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

GP30: Ymateb gan: | Response from: Dr Alison Van Buren, Dr Sarah Smith, Dr Gemma Bryning and Dr Siwan Rees (Town Gate Practice, Chepstow).

INQUIRY INTO THE FUTURE OF GENERAL PRACTICE IN WALES

Report from TOWN GATE PRACTICE, CHEPSTOW for Welsh government

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Primary care should be a branch of medicine that is highly attractive to medical graduates because it provides huge job satisfaction through the care and treatment of many generations of the same family, cradle to grave. The A-level candidates that apply to study medicine are top of their year – they fight for their degree place – they could have chosen law, where the financial remuneration would be at least twice the amount they would ever earn in the NHS, but instead they chose to serve in the NHS.

Over the last ten years primary care has been driven into the ground through under-resourcing and a systematic destruction of primary care's reputation in the media. This scandalous erosion of public trust by the media has been allowed to continue unchecked by government. Many medical stories, even on the BBC, are poorly investigated and inaccurately reported. Occasionally we have had cause to submit complaints of bias and inaccuracy, and this has led to some stories being corrected or withdrawn.

Here are more of the stark realities of working in primary care. There are countless examples demonstrating a lack of joined up thinking that forgets the patient should be at the centre of everything we do.

Complex forms - there is pretty much a form for everything. They are not easily accessible or in the same place, and we are not notified of form updates or modifications. If you submit a referral on an old form, the referral is declined despite it containing all the relevant clinical information. This unnecessarily slows the patient path through the NHS. Examples:

1. Diabetic retinal screening forms have recently changed. As the form is now accessed via the internet, we can no longer pre-populate it. It takes about 5 minutes to fill in and this must be online. Given that our appointments are 12 minutes, you can see how labour intensive this is, especially given that, at diagnosis, the patient also must be given a lot of information, perhaps start medication which requires an explanation, and have a referral to the diabetic education course MyDesmond.
2. In addition to this exercise on referral is an onerous process via EMIS our software programme.
3. Paediatric community physiotherapy and occupational therapy, by their own admission, have significant overlap and yet if a GP picks the wrong form to fill in the referral is rejected, and an almost identical form must be filled in and

resubmitted before the referral can be accepted. The turn around for this is more than a week.

Referral pathways. We are a border practice, and Welsh vs English referral pathways vary wildly:

1. In Wales, a patient presenting with rectal bleeding can be referred on the USC (urgent suspected cancer) pathway without a FIT test, but England requires a FIT test result for the same before referral will be accepted.
2. In general, colorectal referrals in England require a faecal calprotectin test result no matter what the age of the patient in order to be accepted but the ABUHB lab in Wales won't process a faecal calprotectin in the over 50s.
3. If a patient in Wales is found to be anaemic with a positive FIT test, they are seen very quickly for colonoscopy on the STT (straight to test) pathway – if a malignancy is ruled out, they are discharged back to the GP even if other pathologies, such as actively bleeding haemorrhoids, are found. The GP then needs to re-refer the patient back to the colorectal team asking for surgical treatment of the haemorrhoids – this is extremely inefficient. We are actively addressing this issue with secondary care who are very receptive to our concerns.
4. With respect to autism - in Wales patients can self-refer and in England there is a complex for the patient and GP to complete.
5. Crossover between paediatric physio and paediatric OT. Referrals done outside of the consultation.
6. Frequently, consultants in Bristol won't accept referrals without us requesting an investigation that we don't have access to. We end up wasting hours of time corresponding. E.g. A cardiologist asking us to arrange a Holter monitor and a chest physician asking us to arrange a CT in Southmead.

Primary and secondary care harmonisation:

1. In primary care, most referrals are based on clinical findings, not the results of specialist tests. Some symptoms fall under the remit of more than one clinical speciality meaning that there is significant crossover. For example, shortness of breath in the elderly, and pelvic pain in women. The older generation lose out with the former example, and women lose out with the latter. Many people have multiple co-morbidities contributing to their shortness of breath: heart failure, atrial fibrillation, COPD, anaemia but are under the separate specialities of cardiology, chest clinic and gastroenterology rather than Care of the Elderly where a more holistic approach could be taken. With respect to female pelvic pain, medical misogyny is alive and well; a patient with serious gynaecological pelvic pathology was recently told she had IBS and to drink peppermint tea. In this example, a lack of access to timely specialist tests helped outdated, firmly held beliefs to perpetuate poor care.
2. Haematology – the ABUHB haematologists are amazing. They are available for advice that they provide in a timely fashion. They fully understand the pressures of

primary care and do their utmost to help us help our patients in the most practical way.

