Capacity & demand: Waitaha | Canterbury general practice survey

April 2024

CCN

Foreword

The Canterbury Clinical Network Primary Care Taskforce would like to acknowledge the time taken by Canterbury general practice teams to complete the survey that explored the capacity pressures on general practice and local changes that could support capacity and improve whānau access to general practice services. The comprehensive responses provided and the offers to assist with the ongoing work of the Taskforce has been impressive and humbling.

The findings of the survey and content of this report are not intended as a criticism of any individual or organisation; rather it is a reflection on the Canterbury health system in June 2023.

Many of the findings outlined in the report may not be a surprise, yet the value of quantifying and documenting the views of general practices in Canterbury on what is influencing the demand for services and capacity pressure being experienced locally cannot be overestimated. It provides a platform for enabling and, as a system locally, progressing small changes to sustain general practice in Waitaha while national policy changes are progressed. The findings also amplify the contribution of our local voice to those advocating for primary care.

Whilst the survey captures the views of general practice, the findings highlight multiple and interrelated factors across the Canterbury health system that are impacting the sustainability of general practice and the wellbeing of the workforce.

We recognise that making changes in a system under pressure is difficult. To address these findings requires the willingness and commitment of people across all parts of the Waitaha health system – the workforce, providers, and funders – to engage in open dialogue, to listen, collaborate and importantly act. This much predicted situation of insufficient capacity in general practice to meet the growing demand for care requires 'the whole system to be working for the whole system to work", (Timmins N., Ham C. 2007).

We also recognise that these local changes alone are insufficient to address the future viability of general practice; they must be accompanied by sustainable funding.

As we progress this mahi, I would like to extend a heartfelt thank you to general practice teams for continuing to provide access to care for whānau in such a challenging environment.

Canterbury Clinical Network Primary Care Taskforce

Dr Kim Burgess
Primary Care Taskforce Chair

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1. Executive Summary

The Canterbury Clinical Network (CCN) established the Primary Care Taskforce (PCTF) in March 2023 to provide leadership to local initiatives or models of care that would improve whānau access to care by relieving primary care capacity pressures, with an initial focus on General Practice. Membership of the PCTF included leaders from across the health system and community.

The PCTF surveyed general practices in Canterbury | Waitaha (June 2023) to strengthen their understanding of the current pressures in general practice and guide where they concentrate their efforts to address capacity pressures and improve communities' access to care. The PCTF's focus was on exploring local actions, rather than the well-recognised national changes required such as addressing the funding model of general practice and wider community care sector.

Three role appropriate surveys were distributed with comprehensive responses received from 105 General Practitioners (GPs), 81 Practice Nurses (PNs) and 48 Practice Managers (PM). Assuming most practies have only one PM, responses were received from at least 41% of practices in Waitaha. The respondents' practice type (size, rurality and Very Low Cost Access (VLCA) status) was broadly similar to that of all general practices in Waitaha.

The survey explored four key areas of general practice: capacity, current workforce, initiatives implemented to support capacity, and where the PCTF should focus their efforts. The survey findings are summarised below.

Capacity of general practice

Respondents rated their overall capacity to provide general practice services as reasonable. When capacity was rated by the streams of work within general practice, respondents identified that the capacity to provide acute care and care for people with complex needs rated above reasonable at 3.3/5, while capacity to provide proactive and preventative care was considered below reasonable at 2.7/5.

Comparing responses between people working in rural and urban practices, respondents working in rural practices rated:

- Overall capacity lower (2.7/5) than urban respondents (3.0/5); and
- Care for people that are acutely unwell higher (3.8/5) than urban respondents (3.2/5).

GPs and PNs identified the following factors as significantly impacting capacity:

- The expectation that general practice provide care previously provided in secondary care.
- Increased compliance or administration requirements.
- An inability to access services for people with complex social and wellbeing needs.
- The ongoing monitoring of people waiting for their first specialist appointments and/or planned care procedures.
- Inefficient referral pathways or healthcare process.
- The inability to recruit into vacancies and/or staff retention issues.

Further exploration of the efficiency of specific referral pathways highlighted the need to streamline several pathways and the opportunity to improve communication between secondary care and general practice. Examples given included greater clarity on referral processes, acceptance criteria and reducing the requests for additional information.

Workforce, vacancies, and workforce retention

Most general practices in Waitaha responding to the survey employ or involve health professionals and healthcare workers that are not traditionally part of a general practice team. Most commonly these include Health Improvement Practitioners, Health Coaches and/or Health Care Assistants. Furthermore 20% of practices involve Nurse Practitioners, Nurse Prescribers, and/or Pharmacists.

Some 38% (18) of practices reported GP vacancies totalling 20 FTE. At a lower rate were PN vacancies with 20% (10) of practices reporting vacancies totalling 7 FTE. 30% (14) of practices reported they had no vacancies.

More than half of the GP (59%) and PN (53%) respondents signalled they were contemplating leaving or retiring from general practice in the next three to five years. When viewed by rurality, greater numbers of GP (65%) and PN (71%) respondents working in rural practices indicated an intention to leave or retire.

When asked what would enable them to continue contributing to primary care, commonly identified factors were:

- An increase in primary care funding to attract and retain workforce and / or provide extended care for people with complex needs.
- A reduction in administration.
- Enhanced clinical and wellbeing support.
- An ability to work part time.

Initiatives implemented to support capacity

Most practices had implemented a range of initiatives to support their capacity to provide healthcare. Most frequently implemented were reserved same day appointments (88%), and phone consultations (77%). Approximately 40% of practices reported implementing acute clinical triage, streamlining back-office functions, and employing non-traditional workforce.

The barriers and enablers to implementing these changes including alternative approaches to clinical inbox management were explored in depth. Respondents identified templates and guidelines, examples from other practices, peer support, understanding the benefits, and medico-legal risks and mitigation strategies, would assist them implementing a new approach to inbox management.

Where the PCTF focus their efforts

Comprehensive responses were provided on where the taskforce should focus their efforts. Recommendations including the recruitment and retention of staff, advocacy for primary care and general practice funding, improving the interface between secondary care and general practice, and reducing the administration burden.

Common themes

Several interrelated factors contributing to the capacity pressures in general practice were evident throughout the survey responses. These are discussed in the report and summarised below.

Increased administration

Repeat referrals and investigations for people waiting for specialist care and the additional use of electronic messaging are contributing to the increased volume of general practice administration tasks. The constant pressure to manage clinical inbox tasks is a significant factor influencing GPs' decisions to depart, reduce hours or retire early from general practice.

Primary / secondary care interface

Insufficient capacity to meet the demands for secondary care services is resulting in more being asked of primary care. This is contributing to the capacity pressure and stress experienced by the general practice workforce as patients repeatedly seek referrals and ongoing care for complex needs while waiting for specialist services. The additional shift of services from secondary care (often with no or insufficient funding) is further impacting general practice's capacity and sustainability.

General practice workforce

The ability to retain the workforce is being influenced by the increased administration, increased volume of patients with complex needs, and a workload identified by many respondents as stressful and unsustainable. GPs are choosing to work part time to maintain their wellbeing, and high numbers of GPs and PNs are signalling their plan to leave or retire. Any further reductions in the workforce will exacerbate the demand on those remaining and ability to sustain their workload.

Funding as enabling general practice

Despite the survey focusing on local opportunities to improve general practice capacity, the limitations of the current funding of general practice were frequently raised. This was often in the context of additional funding to retain current staff, employ additional (non-traditional) workforce that can ease capacity pressures, provide longer appointments for people with complex needs and sustain general practice services.

Recommendations

The survey informed development of local actions to support capacity pressures in general practice. These include:

- Reducing the administration burden to reclaim the joy of general practice.
- Improving the primary and secondary care interface to recapture the relationships across the system.
- Increasing the retention of the workforce including the current and future GPs and PNs.
- Supporting the development of the Primary Care Team to better strengthen a team approach to providing healthcare.
- Promoting primary and community provider collaboration.
- Supporting the transfer of ownership of general practices.
- Advocating for and amplifying the voice of general practice / primary care.

A system response

The survey reinforces that general practice is part of a complex system with multiple interrelated factors influencing the ability of practices to meet communities' needs for comprehensive care. While much is already known about general practice capacity pressures, this survey has added to this body of knowledge by expanding information about factors influencing general practice capacity and where opportunities exist to address this situation.

The survey has also made more visible the key factors significantly impacting the capacity of general practice in Waitaha. This local evidence is invaluable and highlights where a system response is needed to progress the recommended actions.

While national work is required to sustain general practice, the survey findings indicate that the collective effort and resources of people and organisations locally can make a meaningful contribution to supporting general practice and maintaining whānau and communities' access to services.

2. Introduction

Recent reports identify the significant challenges general practice face in meeting the healthcare needs of communities, and the impact of this on access to care (GenPro, 2022. Gorman & Horn, 2023). Multiple factors are contributing to this situation which Betty et al. (2023) describe as a "perfect storm" arising from "increasing complexity of care, unsolicited work resulting from a lack of capacity elsewhere in the system, funding formula long since unfit for purpose and workforce shortages" (p.9).

The CCN established the PCTF in March 2023 to provide leadership to local initiatives or models of care that would improve whānau access to care by relieving primary care capacity pressures, with an initial focus on general practice.

In Canterbury | Waitaha over the last two decades, several initiatives have sought to resource and strengthen the role of primary care as an integrated part of the health system. Despite these previous efforts, Canterbury general practices were anecdotally struggling to find the capacity to meet the demand for services. In this context the PCTF wanted to understand the current issues locally and what could be done to support practice capacity and access to care in Waitaha.

Given the national discussions underway on primary care funding, the PCTF chose not to focus on funding but to focus on local initiatives seeking solutions that would complement the national activity required to sustain and realise the full potential of primary care.

The PCTF activity is supported by and aligns with the work of local organisations including PHOs, Canterbury Community Pharmacy Group, and Te Whatu Ora – Waitaha. Membership includes PHO, Pharmacy and Allied Health clinical leaders, people who provide a consumer, Māori, Pacific and Tāngata Whaikaha perspective and leaders from Te Whatu Ora Commissioning and Improvement and Innovation Directorates, see Section 11.

In June 2023, the PCTF sought views from the general practice workforce to better understand the pressures on general practice and inform where to focus their efforts. Three role appropriate surveys were distributed to General Practitioners (GPs), Practice Nurses (PNs) and Practice Managers (PMs) seeking information on:

1. The capacity of general practice to provide services and factors impacting capacity.
2. The workforce, including vacancies and workforce retention.
3. The uptake of initiatives that impact capacity, including barriers and enablers to implementing these.
4. Where the PCTF should focus their efforts.

Findings are grouped in these four areas through this report.

3. Methodology

The PCTF led the development of the survey, which was distributed to general practice via the three Canterbury PHOs: Christchurch PHO, Pegasus Health, and Waitaha Primary Health.

Survey responses were gathered using a mixture of Likert scales, binary and multiple preset answers, and free text options. Thematic analysis was undertaken on all free text responses. In some instances, on-line tools (e.g., Chat GPT) were used to identify key themes that were subsequently reviewed and refined.

Survey questions and responses were mapped into the four areas, listed above for the analysis. Where questions were replicated across the three surveys the analysis explored any similarity and variance of responses between the different roles, (e.g., between GP and PN respondents). These findings are discussed in the report.

Respondents were asked to either provide the name of their practice or describe the practice by size, rurality and Very Low Cost Access (VLCA) status. Where relevant the analysis and reporting by domicile are included in this document.

A wānanga involving the PCTF members and system leaders including secondary care and Te Whatu Ora commissioners, reviewed and refined the draft survey findings, and guided the development of the recommendations included in this report.

4. Limitations and assumptions

- The three Waitaha PHOs[1] distributed the survey in different ways to their member practices. This may have influenced the proportion of GP and PN responses between the PHOs.
- Multiple responses could be submitted from one general practice, e.g., multiple GPs, PNs or a mix of the two in the same practice. As most practices have only one PM, it is assumed each PM response relates to one general practice. This supports the estimate that 41% of general practices in Waitaha (48 PM responses from 118 practices) provided a response. This sample size makes it reasonable to conclude the PM sentiments are reflective of those across all general practices.
- Confirming a denominator for the GP and PN workforce is problematic. Using contact details in the Pegasus Health Client Relationship Management system suggests the total number of GPs and PNs in Waitaha is 747 GPs and 754 PNs. While this would imply a response rate of 14% (GP) and 11% (PN), it is considered a sizeable underestimate as clinicians that have retired, departed from general practice, or are working at the 24-Hour Surgery are included in this database.

5. Survey Findings

Findings from the four information categories are discussed in detail below.

Section One: General practice capacity

MEASURE OF CAPACITY

All three surveys asked respondents to *'Rate the overall capacity of your general practice to meet the demand for healthcare services'*, and the '*Capacity of your general practice across three different streams of work'*:

- Care for people who are acutely unwell.
- Care for people/whānau with chronic health conditions.
- Proactive screening, health promotion and preventative work.

Ratings were from 1 to 5 (1-Very Poor, 2-Poor, 3-Reasonable, 4-Good, and 5-Very Good).

This was completed by all respondents.

Findings – by role

The overall capacity of general practice to meet the demand for healthcare services was rated just below reasonable, (3.0/5). When rated by the different streams of work:

- Capacity to provide 'Proactive screening, health promotion and preventative work' was rated the lowest at 2.7/ 5.
- Capacity to provide 'Care for people / whānau with chronic health conditions' and 'Care for people who are acutely unwell', were rated equally at 3.3/5 placing both slightly above reasonable.

PMs tended to rate overall capacity to provide healthcare higher than GPs and PNs. See Figure 1.

[1] Pegasus Health distributed the survey link directly to all staff. Waitaha Primary Health and Christchurch PHO distributed the link to Practice Managers for distribution to staff within each general practice.

