BMA Cymru Wales

Senedd Cymru Health and Social Care Committee inquiry: The future of general practice in Wales

Response by BMA Cymru Wales

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Introduction

BMA Cymru Wales is pleased to provide a response to Senedd Cymru's Health and Social Care Committee's inquiry into the future of general practice in Wales.

We commend the committee for taking forward such a broad ranging inquiry into an area that is vitally important to the health and wellbeing of all Welsh citizens. Our Save Our Surgeries campaign[i] has shed light on the long-standing issues affecting general practice including the workforce difficulties and chronic underfunding. The public petition calling for fair and adequate funding for general practice[ii] attracted 21.6k signatures, demonstrating the public will for the sector to be restored to a sustainable footing with appropriate investment.

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives. The BMA's General Practitioners Committee Wales (GPC Wales) represents all GPs working in Wales. It is the representative body that negotiates the General Medical Services (GMS) contract with the Welsh Government and NHS Wales, and works to improve the care of patients and the working lives of doctors.

This document provides a response to each of the key issues identified by the Health and Social Care Committee in the inquiry's terms of reference.

1) Challenges threatening the sustainability of general practice, including:

a) The funding model for general practice and current financial pressures,

The GMS contract is the primary funding mechanism for general practices. It outlines the terms under which GPs provide services to the NHS and to what extent they must provide services. The contract includes various elements such as the core funding for unified services (the 'Global sum'), additional funding for supplementary services, and specific payments for achieving Quality Improvement Framework (QIF) projects. The regulations underpinning the Welsh GMS contract were most recently updated in 2023 with the passage of the *National Health Service (General Medical Services Contracts) (Wales) Regulations 2023*[iii].

The GP partnership model is the traditional and most widely used model of general practice in Wales, and the wider UK, since the inception of the NHS. In this model, individual GPs or several GPs operate as self-employed contractors who establish a partnership that holds a contract with local health boards to provide NHS services, rather than being directly salaried employees of the NHS. Individuals who are not GPs (or even doctors), such as business managers, can become partners provided the partnership has at least one qualified GP in order to hold an NHS contract. This model allows GPs to have a stake in the practice, sharing

[i] bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/wales-save-our-surgeries-campaign
[ii] petitions.senedd.wales/petitions/245944
[iii] legislation.gov.uk/wsi/2023/953/contents

both the profits and the risks. The partnership model is valued for its ability to provide continuity of care, as partners are more likely to stay in the same practice for extended periods and become embedded within communities. Amongst other benefits, continuity of care is widely recognised as having a positive effect on mortality rates (Pereira Gray, et al. 2018). The model also encourages GPs to invest in their practices and enables innovation in service delivery, allowing them to adapt, in an agile manner, how services are provided. This was particularly evident during the COVID-19 pandemic.

However, it comes with challenges, such as financial liabilities and risks, as well as administrative burdens. Where GP partners cannot continue to provide the services required by the terms of their contract, they can hand back the contract to their commissioning health board. The reasons behind this unfortunate circumstance are often wide-ranging, and not always financial. For example, practices may struggle to attract new GPs to the partnership following the retirement of longstanding partners, and be unable to afford to employ salaried GPs to make up the workload gap. This, in turn, results in the additional workload falling upon the remaining GPs and can accelerate professional burnout; coupled with increasing liabilities for premises and employment contracts.

External factors may destabilise otherwise stable practices: the closure of neighbouring practices can result in a sudden increase in a practice's patient list size without the infrastructure being in place to accommodate. Changes to premises leases by landlords or the refinancing of loans can drive practices to the wall financially. In rural areas, many practices have dispensing privileges in the absence of accessible community pharmacies. Income from providing this service historically has propped up the provision of GMS in that area. Changes to local pharmacy provisions can destabilise this and jeopardise the survival of practices.

How are GP partnerships funded?

Most of the money a practice receives derives from the **global sum payment**, which in theory is the funding for delivering the core part of the contract, known in the 2023 GMS contract regulations as '*unified*' services.

The global sum is calculated on a '*per weighted patient*' basis and is outlined in the annually updated Statement of Financial Entitlements (SFE) directions[iv]. The payment per practice reflects the practice registered population but is adjusted via the global sum allocation formula, better known as the *Carr-Hill formula*, which applies various weightings accounting for age, gender, and mortality.

[iv] gov.wales/financial-entitlement-directions-local-health-boards

The Carr-Hill formula

This formula was first introduced with the 2004 GMS contract, and as a result, the weightings used derive from late 1990s/early 2000s population data. This data is no longer reflective of the current population demographics in Wales.

GPC Wales believes that there is a need to review the appropriateness of the funding allocation formula for Welsh general practice. However, making ad hoc and immediate adjustments without considering the broader impacts would risk further destabilising many practices in a time of significant financial challenge.

This review would need to be extensive and require major upfront investment to procure specialist input, including population health and financial modelling expertise. This was the approach taken in Scotland prior to the introduction of their new funding formula with the 2018 contract[v]. Recommendations of this review would inform the next steps for funding allocation in Wales.

Practices also receive a proportion of funding under the **Quality Improvement Framework (QIF)** if they choose to participate in this optional activity. The QIF aims to enhance the quality of care provided by general practices, consisting of two domains: Access, and Quality Improvement projects. It operates on an annual cycle, with specific objectives and quarterly reporting requirements. Each requirement/project is allocated a set number of points (with an annually adjusted financial value), and practices earn points based on their performance in those areas. QIF replaces the previous Quality Outcomes Framework (QOF) and the Quality Assurance and Improvement Framework (QAIF), with the assurance measures from these systems now embedded in the overall GMS contract assurance framework.

Practices also receive funding to provide **Supplementary Services** in addition to the basic contract requirements. These were previously known as *Enhanced* services. These include Minor surgery, Care Homes services, and Vaccination & immunisation programmes amongst others. Practices receive extra payments for delivering these services, should they determine it is feasible to provide them, and it is of benefit to their patient population. Supplementary Services can be Directed, negotiated nationally and must be offered to all practices by health boards, or Local, which are negotiated locally between Local Medical Committees and health boards.

Further funding sources include IT and premises costs (arrangements differ depending on whether the premises are rented or owned), medicines reimbursement, training fees and other health board administered funds.

There is a Contract Assurance Framework[vi] built into the 2023 GMS contract regulations, which health boards use to assess the delivery of contract requirements by GP practices, using various data sources and metrics to reduce undue bureaucracy. The framework sets out multiple stages of escalation that the commissioning health board can take if a practice

[v].Deloitte/Scottish Government (2016) *Scottish Allocation Formula – GMS: Unit cost formula review*
[vi] gov.wales/sites/default/files/publications/2023-10/unified-contract-assurance-framework_0.pdf

struggles to meet the contract terms, with the ultimate sanction being to issue a breach notice.

Dispensing GP practices, who play a vital role in rural general practice, have different funding mechanisms in addition to those above. They are typically situated in rural areas and serve patients where pharmacies are not commercially viable or accessible. Dispensing practices require bigger premises to accommodate the additional dispensing requirements, and due to rurality will often operate on a multi-site basis. In Wales, approximately 68 practices (c.18% of the total) offer a dispensing service as of December 2024, serving over 190.7k patients[vii]. Practices being able to dispense has been crucial for maintaining GMS in many parts of Wales: historically the income from dispensing has ensured the continued viability of these practices. However, for a variety of factors succinctly outlined by the Dispensing Doctors Association (Dispensing Doctors Association 2025) and expanded upon in greater detail below, the future of dispensing is in trouble. The dispensing system needs contractual and regulatory reform to ensure the continued viability of rural general practice in Wales.

General Medical Services Contract Negotiations: Representing the Voice of the GP Profession

Negotiations on the GMS contract occur annually on a tripartite basis between the executive team of the BMA's GPC Wales committee, NHS Wales and the Welsh Government. Discussions cover iterative changes to the contract, and the associated annual financial changes. An overview of the process is provided in Annex A.

GMS contract negotiations for 2024/25 were significantly delayed, partly due to the major political events in both Westminster and Cardiff Bay, until September and October 2024. The delay created uncertainty for GP practices; being liable for increasing costs, and for hard-working staff who would expect an uplift in their pay.

The eventual 'best and final' proposal from the Welsh Government fell significantly short of the costed expectations of GPC Wales. It did not demonstrate action towards tackling the critical issues facing Welsh general practice as outlined in the widely acknowledged Save Our Surgeries campaign[viii]. GPC Wales resolved to put this offer to the Welsh GP profession in a referendum in November 2024.

A resounding 99% of GP members in Wales, on a 68% turnout, voted to reject the original contract offer for 2024/25. This resulted in an improved offer from the Welsh Government which was negotiated in resumed tripartite talks in January 2025. This new deal saw £52.1m of new investment, almost doubling the initial investment proposed in the original offer, with the increased quantum intended as a practice stabilisation payment. This sum represents an uplift of 11% of the total Wales GMS contract value. Following much debate, GPC Wales voted unanimously to accept this improved offer on 23 January. Table 1 presents the financial breakdown of the 2024/25 contract:

[vii] Figures provided by the Dispensing Doctors Association (DDA)
[viii] bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/wales-save-our-surgeries-campaign

	GMS contract element	£ of investment
Recurrent funding 24/25	DDRB recommended 6% pay uplift for GP partners	£10.6 m
	DDRB recommended 6% pay uplift applied to salaried GPs and all practice staff	£12.7 m
	General practice expenses	£1.8m
Transfer of existing funding to Global Sum	*Learning Disabilities DSS to become part of unified services*	£0.5m
In year non-recurrent funding 24/25	Practice stabilisation payment	£23.0m
Additional capacity fund	Additional Capacity fund investment for 24/25 (with commitment to continue for 25/26)	£4m

Table 1 - Financial changes from 24/25 GMS contract agreement

Other contractual changes agreed include:

- Additions to 'unified services': Covid antiviral treatments for immunocompromised patients; transfer of the current Learning Disability Directed Supplementary Service, with qualifying definition to be agreed.
- Collection of data via GP systems on patient frailty and ethnicity.
- QI project 25-26 on measures of Continuity of care - subject to approval by the GMS quality committee.
- Practices to enable the repeat prescribing functionality of the NHS Wales App and to assist patients with Welsh Identity Verification Service (WIVS) for those unable to register for the NHS Wales app online.
- Review of the access standards reporting requirements for the 2025/26 year and the longer-term future of the system.
- Engagement in discussions about the development of GP collaboratives.

