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

GP52 : Ymateb gan: Diwedd Dwfn Cymru| Response from: Deep End Cymru

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Deep End Cymru evidence for the Senedd inquiry into the future of general practice in Wales

Meddygon Teulu yn y Pen Dwfn
GPs at the Deep End

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Webpage Deep End Wales Project

This evidence is submitted on behalf of the Steering Group of Deep End Cymru. We are happy for this to be published with the Deep End Cymru name, and none of it is confidential.

Who we are

Deep End Cymru is a network of the GP practices serving the most deprived communities in Wales. We started with 100 practices in 2022, and are now 91 as practices have merged and closed. We have a high level of engagement from GPs, practice managers and other staff. They say that they love their jobs, and they love working in their communities, but that it is really hard work, and getting harder. Please listen to a 10 minute description of life as a GP in a Valleys community here, from our Deep End Chair, Dr Neil James

Figure 1: GP Practices by deprivation, ranked 1 to 389 in January 2022

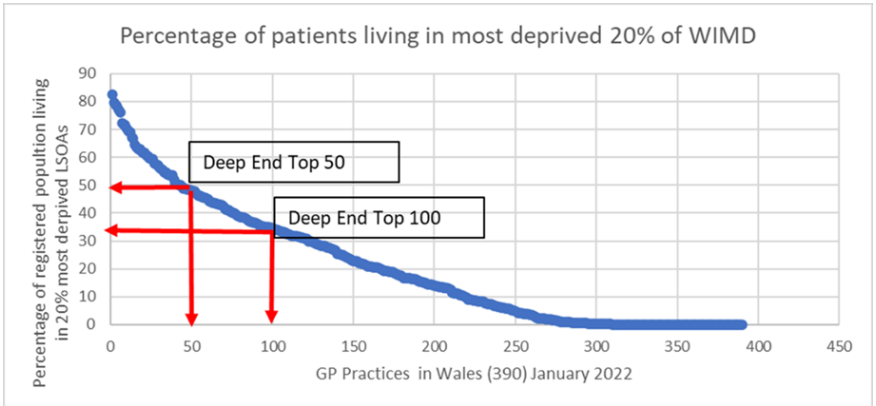


Figure 2: Map of Deep End practices

In our most recent Round Table, participants identified the strengths of Deep End GP Practices:

- We have real life experiences and are face-to-face with patients daily. This gives us authenticity and expertise.
- We work and live in communities. We are connected to communities
- We have an understanding of the complexity of these communities and see a picture of the community from seeing many patients.
- We understand the context around healthcare, and wider needs/factors.

- We see communities as having assets, not just deficits. We can tell a positive story about our communities.
- We have insight, which we could turn into powerful stories.
- We can deliver real change, in communities where it will be felt, and deliver return on investment.
- We love our jobs and the difference we make, and we want to improve.
- We have effective relationships with each other and others.

Introduction

Many of our patients should have lived longer and healthier lives

People are getting sick too young and are dying too young, because of the circumstances they are born into. Poverty makes people physically and mentally unwell. In mitigating the impact of these determinants of health, we trust the NHS at least to be fair and effective and efficient in dealing with everyone. However, we have been disinvesting in the services that add most value to life (primary care and social care) and we have been distributing our investment inequitably (those who need the care the most, are least likely to receive it)

Our evidence is focused on the Inverse Care Law:
"The availability of good medical 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."[1]

Wales does not have an explicit Health Inequalities strategy to drive more equitable decision, in spite of multiple calls. Equity and social justice are said to be a golden thread though all the major health policies and strategies, but we are failing to translate this this into implementation, which is where a practical strategy would help. We would like clear guidance for the public sector on making the radical and difficult decisions to move resources into the community and redistribute it according to healthcare needs.

The Inverse Care Law is a policy of the NHS which restricts care in relation to need: it is a form of rationing, and we can choose to make different decisions.

We feel that this is becoming increasingly urgent and needs to come out of the "too difficult" box.

Challenges threatening the sustainability of general practice

All the factors that are challenging the sustainability of general practice are worse for those serving the communities and groups that most need these services.

Wales has a population that is generally older and sicker than the UK as a whole and therefore has greater primary healthcare needs. And within this, healthcare needs are driven by deprivation, with significant socio-economic gradient in almost all major conditions that affect length and quality of life. And people with multiple disadvantage face a cliff edge of poor health and early death. We know that the NHS budget could add value to society if spent where it has the biggest impact: for example, a

[1] Julian Tudor Hart THE INVERSE CARE LAW - The Lancet

report for the NHS Confederation (2024) 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.

The NHS Wales leadership undervalues primary care expertise and value in contributing to strategic decisions for transformation.

These voices with solutions are not heard while there is disconnection between government, Health Boards and primary care. That dissonance means that there is no clear understanding of the structural problems that face general practice, particularly in areas of high deprivation, and hence the structural problems persist down the generations.

