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National Assembly for Wales / Cynulliad Cenedlaethol Cymru Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into the GP workforce in Wales / Ymchwiliad i'r gweithlu Meddygon Teulu yng Nghymru

Evidence from BMA Wales – GP 01 / Tystiolaeth gan BMA Cymru – GP 01

INQUIRY INTO THE GP WORKFORCE

National Assembly for Wales, Health and Social Care Committee

Response from BMA Cymru Wales

16 January 2015

INTRODUCTION

BMA Cymru Wales welcomes the opportunity to contribute to the Health and Social Care Committee's inquiry into the GP workforce in Wales.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents over 7,000 members in Wales from every branch of the medical profession.

OVERVIEW

In an ever-evolving healthcare environment the independent contractor model has been at the heart of general practice's flexibility and innovation, which has been vital for affordable NHS care. It is well

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documented that high-quality primary care provides excellent value for money,^{1,2,3,4,5} at around £23 per consultation.

Accessible and well-resourced general practices are essential if NHS Wales is to deliver good health outcomes to patients in all parts of Wales. Yet, general practice is facing unprecedented challenges; we recognise that there needs to be fundamental change to make the provision of general practice in Wales sustainable.

Last year, the BMA's General Practice Committee Wales published a strategy⁶ intended to chart a way forward to a more certain future. Many of the recommendations in that document are replicated here.

MODERN GENERAL PRACTICE

There is a clear and increasing requirement for the GP workforce to be able to respond effectively to the growing demand for primary care services. This demand has been driven by a range of factors,⁷ including:

- population growth, higher birth rates and an ageing population;
- increased prevalence of chronic conditions (e.g. diabetes, obesity, dementia) and multi-morbidity;
- patients with higher expectations;
- increasing non-clinical duties (for example, multiple inspections from QOF, CHC, HIW visits, post payment verification visits; adapting funding changes; engaging in GP clusters and with health board initiatives e.g. prescribing leads); and
- policy initiatives for better-quality care, delivered closer to home.

GPs have increasingly reported they have never known a time when the workload was so intense; many say that services are under immense strain. We regularly hear from members that stress related illnesses are becoming increasingly common. Burnout is a very serious threat to the sustainability of general practice, not to mention to individual doctor health.

In attempting to respond to rising demand, the role of the GP has evolved and individual GPs are more accustomed than ever to innovating in order to improve practice operations and be more effective – for example: reviewing skill-mix; reducing the number of missed appointments; taking a prudent approach to prescribing; increasing the use of new technology; and engaging in cluster networks.

Working pattern preferences have also changed. The younger generation of GPs have different expectations and lifestyle desires than their predecessors. Partnerships are no longer seen as the end point of a career for some in general practice, as they increasingly resemble an overburdened path due to increased workload, bureaucracy and financial responsibility. This needs to be urgently addressed; and the impossible pressures of GP partnership need to be removed to make it an attractive option – for new and existing GPs alike. The partnership model needs to be maintained, supported by flexible career

¹ A Survey of Primary Care Physicians in 11 Countries, 2009. Perspectives on Care, Cost and Experiences. Schoen, Obsorn, Doty, Squires, Peugh, Applebaum: Commonwealth Fund 2009. Available at:

<http://www.commonwealthfund.org/Surveys/2009/Nov/2009-Commonwealth-Fund-International-Health-Policy-Survey.aspx>

² Barbara Starfield, Leiyu Shi, and James Macinko, 2005. Contribution of Primary Care to Health Systems and Health.

³ Pierard E. 2009. The effect of physician supply on health status as measured in the National Population Health Survey. Waterloo [Canada]: University of Waterloo. Available at: http://economics.uwaterloo.ca/documents/TheEffectPaperPierard_000.pdf

⁴ Oldham, et al. 2012. Primary Care – the central function and main focus: Report of the Primary care Working Group. The Global Health Policy Summit.

