Draft Budget 2018-19
RCGP Scotland

The Royal College of General Practitioners (RCGP) is the professional membership body for family doctors in the UK and overseas. The College is committed to improving patient care, clinical standards and GP training. Its objectives, in concern for care for patients, are to shape the future of general practice, ensure GP education meets the changing needs of primary care throughout the UK, grow and support a strong, engaged membership and to be the voice of the GP.

The College in Scotland came into existence in 1953 (one year after the UK College), when a Scottish Council was created to take forward the College’s interests within the Scottish Health Service. We currently represent around 5,000 GP members and Associates in Training throughout Scotland.

1. Do you consider that the Scottish Government’s health and sport budget for 2017-18 reflects its stated priorities as set out in the National Performance Framework, the LDP standards and the National health and wellbeing outcomes? If not, how could the budget be adjusted to better reflect priorities?

A serious funding deficit exists for general practice and through which general practice may fulfil its potential in achieving these goals. In the face of over a decade of consistent cuts to the percentage share of NHS Scotland spending being made available through which to provide general practice services, RCGP has been calling consistently for 11% of the annual budget of NHS Scotland to be delivered to general practice. In 2014, RCGP published a report compiled by Deloitte, entitled Under Pressure. In it, Deloitte illustrated how, by 2017, a funding gap of 25% would exist for general practice in Scotland, based on increases in consultation rates, and funding for general practice falling to 7.4% of NHS Scotland’s budget by 2017/18. With predictable consequences, funding for general practice in Scotland was allowed to drop to 7.4% by 2014/15 and in 2015/16 it stood at 7.2%. The funding gap for general practice is unsustainable. Action should be taken urgently to preserve patient safety by resourcing general practice with 11% of NHS Scotland’s budget.

There has perhaps never been a greater need for clarification in Scotland on the funding for general practice, and on the role and capacity of the wider multidisciplinary team.
The National Performance Framework, the LDP standards and the National health and wellbeing outcomes express many of the objectives which general practice’s Core Values deliver. Below is an outline of how those values and their desired outcomes rely upon increased funding for general practice services.

The National Performance Framework states, among other objectives, that:

- Our children have the best start in life and are ready to succeed
- We live longer, healthier lives
- We have tackled the significant inequalities in Scottish society
- We live in well-designed, sustainable places where we are able to access the amenities and services we need
- We have strong, resilient and supportive communities
- Our people are able to maintain their independence as they get older and are able to access appropriate support when they need it
- Our public services are high quality, continually improving, efficient and responsive to local people’s needs

For children to ‘have the best start in life’ their early healthcare is vital. GPs provide the essential first point of contact, continuity and co-ordination of care for children in the context of their communities, supported by the wider primary care team, and should be appropriately funded. If we are to live longer and healthier lives, out of hospital, GPs must be enabled not only to care for new episodes of illness but also to deliver long term co-ordinated care for long term conditions and indeed to assist patients to live healthier lives to prevent illness. If we wish to see the elderly maintain their independence and remain out of hospital or care for as long as possible then the central service through which to achieve that objective is general practice.

The ‘significant inequalities in Scottish society’ cannot wait for the efforts made to tackle their root causes to take effect on the health of the population. The results of inequalities are so profound in terms of health and wellbeing that funding must be made available as soon as possible through which to appropriately care for patients in areas of deprivation. In 2015, RCGP published a paper on Health Inequalities which contained six recommendations. One recommendation is particularly applicable to this consultation:

‘As part of a wider rebalancing of resources towards general practice, direct more NHS funding into GP and wider primary care services in those areas where health inequalities are currently worst.’

This action should be taken urgently.
Being able to access ‘the amenities and services we need’ extends to appropriate healthcare facilities and, in particular, general practices. The worrying trend of general practices closing and practices moving to ‘2C’ contract, whereby they hand back responsibility for their patients’ care to health boards, suggests that the crisis in the service is such that this amenity and service may not be available for all far into the future.

