Lothian Local Medical Committee

Chairs Report

March 2020

Dear colleagues

This is my third and final report to Lothian Local Medical Committee.

My term as Chair ends in the autumn and there will be an election for a new Chair then.

I continue to enjoy the role of Chair and will continue to give it my best over the next 6 months until I pass the baton on the next person or persons (if 2 people propose a job share Co-chair).

Lothian LMC is a wonderful team of enthusiastic and committed GPs seeking to ensure that we represent , support and inform Lothian General Practice.

This review is therefore a summary of some of the work done by many fantastic colleagues.

REPRESENTING LOTHIAN GPs

We have sought partnership working wherever possible with our NHS Lothian (NHSL) and Health and Social Care Partnership (HSCP) colleagues as part of 'Team Lothian'

We genuinely believe that we have a shared aspiration with our partner organisations to have healthy and sustainable general practices in Lothian.

The decade of denigration of GP has had a negative impact the performance of the whole health and social care system in Lothian. A doubling of WTE consultant numbers whilst allowing GP WTE numbers to flatline may have had short term effects on easy to measure targets but most people would accept that healthy sustainable general practice is critical to NHS Lothian.

To this end we have supported 'era 3' working.

We have endorsed Tripartite working with NHSL and the 4 Lothian HSCPs

We have strongly supported the work of the Lothian Interface Group (LIG) and are grateful for the work that the group have done trying to do in finding solutions to problems at the primary/secondary care interface.

We provide ongoing input in to the development of the Modern Out-patient seeking to ensure that the 'GP impact' factor is measured, costed and paid for. The Scottish Access Collaborative principles are agreed by all, the problem is implementing the statement that 'resource should follow workload'.

We have ensured that the numerous specialty specific interface groups have GPs who are paid to contribute their professional advice as 'expert-medical generalists' rather than it been seen as voluntary work. It will be some time before every GP has a non-clinical programmed activity (SPA) costed in to their contract, in the meantime we will continue to insist that GPs and practices do not

have to pay for the 'privilege' of providing professional advice. There are some excellent examples of interface working in Lothian, from Laboratory services to diabetes and Radiology to Respiratory, there are too many to mention here.

Lothian has developed a sophisticated way of agreeing who does what at the interface with some of the best referrals guidance available anywhere on the refHelp website. We hope that all doctors working in Lothian will use this to ensure that the right people get the right specialist in a timely way. Lothian LMC supports the expansion of this crucial interface service.

We have also supported the development and work of the Flow centre. We continue to provide constructive feedback to help the team further improve it's performance.

We have made Lothian LMC more representative of all Lothian GPs. 119 out of the 120 Lothian practices contribute the voluntary levy and Lothian Association of Sessional GPs and Lothian Unscheduled Care service also have paid for representation.

We have represented Lothian GPs at national conferences and working groups. E.g. we contributed to the Gillies report into increasing involvement of GP in Undergraduate Medical Education. Through our involvement we were able to negotiate an increase in the standard teaching rate from £40 to £85.This will underpin a sustainable expansion of teaching by GPs which underpin teaching that is relevant to achieving 'Our 2020 Vision' Collective bargaining works better than 120 individual practices having a go.

Lothian GPs supported the 2018 GMS contract in the ballot seeking GP opinion. We have therefore worked to get the maximum value from the funding that has been attached. The first 2 years funding has been relatively small, but it increases significantly over the financial years 2020/21 & 2021/22. We are delighted that NHSL has agreed to long term additional funding of £5M pa to supplement the Primary Care Improvement Fund (PCIF) resource allocated to Lothian from our national contract agreement. **(See Appendix A for details)**

We have supported Lothian GP Sub-committee in the significantly expanded role it has been given as part of the 2018 GMS contract. **(See Appendix B for full detail of GP subcommittee report)**

Practices need to plan. We will seek clarity as to the likely level of support that practices will actually see in the Primary Care Improvement Plan 3 that HSCPs will put forward in May. We will also hear from NHSL what their interpretation of Nicola Sturgeon's 11% pledge to GPs in the next few months.

We sincerely hope that the additional investment will allow us to meet demand sustainably going forward. We will continue to work in a collegiate and professional way with our corporate partners but will not collude with plans that lead to unsustainable General Practice. This includes supporting Realistic Medicine and actions to protect the environment.

In summary we must reduce unnecessary demand on all NHS resources where appropriate whilst increasing funding if we are to achieve a sustainable future.

SUPPORTING LOTHIAN GPs

This is a crucial role for Lothian LMC. We will not list all the practices that we have supported or advised over the past year. This is the bread and butter work of the office and no week is the same, we do this quietly behind the scenes to achieve fair outcomes for GPs in Lothian.

