RCGP Scotland response to call for evidence on winter planning 2023-24

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

1. Winter Resilience Overview 2022-23

How effective were government actions to support winter resilience across health and care systems last year?

Last winter, general practice experienced profound pressures as it dealt with a Strep A outbreak, flu and ongoing high levels of Covid. The failure of the public health messaging to effectively communicate to the public key information about the Strep A outbreak had a definite effect; parents of children were understandably concerned, and without an effective communications plan to equip them with key facts or signpost them to appropriate treatment pathways, much of the pressure fell upon general practice, by default. GPs reported being overwhelmed, some with 50-100 patient contacts per half day session, compromising patient safety and GP wellbeing.

We note from the latest GMC survey that, yet again, GPs are facing the highest risk of burnout of any medical profession.[1] Last winter was damaging for patients, but it was also damaging for the profession and GPs, some of whom have left or reduced their sessions because of that experience. We need to consider that winter resilience planning will have a direct effect on GP retention.

There seems to be a strategic and cultural failure to systematically involve general practice in planning for healthcare which GPs and their teams deliver. It is our view that general practice must be involved in national winter resilience planning, and this must be viewed as an ongoing, rolling programme, not one which is started each year in autumn, by which time it is too late.

The difficulties faced in 2022-23 were compounded by the long-term structural issues suffered by general practice, including a lack of adequate workforce, absence of protected learning time and an ageing population with increasing complexity and widespread reports of rising demand. This exerted significant and unsustainable pressures on general practice and contributed to a very challenging period for GPs and their teams.

These issues are by no means limited to the winter period, and the pressures felt by GPs year-round are at levels which were previously a feature of the cold season. While the health system and general practice would benefit from bolstering of support and services during the winter months, a longer-term view is also needed to resolve the pressures which exist across the entire calendar year.

Despite its winter resilience document outlining that care had to be moved to the community, the Scottish Government failed to plan for appropriate in-hours primary medical care. It is of no surprise to us, or others in the profession, that 10% of GP practices in Scotland have now closed their lists, meaning that increasing numbers of patients will not be able to register with a GP. This is an especially difficult proposition considering Scotland's expanding and ageing population. If the Scottish Government wishes to have care closer to home, it simply cannot afford to repeat

[1] The State of Medical Education and Practice in the UK: workplace experiences 2023. General Medical Council

the processes it adopted last winter, where strategic documents indicated that more care in the community was needed but for which appropriate support was not provided.

As we have seen in a range of policy publications and public messaging, much of the narrative from the government regarding health has been concerned with care closer to home, A & E admission avoidance and early discharge. This was clearly described in last year's winter plan, whose very first priority was where *"clinically appropriate, ensure people receive care at home, or as close to home as possible."*[2] The opening paragraph stated that *"We recognise that primary and community care is for many people, the front door to the health service, where their needs are first raised. We are supporting primary care, not just to reduce pressure on hospitals, but to provide essential care where it is needed most – in our local communities."* We have since seen available funding to general practice cut. There is mention of ensuring effective access arrangements in primary care (p.5) with no reference either to the funding cuts, that the existing workload and expectation already overwhelms and to the falling number of Whole Time Equivalent (WTE) GPs, with out of hours general practice also struggling. The promise that *"We will provide sustainability funding to support GP practices to continue providing a high level of care to patients through winter and into next year"* (p.6) was of course not kept, with an impact not only on workload but on professional trust.

The partial withdrawal of the sustainability funding was an astonishing and deeply damaging decision, and it is difficult to understand the public health or strategic rationale for this approach, considering the stated government intentions regarding its vision for the Scottish NHS. This funding was welcome as it had no strings attached, allowing practices to deploy it in a flexible and targeted manner. Such flexibility is also needed in regard to the type of health care worker because of workforce availability, for example allowing 'internal locums' (when existing practice staff cover by doing extra hours as the practice is unable to employ external locums due to availability) to cover sessions. Restoration of this funding would be impactful and welcomed amongst GPs. The removal of the Mental Health and Wellbeing monies was also damaging when mental health is a growing GP workload, GPs are taking on more secondary care work because of staff shortages in that sector and Scottish Government has expressed its commitment to both improving mental health and reducing health inequalities.