3. We no longer have access to lumbar spine MRIs for patients with sciatica that requires intervention on either side of the border; instead, we must refer to trauma and orthopaedics. The latter has an unacceptably long waiting list. The patient, who may not be able to work because of their back pain, sciatica and neurology, waits over a year to be seen and at this appointment they are told they need an MRI…….after they have it, they then wait for a follow up appointment where they are told what intervention is suitable, then they wait for the intervention. By the time they receive treatment they are years down the line. None of this makes clinical or ethical sense. Patients get angry and frustrated, and many believe that GPs are withholding access to tests. They do not accept explanations that GPs must follow certain referral pathways. This has led to several difficult and frightening consultations.

4. The waiting list for neurology is unacceptably long leaving people with MS, Parkinsons and epilepsy with upsetting feelings of uncertainty and fear.

5. Dermatology – a fantastic department with a great primary-secondary care interface. We work so well together. They have provided dermoscopy training for us which was invaluable. They provide helpful email advice and support us in managing our patients whilst they are on the waiting list. We cannot praise them highly enough.

6. Autism and ADHD – these services are grossly inadequately funded – waiting lists of three years are unacceptable.

7. Primary mental health – we are unclear what is going wrong with this service. We receive countless letters from the primary mental health service saying that patient X did not respond to two letters inviting them to ring and book an appointment. Our patients, however, report not receiving any letters. We don't know if the letters are not being sent out or whether there is a problem with the postal service in Chepstow. In secondary care, the patient seems to get an appointment and is commenced on medication but then discharged despite the clinician not knowing if the medication suited them or was effective for them. We have tried addressing this numerous times.

Day to day functioning:

1.We are obliged to see not only those who are ill but also obliged those who believe themselves to be ill. As in all walks of life we have difficult individuals registered with us. They regularly insult receptionists, make unfounded complaints that are time-consuming to respond to, and present unnecessarily frequently, reducing the amount of time available for other, more clinically vulnerable, patients. They use emotive language and stop the practice from functioning efficiently. A significant minority do not tell the truth in order to get a same day appointment. Examples include: telling the receptionist their throat is

so sore they can't swallow their own saliva (in reality the patient had woken up with a sore throat two hours prior and could swallow), reporting an inability to weight bear on a painful knee (the patient walks easily into the consulting room). Exaggeration of symptoms in order to be given a same day appointment is common. Thankfully the unpleasant individuals described above are very much in the minority but take up a disproportionate amount of time.

1. CEPP targets and other projects can contradict each other – eg reducing incontinence in the elderly vs reducing anticholinergic medications in the elderly (anticholinergics are required to treat incontinence)

2. Funding streams. There are so many hoops to jump through in order to earn money needed to run the practice and fund imposed pay rises. Not infrequently we are offered money for things we don't need but not for things we do need. Whilst the WG funded holistic reviews are worthwhile, the short notice for funding meant significant rearrangement of appointments in the midst of winter pressures. We may be told that there is money available to by a piece of kit that we already have but that we can't use the money for anything else.

3. Stipulations about work space for private work out of hours, risk losing notional rent and yet we are stuck with being classed as a private business for NI employers contributions but classed as NHS for the employers allowance meaning we can't claim for the increased financial outlay whilst being solely reliant on government funding to pay all our bills. The only way to improve the financial viability of the practice is to increase our private work but we are constrained by rules over what percentage floor space can be used for said work.

4. Political comments/soundbites can be wholly unhelpful to our working day. Patients want to discuss them within the 12 minutes that we have for their clinical problem – telling them 'this is neither the time nor the place' never works and is more likely to result in a complaint that the GP wasn't listening, which then takes more time to resolve than the slowed up appointment. Examples of the soundbites are:1) ' we have too many hospitals/ hospital beds' (no – we don't have enough) 2) 'bring back the family doctor' – we very much work on a family doctor basis but patients are more likely to believe the media soundbite than their own reality. To put this into perspective, a family member of one of our partners wholeheartedly believes that GPs don't do house calls anymore, even though he has had one himself.