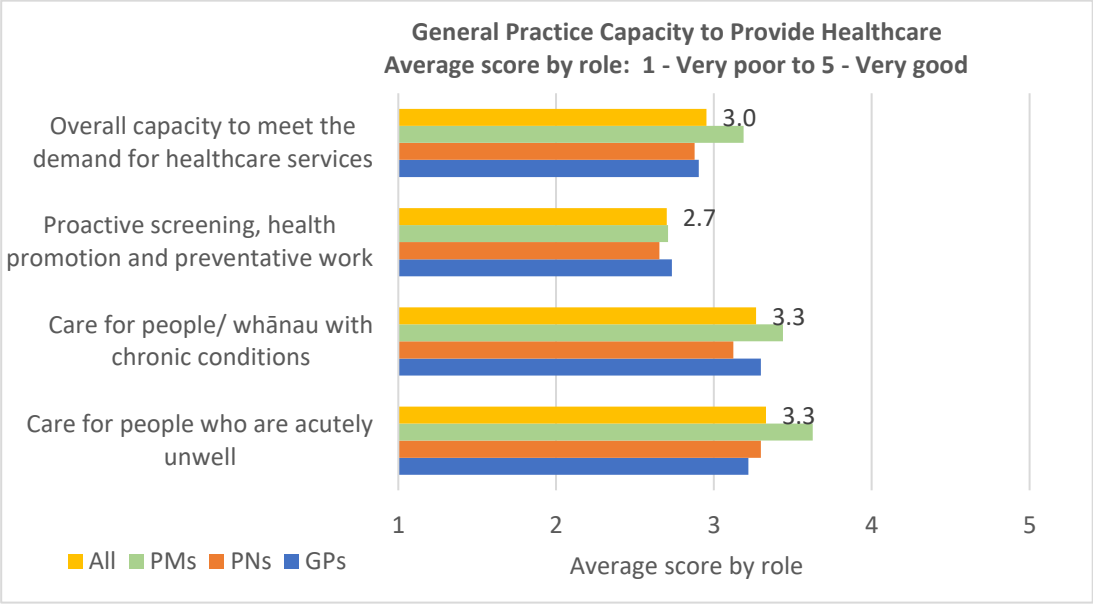

Figure 1: General practice capacity to provide healthcare by role.

Findings – by domicile

When viewed by domicile, respondents from rural practices rated:

- Overall capacity to meet the demand for healthcare services lower at 2.7/5 compared to 3/5 for urban respondents.
- The capacity to provide 'Care for people who are acutely unwell' higher at 3.8/5 compared to 3.2/5 for urban respondents.

See Figure 2.

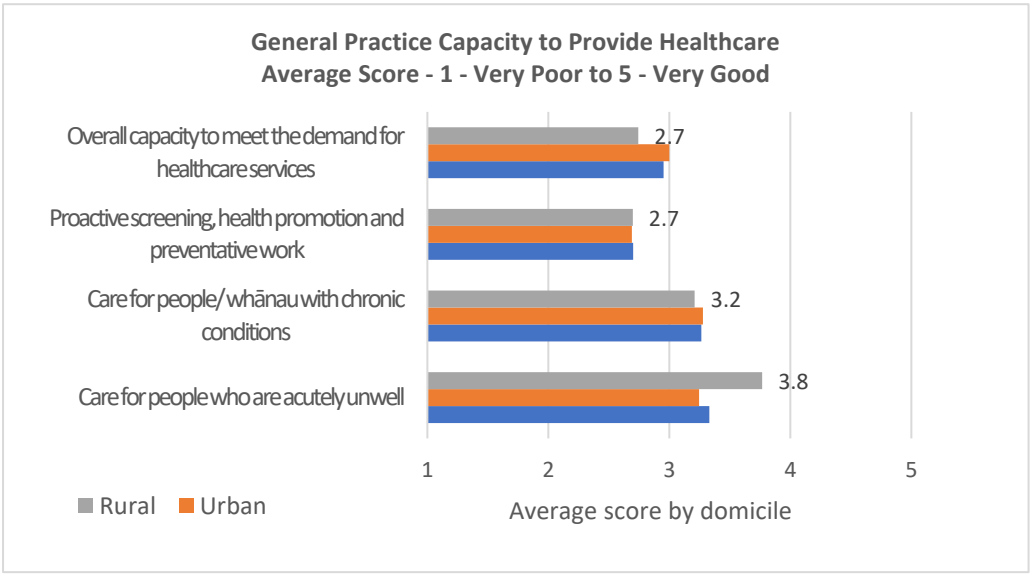

Figure 2: General practice capacity to provide healthcare by domicile.

Third Next Available Appointment (TNAA)

PMs were asked '*When is the third next available routine appointment for a general practitioner in your practice',* with 48 responses received.

Note: This measure is usually applied to individual GPs and Nurse Practitioners (NPs) to explore variations in access to routine appointments within the practice. The survey asked PMs to generate an average TNAA across all GPs and NPs within the practice, to indicate the days a patient must wait to access a routine appointment. Given this less common application of TNAA, an information sheet (here) was developed to guide PMs with calculating their response. The unfamiliarity with this approach may have influenced the responses and validity of the findings.

Findings

The weighted average TNAA for all respondents was 6.6 days or approximately one week. A TNAA of two days was selected by 35% (17 respondents), followed by one week by 23% (11), see Figure 3.

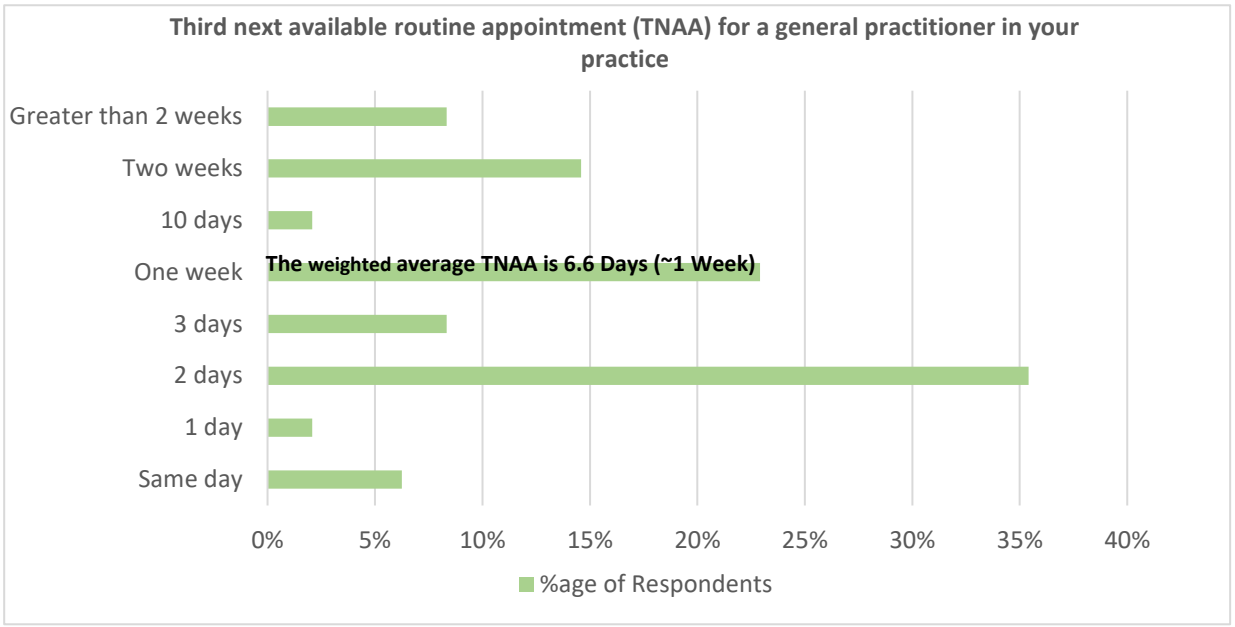

Figure 3:Third Next Available Appointment.

Availability of routine appointments

PMs were asked for *'Any additional comments on the availability of routine appointments'* with 23 (48%) responses provided. Themes from the analysis included:

- **Same day access to urgent and acute care:** Multiple approaches to ensure availability of same day appointments were described by 35% (8 respondents) including keeping acute slots, streaming acutes, an allocated 'duty doctor' and employing a person for the 'overflows.'
- **Regular GP versus any GP:** 26% (6 respondents) raised that availability of appointments varied if a patient was willing to see any GP versus their usual clinician.
- **Usefulness of TNAA:** This was queried by some respondents, with most noting the variation between GPs and people's preference for seeing their regular clinician.
- **Impact of staff availability**: Sickness, leave and the availability of locums were all raised as having a significant impact on the availability of appointments.

'*Realistically some people are waiting four weeks to see the particular General Practitioner they want to see but if they don't mind seeing anyone, they can see our locum or one of the other doctors.'*

FACTORS IMPACTING CAPACITY

Rank factors impacting capacity

The GP and PN surveys asked respondents to rank '*What was impacting general practice capacity to provide healthcare services*'. Up to eleven role appropriate options were provided and comment sought on any other reasons not listed. A weighted average was applied to the ranked results within each survey.

Findings

All clinicians ranked the expectation that general practice provide care previously provided in secondary care as the most important factor impacting general practice capacity to provide healthcare services.

GPs and PNs also ranked the following in their top five options:

- Increased compliance or administration requirements, (GPs 2nd, PNs 4th)
- Inability to access services for people with complex social and wellbeing needs, (GPs 4th, PNs 2nd)
- Ongoing monitoring of people waiting for their first specialist appointments and/or planned care procedures, (both 5th).

GPs included 'Referral pathway or healthcare process is inefficient or requires excessive work-up' in their top five (3rd); whereas PNs included the 'Inability to recruit into vacancies and/or staff retention issues' (3rd). See Figure 4.

Rank	General Practitioner	Practice Nurse	Practice Manager
1st	Expectation that general practice provide care previously provided in secondary care	Expectation that general practice provide care previously provided in secondary care	Increased compliance or administration requirements
2nd	Increased compliance or administration requirements	Inability to access services for people with complex social and wellbeing needs	Inability to recruit into current vacancies and/or staff retention issues
3rd	Referral pathway or healthcare process is inefficient or requires excessive work-up	Inability to recruit into current vacancies and/or staff retention issues	Inability to access services for people with complex social and wellbeing needs
4th	Inability to access services for people with complex social and wellbeing needs	Increased compliance or administration requirements	Health and wellbeing of the practice team
5th	Ongoing monitoring of people waiting for their first specialist appointments and/or planned care procedures	Ongoing monitoring of people waiting for their first specialist appointments and/or planned care procedures	Inefficient processes e.g., within practice or between practice and other organisations
6th	Inability to recruit into current vacancies and/or staff retention issues	Health and wellbeing of the practice team	Other
7th	Lack of ready and timely access to diagnostics	Referral pathway or healthcare process this is inefficient or requires excessive work-up	
8th	Time involved contacting a registrar / SMO / specialist service	Lack of ready and timely access to diagnostics	
9th	Health and wellbeing of the practice team	Lack of experienced primary health nurses and allied staff	
10th	Other	Time involved contacting a registrar / SMO / specialist service	
11th		Other	

Figure 4: Factors impacting general practice capacity.
The colours highlight commonalities in the options between roles, white cells show the ranking of unique options.

Inefficient referral pathways and processes

The GP and PN surveys asked respondents *'If you ranked inefficient referral pathways or healthcare processes as having a high impact on your general practice's capacity, which specific pathways or process should be streamlined?'*

Responses were received from 57% (60) GPs and 33% (27) PNs.

General Practitioner findings

GPs provided responses on specific pathways or processes that should be streamlined alongside general comments.

Specific pathways or processes:

Most frequently raised were Orthopaedic (18 %, 11) and Mental Health (17%, 10) pathways or processes.

- **Orthopaedics:** Multiple responses commented on the referral process particularly for joint replacements including the inconsistent triage criteria, arbitrary nature of referrals being declined, multiple referrals being required before acceptance, and the frequent request for (seemingly unnecessary) additional information; e.g., up-to-date weight, or x-rays. Also raised were the long response times for urgent Orthopaedic advice.

  'Bounced back referrals to orthopaedics because a BMI or an x-ray is older than their nominal cut off is a frustrating waste of time as the information needs updating and then a new referral done. Would be better if someone just contacted the person for their weight or arranged a more current x-ray or kept them on hold pending an update through ERMS.'

- **Mental Health pathways:** Issues raised included the lack of capacity and limited access to Mental Health services, and the siloed approach to Mental Health and Addiction services.

  'Simply rejecting (a referral) because one silo identifies drug misuse is a problem, whilst the other identifies and rejects it because of mood psychiatric issues present, is completely unhelpful.'

- **Other pathways and services:** Gynaecology, Ophthalmology, Neurology, Urology, Chronic Pelvic Pain, and Cognitive Impairment pathways and processes were also raised as needing to be streamlining by three or less respondents. Comments included difficulty getting advice, the administrative burden being transferred to general practice, and the inappropriate transfer of responsibilities for ordering of tests. The lack of a Dermatologist to refer to was also noted.
- **Haematology pathway:** This was identified by some respondents as needing to be streamlined, and alongside Nephrology and Respiratory services recognised by one respondent as '*giving brilliant advice'.*

General comments on the referral processes and pathways:

- **Communication and feedback:** Respondents expressed the need for clearer feedback on the acceptance or non-acceptance of referrals, better visibility of the timing of triaging, noting *'this would assist general practitioners in communications with their patients'*, and departments taking responsibility for conveying results or progressing tasks (e.g., patient communication), instead of requesting primary care undertake this.
- **Routine follow up:** Several people raised the need to not routinely tell patients to follow up with their GP after discharge, requesting patients are given '*a set of expectations and safety net, and only recommend follow up (with the GP) if absolutely necessary*.'
- **HealthPathways:** While respondents valued the guidance HealthPathways provided, several commented they had become complex, required extensive time to undertake the investigations required, and did not always reflect current acceptance criteria.

> *'HealthPathways has improved uniformity in GP behaviour and is a good resource but has simply moved the work from secondary care to general practice at a time when both are overloaded.'*

Comments on addressing these issues included:

- **Funding:** Some respondents raised the need for additional funding for the increased workload associated with repeat appointments to manage patients unable to access secondary care services including navigating pathways and undertaking investigations that had previously occurred in secondary care. Also raised were the costs incurred by patients from repeat visits while waiting for specialist care.

> *'When a patient has been referred and then declined due to lack of capacity there needs to be funding provided in primary care to look after these people.'*

- **Access to Diagnostics:** Multiple respondents requested easier access to diagnostics including for ultrasounds, nerve conduction studies, and CT/MRI scans. Respondents noted this would reduce referrals to outpatients and expedite the treatment process.