⁵ Kringos et al. 2013. Europe's strong primary care systems are linked to better population health but also higher health spending. Health Affairs:32(4),686-694 Available at: <http://nvl002.nivel.nl/postprint/PPpp5128.pdf>

⁶ BMA Cymru Wales 'General Practice – a prescription for a healthy future' 2014. Available at: <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales>

⁷ CFWI GP in-depth review: Preliminary findings 2013. Available at: <http://www.cfwl.org.uk/publications/gp-in-depth-review-preliminary-findings/@@publication-detail>

options for both men and women. We feel this is essential for being able to attract and retain new doctors to the profession, but note that few such flexible opportunities exist.

In terms of the size of the existing workforce, Wales has 2,617 GPs. This represents 85 GPs per 100,000 patients – the lowest ratio of GPs to patients in the UK.⁸ The number of GPs in Wales has risen in absolute terms by 11.2% over the last ten years, but this figure may be misleading because an increasing number of GPs are working less than full-time. When the number of GPs is expressed in terms of whole time equivalents, it has in fact remained broadly static over this time period, whilst the overall number of health board staff has increased by 19.7% (with some staff groups up by 120%).⁹

A report by the Kings Fund¹⁰ highlighted that the looming shortage of GPs, and the oversupply of hospital specialists, will undermine the drive to safeguard the NHS in the future. The think-tank said the workforce needs to be rebalanced to drive down future costs and prepare for the future needs of the NHS. The projected imbalances between different specialties will have serious implications for patient care and come on top of reports showing wider staff shortages in key areas such as emergency care.

Between 2003 and 2013, the proportion of GPs aged over 55 in Wales increased by 42.1%. While the number of practitioners below 45-years-old also increased, the rate of increase was significantly slower at just 1.2% throughout the same period^{11,12}. At the same time, the number of GPs under 50 planning to leave the profession has reached an all-time high.¹³ In 2014, 23.4% of all GPs were aged 55 and over – the figures are likely to be much higher in rural and more deprived areas.

The retirement bulge will occur over the next few years; but in combination with both poor recruitment, and concerns over a ‘brain drain’ with doctors choosing to leave the profession in the UK, the result will be a significant shortfall of GPs. This is a scenario that the BMA has previously warned about as a ‘perfect storm’.

Vitality, the GP workforce in Wales needs to increase to more sustainable levels. We estimate that, in addition to other measures, Wales needs at least 200 GP specialty trainee places each year, a rise from the current number of 136. Welsh Government will need to take action to attract trainees to these posts. Since it will take a minimum of three years to train these individuals, it will not significantly mitigate any supply shortfall that exists currently, or could emerge in the next few years.

Other measures, alongside trainee expansion, are therefore required; these are discussed in the sections that follow. These other measures also recognise the fact that an increase in capacity alone may not provide a long term solution – i.e. more GPs working equally as hard while demand continues to rise.

The Welsh Government is planning for more work to be done in primary care and for care planning to be managed through GP cluster networks. Primary care needs the workforce, infrastructure and resources to do the job. Despite strong evidence to support further investment, the share of total NHS expenditure allocated to Welsh GMS has fallen from 10.3% in 2007 to 7.9 %.¹⁴

The Shape of Training Review,¹⁵ and the implementation of its recommendations, are likely to have a considerable impact on the GP training curriculum – the review correctly identifies the huge challenges faced by the NHS in delivering a high-quality health service to a changing patient population in the decades ahead. These challenges are real and serious but the remedies suggested by Shape of Training

⁸ GMC State of Medical Education and Practice in the UK 2014

⁹ BMA Cymru Wales ‘General Practice – a prescription for a healthy future’ 2014. Available at: <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales>

¹⁰ King's Fund report on NHS workforce development, 24 July 2013

¹¹ <http://www.walesonline.co.uk/news/wales-news/fresh-concerns-raised-gp-recruitment-6882121>

¹² <https://stats.wales.gov.uk/Catalogue/Health-and-Social-Care/General-Medical-Services>

¹³ Centre for Health Economics, University of Manchester Seventh National GP Worklife Survey

¹⁴ Figures supplied to GPC Wales by Welsh Government

¹⁵ <http://www.shapeoftraining.co.uk/home.asp>

do not offer the right solutions for patients and could risk all that currently works well in high quality medical education; for that reason the BMA has called for a pause in the review.

