REPORT TO: **MORAY INTEGRATION JOINT BOARD ON 25 MAY 2023**

SUBJECT: **GENERAL PRACTICE SUSTAINABILITY IN MORAY**

BY: **HEAD OF SERVICE**

1. REASON FOR REPORT

1.1. To inform the Board of sustainability issues in general practice across Moray.

2. RECOMMENDATION

2.1. It is recommended that the Moray Integration Joint Board (MIJB):

i) considers and notes the contents of this report; and

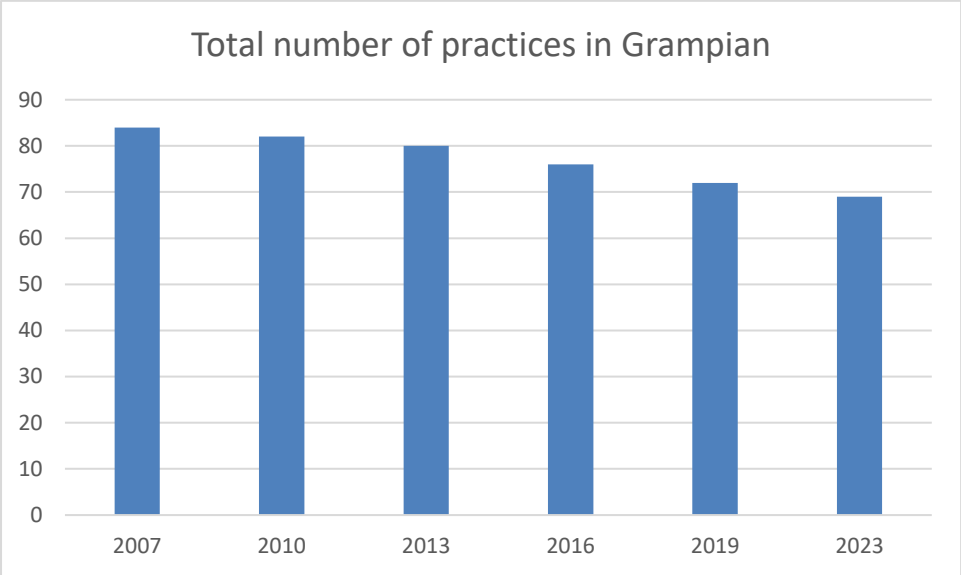
ii) agrees the actions and risk mitigation as detailed in section 4 of the report.

3. BACKGROUND

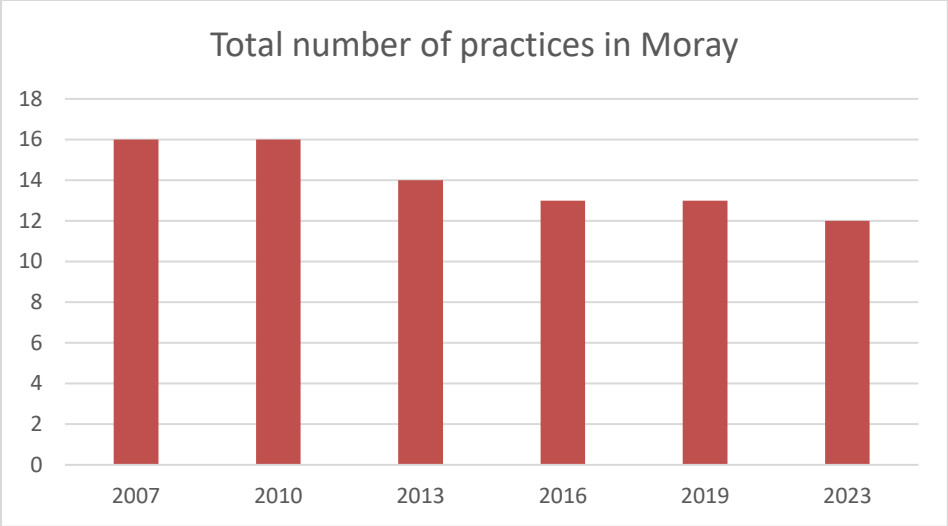
3.1. General Practice nationally are facing a serious and prolonged sustainability challenge. These challenges are felt acutely in Moray, with long standing recruitment and retention issues across Grampian. Some practices are struggling to maintain services, and there is the threat of more practices handing back contracts.

3.2. We have a decreasing number of practices and a falling GP headcount dealing with an increasing ageing population that has more complex health needs. Society as a whole is also becoming more challenging in expectations of services. There has not been a corresponding increase in investment in General Practice

3.3. Total number of practices in Grampian:

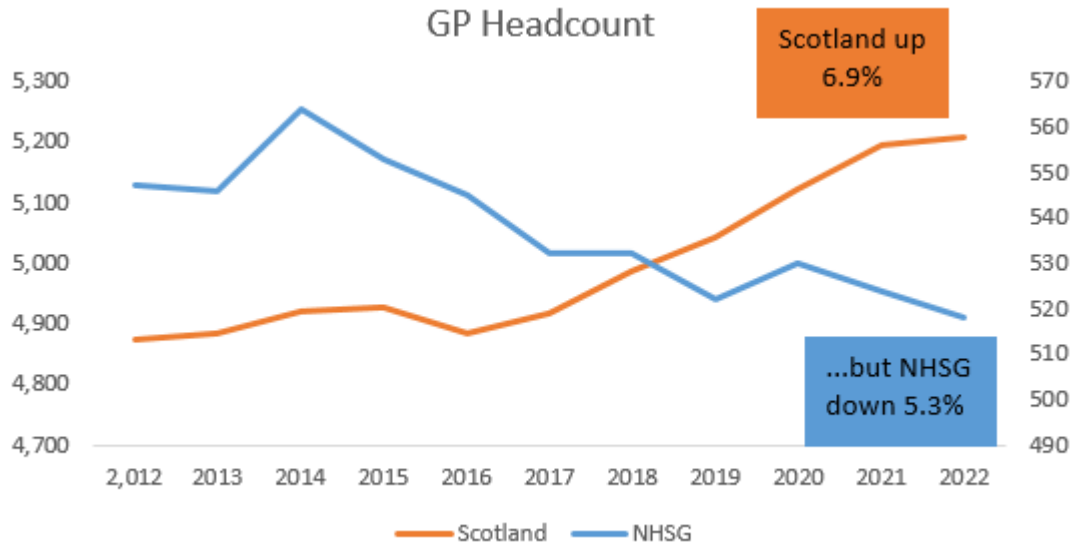


Practice numbers in Grampian have gradually declined from 84 in 2007 to 69 in 2023, a decrease of just under 18%.