The Inverse Care Law is embedded in General Practice in Wales

In primary and community care, money and resources are inequitably distributed through multiple, embedded and often obscure mechanisms:

a. GP practices in deprived areas everywhere experience significantly greater workload, and their patients have greater unmet need[2][3]
b. But Welsh GP practices with more patients from most deprived areas receive less funding, with practices in most deprived areas receiving around 5% less funds (£50-60k a year)[4][5]
c. Welsh practices with more patients from the most deprived areas are folding at twice the rate of other practices[6]. They are more stressed, because they have more patients and a smaller workforce, with GP partners who have on average 764 (30%) more patients.
d. Outside the GP contract, other funding streams into wider primary care can be small, obscure, short term, with many strings attached and usually not weighted by population need. This has probably exacerbated the Inverse Care Law, especially in the wider primary care team workforce encouraged through the Primary Care Model for Wales. For example, additional Direct Patient Care staff are almost twice as likely to be working in the least deprived areas[7]

Recruitment and retention of all NHS staff does not sufficiently address health equity

The policies and processes for staff in the NHS do not sufficiently prioritise primary care and furthermore do not encourage taking up the satisfying roles serving more deprived communities and vulnerable groups. In General Practice, people tend to work where they train, and many young health workers are highly motivated and keen to be supported into such roles, if they only got the opportunity. [8] We strongly believe that there should be more training on health equity for all

[2] General practice funding underpins the persistence of the inverse care law: cross-sectional study in Scotland | British Journal of General Practice
[3] Tackling the inverse care law | The Health Foundation
[4] Exploring the equity of distribution of general medical services funding allocations in Wales: a time-series analysis | BJGP Open
[5] Inverse Care Law Study Group
[6] Deep End Cymru Report First Phase 2024
[7] Deep End Cymru Report First Phase 2024
[8] Deep End Wales Project Round Table report October 2024 on Education and Training

healthcare students, and for all staff working in the NHS. We are keen to explore a Health Equity GP Training scheme, similar to the very successful schemes in Dublin[9] and Manchester.

GP practices in the more deprived areas are quietly drowning

There are many more general practices that have closed or merged in deprived communities than in more rural areas
Since January 2022, 18 GP practices have closed or merged:

- **10 of top 100 Deep End practices = 10%**
- **8 of remaining 290 practices = 2.8%**

Source: Stats Wales

Pulse Magazine produced a map of all GP practice closures between 2013 and 2021 across the UK which left a gap in provision. They report that:

"They were in postcodes that were in more deprived areas than other average surgeries. 69% of practices that closed for good in England received lower funding per patient the last full financial year before they closed than the average funding for that financial year; Practices in deprived areas were more likely to close, and told Pulse their workload is higher, their patient population is less prone to self-care but they also miss out on funding that practices in more affluent areas receive"

The funding model for general practice and current financial pressures

In Wales, general practice has largely been provided by independent contractors via the tripartite GMS contract between Welsh Government, the BMA and Health Boards. There have been very limited attempts at other models of provision.

It is not transparent how resources are allocated to each Health Board by the Welsh Government, and how this affects funding for primary, community and general practice services within and between Heath Boards.

The allocation of resources across the NHS is obscure. This should be completely transparent and we believe these decisions should be subject to the Socio-economic Duty which was enacted in 2021, and allocated using a proportionate universalist methodology, for example, the Technical Advisory Group on Resource Allocation (TAGRA) in Scotland, or the Advisory Committee on Resource Allocation (ACRA) in England.

In particular, the GMS contract should be based on population need using updated formulae, as the Carr Hill formula is agreed to be unfit for purpose, with some bizarre results. We believe that the Carr Hill formula has resulted in lower payments to Welsh practices compared to English practices for decades, and that its methodology is not transferable to Wales. A study in 2010 showed that:

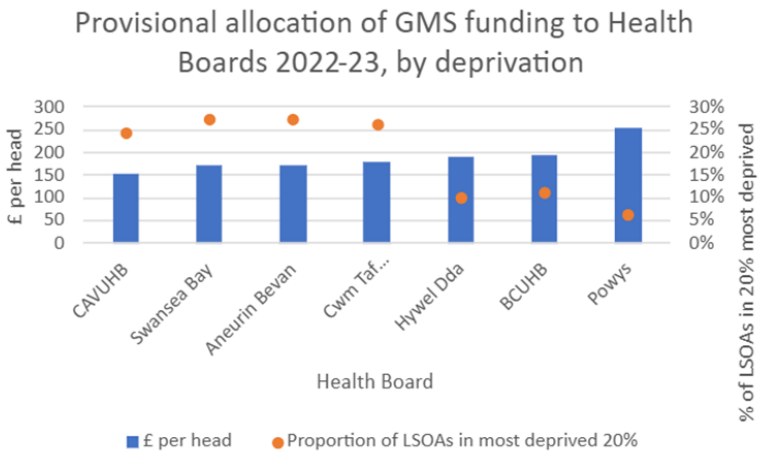
> "The formula modifications increased the Global Sum for 99.5% of English practices, while it reduced entitlement for every Welsh practice. In 2008 ***Welsh practices received approximately £6.15 (9%) less funding per patient per year than an identical English practice***. This deficit will increase to 11.2% when the Minimum Practice Income Guarantee is abolished"

[9] Medicine on the margins. An innovative GP training programme prepares GPs for work with underserved communities - PubMed

As well as overall less funding than in England, GP Practices in the most deprived areas receive around 5% less funds (£50-60k a year)[10] The current contract negotiations may well be breaching the Socioeconomic Duty, which requires impact assessments of all strategic decisions which may significantly affect socioeconomic groups differently (which it clearly does)

The average payment per patient in 2022-23 ranged from £150 in Cardiff and Vale and £250 in Powys. This is great value for a full year of care. However, there is an inverse relationship with deprivation which is a driver of health needs. We believe that the relatively high proportion of dispensing practices in more rural areas may account for some of this unwarranted variation, rather than variation in true healthcare needs (such as the prevalence of long term conditions, multiple co-morbidities, or high avoidable mortality, or a more elderly population) . This is based on analysis in England[11], but it is very likely that similar effects play out in the Welsh contract.