Individual support often leads to broader representation e.g. current constructive work to ensure properly resourced CAMHS and GIC services have come from constituents

The Lothian Doctors Support Group (DSG) has a received a commitment to long term funding from our HSCPs to support GP wellbeing in Lothian. We work with Nigel Williams (Director of Primary Care) and our NHSL and HSCP colleagues to try to ensure that GPs on the Lothian performers list are safe and well.

GP wellbeing is vital for retention and patient safety. We have strongly supported the work of our RCGP and BMA colleagues in this area. In particular we have provided feedback to Dr Kirsten Wooley on the plans to develop a GP wellbeing service in Scotland.

We have provided a summary of resources available to GPs on our website. www.lothianlmc.co.uk

INFORMING LOTHIAN GPs

We have embraced Twitter as a means of spreading information and influencing narratives.

We have over 180 followers (compared to approx. 9 a year ago) We would commend all GPs sign up to twitter and follow us. You do not need to tweet if you don't want to, you can just follow us @lothianlmc

The LMC office has revamped our website, www.lothianlmc.co.uk . It has many useful links and resources for practices. Have a look and let us know what you think.

We have run a workshop on 'How to get the most out of the new contract'. Most events over the last 3 years have high turnouts and we value the feedback from the Roadshows and workshops that we run.

We have been delighted to have a number of GP trainees attend LMC and have shared key reports via the trainer network.

We are delighted that all constituencies have their allocation of representatives and are grateful for the work that goes on locally often by word of mouth between colleagues at meetings. If you are unsure who your LMC rep is, please look on our website for details.

We try not to overload you with emails but send out information that we think is of value you to you and your practice every week or two. From guidance on data protection through to an update on Gender identity services we work hard to ensure we give you reliable, useful information.

It is a pleasure to work with such a capable, committed group of colleagues.

Drummond Begg

March 2020

Appendix A

Estimated additional funding for investment 'in direct support of GP'

	18/19	19/20	20/21	21/22
PCIF LOTHIAN*	6.7	8.1	16.3	22.9
NHSL INVESTMENT	4.0	5.0	5.0	5.0
TOTAL	10.7	13.1	21.3	27.9
EAST LOTHIAN	1.3	1.6	2.6	3.4
EDINBURGH	6.1	7.5	12.1	15.9
MIDLOTHIAN	1.1	1.3	2.1	2.8
WEST LOTHIAN	2.3	2.8	4.5	5.9

APPENDIX B

GETTING THE BALANCE RIGHT – ENABLING LOTHIAN GENERAL PRACTICE TO DELIVER 'OUR 2020 VISION'

Lothian GP Sub-committee

Introduction

Lothian GP sub-committee is a professional advisory committee. It represents the views of general practices in Lothian.

We (Lothian GP subcommittee) support 'Our 2020 Vision'[1] created by Scottish Government (SG) in 2011. This vision was based on plans laid out in 'Delivering for Health'[2] created by SG in 2005.

Much of the aspiration of NHS Lothian Health Boards (NHSL) strategic plan 2014-2024 and Integrated Joint Board plans are based on 'Our 2020 Vision'. NHSL's stated aim is to 'support the shift in the balance of care from secondary to primary and community care services and ensure this transfer of care is appropriately resourced'

We support the vision for GP laid out in RCGP 'Fit for the Future'[3] report and the '2018 GMS contract in Scotland'[4] agreed between SG and Scottish GPs.

This report aims to help our NHSL and IJB colleagues find ways to create a better balance in our healthcare system that their respective plans aspire to.

We have created a list of key recommendations on page 12 but hope the content of this report and its links to other resources provides a useful summary of the issues with realistic recommendations.

Background

Healthcare reports[5] over the last two decades have consistently recommended more community-based generalist healthcare provision - there appears to be an absolute consensus on the need for resource redistribution. And yet……

We have seen no real increase in the number of WTE generalist community-based doctors and a doubling in the number of WTE specialist hospital-based doctors in Scotland. (*Between 1996-2017 GP numbers 3472 to 3575, Consultants 2601 to 5375 WTE – taken from ISD Scotland)*

We support whole system redesign which puts the person living at home as the starting point and we prefer whole system metrics to targets that only focus on one part of the system.

There appears to be a significant gap between the aims of the vision and strategy for our health service leaders and actual implementation on the ground. There continues to be 'silo based' planning at SG and Board level.

This section summarises the key vision/strategy documents that NHS Lothian has been implementing over the last decade. Most of the deadlines for delivery are coming up over the next 12 to 24 months and there will need to be greater focus on community-based services if we are to deliver the reforms required. It also provides a summary of the 'GP vision' created by RCGP to illustrate what future general practice might look like if appropriately resourced.