We continue to have significant reservations about the non-recurrent nature of the practice stabilisation funding, as practices will continue to be liable for increased minimum wage rates and other increased costs into the new financial year. However, we appreciate that the funding being non-recurrent was unavoidable at this late stage in the budgetary cycle, and the funding was necessary given the challenging circumstances that many practices face. We have secured assurances on early contract discussions for 2025/26 in the hope that this investment can be made recurrent, and an earlier agreement can be reached to avoid the uncertainty and delayed announcements of the last two years.

We know that GP members in Wales are unsatisfied with recent contract agreements, feeling that they do not address the current challenges, let alone establish the building blocks for a more sustainable future. In addition to the resounding rejection of the original

2024/25 contract proposal in the referendum, 95% of GP respondents (n = 269) to an April 2024 survey by GPCW said that they felt negatively about the future of general practice following the conclusion of the previous year's 2023/24 negotiations, which ended without agreement. Furthermore, 75% of GP contractor respondents to that survey said they would be willing to undertake collective action short of a contract breach should there be no viable progress toward addressing the fundamental issues facing general practice within negotiations.

We remain committed to working constructively with the Welsh Government and NHS Wales. We hope to see the commitments towards early talks for 2025/26 realised in order to achieve stability and certainty for GPs in Wales. Our focus will be on addressing the burning platform of general practice and resolving the known unavoidable costs that GP practices will face from April 2025 onward, such as further statutory wage increases and National Insurance contributions. Should progress not be apparent, we may need to consult and, indeed, ballot our GP membership regarding potential collective action. This difficult step would not be pursued lightly. Nevertheless, it could ultimately be necessary to protect the wellbeing of the profession and patients alike, by allowing practices to focus on delivering safe care in the face of inadequate funding.

GP pay and Expenses: How the escalating costs of doing business have led to pay erosion

GP practices, as small independent businesses, are responsible for paying all operating costs out of the income they receive. NHS Digital's *GP Earnings and Expenses Estimates* report is published annually and analyses a representative sample of GP practice self-assessment tax returns to HMRC[ix]. This analysis shows that two-thirds of practice expenses relate to staffing costs (66.1% of all expenses in 2022-23), with the next largest expense categories being 'Other' (15%), Premises costs (11%) and General business expenses (6%). Further analysis shows that staffing costs as a proportion of expenses are rising: in 2006/07 they comprised 58% of all expenses, rising to a high of 66.8% in 2021/22.

Crucially, general practice cannot run on a deficit and therefore, cannot benefit from any 'bailouts' or run debts over the long term, unlike other parts of the NHS. GP partners are personally liable for any losses made by their practice.

GP partners (also known as GP contractors) are paid according to their 'drawings' from the partnership, being dependent on what is left once all expenses have been accounted for. As part of their annual analysis, NHS Digital calculates the average GP '*Expenses to Earnings Ratio*' (EER). As per the most recent available data (2022-23), the EER stands at 66.3%. This is the highest proportion on record.

The EER helps to determine how funding uplifts are apportioned to the GMS contract in annual negotiations. For instance, a recommendation by the independent Doctors and Dentist Remuneration Board (DDRB) of a pay uplift for GP partners of 6% will be applied to the 33.7% of the contract value representing 'GP earnings' in the EER. Likewise, uplifts to pay

[ix] NHS Digital '*GP Earnings and Expenses Estimates, 2022/23*' digital.nhs.uk/data-and-information/publications/statistical/gp-earnings-and-expenses-estimates/2022-23

for salaried GP and other staff, as well as any other expense increases, would be apportioned to the 66.3% of the contract value representing expenses.

GP partners, as business owners, do have a degree of control of their profit margins. However, their incomes are capped, and the only available method to control margins is to reduce expenses (e.g. reducing staffing levels, staff pay or non-essential service provision). Ultimately, without a sufficient contract uplift to cover these rising costs, the DDRB's intended pay awards cannot be realised for GP partners. This can be best illustrated by the experience of the successive contract rounds in recent years. During a time of high inflation, contract agreements failed to deliver uplifts which delivered any real terms pay increases for contractor GPs. This fact was acknowledged by the DDRB in their most recent report (DDRB 2024, p120).

GP partner members told us in a March 2024 survey that they had only received a 0.3% pay uplift during the 2023/24 financial year, as the overall investment hadn't matched rising expenses. This 'increase' fell substantially short of the DDRB's recommendation of a 6% uplift, which the Welsh Government failed to meet by offering a theoretical 5% pay uplift. Ultimately, this means that GP partner pay has seen severe erosion, with our calculations in November 2024 (British Medical Association 2024, p83) suggesting a decline of 29% since 2008/09 based on the Retail Price Index (RPI). Alongside the other liabilities and pressures of partnership, this decline in reward is a significant disincentive to GP partners remaining in the service.

Salaried GPs in Wales that are employed by GP practices are paid according to a pay range recommended annually by the Doctors' and Dentists' Remuneration Body (DDRB). The pay range for salaried GPs in Wales for the 2024/25 financial year is between £71,061 and £107,229[x]. NHS Digital includes salaried GP data in their annual average earnings and expenses time-series. GPs employed on terms of the BMA model contract are entitled to a guaranteed pay rise each year in line with the decision by the government(s) in response to the DDRB. Furthermore, since initially negotiated in approximately 2021, the Welsh GMS contract's SFE requires that practices pass on an annually defined pay award to all employed staff, including salaried GPs - and declare to their health board that they have done so. However, the significant financial pressures experienced by practices across Wales ultimately mean that they have a reduced capacity to offer permanent or sessional job opportunities for GPs including those who are newly qualified, leading to reports of under and unemployment of GPs.

The funding challenges facing Dispensing Doctors and the need for reform

As previously noted, around 18% of all Welsh GP practices offer dispensing services and there are a range of specific financial challenges that they must deal with, in addition to the broader issues common to all GPs.

The dispensing GP model requires practices to purchase drugs from pharmaceutical wholesalers, which they then dispense to patients. The full drug cost, including VAT, is paid at time of purchase. Once the required prescription forms are completed, practices are reimbursed for drug costs, net of VAT, at current tariff prices, minus a discount abatement

[x] bma.org.uk/pay-and-contracts/pay/gp-pay/salaried-gp-pay-ranges

or '*clawback*'. Tarriff prices have failed to take account of market forces and do not reflect the actual costs of the drugs, leading to financial losses for practices before clawback is even considered. The percentage of clawback incurred is dependent on dispensing volumes, and this 'discount scale' is published in twice annually in the SFE. This scale is adjusted for any over or underspend of the dispensing envelope in preceding two years. On average the clawback adjustment of money returned to the NHS is around 11.1%. Unlike dispensing practices, community pharmacies are entitled to a broad range of exceptions to this. This clawback system stems from a time where dispensers/pharmacies were more able to negotiate purchasing discounts, and therefore it does not reflect the current market. This clearly needs reform.

Remuneration for managing a dispensing service in rural practices is provided through a dispensing fee, paid on a per item basis. There is an agreed annual dispensing pot or '*envelope*' that is calculated on an England and Wales level. The calculation of the dispensing fee was established in 2012 and adheres to a complex formula, with the fee scale published in the SFE.

The dispensing fee is divided into two elements: 60% cost and 40% profit. The *cost* element is intended to cover dispensing staff salaries and other overheads. It is not uplifted by an annual DDRB recommendation or by inflation, but varied only by volume of dispensing changes, meaning that cost rises associated with purely dispensing staff (e.g. statutory wage rises or national insurance increases) are not covered in annual GMS contract negotiations. The *profit* element is increased annually but based on financial changes to the English GMS contract, due to the joint nature of the envelope. Limitations of this formula and the lack of any uplift to the cost element as a consequence of multi-year deals in England mean that there has been minima real terms uplift to the dispensing fee since 2012. Another complication is that the dispensing fee is paid on a tiered system per prescribing doctor rather than per practice. As a result of these factors, the current fee scale is lower than in 2018 and therefore drugs are being dispensed at a financial loss to those practices.

GPC Wales has held positive initial discussions with Welsh Government about reforms to this system for Wales, including disaggregating elements which rely on the English contract. However, this has yet to make substantive progress, and renewed momentum is direly needed.

General practice has suffered from years of chronic underfunding

Decreasing pay for GP partners and scant job opportunities for sessional and newly qualified GPs are symptoms of the core issue at hand: the chronic long-term underfunding of general practice in Wales. As our *Save Our Surgeries* campaign has illustrated, between 2012 and 2024, a hundred GP practices in Wales disappeared while the equivalent number of full-time GPs decreased by 25%.

Despite the rhetoric and stated aims of the Welsh Government's *A Healthier Wales* calling for a "*shift in resources to the community*" to redress the health system's reliance on traditional hospital services, the proportion of NHS funding provided to general practice has continually declined over the past 20 years.

