

RCGP Scotland consultation response: 500 additional medical school places

RCGP Scotland welcomes the opportunity to respond to this consultation. As the membership body for general practitioners in Scotland, we exist to promote and maintain the highest standards of patient care.

In regard to an increase to the number of medical school training places available, we would make the following general points:

1. Scotland's health and healthcare landscape

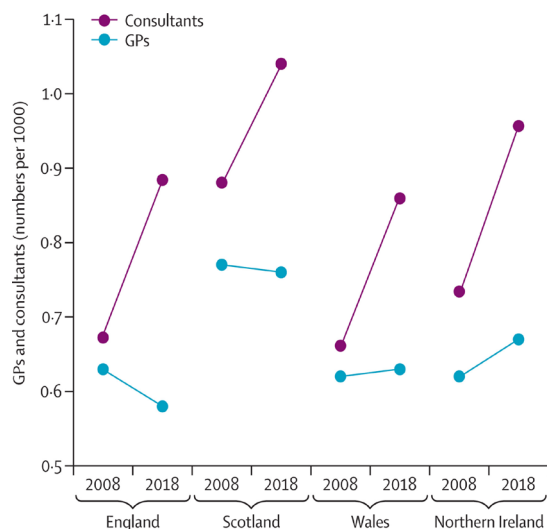
Scotland has both a growing and ageing population, estimated to grow by 2% between 2018 and 2028 with a 50% increase in over 60s projected by 2033. As of February 2023, GPs in Scotland are conducting over 1.5 million appointments per month. In addition, many GPs are reporting that patients now present with a greater and more complex mix of conditions and need than ever before. This confluence of conditions has presented GPs with a complex landscape of managing patient health in Scotland, particularly as the vast majority of people are still managed in general practice.

Despite this, however, Whole Time Equivalent (WTE) GP numbers have stagnated, with no rise since 2013. The Scottish Government's target of recruiting an additional 800 GPs (from 2017) by 2027 is not on track to be met, a point reinforced in Audit Scotland's 2022 report into the state of the NHS, stating that it considers workforce capacity to be the single biggest risk to NHS recovery.¹ For GPs, this represents a precarious reality in which fewer and fewer GPs are having to treat an older and sicker population. This has led to the current GP workforce feeling unsustainably stretched, with unsafe workloads, and little reprieve in sight.

In contrast to this lack of expansion of the primary care workforce, in 6 years (2013-2019) consultant numbers increased by 14%, now sitting 24% higher than in 2013, and with WTE continuing to rise, though at a slower rate.² This growth can and must be replicated moving forward in regard to GP WTE numbers.

¹ <https://www.audit-scotland.gov.uk/publications/nhs-in-scotland-2022>

² [06 December 2022 Workforce | Turas Data Intelligence \(nhs.scot\)](#)



Source: Securing a sustainable and fit-for-purpose UK health and care workforce. The Lancet. Health policy | VOLUME 397, ISSUE 10288, P1992-2011, May 22, 2021.

It is crucial that medical schools are equipped to train a sufficient number of GPs to meet the needs of Scotland's population. A move to a workforce favouring general practice, psychiatry and community settings is a necessary change but one at present facing numerous barriers, many of which are rooted in student's medical school experience.

2. Medical school training and supporting primary care

As noted above, the growth of the secondary care consultant workforce needs to be replicated in primary care, and this process begins with the experience and opportunities provided to students during medical school. We support the need for medical student expansion to be undertaken alongside a full implementation of the recommendations of the report by Professor John Gillies into undergraduate medical education in Scotland.³

We know that medical students continue to witness the denigration of the GP profession in universities, which has an obvious and adverse effect on these students' career choices, though the Increasing Undergraduate Education in Primary Care Working Group has ensured progress in some areas. We need a better understanding of what sorts of students we should be enrolling to medical school and changing approaches to ensure that those with this orientation are enabled to do so, as currently we are producing an output which does not match our needs. We require an active sampling of medical student experiences in regard to the portrayal of these specialties, with reporting at ministerial level. There needs to be a full account of how we will ensure downstream measures to guarantee, as much as possible, that those graduating will then have a positive and holistic experience of general practice in

³ [Undergraduate medical education in Scotland: Enabling more general practice based teaching](#)

Foundation years and beyond. More fundamentally we need a re-setting of all the current gradients favouring the choice of hospital specialities.

To do so, several changes in relation to medical school training are needed, including greater profiles in medical schools of GPs and more academic opportunities at every stage of their learning career. We also need longer training in general practice; we now lag woefully behind England and Wales who are beginning to achieve a full two years of the GP training scheme in general practice.