Practice numbers in Moray have decreased from 16 in 2007 to 12 in 2023, a decrease of 25%.

3.4 GP Headcount



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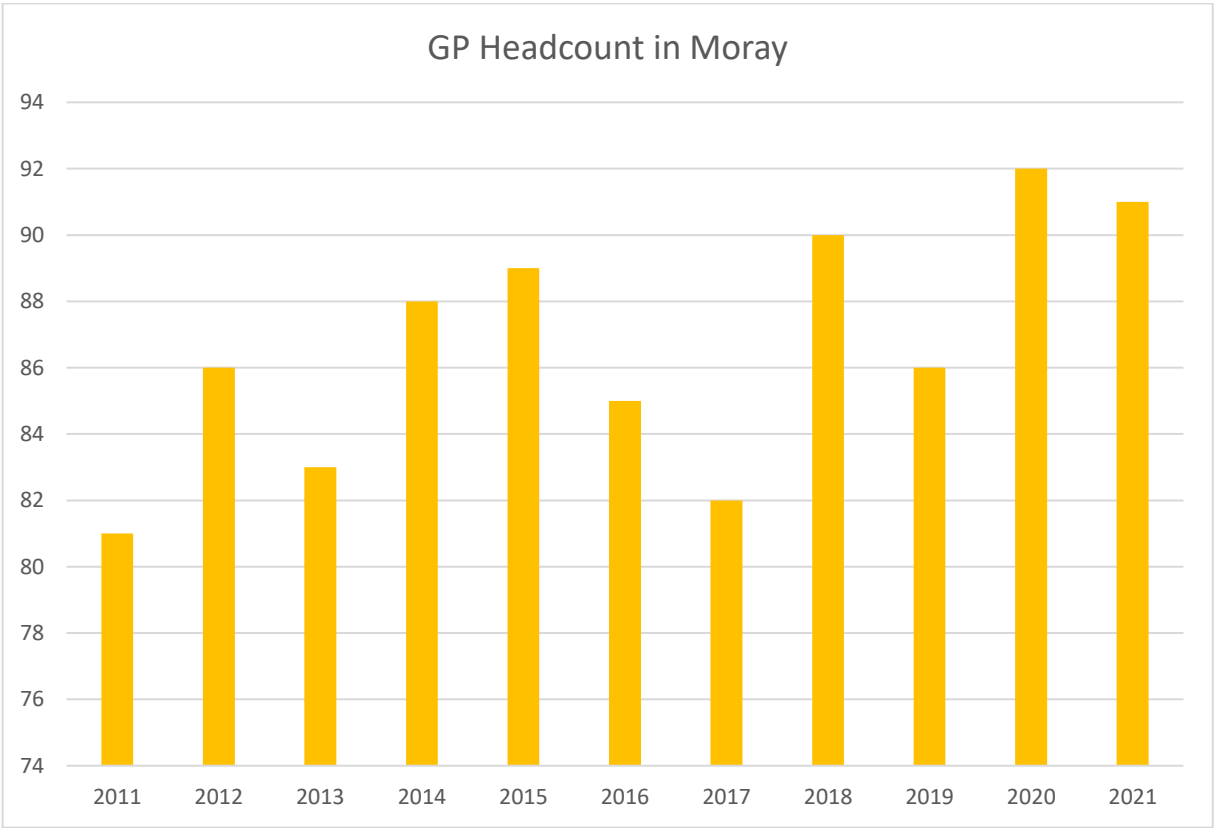
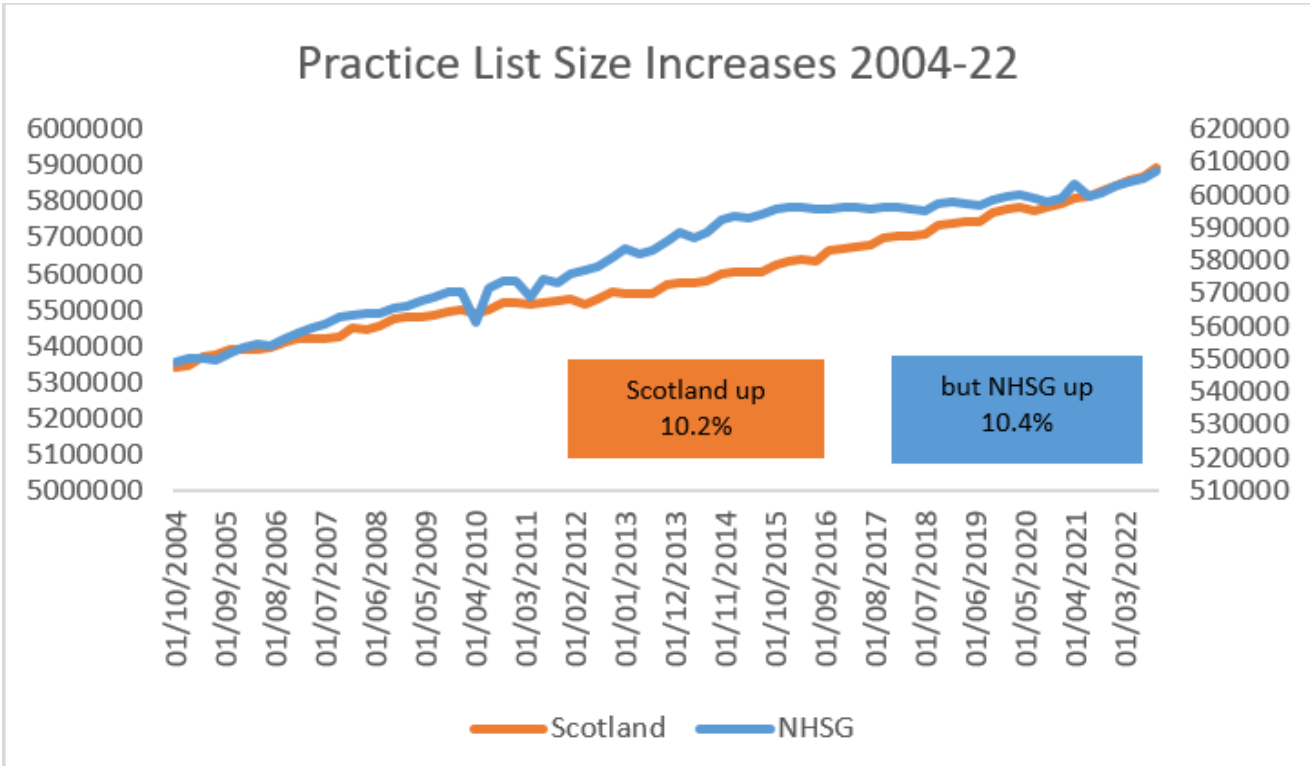
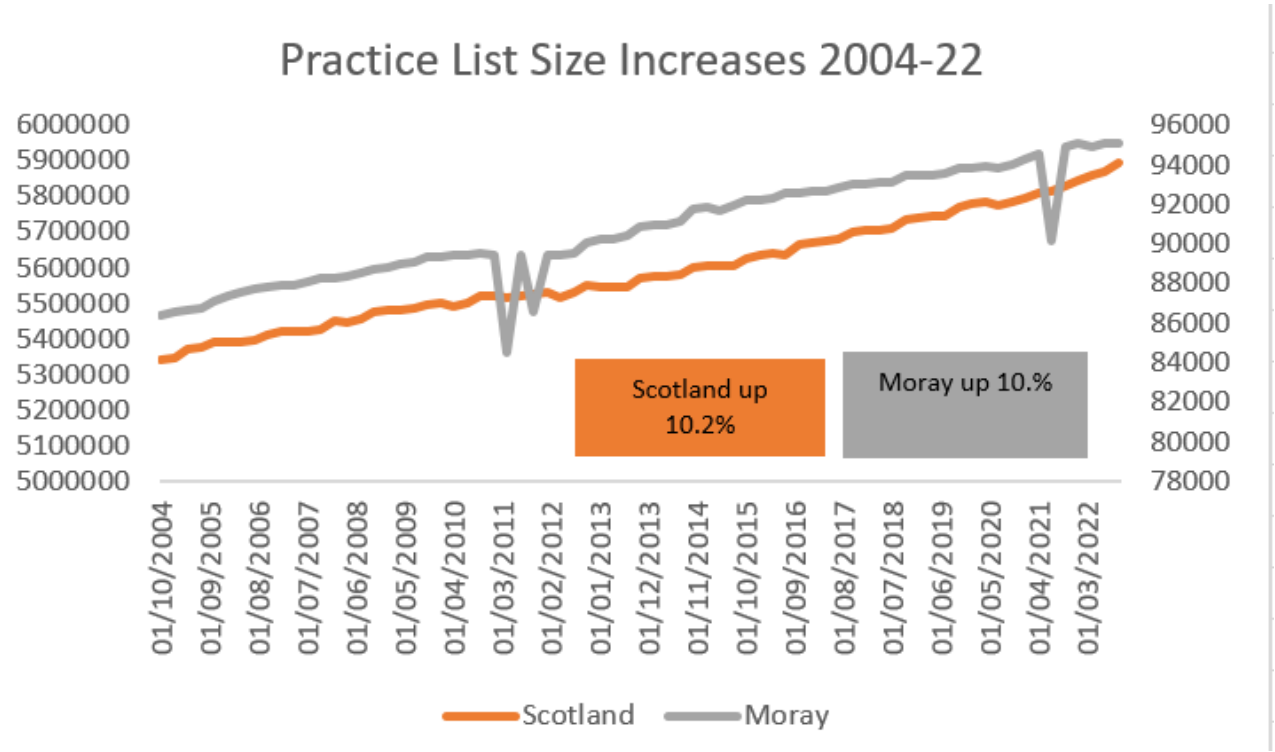