Our analysis from various sources, including Welsh Government supplementary budget data, suggests that as of 2023/24, a mere 6.01% of the NHS Wales budget is invested into GMS (equating to approx. £639m of £10.4bn). This is illustrated in Figure 1. This proportion was once at 8.7% in 2005/06:

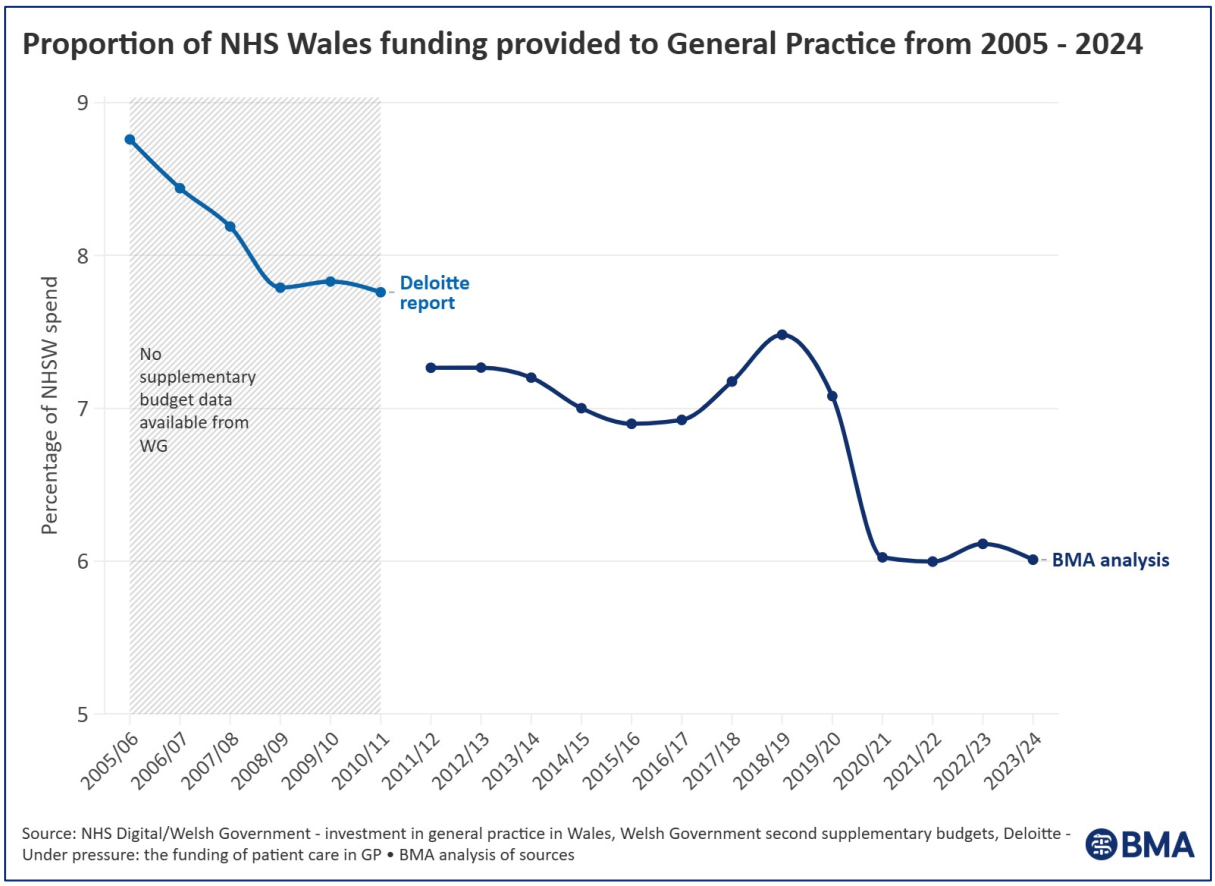

Figure 1 - Proportion of NHS Wales funding invested in General Practice

We suggest the reduction in spending on GMS services for 23/24 will have been exacerbated by the Welsh Government bailout of Health board deficits during November 2023 (Minister for Health and Social Services 2023). The value of the bailout amounted to approximately 107% of the total GMS core contract value at 22/23.

For general practice to have a sustainable future, this trend must be reversed through restoration toward previous resource levels. Resource restoration is essential to secure sufficient investment for a workforce that meets the inexorable workload that GMS practices manage daily on behalf of the NHS in Wales, whilst maintaining the well-being of those who deliver that care.

Analysis by Deloitte, in a report on behalf of RCGP (Deloitte/RCGP 2014, p15), illustrates the picture across the UK during the period 2003-2013. In 2005/06, with the advent of the then new GMS contract, the proportion of spend at a UK level was over 10% of the NHS budget, and there were ambitious expansion plans for new services, excellent recruitment and retention, oversubscribed training and high morale.

Our findings for the intervening years demonstrate that there has been a gradual decline in the proportion of NHS Wales finance available to general practice. Welsh Government must commit to a reversal of this underfunding by restoring the previous 8.7% of the total Welsh NHS budget directly into GMS within the next three years, with an aspiration to invest closer to 11% of NHS spending directly into GMS within the next five years. We acknowledge that this would represent a major redirection and reprioritisation within the NHS Wales budget (as illustrated in Table 2), and likely require additional investment.

	£M
SPENDING ON GMS IF AT 8.7% OF NHS WALES BUDGET	**£931.9m**
ADDITIONAL INVESTMENT NEEDED WITHIN 3 YEARS	+£292.7m
SPENDING ON GMS IF AT 10.95% OF NHS WALES BUDGET	**£1,164.8m**
ADDITIONAL INVESTMENT NEEDED WITHIN 5 YEARS	+£525.7m

Table 2 - What resource restoration to general practice will look like (Based on 2023/24 Welsh Government supplementary budget and Investment in General Practice data)

The incremental restoration of investment is an achievable goal and should be a shared aspiration. This goal, once achieved, can help to bring about a disproportionate improvement in wider population health and significant longitudinal benefits to the entire health and social care system. It will allow for a greater focus on prevention, better condition management closer to home (a long-standing Welsh Government commitment), and more coherent community provision with clearly defined outcomes. When adequately funded, general practice is a tried, tested and value-for-money vehicle for service delivery with built-in contractual assurance mechanisms.

b) the efficacy of different models for managing general practice,

The independent contractor model of general practice

Across the UK, GPs have largely maintained their independent contractor status of GP partnership since the establishment of the NHS in 1948. The traditional 'small business' model of general practice was accommodated and largely maintained within the new system (Kmietowicz 2006). Major changes from the 1960s onwards brought about new payment systems which entitled GPs to claim back 70% of staff costs and 100% of premises costs from the NHS. However, changes to expense reimbursement introduced in the major reforms of the 2004 GMS contract served to reduce contractual and financial risk on the NHS, at the expense of independent contractors.

Structurally, this model has repeatedly been modified to maintain it within the changing NHS system. This includes the introduction of alternative contracts allowing for the provision of services by different legal entities, the increased working at scale across multi-site practices, and the growth in non-partner salaried GPs within the workforce. The nature of core services provided by all GP practices has been defined and redefined with contract iterations: for example, practices were able to opt-out from providing 'Out of Hours' services

with the 2004 GMS contract reforms, ending the traditional responsibility for 24/7 patient care.

It is widely recognised ((UK Parliament Health and Social Care Committee 2022), (RCGP 2023)) that, when properly resourced, the partnership model of general practice is associated with many benefits: for patients, the wider health economy and GPs themselves.

- **Autonomy, Adaptability and Flexibility**: GPs working in partnership have the freedom to make decisions about their practice, including how they manage their time and resources. This autonomy allows them to tailor their NHS services to meet the specific local needs and adapt quickly to changing circumstances. In this model, practices can adapt to the health needs of their local population and provide supplementary services (directed or local) to meet them. Partnerships have been found to foster "*entrepreneurialism and creativity*" and larger federated practices in particular can "*release economies of scale*" and develop "*improved management capacity*" (Mathew and Jones 2024).
- **Continuity of Care**: The model supports continuity of care, which is associated with better patient outcomes including lower mortality rates (Pereira Gray, et al. 2018). GP partners are more likely to remain working at the same surgery for longer (Ding, Hann and Sibbald 2008) than salaried GPs and thus become embedded in their communities. Patients often see the same GP over time, and indeed members of the same family, building a strong doctor-patient relationship that can lead to more personalised and effective care.
- **Value for Money**: GP partners have control over their practice, including staffing, services offered, and crucially, the financial management. We have previously outlined that practices are unable to operate at a deficit as small businesses. Indeed, the RCGP have said that the "*partnership model of general practice is extremely good value for money for the NHS"* due to the goodwill of GP partners who have a critical financial stake in the organisations. The Darzi report on the NHS in England in 2024 also stated that "*spending in primary and community services had a superior return on investment*" compared to hospital services (Prof Lord Darzi 2024, p74).

A relatively recent partnership-focused initiative introduced into the GP contract is the **Partnership Premium Scheme**, launched as part of the 2019-2020 GMS Contract agreement. This scheme aims to incentivise GPs into partnership by providing additional payments to GP partners based on the number of clinical sessions they undertake as a partner. Payments are made quarterly. However, the scheme has been somewhat devalued given the absence of any uplift mechanism which can adjust for inflation and GP pay rises. We have agreed with the Welsh Government to review this ahead of the forthcoming contract negotiations. The Partnership Premium scheme effectively replaces the previous Seniority scheme, which rewarded length of commitment. This is now closed to new entrants but maintained at current levels for existing recipients.