Our 2020 Vision (SG 2011)

Our '2020 Vision'

Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

By 2020, 'We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission'

Action Required to achieve Our 2020 Vision

- *We need a shared understanding with everyone involved in delivering healthcare services which sets out what they should expect in terms of support, involvement and reward alongside their commitment to strong visible and effective engagement and leadership which ensures a real shared ownership of the challenges and solutions.*

- *We need to develop a shared understanding with the people of Scotland which sets out what they should expect in terms of high quality healthcare services alongside their shared responsibility for prevention, anticipation, self management and appropriate use of both planned and unscheduled/ emergency healthcare services, ensuring that they are able to stay healthy, at home, or in a community setting as long as possible and appropriate.*

- *We need to secure integrated working between health and social care, and more effective working with other agencies and with the Third and Independent Sectors.*

- *We need to prioritise anticipatory care and preventative spend*

- *We need to prioritise support for people to stay at home/in a homely setting as long as this is appropriate, and avoid the need for unplanned or emergency admission to hospital wherever possible.*

- *We need to make sure people are admitted to hospital only when it is not possible or appropriate to treat them in the community - and where someone does have to go to hospital, it should be as a day case where possible.*

- *Caring for more people in the community and doing more procedures as day cases where appropriate will result in a shift from acute to community-based care. This shift will be recognised as a positive improvement in the quality of our healthcare services, progress towards our vision and therefore the kind of service change we expect to see.*

NHS Lothian strategic plan 2014-2024 (see Appendix 1)

Integrated Joint Board plans (See David Small report)

RCGP vision

Please watch and read the RCGP 'Fit for Future' Vision - https://www.rcgp.org.uk/policy/future-vision/our-vision.aspx

GP sub-committee supports RCGP 'Fit for the Future' and the RCGP Scotland report 'From the Frontline' – The changing landscape of Scottish General Practice - https://www.rcgp.org.uk/-/media/Files/RCGP-Faculties-and-Devolved-Nations/Scotland/RCGP-Scotland/2019/RCGP-scotland-frontline-june-2019.ashx?la=en

Enablers for change

New GP contract

We believe the 2018 GMS contract[4] plan to be delivered as agreed by April 2021 will help stabilise practices across Lothian.

The new Tripartite[6] working arrangements for new contract implementation are working well and , on the whole, have helped build constructive solution focused relationships. GP sub-committee acknowledges the hard work and commitment of our HSCP and NHSL colleagues.

The new contract is pragmatic and reflects the significant issues that continue in GP recruitment, it therefore focuses initiatives that should be jointly agreed with and 'in direct support' of all our practices in Lothian

• *The GP as expert medical generalist will focus on undifferentiated presentations, complex care and quality and leadership. All are equally important.*

• *GPs will lead and be part of an extended team of primary care professionals.*

• *GPs will have more time to spend with the people who need them most.*

The principles of contact, comprehensiveness, continuity and co-ordination of care for patients underpin the proposals

Key changes anticipated in the new contract by 2021 are outlined in **Appendix 2**

Lothian Local Medical Committee (LMC) has supported the GP sub-committee in its engagement in new 'tripartite working arrangements' to develop high trust 'era 3'[7] type working relationships.

The LMC has written a letter expressing its view that the implementation of the contract agreed in the Memorandum of Understanding[4] is unlikely to be achieved by April 2021 even with the hard work and progress being made. GP sub-committee and LMC understand that SG have given a 4-year funding package increasing in to 2022 whilst setting a 3-year contract implementation period with a 2021 deadline. It is essential that all existing resource is maintained and that we do not see new unresourced work nor 'lateral cost shift' over the 3-year plan.

Maintaining the core values of General Practice

Successful change involves reaffirming and incorporating what works well.

There are various definitions of the core values of general practice. Barbara Starfield defined the four pillars of primary care as first-contact care, continuity of care, comprehensive care, and co-ordination of care. The King's Fund[8] has also articulated the four core attributes of general practice as person-centred holistic care, accessible care, co-ordination and continuity and community focus. Although it might be expressed in different ways, common to these definitions is the strong relationship between GP as expert medical generalist and the patients, families and communities they serve. While care will be delivered in different ways in the future, and more tasks will be performed by other members of the extended practice team, relationship-based care must remain at the heart of general practice.

General Practice has a culture of being frugal. Being a cost-effective practitioner is part of GP training[9] and is embedded in GP culture. We have developed 'signposting' to help people navigate

our complex health systems to see the right person, at the right time and right place. We strongly support 'self-care' and 'pharmacy first' initiatives and would strongly urge NHS Lothian to develop these further.

General Practice and the environment

As independent contractors working in a fixed capitation fee-based system , GPs naturally 'Reduce, Reuse and Recycle'. We frequently find ourselves challenging ill-considered 'risk averse' policies that have significant environmental and financial costs. Our balanced approach to 'risks and benefits' is often misunderstood as ignorance or even worse 'cost saving at the expense of patients'.

We support moves to reduce demand for healthcare that adds little value and seek support in our appropriate questioning of those with an interest in doing more. We welcome and embrace significant advances in healthcare but also challenge the 'more is better' culture.

