Dumfries and Galloway
Integration Joint Board

14th July 2016

This Report relates to
Item 17 on the Agenda

Update of General Practice Medical Staffing

Dr Angus Cameron, Medical Director

For Noting

Approved for Submission by	Julie White, Chief Officer
Author	Dr Angus Cameron – Medical Director
List of Background Papers:	
Appendices	

SECTION 1: REPORT CONTENT

Title/Subject:	Update of General Practice Medical Staffing
Meeting:	Dumfries and Galloway Integration Joint Board
Date:	14th July 2016
Submitted By:	Dr Angus Cameron
Action:	For Noting

1. Introduction

1.1 This Paper alerts the Integration Joint Board of the high risk to the sustainable provision of General Medical Services across Dumfries and Galloway. The threat to the sustainability of General Practice arises from a failure to recruit (in the face of national shortages of qualified GPs) and a significant proportion of Doctors who are planning to retire within the next 3 years.

It is likely that despite our best efforts to recruit young Doctors into local General Practice, we will be forced to support significant changes in service provision over the next few years. The recruitment challenge will also impact significantly on the GP Out of Hours Service.

The Integration Joint Board is asked to note the severe challenges that this poses.

2. Executive Summary

2.1 General Practice across Dumfries and Galloway faces considerable challenges currently as a result of increasing demand and reducing capacity.

3. Recommendations

3.1 The Integration Joint Board is asked to:

- Note the considerable recruitment challenges facing general practice in Dumfries and Galloway and note the steps that have been taken to minimise the impact of this
- Note the current specific challenges relating to the Wigtown and Merrick Practice in Wigtownshire and the proposal to merge these Practices as of 1st September 2016.

4. Background

4.1 General Practice in Dumfries & Galloway provides a high volume, locally accessible, comprehensive section of healthcare: With an average rate of consultation of 5 surgery visits per person per year, General Practice provides

around 750,000 face to face patient contacts per year. This figure has been slowly increasing over the last 15 years – but more significantly, GPs report that they are dealing with increasingly complex consultations related to an aging population, increased prevalence of long-term conditions, increased health anxiety & expectations, and an increased level of complexity of medication regimes. There is some evidence that there has been a gradual shift of some work from secondary care to primary care that has not been supported by an increase in the General Practice workforce.

GPs also provide a range of other services, depending on the practice situation. In addition to General Medical Services some GPs provide input to our cottage hospitals, and contribute shifts to the Out of Hours Service. GPs provide input to care and nursing homes across the region, and may provide a range of other services such as medical care to the police custody suite, forensic medical services, prison healthcare, minor injuries services, minor surgery and drug addiction services. A minority of practices provide a dispensing service, providing medicines in the more rural areas. For this reason, a decrease in the supply of General Practitioners may cause service disruption beyond the usual setting of General Practice

Traditionally, General Medical Services have been provided from 35 practices by a total of 135 partners, with a number of locum doctors in the region (around 30) who have been able to support practices on an ad hoc basis. However the number of partners has been falling significantly, with the result that only 118 partners are working across 34 practices (Kirkcudbright and Gatehouse practices merged around 4 years ago).

Some rural practices have traditionally provided services from branch surgeries: This makes the service even more accessible in rural areas, though is an inefficient way of working for the doctors. Internet connections in branch surgeries may be particularly slow resulting in a further inefficiency. One of the practices in Moffat has, for example, branch surgery arrangements in Crawford, Leadhills and Wanlockhead.

It is important to note that practices work as independent sub-contractors: they are not paid a salary – instead the Board has a contract with each practice which details the range of services to be provided for an agreed list of patients. While the cost of premises, and IT systems are provided by the Board, practices take on all the employment risks etc in running what are in effect small businesses. The Board does not direct day to day work within practices and has no direct role in management of practices.

There is an alternative to this independent contractor status: This can be used where a practice has handed back its contract – usually due to recruitment problems. Practices are then directly managed by Boards under what is known as a 2c contract. The Board employs salaried GPs, and all other staff, and is responsible for all risks (eg vacancies, locum provision, sickness etc). There are currently no 2c practices in Dumfries & Galloway. Across Scotland there are approximately 40 “2c” practices - usually as a result of recruitment failure, or extreme rurality (such as island practices). Reports from other

Boards indicate that where a “2c” contract is arranged, Boards may have to pay extremely high sums to locum doctors to provide a service (with little ongoing continuity), and have to provide management of day to day issues within practices. There is general agreement that from the Boards point of view, it is more satisfactory to maintain traditional sub-contractor contracting. NHS Dumfries & Galloway plans to avoid “2c” practices if at all possible, though has researched the practicalities of setting up such arrangements.