Some disadvantages are widely associated with the partnership model, including the individual financial risks during challenging economic circumstances. These include:

- **Financial liabilities**: Independent contractors personally bear all financial liabilities and risks associated with running a practice. This includes managing expenses such as staff salaries, premises costs and other operational expenses, and, on occasion, property ownership. As outlined above, years of underinvestment in general practice puts immense strain on contractors liable to cover these costs. Where contract uplifts are insufficient to cover rising expenses, practices have limited means to raise alternative funding to accommodate the shortfall.
- **Workload and Stress**: The model can lead to high workloads and stress for all GPs, but with ultimate responsibility for delivery falling on the contract holders, i.e. partners. GP partners rated their daily workload at 83/100 in an April 2024 survey and 98% said they felt some level of wellbeing concerns as a result. The responsibility of managing a practice, along with clinical duties, can be overwhelming. This has been linked to issues such as burnout and mental health problems among GPs.
- **Recruitment and retention**: There has been a noticeable decline in the number of GP partners, with StatsWales data demonstrating an 8% reduction in partner headcount in Wales since March 2020 compared to a 46% increase in salaried GPs over that period. Despite many wishing to enter a partnership in future if conditions are stabilised (The Kings Fund 2022), early career GPs are less inclined to take on the responsibilities of partnership, with the cost-of-living crisis and pay erosion affecting their ability to 'buy-in' to the partnership. This has been witnessed in England with the number of GP partners under 40 falling by 53% from 2015 to 2024 (Nuffield Trust 2025).
- **Variation between practices**: From a Health board or Welsh Government perspective, there is a perception that the model can hamper the universality of service provision for patients. While practices must provide unified services required by their contract, partners can determine whether it is viable for the practice to offer certain supplementary services to its patient list.
- **Lack of Political Support**: Primarily in England, the independent contractor model has faced criticism from politicians across the political spectrum, threatening its sustainability. This was particularly acute during the pandemic. This lack of political support can undermine the model and create uncertainty for GPs and practices. The Welsh Government has publicly stated its support for the continuation of the model. However, we continue to call for rhetoric to become a reality, as reflected in key calls of the Save Our Surgeries campaign.

While the independent contractor model of general practice comes with inherent risks and challenges, GPC Wales believes that with proper resourcing and support, the benefits of autonomy, adaptability, and flexibility for GPs can outweigh these risks, ensuring the continued effectiveness of general practice for the patient population of Wales.

A starting point would be to review and reform the process by which practices are reimbursed for the costs incurred as part of doing business. As recognised by the DDRB in their 2024 report (p20), contract uplifts in recent years have failed to take account of increased expenses due to inflation, thus negating any intended pay uplifts. This could

include consideration of an index-linked and ringfenced expenses uplift, direct reimbursement of staffing costs (or a proportion thereof), or direct reimbursement of any premises costs including management fees. This would represent progress toward partial de-risking of the model and help to ensure its continuation.

The current restrictions on the legal structures by which GP partnerships are entitled to hold NHS contracts must be reviewed, to allow alternatives to the current unlimited liability partnerships[xi] that most GPs hold. The current situation means partners are "*jointly and severally*" liable for any losses resulting from financial difficulties, with each partner potentially liable on a personal basis for the entire value of the debt. This personal risk is not palatable for future generations of GPs and not sustainable for current contract holders. Alternative structures could include community interest companies (CIC) or limited liability partnerships (LLPs).

Existing GMS contract regulations[xii] prevent contracts being held by LLPs. While not without their own risks and complexities, LLPs offer additional protections from liabilities for individual partners. An LLP is a separate legal entity, which means it has legal capacity to enter into agreements or contracts, assume obligations, incur, and pay debts, sue and be sued, and to be held responsible for its actions. It will continue in existence despite any change in membership, thus making transferring ownership and succession much more straightforward. The structure also offers more flexibility in management structures and decision making. It is vitally important that any reforms are considered alongside pension eligibility regulations, which currently prevent LLP or CIC employed staff from being part of the NHS pension scheme.

Directly managed practices

The managed practice model in Wales involves GP practices being directly managed by health boards in order to continue the provision of primary medical services in that practice area. Health boards will operate the practice with directly employed salaried GPs and/or sessional locum GPs, alongside the wider practice team. This eventuality usually occurs when GP partners have handed their GMS contracts back due to the pressures we have previously mentioned, or upon retirement. When this happens, health boards have several options: to seek new independent contractor GPs via a vacant practice panel; to disperse the practice population amongst neighbouring practices; to enable existing GMS practices to merge; or to directly manage the practice.

We would argue that this model has not been consciously designed but stems from the health boards being forced to intervene due to their responsibilities as providers of healthcare for their population.

Managed practices are subject to the *Local Health board Medical Services (Wales) Directions 2024*[xiii], which sets out the requirements to provide equivalent services to practices operating under the standard GMS contract. However, we have heard from members anecdotally that many supplementary services are not offered to managed practice patients

[xi] Governed by the *Partnership Act 1890* legislation.gov.uk/ukpga/Vict/53-54/39/contents
[xii] legislation.gov.uk/wsi/2023/953/regulation/6
[xiii] gov.wales/local-health-board-medical-services-wales-directions-2024

and that operational hours may vary. It remains a concern that health boards are simultaneously responsible for providing services in these settings, while also overseeing the contract assurance requirements.

This model has become more prevalent in recent years, initially in North and West Wales but more recently in areas such as Gwent. BMA Cymru Wales conducted a series of Freedom of Information Requests to health boards regarding their operation of managed practices across the time period 2018/19 and 2022/23[xiv]. During this time:

- 38 GP practices handed back their contracts, with a noticeable disparity across health boards.
- The number of practices being directly managed varied from 23 to 29, with some returning to independent contractor status (otherwise known as 'GMS') and others closed. This varied considerably between health boards, with Betsi Cadwaladr UHB managing up to 15 sites and Cardiff & Vale UHB having none.
- A total overspend in the region of £31.6m was accumulated, i.e. additional spending over and above what practices would have received if they were operated as GMS practices. This was particularly high in the 2022/23 year with an overspend of £10.9m. This represents a total overspend of 24% over the time period.

This means that patients in managed practices received an average of **£53.38** more than they would have received by the traditional global sum allocation to GMS practices. This equates to an increased per-patient spend of approximately 33%. Statistics regarding the number of practices managed and their staff profile can now be found on StatsWales, although this lacks financial transparency.

GPC Wales has expressed concerns about the managed practice model over a significant period of time. As our findings demonstrate, the model is far more costly compared to the traditional independent contractor model and offers significantly worse value for money for patients. The significant overspends can be attributed to increased management costs and the need to incur sessional locum GPs, although there has been an increasing move toward substantive salaried roles. We acknowledge that the model is necessary in some areas to ensure the continued provision of primary medical services for patients that would otherwise have no access to healthcare. However, it is not a preferred long-term solution due to its higher costs and inefficiencies.

Private GP services

It is important to make the distinction between the independent contractor model of general practice, where GP partnerships are contracted to provide NHS funded services available to patients free at the point of delivery, and purely private general practice.

The latter are services are provided by GPs entirely outside of the NHS, which are typically paid for directly by patients or through private health insurance. Private GPs offer a range of services, including consultations, diagnostic tests, and treatments, often with easier access

[xiv] Interactive infographic on Freedom of Information Requests on Managed Practices 2018/19-2022/23: public.flourish.studio/story/1942910/

and more flexible appointment options compared to under pressure NHS services. Fully private GP practices are being established across Wales (BBC Wales 2023) (2024), as a direct result of the critical issues facing NHS general practice as described in this response. Further afield, some NHS practices in the UK have often provide private appointments to non-registered patients outside of the core GP contract hours, as a means to make up for chronic funding shortfalls (Torjesen 2024).

Under the GMS contract regulations, all NHS contracted GP practices are restricted from providing treatment to their own registered patients on a paid for basis, even if there was both patient demand and staff capacity for offering distinct services outside of core NHS hours, e.g. minor surgery not otherwise offered on the NHS. Additionally, contractors under certain premises arrangements are prevented from raising a certain proportion of income through non-NHS treatment. Practices are entitled to levy fees and charges for certain limited activities such as workplace medicals, and non-NHS vaccinations & certification for travel purposes[xv].

This means there is an uneven playing field for practices in relation to community pharmacies for the annual flu programme. GP practices are unable to opportunistically offer a paid for flu jab to their registered patients that do not fall within the annually announced eligible groups.

We remain committed to the principle of free at the point of delivery NHS funded care; and a widespread deviation from this principle could invariably worsen the Inverse Care Law. However, there are contractual provisions which put restrictions on practices and their ability to supplement funding shortfalls. While current workforce and workload pressures would it difficult for practices to offer non-NHS treatments, vaccinations and other services to their own patients, there is a need to review these provisions as the alternative could amount to a further increase in purely private GP services.

c) the suitability and maintenance of general practice estates and access to digital technology;

General practice estates

GPs in Wales (and across the UK) typically occupy their premises in one of two main ways: outright ownership or rental. Many GP practices are owned by the GP partners themselves and are termed as owner-occupied. The property might be owned outright or financed through a mortgage or loan. When the premises are owned outright, the practice receives notional rent reimbursements from the NHS for the space used for NHS purposes. If the property is subject to a mortgage or loan, the practice receives either the notional rent or a cost rent reimbursement, which is based on the borrowing costs. Owners remain liable for all aspects of the building, including if the practice hands back its GMS contract.

An increasing number of GP practices operate from leased premises. These can be owned by former GP partners, private landlords, or public bodies such as the health board. Practices that lease their premises receive a leasehold cost rent reimbursement from the NHS, which

[xv] Please refer to *NHS (GMS Contracts) (Wales) Regulations 2023* paragraphs 21 and 22 legislation.gov.uk/wsi/2023/953/regulation/21/made; legislation.gov.uk/wsi/2023/953/regulation/22/made

should not exceed the actual lease rent paid. Leased premises will be subject to service charges from the landlord in addition to the usual maintenance and cleaning fees.