GP Headcount in Moray appears to have increased by 12%, against an overall population increase of around 3%. However local information about equivalent Whole Time Equivalent GPs in not accurately available, but has decreased across the 10 year period due to GPs choosing to work less sessions.

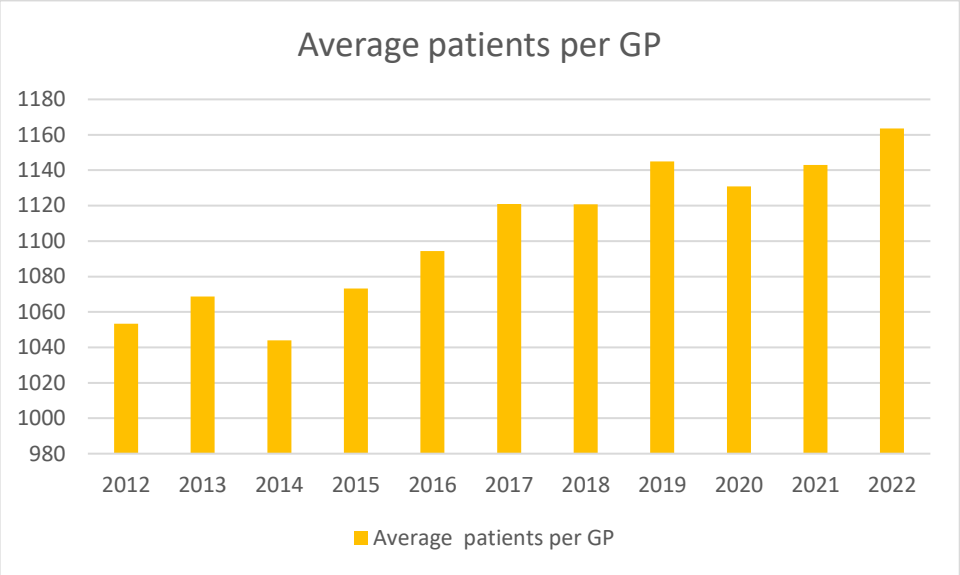
3.5 Population Growth





Moray's practice list size increases are similar to those in the rest of Grampian and Scotland.

