

Royal College of General Practitioners (SCOTLAND) ANALYSIS OF THE PROPOSED NEW GP CONTRACT 2018

Overview

A proposed new General Medical Services (GMS) contract for Scotland was published by the British Medical Association (BMA) and Scottish Government on 13 November 2017. There has been much discussion and debate about how the new contract will affect our profession in the future. Opinions are divided, partly reflecting the diversity within the GP profession, differing working circumstances and the communities that they serve.

As the professional body for GPs in Scotland, the RCGP's role is to consider any proposals in light of whether they will continue to deliver safe, equitable, and high-quality care, whilst protecting the unique and crucial role of the GP; and whether the contract makes our profession more sustainable and more attractive in terms of retention and recruitment.

In recognition of the need to put the questions and concerns raised by RCGP members to the BMA's Scottish General Practitioner Committee (BMA SGPC) negotiating team, a Special Meeting of Scottish Council was held on 25 November 2017, with the proposed new contract as the sole item on the agenda.

Despite the tight timescale, all possible efforts were made to encourage Member engagement in the process: through official Royal College of General Practitioners (Scotland) (RCGP Scotland) networks such as Scottish Council, faculties, Executive Board, the weekly Chair's blog, and on social media. Questions were fed in through a variety of sources and collated into themes. There were many additional questions raised during the meeting under each theme, and these are also listed for information.

There was an agreement that the meeting would not be live-tweeted or directly quoted to allow a more open and honest inter-professional approach to discussion of these complex issues.

The format of the meeting was a Power Point presentation from Dr Alan McDevitt, Chair of SGPC, which can also be viewed on the [BMA website](#) followed by a question and answer session from Scottish Council members, either in person, or via telephone or Skype (attendance listed at appendix 1).

Scottish Council members had been asked in advance of the meeting to examine the contract and analyse and question it through the prism of the RCGP Scotland's [Core Values](#) document which is also included as appendix 2. This was intended to provide a guide for analysis of the contract in terms of whether it protects the agreed values of the profession, in addition to any personal questions raised.

This paper summarises the key themes that had been highlighted as potential challenges for the profession with questions that were posed during this meeting. The paper does not attempt to paraphrase the answers given by SGPC; instead these questions have been specifically shared with SGPC for inclusion on the BMA [FAQ page](#).

The meeting also covered the main areas of potential opportunities within the contract in terms of the crucial role of RCGP Scotland in shaping the future of general practice. These areas are also covered in the paper.

The SGPC representatives in attendance during the meeting made clear that the proposals offered for Phase One of the contract are not open to further negotiation.

RCGP Scotland has requested however, a re-wording of the draft co-produced Memorandum of Understanding (MOU) to specifically include an explicit acknowledgement of the role of RCGP in setting the quality standards for the profession.

The proposed new GMS contract for 2018 is set out in seven distinct chapters:

1. The role of GPs in Scotland – Expert Medical Generalists
2. Pay and expenses
3. Manageable workload
4. Improving infrastructure and reducing risk
5. Better care for patients
6. Better health in communities
7. The role of the practice.

Key aims of the new contract:

- Maintain independent contractor (IC) status model
- Reduce risk for ICs (premises, staff, joint data controller arrangements)
- Maintain stability (income)
- Reduce workload (expanding multidisciplinary primary care team, primary legislation)
- Increase recruitment and retention (by making general practice more attractive).

Key headlines from the contract:

- Proposes to refocus the GP role as ‘expert medical generalists’. This will mean moving some work currently carried out by GPs to members of the wider primary care team.
- SGPC, Scottish Government, NHS Boards and Integration Authorities have agreed priorities for service redesign in Scottish primary care over the next three years. These priorities include vaccination services, pharmacotherapy services, community treatment and care services, urgent care services and additional professional services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services.
- General Practice funding will be reformed in a phased approach. Phase 1, from April 2018, will see a new funding formula introduced, which is intended to better reflect practice workload. This will include an extra £23m next year to GMS, with the intention of improving services where workload is highest, within practices in deprived areas and those with a higher percentage of frail patients. It repeats the previously announced commitment that £250m of the £500m announced for primary care, will go ‘in direct support’ of general practice by 2021/22.
- A practice income guarantee will be introduced to ensure stability in practice income.
- A new minimum earnings expectation to ensure no GP partner earns less than £80,430 (including pension contributions) NHS income for a whole-time equivalent post from April 2019. BMA evidence indicates this will benefit approximately one fifth of GP partners in Scotland.
- A new GP Premises Sustainability Fund worth £30m over three years – to move towards a model that does not presume GPs own their own premises. NHS Boards will gradually take on the responsibility from GP contractors for negotiating and entering into leases for practice premises until 2043, by when no GP will own their premises.

- Reduction in information sharing risk by becoming joint data-controllers with NHS Boards.
- Improvement in online access for repeat prescriptions and appointment booking where the practice has the functionality to implement.

Analysis of the new GMS contract

The themes that were discussed fall largely into the following areas:

- The logistics of service redesign
- The proposed future workforce
- Assessing the proposed contract against the 'Four Cs' of Primary Care
- Patient engagement
- The impact on remote and rural practice
- The impact on Out of Hours services
- Resources

The Logistics of Service Redesign

A Memorandum of Understanding (MOU), in development between Integration Authorities, SGPC, NHS Boards and the Scottish Government, will set out agreed principles of service redesign (including patient safety and person-centred care), ringfenced resources to enable the change to happen, new national and local oversight arrangements and agreed priorities. The College is not mentioned in the MOU, including under the list of 'key stakeholders'.

The MOU recognises that SGPC and the Scottish Government are the two negotiating parties on commercial general practitioner contractual matters in Scotland. It also goes on to say that the MOU will be signed between the Scottish Government, SGPC, Integration Authorities and NHS Boards, and recognises the statutory role of Integration Boards in commissioning service redesign to support the role of the GP as an expert medical generalist.

The intention is for the GP Clusters to play a crucial role in influencing local service redesign. It is not clear what role it is envisaged the College would play.

Questions raised:

1. What opportunities will exist for the College to get involved with service redesign and how will it affect the landscape of the future of Scottish general practice?
2. What will happen if there is a 'no' vote on this contract at the conclusion of the process in January?
3. Will GP Clusters have adequate resource and time to fulfil their intended roles under the new proposals?
4. Can we seek assurance that there is not an intention to move towards a salaried model of general practice with phase two?
5. Can practitioners be assured that HMRC will not denote the new arrangements as 'salaried'?
6. Clusters are currently GP-based. Is there an intention for them to include the wider MDT given proposed new models of working?
7. Will the RCGP be involved in the national monitoring process?
8. With the loss of QOF, how can we ensure that there is a consistent approach to minimum quality standards within practices, and how will this be resourced?
9. How will IT be developed to support this process?
10. What checks and balances will be in place to ensure that any unintended consequences of this new model are picked up early in the process?
11. Will there be patient engagement in locality planning?