The GP Out of Hours Service is provided by a mix of salaried doctors who are on an employment contract, and shifts that are provided by local GPs. Permanent Out of Hours work is clearly not attractive and we have – like other Boards- struggled to recruit and retain salaried doctors in the Out of Hours service. The filling of shifts by local GPs is becoming much less popular, due to the increasing day-time workload caused by both increased workload generally, and the extra work that results as a result of long-standing vacancies within practices.

Although there are day to day changes in the situation, there are currently vacancies in all 3 practices in the Waverley Health Centre, in Wigtown, The Merrick practice in Newton Stewart, Kirkcudbright (2), St Michaels Practice, Dumfries, Lochthorn Medical Centre, Thornhill Practice, Sanquhar, both Moffat Practices, Gretna and Cannonbie. To varying degrees all of the above practices are at risk of being unable to continue to provide the full range of General Medical Services. Some of the vacancies have existed for up to 18 months and despite repeated attempts to recruit some practices have had no applicants.

4.2 Wigtown practice is a two doctor practice with additional input from an Advanced Nurse Practitioner. One of the doctors is retiring on 1st September, and the Advanced Nurse Practitioner is leaving. Multiple attempts to recruit have not resulted in any applicants. The remaining doctor would be unable to provide a safe and effective service for the patients of the practice. It is likely that he would leave the practice, meaning that the Board would have to pick up responsibility for the practice and run it using locums – and given the shortage of locums at the moment it is certain that the Board would have to pay out a great deal to attract doctors to the area.

However the local GPs have proposed a merger with the Merrick Practice in Newton Stewart which the Board has supported. The merging with the 3 doctor Merrick Practice (albeit there is one vacancy there at present) allows the doctors to combine workloads and sustain services. Although there is a drawback in that there will be no afternoon surgeries delivered in Wigtown, afternoon and evening surgeries will be available in Newton Stewart Health Centre – Newton Stewart is approximately 6 miles away. A significant proportion of patients currently with the Wigtown practice live in Newton Stewart, so services for them will actually be more accessible.

5. Main Body Of The Report

5.1 **GP Training**:

Young doctors can start their three year or four year training after having successfully completed 2 years as a Foundation Doctor working in hospital. The GP training programme sees doctors rotate through a number of hospital posts as well as attachments to practices during their 3 or 4 years. Dumfries & Galloway offers 14 new GP training rotations each year. It is important to maximise the local training as experience shows that a high proportion of locally trained GPs stay within the area after completion of training.

Doctors are allocated to training rotations after a national competitive selection process. Unfortunately we have not filled our rotations for several years as younger doctors prefer to stay closer to the central belt, and for many, Dumfries & Galloway is seen as a distant and unknown location for training. 10 to 15 years ago most GP trainees were male and single – now they are more likely to be female and married – and spouse employment is likely to be better in the central belt, supplying another reason to stay there, along with the fact that many have purchased houses by the time they are considering GP training.

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This year we have filled 50% of posts after the first round of recruitment, and will have a number of vacant rotations. This presents numerous problems: the hospital posts will be vacant, requiring considerable efforts to recruit to them, training practices will have a reduced workforce to provide services, and of course, there will be a local shortage of trained GPs 3 or 4 years from now.

Dumfries & Galloway has an active education committee and a dedicated Director of Medical education. Through enormous amounts of work, Dumfries & Galloway has achieved a reputation of excellence in training that has allowed us to increase on the very low levels of GP training places filled, but the situation remains critical

. Scottish Government has announced extra funding so that, across Scotland, the number of places will increase from 300 to 400. However as General Practice is an unpopular career choice at present, it is not clear that these increased numbers of posts will fill. It is also possible that the increase in posts, by increasing the number of posts within the central belt, will have an impact of reducing the number of GP trainees who elect to come to Dumfries & Galloway.