Figure 3: the inverse relationships between funding per patient and deprivation across Health Boards



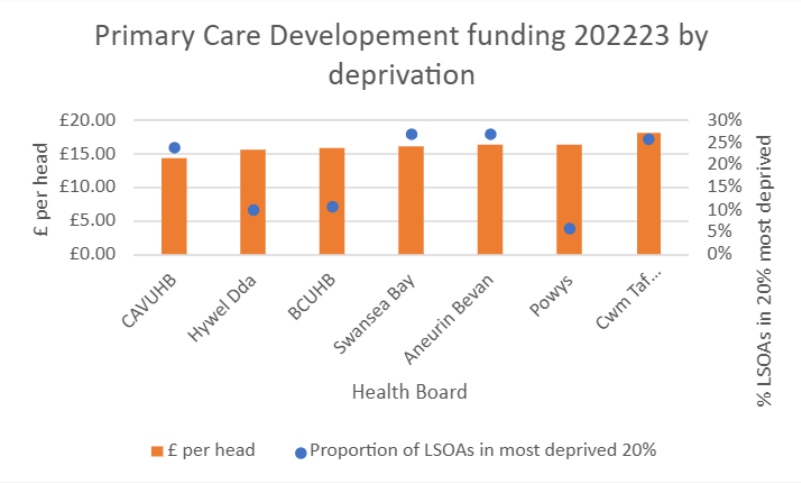
Source: https://www.gov.wales/health-board-allocations

Other much smaller funding streams, such as Cluster funds and Primary Care Development funds, are not allocated with any regard to population need or the variation in workload and staffing of General Practices.

[10] Exploring the equity of distribution of general medical services funding allocations in Wales: a time-series analysis | BJGP Open

[11] Exploring the impact of dispensing practices on equity in NHS payments to general practices - Health Equity Evidence Centre

Figure 4: Primary Care Development funding is the same in every Health Board



Source: https://www.gov.wales/health-board-allocations

We believe that it is core generalist holistic relationship-based care, which is matched to needs, that makes the difference to unfair health outcomes. Rather than any number of "icing on the cake" initiatives outside primary care that have been the policy approach so far. We believe that we need to shift core resources to better match genuine needs.

We believe that the independent contractor status works very well for our Deep End practices, until it doesn't. The model is fragile, and prone to failure when market forces are overwhelming. If income falls, if staff leave and cannot be replaced, then practices can fail. This can be a disaster for patients, especially for those with the greatest needs. There have been very limited alternative models tried, such as provision run directly by Health Boards (managed practices), alternative contracts or Community Interest Companies (CICs). The most recent alternative still used the GMS contract, although with partners based elsewhere and not personally providing clinical services. Of the 9 practices involved, 7 are Deep End practices, which is an indicator of the fragility of practices serving the most deprived communities. A number of these contracts were returned to the Health Board within months, with concerns about quality of services, which is another indicator of the Inverse Care Law.

We believe that alternative models of provision should be actively explored, tried and evaluated with the agreement of local communities and GP Practices.

The general practice workforce

The General Practitioner is a specialist in generalism. This is a crucial leadership role, being the only person in the primary care team who has a full overview of an individual and their family and community

The role of GPs 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.

We analysed the general practice workforce in the setting up phase of Deep End and found some stark inequities:

Table 1: Comparison between GP Practices with the highest and lowest proportion of patients living in deprived communities in 2022 in Wales

