Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar dyfodol ymarfer cyffredinol yng Nghymru

This response was submitted to the Health and Social Care Committee consultation on the future of general practice in Wales

GP22: Ymateb gan: Meddygon yn Unite - Cymru | Response from: Doctors in Unite - Cymru

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SUBMISSION TO SENEDD HEALTH AND SOCIAL CARE COMMITTEE

Inquiry into the future of general practice in Wales

Over two decades ago The Review of Health and Social Care in Wales (Wanless Review 2003) recommended that there needed to be a greater emphasis on prevention and early intervention to ensure that the health and care service in Wales would be able to meet future demands. It noted that the primary care service at that time required considerable development to fulfil its enhanced role in addressing that agenda.

Since there have been several changes and events which have affected how health and social care are delivered in Wales. Virtually all staff have been subject to new contractual arrangements, the Internal Market in health in Wales has been abolished and there has been a significant increase in investment up to 2010 and followed by a period of Austerity which may just be coming to an end. Over that time the levels of patient satisfaction with the service went from a peak in 2010 to a record low in recent years – very much paralleling the inadequate investment levels.

And yet at the end of all of this, can we say that the transformative change that Wanless outlined has been achieved and that our health and care services are on a more sustainable footing? The 2018 report of the Parliamentary Review of Health and Social Care in Wales and the Wales Audit Office report on Primary Care suggested not. Indeed, it would not be far off the mark to say the Welsh Government's current health and social care strategies, with some contextual tweaks for the Covid pandemic and a dozen years of Austerity, could be read as a response to the Wanless Review recommendations as much as to the Parliamentary Review.

Doctors in Unite (Cymru) broadly support the recommendation of the Wanless and Parliamentary Reviews. We believe that a sustainable NHS and social care service needs to be based on a strong and vibrant primary and community health service linked to strong and vibrant social care.

A Healthier Wales (2018) envisaged that patients should only go to hospital when it is essential. That is clearly not happening with too many people ending up in A/E Departments and hospital beds because of primary or social care failures. And equally too many people stay too long in hospital because arrangements cannot be made to allow them to be discharged to their homes and communities in a timely fashion.

We hope that this this review by the Senedd's Health and Social Care Committee into the general practice in Wales might provide some insight into why many of the expectations from the beginning of this millennium have yet to be realised as well as providing a set of proposals and recommendations as to way forward.

THE BASICS.
General practice is the major gateway to the NHS in Wales. It is not a gatekeeper which implies that the purpose is to place limits on access to other services.

As a gateway, general practice and primary care either delivers personal care itself or it directs patients to care pathways. Evaluating what is the proper pathway is a shared decision between the patient (who knows what is important to themselves) and their clinician.

In the NHS the quality of these decisions is affected by the nature of the relationship between patient and clinician. This relationship should be personal, based on mutual respect and continuity of care. These factors are known to provide more patient satisfaction and better outcomes in contrast to a series of episodic, transactional interactions. A public service delivery model is more likely to deliver this than would be the case in a more market orientated service.

The modern health and social care service is getting more complex and more difficult to negotiate. A personal generalist physician had a key role in facilitating a smooth passage through the system to ensure that patients get the right care, at the right place and at the appropriate time.

English data from the Kings Fund has estimated that GP and community health service are dealing with almost twice as many patients as hospital in-patient, out-patient and A/E departments. Based on this analysis the NHS overall is seeing 2.5 as many patients as it was 20 years ago. These figures should not be surprising as our population is getting larger and older with more patients presenting with multiple complex problems. Considering that it has an older, sicker and poorer population, there is no reason to assume that the situation in Wales is any different.

The burden of ill health is not equally spread across Wales with significance gradients evident by socio- economic disadvantage, gender, ethnicity and under-lying health status (e.g. patients with serious mental health problems also have disproportionately more physical ill health). Women in our most socially disadvantaged areas have 17 years less healthy life expectancy and 10 more years of poor health compared to those in the most advantaged areas. And these are problems that are getting worse and inequalities increasing. Improvements in life expectancy have virtually stalled for the first time ever following over a decade of Austerity with an actual decline for certain groups such as poorer women.