Quality clusters /Realistic Medicine

The development of Quality clusters is a positive move in contrast to the worst excesses of the previous 'top down' Quality and Outcomes Framework for general practice. This document doesn't detail the significant work GP Quality Clusters have been involved in. For the small amount of resource invested they appear to 'punch above their weight' in terms of value for money.

GPs in Lothian have embraced the principles of 'Realistic medicine'[10] as it is synergistic with the GP culture of waste reduction and doing the maximum amount of good to the maximum number of people. This can sometimes lead to misunderstanding and denigration of GPs by single disease focused clinicians/charities/pressure groups. We would like to ensure that all parts of NHSL are signed up to Realistic Medicine. We would like to see all clinicians following refHelp for referrals, eLJF for prescriptions and national screening guidelines both in private and NHS practice. We believe that system-wide use of refHelp and eLJF will contribute to waste reduction and efficiency

Lothian has invested significantly in its' Quality Academy and Quality improvement. There is still very little in the new contract to fund the sort of level of non-clinical SPAs[11] that GPs and their teams require. It remains a significant challenge to ensure that Quality improvement initiatives have GPs involved as independent contractors GPs are still being asked to pay for their locums to attend meetings. NHSL quite rightly invests approximately £15M in consultant non-clinical programmed activity time but struggles to pay for a few sessions of GP time to be involved in projects that they can often add significant 'bang for buck' with their whole system/population-based view. This culture must change going forward.

Feedback from Quality Cluster leads is that it is not just GP time that is limited but also

i) Project management support
ii) Data analyst time
iii) QI support – the Primary Care Quality team and Quality Academy provide excellent training. We would suggest that Practice Quality leads should have locum backfill costs approved for training
iv) Admin support is reported as patchy in both quality and quantity
v) Further support for the coordinating role of the Primary Care Quality Team to take the projects that clusters have been successful and rolling them out on a wider scale.

We are delighted that Edinburgh University has appointed 2 new Professors of GP with NHSL support. There is a significant issue with recruitment of the next generation of GP academics. We ask that NHSL explore ways in which it can do its bit in encouraging academic GP. In particular we seek

the creation of further Clinical Development fellows who will work with GP Clusters / GP academics. We would like to pilot one-year FY3 posts focused on work out with a hospital setting for a year to be involved in the whole system quality improvement work that we do. The FY3s would still take part in a hospital rota similar to FY2s in GP placements. It will also help recruitment as only 1/3 of Foundation doctors in Scotland are permitted experience in GP and even then, it is only for 4 months.

The measure of quality

A couple of structures that help frame our thinking about quality

i) Maxwell's dimensions (3ES and 3As)

Effectiveness , Efficiency, Equity

Acceptability, Appropriateness, Accessibility

ii) Institute of Medicine (in NHS Scotland's Quality Strategy 2010)[12]

Person-centred, Safe, Effective, Efficient, Equitable, Timely

A 'Deep -End' practice is different to rural practice which is different to a practice with a large number of students. Variety in practice make up and service provision reflects the strength of 'localism' and there is a lot of 'explained / appropriate variation' which is misunderstood by those with no experience of working in a primary care setting. Discovering 'unexplained variation' can help service development but great care must be taken in evaluating complex systems. GP clusters will have a clear role in quality planning, quality improvement and quality assurance

3 key factors seem to affect the quality of service

1) Access
2) Continuity
3) Sustainability

Any initiative should assess the impact on these 3 factors

Access should be to the right person at the right time at the right place using the right platform (face to face, telephone, video or email). Sustainability is ensuring that any system is appropriately resourced to ensure we do not destroy more GPs and their practices – we must learn the lessons of the past decade, losing so many £500K assets[13] has been careless to say the least.

Continuity of care reimagined

Continuity of care will remain at the core of general practice. But, as multidisciplinary team working becomes the norm, continuity will be developed in new ways. Triage, first-contact care and basic diagnosis will typically be shared with other members of the practice team, drawing on the skills of the GP as required. GPs will continue to provide hands-on care but will focus their surgery time more – though not exclusively – on providing enhanced relational continuity and holistic care to patients with more complex needs and multiple health problems. Not every patient will need or want to see the same GP every time they visit their surgery. However, practices should aspire to deliver where appropriate and desirable continuity with the same doctor(s). There are good examples of 'buddy systems' for palliative care or people with complex needs. Patients will have a shorter wait to see a GP but will be aware that, if they want to see their preferred GP(s), it may take longer.

All patients will benefit from organisational forms of continuity: their care will be coordinated and seamless, they will be supported to navigate through the health system (e.g. the interface between

primary and secondary care), their electronic care records will be accessible to all professionals involved in their care and, consequently, they will not have to keep repeating their story. Providing continuity will be an integral part of the role of every member of the practice team. New forms of relational continuity, which are compatible with multidisciplinary (MDT) team working, will be developed, for example, building a trusting relationship with a micro-team or a named keyworker in the practice team. General practices and their attached MDTs should be able to develop long term trusting relationships which can improve efficiency.

