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

Inquiry into the GP workforce in Wales / Ymchwiliad i'r gweithlu Meddygon Teulu yng Nghymru
Evidence from Wales Deanery – GP 03 / Tystiolaeth gan Deoniaeth Cymru – GP 03

Health & Social Care Committee inquiry into the GP workforce in Wales: An invited paper from the GP Section of the Wales Deanery

January 2015

1. Introduction

1.1. The Health and Social Care Committee has asked the Deanery (The School of Postgraduate Medical and Dental Education in Wales) to give evidence to this inquiry. Here we outline the most important factors as we see them. We trust this will facilitate the Committee's further exploration of matters with two Deanery representatives:

Dr Martin Sullivan (Associate Dean for GP Training in Wales)
Ms Mary Beech (Operational Lead for GP Training in Wales)

1.2. To aid discussion we provide an overview of a fairly typical GP training/working continuum. **Deanery supervised stages in bold**

- 5-6 years Medical School education
- **2 years** **working and training as a Foundation doctor**
- **3 years** **working and training as a GP registrar (based in hospital posts and accredited GP training practices)**
- 1-5 years working as a GP locum
- 15-30 years working as a GP partner or as a salaried GP

2. What are the barriers to GP recruitment and retention in Wales?

Firstly, we provide our understanding of the extent of recruitment and retention problems in Wales relating to the GP training continuum:

2.1. Attraction and recruitment of 2nd year Foundation doctors into GP Specialty Training is a well established and growing problem throughout most of the UK, including Wales.

2.2. In Wales, the GP Specialty Training applicant to recruitment target ratio is around the already low UK average and (as everywhere else in the UK) has been declining significantly over the last decade.

2.3. Comparing GP training recruitment targets in isolation however masks an even greater problem for Wales, than for other areas of the

UK. The current recruitment target (given to The Wales Deanery by Welsh Government 10 years ago) is now much lower comparatively per head of population than elsewhere in Britain.
Roughly, GP training recruitment target: population ratios are ***Wales*** *136 to 3 million;* ***England*** *3225 to 50 million;* ***Scotland*** *296 to 5 million.*

2.4. On completion of annual recruitment rounds, the vast majority, of the already low number of GP Training entrants recruited in Wales, consistently refuse to take up employment/training offers outside of North East, South East or South Central Wales.

2.5. The following factors add further to the growing deficit of new GPs available to work in Wales:

- significant attrition (for various reasons) during GP training
- a growing preference for part time training (currently 40% of final year GP specialty trainees currently work part time in Wales)
- choosing not to work in this hard pressed specialty once qualified
- significant and increasing emigration to perceived better opportunities for newly qualified GPs in Australia and elsewhere.

2.6. Monitoring retention of the fully qualified GP workforce in Wales is outside the Deanery's organisational remit; but, through our networks, we are aware that career change and premature retirement amongst established GPs is another highly significant and increasing problem.

Secondly, we provide an overview of barriers to recruitment and retention. The factors listed here apply to recruitment into and attrition from both the established GP workforce in Wales and GP Specialty Training. Some factors are more pertinent at certain stages of the continuum; but most interplay throughout.

2.7. Most importantly GPs, GP specialty trainees, foundation doctors and students increasingly see the impact of unfettered demand for GP services, which in many areas has become unmanageable.

- They experience a more demanding and rapidly ageing population with increased co-morbidity and complexity as well as increasing expectations fuelled by media campaigns and huge numbers of single interest pressure groups.
- They also see little governmental support to try to alleviate these pressures e.g. public awareness campaigns to reduce demand; and restraining pressure groups promoting poorly evidenced health campaigns which further increase GP workload.
- They (along with the public) perpetually read ill-conceived and politically driven press reports undermining GPs' worth and belittling their contributions, whilst, as they see it, day in day out

GPs work very long days, striving to keep some a lid on pressures on secondary care and keeping the NHS in general from imploding.

2.8. Failings of secondary care conveyed regularly to GPs by patients (e.g. frequent patient dissatisfaction with hospital communication and other systems); as well as illogical denial of direct GP access to investigative facilities, create needless further burdens, reduce GPs' ability to create efficiencies for patients and further deflate GP morale.

2.9. The unrelenting diversion of activity from secondary care, without adequate accompanying resource to an already undermanned primary care workforce, adds to the rapidly deepening gloom.

2.10. A recognition that 24/7 access to General Practice in tandem with other political promises of continuity of care, is a circle that cannot be squared. GPs working long, pressurised day shifts, know that existing out of hours primary care services (mainly staffed by local GPs choosing to earn their living in this way) are well organised and exemplary in most parts of Wales when compared to large parts of England. These GP Out of Hours services in Wales could be even more cost effective and further reduce pressure on A&E if this service was appropriately trumpeted by health care managers where it is so effective; and should be much more appropriately resourced.

2.11. The integration of primary and secondary care into unified LHBs in Wales has not led to significant integration of services. There is a strongly held view amongst GPs that currently imposed and poorly resourced (rather than voluntary and reasonably incentivised) practice federations and networks will inevitably fail. Primary care in Wales feels much more disenfranchised than under previous NHS administrative structures. This widespread feeling exacerbates a parallel appreciation of the hugely diminished proportion of overall NHS budget committed to primary care in recent years.