If patients are to get timely care within their communities, benefit from preventive services and have long term management of their chronic illnesses, we must strengthen our public health interventions along with strengthening our primary and community care service including general practice.

HOW WE GOT HERE.
When Nye Bevan created the NHS, primary care medical practitioners and dentists - unlike hospital consultant and junior staff - refused to become state employees but instead remained as owners of independent businesses. They then became "independent contractors" to the NHS based on nationally agreed rates.

Running general practice became akin to running a small business with a very large number of competing single handed practices serving local communities from private houses or small converted local commercial premises.

In 1966 GP Charter saw GPs become eligible to a range of allowances and reimbursement for practice staff. This led to a renaissance in the discipline with the growth of partnership practice, employment of ancillary support staff and better premises. Competition for patients became less intense and over time these practices began to work more closely in areas such as out of hours rotas and formal GP training.

Through the subsequent decades the nature of general practice changed with larger partnership practices serving bigger population bases. While vaccination, paediatric surveillance and maternity services were always important part of community-based care, there was a growing awareness of preventive medicine (e.g. risks of smoking, high blood pressure, high cholesterol, early cancer detection etc.) and the management of chronic illness (diabetes, asthma, epilepsy etc.).This led to proportionately less time was taken up with dealing with the episodic treatments of short-term illnesses.

The 2004 New Contract was attempted to respond to this evolving terrain. It changed overall structure of the contract payments. A core Global Sum allowance, which attempted to better reflect core workload, was introduced. Payments for the management of a range of long-term conditions and practice performance, called Quality and Outcomes Framework (QOF), began. In addition a range of enhanced payments for specified / designated services, deemed outside the core GP contract, were introduced at either national or local levels.

GPs were no longer obliged to make arrangements for the 24 hours cover of their patients. And over this time alternatives to the mainstream General Medical Services (GMS) such as Personal Medical Services (PMS) and Alternative Provider Medical Services were offered.

In the short term the 2004 New Contract was supported by a significant injection of funds with many of the changes welcomed as a recognition of the direction that general practice was moving and as the gender mix of the profession changed. And the revised working hours made the practice employment of salaried doctors a less contentious issue.
The QOF accelerated the introduction of electronic records and the supervision of chronic conditions but at the price of a more industrialised and transactional ways of working.

WHERE WE ARE NOW.
Following 14 years of Austerity and the Covid Pandemic our health and social care system is in a serious state of crisis.

The problems of the hospital service, long waiting lists, backlogs at A/E Departments and delayed transfer to social care or community settings are rarely out of the news as Austerity began bite from 2010 onwards. But over the last decade the problems of general practice and primary access also began to emerge as a serious public concern.

This is at odds with the aspirations of the Wanless and Parliamentary Reviews, the Wales Audit Office report on Primary Care and Welsh Government policy statements such A Healthier Wales and the Strategic Programme for Primary Care. A vibrant and thriving primary care and general practice is essential for the sustainability of the wider NHS and

social care sectors but it is clearly not in place. And its failures to deliver is compounding the problems from which the whole system is suffering.

While the UK level of expenditure on health as a proportion of overall GDP is close to other industrialised countries, the per capita spend continues to be towards towards the lower end of the scale compared to countries like France, Germany, Netherlands, Sweden and the Irish Republic.

The Institute for Fiscal Studies analysis showed that the levels of health spending in the UK devolved administrations has been higher than in England. It pointed out that in1999–2000 Scotland spent 22% more per person than England, Wales spent 12% more and Northern Ireland spent 15%. But in 2019–20, on the eve of the pandemic, Scotland spent just 3% more, while Wales and Northern Ireland each spent 7% more. The higher level of spending in Wales, the IFS said, could be accounted for the older Welsh age profile.

And while this may be true the effects of the Barnett Formula and local political decisions are the crucially important factors. Under the vagaries of the Barnett formula increased public expenditure will tend to lead to a convergence in the level of overall devolved expenditure while cut-backs will widen it. So, it is inevitable that the relative level of health spending in Wales will have increased following over a decade of financial austerity and financial restraint.

