A PLANNED PRIMARY CARE WORKFORCE FOR WALES

Consultation by Welsh Government

Response from BMA Cymru Wales

28 August 2015

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the Welsh Government on ‘A Planned Primary Care Workforce for Wales: Approach and development actions to be taken in support of the plan for a primary care service in Wales up to 2018’.

The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 153,000, which continues to grow every year. BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

Fundamentally, the development of a robust workforce plan, encompassing both training and service needs and applying to the whole practice/primary care team, is extremely welcome. It is something that we have been calling to be established for a considerable time.

We are delighted that many of the recommendations for change that are set out in the BMA’s General Practitioners Committee Wales (GPC Wales) strategy document, General Practice: A prescription for a healthy future, are included in the plan.

General practice is going through one of the most challenging periods since the inception of the NHS. Economic austerity and ever increasing levels of ill health present a huge challenge. The need to place general practice on a more sustainable footing has therefore never been starker; and we recognise that alongside supporting the independent contractor model, which has been at the heart of general

1 BMA Cymru Wales. General Practice: A prescription for a healthy future. 2014. Available at: http://bma.org.uk/gpcwales

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practice’s flexibility and innovation, there needs to be fundamental change to make the provision of general practice in Wales viable for the long-term.

We therefore welcome the focus now be placed by Welsh Government on developing a more sustainable primary care workforce. This adds to other initiatives such as the genuine reduction in the bureaucratic burden on general practice which we have agreed with Welsh Government through recent contract negotiations.

Whilst we welcome much of what this plan contains, however, we are concerned that some important areas are either not addressed, or not fully addressed, within it. Such omissions risk undermining the overall approach, and the ability of the plan’s intended aims to be fully realised.

Chief amongst the areas not referenced in the plan is the level of overall investment in general practice. Despite strong evidence to support further investment, the share of total NHS expenditure allocated to General Medical Services (GMS) in Wales had fallen from 10.3% in 2007 to 7.9% in 2014.2 This has also coincided with a drop of over £11,000 a year in average GP earnings between 2005-06 and 2012-13,2 at the same time as pension and indemnity costs have been running far ahead of general inflation.

Another area which we feel merits detailed attention is the provision of out of hours’ (OOH) GP services. We are greatly concerned that there has been under investment in OOH GP services in Wales since 2004 and feel this is irreconcilable with Welsh Government commitments to improve unscheduled care. It also has a clear knock-on effect on workload implications for practices during core daytime hours. Without adequate investment it will not be possible to attract and retain sufficient capacity in the workforce, particularly at weekends and over public holiday periods.

We believe there is an urgent need to review the way in which OOH services are provided, whilst also considering the planned introduction of the 111 service in Wales and ensuring its appropriate use. GPs should be more involved in the planning and development of OOH services, through strengthened working arrangements involving GP clusters. In our view, competitive remuneration rates should be set to create attractive OOH GP salaried careers and to encourage the participation of local GPs. Dedicated funding for continuous professional development within OOH work should also be considered.

In other areas of the plan, we feel there is insufficient detail for us to assess the merits or otherwise of the actions proposed, or to offer an adequately considered response. On such example is the proposed role of Advanced Practitioner which, it seems, carries a number of definitions. As such, there is widespread ambiguity regarding how many aspects of this type of role will work within wider primary care teams in Wales.

We do, however, look forward to engaging further as the design and implementation of this plan progresses.

In relation to the way in which the plan is structured, we strongly agree with the four main areas identified for action and consider these to be appropriate themes on which to focus. We have therefore structured the remainder of our response around those four headings:

1. Putting in place the foundations for a more robust approach to workforce planning.

We agree that a planned approach, taking a whole system view of healthcare, is needed to secure a workforce that is appropriate in terms of both size and skill-mix for the long-term sustainability of healthcare in Wales. Such an approach should, in our view, include investing in those already working in

2 Figures supplied to GPC Wales by Welsh Government
3 http://www.hscic.gov.uk/article/2021/Website-Search?productid=13317&q=GP+earnings+and+expenses&sort=Relevance&size=10&page=1&area=both#top
primary care to extend their skills and/or work in different ways in order to deliver clinically-appropriate care or treatment which is decided upon on the basis of clinical need.