2. The Proposed Future Workforce

2.1 The GP Workforce

The National Health and Social Care workforce plan specifically relating to the primary care workforce is due to be published in 'early 2018' following the conclusion of the Scottish GMS contract negotiations, having originally been scheduled for publication in November 2017. The Plan will set out a range of options at national, regional and local level for the recruitment and retention of GPs and the expansion of the capacity and capability of the multi-disciplinary team. This will include plans for recruitment, training and development of specific professional groups and roles.

Despite the Scottish Government's workforce plan not being expected for publication until early in 2018, on 01 December 2017, at the BMA's Scottish LMC Conference, Shona Robison MSP, Cabinet Secretary for Health and Sport, announced that the Government will aim to increase the GP workforce by at least 800 over the next decade. Analysis undertaken by the RCGP indicates that the GP workforce needs to be expanded by 856 WTE GPs by 2021. The College looks forward to understanding the finer detail of the Cabinet Secretary's announcement and also in working together with stakeholders to achieve appropriate growth in GP numbers.

The contract seeks to reduce workload and make general practice a more appealing career choice by moving work to other members of the wider primary care team where appropriate. The College has long been clear that any expansion of the wider team cannot be at the expense of not increasing the GP workforce and the College is therefore encouraged that the Government has so far committed to increasing the GP workforce by 800 over the next decade. As demand increases, it will only be through an increase in the number of GPs, as well as the numbers of colleagues in the wider primary care team, that will enable Scottish general practice, and indeed the wider NHS to thrive and survive.

The College supports the independent contractor model and the efficiency and cost-effectiveness it brings to support the whole of the NHS. The MOU states that the GP footprint is estimated as being up to four times the direct investment in primary medical services; without the cost-effectiveness that GPs bring to the wider NHS, it is unlikely that the NHS would have been so successful in delivering the level of care it has since inception. Funding a more expensive non-GP service will affect the sustainability of the wider NHS (expense being measured in terms of ability to risk manage, make decisions to treat/not to treat, refer on etc.). This feeds directly into our belief in explicitly growing the GP workforce.

Questions raised:

1. Why is the workforce plan not available until after the poll on the contract has closed?
2. What consideration has been given to postponing the poll until after the publication of the workforce plan, especially as so much of the contract depends on expanding the wider primary care team?
3. Can we see written assurances, perhaps in the MOU, that there is an intention through this contract to appropriately grow the GP workforce, and that plans to expand the wider primary care team are to complement and not replace the unique role of the GP? [This question has to some extent been answered by the Scottish Government's announcement, noted above.]
4. What assurances are available to those practices that have a lower patient to GP ratio by choice that this will be allowed to continue? Can we seek written assurance that there is not an intention, either on the part of the BMA or on the part of Scottish Government, to move towards a salaried model of general practice with Phase 2?

5. How will current GP workforce be measured given the unpredictable nature of the sessional GP workforce?
6. Is there an intention to reduce GP numbers in the future if the intention is for their workload to reduce?
7. If local services are unexpectedly withdrawn (e.g. intermediate care) will there be the ability to adjust-up the number of GPs required to manage additional workload?

2.2 The Extended Primary Care Team Workforce

The main themes raised during the discussions were around the capacity for this workforce to increase, and the model under which they will be employed.

Health and Social Care Partnerships (HSCPs) and NHS Boards will 'place additional primary care staff in GP practices and the community'. New staff in these roles will be the employees of the HSCP and health board and will not be employed by the practice. The College has always been clear that any new model of care needs to focus on drawing on the expertise and support of a wider multi-disciplinary team at the same time as expanding the GP workforce where the GP remains as the centre and leader of this team.

The new GMS contract makes references to GPs remaining as the 'clinical leaders' of MDTs, but says that new members of the wider team would be employed directly by health boards. This will result in these individuals looking to the GP for clinical leadership, but being line managed from elsewhere. A ComRes survey carried out over August and September 2017 among members of RCGP Scotland asked, '*As alternative models of delivering GP care are explored, how important is it for the primary care team to remain based within a GP practice?*' 95% answered either 'Fairly important' (20%) or 'Very important' (75%). The survey went on to ask, '*who should be the employers of core clinical staff in general practice?*' 72% responded that this should remain as it was, with core clinical staff employed by GPs, while 17% preferred an alternative employment status.

The contract highlights areas where there are effective teams whose membership have different employers, citing practices who have experience working with district nurses and other professionals not employed directly by the practice team. There is a balance to be struck here between reduction in risk to practices versus the erosion in practice autonomy and flexibility. There is also anecdotal evidence of the experiences in this model being variable, raising issues such as a lack of agility and potential conflicts between GP expectations and those of line managers at Health Board level.

During the development of this proposed model of care, some consideration will have to have been given to the extra number of medical professionals that will be needed to achieve its outcomes, but the College has been informed that the detail relating to the extended primary care workforce team is not yet available as it is to be included in the primary care workforce plan, to be released in early 2018.

Despite the Cabinet Secretary's recent announcement that the Scottish Government aim to increase the number of GPs by 800 over the next decade, there are still questions to be raised regarding the ability to recruit the (as yet unknown numbers of) extra members of the wider primary care team. At present, we know there were, at last report, 3,200 nursing and midwifery vacancies across Scotland, and anecdotal evidence of waits of up to a year for physiotherapy appointments in rural areas.

Questions raised:

1. Could we have clarity regarding who will hold the responsibility for training, mentoring and clinical decision support, and crucially where the capacity for this will come from?

2. How will practices ensure that the staff recruited as part of the expansion of the wider team are the 'right' ones and fit with the existing team if they are not directly involved with recruitment?
3. What control over team member retention will practices have? What limits may be placed on Health Boards moving a member of the team from place to place, so leaving practices without team stability and patients without continuity of care?
4. What assurances are there for training practices that HCPs will remain post-training for a minimum period of time ('social contract')?
5. How feasible will it be to house these extra members of the wider MDT given existing premises issues?
6. Do you foresee an increase in managerial staff at a Health Board level to manage members of the wider multidisciplinary team? If so, what are the funding implications of this increase and do you envisage this coming out of the £250m 'in direct support of general practice'?
8. Given that this contract relies very heavily on the extended multidisciplinary workforce, how can we be assured that Integration Authorities will deliver that workforce in a nimble and timely fashion?
9. What are the governance arrangements when GPs are not employers but are the senior clinical decision makers? Will this be the remit of the Health Board if there are complaints, performance issues or disciplinary procedures?
10. Where will these additional staff come from given existing vacancies in other professional groups? Will they not also take several years to train?
11. How can we ensure that care is not fragmented through widening of the primary care team?
12. How can practices in harder-to-recruit-to areas be assured that staff in these roles will not gravitate to more 'popular' areas (e.g. the central belt)?
13. What will be the role of the third sector, particularly for patients with mental health needs and social isolation?
14. What has been the reaction of other professional groups to the suggestion that the GPs will lead the teams?