In 2010- 2011 general medical services received 7.6% of NHS spending in Wales (NHS Summarised Accounts). The number of WTE GPs at that stage was 1,860 (approx.) and the average list size 1,640 (based on Welsh population). The number of GPs had increased by over 10% from the introduction of the 2004 Contract. Just under 30% of the GPs were women. (Stats Wales 2013).

GMS services dropped to under 6% of NHS spending in 2022-23. The number of WTE GPs in September 2024 was 1461 which would give a list size of about 1,960 (Welsh population) with calculation from the BMA and RCGP putting it even higher at over 2,200. Over 50% of FTEs GPs were women.

While there have been changes to the way the data was been collected over this period, there can be no doubt about the overall message. The number of full-time equivalent GPs in Wales have gone down while the population and list sizes have gone up. And this is taking place as the population gets older with more complex conditions. These figures are in contrast with an overall increase of one third in overall NHS employment and a 41% increase in medical and dental staff between 2011 and 2024.

A further feature over this period has been the growth of “salaried GPs”. Up to the turn of the Millennia there were only a few salaried GPs (excluding GP registrars and a handful of retainees) but by the end of 2024 they made up about 15% of FTE. There were also about 5-10% of the workforce working as locums who are nominally self-employed.

In addition, 15-20 practices are directly managed predominantly in Betsi Cadwallader UHB with a few scattered throughout the rest of Wales. The BMA has pointed out that these practices “over-spend” by an average of 24% compared to their income though it did not contemplate the possibility that this could reflect the real cost of running such practices as virtually all of them were where GMS contracts were either handed back or were simply unviable.

The characteristics of practices are changing with a continuing decline in the number of single-handed and smaller GP practices. Well over half of GPs partners work in practices with five of more colleagues and up to 45-50% of practices now employ 30 or more staff. In the last four years the number of practice support staff has increased by 10% to over 8,300 with approximately 30% providing direct patient care. As the number of practices decrease the number of patients per partnership increases from 6,780 in 2013 to 8378 a decade later (BMA Save our Surgeries). These bigger practices can create problems for continuity of care and as they are centralised in larger premises be more distant from where patients live.

ACCESS TO SERVICES.

Access to services is a crucial element of the public experience NHS use. This includes getting a convenient, timely appointment with their clinician with sufficient time to deal with their problem. Where that is not possible people will either defer care or seek it elsewhere such as at Accident and Emergency Departments. A Kings Fund study indicated that this was more likely to happen for people coming from socially disadvantaged areas.

In 2012-13 92% of people reported that they were satisfied with the GP care with about 95% finding it easy to get an appointment but over the decades of Austerity things deteriorated. In 2021-22 58% of the population saw their GP compared to 76% two years earlier – with 50% of appointments with a GP being held face-to-face, 49% were over the phone and 1% were by video call. This contrasts with 67% of consultations being face to face in 2020-21. Additionally, 71% of people in good health were able to easily book a convenient time whilst only 51% of those in bad health found that booking a convenient time was easy.

Since the Covid pandemic there were about 1.751 million appointments per month (approx. range 1.44m to 1.95m) available in Wales with a substantial proportion of the consultations on-line. Very many users do appreciate the convenience of digital consultations but, as the Public Health Wales survey (2023) on digital health use in Wales shows, many others find it a barrier. It reported that only 20% felt that technology provided a better patient experience compared to 50% who disagreed. This was more likely to be the case with older people with poor health. And much less use was likely to made of IT to deal with clinical matters as opposed to getting information or administrative tasks. Though use has increased since Covid there does not seem to be any groundswell of enthusiasm to replace face to face care with digital substitutes.

While IT is seen as a catalyst for major future change in the way health and social care is delivered there needs to be reasonable expectations on how fast people wish to engage with new technology and there needs to be a greater understanding of the problems that users face in doing so. There is a regular rhetoric about designing IT services around users without fully acknowledging the totality of the reasons why users still wish to give primacy to the personal human interactions.

