risk’ and would, therefore, be seen within the next few days at a consultant-led DVT clinic attached to a ward in Aberdeen Royal Infirmary (ARI). The Registrar asked the GP to arrange daily Fragmin injections until the patient could be seen at ARI. This required considerable effort to locate the required medication, find an appointment in an already fully-booked practice nurse clinic, and re-contact the patient to co-ordinate a treatment schedule. Although the GP could see that this arrangement could help avoid unnecessary admissions and benefit patients, the GP and his other GP colleagues were unaware of the existence of the DVT Clinic and had not been consulted about or advised of the expectation that GPs would, in the absence of further testing, take on the additional workload of providing drug treatment for patients with suspected DVTs.

Recommendation 4

The Scottish Government should commission research into reasons for variation in referral rates to inform service redesign and lead to improvements to training and education.

Progress to date

In the absence of evidence-based research on GP referrals and as part of the UK negotiations on the Quality and Outcomes Framework, SGPC and the Scottish Government have negotiated new Quality and Productivity indicators which are aimed at securing more effective use of NHS resources. These include reducing emergency admissions by providing care to patients through the use of alternative care pathways and reducing hospital outpatient referrals.

Recommendation 5

Healthcare professionals should lead the development of Community Health Partnerships.
Progress to date
The Scottish Government has accepted the need for greater medical involvement in the development and operation of CHPs. The need for reform is urgent. An Audit Scotland review of CHPs revealed significant failings in the governance of these organisations as well as a failure to achieve many of the organisational objectives such as reducing emergency admissions. SGPC considered that this report signalled a need for the Scottish Government to conduct a complete review of the structure and function of CHPs. In December 2011, the Scottish Government set out its plan to integrate adult health and social care and proposed that CHPs would be replaced with Health and Social Care Partnerships which will be the joint responsibility of the NHS and local authority. Under these new arrangements, the role of clinicians and social care professionals in the planning of services for older people will be strengthened. BMA Scotland recognises that greater integration between health and social care services is important, and welcomes the commitment to a strengthened role for clinicians, but maintains that the new partnerships must be clinically driven and supported by management to avoid the pitfalls of their predecessors.

Priority for Action
Greater consideration must be given to the impact on primary and community NHS services of achieving ‘efficiencies’ in secondary care; for example the effects on primary and community care of early discharge of patients from hospital and of prescribing and referral decisions taken by secondary care doctors.
Workforce

Recommendation 1
The Scottish Government should continue to regularly review primary care workforce data and trends to inform planning.

Progress to date
BMA Scotland has membership of the Government’s Reshaping the Medical Workforce strategic group on medical workforce planning. In December 2009, the NHS Scotland Information and Statistics Division (ISD) published the Primary Care Workforce Planning Survey which included information on headcount, whole time equivalent, vacancies and locum/agency usage for GPs and nursing staff. The results provided information that may be used to support national, regional and local workforce planning in primary care over the next few years. There has been a relatively small increase in the GP workforce over the past decade but this is insignificant when compared to the steady increase in the average patient list size per GP in Scotland over the same period (average GP list size has increased by 3% since 2006).

Based on the data currently available, the Scottish Government has maintained GP trainee numbers rather than reduced them as is being done in most other specialties. A shortfall in recruitment to general practice however, has led to some posts, particularly in remote and rural areas, being difficult to fill or remaining unfilled. The Scottish Government has stated its intention to hold discussions with key stakeholders, including SGPC, on what evidence is needed to inform future general practice specialty training numbers.

Without a planned increase in the number of GPs working in Scotland which takes into account the need to provide care to an aging population and a rising prevalence of long term conditions, the Scottish Government’s aspirations on access and shifting the balance of care are unlikely to be achieved. Better and more reliable data on the GP workforce should be collected and analysed. Within the current financial climate it is important, first and foremost, to maintain the general practice workforce and ensure that it doesn’t erode due to reductions in health budgets. With reference to concerns set out in the Health Inequalities section of this report, national workforce planning should take into account the need to introduce longer GP appointment times to deal with patients with complex conditions.

Furthermore, national planning should also tackle the growing problem of GP recruitment to remote and rural areas. GP practices, particularly those serving isolated communities, are increasingly finding it difficult to recruit new GPs or to attract GP trainees. SGPC continues to highlight the value of ‘Golden Hello’ payments to support GP recruitment in all ‘hard to recruit’ areas of Scotland, but further action-oriented planning is needed to address the growing problem of remote and rural recruitment and retention.

Recommendation 2
NHS Education for Scotland should support practices to further develop and promote the skills of the primary healthcare team.

Progress to date
In addition to its practice manager network, NHS Education for Scotland (NES) has recently appointed a lead post within its Medicine Directorate to develop a general practice nursing model of vocational training and a network of learning for professional and practice development. SGPC has been involved in supporting NES to develop this work.

10 ISD Scotland Primary Care Workforce Planning Survey, 2009
Recommendation 3
The Scottish Government should establish reliable information about locum GPs working in Scotland.

Progress to date
SGPC continues to press the Scottish Government about the need for ISD to collect reliable data about locum GPs working in Scotland. Comprehensive data on all general practitioners working in Scotland could better support the GP appraisal and revalidation process and potentially lead to greater national consistency and reliability of clinical governance arrangements. SGPC is also calling for individual prescriber numbers for all GPs. SGPC has raised this issue on a number of occasions with the Practitioner Services Division (PSD). SGPC continues to press for a speedy resolution to this matter particularly in the light of forthcoming revalidation requirements.

Recommendation 4
The Scottish Government should create a working group to consider measures, such as contractual incentives, to encourage practices to take on more partners.

Progress to date
No progress to date.