Feedback from members over a significant period has highlighted several consistent issues in relation to the current GP estate. Figure 2 displays the premises issues which respondents to a 2024 GPC Wales survey were asked to rank in terms of their impact on the sustainability of their practice.

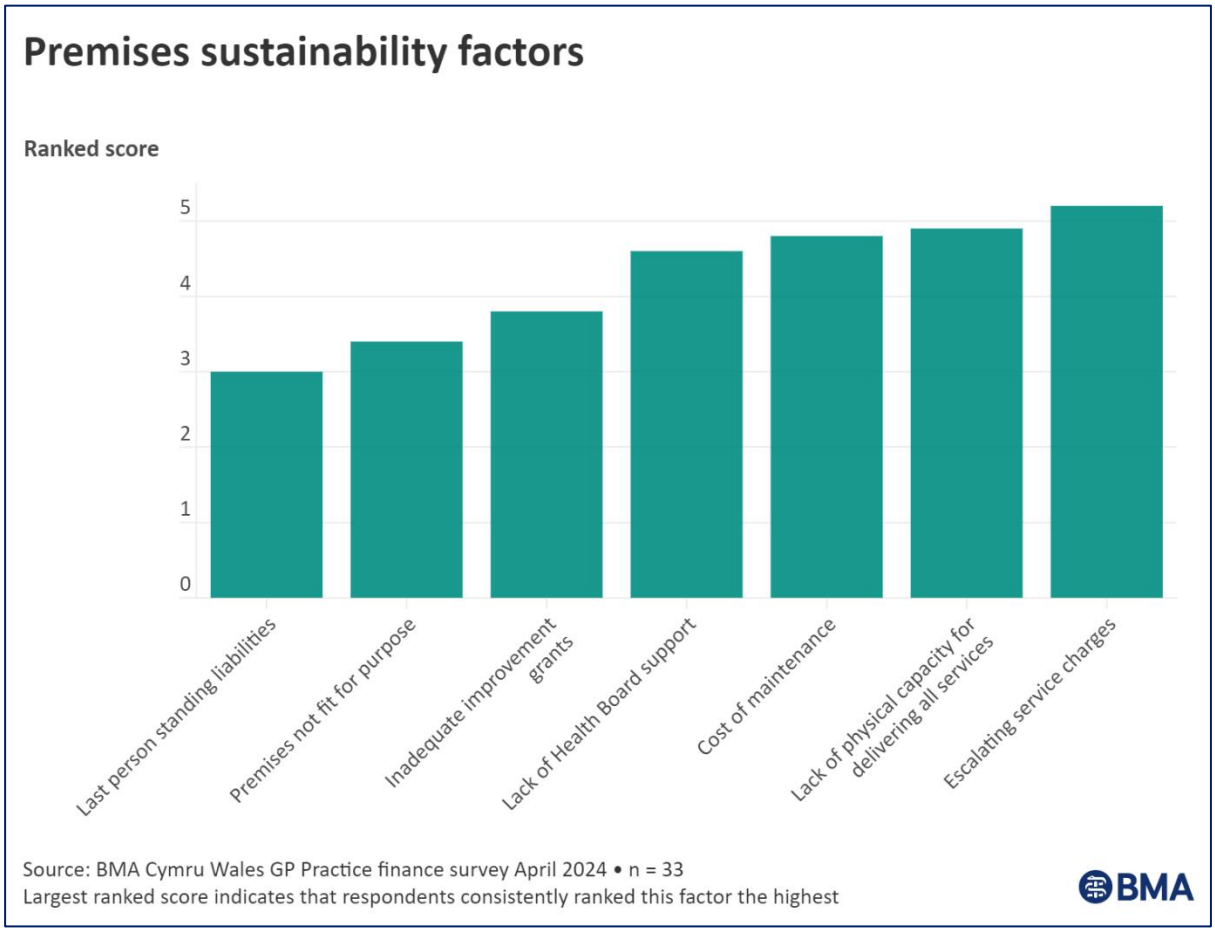

Figure 2 - Premises factors affecting practice sustainability as ranked by practices

Service Charges and Funding:

The impact of service charges for rental premises is significant. There is a need to update the 2015 Premises Cost (Wales) Directions, particularly regarding sizing, multiple occupancy, and how service charges are handled.

Inadequate Improvement grants:

Practices are eligible to apply for grants from their health board to improve or extend their premises under the Premises Cost Directions. However, the value of grants is often insufficient, with obtaining 100% funded grants being extremely difficult. Practices should also be able to access bespoke grants where practices wish to improve access for those with disabilities or enhanced access needs.

Shared Usage and Space:

The increase in health board-owned and developed premises coupled with the rise of multi-disciplinary working under the Primary Care Model for Wales has made shared usage of premises commonplace. However, this can lead to disputes over space and rent calculations, particularly when co-located services are delivered by health board staff. A formula for rent payment calculation based on usage of practice space is necessary.

Ownership and Lease Arrangements:

The current funding structure creates barriers for GP partners, particularly regarding estate ownership and lease arrangements. There has been a general trend in recent from GP-owned premises to leasehold arrangements, with a reluctance from young GPs to enter into ownership, but significant numbers of owned premises remain . GP partner owner-occupiers remain at risk of Last Person Standing liabilities: the situation where one partner is left alone when other partners retire of leave, potentially facing the full financial and operational burden of the practice, including premises liabilities and obligations. A Welsh Health Circular issued by the Chief Medical Officer in 2018, negotiated by GPC Wales and the Welsh Government[xvi], sets out the premises options health boards have available to support partners in this eventuality. However, this policy direction falls short of partial or complete de-risking.

Maintenance and Safety:

The physical condition of buildings, particularly their functional suitability and safety, are critical concerns. While a GPC Wales survey in early 2024 revealed no instances of Reinforced Autoclaved Aerated Concrete (RAAC) in member premises, there are nevertheless known issues regarding the condition of many practices, in particular compliance with accessibility requirements. This was illustrated in a report commissioned by the Welsh Government on the future of primary care premises in Wales (Archus/Welsh Government 2021) which found that in 2021 around 13% of GP premises in Wales were in a category C condition: '*operational but major repair of replacement needed* soon'. There is a need for an improved estates strategy that can enable GPs and their teams to practice in modern, fit-for-purpose settings.

Training and Capacity Issues:

Over the last decade, there has been a trend toward an increased proportion of education and training for health professions taking place in primary care settings. In principle, this is to be commended, given that it provides professionals with experience in the challenges of working outside of acute settings. However, the physical capacity for training within practices is limited with a paucity of consulting rooms which can be used for this purpose. This comes in addition to capacity issues amongst trainers themselves.

GPC Wales is represented on an ongoing collaborative Premises Task and Finish Group that aims to address various issues related to primary care premises in Wales. The group brings together key stakeholders from the Welsh Government, health boards, and other relevant

[xvi] *Welsh Health Circular (2020) 018* gov.wales/sites/default/files/publications/2020-10/support-for-gp-premises-liabilities.pdf

agencies. The group's remit is to identify and resolve the longstanding premises issues and to develop strategies to improve, including an update to relevant directions taking into account development in other nations.

Access to digital technology

GPs in Wales benefit from relatively good access to digital technology, particularly when compared to the provision in hospital settings. Patient records in general practice have all been electronic for a significant time period and typically cover the duration of a patient's lifespan ('cradle to the grave'). In contrast, in secondary care, the patient record can still be paper-based and specific to a particular condition or department. There are several systems that allow practices to communicate electronically with secondary care departments, such as the Welsh Clinical Communications Gateway, which enables referrals. However, its usage is not uniform across NHS Wales.

The GMS IM&T framework aims to provide a standardised approach to procuring and deploying IT systems for GMS practices in Wales, ensuring that practices have access to the necessary technology to deliver quality care. This framework is led by the GMS I&MT Board, featuring representation by GPC Wales, and data and digital matters led on an operational basis by Digital Health & Care Wales, which provides practices with many IT infrastructure and security services. It is funded by top-slicing a proportion of the total GMS contract value.

Procurement exercises for the core GP practice clinical systems are conducted every five years; practices are able to choose between approved clinical systems developed by commercial providers who can demonstrate compliance with the requirements set by the framework. Traditionally, two major companies have provided GP clinical systems in the Welsh market, although during the last procurement exercise GMS was left with one monopoly supplier following conclusion of the process.,

While the core clinical systems and other elements of digital technology are funded centrally, it does not provide practices with funding for digital access tools, such as those which emerged during the pandemic for online consultations, imaging and video calls. Practices are required to fund these tools themselves, in part to meet the contractual requirements for electronic access methods for non-urgent issues within core hours, therefore creating an additional business expense.

The NHS Wales App

Some of this functionality can be delivered by the NHS Wales app that has been rolled out gradually since 2023, although many practices rely upon the bespoke functions offered by third-party packages.

The app is a welcome tool for patients to access a range of services, and the 2024/25 contract agreement will see the repeat prescription functionality enabled by all practices. The app can also allow advance booking of appointments and access to the summary care record. While the app can create these new routes for patients to contact their practice, it will not in itself unlock capacity for new appointments, or alleviate any demand upon GPs and their staff. As discussed elsewhere, practices are experiencing chronic funding and

workforce challenges in meeting the existing demand, which has seen approximately 6m digital queries to practices in 2023/24 on top of 29m telephone calls.

