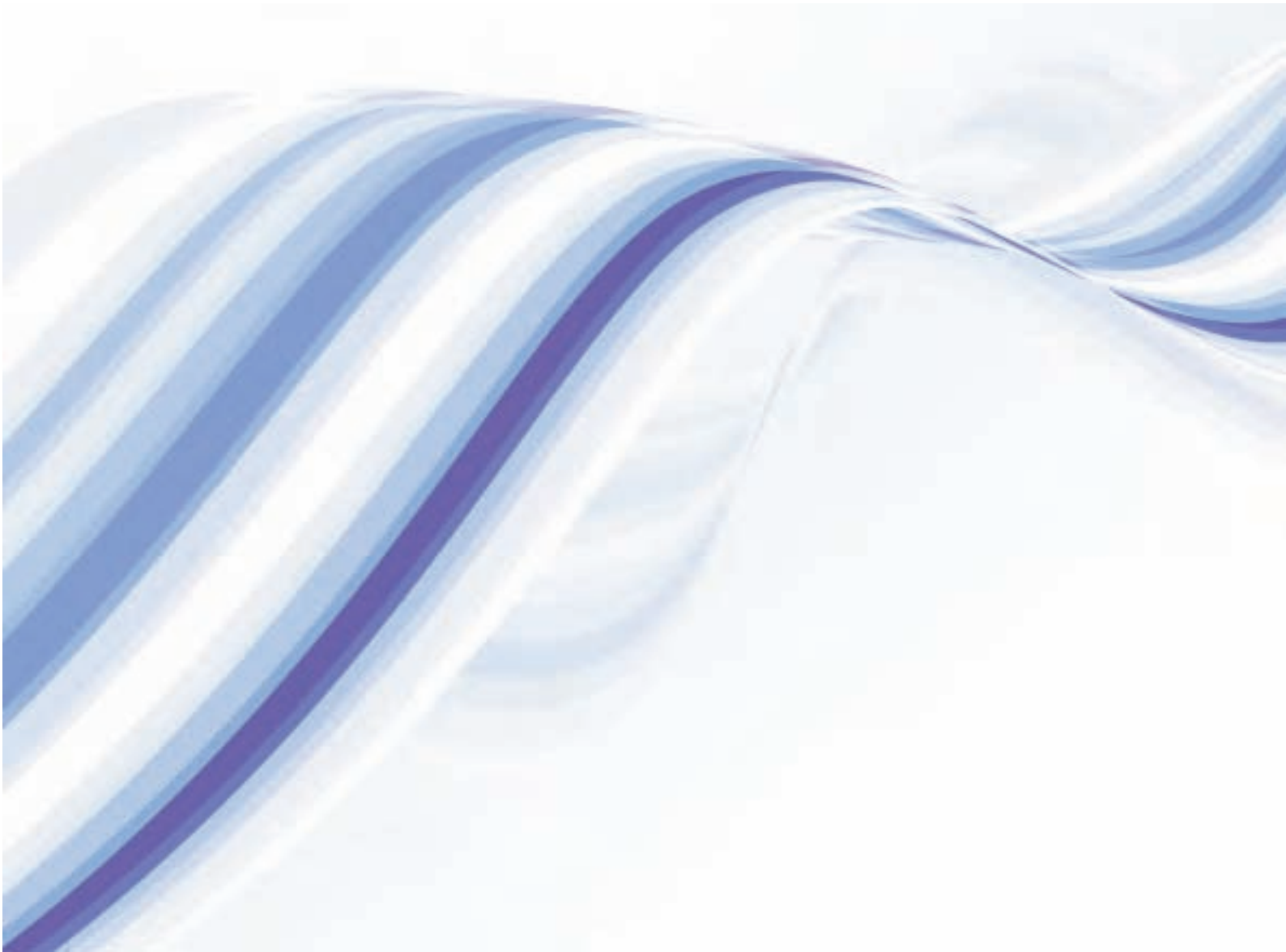


General Practice in Scotland: The Way Ahead – Final Report

February 2010



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Foreword

General practice in Scotland is at a crossroads. The Scottish Parliament has demonstrated a commitment to the NHS by passing legislation to prevent commercial companies contracting for NHS general practice services. We welcome this commitment to a publicly provided and delivered service, and believe that this signals an opportunity to develop a clear policy direction for general practice in Scotland.

The Scottish General Practitioners Committee of the BMA has therefore consulted with the public, the profession, patient groups and health charities to hear views on what the priorities should be and to help us to balance the needs and expectations of our patients with the resources available in general practice.

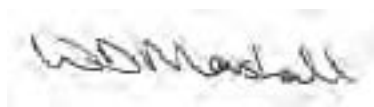
General practice has seen great change in the last 30 years. General practitioners provide a comprehensive service, managing undifferentiated illness and often balancing patients' multiple, and at times complex, needs and when required guiding their patients on to other services. They also play a leading role in co-ordinating many of the preventative initiatives of the NHS, such as the national winter flu vaccination programmes.

General practice is now wider than just the role of the doctor; it comprises a skilled team of individuals, including administrators, receptionists, practice managers, practice nurses, community nurses and GPs working together in the practice to deliver care to patients.

We all recognise that public sector spending will be limited as a result of the current economic climate, it is therefore important that the NHS becomes much more efficient. For general practice, that means implementing policies that are evidence-based and will deliver real improvements to patient health outcomes. In these difficult times, it is important for NHS managers to support clinicians to ensure that primary care policies are practical and beneficial to patient care.

Responses from GPs to this consultation reflected how difficult GPs are finding it to cope with their workload while preserving what patients value the most – the time to talk to their doctor. GPs are passionate about their work and are hugely committed to their communities. Consultation responses also reflected the frustration that patients and patient representative organisations have about the NHS and access to services.

I thank every one who contributed to our consultation process for the time they have taken to express their views. I hope that policy makers can see that general practice wants to help drive forward positive change that delivers real improvements for our patients.



Dr Dean Marshall
Chairman, Scottish General Practitioners Committee
BMA Scotland

Introduction

This report is the end point of a year long process by the BMA's Scottish General Practitioners Committee which sought the views of the public, patients, professional groups, NHS managers and health charities/organisations on the future direction of general practice in Scotland.

The original consultation document focused on six key areas: Access, Out of Hours Care, the Balance of Care, Workforce, Infrastructure (premises and IT) and Health Inequalities. We believed that if we could define policy and recommend a way forward for each of these areas, it would help to ensure the continuation of a high quality general practice that is responsive to patient needs and is provided with equity across Scotland; underpinning the founding principles of the NHS.

The recommendations outlined in this document reflect the responses we have received to our consultation.

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The Role and Values of General Practice

- General practice is a fundamental element of healthcare provision in the UK. It provides primary, continuing, comprehensive, holistic medical care to individuals, families and communities.
- Every citizen has the right to be registered with a GP. Registration provides benefits which include personal and organisational continuity of care; co-ordination and comprehensiveness of care; longitudinal care; lifelong medical records and confidentiality.
- General practice is underpinned by the professionalism of GPs and their staff.
- The core values of general practice include:
 - the promotion of a health service that is universal and free at the point of delivery.
 - the provision of continuous, comprehensive and high quality care that is accessible to patients when they need it.
 - clinical professionalism with a focus on continuing professional development, partnerships with patients, meeting patient needs and patient safety.
 - appropriate and timely referral to other healthcare services where this is needed.
 - constructive and communicative partnership working with other healthcare providers and services.
 - continuous improvement in service quality.
 - appropriate and timely evolution of service delivery.

Executive Summary

This policy document provides analysis and recommendations for six key areas to drive forward policy for Scottish general practice: access, out of hours, health inequalities, balance of care, workforce and infrastructure. It recognises the need for a whole system approach towards creating policies for NHS general practice that must be evidence based and improve outcomes and quality of care delivered to patients.

The Way Ahead: Access

It is clear from consultation responses that GPs and patients find current appointment systems frustrating. There was support across respondent groups for increased access to GPs; better engagement between practices and the development of access arrangements. It is recognised that patient feedback is important, but the link between practice resources and patient perceptions has disenfranchised the profession. In order to make best use of GP and other NHS services, more should be done to manage demand, for example promoting self care and providing people with information on how best to access NHS services.

Recommendations:

1. 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.
2. The Scottish Government should re-engage GPs in the patient access agenda by removing the current link between patient perception of 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.
3. The Scottish Government should seek to make 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.
4. The transfer of work from GPs to other health professionals should be evidence-based, monitored and evaluated to assess benefit.

The Way Ahead: Out of Hours

Demand for out of hours care is increasing across all services (A&E, NHS 24 and Scottish Ambulance Service) however there remains a lack of awareness that NHS 24 is the first point of contact for all non-urgent out of hours care. There is support from within the profession and the public for greater involvement of GPs in the planning and development of out of hours services however it would be impractical for GPs to return to having sole responsibility for delivering out of hours care.

Recommendations:

1. The Scottish Government and NHS Scotland should do more to raise awareness and increase public understanding of the role of NHS 24 as the initial point of contact for out of hours services.
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.

3. NHS 24 should focus on improving its core business of call triage and integration with local services rather than planning further service expansion.
4. The current NHS QIS national core standards for out of hours services should be reviewed using the principles and methodology of the Quality Strategy.
5. Health boards should establish a local-multidisciplinary strategic group to review out of hours activity data and gather evidence of successful delivery models in order to improve current out of hours patient care pathways.

The Way Ahead: Health Inequalities

Reducing health inequalities has been a key policy for successive governments. Inequalities cannot be reduced by general practice in isolation as poor health is often a result of inequalities in other areas of life such as inadequate housing, poor educational achievement and unemployment. It is critical that resources are allocated according to need. The 'inverse care law', the principle that the availability of good medical or social care tends to vary inversely with the needs of the population served, is still evident in Scotland today and it remains the case that those with the poorest health often have the most difficulty accessing appropriate healthcare.

Recommendations:

1. Health boards should encourage greater joint working between health and social care to address health inequalities.
2. The Scottish Government should provide additional support for GP practices in areas with the highest need.
3. RCGP Scotland should consider conducting further research to quantify the increased workload and needs impact in areas of deprivation.
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 needs.
5. The Scottish Government and NHS Quality Improvement Scotland should ensure that the Quality and Outcomes Framework is supported by adequate and consistent funding and remains comprehensive and evidence based.
6. The Scottish Government should develop measures to improve recruitment and retention of GPs in areas with the poorest health outcomes.

