Royal College of General Practitioners
SCOTLAND

Mr Lewis Macdonald MSP
Convenor, Health and Sport Committee
T3.40
The Scottish Parliament,
Edinburgh
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By email: healthandsport@parliament.scot

09 March 2020

Dear Mr Macdonald,

Thank you for your letter dated 28 February 2020 regarding the oral evidence that I provided to Committee members on 18 February on behalf of the Royal College of General Practitioners Scotland. This evidence formed part of the Committee's inquiry into the demand and supply of medicines.

I intend to respond to each of your points in turn:

**Medical Curriculum**

In your letter you asked for further detail on the role of the Royal College of GPs in ensuring that managing discussions with patients on their prescriptions is an essential element of training for doctors.

Following medical school GPs currently undertake three years of GP Specialty Training (GPST) and must pass the MRCGP before they are fully qualified to practise in the UK. GP specialty training covers all aspects of modern day general practice, which by its nature is increasingly complex and diverse. Despite the increasing complexity of modern general practice, the length of GP specialty training has not kept pace, remaining at three years in length, compared to the standard training length of seven years for other medical specialties. RCGP has been clear that the current training arrangements are failing to adequately prepare trainees for the demands of the evolving GP role and have advocated for a four-year training programme. RCGP would also like to see an increased proportion of training during this time spent in frontline general practice, where trainees will be able to gain greater experience of core general practice, including medicines management. In order for a four-year, practice-embedded training to be introduced, increased investment is required in training programmes and general practice infrastructure to enable such an overhaul.

The current GPST programme does already have a focus on medicines management, with the College delivering a new prescribing assessment that is a compulsory part of the third year of GPST (GP ST3). More information about the pilot of this assessment, which has now been made compulsory can be found on the RCGP website here.

**Physical medicines Reviews**

You have welcomed my views on the importance of medicine reviews, why these do not always happen and the role that the Royal College of GPs can play in ensuring reviews take place.

It is clear that there is a need to encourage more in-depth level 3 medication reviews. Such reviews, carried out with patients and carers, are hugely valuable in terms of increasing

patient understanding of why certain prescribing decisions are made and encourage patients and carers to play a role in the development of those decisions. Previously, yearly medication reviews (level 2) were incentivised as part of the Quality Outcomes Framework (QOF) which was removed in 2016 and replaced with GP Clusters across Scotland. The abolition of QOF was well received by the profession at the time and provided an opportunity to re-energise Quality Improvement initiatives with a focus on local prioritisation by the profession according to the needs of the local population. However, since this time the workforce challenges being experienced across general practice and the resultant, significant pressures on GPs' workload has adversely affected the ability of GPs to carry out as many in-depth medication reviews as they would hope to.

There are opportunities presented within the nGMS and specifically through the bolstering of practice-based pharmacotherapy teams to assist with enabling more medicine reviews to take place. However, the workforce challenges being experienced by our pharmacist colleagues are acting as a barrier to these services being made available to GPs across Scotland.

RCGP will continue to support clinicians to carry out medication reviews through the provision of high-quality training which focuses on medicines management, alongside the plethora of additional skills and attributes required to practise as a GP.

**Sharing Best Practice in Advances of Technology**

You have stated that the Committee would welcome my views on the role of the RCGP in ensuring that advances in technology are shared at an appropriate pace throughout the country.

The use of IT tools such as Scottish Therapeutics Utility and P-DQIP are helpful in terms of targeting reviews for areas which have significant impact for patients, for instance in terms of bleeding or patients at risk of falls. GP Clusters are currently being encouraged to use such tools as part of their Quality Improvement work and GP Clusters provide an opportunity to enable the sharing of best practice, both in terms of technology and beyond, among GP practices across Scotland. RCGP Scotland was integral to the creation of GP Clusters following the abolition of QOF in 2016 and have continued to support and champion their development. The potential of Clusters to deliver Quality Improvement is enormous, however it is clear that they are facing significant barriers. RCGP Scotland has provided funding for three Local Advocates to consult with Clusters and understand the challenges that they are facing in more depth. A clear challenge identified was the variance of resource that Clusters receive across the country, with funding provided to Cluster Quality Leads (CQLs) based within Clusters varying considerably from Health Board to Health Board. If Clusters are to continue to provide meaningful and sustainable Quality work in place of QOF, the issue of funding needs to be addressed at a Health Board level. Alongside the work of the Local Advocates, in relation to Clusters, RCGP Scotland has also worked with a number of organisations, including the Scottish Government, ISD and the Scottish School of Primary Care to develop resources and the National Guidance for GP Clusters as well as the Improving Together Interactive Toolkit. Work is also currently ongoing by RCGP Scotland to develop a series of modules which practices and Clusters could consider using to develop their team's knowledge, skills and cultures in Quality Improvement. The intention of this work is to help drive the Quality work of Clusters throughout Scotland, providing criteria as well as practical resources in relation to demonstrating quality patient care. The development of

these resources is at an early stage, with a module currently being piloted in the North East of Scotland.

On behalf of RCGP, I have worked closely with the Scottish Access Collaborative (SAC) which aims to improve the primary and secondary care interface and in doing so aims to rectify some of the identified prescribing issues which occur around hospital admissions, discharges and with patient medication. This is an important initiative, however GPs at a local level are finding it difficult to engage with SAC due to their incredibly heavy workloads and the lack of funding available to secure locum cover to enable GPs to create the time to engage with this work. RCGP Scotland does however continue to contribute to and promote this work at a national level and encourage GPs to get involved if possible.

Ensuring that best practice in advances of technology are shared throughout Scotland also relies on enabling interfaces of care (both within primary and between primary, secondary and social care) to operate effectively. RCGP Scotland is committed to helping improve these vital connections and have worked on the creation of Interface Groups at a Health Board level. This is a Scottish Government funded project delivered by RCGP Scotland which aims to improve interface working to help reduce clinical errors, improve efficiency and encourage shared learning. While successful in some areas, the project has experienced problems in engaging with some Health Boards around the importance of interface working. The lack of engagement in some areas has led to clinicians carrying out vital interface working in their own time with no funded support, which is inevitably unsustainable and does not enable the sharing of best practice across the country. In order for Interface Groups to reach their full potential, they need to be formally brought into the Health Board structure and all clinicians involved with this work (both in primary and secondary care) require adequate funding and time to devote to this project.

I trust this information will be of use to committee members. Should you require any further information, please do not hesitate to contact me.

Yours sincerely,

**Dr David Shackles MBChB DCCH MRCGP**
**RCGP Scotland Executive Officer for Interface and Out of Hours Working**