The management of primary care requires a very different skill set from running hospitals. As such, we do not consider that the specialist nature of this work is necessarily well suited to being delivered across Wales by seven small primary care teams based within each local health board. We therefore believe that primary care management expertise might be better consolidated into a single primary care authority for Wales.

Data collection and availability

One of the keystones for a more robust approach has to be improving data availability and analysis. However, assessing the true performance of the NHS in Wales presents long-standing difficulties. As far back as 2003, Sir Derek Wanless pointed out that data quality was poor and there was lack of robust evidence to support decision making.4

In 2005 the Welsh Government’s strategy Designed for Life5 emphasised the importance of bench-marking services using comparative data to set a strategic agenda relevant to each locality, and to focus on service improvement. Nine years later, however, we is very little evidence of that bench-marking or comparative data are being used across the NHS in Wales.

Chapter 7 of General Practice: A prescription for a healthy future deals with data availability and continuous service improvement, and makes a series of recommendations which could be incorporated into this Welsh Government plan.

The paucity of data and evidence gathering on the GP workforce in Wales is plainly portrayed by the fact that neither Welsh Government, nor health boards in Wales, hold or publish data on GP vacancies. The same is also true of the medical workforce in secondary care; health boards are supposed to collect vacancy data, but our experience has been that a Freedom of Information request is required to obtain it. Even then, the responses would appear to be highly inaccurate (largely due to the use of a fundamentally flawed definition which means a vacancy is only counted as such when an active process is underway to fill it).

We recognise that GP practices have much to contribute to improving data collection, especially in terms of engaging with clusters to identify and map the primary care workforce in their localities. GPC Wales, on behalf of the profession, has been engaging with Welsh Government to develop appropriate mechanisms to support the improvement of data availability via practice development plans.

Also as set out in General Practice: A prescription for a healthy future, the availability of transparent and open financial data is equally as important as clinical and management data in order to effectively monitor GMS expenditure. The recently established Welsh GMS Enhanced Services and Directly Administered Funds Committee has enabled Wales to make use of a contract management mechanism that has worked very effectively at a UK level for many years. For the first time this provides comprehensive assurance and monitoring of GMS expenditure enabling comparisons to be undertaken across Wales.

We very much support the suggested action to develop a mechanism to gather activity and workload data in primary care.

Identifying future service models/assessing service demand

In order to design and deliver the intended shift of services into primary care, it is essential to make sure that decisions are evidence-based and relevant to local health needs. We are pleased to see that this is

recognised in the plan, along with the role that clusters have to play in supporting local health needs assessments and allocating appropriate resources. We strongly agree that this is essential for forecasting the potential future demand on primary care, future training needs, the new partners that primary care will need to work with (or work differently with), and what they will be expected to deliver. Clusters need to be resourced and supported appropriately to achieve this.

One area which is not mentioned in the document is the need to look at the growing demand for services and be honest and open about what can and cannot be delivered – as well as what should or should not be delivered. As part of this, we would suggest that measures to mitigate the impact of regular missed appointments should be considered.

We support a systematic review of services to identify the ‘full-range of traditionally hospital-based services (or parts of services) which will in future be delivered in the community’. This review will also need to consider the shift in resources, or new investment, which will be required to deliver this. It will additionally need to consider what measures may be necessary to appropriately mitigate any impact on those services and staff which will still be based in secondary, acute or other care settings, as well as any need to connect and communicate with them.

We believe that the variability of the Integrated Medium Term Plans (IMTPs) that health boards are required to submit to Welsh Government requires urgent redress. Each should contain detailed data on the primary care workforce and clearly outline how the local needs analysis by clusters has informed both strategic decisions and strategic direction. IMTPs should be subject to scrutiny at both national and local level (including by cluster), with an agreed format and standard of data sets to enable effective comparisons to be undertaken.