The Way Ahead: Balance of Care

Modernising healthcare requires services to be designed around the needs of the patient, but within the constraints of existing available resources. There has been a drive by the current and previous administrations to 'shift' the balance of care so that more care is provided in the community, closer to patients' homes. Efforts to improve hospital efficiency and reduce waiting times are impacting on the workload of primary care. A whole system approach for the creation of care pathways is required and improved communication and information sharing between primary and secondary care is essential.

Recommendations:

1. The Scottish Government and NHS Scotland should promote clinical leadership in the redesign of services.
2. The Scottish Government and NHS Scotland should encourage and support joint working between primary and secondary care healthcare professionals on the redesign of patient pathways to achieve the optimum balance of care (including emergency admissions).
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.

4. The Scottish Government should commission research into reasons for variation in referral rates to help inform service redesign and lead to improvements to training and education.
5. Healthcare professionals should lead the development of Community Health Partnerships.

The Way Ahead: Workforce

The way in which primary care in Scotland is organised has changed radically in the 21st century which has consequences for workforce planning. There are emerging trends in general practice which will have consequences on long term workforce planning, eg increased demand for less than full time working, portfolio careers, increased salaried posts and more women entering the profession. General practice however is wider than just the GP, it involves the practice staff (eg practice nurses) and the wider primary healthcare team (eg health visitors) and these professionals should be integrated into the delivery of GMS services. A series of short term and unpredictable funding arrangements for GP practices has made it difficult for practices to implement long term plans for services and employment of staff.

Recommendations:

1. The Scottish Government should continue to regularly review primary care workforce data and trends to inform planning.
2. NHS Education for Scotland should support practices to further develop and promote the skills of the primary healthcare team.
3. The Scottish Government should establish reliable information about locum GPs working in Scotland.
4. The Scottish Government should create a working group to consider measures, such as contractual incentives, to encourage practices to take on partners.
5. NHS Education for Scotland should create more training placements in remote and rural practices.
6. NHS Education for Scotland should review contractual arrangements for the employment of GP Specialty Registrars in their general practice placement.

The Way Ahead: Infrastructure

Premises

With the shift in the balance of care requiring more services to be available in GP practices, there has been increasing pressure to absorb additional work or develop services. This is increasing the pressure on GP premises, many of which are no longer fit for purpose and in need of replacement or re-development. With an increasing population in Scotland, many towns are experiencing rapid expansion. However little account is taken into the impact this will have on local health services, including GP practice list sizes.

Recommendations:

1. The Scottish Government should give greater priority to premises funding and a return to ring-fenced funding should be supported.
2. GP owned premises development must be maintained as a viable option where suitable for local needs.
3. The Scottish Government should establish a national arrangement for ensuring new premises are built where they are needed.

Information Technology

General practice has adapted well to the use of new technologies. More than 90% of practices in Scotland are paperless or paper light and rely heavily on their clinical IT systems. It is therefore essential that practices have confidence in the IT systems that are available to them. Although there is a need to improve information sharing between primary and secondary care to ensure effective and safe patient care, concerns have been expressed about the impact of this on patient confidentiality.

Recommendations:

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.
2. The Scottish Government should undertake a national review of data sharing and patient confidentiality across NHS IT systems.
3. BMA Scotland and the Scottish Government should encourage clinician involvement in the eHealth Programme and increase this where possible.

The Way Ahead: Access

Introduction

The patient journey begins when patients and/or their carers make decisions about how and when to access NHS services. Those decisions can have a major impact on the effectiveness and timeliness of the care patients receive, and the extent to which NHS services can operate efficiently and effectively. If patients don't know enough about how best to access services, or how to use services appropriately, the NHS will struggle to provide the most appropriate cost effective care to the population.

Demand on all NHS services is high due to many factors including an ageing population, increased availability of treatments and rising patient expectations. Approximately 90% of NHS consultations take place in primary care settings¹ and general practice consultation rates are high: estimated at 21.8 million patient contacts with GPs and practice nurses in Scotland during 2007/2008.² General practice faces the difficult and ongoing problem of balancing patient demand and preferences for services within the available and most clinically appropriate resources, while also ensuring that those in most need of urgent care are correctly prioritised.

International comparisons of health care systems confirm that primary care led systems are efficient and cost effective,³ and the UK system performs well in comparison with the health systems of other developed nations.^{4,5}

The majority of practices are meeting Scottish Government targets for 48 hour and advanced access.⁶ However some patients report problems in getting appointments that suit them and this was reflected in some of the consultation responses. Patients and GPs tell us of their frustration with systems for same day appointments, while advance booking can lead to non-urgent appointments being booked up for weeks ahead.

Somehow an acceptable balance needs to be struck on the different types of access arrangements that patients require allowing GPs to provide the best and most appropriate level of access within available resources.

Consultation Responses

Access to GP services generated a large number of consultation responses but very little consensus on single issues. Four main themes emerged:

- General access to GP services
- Appointment systems
- Patient expectations and information
- Transfer of work to other health professionals

General access to GP services

Patient groups and GPs both commented that current access systems were too rigid and should be more flexible, locally driven and reflect the needs of patients. There was support across respondent groups for increased access to GPs; better engagement between GP practices and their patients in the development of access arrangements; and greater focus on continuity of care. Patient groups and NHS organisations favoured an increase in the forms of access available to patients (eg use of email and online booking systems), but members of the public and GPs concurred that face to face contact remained the most important form of access. Some respondents supported direct patient access to allied health professionals; promotion of education and support for patient self management; and increased GP use of other local health and voluntary services.

Appointment Systems

The need to improve appointment systems generated the most consensus and there was wide support for longer GP consultation times and longer appointments for those with complex problems. There was patient group support for mechanisms such as text messages to reduce missed appointments. GP and patient organisation respondents raised concerns that extended access appointments were not fully utilised and represented poor value for money. Other respondents thought that advertising of normal and extended opening hours could be improved.

Patient expectations and information

There was consistency across groups on the need to manage patient expectations and demand, and provide more information to the public on what the NHS is able to provide. Suggestions for achieving this included: open debate on appropriate allocation of resources; use of the school curriculum to inform the appropriate use of NHS services; NHS leaflets outlining patient responsibilities; and increasing public awareness about the costs of providing health services.

Transfer of work to other health professionals

There was a mixed response across groups to the concept of transferring work from general practice to other health professionals. Where this was supported, all groups placed conditions on this including the need for: careful analysis and monitoring of the advantages and disadvantages of any transfer; the provision of additional funding to support the transfer; and consideration of how transferring work to others will impact on patient care, including the requirement to travel to locations (other than the GP practice) for appointments with another health professional.

Key priority areas:

1. Access and appointment systems.
2. Managing patient demand on NHS services.
3. Transfer of work from general practice to other health professionals.

1. Access and appointment systems

'Good access' to general practice is subjective and difficult to define as it is largely based on the views of an individual and relates to a personal need or experience. The mixed and inconsistent consultation responses received on this subject imply that there is no universal view on what constitutes 'good access'. While some patients want increased use of email and telephone consultations, others place the greatest value on face to face consultations with members of the practice healthcare team.

All GP practices should provide the best possible access to services for their patients in the context of patient demand and preferences, and within the constraints of available infrastructure and resources. GP practice access can be optimised through greater organisational efficiency but there are limits to what can be provided within a resource-limited primary care led system. GP practices should, nevertheless, strive for continuous improvement. Politicians and patients want improved access to GPs but, as with many targets, greater focus on one area inevitably leads to reduced focus on another. Stretching GP services too thinly or directing policy too rigidly, risks undermining the ability of practices to manage the delicate balance of maintaining the six dimensions of quality in health care (comprising safety, effectiveness, patient centredness, timeliness, efficiency and equity).⁷

In attempting to maintain that balance, GP practices may find that patient preferences do not always match clinical expertise or availability. Patients preferring to see a favoured GP may be dissatisfied when they are signposted to another GP or health professional within the practice who has greater expertise in managing their clinical condition (eg diabetes care). But by making best use of the skills

within the practice, patients can be managed more effectively and efficiently in terms of optimal prescribing and reduced consultations. Particularly in larger practices, it will be increasingly important for patients to understand and recognise that continuity of care and 'good access' may increasingly be across a general practice team and not based solely around an individual GP. This is inevitable against a background of GP practice expansion; increased clinical subspecialisation; expanded clinical roles of the primary healthcare team; and an increase in part-time working and GP portfolio careers. The Royal College of General Practitioners has suggested that the key to improved patient access is for GP practices to federate and share responsibility for developing services for their communities.⁸ This potential development relies on GPs working together with other practices and patients accepting that continuity of care will lie with a practice team.

In recent years Government policies aimed at improving access to GP services, such as the 48 hour access guarantee and extended GP hours arrangements, have been implemented on an undifferentiated basis across Scotland. It is clear from the feedback to our consultation and other research⁹ that GPs and patients agree that current access systems are too rigid and should be more flexible, locally driven and reflect the needs and preferences of patients in the context of their locality. Although extended hours surgeries can be appropriate for some patient populations, they may not be appropriate for others, particularly remote and rural areas with sparse populations. GPs have told us that that extended hours appointments are often under-utilised and represent a poor use of valuable NHS resources. Current extended hours arrangements, which do not take account of local need and demand, should be reviewed and revised urgently.

It is important for GPs to recognise the value of seeking feedback from patients and use this as a basis upon which to adapt and improve the service they provide. However, recent actions of the Scottish Government have alienated GPs from the improving access agenda. The withdrawal of substantial amounts of funding from GP practices on the basis of a national survey of patient perceptions of the access that GPs provide to their services has damaged relationships between the Government and the GP profession. Many GPs believe that they have lost funding despite providing a good service; a view that has received some support.¹⁰

When the boundaries of organisational efficiency have been reached, additional investment may be necessary to meet the demands of urgent, early and advance booking (for example the employment of GP locums to cover absences or periods of high demand). The need to invest to improve access to services is recognised in other areas of the NHS, for example the provision of additional funding to the secondary care sector to reduce waiting lists. Under current GP access policy, the withdrawal of funding from GP practices as a result of the outcomes of a patient access survey is likely to reduce rather than enhance access to GP services, particularly if GP practices believe that investing to improve access systems might not result in improved patient perceptions of access.