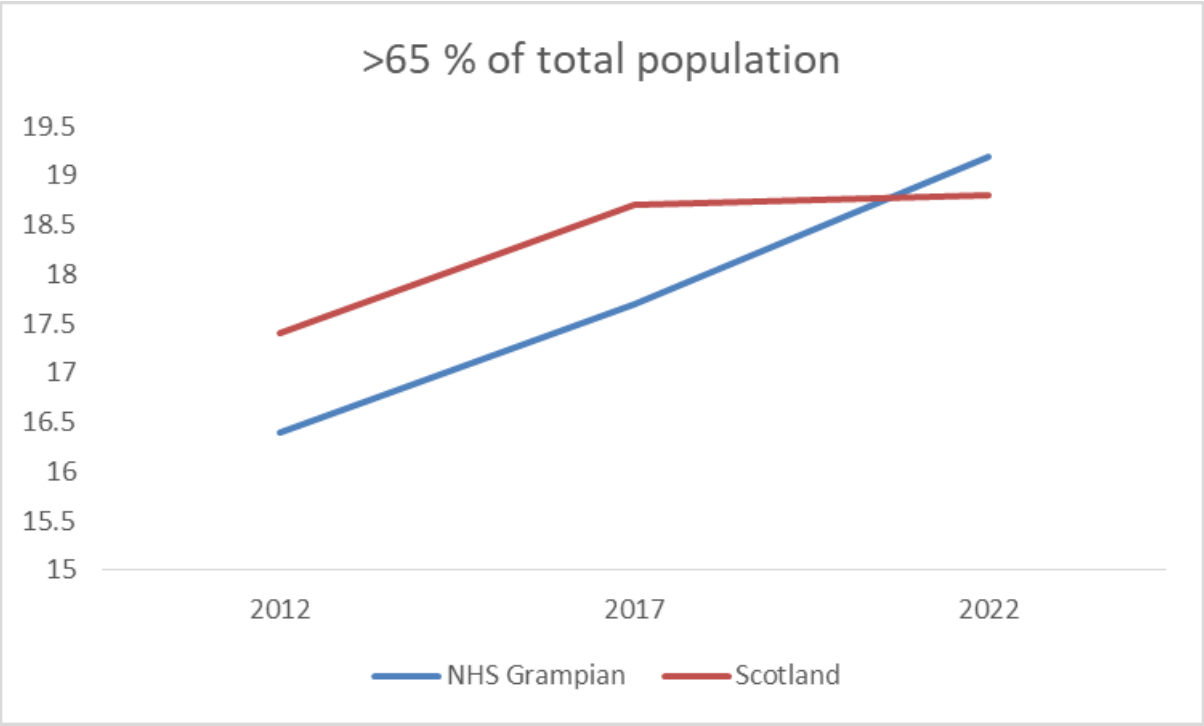
3.6 Patients per GP



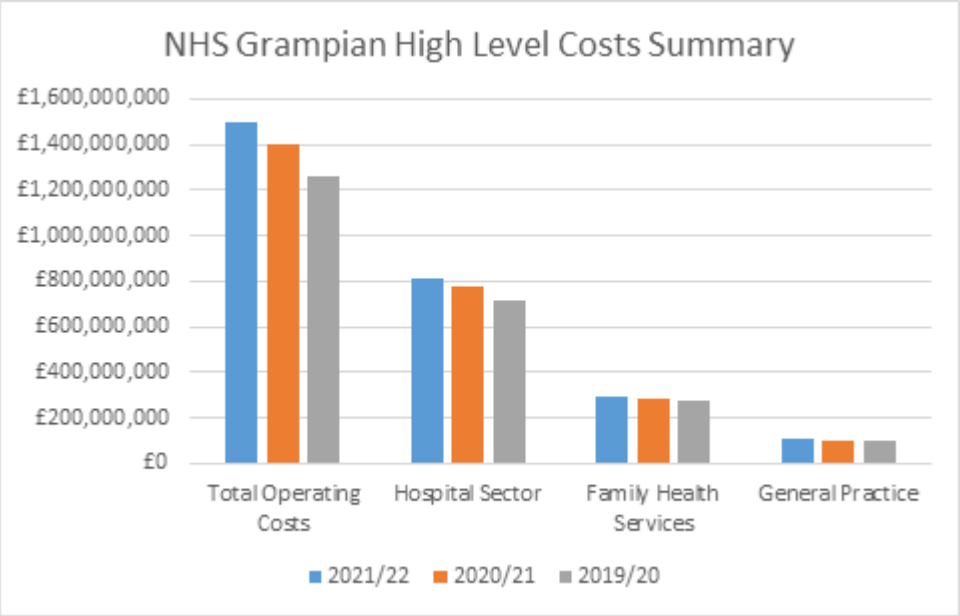
The Grampian average patients per GP in 2022 was 1164

The corresponding Moray figure is lower at 1033, but there appears to have been a similar increase over the past 10 year period, and the Whole Time Equivalent (WTE) reduction will further influence this.

3.7 An aging population equals increased morbidity and complexity



3.8 Expenditure - GP funding over time as total of NHS expenditure



3.9 GP funding has actually decreased from 7.8% to 7.0% as a proportion of NHS Grampian operating cost, while spending on other services has increased by 18%. This is despite 90% of all NHS contacts occurring in Primary care with GPs seeing close to 10% of the population every week. General practice is good value for money seeing a large number of patients for a small proportion of NHS Grampian's total spend on healthcare.