Local and wider patient care pathways and referral procedures will need to be mapped and tested rigorously; with outcomes shared and local pockets of good practice, e.g. at cluster level, built upon elsewhere where it is relevant to do so.

The plan strongly advocates for greater alignment between the commissioning of medical and non-medical education, and to consider training for professionals not currently in either system in order to ‘develop a prudent workforce where medical and non-medical skills are both part of the skill-mix in accordance with need’. This aligns with the recommendation put forward by the recent Health Professional Education Investment (HPEI) Review.

Whilst the HPEI report supports the proposal to establish a single body for strategic workforce planning, education commissioning and organisation role design, the arguments put forward within it to justify this suggestion lack sufficient substance to present it as a compelling conclusion. For instance, a key part of the rationale presented in the report was that the HPEI Panel was bemused by the number of bodies that exist in commissioning and providing education, training and development for health professionals in Wales. However, that is not in itself sufficient argument for the creation of a single body to undertake this role, and we further note that no other models were assessed within the report by way of comparison.

We agree there is a need to develop a more collaborative all-Wales approach to education commissioning that is based on an improved process of workforce planning. A single body could be one way of delivering that, but we do not think the case has been made that it’s the only option. More broadly, we have concerns that there may be an assumption that Wales can plan its medical workforce independently of the rest of the UK, but such an assumption would not in our view take account of the reality of global workforce mobility.

Given the recognised recruitment crisis in general practice, if the alignment of commissioning of medical and non-medical training goes ahead, we would seek assurance that appropriate safeguards would be put in place to ensure that funding would not be diverted away from medical training. Given that it is
recognised we have a problem in Wales relating to shortages of certain types of doctors, this would surely highlight the inadvisability of diverting any funding away from the training of doctors.

One of the actions listed in the plan relates to the development of Welsh language abilities in primary care. BMA Cymru Wales believes that we must support the use of the Welsh language within primary care settings for the benefit of Welsh-speaking patients, and we very much recognise that it benefits patients to have the ability to communicate with healthcare practitioners in their first language. Where possible, we believe that staff who are not bilingual but are working in Welsh-speaking areas should receive encouragement and support to learn Welsh free of charge. We consider that fluency in the Welsh language should be seen as an additional qualification for doctors but it should only be seen as a deciding factor in an appointment between candidates that are otherwise of equal clinical ability and qualification, as appointing the best possible candidate should take priority. We also recognise that specific training may be required to enable some doctors to have sufficient competence to undertake consultations through the medium of Welsh even if they are fluent in conversational Welsh.

We very much endorse moves to strengthen health and social care integration, and are keen to contribute to work around the development of a joint process for workforce planning in the near future. We feel that the aim to broaden the range of professionals who can play a part in admission, discharge and putting care plans in place is to be welcomed. This needs, however, to be supported by sound and responsive communications systems between all partners in a manner that is clinically appropriate and provides appropriate safeguards in relation to data confidentiality.

We believe it is important to fully evaluate the investments made through the Intermediate Care Fund in order to identify areas for wider joint initiatives and promote wider evidence-based integration where it is appropriate to do so. We feel that clusters would be ideally placed to help deliver the sharing and tailoring of best practice with relevance to the specific health needs of their localities and populations.

2. **Supporting the continuing development of primary care clusters and the sharing of best practice.**

We welcome the emphasis being placed on GP clusters which offer ways to share workload and provide more efficient and more accessible services for patients. GPC Wales continues to engage with Welsh Government and health boards to facilitate effective cluster working mid-way into the three-year cluster development programme. Indeed, we note that GP cluster networking has been built into the GMS contract for 2014-15 as a foundation on which to build.

Currently, however, we hear very mixed reports from GPs across Wales of their cluster experiences to date; whilst some clusters are flourishing, others appear to be struggling to understand the concept and vision. We have heard reports that the involvement of community, secondary and social care is very limited in some clusters. Some GPs have highlighted an unwillingness on behalf of health boards to share decision making, and that their experience of cluster networking is little more than irregular meetings organised by health boards to administer parts of the Quality Outcomes Framework (QOF).