> *[Regarding the investigation of abdominal pain]*
> *'General practice access to CT and MRI would help speed the process up and be more efficient in terms of the specialist's time.'*

- **Streamline Baseline Tests:** The need to reduce the required information for baseline tests like chest X-rays, spirometry, sleep studies, and ultrasound scans was raised.
- **Optimise the Electronic Request Management System (ERMS) user interface:** Comments included eliminating unnecessary questionnaires; e.g., COVID questionnaire, and improving back-end coding solutions for data entry.
- **Specialist General Practitioner admitting rights:** Direct admitting rights for specialist GPs were advocated by one respondent, noting *'[we] shouldn't have to waste time in talking to someone as well unless we want advice'.*

While acknowledging the capacity pressures on secondary care, some respondents expressed frustration about the impact this was having on primary care.

> *'We must stop the knee jerk response of primary care being used as a secretarial service for the hospital. In the time it takes to write the letter to us someone in the hospital could have picked the phone up and rung the patient. Stop dumping on us to solve capacity problems.'*

Practice Nurse findings

PNs also noted specific pathways or processes that should be streamlined alongside general comments.

Specific pathways or processes

- **Orthopaedic and Mental Health:** Similar to GP responses, multiple PNs commented on the need to streamline Orthopaedic and Mental Health pathways.

Unique to PNs' responses were the identification of the following specialist pathways or processes by one to three respondents:

- **Aged Care and Community Services**
- **Haematology, Cardiac (Echoes), Child Health, Diabetes and Gender Diverse services**
- **Referrals for subsidised procedures** with the complicated referral pathway for Aclasta and Iron Infusions raised:

> *'Both of these pathways have so many drop down boxes it is very time consuming to sift through to find what is required. Even doing a CVDRA takes more time than it ever used to as more and more information is required.'*

General comments from PN respondents, mirroring those of GPs, included:

- **Referral decline rate** due to the lack of capacity in secondary care and the impact of this on general practice.
- **Inefficiencies** from referrals returned as 'incomplete' creating more paperwork, and a system that is *'clunky and hard to use'*.
- **HealthPathways** being outdated.

Three respondents stated they had no issues, with one commenting *'I find it a normal below average public heath referral system.'*

Practice Manager: Inefficient processes in your general practice's capacity

PMs were asked '*If you ranked inefficient processes as having a high impact on your general practice's capacity, which specific processes should be streamlined?*' Responses provided by 35% (17) PMs are summarised below:

- **Secondary care capacity:** Most responses commented that secondary care capacity was impacting the workload and capacity in general practice; e.g., from repeat or declined referrals, medicines reconciliation, patient costs and fewer appointments being available for primary health needs. Respondents requested that secondary care processes be streamlined, and the rate of accepted referrals increased.
- **Other processes:** Also identified as needing to be streamlined included the management of clinical inboxes, distribution of health information for patients, connectivity between patient management systems to enable transfer of notes, repeat prescriptions, and ACC requests for background patient information.

> *'Patients are requiring multiple referrals to be able to access the care they need from secondary services. This increases the administration burden on GP's and results in less face-to-face appointments being available.'*

Time involved contacting a registrar, Specialist Medical Officer (SMO), or specialist area

The GP and PN surveys asked, *'If you ranked time involved contacting a registrar / SMO / specialist area as having a high impact on your general practice's capacity, which service areas do you want more streamlined access to'*, with responses received from 54% (58) GPs and 25% (20) PNs.

General Practitioner findings

- **Not an Issue:** Multiple respondents commented that contacting a registrar, SMO or a specialist area was not an issue (38%, 22 respondents), noting it '*generally works well'* and '*is acceptable'*.
- **Specific Specialist Areas:** Most frequently identified areas as needing more streamlined access were Orthopaedics (9%, 10 respondents), Mental Health (7%, 4) and General Surgery (7%, 4) services. Other specialist areas identified by one or two respondents were Ophthalmology, Paediatrics Urology, Gynaecology, General Medicine, Cardiology, Neurology and Plastics.

> *'I really appreciate being able to discuss things with the Consultants themselves – often [they] can answer question very well and sometimes a referral is no longer indicated.'*

- **Streamlined access across all areas:** Multiple responses (28%, 16) commented on the need to streamline access including the inefficiency of using a phone as the primary means of communication, issues of voicemail messages instructing callers not to leave a message, and some switchboards not being answered or forwarding callers to the wrong department. Suggestions on improvements included the need for a call back system or a registrar that is not also dealing with admissions or theatre.

> *'Getting put through to the duty registrar's mobile which then goes to voicemail and asks not to leave a message but to call back is a frustrating waste of time as you have to try again through switch board and often this is repeated several times.'*

Practice Nurse findings

- **Not an Issue:** Like GP responses, many PNs commented that communication with registrars, SMOs or specialist areas was not a problem.
- Some PNs noted they did not contact specialists or that specialists did not talk to PNs which at times created a problem for GPs.

Section Two: Workforce

RETENTION OF WORKFORCE

The GP and PN surveys asked, *'Are you contemplating leaving or retiring from general practice in the near future (next 3-5 years)'.*

Findings overall

Many GPs (59%, 62) and PNs (53%, 43) indicated their intention to leave or retire. The remaining respondents indicated they were not contemplating retirement, GPs (27%, 28) and PNs (25%, 20); or were unsure, GPs (14%, 15), PNs (22%,18).

See Figure 5.

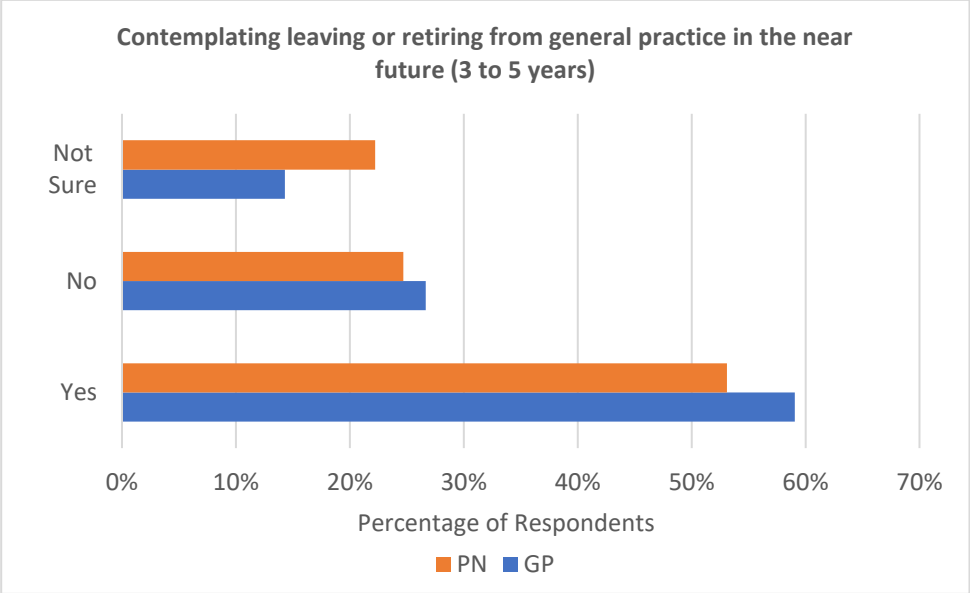

Figure 5: Percentage of GPs and PNs contemplating leaving or retiring.

Findings – by domicile

When viewed by domicile, responses from GPs working in rural practices indicated that:

- 65% (11) were contemplating leaving or retiring compared to 58% (49) urban respondents; and
- A further 29% (5) were unsure compared to 10% (8) urban respondents.
- Notably only one of the 17 rural GP respondents indicated they were not contemplating leaving or retiring.

See Figure 6.

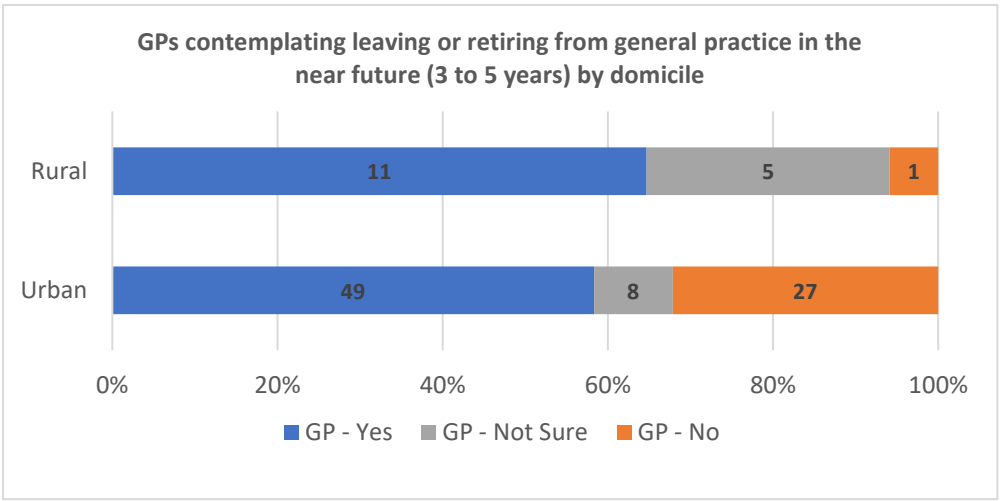

Figure 6:Percentage of GPs contemplating leaving or retiring, by domicile.

Respondents from PNs working in rural practices indicated that:

- 71% (10) were contemplating leaving or retiring compared to 48% (32) urban respondents; and
- A further 29% (4) were unsure compared to 21% (14) urban respondents.
- Notably none of the 14 rural PN respondents indicated they were not contemplating leaving or retiring.

See Figure 7.

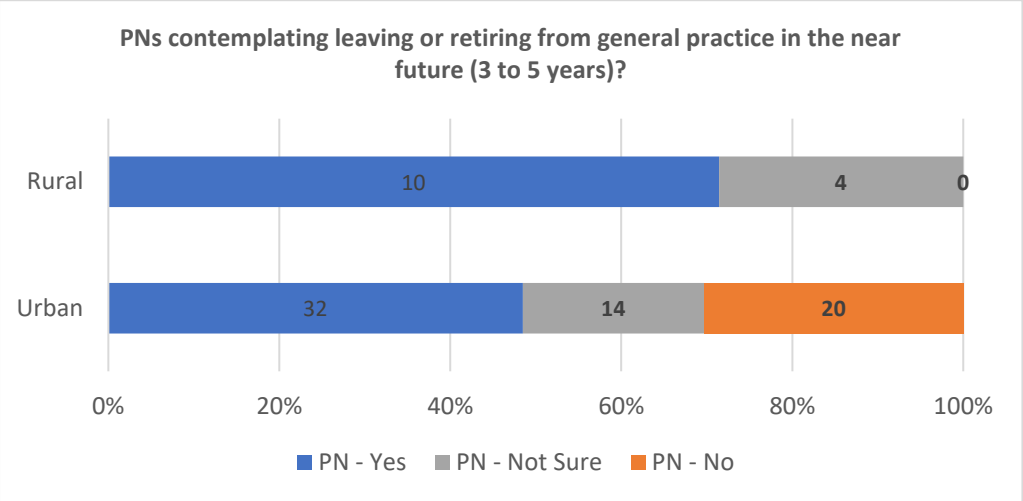

Figure 7: Percentage of PNs contemplating leaving or retiring, by domicile.

What would encourage staff to delay or stage their retirement plan

Respondents that confirmed they were contemplating leaving or retiring from general practice or were not sure, were asked *'What, if anything, might encourage you to decide to delay or stage your retirement',* with responses received from all 77 GPs and 61 PNs.

General Practitioner findings

Analysis of responses identified the following seven interconnected themes:

- **Adequate funding of general practice** to enable longer appointments for the increasing number of patients with complex needs; providing care previously delivered by secondary care services; to better incentivise doctors into general practice; and to employ additional practice staff.
- **Better remuneration:** Many respondents raised the need for better pay linking this to:
  - Less 'unpaid' administration and paperwork.
  - Parity with overseas roles; e.g., locum work in Australia.
  - Entitlements on par with secondary care; e.g., Continuing Medical Education (CME) allowance.
- **Decrease in paperwork, administrative tasks, and inbox management:** Reducing the amount of administration and non-patient facing activity involved in general practice was frequently mentioned as an incentive to delay or stage retirement.
- **Better work life balance – flexibility / holidays / no on call / part time options:** A clear sentiment from respondents was that being a GP is a full-time role with additional expectations. The ability to work part time, take holidays and reduce the on-call load were all raised as supporting retention.

'Ability to take holidays, more funding for my staff, not having to do unfunded work like …, not having to do after hours and getting underpaid for it.'

- **Finding replacement staff:** The lack of staff to share the clinical load and enable a shift to part-time work, or to take over the practice.
- **Improved capacity in secondary care and better access to diagnostics and resources:** Reducing the burden of work resulting from under-capacity in secondary care.

'Better pay, feeling valued by the system, not being dumped on by lack of capacity elsewhere, not having to do after hours, less hoops to jump through to get people seen.'

- **Longer appointment times:** Having 20-minute appointments for people with complex needs.

'Less paperwork, having the hospital see patients I refer so I'm not feeling stressed about managing complex patients in 15-minute consults that should be seen in secondary care, better pay and paid paperwork. A change from the model of 15-minute consults which are just not realistic for patients with multiple complex medical and social issues. I miss having some straightforward consults in between the complex ones to ease the pressure, now nurses see things like UTIs and otitis media in kids etc.'

Following the main themes above, also raised were:

- **Nothing could be done to delay or stage retirement:** Respondents noted it was *'too late'* and they were *'burned out'* having reached retirement age or being unable to continue as a full-time GP.
- **Being valued and reduced stress:** Some respondents commented on feeling stressed by the workload and a lack of job satisfaction from not being able to do a 'good job' due to time constraints and a lack of access to other services. Addressing these factors could help delay retirement.

'The job has become very demanding and there is no down time anymore.'

- **Changing to a non-GP doctor role** such as training in a speciality area, avoiding acute care or taking on other work that required less paperwork.