As health and social care needs grow in both volume and complexity, and health budgets remain constrained, pressure on the current fragmented system will continue to build. The downward pressure on GP income and working conditions has reached a nadir where the very infrastructure of practices is under threat. When practices fail to recruit, they are often forced into reducing the services that they offer to their patients. This is in no one's best interests.

There needs to be a recognition that with improved resources, enhanced GP training, and a significant expansion of the workforce, general practice can help to address the pressures posed by changing demographics and rising co-morbidity.

In the sections that follow, we provide commentary and offer recommendations on each of the three terms of reference areas of the inquiry, namely:

1. barriers to GP recruitment and retention;
2. whether the commissioning and delivery of medical training currently supports a sustainable GP workforce; and
3. the actions needed to ensure the sustainability of the GP workforce.

Cutting across all of this is the need for a comprehensive workforce strategy for primary care in Wales; one which includes the whole practice team.

RESPONSE (TO TERMS OF REFERENCE)

1 - BARRIERS TO GP RECRUITMENT AND RETENTION

As noted in the preceding section there are a multitude of factors that are combining to negatively affect both the retention of existing GPs in Wales and the attractiveness of entering a career in general practice. These factors include:

Workload

Almost half of the GPs who responded to the recent General Practitioners' Committee UK (GPC UK) survey revealed that increasing workloads and rising pressures were becoming unmanageable or unsustainable all of the time,¹⁶ with 89.4% of GPs indicating 'very high/high levels' of pressure at work.¹⁷ This is the single biggest issue reported to us by general practitioners.

Stress and burnout

Many GPs report that they feel an unsustainable level of pressure in their work, and many are choosing to leave the profession altogether¹⁸ or to move abroad.¹⁹ The Lack of occupational health provision for primary care is a serious problem.

Potential applicants to GP training are put off by well-documented reports of the stressful nature of working in general practice. In the most recent National Survey of GPs the level of overall job satisfaction reported was lower than in all surveys undertaken since 2001.²⁰ Of all BMA membership grades, GPs

¹⁶ BMA GPC online workforce survey, 26 March 2014

¹⁷ BMA UK 2013 Omnibus Survey

¹⁸ CFWI, July 2014. In-depth review of the general practitioner workforce; and HEE Securing the Future GP Workforce, Delivering the Mandate on GP Expansion - GP Taskforce Report 2014

¹⁹ GMC p57 State of medical education and practice in the UK 2014

²⁰ <http://www.population-health.manchester.ac.uk/healtheconomics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf>

report the lowest average satisfaction with their work-life balance,²¹ and GPs, by far, use 'Doctors for Doctors' (the BMA's 24/7 counselling and personal support service) the most.

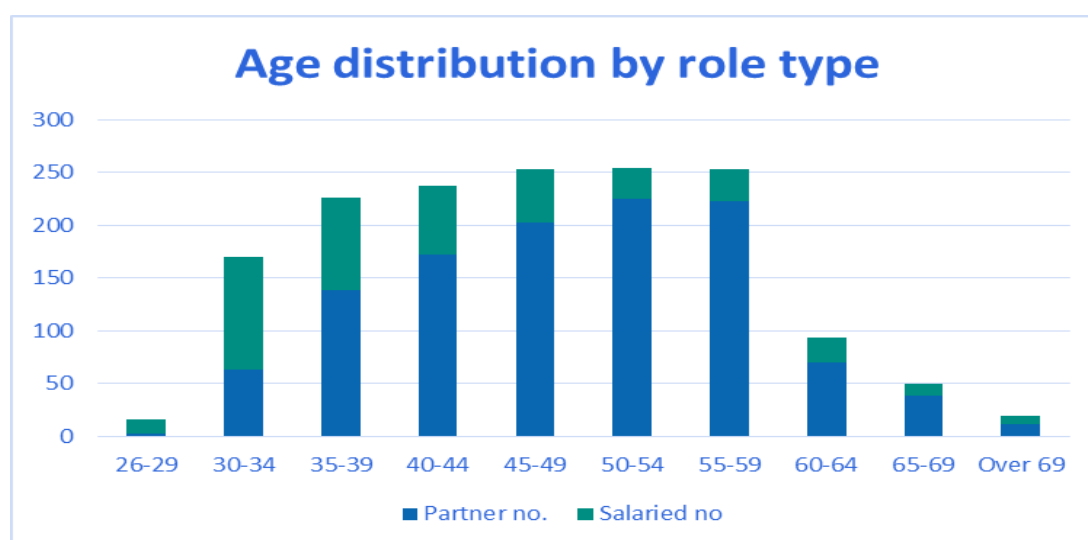
GP training arrangements

Against the background of recruitment problems and an ageing workforce, it is imperative that adequate numbers of new GPs are trained – despite longstanding commitments to expand primary care, the overall number of training places in Wales has remained static. It is also imperative that they are trained appropriately 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 – this includes myths around mandatory use of the Welsh language.

