



# GENERAL PRACTICE – A PRESCRIPTION FOR A HEALTHY FUTURE



## FOREWORD

General practice has been the cornerstone of the NHS since it was formed more than 60 years ago. In Wales we are fortunate that the Welsh Government has made a strong commitment that it will remain that way. General Practice, like the rest of the NHS, is facing unprecedented challenges. It is clear that the NHS is slowly becoming overwhelmed. If it is to survive in its current form, there will have to be fundamental change. There is now a strong body of scientific and economic evidence confirming that the status quo is not an option. The purpose of our strategy is to describe the changes that we believe are needed and to set out the evidence on which our proposals are based.

Whilst the economy is recovering, the impact of the recession will last at least another 5 years. The NHS is being asked to treat more patients and a higher proportion of the elderly with less money. This has been described by some as a 'perfect storm'. For GPs this comes on top of a series of below inflation pay settlements which threaten the viability of many practices. Against that background, the Welsh Government is planning for more work to be done in primary care and for care planning to be managed through GP cluster networks. This cannot happen unless primary care is provided with the workforce, infrastructure and stability to do the job. This strategy makes the case for the investment that is required to deliver all those things.

In drawing up our proposals we undertook an extensive literature search. We looked at every major Welsh Government health strategy and review going back to 2001. This work confirmed that Welsh Government has always been positive about primary care. The aim to create a "primary care led NHS" was first set out 14 years ago. Successive ministers have made commitments to involve GPs in the running of the NHS; to expand primary care; invest in the development of extended primary care teams; and to locate these teams in modern purpose built resource centres. Despite the good intentions, none of this has happened in the way that was intended. Putting this right at a time of severe financial austerity is the enormous challenge that we now face.

Our strategy comprises 8 chapters which highlight the key issues, set out the rationale and make recommendations for change. Some of what we say is hard hitting, but none of it is new. Over the last 15 years the problems of the NHS in Wales have been subject to considerable scrutiny. The conclusions and recommendation of independent experts like Sir Derek Wanless and McKinsey & Co Consultants are remarkably similar. Some of this work is dated, but the content is as true now as it was then. Our proposals draw strongly on these proposals and the evidence that they assembled. We believe that if the areas of concern are addressed effectively, it will ensure that high quality general practice is maintained. It is our goal that patients continue to have access to a high quality service which is responsive to patient needs and provided equitably across Wales.

We would welcome constructive feedback on our proposals via letter to the BMA Cymru office (GPC Wales c/o BMA Cymru, 5th floor, 2 Caspian Point, Caspian Way, Cardiff. CF10 4DQ) or email to [info.gpcwales@bma.org.uk](mailto:info.gpcwales@bma.org.uk).



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**July 2014**

## EXECUTIVE SUMMARY

General practice is going through one of the most challenging periods since the inception of the NHS. Economic austerity and ever increasing levels of ill health present a huge challenge. This strategy has been commissioned by GPC Wales to chart a way forward. It is divided into 8 chapters. Each one sets out the key issues, discusses the options and makes recommendations for change:

**Chapter 1 – General Practice Provision: Value, Model & Finance** – There is overwhelming evidence that demonstrates the excellent value for money offered by the UK model of general practice. There is very little evidence to suggest that any alternatives whether wholly salaried or some form of social enterprise would be either effective or affordable. Previous experience of health boards suggests that a wholly salaried service would cost more and require disproportionate management effort. Despite strong evidence to support further investment, the share of total NHS expenditure allocated to Welsh GMS has fallen from 10.3% to 7.9%.

**Chapter 2 – Workforce** – The ageing population, growth in chronic disease, greater complexity of care and transfer of work from hospitals have combined to place unsustainable strains on GMS primary care. Health board staff numbers have increased by 19.7% over 10 years, with some staff groups up by 120%. By contrast, the numbers of GPs has risen by a mere 11.2% and the whole time equivalent has remained broadly static. Over the last decade the proportion of GPs aged over 55 has increased by 39%. The positive effect of the 2004 contract on morale has been lost and GP shortages are widespread, especially in areas of greatest need. Changes in taxation and pensions have acted as a disincentive for GPs to continue working. Numbers of GP trainees in Wales remain static. **The statistics that are available all point to the onset of a GP recruitment crisis for which Wales is ill-prepared.**

**Chapter 3 – Access** – Politicians need to become more realistic about the level of access that can be delivered within limited and declining resources. The Welsh Government's 2001 policy commitment to provide all patients with access to a member of the primary care team within 24 hours is no longer deliverable and requires up-dating. GPC Wales strongly supports the objective of good access to primary medical care for all. Ideally GP surgeries would be open 7 days a week but the NHS in Wales has neither the money nor the workforce to support this. Resource limitations will mean that urgent access can only be guaranteed for those who demonstrate a clinical need. Patients with non urgent conditions and those who require routine management of long term conditions may need to wait longer. Out Of Hours care has been chronically under-funded since LHBs took it over in 2004. Over that period, LHBs have received average funding uplifts of 3% p.a. from government but Out Of Hours service budgets have risen by only 0.6%. Disinvestment in this service has had serious knock on consequences for the whole of unscheduled care. In many areas there are insufficient GPs to fill rosters. There is an urgent need to review the way Out Of Hours services are provided.

**Chapter 4 – GP Cluster Networks** – Prior to devolution GPs were increasingly involved in commissioning services. Following the abolition of fund holding, Welsh Government launched a series of initiatives to involve GPs in local management of the NHS. Very little progress has been made and the management of the NHS locally is still completely dominated by NHS managers. Development of primary care teams was put into reverse by LHBs, doing substantial damage to efforts to integrate primary and community care. In 2013, LHBs were set ambitious targets to establish local bodies with decision making and financial powers, but in most areas very little has changed. As a result, local commissioning expertise and the enthusiasm generated in the 1990s has been almost completely lost. In most areas GP cluster networks are no more than irregular meetings organised by LHBs to administer QOF. GPC Wales is committed to cluster networks, but

they will only work if there is a fundamental change in attitude by LHBs. LHBs must let go and provide clusters with the support and resources to do the job.

**Chapter 5 – Premises** – In 2002 a detailed survey of GP premises across Wales revealed the need for the replacement or renewal of about one third of all premises. The Welsh Government established a centrally managed programme but this was completely dominated by third party developers using institutional money. The cost of premises for the average surgery increased by 4 or 5 fold and progress was often bureaucratic and slow. The GMS premises budget rose by 62% between 2004 and 2013 when it ran out of money. In 2013 responsibility for GP premises was passed to LHBs without a budget. Premises data is not routinely disclosed by LHBs. GPC Wales estimates that the programme of development set out in 2004 may not even be half finished. There is an urgent need to look at more affordable ways of completing the programme. Without primary care capacity, in some areas it will be impossible for LHBs to deliver their financial plans which rely heavily on transferring work into primary care.

**Chapter 6 – Information Technology** – Welsh general practice with excellent support from Welsh Government has a world class IT system. It stores vast amounts of information on the health care of individuals and practice populations. Whilst IT in primary care is outstanding, the NHS is a long way from achieving the objective of a single health record. Additional investment is required to bring hospital IT systems up to the standard of primary care. The connections between primary care and hospital are improving, but there is still a long way to go. Connectivity with social care is almost non-existent, which impedes real integration of care. Significant investment in IT is therefore still required. In times of austerity these budgets will be a target for savings. GPC Wales believes it would be short sighted to submit to such pressures.