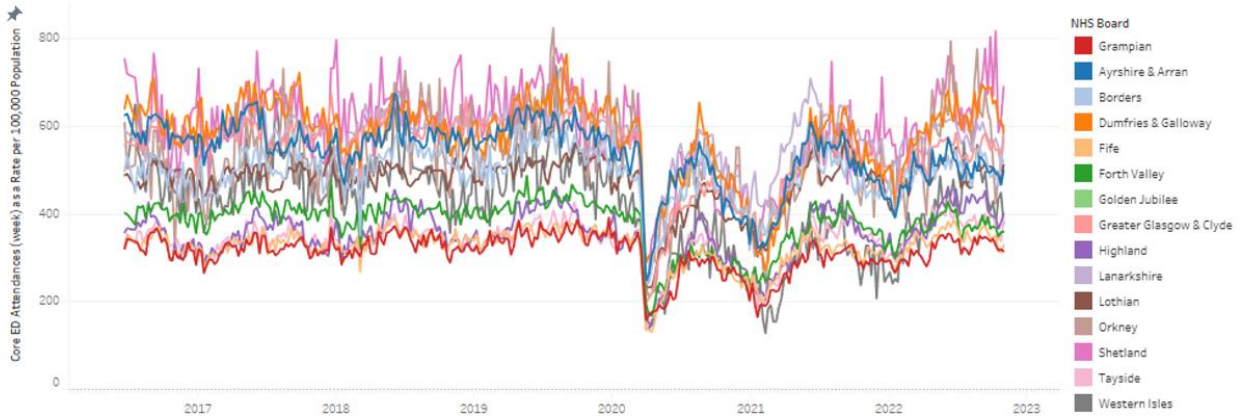
Impact on Emergency Attendance and Admissions

3.10 General Practice is a successful gatekeeper for secondary care services, with Grampian having some of the lowest ED and admission rates in Scotland. Within Grampian, Moray has the lowest figures.

NHS Grampian has one of the lowest ED attendance rates in Scotland

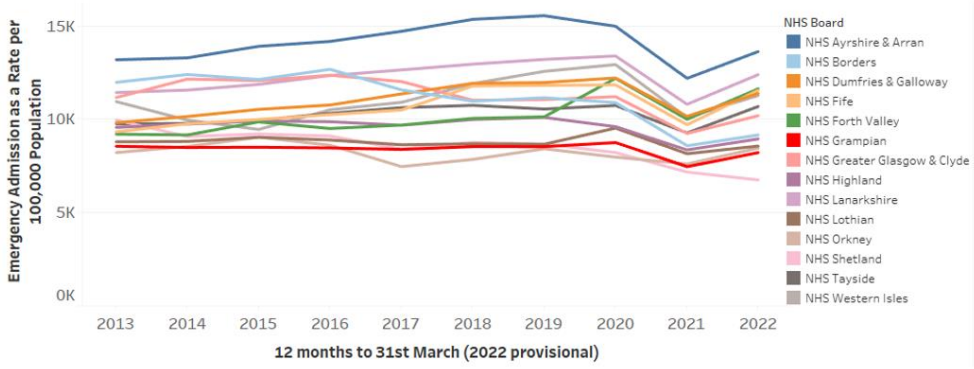
Weekly attendance rates for the last 6 months average around 335 per 100,000 popn

- compared to a national average of 495
- around 5% lower than the same period pre-covid