Interface working

We should put people (formally known as patients) at the centre of every pathway of care that we create. Every step of the pathway should be funded appropriately, and GP should not be seen as the default place of care without properly agreed pathways and resourcing.

Lothian GP sub-committee continues to support the work of the Lothian Interface Group and Lothian Area Medical Committee. We are keen to see efficient care pathways that are safe, effective and kind. There has been some progress in reforms factoring in the impact on GP/Primary team in service redesign proposals. There is a long way to go and we need a change in culture which moves away from silo based 'not my problem' to whole system thinking. We must create pathways in which budgets can be pooled to create more seamless and efficient services for the people we serve. We have seen some progress in the interface between Community Mental Health Teams (CMHTs) and GPs pooling Action 15 and PCIF resource to create effective open access mental health services. We will need to see a significant culture shift in transferring or sharing resources if the 'Modern Out-patient' is to be delivered effectively.

We support moves to reduce out-patient waiting times and hope that the massive £21M additional investment leads to a long-term change in a system that currently offers waiting times of greater than 3 months for routine problems and 2 weeks for urgent problems.

Where appropriate, we support GPs and consultants working alongside each other to improve understanding. This may be done in sectors as with our CMHTs in the community or in hospital departments (e.g. Dermatology, A/E, Gynae)

An area of successful co-creation of effective care pathways has been the development of *refHelp*. This web-based resource is available to all clinicians in Lothian to help guide them on appropriate referrals and alternative management. It is co-created by the relevant specialty consultant and a team of experienced GPs. The GP sub-committee delegates authority to approve new pathways and receives contentious issues for agreement at full committee when required. We have recommended the use of *refHelp* by all referring clinicians in Lothian (Consultants, advanced practitioners, GPs). This is to avoid the unnecessary duplication that can occur when someone sees a doctor to be told to see another doctor to be referred to see another doctor.

We recommend that NHSL sets up a 'Stop duplication' team to ensure that all qualified doctors seeing a patient can prescribe or issue a fit note in all departments. There is no need for people to see 2 doctors within a few days because of an incomplete initial consultation – we should aim to get it right first time to avoid expensive duplication of valuable doctor and patient time.

GPs are expert in running extremely cost-effective and accessible out-patient services, we commend some of the innovative systems developed by GPs to manage our appointments systems efficiently. We support the development of 'patient initiated follow up' provided there is no unresourced 'backflow' into primary care.

We support the Scottish Access Collaborative Six Core Principles

1. *Patients should not be asked to travel unless there is a clear clinical benefit, and that any changes should not increase the workload for primary, secondary or social care in an unplanned/unresourced way.*
2. *All referrals should either be vetted by a consultant/senior decision maker or processed via a system wide agreed pathway.*
3. *Referral pathways (including self-management) should be clear and published for all to see*
4. *Each hospital and referral system should have a joint and clear understanding of demand and capacity*
5. *Each local system should have a clear understanding of access to diagnostics as part of pathway management*
6. *Improved and published metrics including how we record and measure virtual/ tele-health / tech-enabled care*

We acknowledge the successes where systems have been 'flipped' with focus being on getting care near to home properly resourced e.g. the NUKA model in Alaska[14] and the Canterbury model in New Zealand[15] and believe that the core principles laid out in RCGP vision mirror the changes made in these.

IT

We are living in the 4th Industrial age but the new GP contract and NHS Lothian strategy document do not really embrace assisted intelligence in GP as a major source of 'untapped capacity' to take on some of the high-volume repetitive work that goes on in the system.

In terms of day to day performance we acknowledge the benefit of moving practices to a Central server in terms of speed and reliability. Effective IT systems are absolutely essential to allow GPs to manage the volume of work required to meet demand and we are grateful for our eHealth colleagues hard work in trying to ensure that our frontline function means that we get high priority in IT resource allocation.

GP sub and eHealth team agreed a set of priorities for the coming year (Appendix….). Getting essential connectivity right remains a challenge and lack of investment can mean inefficient pathways of care remain unchanged.

Although a national issue – efficient electronic prescribing should have happened 5 years ago in order to reduce pharmacist and GP workload along with a better service to patients. It is right to critically appraise systems to ensure that they are genuinely safer and more effective. Valid concerns should be overcome by developers not used to block investment. We have a Pharmacist and GP manpower crisis and can no longer afford flabby ineffective committees to spend a few more years talking about this, this needs project managed with clear timelines and outcomes. Lothian LMC has highlighted this issue as one of its 'Big 3 asks' for 2019 and the GP subcommittee notes that the Danish system[16] seems to have worked well for a number of years.