**Chapter 7 – Data Availability and Service Improvement** – Assessing NHS performance in Wales is a long standing problem. Wales still depends on the NHS Information Centre in England to analyse and publish much of its primary care data.. As far back as 2003 Sir Derek Wanless pointed out that data quality was poor and there was lack of robust evidence to support decision making. There is a need for much more openness with clinical and financial data. Commitments on benchmarking and use of comparative data made in Designed for Life in 2005 should be implemented. Data on finance and relative performance should be available on the website of every NHS organisation. If the NHS in Wales is to achieve the step change in efficiency that is required to cope with further austerity, the collection, analysis and sharing of data must improve.

**Chapter 8 – Leadership** – There are encouraging signs that the UK economy is emerging from recession. Unfortunately the size of the accumulated deficit means that we are no more than half way through the programme of expenditure cuts. If the NHS is to survive as we currently know it, then radical change will be necessary. Change will affect everyone involved in the NHS, especially patients. These changes present a huge leadership challenge which will need to focus on how limited resources can be best utilised. At the highest level much greater candour will be required from politicians about what can be achieved from diminishing NHS funding. GPC Wales is calling for a cross party political consensus around the need to make best use of scarce resources. As it is currently structured, the Welsh Government is ill-prepared to run its own contracts as support historically provided from England is gradually withdrawn.

## KEY RECOMMENDATIONS

- *Increase the share of the Welsh NHS budget allocated to the GMS contract to the 2007 level of 10.3%, and maintain the investment value; to be achieved over a 3 year period 2015/16 to 2018/19.*
- *Politicians to promote realistic messages about what can be delivered within NHS resources, amending access policy to provide rapid access only for those with urgent clinical need and encouraging self help and restraint.*
- *OOH to receive its fair share of investment, with uplifts to correct 10 years of underfunding. To be implemented with the 2014 Welsh budget and on a phased basis over 3 years.*
- *GP cluster networks to be given real decision making power with delegated budgets, accompanied by resources to support their training and development needs.*
- *Undertake a review of the condition of primary care premises in Wales to include costs for all necessary extension, refurbishments and replacements by March 2015. Consult with GPC Wales about more cost effective alternatives to PFI funding including making full use of the 2004 premises flexibilities to encourage GP led development*
- *Subject to appropriate safeguards on patient data, prioritise linking up primary, secondary and social care IT systems to help facilitate the development of integrated care.*
- *Establish a programme to identify what clinical management and financial data sets are necessary best to support the efficient delivery of healthcare in Wales.*



## CHAPTER 1: GENERAL PRACTICE PROVISION: VALUE, MODEL & FINANCE

### KEY ISSUES

- Extensive evidence pointing to the high value of the independent contractor model of general practice provision has tended to be overlooked.
- Incomplete understanding of the limitations of alternative models of general practice provision.
- Uncertainty over preferred models of general practice provision.
- Lack of appreciation of the cost effectiveness of investing in general practice services.
- Failure to expand general practice in line with successive policy commitments.
- Erosion of GMS funding since 2007, blighting the development of services.

### DISCUSSION

#### Value

There is widespread evidence to support the value for money and cost effectiveness of the traditional UK model of general practice. For example: The Commonwealth Fund report of 2009;<sup>1</sup> Starfield in 2005;<sup>2</sup> Oldfield in 2012;<sup>3</sup> Kringos et al & Haggerty et al in 2013<sup>4</sup> and Pierard in 2009.<sup>5</sup> Key themes running through these studies reinforce that investing in primary care through general practitioner (GP) led services is good for the populations' health and an effective use of healthcare resources. It reduces health inequities, effects lower rates of unnecessary hospitalisation and reduces reliance on more costly secondary and tertiary care services. Primary and Community care is a highly effective means of healthcare delivery in terms of both cost and quality. Despite this wealth of evidence its value and potential remains relatively unappreciated and untapped within healthcare in Wales.

#### Model

General Practice in Wales is primarily delivered through GP partnerships where GPs lead teams of staff delivering a wide range of primary and community care services to their patients. Practices vary from single handed to 8 or more partners, but all deliver the same core services under a single national General Medical Services contract.<sup>6</sup> GPs are classed as "independent contractors" meaning they are not employed by the NHS but "contract their services" to the NHS.

#### Independent contractor models

**Alternative models of primary care provision have been put forward with very little evidence to support them. While there is a place for a mixed economy of provision, the evidence overwhelmingly supports the independent contractor model as being most effective.<sup>1,2,3,4,5</sup> It has stood the test of time. Studies have repeatedly confirmed that the independent contractor model is excellent value for money, responds and adapts quickly to service change, requires minimal management, is cash limited, innovative, fleet footed, and promotes a primary care team ethos. It provides familiarity and stability and continues to command the confidence of patients. It is a well recognised, easily accessible, familiar model of access to health services for patients and frequently fulfils an independent patient advocacy role that is trusted and valued. Most significantly, it consistently scores high patient satisfaction ratings.<sup>7</sup> It has formed the cornerstone of the NHS for 66 years, and continues to do so.**

#### Salaried service

A salaried GP service is the most commonly promoted alternative to the independent contractor model. While having an important place in primary care provision, there is little reliable evidence to support the case for wholesale change to this model. Anecdotal evidence from LHBs suggests

that wholly salaried practices are more expensive and require disproportionate management effort. Working on a salaried basis remains attractive to some GPs. It is valuable in supporting flexible career choices and undoubtedly assists in retaining doctors in general practice at the beginning and end of their careers. There is however no evidence to support a wholly salaried service as the principal mode of general practice delivery.

### **Social enterprise model**

More recently there have been proposals to deliver GMS jointly with community and social services through social enterprise models.<sup>8</sup> The “John Lewis” model is often quoted. This model aims to utilise a broader skill mix, with for example, nurse practitioners and pharmacists performing components of the traditional GP role. Typically staff are more involved with the management of the services and share in the risks and rewards. There are instances where such models have worked well, but there is no research to provide assurance that such models would be stable or more cost effective in the long term. A move to a service-wide social enterprise model would be the biggest change to the NHS since 1948. It would require a reconfiguration project that would consume substantial energy and resources. It would distract the NHS from the focus on service delivery at a time of austerity and could destabilise primary care in the process. This would be high risk and there is little evidence or guarantee of its viability or long term success.

### **Developing wider skill mix**

Welsh health policy since 2001 has looked to adjust staff skill mix to create the optimum combination of health professionals to deliver primary care.<sup>9</sup> General Practice and the General Practitioner Committee for Wales (GPC Wales) has supported this policy direction. It has also promoted the development of GPs with special interest and closer working of secondary care specialists within primary care where this is appropriate. As GP cluster networks mature and begin to work on an integrated basis, skill mix will need to be further refined. Whilst GPs welcome the opportunity to share and delegate work within teams, this must be driven by best evidence around clinical safety, quality of service and cost-effectiveness.