3. Assessing the proposed contract against the 'Four Cs' of Primary Care

According to the contract document, Barbara Starfield's 'Four Cs' of primary care acted as a guiding principle throughout the negotiations, and the 2018 Scottish GMS contract is intended to allow GPs to deliver these four Cs in a sustainable and consistent manner in the future. Chapter 6, 'Better Care for Patients', looks at each one in turn.

RCGP Scotland's *Core Values* document, lists the Four Cs among its tests of new models of care:

- Contact: General practice is the default place, the first point of contact, for the vast majority of patients seeking access to healthcare for the first time.
- Comprehensiveness: It's not just about seeing the person and their presenting complaint. GPs see people in their holistic lived experience. GPs are uniquely placed to deal with aspects of medical, social, and psychological factors. GPs ask people about something they didn't come in for and take the time to listen, identifying major issues.
- Continuity: GPs are there from cradle to grave, with care benefitting from long term relationships with patients.
- Coordination: Critically, GPs are able to oversee care from multiple providers and act as a 'system failure service' for the NHS. When anything goes wrong, GPs are usually the ones to hear about it. The co-ordination of services at primary care level is an

important determining element in the responsiveness of health services provision and the health system as a whole.

Although just one part of the *Core Values* of general practice, these four principles can be tested against the new contract. Indeed, chapter six of the contract goes into some detail examining each of the four Cs in turn. The new proposed contract poses some questions about the way in which it takes forward these principles, especially regarding the shift in first point access away from the GP to other members of the wider primary care team.

Question:

1. Is the 'expert medical generalist' term too narrow a definition to include the essence of what a GP is?

3.1 Contact

What the contract says under its section on 'contact':

'Improving patient access to primary care and general practice is multi-faceted. Access in general practice is influenced by a range of issues: the location of the practice; when it is open; how easy it is to make appointments; and the speed of access to appropriate care.'

The contract talks here about maintaining core hours of 8am to 6.30pm, of improving access for patients using the internet where the facilities exist, and improving awareness of extended opening hours where this exists. The contract makes clear here what it has stated elsewhere: that while contact with primary care and general practice will be maintained, the GP will not necessarily be the first point of contact.

Questions raised:

1. What assurances can be given that patients will be able to make contact with a member of the wider multidisciplinary team within these stated hours (i.e. will they mirror GP hours)?
2. Will GPs have the ability to offer longer appointments?
3. Do we know that this new GP role (of only being involved in the more complex care) is attractive to younger GPs or those considering general practice as a career?

3.2 Comprehensiveness

What the contract says under its section on 'comprehensiveness':

'Ensuring patients have sufficient time with their GP when it is needed means recognising that not all patient needs at all times require the expertise of a doctor. The agreement on service redesign reflected in the Memorandum of Understanding will underpin the contract and allow GPs to have more time to deliver the type of care that only their skills and training can provide. At the same time, comprehensive patient care will be maintained within an expanded primary and community care team, with GPs having a more prominent clinical leadership role.'

Questions raised:

1. By removing the GP from significantly more consultations, how will the holistic approach of the expert medical generalist be applicable to everyone?
2. Will this lead to GPs providing that holistic care to fewer patients?

3. Will the loss of that holistic approach mean more patients will be seen in silos, without that expert overview of a range of medical, psychological and social factors (i.e. fragmentation of care)?
4. How can ongoing generalist training be maintained given that there is a need to ensure adequate exposure to the 'simple things' to recognise the more 'complex things'?

3.3 Continuity

What the contract says under its section on 'continuity':

'Continuity of care – the development of lifelong therapeutic relationships between doctor and patient – is a distinctive hallmark of general practice. The aim of the workload reduction measures described in chapter four is to free up GP capacity for those times when only the expertise of a doctor is sufficient.'

Scottish Government and SGPC agree it is not appropriate to contractually define consultation lengths, as that will continue to be a matter for clinical judgement. Freeing up capacity, through the redesign of services over the next three years, will allow for longer GP consultations when required by patients, particularly for complex care.

Questions:

1. Will patients being signposted more and more to other, seemingly appropriate members of the wider team mean more fragmented care that makes it more difficult to establish and maintain those cherished and vital long-term relationships?
2. What effect will this have on the general capacity for shared decision making and tolerance of uncertainty and risk between patient and professional, if there has not been an established relationship of trust already built up 'in sickness and in health'? How does this support the delivery of Realistic Medicine?
3. What assurance can be provided that continuity of care will be maintained given that the wider practice team, under this contract, will be employed by the Health Board?
4. What consideration has been given to the effect of any loss of continuity of care, and the subsequently altered relationship with patients and communities, on general practitioners' job satisfaction and so to recruitment and retention?

3.4 Coordination

What the contract says under its section on 'coordination':

'The 2004 GMS contract requires each practice to make a practice leaflet available to patients. This requirement will remain and the practice leaflet will continue to include important information for patients about the practice and how they can access available healthcare services in their local surgery. This includes: the name of the contractor; partners and all healthcare professionals who deliver services; how to register with the practice; the practice area; and the opening time of the practice premises; as well as how to access services in core hours of 08:00 to 18:30'

Questions:

1. Does expanding the role and remit of the wider team make it easier or more difficult for a GP to coordinate care?
2. Will GPs continue to be aware of patients' movements through the healthcare system (both primary and secondary care)? How?
3. Will this contract make the role of the 'senior clinical leader' more difficult in terms of overseeing other members of the MDT?
4. What IT will be available to support this coordination role given existing inadequate IT interfaces? (Contract references 'appropriate tools')

4. Patient Engagement

There are some fundamental changes proposed in the contract about the way in which a patient will navigate their way through the practice and the primary care system and how they will experience care provision. There appears to be little explanation, other than the previously described leaflet, about how this will be communicated to patients and it is essential that it is not viewed by patients as a move to restrictive rationing. Change in culture and acceptance of new models of care cannot be expected to be led by health care professionals alone in the vacuum of their consulting rooms and practices.