Getting GPs re-engaged with policies on patient access will be a challenge. There is a shared desire to develop patient feedback and access systems which are flexible and locally driven. It is important to support rather than penalise GP practices that are struggling to meet access targets and are having difficulties balancing demand, quality and patient preferences for access within finite resources. Consideration should be given at local level to utilising the skills of experienced practice managers who have introduced and managed successful access arrangements and can share their experience to support these practices.

2. Managing patient demand on NHS services

Consultation responses indicate clear public recognition that NHS resources will always be finite; that demand on services has to be managed; that there is a need for public debate and openness about what the NHS can provide; and that there is a place for public education on when and how NHS services should be used.

The pattern and extent of patient demand on general practice is influenced by a range of external factors, the majority of which are outside the control of general practitioners. Local geography, population density and diversity, levels of morbidity, patient preferences and behaviours, and the availability of public transport are a few key factors. Another major factor, as outlined above, is government policy.

With demand rising, whole system solutions are required to manage and balance that demand. Potential measures to try to achieve this include:

- Every person diagnosed with a long term condition should know how to access appropriate information on their condition and how to develop their self management skills through education available from the NHS and voluntary and community sector organisations. Every patient should also know who, in addition to their GP, may be able to give advice and support.
- Careful consideration of the implications of introducing new health policies, particularly those aimed at improving individual lifestyles and population screening.

Longer GP consultation times provide the opportunity to incorporate important elements of care and may increase quality in prescribing,¹¹ but this cannot be achieved unless GP practice workload is carefully managed and inappropriate or less important demand is reduced. Without an increase in the number of GPs, a longer appointment for one patient inevitably reduces the number of available appointments for other patients.

Research indicates that people in Scotland prefer to manage self-limiting illness and are willing to use community pharmacists when professional help is required, but researchers in Aberdeen have found that Government policies aimed at reducing waiting times to see a GP may discourage some patients from practising self-care.¹² These findings support concerns from the GP profession and others¹³ that Government initiatives on access are not evidence-based and have been introduced with insufficient evaluation of their impact.

Increasingly, policy makers are looking to improve the future health of the population and manage demand on NHS services through health promotion measures. Although this strategy makes sense, general practice is expected to add to its already expansive role by taking on much of this work. The need to manage workload¹⁴ and bureaucracy¹⁵ in general practice is well-recognised and was one of the primary reasons for negotiation of a new general medical services contract (introduced in 2004) following recognition of recruitment, retention and morale problems. The new GMS contract promised better management of GP workload and new resources to support any new or additional work. Consequently, any substantial increase in workload through new health promotion measures would require investment and expansion of general practice to safeguard core practice service delivery (as defined in the GMS contract as the clinical management of those who are unwell or believe themselves to be unwell). Policy makers need to assess the potential impact of any new policies that affect or involve general practice and enter into early discussions with the BMA and the Royal College of General Practitioners before they are developed. This would help identify proposals which have no clear evidence-base; which might inappropriately increase GP workload; and which could, if introduced, have a detrimental effect on the delivery of other core clinical services.

While there is a role for GPs and practice nurses to offer lifestyle advice, skilled staff from other health and social care agencies are often better placed to deliver these messages. For example, greater use of public health campaigns and messages on how best to access health services, delivered via the school curriculum might address lifestyle issues at an earlier stage before patterns of behaviour are well-established.

3. Transfer of work from general practice to other health professionals

The discussion above highlights that GPs and their staff already have a high workload and many GP practices are working to their full capacity. There were mixed views across respondent groups on whether GP work should be transferred to other health professionals. Where this was supported, respondents favoured careful evaluation and piloting of proposed changes with ongoing monitoring by health boards and their Community Health Partnerships (CHPs) to demonstrate benefit to patients.

Key recommendations:

1. 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.
2. The Scottish Government should re-engage GPs in the patient access agenda by removing the current link between patient perception of access and the resourcing of GP practices and working with the profession to:
 - i. 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.
 - ii. identify flexible solutions for optimising GP patient access which can be tailored to suit local circumstances.
 - iii. develop mechanisms for locally based systems of support for GP practices experiencing difficulty in maintaining access for patients.
3. The Scottish Government should seek to make best use of GP and other NHS services through:
 - i. the promotion of appropriate self-care
 - ii. public education programmes on using and accessing NHS services and the consequences of inappropriate demand on services, possibly as part of the educational curriculum
4. The transfer of work from GPs to other health professionals should be evidence-based, monitored and evaluated to assess benefit.

The Way Ahead: Out of Hours Care

Introduction

Patient services during the out of hours period have undergone radical changes in the last decade. The most significant change took place in 2004 with the introduction of the GMS contract which allowed health boards to take over responsibility for the provision of out of hours care. It was also around this time that the Government extended the role of NHS 24 to become the first point of contact for patients outside traditional GP practice opening hours (8am to 6.30pm). NHS 24 would provide triage services for patients and would refer cases on, where necessary, to locally based out of hours services. Despite this central role of NHS 24, respondents to our consultation highlighted a degree of anxiety, frustration and uncertainty about accessing the right services out of hours at a time when they are likely to feel most vulnerable.

It is important that the public is aware of the options available to them when they require care out of hours. It is clear that more needs to be done to inform the public about how to access health services out of hours. This is an issue that will require the Scottish Government to seek the views of relevant professionals working across the NHS including: secondary care professionals, particularly those working in accident and emergency departments, and other community care providers, including pharmacy and social care services.

Following the introduction of the GMS contract the vast majority of GPs (95%) opted out of the responsibility for providing out of hours care to their patients, however almost 50% of GPs (1,400) continue to deliver out of hours care to varying degrees.¹⁶

It is acknowledged that some patients feel let down by GPs giving up 24 hour responsibility, but delivering the service was becoming an increasing burden for doctors across Scotland as they reported the volume of calls being received and the work intensity required was increasing year on year. Consequently the previous arrangements were becoming unsustainable. NHS 24's early difficulties demonstrate the challenges of delivering a service out of hours.

The 2005 review of NHS 24 highlighted a series of management failures throughout the organisation which had led to patients receiving poor levels of service.¹⁷ Since then, NHS 24 has worked to implement many of the recommendations of the review group including the creation of regional call centres and closer working between NHS 24 and local health boards. This progress has been significant and has delivered an improved service; however it is clear from the views of the profession and the public that there remains a need for further improvements to the service and that a concerted effort is required to try to win back the confidence of the profession.¹⁸

Consultation responses

An audit of primary care out of hours services conducted by Audit Scotland in 2007¹⁹ included a survey of patients who had used NHS 24 services. This survey found high levels of patient satisfaction with the service. However responses to our own consultation offer a mixed reaction to the services provided by NHS 24. Views of individual patients and community councils in particular demonstrated unhappiness with elements of the service, with many perceiving NHS 24 as a replacement for GP out of hours services, rather than it being part of an integrated out of hours service.

The majority of respondents supported the continuation of NHS 24 to provide a telephone triage service and expressed a view that the service should focus on improving its core business rather than widening its remit. Many considered that NHS 24 in its current form is not working optimally and supported calls for improvements, particularly in terms of integration with local out of hours service providers.

There was support from patients, NHS managers and the profession for out of hours services to be locally driven with greater integration between health boards and NHS 24. It was also widely accepted that a 'one size fits all' approach is not appropriate for a country with such diverse geography and population needs as exists in Scotland.

There was strong support from within the profession and the public for greater involvement of GPs in the planning and development of out of hours services. There was a desire, from the public, for GPs to be more prominently involved in out of hours care, particularly in rural communities. Whilst many GPs continue to be involved in the delivery of out of hours services, GP respondents said it would be completely impractical to return to a situation where sole responsibility for delivering out of hours services lay with GP practices because of the increasing volume of calls being received out of hours, the intensity of daytime work and the subsequent problems this would create in relation to recruitment and retention of GPs. A model of multidisciplinary out of hours provision was the preferred option for respondents, particularly among NHS organisations and health organisation/charity respondents.

There was also a view that there should be a wider discussion with the public about what level of out of hours services should be provided and what patients should expect. This kind of public debate is necessary to manage raised expectations, particularly at a time when NHS budgets are facing increasing pressures.

Patient groups, such as the Long Term Conditions Alliance Scotland, supported the concept of informing patients on responsible and appropriate use of out of hours services and greater use of self management for patients with chronic conditions. There was also strong support for more work to be done in the area of palliative care where GPs and patient groups believed that better information sharing was required.

Key priority areas:

1. The increasing demand for out of hours services.
2. The range and level of services available out of hours.
3. Integration between NHS 24 and local services.
4. NHS Quality Improvement Scotland core national out of hours standards.
5. Joint working between NHS 24, health boards and GPs.

1. The increasing demand for out of hours services

Demand for NHS emergency and out of hours services is increasing. In 2006/07 there were more than half a million urgent 999 calls to ambulance services, an increase of 41,000 on the previous year.²⁰ Studies show that 20% of 999 calls do not result in patients being taken into hospital.²¹ It could therefore be argued that the availability of a triage service should reduce the number of calls to the ambulance service. Steps are being taken to improve communication between services; NHS 24 and the Scottish Ambulance Service now have shared information systems that allow call contacts to be passed between them, so that non-urgent 999 calls are passed over to NHS 24 for onward handling, and urgent NHS 24 calls are passed to the ambulance service.

It is reported that in 2006/07 there were 1.55 million A&E visits, an increase of 50,000 on the previous year.²² Many patients attend A&E when they could have been treated elsewhere within the NHS system and an assessment over the telephone could offer a more convenient way of helping them to access appropriate services. This is the essential role of NHS 24. However, despite NHS 24 taking on the role of telephone triage, demand across all services (NHS 24, A&E and Scottish Ambulance Services) is increasing.²³ This continued rise in demand must be addressed. In

order to do so, it is important to understand why patients are seeking more support out of hours and the decision making process they undertake when contacting an out of hours service.

Out of hours care encompasses all aspects of the health service: general practice, secondary care and community care, all of which can be accessed by first contacting NHS 24. More should be done to promote NHS 24 to the public as the first point of contact for non emergency calls out of hours.

2. The range and level of services available out of hours

There are mixed views amongst the public and the profession about the appropriateness of the levels of service that they currently have access to during the out of hours period. This is particularly controversial in some remote and rural communities in Scotland where there is a perception that a lack of local GP presence means that there is little medical support in the area during the out of hours period.