It is hoped that IT will empower people to engage more actively with their health care but this not likely to happen if the user-interfaces are riddled with delays, complex pathways, poor functionality and even problems with legibility. It must be of concern that the reviews of the NHS Wales App on Play Store have been as low 2 /5.

INVERSE CARE LAW.

In 1971 the Lancet published a watershed paper by Glyncorrwg general practitioner Dr Julian Tudor Hart entitled “The Inverse Care Law”. Its analysis, over half a century later, still stands the test of time. In summary its key message is “The availability of good care tends to vary with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced.” The first part of this summary is regularly quoted and referenced while the second is studiously ignored by many. Both parts however are intrinsic to an understanding of Dr. Hart's key message == best and most equitable care is delivered by a public service health and social care system.

The maldistribution of health care resources is still with us with the areas with the greatest need getting the least share. The National Survey (2022) reported that 67% of those in material deprivation saw a GP compared with 57% of people who were not materially deprived. This might seem to be encouraging as a higher proportion from socially disadvantaged areas were accessing the service. But evidence from Scotland suggests that although though consultation rates increased with deprivation, the social gradients in multi-morbidity were much steeper and so the mismatch remains.

A study by the Deep End Cymru network showed that the 100 practices serving areas with the highest levels of social deprivation have larger list sizes, compared to the 100 Practices with the least proportion of patients in the most deprived areas. They have 266 (13.2%) more patients per fully qualified GP. This is more marked for partners, with GP partners serving disadvantaged areas having on average 764 (29.7%) more patients. For direct patient care staff, the difference is even more stark; staff in these practices are serving an average of 1927 (77.7%) more patients than staff working in the most affluent areas. These findings are similar to those produced by Stats Wales in 2022 which reported that practice lists were higher in the most deprived quintile area on the WIMD while practices in the least deprived quintile had the greatest number of GPs, nurses, direct patient care staff and admin staff per 10,000 practice population.

The recent report on Supporting Chronic Illness by the Senedd Health and Social Care Committee said that almost one fifth of adults in Wales suffer from two or more chronic illnesses. It pointed out that the opportunity to talk to a healthcare professional, ideally during a face-to-face appointment, about their treatment options and what matters to them is incredibly important to people living with chronic conditions. These conditions can constitute up to 50% of GP consultations and time needs to be made available for these discussions to take place. The Chief Scientific Officer from Health pointed out that people living in disadvantaged areas or in vulnerable groups are more likely to be living with multiple conditions. The likelihood of living with multiple conditions increases with age although almost a third of people living with complex multi-morbidity are under 65years of age.

Public Health Wales also pointed out that promoting preventive services and addressing health inequalities could save the NHS well over £300 million per year. Its study showed that the greatest cost differentials were in the use of A/E Services, emergency admissions and maternity in-patient admissions -- areas where more effective primary and social care can make a difference. The spend on hospital care is higher on people in more deprived areas; the social gradient is greatest for unplanned care which may indicate a higher risk of trauma, injuries and other unplanned care needs, and may indicate opportunities to diagnose and manage long term conditions better in the community, focusing on more deprived areas.

The 2024 Doctors & Dentists Pay Review showed that contractor GPs in Wales have the lowest levels of income across the UK, the pre-tax income being one third higher in England. And within Wales there is evidence that practices serving the more disadvantaged areas receive lower levels of funding. This is possibly due to the weakness of the Carr-Hill formula in the allocation global funds to practices and the challenges of securing high QOF payments for preventive services.

Within the wider national picture of clear evidence of a failure to support all primary care and general practice within NHS Wales, there is therefore the additional issue of inequity with the resource and capacity allocations within primary care and general practice.

In his 2016 Annual Report the Welsh CMO made the argument for a move towards "proportionate universalism" to address the health inequalities in Wales. He said a one size fits all health and care service will not allocate resources in line with need and could end up exacerbating rather than alleviating health inequalities. Almost a decade on this still true.

PUBLIC HEALTH - HEALTHIER PUBLIC.