The whole document reflects a focus on secondary and social care, with very little attention given to primary care or the pressures and limits of general practice which would be expected to prevent these impacts upon other sectors. The second priority was to expand the workforce, yet there is no acknowledgement of the shrinking medical workforce in general practice, despite that so often determining what happens in the rest of the system. General practice has generally not seen the benefits of the new institutions and processes detailed in the workforce 'pillars' section of the 2022 National Workforce Strategy for Health and Social Care in Scotland.

We note in last year's plan (Priority 2): *"We are expanding our trainee doctor workforce by increasing the number of available medical training places. 139 additional trainee doctor posts were created for Autumn 2022 in a variety of specialties, creating additional workforce to meet winter pressures as well as future consultant supply"* with no mention of GP supply. Consultant numbers have grown substantially over recent years, whilst GP WTEs have dropped and this complete lack of reference to general practice is telling. A shortage of fully trained GPs undoubtedly undermines the government's stated ambition of moving care closer to home. It is messages such as these that understandably make the wider GP community feel that they, and their contribution are not valued.

[2] Scottish Government Winter Resilience Overview 2022-23

10% of practices in Scotland now have closed lists[3], with that figure set to rise, thereby reducing primary care access yet further. Some of those closures may have resulted from the severe pressures of last winter where GPs felt inadequately supported on multiple levels. We need to ensure sufficient growth in capacity to at least reverse list closures, and efforts to achieve this deserve as much urgency from the government as reducing A&E waiting times and hospital waiting lists.

In terms of Priority 4 of the plan, we support the establishment of a Patient Safety Commissioner and expressed that in feedback to the consultation, involving our patient group. We note the desire *"to deliver a safe, resilient and sustainable out of hours service across Scotland to ensure patients have access to urgent primary care 24/7"* and suggest that too was compromised by falling GP numbers, with eight NHS Boards having *to "take additional action at least weekly to ensure shifts are filled, either by extending shifts, having nurses cover GP shifts, reducing triage cover or use of standby/on-call/backup shifts."*[4] We are aware from members that difficulty accessing out of hours systems meant that patients did not persist in their attempts to contact the service, and instead waited until their practice was next open, sometimes resulting in a worsening of their health condition.

What additional priorities should inform actions to support winter resilience across our health and care system this year?

There must be a strategic focus, backed by clear operational plans and resource, on supporting general practice, and some sense of equity of approach with other frontline services. As above, the narrative that planning should prioritise minimising A & E presentations or admissions, or social care bed blockages massively understates the importance of supporting primary care and the role it plays in propping up the entire healthcare system.

It is frustrating that the focus on secondary care, fails to then recognise that a well-resourced and functioning primary care prevents unnecessary admissions and benefits secondary and social care, including flow through the system. For patients, all flows potentially both begin and end with their GP, and as such, primary care must be a major focus and pillar of winter resilience.

2. **Capacity and system flow**

What were the key factors limiting capacity and delivery in the NHS and social care last winter?

In terms of primary care:

- Lack of government messaging to patients
- Lack of GPs, with documented further falls in WTE numbers
- Severe pressures on the Out of Hours service
- Lack of the extended Multi-Disciplinary Team
- Shortage of district nurses, physiotherapists and OTs
- Managing patients on secondary care waiting lists
- Lack of appropriate data
- Lack of adequate premises

[3] https://www.bma.org.uk/advice-and-support/gp-practices/funding-and-contracts/the-sustainability-crisis-in-gp-practice-in-scotland

[4] https://publichealthscotland.scot/publications/primary-care-workforce-survey/primary-care-out-of-hours-workforce-survey-2022/

Was the flow through the NHS and social care adequately maintained last year?

No.

The concept of 'flow' has come to mean through hospitals, and we suspect most will infer this when they consider the question. The Scottish Government's narrative and planning focus regarding patient flow remains fixated upon preventing admissions, freeing up care beds and overlooks the role of primary care and general practice especially in relation to the 'flow of patients'. But flow starts with general practice, where we saw massive flows into the system which exceeded workforce capacity. GPs work hard to stem flow into hospitals especially, aiming to keep patients at home wherever possible, particularly the frail elderly and those in care homes. This is part of generalist practice; following the principles of realistic medicine and avoiding the harm that the evidence now tells us is suffered by this group of patients by prolonged, or unnecessary, admission.

GPs also continue to provide palliative care to those in the communities. There is at present a diminished community nurse workforce, despite the intention of the 2022-23 plan to increase numbers. Hospital @ Home is useful but treats a tiny fraction of the ill and housebound patients in the community, who are generally managed entirely by their GPs and whose treatment must be seen in that context. Priority 4 refers to more end-of-life care at home and an *"increase in community capacity to enable patients to be discharged to their own home"*. It is of course GPs that provide such care and yet this was the only group of professionals with a major involvement that were not mentioned at all in that entire section.

The flow to outpatients should allow a smooth handing over of care to a specialist for that particular health issue, but there is now a strong back current into general practice, where GP teams continue to manage people with significant conditions, often worsening, whilst they wait to be seen, sometimes for years.

Last winter, the failure to focus on the full pathway of patient treatment will likely have impacted upon the overall flow. To provide the best possible patient journey through the healthcare system, general practice must be equipped with sufficient funding, capacity and support to support the flow of patients on the sole basis of need.

We also note that GPs regularly receive communications from secondary care alerting them that the system is on 'red alert' and instructing them to strongly consider other alternatives to admission however no such system is in operation from primary care to secondary care.

How can capacity be maximised to meet demand, and maintain integrated health and social care services, throughout the coming autumn and winter?

It's unlikely that capacity can be bolstered within general practice, to any significant degree, before the winter period commences. The removal of the PCIF underspend has limited opportunities to recruit more MDT members opportunistically, and the WTE GP workforce is shrinking. The sustainability funding did help through allowing practices to maximise locum coverage, albeit some of it 'internal' due to shortages.

There are no very quick fixes but what would made a short to medium term difference would be the following:

- Deploy robust public messaging from the Scottish Government well in advance of winter to alert the public to what the reality of the situation might be, for example a move to increased telephone triaging to ensure we are treating patients according to clinical urgency and not demand and that some routine work might not be reached.
- Promote self-management and the use of other appropriate avenues of care, including Pharmacy First, and online resources such as NHS Inform.
- Ensure that the messaging can rapidly be increased or amended if the situation demands, for example another Strep-A or similar outbreak.
- Treat winter planning as an ongoing, rolling programme – not one that starts in early autumn each year by which time it is too late. This requires elective, resourced planning, with GPs as an integral part of that, both at NHS Boards and the Scottish Government level. Key stakeholders who need to be involved at all stages include the Scottish General Practitioners Committee, the Royal College of General Practitioners, Primary Care Leads and GP Sub-Committees with planned and backfilled cover to allow for this, taking into account that GPs are independent contractors.
- Increase the understanding within secondary care of the winter pressures within primary care – there is increased demand in primary care but no increased resource. Often hospitals send out red alerts asking general practice to take further steps to avoid admissions but there is no additional resource within primary care to absorb this. It is the GPs who carry the uncertainty and bear the risk in these situations and as GMC surveys have demonstrated this results in increased disillusionment and burnout.
- Ensure that admission pathways have no delays and do not involve multiple conversations with secondary care colleagues which take time and are often subject to delays – in periods of increased demand, general practice may not have the functional capacity to follow the usual processes such as pathways for admission and this needs to be accounted for.
- Recognise the additional demands and pressure put on general practice due to delays of ambulance attendance for admissions and transfer to hospital.
- Recognise that requests by the Scottish Ambulance Service for GP opinions on patients who have not been seen by the GP shifts additional strain and risk onto general practice.
- Put in place a contingency plan to increase community nurse numbers at short notice; given the likelihood of increase in early discharges from hospital of complex, frail patients over the winter period, this is crucial.
- Instigate clear escalation procedures which general practices can use if they identify issues (for example significant staff absence, technical failure, overwhelming demand) backed up by a robust support mechanism that is known and understood by GPs, and which can be rapidly deployed.
- Instigate systems to alert patients when practices have reached saturation point backed up by a nationally supported system to divert calls elsewhere.
- Reinstate nationally supported Protected Learning Time which would allow practices to undertake winter planning exercises each year and therefore be better prepared.
- Reinstate the sustainability fund which goes direct to practices and would allow them to flexibly provide more capacity.