A community cannot be 'strong, resilient and supportive' without access to appropriate healthcare. However, communities across Scotland now face the prospect of losing general practices as a part of their own vital infrastructure. With the number of GPs planning to leave the profession likely to exceed those coming into the profession for some years, practices are likely to continue to close. The Govan SHIP project, funded by Scottish Government, has shown how this can be averted through increased funding to general practice.

It is impossible for any service to maintain its quality, its success in improvement, its efficiency and its responsiveness to needs when suffering over a decade of cuts to its percentage share of NHS Scotland funding.

The Local Delivery Plan (LDP) Standards, among other stipulations, require:

- GPs to provide 48 Hour access or advance booking to an appropriate member of the GP team for at least 90 per cent of patients.

The LDP performance report of NHS Scotland for 2015/16 shows declining trends in performance against this standard between 2011/12 and 2015/16. The crisis in general practice has resulted in a situation where it is unlikely this trend will have been reversed. Indeed, it is likely the graphs’ gradients will have become steeper.

Repeated difficulty in achieving the LDP Standard on Accident and Emergency Waiting Times has been exacerbated. It is the general practitioner who is best placed to serve many who, having found difficulty in securing a GP appointment, would otherwise feel it necessary to attend Accident and Emergency departments. In June 2017, Dr Chaand Nagpaul, Chair of the British Medical Association (BMA), speaking at the BMA’s annual conference in Bournemouth, reported that, ‘a six per cent reduction in GP appointment capacity would double the number of patients attending A&E if they went there instead – highlighting why under-resourcing general practice is so damaging for the NHS.’

Efforts to detect cancer early will clearly be boosted with more GP time to attend to presenting patients. This correlation applies equally to efforts to meet standards relating to Detect Cancer Early, Alcohol Brief Interventions, Sickness Absence and Smoking Cessation. RCGP’s Spend to Save work has shown clearly that the financial performance of Scotland’s NHS can be improved through increasing the percentage funding available to general practice.

The National Health and Wellbeing Outcomes require that the following outcomes will be achieved:
- **Outcome 1:** People are able to look after and improve their own health and wellbeing and live in good health for longer

This outcome requires appropriate care from suitably qualified general practitioners with enough time to offer patients. Safe increases of health literacy are most easily achieved through the work of general practitioners. *Realistic Medicine* in large part describes the role of the GP.

- **Outcome 2:** People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

The GP’s treatment of each patient in a holistic manner, attending to their physical, psychological and social situations, is key to the delivery of this outcome.

- **Outcome 3:** People who use health and social care services have positive experiences of those services, and have their dignity respected

Positive experience relies on the clinician having time to attend actively to their patient. Dignity relies upon the privacy of the consulting room, as opposed to, for example, the public nature of the reception desk queue, especially in smaller communities.

- **Outcome 4:** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Again, the holistic nature of the GP’s perspective on the patient is paramount in this outcome. Similarly, an unstressed clinician, free from ‘burnout’ is vital to this aim. The Scottish Government funded Govan SHIP project has illustrated the efficiency of increasing funding directly to practices to deal with burnout, retention and recruitment issues.

- **Outcome 5:** Health and social care services contribute to reducing health inequalities

In areas of deprivation, both rural and urban, GP services are vital to the health and wellbeing of the population. Practices in these areas do not receive sufficient funding, as clearly demonstrated through the work of the *Deep End* and that of Dr Helene Irvine, Consultant in Public Health Medicine at NHS Greater Glasgow and Clyde Health Board.

The Official Report of the Health and Sport Committee from Tuesday, 21 March 2017, records Alison Johnstone MSP asking a question ‘specifically around GPs and health inequality’. She said, ‘I am interested in your expert views on whether we are funding GP services adequately, particularly in those areas of need (Column 29). Dr Eleanor Hothersall, Consultant in Public Health Medicine at NHS Tayside, answered that ‘General practice funding is part of the issue … We say that we want something, but then we cannot have it on the ground because we do not have the people or the facilities available, because of systematic disinvestment over a very long time at every level’.
• **Outcome 6.** People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

Not only can GPs provide appropriate services for those receiving care, so reducing stress and burnout among carers, but they equally offer their services to those carers.