In his 2016 Annual Report the CMO also pointed out that much of ill-health is due to socio-economic determinants outside the control of clinical health services. This is clearly the case, but he went on to point out that health care can make a 15-43% difference in outcomes. But outside of health outcomes health services themselves can be a determinant of socio-economic well-being.

A report for the NHS Confederation (2023) demonstrated that for every additional £1 spent on primary or community care could have increased economic output by £14, compared to around £4 from wider NHS investment. While the precise mechanisms of this benefit are not clear factors such as increased staff numbers, procurement policies and better health outcomes effect the wider workforce. The UK has far higher levels of health related worklessness than most advanced industrial countries at 7% of the workforce. In the year to 2024, 162,300 people in Wales said that they were economically inactive because of long-term illness, a third (33.8%) of all the people who are economically inactive This was underpinned by the NHS in 10 + Years report which calculated that mental health problems cost the Welsh economy £4.8bn / year with cardio-vascular disease costing £800m and dementia £700m.

A recent editorial in the BMJ argued that while poor quality employment is a health risk overall being in work is good for health suggesting that a range of health care interventions, most of which could be delivered at a community level, could have an important role to play in easing the transition back to work. Traditionally GPs have been reluctant to engage with "social problems" such as this but, as "patient's advocates" they have a clear role to play with many of the crucial services being delivered as part of wider community and public health teams.

This link to a wider public health agenda can also apply in other areas. The recent GP contract revision will require GPs to proactively identify and record people who are living with severe or moderate frailty using an evidenced-based tool. The *NHS in 10+ Years* report highlighted the importance of healthy ageing and need to develop preventive pathways to address growing frailty as our population gets older as even those with mild

frailty have a double mortality risk and the future cost of care could run into billions of pounds.

In its 2022 policy statement, Primary Care and Public Health, Doctors in Unite pointed out how important it is to develop strong links between primary care and public health at a community level both in terms of health service planning and delivery. General practice must be firmly rooted in its communities, committed to understanding them and the diverse people who live in them, and supporting them in pursuing their own health.

Though A Healthier Wales strongly advocates greater public engagement with our health care system there is a real lack of democratic accountability and transparency in the NHS particularly at health board and trust level. The members of most health boards do have a wide range of professional skills, but they are rarely representative of the communities they serve, particularly those areas where need is the greatest and the service is under most pressure.

There should be statutory duty for each health board to provide regular reports to local elected representatives of the local authorities in their area on the performance of the NHS at primary care cluster level to include public health as well as health and social care delivery. These reports should be subject to democratic scrutiny by local elected representatives and other local stakeholders including NHS staff, Lllais and the third sector.

MOVING FORWARD.

As set out in *A Healthier Wales*, and in many other reports and reviews, general practice and primary care are crucial to a sustainable NHS and social care system.

- People need to get adequate timely care in their communities, otherwise they will end up using more inappropriate facilities such as our A/E Departments.
- With the growing prevalence of ever more complex multi-morbidity clinicians must work with patients to identify risk factors and early disease to optimise their care and well-being to mitigate preventable end-stage disease and hospital admissions.
- Too many patients are spending too long in hospital. Our primary care, community health and social care services must be strengthened so that only those whose clinical condition require them to be in hospital should be there.
- Our health and social care system is getting ever more difficult to access and negotiate. This is a particular problem where health literacy is low. GPs, and other members of the primary health care team, must be active advocates and champions for their patients to ensure that they access the best and most appropriate care.
- General practice, primary care, community and public health must all work together in a linked-up way to promote and protect the health and well-being of the populations that they serve.

Delivering this in Wales will be seen within the context of Providing Prudent Health Care and the Welsh Primary Care Model. These approaches have a lot of strengths and underlie the NHS Wales Primary Care Strategic Programme.However the uncritical application of these approaches will shift the focus from strengthening individual practices and result in the fragmentation of personal care. They were developed during the period of Austerity and seem to reflect a need for health and social care to adjust to this. They pay insufficient attention to strengthening core general practice team as they don't emphasise the importance of increasing GP numbers and reducing list sizes. Alternative care

pathways, including self-help programmes and pharmacist access schemes, are encouraged. They are worthwhile in themselves but they are no substitute for investment in core general practice provision. Equally service planning and delivery through primary care clusters has a lot of merit but its full potential may not be achieved if practices find it too difficult to engage because of their own workload, staffing problems or little tangible benefit for their own patient populations.

