Public Accounts Committee

Meeting Venue:
Committee Room 3 - Senedd

Meeting date:
10 December 2013

Meeting time:
09:00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:

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Committee Clerk
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Agenda

1 Introductions, apologies and substitutions (09:00)

2 Unscheduled Care: Evidence Session (09:00-09:45)
Dr Mark Poulden - Welsh Chair of the College of Emergency Medicine

3 Unscheduled Care: Evidence Session (09:45-10:30)
Baroness Finlay of Llandaff
Veronica Snow - National Programme lead for end of life care

4 Papers to note (10:30) (Pages 1 - 3)

Health Finances 2012-13 and Beyond: Letter from David Sissling (27 November 2013) (Pages 4 - 11)

Unscheduled Care: Additional information from the BMA (Pages 12 - 29)

Help to Buy - Wales shared equity scheme: Letter from Minister for Housing and Regeneration dated 4 December 2013 (Pages 30 - 31)

5 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business: (10:30)
Item 6

6 Unscheduled Care: Consideration of Evidence Received (10:30-10:40)

7 Ways of working: Consideration of proposals for new ways of working (10:40-11:00) (Pages 32 - 45)

PAC(4)-33-13 (paper 1)
PAC(4)-33-13 (paper 2)

Public Accounts Committee

Meeting Venue:	Committee Room 3 – Senedd
Meeting date:	Tuesday, 3 December 2013
Meeting time:	09:00 – 11:02

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_400000_03_12_2013&t=0&l=en

Concise Minutes:

Assembly Members:	Darren Millar (Chair) Mohammad Asghar (Oscar) AM Mike Hedges Julie Morgan Jenny Rathbone Aled Roberts Jocelyn Davies Sandy Mewies
Witnesses:	Dr Ruth Hussey, Chief Medical Officer Dr Grant Robinson, Aneurin Bevan Health Board David Sissling, Director General for Health and Social Services, Welsh Government
Committee Staff:	Fay Buckle (Clerk) Claire Griffiths (Deputy Clerk) Joanest Jackson (Legal Advisor)

1 Introductions, apologies and substitutions

1. The Chair welcomed the Members to Committee.

2 Unscheduled Care: Response from the Welsh Government

2.1 The Committee questioned David Sissling Director General for Health & Social Services/Chief Executive, NHS Wales, Ruth Hussey, Chief Medical Officer and Dr Grant Robinson, Clinical Lead for Unscheduled Care, Welsh Government on Unscheduled Care.

Action points:

David Sissling agreed to:

- Share the checklist used when auditing primary care
- Investigate further the percentage of GP practices offering appointments after 5pm and their frequency
- Check the definition of 'did not attend'
- Send a note on the timeline of the implementation of the 111 service and provide regular updates on the service
- Send a note on the Deanery figures for GP training

3 Papers to note

3.1 The papers were noted.

3.1 Health Finances 2012-13 and Beyond: Letter from Adam Cairns, Chief Executive of Cardiff and Vale University Health Board (14 November 2013)

4 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:

9.1 The motion was agreed for agenda items 4, 5, 6, 7 & 8 to be discussed in private along with the paper for item 10.

5 Consultant Contract in Wales: Update from the Welsh Government

4.1 The responses were noted and the Auditor General advised Committee that the WAO intends to undertake further work on this issue. The Committee will return to this issue when the results of that work is available.

6 Maternity Services in Wales: Update from the Welsh Government

5.1 Committee noted the further response from the Welsh Government and agreed to share it with the Health and Social Care Committee.

7 Hospital Catering and Patient Nutrition: Update from the Welsh Government

6.1 Committee noted the further response from the Welsh Government and agreed to invite Professor White to Committee to discuss their concerns.

8 Civil Emergencies in Wales: Update from the Welsh Government

7.1 Committee were content with the satisfactory response from the Welsh Government.

9 Capital Investment in Schools: Update from the Welsh Government

8.1 Committee noted the further response from the Welsh Government and agreed to share it with the Children and Young People Committee.

10 Senior Management Pay: Consideration of analysis paper

10.1 Committee noted the draft memorandum from the WAO and that further work is required on the paper before it will be published in the public domain.

10.2 Committee discussed how they wish to focus their work on this inquiry.

Yr Adran Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Cyffredinol • Prif Weithredwr, GIG Cymru

Department for Health and Social Services
Director General • Chief Executive, NHS Wales

Llywodraeth Cymru
Welsh Government

Mr Darren Millar AM
Chair
Public Accounts Committee
National Assembly for Wales
Cardiff Bay
Cardiff
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Our Ref: DS/MS/KF/TLT

27 November 2013

Dear Darren

PAC – Follow up actions from the meeting on 5th November 2013.

I refer to our attendance at the Public Accounts Committee on 5 November. I am pleased to provide further information in respect of:

- Details of the costs incurred by Health Boards for external support with their budget management;
- Details of the Townsend Formula;
- Analysis undertaken on the cancellation of elective procedures during winter 2012/13;

External Support with budget management

In response to questions raised by Committee members we highlighted four organisations which have commissioned external expertise to support and strengthen their planning and financial management arrangements. These are Cardiff and the Vale University Health Board, Powys Teaching Health Board, Hywel Dda Health Board and Betsi Cadwaladr University Health Board.

The work is significant and extensive. It has to be seen in the context of the requirement for the Boards to develop and implement plans which deliver very significant savings whilst maintaining appropriate service standards. The detailed nature of the commissioned support is specific to the requirements of each organisation but generally includes :

- Detailed analysis of underlying financial pressures
- Short, medium and long term modelling of options to contain cost or deliver significant savings

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- Application of relevant benchmarking to ensure the Health Board is pursuing and adopting proven good practice
- Assessment of internal capacity and capabilities for delivery
- Recommendations to enable stronger internal budgetary control arrangements
- Provision of programme and project management support

Generally the approach taken could be described as 'invest to save' with the major work in each case being commissioned through the UK Government Procurement Framework arrangements. These contract arrangements were agreed nationally to secure value for money in the rates charged for such work and to ensure compliance with EU and other procurement requirements. As you will see (Annex 1) the external support procured by each LHB is enabling a wide range of benefits which have value considerably in excess of the costs incurred.

Details of the Townsend Formula

There are a number of reports and reviews that set out the history and development of the formula. I could provide the reports to the committee if required. However I think it is appropriate at this stage to offer the Committee a summary of relevant aspects:

The Townsend model (formula) was originally commissioned by the Assembly in 2000 and it was known as the Direct Needs Allocation formula. In contrast to the more common use "indirect" allocation measures of health (such as age, sex, mortality and deprivation) the Townsend formula used data on reported direct health needs to derive target allocation shares for each Health Board.

In simple terms, the formula determined the target distribution of the NHS revenue allocation between Health Boards in proportion to their population, weighted for their share of direct health need and adjusted to recognise the cost of meeting that need. It was underpinned by the following key principles:

- It measures health need independently of demand and supply;
- It was aimed at allocating resources where need is greatest not utilisation the highest;
- It is relative – it aims to fairly distribute a pre determined total allocation
- It accepts the national pattern of investment between health conditions.

The formula is particularly based on the Welsh Health Survey (WHS) supplemented with data from other sources.

In 2002 the National Assembly agreed that the implementation of the formula would be based on the differential distribution of growth funding to those areas most under target so that no organisation suffered a reduction in their allocation.

Since the creation of the seven Local Health Boards in 2009, questions have been raised as to suitability of the current formula in meeting future needs. A commitment to review the allocation basis was given under the "Together for Health – Financial Regime" commitments. This review will be complex and will take some time to complete. It has

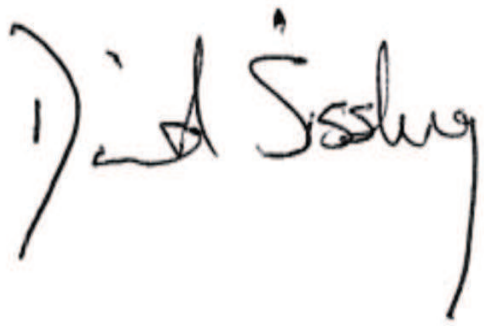
started with a current focus on clarification of objectives, detailed scoping and project establishment. We anticipate the exercise will be completed in 2015.