RCGP Scotland patient engagement group (P3) Chair, Colin Angus, has opened a dialogue with Scottish Government about ensuring the patient voice is heard.

Questions raised:

1. Does there need to be an ongoing national conversation led by the Scottish Government to explain to patients how they will access and experience general practice care in future, to allow them to understand why this is happening and how it is being driven?
2. Can we reasonably expect an already exhausted and demoralised workforce to take on this educational role alone?
3. Will there be training available to practice receptionists to deliver high quality signposting advice as this is currently done on a very ad hoc basis and is difficult to do well?

5. What is the impact on remote and rural practices?

What the contract says:

'The rural and remote GP shares much of the same generalist workload as their colleagues in urban areas. In many areas, being a rural GP means being the expert medical generalist providing the broadest range of skills because of their remoteness, because they usually have smaller primary care teams and because the locality services that may be available in areas with larger populations may not be available.'

Many remote and rural GPs have chosen to work where they do in part because it fits with their desire to provide a more complete primary care service to their patients and see delivery of some services as welcome opportunities to engage with their patients. In some rural areas where there are larger list sizes, there will be the opportunity to move the responsibility for some services like immunisations to reduce workload pressures.

Chapter four describes the Vaccination Transformation Programme which will transfer responsibility for the delivery of vaccinations from GPs to NHS Boards. On completion of the programme to the satisfaction of the SGPC, Scottish Government and local delivery and commissioning partners, the relevant Additional and Enhanced Services for vaccinations will no longer be included in the Scottish GMS contract. In rare circumstances, it may be appropriate for GP practices, such as small remote and rural practices, to agree to continue delivering these services through locally agreed contract options.

Phase one of the contract will see a new GP workload based resource allocation formula to replace the existing Scottish Allocation Formula (SAF). Methodological improvements in the new GP Workload Formula are intended to mean that isolated pockets of rural deprivation are

better addressed by the new formula. There is a discussion among remote and rural GPs as to whether the reliance on the Scottish Index of Multiple Deprivation (SIMD) as the measure of deprivation has delivered an adequate degree of correlation with rural deprivation.

It is intended to look at pay and expenses as part of phase 2, with particular attention given to remote and rural practices. In necessarily small, remote GP practices, extra resources will continue to be made available to ensure long-term sustainability. Remote GP practices will, as they do now, continue to provide a broader range of services more appropriate to remote settings. We know that rural GP practices have, on average, higher expenses per patient than urban ones. Partly, these can be explained by the diseconomies of scale of small GP practices and the costs of dispensing, or having one or more site/branch surgeries and we recognise that these differences will need to be addressed by proposals for Phase 2.

Questions raised:

1. Will there be separate provisions made for remote and rural practices?
2. Will the polling responses be broken down by geographical area?
3. What assurances can you offer the College and the Rural GP Association of Scotland over protecting rural GP funding, and that payment for the job will reflect the additional services they do?
4. What assurances can be offered that Advanced Nurse Practitioners will not be allowed to replace GPs in remote and rural areas?
5. Does the use of the Scottish Index of Multiple Deprivation (SIMD) as the measure of deprivation adequately correlate with rural deprivation?
6. What assurances can you offer to GPs that they will be protected against additional workload with no resource attached, if IJBs and NHS Boards reallocate or remove funding for the expanded teams in their area as a result of, for instance, recruitment difficulties?
7. Is there a role for the RCGP on the short life working group that is being established?

6. What is the impact on Out of Hours services?

There will be changes to arrangements for Out of Hours services. Instead of the current opt-out arrangement a new opt-in Enhanced Service will be developed for those practices that choose to provide Out of Hours services.

The new Out of Hours Enhanced Service will have a nationally agreed specification, building on the quality recommendations within Professor Sir Lewis Ritchie's Out of Hours review and covering areas such as record keeping, anticipatory care planning, key information summaries, use of Adastra and NHS24.

This will contribute to a consistency of approach to the provision of unscheduled care services across Scotland where practice-based service level agreements are in place. There is also an opportunity to develop a nationally agreed quality and person-centred specification which could be used by all NHS Boards to test and benchmark their current local service level agreements.

Questions raised:

1. Has any analysis been done about the unintended consequences of expanding the in-hours workforce, by inadvertently moving staff (i.e. Paramedics and Advanced Nurse Practitioners) to a setting with fewer anti-social hours? How can we avoid a drain of experience away from OOH?
2. What levels of service for patients will be guaranteed where GPs choose not to 'opt-in' to OOH services?

7. What resource being promised?

It is difficult to extract hard facts and figure here as the contract as written doesn't contain the level of detail required to conduct a detailed breakdown. However, the contract does reveal the following funding information:

- Minimum earnings – no GP partner to earn less than £80,430 (including pensions contributions – equating to around £70, 000 for WTE/40 hour week) from April 2019 – this is expected to benefit around 1 in 5 of GP partners in Scotland
- GP premises fund - £30m over 3 years (£10m per year) – this represents a 24% increase in funding for supporting GPs with premises, compared with 2015/16 (two years ago)
- Confirmation of the commitment to invest an extra £250m 'in direct support of general practice' by 2021/22, beginning with an extra £23m next year
- In 2020/21 a 'Phase 2' will be enacted, assuming a successful second poll of GPs and consideration from SGPC, introducing a guaranteed income range and direct reimbursement of expenses. The income range will be 'comparable to that of consultants'.
- In 'necessarily small remote GP practices, extra resources will continue to be made available to ensure long-term sustainability.' It is not explicitly clear to whom the resource will be made available nor at what level.

Questions raised:

1. What detail is available about the plans for the implementation of the recurring £250m 'in direct support of general practice' by 2021/22?
2. What conversations have been had with Scottish Government around the other £250m 'for our GP practices and health centres' as promised by the First Minister in her October 2016 speech?
3. Do we believe that the £250m 'in direct support of general practice' is going to adequately support the model this contract seeks to implement?
4. How was the minimum income figure of £70,000 for WTE GP reached?
5. How will Scottish Government use the mandatory information provided by GPs on their income?

Lack of Detail around Phase Two of the Contract

Phase One of the contract poll from April 2018 seeks to introduce a new funding formula, the GP Workload Formula, which will replace the existing Scottish Allocation Formula (SAF). Additional investment of £23 million has been identified for additional funding that some practices will receive under the new formula, whilst protecting the income of all other practices. The impact of the new formula on GP practice funding has been calculated for each GP practice in Scotland, and all practices should now have received these letters. The minimum earnings expectation for WTE GP partners also falls under Phase one.