3. Enhanced data gathering to underpin workforce planning

At all stages of primary care, Scotland suffers from a lack of regularly tracked, relevant data. Such information is important not only for measuring the current state of GP workforce and workload, but, critically, for forward planning and resourcing.

In relation to medical schools, Scottish universities have developed multiple approaches to teaching, with many innovative schemes. However, we currently have no mechanism for assessing how well these work, nor do we capture the final career choice of those participating. Scottish academic GPs have called for the small amount of funding needed to track these students going forward, funding which has not been forthcoming to date. This is also the 10th – and to date completely unaddressed – recommendation of the report on increasing undergraduate medicine teaching in primary care.⁴ We are now seeing expansion of the medical student programme without the evidence base of what works, which we could have firmly established by now had this recommendation been implemented.

We are yet again witnessing a piecemeal approach to workforce planning, without a comprehensive, overarching plan. There is now not only a crisis of GP provision, but one too of premises, which have failed to expand with the population. Some medical schools have been forced to amend their GP programmes to adapt to smaller numbers and GP trainers are facing increased pressure too, not least because of the added capacity required for our growing International Medical Graduate (IMG) workforce and less than full time training, also a growing trend, as well as the huge expansion in training and clinical supervision requirements of the extended MDT.

Consultation questions

We would be particularly interested in receiving comments on the proposed criteria that will be used to evaluate bids:

1. Align undergraduate expansion to areas of Scotland that are under-served for healthcare including deprived and remote and rural areas.

We support this as we recognise there are gaps in services and would like to see this expansion especially focused upon general practice, where there is urgent need to

⁴ <https://www.gov.scot/publications/undergraduate-medical-education-scotland-enabling-more-general-practice-based-teaching/documents/>

stabilise and ensure the enduring operation of current practices. General practice is the mainstay of healthcare provision in remote and rural areas; however, these practices are increasingly needing to resort to the more expensive 2C format to operate. This can sometimes lead to them operating without GPs who have been with the practice long-term, a setting which often fails to provide the benefits to the community of ongoing and especially long-term continuity of care.

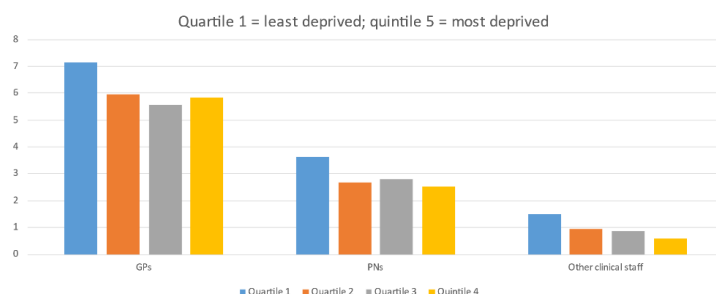
Whilst we don't yet have detail round the outcome of the ScotGEM programme, it was clearly successful, and the stated intentions of many students was to consider a career in rural general practice.⁵ The indications are that students entering a graduate programme (such as ScotGEM) are more likely to wish to be GPs, and we should have more formal outcome data soon. It would be helpful to consider the expansion of medical graduate programmes in this space, as well.

The case for resourcing general practice in deprived areas has been made many times, both by GPs at the Deep End⁶, and Scottish Government's Health Inequalities Short Life Working Group.

2. Support teaching, research, and practice in areas of Scotland that are underserved for healthcare including deprived and remote and rural areas.

We would support all of the above, and as health inequalities are widespread and deepening, we urgently need to move to a position whereby all medical students or doctors in training are exposed to teaching related to deprived and, if possible, remote populations. As noted in the independent review into Health Inequalities in Scotland, "despite well intended policy interventions, the gap in health and wellbeing outcomes is widening ... Scotland has the lowest life expectancy in Western Europe"⁷. We also know that there is a dominating inverse-care law operating in Scottish general practice.⁸

Estimated WTE/10,000 patients by practice deprivation



Source: Deep End Report 33 Increasing undergraduate education in primary care in areas of socio-economic deprivation (the Deep End). August 2018. [Click here & type subtitle \(gla.ac.uk\)](https://www.gla.ac.uk)

⁵ Professor Jon Dowell; previous ScotGEM Programme Director; personal communication.