GPs are highly trained primary care specialists equipped to deal with undifferentiated health needs. They use time efficiently, make decisions quickly, manage clinical risk as safely as possible in the best interests of their patients and are prudent in the use of health service resources. The role carries high levels of responsibility and accountability. The role of the GP is unique and critical to maintaining an holistic view of a patient’s health care needs. Where health and social care services remain fragmented and pose a risk to patient safety, the role of the GP as the gatekeeper and coordinator of care is essential in achieving the most effective use of resources. This role is most valued and trusted by patients and must remain the bedrock of Welsh health policy.

### **Finance**

It is widely recognised that the NHS in Wales is living beyond its means.<sup>10,11</sup> Its recovery plans are all predicated on the notion that hospitals can concentrate on more complex care by transferring routine work into primary care. WG health policy post devolution has consistently committed to the expansion of primary care and the delivery of more services closer to home.<sup>8,12,13</sup> In 2007, the Wales Audit Office<sup>14</sup> recommended that: “The Assembly Government and LHBs must work together to develop a framework to encourage disinvestment in secondary care to free-up resources to improve primary and community services by the end of 2007.” This recommendation was accepted but it is difficult to identify any substantial evidence of its implementation. Analysis of financial trends since 2007 suggests that the reverse has happened.

### Cost of the GP consultation

The current system of a partnership model of GP delivered primary care does so with a cost of £153<sup>15</sup> per person for a whole year. This provides an average of over 6 consultations per person per year or £23 per consultation. In comparison, each regular hospital consultation costs £240<sup>16</sup> – ten times more expensive, while a simple call to NHS Direct with no medical intervention costs £26.<sup>17</sup> The new GMS contract<sup>6</sup> initially brought a significant increase in investment in primary care but this has subsequently failed to keep pace with the rest of the NHS.

### Resources spent in general practice

The GMS contract share of total NHS funding reached a peak at 10.3% in 2005/6, but has subsequently fallen to 7.9%.<sup>18</sup> In real terms, funding has been falling since 2007/8 with the consequent adverse effect on innovation and the ability to truly enable expansion of care in the community.

On the background of diminishing investment in primary care, and an ageing population with increasing incidence of chronic conditions, the primary care workforce has been working harder simply to stand still. The new GMS Contract 2004 included the Minimum Practice Investment Guarantee, an undertaking that over 3 years investment would increase by at least 33% to fund an expansion of GMS primary care. Since then, in real terms, funding has been repeatedly eroded, despite significant increases in core work. WG has an impressive range of policy commitments that require additional primary care capacity. These are currently undeliverable without the accompanying investment.

## RECOMMENDATIONS

- Welsh Government should clarify its policy on the preferred model for delivering GMS. It should recognise the strong body of evidence supporting the cost effectiveness of the traditional UK independent contractor model of GMS primary care and commit to this model.
- Welsh Government should recognise that the salaried GP model has an important place in primary care delivery in support of the mainstream and partnership model, but not as a principal mode of delivery.
- Health Boards to develop the mechanism for devolving budgets for shared working in line with the WG financial framework by December 2014 in preparation for financial year 2015/16.
- Continue to review the skill mix of primary health care teams and community provision based on best evidence.
- Recognise and value the role of the GP as care coordinator and gatekeeper of care, maintaining a holistic overview of the needs of the patient.
- Implement the 2007 Wales Audit Office recommendation to develop a framework to encourage disinvestment in secondary care to free-up resources to improve primary and community services by April 2015.
- Increase the share of the Welsh NHS budget allocated to the GMS contract to the 2007 level of 10.3%, and maintain the investment value; to be achieved over a 3 year period 2015/16 to 2018/19.
- All new primary care policies should be accompanied by detailed financial plans and monitoring arrangements to ensure viability and guarantee delivery.



## CHAPTER 2: WORKFORCE

### KEY ISSUES

- Absence of a workforce strategy for primary care.
- Paucity of reliable data to measure and monitor primary care workforce.
- Recruitment and retention problems for both daytime and Out Of Hours services.
- GPs considering early retirement due to pension changes, pay cuts, and unmanageable workloads.
- Ageing GP workforce storing up future problems.
- Too few GPs in training.
- Lack of incentives for doctors to work in Wales.
- Lack of flexible career scheme options for GPs.
- Need to review the GP Returner Scheme.
- Lack of occupational health provision to keep over-stressed GPs in work.
- Uncertainty over implementation of RCGP's recommendation to extend GP training to 4 years.

### DISCUSSION

The ageing population, growth in chronic disease, greater complexity of care and unfunded transfer of work into general practice all contribute to unreasonable increases in GP workload. GP consultations have risen to over 19 million a year, an average of 6 appointments per annum for every person in Wales. In 2003/4 GPs were prescribing an average of 17 items per head of population, 10 years later that number increased by 45% to 24.8 items.<sup>19</sup> This is a very reliable marker that illustrates the inexorable rise in the volume of chronic disease over the last decade and effective early detection and management by GPs.

#### GP workforce numbers

Against this background, the GP workforce headcount has increased by 11.2% over the period 2000-2013.<sup>20</sup> By comparison consultant numbers have increased by 62% and nurse managers by 120%.<sup>21</sup> The whole time equivalent for GPs is said to have increased by 10.5%, but the methodology for calculating this appears to be flawed. GPC Wales believes that the whole time equivalent number has remained broadly static. This results from many GPs working fewer sessions to cope with stress and avoidance of burnout; increasing numbers of GPs taking up portfolio careers combining general practice with areas of special interest; and GPs undertaking a wide variety of sessional roles in support of LHBS and government agencies. To meet the increasing workload requirement of general practice, a like for like replacement of one retiring GP is no longer sustainable. Workforce experts at NLIAH and the Centre for Workforce Intelligence estimate that at least 1.6 GPs are needed to replace one retiring GP.

#### Factors affecting recruitment and retention

One of the main objectives of the 2004 GMS contract was to address the GP recruitment crisis that began around 2000.<sup>22</sup> The new contract achieved this objective having a positive impact on recruitment and made working in GMS much more attractive. By 2006 there was an adequate supply of GPs to cover the work. The economic recession and below inflation pay settlements leading to actual reductions in average incomes from 2007 onwards have created new recruitment problems, (particularly in deprived areas where need is greatest). This has been exacerbated by adverse changes to pension contributions and pension taxation law. The age structure of the GP

workforce gives further cause for concern. In 2002, 17.1% of the GP workforce was 55 or over; this has now risen to 23.4%,<sup>23</sup> an increase of nearly 39%.

### GP training

Against the background of recruitment problems and an ageing workforce, it is imperative that adequate numbers of new GPs are trained. Wales currently funds training for 136 places per annum, not all of which are filled. Unfilled training places are an issue that all 4 UK health departments are having to address. It is probably exacerbated by the fact that Wales has the lowest number of Foundation Level 2 (FY2) posts in general practice (24% compared to a 55% average across rest of UK). GPC Wales notes that next year there will be a 1 year increase of numbers of posts to 36% to account for the increase in numbers of FY2 doctors in Wales. Unless WG retains these posts permanently, subsequent years will see the number of posts revert to 24%. The overall number of training places in Wales has remained static despite longstanding commitments to expand primary care. By contrast, in England, the Government is committed to a 30% increase in GP training numbers and an aspiration that 50% of trainees will enter general practice.<sup>24</sup>

Paucity of data and the absence of a robust primary care workforce strategy make it difficult to estimate the precise workforce requirement for Wales. Extrapolating the primary care health needs of England, GPC Wales estimates that training places in Wales would need to rise to 200 per annum.

