

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](#)

GP58: Ymateb gan: Dr Virginia Iles | Response from: Dr Virginia Iles



Inquiry into the future of general practice in Wales

Submitted by Dr V Iles

My nineteen years as a GP in Wales have provided a broad perspective on the challenges facing general practice. From my initial twelve years as a GP partner in Pontypool, Torfaen, to my current seven years working in North Cardiff, I've witnessed increasing strain on primary care across diverse communities, rural and urban, deprived and less deprived. This submission aims to highlight the critical issues, focus on funding, workforce, service models and infrastructure.

Challenges threatening the sustainability of general practice:

The funding model for general practice and current financial pressures

The cornerstone of our funding, the GMS contract, operates by funding per registered patient, however the workload per patient has dramatically increased. This demand on primary care is caused by a great many of factors. For example, the increasing elderly population, 4.3% of my practice population is now over 85 years old, requiring complex care, and require home visits. A single home visit can consume the same time as four patients in the surgery yet this added complexity is not reflected in GMS funding.

In addition to the aging population, significant increases in chronic disease, have increased demand on our services. For example I have 10000 patients registered at my practice, 500 of these have diabetes, this is double the numbers compared to 20 years ago. Medical advances mean treatment is more complicated. Every diabetic needs extensive intervention and follow up, and presents with more complications, the number of attendances/patient/year increasing by two, three, four, five, six? but there is no increase in funding per patient, other than the below inflation increases to GMS.

Other workload pressures include increasing complex consultations requiring language line translators, these require double appointments.

Furthermore the shift of workload from secondary to primary care, for example complex Diabetes, Severe mental illness, and Cardiac Failure, while positive, has not been accompanied by commensurate funding.

Inappropriate requests to GP's through poor secondary/ primary care interface are increasing. Patients are turning to private providers who then also ask for inappropriate primary care investigations or medications. Along with worsening secondary care waiting times for appointments and investigations, resulting in demands from patients seeking expedited care.

Unlike our secondary care colleagues we do not have waiting lists, although perhaps we should introduce them. The doors to General Practice open and the flood begins.

Consider this: to employ a full-time salaried GP to cover the essential home visits for the frail, the increase in chronic disease workload, costing around £80,000 (including NI and

pension) would significantly impact partner income. We are a five partner practice, my personal income would therefore drop by about £16000.

Ideally, I would employ a second Specialist nurse in Diabetes to adequately provide Diabetic care, but at cost to practice ~ £55000 (including NI and pension), with no extra funding, my personal income drops by up to £11000.

The Carr-Hill Formulary designed to address funding in the most deprived areas is based on data gathered in 1998, and on age, sex, practice additional needs, rural location. It does not take into account Frailty of old age. For example my practice has a Carr-Hill ratio just below 0.9% causing a discrepancy of nearly £250000/ annum compared to a practice in a rural location somewhere else in Wales. These factors have been compounded in recent years, and so the discrepancy between practices growing, by more and more funding moving out of Local enhanced Services and previous QOF or QAIF, into Global Sum. We could previously make up some of this funding shortfall by hitting the targets on QOF/QAIF and engaging in all Enhanced Services which were not party to the Carr Hill Formulary.

Further to these concerns, despite the increasing pressures on Primary Care, the overall funding has not kept pace with Secondary Care.

Question for the Senedd:

Why does funding not follow the shift of care into communities given the acknowledged benefits ?

We have calculated our GMS core funding no longer covers core services. We rely on supplementary income to remain viable, such as Partnership Premium (a small fund given to Partners quarterly in recognition of experience,) teaching of Registrars and Students, the provision of joint injections and IUS/IUS contraception, Private insurance reports and some enhanced services.

A one-off practice stabilisation fund is not a practical answer to the long term financial difficulties that increasing National Insurance and minimum wage is going to cause for Primary Care. Unlike most other business we are unable to pass any of these costs onto our customers.