These differing experiences, which need to be monitored by Welsh Government, were confirmed in a recent survey we undertook amongst GPs in Wales – the findings of which have already been shared with Welsh Government officials.

We strongly support the proposal to progress an all-Wales action plan to support the development of all 64 clusters. This will need to outline the support arrangements for practices that wish to engage in their local cluster. The proposed national programme for the organisational development needs of clusters will in our view require to be extremely flexible in order to suit local needs. It will also need to be easy and clear to interpret, and able to be mapped across the different clusters at all levels of their development. The establishment of a national set of core governance standards for clusters is important, but this needs to be undertaken collaboratively. We would therefore ask to be involved in taking that work forward.
Clusters do have a long way to go in order to reach their potential for horizontal integration in sharing services, skills, resource and education across their areas. We believe that, as a starting point, GP cluster networks should look to re-create integrated primary health care teams.

It is clear to us that Welsh policy and initiatives implemented since 1998 (when fundholding for GP practices ended) have failed to engage GPs because they have not been given the drivers for change, either clinical or financial. Before then, practices were engaged at a local level with hospital and community providers, and extended primary care teams were beginning to deliver community services focused around individual practices which maintained continuity of care and clinical cooperation. Extended primary care teams were replaced by managerially-driven geographic teams which led to a marked reduction of integration, cooperation and local communication.

Provided they are resourced appropriately, BMA Cymru Wales believes that clusters possess the potential to re-ignite networking – both across practices, and between practices and other community and secondary care partners – whilst also helping to relieve some of the pressures that practices experience. For patients, clusters could enable the development of a more coordinated and seamless service, delivered locally. We are pleased to see the role of Public Health Wales in supporting effective population health action, as well as the proposal to develop online resources to support cluster working and to facilitate the sharing of best practice and innovation. With increasing autonomy there is real potential to work closely with Community Health Councils, social services departments and others to provide more integrated services closer to home and become wider primary care clusters.

Clusters working together can support individual practices to be sustainable for the future by working more collaboratively across natural geographical areas and avoiding duplication. We know that ‘working at scale’ is inevitable, and GPC Wales has previously advised that this is something practices need to be aware of. GPC Wales recently published a briefing entitled How GPs can be supported by working together which considers a range of practical means by which practices can collaborate effectively.

Effective GP cluster networking will require a fundamental change of culture and approach, including having elements of commonality across Wales, and having common administrative structures adequately resourced and supported. They also require a degree of permanence in terms of a correspondence address, email, website and officers – whilst resisting micro-management by health boards and removing any unnecessary bureaucracy.

Reshaping care will also require close collaboration and joint decision making with hospital consultants as key contributors to the networks. We believe that the potential for better coordinated and streamlined patient care will be dependent on health boards allowing resources to be devolved and refocused on clinical advice generated through collaborative cluster networks.

The Royal College of General Practitioners (RCGP) in collaboration with the King’s Fund have developed a Primary care federations toolkit6 which is intended to help managers and primary care practitioners take federated working forward collaboratively. The GPC UK paper, Developing General Practice – Providing Healthcare Solutions for the Future7, expands further on the value and importance of the primary health care team working in collaboration with other health care providers and the value of collaborative alliances or federations. Lessons from these documents should be incorporated into the development of GP cluster working.

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3. Investing in the development of the wider primary care workforce.

We are glad the plan notes that the need to stabilise the GP workforce is key to delivering the wider ‘prudent workforce’ Welsh Government seeks to pursue. We strongly agree with the policy intention to deliver more care closer to home, and that to achieve this a wide range of professionals working as part of a coordinated team will be required.

Certainly there is a lot of work being undertaken by GPs that could be more appropriately be delivered by other professionals. However, the volume of some of this work might not necessitate the placing of those professionals within individual GP practices – but this may well work across multiple practices or clusters.