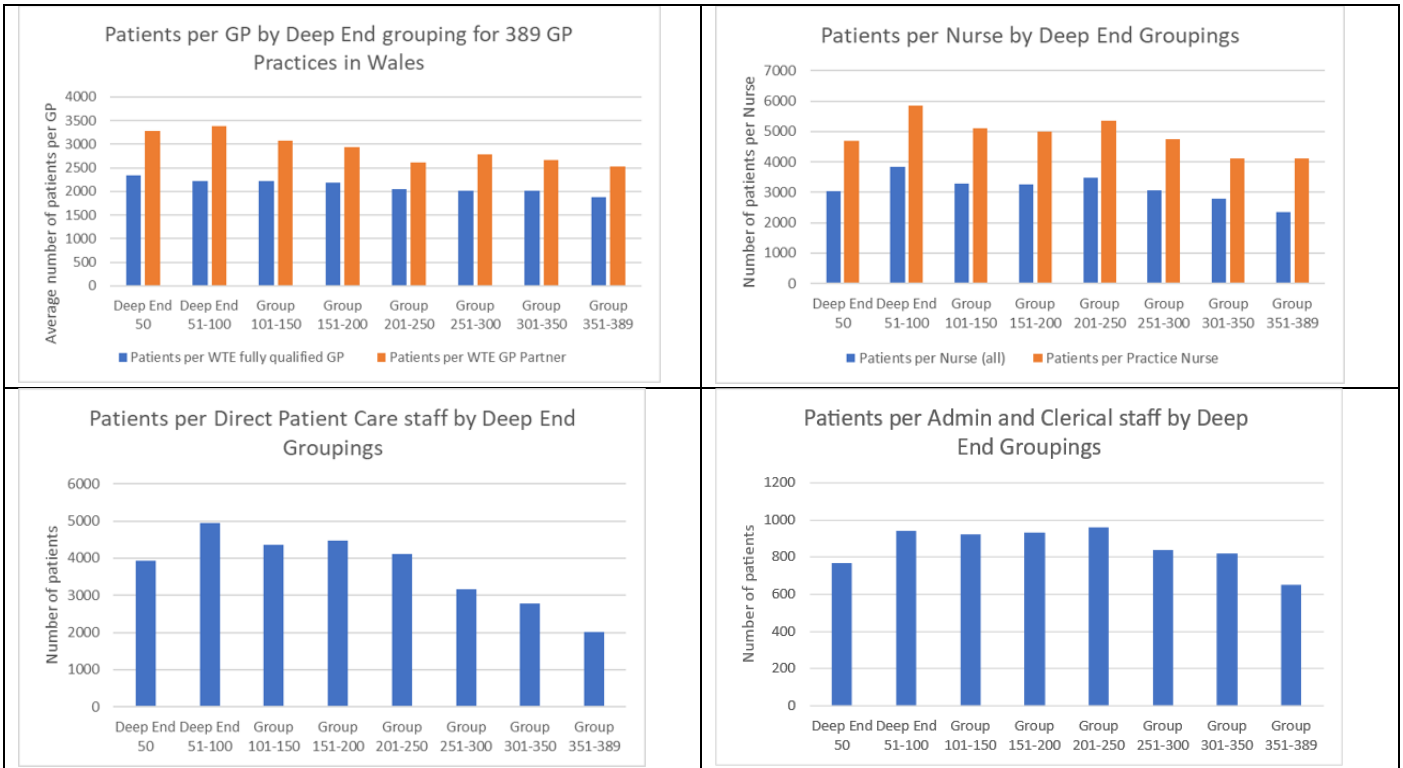
	Most Deep End 50 practices	Least Deep End 88 practices	Absolute difference	Percentage difference
Patients per WTE fully qualified GP	2272	2007	266	13.2%
Patients per WTE GP Partner	3336	2572	764	29.7%

Sources: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/General-Medical-Services/General-practice-population/deprivation-at-gppracticelevel and the Wales National Workforce Reporting System

Deep End GPs have more patients overall, 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. And Deep End practices have fewer partners and relatively more salaried GPs, so that partners in the Deep End have on average 764 (29.7%) more patients each.

This means that they have much less time and headspace for leading the practice, improving quality of care and engaging with Clusters and partner agencies

Figure 5: General Practice workforce by grouping (all GP practices divided into 8 groups of 50 in each)



Sources: Workforce data was taken from the Wales National Workforce Reporting System for November 2022, which was taken as the baseline when Deep End Cymru was launched. Deprivation data was taken from the latest available on Welsh Stats website, which was January 2022. (Deprivation at GP practice level (gov.wales))

Staff Wellbeing is crucial to providing a good service for patients

Deep End GP Practices have highlighted the well being of their whole practice team as crucial to providing the best service for patients. It can be much more challenging to provide a service in these communities and for heath inclusion groups with complex needs.

Patients need more time and expertise from frontline staff, when they do not have English as a first language, have low health literacy, have multiple co-morbidities and feel unwell, when they have a history of trauma and poor experiences with health care services, when they are homeless, and when they have complex needs.

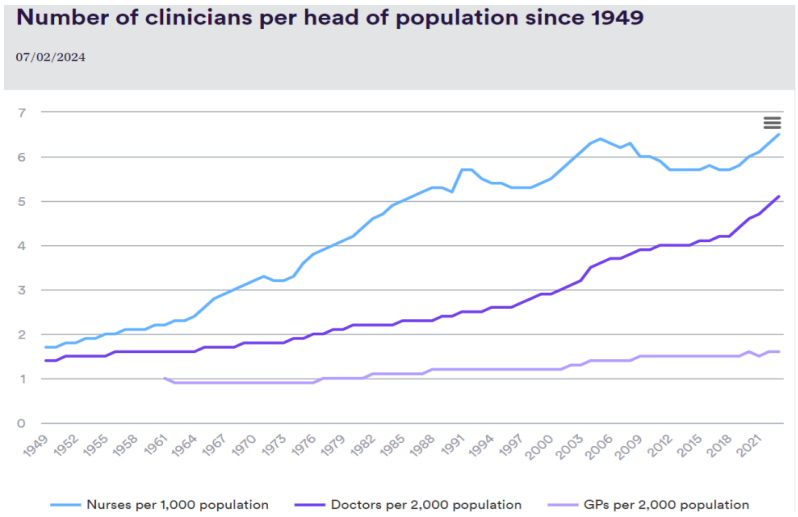
Clinical and non-clinical staff are at higher risk of burnout.