Partnerships and GP Principles

GP partnerships are increasingly being seen as unattractive, and therefore not sought after, due to the workload, bureaucracy and financial responsibility they involve – all for very little gain. In other circumstances, if such pressures are addressed, then many of the new generation of GPs have indicated that they would want to enter GP partnerships.

The graph below details the age profile of BMA GP members in Wales and their salaried/partnership split:



BMA GP members in Wales who work part-time comprise a quarter of those who are salaried GPs, compared to just 7% of those who are partners.

Lack of career flexibility

Flexible career schemes, for example posts that combine general practice partnership with an ability to undertake other roles within NHS Wales, are highly popular but very rarely supported.

Retainer and return-to-practice schemes

There is a lack of sufficient investment in making GP retainer and returner schemes accessible. The returner programmes are relatively inflexible in duration and content, regardless of the individual situation. They are costly, and the exit criteria often act as a deterrent for some individuals.

Out-of-Hours (OOH)

There has been under investment in OOH services since 2004. This is irreconcilable with Welsh Government commitments to improve unscheduled care. Without adequate investment, it is impossible to attract and retain capacity – particularly at weekends and over public holiday periods.

²¹ BMA Quarterly tracker survey, September 2014

We note that there is no mention of OOH services in the Welsh Government's proposed primary care plan, despite the fact they operate for more hours of the day than in-hours services.

Barriers to recruitment and retention in specific areas

In more deprived areas poor local amenities, smaller practices and a higher workload generated by a disadvantaged population act as disincentives for GPs to work in such areas.²² Current core GP funding arrangements do not properly recognise deprivation.²³

Rurality causes similar recruitment difficulties. Issues in rural areas – such as limited choice of local schools, lack of career options for spouse or wider family members, lack of local amenities – act as disincentives, especially for younger GPs. Rural practices are also threatened by issues over their financial stability related to inadequate resourcing, threats to funding for dispensing practices and the forthcoming phasing out of Minimum Practice Income Guarantee (MPIG) funding.²⁴

Hospital Waiting Times

The shift of work from secondary care to general practice has not been accompanied by resources moving in the same direction. This adversely affects the ability of GPs to do the job, puts services under immense strain, and further damages the morale of GPs.

This is further exacerbated by frustration over long secondary care waiting times, difficulties accessing some diagnostics, inadequate administrative systems within hospitals adding to GP workload (e.g. delayed clinic letters, poor discharge letters, chasing appointments), acute intakes regularly closing and the cancellation of routine surgery meaning that the patient's condition worsens in the interim and more GP appointments are required – often consuming more health resources, particularly around prescribing.

Successive adverse policies

Pension changes, a series of below-inflation pay increases, wide underinvestment (e.g. in premises) and the transfer of more work into primary care have added to the stresses on an already demoralised workforce, and pushed more and more GPs to consider leaving the profession. Government policies on extending GP access are unrealistic and irresponsible; there are not enough GPs to cover even core weekday hours let alone evenings and weekends.

Lack of incentives to work in Wales

There are no 'made in Wales' policies that act to attract GPs to Wales and which make Wales stand out as a positive place to work. We have put forward a number of suggested incentive options to Welsh Government to help address shortages across the medical profession – none of the ideas have, so far, been taken forward.

For Welsh GPs, this is compounded by that fact that they earn less than English counterparts²⁵ which impacts on a GP's decision as to where to work – whilst this is not the only factor affecting recruitment, in light of the higher workload and the other factors noted, it does need to be acknowledged.