• **Outcome 7.** People using health and social care services are safe from harm.

GPs have successfully achieved a degree in medicine, completed two years’ foundation doctor training and three years’ specialty training in general practice. Their generalism allows them to diagnose the broadest spectrum of disease of any member of the NHS workforce. Such generalism keeps patients safe. Patient safety is at risk from the persistent underfunding of general practice since 2005/06.

GPs provide safety in a wide range of other ways. For example, during the long waiting times endured by those seeking access to specialist care while suffering mental distress, GPs must manage the care of the patient. As another example, GPs manage the reactions of patients to medications while the patient remains in the community. GPs safely co-ordinate patients’ pathways through the health system.

• **Outcome 8.** People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

This outcome requires GPs to be able to offer appropriate care, with enough time to offer patients. The heavily ‘transactional’ nature of hurried appointments with patients is dissatisfying to GPs as it frustrates their ability to build a relationship and look at the patient as a ‘whole’ person. Continuity of care is a major asset of general practice.

• **Outcome 9.** Resources are used effectively and efficiently in the provision of health and social care services.

Reassuring the ‘worried well’ of their wellbeing is a major service to Scotland’s NHS, saving a substantial portion of NHS Scotland’s budget through the ‘gatekeeper’ function of the GP. The consequences of underfunding GPs in this regard may be seen in some small measure through the unnecessary rise in Accident and Emergency attendance referenced earlier. That logic may be extrapolated to cover the whole of our health service.

In 2015 the College outlined ‘a saving of up to £1.9 billion to the NHS across the UK as a whole by 2020’ through increased government spending on general practice. With around 90% of patient contact with the NHS in Scotland coming through primary care, it is clear that that investment to allow the outcomes both Scottish Government and GPs wish to be realised must be made available if meaningful progress in effectiveness and efficiency is to be made.
2. For the health and sport budget for 2018-19 where do you suggest any additional resources could be most effectively deployed and where could any further savings be found? What evidence supports your views?

As described and evidenced above, the most assured way of effectively deploying resources within the NHS in Scotland is to raise the percentage share general practice receives until it reaches 11% of the NHS Scotland budget. It has also been described above how further savings for the NHS in Scotland could be found.

3. Is sufficient information available to support scrutiny of the Scottish Government’s health and sport budget? If not, what additional information would help support budget scrutiny?

Appropriate time for scrutiny and change must be built into the Scottish Government’s budgeting process if that process is to be meaningful.

Scottish Government should make clear its definition of primary care. Currently, according to the Information Services Division of NHS Scotland’s Cost Book ‘R300’ report for April 2015 to March 2016, primary care in Scotland receives around 23% of the NHS Scotland budget, yet Scottish Government repeatedly speak of ‘raising’ the primary care budget to 11%. As outlined by RCGP Scotland, this uncertainty creates room for misunderstanding and mistaken decision making. We believe that the definition of primary care offered in The future of primary care in Scotland: a view from the professions, a document created with professional bodies directly involved in primary care provision, offers an appropriate and professionally relevant definition. Scottish Government has been invited to endorse this definition in order to further develop an environment of collegiate working and innovation amongst the primary care workforce, and to provide a stable and sound platform from which to develop primary care services. We recommend that such a step be taken at the earliest opportunity.

BMA Scotland has recently suggested that the costs of running general practices managed by health boards are in some cases up to double that of those managed as independent contractors. Research should be undertaken, preferably through the Scottish School of Primary Care, to provide evidence through which to better understand the situation.

4. What impact has the integration of health and social care budgets had on ensuring resources are directed at achieving the Scottish Government’s desired outcomes?

RCGP Scotland would value reassurance that all budgets set aside for the delivery of general practice services in Scotland will be made available to general practitioners to deliver these services, whichever route it should follow to arrive there in a timely manner.