Our staff are our greatest asset. We want them to be paid well, treated with respect and valued, and to be given the education and resources to do their job well.

The workforce is not shifting into the community to support health policies

Health policy priorities have long been to shift care closer to home, shift to prevention and self-care. Workforce policies do not appear to have supported this, as can be seen by where the major clinical staff have been employed over the years

Figure 7 UK trends in numbers of doctors and nurses per head of population since 1949



Source: [The NHS workforce in numbers | Nuffield Trust]

We want GPs to have enough time with each patient and be able to provide continuity of care to those who need it most. This would mean a safe ratio of patients per full-time equivalent GP, which should be no more than 1000 in deprived areas where there should be greater numbers of consultations offered per person.

The patient experience of general practice

People generally value their local general practice very highly, as survey over the years have confirmed, but the levels of satisfaction are falling, and are worse for those who live in the most deprived areas and those who have worse health.

We do not want a system that responds to demand (that is, those who make the most noise), instead we want a healthcare system that responds to those with the greatest needs, and who are often least

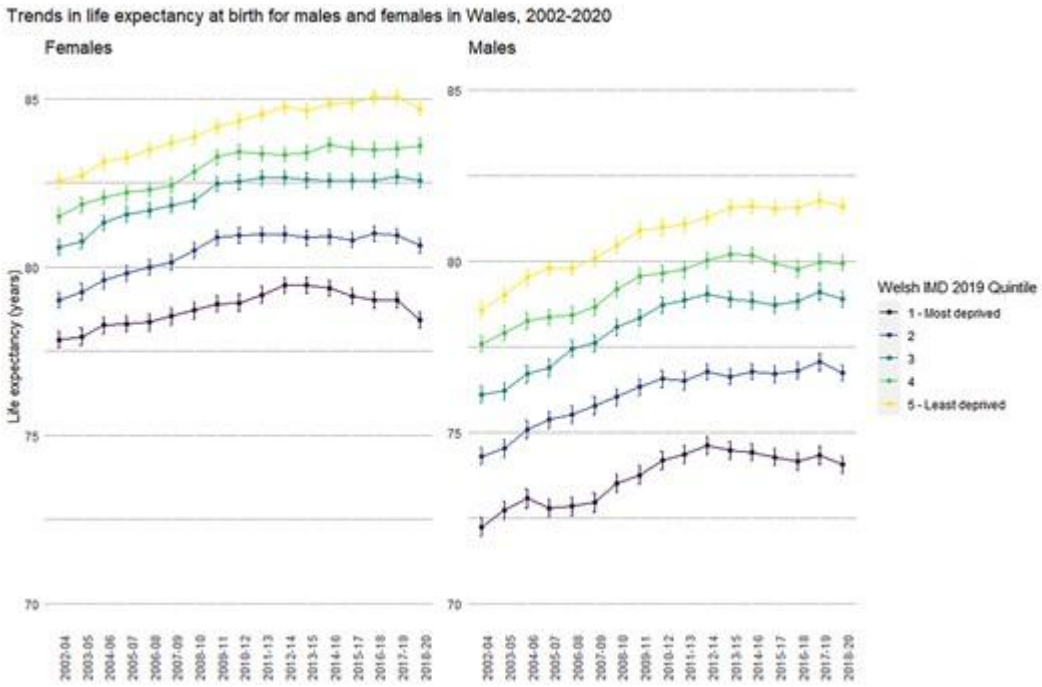
able to put these across. We need time, people, skills and energy to make our general practices respond to real needs.

People in more deprived communities are more likely to die younger, and also spend much more of their lives struggling with poor mental and physical wellbeing

Life expectancy inequalities in Wales got worse between 2002 and 2020[12], even before the pandemic, see Figure 8. This was because of decreases in life expectancy amongst the most deprived quintiles. Life expectancy rose for all quintiles initially before plateauing around 2012–14. Life expectancy for the most deprived quintile (quintile 1) fell for both sexes between 2012–14 and 2018–20, with a steeper decline for females in the most recent period.

Conditions contributing to current inequalities in premature mortality are cardiovascular disease, cancers, respiratory disease and alcohol-related deaths.

Figure 8 Trends in life expectancy in Wales



A report looking ahead to 2040 in England[13] found that "a small group of long-term conditions contribute to most of the observed health inequalities, out of which chronic pain, type 2 diabetes and anxiety and depression are projected to increase at a faster rate in the 10% most deprived areas by 2040. These conditions are typically managed in primary care, underlining the need to invest in general practice, particularly in the most deprived areas, and community-based services and focus on prevention and early intervention"

[12] Contribution of avoidable mortality to life expectancy inequalities in Wales: a decomposition by age and by cause between 2002 and 2020 | Journal of Public Health | Oxford Academic