There is less clarity around funding arrangements for phase two. The reasons given for this are:

- Time is needed to develop the administrative capacity to enable the direct reimbursement of expenses and payment of income

- Data collection is needed to allow calculations of impact on individual partners for any change in funding models.

There is also a statement in the contract that there will be no move to phase two until there is a proposal that is acceptable to the profession.

Questions raised:

1. Are we able to have any more detail on phase two before we vote for phase one?
2. Will the learning from phase one influence the direction of travel for phase two?
3. Has the need for a robust evaluation and research (e.g. by the Scottish School of Primary Care) been considered and has funding been identified for this?
4. What if there is a yes-vote for phase one, and a no-vote for phase two? Do we remain in limbo?
5. What are the benefits of remaining an independent contractor under phase two?
6. Is there an assurance that GP income will be protected at both Phase 1 and Phase 2?

Lack of flexibility offered within the contract

This is a nationally negotiated contract, but there is recognition within it of the need to better understand and support the needs of specific groups, e.g. remote and rural.

There is also explicit recognition of the RCGP's paper, *'The essence of general practice'*, contained within the contract, specifically that, *'contracts should be used to enable rather than limit the developments in general practice'*.

Questions raised:

1. Is there scope to apply the contract flexibly according to local community needs, given the diversity of the population? (e.g. recruitment difficulties in remote and rural making the health-board employment of wider teams less possible to achieve?)

Areas discussed as potential opportunities for the RCGP

1. GP Training

Several additional training needs are identified for GPs within the document: Quality Improvement role, leadership, data analysis, mentoring and training of non-medical staff, understanding NHS reporting structures. RCGP must be the leaders on this aspect. Training is not a devolved issue, but RCGP must have a strong stance due to the emergence of these additional training needs. Given the pressures on the existing curriculum, these underline the need for the introduction of an extended and enhanced programme of postgraduate GP training, lasting a minimum of four years.

2. Quality

Given the increasing importance of the role of GP Quality Clusters in designing local services, professional support for these clusters is another vital role for the RCGP, for example through the newly appointed RCGP Local Advocates and the ongoing work of the Executive Officer for Quality.

There is also a clear role for the RCGP in setting quality standards for the national oversight group, and we have requested that this be included in the MOU.

Furthermore, there is a potential role for the RCGP and SGPC to jointly monitor whether the changes are implemented (similar to roles adopted for the GP Forward View in England)

3. IT Developments

A new joint SGPC and RCGP IT working group has been proposed to work together on IT development. High-functioning IT is crucial to the delivery of the proposed new contract.

4. Interface

There is ongoing joint working between RCGP and Scottish Government to facilitate the creation of dedicated primary-secondary care interface groups across every health board area in Scotland, in recognition that high functioning interfaces are crucial in moving forward to improve practice sustainability.

5. GP Wellbeing

It is possible that, through better educational and training opportunities, an intention to increase the amount of protected time to innovate, the provision of longer consultations to some patients, and through improved perceptions of general practice as a career, GP wellbeing may improve. The RCGP is committed to promoting excellent practitioner wellbeing and already provides a number of Continuing Professional Development courses focused on a range of areas, including GP wellbeing, which the College would be keen to develop further.

Appendix 1

Attendance at the Special Meeting of RCGP Scottish Council, held on Saturday 25 November 2017

Members of Scottish Council:

Dr Carey Lunan, Chair RCGP Scottish Council
Dr Alasdair Forbes, Deputy Chair (Policy) RCGP Scottish Council
Dr Stuart Blake, Ballot Member
Dr John Duncan, North East Scotland Faculty Representative
Dr Lizzie Finlayson, North East Scotland Faculty Deputy Representative
Dr Scott Jamieson (via teleconference), East Scotland Faculty Representative
Dr Amy Knighton, Chair, RCGP Scotland AiT and First5 Committee
Dr Miles Mack (via Skype), North Scotland UK Council Representative
Dr Morag Martindale, Ballot Member
Dr Jim McKinlay, West Scotland Faculty Representative
Dr Chris McHugh, West Scotland Faculty Deputy Representative
Dr Elaine McNaughton (via teleconference), East Scotland Faculty UK Council Representative
Dr Libby Morris, Ballot Member
Dr Brian Robson (via teleconference), West Scotland Faculty Representative
Dr David Shackles, East Scotland Faculty Representative
Dr David Stephens (via Skype), North Scotland Faculty Representative
Dr Chris Williams, North Scotland Faculty Representative

Observers:

Colin Angus, Chair, RCGP Scotland Patient Group
Dr Jenny Bennison, RCGP Scotland Executive Officer (Quality Improvement)
Dr Alan McDevitt, Chair, BMA Scottish General Practitioners Committee
Dr Graham Kramer, RCGP Scotland Executive Officer (Patient and Public)
Dr Ken McLean, RCGP Scotland Executive Officer (Membership)
Dr Stewart Mercer, Director, Scottish School of Primary Care

Guest:

Dr Andrew Cowie, BMA Scottish General Practitioners Committee

Staff:

John Anderson, Committees and Executive Officer
Lizzie Edwards, Policy and Public Affairs Officer
Laura Gillies, RCGP Scotland Manager
Ashleigh Simpson (via teleconference), Devolved Councils Campaigns Officer
Mark Thomas (via teleconference), Executive Director of Policy and Engagement
David Webster, Communications and Public Affairs Manager
Ed Wilson (via teleconference), Head of Devolved Councils



The *Core Values* of general practice: a summary promoting excellence in primary care

Core Values is a document written by RCGP Scotland through which GPs gave an agreed description of what the core values of general practice are. This is a summary of that description.

- The way healthcare is delivered is having to change.
- Healthcare will be increasingly delivered within the community.
- RCGP supports this direction of travel and the necessary expansion of the wider multidisciplinary primary care team.
- Patient expectation and demand for GP services is growing, yet percentage-share funding for general practice has continued to fall over the last decade and there is an increasing shortage of GPs.
- Developing new models of care may be a solution to this challenge. In the context of any proposed changes, the specific role of the GP and the potential impact on patient care must be considered.
- RCGP Scotland's *Core Values* is intended to provide a guidance framework to ensure that any new models of care ensure high quality and are patient-centred.

To promote and protect patient care, general practice must:

Protect the key roles of general practice

- Look after the whole person instead of separate conditions
- Prevent ill-health
- Co-ordinate care and provide continuity for patients
- Diagnose from symptoms presented by individuals in their own, personal context
- Manage chronic and multiple medical conditions
- Deliver palliative and end of life care
- Teach colleagues and improve personal knowledge
- Work as part of a team

Safeguard and promote the key advantages of general practice

- The trust achieved through treating patients with compassion and good quality care - essential for shared decisions and avoiding over-medicalisation.
- The GP co-ordinating their patients' care.
- The continuity of care provided by GPs developing a strong relationship with patients, often over many years.