It is important that a one-size-fits-all approach is not used to develop the wider primary care workforce across Wales. Instead, we feel that the team of professionals needed to meet local population health needs should be identified and determined locally. An example of this is given on page 20 of the plan where it talks about the different ways in which the role of advanced practice pharmacists may develop to suit local needs for the safe use of medicines across multiple sites.

Facilitating and providing for increased use of wider professions in local healthcare delivery will need to be part of the ‘culture’ of clusters. However, they must be given the resources to deliver on that agenda. While training places in some professions has increased, it will be some time before the numbers needed are actually in the workplace – assuming, that is, they stay in Wales once trained.

We would specifically be grateful for clarification and more detail on the proposed role of Physician Associates, and the value that role will add, given that there are various descriptions of this role and the training and regulation requirements that will be attached to it. The document states that a task and finish group has been set up to consider how best to take this role forward in Wales. Given the implications for the role to have an ‘immediate impact’ on GP workload, we would request to be part of that task and finish group.

In our view, the establishment of common education programmes should be welcomed as this should encourage inter-professional learning. However, we would note that undergraduate and postgraduate education curricula, leading to examinations and qualifications, are approved by the relevant UK regulatory bodies (e.g. GMC, GDC, GNC etc). Also, education programmes have been developed with defined learning outcomes and assessments which vary between different professions. Agreement would therefore have to be reached with these regulatory bodies before such common programmes could be established. It would also be important to ensure that medical training can continue to provide clinicians with the particular skills and expertise they require.

We note that there are a series of references to ways in which training might be changed, including looking at multi-disciplinary training, but would question how this might impact on ensuring training continues to meet existing recognised standards set by appropriate regulatory bodies such as the GMC and Royal colleges. We would therefore seek assurances that there would not be a dilution of training experience, or the creation of qualifications which might not then be recognised outside of Wales, since this would be detrimental to attracting both new trainees and doctors to Wales.

We are alarmed at the statement on page 26 of the plan that Service Increment for Teaching (SIFT) funding is no longer appropriate and should cease because, as referred to in the HPEI Review, it shows how education investment in Wales is ‘currently disproportionately aligned to the medical profession’. The plan therefore proposes removing SIFT funding in order to support the wider range of healthcare professionals. In our view, this shows a fundamental misunderstanding of the role of SIFT funding which is specifically provided by Welsh Government to cover the additional costs incurred by health boards and GP practices for teaching medical and dental students.

Without SIFT funding many GP practices will inevitably start reconsidering whether they should continue to provide placements. This would be counterproductive, given the intention for more training to be
delivered in the community. Any reduction in the availability of placements would most certainly have a negative impact on future recruitment and retention within general practice.

Indeed, we have previously highlighted the need for increased funding to practices to cover the costs of training. We believe there is a need for an enhanced trainers’ grant to recognise the impact that training has on the delivery of routine practice work. It is widely acknowledged that the workload involved, particularly the e-portfolio, is cumbersome and is becoming more onerous. The foundation placement fee and GP trainer’s grant no longer reflect the current workload associated with training foundation and general practice trainees. An uplift proportionate to the workload is therefore essential in our view.

We would also oppose the suggestion in the plan that free accommodation for F1 trainees should be removed. No impact assessment has been provided for this and we see no justification for it. In our view, this provision remains a key recruitment incentive for attracting doctors in training from across the UK and beyond, and we strongly believe this made-in-Wales policy should be retained.

The proposal to work with stakeholders to establish a different funding mechanism for doctors in training to ‘remove the tension’ between the Wales Deanery and health boards when determining the training landscape across Wales is not sufficiently explained. We would therefore seek clarification on what this might mean and suggest that any such proposals should be subject to full and meaningful consultation.

Proposals to increase work experience placements and apprenticeship opportunities within care settings are to be welcomed in our view, as are the measures proposed for optometry and paramedical roles.

Any proposed additional investments in training clearly need to work for Wales. In practice, however, we need to recognise that after training individuals often choose to go elsewhere to work. Measures aimed at boosting post-training retention, in order to maximise the return on this investment, should therefore be built into the plan.