⁶ <https://www.gla.ac.uk/connect/publicengagement/projectsandevents/gpsatthedeepend/>

⁷ https://www.gla.ac.uk/media/Media_892338_smx.pdf

⁸ [University of Glasgow - Research Institutes - Institute of Health & Wellbeing - Research - General Practice and Primary Care - The Scottish Deep End Project - Recent additions \(January 2022\).](https://www.gla.ac.uk/research/research-institutes/institute-of-health-and-wellbeing/research-general-practice-and-primary-care-the-scottish-deep-end-project-recent-additions)

We urgently need to address this through concerted effort throughout the medical training lifespan, from enrolment into medical school all the way to ensuring better GPST training opportunities in practices which are serving socioeconomically deprived populations. We know that such practices are less likely to train, but there is much that can be done to improve this situation. Evidence to support this is clearly outlined in the GPs at the Deep End report into Increasing undergraduate education in primary care in areas of socio-economic deprivation⁹. The Scottish Government itself has powerfully outlined the case for further support in this area.¹⁰

Rural general practice is also facing difficulty, with rising number of 2C practices, and difficulties recruiting. The Remote and Rural General Practice working group has ably outlined the challenges,¹¹ particularly in remote settings We have seen innovation¹², including the 'Rediscover the Joy' approach, and the development of various educational resources.¹³ Early indications are that ScotGEM has been successful in producing GPs keen to work in rural settings and we need to see the learnings from that programme understood and incorporated into others. The lack of outcome data for our medical school programmes again continues to hinder workforce forecasting and planning.

Despite its small size, Scotland is already a world leading nation on academic research into under- served populations. A further expansion of this, however, would be highly welcomed. Yet again, there is a marked and unjustified divide between primary and secondary care in relation to research opportunities, with secondary care doctors having longer training, more opportunity for research prior to becoming consultants, protected time for non-clinical work including teaching and research built into their contractual, structures, more Fellowship and PhD possibilities. The Scottish School of Primary Care receives drastically less funding than its English and Welsh equivalents.

3. Support GP, psychiatry, care of the elderly and community-based learning in all aspects of the curriculum.

We would support an expansion of the Care of the Elderly medical workforce, to reflect the demographic changes outlined above. However, this should not be prioritised over the expansion of GP numbers, which must be seen as the over-riding 'prime' directive in terms of workforce. Barriers to GP access or lack of access to a consistent practice (an increasing phenomenon in Scotland) will have an overwhelmingly detrimental effect on the elderly. What is needed is expansion of care in the community for the frail elderly especially. We know that prolonged inpatient care is harmful for this group of patients, and key to keeping people at home is an expansion of generalist care: specialists attend to a very small percentage of this

⁹ Deep End Report 33 Increasing undergraduate education in primary care in areas of socio-economic deprivation (the Deep End). August 2018. [Click here & type subtitle \(gla.ac.uk\)](http://www.gla.ac.uk)

¹⁰ [Primary Care Health Inequalities Short-Life Working Group: report - gov.scot \(www.gov.scot\)](http://www.gov.scot)

¹¹ [Shaping the Future Together: Remote and Rural General Practice Working Group report - gov.scot \(www.gov.scot\)](http://www.gov.scot)

¹² <https://www.srmc.scot.nhs.uk/>

¹³ [Remote and rural healthcare education alliance \(RRHEAL\) | NH \(scot.nhs.uk\)](http://www.scot.nhs.uk)

population for short periods of time. Earlier discharge improves patient outcomes, but that requires a GP (and other community-based) workforce expansion. GPs are also the primary and almost always the sole medical workforce for Scotland's 33,000 care and nursing home patients,¹⁴ the majority of whom will need palliative care within a couple of years of moving into a home. Again, it is essential that primary care receives the predominant focus necessary to provide the care required by Scotland's increasingly elderly population. The British Geriatrics Society (BGS) March 2023 blueprint for preventing and caring for the frail elderly population 'Joining the Dots'¹⁵ outlines the need for expansion of the generalist workforce (many of the actions to prevent frailty lie with primary care) and for integrated workforce planning. It is not clear how the additional 500 medical school places fit into this wider workforce plan.

On a similar theme, we know that in Scotland multimorbidity is more common than single morbidity, with steep gradients with both age and deprivation. This requires practice-based holistic care over a lifetime, with chronic disease and preventative work by Practice and Community Nurses being especially key. All health care workers need 'lived professional experience' of this if we are going to have an appropriate and cost-effective approach to care. In turn, teaching and training in the community is key to developing the long-term perspectives and skills needed for our population's medical complexity and health inequalities.

Finally, we know that almost all community based mental health is done by GPs,¹⁶ who are now also having to take on rising workloads. The reasons for this include the effects of the pandemic, the cost-of-living crisis and so on, but also because faltering and sometimes absent specialist mental health services mean that GPs are taking on more of that care. This requires sustaining patients on long waiting lists and having to cope with less access to advice and support. It is crucial that we see an expansion of psychiatrist numbers to address the current shortfall, however this must be part of an integrated planning process, recognising that even that expansion will not be able to adequately deliver without an expanded GP team, too.