- The flexibility to treat patients in a way that best meets their needs.
- Providing contact, as GPs engage with around 90% of patients over a five-year period, including 'hard to reach' groups.
- The leadership and innovations provided by GPs based on their multidisciplinary knowledge and experience of local circumstances and communities.

Ensure that care is integrated and patient centred

- Ensure community-based services are person centred and led by GPs.
- Ensure GPs continue to act as independent advocates for their patients.
- Ensure GPs will co-ordinate patient care, working with other healthcare professionals to ensure care focuses on the whole person rather than the condition.
- Develop IT resources and communication structures which allow for effective cooperation and networking between GPs and other healthcare professionals.
- Ensure that general practice and primary care are each adequately funded, with appropriate investment in robust evaluation of any new models of care.

Reflect the Four Cs

- **Contact:** General practice is the first point of contact for the majority of patients seeking access to healthcare for the first time.
- **Comprehensiveness:** GPs see patients as a person rather than a condition, taking into account medical, social and psychological factors. GPs ask people about something they didn't come in for and take the time to listen, identifying major issues.
- **Continuity:** GPs care for their patients from cradle to grave, developing strong relationships with their patients.
- **Co-ordination:** GPs coordinate patient care, overseeing treatment from multiple providers and guiding patients through the healthcare system.

Involve patients

- Patient participation and feedback should be central to the development of any new model.
- RCGP Scotland will seek the input and guidance of its Patient Partnership in Practice (P³) Group in responding to new models of care.

Any future new models of care must fully reflect, safeguard and promote these core values and will be assessed on that basis.

Core values : *Cum Scientia Caritas*

Benchmarks, scales and yardsticks

Introduction

The landscape in which general practice in Scotland operates is changing rapidly. The Scottish Government's *2020 Vision* demands that more care be provided 'at home or in a homely setting', which will inevitably lead to a shifting of work outwith hospitals.ⁱ The Integration of Health and Social Care, towards the *2020 Vision*, is now in operation but the nature and extent of new arrangements on the work of GPs and their teams will take some time to become clear. For over a decade the share of NHS Scotland funding delivered to general practice through the Scottish Government budget has been reduced consistently, from 9.8% in 2005/06 to 7.4% in 2014/15, with final figures for 2015/16 almost certain to show significant further losses. Workforce numbers and GP trainee recruitment are at a low and perhaps unsustainable level and almost a third of practitioners are considering retirement within the next five years, with a further 14% wishing to reduce their working commitment to part time. Meanwhile, patient expectation and demand continues to grow. In this context the establishment of new ways of delivering general practice care has been suggested and Scottish Government has made clear its willingness to act decisively to ensure this work progresses.

The nature of the GP team is also changing. The future role for the general practitioner is being proposed, according to a December 2015 BMA Scotland briefing, as one of supporting a wide range of other clinical professionals while working as an 'expert medical generalist'ⁱⁱ and 'senior clinical decision maker in the community, who will focus on:

- Complex care in the community
- Undifferentiated presentations
- Whole system quality improvement and clinical leadership'ⁱⁱⁱ

In considering Out of Hours care, Professor Sir Lewis Ritchie noted in his report's Key Messages that, 'Future urgent care will be delivered by well-led and trained multidisciplinary and multi-sectoral teams. GPs will no longer be the default health care professionals to see patients for urgent care, but they must continue to be an essential part of multidisciplinary urgent care teams, providing clinical leadership and expertise, particularly for complex cases. People seeking help need to see the right professional at the right time, according to need.'^{iv}

This shift has been developing over some time. In Gillies, Mercer, Lyon et al.'s 'Distilling the essence of general practice' (the *Essence*) it is remarked that,

'Although the direction of NHS policy appears to suggest that many functions of the GP can be performed by other professionals, including pharmacists and nurses, GPs are still uniquely trained, motivated, and situated, geographically, historically, and culturally to take forward this task [the consultation] in the 21st century.'^v

The BMA has also recognised some dangers inherent in this approach to teams, although it concerned both secondary and primary care. *The Role of the Doctor* states explicitly that, in this instance, 'Where such role substitution is employed, there is a risk that patients do not have access to the range of knowledge and skills that characterise a doctor's holistic approach to care.'^{vi}

Roles, responsibilities and lines of communication within teams must be clearly and appropriately defined.

Increasingly, with the introduction of other clinical staff in practices, GPs no longer undertake routine work such as chronic disease management, ante-natal care and the monitoring of patients on oral contraceptives. It has been proposed, within the negotiation of the new Scottish GMS contract of 2017, that further removal of the GP from aspects of healthcare presents the only viable solution to current GP workload and recruitment problems. The GP, as the 'senior clinical decision maker' in a team, 'would be less involved in the more routine tasks and require a greater reliance on other health professions in the wider community team'.^{vii}

An increased emphasis on care planning is proposed together with the further development of patient health literacy and self care, particularly in those with long term conditions. The proposals suggest increasing options for patients to self refer to other areas of the primary care team, such as optometry, physiotherapy and podiatry, alongside maintaining existing routes to pharmacy, midwifery, nursing and other specialisms.

In the context of such proposed change, it is vital that the profession consider the role of the GP within these new models of care and the potential impact on patient outcomes.

Cum Scientia Caritas

In its successful manifesto for the 2016 Scottish Parliamentary election, *Promoting general practice*, RCGP Scotland made plain that,

'With the Scottish Government committing to the trial of new models of primary care in the development of the planned 2017 General Medical Services contract, it must be acknowledged that any new model can only be made fit for purpose with the full engagement of the profession.'^{viii}

The College has a duty to put forward the standards that should be aspired to. So great are the changes currently proposed that the College must comment from the foundations represented through its motto, *cum scientia caritas* ('compassion with knowledge').

Science and 'compassion' or 'care' are not always clear bedfellows to those outside healthcare. Indeed, it could be argued from one perspective that the cold logic of the first has no place for the second, or from another that the emphasis on subjective need is incompatible with objective practice. Michael B Taylor, in his discussion paper 'Compassion: its neglect and importance' recognises this and confronts it.