The decline in the GP workforce needs to be addressed urgently. At a minimum this require more finance to be directed to general practice to allow more GPs to be recruited with clear targets being set to achieve average list sizes of 1,500 / FT GP by the end of the next Senedd term with a phased programme to reach a 1,000 / GP as recommended by GPC-E. In achieving these targets priority must be given areas where need is greatest and the service is under the most pressure.

To deliver these targets it is crucial that the present increased level of GP registrars in training is maintained. However almost a quarter of those who complete the GP training here leave Wales with 39% of medical students planing to leave Wales after qualifying with a significant number giving the poor state of the Welsh NHS as their reason. This represents both a real challenge and an opportunity to increase the GP workforce size though providing better and more exciting career prospects here.

A key factor is also to ensure that doctors in training have the opportunities to learn in practices in socially disadvantages areas. Research has shown working and training as a GP in areas of socioeconomic deprivation is challenging. It has also been shown that practices in such areas are less likely to offer training to prospective GPs. Some parts of Wales already benefit from a GP trainee incentive scheme. This should be reviewed to assess if more can be done to provide training opportunities in our most disadvantaged and under-doctored communities.

General practice must work no matter what the delivery model. More frontline GPs and stronger primary health care teams are essential. And while short term ad-hoc solutions are better than no solutions at all, we need more sustained strategic approaches that recognise the long-term changing patterns of need and professional practice. The independent contractor / partnership model remains the predominant model of general practice delivery. In many places it is working well with many doctors using the model to provide innovative, high-quality care. But almost without exception all contractor practices are working under unacceptable pressures.

These practices need to have increased and predictable funding streams that will allow them to evolve and develop to meet the growing demands they face. This will require increased funding and support for all practices but will also require a review of the Carr-Hill formula and the QOF payments to assess their capacity to reliably fund practice in dealing with the highest need and workload pressures.

The Welsh Government needs to work with the GP profession on a new high trust relationship where practices are given greater autonomy to meet the needs of their population in a patient sensitive and accountable way. As well, steps need to be taken to deal with a range of perverse elements of the current contract such as unnecessary bureaucracy and the burden of being left as “the last person standing” in relation to the ownership and disposal of practice assets. Staffing numbers need to increase to both address current pressures and the growing burden of unmet need.

This needs to be delivered in new or upgraded facilities which are appropriate to a 21st century wider primary care team. A review of all GP premises was announced in 2020 but to date the no report has been forthcoming. These facilities should be capable of being community assets where patients can be seen in a comfortable, convenient and timely way. They must be capable of hosting a full range of personal medical and public health provision. It will be important to ensure that these buildings can be easily and conveniently accessed by those with a disability, children and those who do not have ready access to personal or public transport. In renewing this infrastructure, pro-active priority must be given to where facilities are currently least fit for purpose.

In making the case for increased primary and community care investment we need to acknowledge that major gaps will remain in the organisation and delivery of the GP workforce. The Inverse Care Law tells us that allowing the conventional market mechanisms, including the business decisions of general practice partnerships, is unlikely to mitigate the present unequal distribution of primary care capacity.

Even with a much-needed increase in resources there is a need for public sector intervention to address market failures in the distribution of health care capacity. In the past there were measures which ensured a more equitable GP workforce (e.g. Medical Practices Committee which was abolished in 2001). In addition, the judicious use of Directed Enhanced Services (DES), Local Enhanced Services (LES) or PMS contracts could go some way to achieve this with the context of the independent contractor model linked to a more equitable and workload sensitive Global Sum allocation. In other places schemes such as GP training incentive schemes, “golden hellos”, clinical academic fellowships and the possibility of targeting medical student recruitment to attract students with local connections have been used to attract doctors to under-provided or high workload areas.

NEW GMS CONTRACT.