The efficacy of different models for managing general practice:

Increasing use of other health professionals is useful in primary care, we have been able to share Paramedic within our cluster to help with house visits. Unfortunately, this funding is now threatened. Physiotherapist are helpful for Musculoskeletal disease, Mental Health practitioners for the increasing mental health epidemic, but none of these have the extensive training and skills that Doctors use to treat their patients, physical, mentally, emotionally and socially, often having known and understood not just this generation of a family but one or two before. It is only now that some evidence is emerging about the efficiency of the Doctor- Patient long term relationship, decreasing investigations, improving long term outcomes and improving patient experience.

The introduction of Urgent Primary Care Centres (UPCC) raises serious concerns about efficiency and funding.

In a UPCC session (a session being one morning or afternoon of work) a practitioner sees 14 patients, with simple conditions such as cough, rash, back pain. They do not know the patient, they are unable to order investigations, or manage chronic diseases such as Diabetes, asthma, frailty. They cannot provide sick notes, they cannot refer patients. They cannot add prescriptions to patients repeat medication. There is risk the patient is not followed up for investigations at their own practice, say for example if they need a Chest X-ray because communication links are poor between the UPCC and the place the practice is registered due to poor IT services.

In contrast a session at my practice, I will see 14 patients face to face, I will deal with the acute problems, I will arrange follow up and referrals, I will look at the chronic disease and medication, arrange tests and receive tests. I will in addition follow up about 4 other patients, I will assess around 30 blood/xray results and arrange appropriate action, I will process 20 hospital letters with actions. In total my number of contact with patients or their notes might exceed 40 or 50. The value for money provided by traditional GP practices vastly exceeds UPCC, and yet the funding is given there.

In addition to the inefficiency of this model of care. Also consider the impact of funding outside of General Practice.

Scenario 1.

UPCC destabilizes local GP practices by attracting GPs with less demanding roles. Local practices have increased Locums costs to backfill vacant posts. Practices collapse and Contract is handed back to Health Board- this happened in my previous partnership, you may have seen it in the news recently. The contract was then awarded to a large scale, financially driven company, with subsequent significant concerns over patient care. I would like you also to consider that LHB managed GP practices cost one third more than Partnership run practices.

Scenario 2

Local GP practices who are under financial strain subcontract out their GP's to work at UPCC to prop up their business. The local GP practice loses a full morning or full day of GP appointments, capacity reduced, and access worsens. The GP sent to UPCC provides basic care for basic conditions on patients they do not know. This has happened in Cardiff.

Question to the Senedd:

Why is investment not directed into existing GP practices, which are demonstrably more cost-effective?

Would Welsh Government consider abolishing the Partnership model completely and employing Salaried General Practitioners? I think most GPs would be happy to take a proper Consultant wage under the same terms and conditions and pass on the business risk to the

Health Boards. I do not think it would be cost effective for you, and you do not have the Capital Expenditure for the infrastructure.

The suitability and maintenance of General Practice estates and access to digital technology:

Primary Care Infrastructure

The infrastructure of primary care is largely maintained by Partnerships. There are two generally used models:

1. The partnership owns the building.
2. The building is built and owned by private investor and has a leaseback arrangement with the Partnership.

Problems

1. Partnership owned.

The value of GP premises are elevated due to guaranteed rent reimbursement. When a new partner buys into the building they take on substantial risk; if the business fails and NHS services are no longer provided from the building, the value of the premises is reduced (by roughly a third) thus leaving a partner in negative equity. This deters new partners.

Many of these buildings are getting old and requiring considerable investment. For example ours has leaking windows, broken and old clinical units, cracked flooring, stained seating etc etc. Partnerships do not have additional funding to repair these buildings, and rent reimbursement does not keep up with the inflated cost of maintenance. There are no significant grants or funding available to help with this.

Most older buildings have insufficient space to take on further primary care employees or trainees. We are limited by 9 consultation rooms. We would gladly take on further training responsibilities such as Trainee nurses, GP registrars or students, but we do not have the room to do this. Even if we had the funds to take on further staff we would not have space to accommodate them.

2. Leaseback

Leaseback arrangements also pose risk, especially near their end, particularly full repairing lease arrangements. Recruitment of Partners is essential to maintain the Primary Care Infrastructure.