'Talking of compassion in a scientific journal such as this is awkward and even a little embarrassing, partly because there are no units of measurement. The nearest surrogate is the soulless 'continuity of care'. We have rightly become comfortable with numbers because of the power they have brought with the advancement of scientific method, but it is folly to neglect what is important simply because it cannot be counted.'^{ix}

The profession of the general practitioner expresses values that explicitly and consciously combine the two. It has done so since its beginnings and throughout its development. Dr

D.L. Crombie, commenting on *caritas* as 'compassion' and 'feeling with' in his delivery of the annual James Mackenzie Lecture, remarked that,

'It is this "feeling with" which enables a doctor to bring to bear on the problems of his patients, information which cannot yet, and probably never will be, obtained by "scientific" methods. Scientific method is subsumed by the chains of reasoning which logically link identifiable and identified causes with effects.'^x

A combination is required. Quantities of evidence make plain that such a combination is greatly to the advantage of patients, with better health outcomes resulting.

Similarly, the logic of how to respond under reduced funding and considerable challenges to workforce numbers must be tempered with those values. Balanced with science, the nature of appropriate patient care, then, must be the measuring tool within the general practitioner's mind when assessing whether any new model is fit for purpose in appropriately meeting the needs of patients. Faced with proposals of such momentous change, the profession may gratefully rely upon previously defined frameworks and standards through which to define what such care is and how it may be expressed. After months of RCGP Scottish Council's consideration of those frameworks and standards, then, the College is in a position to establish the core values that should be preserved in any new model of care. These values should also be considered as starting principles for the 'peer-led, values driven' approach of the proposed Scottish GP Quality Clusters.

The First Minister, Nicola Sturgeon MSP, then Deputy First Minister and Cabinet Secretary for Health and Wellbeing, in her Foreword to RCGP Scotland's document, *The Future of General Practice in Scotland: A Vision*, echoes Iona Heath's famous assertion that 'The consultation is the foundation of general practice'.^{xi} She said,

'Patients in Scotland have told us that they need and want ... continuity of care and clinical excellence. It is encouraging that the College highlights a core skill within general practice as the ability to communicate in a meaningful way with patients, relatives and carers. I share the RCGP Scotland belief that high quality GP consultations should be the main focal point for enabling patient centred local care in future and where necessary seamless access to secondary care services.'^{xii}

In the First Minister's belief lies encouragement and the political authority to act.

Benchmarks, Scales and Yardsticks

The roles, advantages, tests and values outlined below have been formally considered by RCGP Scotland's Scottish Council, coming, as they do, from solid and tested previous work. Indeed, members of that Council have produced one of the papers providing them, the *Essence*. They are set, through this paper, as benchmarks, scales and yardsticks through which approaches to general practice may be measured.

The *Essence* was written from a forward thinking point of view, 'exploring the core values of general practice with an emphasis on the future'. It is very clear as to its own relevance to our purposes, advising that 'Successful adaptation to future challenges needs local GP leaders who have vision, and can see the opportunities ahead and respond in a way that does not compromise core values.'

Ten key roles

In exploring 'those characteristics that are at its [general practice's] heart and central to its purpose and ethos, and that, therefore, should be of principal concern in shaping its future',

the *Essence* identified seven 'Key roles for future GPs' in its section 'Essential future roles and personal qualities'. Those seven key roles were as follows:

- Chronic disease management
- Prevention of ill-health
- Teaching colleagues/self
- Team working
- Holistic/personal care
- Continuity/coordinated care
- Generalist

Included within the role of the generalist clinician, in which managing the range of diseases and contexts presenting in general practice is implicit, it is appropriate to specify the further key role of diagnostician of undifferentiated presentations, acknowledging the challenge of uncertainty that this brings to the role of the general practitioner. Also, in the evolving context of our ageing population and the increase in multiple morbidity, we would add to these eight key roles two further key roles: that of managing the complexity of multiple conditions and that of delivering palliative and end of life care. These extended, ten key roles form the first measuring tool RCGP Scotland will use to identify appropriate descriptions of general practice.

Six key advantages

The *Essence* provides a second scale, that of the six 'Key advantages of general practice'. These six key advantages are 'central to the future development of primary care' and are described as follows:

- **Trust:** achieved by high-quality empathic communication with patients and past experience of good-quality care; essential for concordance with treatment, co-creation of health, effective gatekeeping, and avoidance of medicalisation. Underpinned by local perceptions of altruism, fair dealing and other personal qualities, competence, integrity, and probity, and by both rhetoric and an assumption of good intentions.
- **Coordination:** in dealing with patients' multiple problems and issues; between patients and relatives/partners, between GP and members of the primary healthcare team, social work, and voluntary agencies, between hospital consultant-led and primary care services.
- **Continuity:** generated by repeated contacts, developing and strengthening relationships with patients over months and years. Challenged by many trends, including new working patterns among GPs including daytime working and multiple providers of care. [The original 2008 *Essence* document included a challenge from the 'feminisation' of general practice and one from GP-led health centres.]
- **Flexibility:** to address problems in the order and at a pace that suits patients; adapting clinical evidence to the individual patient, nGMS contract requirements to local community needs; balancing individual and population approaches in day-to-day work [to which may be added the modern challenge of balancing the increasing demand of those who need quick access with those who need continuity]; dealing capably with continuing NHS change; liaising effectively with local voluntary organisations; and innovating to good effect.
- **Coverage:** comprising over 90% contact with list populations over a 5-year period, including many who are 'hard to reach' using one-off screening approaches, so that special measures to enhance coverage are required for very few people. This cumulative approach to population coverage is much more sustainable than screening.

- Leadership: including the ability to implement change quickly, based on multidisciplinary knowledge and experience of local circumstances, staffing, and population characteristics.

Five tests of integrated care

As part of the solutions based work around the RCGP Scotland document, *A blueprint for Scottish general practice (the Blueprint)*, in order to ensure ‘that patient centred care is hardwired into emerging new models by building on the strengths of general practice’, five tests to be applied to integrated care were developed.^{xiii} This is in harmony with the Scottish Government’s clear desire to see ‘care that is person centred rather than condition focussed’^{xiv}. The Chief Medical Officer’s Annual Report 2014-15 describes how ‘The person centred portfolio in Scottish Government is driving and supporting policies and quality improvements that help reshape health and care through the lens of people using services.’^{xv}

The rationale behind the tests was simply expressed. ‘The doctor-patient relationship must be protected. In the context of rising levels of multiple morbidity, these new models will need to move away from the traditional NHS focus on single-disease pathways and individual episodes of care. It is vital, therefore, that these emerging models build on the strengths of general practice, including the ‘local’ nature of GP services, their generalist scope, the continuity of care they provide to individuals and families and the population level perspective they are able to take through the registered patient list.’ In this the *Blueprint* reflects Joanne Reeve in her *Protecting Generalism* assertion that,