5. High staff turnover is now the norm. We are constantly training new staff. Reasons for the high turnover include being insulted by patients regularly, poor pay, being expected to wait for back pay as pay rises are announced before negotiations have taken place on how those pay rises are going to be funded. This results in low morale.

6. Contract negotiations are always retrospective - no other company could work like this. Can you imagine any other business working in this way – providing a

service but not being able to charge for it, instead being told how much the government is willing to pay for it and that sum being woefully inadequate for the skills of the clinicians providing said service.

7. Meetings: we are expected to attend regular health board meetings as well as safeguarding meetings, palliative care meetings, health visitor meetings, mental health meetings – these cannot take place instead of our clinical commitments – they are in addition. Consequently, they are always squeezed into the time in between morning and afternoon surgery that is already allocated to blood results, home visits and document filing (clinic letters).

8. Pension trap – if we work more hours, we are at a higher risk of breaching the annual allowance. Breaching the annual allowance is a considerable stress. Whilst the McCloud judgement has been helpful, there is further stress in checking that the new pension calculations are correct and the claim back process is slow.

9. Teaching is on top of our clinical commitment. As well as all the above, we train the next generation of GPs. We train medical students and GP registrars. Whilst this is very rewarding, it takes time and effort to prepare tutorials, and provide hot reviews, all of which is additional to our clinical commitments.

10. Ambulance availability hampers our daily work. Not infrequently we see a patient who needs transfer to hospital, and it is unsafe for a relative to take them. In the past 12 months, I've been refused an ambulance for someone having a heart attack (chest pain with ST elevation on ECG) – the 999 call handler apologised and just said there were no ambulances. We have also experienced long waits for septic patients with low oxygen levels such that we have run out of oxygen cylinders during the wait for emergency transfer. Because patients have experienced things like this a significant minority now refuse to go to hospital because of previous distressing experiences; this is particularly with respect to the wait in A&E at the Grange. They report unhygienic toilets, no seating for unwell patients, no medical help during the wait, and members of our staff corroborate this when they have attended either personally or with relatives.

11. Frequently we are not able to provide a GP for meetings such as safeguarding as they are often at short notice, and we are too stretched for a GP to attend a meeting that might last 1-2 hours. We always send the required reports but freeing up a doctor for a long meeting means that 12 other patients lose out on appointments and need to be re-scheduled.

12. The interface between the health board and primary care can be difficult when it comes to deadlines. Our practice managers are bombarded by emails daily – some just need cascading to all doctors, some are meaningless, but some are important and demand a response within an unreasonable timeframe. It is not unusual to receive an email from the health board regarding, for example, on a Wednesday afternoon demanding a response or action by Friday – the action

required might need the involvement of the whole partnership, i.e. an all doctor response and it is impossible to schedule a timely meeting when some doctors are on days off (with caring responsibilities on those days) and the rest are conducting booked and same day surgeries. When it is the opposite way round, we may contact the health board for an urgent response, and we hear nothing for weeks and have to chase for a response multiple times. This being said, we have a good working relationship with Liam Taylor, our head of primary care.

We are disappointed that no visible effort is being made by government to provide explanation to the public as to why most GPs are not 'full time'. Typically, in our practice, a ¾ time GP would work approximately 36 hours over three days. On our 'off days' we are frequently doing admin, attending medical meetings and completing compulsory training. Many GPs are also caring for elderly relatives and need to take them to hospital or GP appointments. In addition, GP partners need time to run their business. The government could do a lot to inform the public and champion primary care. Most GPs are just waiting to get to 60 so that they can retire. Many would be happy to stay in the job longer were the NHS system to work well and the primary care working environment improve.

We feel the GP partnership model delivers the most efficient primary health care. The pay gap between salaried GPs and partners is narrowing. You will know that salaried GPs tend to work within a standard BMA contract that stipulates how long a surgery can be, what work is considered within their remit and what is not etc. Partners do what is necessary to get the job done whether that is staying late, completing admin from home, or covering for sick colleagues. Salaried GPs do not do this. A salaried service will result in less consultations and, effectively, a 'work to rule' situation. During the whole history of the NHS, GP partners have worked on significant levels of good will. The good will towards our patients remains; they are the reason we do what we do. Please protect the partnership model and plan a future for general practice that makes primary care an option that doctors readily apply for.