This urgent need for a broad reform of the 2004 GMS contract begs the question as to whether there is a need for a more fundamental stocktake of the current contract with a view to negotiating a totally new GMS contact. For all its strengths and weaknesses a strong case can be made for saying the 2004 contract has come to the end of its useful life and a fresh start is needed as part of the reviving general practice and primary care.

As time has gone on the 2004 Contract has morphed into creating a service that no longer satisfies anyone. The design of a new contract must deliver a service that is more in line with public expectation and needs … a timely, convenient, quality public service. But it must also deliver for the medical profession.

The present contract has become too complex, too transactional and is undermining the ability of general practice to provide a quality long-term service build on personal and professional relationships. And too many doctors no longer finds that it offer them a satisfactory career path or professional future.

In addition there is the likely prospect of a new GMS contract being negotiated in England. And while it is not possible to predict the detail of that contract at this stage we have to be alert to the possibility that it could be more attractive to what is being offered here in Wales.

The broad minimums of such a contract are clear enough – why not a contract with list sizes on a par with Scotland and income levels on par with England? Negotiations

between the Welsh Government and the profession will decide the precise form of a new contact with a number of potentially contentious issues to be resolved. But the present weaknesses of the 2004 contract are the obvious points of departure.

Agreement will have be be reached on what are the core functions and requirements of modern day general practice and where does it fits into the wider agenda set out in *A Healthier Wales* and the very many reports and reviews that preceded it. The simpler the contact the better but it must be capable of delivering continuing personalised care over the range of community based services that are essential to sustain our overall health and social care service.

While the GMC contract is based on a small independent business model, those who work in general practice see themselves very much part of the wider NHS family. This is important and represents a set of values that need to be protected.

This new contract must not open the door that will lead down a road of corporate capture that our dentistry, pharmacy and optometry service have gone down and which is evident in much of our social care provision. A key safeguard will be to get rid of the APMS contract option which is an Trojan Horse to the corporate capture our general practice and primary care care sector – as has happening in dentistry, optometry and pharmacy services

PUBLIC SERVICE GENERAL PRACTICE.

The increasing number of salaried GPs and the failure of many existing contractor partnerships is bringing the future of this small business model of general practice into question. Very many organisations including a House of Lords Select Committee, NHS Confederation Wales, the Kings Fund, Nuffield Trust and the IPPR have called into question its long term viability with newly qualified doctors expressing concerns about workload, business bureaucracy and financial commitments. The BMA and RCGP's continuing commitment to the independent contractor model has prevented them of acknowledging these changes in reality and attitude. Sadly both organisations have yet to engage in any fresh thinking on how general practice can delivered outside the small business, partnership model.

A lot of work needs to be done to develop a national contract for salaried GPs which will underpin the key roles of GPs as continuing, generalist personal physicians and patient advocates. A national NHS Salaried GP Service should reflect the emerging and evolving aspirations of a new generation of doctors who plan to enter general practice. It should offer terms of service and a career pathway that will be capable of recruiting and retaining a contented workforce.

Within a public service, being a salaried GP should be a positive career choice and not merely a half-way house to becoming an independent contractor. These positions should provide the opportunity for developing portfolio careers with a range of extended responsibilities such as has been suggested by the RCGP. Salaried NHS GP practices need a clear vision of their roles and to have a clinical team and management structure which respects their vital professional values, autonomy and independence.

Doctors in Unite has published a series of proposals which would very usefully inform such discussions and planning. Multi-disciplinary primary care teams should be led and managed by Consultants in General Practice, making the most use of their very long and

intensive training in medical generalism. They need to lead, coordinate and supervise as well as being a clinical resource. Teams such as this can be set up with an NHS Consultant Contract. Some GP teams could be created by just switching from APMS, PMS or GMS contracts wholesale with others being set up as new with a priority given to those areas where need is greatest or where contractor practices have failed. There needs to be two key provisos: there must be protection against any corporate ownership of these teams, and there must be a solution to ensure good premises in the right place for the neediest patients to easily reach.

