PC 44
Ymchwiliad i ofal sylfaenol
Inquiry into primary care
Ymateb gan: Dr Kay Saunders
Response from: Dr Kay Saunders

National Assembly for Wales, Consultation on Primary Care February 2017

Comments for The National Assembly for Wales Health Social care and Sport Committee
From Dr Kay Saunders
I have been a GP in Butetown, Cardiff for 22 years. I write in an individual capacity.
The consultation asks for general views on any or all of a list of points regarding GP cluster networks in Wales.
I have been greatly disappointed by the cluster developments;

1) Clusters are a new, and to my view, an **uncertain tier** of the NHS. As NHS controlled bodies Clusters have no guaranteed future or funding. There is a widely held concern that over time Clusters will go the same way as FHSAs, FPCs, AHAs, SHAs, LHGs and the 22 LHBs.

2) Unlike LHBs they have **no legal status** and cannot spend or receive money. They can only provide care through staff seconded by the LHB, staff employed on the behalf of the cluster by the LHB or through payments from the LHB to individual practices.

3) The decision making processes and accountability of Clusters is variable or completely absent. Progress appears very dependent upon the skills and personalities of the LHB appointed cluster GP leads. The plans to which my practice has contributed have made no difference at all. It has been a demoralising, time consuming tick box exercise.

4) The cluster remit goes well beyond General Medical Services and, over time, they may be hoped to include membership from hospital staff, social care, local authorities and the 3rd sector, but with no structure to support or encourage this. The remit of Clusters is very wide, including assessing the health and social care needs of local populations, planning and coordinating delivering services and facilitating all parts of the NHS to work together with social services. Clusters are intended to be locally sensitive organisations, typically working with populations of 50-80,000. Given these hopes and expectations, their structure is not robust. There is a clear overlap with what LHBs are tasked to do, and the population sizes covered are too small to make any significant, reliable, consistent difference.

5) Clusters meet for a short time 3 or 4 times a year and have no permanent officer or accommodation therefore lacking the appropriate executive and infrastructure to provide and manage developments of medical services in the community at scale. Given the expectations, this is a **very amateur structure**. There is in my experience no momentum between the meetings. It is very hard to be enthusiastic when struggling to provide the day to day, GMS, sharp end service, especially when facing workforce gaps in the practice.

6) To add to the uncertainty, funding for GP participation in Clusters is through the QOF section of the GMS contract, which is subject to constant review and change. It also means that a slight deviation from the set requirements means the funding is not available even if most of the work has been provided. This route of funding is very odd. It also means that meetings are dominated by the requirements to fill in unwieldy pages of tables in indigestible "reports" in order to fulfil QOF requirements.

7) I have seen no prospect of any reduction of demand on GPs. Indeed the extra things being asked of us are adding to an increasingly unbearable workload. Theoretically clusters could encourage new ways of working, but for the reasons set out above are not constituted in a way to enable this.

8) "Emerging multi-disciplinary teams" are not emerging from the destructive management policies of the last 10+ years. These policies decimated professional links between, for example, practices, district nurses health visitors and social workers. Reinstating proper multidisciplinary working is NOT in the gift of clusters, but the management structures of the LHB.

9) Workforce challenges should not be under-estimated. They are biting currently and are likely to get worse. It has become very **difficult to recruit GPs**, even in Cardiff. Practice nurses are also now in short supply, and with there still being no core vocational training scheme (and I don't mean rarefied degree type courses, but practical practice nursing skills), each practice if recruiting a nurse from secondary care has to cobble together training for what is a very different role.

10) Regarding the use of the funding allocated directly to clusters, in my cluster it is not being spent productively. It was eventually agreed to employ a cluster pharmacist, but the slow recruitment process eventually resulted in the pharmacist not starting till November 2016 for the current financial year, and my practice has an allocation of one day a fortnight. Our cluster is massively underspent on its allocation, and suggestions that would make a real difference have been ignored (like a salaried GP to work in the nursing homes).