Cross-border interaction

While electronic communication between practices within the NHS Wales system is relatively positive (and secondary care to a lesser extent), there are significant cross-border challenges when Welsh GPs seek to refer patients for specialist treatment in England and vice-versa. A significant section of the Welsh population lives along the England/Wales border, and their nearest GP practice or hospital specialty may be across the border from where they live – making communication between health providers difficult.

In evidence to the UK Parliament's Welsh Affairs Committee evidence session on Cross-border healthcare (BMA Cymru Wales 2025), we raised significant concerns about the inability of Welsh doctors to access patient results from English hospitals electronically in a timely fashion, and the extreme difficulties in communicating clinical information relating to referrals. With several highly specialised services only being available in England, this problem can apply to all practices and not merely those on the border.

Electronic prescribing

An area where Welsh general practice has lagged behind is the absence of electronic prescribing, which has been the norm in England for over a decade. After extended lobbying of the Welsh Government by BMA Cymru Wales and other bodies, the Electronic Prescribing System (EPS) is currently being rolled out to GP practices across Wales and was enabled legislatively within the 2023 GP contract regulations. The EPS enables prescriptions to be sent electronically from the practice to the pharmacy of a patient's choice without requiring a paper prescription form to be manually signed by the prescribing GP. This has significant workload benefits as well as reducing the use of paper. The first electronic prescription was issued in Wales in November 2023, with a gradual rollout dependent on practice readiness to adopt the new systems.

While this is extremely positive for most practices in Wales, there are significant barriers to the rollout of EPS amongst dispensing GP practices, who are the cornerstone of healthcare provision across rural Wales. Dispensing practices are concerned about the costs associated with implementing EPS given their specific circumstances. They need EPS-compliant Patient Medication Record (PMR) software, which incurs initial set-up costs and ongoing maintenance expenses. There is currently no funding stream to cover these costs, and dispensing practices are unlikely to engage with EPS until this issue is resolved. GPC Wales and the DDA have advocated for NHS Wales to find a funding stream to cover the costs of EPS implementation for dispensing practices. These extraordinary costs should not be taken from the core GMS budget, and a solution must be found to enable further progress.

GPs as data controllers

As data controllers for patient records, GPs have significant personal responsibilities for information governance and can be at significant financial risk of fines by the Information Commissioner's Office in the event of any breaches. GPC Wales is wholly aligned with the theoretical concept of safe and legal access for patients to their medical information through

electronic means. However, significant risks must be addressed through legislative change and other means.

For a more extensive summary of issues relating to information governance in general practice, and potential solutions, we would suggest the committee refer to our prior correspondence to the Senedd Equality and Social Justice Committee[xvii] in April and August 2023 (BMA Cymru Wales 2023).

2) The general practice workforce, including workforce planning, the recruitment of new staff into general practice, the retention of experienced staff, staff workload and wellbeing, training and continuing professional development, and the growth of the multidisciplinary team;

Workforce planning for GPs in Wales is poor and needs to include an assessment of population need

Workforce planning for GPs in Wales is unquestionably poor. Recently, BMA Cymru Wales has expressed our concerns about the HEIW Education and Training Plan (ETP) for 2025/26 published in February. Specifically, we are very concerned about the reduced number of medical training places (both GP and secondary care) to be funded by the Welsh Government for 2025/26 compared to that requested by HEIW. Whilst the original allocation of GP Specialty Training (or GP ST1) places had been between 200 and 220, the plan committed to only 160.

The decision to reduce training places from the original recommended allocation comes at a time when workforce trends suggest that more GPs than ever are needed to accommodate increasing preferences for less than full-time equivalent working and portfolio careers. We have 25% fewer full-time equivalent GPs working at practices than in 2013. At January 2024, Wales needed 718 additional GPs to match the average number of GPs per 1000 people in other European countries (BMA Cymru Wales 2024).

In the BMA Cymru Wales response to the draft 2025/26 ETP from June 2024, we reiterated our concerns that the plan lacked any visible link with other workforce plans or assessment of population health needs. It is important to note another delay in publishing the final plan, which has been subject to significant change without stakeholder engagement.

The BMA continues to call on the Welsh government to produce a workforce strategy to ensure that Wales trains, recruits, and retains enough GPs to move toward the OECD average number of GPs per 1000 people. This must feature a renewed focus on retaining existing GPs and tackling the problems driving them out of the profession.

A comprehensive workforce strategy with suitable planning based on population needs would help identify risks to a sustainable workforce. Audit Wales, for example, has identified that comparative GP training levels in Wales could fall far behind NHS England if the numbers promised in England's NHS Long Term Workforce Plan come to fruition (Audit

[xvii] business.senedd.wales/mgIssueHistoryChronology.aspx?IId=40950&Opt=2

Wales 2025, p18). This could impact the ability to recruit into GP training places at the required levels in Wales.

The workload of GPs is too high, badly affecting their personal wellbeing

In the last ten years, the number of patients registered at GP practices in Wales has increased by 93,317 (2.9%).[xviii] In the same period, the number of practices decreased from 470 to 386 (18%), and the equivalent number of full-time GPs decreased by 456 (21.7%) from 1901 to 1445.[xix]

The growing and ageing population is living longer with more complex needs. Increasing amounts of work have moved from secondary care to general practice, and record-breaking hospital waiting lists have exacerbated this further. Despite heavy investment in an expanded workforce, secondary care waiting times have soared with GPs left to manage the physical and psychological patient consequences of waiting long periods for care.

According to a BMA Cymru Wales survey, GPs report excessive workloads, with an average workload rating of 79 out of 100, with 0 representing 'manageable' and 100 representing 'constantly excessive'. This pressure is causing practices to consider reducing their education and training commitments, which could negatively impact the future workforce.

There is a low level of morale among GPs. In the same survey, 26.6% of respondents said they were considering leaving the profession '*in the near future*'. Only just over half of GP partners who answered the survey said they see themselves remaining in their current position in three years. GPs work tirelessly for their communities, but sadly, their efforts to keep up with an ever-increasing workload are detrimental to their mental wellbeing, with many reporting burnout, overwhelm, and fatigue. Figure 3 illustrates the wellbeing cycle affecting many GPs in Wales.

Studies have demonstrated that there is an association between burnout/poor wellbeing amongst GPs with patient safety. A 2018 study concluded that "*A higher number of hours spent on administrative tasks, a higher number of patients seen per day, and feeling less supported were associated with higher burnout levels, which in turn was associated with worse perceptions of safety*" (Hall, et al. 2019). This was true was prior to the COVID-19 pandemic, which is known to have exacerbated existing wellbeing concerns amongst all areas of the medical profession, including GPs (University of York 2021).

[xviii] Data from NHS Wales Shared Services Partnership GP practice analysis timeseries and StatsWales data Patients registered at a GP practice in Wales

[xix] Full time equivalent (FTE). Total count represents 'GP providers' which represents GP partners and salaried GPs

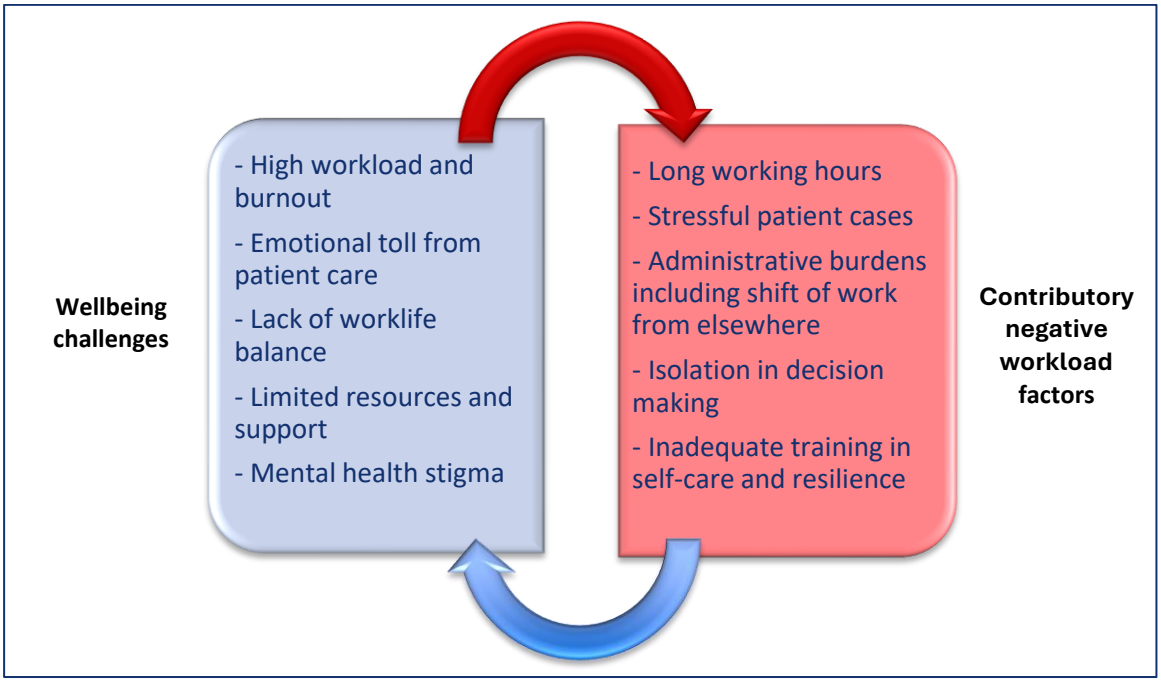

Figure 3 - Representation of current wellbeing cycle facing GPs in Wales

The risk to the health service that poor wellbeing poses is substantial. If the poor wellbeing of GPs is not addressed, we will continue to see worrying trends of GP, leaving in numbers that affect capacity, patient care, and the ability of remaining practitioners to remain well.