'Changing the work e.g., less acute care, maybe remote admin work/ some telehealth? Also, I am pretty interested in becoming a peripatetic LARC trainer. I could envisage this being a flexi-time option for me to 'pass on' expertise whilst being in [a] more limited field of practice -which might suit an older GP.'

Practice Nurse findings

Practice nurse respondents identified better pay / pay parity and increased staffing as the two most important factors that would influence their decision to delay leaving or retiring.

- **Better remuneration:** Of the 56% (43) PN responses better pay was the critical factor noting the need to gain pay parity with peers employed by Te Whatu Ora.
- **Recognition of knowledge and skills** was also raised as influencing their decision.

'Financial acknowledgement and respect of the knowledge and skill to do telephone triage, assessments and management of health crisis, chronic health conditions that take a load off the minimally staffed GP service.'

CURRENT WORKFORCE & VACANCIES

Current workforce including non-traditional roles

PMs were asked to *'Indicate the number of full-time equivalents (FTE) employed or in your practice from a list of core roles[2] and additional roles not historically part of general practice[3]'.* All (48) PMs provided a response.

Note: Analysis of the findings assumes each PM response is one unique practice.

Findings

Traditional roles:

- One practice has no GP, and three have less than one FTE.
- Two practices have no PN and one less than one FTE.
- Most practices have a PM, with the majority (56%, 27) being one FTE, and a third (33%, 16) less than one FTE.

Non-traditional roles:

- Over half of practices employ or involve Health Care Assistants (58%, 28), Health Improvement Practitioners (56%, 27) and Health Coaches (60%, 29) at similar levels.
- Lower numbers employ or involve Nurse Practitioners (19%, 9), Nurse Prescribers (19%, 9), Pharmacists (17%, 8), and Physiotherapists (15%, 7) at similar levels.
- A limited numbers of practices employ or involve a range of other roles (mostly at one FTE or less) including Diabetes Nurse Specialist, Social Workers, Paramedics, Kaiāwhina, Physician Assistants and Care Coordinators and Māori Health Specialist.

See Figures 8 and 9 below.

[2] General Practitioner, Practice Nurse, Administrator, Reception, Practice Manager

[3] Nurse Practitioner, Nurse Prescriber, Pharmacist, Care Coordinator, Kaiāwhina, Health Care Assistant, Physician Assistant, Enrolled Nurse, Physiotherapist, Social Worker, Health Improvement Practitioner, Health Coach, Paramedic, Diabetes Nurse Specialist.

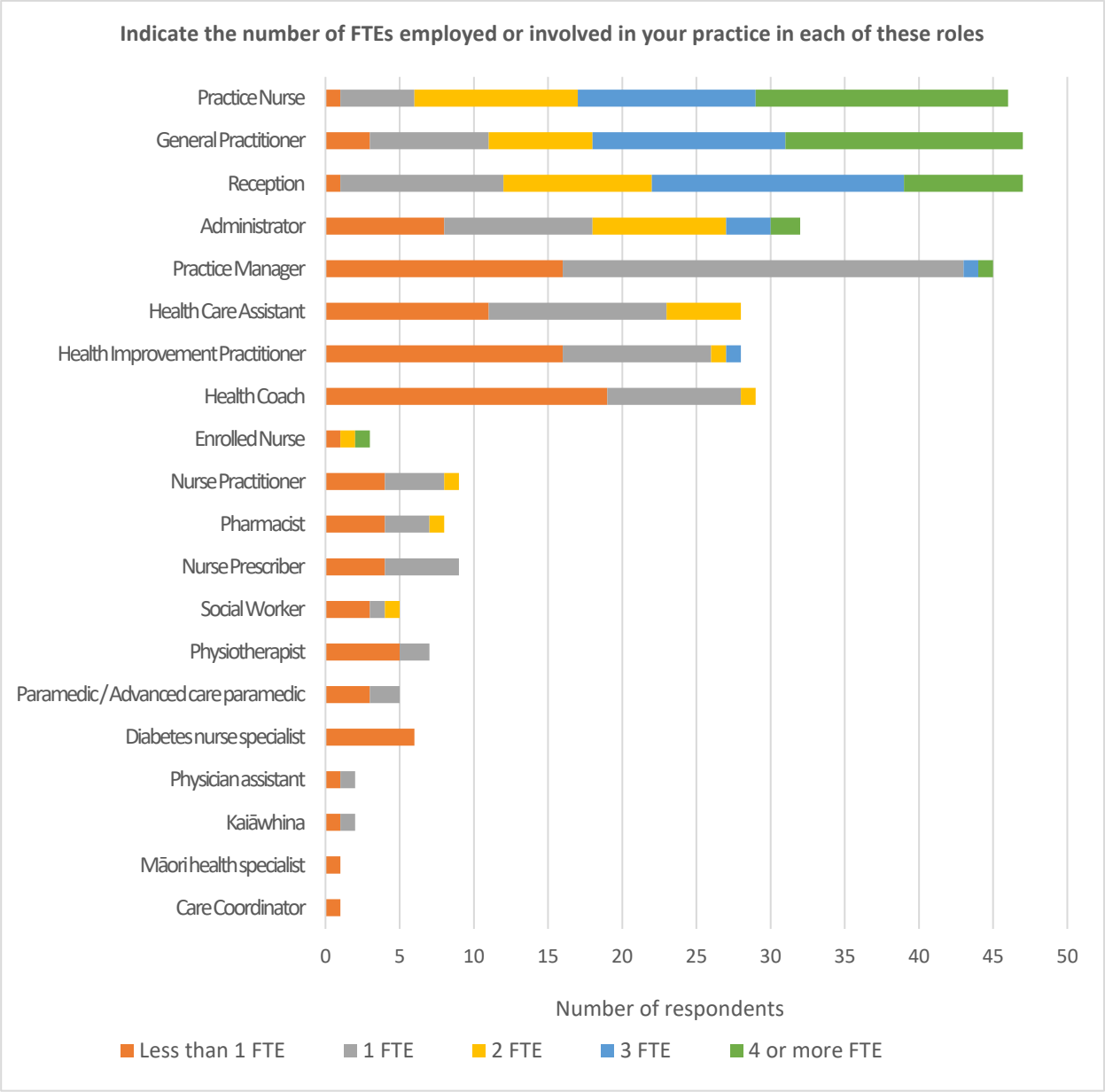

Figure 8: Number of FTEs (Full Time Equivalents) employed or involved in your practice in each of the roles.

	None	Less than 1 FTE	1 FTE	2 FTE	3 FTE	4 or more FTE	Approx. number respondents employed / involved in this role*
Practice Nurse	2	1	5	11	12	17	46
General Practitioner	1	3	8	7	13	16	47
Reception	1	1	11	10	17	8	47
Administrator	16	8	10	9	3	2	32
Practice Manager	3	16	27	0	1	1	45
Health Care Assistant	20	11	12	5	0	0	28
Health Improvement Practitioner	20	16	10	1	1	0	28
Health Coach	19	19	9	1	0	0	29
Enrolled Nurse	45	1	0	1	0	1	3
Nurse Practitioner	39	4	4	1	0	0	9
Nurse Prescriber	39	4	5	0	0	0	9
Pharmacist	40	4	3	1	0	0	8
Physiotherapist	41	5	2	0	0	0	7
Social Worker	43	3	1	1	0	0	5
Paramedic / Advanced care Paramedic	43	3	2	0	0	0	5
Diabetes nurse specialist	42	6	0	0	0	0	6
Kaiāwhina	46	1	1	0	0	0	2
Physician assistant	46	1	1	0	0	0	2
Care Coordinator	47	1	0	0	0	0	1
Māori health specialist	47	1	0	0	0	0	1

Figure 9: Number of Full Time Equivalents (FTE) employed or involved in your practice in each of the roles.
*These numbers are from the 48 Practice Mangers that responded to the survey.

Vacancies in general practice

PMs were asked to *Identify the number of vacancies the general practice currently has including any non-traditional roles'.*

Findings

Responses from all (48) PMs indicated:

- 30% (14) practices have no vacancies.
- The highest FTE vacancy is for GP totalling 19.6 FTE across 38% (18) practices. When Nurse Practitioner responses are included this increased to 23 FTE across 42% (20) practices.
- PN vacancies totalling 6.9 FTE exist in 20% (10) practices.

In the corresponding free-text, two sites identified the need for more clinical resource, while noting they '*did not have the funding to sustain them at a level that meets the need of the community'*. Two sites also stated the requirement to cover after-hours impacted their ability to recruit.

See Figure 10.

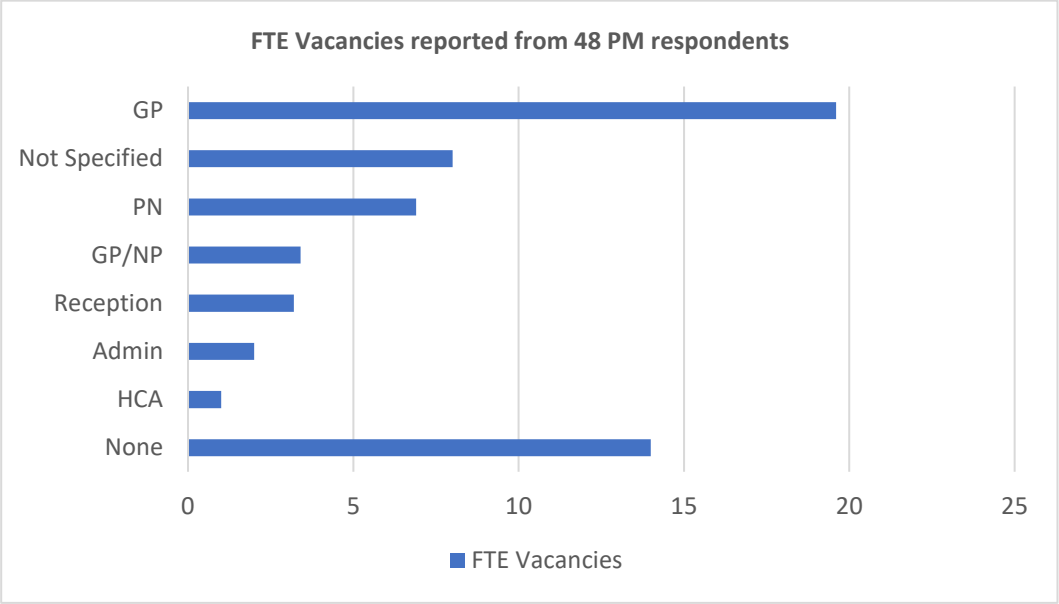

Figure 10: Vacancies by role and FTE.

Consideration of using an alternative workforce

GPs were asked '*If you ranked inability to recruit into current vacancies as having a high impact on your general practice's capacity, would you consider using alternative workforces to address these staff shortages, e.g., paramedics for some activities undertaken by practice nurses?*' The responses are summarised below:

- **Already using alternative workforces:** Many respondents indicated their practice was already using Paramedics, Nurse Practitioners, Physician Assistants, or other healthcare professionals to address staff shortages.
- **Need for more GPs:** Many respondents emphasised the need for more GPs rather than relying solely on alternative workforces, noting this is the primary issue that needs to be addressed.
- **Funding:** Some respondents expressed the need for adequate funding to support these initiatives and ensure they are feasible.
- **Recruitment challenges:** Some respondents mentioned difficulties recruiting healthcare professionals, such as Nurse Practitioners.
- **Administrative and logistical challenges:** A few respondents highlighted the administrative and legal complexities associated with employing alternative workforces including regulatory or bureaucratic barriers; e.g., employing Physician Assistants.
- **Supervision requirements:** Some respondents raised the need for experienced clinicians to train and supervise alternative workforces and the impact of additional staff on the workload of existing staff.
- **Support for expanding or upskilling nursing staff:** Some respondents expressed support for expanding the role of NPs and PNs to take on additional responsibilities, including prescribing.
- **Limited physical capacity:** Some respondents noted that the limited space to accommodate additional healthcare professionals.
- **Negative sentiment:** Two respondents expressed negative sentiments toward alternative workforces, citing concerns about overseas healthcare professionals or general frustration about the workforce shortage.

WORKFORCE RECOMMENDATIONS

The PM and PN surveys asked respondents to identify '*What if any additional role(s) they would recommend to other practices to employ / involve in their delivery of healthcare and why?'*

There were strong correlations between the two respondent groups with frequent recommendations including:

- **Health Coach (HC) and Health Improvement Practitioners (HIP):** These were highly recommended by multiple respondents and described as excellent additions, particularly for communities with low health literacy. Reasons given including that the HCs / HIPs provide increased patient support, reduced or supplemented GP visits, and assisted with non-clinical patient support and lifestyle needs. One respondent described their inclusion as a *'game-changer'* that reduced pressure on GPs, PNs and NPs and resulted in better management of patients with complex needs.
- **Health Care Assistants** were considered beneficial by taking on tasks such as blood tests, vital recordings, collecting patients, performing basic observations, and cleaning rooms, allowing PNs to focus more on patient care and prevention.
- **Nurse Practitioners** in the healthcare team were recommended for improved access and supporting the GP workload.
- **Other suggestions** included having a pharmacist (for reviewing medications and reconciliation discharge scripts), Social Worker, Care Coordinator (for shared inbox management, recall reminders, acute care plan and assisting with minor surgeries) and additional administration resource.

BARRIERS & ENABLERS TO INVOLVING NEW ROLES

Barriers to employing or involving new roles

PMs were asked to '*Identify any other barriers to employing or involving new roles in your general practice that are not identified elsewhere in the survey'.* Responses included:

- **A lack of funding** to employ or involve additional roles was the overwhelming response. This included financial constraints and the inability to compete with wages offered elsewhere. Some responses highlighted the upcoming increase in nurses' wages as a financial challenge.
- **Rurality** was raised as facing challenges in attracting and retaining professionals.
- **Role-specific challenges:** The cost of extra studies to become a NP, pay rate discrepancies for nurses and Health Care Assistant roles compared to secondary care colleagues, and the challenge of covering maternity leave within existing pay structures were also mentioned.
- **Physical space** for additional people

Enablers to employing or involving new roles

PMs were asked to '*Identify any other ways your practice could be supported to employ or involve new roles, that have not been identified elsewhere in the survey'* with the following themes identified in the responses.