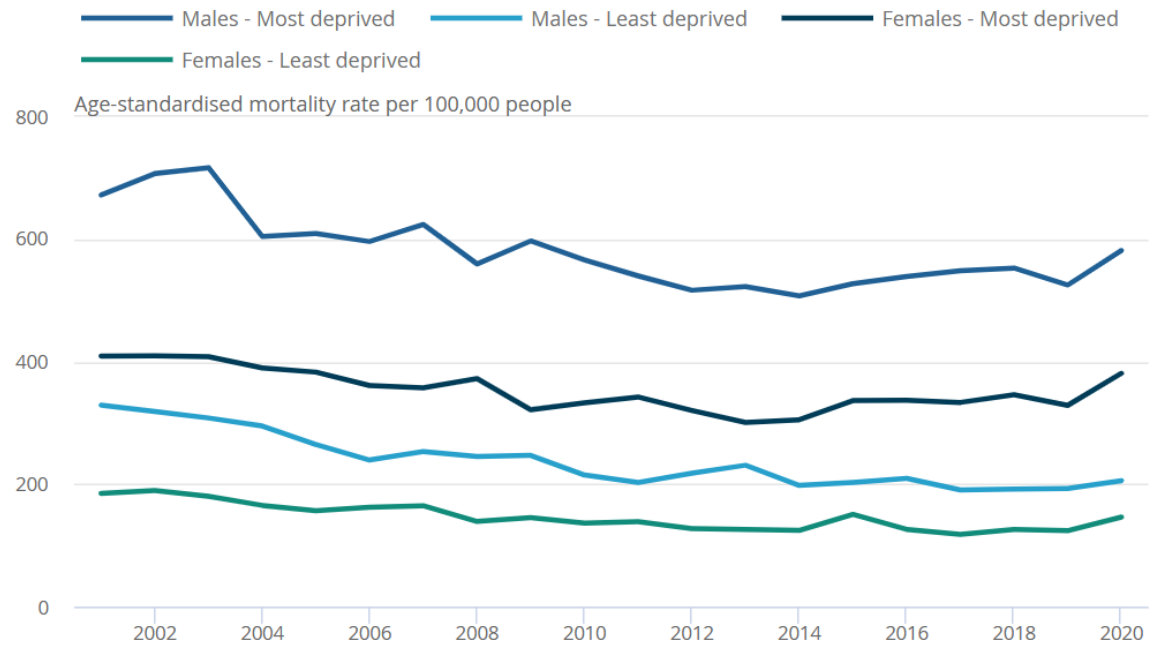
[13] Health inequalities in 2040 | The Health Foundation

Avoidable Mortality: what can we do to prevent or treat the conditions that make people die prematurely?
Most of the actions are in the community and more of the impact is in deprived communities

Our patients are dying too young from avoidable causes. 37.0% of all male deaths in the most deprived areas of Wales are estimated to be avoidable, compared with 18.9% in the least deprived areas in 2020; for females it was 25.7% and 14.1% respectively.

Avoidable mortality refers to deaths that are preventable or treatable. Factors in the inequity are COVID19, cancer, circulatory diseases, injuries and drug and alcohol related deaths. Many of these causes are amenable to interventions provided in primary care rather than secondary care.

Figure 9: Trends in avoidable mortality in Wales 2002-2020



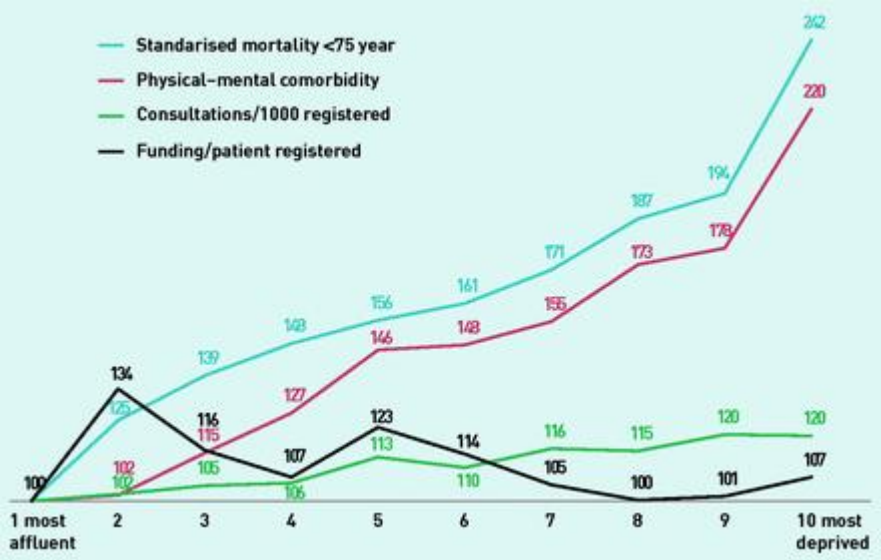
Source: Socioeconomic inequalities in avoidable mortality in Wales - Office for National Statistics (ons.gov.uk)

People from more deprived communities are more likely to be registered with a General Practice that has fewer doctors and other staff, meaning less time for each patient. Although 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, the rise in consultation rates with increasing deprivation is not enough to match the increase in multimorbidity.

Men living in the most deprived communities in Wales spend an average of 13.3 more years living in poor health.
Women living in the most deprived communities spend an average of 16.9 more years living in poor health

There is strong evidence of a mismatch in need, for example a powerful study from Scotland[14] as shown in Figure 9

Figure 9 Percentage differences for deprivation deciles, compared with the least deprived (with least deprived decile adjusted to = 100) for a selection of variables.