General practice finds itself in a unique position in which many GPs report high burnout levels while others have a desire to work more hours. In a recent UK-wide BMA survey of sessional GPs[xx], half of non-partner GPs in Wales (49.3%) said they would like to work more. At first, this may seem nonsensical. The issue is that there are not enough GPs in post to meet patient demand, but at the same time there is un- and underemployment of GPs, meaning that there are qualified GPs who cannot find suitable work. This is a funding issue, as practices have been forced not to hire the GPs they need as they lack the funding or can only offer part-time roles. They might also not be able to offer competitive pay. This means that there are GPs who cannot find work at all or can only find part-time or underpaid roles. As well as being damaging for the future of general practice, it is personally damaging for the self-worth and wellbeing of the GPs in that situation (See Annex B for a selection of comments from Welsh respondents to this survey).

Recruitment of new GPs and retention of existing GPs in general practice needs urgent attention

There is evidence that a proportion of young GPs still want to enter partnerships once working conditions are stabilised (The Kings Fund 2022). However, there is a need for immediate and sustained intervention by the Welsh Government and health boards to bring about sustainable conditions where the partnership model can thrive. The scale of the crisis

[xx] bma.org.uk/our-campaigns/gp-campaigns/workforce/tackling-gp-unemployment-in-the-uk-sessional-gp-survey/

is illustrated by recent joiners and leavers data for different GP types (Figure 4) which show a marked decrease in GP partner numbers in the last four years.

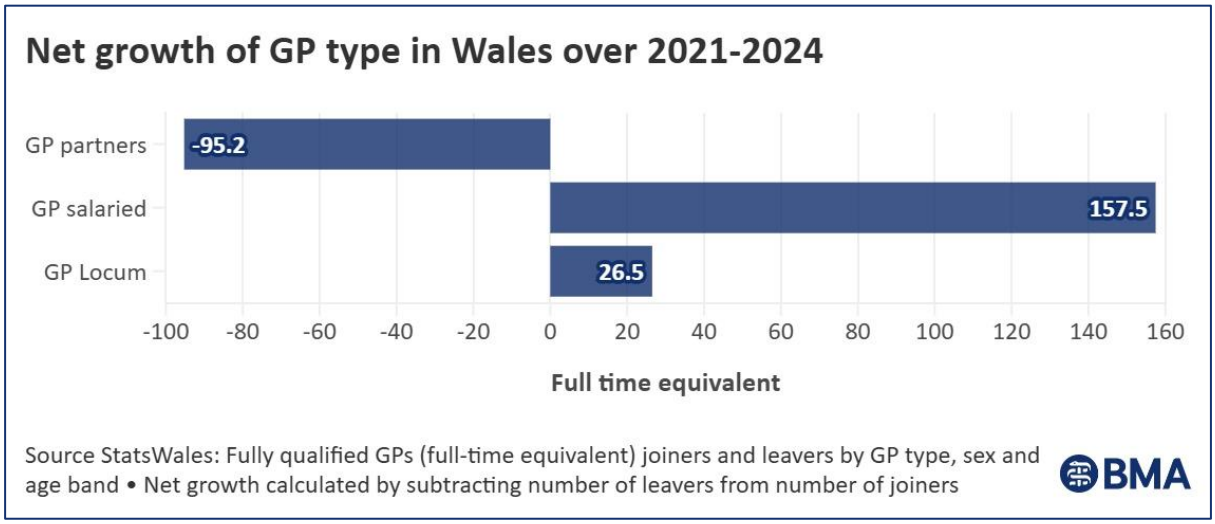

Figure 4 – Net growth of GP type in Wales 2021-2024

Despite the gradual increase in GP trainee headcount in recent years (prior to this current year), we need to train higher numbers of GPs to deliver upon the policy goals of A Healthier Wales, to deal with patient demands, and to accommodate the increased preference for less than full time working and portfolio careers. Compared to other NHS staff groups and other branches of medical practice, the relative headcount of fully qualified GPs has stagnated since 2009. There has only been a 1.8% increase in GP headcount since 2009, compared to a 44% increase in the total consultant headcount. The picture is even worse when considering full-time equivalent working: as of March 2024, we had 25% fewer FTE GPs working at practices than in 2013.

Measures to increase retention of our most experienced GPs are vitally important. Significant numbers of GP partners are exiting the workforce, changing their roles, or looking to leave soon. Only 53% of GP partner respondents told us in 2024 survey that they saw themselves working in their current role in three years' time.

It is paradoxical that at a time of immense workforce need, we hear concerning reports of widespread underemployment or unemployment by sessional and newly qualified GPs. This can in part be attributed to the crippling financial pressures that practices have been facing in recent years: practices are unable to afford to offer substantive salaried roles or rely upon locum GPs in the same way as they used to. There is a ready and trained workforce who are available to relieve some of the immediate pressures and in time facilitate the shift left of services closer to home. However, this can only be unlocked with reprioritisation of investment.

Unfortunately, capacity in the current primary care estate itself may be insufficient to meet the increasing demand for space for the current and future workforce. This, coupled with the extreme workload pressures upon the GP trainers, highlights the need for further investment in the workforce and premises.

3) The patient experience of general practice, including equitable access to care, effective management of patient demand, the quality of care, and public trust in the services provided;

An overarching theme of this submission, and indeed of healthcare across Wales and the UK, is that there is a growing gap between demand and capacity. This impacts on doctors' morale, wellbeing, and patients' healthcare experience. According to a BMA Cymru Survey, GPs feel their high workload is detrimental to patient care, with 80% of respondents fearing that they are unable to provide quality and safe care to patients. However, there is still no official analysis of unmet needs. This needs to be addressed urgently if we are to work towards better access for patients.

Management of patient demand and expectations is something GPs continue to grapple with. As noted in the Save Our Surgeries campaign update report (BMA Cymru Wales, 2024), data from 2021-2024 revealed that on average GPs delivered over 1.6m appointments per month: the equivalent of the entire Welsh population having an appointment every two months. Demand remains high throughout the year; between July and September 2024, an estimated 4.7 million appointments were scheduled. 65.7% of these were face-to-face, an increase of 1.2 percentage points from the same period in the previous year. GP workloads continue to increase year on year.[xxi].

A good doctor-patient relationship is an important part of general practice but is becoming increasingly uncommon. Continuity of care helps patients feel more comfortable with disclosing their problems, and doctors can get a better sense of a patient's diagnosis the more they can understand them as a person. Unfortunately, doctors are operating in an environment in which a lack of capacity means flexibility is essential. Practices find themselves only able to offer the first available doctor rather than the patient's usual doctor. This problem is caused by a dearth of GPs in Wales and exacerbated by the prevailing emphasis on access within the contract. To meet the access commitments implemented by the Welsh Government, GPs have to assign any available doctor to a patient rather than whoever they would prefer to see. Continuity of care is thus removed.

Subject to approval, a long-term Continuity of care Quality Improvement project for practices continuity will be launched for 2025/26 and will aid practices to track this important factor over a long-term period. The contractual access standards will also be evaluated by the tripartite negotiating group. These two pieces of work will be extremely important to determine the how the GMS contract can seek to set an appropriate balance between the emphasis on '*access at all costs'* and the continuity of patient care.

Equitable access to care is essential to addressing health inequalities. The gap in life expectancy between the least and most deprived population in Wales has generally increased in recent years for males and females, suggesting growing inequality (Public Health Wales Observatory 2022). The health problems caused or worsened by a person's socio-economic circumstances, such as poverty and institutional racism, are seen by all doctors, daily. GPs are uniquely positioned to address health inequalities as the first point of

[xxi] *General Practice activity data Jul – Sep 24* gov.wales/general-practice-activity-july-september-2024-html

contact for most patients. To address health inequalities in Wales, investing in general practice must be a priority.

4) Opportunities to improve general practice to make it fit for the future and take a more preventative approach to care.

Resource restoration is essential to secure sufficient investment to deliver a workforce that meets the inexorable workload that GMS practices manage daily on behalf of the NHS in Wales whilst maintaining the well-being of those who deliver that care.

Welsh Government must commit to a reversal of this underfunding by restoring the previous 8.7% of the total Welsh NHS budget directly into GMS within the next three years, with an aspiration to invest closer to 11% of NHS spending directly into GMS within the next five years. We acknowledge that this would represent a major redirection and reprioritisation.. We must course correct to restore general practice funding towards those historic levels.

Additionally, the Welsh Statement of Financial Entitlement (SFE) lacks a population growth uplift factor similar to that in the Scottish equivalent. This means that year on year there has been a continuous compound depreciation of existing resource at a practice level with a rising population.

General practice, when adequately resourced, can deliver upon the preventative agenda as outlined in A Healthier Wales. It could deliver upon initiatives such as:

- Waiting list reviews,
- Early supported discharge care
- Community based diagnostics
- Accommodate the transfer of chronic disease care out of hospital settings, e.g. holistic diabetes care.

Crucially, increased investment would bring about improved retention of GPs across all parts of the career spectrum and aid recruitment of GPs and staff into general practice. This workforce boost will lessen the workload per GP and ensure GP workload is kept at safe levels. These better working conditions alongside better reward, will undoubtedly improve the wellbeing of our workforce. Achieving safe working conditions for our GPs and their staff and embedding national standards in line with existing BMA guidance on safe working (BMA Cymru Wales 2023) should be a shared goal for us all.

In the summer, BMA UK will be publishing a project entitled *Value of a GP*, which will comprehensively demonstrate the case for investment in general practice and GPs from a political, strategic, economic, and health outcomes perspective. When this is published, we will ensure that the Health & Social Care Committee receive a copy of the publication.

Recommendations

We hope this document provides the Senedd Health and Social Care Committee with an overview of the many critical issues facing general practice in Wales, along with a pathway to safeguard its future so that GPs can play their proper role in prevention and ensuring citizen wellbeing.