11) To improve population health outcomes and target health inequalities, more attention should be paid to **fiscal policies** and reversing general inequalities. Welsh Government has made some progress on this, on smoking policy and hopefully on alcohol. The UK is in thrall to multinational companies' interests, eg those feeding our populations with overt and hidden sugar and other unhealthy foods. Primary care cannot be expected to make significant impact on this. The **benefits system** is a UK matter, and I see many people falling foul of increasingly brutal policies (eg "sanctions", unfair work assessments and "bedroom tax"). Our workload from the resulting medical consequences is soul destroying, and an increasing, unnecessary drain on our resources. How can healthy lifestyles be promoted when swimming pools, leisure centres, and libraries are closing, and playing fields are being built upon? **Get the fiscal policies in place to support a healthy population and let us be doctors, not those trying to counter forces much larger than us**.

12) We have 64 clusters in Wales, meant to be spending about £10 million per annum, plus the QOF point resources. Each cluster might have some superficially worthwhile looking projects (some more than others as clusters are very variable), but the overall impact of the policy I think will be minimal. It seems to me that because money has been given to clusters, it has starved practices of resources to improve sustainability. I can see little evidence that the strategic objectives of clusters have even been started, certainly not in my direct experience. I cannot see how they can support Welsh Government Primary care Plan or the Setting the Direction vision.

13) Section 6 of QOF is entitled "Cluster Network Development Domain: Strategic context". This includes hopes for new models of care such as the possibility of closer co-operation between practices in an area, of cross referral for clinical care and of federations of GP practices. In the Cardiff and Vale area, a group of GPs led discussions with GPs across all the

cluster areas, and then tried to engage with the LHB to develop a **GP confederation**. I attach a paper from April 2016 that a group of us wrote after preliminary discussions with the LHB (it is clearly impossible to set such a structure up without LHB support as the LHB would be the commissioning body). I thought we were offering an exciting possibility to help the LHB with many difficult issues, including mechanisms to make progress with their "Shaping Our Future Wellbeing Strategy". Our proposed structure was fully compatible with and complementary to clusters. I feel we were led along a false path by the LHB and then ignored. It would now be very difficult to reawaken enthusiasm from all the practices that were keen to engage in this project.

14) Referring again to the LHB "Shaping our Future Wellbeing Strategy", this glossy document was produced in late 2015. I cannot think of any meaningful progress in achieving the aims of this strategy.

15) I am concerned that there is a complete absence of primary care representation at the top table at either WG or the LHBs. The rhetoric since the start of the Welsh Assembly has been of a primary care led NHS. However, on the ground primary care has been repeatedly neglected. In 2003 Directors of Contractors Services were marginalised and their successors banished into a small corner of Shared Service - a data entry body for LHBs, but, I wish to emphasise, a knowledgeable and much valued service. The Director of Primary Care post in the Assembly went with John Sweeney in 2008. In 2009 Edwina Hart reorganised the NHS, a very welcome abolishing of the purchaser provider split. However, despite the promises and intentions, primary care became a minor function of NHS Trusts run by the barons of secondary care. The 4 primary care contracts are too complex to be run properly by 7 small LHB departments. Maybe WG could think about central contract management 'at scale' retaining a degree of local sensitivity. I hear constantly of friction between GPs and LHBs. Many feel we have to battle with an LHB rather than being encouraged and supported. WG ideals and intentions often don't get past an LHB. Clusters are weak, totally dominated by hospital managers in LHBs.

16) I wish to commend WG in the recent suspension of much of QOF. This demonstrates the long-standing good working relationship between GPCWales and the Assembly. It is a very sensible, supportive development which respects the integrity of GPs and is realistic about the pressures we are under. Thank you.

17) I am sorry I have written such a negative contribution to this consultation. As I said, I am deeply disappointed in the cluster venture, an idea entered into for good reasons, but stifled in many clusters by the dead hand of the LHBs and their processes, and the exhaustion of most GPs.

18) The basic job of being a GP remains a very complex and rewarding one, but only if there is enough time to do it properly. I would like to extend an invitation to any member of the National Assembly for Wales Health Social care and Sport Committee to come and spend a morning with me in my surgery in Butetown, telephone 02920 483126 (it is within easy walking distance of the Senedd). My practice covers a fascinating demography, from hostel to penthouse, you would be very welcome to come get a glimpse of how we work and the breadth of what we deal with.

Kay Saunders 1/2/17
Butetown Medical Practice, Plas Iona, Cardiff, CF10 5HW