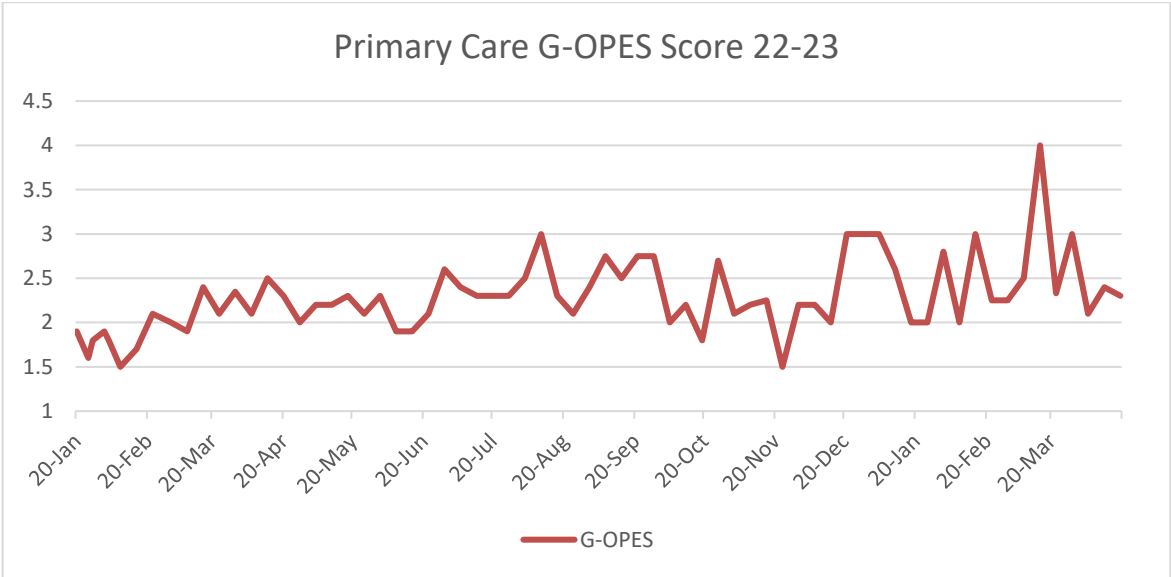


NHS Grampian also has one of the lowest emergency admission rates in Scotland

- Emergency admission rate of 8213 for 2021/22 compared to 10,341 nationally

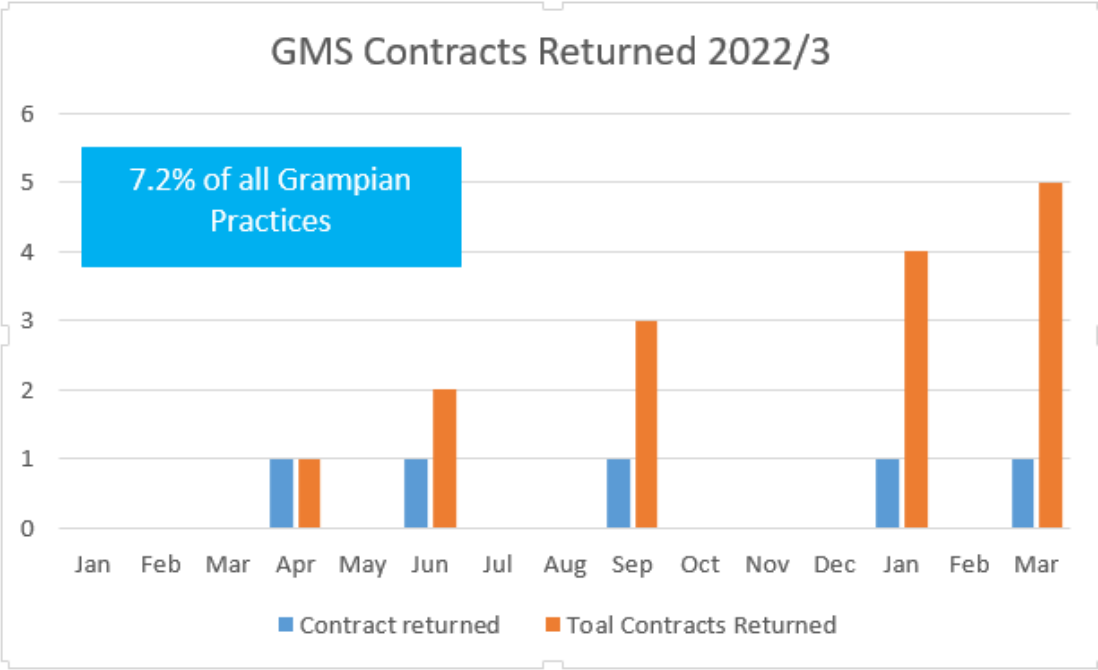


3.11 G-OPES Performance



The GPAS (General practice Alert System) practice metric is currently under test and is anticipated to provide further data beyond the Grampian Operational Pressure Escalation System (G-OPES) which is shown above. G-OPES has not accurately captured Primary Care activity.

3.12 Practices returning contracts:



This is the extreme scenario when a practice feels unable to continue to meet its General Medical Services (GMS) contractual requirements, so hands back its contract to the Health Board. The graph above indicates just over 7% of Grampian practices felt the need to do this in the past 12 months.

3.13 Morale and Wellbeing - May 2021 BMA wellbeing survey indicates low levels of morale:

- 66.8% responders described workload as unmanageable with 57.1% of responders saying it had got worse since the pandemic.
- 73.3 % stated –"struggling to cope and my work is having a negative impact on my physical and mental wellbeing".
- 70.2% stated the last year had made them more likely to take early retirement.
- 87.7% stated they had been subjected to verbal or physical abuse within the last month.

Recruitment and retention

3.14 As illustrated above the total head count is falling for General practitioners. Clinical and workload pressures, long working hours and work related stress together with comparatively higher numbers of female GPs has meant full time equivalent GP numbers are also reduced. Those working full time often have a more diverse work portfolio to provide variety of work and importantly guard against burn out. This, combined with lower numbers of GPs overall decreases patient facing time. There is a rise in Advanced Clinical Practitioners that has filled in some of the created shortfall. However this pool of workforce has latterly become increasingly hard to recruit to as well. The need for their skills is well recognised across the whole health system and not enough are being trained to meet the demand. There are the same recruitment challenges for attracting new staff to come to the Grampian region as experienced for GPs. Often the populations with the highest levels of need associated with deprivation are the same areas that can find it hardest to recruit.

The Primary Care Improvement Plan (PCIP)

3.15 PCIP has not fully delivered locally – the 2018 contract was agreed to address the recognised sustainability issues in General Practice. It aimed to achieve this by removing workload from GPs and widening the primary care workforce. However the combination of funding shortfalls which have limited the ability to fulfil the objectives of memorandum of understanding and the recruitment issues highlighted above means that the PCIP has fallen well short of its full potential. From the outset local GPs were concerned that the new contract was not suitable for a more rural population such as ours in Grampian and Moray, and the vast majority Grampian GPs did not vote for this contract. Subsequent claw back of underspend payments and lack of agreed national flexibility for using this money has meant NHS Grampian General Practice has been adversely and disproportionally affected by recruitment problems and funding clawbacks, and therefore not had the same access to the resource and funding when compared with other areas of the country who have been better able to recruit PCIP staff.

