PC 32
Ymchwiliad i ofal sylfaenol
Inquiry into primary care
Ymateb gan: Rhwydwaith Canser Cymru
Response from: Wales Cancer Network

Health and Social care committee consultation on Primary care

Please see below the response from the Wales Cancer Network

- How GP cluster networks in Wales can assist in reducing demand on GPs and the extent to which clusters can provide a more accessible route to care (including mental health support in primary care).

Individual GP practices often do not have the capacity (and financial security) to try out new models of working involving other professionals, or economies of scale prevent them from considering such options. Clusters have the potential to support and facilitate a group of practices working together to adopt a new role or new ways of working that they wouldn't otherwise be able to do individually, helping practices share the benefits and the risks. However these models and changes need to be driven by practices not imposed by clusters.

Clusters also provide opportunity for sub specialisation at a practical level (beyond a single GP practice) and this can lead to better educated and informed GPs as well as stronger links between secondary and primary care at a specialist disease level e.g. cancer.

- The emerging multi-disciplinary team (how health and care professionals fit into the new cluster model and how their contribution can be measured).

The multi disciplinary nature of the team is important especially in patients who are living with cancer. Often their needs are not medical or physical but are more emotional and financial. The ability to refer to a team with different facets may provide more appropriate interventions whilst moving away from all of the onus being on the GP.

- The current and future workforce challenges.

There are several challenges. The acknowledgement that the role of the GP is changing and that there is need to involve other professionals as primary service providers within primary care. However there is still the feeling that GPs retain ultimate responsibility, therefore the competency and governance structure around other professionals taking on roles traditionally carried out by GPs is important. GP workforce is increasingly part time (due to increasing number of GPs, mainly female, with caring responsibilities but also due to work pressures). The traditional GP Contractor model was attractive as it provided a degree of control and autonomy. But because of increasing pressures, it is now seen as a burden by many newer GPs rather than a benefit. The advantage of the GP model is that it allows easy portfolio working (taking on other roles such as GP

training, GPwSI, medical leadership etc). However this has an impact on workforce capacity for direct patient care.

A further challenge is the generalist nature of primary and community based care. There is a perception that some ill health is very specialised in nature and as such it may deter primary care form becoming involved. However it is more likely that the reality is that good two way communication and education is what is required.

- The funding allocated directly to clusters to enable GP practices to try out new ways of working; how monies are being used to reduce the pressure on GP practices, improve services and access available to patients.

Often it is felt that clusters (and LHBs) dictate what the monies are spent on. There would be value to using some monies to provide practices time and resources to support them to develop ideas into working models (dedicated service development support, facilitated workshops etc). Primary Care professionals often have good ideas but don't have the skills, experience or time to develop these ideas. It is undoubtedly the case that funded discussion time is valuable.

- Workload challenges and the shift to primary prevention in general practice to improve population health outcomes and target health inequalities.

Primary prevention – Primary care staff who can become Lifestyle Advocates are being trained by Public Health in some clusters. The hope is that these staff will motivate patients to make better lifestyle choices.

There may be a question whether this opportunity is underutilised. Some GPs although by no means all, will be embedded within their communities and indeed Clusters should very much reflect the communities they serve. Both are well placed to engage with their communities in improving health through primary prevention.

- The maturity of clusters and the progress of cluster working in different Local Health Boards, identifying examples of best practice.

The maturity of clusters is at a variable pace. However we would note that where they are more nature engagement with the cancer agenda is notable. The early diagnosis projects in ABMU and Cwm Taf have engaged well with clusters to the extent that cluster leads are co-driving these developments

- Local and national leadership supporting the development of the cluster infrastructure; how the actions being taken complement those in the Welsh Government's primary care plan and 2010 vision, Setting the Direction

The F4C programme is a good example of using the skills and resources of primary care to develop a primary care focused clinical leadership model in an area of health care that is traditionally seen as a specialist area. This needs to be considered and

encouraged across the board. But this must be done with the intention of supporting primary care, NOT to address pressures and problems in Secondary care.

- Greater detail on the aspects being evaluated, the support being supplied centrally and the criteria in place to determine the success or otherwise of clusters, including how input from local communities is being incorporated into the development and testing being undertaken.

This should be a matrix approach – laterally how Clusters link together their constituent practices and clusters themselves and vertically with secondary and tertiary services. This matrix may sit then within the context of networks affiliated to chronic disease such as cancer