Analysis undertaken on the postponement of elective procedures during winter 2012/13

During the course of the Committee meeting we described the factors which led to an increased level of postponed elective operations. We highlighted the impact of very harsh prolonged weather conditions and the implications of an increasingly elderly population. An increase in average length of stay for emergency medical patients resulted in a requirement to utilise some surgical bed capacity for patients admitted as emergencies. The increase in lengths of stay occurred to an extent in previous years but was particularly marked in 2012/13. Annex 2 provides an analysis of postponed operations and relevant information regarding length of stay for patients admitted as emergencies.

I trust that the further information provided is helpful.

Yours sincerely



David Sissling

Annex 1

External support obtained by each LHB

Cardiff and Vale University Health Board

The Health Board engaged Ernst and Young (E&Y) in 2 phases. The first in 2012/13 was at a cost of £656k and the second in 2013/14 was at a cost of £781k.

During the course of 2012 the scale of the short and longer term financial challenges facing the Board became apparent. They had achieved financial balance in 2011/12 and 2012/13 but had only done so with significant financial brokerage and non recurrent financial support. They were moreover required to address further substantial cost pressures in future years.

The first phase of the work was commissioned December 2012. E&Y provided the Board with extensive external expertise and capacity to help them address the significant financial challenges the Board faced in 2013/14.

The main benefits from this work were:

- E&Y helped validate the scale of the financial challenges facing the UHB in 2013/14. They worked alongside Clinical Boards, carrying out rigorous analysis and developing options to drive up efficiency and deliver savings. This led to the finalisation of detailed efficiency plans which were owned by budget holders.
- They supported the UHB to deliver these savings by providing significant project management support and advice on the main areas of improvement.
- Their support helped the UHB identify £56.7m savings in 2013/14, equivalent to 5% of their total income. The Health Board is currently delivering this level of savings.

Phase 2 of the work focused on the development of the 3 year integrated business plan. E&Y worked with the Board to identify further efficiency and savings totalling £49m (4.5%) in 2014/15 and £45m (4%) in 2015/16. The main benefits of this work are:

- A three year financial plan developed by the Board which will put the organisation back into recurrent financial balance in 2014/15.
- Very detailed specification of the actions necessary to deliver improved efficiencies and enhanced savings.

In summary, E&Y have helped the organisation embed the savings and improvements necessary to put the organisation back into recurrent financial balance in 2014/15, providing support, advice and material that has identified £150m of savings from 2013/14 to 2015/16.

Powys

Powys commissioned Deloitte's at a cost of £80k to review the underlying financial issues facing the Health Board, assess Board's capability to meet these challenges and recommend further cost reduction and savings programmes.

The final report was produced in September 2013. The main outcomes and benefits are:

- Provision of advice and challenge to the Board on its approach to service and financial planning;
- Provision of analysis regarding the additional scope for savings and cost reduction;
- Specific identification of additional cost reduction opportunities. These total £5.5m over 5 years.

Hywel Dda

Hywel Dda commissioned Ernst & Young (E&Y) in August2013. The total cost of the work is £491k. It is organised into a number of phases.

Phase 1 : Review of Clinical Strategy and Productivity

- Review, challenge and revise the existing clinical service strategy.
- Quantify savings required to achieve recurrent breakeven in 3 year planning framework.
- Introduce additional budgetary, governance and performance management control to ensure in year financial improvement is maximised.
- Assess current efficiency and productivity in key areas and quantify savings which could be made by enhanced productivity.

Phase 2 : Development of Integrated 3 Year Business Plan and Cost Reduction Support

- On the basis of the testing done in phase 1, to identify the future clinical models that need to be in place over the next 3 years. This will acknowledge the specific matters of context e.g. rurality
- Support the production of a 3 year Integrated Business plan. This enables alignment of key service, workforce and financial priorities.

Phase 3 : Further Support to the Development of the 3 Year Integrated Plan

- Support the development of detailed implementation plans with a facilitation of effective internal and external engagement.
- Support the establishment of associated clinical models in key areas – Emergency and Urgent Care, Obstetrics and Paediatrics, Trauma, Orthopaedics and Acute surgery, Speciality Medicine, Integrated Care for the Elderly.

The benefits of the work relating to 2013/14 are already evident. The Health Board is delivering enhanced savings and has more secure budgetary cost management arrangements. The second and third phase are not completed but will result in a 3 year plan with improved levels of savings and enhanced management controls.

Hywel Dda have also commissioned support from MBI Health Group at a cost of £50,000. This support has focused on the provision of advice and recommendation regarding internal performance management, governance, accountability and risk. The areas which have been covered are :

- RTT
- Theatres
- Continuing Health Care

Betsi Cadwaladr

Betsi Cadwaladr commissioned Deloittes at a cost of £288k in August 2013. Their work will cover the following :

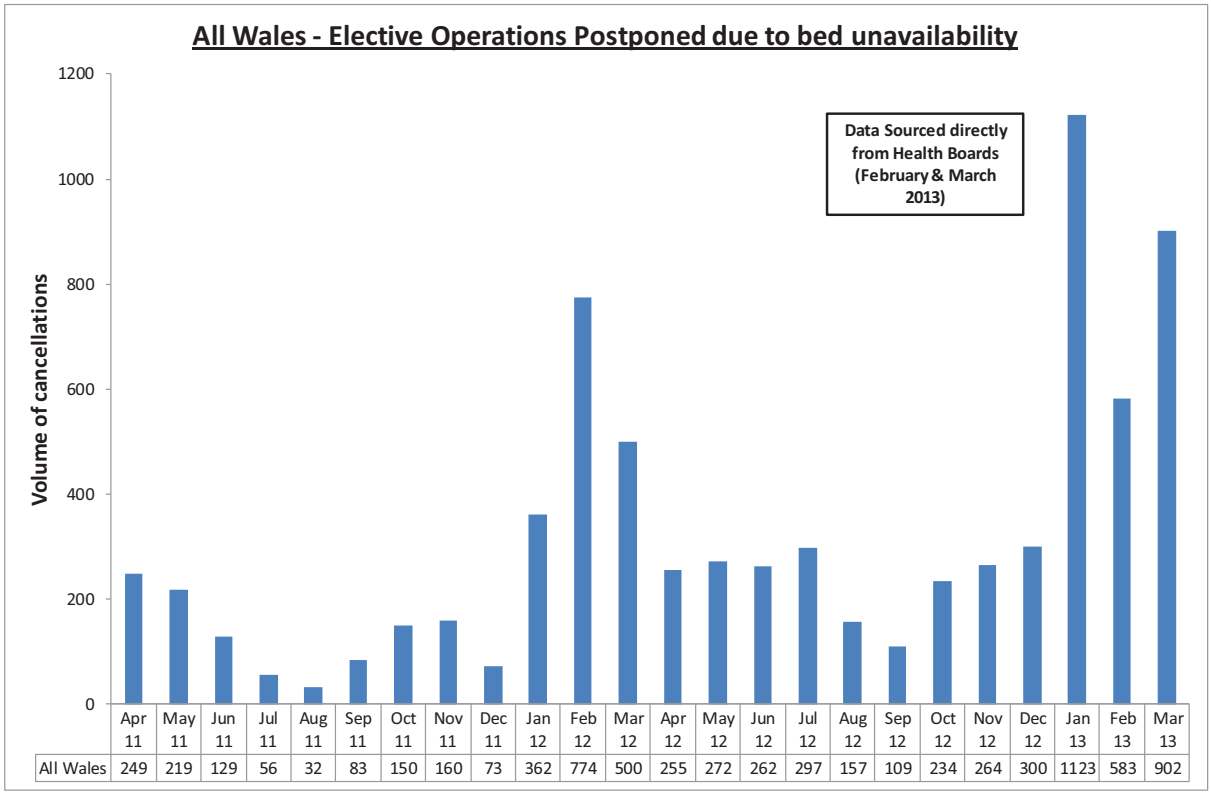
Phase 1

- Review of overall financial plans and risks for 2013/14
- Review specific 2013/14 savings plans for robustness and deliverability
- Assess current financial performance against expectations
- Develop recommendations for further in year savings opportunities