Continuity of care has been shown to improve satisfaction and trust, reduce healthcare utilisation, health inequalities and reduce mortality

We believe that continuity of care should be the top priority for general practices, especially for those with the most complex needs. It is not a zero-sum game with access, because greater continuity reduces demand and allows better access. However, a focus on access alone causes fragmentation of care, increased encounters and poorer outcomes.

People go missing when we are inflexible and uncaring. People who miss appointments have significantly worse health and a significantly higher mortality.

"Missingness" is an emerging concept which is very relevant to the Inverse Care Law. It can be defined as the "repeated tendency not to take up offers of care, such that it has a negative impact on the person and their life chances"[15] Punitive actions do not work (such as fining for missing appointments) This should rather be seen as a risk factor for poorer health outcomes and a need for different approaches. Going missing is more related with service factors than individual patient factors, and that means general practice has to find better ways to provide equitable access and continuity for everyone.

Unmet need is not accounted for in GMS funding formulae such as Carr Hill, and we believe that the additional workload in reaching out to those who are not presenting but have greater needs should be included in resource allocation.

[14] General practice funding underpins the persistence of the inverse care law: cross-sectional study in Scotland | British Journal of General Practice

[15] Understanding the causes of missingness in primary care: a realist review | BMC Medicine | Full Text

People have much greater non-medical needs in more deprived areas which impact on their physical and mental health, and the workload of general practice

We know that many individuals and families come to their GP Practice with problems that cannot be solved by the NHS alone. We know that what keeps people well is much more about their circumstances, such as their financial security, their housing, their social connections. It is estimated that 1 in 5 GP appointments are for non-medical issues such as housing, loneliness, relationships or debt[16] The personal experience of our Deep End GPs is these are factors in at least a third of the consultations that we have with patients in the most deprived communities and vulnerable groups.

We believe that we have a role in the NHS to identify the non-medical needs of our patients and connect them to the community assets that will meet these needs. GP practices are still the first port of call for large numbers of people, especially those in more deprived communities. We know that many people are not getting the support that they would benefit from. For example, there is good evidence that welfare rights services co-located in health settings increase family incomes: a systematic review showed that "studies demonstrated improved financial security for participants, generating an average of £27 of social, economic and environmental return per £1 invested"[17]. For other issues, there is growing evidence of good returns on investment[18].
Also, many people come to us with a "medical" issue such as anxiety, depression, stress, high blood pressure and chronic pain where the underlying cause is their circumstances. And we know that where the underlying causes can be alleviated, this will improve people's health and wellbeing.
When we help people get these needs met, then we expect:

- Reduced poverty in families
- Improvements in mental health
- Reduced demand on primary care and the NHS
- Reduced trauma and safeguarding issues in families
- People being better able to manage their own health using the community and third sector services
- Better management of chronic conditions and risk factors

Waiting times are top priority for Government: long waits affect Deep End patients more and increase Deep End workload more

We know that more people in Wales are waiting for diagnostics and treatments. We know that in England the impact of these waits is very unfairly distributed[19]. The data is not public in Wales, but we believe there is a similar picture of people from more deprived areas being likely to be on a waiting list, and more likely to suffer adverse consequences (employment loss, poverty etc). While they are waiting, they are consulting their GP practice more often to manage their conditions, and so secondary care waits have a bigger impact on Deep End General Practices. Measures to tackle witing times in Wales are welcome and should include actions to ensure equity based on real needs and not just time on the list. A good example is the UHCW HEART Tool (Health Equity And Referral to Treatment) for allocating bookings

[16] How does Social Prescribing work in the NHS – National Academy for Social Prescribing | NASP
[17] Sian Reece, Trevor A. Sheldon, Josie Dickerson, Kate E. Pickett, A review of the effectiveness and experiences of welfare advice services co-located in health settings: A critical narrative systematic review, Social Science & Medicine, Volume 296, 2022, https://doi.org/10.1016/j.socscimed.2022.114746.
[18] Economic evidence – National Academy for Social Prescribing | NASP
[19] Analysis reveals 'hugely concerning' disparities in waiting times between different patient groups in England | Nuffield Trust

Opportunities to improve general practice

1. **Ensure that there is a proportionate universalist approach in all strategic decisions**, especially in funding and workforce planning. The Inverse Care Law is not well-recognised and therefore is persistent in Wales, with inequity in allocation of resources at all levels in healthcare. Unmet need is not accounted for in any funding formulae such as Carr Hill, and we believe that the workload in reaching out to those who are not presenting but have greater needs should be included in resource allocation. We want equity, not equality. The Welsh Government should address the Inverse Care Law in funding and workforce through all means, including its power to negotiate the GMS contract. Continuing failure to do so risks contravening the Socioeconomic Duty.

2. **There should be a cross-Government Health Inequalities strategy** to drive more equitable decision- making to guide implementation of health policies, We want this to spell out the radical and difficult decisions that will move resources into the community and redistribute it according to healthcare needs.