Wales remains a net exporter of doctors and that is an issue that should be accounted for and tackled via a comprehensive workforce strategy.

GP training should evolve to reflect and accommodate changes in health care. GP training is shorter than all other UK medical or surgical specialties. It is less than half the duration of some specialties. In its 2012 report "Preparing the Future GP: The case for Enhanced GP Training" the RCGP makes a compelling case for the extension of GP training to 4 years to prepare young doctors for the rigours of modern general practice. Whilst this will have a minor negative impact on workforce capacity, GPC Wales believes this should be implemented in Wales as soon as possible.

### Potential solutions

In addition to increasing the GP training numbers, it will be necessary to develop incentives to retain those trained and to encourage new doctors to move to Wales. Options might include; the introduction of an enhanced "golden hello" scheme (e.g. similar to those in private industry where individual GPs can choose from a range of incentives to meet their personal needs), a "golden handcuffs" scheme; creation of rural academic scholarships; financial incentives for junior doctors (such as paying student loans); the creation of portfolio job options that recognise that some GPs wish to retain or develop special interests. Welsh Government needs to look at enabling more innovative flexible career schemes that combine General Practice partnership with ability to undertake other roles within NHS Wales.

Multiple surveys of GPs in training and newly qualified GPs indicate that, should the pressures within General Practice be addressed, they would wish to enter partnership whilst also maintaining other areas of specialist interest. In 2012 the costs of training a GP was estimated by the University of Kent at £498,000,<sup>25</sup> so it makes sound economic sense to provide strong incentives and support to GPs that wish to return to work. The GP Returner Scheme should therefore be revised so that it can be individually tailored to the needs of returning GPs and thereby remove some of the barriers to returning.

The primary and community care workforce is not just made up of general practitioners and it is important that Wales has a robust workforce strategy that takes into account the entire primary care workforce – in particular practice nurses and district nurses – to ensure adequately resourced primary health care teams wrapped around the practice as well and strengthened community teams.

### Occupational health needs

With ever increasing volumes and complexity of work, the need for a comprehensive occupational health service for primary care is long overdue. The justification for this is both moral and economic. Given the significant cost of training GPs it makes complete sense to preserve and protect that investment. General practice and its staff are not currently part of the NHS Occupational Health Service. This is an oversight that Welsh Government has long promised to address.<sup>8</sup> Burnout, stress, low morale and risks of mental health illness have become more prevalent over the last 10 years. GPs in Wales have access to “Health 4 Health Professionals Wellbeing at Work” but do not have access to the comprehensive occupational health services provided to other parts of the NHS. A comprehensive occupational health service for general practice should therefore be a priority.

### RECOMMENDATIONS

- A Primary Care Workforce plan to be agreed in collaboration with the BMA by October 2014.
- Workforce planning to be moved back into Welsh Government to give it greater strategic priority by April 2015 in preparation for 2015/16 contract year.
- Implement quarterly data collection to pinpoint shortages, monitor growth in workload and ensure that workforce numbers are adequate to deliver new policies by April 2015.
- Expand workforce data collection to a quarterly basis and review methodology for calculating whole time equivalent GP numbers.
- Launch an active recruitment campaign to encourage doctors and nurses to train and work in Wales.
- Introduce support programmes tailored to the needs of doctors who wish to return to work in general practice.
- Introduce a flexible career scheme.
- Introduce support programmes tailored to the needs of individual doctors who wish to return to work in general practice.
- Expand GP Specialty Training places on a phased basis from 136 to 200 by December 2017 and permanently increase Foundation Level 2 posts in general practice by over 50% to bring Wales into line with other parts of the UK.
- Extend specialty training to 4 years as set out in RCGP’s Preparing the Future GP: The case for 4 year Training.
- Provide GPs and primary care staff with access to comprehensive NHS occupational health services by December 2014.
- All future policies must include full consideration of workforce implications.

## CHAPTER 3: ACCESS

### KEY ISSUES

- Promises from politicians to the public on access have been unrealistic.
- Need for realism about access and the trade off between rapid access and booked appointments.
- Poor use of GP time arising from inappropriate use of appointments and GPs involved in form filling and chasing referrals across NHS and social care.
- Lack of progress in conveying the crucially important self care agenda.
- Need for recognition that financial and workforce constraints dictate that difficult decisions need to be made on access priorities.
- Seven day opening and extended hours at every GP surgery are unnecessary, unaffordable and undeliverable within the current workforce and budget.
- Out Of Hours services need urgent review.
- Funding for Out Of Hours services has dropped year on year in real terms since 2004 and this has adversely affected the development of services to patients.

### DISCUSSION

#### Daytime Service

Every person in Wales is entitled to seek an appointment with a GP. This results in over 19 million GP practice appointments per year. It would be inappropriate to actively deny patients free access to appointments, but there is a dilemma in juggling routine demand against emergency access. No appointment system whether booked, open access or mixed has proven a perfect solution. Achieving good access and maintaining patient satisfaction is a major challenge. In an endeavour to give priority to patients with the greatest clinical need, there can be delay for others. Appointment systems are under constant review in an effort to allow patients to book ahead while maintaining availability for those requiring urgent attention.

GP Access surveys conducted by MORI confirm that patients are generally very satisfied with the level of access.<sup>26</sup> Reports from Community Health Councils are also generally very positive. Nonetheless, some patients report problems in getting appointments that suit them. Others find systems for "same day" appointments frustrating, especially when having to compete to get through by telephone first thing in the morning. Difficulty in booking an appointment in advance can also cause issues with employers and childcare. Alternatively, unhindered advance booking can lead to non-urgent appointments being booked weeks ahead. The systems devised to address these competing priorities have caused some patients to believe that services are designed to suit the practice rather than its patients.

Given the inexorable rise in demand for health care and the current financial and workforce constraints, a balance needs to be struck on access arrangements. The aim should be to provide the best and most appropriate level of access within available resources. It may also be necessary to distinguish between patients' desires and needs. In this context there has never been a more pressing time to involve the public in the debate on how to strike this very difficult balance. Practical approaches are also needed. GPC Wales has already made inroads into this problem with the **"Sort it in one call"** policy.<sup>27</sup> This aims to ensure that every patient who rings for an appointment has an agreed outcome without the need to ring back.

### Extended opening

WG initiatives on GMS opening hours have taken a number of forms since 2004. In 2008 the Extended Opening DES was launched funding practices to deliver extra surgeries.<sup>28</sup> This was followed by a Ministerial commitment to 8 am to 8 pm opening across primary care,<sup>29</sup> then the 2011 manifesto commitment to evening and weekend opening.<sup>30</sup> Neither of the latter initiatives was accompanied by additional funding. Extending opening hours to 8 pm represents a 14% increase in the working day. To be truly cost-effective there must be demonstrable patient demand that cannot otherwise be met. There also needs to be concurrent access to the diagnostic, clinical and social care services that are an essential part of good primary care. Even if extended opening is cost-effective, the capacity of the GP workforce is insufficient to take on a 14% expansion in the working day. The policy to refocus care from hospital into primary care presents further challenges to capacity that is already insufficient.