Phase 2

- Review longer term financial plans and support the development of the 3 year integrated delivery plan
- Quantify deliverable savings for next 3 years for each clinical group
- Review clinical pathway proposals to ensure 3 year alignment between demand, service provision and financial aspects
- Develop 'best practice' redesign model for diabetic pathway
- Recommend performance management and delivery support arrangements

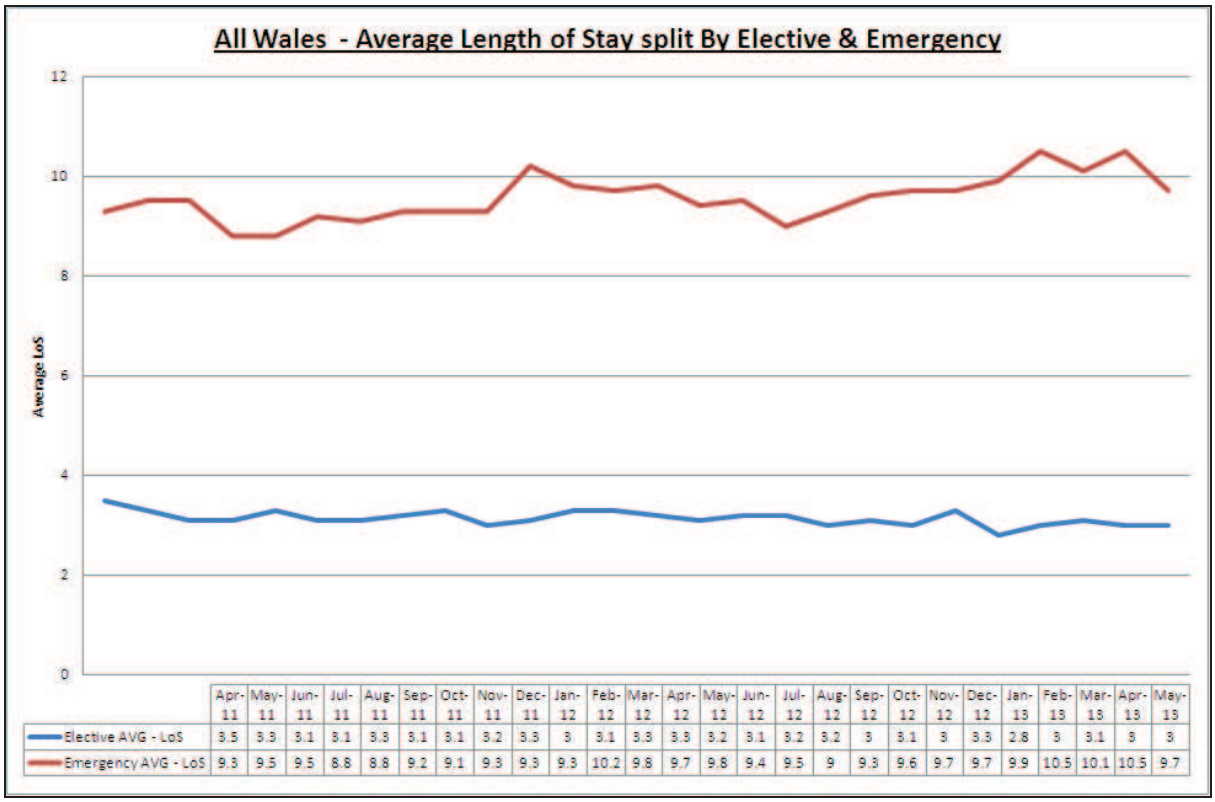
Significant elements of this work have been completed particularly in respect of Phase 1. The benefits are considerable – in year savings programmes have been improved and delivery arrangements have been strengthened.



	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13
All Wales	249	219	129	56	32	83	150	160	73	362	774	500	255	272	262	297	157	109	234	264	300	1123	583	902

Figure 1.

During the final quarter of 2012/13, the average length of stay for emergency patients increased from 9.7 days in December to 10.1 days in March, an increase of 0.4 days. This increased medical bed occupancy by 310 beds, or 29,700 bed days more than the average volumes experienced in the final quarter of previous years.



	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13
Elective AVG - LoS	3.5	3.3	3.1	3.1	3.3	3.1	3.1	3.2	3.3	3	3.1	3.3	3.3	3.2	3.1	3.2	3.2	3	3.1	3	3.3	2.8	3	3.1	3	3
Emergency AVG - LoS	9.3	9.5	9.5	8.8	8.8	9.2	9.1	9.3	9.3	9.3	10.2	9.8	9.7	9.8	9.4	9.5	9	9.3	9.6	9.7	9.7	9.9	10.5	10.1	10.5	9.7

Figure 2.

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BMA CYMRU WALES

General Practitioners Committee (Wales)

Monday 23rd August, 2010

Our Ref: DB/DM

Dear Doctor / practice manager,

Following some negative comments received by LMCs, I felt it would be helpful to write to all Practices again to clarify and contextualise why "sort it in one call" has been proposed by GPC Wales.

The "sort it in one call" policy was fully debated at the most recent GPC Wales meeting in July 2010 and on the GPC list server and all 5 LMC secretariats in Wales were party to those discussions. The adoption of the policy was included in a recent negotiations report to LMCs. However, having reviewed how the actual press release was cascaded to practices, It is clear that the press release went out quite quickly after being sent to LMCs meaning that they did not have enough time to get the press release out to practices. As chairman this was my responsibility and I apologise to those practices that were taken unawares. This lesson has been learnt for the future.

That said, the underlying message that practices should be able to accommodate requests for a consultation at the first contact rather than using a "surgery full" response to limit demand is still I feel a minimum expectation in 2010, in line with GPC UK policy 2009 "Developing General Practice: Listening to Patients" [1] and what both patients and politicians say they expect.

It is not a resource issue as the patients are still seen unless practices are using repeat calls to choke demand. There is no suggestion that practices should increase their appointment numbers (unless they feel they need to) nor does it mean giving an appointment for that date, it is designed to merely enable patients to access an available consultation on request. I am sure you will appreciate the frustration that patients or their carers experience having to ring repeatedly to secure an appointment. In addition, this "sort it in one call" policy is designed to reduce stress on practice reception staff who should experience less dissatisfied and unhappy patients as they will be able to offer an appointment. Thus GPC Wales believes that there are positive benefits for both practices and patient's.

For information, GPC Wales is currently negotiating to try and improve the counting mechanism for PE7 in Wales this year and we believe that a positive position on patient access will help both these negotiations and the coming year's PE7 and QOF scores which will also benefit practices.

We believe that the majority of practices across Wales are offering an appointment on the first phone call and there will be no need for any revisions, but not all do. This campaign is an opportunity for all practices to review their systems to ensure they are patient friendly. Patient bodies and politicians have received this policy warmly as it demonstrates that GP's in Wales are listening to, and responding to what their patients need.

As always, your feedback and comments are always welcome either directly or via LMCs and your opinions and thoughts are valued and essential to the effective working of GPC Wales and the BMA.

Yours sincerely,

Dr. David Bailey
Chairman
General Practitioners Committee (Wales)

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1 http://www.bma.org.uk/employmentandcontracts/independent_contractors/managing_your_practice/listenpatient.jsp

“Sort it in one call”

Senior doctors in Wales are asking all GP practices across the country to ‘sort it in one call’.

The chairman of the BMA’s GP Committee (GPC Wales) Dr David Bailey has written to every practice asking them to resolve the appointment system which is causing wide scale problems to both doctors and patients.

“One of the principal complaints from both the public and politicians to GPC Wales is the continued policy in some GP practices in Wales to open appointments on the day and insist that patients phone in the morning to book and then tell them to phone back the following day once all the appointments are gone.

“This appears to be a legacy of the discredited “Advanced Access” programme and can lead to patients having to phone repeatedly to obtain a single appointment.

“In the opinion of GPC Wales this is no longer acceptable practice in 2010 and we would like to ask all Welsh practices to support a policy of “sort it in one call” for patients ringing for appointments.