As stated previously, it is important to identify the public beliefs that underpin demand for out of hours services, including levels of understanding about self management and self care, to identify why and how people decide to access care out of hours.

It is acknowledged that providing care in rural areas is significantly more costly than providing a similar service in urban areas. For example, the cost per head of population of providing out of hours care in an urban area such as Greater Glasgow is £7.61 but rises to £43.63 in the Argyll and Bute area.²⁴ For small rural communities, NHS managers and Government must consider the development of unique solutions which provide sustainable out of hours services for residents, but which may not follow a traditional model.

3. Integration between NHS 24 and local services

Respondents were supportive of the concept of NHS 24 but did suggest that there were areas of its work that needed to be improved. Respondents also expressed the view that NHS 24 should focus on improving its core business rather than working to further expand its services.

Health boards should consider mapping emergency and out of hours services in the community to monitor levels of demand so that the local systems are comprehensive, geared to patients' needs and avoids both gaps and duplication of provision. This would help to ensure that services across primary and secondary care are coordinated, planned and managed so that the appropriate level of service is available. This profiling of services would need to take account of the requirements of patients with special needs and include services provided by local authorities and the voluntary sector.

A key challenge for out of hours services is to provide care for people living with long term conditions to avoid unnecessary hospital admissions out of hours. The Long Term Conditions Alliance in Scotland promotes self management for patients as an essential strand to any out of hours care strategy.

Organisations representing patients with particular health needs stated a preference for local GPs to provide their out of hours care, since they are likely to have a better understanding of their patients' needs. The introduction of Emergency Care Summaries (ECS) and the forthcoming electronic Palliative Care Summaries (ePCS) are positive developments to help share important information with out of hours services. It would be helpful if clinical IT systems allowed better integration with GP systems to allow easy transfer of information about changes in patients' health, particularly important in palliative care.

4. NHS Quality Improvement Scotland core national out of hours standards

Evidence from NHS Quality Improvement Scotland (NHS QIS) shows that patients in Scotland are by and large, receiving a high quality out of hours service that is safe, reliable and effective.²⁵

It is widely acknowledged, however, that 'one size does not fit all' and the current national standards do not reflect this adequately. As noted above, there are challenges in addressing the needs of particular local communities or patient groups within services that are developed on a regional basis. There are also variable levels of integration with local services. Integrated care that is sensitive to the needs of the individual and the local community is most appropriately provided by local units. This would allow unique solutions to local problems and can be based on needs assessment.

The core standards for out of hours services were developed in 2004 by NHS QIS.²⁶ However with the move towards greater local integration, there should be a review of these standards with a new emphasis on quality, utilising the principles of the Scottish Government's draft Quality Strategy²⁷ and reflecting the devolved nature of services. NHS QIS should continue to conduct reviews at health board level to ensure implementation is of a consistent standard across the country.

5. Joint working on out of hours issues between NHS 24, health boards and GPs

Many respondents to the consultation seemed to consider NHS 24 as a replacement to locally provided services instead of an entry point to local established units. There was a positive response to the proposal for greater involvement of GPs in developing and commissioning out of hours services to complement the telephone triage service provided by NHS 24.

In response to criticisms of the centralised structure of NHS 24 in the 2005 review, the service established five local centres in Inverness, Dundee, East Kilbride, Kilmarnock and Dumfries. These local centres were created to help support the development of closer strategic relationships with the host territorial health boards. However it is clear from consultation responses that local integration is far from complete.

Closer integration between primary care out of hours services and A&E care needs to be established with co-location of GP out of hours centres and A&E departments being a solution that may, in some circumstances, suit urban environments but would need to be carefully monitored to ensure that it does not increase out of hours attendances. This approach, however, may not be practical for remote and rural communities and alternative solutions might need to be considered.

Out of hours services in primary care are provided by a range of health professionals working locally in out of hours centres and within NHS 24. It is essential that consideration is given to the appropriate skill mix of staff, and thought given to the most effective and efficient use of the skills of the various groups of professionals.

Key recommendations:

1. The Scottish Government and NHS Scotland should do more to raise awareness and increase public understanding of the role of NHS 24 as the initial point of contact for out of hours services.
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.
3. NHS 24 should focus on improving its core business of call triage and integration with local services rather than planning further service expansion.
4. The current NHS QIS national core standards for out of hours services should be reviewed using the principles and methodology of the Scottish Government draft Quality Strategy.
5. Health boards should establish a local-multidisciplinary strategic group to review out of hours activity data and gather evidence of successful delivery models in order to improve current out of hours patient care pathways.

The Way Ahead: Reducing Health Inequalities

Introduction

A desire to address health inequalities has been a key theme of health policies announced by governments in the UK. Increasingly primary care is seen as a crucial operational setting in which to address such inequalities. This section of our consultation received the most responses although there is very little consensus on how a reduction in health inequalities can be achieved. This is a reflection of the national challenge that successive governments face in addressing inequalities.

Poor health is often a result of inequalities in other areas of life such as inadequate housing, poor educational achievement and unemployment. Research shows that people who are most affected by societal inequalities related to factors such as low income, gender, social position, ethnic origin, geography, age and disability are more likely to have poorer physical and mental health than the general population.

A major cause for concern is that inequalities in health status are increasing within Scotland (as seen, for example, in significantly greater increases in life expectancy in more affluent parts of Scotland compared to the least affluent).²⁸ Thus, the narrowing of this gap is now one of the main aims of the health improvement challenge in Scotland.

The challenge for primary care is that services are needed and delivered disproportionately across the population, but those with the poorest health and the greatest need often have the most difficulty in navigating their way through the health care system. This may be, for example, through lack of knowledge as to how to get the best out of the system, a lack of understanding of how and why poor health occurs, or a lack of confidence or power in negotiating the care that they need. This can make it difficult for practices to get patients to turn up to appointments regularly or can lead to poor compliance with treatments. All of these can, in turn, result in poor health outcomes which subsequently create further difficulties and strains for patients, services and practitioners.

The 'inverse care law' is the principle that the availability of good medical or social care tends to vary inversely with the need of the population served.²⁹ Research suggests that the inverse care law is still evident in Scotland. A 2007 study of primary care encounters in deprived and affluent areas of Scotland concluded that 'poorer access, less time, higher GP stress and lower patient enablement are some of the ways that the inverse care law continues to operate within the NHS and confounds attempts to narrow health inequalities'.³⁰

Consultation Responses

At the time of the BMA's consultation on 'The Way Ahead', the Royal College of General Practitioners held a special event for 100 GP practices working in the most deprived parts of Scotland. The report of this meeting provides valuable insight into the demands and pressures faced by GPs working in these practices, and has been considered in developing this final report.³¹

Doctor/patient consultations in deprived practices are characterised by:

- High demand
- Short time available
- Greater psychological and physical morbidity
- More multi-morbidity
- Less self management reported by patients with complex problems
- Greater GP stress

GPs working in these practices believe they have insufficient time and other resources to address the volume of need and demand.

Identifying and reducing health inequalities

The original consultation document focused on deprivation as the primary source of health inequalities. Respondents highlighted a range of factors that contribute to inequalities such as:

- Ethnicity: for example, the prevalence of cardiovascular disease and diabetes is much higher among Scottish South Asians.³²
- People with complex communication needs/learning difficulties/mental health issues: for example, people with learning disabilities and people with mental health problems are more likely to have significant health risks and major health problems.³³
- Long term conditions: around a quarter of people with a long term condition in the UK live with three or more conditions.³⁴ Long term conditions account for around 80% of GP consultations.³⁵
- Remote and rural areas: there is evidence that the remote rural population of Scotland appears to have experienced the greatest rise in health inequalities, particularly in recent years.³⁶
- Carers: research shows that unpaid carers experience greater health inequalities compared with the general population.³⁷

Funding

Central to any strategy aimed at tackling health inequalities through general practice has to be the allocation of resources according to need. Many studies have shown increased GP workload in practices in disadvantaged areas. This has been evidenced in terms of higher disease prevalence rates, increased co-morbidity rates, increased demand for home visits and increased number of multiple problems (especially mild-moderate mental illness) in patients attending GP consultations in these areas.³⁸

Some respondents to our consultation believe that additional funding is needed to help practices working in areas where inequalities are greatest. It is recognised that in the current economic climate it is unlikely that extra funds will be available, but funding cannot simply be taken from other practices. It will be important to find cost neutral solutions, where possible, when addressing the issue of health inequalities.

GPs attending the RCGP event identified where differences could be made to prevent patients falling through gaps in the system (eg patients with combined mental health and addiction problems). By delivering services locally in a location familiar to patients, attendance and continuity of care could be improved.

Quality and Outcomes Framework (QOF)

The QOF was introduced in April 2004 as part of the GMS contract. This is essentially a target-based system where practices are funded based on performance. Almost all of the points relate to evidence-based clinical interventions proven to benefit patient outcomes. The framework has, in particular, delivered benefits to patients with long term conditions, including chronic heart disease, asthma and diabetes.

The QOF has been a very successful element of the new GMS contract and has led to all patients across Scotland having access to a consistent standard of treatment irrespective of where they live. Practice achievement of points is as high in practices in deprived areas as for practices in more affluent areas. Research shows that, following the introduction of the QOF, GPs are delivering dramatic improvements to the care and treatment of patients with long term conditions, reducing hospital admissions and saving lives.³⁹

For example:

- The QOF is helping to reduce inequalities, ensuring that patients get consistent evidence based care wherever they live.
- Hospital admissions for patients with asthma have been reduced.⁴⁰
- The QOF is improving the management of diabetes, which when uncontrolled can lead to cardiovascular disease, blindness and kidney failure.⁴¹
- Improved blood pressure monitoring and control can prevent 43,000 strokes and 83,000 cases of ischaemic heart disease across the UK.⁴²
- In Lothian, the QOF is considered a significant factor in reducing admission rates for heart attack, stroke and type 2 diabetes.⁴³

These are all conditions which have a higher prevalence in deprived communities and therefore the impact on improving patient outcomes is proportionately greater for this group.

More than half of GPs and a quarter of responses from health organisations and charities particularly commented that the QOF is a success and should be protected and further developed. However they also highlighted the need for certainty and consistency of QOF funding in order to plan services for the longer term.

Key priority areas:

1. Reduce health inequalities.
2. Quantify the extent of unmet need.
3. Early detection, preventative and anticipatory care.
4. The quality and outcomes framework as a means to address health inequalities.
5. Continuity of care.