- **Additional funding:** Funding to recruit and retain clinical staff was the most common response. This included funding for PNs or Pharmacists, and incentives for GPs to work in rural practices.
- **Affordable recruitment support for** locums and permanent GPs, PNs, and Receptionists. This included support to advertise the jobs, provide relocation packages, and a request for PHO assistance with a recruitment pool or recruitment processes.
- **Training and education opportunities:** This included setting up peer groups for Administrators, Receptionists, and PMs.
- **Examples in other practices*:*** Practices express the desire for real-life examples of successes in other practices and data on the financial benefits, patient care outcomes, and staff well-being resulting from introducing the new roles.

- **Other suggestions:** Improved systems for relieving staff, better understanding / training on specific software or systems like Indici or Beefound (a locum recruitment site provided by Pegasus Health), incentives for recalls and performance metrics, networking among practices, lobbying for regulatory changes for specific roles, and providing supervision for nursing staff upskilling. There was a request for more information on roles.

PMs were asked to '*Identify if there were any roles, they would like to learn more about, with a view to using them in their practice sometime in the future'.*

Some respondents requested information on Pharmacists, Nurse Practitioners, Care Coordinators, Kaiāwhina, Nurse Specialist (e.g., Diabetes), Social Worker and Paramedic roles.

Section Three: Initiatives to support general practice capacity

INITIATIVES TO SUPPORT CAPACITY

Initiatives implemented to support capacity

PMs were asked to '*Identify any changes you have implemented to manage the capacity in your practice'.* Responses from all (48) PMs indicated:

- Most frequently implemented were reserved appointments for patients with acute needs (88%, 42), and phone consults (77%, 37).
- The next most frequently implemented, at similar rates, were acute clinical triage (48%, 23), streamlined administration (44%, 21), employment of non-traditional staff (40%, 19), and alternative approaches to inbox management (38%, 18).
- No changes had been implemented by 4% (2) practices.

'Other' responses were split evenly between hiring more staff and no changes being necessary or that they already used the suggested changes. See Figure 11.

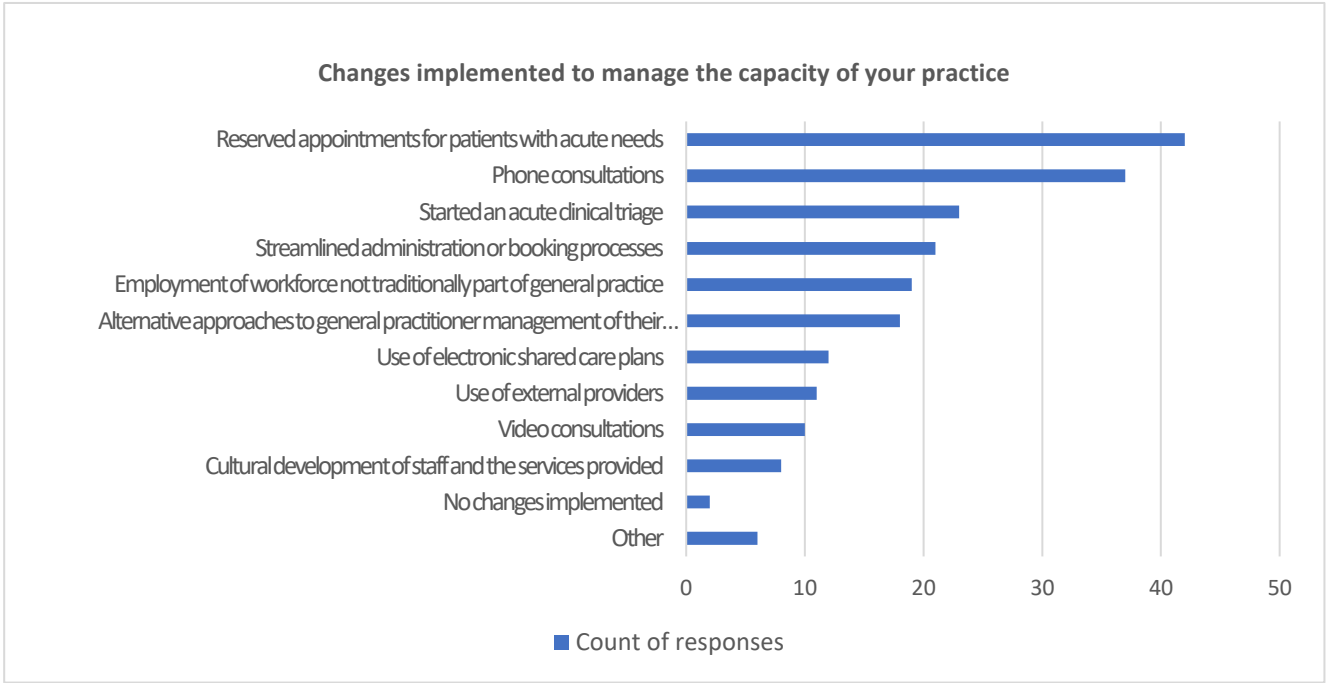

Figure 11: Changes you have implemented.

Implementation of patient portals

PM were asked *'Do you have a patient portal'*, '*What can patients do through the portal'* and *'Does the availability of routine appointments differ when booking through a patient portal'*.

Responses provided by all (48) PMs indicated that 75% (36) were using a patient portal in their practice. See Figure 12.

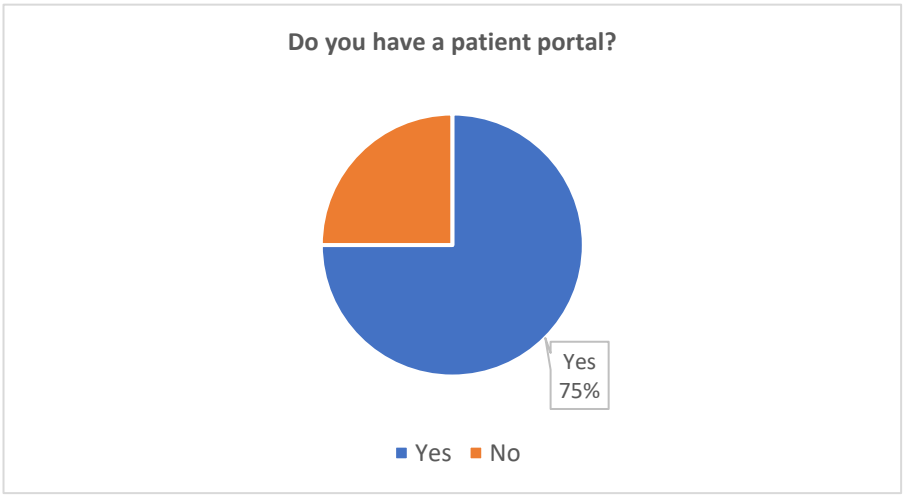

Figure 12: Uptake of patient portals.

Portal features enabled

Of the 36 PMs that stated they had a portal:

- All reported patients could order a repeat prescription.
- Most reported patients could see their lab results (89%, 32), or book an appointment (83%, 30).
- 'Other' responses (17%, 6) indicated the practice has enabled advanced features such as patient reading notes in clinical records and sending to or receiving messages from patients.

See Figure 13.

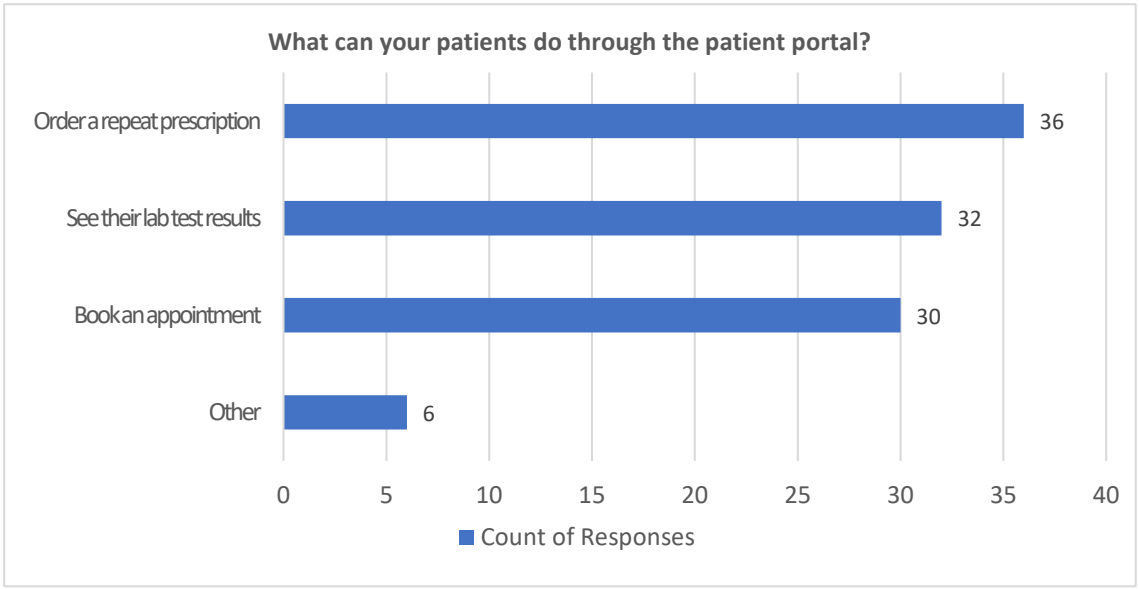

Figure 13: Patient portal features.

Appointment availability

Of the 36 respondents with a portal, most (67%, 24) indicated that appointment availability was the same via this and other booking methods.

CLINICAL INBOX MANAGEMENT

Utilisation of an alternative approach to clinical inbox management

GP were asked '*Do you use an alternative approach to managing your clinical inbox messages'.* Those answering yes, were asked to briefly describe their approach.

Findings

Of the 104 respondents, 21% (22) indicated that they used an alternative approach while 79% (82) stated they did not; see Figure 14.

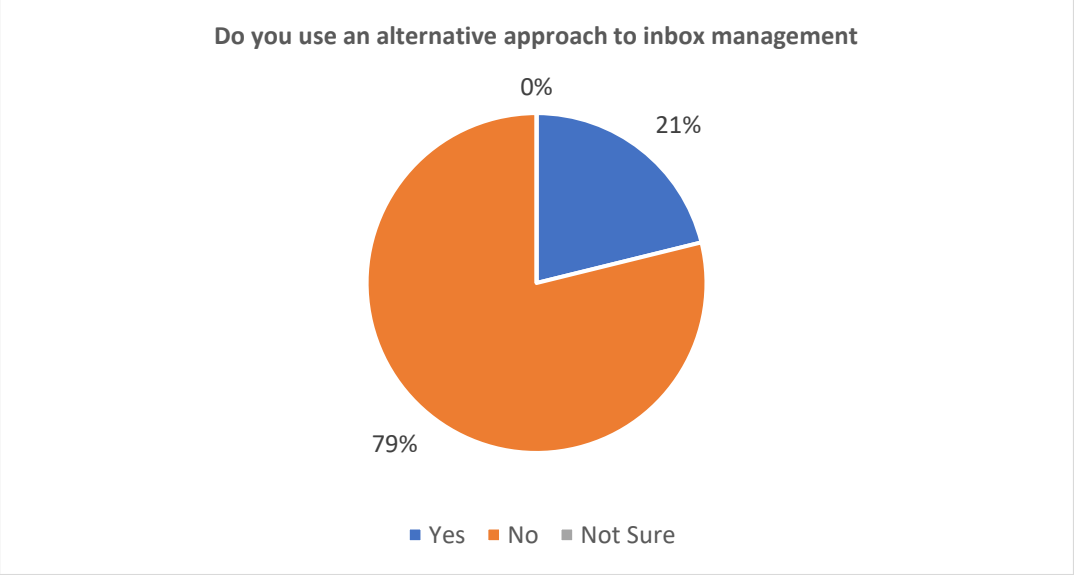

Figure 14: Use of alternative approach to inbox management.

Description of approaches

People in a range of roles managed the clinical inbox. In some instances, two or more people actioned different messages in the same inbox; see Figure 15.

All roles screened and reviewed inbox messages, with most filing an agreed selection of normal results. Three respondents described using a GP that was working part time, semi-retired or on maternity leave to undertake this work.

Some GPs working part time commented on the assurance that someone was managing their inbox on their days off.

> *'As I only work very part time it gives me peace of mind that any significant unexpected results are often dealt with before I get to them. Ditto simple problems like patients needing candida treatment etc.'*

Role	Number of respondents describing this role as undertaking Inbox management
Practice Nurse	5
Part-time General Practitioner	3
Clinical Assistant	3
Pharmacist	2
Health Care Assistant	1
Receptionists	1
Medical Administrator	1

Figure 15: Roles undertaking Inbox Management.

Barriers and enablers to clinical inbox management

GPs were asked to select as many options as applied to questions of barriers and enablers to adopting an alternative approach to inbox management.

Barriers

Of the 83 responses:

- Over half selected concern about clinical responsibility (70%, 58), and a preference for managing their own inbox (53%, 44), as barriers to implementation.
- Also frequently selected were insufficient capacity to provide supervision (40%, 33), and time to assess or implement an alternative approach (37%, 31). See Figure 16.

'It is important to me that information coming back to me about patients, is seen by myself before the patient returns.'

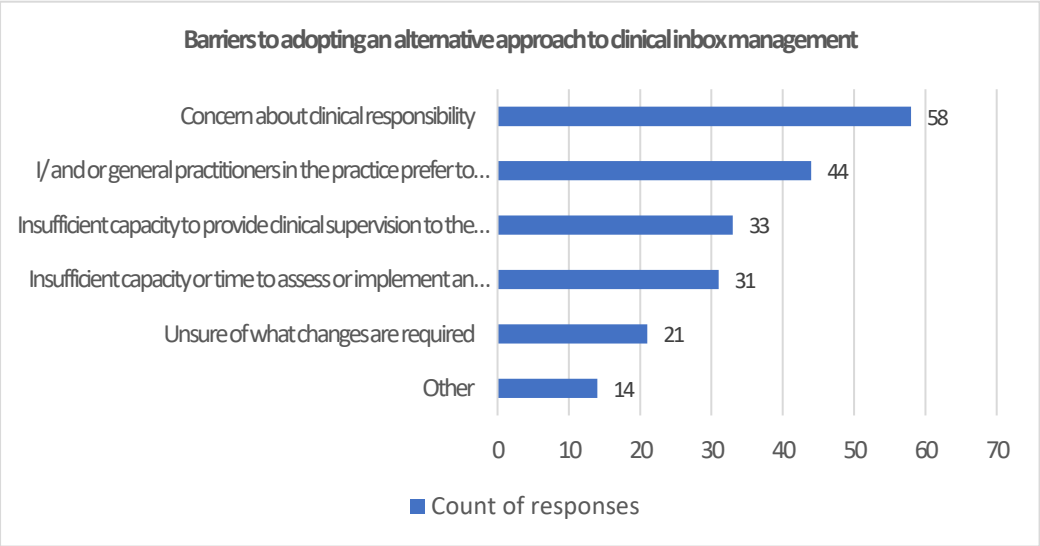

Figure 16: Barriers to implementing an alternative approach to inbox management.