“This refers to **requests for appointments only** as this is an activity invariably completed at the reception desk. Patients should be able to ring off with an appointment or instruction on a time to attend for urgent consultation or at least having been given the offer of an appointment in every case.”

Whilst obviously it is still acceptable for practices to set aside quiet times for other patient service activities – chasing correspondence, giving out results etc - the principle function of GPs is to provide healthcare advice and treatment to their registered list.

“We feel that making this process as painless as possible for patients will enhance the standing of general practice, improve patient perceptions of the service being provided and dramatically reduce complaints at a stroke,” added Dr Bailey.

General Practice workforce issues

Overview

There is a need for the GP workforce to be able to respond to the strategic direction and recommendations in "Setting the Direction" and the proposals within the "Local Integrated Care Plan document" and support the current transition towards service provision in primary care and the shift of activity from the secondary sector.
Currently, the size of the workforce means that GPs are really only able to be reactive. With a true increase in numbers, they would be able to be more proactive in service delivery; enable true integrated working; improve access and ensure Welsh Government achieves its high profile objectives.
The need to increase the GP workforce across the UK has been confirmed by Centre for Workforce Intelligence and the Royal College for General Practitioners.

This requires Wales to retain the necessary supply of GPs to;

- Promote practice development.
- Support an increase in the range of services available to patients
- Link to HB, WG and locality priorities
- Secure access to primary care services for patients in Wales by having a supply of GPs in the context of anticipated levels of retirement and the changing demographics of the GP workforce.
- Ensure the risk management and expert generalist skills that GPs have, in the context of an ageing population, and increased co-morbidities is maintained.

GPC Wales continues to highlight concerns around General Practice workforce namely:

- High levels of partnership vacancies across Mid & West Wales and also in North Wales – particularly the Lleyn Peninsula. This situation is likely to be replicated in other parts of works with increasing retirements.
- Partnerships across Wales reporting reduced number of applicants for partnership vacancies
- OOH services identifying fragility of workforce to staff rotas
- Practices across Wales reporting difficulties in finding sessional doctors
- Incomplete recruitment to GP training – the Deanery has capacity to appoint 136 places but due to factors including quality of applicants, trainees being out of programme has meant that it has, for the last few years, not recruited to a full compliment
- VTS programmes reporting difficulties in attracting trainees to programmes outside of urban conurbations
- Concerns about extended GP training – funding not committed, potential shortfall of doctors exiting training with extension
- Potential impact of Shape of Training review
- Concerns about impact of threats to remove MPIG from practices leaving the practice concerned about viability and also affecting the likelihood of new partners choosing to work in a practice with high MPIG

- Barriers to returner programme – non flexible on whole: often fixed to 3 or 6 month duration, COGPED guidance refers to requirement to pass AKT as an exit criteria. Limited number of spaces funded by Welsh Government (currently 5 / annum)
- Other factors affecting workforce generally: feminisation, more doctors wanting to work less than full time irrespective of gender for multitude of reasons: (increasing stress/low morale in workforce meaning more reducing commitment, want to do portfolio working, childcare/caring commitments), pension changes, potential negative impact of revalidation and changes to immigration rules which has impacted negatively on whole of healthcare recruitment.
- Negative impact of having to manage more patients who cannot get hospital treatment quickly enough and the increasing shift left of work from hospital to GP. The lack of recognition or resource moving with this work adversely affects morale of GPs in Wales. This is further exacerbated by frustration over long secondary care waiting times, acute intakes regularly closing and cancellation of routine surgery.
- Some GPs report that the seeming disregard of GP opinion by Health Boards contributes to low morale
- Welsh GPs earn on average 10-15% less than English counterpart which impacts on a GPs decision as to where to work – this is one inequity that is often ignored by WG and Health Boards when considering initiatives to recruit General Practice and whilst it is not the only factor affecting recruitment, it needs to be acknowledged.
- We know that you simply can't replace on a 1:1 basis – it is estimated that for every retiring GP you need 1.6 GPs to replace them
- General Practice across UK being subject to a major negative media onslaught which means that General Practice

GPC Wales appreciates that service reconfiguration, shape of training review and implementation of recommendations might well inform and shape the primary care workforce needs in the medium to long term, but the reality is that there is a very real immediate crisis.

What evidence is there to support the need to increase General Practice numbers?

- **Centre for Workforce Intelligence Report**
  March 2013 – confirmed need to increase GP training numbers, make GP a more attractive career option and demonstrated that an accessible and well-resourced GP workforce is essential if NHS is to deliver good patient outcomes
- **RCGP 2022 report**
- **Keogh report in England**
  The Keogh Report in England implies more GPs in England in order to provide a 7 day a week response to service urgent care. As a result the workforce agency in England has increased the target for training GPs up from 2800 to 3200 per annum. They also say that the number of doctors in training going into general practice should increase to 50%.

- **Annual Workforce survey**
  (http://wales.gov.uk/topics/statistics/headlines/health2013/general-medical-practitioners-2002-2012/?lang=en)
  The Welsh GP workforce declined by 7 last year, it is increasingly elderly and feminisation continues unabated. All these trends spell danger.
- **Older person's Strategy consultation document**
  Birth rates have been falling while increases in life expectancy for men are predicted to rise from 76.4 years in 2004 to 80.3 years in 2024 and for women the rise will be from 80.7 years to 84.0 years in the same period. An increasing proportion of the population will be of pensionable age. In 1917, King George V sent 24 telegrams to congratulate everyone who was celebrating their 100th birthday that year. The tradition has carried on and in 1952, in the first year of her reign, Queen Elizabeth II sent 200 telegrams. In 2007, she sent out 4,623 messages of congratulations, now in the form of birthday cards. On the basis of population projections, it is anticipated that by 2031 nearly 40,000 people living in Britain will be over 100 years of age.
- **Way Forward Symposium 2003**
  Confirmed adverse impact of retirements over 10 years in terms of causing a significant reduction in workforce numbers, range of incentives and career opportunities needed for senior GPs to improve retention of experienced GPs, need to review returner scheme to ensure can incorporate needs of senior GPs, consider appropriate financial / pension incentives to attract and retain senior GPs in difficult to attract areas, need for adequate premises and support for GP teams and identified need for a comprehensive occupational health service.
- **Review of General Practice Recruitment and Retention in Wales 2003**
  Recognised need for adequate capacity within GP workforce, GP being a less attractive career option resulting in shortage of GPs leading to increased workload and worsened demoralisation.
  This report highlighted a number of priorities and solutions for increasing the workforce within 2 years and over 5 years.
  This again confirmed need to consider financial incentives in wider context of ensuring access to education, support, flexibility of career opportunities tailored to needs / wants of individual GPs
- **Numbers of prescriptions issued**
  Welsh GPs issued 73m prescriptions last year and the number has increased by 58% over the last 10 years. As you know this is due to advances in technology, but also to the ageing population. Many of those drugs are complex and need more monitoring. It is not possible to continue doing more with the same number of GPs.

<u>What is value of partnership/independent contractor model over salaried model?</u>

This is very succinctly outlined in the GPC document: "Focus on Taking on new partners – Guidance for GPs" (March 2011), BMJ Careers article Dec 6 2011: "The GP partnerships debate" & 2011 "GP partners more cost effective than salaried GPs"

It must also be noted that directly managed practice using salaried GPs have higher management costs and lower QOF scores. The Starfield research shows that the traditional model of UK independent contractor provided primary care is world class in terms of efficiency. The experience of the Primary Care Support Unit in Cwm Taf clearly demonstrated the value of returning practices to independent contractor status.

What can be done NOW to help ensure the sustainability of General Practice?