Given static workforce and the inexorable rise in hours worked by GPs, extended opening could only be delivered by moving to shift working. The consequence would be fewer appointments during the normal working day. This would have a negative effect on core clinical work and it would worsen daytime access. Shift working and attempts to squeeze more hours from the existing workforce raise significant patient safety issues. Access to a GP 24/7 is already available through a combination of GP practices and Out Of Hours services. The aspiration to move to 7 day availability for routine NHS services is entirely valid. It is also understandable for patients to want their family doctor to return to taking 24 hour responsibility. The harsh reality is that neither of these aspirations is currently affordable or achievable.

### 24 hour access

The public expectation that routine services can be available 24 hours a day is damaging to the NHS. In 2001 the Welsh Government made a commitment that all patients should be able to get access to a member of the primary care team within 24 hours.<sup>31</sup> This has never been fully delivered and, given the current workforce constraints, it will not be achieved in the foreseeable future. The objective must be to provide timely consultations to accommodate urgent care for those who cannot wait. The focus must be on what can be afforded and delivered within current workforce capacity. Without substantial additional funding and expansion of the GP workforce, rapid access for all patients, regardless of need is unaffordable and the policy should be revised.

Same day access for routine clinical issues is unnecessary in the majority of cases. Most patients require an appointment in a safe clinical timeframe. The daytime service should concentrate on providing rapid access, only to patients with the greatest clinical need. Improved daytime access for acute illnesses, the frail and the vulnerable would assist in reducing hospital attendances. A fundamentally different message is required for those with self-limiting illness or routine health needs. NHS services are a limited and valuable commodity and should only be used when they are really needed.<sup>32</sup>

The availability of non-urgent care should be allocated so as to conserve limited capacity and resources. This may involve the delivery of messages that may not be popular with patients. The options available to the NHS are limited. It is difficult to see how the current patterns of services are sustainable without radical change in delivery and expectations. A political consensus with public engagement will be required to achieve this. It is no longer acceptable for political parties to approach elections out-bidding each other with promises on the NHS that are unaffordable and undeliverable.

### Out Of Hours

Out Of Hours services are the frontline of primary care for 70% of the week, providing care when GP surgeries are closed. The table below shows that Out Of Hours services receive only 0.5% of total NHS funding to provide a key element of the unscheduled care provision. The average annual uplift for inflation over the last 8 years has been 0.6% when LHBs have received an average increase of 3%. It has been a soft target for cuts, with funding repeatedly eroded by inflation. This pattern of disinvestment is irreconcilable with government commitments to prioritise the improvement of unscheduled care.

### Investment in Out Of Hours Services in Wales 2005 – 2012<sup>15, 33</sup>

Year	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
£m	31.8	32.5	33.0	32.0	31.6	33.2	33.4	33.1
OOH		+2.2%	+1.5%	-3%	-1.2%	+5.1%	+0.6%	-0.9%
LHB Allocations		+9.4%	+6.6%	+0.1%	+3.1%	+0.2%	+1.4%	+4.0%

The current model of Out Of Hours care is broadly based on the pre 2004 contract model of GP co-operatives. This involved groupings of practitioners working together in a rota system which enabled GPs to share responsibility for caring for their patients when surgeries were closed. In 2004 LHBs took over responsibility for Out Of Hours care. The service models put in place relied heavily on GPs to work sessions on a sub contract basis. From the outset there were staffing problems in certain areas. In some parts of Wales the service is breaking down because it is not possible to find GPs to fill shifts, as they struggle to sustain daytime services.

There is significant value to having local GPs involved in OOH service provision. With a finite and depleted workforce, the same cohort cannot deliver safely both daytime and OOH care. Given the substantial increases in both daytime and out of hours workloads, a return to GPs working a full day following a night shift would now be considered unsafe. Unless Out Of Hours services are provided with a fair share of investment it will be impossible to attract and increase capacity, particularly on bank holidays and weekends. For those doctors wishing to work predominantly in OOH services it must provide a competitively remunerated career choice.

Concerns over the viability of the current model of OOH provision, which relies significantly on sub contracted labour, must be addressed urgently. Given the difficulties in finding sub-contract OOH GPs, a move to a larger core of OOH salaried GPs may be necessary. This approach has the advantage of providing a stable core workforce whilst maintaining the links to daytime services. There have been some economies of scale achieved by reducing the number of OOH providers, but this alone is insufficient. Further rationalisation of the service to obtain economies of scale may merit consideration. GPs must be involved in the planning and running of these Out Of Hours services as it is GPs that will do most of the work.

**RECOMMENDATIONS**

- Politicians to promote realistic messages about what can be delivered within NHS resources, encouraging self help and restraint where appropriate.
- Review the “Choose Well” campaign and ensure Welsh patients understand their choices and are enabled to utilise them appropriately (including GP, ambulance services, Welsh eye care services, pharmacy services, dental services).
- Amend access policy to provide rapid access only for those with urgent clinical need.
- Cross party support should be sought for messages that OOH is for urgent care only and that home visits are only to be provided when clinically necessary.
- OOH to receive its fair share of investment, with uplifts to correct 10 years of underfunding. To be implemented with the 2014 Welsh budget and on a phased basis over 3 years.
- Review the pattern of Out Of Hours provision to consider whether it is possible to achieve greater economies of scale.
- Set competitive remuneration rates that create an attractive OOH GP salaried career, and ensure participation of local GPs.
- GPs to be involved in the planning and development of OOH services through strengthened GP clusters working arrangements.



## CHAPTER 4: GP CLUSTER NETWORK WORKING

### KEY ISSUES

- Primary and community health care teams, a key component of Welsh health policy in 2001, have been dismantled, undermining the process of integration.
- GP cluster networks lack permanence and the staffing and financial resources to enable them to function effectively.
- Welsh Government seems reluctant to use its powers of direction to require the delivery of GP cluster networks by Health Boards on a consistent basis across Wales.
- The spirit of innovation and engagement felt by GPs in the 1990s has been completely lost.
- GPC Wales supported “Setting the Direction” in 2009, but very little was delivered.
- LHBs appear committed to command and control approach, playing lip service to GP cluster networks, but in practice unwilling to let go. As a result GPs are reluctant to engage.
- In most parts of Wales GP cluster networks are no more than quarterly meetings led by the LHB to administer the QP cluster domain of QOF.

### DISCUSSION

In 1997 over half of all Welsh practices were fundholding. Whatever the issues around inequality, practices were engaged at a local level with hospital and community providers in a way not seen before or since. Even those practices that objected to the inequities of fundholding developed commissioning groups to act as local drivers for patient services. Fundholding ended in 1998 and with it much of the local innovation that it promoted. A succession of reorganisations have attempted to engage GPs; from LHGs<sup>9,34</sup> through “Designed For Life”<sup>11</sup> and “Setting the Direction”<sup>35</sup>, all with limited success.