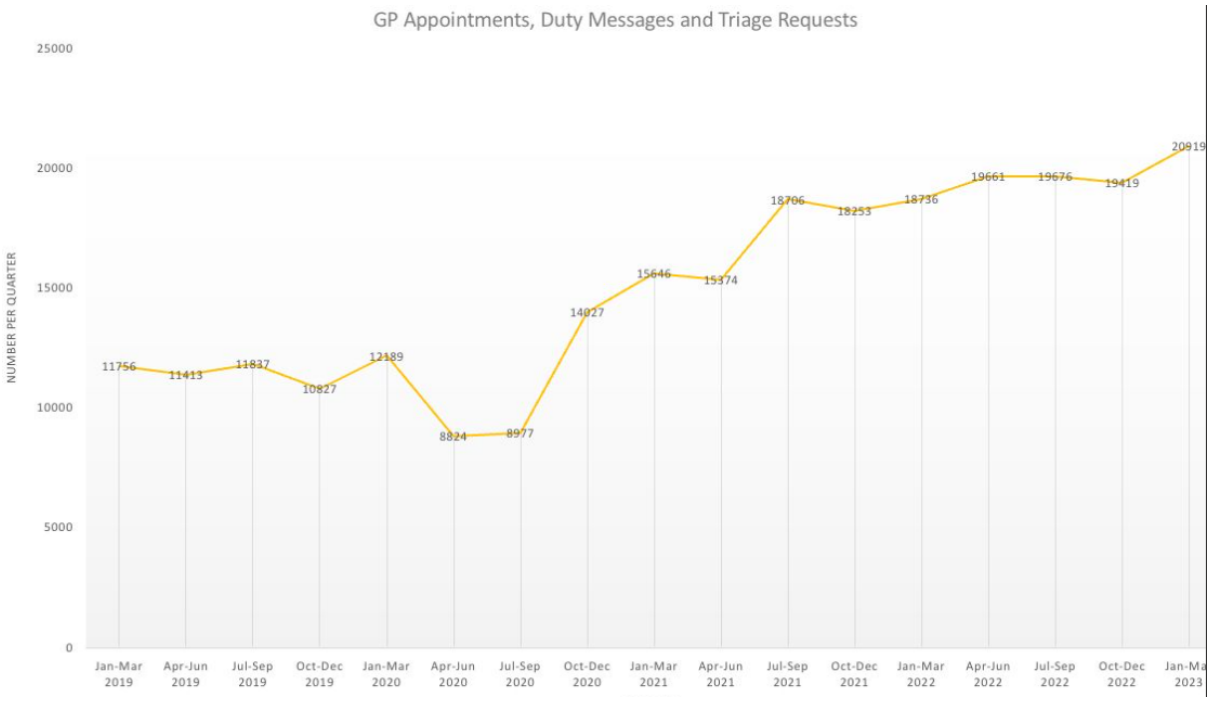
Pulled funding streams

3.16 As well as the claw back of PCIP underspend general practice has also seen a reduction and removal of transitionary/sustainability payments, initially cut by 1/3 in the second half of the 22/23 financial year and then stopped altogether in 23/24 financial year. These payments were meant to help support practices who had not had the full PCIP staff delivered. In a further cut mental health support funding planned for 22-23 was cancelled. This has meant practices have not had the support of additional staff and have also lost funding – leaving practices to face increasing patient demand with fewer staff and reduced financial support.

Population demographic changes

3.17 These are illustrated in the graphs in sections above. As our local population becomes more elderly, our patients have a greater number of chronic disease conditions and their health needs become more complex. They need to use practice services more often, needing more clinical time and often needing higher levels of input and support. If we are to treat patients at home and in their own communities (rather than hospital), and remembering the important Gatekeeper role of GPs, we need to be able to manage our aging population (and the associated clinical demand) effectively in General Practice. There has not been an equivalent increase in funding to recognise this change.

3.18 Population behavioural changes and expectation and demand of patients has increased over the last decade. The rise of the internet and political promises has all meant that as a population we expect our demands to be met more quickly. The number of times on average a patient consults their general practices has increased significantly. Although alternative flexible modes of access such as telephone and video consultations and online eConsultations have provided access to those that choose this method, increasing levels of demand have not been matched with an equivalent increase in funding to recognise this change.



Increase in clinical activity at Maryhill Practice over past 4 years. This includes taking over of Elgin Community Surgery, but there has not been a corresponding increase in clinical staff due to recruitment challenges.

Transfer of work

3.19 There is a national drive to provide more medical care closer to a patient's home than ever before. This is laudable but has meant a further transfer of work from secondary to primary care. The funding to resource this work transfer has usually not followed.

Impact of waiting lists in Secondary care

3.20 Many hospital departments already had long waiting times however the impact of the covid-19 pandemic has significantly lengthened many of these. Whilst waiting for hospital treatments and investigations, patients suffer worsening health problems and need to consult their GPs more often, reducing available appointments for other patients, for support with these symptoms as they await the surgery or outpatient clinics that will definitively address these issues. The additional work generated is currently poorly recognised by the wider system and is unresourced.

Premises

3.21 There has been minimal significant investment in the General practice estate. Central funding has led to several large capital projects on the Foresterhill site. However despite 90% of all health contacts taking place in Primary Care there has not been an equivalent investment in the primary care estate. This has led to several practices working in unsatisfactory conditions including porta cabins well beyond their expiry date. It can be difficult to attract new staff to work in these surroundings. Some practices have also seen their reimbursement for providing health services from privately owned buildings fall at the same time as borrowing costs are rising.

Utility costs

3.22 A more recent concern is a dramatic rises in utility costs. Some practices are reporting a 3x increase in their bills. Some of these costs were already high due to the lack of heat efficiency in many out dated buildings. At the time of writing there is not a way for NHS Grampian practices to on-board onto the national reduced tariff that support secondary care costs and primary care in other parts of the country. The rising business and running costs for practices is not resourced and, unless addressed, will impact on practices' ability to employ more staff and expand services to patients.

Pension costs

3.23 Similar to the situation facing hospital doctors, the tax penalties for GP's relating to the NHS pension annual allowance (AA) and life time allowance (LTA) have proven to be a disincentive for practitioners to increase their working hours or continue to work in the latter stages of their career and has led in many cases to early retirements. This issue has been partially addressed and reversed in the most recent UK budget but future governments may choose to backtrack on these decisions, and so further uncertainty remains at a time when we need to retain and maximise our GP workforce. The recent changes have focussed on LTA over AA, and in future years the degree of relief could fall away quickly.

Locum costs

3.24 The costs of backfilling for illness, pregnancy or an inability to recruit permanent staff has escalated. Twenty years ago a day's GP locum would cost £250-£300. Now the costs can be anything from £600 to £1200 due to market forces. Locums often restrict what they will do (for example, no house visits and minimal administration) and do not provide the same continuity of care as a permanent GP or member of staff. There is little financial incentive for locums to take on permanent positions which also has a negative impact on the continuity of patient care.

Falling profit

3.25 The above impact on costs has impacted on the profits associated with the current majority independent practice model. As income falls and business costs increase, taking into account the additional workload and responsibility involved, the gap in earnings associated with being a partner and the earnings of a salaried GP have narrowed. Ultimately, this means fewer GPs want to be GP Partners and rising costs and workload pressures have been a major factor in some recent contracts being handed back.

Changing GP expectations

3.26 There has been fairly consistent feedback that the majority of the current newly qualifying GPs do not want to commit to the traditional partnership model due to the expectations and risk that is involved in taking on that responsibility. This has destabilised practices that can't recruit new partners and leads to a fear of "the last man standing" scenario for existing GP partners.