Enablers

Of the 106 responses:

- A third (32%, 34) identified that knowledge of clinical or medico-legal risks, and examples of how it has been implemented in other practices, would assist them adopting an alternative approach to inbox management.
- The following six options were selected at similar rates: understanding the benefits (25%, 26), assistance training a person (24%, 25), external project person to facilitate change (22%, 23), upskilling general practitioners (21%, 22), assistance with recruiting (20%, 21), and templates / guidelines (19%, 20).

When 'Other' was selected, comments included that it was not necessary, not a priority, and funding would be required to enable this change. One respondent stating this was a *'dangerous idea'*.

See Figure 17.

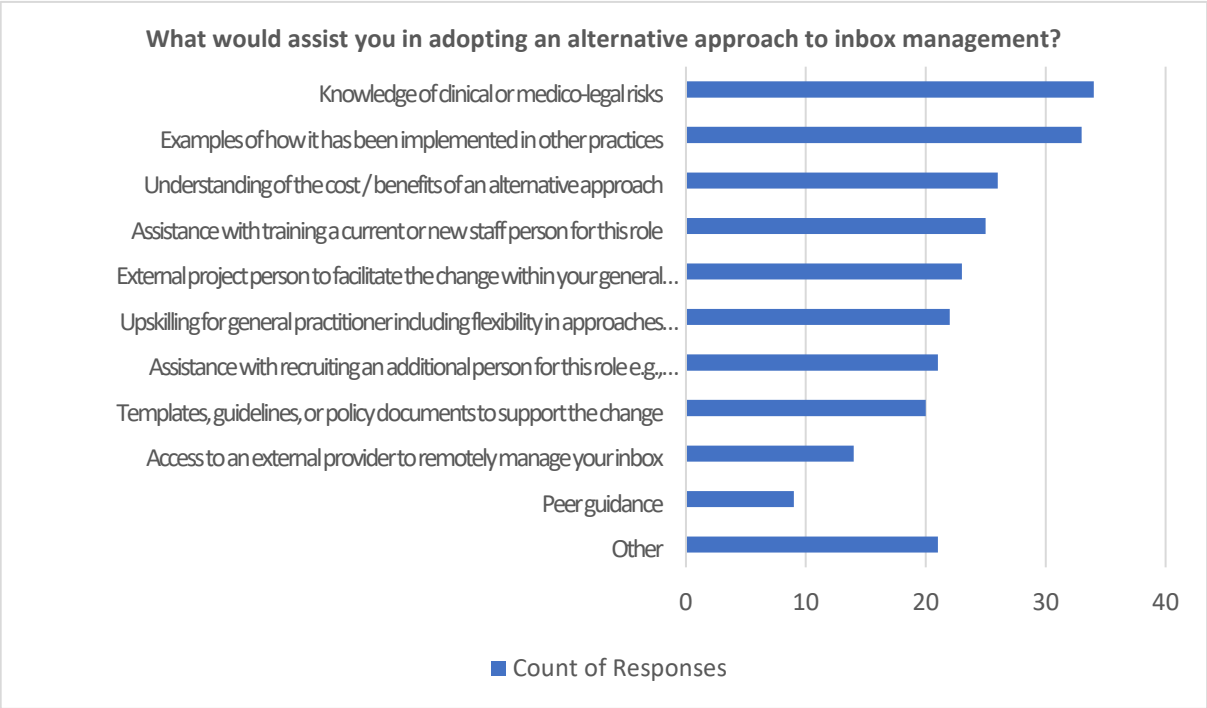

Figure 17: Enablers to adopting an alternative approach to inbox management.

IMPLEMENTING CHANGES

Barriers to implementing changes

The PN and PM surveys asked respondents to select from a similar set of options of potential barriers to implementing changes.

- Insufficient capacity, or time within the practice to assess or implement the changes, were the most selected options by both PNs (71%, 58) and PMs (77%, 24).
- Concerns about clinical responsibility were the next most common for both roles, PNs (36%, 29) and PMs (45%, 14).
- 'Other' responses received from both PNs and PMs related to the inability to find or fund staff required to make the changes and not having the physical space to accommodate staff, see Figure 18.

'Space to provide services from, with increased demand we have been unable to match infrastructure.'

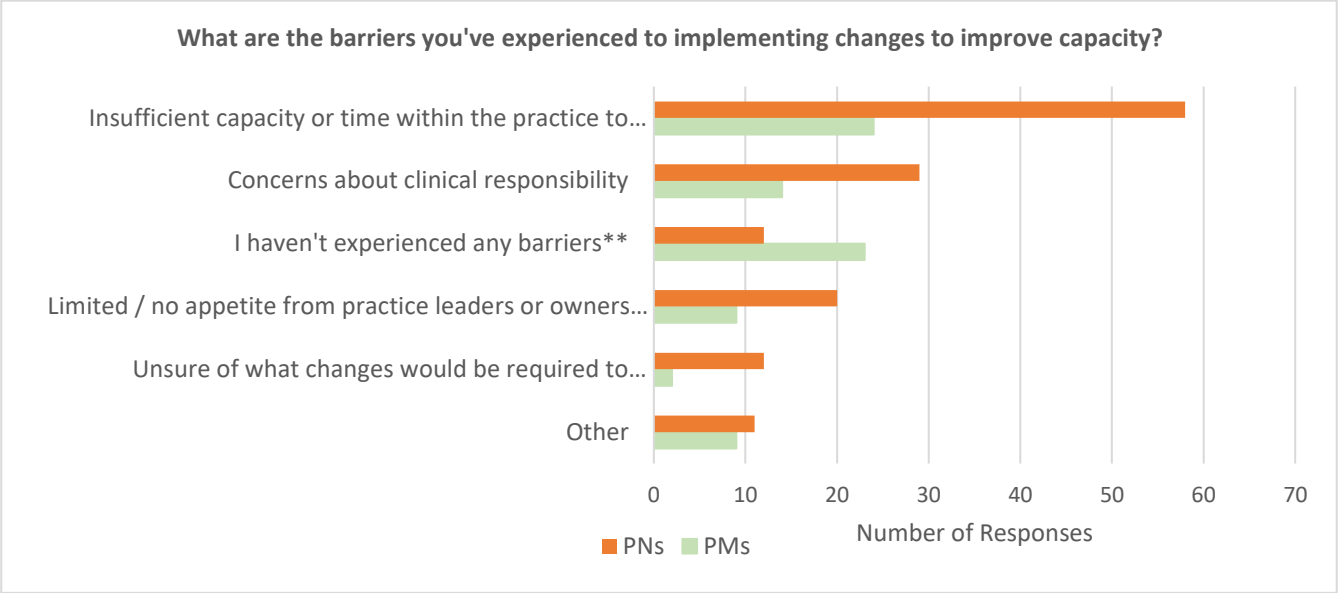

Figure 18: Practice Nurses and Practice Mangers: Barriers to implementing changes to improve capacity.
**Note There were minor differences in how this question was worded between the PN and PM surveys.*

Enablers to implementing changes

PNs and PMs were asked to select from a similar set of options of enablers to implement changes. The most frequently selected options across both roles were:

- Templates guidelines or policy documents.
- Upskilling of a current or new staff member.
- Peer support or guidance; e.g., from clinical lead.
- Less frequent choices were project management support, and knowledge of the risks of making a change.

'Other' responses for PNs including change management. Both PNs and PMs identified funding for staff and increasing the physical space to accommodate changes as enablers.

See Figure 19.

> '*Currently everyone [is] too busy getting through the day-to-day struggle without thinking about anything new unless we have to.*'

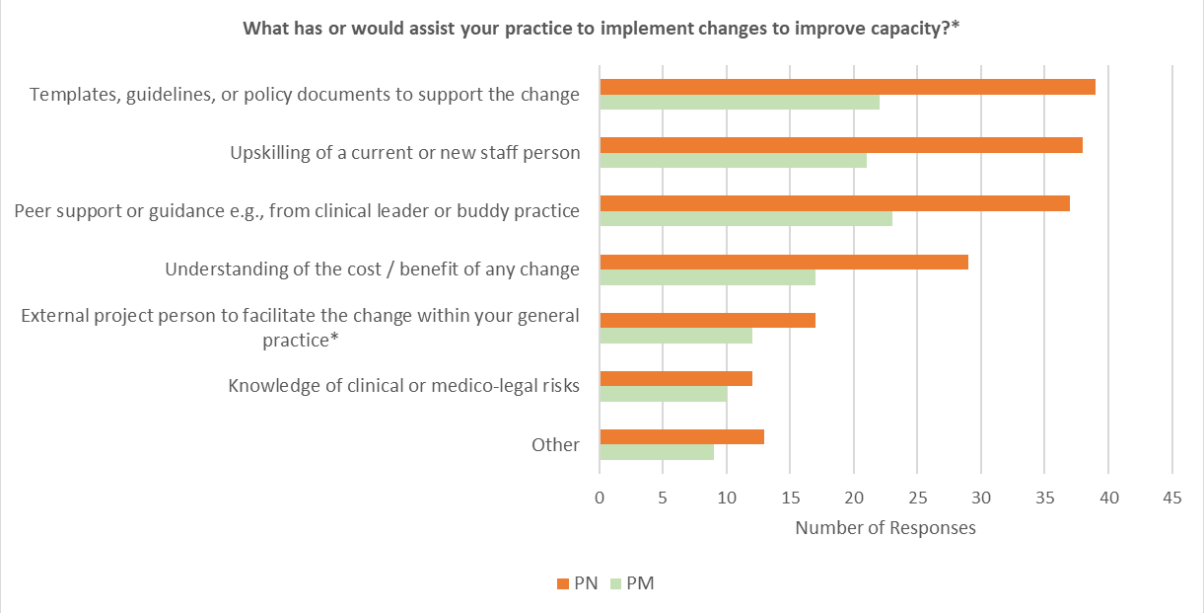

Figure 19: Practice Nurse and Practice Manager enablers of implementing changes to improve capacity.
**Note There were minor differences in how this question was worded between the PN and PM surveys.*

CHANGES RECOMMENDED TO OTHER PRACTICES

All surveys asked respondents '*What changes have they implemented that they would recommend to other practices and the reasons for that recommendation'*.

Responses from all roles recommended:

- **Employ / involve other healthcare professionals and staff:** Hiring and utilising other healthcare professionals including Clinical Assistants, Pharmacists, Nurse Practitioners, Occupational Therapists, Paramedics, Health Improvement Practitioners, Health Coaches, Midwives, and Physiotherapists was recommended. Respondents noted that these roles alleviated the workload of GPs and PNs, improved patient care, provided support and streamlined work in specific areas such as medication management, repeat prescriptions and acute care. They also reduced errors and provided opportunities for learning and professional development.

  'Employed a pharmacist and occupational therapist. Make good use of HIP and health coach, have a strong focus on staff wellbeing, have a clinical assistant to help manage inbox.'

- **Training, upskilling, and utilising staff:** Investing in training and upskilling staff members (e.g., Nurse Prescriber, nurse triaging, Nurse Practitioner, acute care management, Health Care Assistants) to better utilise current resources, free up GPs and PNs time and provide more efficient care.

  'Utilising practice nurses to their fullest potential by expanding their scope of practice, such as phone triage, minor ailment assessment, and additional training opportunities, has proven beneficial.'

- **Better utilising administration and support staff** to take over routine administrative tasks of GPs and PNs so they can focus on more complex responsibilities and patient care.
- **Acute on the day appointments and acute teams:** Having a dedicated and good number of acute appointments was recommended to facilitate timely acute care delivery, address urgent issues promptly, and reduce the need for patients to seek care elsewhere. One respondent recommending utilising a *'duty doctor'* for acutes.
- **GP and / or PN triaging:** Recommendations included having a dedicated team for phone triage and assessment to improve the efficiency of patient care, ensure appropriate triaging, streamline the workflow, reduce pressure on routine appointments, and enable patient access to timely care.
- **Limiting practice size and enrolment:** Some GPs and PNs recommended limiting their patient numbers and closing books to ensure they provide better service and quality of care to existing patients. Some also noting this prevents the practice staff being overwhelmed with an excessive workload.

General Practitioner only recommendations:

Comprehensive responses were provided by 68% (72) GPs with the following recommendations offered:

- **Team collaboration and support:** GPs emphasised the importance of teamwork and collaboration. Specific recommendations included having regular team meetings, a flat hierarchy, and involving other health professionals like Pharmacists, Midwives, and Physiotherapists to provide more comprehensive and coordinated care for patients with complex needs.
- **Focus on staff wellbeing and work-life balance:** Placing emphasis on staff wellbeing by managing workload, allowing for leave, and creating a supportive work environment was recommended to prevent burnout and improve overall job satisfaction, leading to better patient care.
- **Telehealth and online consultations:** Including online consultations, noting when appropriate this enables easier access to healthcare and reduces the need for in-person visits. Some respondents noted this also improved patient communication.
- **Training and mentorship:** Taking on registrars and interns to help share the workload and provide teaching opportunities.