Our recommendations build upon those expressed in our ongoing Save Our Surgeries campaign, originally launched in 2023. We would ask that committee members consider the following calls as part of their inquiry:

1. Welsh Government must commit to funding general practice properly, restoring the proportion of the NHS Wales budget spent in general practice to the historic level of 8.7% within three years, with an aspiration to increase to nearer 11% in the next five years.
2. Welsh Government must commit to a review of the appropriateness of the current funding allocation formula for Welsh general practice, involving specialist population health and financial expertise. This must include extensive modelling of the consequences of any potential adjustments and inclusion of any new factors in the formula. Recommendations of this review would inform the next steps for GP funding allocation in Wales.
3. Welsh Government to work with GPC Wales and NHS Wales representatives to develop plans for the implementation of a national standard for safe working, taking into account the existing BMA guidance. To maintain safe and high-quality service delivery for practitioners and patients, this should consider a maximum number of patients that GPs can reasonably deal with during a working day.
4. Welsh Government and HEIW to enact long-term investment in increasing the GP workforce, including a GP-focused and prioritised workforce strategy to increase the number of GPs in Wales toward the OECD average. Measures must be immediately implemented to retain existing doctors, ensure practices can afford to employ under/unemployed GPs and tackle the problems driving GPs out of the profession. This needs to include an anticipation of expanded and appropriately funded premises to train the new GPs that Wales desperately needs.
5. Welsh Government must support the conditions to enable the contractor model of general practice to be stabilised and then thrive once again: mitigating unnecessary risk and workload issues to retain the flexibility, commitment and continuity that a contractor services model offers. This will mean balancing the risk and reward for younger doctors and those at the end of their careers, as well as supporting a variety of rewarding salaried and freelance roles within a service much more geared to working at scale. This must include a review of the regulations which restrict certain legal structures holding GMS contracts, and other contractual restrictions.

6. Welsh Government must consider reforms to the GMS contract annual negotiation process to ensure fair remuneration for GP partners, salaried GP and all practice staff by instilling several key guiding principles:

    - Dissociation of the annual GP and staff pay awards from wider contractual change.
    - Transfer of work into GMS necessitates transfer of resource.
    - Pay awards to be enabled and protected each year by a sufficient expense uplift, as per the expectations of the DDRB.
    - An ongoing commitment for an index-linked and ringfenced uplift to expenses, and a population growth factor to adjust global sum for local practice populations.

7. Welsh Government to build on existing commitments for reforms to the Dispensing doctor system, and work on a tripartite basis to progress areas including:

    - Removal of dispensing fee system; introduction of a capitation-based system for dispensing patients, with uplifts linked to Welsh GMS contract pay and expenses awards
    - Protect practices from drug related financial losses: removal of discount abatement and consideration of reimbursement for loss-making drugs
    - Consider introduction of a dispensing IT fund, including distinct non-GMS funding for electronic prescribing, which would also allow practices access to technological innovations such as ATMs, robotic tools.

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Annex A: Structure of Welsh GP contract negotiations

Following the major reforms of the 'new' GMS contract in 2004, negotiations on annual changes to the GMS contract and the associated financial details were held on largely a UK-wide basis between the BMA's General Practitioners Committee UK (GPCUK) and the UK Government/Department of Health.

Beginning in the early 2010s, negotiations in the nations took place between the relevant General Practitioners Committees (e.g. GPC Wales) and their respective government, leading to significant divergence in approach and contractual structure. This divergence has been formalised in legislative terms with a new GMS contract in Scotland in 2018 and the new Welsh GMS contract regulations 2023.

The current process in Wales for GMS negotiations has been in operation since from c.2017/18 with some iterations. It operates annually on a tripartite basis between Welsh Government officials, NHS Wales representatives and the executive team of GPC Wales. The process is overseen in governance terms by the GMS Contract Reform Group (CRG) featuring representatives from all parties.

The annual process begins with a formal letter from WG inviting GPCW to submit a mandate of asks, consisting of financial requests and proposed contract changes relating to services. Equivalent mandates are produced by NHS Wales health board representatives and Welsh Government, although this usually takes the form of a joint WG/NHS mandate.

All mandates are shared and then discussed at a joint mandate setting meeting. The resulting joint mandate document is then submitted to the NHS Wales Leadership Group and ultimately Cabinet Secretary for Health and Social Services for sign off. This then determines the scope of negotiations, which include extensive discussions on the financial elements of the contract including the recommendations of the DDRB.

Once negotiation meetings conclude, a final contract agreement is produced by Welsh Government officials and reviewed by all members of the tripartite group. This document is put to a vote of the full committee of GPC Wales, and potentially to a referendum of the wider BMA GP membership in Wales, as was the case in 2024.

In recent years, to the great frustration of GPC Wales, Welsh Government have insisted upon linking pay and expenses discussions to wider contractual change. Our dissatisfaction at this state of affairs has been expressed publicly and directly to Ministers. This does not necessarily occur in other nations, where the process can be more timely in taking account of the DDRB recommendations.

Negotiations usually took place prior to the start of the financial year with adjustments to the settlement applied once the DDRB has reported. However, given that Welsh Government financial envelope for any uplifts depends to a large degree upon the extent of Barnett consequentials from the UK Government's reaction to DDRB recommendations, in practice the process has slipped until Spring/early Summer. Budget pressures in recent years and political factors in Cardiff Bay and Westminster have further exacerbated delays,

meaning that last year's contract talks did not begin until late Summer, already several months into the financial year.

It is our view that the association of financial adjustments to wider contract change leads to a drawn-out process: as expected GPC Wales will negotiate strongly against inadequately resourced contractual changes that would worsen pressures upon our members. Ultimately, these delays create great uncertainty for practices and their employed salaried GPs and wider practice staff.

On successful conclusion of the 2024/25 contract negotiations, Welsh Government commitment to beginning 2025/26 negotiations as early as possible, potentially in advance of a settled budget position. This has commenced, with a request from Welsh Government to exchange mandates by 15 April 2025.

Information regarding current and past Welsh GMS contract agreements can be found at: bma.org.uk/pay-and-contracts/contracts#:~:text=BMA%20guidance-,GP%20contract,-Guidance%20on%20the

Annex B: Extracts from recent BMA Sessional GP survey regarding underemployment and unemployment

Please provide us with more information regarding the impact, if any, that the reduced availability of GP work has had on your personal health and wellbeing? *45 comments received*
Constant worry of finances as main earner in family
Constantly feel stressed about work availability and impact on financial security . Affects mood and sleep considerably
Worry about money/finances, unable to pay for private IVF, very emotional at lifelong impact of this
Very anxious about not working (and) losing my licence.
The knowledge that I have no permanent income, and that OOH/locum work is in higher demand, making it almost impossible for newly qualified GPs to work, has given me an overall much higher level of background stress. I have considered retraining in a different specialty to secure income. I have been unable to buy a house as I am constantly worried that I will be without income.
I developed gastrointestinal problems due to persistent stress and worry. I am looking at moving abroad.
There is a level of underlying stress and anxiety about job security and finances especially as we have a baby in childcare which costs a lot. Considering whether or not we can afford to have a second child is not something I thought I would have to do as a GP
Loss of self-worth having never been unable to work since graduation nearly 40 years ago
I feel ashamed having to counsel patients about importance of their better lifestyle choices and at the same time finishing the days with feeling that in order to fulfil my most important duties there is no time left for my personal physical activity, fitness or time to relax other than eat and sleep
I'm feeling pretty burned out. I'm worrying about the future and worrying about my pension. My partner is ill and I am the sole breadwinner. What I thought was a safe and well-respected career, turns out not to be. I am that demoralised, when asked by younger people about becoming a Dr or GP, I cannot recommend it at all. It feels very much that we are no longer required by health boards or the NHS.

Please provide us with information regarding what you believe is causing or contributing to this unemployment and underemployment crisis for GPs? *58 comments received*
Underfunding of general practice, secondary care failing to see and manage patients meaning GP is an awful job and you are broken after a couple of days work. Practices can't afford to employ more people, and young trainees are not prepared to take on work beyond that contracted and this doesn't meet demand
Extreme lack of funding. So many surgeries would employ more GPs, but they can't afford to. I was working at a surgery on a 12-month contract that they were hoping to make permanent but could not be due to finances. So that role ended in March 24. This left us in a financial mess because finding other work around childcare was extremely difficult.
In Wales practice budgets are really stretched and they are making do with as few staff as possible
My old practice has gone from 1 GP to 1400 patients to 1 GP for 1800 patients
I think it is the general squeeze on practice finances and individual GPs pay. I do know of GPs who work maybe 3 days as a partner in their practice now taking on a regular day on a contract in a health board run practice for an extra day a week.
The financial crisis affecting GP surgeries. All partners are losing money, so they are doing locums and working OOH too so less work for locums. Surgeries cannot afford to employ locum and salaried GPs and just accepting that they will provide reduced medical cover. I am fortunate to be working in a teaching role but that is filled with uncertainty due to financial crisis affecting UK universities.
In my experience I sometimes feel that being a woman with childcare responsibilities reduces my opportunities to get a GP locum or salaried post.
Total undervaluation and underinvestment in general practice. We aren't valued or paid appropriately for our expertise
Terrible working conditions in General Practice are nearly as important as remuneration. Over the course of a long career as a GP I have worked as a partner, salaried GP, locum GP and out-of-hours GP. As a partner the main issue was workload. As a salaried GP both workload and remuneration were problematic. The workload issues have forced many GPs into locum work, as this is currently the only way to have control over one's workload.
Governments have no real plan, they have no understanding of the issue