Separate medical performers lists

The existence of separate performers lists for England and Wales has a number of detrimental impacts. For instance GPs on the English performers list may not be immediately able to take up vacancies that may exist within practices in Wales. In border areas, having separate lists can prevent GP colleagues in

²² Sibbald, B. (2005) Putting General Practitioners where they are needed: an overview of strategies to correct maldistribution. National Primary Care Research and Development Centre, University of Manchester. Available at:

<http://www.medicine.manchester.ac.uk/primarycare/npcrdc-archive/archive/PublicationDetail.cfm/ID/139.htm>

²³ <http://www.gponline.com/why-gp-funding-linked-deprivation/article/1328431>

²⁴ BMA General Practitioners Committee Wales. 2014. GPCW Chair's speech to the national LMC Conference. Available at: <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales/lmc-conference-speech>

²⁵ HSCIC GP Earnings and Expenses, 2012/13, p6

nearby practices, on either side, from simply being able to cover for each other in the way that might often happen between practices on the same side of the border. In the same way, the separate lists also limit the availability of locums for border practices.

Lack of data

Assessment of the true performance of NHS Wales, and its workforce numbers or requirements, is difficult due to the inadequate availability and reliability of data.

2 - WHETHER THE COMMISSIONING AND DELIVERY OF MEDICAL TRAINING CURRENTLY SUPPORTS A SUSTAINABLE GP WORKFORCE

Improve the attractiveness of training in general practice

In 2014, across the UK only 5559 GP trainee applications were received during the first round of the selection process – the lowest number of applications since 2009.²⁶ General practice has become the least popular specialty, second only to psychiatry.

Unfilled training places are a problem across the UK – in Wales this is exacerbated by the fact that we have the lowest number of Foundation Level 2 (FY2) posts in general practice (24%²⁷ compared to a UK average of 55%). The Department of Health has committed to a 30% increase in training places in England.²⁸

Whilst working to improve the image of general practice in medical schools, GP placements need to attract more doctors into general practice. 670 applicants who applied to general practice last year eventually chose other specialties.²⁹ Improving the attractiveness of training in general practice could include financial incentives, for example, and the provision of high quality accommodation for trainees and their families alongside adequate relocation expenses – this is especially needed in areas that are currently less popular.

The profession, the Welsh Deanery, medical schools and the Welsh Government need to work together to inspire and incentivise these applicants to choose a career in general practice. This will require new investment.

Increase exposure to general practice through foundation year placements

Consideration should be given to making foundation year GP placements mandatory for all doctors in training.

Increase the number of GP specialty trainee places

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, which is not available in Wales, we estimate that Wales needs at least 200 GP specialty trainees each year, there are currently 136 places. The numbers need to be reviewed regularly and against sound evidence/data (currently lacking). If demand on GPs increases at a faster pace than projected, additional measures should be considered. As we have noted, an increase in numbers alone will not solve the recruitment problem.

Ensure lead employer for GP trainees is implemented

This would ensure stability and, for example, would enable access to such things as childcare vouchers and mortgages – as the individual would not be moving employer every six months. It would also enable consistent human resources advice to be given.

²⁶ General Practice National Recruitment Office & HEE MWAG Specialty Recruitment Update, Feb 2014

²⁷ note current 1 year increase to 34% in Wales

²⁸ DoH HEE Mandate 2013

²⁹ General Practice Recruitment Data, HEE, 2014

Support training practices

Consideration should be given to 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 essential. The premises strategy also needs to ensure adequate space for GP training.

Extend GP Training

The RCGP makes a compelling case for extending GP training to four years³⁰ to prepare young doctors for the rigours of modern general practice. We recognise that this proposal would create a 'fallow' year where fewer GPs would exit training, temporarily compounding the already bleak environment of recruitment.

However, the GP specialty training programme needs to be planned to suit the challenges facing a 21st century GP, who is only part clinician, but also manager, commissioner, employer, negotiator, educator and book keeper. Many young GPs cite a lack of readiness as a reason they wish to defer joining partnerships following the completion of their training.

3 - THE ACTIONS NEEDED TO ENSURE THE SUSTAINABILITY OF THE GP WORKFORCE.

Increasing the GP workforce and training numbers should be a priority. However, as noted in the overview section above, we recognise that an increase in workforce numbers in isolation may not deliver better services to patients in the long-run.