I. **Look at new types of models such as**:

- ***Joint / shared GP / HB contracts***:
  This is where GPs work certain % of time in practice and then rest of contract time in mix of OOH work / work on HB priorities (e.g. audit, network pathways) – with agreement of HB this % then changes over period of time to enable succession planning
  This could be linked to research or even to leadership training.
  E.G. a GP works 2 sessions in practice, 2 OOH sessions and 4 doing work for Health Board (e.g. pathwork development, network priority work, clinic/service provision in area of specialty) then Yr's 2-5 as more sessions become available the GP works progressively more sessions in the practice, reducing HB / OOH sessions until succession planning complete with host practice
- ***Encourage federations of practices***
  This could be: practices making informal arrangements to share staff or working collaboratively on provision of services to patients either in individual premises or in jointly shared premises. It could of course include practices formally merging / joining together.
- ***Look at schemes to retain older GPs***
  Look at enhancing / developing new options for retainer schemes where the "retained" older GP mentors new GPs / does some sessions in practice +/- some HB priority work
- ***Retain and develop GPs who are unable to work full-time for specified and short term reasons.***
  This is designed to avoid performers in exceptional circumstances becoming returners and having to go through the formal processes this involves (see below)
- ***Consider a form of new expanding practice allowance***
  This would enable development of staff and succession planning and be paid for say 24 months after which the rising list would self-fund the practice expansion.
  Currently practices have to see a significant rise in population numbers in order to have enough funding to take on additional partners.
- ***Consider possible additional enhancements for difficult to recruit areas***
  Golden handcuffs type system tied to a certain amount of time + / - commitment to an area e.g. interest free loans, contributions towards student loans, contribution to examination fees with post-graduation tie in, provision of childcare vouchers or even better, childcare in surgery, preferential rate mortgages and car loans

II. **Commit monies to returner scheme**
  This would mean that no matter how many apply then there will be monies to enable them to return without difficulty
  It costs around £350-500k to train a GP and around £30k to enable them to return – very cost effective and returners tend to be committed to the area they retrain in

III. **Work on returner scheme requirements**

Currently all potential returners have to go through an assessment process and pass certain criteria to access the scheme – this applies whether you have been out of practice for 20 years OR have been working in a country with a similar NHS system and doing General Practice work – surely latter should be an orientation scheme and of short duration
The programmes are relatively inflexible in duration and content
The exit criteria are a potential deterrent e.g. need to pass AKT / CSA etc.
We appreciate the potential challenges to Deaneries with flexible schemes but believe that robust application of decision making would overcome this and the schemes should be flexible to the needs of the individual doctor

IV. **Commit to funding remediation where appropriate & making it accessible**

Losing GPs to the workforce purely on basis of not being able to access a retraining / advanced practice to support doctor OR doctor not being able to afford the retraining means a significant risk of losing a remediable doctor from the workforce.
Whilst we appreciate that the costs vs. benefits to Health Boards isn't always easy to define or quantify it makes economic sense.
Where it is clear that the doctor is not remediable then we need to be bold and state that.

V. **Take forward lead employer for GP trainees**

This would enable access to childcare vouchers, ease of accessing mortgages etc as not moving employer every 6 months and enable consistent HR advice

VI. **Consider enhancements / inducements for training in rural areas**

e.g. contribution to examination fees / students loans and link it to a "handcuffs" deal where they stay and work in that area for around 5 years say; Possible rural academic fellowship.

VII. **Commit to monies for extended GP training**

The funding needs to be in place. However, consideration should be given to an enhanced trainers grant to recognise the impact that training has on practice work.
The service element of trainees cannot be quantified but is dependent on the individual and often overstated.
Through supplementing the training grant that would enable practices and trainers to spend more time training our future GP workforce whilst having enough resource to backfill this time and investment.

VIII. **Enable / support development of mentorship scheme & full Occupational Health Service**

GPs in Wales have access to Health 4 Health Professionals, Wellbeing at work but no complete Occupational Health Service.
Burnout, stress, low morale and risks of mental health illness has become more prevalent in the primary care workforce over the last 10 years and accelerated of late.

Charlotte Jones

July 2013

Developing General Practice today

Providing healthcare solutions for the future

BMA

Foreword

General practice has been the cornerstone of the NHS since it was formed over 65 years ago. The UK family doctor service is admired around the world – for its equitable, cost effective and leading edge provision of locally accessible, high quality care. Every year in England more than 300 million patient consultations take place in general practice[1]. GPs are generalists who are experts in providing holistic care. They are used to managing complex medical problems and dealing with uncertainty. For most patients, their GP is the first, and sometimes only, point of contact in the NHS.

General practice has never stood still. It has been constantly evolving. Today's GP practices are providers of an expanding and more specialist array of care once only done in hospitals. This means that more patients are able to be treated close to home at their local surgery. Many GPs are also clinical leaders in their communities, helping to shape and develop local services through local commissioning arrangements.

NHS general practice delivers outstanding value for money. The quality and standards of care provided by UK GPs are well recognised internationally, as well as by patients who consistently report high satisfaction levels with the services proved by general practice[2]. The success of NHS general practice has contributed to more of our patients living longer and being able to live with more complex long-term conditions.

In this paper, we bring together our case for general practice, the ways in which it can help provide solutions to some of the most difficult challenges the NHS faces, and how general practice needs to be supported and developed to achieve its full potential. Our vision is that with adequate support and development, general practice can be enabled to be at the forefront of the transformation that the NHS needs, and with a compelling economic argument that investment in general practice will be key to delivering the cost efficiencies required for a sustainable future NHS.

This document draws on existing policy as well as the experiences and views of the BMA General Practitioners Committee and our wider membership. We hope it will be useful for GPs, policy makers and other NHS stakeholders. We will explore the key ideas further in a series of discussion papers and events over the coming months.

We would welcome your views about the important issues we have raised; together we can make the greatness of general practice even greater.

Dr Chaand Nagpaul
Chairman, General Practitioners Committee

1 https://www.gov.uk/government/speeches/primary-care-and-the-modern-family-doctor
2 https://www.gov.uk/government/publications/results-of-gp-patient-survey

General Practice – Building on a Solid Foundation

In spite of the many challenges ahead, general practice remains one of the UK's most important and valued public services.[3] It manages a huge and increasing workload with more than 300 million people being seen and treated by GPs and practice nurses every year. UK general practice is recognised throughout the world as one of the most cost-effective, high quality means to deliver care.[4]

The model of general practice in the UK has remained remarkably stable since the inception of the NHS in 1948, despite the very many ways in which GPs have adapted to the huge changes that have happened to society and technology during that time.

GPs have successfully developed and changed but based on a solid foundation of core values: to consider patients as people, to help them manage their health through life and their interactions with the NHS and provide high-quality generalist medical care.

Although general practice always needs to evolve it has five clear strengths that underpin its success and which should be built upon for the future.

Continuity and co-ordination of care

Everyone living in the UK is encouraged to register with a local GP practice. GP practices have long term contracts to provide a broad range of primary care for patients living in their community who are on their registered list. As such, many individuals and families remain registered with and have continuity of care provided by the same GP practice over generations – and those individuals may often see the same GP over many years. GPs get to know children as they grow up and adults as they grow into old age. They not only know their patients' medical histories, but also their social context, personalities and preferences – and the greater the knowledge of the individual they have, the more tailored their advice and care can be. General practices are also a central part of the local community. In the UK, 99 per cent of the population is registered with a GP practice. In the United States, it is just 17 per cent. As part of the GP contract, general practices are also responsible for overseeing the long term care of their patients, co-coordinating care and acting as the lynchpin for patients with long term conditions or multiple health problems who may have to see multiple health and social care professionals.[5]

Patient advocacy

GPs are usually members of the communities they serve and are often the first and only port of call for patients seeking health and social care advice. They have a freedom and a responsibility to advocate for their patients across occupational, medical and social care sectors. GPs are an integral part of the NHS family, but the fact that practices operate as independent contractors enables GPs to advocate strongly on behalf of their individual patients as well as for the health needs of their local communities as a whole. It is why patients trust their GP so highly, because they know that they are on their side.

3 https://www.gov.uk/government/publications/results-of-gp-patient-survey
4 A survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs and Experiences. Schoen, Osborn,Doty,Squires,Peugh,Applebaum, The Commonwealth Fund 2009
5 Macinko J, Starfield B, Shi L. Is primary care effective? Quantifying the health benefits of primary care physician supply in the United States. International Journal of Health Services 2007

Flexibility and innovation

GPs as independent contractors also retain a degree of flexibility within the system that allows practices to implement imaginative solutions quickly to meet the needs of their patients. GPs have led generalist care advances in many areas including commissioning and delivering community services, innovating IT solutions and leading collaborative care for their patients.