Agenda for Change (AfC) Uplift

3.27 The recent significant pay uplift awarded to health board (PCIP) employed staff via AfC has not been matched by a pay uplift to staff working in general practice (awarded via the DDRB). The effect on practices has been significant, creating inequity and discord between staff members often doing the same job. Due to current workload pressures, even very stable and well run practices will be at risk if staff chose to leave and cannot be replaced. This presents a real and current danger to the sustainability of many GP practices.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

Sustainability working group (SWG)

4.1 This was formed in March 2022 and originally focused on General practice but now with the wider remit of all Primary care. It meets regularly and has a well spread representation including clinical leads from General Practice, Optometry, Pharmacy and Dental and Primary Care Managers and officer bearers from the GP representative groups. It has a broad agenda covering the key topics outlined in this paper and often leads onto smaller action groups on specific areas of interest.

Early warning systems

4.2 The SWG developed a document to standardise the relationship between Health and Social Care Partnerships (HSCPs) and practices. It also covered the important role of the Local Medical Committee (LMC) in supporting practices. These relationships are key in ensuring early warning and early support to areas that might be struggling. It also outlined to practices what types of support would be available in which circumstances. It is now utilised by HSCPs in planning their practice visits and communications and has been shared with all practices via the GP bulletin.

Escalation Plan

4.3 Since beginning of covid this national document has been widely used locally to allow practices, upon successfully applying for permission through primary care contracts, to temporarily reduce their level of service provision in situations where they did not have the full capacity to deliver the whole breath of the GMS contract and any enhanced services.

Continuity Plan

4.4 In a situation where the above escalation plan was not robust enough due to a large number of practices being impacted threatening the ability to provide even essential urgent care NHS Grampian is developing a plan to allow this care to be delivered by a centralised approach akin to a day time GMED-style service.

Unscheduled Care (USC) Teams

4.5 A potential solution to day time general practice workload has been seen as having separate unscheduled care teams. Moray used winter pressure money to pilot a Daytime urgent care service project (DUCs) - this will be fully evaluated and then an assessment done of costs and staffing to see if would benefit continuing in Moray and being rolled out to the other partnerships.

Future of General practice workshop/new models of working

4.6 It is clear to most that continuing to do the same with the changing demographics and increasing population demands is not going to result in a sustainable service. HSCM have therefore began conversations locally about what a future sustainable model of general practice could look like.

Advertising vacancies

4.7 The Grampian section of the GP jobs has been updated to make more relevant but above and beyond that Jo Raine-Mitchell is leading a piece of working to make a proposal to chief officers to commission some market research to lead to a more targeted advertising campaign for primary care in General practice and a more bespoke website to attract those who may be interested to work in Grampian.

Issues with medical student places not being offered to local candidates

4.8 Current medical school funding arrangement incentivise non UK students due to higher revenue. These students will often not remain in the UK and further pressure the recruitment / retention difficulties outlined above. Pressures in General Practice also offer a barrier to a rewarding training experience to medical students that promotes a career in General Practice. There are challenges here with medical students numbers locally increasing by 50% to 300 per year, with no apparent plan for the infrastructure involved.

Education/training/management resources for practices shared

4.9 A factor in many failing practices is the loss of senior experience/leadership. There is therefore promotion of relevant courses to GPs and practice managers and other senior staff.

Webinar series

4.10 Similar to above there are a variety of topics that practices are less knowledgeable including premises, statements of financial entitlement. So a series of webinars are planned to help better inform.

Twice weekly bulletin to all practices

4.11 This initiative was started as a response to Covid-19 but has continued to better highlight relevant issues to practices in one document rather than a series of emails.

Patient engagement and communication group

4.12 This group now meets across all 4 primary care contractor groups having initially started as a general practice initiative to look at how best to engage and communicate with patients and elected members. It has led to radio campaigns, a patient facing website and a number of resources for practices to share physically in their practices and on social media to promote better functioning of the practice and patient understanding of how practices have had to adapt.

Wellbeing

4.13 General practice wellbeing resources are now regularly shared in the bulletin. An all-encompassing document is also being prepared to bring them all together in one resource. Endowment fund is being explored to see if we can provide a primary care arm of the successful We Care programme for NHS employed staff and associated counselling.

National sustainability conversations

4.14 A number of Grampian primary care leaders engage with national meetings around sustainability – regularly sharing the tools and thoughts from local discussions.

Utility bills

4.15 Pushing for a local or national solution to practices being able to sign up to the reduced rate negotiated for public service energy supply.

Data Gathering

4.16 As illustrated above the importance of good quality data is now recognised by GP leaders and a number of initiatives are put in place to improve this.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"
Functional Primary Care is crucial to the wider Moray system, and issues within this will be felt in all other sectors and impede Strategic delivery aims. In addition the Moray Portfolio has overall operational responsibility for Primary Care in Grampian, so wider Grampian sustainability issues will impact operationally on the Moray Portfolio.

(b) Policy and Legal
None

(c) Financial implications
Additional backfill and support costs for Practices needing help, and the risk of increased costs if we have 2C Practices.

(d) Risk Implications and Mitigation
Sections 3 highlights issues across the system. Section 4 indicates mitigations in place.

(e) Staffing Implications
None

(f) Property
None

(g) Equalities/Socio Economic Impact
Lowest SIMD quintile areas have decreased access to Primary Care across Scotland, and sustainability issues in Primary Care would be expected to exacerbate this.

(h) Climate Change and Biodiversity Impacts
None

(i) Directions
None

(j) Consultations
The Chief Officer, Health and Social Care Moray, GP Clinical Lead, Primary Care Contract Manager, Clinical Director Primary Care, Locality Managers, Interim Chief Financial Officer, Chief Nurse and Tracey Sutherland, Committee Services Officer were all consulted in the preparation of this report and any comments have been included.

6. CONCLUSION

6.1. General Practice in both Grampian and Moray are experiencing an unprecedented period of sustainability pressure that is impacting on operational delivery.

6.2 The impact of this instability in General Practice will be felt across the entire Moray Health and Social Care system.

Author of Report: Stuart Reary and Peter Maclean
Background Papers:
Ref: