Bearsden & Milngavie GP Cluster response to the East Dunbartonshire HSCP Strategic Plan 2025 – 2030: Phase 1 Consultation (August 2024)

This response has been prepared on behalf of all 5 GP practices within Bearsden and Milngavie GP Cluster serving a total population of approximately 42,000 patients or 38% of East Dunbartonshire's population. The practices involved in writing this response are: Ashfield Medical Practice, Denbridge Medical Practice, Kersland House Surgery, Kessington Medical Centre and The Terrace Medical Practice.

We welcome this opportunity to contribute to the development of the HSCP strategic plan for 2025 to 2030, in particular recognising the growing healthcare demands of an ageing population which include increasing multi-morbidity, frailty and end of life care. In this context, the importance of improved prevention, community-based care and support will place significant added challenges on already overwhelmed primary care providers in the very near future.

We were surprised by the absence of any demographic data in the consultation document given that the ageing population is the greatest challenge that the HSCP faces. To help demonstrate the challenges we face as a GP Cluster we present our own data against those for East Dunbartonshire and Scotland. In Bearsden and Milngavie we have one of the oldest populations in Scotland and population projections indicate that these figures will increase substantially and rapidly.

Table 1: Age groups as % of population in 2024

	East Dunbartonshire	West Cluster (Bearsden and Milngavie)	East Cluster (Kirkintilloch, Bishopbriggs and Lennoxtown)	Scotland
65+	24.3%	24.9%	20.8%	20.1%
75+	11.8%	12.9%	9.8%	9.1%
85+	3.5%	3.8%	2.7%	2.4%

Of note these figures show a higher proportion of elderly patients in practices in the West Cluster (Bearsden & Milngavie) compared to the rest of East Dunbartonshire.

East Dunbartonshire Council's own projections, based on data from National Records of Scotland (NRS) state that *between 2018 and 2028:*

- *Children aged 0-15 are projected to increase by 4.5%.*
- *The working age population is predicted to increase by 3%.*
- *Those of pensionable age and over are projected to rise by 5%.*

- *The highest population increase is expected to be seen in those aged 75 and over with a **predicted increase of 26%.***

Longer term NRS projections for East Dunbartonshire for 2043 show the 65+ age group will make up 26.6% of the population. Some practices within Bearsden and Milngavie are already effectively at this point in regard to their practice populations, meaning they are essentially 20 years ahead of the curve on this issue.

Starting from such a high aged baseline, any further projected ageing in the population will have huge workload implications for us and at present it is hard to see how we will have the capacity to cope with such demand.

Given that data from East Dunbartonshire's health and wellbeing survey from 22/23 indicated that around 60% of those aged 65 and over have at least one limiting long term illness or condition, this increasing age profile not only has significant implications for the demand for community based health and social care, but also on the availability of an adequate workforce to meet this demand.

We note that healthy life expectancy is also declining within the local population which will further drive demand for both health and social care.

Whilst out with the remit of this consultation, it is vital to both understand and acknowledge the precarious state of General Practice in Scotland just now and also recognise that practices in East Dunbartonshire are absolutely not immune from this. This rapid demographic shift, with the huge increased workload it will bring, comes at a time when full time equivalent GP numbers continue to fall in Scotland and have reduced by 5.4% since 2013. Also, an increasing number of GP practices across the country are either closing or handing back their contracts to Health Boards as they simply cannot cope with demand. Lastly, practices are having to deal with significant reductions in their real terms operating budgets often by reducing the level of service they provide to patients.

We must also remain cognisant that the amount of capacity that GP practices have available and the number of appointments they can safely offer is ultimately driven by the Scottish Government's investment and workforce planning decisions and the level to which it wishes to prioritise General Practice within NHS Scotland. Given that a declining proportion of the total NHS budget in Scotland has been allocated to General Practice in recent years it would suggest we are not seen as a priority at this time, all when demand for GP services has never been higher and is growing rapidly.

We also note that the consultation document identified the two most commonly cited strategic plan themes when benchmarking with other HSCP strategies as "*care closer to/at home and prevention"*. General Practice is a lynchpin in delivering such services, but it requires suitable and adequate planning and resourcing, within a

broader framework of suitably and adequately planned and resourced health and social care services to do this.

General comments on the consultation:

While we welcome the chance to engage in the development of this strategic plan we feel the consultation document lacks detail about both the challenges it seeks to address, particularly around the rapidly changing demography in the area and also the changes it seeks to achieve. It would help to lay out more clearly what difference this strategic plan is intended to make.

The evidence presented to the public on which this consultation is based appears to be very limited. We were particularly surprised that the consultation document has little or no mention of the significant demographic changes projected for East Dunbartonshire in the period 2025 to 2030 and the huge implications that these have for health and social care services in the area. Ideally the Joint Strategic Needs Assessment that is referred to in the document should be readily available to responders.

Q1. What HSCP Services in your area work well for you?

As a GP Cluster we greatly appreciate the hard work and dedication of all our colleagues across the HSCP, however a consistent theme on speaking to them is one of low morale and growing workloads.

In particular, our in-house pharmacy, physiotherapy and visiting ANP colleagues have been welcome recent additions to our wider team of colleagues, albeit we need more such resource to help deal with an ageing population.

Again, whilst out with the scope of this consultation, it is essential that whole time equivalent GP numbers rise significantly to help meet the increasing and complex workload associated with an ageing population.

Q2. What Health and Social Care services could do better?

a) We are already experiencing significant increases in the demand for primary care services as our practice populations rapidly age. Health and social care services must get better at working together to plan and prepare for these inevitable changes.

   As a GP Cluster we were surprised that these population projections, which will directly impact us, have not been proactively shared with us by the HSCP for discussion, especially as we are central to addressing the challenges these population changes will bring. Moving forwards this must change.

b) The HSCP should be proactive and honest in communicating with the public about the challenges it faces based on population projections. This consultation document is an example of where that doesn't happen, which

risks unrealistically raising the expectations of the public as to what can be achieved and delivered.

c) All GP practice buildings in Bearden and Milngavie are now very old and essentially no longer fit for purpose to deliver modern high quality healthcare and meet the growing demands of an ageing population. Being co-located with other HSCP care providers in a modern fit for purpose building, ideally with other local GP practices, would help us provide more joined up and aligned care, and would support more effective partnership working and shared decision making between care providers working with the same practice population. This would improve both the efficiency and effectiveness of service provision.

d) Social care provision should be more responsive and proportionate to the current and growing level of demand in the HSCP population.

e) This requires having an adequate and well paid workforce to ensure staff retention. Currently too many patients are experiencing unnecessary hospital admissions or delayed hospital discharges due to a lack of suitable social care. In the focus to support rapid discharge and avoidance of admission we must not lose sight of the value and importance of more routine social care and the proactive benefit this can bring to a wider group of patients. As part of this point, and whilst out with the remit of this HSCP consultation, it is important to recognise that for this to work it would also require significant additional GP resources to support social care services in meeting the increasingly complex care needs of frail elderly patients in the community.

f) District Nurses are absolutely critical to supporting our role looking after frail patients at home, often at the end of life. Given the population predictions their numbers will need to increase significantly.

Q3. Do you agree with the challenges presented?

While we don't necessarily disagree with the challenges laid out in the consultation document, our view is that these are too vague and non-specific, and do not reflect or acknowledge the major issue that health and social care services in East Dunbartonshire are, and will increasingly face - namely the massive demographic shift that is already happening. A number of the challenges that are listed result from this shift.

Further, we would like to see the listed challenges weighted or quantified in terms of their likely impact on the delivery of future health and social care services. Our experience is that health and social care services are very stretched and in such circumstances there is a need to prioritise those challenges that present the greatest

threat to provision of health and social care services. For example, increasing frailty and multi-morbidity, growing need for home visits, requirements for chronic disease management and supporting end of life care at home, to name a few, are likely to push primary care beyond its current limited capacity if not addressed quickly. These should be specifically listed as challenges to be addressed by the strategy as priorities.

A particular challenge for local GP practices is caring for the large and growing number of patients (currently over 500) residing in nursing homes in the area. These represent some of our frailest and most complex patients, often at the end of life, however the current resourcing for GP practices to care for these patients does not reflect the true level of input required to provide high quality and holistic care. To illustrate the point about the growing workload, we are aware that a planning application has recently been submitted to the Council for the construction of another 60 bedded nursing home in the area.

A similar challenge which needs acknowledged is the additional demand for services that arises from new housing developments in the area. Planning decisions seem to be taken with little, if indeed any, consideration as regards their impact on local health and social care services and how they will cope.

As GPs we are concerned by the issue of the growing pressure on prescribing budgets that the HSCP is now responsible for. This budgetary pressure will inevitably continue to increase due a combination of the rapid growth in the elderly population and their health needs, medical advances and inflation which always runs higher in the healthcare sector. Ironically most of the expensive drugs issued by GPs in the community are initiated in secondary care and prescribed on their behalf.

There appears to have been a longstanding implicit assumption in healthcare planning decisions both at a local and national level, usually by those outside the sector, that GP and primary care capacity is both limitless and free. This is best demonstrated by the continual and growing unfunded transfer of work into the community from secondary care. We face a daily battle attempting to both manage and pass this workload back to secondary care where the budget and workforce to undertake this work sit. If the intention is for workload to be transferred into the community, then it must be funded appropriately.

We fully concur that patients are better treated in the community where possible but unless this is suitably funded this inevitably further impacts on the ability of primary care to work effectively and will ironically result in more patients having to be seen and treated in, and even admitted to, secondary care.

Loneliness and social isolation in the elderly is a growing challenge that drives a large proportion of healthcare contacts.

Along with the increasing proportion and numbers of elderly patients, we also feel that other important challenges are not currently listed, e.g. the proportion of people considered housebound and the resultant increased challenge and cost in delivering services to this group, the proportion of people who are disabled, and the reduction in valuable community based services provided by the voluntary sector.

If a broader list of challenges is to be included, we also feel that there would be merit in providing more detail and specifics. For example, *'health and social inequalities'* is a very broad heading and it would be good to tease out further what the specific future challenges there are likely to be in East Dunbartonshire in order that the strategic plan addresses these appropriately. For example, what are the local health and social inequalities in the East Dunbartonshire area that need to be addressed in this future strategy?

There are some comments in this document that we do not agree with, for example the statement that most issues are similar to neighbouring HSCPs. This is not true in terms of the extent of the demographic changes nor in relation to the impact of deprivation. The lower level of deprivation in many parts of East Dunbartonshire does not, however, mean that the demands on primary, community and social care are less. The pressures are different but large and growing, and these are not fully acknowledged in this consultation.

In terms of general practice specifically, our key challenges for the immediate future are those of workforce, workload, funding and premises. There are falling numbers of full time equivalent GPs nationally, a rapidly increasing workload from the ageing population, primary care budgets are significantly falling in real terms despite increasing demands in the population and lastly many practice premises are not fit for purpose.

As a final point in this section, it is important to note that the HSCP are not best placed to address all the challenges that are listed, and that consideration needs to be given, in the future strategy, to working with and supporting the appropriate agencies (who will often be in the third or voluntary sector) to address these (for example, building capacity to enable social and community wellbeing, and addressing social isolation).

Q4. Do you think the improvement and development themes are the right ones?

While we recognise and accept that the themes listed are all important and, in an ideal world where primary and social care based capacity was adequate, would be the '*right ones'*, in the current context they risk failing to address the challenges that most threaten good health and social care service delivery. It is also important to note that, in a wider context of public services that have endured austerity, a population still reeling from the pandemic and cost of living crisis, and a workforce

that is under resourced and weary, it is important to be realistic about the current context within which this strategy will need to operate.

The improvement and development themes are also very broad and vague, and say very little about the intended improvements in HSCP services or third sector services. There is, again, no mention of the specifics of the demographic shift. More specifics about what these 'improvement and development themes' mean for the East Dunbartonshire strategy would be helpful. For example, *"People are enabled to have power and control over their own lives, ensuring that they can get the support they need that is right for them at that time".* What does this actually mean for HSCP services? There needs to be a clear recognition that if primary, community and social care provision is inadequately resourced then these statements are largely meaningless.

Furthermore, the theme '*empowered and connected communities' ("Community members will be empowered to support their communities and be involved, and participate in, the ongoing sustainable development of their community, and have access to information, advice and resources to enable them to live independently and without formal intervention")* doesn't reflect the stark reality that, as people age and experience more health problems, they require more support to keep them at home and living independently. We should be working towards services that are able to provide more timely and appropriate support to help maximise independence and quality of life.

A key issue that should be mentioned here is improving capacity in primary and community care. Increasingly, a lack of community based health and social care capacity is causing an expensive cocktail of delayed discharges, unnecessary A&E and OOH attendances and avoidable admissions. In particular both delayed discharges and avoidable admissions in turn have a further adverse impact on community and primary care by delaying outpatient clinics, investigations and elective treatment resulting in patients who are waiting requiring increased treatment support in the community. This is an unfortunate vicious cycle that should be addressed.

Furthermore, lack of investment, and indeed disinvestment in third and voluntary sector services and support and community development services mean that more people turn to primary and community care with social problems and loneliness.

Q5. Do you think that the enablers for change identified in the consultation report are the right ones?

Again, whilst we agree broadly with the list, we feel they lack detail.

In regard to the enabler *'Workforce and Organisational Development',* it should recognise the fact that many staff mental health and wellbeing issues are currently due to a lack of adequate workforce and resources required to deal with an

increasing workload. Training courses, staff wellbeing initiatives or counselling are not going to make a difference without recognising and addressing the core underlying concerns that staff have.

Q6. Any other comments?

Overall, we feel the document lacks detail and were disappointed it didn't provide details on the huge demographic challenges facing HSCP services in East Dunbartonshire. At the same time, it potentially over-promises what can be achieved in the timeframe and the resources likely to be available.

The rapidly ageing population and the challenges this brings cannot be ignored or down played despite current budgetary constraints. Realistically this will require detailed strategic planning at both a local and national level well beyond the 5 year timeframe currently being considered, failure to do so will have foreseeably disastrous consequences for the reasons outlined in this document.

We would suggest that there is an urgent need for more honesty and a frank discussion with the public in East Dunbartonshire about the current challenges faced and what can be realistically achieved in 2025-2030 with the projected resourcing.

There appears to have been a long standing hope and expectation at HSCP, Health Board and Scottish Government level that General Practice will simply absorb whatever additional workload is thrown at it, usually with inadequate, if indeed any extra resources. Across Scotland General Practice teams are already fully stretched and within practices there is no longer the workforce, capacity, resilience or indeed goodwill to absorb anymore inadequately resourced work.

General Practice is a lynchpin in delivering this strategy but is itself in a very precarious position. The rapidly ageing population and their associated increasing healthcare needs are likely to be destabilising for practices. This strategy should acknowledge that without adequate resourcing for General Practices to meet these needs then as independent contractors there is both a real and increasing risk of GP practices either handing back their contracts to the Health Board or closing entirely as is already happening across Scotland.