Holistic and preventative care

As GPs are responsible for the ongoing care of all patients on their list, they deliver a whole person approach. GPs are expert generalists, taking into account their patients' physical, psychological and social needs, helping patients to reduce risk and manage uncertainty, and connecting patients with more specialist support when necessary. This model in particular optimises the management of long-term conditions and co-morbidities. GPs also successfully deliver national public health preventive programmes such as annual influenza immunisations, cervical cytology and child health surveillance. Everyone living in the UK is encouraged to register so that GPs have sight of whole populations, not just individuals who need active care.

Coordinating efficient use of NHS resources

GPs are generally the first point of contact for NHS patients. An individual usually needs to see his or her GP to secure a referral to specialist hospital care or community health services, if required. In this way, GPs ensure patients are referred to the most appropriate specialist care, making responsible use of NHS resources and having a crucial role in the sustainability of the future NHS. GPs play a vital role in helping patients understand their care options – whether self-care, low-level support or more specialist care – and so match the needs of patients to the most appropriate service. In making these decisions repeatedly every day, GPs are experts in managing risk and are skilled at identifying the serious and rare from the many more common clinical presentations that can be safely managed in primary care.

General Practice – challenges now and in the future

An immediate crisis – workload, morale and workforce pressures

More than ever before, general practice is under severe pressure. The latest national GP worklife survey funded by the Department of Health[6] revealed the lowest levels of job satisfaction amongst GPs since before the introduction of the new GP contract in 2004, the highest levels of stress since the start of the survey series in 1998, and a substantial increase over the last two years in the proportion of GPs intending to quit direct patient care within the next five years.

The single biggest issue is the increase in demand and workload without a comparable increase in resources. In England, over 300 million consultations took place in general practice in 2009, over 80 million more than in 1995.[7] The average member of the public now sees a GP almost six times every year – twice as much as a decade ago. The average time a GP spends with each patient is now just under 12 minutes compared with just over eight minutes in 1993, highlighting the increasing complexity of managing more long-term conditions that patients are living with.[8]

6 Seventh national GP worklife survey: http://www.population-health.manchester.ac.uk/healtheconomics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf
7 Health and Social Care Information Centre, Trends in consultation rates in general practice, 2 September 2009
8 Health and Social Care Information Centre, Trends in consultation rates in general practice, 2 September 2009

A rising workload without an expansion in the workforce to be able to respond appropriately impacts directly on access, quality and the ability to innovate. An analysis by the Centre for Workforce Intelligence[9] concluded that the increased demand for GP services points to a workforce under considerable strain and with insufficient capacity to meet expected patient needs. There is a clear need to substantially lift workforce numbers to more sustainable levels. However junior doctors are not choosing general practice as a career choice in anything like enough numbers to meet the expected workforce needs[10].

The Government's imposed changes to the GP contract in April 2013 have only added to workload and further undermined morale. The largest survey of GP opinion since changes to the contract were imposed, published by the BMA in September 2013, found that 97 per cent have seen bureaucracy and box ticking increase in the past year[11]. The use of targets within the GP contract has expanded to create clinically dubious, one-size-fits-all incentives and a huge volume of box-ticking, with nine out of 10 GPs stating this had taken them away from spending time on attending to patients needs, and 82% of GPs reporting that such target chasing had reduced routine available appointments to patients. It is not surprising therefore that 86% of GPs report their morale worse this year than last.

Austerity and efficiency savings

The economic crisis is putting all parts of the UK, both public and private sectors, under unprecedented financial pressure, and the NHS is no exception. Between now and 2020, it is estimated that the NHS in England alone must make efficiencies of £30 billion. However general practice has to face this future challenge following years of under-investment which has led to the current crisis we face.

Spending on GP services increased by 10.2% between 2006/07 and 2010/11 – compared to a 41.9% increase in spending on hospital services – but practice expenses have been rising faster. The proportion of NHS funding supporting general practice in England has fallen from 10.4% in 2005/6 to 7.47% in 2012/13.[13]

A growing and ageing population with more complex health needs

The UK population is increasing and at 63.7 million is at its highest ever. Not only does this mean that there are more people in absolute terms for general practice to care for this increase is likely to continue as last year, over 813,000 babies were born, which was the highest number for 40 years.

The UK is also growing older. Over the last 50 years, the average life span has increased by 10 years for a man and eight years for a woman. Older people are more likely to live with a health condition and often more than one. By 2021, more than one million people are predicted to be living with dementia and by 2030 three million people will be living with or beyond cancer. By 2035 there are expected to be an additional 550,000 cases of diabetes and 400,000 additional cases of heart disease in England. The number of people with multiple long-term conditions is set to grow from 1.9 to 2.9 million from 2008 to 2018.

As the number of people with long-term conditions increases, so too will demand on GPs: although patients with long-term conditions account for around 29% of the population, they make up 50% of all GP appointments.

9 http://www.cfwi.org.uk/publications/how-could-the-community-workforce-alleviate-some-of-the-pressure-on-general-practitioners-and-improve-joint-working-across-primary-and-community-care
10 http://www.bma.org.uk/cohortstudy
11 http://bma.org.uk/working-for-change/negotiating-for-the-profession/general-practitioners-committee/gp-workload-survey-chaand-letter
12 Source: HM Treasury Public Expenditure Statistical Analysis 2013, 2012, 2011, 2010: total DEL (resource + capital)

Changing patterns of care – moving care closer to home

Changing population demographics mean that current models of healthcare are rapidly becoming outdated. Health reform is focused on moving care closer to home, delivering more services in community settings and encouraging closer collaboration between providers. The movement of care "out of hospital" is a policy driver in all devolved nations in the UK, augmented by an economic argument of reducing the greater expense of hospitalisation.

This shift of care from secondary to primary and community settings must logically be accompanied by a commensurate investment in General Practice. Yet, as highlighted earlier, the reality has been a reduction in the proportion of overall NHS funding spent on general practice. This trend is unsustainable and is at the root of the current workload and workforce pressures experienced by GPs and their staff.

In many areas, commissioners are undertaking wide ranging reviews of current acute providers with a view to reconfiguring services; a particularly challenging task in the context of enormous financial pressures on health service budgets and the requirement for commissioners to find year on year efficiency savings.

Unless there is increased capacity in general practice, primary care and community settings to absorb this transfer of care out of hospitals, the quality of care for patients will suffer, and with adverse effects.

Health system reform

The Health and Social Care Act (2012) radically reformed health structures in England. The new commissioning structures pose challenges to general practices both as providers and to GPs in their new role as commissioners. The reforms were extensive and the transition timescales far too hurried. Area Teams have far fewer staff and resources than their predecessor PCTs. As a result, the support practices may need to help with development is often absent. With many more organisations to work with practices are struggling to build productive relationships in a more complex and at times fragmented new system.

Practices are also the constituent members of CCGs, which have responsibility for commissioning secondary care services. This new role in commissioning places extra demands on already work saturated general practices and many are struggling to find the time to get involved with their CCG.[13]

The Act also promotes competition and plurality of provision as a lever to improve quality of services. The evidence for the effectiveness of competition in health is limited, yet in the meantime, commissioners are now required to move services out to competitive tender. General practices find themselves in competition with large scale, corporate entities and many lack the commercial expertise to bid in complex and costly procurement processes. These procurement and tendering processes risk destabilising existing services by salami slicing elements of care currently delivered by local practices, so reducing the comprehensive, cost effective, high quality care a single practice can provide to a population.

The huge upheaval of constant NHS reform and regulatory change has left GPs and practices anxious and uncertain about the future. Time is needed for the new structures and procedures to bed in without more top down management and imposition, or there is a risk of stifling innovation and further demoralizing the profession, both of which will have a negative effect on patient care.

13 BMA GPC Survey of GP Workload September 2013, available at: http://bma.org.uk/working-for-change/negotiating-for-the-profession/general-practitioners-committee/gp-workload-survey

Changing patient and public expectations

Public satisfaction with the NHS and with general practice, in particular, remains very high. However, there is much variation in what patients want in terms of access, for example in terms of the trade-off between immediate access and the desire to see a named GP, as well as that between austerity in the NHS and affordability for extended access and services.

