

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [dyfodol ymarfer cyffredinol yng Nghymru](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on [the future of general practice in Wales](#)

GP11 : Ymateb gan: | Response from: Nicholas Prigg

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- Challenges threatening GP sustainability

- o It is an open secret that HB-run practices cost significantly more than GMS-run ones. The level of extra funding is kept confidential, but if GMS could access this money we could provide a far better service by employing more staff. I don't think any UK Government wants to know exactly what happens in GP, because knowing the level of activity wouldn't suit their agenda to say GPs are under-performing despite the fact GPs have never done so much. An example of this in Wales is that NHS Wales computers can't interrogate EMIS to tell if individual consultations were phone/F2F/visit etc. And a lot of work is not logged as an appointment – eg we see a letter/pathology report requiring us to contact the patient immediately – most GPs just 'do it' rather than add an appointment to the screen. Certainly in BCU, GPs have the most complete (versus any of the hospitals), electronic, dataset because of 25+ years of EMIS & Vision. QOF did gather more data for WG, and I appreciate QOF had served its purpose, but it did also provide an element of showing what we were and weren't doing. If we moved to an item of service contract it would be helpful for us, it would show the level of complexity we are dealing with in our current, aging population. It would also reflect the way that many people (understandably) present to us with more than one issue – this can easily be coded in our computer systems and could be retrieved (anonymously) relatively easily. Practices who previously had an MPIG income stream are still paying the penalty for the way the Carr-Hill formula is calculated – and should Carr-Hill be reviewed 20+ years after its design? Primary care has altered huge amounts in that time.

- o There is the financial efficacy and the practical efficacy – continuity of care goes a long way to aking the system efficient, but we are currently prioritising access & cost-savings, which has impacted on continuity – and is consequently likely to be costing more.

- o WG want to move care closer to people's homes and therefore into primary care. We need the facilities to provide this – shifting care out of the hospital is going to mean we need more GPs, nurses etc in the community – they need accommodating. Facilities need to be fit for purpose (some are, some aren't). There needs to be a recognition that requirements in the community will grow as more 'left shift' occurs – so any new build/re-development requires room to grow/future proof. There are going to be more students in primary care – Bangor med student, ACPs etc – they need clinical space. IT systems need to be designed to work for us rather than block us – eg Emis community, phones embedded within the IT system (to avoid transcription errors when punching the number into a desk phone). We need to look at software that's available elsewhere – eg Arden templates, would they work in Wales? We need to update to contemporary coding systems – why aren't Wales going to Snomed – all the new, external software, is going to be based around that. Look at AI to document consultations and read clinic letters (but will probably need Snomed for the coding).

- GP Work force

- o Most newly qualified GPs want a portfolio career and will work less than full time in practice. They may or may not have roles related to being a GP the rest of the week. I worry that we will see GMS fail because it can't attract new partners when the old ones retire. It is fair enough for practices to employ some salaried GPs, but they typically see themselves in a 'salaried role' and will leave at the end of their hours and partners have to sort things out – this disincentivises people from becoming partners. Ultimately I can see a situation whereby the

majority of practices are run by salaried GPs with management input from the HB or mega-partnerships/companies. Is this the model WG wants? If so, WG should be honest about this.

- o This could be the most rewarding job, but it's impossible to audit job satisfaction. Having some reflection time each day would allow more clinical discussions in surgeries and could reduce hospital referrals.

- o MDTs need to have time (& money) invested in them – it's hard for practices to invest time in new ACPs if they have a huge waiting list of patients to be seen – you fire-fight through. If practices take on ACPs we need HB support to provide governance around their role – eg physios have very different PDP aspirations to GPs and nurses. The fact we can't provide that governance makes us reluctant to employ them, even if they could be useful in 1ry care. Somehow Clusters need to provide a network where ACPs could team up for training + PDP.

- o Workload is going up as we see the bulge of 'baby-boomers' go through, increasing complexity of care, the delays of being seen in OPD by many hospital specialities. Left-shift of work to 1ry care

- Pt experience

- o Continuity of care would improve pt satisfaction

- o WG, the HB etc need to be realistic about what 1ry care is there to do. There needs to be a recognition that work has 'left-shifted', WTE consultant numbers have gone up dramatically in the last 10-15 but WTE GPs has barely altered. It's not GPs 'fault' that ED is v busy and GPs shouldn't be doing more to save ED. (I'm not getting at my ED colleagues, I think the pt flow through the hospital and beyond is a large part of the problem).

- o Pts have high expectations from multiple sources – politicians, press, social media etc. Somehow we need to manage these

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- Opportunities

- o I think GP will become an increasingly MDT team. How this will be funded needs careful consideration. It's a 'brave' decision in the current economic target to employ 2 Nurse Practitioners when a WTE salaried GP leaves (which would be roughly cost neutral) – challenges recruiting nurse prac's, they can be of 'variable' quality and may create a lot of work for the remaining GPs. Should the practice just replace with another salaried GP – at least they'll know roughly what they are getting? Likewise with physios, pharmacists etc

- o We can take work away from 2ndry care, but it needs to be funded appropriately – eg there's an admission avoidance LES (not called that, but something similar) – practice gets paid £160; but if that keeps someone out of hospital how much has that saved (even allowing for CRT getting involved)? We could do a lot of the dermatology with investment in kit and training and a LES – could dramatically reduce the referrals to derm and save £££. There are many other, exciting opportunities, but allowing things to creep into GMS is not sustainable.