Welsh policy from 1998 has failed to engage GPs because they have not been given drivers for change, either clinical or financial. Health Boards have retained all decisions on changing care and organising local community led services. The local commissioning expertise developed through fundholding has largely been lost. Extended primary care teams have been systematically dismantled. These teams were beginning to deliver community services focused around individual practices, maintaining continuity of care and clinical cooperation. They provided efficient use of health professional expertise, working on an integrated basis for the benefit of local patients. Extended primary care teams were replaced by managerially driven geographic teams which led to a marked reduction of integration, cooperation and local communication.

In 2013 “Delivering Local Health Care”<sup>36</sup> attempted to progress ideas from previous strategies. It made ambitious commitments on the development of GP cluster working (referred to as locality working). This included significant changes to Out Of Hours care, workforce planning and managing the frail elderly. It committed to a new financial regime to share care savings with GP cluster networks. Many of the targets set for delivery in 2013 have not been met and in most areas GP cluster networking is little more than irregular meetings organised by LHBs to administer parts of QOF. The involvement of community, secondary and social care is very limited. GPs in Wales report unwillingness on behalf of LHBs to let go. Despite a policy which favours primary care led NHS, there is little evidence of sharing of the information required to take decisions or delegation of responsibility. Even within the GMS contract where consultation is a contractual requirement, GP involvement tends to be limited to making comments on proposals that have been developed by NHS managers.



The RCGP in collaboration with the King's Fund have developed a "Primary care federations toolkit" which helps enable managers and primary care practitioners take federated working forward collaboratively. The GPC UK paper on "Developing General Practice – Providing Healthcare Solutions for the Future" expands further on the value and importance of the primary health care team working in collaboration with other health care providers and the value of collaborative alliances or federations. The GPC NI paper on federations in Northern Ireland looks at how similar groupings can deliver the Northern Ireland Government's "Transforming Your Care" policy document. Lessons from these documents should be incorporated into the development of GP cluster working.

### The way forward

For GP cluster networks to function effectively there needs to be a fundamental change of culture and approach. Welsh GPs have no desire to follow the English model, but there are lessons to learn from the way that structural change has been delivered on a timely basis in England. Effective GP cluster networking requires elements of commonality across Wales, including sharing of good practice and having common administrative structures adequately resourced and supported. They also require a degree of permanence in terms of a correspondence address, email, website and officers. Wales will need to re-create the culture of autonomy and innovation of the 1990s if it is to realise the benefits of cluster working. LHBs must resist the temptation to micro-manage by requiring GPs to produce plans and fill in pro-forma for every action they take.

In the current financial situation duplication is untenable. Resource must transfer from LHBs to GP cluster networks. As with the creation of LHGs in 1998, Welsh Government guidance will be needed to lead the process and monitor progress through development of financial and governance accountability structures.<sup>37</sup> As a starting point, GP cluster networks should look to recreate integrated primary health care teams and to examine available data on population needs to identify those aspects of care that might be addressed by cooperative work between practices and community staff. GP cluster networks should develop horizontal integration in sharing services, skills, resource and education across their areas.

GP cluster networking has been built into the GMS contract for 2014/15 as a foundation on which to build.<sup>38</sup> In the longer term GP cluster networks could manage community staff, take on delegated budgets and drive service delivery to patients. With increasing autonomy there is real potential to work closely with Community Health Councils, Social Services and other parties to provide more integrated services closer to home. Reshaping care will require close collaboration and joint decision making with hospital consultants as key contributors to the networks. The potential for better coordinated and streamlined patient care is dependent on LHBs allowing resources to be devolved and refocused on clinical advice generated through collaborative GP cluster networks.

### RECOMMENDATIONS

- Welsh Government to provide greater support and guidance on the delivery of a consistent model of GP cluster networking across Wales to agreed timescales. Lessons should be learned from the project management skills used to implement CCGs in England.
- The development of GP cluster networking should be monitored by Welsh Government and reported on a regular basis, at least quarterly.
- GP cluster networks to be established on a permanent basis with an address, website, chair, secretary, finance officer and office support with consideration to some shared services approach.
- GP cluster networks to be given responsibility for community health services as an early stage of development.
- Local Health Boards to make a step change in willingness to delegate and to operate on the basis of high trust rather than command and control.
- GP cluster networks to be given real decision making power with delegated budgets, accompanied by budgets to support training and development of cluster working.
- GPs to be consulted and included in developing cluster arrangements – full reimbursement for time commitment to be recognised.
- GP cluster networks will need to be clinically led, but with a voice from both patients, social care, hospital consultants and other community partners as they mature.



## CHAPTER 5: PREMISES

### KEY ISSUES

- No clear premises strategy from either Welsh Government or Health Boards.
- Need to modernise or replace many premises that were identified as in need of investment since 2004.
- The requirement to sign leases with onerous terms and conditions is a barrier to young GPs taking on partnerships.
- Responsibility for determining applications for premises projects transferred to Health Boards in 2013 without a budget.
- PFI projects have taken a disproportionate share of funding leaving other projects without funding to modernise and expand. The high cost of private finance initiatives (PFI) has exhausted the primary care premises budget before the job was half complete.
- Current economic climate means no obvious funding stream for premises development and reluctance of Health Boards to use any of their allocations.
- The financial plan for the NHS is dependent on reconfiguration which involves much more activity in primary care, but this is impossible where premises are inadequate.

### DISCUSSION

The expanding remit for community provided services in today's NHS means that the need for adequate premises has never been greater. Unfortunately, the gap between current provision and current requirement is widening. A survey of GP premises was undertaken in 2002 by external consultants, Property Tectonics, and the resulting database is known as PCEIS (Primary Care Estate Information System). It showed that around a third of the primary care estate in Wales needed either improvement or renewal and suggested a number of ways to enable this. LHBs are responsible for maintaining this database, which is confidential and password protected. Lack of data makes it difficult for us to assess the full extent of the problem.

As part of the new GMS Contract in 2004, eight flexibilities were implemented to improve the quality of premises provision. The flexibilities were intended to remove impediments to the development of surgery premises encountered by GPs. Examples include higher levels of reimbursement for developments in deprived areas where market rents are depressed or grants to provide help where negative equity is an issue. These are fully explained in the BMA publication *Focus on Premises* published in January 2004.

#### What has happened in reality?

In practice, from 2004 the market was monopolised by third party developers funded from outside Wales. The Welsh Government Primary Care Estates Forum gave approval to build much larger premises under terms significantly more favourable than the cost rent schemes available to GPs. There was no shortage of money because these developments offered high returns and little or no risk, as payments were Government backed. The Primary Care Estates Forum approved 59 new schemes between 2004 and 2013, and 57 funded via Private Finance Initiatives (PFI).<sup>39</sup> Thus is one of the key factors in long-term continuity in General practice, premises ownership has essentially ceased to be a driver for recruitment of GPs to Wales.