In addition to supporting partnership working, we must also embrace new measures and ways of working to ensure the delivery of high quality, personalised and integrated care and to attract and retain GPs.

For instance we believe that a salaried service is valuable for supporting flexible careers and may help to retain doctors at the beginning and end of their careers, and thus plays an important role supporting the mainstream partnership model.

There are a number of measures that can be taken to support the partnership model and to help ensure the sustainability of general practice in Wales. 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 situation is only likely to worsen.

All of these have previously been put to Welsh Government, they include:

- ***Look at new models of care and practice viability, for example:***

- i. Support flexible career and training schemes:

Wales needs to create environments where the new generations of both male and female GPs seeking different ways of working can flourish. Sessions spent in portfolio roles, for example, offers both variety and ways of preventing burnout.

More opportunities for flexibility are needed that combine general practice partnership with an ability to undertake other roles in NHS Wales. For example, where a GP works a certain amount of time in practice and then the rest of their contract time in a mix of out-of-hours work, or work on health board priorities (e.g. audit, network pathways, using or acquiring specialist skills).

³⁰ RCGP, 2012 'Preparing the Future GP: the case for enhanced GP training'

The increase in the proportion of the medical school intake who are women has led to a more equal gender balance in GP training and has changed the composition of the profession – we celebrate the fact that there are more female doctors now than ever before; 48% of doctors on the GP Register in Wales are now female.³¹ However, a dedicated piece of work needs to be commissioned to explore the multifactorial complexities behind why 40% of female GPs in the UK have left the profession by the age of 40.

Doctors in less than full-time training are expected to take at least five years to train, compared to three or four years for the majority of GPs in full-time training. This should be considered in workforce planning since it will reduce the rate of production of trained GPs.

ii. A salaried service

A salaried GP service is the most commonly promoted alternative to the independent contractor model and it remains attractive to some GPs. According to the King's Fund,³² salaried GPs give flexibility, as they often have short-term contracts and do not have the financial commitment of GP partners.

Whilst having an important place in primary care provision, there is little reliable evidence to support the case for wholesale change. Evidence from health boards suggests that a salaried service is more expensive and requires a lot of management involvement.

iii. Encourage federations of practices where appropriate:

This could involve practices making informal arrangements to share staff or work collaboratively on the provision of services to patients, either in individual premises or in jointly-shared premises. It could, of course, also include practices formally merging or joining together.

The GPC UK paper 'Developing General Practice – providing health care solutions for the future' expands on the value and importance of the primary care health team working in collaboration with other health care providers, and the value of collaborative alliances and federations tailored to local population needs.³³

iv. Develop opportunities for collaboration and innovation in primary care:

The expansion of the primary care team with pharmacists, health visitors, district nurses etc. can address some of the workload issues. There is currently a shortage of practice and district nurses, which has a knock on effect on GP workload. The King's Fund report on the future of general practice goes further by suggesting GPs, dentists and optometrists collaborate to create a much larger primary care team.³⁴ However, this is likely to be an option in the medium to long term rather than an immediate one.

GPs are part of a wider primary care workforce – we must ensure that each element is complimentary and presents an effective use of skill mix and, in line with the principles of prudent healthcare,³⁵ does not duplicate or complicate other parts of care pathways or delivery.

The GP Cluster Network also, if properly supported and operational, holds some potential to assist in the area of collaboration, the sharing of innovation and best practice.

v. Introduce an expanding practice allowance:

³¹ GMC State of Medical Education and Practice in the UK, 2014

³² The King's Fund, 2011. Improving the quality of care in general practice: report of an independent enquiry commissioned by the King's Fund. Available at: <http://www.kingsfund.org.uk/publications/improving-quality-care-general-practice>

³³ GPC UK Vision Document. Available at: <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-vision/improving-urgent-and-oo-h-care>

³⁴ Securing the future of general practice: new models of primary care, The King's Fund, July 2013

³⁵ <http://wales.gov.uk/topics/health/nhswales/prudent-healthcare/?lang=en>

Currently practices have to see a significant rise in population numbers in order to have enough funding to take on additional partners. An expanding practice allowance would enable the development of staff and succession planning. It could for instance be paid for 24 months, after which the rising list would self-fund the practice expansion.