With changes to University funding, Medical schools find it financially advantageous to recruit students from overseas. Such students may comprise up to 20% or more of medical school output. It is re4cognised that many of these doctors leave the NHS after the two year foundation training, and return to their native country. In addition the drop out from a medical career is higher than previously, and a number of young doctors leave Scotland to work in Australia and other English speaking nations. This exacerbates the situation considerably.

5.2 **GP Retirement**:

In common with the rest of the country, Dumfries & Galloway has a disproportionately high proportion of doctors who are in their 50s and 60s. These experienced doctors are leaving the profession in considerable numbers at an earlier stage than their predecessors – this is because of increased workload & pressure, and the impact of changes to pension arrangements, meaning that GPs get a disproportionately lower overall remuneration after tax once they have exceeded the pension pot threshold.

. 32 of the 118 GPs (27%) are over the age of 55, and 22 of the GPs (18%) are between 50 and 54. On current trends it therefore suggests that around a third of all GPs in Dumfries & Galloway will retire within the next 8-10 years – with many retiring within the next 3 years. Given that we are not currently recruiting enough replacements, and are not currently training sufficient to replace these doctors, it seems self-evident that practices will continue to face severe recruitment difficulties for the foreseeable future.

5.3 **Practice choices amongst younger Doctors**:

Traditionally recently qualified GPs have joined partnerships, taking on a shared responsibility for employing staff and running a small business. In addition a number of practices have required an incoming doctor to purchase (usually through a mortgage) a share of the practice premises. It is less common now for practices to own premises, but 6 of the practices who have a current vacancy own their own premises. (A notional rent is paid by the Health Board to practices who provide their own premises).

Repeated surveys have shown that young doctors do not wish to work in practices where they are required to take on a partnership, and certainly do not wish to purchase a share of premises. They also prefer overall not to work in smaller rural practices where there may be challenging issues in relation to taking annual leave, or dealing with the consequences of either sickness or maternity leave in a partner. In addition, we know that spouse employment prospects play a much stronger part in decisions regarding choice of practice than previously.

Some younger doctors who have completed training do not wish to commit to a practice initially, and may spend 1 to 2 years providing locums before joining a practice.

In addition, a fully trained GP has an internationally recognised qualification and a small number of qualified GPs leave the country at that stage in their career to work particularly in Australia and New Zealand.

It is also evident that female GPs may be more inclined to work on a part-time basis. (a trend which is also being seen in some male doctors as well). This may be harder to accommodate in smaller rural practices.

All of these factors illustrate why Dumfries & Galloway, despite some obvious advantages relating to house prices, and excellent schooling, struggle to recruit qualified GPs to the region. The problems are particularly acute in the west of the region, and there are serious concerns in relation to the three practices in the Waverley Medical Centre in Stranraer: There used to be 14 GPs who worked in the Medical Centre – this has fallen to 9 and will shortly reduce to 8. Only 2 of the current GPs there are under the age of 54, and one of those 2 has just started maternity leave. The Waverley Medical Centre has traditionally also had 2 training posts – but from August both posts will be empty due to a failure to recruit.

5.4 **Initiatives to enhance recruitment:**

Although the responsibility for recruiting and appointing new doctors remains with the practices, the Board has been active in trying to enhance recruitment to practices within the area. This has been through both short-term measures, and longer-term strategies.

The Board has funded full page adverts in the BMJ, advertising a number of practice vacancies at one go. The Board has set up an attractive website – www.dumfriesmedicalrecruitment.co.uk where all practice vacancies are advertised, along with a detail about various aspects of the region, and a short video where recently appointed GPs describe the advantages of the area for both careers, and for training. The Board has attended a number of recruitment and training meetings, along with GPs, promoting practices and the recruitment website to a wide range of GPs and GP trainees.

The Board has retained the “Golden Hello” of £5,000 for new doctors joining their first practice. Practices with greater overall deprivation can now increase that amount up to £12,500 – the Board pays the Golden Hello, and recoups some of it if the doctor leaves within 3 years.

The Medical Director arranges to meet all trainees in their final year to discuss options for employment within the area: Some doctors want to experience further hospital posts before settling as a GP, and these are arranged where possible. In some cases a successful mix of practice and hospital posts has been arranged. Where it is possible, the Board gives assistance in spouse employment.