GMS Premises investment in Wales has increased from £24.0million to £38.9 million between 2004 and 2013.<sup>35</sup> The increase is almost wholly accounted for by annual revenue spend of £11.6 million to PFI projects. In 2013 the Primary Care Premises Forum ran out of money. It declared a moratorium on development and then transferred responsibility for premises provision to LHBs without a budget. **There is now very little prospect of new premises development without a much more cost effective approach. This will prevent new GPs investing in their premises and taking a permanent long term stake in their practices. GPC Wales is also concerned that the £2.3 million revenue budget to support improvement grants for existing premises is under threat.**

The 59 premises built since 2004 could be less than half of what is required. We cannot know for sure as premises data is not published. What we do know is that there are substantial numbers of practices working in premises that are too small or not fit for purpose. In some areas this will stall the policy to transfer work from secondary care. This is a key component of the NHS financial recovery plan. **It is always short sighted of public services to fail to invest in sound infrastructure and primary care is no exception. GPC Wales believes that the system of PFI funding is unaffordable and alternatives are needed urgently.**

#### RECOMMENDATIONS

- Undertake a review of the condition of primary care premises in Wales to include costs for all necessary extension, refurbishments and replacements by March 2015.
- Publish premises investment plans by LHB for the next 3 years.
- Consult with GPC Wales about more cost effective alternatives to PFI funding including making full use of the 2004 premises flexibilities to encourage GP led development.
- Consider refurbishment, surgery extensions and recycling of existing NHS land and buildings as an alternative to new build.
- Confirm that funding will be available for improvement grants and ring fence a budget.
- Welsh Government to support Health Boards taking over leases when individual practices are in crisis and at risk of closing.

## CHAPTER 6: INFORMATION TECHNOLOGY

### KEY ISSUES

- Secondary care IT systems lag well behind primary care with poor linkages.
- Electronic communication between primary and secondary care is improving slowly.
- IT communication between health and social care is poor and leads to duplication and potential for confusion.
- My Health Online offers the potential for patients to gain direct electronic access to primary care, but there is a need to escalate the opportunities to benefit from smart technology.
- Large volumes of data are available, but very little is analysed or published.
- Wales has an excellent record on development of primary care IT. Investment must be maintained to protect and maintain this position of being at the cutting edge.

### DISCUSSION

Good information technology, used to record data on patients as they move around the NHS, is an essential requirement for every modern health system. Ideally, there should be a single health record for every patient that is accessible to every part of health and social care. Different professionals will have different levels of access to information in line with data governance rules. IT systems in Wales have developed on an ad hoc basis and we are retrospectively attempting to join them up. Some progress has been made to make hospital systems communicate with primary care through both the Welsh Clinical Communication Gateway (WCCG) and implementation of the Individual Health Record (IHR), but connection with social care has not happened. This leads to unnecessary duplication of effort and potential risks to patients. Important information is not being made available to parts of the system that is supposed to be integrated.

Welsh primary care has one of the best IT systems in the world. It is specific to tasks, comprehensive in its availability, used by all practices and has a wealth of data which is retrievable in various formats. By 2015 there will be only two systems available to minimise communication problems whilst driving innovation through competition. By contrast hospitals systems do not communicate with each other or with WG. Community staff working in primary care use secondary care systems; their data duplicates data held by the practice in which they are hosted. Audit+ is a powerful additional tool available to primary care. It has the potential to assist locality networks in identifying local issues and improving productivity. To expand its use GPs will require assurance that it will be used constructively to support development and not to micro-manage. The SAIL database is another Welsh innovation in IT which has the ability to support GP cluster networks to meet population needs on a local, regional and national basis.

There has been progress in recent years in improving connectivity with secondary care and also with patients. Electronic referral and discharge are now used in many parts of Wales. My Health Online provides the opportunity for patients to book appointments and order repeat prescriptions online, potentially reducing pressure on busy surgery receptions and providing patients with more convenient access to medical services. This work is progressing steadily and should eventually lead to the ability for patients to view elements of their records online. My Health On Line might enable e-consultations via Skype or email, provided the principle of such an approach proves to be feasible.

Commitments to collecting and sharing data have been a recurring feature of Welsh strategy documents, most recently in 2011 – ‘Together for Health’<sup>40</sup> stated:

“Clinical staff will be expected constantly to compare their performances with others both inside and outside Wales and... The Government and the NHS will make a step change in the availability of information.”

Despite these commitments, progress on making data freely available on NHS performance has been very limited. Neither WG nor LHBs publish data on performance. For primary care, vast amounts of data are available from QOF registers, practice systems and the Exeter payments system. Parts of these data are published in statistical publications 1-2 years in arrears. Published data concentrates on high level information and there is little comparative data at local level. For the best source of detailed data on general practice in Wales it is still necessary to go to NHS England websites. Financial information on the GMS contract has been hard for GPs to obtain. In some instances even Freedom of Information requests have failed to persuade LHBs to share very basic data. The use of data to drive continuous service improvement is covered in Chapter 7.

#### RECOMMENDATIONS

- Prioritise linking up primary, secondary and social care systems to help facilitate the development of integrated care.
- Data on NHS activities and costs to be made freely available to facilitate better performance management at every level.
- All clinical staff working in each GP cluster network should, where appropriate, be able to access data on patients for whom they are caring.
- Create a resource similar to the NHS Information Centre in England so that Wales does not have to rely on an English body for its primary care data.
- IT departments to work much more closely with health economists and statisticians to produce real time data on the performance of the NHS by December 2014.
- Enhance patients’ ability to utilise modern technology to access records and services in order to minimise workload to practices by July 2015.
- In order to drive up efficiency, IT investment must remain a priority throughout the recession
- Develop the use of Audit+ to give real time comparative data to practices and GP cluster network planners.
- Develop further, support for the SAIL database amongst the GP community to enable practices and localities to have access to additional population level data.
- Maintain the confidence of patients and the public in the use of patient identifiable data through robust information governance processes.

## CHAPTER 7: DATA AVAILABILITY & CONTINUOUS SERVICE IMPROVEMENT

### KEY ISSUES

- Inadequate and absent clinical and management data.
- Inadequate use of data to drive efficient and effective healthcare.
- Inadequate monitoring of available data to improve performance.
- Paucity of transparent financial data.
- Paucity of comparative data sets.
- Inadequate evidence based policy making.
- Statistical publications are limited and historic.

### DISCUSSION

Assessment of the performance of the NHS in Wales is difficult due to inadequate availability of data. The lack of robust and appropriate data to enable the NHS in Wales to plan and monitor health services was first highlighted more than a decade ago in the Primary Care Strategy 2001,<sup>41</sup> Townsend Report (2001)<sup>42</sup> and Wanless Report (2003).<sup>43</sup> These reports confirmed that data quality in Wales is poor and there is a lack of robust evidence to support decision making. These early reports made clear that appropriate monitoring was hampered and health and social care organisations are less efficient than they could be. In 2010 the NHS 5 Year Service, Workforce and Financial Strategic Framework<sup>10</sup> reinforced further that there was sub-optimal use of resources and that outcomes could be improved. It is difficult to see how this will be achieved without the availability of appropriate data. This issue was most recently highlighted by the difficulty practices experienced in fulfilling their contractual requirements to review the various streams of patient data as part of the QOF QP in 2012/13 and 2013/14.