Recommendation 5
NHS Education for Scotland should create more training places in remote and rural practices.

Progress to date
Recognising the recent difficulties in attracting trainees to remote and rural practices, NHS Education for Scotland (NES) is introducing a National Remote and Rural programme from August 2012. NES has also been involved in the implementation of a Remote and Rural Healthcare Educational Alliance and is reconsidering the design of the rural GP Specialty Training programme.

Recommendation 6
NHS Education for Scotland should review contractual arrangements for the employment of GP Specialty Trainees in their general practice placement.

Progress to date
From August 2011, GP trainees in Scotland have been employed by NES under the terms of the UK GP trainee contract for the duration of the general practice component of their training programme. This arrangement, as a result of negotiations between SGPC and NES, provides clarity and security for GP trainees and sets out clearly the responsibilities of both NES and GP trainers.

Priorities for Action
SGHD must take the lead in considering and helping NHS Boards introduce more innovative ways to recruit GPs into remote and rural areas.

SGHD should consider the workforce planning implications of the desirability of increasing GP appointment times to allow for the needs of patients with complex conditions to be met within primary care with minimal referral elsewhere.
Infrastructure

Premises

**Recommendation 1**
The Scottish Government should give greater priority to premises funding and a return to ring-fenced funding should be supported.

**Progress to date**
The Scottish Government has said that it recently devoted some resource to “taking stock of and rearticulating a vision for primary care premises”. This is particularly important in the context of the significant reduction to the capital expenditure budget in Scotland. The Government's intention is to help ensure that premises that are fit for purpose to deliver high quality person-centred care are available where they are needed.

Despite this approach, GPs continue to highlight serious failings in the funding mechanisms for new premises and during a debate on premises at the 2011 annual conference of Scottish Local Medical Committees, GPs passed a resolution that was highly critical of the primary care premises strategy in Scotland.

**Recommendation 2**
GP-owned premises development must be maintained as a viable option where suitable for local needs.

**Progress to date**
With regard to premises development [as stated above], the Scottish Government has committed to consult with NHS Boards and other stakeholders to consider the need for any changes or clarifications to the existing premises regulations, directions and associated guidance, and consider the availability and best use of existing funding routes. GPs continue to tell us that the current cost-rent model should be restructured to make increased investment more attractive.

**Recommendation 3**
The Scottish Government should establish a national arrangement for ensuring new premises are built where they are needed.

**Progress to date**
As mentioned previously, it is the Government's stated intention to help ensure that premises that are fit for purpose to deliver high quality person-centred care are available where they are needed. However GPs continue to express concerns over the lack of consideration of health service needs in areas with growing populations.

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12 That this conference depletes the lack of a coherent primary care premises strategy in Scotland and:

i. insists that primary care premises need to be supported to facilitate the delivery of primary care to patients and to enable policies, such as shifting the balance of care, to be implemented

ii. instructs the SGPC to seek an early meeting with ministers to demand action to address this problem.
Case Study

Dr David Bell, Secretary of the Grampian Local Medical Committee, said:
“We have been trying for years to get local authority planners to tell us about significant developments to allow the health service to plan.

“We now are likely to have a new town south of Aberdeen, and this will overwhelm the existing primary care and GP provision for the area. Since there is no method in the 2004 contract of starting up a practice with financial support, this will create a major issue for the service.

“Often planning applications include planning gain, which is often “provision of GP premises”. This is done without reference to NHS Grampian and the outcome is often inadequate. In Balmedie, for example, a large housing development offered a shop unit which was clearly inadequate for modern GP premises. When this was pointed out the offer was withdrawn but the development went ahead. The Trump golf development north of Aberdeen will bring in several hundred houses as well as the hotel. No allowance has been made for this either.”
Information Technology

Recommendation 1
The Scottish Government should ensure that existing IT systems, which improve appropriate information sharing between primary and secondary care whilst maintaining confidentiality, are developed and made available across Scotland.

Progress to date
SGPC has representation on the national Clinical Portal Board and continues to call for further safeguards to protect patient confidentiality by introducing proper identity and access procedures for electronic records.

In general, SGPC views about protecting patient confidentiality are shared across the profession and, following debate at the BMA’s Annual Conference in 2010, the call for identity and access management systems has now become UK-wide BMA policy. BMA Scotland has also produced information for doctors to raise awareness of the risk of disciplinary action against doctors inappropriately accessing patient records.

The Scottish Government is currently consulting on changing the purpose of the Emergency Care Summary (ECS) to include access in secondary care settings to information on prescribed medication. SGPC and the Scottish Government have agreed a change to access arrangements for the Emergency Care Summary to support medicines reconciliation in scheduled secondary care settings. SGPC has specified a number of conditions that are required for our continued support of this arrangement, which includes adequate identity management and role-based access in place. SGPC’s continued support for this process is dependent on satisfactory implementation of the access arrangements and safeguards and we will continue to monitor this as part of the roll out of these arrangements.

Recommendation 2
The Scottish Government should undertake a national review of data sharing and patient confidentiality across NHS IT systems.

Progress to date
The national Clinical Portal Board, which includes BMA/SGPC representation, provides a forum for discussion on data sharing for direct clinical care through the clinical portal. SGPC is participating in a national short life working group which has been formed to discuss the data sharing principles for Scotland. This group will focus on the non-clinical (i.e. not for direct patient care) use of data such as analysis of needs, audit and research.

Recommendation 3
BMA Scotland and the Scottish Government should encourage clinician involvement in the e-Health programme and increase this where possible.

See above response to Recommendation 2.

Priority for Action
The Scottish Government should work with SGPC and the BMA to ensure the security of patient information as it develops information sharing between health and social care as set out in the e-Health Strategy.

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