The Board has sought to increase the number of trainees coming to train in the area: It has done this by developing GP training to a high standard, and now has a good reputation as a training region for General Practice. We

recognise that trainees do not generally want to work in the west of the region, where social/professional isolation is a more significant problem. To help overcome this problem the Board has led an initiative with the council and the police to develop suitable accommodation for young professionals = aiming to assist in the regeneration of Stranraer by developing suitable accommodation for young professionals (trainee doctors, teachers, social workers and police) which will be available for rent at a modest price by trainees.

We have developed two posts of "Rural Practice Fellow" which are one year posts funded partially by NHS Education Scotland (50%) and the Board (50%). Post holders work in rural practices and hospitals, developing a range of skills and undertaking some research over a one year appointment. The idea is that the rural practice fellows will then settle in the area.

The Director of Medical Education has forged links with the Falkland Islands and it is now possible for both the rural fellow and the GP trainees to spend up to three months working in a very rural setting in the Falklands to experience a dramatic but enjoyable training in extremely rural practice/hospital medicine. These arrangements have yet to be taken up.

We know that doctors who train in rural areas are much more likely to return to the area, and so we have arranged for D&G to have a much higher profile in both the training of under-graduates, and post-graduates. Starting in September, we will be working with Dundee to provide extended teaching and training of medical students in rural practices, with students staying for up to 1 year in the area.

We have been collaborating with Dundee in submitting a bid to Scottish Government to jointly provide a new Medical School for graduates of other health disciplines: This appears to have been successful and was announced in the Cabinet Secretaries speech earlier this month at the NHS National Event. It is anticipated that the Medical School will open in September 2017, with Dumfries and Galloway providing a major role in teaching – and thus hopefully attracting both teaching doctors, as well as students later in their career.

5.5 **Building Capacity:**

Over the last 10 – 12 years there has been a development of the workforce in General Practices, with an increasingly multi-disciplinary workforce providing care. All practices have recruited and trained practice nurses who play a major role in the management of long-term conditions (especially supporting patients in self-management), immunisations, cervical smears and other duties. In addition practices have recruited phlebotomists and other Healthcare Assistant staff to take blood tests, arrange simple tests such as ECGs and audiology screening. This allows GPs to spend more time on the more complex problems.

They have played a significant role in releasing GP capacity We recognise that despite our best efforts, we will probably not recruit replacement GPs in

sufficient numbers to maintain services, and so have been supporting practices by enhancing the multidisciplinary team: For over 10 years GP practices have all had access to counsellors to provide management of minor anxiety and depression, and primary mental health care workers and specialist nurses have worked across practices to support care of patients in communities.

We believe that Advanced Nurse Practitioners – nurses with around 3 years of extra training, can provide many of the roles required of a GP, and plan to support the recruitment and training of 4 nurses per year to become Advanced Nurse Practitioners. This will be a vital increase in useful capacity across the region.

Nationally there is a belief that practice attached pharmacists can play a significant role in supporting GPs, and the Scottish Government has provided funding to support the attachment of 140 pharmacists across the countries 1,000 GP practices. Dumfries & Galloway is in the second year of developing a local pharmacist resource.

A considerable proportion of patients presenting to GPs suffer from relatively minor musculo-skeletal problems, and there is good evidence that they can be dealt with satisfactorily by physiotherapists. We are therefore attempting to divert patients from practices to attend physiotherapists. This is supported by a help-line run by NHS 24 which can give suitable advice to patients where appropriate, or divert them direct to the physiotherapists. Local experience suggests that patients seek appointments with their GP before seeing a physiotherapist and we are trying to advertise this service more widely. In order to successfully divert patients from practices, sufficient resources must be available to support a minimal waiting time for physiotherapist attention, otherwise patients will continue to gravitate towards their GP.

The Board has also supported practices to try what are called access initiatives. This involves redesigning the flow of patients within General Practice to make their management more efficient. In one practice for example, patients who phone in the morning are not given an appointment, but instead a GP phones them back and discusses the presenting problem. It has been found that around one third of patients who are known to the GP can be dealt with by a simple phone call instead of an appointment, providing a useful service for the patient, and decreasing the number of appointments required. This has allowed one practice to develop a standard of service where all patients are seen on the day of phoning, and the practice starts the next day with an appointment book free of any booked consultations. This development appears to have a very positive impact on all staff within the practice, as well as providing a more responsive service for patients.

