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

GP21 : Ymateb gan: | Response from: Dr James Pink

To whom it may concern:

Thank you for allowing us the opportunity to share our experience and thoughts regarding the future of general practice in Wales. I am a GP partner in Llanishen in Cardiff since 2011. Prior to that I worked as a GP partner in Chepstow, and prior to that as a salaried GP in Treorchy and Mountain Ash, employed under the academic fellow scheme for Cardiff University. In my 19 years of being a GP, I have been involved in research, undergraduate teaching, training of GPs, nurses and pharmacists, GP appraisal and as the cluster lead for Cardiff North. I therefore believe I have extensive experience of general practice in Wales across various settings, which inform my opinions. I will address each of the inquiry questions in turn.

- **Challenges threatening the sustainability of general practice, including:**

- **the funding model for general practice and current financial pressures,**

The two biggest challenges facing the sustainability of primary care are increasing demand and insufficient funding to meet this demand. Societal changes, increases in chronic diseases, more complex poly pharmacy, frailty and obesity have all increased significantly since the introduction of the GMS contract in 2004. GMS practices get funded per registered patient, so if these same patients visit twice as often, the practices do twice the work for the same funding. In reality, this means the practices have to employ more staff to meet this demand , which leads to the ironic situation for GP partners of being paid less for doing more. Uplifts in GMS funding have barely covered inflation over the years, let alone this significant increase in work for the same number of registered patients. As well as population factors, GMS practices have also seen an increased shift of work from secondary to primary care. Chronic diseases which used to be managed in hospital outpatient clinics are now being managed in primary care, almost always without the transfer of funding. The above issues have been well publicised by the BMA.

An issue which has been overlooked is the way in which GMS income is distributed. At the onset of the GMS contract in Wales in 2004, a decision was made to use the Global Sum allocation formula developed in England by Professor Carr-Hill and apply this to Wales. The Carr-Hill formula is supposed to ensure that practices with higher need are funded better to meet this need. Sadly, the formula and its application in Wales has many flaws and this is leading to significant discrepancies in funding across Wales. Carr-Hill components include age and sex of population, practice additional needs (based on data from 1998-2001, and not updated since) and rurality (which instantly means that Cardiff, the most population dense region is underfunded compared to the rest of Wales, and even more significantly compared to similar sized town in England.

My practice in Llanishen has approximately 10,000 registered patients,
According to 2021 census, 2.6% of the Welsh population is over 85. Llanishen court surgery has 416 patients over 85 years, many of whom are frail and housebound. This is 4.3% of the population. If the Carr-Hill formula was fit for purpose, one would reasonably expect a practice with 65% more frail and elderly than average to get greater than average funding. However , with a Carr-Hill ratio of 0.87% our practice in Llanishen is in the bottom 20 poorest funded practices in Wales. In fact, all 10 GMS practices in Cardiff North are in the bottom 20 in terms of Welsh funding.

Using data regarding Carr-Hill allocations and patient populations throughout Wales, we are able to match our population demographics with other practices with similar deprivation and age / sex distribution and have found a funding differential of approximately £250,000 between a matched practice in Pembrokeshire and ours. This is approx the cost of 20 extra GP sessions (or 40 extra nurse practitioner sessions).

This funding disparity clearly has an impact on access, the quality of care we can provide to our patients and the morale of all staff.

There is undoubtedly a big issue regarding the size of the primary care funding pot in Wales, which the BMA is rightly trying to address. An equally important but neglected aspect of negotiations is to ensure that this finite resource is fairly allocated. Currently, the biggest cluster in Wales (Cardiff North, population of 105,000 patients) is by some margin the most underfunded and patients and their doctors in this area are therefore discriminated against due to an outdated and no longer fit for purpose funding allocation formula. Our patients should not be penalised for living in Cardiff. My colleague Matthew Jones, a GP in St Isan's Road surgery will be submitting a comprehensive paper to this inquiry regarding the Carr-Hill formula.

- **the efficacy of different models for managing general practice,**

The superpower of NHS general practice is the opportunity for patients to develop a long- term therapeutic relationship with their GP. This allows the GP to help the patient navigate their way through their physical, psychological and social challenges often without the need for involvement with any other professional. A good GP given the right environment can play the role of a physician, social worker, counsellor and health coach, whilst maintaining the role of senior decision maker. The value of this approach to general practice is immeasurable in terms patient satisfaction and NHS efficacy. Employing other health professionals to work in primary care has an important role as long as this is considered ***an addition*** rather than ***a substitute*** for a qualified GP. For example, if our funding allowed, I would very much like to employ a pharmacist to help with medicines management, but I would not expect them to see undifferentiated patients with a mixture of physical and psychological ailments, as my GP colleagues do. GPs have extensive training and a specific skill set and should be respected as

such. I very much support the idea of GPs acting as “primary care consultants”, providing clinical governance and guidance to multi-disciplinary teams, but this approach would have to be carefully modelled to ensure that safety, quality and efficiency were being achieved.