Questions to the Senedd

Do you want to purchase and extend my premises to ensure sufficient space and good conditions for primary care consultations to take place?

Do you have capital expenditure waiting to be used on a primary care infrastructure when partnerships collapse?

Will you be building multiple large Community Hub centres to house all the primary care Healthcare workers in Wales over the next 10 years?

Do you prefer partnerships to have continued responsibility and risk for primary care infrastructure? If so how are you going to support us to maintain our business?

Technology Infrastructure

Digital technology in Wales lags significantly. We still do not have electronic prescribing, over a decade after England. We are awaiting transfer to EMIS from Vision, and have been for over a year. We have disjointed clunky systems such as a non-integrated Radiology request system, non-integrated Consultant advice messaging system. Letters from secondary care can take months to reach us, we still have paper letters which then have to be scanned into our computer system. Digital technology and AI could revolutionise the NHS, the cost savings if Hospital, Primary care, district nurses, Pharmacies all used the same systems would be immense.

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 continued professional development, and the growth of the multidisciplinary team:

The disparity in remuneration between GPs and hospital consultants is stark. For example a Consultant with equivalent number of years' experience as me, in Wales, has a basic salary of £140,000. Within this they have protected time for Teaching, Professional Development, Management, and Service Provision. I have none of this. They have more holiday and have no financial risk. As a full time partner, I took home half of this in 2022/23. Going forward, it would seem reasonable that Partners take equivalent salary from GMS earnings, ensuring this encompasses the same protected time for the above tasks. I would then propose any funding that is left from GMS global sum is used to fund any additional GP appointments or Allied Healthcare professionals we usually employ. Currently we employ 4 other Salaried GP Doctors- I suspect we would not have any funds left to pay them if we took that equivalent salary.

Our very experienced Salaried Doctors, who are Consultants in General Practice in their own right, earn about £65000/annum whole time equivalent if compared to hospital doctors.

Despite the poor remuneration there are more GPs looking for work in Cardiff presently than work available. Locum work, salaried jobs, and non-clinical GP jobs have dried up, despite the enormous workload and unmet patient needs in primary care. Very few practices are able to recruit because there is no funding to pay for new GPs, allied staff, or non-clinical staff. I would not advise a friend to become a GP over a hospital doctor (consultant or even lower grades).

Question for the Senedd

Welsh Government are training new GP's I would to ask where and by who they will be employed, and by what funding?

Attracting and retaining non-clinical practice staff is difficult, poor funding has resulted in increasing workload for many of these staff on minimum wage. Small business difficulties are rife, currently we employ 24 staff, today I have 8 of these on sick leave, the impact on other staff wellbeing is evident. I have spent time in my practice covering other job roles including receptionist, script clerk, and administrator due to sickness. Despite these difficulties, the NHS continues to underestimate the efficiencies of small businesses run by Partners who are invested emotionally and financially in their success, and in non-clinical staff that go above and beyond their call of duty because they work in a team, providing care for patients that they do not want to let down. With regard to possible answers, appropriate funding, collaborative working, and AI, technology infrastructure would all improve workforce difficulties.

Training and Development

General Practice does not receive funding for training and development, it is all undertaken in our own time (evenings and weekends). We previously received quarterly protected meetings, provided by the Health Board, when the whole practice received teaching, met our secondary care colleagues and improved primary/secondary interface. The Health Board previously provided out of hours cover for our practices to close for the half day. Cardiff and Vale Health Board provide recorded webinars we can access in our "lunchtime" between clinics but actually we do not have time for lunch breaks, we simply have to continue with clinical work as well processing results/letter/prescription queries/phoning patients/ house visits/managerial meetings/ MDT meetings with frailty or Health Visitors etc etc. I would never have time to watch a webinar during the working day which is already very long.

Conclusion

Unfortunately, General Practice is under significant threat, years of underfunding, increasing workload and a lack of support from Government have led to a decline in patient care and GP well-being. Urgent action is needed to address these issues and ensure the sustainability of primary care.

Additional point

Submitted by Dr V Iles

Apologies, one further point I would like to make regards remuneration. GP pays employer and employee pension on their profit. Therefore my pension contributions take 30% of my income.