Patients and public also want more information about health and about their care. Many wish more involvement and engagement, from determining individual care plans through to shaping local services. The report of the Francis Inquiry stressed the importance of public and patient engagement and highlighted what can go wrong when this is not achieved.

General Practice – providing solutions for the future

We believe that a properly developed and supported general practice will be fundamental to providing real solutions to the significant challenges facing the NHS. In particular the cost effectiveness of general practice and its ability in turn to release cost efficiencies in the whole system will be key to enabling the NHS to be sustainable within an increasingly challenging financial environment.

Four important areas include:

1. More integrated care, closer to home, delivered by a team built around the GP practice

GPs as expert generalists build longstanding relationships with their patients and local communities. They are key to developing services that support the growing number of patients with multiple, complex, long-term health problems and helping them manage their conditions at home and in the community with support from the right specialists at the right times.

To develop this further there is a need to:

a) Expand the infrastructure of general practice and primary care within an integrated approach

Enablers to achieve this include:

- Increasing the numbers of GPs, practice and community nurses, to provide an accessible, high quality, comprehensive service across all communities.
- Community health care teams built around GP practices. Collaborative working across localities with practices either singly or collectively employing or directly managing community nurses who, working together with practice nurses, will provide a seamless and more flexible nursing service for patients in the community.
- Secondary care clinicians and GPs working collaboratively to design and provide care pathways for local health economies, bringing more diagnostics and specialist care out of hospital and into community settings, including hospital-based specialists visiting nursing and residential homes and working alongside GPs in practices when appropriate.
- Patients with long-term and complex needs should be jointly managed through an integrated team in line with a single care plan led by the most appropriate named clinician. This would require a much greater alignment of incentives and funding streams between general practices and hospital and community service providers.
- Specialists given the opportunity to collaborate with and to support primary care, such as in general medicine, elderly care, mental health and paediatrics, acting as a specialist resource across localities to optimise patients' complex health needs and help to prevent unnecessary hospital attendances and admissions.
- A shift to community based care with more doctors and nurses in the NHS working in general practices and community settings or having had experience of working in such settings.
- Joint training and education for GPs and secondary care clinicians.
- Greater collaboration between community pharmacists and practices with a practice-aligned pharmacist undertaking medicines management and other elements of chronic disease management.
- Greater collaboration between practices and social care services, with named social workers or team leaders aligned to every practice and regularly attending multidisciplinary meetings.
- Citizens Advice Bureau and other advice and social support services to be sited in or linked to specific practices to ensure a comprehensive service is available across a community.
- Expand and develop practice premises to allow for delivering increased care in the community, including space for teaching, training and research.

b) Enhance proactive and personalised care for vulnerable patients and those with complex or multiple long-term conditions.

Enablers to achieve this include:

- Proactive case management with GPs leading the coordination of care, within a multidisciplinary and multiagency approach. Whilst GPs should lead this process, day-to-day coordination and delivery of care would often be by other members of the extended practice-based team.

- Longer consultation times so GPs can fully meet the needs of their patients who are living with many and increasingly complex long-term conditions, so providing increased personalised care for each and every patient who needs it.

- Empowering patients and their carers to develop their knowledge, skills and confidence to become active partners in their health care.

- Using one clinical electronic record by all members of the extended practice team.

- Sharing electronic care records (with requisite consent and information governance standards) with other providers of care to optimise personalised care in the community

c) Reduce the need for hospital admission and attendance

Enablers to achieve this include:

- CCGs commissioning with the intention of achieving a "whole system" approach with aligned incentives between different providers, reforming the current divisive tariff payment system and removing counter-productive targets such as crude A&E waiting times.

- A more effective, responsive integrated urgent care system (see below) that avoids the need for patients to be admitted to hospital.

- Practices providing timely access e.g. via a dedicated telephone number or line to enable services managing patients in emergency situations to be able to promptly seek advice that may avoid a transfer to hospital

- For those patients who would benefit, having one single, simple, short and clear care plan so that all those who might provide care in emergency situations are aware of the patient's condition, needs and wishes

- Expand the availability of short-term nursing or residential home beds that can be immediately available for patients who would otherwise require admission to hospital

2. Improving urgent and out of hours care services

Urgent care day and night on every day of the year is provided by GPs, either through their practices or via GP out-of-hours (OOH) organisations covering their practice area. Just as practices have been coping with an increased workload with reduced resources, similarly GP OOH organisations have had similar pressures. Improvements can be made so optimising access to appropriate urgent care in and out-of-hours and enhancing self-management.

Enablers to achieve this include:

- Clinical commissioning groups commissioning integrated models of out-of-hours care, bringing together community nursing, social care, walk-in-centres, pharmacy, OOH general practice organisations, NHS 111 services, minor injury units, ambulance services and hospital emergency services so providing a joined up and consistent approach to urgent care.

- High quality first point of contact urgent care telephone triage, led by clinicians rather than relying solely on computer algorithms allowing a presenting problem to be managed in the most efficient and cost effective way.

- Removing the compulsion for competitive tendering from the provision of urgent and unscheduled care, thus enabling commissioners to select the best option in the interest of patient safety and the efficient use of NHS resource.

- Awarding contracts based on a provider's existing experience and expertise in successfully delivering safe, high quality OOH care.

- Lift A&E minor attendances out of PbR and tariff arrangements and give CCGs the responsiblility and the budget for commissioning an integrated community and hospital service for unscheduled care.

- Ensuring consistent health and wellbeing messages to patients through better co-ordination of information materials provided by different parts of the NHS to ensure appropriate use of urgent care services.

- Setting a minimum clinical staff/population ratio for OOH organisations.

- Enabling patients to access to their Summary Care Record and providing better access of clinical information for OOH providers to improve standards and continuity of care.

- Improving the quality of clinical information and reducing the length of primary post event messages passed on to general practice providers by NHS 111 and after each and every attendance at A&E.

- GP practices to be more closely involved in monitoring the quality of care provided by OOH providers and CCGs to act on the concerns raised by practices

3. Improved accessibility and local accountability

Workload and workforce pressures have made it more difficult to maintain the levels of accessibility and quality of care GPs want to be able to deliver and know their patients need.

Enablers to achieve this include:

- GPs working in larger practices and/or across groups of practices in collaborative alliances or federations. Practices should be supported to maintain their unique identity and relationship with their patients whilst working together with others to share "back office" functions, organisational learning and standards as appropriate.

- Collaborating with other practices to provide extended hours surgeries at a range of

different times across a community.

- Offering more alternatives to a face-to-face consultation when clinically appropriate, such as dedicated telephone and/or Skype-like surgeries

- Clinicians meeting in larger groups for peer-group learning, sharing ideas and reviewing the clinical care offered to patients in their community to improve performance and consistency.

- GP practices providing more meaningful information about their services and the quality of care they provide, than is currently provided on the NHS Choices website, taking in to account the context of the community they serve.

- Encouraging GPs to build on their role as patient advocates by challenging and reporting on poor care provided by local health or social care providers.

4. Empowering patients as partners

Too often in recent years policies have been introduced that have disempowered patients rather than empowering them. Patients have a key role to play as partners in both supporting the development of general practice and in ensuring the sustainability of the NHS as a whole

Enablers to achieve this include:

- Strengthening patients' input to the organisation and delivery of their general practice services though the development of practice-based patient participation groups.

- Increasing the local patient voice within clinical commissioning group decision making.

- Investing in public education campaigns and better health education, particularly as part of the school curriculum

- Empowering patients to self-care where appropriate, avoiding the inconvenience of unnecessarily accessing healthcare services. This could be via consistent information that is easily available through, for example electronic kiosks in public places, including in health care settings, and via accredited websites.

- Greater involvement of patients as partners, providing longer consultation times where appropriate, in order to share in decisions and management of their care including the co-creation of care plans when appropriate.