2.12. The potential GP workforce is very different to past generations. World-wide urbanising forces are a major issue in attracting trainees to more remote parts of many countries.

2.13. The geography and infrastructure of Wales requires some practices serving widespread populations to have multiple premises. The redirection of The Minimum Practice Income Guarantee (MPIG) has been somewhat ameliorated in Wales. But for many practices there will now be no reparation for operating multiple premises; and this can only exacerbate recruitment and retention problems in rural areas.

2.14. The established GP workforce, meanwhile, well understands that options for liberation from perceived intolerable working conditions are attainable for many of them. Pay and pension changes are adding

fuel to these fires, stoking increasing trends in career change, emigration and the early retirement of many GPs.

3. Does the commissioning and delivery of medical training currently support a sustainable GP workforce?

3.1. The quality of training for GP in Wales compares favourably with the best in the UK (GMC trainee feedback) and is also the most highly rated specialty for overall training experience in Wales (GMC trainee feedback). Thus any failure to attract applicants cannot be attributed to the quality, reputation or experience of GP training in Wales. The production, once recruited, of new GPs of appropriate quality (in terms of UK GMC standards) is strongly promoted by a highly committed, well trained and well supported faculty of GP medical educators and trainers throughout the whole of Wales.

3.2. The numerical sufficiency of new GPs produced and staying in Wales is a very different matter. The factors relating to working pressures as well as terms and conditions and the consequential unattractiveness of the job of General Practice apply everywhere in the UK. However, global trends in urbanisation impact more on Wales and many other more remote (as the available applicant pool sees it) parts of Britain. The potential applicant pool specific reasons behind this insufficiency are multiple; and many have been covered earlier in this paper.

3.3. The Deanery regularly attends careers events at regional, Wales and UK levels to attract would be trainees to Wales and to the specialty of General Practice. Professionally produced internet materials add support to the acknowledged very good reputation of GP training in Wales. Sadly, the prevailing “push” forces outlined in this paper increasingly trump all efforts, as in most of the rest of the UK, to attract anything like enough applicants.

4. Which actions are needed to ensure the sustainability of the GP workforce?

Radical training initiatives need to be introduced in Wales:

4.1. Ensure that much more student time and a much more appropriate proportion of existing Welsh Medical School funding is spent on General Practice placements. This will increase exposure to this excellent learning environment and to more credible role models.

4.2. Set significant quotas for appointees to Welsh Medical Schools who have proof of perhaps 2 or 3 years’ prior recent residence in Wales. There are examples in other countries of this type of policy working well in terms of retaining doctors services once qualified.

4.3. Fund a significant and permanent increase in the percentage of foundation trainees in Wales able to undertake just one of their six required foundation placements in General Practice during their two year programmes. Foundation doctor exposure to GP in Wales is still by far the UK's lowest (average in UK 55%), despite temporary funding for a small uplift from 24% to 30% for academic years 2014 and 2015.

4.4. Restore the reduced salary supplement for GP trainees in Wales; from 45% back to the 65% it was only a few years ago. This would once more match the salaries achieved by trainees in competing hospital specialties and also afford serious advantage for Wales over competitor nations in attracting young Drs into GP training in Wales.

4.5. Establish schemes, post GP qualification, to allow development of supplementary specialist (GP special interest) skills and other career development pathways (e.g. GP network leadership and management training opportunities). This approach is supported by the Shape of Training Review (Greenaway Report) of 2013 and by the GMC's current work on 'credentialing'.

4.6. Commit to the introduction, once all the devolved nations can agree, of four year long General Practice Specialty Training; the very strong educational case for which has been accepted widely.

Well targeted initiatives, meaningfully affecting the attraction and retention of qualified GPs, in Welsh localities are needed

4.7. Consider meaningful contractual incentives in appropriately identified "hard to recruit" areas. Payment should occur only on satisfactory completion of, perhaps, 2 -3 year contracts. GPs attracted in this way may well "put down roots" and choose to stay.

4.8. Value and trumpet the GP partnership model where this works very well (in the majority of settings throughout Wales, as LHB managers can readily evidence) AND actively promote complimentary GP career models (including contracts with mixes of hospital front door; out of hours; conventional general practice and GP network support and management roles).

4.9. Encourage, support and appropriately incentivise practices that have mutual respect for each others work to voluntarily federate (or continue to try to compel often very disparate GP practices to form networks purely on a locality basis, as now, and ensure failure).

4.10. Introduce schemes to recognise and hence retain talented and highly efficient older GPs. Many might well extend their working lives, continuing to offer effective expertise at the front line patient interface on a part time basis, if balanced, for instance, by appropriate resource to support roles in federation strategy and management.

4.11. Commit to a fully funded GP returner scheme (paying returners at the same rate as a third year GP registrar for 3 to 6 months). This would affordably reveal how many ex-GPs might be prepared to return to the coalface, by reducing the financial stress of doing so.

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