A public service salaried GP practice must not be a larger scale replication of how directly managed GP practices operate at the moment. They need a wider national vision and strategic purpose of meeting the career aspirations of a new generation of doctors and well as allowing continuing employment for those former contractor GPs who wish to reduce their commitments. In addition this new system must be able to fill the gaps left by the business decisions of Independent contractor practices.

There is potential for a GP contract to be held by several public sector bodies. In England some acute trusts seek to vertically integrate general practice into their secondary care provision. In other cases, the contract holding body could also be the same as that which employs other community health workers. While there may be some limited scope for salaried GPs working for NHS trusts in Wales (e.g. Welsh Ambulance Service) in the main the unified health structures here in Wales could offer different options

Primary Care Clusters have not seen themselves as being employing organisations and they are probably too small to take on and replicate employment duties across all of Wales. However they are in a very good position of identify local needs, local service gaps and to plan future provision for their communities in conjunction with their public health colleagues. It is important that needs assessments do not just confine themselves to historic levels of practice but clearly identify where unmet need exists and acknowledge that the complexity of addressing these needs will not be uniform in every situation.

The NHS Wales Shared Services Partnership could be the contractor holder for salaried public service GPs. However how and where they are deployed should be a local matter for health boards and primary care clusters. Such a service must be professionally led and managed as part of mainstream NHS primary care provision. It should not be seen as a stop-gap or fire fighting response to a particular crisis in the contractor provision. It must be sensitive and flexible enough to reflect career ambitions, expertise, years of service, local factors in line with workforce demand as well as clinical and managerial responsibilities. In turn this contract will provide the benchmark for other salaried GPs working in other clinical settings

CONCLUSION.

General practice must work no matter what the delivery model. More frontline GPs and stronger primary health care teams are essential. We need more sustained strategic approaches that recognise the long-term changing patterns of need and professional practice.

Key messages:

- **Investing in primary care services is cost-effective at societal level.** Worldwide evidence is that the stronger the primary care system, the stronger the overall health system is to improve health outcomes, reduce costs, and maximise equity for the

population.

- **Increase GP numbers to produce average list size of 1,500 patients / GP** by end of next Senedd term with longer term target of list sizes of 1,000 patients per GP. Priority should be given to areas of greatest need and pressures

- **Negotiate a new GMC / independent contractor** contract for Wales with the emphasis on a more work and needs sensitive core allowance and less reliance on separate distinct funding streams. Implicit in this will a revised agreement on the content of the core GMC contract.

- **A new GMC contract must address the inequitable deployment** of primary care capacity

- **Investment in public health similarly is highly cost effective.** Most health care interventions that improve life expectancy and healthy life expectancy are delivered at community levels with primary care as the crucial partner.

- **Market failure must be recognised and addressed**: The Government role is always one of stewardship of a health system for its population. There are many different models of financing and providing such services globally. In the UK, General Practice is commissioned by the NHS via a variety of contracts. This has inherent risk of market failure, which carries a high price for patients, especially for those with the greatest needs.

- **Alternative Medical Provider (APMS) Contracts should be abolished** as a it is clear gateway for general practice privatisation.

- **A national NHS salaried contract must be introduced** to run in parallel with the Independent Contractor system. It is not sufficient to rely on the independent contractor route to ensure equitable access and quality of care.

- **Continuity of care**: Continuity of care must be at least as important a goal as access to care because it reduces mortality and inequalities in health outcomes

- **The GP is crucial and not just a cog in the multi-disciplinary primary care team**. The role of Specialist Generalist as the clinical leader for the primary care team is fundamentally what makes primary care in the UK so efficient, cost-effective and highly productive. It cannot be fragmented and adequately replaced by transactional encounters with a multitude of professionals. A multidisciplinary team without GP leadership is more expensive and less effective.

- **Resources should be allocated according to need, using more sophisticated methods than the out-dated Carr Hill formula** to ensure that capacity distribution is planned and not left to the vagaries of the market.

- **A primary care pilot** of joint general practice / public health posts should be undertaken.

- **Increased accountability and scrutiny** for NHS delivery should take place at a local level

March 2025.