General Practice – Turning Solutions into Reality

Government, policy makers and commissioners must now commit to long-term investment in general practice if it is to be in a position to deliver these much needed solutions. This investment will enable the essential building blocks to be put in place that will underpin the successful delivery of change and development in general practice and for the NHS as a whole.

General practice can be supported and enabled by:

1. Sustained and increased funding

Unfortunately, general practice has seen a progressive reduction in its proportion of NHS spend in recent years. We propose that Government sets a target for NHS England to invest in a year on year increase in the proportion of funding in to general practice.

The table below shows the year on year decrease in the proportion of NHS funding invested in general practice in England.

Year	% total investment	% investment excluding dispensed drugs
2004/5	10.00%	N/A
2005/6	10.41%	N/A
2006/7	9.83%	N/A
2007/8	9.17%	N/A
2008/9	8.74%	8.04%
2009/10	8.45%	7.81%
2010/11	8.31%	7.68%
2011/12	8.16%	7.56%
2012/13	8.04%	7.47%

Patient care should be built around their needs for integrated pathways that break down the current barriers between acute care, general practice and community services. Where this involves service reconfiguration then the accepted good principles governing reconfiguration must always apply, principally the need to be based on evidence and supported by a clinical consensus.

2. Expand recruitment and better retention

A greater public commitment towards general practice from the Government downwards, alongside promoting it as a rewarding career choice and dealing with issues that undermine the morale of the existing workforce, would go some way to addressing the impending GP recruitment and retention crisis.

Enablers to achieve this include:

- Expansion of the general practice workforce through increased long-term core funding.
- Greater contract stability to enable practices to invest in an expanded workforce
- Creating long-term incentives to expand partnerships.
- Investing in initiatives to support GP returners back to work.
- Removing barriers and providing support for fully qualified GPs who wish to return to working in the UK.
- Funding innovative schemes such as the Flexible Career Scheme to encourage practices to expand substantive GP posts.
- Providing long-term support for practices in under doctored areas to take on additional staff, so working to reduce health inequalities.
- Providing an NHS occupational health service to support all practice staff.
- Ensuring GP involvement in management and leadership roles is fully resourced to enable full clinical back-fill arrangements in practices.
- Supporting career development with a clearly defined post-graduate training allowance.
- Lengthening GP training to a fully-funded five years with a much greater proportion of time training based in general practice.
- Recognising general practice as a specialty in European law to enhance its credibility as a specialty and to ensure that training meets required standards.
- Enhancing the GP trainer grant and providing a supplement to encourage more trainers in under-doctored areas.
- Supporting GPs to enhance their skills or develop additional special clinical interests.
- Providing a training grant to support practice nurse training.
- Developing a practice nurse training curriculum to promote general practice nursing as an attractive career choice.
- Providing protected learning time for peer review and joint learning.

- Supporting practice manager development and training.
- Greater practice management and financial training as a core component in GP training, to help produce enough GPs with the skills necessary to take on the role of being a GP partner.

3. Premises fit for the future

Investment must be made in better community-based premises if we are to deliver the necessary changes described above. Many premises are sub-standard and not fit for purpose, making the possibility of providing more services in the community extremely difficult.

Enablers to achieve this include:

- A 10 year rolling programme to ensure all practices that require it have a purpose-built surgery, working with NHS bodies, Local Authorities and third-party developers where necessary.
- Creating a general practice premises development fund to support new developments such as primary care hubs providing expanded diagnostics and services in the community for networks of practices, and the expansion of existing premises.
- Practices working together in collaborative alliances, federations or larger practices to make the best use of their available premises to enable a wider range of high quality out-of-hospital services to be located in a complimentary way within a defined community, whilst also ensuring patients retain local access close to their homes.
- Guaranteeing the reimbursement of premises running costs, as specified under the Premises Costs Directions 2013, to give GPs the confidence to move to new developments or significantly refurbish existing premises.

General Practice – Providing healthcare solutions for the future

The increasing financial problems facing the NHS means the pressure to make radical changes in order to deliver effective quality care in the future can no longer be delayed. The crisis of capacity versus demand is not new and neither can it be solved quickly or easily. Investment in workforce and premises will take time to deliver. However a commitment to developing general practice must be made **now** so that these longer term issues can start to be addressed.

General practice should be supported and enabled to evolve in order to meet our patients' needs and that of the NHS. It does not need a central one-size-fits-all destabilising approach nor being forced into change for the sake of changes sake. Instead we must see a new strategic focus towards supporting general practice, encouraging and allowing it to develop based around the needs of their patients and communities.

General practice has always been a sure foundation on which the NHS has been built. With more GPs, spending more time with their patients, working in bigger and more comprehensive teams built around the practice, based in better quality premises and underpinned by a fairer share of NHS resources, general practice can deliver the healthcare solutions for the future. Now more than ever, general practice is offering solutions which will enable the whole NHS to remain sustainable and successful.

Appendix

A few facts about general practice

There are almost 43,000 GPs in the UK – 35,415 in England, 4,287 in Scotland, 2,022 in Wales, and 1,163 in Northern Ireland.[1]

They work mainly from over 10,000 GP practices – 8,316 in England, 1,002 in Scotland, 483 in Wales and 353 in Northern Ireland.[2]

In England, over 300 million consultations take place in general practice every year – almost ten every second – and over 80 million more each year than took place in 1995.[3]

The average time a GP spends with each patient is almost 12 minutes – up from just over eight minutes twenty years ago.[4]

Each GP practice takes between 30 and 50 calls from patients every day.[5]

The average member of the public sees a GP almost six times every year. – twice as much as a decade ago. On average an older person sees their GP over once every month.[6]

Almost 87% of patients rate their experience of GP services as good or very good.[7]

In England in 2012-13, expenditure on GP services accounted for £7.8 billion. Expenditure on secondary care – largely hospitals – was over £70 billion.[8]

Spending on GP services increased by 10.2% between 2006-07 and 2010-11 – compared to a 41.9% increase in spending on hospital services.[9]

19 out of every 20 consultations taking place in general practice are dealt within primary care alone – rather than in hospital or elsewhere in the NHS.[10]

Studies from the US suggest that an increase of just one GP per 10,000 population is associated with a reduction in deaths rates of over 5 per cent.[11]

1 Health and Social Care Information Centre, General practice trends in the UK, 23 January 2013

2 Health and Social Care Information Centre, General practice trends in the UK, 23 January 2013

3 Health and Social Care Information Centre, Trends in consultation rates in general practice, 2 September 2009

4 Health and Social Care Information Centre, Trends in consultation rates in general practice, 2 September 2009

5 Royal College of General Practitioners, The 2022 GP, Compendium of evidence, 17 September 2012

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Carl Sargeant AC / AM
Y Gweinidog Tai ac Adfywio
Minister for Housing and Regeneration

Llywodraeth Cymru
Welsh Government

Ein cyf / Our ref: MB/CS/567013

Darren Millar AM
Chair, Public Accounts Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

04th December 2013

Dear Darren,

Help to Buy - Wales Shared Equity Scheme

In your role as the Chair of the PAC, I am conscious of the need to keep you abreast of any significant announcements made under my portfolio and the financial implications of such initiatives.

As such, I'm writing to inform you that last week I announced the launch of Help to Buy – Wales, a new shared equity loan scheme.

The £170 million scheme will increase the supply of housing in Wales by supporting home ownership and stimulating building activity, giving a welcome boost to the housing sector.

Builders who wish to participate in Help to Buy – Wales can now register with the scheme in preparation for the first shared equity loans to be made available from 2 January 2014. The scheme will end on 31 March 2016.

The scheme itself will give potential buyers access to a Welsh Government shared equity loan of between 10% to 20% of the purchase price of their desired new-build property.

If you wish to know more about Help to Buy – Wales, please get in contact or visit the scheme website:
www.helptobuywales.co.uk.

Bae Caerdydd • Cardiff Bay
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English Enquiry Line 0845 010 3300
Llinell Ymholiadau Cymraeg 0845 010 4400
Correspondence.Carl.Sargeant@wales.gsi.gov.uk

Yours sincerely,

Carl Sargeant AC / AM
Y Gweinidog Tai ac Adfywio
Minister for Housing and Regeneration

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