1. Reduce health inequalities

General practice is only part of a solution to reducing health inequalities. There is significant unmet need amongst the most vulnerable people in Scotland.⁴⁴ In order to address this we must ensure that, as a minimum, everyone has equitable access to existing mainstream healthcare services. Furthermore, respondents to the consultation believed that additional support services should be available to those practices in the areas of greatest need and that multi-disciplinary working be developed to ensure that there is full collaboration from all health and social care providers. Much more work needs to be done to co-ordinate activities with other organisations to develop reliable, integrated schemes to successfully and consistently reduce health inequalities. To achieve this it is vital that more schemes that aim to provide co-ordinated help in this area are adequately piloted.

Community Health Partnerships (CHPs) have the potential to provide a key role in co-ordinating services in local areas where inequalities exist. These organisations have been established specifically to bridge the gap between primary and secondary care and health and social care. The effectiveness of CHPs across the country is variable. The Scottish Government is currently reviewing the role of CHPs and SGPC would welcome the opportunity to engage in this process.

Whilst we recognise that health services have an important role to play in reducing health inequalities, this can only be as a part of a wider approach and must be seen in the context of the efforts required elsewhere to address broader inequalities. Ultimately, despite the introduction of initiatives such as the national minimum wage, new deal, and tax credits, it is only with greater redistributive policies targeted at poverty and income inequalities that we might expect to see a sustained reduction in health inequalities. Until such a time, primary care will continue to strive to address a limited range of the causes of health inequalities and their effects, but can do little more than ameliorate many of the wider impacts of socio-economic inequalities on the health of the population.

2. Quantify the extent of unmet need

Following the introduction of the QOF and the subsequent work done by practices to identify and manage patients with conditions such as diabetes, high blood pressure and asthma, practices have been able to identify a number of patients who would otherwise have not accessed GP services.

Work to identify the nature and extent of unmet need must be brought together as a matter of urgency, so that a strategy can be developed to reduce it. The RCGP initiative to bring together GPs from the 100 most deprived areas of Scotland has identified key characteristics of the demands placed upon practices in these areas. Further research to analyse how this increased workload impacts on practices serving the deprived populations of Scotland would be welcomed.

3. Early detection, preventative and anticipatory care

Good quality anticipatory and preventative care delivered to an individual by a professional with whom they have a long term clinical relationship is a good starting point for addressing inequalities. There is a need to consider the development of innovative ways to specifically address deprivation related health issues. These could be through the roll out of evidence-based targeted health screening programmes. Developing enhanced services (ES) is a useful way of doing this. For example, with high rates of teenage pregnancy and sexually transmitted infections in areas of deprivation, an ES could provide a targeted approach to provide more community based sexual health education and advice. With any such approach, there should be robust analysis of the cost effectiveness and clinical outcomes of projects designed to reduce health inequalities.

4. The Quality and Outcomes Framework (QOF) as a means to address health inequalities

Over the five years that the QOF has been in existence the national prevalence rate of certain diseases has gone up, demonstrating both the true increase in chronic disease associated with demographic changes, and also that the QOF is encouraging practices to actively identify those patients with pre-existing conditions who had not historically come forward. By establishing a uniform standard of care across all practices and across many disease areas (some of which will be higher among lower social economic groups) the QOF contributes to a reduction in health inequality.

Additionally, the introduction of QOF has allowed the collection of a significant clinical evidence base that can help to inform the wider debate on health inequalities.

The QOF has been shown to improve the care of marginalised and disadvantaged groups. Recent changes to QOF payments are intended to improve funding for practices with the highest levels of disease prevalence. However, it is clear that increased resources to practices in deprived areas should not be at the expense of other practices and their patients.

GPs responding to our consultation believed that the QOF should be protected as a mechanism to support the additional resources needed to actively pursue the many patients who do not easily take part in preventative work. The QOF is challenging the inverse care law in that practices in deprived communities are achieving QOF targets in line with practices in less deprived and more affluent areas of Scotland. If key health 'targets' are removed from the QOF on the assumption that they have become 'routine practice', then the universal standards upon which the Framework is based will be undermined and care will become variable. There is a very real risk that the withdrawal of QOF funding will make it impossible to challenge the inverse care law.

5. Continuity of care

Respondents to the consultation considered that continuity of care and the ongoing trust of patients are critical to the work of GPs, particularly when it comes to discussing with patients many of the wider and less tangible lifestyle issues that affect health inequalities. It is therefore essential that continuity of care is preserved within the context of the practice. This will largely be done by recruiting and retaining GPs and wider practice teams.

GPs tell us that recruitment of younger GPs to areas with high levels of deprivation is difficult with existing incentives. Developing general practice premises with more space and resources, allowing a wide range of health professionals to provide a wider range of services available in familiar surroundings may help patients access care and also help alleviate some of the pressures faced by GPs working in more challenging communities, often in isolation.

When considering strategies to help reduce inequalities it is essential to consider the impact of providing care in areas of high deprivation on the local practice workforce. Staff turnover in deprived areas can be high and practices may experience difficulty in attracting and retaining experienced professionals. Where this is a problem, the need to maintain seamless, high quality services to patients can place a significant burden on remaining staff.

The Scottish Government's Draft Quality Strategy⁴⁵ promotes a model of patient centred care where 'all staff, patients and carers can report that they are supported to work together in a relationship which recognises their needs and plans to deliver care to meet those needs'. This requires a shift towards 'relationship-based care' where collaborative decision making is developed and introduced that reflects individual circumstances.

Recommendations:

1. Health boards should encourage greater joint working between health and social care to address health inequalities.
2. The Scottish Government should provide additional support for GP practices in areas with the highest need.
3. RCGP Scotland should consider conducting further research to quantify the increased workload and needs impact in areas of deprivation.
4. Health boards should focus on a preventative approach to health with the development of local, evidence based, enhanced services appropriate to the area's needs.
5. The Scottish Government and NHS Quality Improvement Scotland should ensure that the QOF is supported by adequate and consistent funding and remains comprehensive and evidence based.
6. The Scottish Government should develop measures to improve recruitment and retention of GPs in areas with the poorest health outcomes.

The Way Ahead: The Balance of Care

Introduction

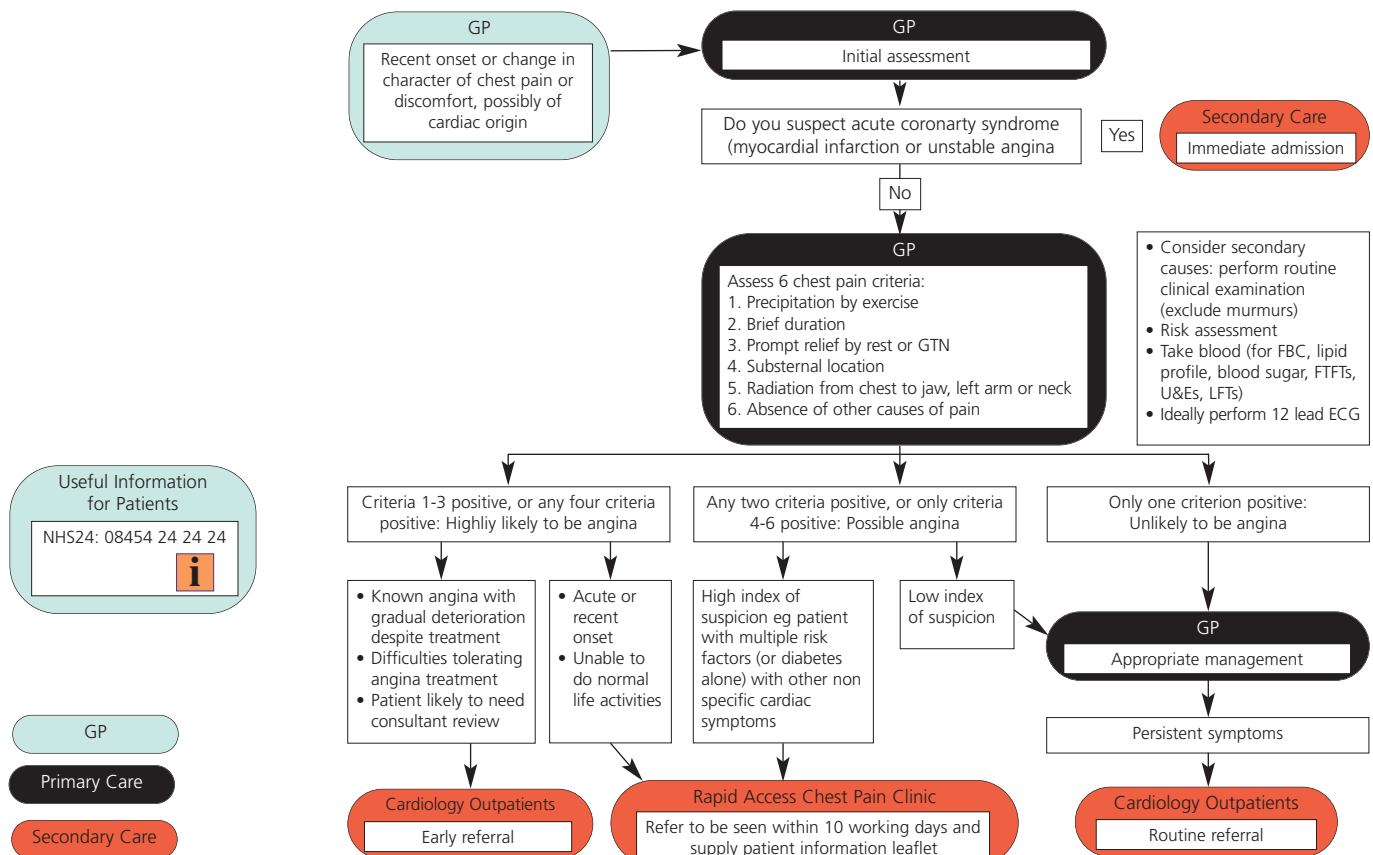
Successive government health policies⁴⁶ have rightly put the patient at the centre of service planning and delivery, also known as the 'care pathway'. This forms an essential part of driving quality care as close to the patient's locality as possible. However, while this may be the aspiration, the NHS works to a fixed budget with limited resources and this is not always possible. It is acknowledged that modernising healthcare requires services to be designed around the needs of the patient, but within existing available resources.