> *'Having trainee interns when available who help on acutes as well as learn that general practice is diverse and interesting. Having registrars and Trainee Intern's and nursing students – good to upskill everyone. Having a Health Care Assistant. Having a rule if you are sick, you stay home. Prioritising so that people can take leave (with internal cover). Regular weekly meetings. Flat hierarchy in structure so all team members entitled to input. Tea room where people can meet / debrief. Use of other specialities like pharmacy, midwife, HIP, health coach, physio on site – good for learning and reducing mistakes.'*

Practice Nurse only recommendations:

Responses were received from 62% PNs with the following recommendations:

- **Specialised portfolios for nurses and nurse-led clinics:** Assigning nurses specialised portfolios such as diabetes, women's health, and child health, along with dedicated clinic / off-the-floor time to focus on specific health issues.
- **Increase standing orders** to enable PNs and other healthcare professionals to carry out certain tasks without direct GP involvement.
- **Monthly Multi-Disciplinary Team hui (meeting)** to facilitate collaboration and information sharing across the entire team, better coordinate care, and provide a more comprehensive approach to patient management.
- **Outreach and home visits with Kaupapa Māori provider:** Work in collaboration with Kaupapa Māori providers to provide outreach and home visits for patients who face barriers accessing care, such as cultural or geographical barriers. This supports practices to better understand and cater to the needs of the community they serve.
- **Chronic condition clinics:** Establish clinics for chronic conditions like heart failure, diabetes, and acute respiratory involving multiple team members to improve the management of these conditions.
- **Utilising technology, apps and electronic communication:** opportunities (e.g., email requests for repeat scripts and photos of rashes) to improve patient communication, streamline processes, and enhance access to care.
- **Structured longer appointments for complex cases and proactive checks.**
- **Incorporating district nurses and district nurse-led clinics:** Including district nurses in the team to improve care coordination and patient experience, especially for patients with complex needs.
- **Utilising locum GPs for sickness or annual leave cover** to prevent disruptions in service provision.
- **Geographical enrolment boundaries:** Implement geographical enrolment boundaries to help manage enrolments and prevent travel and access issues for patients with complex conditions.
- **Improved reception services:** Providing respectful and friendly reception services, as well as ensuring adequate staffing levels to support efficient processes.

Practice Manager only recommendations:

Responses were received from 42% (20) PMs with the following recommendations:

- **Efficient workflow:** Streamlining administrative and reception work and automation of processes.
- **Patient portal and self-management:** Encouraging patients to use the patient portal, e.g., for ordering prescriptions and booking appointments, to streamline administration and provide patients with more control over their healthcare.
- **Collaboration and learning:** Partnering with other practices to exchange knowledge, share learnings and promote innovation.
- **Offsite non-clinical inbox management** for managing non-clinical inboxes.
- **Social worker support** on-site for patient handover, enabling nurses to see more patients. Incorporating a social worker within the practice can provide additional support and streamline patient care, allowing nurses to focus on direct patient interaction.
- **Remote work for doctors to free up room space:** Allowing doctors to work from home for some sessions and conduct phone appointments to free up room space for others and optimise the use of physical resources.

Section Four: Where the Primary Care Taskforce focus their efforts

Respondents were asked where the PCTF Taskforce should focus their efforts to have the most positive impact on Canterbury | Waitaha general practice capacity in the short term, with 100 GPs and 79 PNs providing comprehensive responses.

Workforce recruitment and retention of general practice staff was the most frequently identified area for the PCTF to focus on by both GPs (35%, 35) and PNs (24%, 19). Comments included assistance with:

- Recruiting staff. While this was predominantly for GPs and PNs, also raised was recruitment of Nurse Practitioners, Physician Assistants and Healthcare Assistants.
- Finding locums to cover holidays and illness.
- Improving the efficiency of training pathways to upskill the workforce; e.g., Nurse Prescribers, Pharmacist Prescribers.

'Help in recruitment of new staff (GP, RN, NP, physician assistant). Look at funding to be able to attract new staff. Look at the afterhours arrangements which make it unattractive for new staff to work in the semi-rural areas compared to the cities.'

'Difficult to take leave as never anyone to cover, all at risk of burnout.'

Linked to workforce was a recommended focus on the following:

- Upskilling nurses through specialist training and standing orders, enabling them to run nurse led clinics (e.g., heart failure and diabetes), wound care, suturing, etc., and Healthcare Assistants.
- Utilising the wider primary care team more effectively, in particular Pharmacists (e.g., to treat minor ailments) and Physiotherapists.

General practice funding: This was the second most frequently stated area where the PCTF should focus their efforts by GPs (28%, 28) and PNs (19%, 15). Many comments linked the need to increase funding to achieve the following:

- Address nurses pay disparity.
- Provide care previously provided in secondary care.
- Cover increased administrative tasks; e.g., complex pathways.
- Attract young doctors by making it a financially attractive option.
- Retain GPs or incentivise their return to practice; e.g., from maternity leave.
- Longer appointments for people with complex or chronic illnesses.
- Provide better support for high deprivation and rural communities.
- Train and upskill staff.
- Incentivise same day appointments, acute and after-hours care.
- Fund good initiatives; e.g., skin cancer removals.
- Support community nurses.
- Better recognise experienced GPs and PNs.

'Increase funding to make general practice sustainable and attractive.'

'Good pay across the board in the primary care team, to stop leaching of experienced members to secondary or overseas work. This means capitation increases and recognition that Associates, as I have been for 35 years, (and PNs) need to be paid fairly (practice owners can come over as protective of profits and of not recognising that their business would grind to a halt without the 'coalface workers'). If govt funding is available for good pay, we can retain experienced GPs/PNs, and the extra manpower will work miracles. Also having an incentive to draw back young mothers (or fathers) into the workforce part-time, early on, would help.'

Advocacy: This was stated as a key area for the PCTF to focus on by nine respondents. In most cases this was advocacy for primary care funding (5), with other areas including the return of community-based services, training places, and primary care.

'Advocate for improved funding environment and overall working conditions for general practice.'

Primary / secondary care interface: This was frequently identified by GPs (12%, 12) as an area where the PCTF should focus their efforts. Most comments raised the need to address the shift of work from secondary care to general practice including the communication of changes in referral thresholds, rerouting of assessment and follow ups to primary care. While the capacity pressures in secondary care were acknowledged, the need for *'checks and balances'* and *'better control what work can be shifted safely and sustainably'* was recommended. One respondent suggesting the need to *'work with secondary care to sort out the mess that is primary / secondary communication at present.'*

'It would help if specialties (especially those little affected by winter pressures) do not try to push further work into general practice that could just as easily be done by the specialties themselves. All extra work we are given means there is something else we are unable to do.'

Administration: This was identified by some GPs (8%, 8) as an area where the PCTF should focus their efforts with most comments recommending addressing:

- The volume and management of inbox messages including addressing repeat discharge letters with minor changes from hospital and the 24-Hour Surgery; e.g., through Artificial Intelligence tools, the automation of classifications and medications and inbox management strategies including utilising people working at home.
- Referral pathways between general practice and secondary care.

Also recommended was improving access and funding for **mental health services and health literacy.**

'Put in place systems for easier access for patients with mental health problems to access secondary assessment and care.'

'Education for public re self-management of health care issues and when to seek help.'

Other suggestions included utilising general practice space after hours, public discussion on rationing of health services, a drop-in clinic for respiratory infections, up-to-date patient data, better utilising telehealth, and utilising practice space afterhours.

See also Figure 20.

'*I think the room shortage could be somewhat overcome if they were willing to put on evening clinics, but the reality is they would have to pay staff working in the evenings a higher rate in order to attract them to work out of standard office hours.'*

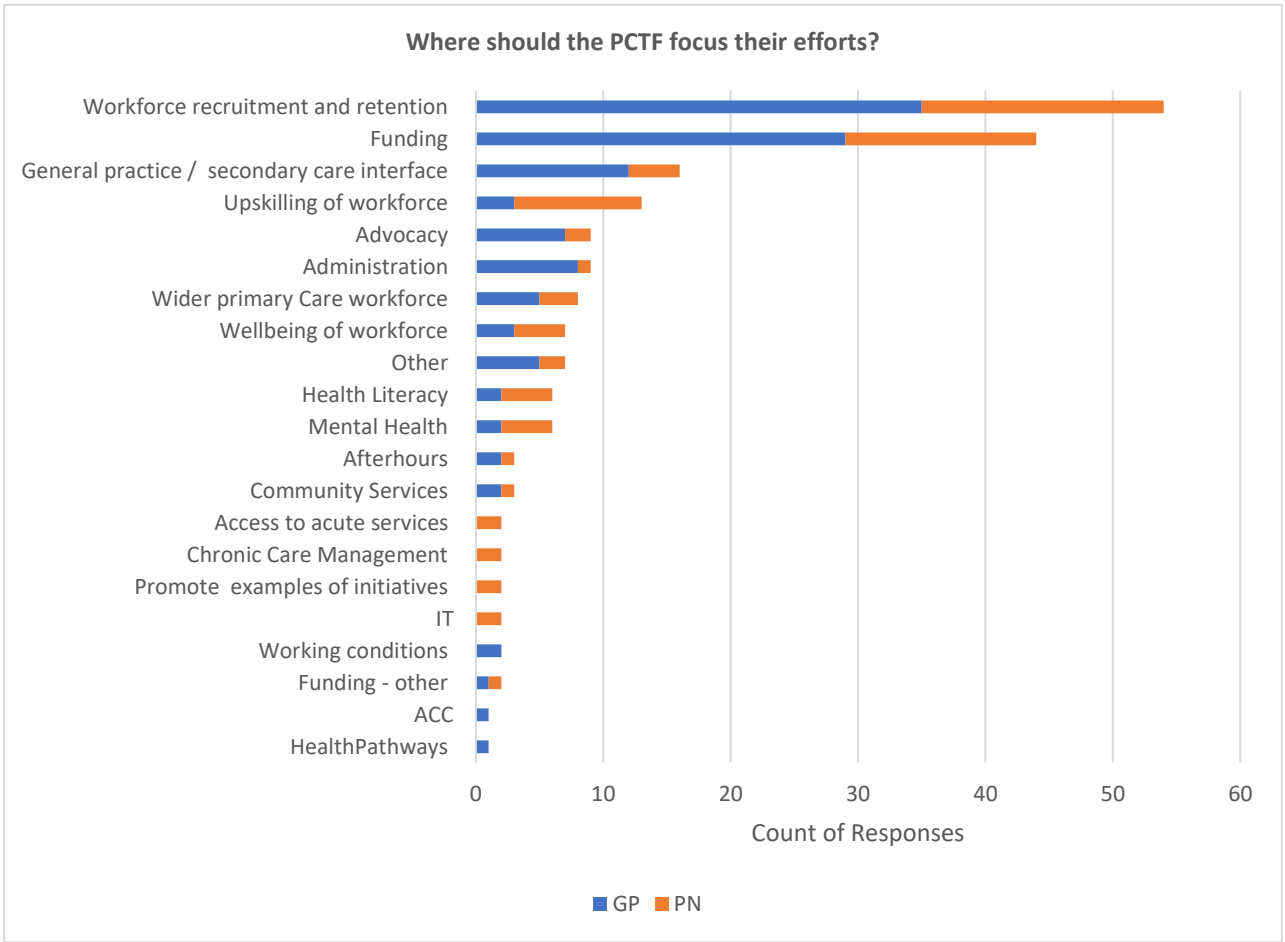

Figure 20: Where the PCTF focus their efforts.

6. Discussion

Recent publications contribute to a view that general practice within Aotearoa is unsustainable with insufficient capacity to meet the populations demand for healthcare (Gorman & Horn,2023. Betty et al., 2023).

The survey of Waitaha general practices sought to understand practice capacity locally and in the context of a district where multiple initiatives were implemented over the last two decades that sought to strengthen general practice and establish a 'one system' ethos. The findings from the survey, demonstrate the extent general practice in Waitaha reflects what is known nationally, and offers further detail about factors contributing to capacity pressures on general practice. The salient insights from the survey and contribution to the national dialogue on general practice are discussed below.

Capacity of general practice

Gaining a system view of general practice capacity is difficult and impacted in part by the availability of tools to easily measure capacity, and the variability of general practice models of care. Acknowledging these limitations, the survey utilised self-reported capacity and the Third Next Available Appointment (TNAA) as a pragmatic repeatable measure of general practice capacity across Waitaha.

Asking respondents to rate capacity overall, and by three broad categories of general practice activity, proved valuable. Analysis of the results suggest that general practice is prioritising their limited capacity to manage people acutely unwell in the community; the consequence of which is reduced capacity to provide proactive screening and preventative healthcare. This potential delay in proactive care raises concerns for the longer-term health of people/whānau. It also highlights the opportunity cost of any further system change that add to the workload of general practice; e.g., transfer of services from secondary to general practice care.

While the survey found little difference between how rural and urban respondents[4] ranked overall capacity, rural respondents ranked their capacity to provide acute care significantly higher. It is assumed this reflects the fewer acute care options accessible in many rural locations.

TNAA is more commonly used to measure capacity between practitioners within a practice, rather than as a measure of total practice capacity. The irregular distribution of responses suggest work is needed to determine the value of this as an overall measure of capacity across multiple general practices. Respondents did highlight that the availability of appointments varied if a patient was willing to see any GP versus their usual clinician; this needs to be considered in future work on appointment availability measures.

Impact of secondary care

The ranking of factors influencing general practice capacity were unequivocal in demonstrating the impact of secondary care activity on general practice. Four of the six factors ranked highest by GPs and PNs related to the interface between primary and secondary care (i.e., care previously provided in secondary care, inefficient referral pathways). This aligns with other national publications that highlight the impact of reduced secondary care capacity on general practice (New Zealand Doctor, 2023). However, the local findings were of particular interest, as past initiatives in Waitaha, such as Canterbury Initiative, had facilitated communications and streamlined referral pathways across the primary and secondary care interface.

In a district that has valued system relationships and communication, these findings reinforce the importance of continued effort and mechanisms that strengthen the interface between primary and secondary care and address emerging issues of communication and system inefficiencies in a timely manner.

[4] Respondents that work in rural or urban practices.

Administration

The increase in administration was also ranked highly by GPs and PNs as impacting general practice capacity. ProCare has estimated a growth in clinical inbox tasks of over 80% in the last 10 years (ProCare, 2023). While acknowledging the differences in how districts manage system communication, (e.g., Canterbury's CC Rule Copy to with Care on HealthPathways), this survey confirms the national trend of a substantial increase in administration in general practice.

