

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](#)

GP13 : Ymateb gan: | Response from: Dr Angharad Fletcher

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Dear sir,

I am writing as a GP Partner and Cluster Lead for NE Flintshire to provide evidence for the committee.

1. Managed LHB practices are 3-5 x more expensive to run compared with GMS and deliver a vastly inferior service without continuity. They are draining the pot and these practices should go out to tender but without prohibitive barriers of tupe which makes a bid financially untenable.
2. GMS is underfunded. Costs have risen significantly over the past 5 years and income has not matched that- which means in some cases surgeries are having to cut staff when the demand is greater than ever.
3. There is no longer a workforce crisis. There are many qualified GPs looking for work. Practices cannot afford to employ them.
4. Unethical to employ vaccination teams on permanent contracts (North East Wales) which is a waste of money and not required. (GMS can deliver vaccination campaigns)
5. Profiteering PFI landlords and long leases are killing practices. The leases are vastly in favour of the landlord.
6. Many services are designed to deal with the symptom of a problem rather than the root cause- e.g. substance misuse teams, type 2 diabetes, pain clinics, mental health- rather than identifying that many of these issues lie in childhood trauma/complex PTSD. More investment is needed in prevention e.g. early start support for under 5s, and much more investment into specialist primary care based trauma psychotherapy- whereby specially trained trauma psychotherapists work alongside GPs to manage the physical and mental symptoms caused by early life trauma.
7. GMS has capacity to opt into far more enhanced services- a win-win. Takes pressure off secondary care and brings money into primary care. Cluster based delivery of ESs. E.g. spirometry, phlebotomy, adult ADHD assessments, GLP-1 for weight loss, pessaries, minor surgery. Providing community based care closer to home without unreasonable waiting times.
8. Continuity and a long trusting relationship works best in primary care. We can reassure and prevent over investigation and over medicalisation. Partnerships mean doctors are personally accountable and should be rewarded for all the hidden work done. Risk averse locums and sessional doctors will mean far more referrals and workload for secondary care in the long run. Allied health care workers cannot make professional decisions and end up creating more workload.
9. Cluster Leadership is a great idea, but revert to the old model and remove ACD which has harmed the maturity of Clusters of old.

In summary, I would like to see far more funding in the GMS Contract, and barriers removed such as premises and leases, to enable us to get on with caring for patients.

Regards,

Dr Angharad Fletcher FRCGP MRCGP MB,BS, BSc. Hons