An essential part of the Scottish Government strategy *Better Health, Better Care* is to make secondary care services more efficient and this has required a 'redesign' of hospital care. Waiting times for secondary care treatment are a key measure of NHS success and as such are politically important. Recent initiatives, including the 18 weeks Referral to Treatment programme (RTT), have placed the focus on streamlining the processes involved from GP referral to hospital treatment.

These processes make up what is known as a Patient Care Pathway which describes the route that a patient will take from their first contact with an NHS member of staff to the completion of their treatment (see figure 1).

Figure 1: Cardiology – Chest Pain Patient Pathway June 2005

Source: NHS Scotland Cardiology Patient Pathways (accessed via the SHOW website: www.pathways.scot.nhs.uk/cardiology.htm)



Consultation Responses

Health organisations and the public agreed that it is desirable to provide care closer to home and there was a view that general practice was capable of delivering the shift in the balance of care, with recognition that this could only be done by increasing capacity and providing appropriate funding.

Respondents generally acknowledged that the balance of care and patient pathways are currently less than optimal and many people identified the need to achieve a better balance of care. It was considered that a whole system approach was required and that this should involve primary and secondary care clinicians, health service managers and social care.

While a systematic review of how to provide healthcare in Scotland (such as the 18 week RTT) is appropriate, it is essential to consider the implications for services in all parts of the NHS.

Key priority areas:

1. Involving clinicians in clinical pathway development.
2. Resources available to support shifting the balance of care.
3. GP referral patterns.
4. Communication and sharing of information between primary and secondary care.

1. Involving clinicians in clinical pathway development

Streamlining clinical pathways and the referral process involves an analysis of the patient journey for a single episode of care. A review of how patients access a particular service often highlights inefficient processes which create waste as well as adding to the length of time that a patient will have to wait for treatment. By rationalising these care pathways and removing processes or stages that add little value to the outcome, reductions in waiting times for treatment can be achieved.

Patient care pathways can be developed so that care can be delivered by a range of health professionals, eg specialist nurses and avoid unnecessary duplication. The use of IT can also speed up previously paper-based bureaucratic processes and free up time previously spent on paperwork. These are just two examples of how redesigning and modernising systems in hospitals are working to reduce patient waiting times.

However a review of a pathway may also identify care processes that can take place before or after the patient is admitted to the hospital which in turn will impact on primary care services as additional new activities are transferred to general practice and community based services (see examples in figure 2).

Many of these changes can make secondary care in hospitals more efficient and lead to improvements for patients. However, the capacity for general practice to absorb this additional work has probably already been reached unless further resources (staff, premises, funding etc) are made available. Analysis of the additional workload created by this shift in the balance of care should be undertaken and a mechanism developed to ensure that there is capacity outside of hospitals to deliver these new activities.

There are various structures within primary care that have the capability to help transfer services from hospitals into the community setting. For example, greater use could be made of community hospitals for pre-hospital investigations or out of hours admissions. The community hospital model could also be adapted for the urban environment to provide a locally based treatment centre. Hospital-based specialists could deliver more community-based clinics to provide post-operative and other services to patients.

Figure 2: Some examples of shifting care include:

- Pre-referral investigations carried out in general practice in order to comply with referral management protocols. For gall bladder surgery patients, for example, it might be expected that the GP will have organised an ultrasound scan and carried out a series of blood tests before referral.
- A requirement for GP referrals to meet inclusion and exclusion criteria. Such criteria are increasingly used by some mental health services many of which will only see patients who meet their criteria. This process can delay referrals and patients can find that they are denied treatment if they do not fit the criteria, eg patients with both addiction and mental health problems.
- Reduced follow-up in secondary care. There has been a reduction in the number of patients brought back for review appointments at hospital out-patient departments.
- Day case surgery is increasingly becoming the norm for many procedures to reduce bed occupancy, which often means that any post operative problems are managed in primary care.
- Rather than have blood tests carried out at a hospital clinic prior to an outpatient appointment, it makes sense to have them carried out a few days before so the results are available at the clinic. Understandably patients want such tests carried out locally to avoid unnecessary travel but general practice does not have the staff or other resources to do this.
- Investigations are sometimes required prior to a patient being admitted to hospital for an elective procedure (if this is not carried out as part of a preadmission assessment by the hospital service).

2. Resources available to support shifting the balance of care

The Auditor General's annual review of the NHS in Scotland⁴⁷ reported that resources within the NHS are still balanced in favour of the hospital sector. It reported that there was limited evidence of any large-scale transfer of resources, including finance and staff, from secondary to primary care. This is not surprising, as shifting the balance of care is a complex issue. Both primary and secondary care services are under pressure to meet increasing patient needs. Government should work with healthcare professionals to identify areas where services can be redesigned to facilitate a shift in the balance of care.

Over the period 2004/05 to 2006/07, the split of spending between the various sectors of the NHS was: hospital services 60%; community services 13%; and family health/GP services 27%. There has been little change to the proportion of resources allocated in subsequent years.

3. GP referral patterns

Analysis of GP referral is a complex issue. The range of patients seen and the services available vary across the country and this affects individual GPs' referral patterns.

There is a need to understand better the variations in referral patterns between different general practitioners. If it is possible to meet patient needs without referral to specialist services, this will help hospitals address their waiting time targets without compromising patient care and will reduce NHS costs. As a gateway to hospital clinical services, it is essential that general practitioners are able to refer patients who would benefit from specialist hospital services. It is important that referral management services are not used as a method for reducing the workload of hospital

services by restricting access for patients. However, as the hospital component of patient care takes up large amounts of the NHS resource, it is essential that general practitioners carefully consider how and why they refer patients to specialist services.

In the first instance, general practitioners should be given accurate information about their referral patterns in comparison to other local general practitioners and also to national averages. Improved direct access to investigations by general practitioners could reduce the need for referral to secondary care. There are examples where the introduction of a Local Enhanced Service has provided a service more locally and reduced the need for hospital referral.

4. Communication and sharing of information between primary and secondary care

Community Health Partnerships (CHPs) were established in 2004 as a means to improve the delivery of health and social care in the community and create greater integration between primary and secondary care. These organisations should have become the cornerstone of the strategy to deliver more care closer to patients' homes. It was initially intended that these organisations would be clinician led and supported by managers; they would reduce bureaucracy and devolve responsibility and decision making to front line organisations working with patients, thus ensuring that services were tailored to local demand. Unfortunately, following their introduction, it appears that in some areas they have become largely management-run, bureaucratic organisations whose main responsibility is to roll out centrally driven initiatives. Subsequently they have failed to gain the support of general practitioners, many of whom feel completely disengaged from these organisations.⁴⁸

The Auditor General has also recognised the lack of integration between health and social care services, particularly in terms of transparency over budget sharing arrangements.⁴⁹ The Auditor's review criticises the lack of evaluation of joint working arrangements. The Scottish Government is currently undertaking a review of CHP arrangements and it is essential that clinicians in both primary and secondary care are consulted before any recommendations are taken forward.

Key recommendations:

1. The Scottish Government and NHS Scotland should promote clinical leadership in the redesign of services.
2. The Scottish Government and NHS Scotland should encourage and support joint working between primary and secondary care healthcare professionals on the redesign of patient pathways to achieve the optimum balance of care (including emergency admissions).
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.
4. The Scottish Government should commission research into reasons for variation in referral rates to help inform service redesign and lead to improvements to training and education.
5. Healthcare professionals should lead the development of Community Health Partnerships.

The Way Ahead: The Right Workforce

Introduction

NHS workforce planning should be based on the premise that patients should have access to the same high standard of service provision across Scotland, delivered by appropriate numbers of trained general practitioners, in collaboration with other skilled health professionals.

The way in which primary care in Scotland is organised has changed radically in the 21st century, profoundly affecting both the GP workforce and impacting on workforce planning. The introduction of the new General Medical Services contract (GMS) was, in part, a response to a growing crisis in recruitment and retention in general practice. At that time, fewer medical school graduates were choosing a career in general practice; the proportion of GP principals aged under-35 in the workforce in Scotland fell from 24.6% in 1990 to 12.4% in 2002. Over the same period, older doctors were choosing to retire early, as the proportion of those aged over 60 more than halved from 7.1% to 3.1%.⁵⁰

For the purpose of this report the term workforce encompasses the general practice team, currently defined by Information Services Division Scotland (ISD) as all GPs (including locums and GP trainees), and practice-employed clinical staff, which includes practice nurses and also health care assistants and phlebotomists.⁵¹

Since 2004 there has been a 10.9% increase in the number of GPs working in Scotland. However, this information does not provide the full picture of the workforce as it measures the headcount of GPs contracted to work in Scottish practices, and does not reflect the sessional commitment of GPs and will therefore not recognise the sharp rise in numbers of general practitioners working less than full time. Another significant trend is the increase in the overall percentage in the number and proportion of salaried GPs, an increase of 155.3% since 2004 (from 188 to 480).⁵² A third major workforce trend is the continuing feminisation of the GP workforce, with 50.7% of contracted GPs being female, compared to 45.4% in 2004.⁵³ This trend is likely to continue as more than 60% of medical school entrants are female.⁵⁴

A study in 1999 identified a growing crisis in GP recruitment and retention stemming from the changing social composition of the workforce, the large proportion of qualified GPs significantly under-utilised within traditional career structures and the problems of matching labour supply and demand at a local level.⁵⁵ These indicators are still relevant in 2010, and there needs to be a co-ordinated long-term strategy to organise workforce planning for primary medical care in Scotland. The change in the balance of care, as outlined in current Government policy (*Better Health Better Care*) indicates that the role of general practitioners will encompass increasingly more complex work delivering locally based services to those with complex care needs.⁵⁶ The delivery of high quality primary healthcare in Scotland depends on the development of a sustainable highly trained, committed and motivated workforce.

Consultation Responses

The consultation responses highlighted a broad consensus across all respondents that an appropriate workforce in Scotland must be developed and sustained, with many respondents calling for more robust workforce data collection. All sectors supported the need for stability of long-term funding to allow practices to plan with certainty and make informed choices about the appropriate composition of practice staff.

There was a strong response from general practitioners that the GP partnership model for general practice should be actively supported and promoted, and that partnership opportunities should be increased through financial stability and incentives to existing partnerships, to take full advantage

of the flexibility of the independent contractor model. The consultation responses noted the importance of partnership working with other health professionals and the need to create an appropriate skill mix. All practice staff should have access to development opportunities including attractive career paths developed for practice administrative staff.