The opportunity cost of GP time spent on unnecessary administration is evident. More confronting is the survey finding that the increased administration is a significant factor in GPs contemplating leaving or retiring early from general practice.

Knowledge is limited on the extent recent increases in administration result from a growth in inefficient or unnecessary tasks, which would benefit from work to streamline how these are managed, or a growth in necessary tasks; e.g., non-patient facing time responding to email consults. While there is value in exploring this further to guide the most effective response, the impact of the increased administration on workforce retention and practice capacity makes addressing this finding a priority.

Workforce

That over half of GPs (59%) and PNs (53%) are contemplating leaving or retiring from general practice aligns with findings of other studies in Aotearoa and internationally. Unsurprisingly, respondents from rural areas indicate even higher proportions of GPs and PNs are contemplating leaving or retiring from general practice. When viewed alongside information about the workforce coming into general practice and the reduction in GP hours worked (MCNZ, 2022. RNZCGP, 2022), this survey reinforces the view of a looming general practice workforce crisis, particularly in rural areas.

The findings also reinforce the importance of progressing local changes to retain the current workforce. This needs to include changes to the general practice environment so efforts to recruit staff are not undermined by a setting that does not support staff to remain in practice. While the survey sheds light on ways to support the retention of general practice staff, further work to identify local changes that respond to the needs identified by GPs at different career stages is required.

Funding

While the survey focussed on changes that could be made locally, the national funding of general practice continued to be raised often in the context of enabling changes to strengthen the workforce, evolve new models of care, expand primary care teams, and improve access to care. These findings suggest a willingness by respondents to enhance and evolve services to meet whānau and communities needs if adequately resourced to do so.

System impact

Evident through the survey are the interrelated nature of factors impacting general practice capacity. For example, the reduced capacity in secondary care impacts general practice capacity through increased administration and demand for care while patients wait for specialist care. This increased workload on general practice in turn influences GP and PN decisions to leave or retire early from general practice.

Figure 21 below offers a simplistic capture[5] of how pressure in one part of the system influences and is influenced by the rest of the system, and the potential impact of this on people / whānau, workforce, and the cost of providing care.

[5] It does not include the additional multiple contributors to the four system capacity drivers shown in Figure 21.

It reinforces the importance of a system response to the recommended actions within the report. Also, that the work of the PCTF to improve capacity pressures on general practice needs to be progressed in combination with and consideration of other changes being led across the local and national health system.

The effort and resources of the system are required to shift the system under pressure depicted in Figure 21, to a positive system approach of managing capacity.

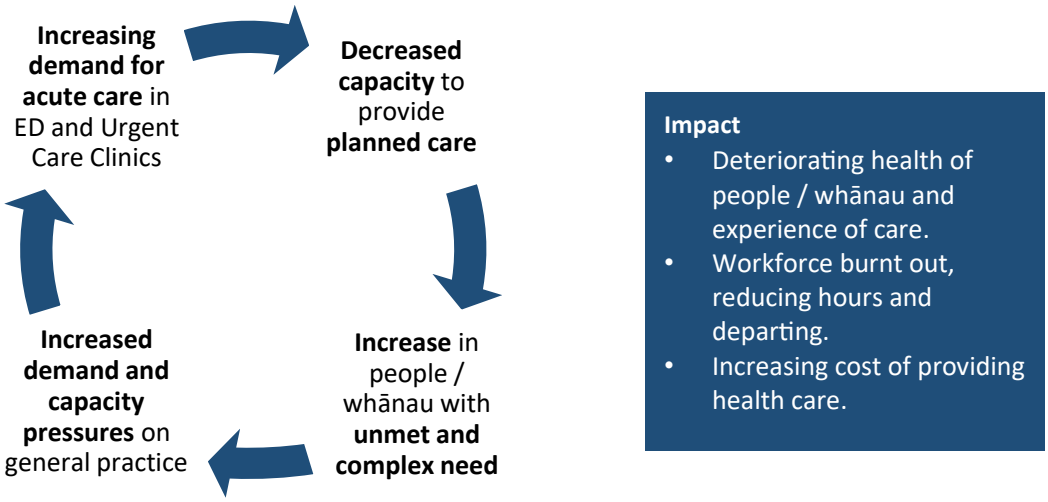

Figure 21: System impact – a simplistic view of a system under pressure.

7. Summary

The survey sought to understand capacity pressure on general practice in Waitaha and guide the implementation of local changes that could improve general practice capacity and access to services for whānau.

The survey findings provide comprehensive information on factors influencing general practice capacity in Canterbury. At a high level, the factors identified as influencing general practice capacity were mostly known, with this survey adding further information to this body of knowledge. However, the value of gathering evidence of the local situation cannot be overstated. Evidence of the local situation is both compelling and persuasive in fostering a system-wide response in Canterbury to progressing local changes that support capacity pressures in general practice and the wider health system.

8. Recommendations

The recommendations below correspond to the survey findings and focus on local actions identified to support general practice capacity and improve access to general practice services for whānau and communities. Progressing these recommendations requires the effort and resources of organisations across the Canterbury health system.

Reduce general practice administration to reclaim the joy of general practice

- Develop and distribute a kete of resources that responds to the survey findings on enablers and barriers to adopting alternative approaches to inbox management.
- Facilitate use of automated tools for inbox management and other routine tasks.
- Reduce administration at the source by addressing two to three problematic primary / secondary care pathways / processes and other messaging or administration tasks of low value.
- Explore opportunities to grow the workforce to support inbox management and other routine tasks.

Improve the primary / secondary care interface to recapture the relationships across the system

- Address two to three problematic primary secondary care pathways / processes.
- Propose how to improve the interface and communication in a comprehensive and sustainable way within a regional mechanism / framework that leverages local relationships and resources.

Increase retention of the current and future GP and PN workforce

- Further explore survey findings on factors influencing GP and PN decisions to leave or retire from general practice and identify local opportunities to improve workforce retention.
- Respond to findings on local opportunities to retain the workforce including a focus on ways to increase the clinical and wellbeing / supervision support available to early to mid-career GPs.

Explore and implement ways to strengthen the team environment and workplace culture within the practice and with providers

- Promote examples of what practices are doing to build a collegial environment in practice.
- Capture lessons and simple ways to build team culture for distribution.

Support further development of the primary care team

- As an initial priority increase the utilisation of pharmacists providing healthcare as part of the general practice / comprehensive primary care team.
- Showcase the value of care coordination / care coordinators as part of the general practice / comprehensive primary care team.

Promote primary care / community provider collaboration

- Promote strengthening of relationships and delivery of integrated care across primary care and community providers / NGOs; e.g., by showcasing examples of collaboration.

Explore ways to support the transfer of ownership of general practices

Advocate and amplify the voice for primary care

- Communicate the survey findings and add PCTF voice to those advocating for primary care.

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10. Appendices

Appendix One: Respondents

Where a respondent did identify their practice, respondents were to state whether the practice accessed VLCA funding, practice size, rurality, location and practice suburb and region.

Most respondents answered these questions naming their practice or completed all the practice characteristics. See Figures 22 and 23.

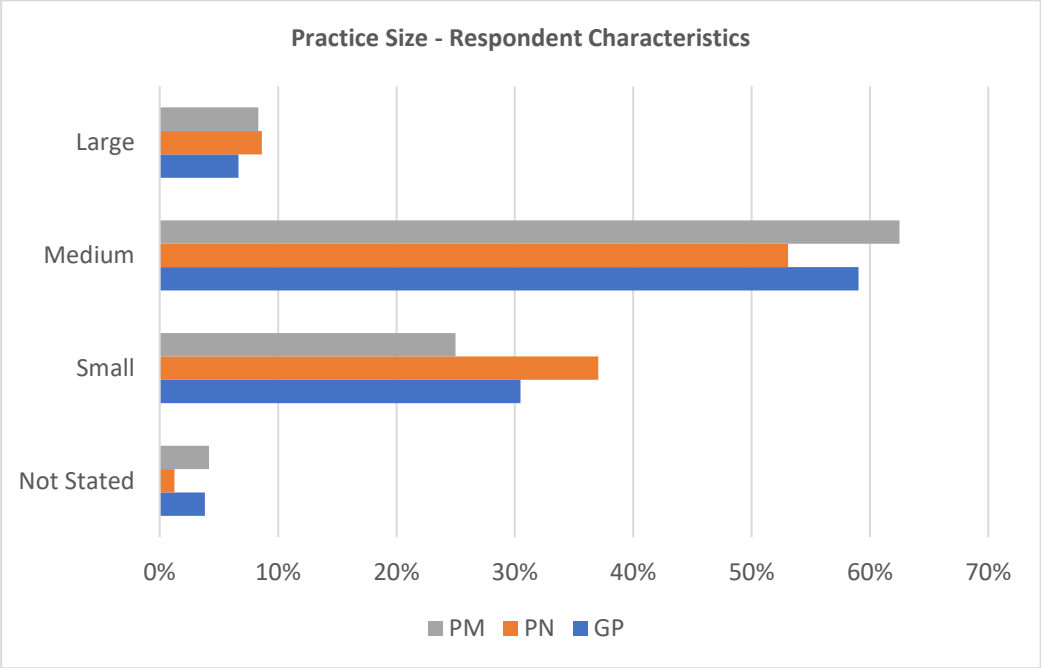

Figure 22: Practice size.

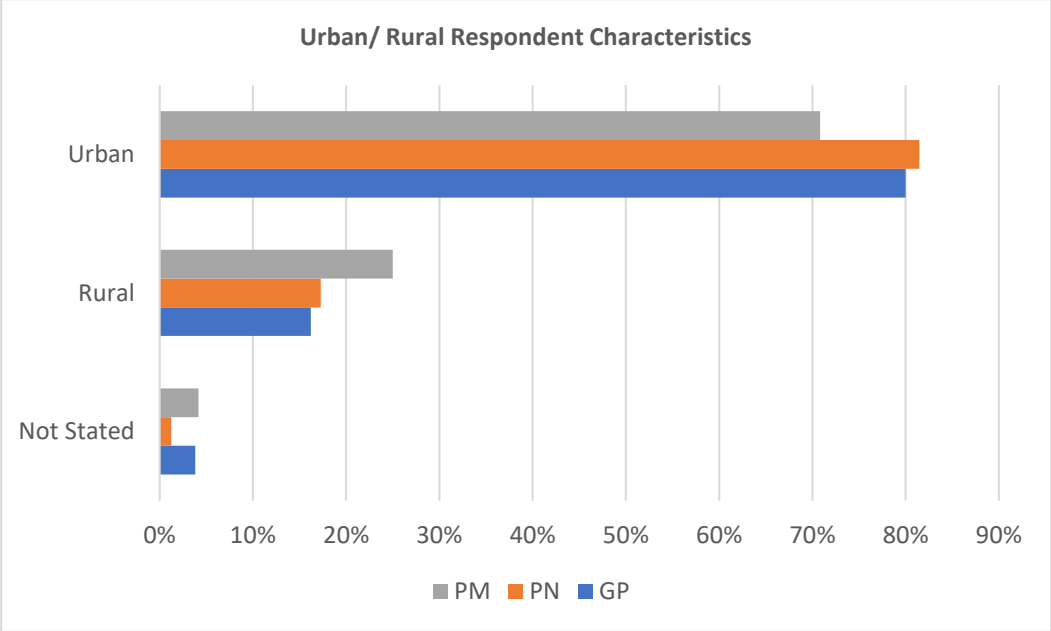

Figure 23: Rurality.

Character Total Number	GP	PN	PM	Total		Character By Percentage	GP	PN	PM	Total
Urban, Full, Medium	47	32	20	99		Urban, Full, Medium	45%	40%	42%	42%
Urban, Full, Large	27	24	10	61		Urban, Full, Large	26%	30%	21%	26%
Rural, Full, Medium	10	6	9	25		Rural, Full, Medium	10%	7%	19%	11%
Rural, Full, Large	5	5	1	11		Rural, Full, Large	5%	6%	2%	5%
Urban, Full, Small	4	3	3	10		Urban, Full, Small	4%	4%	6%	4%
Urban, VLCA, Medium	4	5	1	10		Urban, VLCA, Medium	4%	6%	2%	4%
Not Stated, Not Stated, Not Stated	2	1	2	5		Not Stated, Not Stated, Not Stated	2%	1%	4%	2%
Rural, Full, Small	1	2	1	4		Rural, Full, Small	1%	2%	2%	2%
Urban, VLCA, Small	2	1	0	3		Urban, VLCA, Small	2%	1%	0%	1%
Not Stated, Full, Not Stated	1	0	0	1		Not Stated, Full, Not Stated	1%	0%	0%	0%
Not Stated, VLCA, Not Stated	1	0	0	1		Not Stated, VLCA, Not Stated	1%	0%	0%	0%
Rural, VLCA, Small	0	1	0	1		Rural, VLCA, Small	0%	1%	0%	0%
Rural, VLCA, Medium	1	0	0	1		Rural, VLCA, Medium	1%	0%	0%	0%
Rural, VLCA, Large	0	0	1	1		Rural, VLCA, Large	0%	0%	2%	0%
Urban, VLCA, Large	0	1	0	1		Urban, VLCA, Large	0%	1%	0%	0%
Total	105	81	48	234		Total	100 %	100 %	100 %	100 %

Respondents versus all Waitaha | Canterbury general practices

Multiple methods were used to catergorise rurality. The percentage of practices accessing rural funding (12%) was used as a comparison to survey repondent numbers. With 25% (12) PM indicating they are from rural practices the sample of rural practices may be over represented.

Approximately 7% of Canterbury practices access VLCA funding, and this is similar to the sample proportion.

Using the Pegasus PHO Practice population as a guide (23% large, 15% small and 62% medium) the practice sizes are potentially under-represented by larger practices (~8% cf 23%) and over-represented by smaller ones (~30% cf 15%). However, Pegasus itself is likely over represented of larger practices in Canterbury making the proportion of respondents at least not dissimilar.

11. Acknowledgements

On behalf of the PCTF, I would like to acknowledge this report is a result of the contribution of general practice respondents and people across the Waitaha | Canterbury health system. I would like to express my sincere thanks to:

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Matty Teata

Rachel Thomas

Emeritus Prof. Les Toop

Rawa Wood-Bodley

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Linda Wensley Project Facilitator Primary Care Taskforce