‘Yet generalist practice is more than disease-focused care delivered in a community setting. It is a different approach to understanding and addressing health and illness. Generalism describes a philosophy of practice which is person, not disease, centred; continuous, not episodic; integrates biotechnical and biographical perspectives; and views health as a resource for living and not an end in itself.’^{xvi}

The five tests, then, are that proposed models of integrated care should:

- Ensure community-based services are led by community-based clinicians [GPs] with a person-centred perspective.
- Underpin safe patient care by ensuring that GPs can continue to act as independent advocates for their patients, with the emphasis on the person not the institution.
- Be person focused, responding to the needs of the individual and protecting them from overmedicalisation, with general practitioners working with specialists [and, now, with other clinicians in the community] to contribute to the holistic care of the individual.
- Develop existing structures and resources to work in an increasingly co-operative way, recognising that primary care is a network of providers and requires a network literacy in its management, with the IT to support this.
- Ensure that general practice and primary care funding is sufficient to meet their unique and vital role in delivering person centred care, with investment in robust evaluation of new models of integrated care.

The four Cs

Barbara Starfield has provided general practice with perhaps its most succinct measure, the Four Cs. They are cherished for their effective safeguarding not of general practitioners’ modes of practice but of patient care. In 2015 the Cabinet Secretary for Health, Wellbeing and Sport, Shona Robison MSP, addressed the RCGP Annual Primary Care Conference. Within her address she insisted upon their centrality to general practice, saying,

'From Cumbernauld to Cape Wrath, the services your community needs should be there for you, locally planned and locally delivered, reflecting the Four Cs of contact, comprehensiveness, continuity and co-ordination advocated by the RCGP.'^{xvii}

The Four Cs may be expressed as:

- Contact: General practice is the default place, the first point of contact, for the vast majority of patients seeking access to healthcare for the first time.
- Comprehensiveness: It's not just about seeing the person and their presenting complaint. GPs see people in their holistic lived experience. GPs are uniquely placed to deal with aspects of medical, social, and psychological factors. GPs ask people about something they didn't come in for and take the time to listen, identifying major issues.
- Continuity: GPs are there from cradle to grave, with care benefitting from long term relationships with patients.
- Co-ordination: Critically, GPs are able to oversee care from multiple providers and act as a 'system failure service' for the NHS. When anything goes wrong, GPs are usually the ones to hear about it. The co-ordination of services at primary care level is an important determining element in the responsiveness of health services provision and the health system as a whole.

The Kings Fund & Nuffield Trust set down, as a 'design principle' for primary care, that 'Patients are offered continuity of relationship where this is important, and access at the right time when it is required.'^{xviii} Importantly, RCGP Scotland recognises patients' right to access appropriate care at all times of need, including the ability to consult a general practitioner at any point, 24 hours of the day, seven days a week.

Patient participation

In recognition of the central value of patient centred care the Royal College of General Practitioners has consistently advocated for effective patient representation and on this basis we would not wish for such far reaching change to the delivery of patient care to be trialled without adequate representation from patients.

The *Blueprint* expresses that,

'Patient feedback and participation should be central to the development of any new model. RCGP Scotland will, for its part, continue to seek the input and guidance of its Patient Partnership in Practice (P³) group and others.'^{xix}

It is difficult to envisage any new model of care being understood or accepted by the public without such feedback and participation.

Measurement

These, then, make up the benchmarks, scales and yardsticks general practice must use to evaluate whether any proposed new ways of delivering general practice care in Scotland are models safe to be described as Scottish general practice; the ten key roles, the six key advantages, the five tests of integrated care, the Four Cs and patient feedback and participation. There is much cross pollination between them, indicative of their strength and concrete roots. For example, where the five tests speak of the need to 'contribute to the holistic care of the individual,' the Four Cs speak of how 'GPs see people in their holistic lived experience. GPs are uniquely placed to deal with aspects of medical, social, and psychological factors.' Where the *Essence* describes how 'the inherent strength and

complexity of the doctor-patient relationship supports quality at a much deeper level' Starfield has it described as 'Continuity: GPs are there from cradle to grave, with care benefitting from long term relationships with patients.'

General practice is undoubtedly going to need to do things differently but as we consider these changes, whatever the demographic or geographical context in which these changes occur, RCGP Scotland believes that it is essential that we stay true to the core values in this document that we believe are at the core of how general practice has served the NHS and the population of Scotland with such distinction for the last 60 years and more^{xx} and which can continue to do so into the future.

The College, therefore, asks its members to bring these tests to bear as they engage in the design, development and trial of any new models of care in Scotland through which appropriate patient care may be delivered in future.

Conclusion

This position paper is intended as a sharp and unfailing tool to be used when considering any future development of the role of the general practitioner. It is apparent, however, that the timing of its publication is borne from necessity, during a period of increased pressure on general practitioners to make decisions quickly with regard to the future of their profession. Any decisions must be made from the surety of positive, solid, values based foundations, so looking beyond the short-term horizon, beyond the mid-term, to the long-term future of general practice. The warning against divergence supplied by the participants in the *Essence* project, who represent a spread of career stages, is clear. 'A further concern shared by trainees and trainers was the erosion of the traditional value base of general practice'.

While some of these benchmarks, scales and yardsticks at once welcome and challenge certain aspects of current thinking around future Scottish general practice, that does nothing to reduce their importance nor their accuracy. As the *Essence* has it, 'contracts should be used to enable rather than limit developments in general practice.' It is for current general practitioners to define routes through which to realise and enshrine ambitions, realities and core values.

By way of example only, the question of the role and responsibilities of the wider primary care team, in the light of those of general practitioners, is one such issue. RCGP Scotland's *Blueprint* recognises that, 'the role the wider primary care workforce has to play in delivering services is vital.' The *Blueprint* calls for a widening and extension of that workforce. The *Essence* notes, though, that 'there were tensions between the need for effective teamwork and patients' wish to relate to and sometimes see their own GP, rather than another team member.' That seeming conundrum of core value and possible solution must be openly and explicitly addressed if lasting positive progress is to be made.

The College fully recognises that the pressures to change and to innovate in reaction to the current Scottish context, exemplified in Abraham Lincoln's well recognised words used at the start of the *Essence*, have only increased. 'The dogmas of the quiet past are inadequate to the stormy present.'^{xxi} The quotation may be continued, 'The occasion is piled high with difficulty, and we must rise - with the occasion.' General practice undoubtedly must develop, as it always has, to appropriately meet the needs of patients in whatever context it finds itself. We believe that it is of central importance that new models of care fully reflect and maintain these values into the future.

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