- **Measures to retain existing GPs:**

- i. Develop and invest in returner schemes:

Improving return-to-practice schemes should be a key area of consideration with regards to ways in which retention rates in Wales could be improved. It costs around £500K to train a GP³⁶ and around £30K to enable them to return. In addition, returners tend to be committed to the area in which they retrain. No matter how many individuals apply to the returner scheme, there should be sufficient funding available to enable them to return, and they should be supported to do so – in a flexible way if required.

We believe that for individuals who have been working in a country with a similar NHS system and doing general practice work, the 'returner scheme' should be of much shorter duration. We support the recent paper developed by the Welsh Government, the Royal College of General Practitioners (RCGP) Wales, the Wales Deanery and GPC Wales which proposes amendments to the current scheme and is currently with the Health Minister for consideration.

- ii. Develop and invest in retainer schemes

Incentives and flexible working opportunities should be offered to retain older GPs, including perhaps to those approaching retirement age.

This would be designed to avoid performers in exceptional circumstances becoming returners and having to go through the associated formal processes. For example, there is a need to retain and develop GPs who are unable to work full-time for specified and short term reasons.

The Welsh Government must change its funding priorities and provide fully-funded retainer schemes. Work needs to be undertaken to discover why doctors choose to take early retirement or to leave the profession, and at the same time to ascertain if these doctors have any interest in alternative ways of remaining in practice – for example becoming mentors, or moving to part time working or flexible contracts/portfolio roles.

- iii. Provide a full occupational health service

GPs in Wales have access to Health 4 Health Professionals, but there is no complete occupational health and well-being service. It is widely acknowledged that burnout, stress, low morale and risks of mental health illness are becoming increasingly prevalent.³⁷

BMA Cymru Wales has previously called for a comprehensive all-Wales occupational health service to be developed for all NHS employees. Given the significant cost of training a GP it makes complete economic sense to preserve and protect that investment – a comprehensive service is long overdue. It has been over five years since the recommendations of Sir Mansel Aylward'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.

- **Additional enhancements**

³⁶ <http://hee.nhs.uk/2013/05/28/new-education-and-training-measures-to-improve-patient-care/>

³⁷ <http://www.pulsetoday.co.uk/your-practice/battling-burnout/one-in-eight-gps-have-sought-help-for-stress-in-past-year/20003871.article>

Incentives, such as ‘golden handcuffs’, can be very effective in recruiting GPs to certain areas. For example, in exchange for working in an area for a set amount of time, contributions could be made towards student loan repayments, or to training and examination fees. Incentives should especially be considered for rural and more deprived areas. Such schemes also would help efforts towards widening access to medical education.

Wider incentive schemes also need to be considered to increase the number of applicants to GP training places. For example medical schools could be incentivised to increase the proportion of their graduates selecting General Practice (and other shortage specialties) as first choice careers.

- ***Review of Out-of-Hours (OOH) services***

Out of Hours (OOH) services have been underfunded since health boards took over in 2004; this has a serious knock on effect on the whole of unscheduled care. There is an urgent need to review the way in which OOH services are provided – while considering the introduction of the 111 service and ensuring its appropriate use – as in many areas there simply are not enough GPs to fill rosters.

GPs should be more involved in the planning and development of OOH services through strengthened GP clusters working arrangements. 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 (CPD) within OOH work should also be considered.

- ***Capitalise on local commissioning expertise***

GPs need greater involvement (and a stronger voice) in local NHS management and commissioning, but they have limited capacity to engage in this currently given other pressures on workload.

We are very supportive of GP Cluster Networks, but in many areas they are no more than irregular meetings organised by the health board to administer the Quality and Outcomes Framework (QOF). They will only work if they are given adequate resources and real decision-making power.

- ***Leadership***

The management of primary care requires a very different skill set from running hospitals. The specialist nature of this work may not be well suited to delivery by seven small primary care teams based in each health board. We believe that primary care management expertise should be consolidated into a Primary Care Authority for Wales.

Wales would also benefit from the reinstatement of a Primary Care Directorate within Welsh Government. Given the emphasis on primary care in Welsh health policy, the lack of a dedicated director level post in Welsh Government is, in our view, a major oversight.

