

HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM General Medical Council

Our role.

We welcome the opportunity to contribute to the Health and Sport Committee's consideration of the future development of Primary Care in Scotland.

For context, we are an independent organisation that helps to protect patients and improve medical education and practice across the UK.

- We decide which doctors are qualified to work here and we oversee UK medical education and training.
- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.
- We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

Every patient should receive a high standard of care. Our role is to help achieve that by working closely with doctors, their employers and patients, to make sure that the trust patients have in their doctors is fully justified.

While regulation of the medical profession is reserved to Westminster, the GMC operates within the legal and legislative structures of the different jurisdictions within the UK. As an example of this, our guidance for doctors reflects the laws of all Scotland, and when a law changes we seek senior counsel's advice on whether we would need to update our guidance.

In light of the insights gained through our role as a workforce regulator, we have focussed our response on the first two questions posed by the Committee.

- 1) Considering the Health and Sport Committee's report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities?**
- 2) What are the barriers to delivering a sustainable primary care system in both urban and rural areas?**

We note that service/workforce planning was highlighted as a priority area by Public Panels in Phase One of the Consultation. We recognise that one of the main barriers to delivering a sustainable primary care system is the workforce.

As the way care is delivered changes, we need to ensure that changes to the system architecture aligns with changes to the workforce – for example if more care is

delivered in the community, there will also need to be more people working in the community with the correct skill mix.

We consider three areas are key to addressing the workforce challenge: supply of doctors coming in, support for doctors already in the workforce and strategic change to ensure doctors are set up to deliver care for the future.

On workforce supply:

We are supportive of increased medical school places in under-served areas that have a focus on primary care and programmes such as ScotGEM (Scottish Graduate Entry Medical).

We recognise that there is a reliance on the hugely valuable international medical graduates (IMGs) coming to the UK and we are working to ensure there are no barriers to them joining the UK medical register.

Accordingly, we have increased capacity for the PLAB test doctors take to obtain registration to meet rising demand (a 42% increase over the last year). We support induction for doctors joining the UK, offering a free Welcome to UK Practice session.

We note that many of the difficulties doctors have in joining the workforce are not within the GMC's control but we would support others to make changes to ensure a smooth process between recruitment, registration and induction such as:

- **Training:** We are supportive of increasing places in medical training initiatives as an ethical recruitment method, such as the Scottish Government's International Medical Training Fellowships. We are also working with key stakeholders to develop a small number of early adopter credentials over the coming months, including a proposed remote and rural credential. Credentials will need to include evidence or information that describes patient safety issues and/or gaps in service which represent a risk to patient safety.
- **Legislative reform of the Certificate of Eligibility for GP Registration (CEGPR) route:** While we support the recognition of general practice as a specialty, the legal framework for GP training, the keeping of the GP register, and other applications for GP registration is prescribed in law and is complicated. We are seeking legislative reform to make the CEGPR route more flexible and accessible to make it easier for doctors to join the GP register without lowering standards.
- We can work with providers to support international medical graduates new to the UK, recognising good practice and supporting inductions.

On support for doctors already in the workforce:

We are taking action through our programme of work to support a profession under pressure to address the issues that have been raised with us about the environments in which doctors work, and the impact of systems pressures on medical practice. These pressures are set out in more detail in our report on [The](#)

[state of medical education and practice in the UK](#). We would also highlight the Royal College of General Practitioners Scotland report, *From the Frontline: The changing landscape of Scottish general practice*, which sets out key concerns from the perspective of frontline GPs.

We have also commissioned an independent review of mental health and wellbeing in the medical profession, which includes primary care within its scope. The report's recommendations will be published in the coming months.

As the planning and delivery of primary care changes, leadership will have an increasingly important role. A focus on leadership supports a positive fair workplace culture, and includes regular engagement with staff and positive cohesive team working.

We support leaders with our leadership standards for doctors, through delivery of workshops on our guidance, undergraduate and postgraduate education outcome requirements, supporting leadership schemes (e.g. Project Lift in Scotland), commissioning research on leadership cultures and hosting clinical fellows.

We are building on the work we currently do on clinical leadership to ensure a common approach across the system with an increased focus on multi-disciplinary working. We are also working with health boards in Scotland to pilot our Professional Behaviours, Patient Safety programme which is a collaboration with UK-wide stakeholders to help shape and influence the emerging shared aim of reducing bullying and undermining in medicine and medical settings.

On strategic change:

We recognised that multi-disciplinary teams are crucial and can ensure patients get the best care.

We are keen to work collaboratively with partners in government, NHS Boards, and other professional regulators to ensure that professional regulation and training systems support this, and that all professions work to their full potential.

Specifically, we welcome the recent decision that the GMC should regulate physician associates. We recognise that there is a role for increasing public awareness of how doctors, physician associates and other members of multi-disciplinary teams work together to provide care in a changing landscape. We look forward to working with partners to ensure that physician associates can maximise their contribution to patient care.

Our data and insights

The GMC has data on GPs that may support planning:

- Although our data shows a 1.05% increase in those on the GP register in Scotland between 2012 and 2018 we currently do not have data on the hours

they are working. For GP trainees, there was a drop in numbers in 2016-17 and an increase in 2017-18.

- A high proportion (42%) of Scottish-trained GPs who still have a licence to practise move over 100 miles from where they qualified as a GP, compared to only 30% in England.
- 68% of all licensed doctors who qualified in Scotland remained in Scotland (27% moved to England, 1% Wales, 4% NI). By comparison, 94% of licensed doctors who qualified in England are located there now.

In our annual report on [The state of medical education and practice in the UK](#), we set out some of the challenges in healthcare in 2018, including in primary care.

In that report, we set out data and analysis which shows what is needed to support and retain the current workforce and supply of doctors for the future, recognising that demand for care is increasing in volume and complexity.

We recognise our data and insights can contribute to a strategic approach to workforce planning and delivery that will meet the changing needs of patients and health services, including in primary care, over the coming years.

Much of this data is publicly accessible through the [GMC Data Explorer](#) and we regularly share our findings and work collaboratively with others.