The expansion of the primary care team with pharmacists, health visitors, district nurses and others will hopefully address some current workload issues. There is, however, currently a shortage of practice and district nurses, which has a knock-on effect on GP workload. A joint report by the King’s Fund and Nuffield Trust on the future of general practice goes further than what is being proposed by Welsh Government suggesting that GPs, dentists and optometrists collaborate to create a much larger primary care team, although we recognised this is more an option that could be considered in the medium to long term.

We must ensure that each element of the primary care team is complementary, leading to an effective skills mix. In line with the principles of prudent healthcare, they should also not duplicate or complicate other parts of care pathways or delivery.

4. Stabilising key sections of the current workforce

GPC Wales has consistently raised very serious concerns about the recruitment and retention of GPs and practice nurses. We broadly welcome the contents of this section of the document and note many of the proposed actions are ones that we have put forward previously.

The ‘Practice Sustainability Framework’ is a result of the changes to the GP contract for 2015-16 and 2016-17 which included a commitment to address the sustainability of GP practices (including small and multi-site practices) through the development of an evidence based approach, including a risk matrix, to assess the extent to which access and the continuity of services can be secured for patients, in particular, in rural and deprived urban communities. The framework should allow health boards to target personnel, organisational and financial support where it is most needed to sustain services.

Page 34 of the plan states: ‘in Wales, [GP] numbers moved through the 2,000 barrier for the first time in 2014’. We feel this figure is to an extent disingenuous and may be revealing a distorted picture since it is based on headcount figures, rather than whole-time equivalent (WTE) figures. The small increase in headcount which is noted in the document fails to reflect the huge changes in working patterns for GPs that have taken place over the last 12 years leading to a level of workload that is becoming increasingly unsustainable in certain pockets within Wales.

BMA Cymru Wales believes there needs to be a substantial increase in the commissioning of GP training numbers in Wales, phased in over several years. Based on an extrapolation of the data for England, the equivalent of which is not readily available in Wales, we estimate that Wales needs at least 200 GP specialty trainees each year. At present, however, there are currently only 136 such places, not all of which are filled. We therefore particularly welcome the work that is proposed to inform the future number of GP training places required to meet future demand.

In terms of the numbers of applicants applying per training post available, general practice has become one of the least popular specialties, second only to psychiatry. Unfilled GP training places are a problem across the UK, but in Wales this is exacerbated by the fact that we have the lowest proportion of trainees undertaking placements in general practice at Foundation Level 2 (FY2) – 24% compared to a UK average of 55%. In England, the Department of Health has committed to ensure that 50% of trainees completing foundation level training enter GP training programmes by 2016. We welcome the commitment in the plan to increase the proportion of general practice/community placements which medical students are exposed to. This is consistent with our previous call for consideration to be given to making foundation year GP placements mandatory for all doctors in training.

Welsh Government needs to do more to attract trainees to GP training posts, and to ensure that trainees receive adequate exposure and training in order to deal with the modern day pressures of general practice. Work also needs to be undertaken to dispel a number of negative perceptions about training and working in Wales. However, since it will take a minimum of three years to train these individuals (and at least five years for those in less than full-time training), this will not in itself sufficiently mitigate any supply shortfall that exists currently, or could emerge in the next few years. Therefore more immediate solutions are also needed.

Wales needs to create environments where the new generations of both male and female GPs seeking different ways of working can flourish. More opportunities for flexibility are needed that combine general practice partnership with an ability to undertake other roles in NHS Wales. We are therefore pleased to see action proposed around developing a ‘refreshed offer to GPs in Wales’. We believe that specialist training or portfolio roles have a lot to offer here both in terms of variety and ways of preventing burnout.

The proposal for an occupational health service to be made available to all GPs in Wales is very much welcomed. GPs have access to Health 4 Health Professionals, but there is currently no complete occupational health and well-being service. Despite this, it is widely acknowledged that burnout, stress, low morale and risks of mental health illness are becoming increasingly prevalent.