Without appropriate data and comparative data on which to base decisions and to monitor the performance of the health service we cannot achieve the best use of resources. In 2005 the Welsh Government's strategy, "Designed for Life" committed Welsh Government to improving research, and auditing and evaluating health and social care. It emphasised the importance of benchmarking services using comparative data to set a strategic agenda relevant to each locality, and to focus on service improvement. Nine years later there is very little evidence of benchmarking or the use of comparative data across the NHS in Wales.

The availability of transparent and open financial data is equally as important as clinical and management data in order to monitor effectively and transparently GMS expenditure. To ensure that primary care is delivering optimally to the NHS in Wales and that resources are being appropriately directed there must be open and transparent financial information. The recently established Welsh GMS Enhanced Services and Directly Administered Funds Committee has enabled Wales to make use of a contract management mechanism that has worked very effectively at UK level for many years. For the first time this provides comprehensive assurance and monitoring of GMS expenditure enabling comparisons across Wales.

**RECOMMENDATIONS**

- Establish a programme to identify what clinical management and financial data sets are necessary best to support the efficient delivery of healthcare in Wales (2015).
- All clinical and financial management data must be openly available.
- Introduce health metrics and benchmarking with comparative performance data published on the website of every NHS organisation in Wales (2015).
- Comparative data must be readily available, published and provided regularly to primary care to facilitate service improvement.
- Comparative data should be readily available to support education and training.
- Welsh Government must enhance its Health Statistics Unit to include a health economics function to enable the production of meaningful comparative data that can support improvement.
- Health and Social Care policies should be based on published evidence and include costs and timeframes.
- Build on the success of the Welsh GMS Enhanced Services and Directly Administered Funds Committee.
- Invest in resources proven to deliver resource-effective health gain.





## CHAPTER 8: LEADERSHIP

### KEY ISSUES

- Financial constraints and sustained austerity measures demand better leadership.
- Insufficiently developed leadership at all levels.
- Need to manage resources more effectively.
- Lack of political candour with regards NHS capacity.
- Inadequate management of public expectations.
- Insufficient clinical autonomy and trust in GP's to make the right decisions, organise their practice and locality network.
- 2007 Wales Audit Office recommendations to strengthen GMS contract management and leadership have not been addressed.

### DISCUSSION

The impact of the 2008 recession is enduring and it is predicted that public sector cost control will persist over the next 5 to 10 years.<sup>44,45,46</sup> The NHS will need to find ways of delivering safe and effective health care within constrained budgets while avoiding the temptation to implement short-term measures that are wasteful or deleterious to health care. The notions of rationing and charging within the Welsh NHS, while politically unpalatable, require open and honest debate with the public. It is however entirely conceivable that pursuing the principles of prudent health care and a co-production agenda, while refocusing investment of resources in primary and community care will deliver a model of services that can be contained within the financial resources available. Such an ambitious vision will be impossible to deliver without a motivated and valued medical profession, the leadership capabilities of general practitioners and a well managed service.

#### Cultural change

Creating new models of care and new ways of working, while having the potential for cost effective services more focused on clinical priorities and patients needs, will require understanding and cultural change from doctors, patients, managers and politicians. The scale of the task should not be underestimated, but without leadership from general practice this would seem impossible. The development of general practice cluster networking appears to be a model that could effectively deliver the scale of changes that are required. However, there is an urgent need to create general practice capacity to support such a model with increased engagement, protected time, managerial support and leadership development.

#### Delivering change

Strong leadership is of course required at every level to deliver such fundamental change. Political leadership as well as that of Health Boards and Welsh Government is equally important. While good governance, performance management, monitoring and evaluation are important, so too is clinical freedom and clinical autonomy that operates in the best interests of patients to achieve optimum clinical outcomes and supports the principles of prudent health care and coproduction.

In 2007 the Wales Audit Office concluded that "the way in which the contract is managed must be improved". Despite this recommendation, little has changed. For the system to work effectively it requires excellent leadership in LHBs and Welsh Government. Given the gradual demise of the UK GMS Contract, Wales must plan to administer its own contract if, or when, there is a complete split from England. Primary care requires highly skilled administrators to design and implement contractual mechanisms that are often extremely complex. The management of primary

care requires a very different set of skills from running hospitals. Poorly designed incentives and inadequate monitoring of contractors can be extremely costly. The specialist nature of this work may not be well suited to delivery by 7 very small primary care teams located in each LHB. The Shared Services Partnership includes a primary care function operating at an all-Wales level. Its main purpose is to make payments on instruction from LHBs. This is largely mechanistic and does not go far enough. It would not be suitable to run Welsh primary care contracts.

GPC Wales believes that primary care management expertise should be consolidated into a Primary Care Authority for Wales. Wales would also benefit from the reinstatement of a Primary Care Directorate within Welsh Government. This must provide the existing GMS Branch with additional capacity to cope with the increasing demands that are placed upon it. Given the emphasis on primary care in Welsh health policy, lack of a dedicated director level post in Welsh Government is a major oversight.

#### RECOMMENDATIONS

- Leadership development needs to be embedded in every part of primary care and the health service.
- A comprehensive and integrated leadership programme of clinicians and management should be agreed with the BMA/GPC Wales commencing delivery during 2015.
- GPs to be given the autonomy, support and resources to fulfil their leadership function within GP cluster networks.
- Welsh Government should take a much stronger lead in focusing on performance management, monitoring, evaluating and openly reporting on the performance of the NHS.
- Welsh Government to take responsibility for ensuring that agreed changes are reported on and published regularly.
- Political candour is required in respect of what the NHS can reasonably provide.
- Cross party political consensus around the need to use restraint in consuming expensive and scarce NHS resources is needed.
- Conduct a thorough review of GMS contract management system with a view to creating a Primary Care Authority for Wales in preparation for the possible demise of the UK GMS contract.

## GLOSSARY OF TERMS & ABBREVIATIONS

24/7	Shorthand for 24 hours/day and 7 days/week
Audit +	Software programme capturing agreed data from GP systems
CHC	Community Health Council
Cluster Networks	Groupings of around 6 GP practices covering a population of 30-50k
FY2	Foundation Year 2 placements
GMS	General Medical Services (contract between GP surgeries & LHB)
GP	General Practitioner
HR	Human Resources
IHR	Individual Health Record – an IT programme that enables certain users to have access to a patients significant medical history, drug history, allergies etc
IM&T	Information Management & Technology
IT	Information Technology
LHB	Local Health Board
LHG	Local Health Group (precursor of LHB)
Locality	Geographical area within a HB (e.g. Swansea is a locality)
NHS	National Health Service
NHSDW	NHS Direct Wales
NLIAH	National Leadership and Innovation Agency for Healthcare
OOH	Out Of Hours (i.e. period of time when your surgery is shut)
PFI	Private Finance Initiatives
Phone First	Welsh version of 111 due to be implemented July 2015
QOF	Quality & Outcome Framework – part of GMS contract
RCGP	Royal College of General Practitioners
SAIL	Secure Anonymised Information Linkage system utilising various sources of data
Shift Left	Transfer of work from secondary to primary care
WCCG	Welsh Clinical Communications Gateway – an IT link between primary and secondary care which enables safe, fast transfer of patient data and referrals
WG	Welsh Government

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