4. Increase the number of widening access students (SIMD 20 and care experienced) studying medicine at Scottish universities.

Scottish health inequalities are amongst the worst in western Europe,¹⁷ and - just as we need to ensure we attract medical students with the characteristics necessary to make them choose generalism - we also need more doctors who have experience of poverty and care. There is an extensive health service literature showing that barriers to fully understanding patients worsen outcomes. We also know from the GMC that

¹⁴ <https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2022/06/health-care-home-healthcare-framework-adults-living-care-homes/documents/healthcare-framework-adults-living-care-homes-health-care-home/healthcare-framework-adults-living-care-homes-health-care-home/govscot%3Adocument/healthcare-framework-adults-living-care-homes-health-care-home.pdf>

¹⁵ [BGS Joining the Dots - A blueprint for preventing and managing frailty in older people.pdf](#)

¹⁶ https://elearning.rcgp.org.uk/pluginfile.php/175878/mod_book/chapter/616/RCGP-PS-mental-health-nov-2017.pdf

¹⁷ <https://www.health.org.uk/publications/leave-no-one-behind>

those from more socioeconomically deprived backgrounds fare worse in terms of educational outcomes,¹⁸ and so we need not only greater numbers with those backgrounds, but also more interventions and changes in the learning environment to help them succeed. We know that there are interventions which can support such expansion.¹⁹

5. Increase the number and proportion of Scottish domiciled students studying medicine at Scottish universities.

RCGP Scotland would welcome such an increase, but we would also note that while a greater domiciled student intake is crucial, ensuring that we keep them once they have graduated is equally important.

Currently, the majority of new registrants to the GMC register are IMGs.²⁰ While this is a welcome, and increasingly necessary workforce, the GMC outlines that this is also putting our healthcare systems in a precarious position: “Not only is the flow of IMGs into the workforce unpredictable, but our data also show that IMGs leave the UK workforce at a higher rate.”



Source: Financial Times analysis of OECD Health Workforce Migration statistics

In Scotland an astonishing 28% of IMGs who finished training in Scotland moved to another UK country, while 18% left the profession, higher than any of the other UK nations. We often hear from GP trainers and their leadership that IMGs frequently need additional support if they choose to enter GP training schemes, and this is not accounted for in terms of time or resource, adding additional pressure to GPs already

¹⁸ https://www.gmc-uk.org/-/media/documents/96887270_tackling-disadvantage-in-medical-education-020323.pdf

¹⁹ Full article: Medical education in (and for) areas of socio-economic deprivation in the UK ([tandfonline.com](https://www.tandfonline.com))

²⁰ The state of medical education and practice in the UK: The workforce report 2022 ([gmc-uk.org](https://www.gmc-uk.org))

working at, or over, their clinical and training limits. That same report outlines that 45% of IMG trainees are in general practice, the biggest proportion of any speciality.

We are also hearing from GPs that they are now seeing those they taught in medical schools, or trained in general practice, leaving. It is especially demoralising when so many of the IMGs they train leave practice in Scotland or medical practice altogether. There are real concerns that as GP workload continues at staggeringly high levels, we will continue to lose GPs to early retirement or other career changes too.

There is a growing sense amongst GPs that they are no longer supporting a future workforce which will stay and help ameliorate the crisis we now face, but instead are training GPs who are then forever lost to the Scottish NHS landscape. This is now resulting in a downward spiral, with newly trained GPs becoming wary of staying in the British profession when they see the pressures that GPs, and especially partners, face. There have been such common and reoccurring falsehoods and negative portrayals of general practice from politicians and the media in the past few years which has resulted in widespread and pernicious adverse stereotyping and a profound misunderstanding of the GP role. GPs are central to caring for a population with multimorbidity and large, and growing health inequalities. We have often heard that these societal perceptions are putting students off general practice in Scottish medical schools.

6. Ensure sufficient provision of high-quality educational placements.

We agree that it is vital to have high quality educational placements, and GP tutors in medical schools are crucial to that and to building on the generalist skills needed for some of the other stated areas of expansion. What is also important is learner experience in primary care settings. We need far reaching support for general practice if this is to happen.

The following are areas requiring urgent attention which are, at present, largely unaddressed:

- **Available GPs for teaching** - We know from university colleagues that, currently, undergraduate medical courses are having to adjust to fewer GP tutors; presumably as GPs are under too much pressure to undertake additional work; and that accommodating the additional medical students and 100 GPSTs is proving very challenging.
- **Development of GP practice premises** - many are now inadequate or cannot accommodate new students.
- **Extensive new requirements for training and clinical supervision of the new extended MDT** - who also add to pressure on premises.