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10 note that there has been a current one-year increase in this figure to 34% in Wales


BMA Cymru Wales has recently called for a comprehensive all-Wales occupational health service to be developed for all NHS employees. Given the time and resources it takes to train a GP, it makes complete economic sense to preserve and protect that investment – a comprehensive service is therefore long overdue. It has been over five years since the recommendations of Sir Mansel Ayward’s *One Wales* report into Occupational Health were accepted by the Welsh Government, and yet we are still only in the ‘pilot’ stages of projects.

Key to addressing the recruitment crisis in general practice is to remove the impossible pressures of GP partnership to make it an attractive option, for new and existing GPs alike. GP partnerships are no longer seen as the end point of a career for some in general practice. The partnership model needs to be maintained, supported by flexible career options for both men and women. We feel this is essential for being able to attract and retain new doctors to the profession, but currently few such flexible opportunities exist.

The document states that health board managed practices could develop as part of the response to the recruitment challenges, and that health boards are able to put in place other contractual arrangements for GP practices, depending on the needs of the local population, the service to be provided and the workforce issues faced. We believe that a salaried service can play a valuable role in supporting flexible careers and may help to retain doctors at the beginning and end of their careers; it can thus play an important role supporting the mainstream partnership model. Whilst having an important place in primary care provision, however, we feel there is little reliable evidence to support the case for wholesale change. Indeed, we feel that evidence overwhelmingly supports the independent contractor model as being the most effective. Evidence from health boards would also suggest that a salaried service is more expensive and requires substantial management involvement. It is important to realise that unless the attractiveness of general practice in Wales improves, and the working conditions for permanent staff are addressed, then the recruitment and retention problems in general practice are only likely to worsen.

We welcome the proposal in the plan for ‘additional support for the development of a GP retainer scheme that has wider scope for eligibility that would include those GPs for whom a change in working patterns may be an alternative to early retirement’. In our view, priority needs to be given to supporting GPs in the ten years leading up to retirement age. In 2014, 23.4% of all GPs were aged 55 and over – and the figures are likely to be much higher in rural and more deprived areas. A retirement bulge will occur over the next few years; focus should therefore be placed on identifying education and skills development, as well as on working patterns, that can lead to increased retention amongst this staff group.

We also suggest that the Welsh Government could look into the work which is being undertaken by the NHS Working Longer Group. Preliminary findings and recommendations from its ongoing *Working Longer*

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Review were published last year.\textsuperscript{19} In particular, we note that the Group has discussed the need to gather more data from those who are retiring before normal retirement age in order to better explore the reasons for this. Such information could assist the development of new measures designed to support retention and promote longer career timelines in the future.

The proposal to explore ‘actions that can be taken in regards to sessional thresholds arising as a result of professional indemnity insurance’ is also to be welcomed. Indemnity costs for GPs have been rising but this has not been recognised in the funding provided to practices.

Indeed, we remain deeply concerned that increased practice expenses are not being covered by annual funding increases. It was acknowledged by the Review Body on Doctors’ and Dentists’ Remuneration (DDRBI) in its 2014 report that the formula used for deciding the annual uplift for practices is not fit for purpose meaning that intended increases in pay to GPs net of expenses are not being delivered. This needs to be addressed as a matter of priority as it is a major contributor to the current crisis in general practice that exists in Wales with average incomes for contractor GPs, as we have already mentioned, having dropped by over £11,000 a year between 2005-06 and 2012-13.

We very much welcome the actions in the plan to consider ‘a voluntary bonding scheme to encourage recently qualified GPs to practice in an area that has been difficult to recruit to or which is an area of significant need’ and ‘the reimbursement of student fees accrued during the duration of medical school where an individual decides to pursue a career in general practice’. These echo calls that we have previously made, and we would welcome the opportunity to work with Welsh Government on developing these concepts further.

Finally, we also welcome the intention in the plan to make it ‘easier for GPs who are on a Performers’ List in England to be able to work in Wales’. This proposal also echoes calls we have made on previous occasions.