- Instruct Health Boards to halt and reverse wherever possible, the large and continued flow of unresourced work from secondary to primary care.
- Ensure continuity of the Out of Hours service over the winter period.
- Introduce some flexibility around end of day working which would allow more in-hours GPs to participate in the Out of Hours service.
- Set up a one-stop, fast access service to non-medical support within the community to help keep people at home: social care, physiotherapy and occupational therapy.
- Ensure that GPs have rapid access to hospital investigation to maintain elderly patients at home, for example chest x-rays, with ambulance transfer to and from hospital in a timely manner so they can be dealt with during the working day. This would result in a better outcome for the patient – which is especially important given the piecemeal implementation of Hospital at Home.
- Ensure faster and enhanced access for general practice to a suite of investigations such as CT scans which would decrease the demand for admission and outpatient referrals.

Long term solutions are needed to increase the GP workforce in Scotland. As the recent Audit Scotland report on the NHS clearly outlines,[5] the Scottish Government is not on track to recruit the 800 new headcount GPs it promised to by 2027, despite its continued insistence that it is on track to do this. Additional resources for Muli-Disciplinary Teams may have some benefits, however there is an emerging evidence base that those are considerably fewer than anticipated and certainly far short of what a GP offers. It takes 10 years to train a GP, but we have already lost time when we could have been aiming to increase that capacity. A long-term view is needed in tandem with short- and medium-term action to begin the crucial process of boosting GP capacity in Scotland.

A key area for investment is enabling more effective data gathering and monitoring in relation to GP workforce and activity, where we still lag markedly behind England.[6,7] Secondary care data is regularly reported; outlining wait times, admissions, delayed discharges etc. A similar level of coverage regarding GP activity would enable more effective forward and long-term planning as well as unlocking real time tracking of pressures upon GPs.

3. Workforce and staff wellbeing

- **What factors affected the wellbeing of those providing health and social care support, including both paid and unpaid carers, over the 2022-23 autumn and winter periods?**
- **What should be done this year to ensure staff wellbeing, and ensure those providing support (in all settings) are able to continue to do so?**

Again, the greatest pressures felt by GPs relate to unsustainable workload. We have heard from members who, during the last winter period, were undertaking many dozens more patient contacts per day than is best practice. These GPs are often unable to take a lunch break due to the deluge of patients they have to see each day.

[5] https://www.audit-scotland.gov.uk/uploads/docs/report/2023/nr_230223_nhs_overview.pdf
[6] https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services
[7] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

These pressures have an undoubted effect upon wellbeing, and the recent RCGP tracking survey shows 36% of responding GPs think that is unlikely they will still be working in general practice in five years' time, with unsustainable workload a key factor for many.

4. **Outcomes**

- **Were patient outcomes affected last winter, either positively or negatively?**
- **What recommendations would you make to ensure services best support vulnerable communities and achieve positive outcomes this year?**

It is difficult to consider that patient outcomes weren't affected: waiting lists are long, and most of the patients who are in hospital for longer than they need to be whilst awaiting social care will be the frail elderly. There is clear evidence that long stays are damaging for these patient's wellbeing. We know that mental health presentations are rising, and GPs are aware that both they and specialist services are struggling to manage this increase in volume and severity. There are some outcomes which we know are worse, including excess deaths and late cancer presentations, but the explanations for those are complex and not yet fully understood.

GPs have reported huge pressures and report that they do not feel that they are providing safe care, and we have heard reports of this from many. The GMC survey on the state of British medical practice highlighted that *"over half of GPs (55%) were categorised as struggling with their workload, compared with 38% of all doctors"*.[8] And crucially, *"45% of GPs reported experiencing compromised patient safety or care, and 62% found it difficult to provide sufficient patient care each week"*. It is very difficult to imagine that patient safety has not been compromised, despite the best (and increasingly unsustainable) efforts of GPs and their teams.

We have attached an account (see Appendix 1) – from early January of this year – of a representative group of very senior GPs from one health board, who were asked about their pressures from just the preceding week. We know that part of the supreme effectiveness of general practice relates to elective planned GP care – the bedrock of provision of care for mental health, managing concerning symptoms, diagnosing cancers and other conditions, long-term condition management and palliative care (the latter in terms of many contexts, and not just of the terminally ill) as well as care co-ordination. This was the non-urgent care that was sacrificed or postponed looking after those with acute concerns – particularly during the Strep A and other respiratory outbreaks – yet many of those were overblown by the media and poorly addressed by government messaging. Outcomes arising from that non-urgent care are often long term, and difficult to assess. Whilst we may be aware of patients with misses, or near misses, the impact upon other outcomes will not be so readily evident yet be profoundly important.

5. **Do you have anything else to tell us?**

Under Priority 5 of last year's plans (for planned care and reducing long waits), the Centre for Sustainable Delivery (CfSD) is mentioned with an ambition of ONCE For SCOTLAND pathways. As these pathways largely start in general practice and have significant implications for GPs' ways of working and workload, it is crucial that GPs are part of that work, and we are keen to know the plans for that. Currently, there is no GP representation on any of the CfSD's strategic groups.

[8] The State of Medical Education and Practice in the UK: workplace experiences 2023. General Medical Council

Finally, general practice is at a tipping point. Some practices have already tipped into closing their lists or practices, and some GPs have chosen to leave the profession. So much of last years' plans had implications for general practice, especially the repeated references to moving care into the community. This was accompanied by a narrative about specialist services and Out of Hours general practice, to the exclusion of in-hours general practice. This is not only disappointing, but it is also strategically and operationally inappropriate. This winter, we would hope for better however many GPs are already anticipating that this period will be at least as bad as the last.

Appendix 1 – account from January 2023 from GPs from one Health Board in Scotland

1. "We are running so close to the limit all the time now…we had to stop taking pre-booked appointments and revert back to on the day triage to give our heads above water. Gives some sense of how precarious it all is."

2. On Monday, the practice received 509 E-consults in addition to the 259 that arrived over the weekend, and several hundred phone calls too. 4% of our practice population consulting in a single day.

3. I found out today another colleague is reducing their sessions. It just seems that many people are trying to find alternative work instead of dealing with the pressure faced in a normal session. We are already miles off meeting demand and expectation.

4. In the past month we have had one of our salaried GPs resign stating intolerable workload pressures as her reason for leaving day time GP practice for good (she is 39 and we had done everything we could to support her to stay), another salaried GP colleague who has been in tears repeatedly and has openly said she is not coping and I think we will be supporting her to go off sick with stress and our most senior partner (who is only 53) saying she is close to burn out and may bring her planned retirement from the partnership forward from age 55.

5. One of our partners left in November, having decided that she didn't think the current workload (especially as duty Dr) is safe, she is now partly running a cake baking business, while doing some locums with very fixed workload, she is in her late 40s.... Sometimes I think she might actually be the smart one. With her down, and another GP off long term sick, another coming back gradually after health issues, we are doing mainly on the day appointments. To try and help this we have recruited another GP to start next month, as well as two ANPs, however the reality is that we are going to struggle to find space for them in a building which is far too small.

6. My duty Dr session had just 5 pre-bookable appointments (we could not have more due to anticipated demand). Had 49 triage phone calls in total duty doctor (morning) session. We also had 4 house calls (one afternoon, out of area but we can't remove such patients but takes up disproportionate time), all done by another GP. Of duty Dr phone calls, 15 mentioned the words chest pain, breathless, pneumonia, and many felt they needed to be seen. Another 10 were children with high fevers, sore throats etc or? Strep. I saw 8 face to face and my GP colleagues helped out seeing some others. From March 22 to March 23 we have lost 3 partners, and not even been able to replace them with salaried GPs.

7. Sent at quarter to 11 at night: "Sorry for my late response, long day at the practice and still doing docman at home: ….
   81 duty doc contacts yesterday (7600 patient list size) so not horrific but still a lot… however it is this week we have dropped to one duty doc in the morning (bar Monday where we just don't feel we could cope) to try and free up more routine appointments and to "push back" by triaging and redirecting patients back to later appointments, which was meant to have an impact on duty doc demand by providing more routine appointments. (we previously had 2 AM duty docs just to try and cope with the demand. it all seems just a bit of "moving the deck chairs really" but felt we had to do something to help.
   Ultimately the fact that our next routine available patient bookable appointment is in two weeks' time is an unacceptable wait for a lot of patients which just increases the pressure. 3

of my senior partners were all told at our accountant meeting today that they have been massively stung by the inflation rise on their pensions and have all three today opted for scheme pays and one is planning to drop his sessions.