Doctor's traditionally assess and advise the people they serve with face to face consultations. The human element of our work is important and direct human interaction is an important part of the therapeutic alliance that doctors make with the people they serve. For some problems and in some situations the use of other forms of communication can be of value to the people we serve. We should provide a range of consultation types including telephone, email and video[17]. We do not support the profiteering Babylon 'GP at hand' service which enhances the 'Inverse Care Law'[18] .

Edinburgh has been scoped as a possible area for expansion of this service. Any service that neglects the frail and 'digitally deprived' will not be supported by GP subcommittee. Used appropriately and proportionately non face to face consultations are appropriate where the people we serve seek this.

LUCS

GP is a 24/7 service providing people with urgent access to healthcare. Since 2018 Out of hours urgent health care has been delivered under a different contractual framework however integrated working with In-hours General Practice is vital to deliver patients the urgent healthcare they need within the community. LUCS has excellent links with local services within Lothian and despite the challenges continues to provide a service for the majority of the time from 5 bases. Local care for local people is part of the vision that is articulated and that we must continue to provide. LUCS is working to implement the recommendations from the 2015 Ritchie Review this must continue to be supported alongside development of in-hours community services.

Work has been ongoing for the last two years to develop an Urgent Care Resource Hub within Lothian, this will provide a single point of contact for all services working out of hours. Further work is needed to ascertain the level of need for social, health and third sector services and these services should be developed to ensure consistent and timely access for patients when need them. This is particularly acute for mental health and palliative care services, two services for which there are specific recommendations in the Ritchie Review.

Supporting GP out of hours service must be a priority going forward and we support the work of Sian Tucker locally and nationally.

We should ensure that LUCS is included in Quality cluster work and funded appropriately to support its role in GP training

Recruitment and Retention of GPs

Medical students and doctors in training describe a 'hidden' and an 'informal curriculum' of GP denigration that continues to be taught. It is well described in Val Wass report 'By Choice not by Chance'[19] and unfortunately still exists in Lothian. Edinburgh Medical School has an action plan to reduce GP denigration and we ask NHSL to consider what proactive measures it can take to tackle this issue.

Returners scheme - Hundreds of GPs have stopped working in Lothian and across Scotland over the last decade, it has been the biggest 'withdrawal of labour' that the profession has ever seen. It appears permanent and our attempts to reach out to colleagues over the past two years with a positive message of change with our new contract has seen a minimal response.

Retainer scheme – this well-established scheme helps retain GPs on a very part time basis and reflects the specific challenge that generalists face in keeping 'up to date'. The GP sub-committee supports this scheme.

Wellbeing services – We support the work of the GPs support and Advisory Group in trying to identify and support doctors going through a period of difficulty. Lothian LMC has supported a plan to resource this on a permanent and secure footing.

Undergraduate teaching – we support the Gillies report in its attempt to ensure that 25 % of teaching in medical school is provided by GPs, we hope that NHSL will work with its partners to deliver this as a priority. We reap what we sow, and todays student is tomorrows doctor.

Foundation teaching – we support the Collins reports ambition to ensure that all foundation doctors have a community-based post in their programme. We have a seen a decade with no change in the current 6% of Foundation training time spent in GP overall. We know that UG and Foundation training experience in GP is helpful in recruitment. We ask that NHSL supports a redistribution of training and takes a longer-term view of the value of training in a GP setting.

GP recruitment remains very poor. We estimate that we should have been training 400 GPs per annum in Scotland over the past decade. We have come nowhere near this, typically recruiting 100 too few GP trainees per annum i.e. a deficit of about 1000 when we should be aiming for 800 more. The crisis in GP recruitment is a whole system problem and unfortunately individual silos do not seem to see it as partly their problem. We must modify Medical school and Foundation school experience and stop delaying the reform of our medical education system.

There are powerful vested interests that seek a status quo in the balance of investment in community based and hospital-based training not just in medical training but also in nursing and other disciplines. We ask that NHSL/IJBs ask the question 'how does this help recruitment to community-based work? '.

Premises

The new GP contract has started a 25-year process that will see fewer GPs taking the risk of owning their premises. The contract process is in its infancy but at the time writing the systems set up appear to be working well.

Lothians population continues to grow and we must avoid falling further behind in building appropriate facilities in a community setting over the coming decade.

Accommodating more trainees (medical, nursing, AHPs etc) is now a challenge and we need to release funds to create more consulting space as a priority. Schools manage significant variations in demand through temporary structures and we could learn a lot from them. When there was an increase in training capacity to recover London's recruitment problems portacabins were funded as part of range of rapid solutions. We need whole system thinking with NES, NHSL and Edinburgh University agreeing to pool resource to fund our training premises needs.

Over the past 25 years, almost the entire NHSL estates portfolio for acute services has been rejuvenated. We recognise that much has been done in primary care too e.g. Midlothian has a modern infrastructure, but some areas, especially Edinburgh, require significant investment in keeping with the future model of care delivery.