- ***GP Premises***

There is no obvious funding stream for premises development; responsibility was handed to health boards in 2013 without a budget. A review of the condition of premises is required in order to identify a more affordable way of implementing the 2004 programme of development; it would need to take into account sufficient teaching and learning space. The requirement to sign leases with onerous terms and conditions is also a barrier to young GPs taking on partnerships.

This situation in Wales contrasts greatly with that in England, where £1.25 billion has been identified for investment in premises (£250 million a year for each of five years), meaning that Wales is now significantly lagging behind.

- ***Data availability***

There is a worrying lack of data available on service performance and on workforce numbers and workload – starkly portrayed by the fact that neither Welsh Government, nor Health Boards in Wales, hold data on vacancies.

Chapter seven of the General Practitioners' Committee Wales (GPCW) strategy³⁸ deals with data availability and continuous service improvement. It makes a series of recommendations as to how the paucity of data and evidence gathering can be turned around.

- **Add General Practice to the Migration Advisory Committee (MAC) Shortage Occupation List**

The BMA has submitted evidence to the Migration Advisory Committee (MAC) in support of GPs being included on the shortage occupation list.

The MAC gives considerations to occupations within the UK suffering from workforce shortages on an annual basis. For shortage occupations on the list, individuals from outside of the European Economic Area (EEA) are then able to obtain a short term visa, i.e. two years, to enable them to apply for those vacancies in the UK.

The advantages of inviting non-EEA doctors to fill vacancies are twofold. First, it should alleviate some of the pressure on the overstretched workforce and, secondly, that will enable sufficient numbers of UK/EU GPs to train and qualify in the intervening period.

It is of note that there is a separate shortage occupation list for Scotland; while shortages in Wales and England are contained within the same list (which has the potential to skew specific shortage variations between the two).

- **Retired GPs**

We need to look at avenues to enable retired GPs to return in the event of a major outbreak/emergency situation without having to go through the hurdles of the medical performers' list, GP returner scheme, revalidation etc.

- **Patient Expectations**

Patient's expectations have changed over the last decade, as have the lifestyle factors affecting population health. As individuals we all need to take better responsibility for our health and well-being, and use health services appropriately.

Patients need to be able to access advice as to whether they need to see a health care professional or not; and where the most appropriate place to do so is. There are many advertising campaigns warning patients not to miss symptoms of illness and diseases. These campaigns have been introduced without taking into consideration the need to educate patients on the use of online and other resources to signpost them to relevant services, in line the Welsh Government-backed principles of prudent healthcare.³⁹ Although many patients are beginning to do this, it is poorly advertised at present.

Education (for example on first aid, CPR, and the role of healthy and active lifestyles in warning off a number of illnesses and diseases) should be a compulsory part of the curriculum. The lack of implementation in an effective self-help agenda encourages the inappropriate use of healthcare resources.

CONCLUSION/SUMMARY

³⁸ BMA Cymru Wales 'General Practice – a prescription for a healthy future' 2014. Available at: <http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales>

³⁹ <http://wales.gov.uk/topics/health/nhswales/prudent-healthcare/?lang=en>

We hope the recommendations in this paper, and those contained in our strategy document, will inform the committee's work in this area.

The BMA is currently undertaking a national survey of GP members, covering many of the areas touched upon in this paper – models of working, premises, opening hours, workload, morale, consultation times with patients, and career motivators. We would be happy to share the results for Wales when the survey has concluded.

In representing GPs in Wales, we are wholly committed to working with the Welsh Government, the Wales Deanery, RCGP and others to bring forward lasting change for primary care in Wales.

It is clear that the solution is not a simple turning on of a switch, but a complex, multifactorial change in culture and strategy within the NHS and government, to recognise the clear problem facing us all and to implement action with both immediate and longer-term effects.

A recent BMA survey found that a staggering six in ten GPs in the UK were 'actively considering' leaving the profession.⁴⁰ We are at a watershed moment, and the time to act really is now.

Thank you for the opportunity to respond to this inquiry.

⁴⁰ BMA quarterly tracker survey, Quarter 4, 2014