Trainees rate their general practice experience very highly, but it will be difficult to maintain quality as pressures rise. Our understanding from discussions with university teaching colleagues, is that medical students hugely enjoy the GP attachments, but also see the severe pressures greatly influencing their intentions not to work in general practice despite many positive experiences. We are keen to know how the universities, and Scottish Government, are going to ensure that the students will choose the preferred outcomes, as neither to date have found ways to do so. This should be seen as a challenge and a unique opportunity to address systemic failings and biases: the vision must be to use taxpayers' money to provide our population with the workforce it needs, and increasingly that is in general practice and psychiatry. Therefore, the Scottish Government must focus not only on vision but also upon means of implementation and ongoing governance.

7. Encourage innovation in educational models and use of technology building on the lessons learned from the pandemic.

Prior to the pandemic, general practice had highly developed clinical IT systems, with practices essentially operating paper-free for many years. That IT also allows for audit, quality control, examination of consultations, prescribing, referral patterns and so on, both at an individual and organisational level, providing a solid basis for learning and reflection.

General practice led the way in terms of epidemic response and alternative approaches. Almost overnight it moved to remote consulting, particularly for those with Covid²¹, rapid rollout of telephone triage and adopters of NHS Near Me.²² As a primary care facility, general practice could largely shut down its operations as was possible in – for instance – some elective outpatient work sectors. Staff who needed to self-isolate were rapidly facilitated to work from home, and there was virtual oversight, for example of care home patients too.

Changes in the examination diet were also made, with a move to the Recorded Consultation Assessment (RCA), which itself has subsequently been evaluated, and is to evolve further. General practice training is subject to more scrutiny and examination of outcomes, including for differential attainment, than that of any other specialty.

Finally, with the active input of trainers, NHS Education for Scotland (NES) is in the process of redesigning its GP trainer courses, with a considered hybrid of in person and virtual options.

GPs have a proven track record of learning and adopting new technologies in the workplace. What we need to see is much more integration of that within the medical

²¹ <https://www.bmj.com/content/368/bmj.m1182>

²² <https://tec.scot/programme-areas/near-me/evidence-base>

school environment, facilitating more general practice in reach and outreach. With capacity as tight as it is, innovative approaches are needed now more than ever.

If you wish to submit a bid, the timeline in which this bid could be delivered. Specifically, it would be helpful to receive feedback on what could be delivered were the Scottish Government to ask that students start in the academic year 2025/26, as well as what it would be possible to deliver over a longer timescale.

N/A

Whether medical apprenticeships could be delivered as part of your bid.

We are clearly not in a position to bid but note that longitudinal attachments in general practice are especially successful and appropriate. They allow for medical students to become more embedded and appreciate the aspects of general practice which makes it so effective – comprehensive teams, healthcare planning to reflect the needs of local populations, and above all, knowing patients and providing continuity of care. Practices have also fed back positively about them, most notably in the successful ScotGEM programme. GP training is essentially built on the medical apprenticeship model, and general practice is ideally placed to deliver these, particularly now that Category A payments have been raised. We also need to ensure this applies to Category B payments too, if we are to retain GP tutors.

How the Scottish Government can ensure a level playing field for any Higher Education Institution in Scotland that does not currently have a medical school to submit a bid.

This question needs to be addressed by Scottish Government itself. What also needs to be considered is not just the Higher Education Institutions, but also the requirement for these institutions to engage with the wider GP workforce if we are to deliver the greater number of GPs that are needed.

The Scottish Government needs to have detailed views of the GP training, tutor and clinical supervision landscape, with both data and assessment of quality to support – especially where there is potential to increase numbers and to address any current barriers to doing so.

Any other comments or feedback you think may be relevant.

In summary, we would of course always welcome attempts to expand the GP workforce. However, it is not clear how this can be implemented within current constraints. In particular, it is difficult to see how it will be feasible without a detailed account, expansion and development of GP capacity relating to the teaching, training and GP workforce.

All of these are being further eroded by the loss of GPs at all stages of the pipeline, and there will need to be new and substantial efforts made to retain them if this is going to work. There remain multiple factors both in medical school and beyond,

favouring hospital specialty choices by students and trainees, and these will need to be addressed too. We also note the lack of a cohesive overarching strategy, and that not all the recommendations of the Scottish Government's Undergraduate Medical Education report²³ have been implemented, and we maintain that both will be needed for success.

²³ <https://www.gov.scot/publications/undergraduate-medical-education-scotland-enabling-more-general-practice-based-teaching/pages/3/>