Although the contract focuses on the risk of owning premises we should avoid unfair premises costs that could put off potential future GP partners.

Recommendations for further improvement

We hope that we have highlighted some of the numerous positive initiatives that occur in Lothian.

We are blessed with many committed colleagues in Lothian and enjoy respectful, professional relationships on the whole. The following recommendations are made in the sincere belief that Lothian General Practices have a huge amount to offer to meet the healthcare needs of the population.

We recommend a review of NHSL/IJBs performance against aims of 'Our 2020 Vision' and 2014-2024 NHSL strategy.

Strengthen NHSL/IJB commitment to 'Realistic Medicine' principles at all levels of management.

Strengthen Strategic Planning Committee with GP subcommittee representation and ensure all new developments are aligned with 'Our 2020 Vision'

We recommend a 'Stop duplication' short life working group to ensure that systems are set up to 'get it right first time' (e.g. prescriptions/fit notes/blood tests in out-patients)

We recommend that funding is available to pay for GP non-clinical time to ensure NHSL and IJBs benefit from experienced generalist input at all levels of their organisations

Create Clinical Development fellows (FY3) to work in General Practice to support the work of Quality Clusters and Academic GP work whilst getting further experience in GP.

Ensure that NHSL/IJB proposals include a specific section entitled 'Assessment of impact on General Practice' to assist culture change in line with Scottish Access Collaborative principles.

Ensure that accessible core District General Hospital In-patient and Out-patient services are provided by NHSL Acute services

Fully fund the resource required for HSCPs to implement phase 1 of new GP contract

11% of NHSL total funding is invested 'in direct support of GP' overseen by the GMS Oversight Group

We recommend that all with influence support GP recruitment and retention by allowing redistribution of training resource for Medical School, Foundation School and Specialty training to create a more community and generalist focus.

We recommend that the computer/assisted intelligence systems are 'represented' / considered in meetings/plans in the same way as we consider human skill mix in terms of cost effectiveness.

We recommend that all doctors should embrace 'new' forms of communications technology e.g. telephone, video and email consultations where appropriate for the communities that they serve.

We recommend that GPs no longer handle results of tests ordered by other clinicians

We recommend that we no longer support the high-volume paper based prescribing system (GP to community pharmacy) and advise focus on this high-volume area as an urgent priority given the serious demand /capacity gap in GP and community pharmacy.

Summary

GPs are innovators and their independent – contractor status allows them to be nimbler in adapting to changes than most areas of the NHS. GP run practices are more cost effective than NHSL run practices.

'GPs provide contextual, person-centred care and act as a person's advocate when needed. GPs often look after generations of the same family, providing continuity of care which can help build relationships of trust and shared understanding. It is these less measurable aspects of general practice that allow GPs to hold clinical risk in a community setting, and to share and tolerate uncertainty with people'[20]

We do not require any more vision documents or strategy papers – we require 'Our 2020 Vision' to be supported with appropriate resource to shift the balance of care[21]. The success of the Tripartite oversight group allows a unique opportunity for further investment to go into General Practice with appropriate checks and balances. We need NHSL and our IJB partners to commit to the target set by the First Minister[22] in terms of distribution of resource to support and enhance the work General Practices does. By shifting the balance of care, we hope that we can play our part in a more cost-effective community-based healthcare system fit for current and future needs of the population that we serve.

References (all accessed and accurate July 2019)

1 'Our 2020 Vision' – Scottish Government 2011 https://www2.gov.scot/Topics/Health/Policy/2020-Vision-
2 'Delivering for Health' – Scottish Government 2005 https://www2.gov.scot/Resource/Doc/76169/0018996.pdf
3 RCGP 'Fit for Future' Vision - https://www.rcgp.org.uk/policy/future-vision/our-vision.aspx
4 The 2018 GMS Contract in Scotland - https://www2.gov.scot/Topics/Health/Services/Primary-Care/GP-Contract
5 e.g. 'Shifting the balance of care' – Nuffield Trust – 2017 https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf
6 GMS Oversight Group is a Tripartite structure with equal representation from NHSL , the 4 IJBs and GP subcommittee
7 Don Berwick – Institute of Health Improvement – https://www.youtube.com/watch?v=H2SoHLHufv4
8 https://www.kingsfund.org.uk/sites/default/files/2018-06/Innovative_models_GP_Kings_Fund_June_2018.pdf
9 https://www.rcgp.org.uk/training-exams/training/gp-curriculum-overview/online-curriculum.aspx
10 https://www.gov.scot/publications/chief-medical-officers-annual-report-2014-15/#res492520
11 SPAs are non-clinical programmed activities paid to consultants; GPs are still being asked to pay to attend meetings
12 https://www.gov.scot/publications/healthcare-quality-strategy-nhsscotland/
13 £500K is the estimated cost of training a doctor
14 https://scfnuka.com/
15 https://www.kingsfund.org.uk/sites/default/files/2017-08/Developing_ACSs_final_digital_0.pdf