- **the suitability and maintenance of general practice estates and access to digital technology;**

I also believe that we should embrace digital technology and would expect AI to significantly reduce primary care admin over the next few years, and the introduction of ePrescribing is well overdue. In Wales, if we were to coordinate our IT systems and information governance we have the potential to be a truly joined up health service. Sadly, the reality is that GPs, district nurses, community pharmacists, opticians, dentists and hospital doctors all use different IT systems, with often only limited access to the patient’s medical record if at all. This is as frustrating as it is dangerous. The number of human hours and missed opportunities wasted operating in such a non-cohesive manner is scandalous given the enormous pressure to provide prudent healthcare we are all under.

- **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;**

In Cardiff, we currently have a situation where there are more GPs looking for work than there are available jobs. Our locum colleagues are grateful for any shifts and job adverts for non clinical GP jobs such as teaching and appraisals are significantly over-prescribed. Few practices are recruiting GPs currently as although there is significant patient demand, there is simply no funding to pay for new jobs. Please see earlier comments regarding this. I am sure that addressing the Carr-Hill issue would significantly improve the funding available to recruit new GPs or other clinical staff in Cardiff and this would make meaningful improvements in terms of access.

Prior to the Covid pandemic, Cardiff GPs would meet up quarterly in a hotel conference suite for formal teaching, which would be delivered by local experts. This would allow GPs to keep up to date with latest protocols and developments, meet with secondary care colleagues and most importantly, meet with each other over coffee to discuss shared solutions to common problems. These sessions were supported by the UHB, who funded the meetings and importantly, provided out of hours cover so that surgeries could actually close. This support is no longer available, so as a practice, we are very rarely able to attend these now online meetings. So we receive no important updates,

no chance to network and to develop positive working relationships. Although these meetings only occurred 4 times a year, the negative impact of the decision to cut funding for these is still being felt. GPs are now far more likely to be professionally isolated and working in silos.

As above, I support the concept of MDT working in primary care, but only as an addition to the traditional GP role. I believe that the impact of a practice pharmacist in terms of patient safety and cost efficiency would be significant. Perversely, if our practice employed a pharmacist for £x a year (resulting in a direct cut in the take-home pay of the partners), that pharmacist could save the UHB £1000s in drug costs (by more vigorous medication reviews and deprescribing than we have time to do) and reductions in medication related hospital admissions. However, we would never have these savings recycled back to us to pay for the pharmacist. Clearly, we care greatly about patient safety, but on a purely economic level, we as partners would be personally financing a cost saving measure for the UHB. A mechanism to recycle savings back into GMS should be developed so that initiatives can be introduced which are mutually beneficial.

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

I have recently completed a qualification in lifestyle medicine with the British Society of Lifestyle and this highlights the importance of diet, exercise, sleep, mental health, avoidance of unhealthy behaviours and healthy relationships both in terms of prevention and treatment of chronic illness. There are significant opportunities to incorporate these principles into primary care, but these interventions, although incredibly cost effective for the NHS and society as a whole (reduced burden of chronic disease, drug spend, hospital admissions, time off work etc.) they are time intensive for GPs and other primary care staff. For example, I am now sufficiently qualified to run primary care based NHS weight management services. There is overwhelming evidence that weight loss can help the management countless chronic diseases, but properly assessing and addressing the issues regarding weight gain is complex and time consuming and the current 10-15 minute GP appointment length is insufficient. As per my comments above re pharmacists, if a mechanism was developed to recycle NHS savings back into primary care, then GMS partners could invest in staff to deliver these initiatives at a fraction of the cost of secondary care and with significant long term benefits to individuals and society. But it is unreasonable to expect GPs to continue to devote their own free time or money into these “greater good” projects, when the day-to- day workload is already overwhelming.

However, preventative healthcare is a team sport.

There is almost no point in me advising parents about healthy eating for their children at the same point that Cardiff council allows a McDonalds to be opened across the road from their primary school, which happened a few years ago in Llanishen. Similarly, also in my practice area, there are playing fields in Thornhill which are almost unusable due to drainage issues which have not been addressed for 30 years.

The excellent primary care liaison nurse service, which was launched as a UHB funded service following a successful pilot in Cardiff East has just been decommissioned, which means that the already poor provision for mental health services in Cardiff has now decreased even further. Those patients suffering with mental illness are significantly more likely to develop chronic illness, engage in harmful behaviours etc. And so any savings made by decommissioning of mental health services will likely be paid for in the future, but in a different way.

Conclusion:

I have highlighted a few areas of concern, but I am a strong believer in the fact that if you highlight a problem, you should also be willing to help find a solution. As such, should you require further input, **I would be delighted to be involved in any future discussions regarding preventative / lifestyle interventions in Wales and feel that my 19- years of working across different GP settings in Wales, management experience and lifestyle medicine qualification would be suited to this role.**

Jim

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