3. **Focus on Deep End practices**: these are the ones that are closing and merging fast. Understand that patients in General Practices with a high proportion of patients from disadvantaged communities and groups have a quantitatively and qualitatively different experience, and this needs different support – one size GMS does not fit all. Support independent contractors where they are willing and flourishing, but also the Welsh Government should pro-actively explore alternative models of general practice provision where market failures persist and for specific groups with very high needs.

4. **Reducing waiting times is one step among many to improve health outcomes.** Investing in General practice in more deprived communities will allow more people with (often multiple) long term conditions to be managed in the community which in turn will have a relatively larger impact in reducing waiting lists. All measures to tackle waiting lists should include additional weighting[20] to ensure equity for those from the most disadvantaged groups who are more likely to be on a waiting list and more likely to suffer the consequences such as inability to work and poverty.

5. **Welsh Government to take a lead on exploring alternative primary care models**. We believe that choosing models of service provision should no longer be left to Health Boards to manage ad hoc. The Welsh Government should do more to ensure the GMS contract is fit for their purpose of providing great general practice to everyone who needs it when they need it. We also believe that the Welsh Government should pro-actively explore alternative models of general practice provision where market failures persist and for specific groups with very high needs (services for those in, and leaving, the criminal justice system, those who are in insecure accommodation, asylum seekers and refugees, sex workers, Travellers and any other group with specific primary healthcare needs)

[20]

6. **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 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.

7. **Begin to address the funding equity gap pragmatically and in small steps**. Use the existing *Additional Capacity Fund*[21] set up in 2021 with the original intention being to support practices manage increased demands, without a requirement for additional new work. And with the new Practice Stabilisation Fund, these should be targeted more effectively to provide increased workforce in practices with the highest burden of patient needs, with new renewed criteria to achieve increased scale and reimbursement levels for all practices, with the overall goal of increasing primary care resources as a percentage of the total NHS budget; AND could include differential reimbursement through weighting by deprivation. For example, 100% reimbursement in the quintile of practices with the highest proportion of patients in the most deprived areas, with a sliding scale down to 50% (the current level) in those serving the most affluent quintile areas. Eligible roles for reimbursement should be flexible and include GP, Nurse / Nurse Practitioner / Pharmacist / Management / others.

8. **Training in Deep End Practices** Many health workers love training and working in Deep End practices and with health inclusion services, because it is very fulfilling and interesting work, and teams are often very supportive and close. And health care workers tend to stay in the locality and organisation that they trained in, so it's a strong recruitment strategy to train people where you need them to work. But we are not targeting training to meet population needs, so not everyone who would benefit gets the chance to do this. We believe there could be an expansion of training placements and a shift towards offering opportunities in Deep End practices, and incentives to train and work in more deprived areas, and with health inclusion services. This would require training supervision capacity and funding of trainers' time in those practices; also consideration of salary incentives to train in those areas maybe with commitment to a salaried post (via Additional Capacity Fund) for their first 3-5 years. The same principles work for GPs, Nurses / Nurse Practitioners / Pharmacists / others. We believe that a specific Deep End GP training scheme would be an excellent start and would improve recruitment and retention, as demonstrated by such schemes in the UK[22] and Ireland.[23]

[21] Guidance for the GMS Contract Additional Capacity 2022/23

[22] About | Deprivation-Focused GPST Programme Manchester Deprivation Medicine Training Program

[23] Education NDCGP | healthequity North Dublin City GP Training scheme

9. **Begin to address the Inverse Care Law in GP workforce**: Expand the well-established and successful Academic Fellowship schemes at Cardiff and Swansea Universities[24] [25] These two-year programs offer very early career GPs a combination of clinical work in practices with research and teaching. Only Cardiff University has explicit eligibility criteria to focus on practices in deprived areas, Swansea is open to all practices now, so an expansion would need to focus on Deep End practices only. The programs help GPs develop their skills, confidence and careers, while also supporting practices in underserved areas. This frees up senior doctor / partner time for practice developments of any kind (for example, preparing for a merger with a nearby struggling practice, or setting up an enhanced service). Cardiff is also successful in the high rate of these Fellows who stay on as GPs in Deep End practices. The programs require academic supervision, capacity and funding but are ready and willing to expand in numbers. There could of course be consideration of developing similar schemes with Nurse / Nurse Practitioner / Pharmacist disciplines, and with other relevant universities. The aim should be to Increase GP numbers to produce average list size of no more than 1,500 patients per GP by end of next and no more than 1,000 patients per GP in areas of greatest need.

10. **Value the workforce**. Our staff are our greatest asset. We want them to be paid well, treated with respect, and to be given the education and resources to do their job well. This includes ensuring decent pay, equity focused training, wellbeing support and an Occupational Heath Service.

11. **Fund social prescribing to reduce demand** Ensure that any social prescribing research, guidance and implementation is always with a heath equity lens. Community assets in more deprived communities and for more vulnerable groups should be given priority and receive proportionately greater investment. Social prescribing should focus on basic needs (e.g. financial inclusion, welfare rights advice, housing, child poverty) first. Deep End practices should each have an embedded Link Worker, with community development skills.

[24] Academic Fellows Scheme - School of Medicine - Cardiff University

[25] About | GP Academic Fellowship Scheme