The need to maintain and strengthen the primary healthcare team was a recurring theme in responses, and a multi-disciplinary approach to primary healthcare teams based in general practice is considered essential. The 'Review of Nursing in the Community' and recent efforts to review the working patterns of health visitors in Glasgow were identified by some respondents as potentially destabilising the primary healthcare team, and there were calls for the Scottish Government to work directly with GPs and other professional groups on workforce planning in the future.

Key Priority Areas:

1. Robust and reliable workforce data.
2. Stability of funding to enable long term planning for GP services.
3. The partnership model of general practice.
4. Encouraging medical graduates to enter general practice.
5. Increased training opportunities in rural areas.
6. Developing and supporting primary healthcare teams.

1. Robust and reliable workforce data

Since the introduction of the GMS contract in April 2004, there has been a lack of routinely available management data in terms of workload, numbers and activity to support primary care workforce planning. In 2009, NHS Scotland published the findings of a national primary care workforce planning survey which has captured valuable information on current workforce numbers and the working patterns of GPs and Practice Nurses in Scotland.⁵⁷ Despite the publication of these data, there remains a lack of clear information about GPs exclusively working as locums in Scotland and work should be undertaken at a national level to establish robust and reliable information in this area.

There are a number of significant trends in the GP labour market which have major implications for the development of the workforce. The number of female GPs contracted to work in Scottish practices has risen by 23.8% between 2004 and 2009 compared to a 0.2% increase for males over the same period.⁵⁸ Linked with the overall feminisation of the medical workforce is the sharp increase in part-time working in general practice. There is clear evidence that the proportion of GPs working on a part-time basis continues to rise. The BMA carried out a survey of GP opinion in 2007 which found that 30.9% of GPs described themselves as working part-time.⁵⁹ According to the 2009 primary care workforce survey, patterns of sessional commitment differ significantly by gender, with females much more likely to have a relatively lower sessional commitment on a weekly basis. Nearly 80% of male GPs surveyed had a sessional commitment of eight or more per week, compared with only 27% of females. This clearly underscores the long-term trend.⁶⁰ It is widely assumed that the increase in the proportion of women entering the profession, coupled with an increase in portfolio medical careers and broader societal trends among male and female GPs will lead to a significant increase in patterns of part-time working.⁶¹ This may potentially result in a further shortfall of GP availability in the future if current work patterns and recruitment levels are maintained.⁶²

In order to accommodate these new working patterns, there must be a full range of career options available which are flexible and offer personal professional development and satisfaction. Workforce planning and establishing numbers of trainees is highly dependent on accurate assumptions around

future working patterns, career choices, and part-time working. It seems clear from these patterns that there may need to be increased numbers of trainees to replace GPs who are retiring. The increased drive towards portfolio careers, which do not conform to the traditional full-time career, feminisation of the work-force and early retirement plans mean that detailed further research is required to establish these trends and help the process of future workforce planning.

2. Stability of funding to enable long term planning for GP services

There was a general recognition in consultation responses of the need for practices to have stability of funding which underpins many of the key areas of workforce planning. Practices require long-term certainty about future funding in order to make informed decisions about developing new services tailored to local circumstances and employing the appropriate practice staff member or GP partner to deliver these services. Currently new funding in general practice is largely based on short term enhanced services contracts. This was seen as unhelpful and short-sighted, and does not help the sustainability of practices. Practices need guaranteed long-term income streams in order to create stability that will allow them to plan ahead and develop the appropriate workforce.

3. The partnership model of general practice

GPs responding to the consultation were unanimously concerned about the trend for decreasing GP partnership opportunities across the UK. Contract changes in 2004 and subsequent uncertainty in practice funding has reduced the incentive to recruit partners. In its 2009 Manifesto *Standing up for doctors, standing up for health*, the BMA has called for measures that will encourage practices to offer more GP partnerships, especially in under-doctored areas. It has also called for greater consideration to be given to how funding for primary care can be targeted to provide greater support for new and growing practices.⁶³

The partnership model for general practice should be promoted as it offers the best model for delivering continuity of care, flexibility, and a long term commitment to the locality and the strategic development of the practice. Continuity of care is highly prized by patients and recent studies have shown that while access is important, patients value the quality of clinical care and the continuity of care, which becomes even more important with the increasing complexity of health care issues, the management of chronic conditions and anticipatory care.⁶⁴

Current workforce data reveals an ageing GP workforce,⁶⁵ and it is critical that there are succession planning strategies in place for practices with a greater proportion of younger GPs involved in the planning and delivery of services, especially in remote and rural areas.⁶⁶

GP practices therefore need to be able to undertake long-term succession planning. The current lack of career choice is damaging for the long-term future of general practice, and consideration should be given to contractual incentives to encourage practices to appoint partners. There is a need for a co-ordinated review of GP workforce planning arrangements in Scotland to address the current lack of partnership opportunities and to secure the workforce required to provide and develop future general practice.

4. Encouraging medical graduates to enter general practice

Prior to the introduction of the GMS contract in 2004, recruitment to general practice had been a major source of concern, and it is worrying that the overall number of applicants to GP training from UK Foundation Trainees was significantly lower in 2009 than it has been in previous years.⁶⁷ Failure in the future to recruit high calibre medical graduates to general practice training will significantly impact on workforce capacity and the ability to deliver a sustainable high quality

service across Scotland. Consideration is currently being given to extending general practice training to a five year training programme as recommended in the Tooke report into the future of postgraduate medical training,⁶⁸ and is supported by the BMA.

Following the introduction of 'Modernising Medical Careers' which updated medical training in the UK, junior doctors wishing to pursue a career in general practice now spend increased time in training practice placements. This offers great potential to improve training and learning opportunities but it creates additional pressures and increased workload for the GP practices that deliver training. Should GP training be extended to five years, then the implications for training practices will need to be fully considered.

5. Increased training opportunities in rural areas

Consultation responses indicated a desire among patient groups for a range of specialist skills to be available in GP practices, especially in remote and rural areas, where there is a long-term issue about sustainability. It is important that educational training programmes incorporate appropriate remote and rural placements, particularly at an early stage in a doctor's career, which may include more training opportunities in rural practices. The GP Rural Fellowship Programme also offers recently qualified GPs a further year of supported training in rural practice which gives GPs the opportunity to develop a career in rural practice. This may encourage more doctors to choose to continue their careers in remote and rural areas and could help with recruitment in these traditionally difficult to recruit areas.

6. Developing and supporting primary healthcare teams

Many consultation responses noted the importance of the practice team and the wider primary healthcare team in delivering high quality general practice services and the importance of adequately resourcing the ongoing training and development of all practice staff. Since the introduction of the GMS contract the role of practice staff has developed, with practice nurses playing a significant role in helping practices successfully achieve the requirements of the Quality and Outcomes Framework through chronic disease management and anticipatory care.⁶⁹ As general practice continues to take on additional responsibilities for the prevention and management of long term conditions GPs, as leaders of a practice team and as employers, combine expertise with willingness to take responsibility and manage risk. The primary healthcare team, including 'attached' community staff such as health visitors, must be focused on a general practice population. Patients should receive co-ordinated care from the most appropriate member of the practice team, reflecting the increased complexity of the work done in general practice. Primary healthcare teams should include or have close links to local authority staff providing services to the same people. With an increasingly elderly population, the primary healthcare team needs to seamlessly merge health and social care for their patients.

This vision of a fully developed primary healthcare team fits in with Government policy which calls for effective leadership to tackle workforce challenges together with the importance of multi-disciplinary and multi-agency team working.⁷⁰ GPs should be encouraged and supported to take a leadership responsibility to develop effective and appropriate teams.⁷¹ It is important to ensure that there is continuity of development of practice staff and that there is no crisis in recruitment and retention of practice nurses. There must be clear pathways to develop practice staff, including the development of an integrated national approach to practice nurse competence based training, recognised and supported by the Royal College of Nursing, as referred to in the RCN guidance on good employment practice.⁷²

Key recommendations:

1. The Scottish Government should continue to regularly review primary care workforce data and trends to inform planning.
2. NHS Education for Scotland should support practices to further develop and promote the skills of the primary healthcare team.
3. The Scottish Government should establish reliable information about locum GPs working in Scotland.
4. The Scottish Government should create a working group to consider measures, such as contractual incentives, to encourage practices to take on partners.
5. NHS Education for Scotland should create more training placements in remote and rural practices.
6. NHS Education for Scotland should review contractual arrangements for the employment of GP Specialty Registrars in their general practice placement.

The Way Ahead: Infrastructure (Premises and Information Technology)

Premises

Introduction

GP premises must provide a safe environment for practice staff to deliver care to patients and to train GPs and other health professionals. As general practice evolves, adequate and flexible premises are essential for practices to develop a wider range of services for their patients. This is particularly true for practices in urban deprived communities and remote and rural areas of Scotland.

Pressure on Scottish GP premises, many of which are in need of replacement or re-development, is growing:

- Scotland's population is rising⁷³
- GP practice consultation rates are increasing⁷⁴
- new training requirements require GP trainees to spend 50% more time in general practice⁷⁵
- the GMS contract has introduced additional and more specialised workload
- the additional range of services demanded of general practice as a result of the 'shifting the balance of care' agenda.

A UK-wide BMA survey in 2007 demonstrated that nearly 70% of GP practices wished to extend or build new premises within the preceding 5 years.⁷⁶ A similar survey, focused specifically on GP premises in 2006, revealed that nearly 60% of respondents stated that their premises were not suitable for their present needs and three quarters felt that their premises were not suitable for their anticipated future needs.⁷⁷ These surveys highlight a fundamental problem in primary care: many GP premises are not fit-for-purpose and are insufficient to allow practices to absorb additional work or develop their services.

There is also a need for new premises in areas with major housing developments or substantial population rises. At present there is no established process for identifying areas that require a new practice to be built or funding available for building necessary premises. Furthermore, the current GMS contract is not suitable for funding a new practice (with a small but growing patient list) because funding is largely dependent on the number of registered patients. A new GMS practice would likely need additional funding for fixed costs in the early stages. There should be a requirement for town planning procedures to consider the impact of new housing or expanding communities on local NHS services.