The National Clinical Strategy calls for a greater involvement of voluntary and third sector organisations, as well as social services, in managing patients with long-term health problems. Some work has been taken forward to have greater contact between social workers and GPs, and we continue to work

with local organisations (eg Pain Association Scotland) that are able to provide an invaluable role in supporting self-management by patients.

6. Conclusions

6.1 This paper has described many of the causes of the recruitment challenges facing General Practice in Dumfries & Galloway, and outlined steps that are being taken to minimise the impact.

However there is a high risk that there will not be sufficient GPs to maintain the current organisation of services. It is recognised that effective primary care supports all effective healthcare systems, and without a strong primary care service – specifically General Practice- hospital services will come under extreme stress. It is vital that we support primary care, seeking to support capacity increases.

It is likely that there will be change in the near future. Practices are likely to merge to survive, and branch surgeries may no longer be viable. Both of these changes may make care less accessible, but will help ensure that a service remains (The Board is legally obliged to provide Primary Medical Services for all residents). In supporting change – which will of course be led by practices as independent contractors – we must ensure that we provide practices and premises that are attractive to young doctors, and support them to remain in the area.

The issue of some practices having their own premises, and requiring new partners to buy in to practices may have to end: This is being reviewed by Scottish Government, and may involve the purchase of premises from practices.

In the future, care will be delivered by a much broader multi-disciplinary team, and significant support for patients that is currently provided by practices may be supplied by the third sector providing invaluable services.

However there will remain very significant challenges, and Board members are reminded that Primary Care services should be considered as a priority for investment of new money for the foreseeable future if we are to retain a balanced health and care service.

SECTION 2: COMPLIANCE WITH GOVERNANCE STANDARDS

7. Resource Implications

7.1. The content of this paper and appendices have no immediate financial implications for the Integration Joint Board: While future support may be required locally for changes in General Practice, the funding for GPs is determined centrally and delivered through the General Medical Services budget.

8. Impact on Integration Joint Board Outcomes, Priorities and Policy

8.1 This paper describes the background to the unsustainability of General Practice over the next 3-5 years, which will present a very high risk to achievement of the IJB outcomes. While the exact impact cannot be defined at present, the extent of that impact is likely to be substantial.

9. Legal & Risk Implications

9.1 There are no legal risks identified in this paper: It does however detail severe risk to the achievement of IJB outcomes

10. Consultation

10.1 The extent of the national problem with GP recruitment and retention has been widely trailed in national and now local media. In respect of the changes in Wigtown/Merrick practices consultation was not undertaken prior to the merger – the merger was seen as the only possible alternative to complete collapse of the service in Wigtown. However there has been active involvement of patient participation groups from both practices who have been supportive of the merger. A Community Council meeting has been set up for July which will be attended by the GPs, the Board Medical Director and the locality manager.

11. Community Engagement

11.1 Engagement will now take place with patients on how the merged practice can most satisfactorily meet the needs of its patients with understanding of the limitations imposed by the reduced medical staffing.

12. Equality and Human Rights Impact Assessment

12.1 There is concern that a reduction in the provision of afternoon and evening surgeries at the Wigtown practice will disadvantage those with impaired mobility. It should be noted that a recent survey showed that 73% of all patients at Wigtown surgery arrived by car. A significant number of patients who are registered with the Wigtown surgery live in Newton Stewart so their access will be improved. A small number of patients of the Wigtown practice live outside the practice boundary, and they will be helped to transfer to nearer practices – such as the South Machars Practice at Whithorn

The NHS Board has initiated a process of reviewing what transport services can be enhanced for patients who need assistance to travel to the Newton Stewart area for afternoon and evening surgeries.

Although there may be some impairment of access for some patients, the drive behind the merger has been the preservation of a GP service within Wigtown: alternatives to the merger would have included the more distant provision of all services.

13. Glossary

13.1 The acronyms referred to within this paper are noted below:

IJB	-	Integration Joint Board
GP	-	General Practitioner

14. Exempt reports

14.1. No exemptions are required to be applied to this report.