16 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5348854/ + personal communication from Prof. Stewart Mercer
17 https://www.ed.ac.uk/usher/telescot/projects/vico - Attend Anywhere video consulting.
18 https://www.bmj.com/content/362/bmj.k3216
19 https://www.hee.nhs.uk/sites/default/files/documents/By%20choice%20-%20not%20by%20chance.pdf
20 'From the Frontline' – the changing landscape of Scottish GP – RCGP Scotland
21 https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf
22 11% of total NHS spend on GP by the end of this Parliament (May 2021)

APPENDIX 1 taken from NHS Lothian strategic plan 2014-2024

Population growth, extended life expectancy and the consequent increase in multi-morbidities that have contributed to the increased demand for access to primary care and community services without commensurate increases in capacity The need to address the existing and future capacity short-fall to meet the above increased, and increasing, demand upon Primary and Community services through the review of premises capacity and suitability, the need for additional GP Practices and work-force planning issues associated with GPs and community health teams particularly health visitors and district nurses

Access and the need to consider different models to support access to appointments within general practice, and alternatives to direct GP access to ensure our population wait no longer than 48 hours for a non-urgent appointment to see a GP or appropriate alternate healthcare professional. Demand, Capacity and Access – An Overview summarises the current position across Lothian and provides comment on the future impact associated with the population growth.

Meet public expectations by ensuring timely consultation with an appropriate health care professional, patient and/or carer involvement in decision making about their healthcare choices, access to safe and effective treatment, clear and accessible information and experience of an efficient, approachable and responsive service

Ensuring co-ordination of the care and support needed by patients across primary care, community health and social care and hospital-based services which may all have a part to play in meeting individual's health needs

Support the shift in the balance of care from secondary to primary and community care services and ensure this transfer of care is appropriately resourced

The need for further development of information technology to support timely communication and transfer of information between primary care contractors, hospital and social care services

Increasing demands and issues associated with recruitment and retention of the out of hours workforce which is impacting significantly on delivery of the Lothian Unscheduled Care Service (LUCS)

APPENDIX 2

Anticipated changes to the multi-disciplinary team 'in direct support of GP' by 2021 as laid out in GMS contract agreement.

Pharmacotherapy services HSCP/NHS Board Service •

Repeat prescribing, serial prescribing, 'specials', shortages • Medication and polypharmacy reviews. • Medicines reconciliation • Medication enquiries • Monitoring lab results for high risk medicines

Urgent Care Services HSCP/NHS Board Service •

Assess and treat urgent and emergency care presentations • Home visits • Falls

Additional Professional Services HSCP/NHS Board Service •

Acute musculoskeletal physiotherapy services • Community mental health services • Community link worker services

Community Treatment and Care Services HSCP/NHS Board Service •

Management of minor injuries and dressings, phlebotomy, ear syringing, suture removal • Chronic disease monitoring – routine checks, and related data collection • Screening test results will go directly to requesting physician • Monitoring lab results to pharmacist/general practice nurse • Carrying out requests from secondary care

Vaccination Services HSCP/NHS Board Service •

Provide all vaccinations previously provided by GP practices. • Travel vaccines and travel health advice

General practitioners' Independent contractor – based in the practice •

Default responsibly for a reduced number of primary medical services • Undifferentiated presentations- patients who are ill/believe themselves to be ill, who require diagnosis and cannot choose to see other health professionals • Complex care - including more time with patients who have more than one diagnosis or medical issue • Clinical leadership of extended primary care team to improve patient outcomes • Fewer home visits but more complex and often as part of team assessment and support • Oversight of chronic disease management • Reduced volumes of Docman – outpatient and self-ordered test results • Leading practice team / practice management • Leading clusters • Influencing local system

General Practice nurses Employed by the practice •

Minor illness management (along with community pharmacists via 'Minor Ailments Service')• Chronic disease management • Supporting GP to deliver care planning • Monitoring lab results

Practice manager Employed by the practice •

Contract management • MDT coordination • Contract monitoring • Business planning • Contract and other regulatory compliance • Staff management

Receptionists Employed by the practice •

Organising patient appointments • Supporting patients with information on available services • Managing communications to/from the practice • Managing prescription requests/enquires • Operating call/recall systems • Administration

These ambitious changes build upon existing community resources e.g.

Community pharmacy – we are promoting 'Pharmacy first' signposting especially for self-care purchases and their 'Minor ailments service'

Optometrists – first port of call for all primary care eye problems – including eye emergencies

'Gateway' / direct access services where they exist for Drug, alcohol and Mental health problems

District nurses – running the biggest 'hospital' in Lothian – they accept limitless 'admissions' running huge 'wards' with very ill community based patients 24/7 alongside LUCS and nursing home colleagues.