In the past, ring fenced funding was allocated to health boards specifically for GP premises support and development. However, since the introduction of the GMS contract in 2004 this funding arrangement no longer exists and other cost pressures have meant this area has been increasingly over-looked. The level of premises investment is now at the discretion of health boards.

Traditionally, GP partners in a practice owned their premises and were reimbursed by the NHS for the costs involved.⁷⁸ This arrangement continues to be the most common mechanism for funding established practice premises.⁷⁹ However, applications for new GP owned premises are entirely at the discretion of health boards. Currently, the Scottish Government focus for premises development is the HUB programme, which is dependent on public and private sector funding and is not limited to GP premises but encompasses all local authority/health board joint premises (including health, social care, sports facilities, libraries, etc). The HUB programme is still in its infancy and whether this programme will be a success remains to be demonstrated.

Consultation responses

There was a strong view from a wide spectrum of respondents including GPs, the public, NHS organisations, and other health organisations/charities that many existing premises are inadequate for current purposes and unsuitable for future developments. It is also clear that premises funding is under threat and needs to become an increased priority.

There was support, primarily from NHS organisations, for the co-location of GP practices with other services (diagnostic, specialist services, social services and allied health professionals). However, from the responses it was also clear that there was support for standalone GP premises being funded where necessary and appropriate.

It was noted by some respondents that proposed new housing developments should require an assessment of primary care provision in the area and that necessary premises should be considered from the outset.

Some respondents were clear that traditional arrangements for funding GP owned premises developments should be given greater priority and remain a viable option in the future.

Key priority areas:

1. GP premises must be able to meet current and future needs of general practice.
2. The range of funding arrangements available to support a variety of premises development.
3. National arrangements to ensure new GP practices are built where required.

1. GP premises must be able to meet current and future needs of general practice

GP premises funding should be given a greater priority to ensure there exists adequate infrastructure to support general practice. Without greater investment in primary care generally, which is unlikely in the current economic environment, funding priorities need to be established and current primary care funding arrangements for health boards need to be reviewed. Consideration should be given to reinstating ring-fenced premises funding to ensure central funds are being used to establish and develop premises. Health boards must prioritise premises development for those practices with the greatest need, even if there are considerable obstacles in place. Inadequate premises limit the ability to transfer work to general practice, an essential part of the Scottish Government's shifting the balance of care agenda.

2. The range of funding arrangements available to support a variety of premises development

Different areas and GP practices have different premises needs. While premises must meet legal safety and accessibility requirements, what is required in one area or for one practice may not be suitable elsewhere. Joint premises should be built where appropriate but not to the exclusion of smaller GP premises where they are required. Funding arrangements must be flexible to meet local needs and local premises requirements. While the HUB programme is likely to have a role to play in future premises development it should not be the only route available for developing GP practices. Where appropriate, GP owned premises development should be supported. We recommend that the Scottish Government should review national policy on supporting premises development.

3. National arrangements to ensure new GP practices are built where required

As existing premises become overloaded with a rising population it is inevitable that new GP practices will need to be built in growing communities. The requirement for new premises needs to be assessed in a consistent manner across Scotland and there must be a national mechanism established to ensure that new premises are built where necessary. Availability of primary care services should be considered from the outset where new housing developments are planned. The Scottish Government, in consultation with relevant stakeholders, should establish a process for ensuring that new GP practices are built in areas where they are necessary. Consideration must be given to ensuring a new practice can survive in the early stages: additional funding may be necessary as the practice's patient list is growing. Legislation should be created to ensure that primary care services are considered where major new housing developments are planned.

Recommendations:

1. The Scottish Government should give greater priority to premises funding and a return to ring-fenced funding should be supported.
2. GP owned premises development must be maintained as a viable option where suitable for local needs.
3. The Scottish Government should establish a national arrangement for ensuring new premises are built where they are needed.

Information Technology

Introduction

Primary care computer systems are now essential to assist GPs and practice staff to deliver high quality clinical care to their patients. Practice staff also use IT systems to assist with auditing and planning anticipatory care, to book appointments, maintain patient records, and for sharing patient information with secondary care. General practice has adapted well to the use of new technologies and more than 90% of practices in Scotland are paperless or paper light⁸⁰ and rely heavily on their clinical IT system.

All GP practices in Scotland are entitled to choice of a health board provided clinical computer system.⁸¹ Currently GPASS, a clinical software system owned and operated by NHS Scotland, is used by the majority of GP practices in Scotland. The remaining practices use clinical systems provided by commercial providers. The GMS contract necessitates practices to be more dependent on computer systems in order to meet the requirements of the contract. The clinical computer systems record chronic disease management information about patients and can remind the clinician of opportunities to improve the patient's health when they attend for an appointment. In addition, these systems record and report information required for the quality and outcomes framework and then calculate the payment due to each practice based on achievement in relation to targets. By 2006, however, it was clear that GPASS was not meeting the needs of GPs and the Scottish Local Medical Committee Conference called for GPASS to be replaced.⁸²

Following a subsequent review by Deloitte in 2006⁸³ the Scottish Government made the decision to discontinue GPASS. Procurement to replace GPASS with commercial systems began in July 2009. It is expected that GPASS will no longer be used in Scottish practices after March 2012 and it is likely that practices that have been using GPASS will migrate to established accredited commercial systems.

Information sharing between primary and secondary care is crucial for ensuring effective and safe patient care in a variety of settings but there are considerable concerns about patient confidentiality through insecure information sharing both within and between primary and secondary care. GPs are often frustrated that they are not informed when a patient's medication is changed or discontinued in secondary care. Conversely, secondary care clinicians are similarly frustrated with their lack of ability to access information on current medications and allergies. Sharing of information can greatly improve patient safety and quality of care. However, care has to be taken to ensure that confidentiality is not sacrificed whilst improving the necessary and appropriate sharing of information.

In order to improve access to electronic information NHS Scotland's eHealth Programme is focused on establishing a Clinical Portal Technology. This 'electronic window' will allow clinicians and patients to access clinical information and NHS staff should begin to have access to Clinical Portal in 2010.⁸⁴ While the Clinical Portal will not be a single patient database it will allow clinical information held by a variety of existing systems and databases to be viewed and has the potential to dramatically improve information sharing between primary and secondary care, and with out of hours services.

Consultation responses

Responses relating to Information Technology focused primarily on the need for better information sharing between primary and secondary care. One example cited on multiple occasions was the need for hospital discharge letters to be promptly transferred electronically to GP practices.

Some responses focused on NHS IT generally, calling for improved systems across the sector. Other responses raised specific issues such as ensuring that GP clinical systems cater to the needs of practice attached staff (eg health visitors).

Key priority area:

Improved sharing of information between primary and secondary care in ways which maintain patient confidentiality and improve the patient's care

Improving the sharing of information between primary and secondary care will require progress in several different areas. Existing systems need to be used to their fullest potential. For example, software exists in Scotland for electronically transferring hospital discharge letters to practices.⁸⁵ However, this software is not utilised by all hospitals in Scotland. There is limited guidance outlining process and protocol for clinicians for sharing of information between primary and secondary care. We suggest that national guidelines should be developed, with clinician involvement, to ensure patient information is shared consistently across Scotland. Patient confidentiality requirements are not consistent for the wide variety of NHS IT systems and this should be reviewed on a national basis. The Clinical Portal should be supported by primary and secondary care clinicians and they must continue to be involved in its development. Doctors should have a greater involvement in the eHealth Programme more generally.

Recommendations:

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.
2. The Scottish Government should undertake a national review of data sharing and patient confidentiality across NHS IT systems.
3. BMA Scotland and the Scottish Government should encourage clinician involvement in the eHealth Programme and increase this where possible.

Glossary

Care Pathway

Care pathway describes the route that a patient will take from their first contact with the NHS to the completion of their treatment.

Community Health Partnerships

Community Health Partnerships are sub-divisions of health boards and have the following remit within their locality:

- to deliver primary care services, including community-based specialist services such as mental health and sexual health services
- to work with social services to provide integrated care
- to promote health improvement
- to influence strategic planning, including the primary-secondary care interface

Enhanced services

Enhanced services form part of the 2004 GMS contract. These are contracts for services that are outwith the essential services provided by practices under the GMS contract. Practices can opt in to provide these services. Enhanced services are further categorised into three areas:

Directed enhanced: these are nationally developed services that must be provided by health boards, for example flu vaccinations or services for known violent patients.

National enhanced: these services are funded at an agreed national rate and health boards will decide which services they want to commission for their area and in how many GP practices they will be provided, for example drug and alcohol misuse services, minor injuries, IUD contraceptive fittings.

Local enhanced: these are services that are developed in response to local needs and can be innovative local development schemes or pilots. Funding is negotiated locally between the health board and the local GP practices.

Extended Access Appointments

These are appointments made available in GP practices on weekday evenings, early mornings or Saturday mornings under the Scottish Government's Extended Hours policy.

GP portfolio careers

Increasing numbers of GPs are moving from a single fixed practice commitment to one where they provide a variety of health related work in a diverse range of locations, such as education, management or hospital services. This is termed a 'portfolio career'.

New General Medical Services Contract

General Medical Services (GMS) contract is the main, generic type of contract for general practices in Scotland. Approximately 87% of general practices operate under a GMS contract, which was introduced on 1 April 2004 and is often referred to as the 'new' GMS contract.

Primary Care

Primary care is the term for the health services that play a central role in the local community: GPs, pharmacists, dentists, optometrists and midwives. Primary care providers are usually the first point of contact for a patient. They also follow a patient throughout their care pathway.

Primary healthcare team

The primary healthcare team refers to groups of professionals delivering health services in the community at 'primary' or first points of contact within the health service. The Royal College of General Practitioners has identified a core primary healthcare team membership as consisting of general practitioners, practice nurses, community nurses, health visitors, practice managers and administrative staff. It may also be appropriate for other personnel, eg midwives, counsellors and psychiatric nurses to be members of the team.

Quality and Outcomes Framework (QOF)

The Quality and Outcomes Framework is part of the new General Medical Services contract. It measures a general practice's achievement against a set of evidence-based indicators, with payments made to practices on the basis of their achievements.

Secondary Care

Secondary care is defined as a service provided by medical specialists who generally do not have first contact with patients (accident and emergency being the main exception). Secondary care is usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

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- believes that GPASS has failed general practice and is not fit for purpose
 - considers the continuation of GPASS to be a poor use of public funds
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