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Primary Care Services – **Abertawe Bro Morgannwg University Health Board**

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Contents

The Health Board has clear plans for primary care coupled with strong leadership and oversight of clusters but financial recovery and secondary care are taking focus from primary care planning and performance is not strong.

Summary report

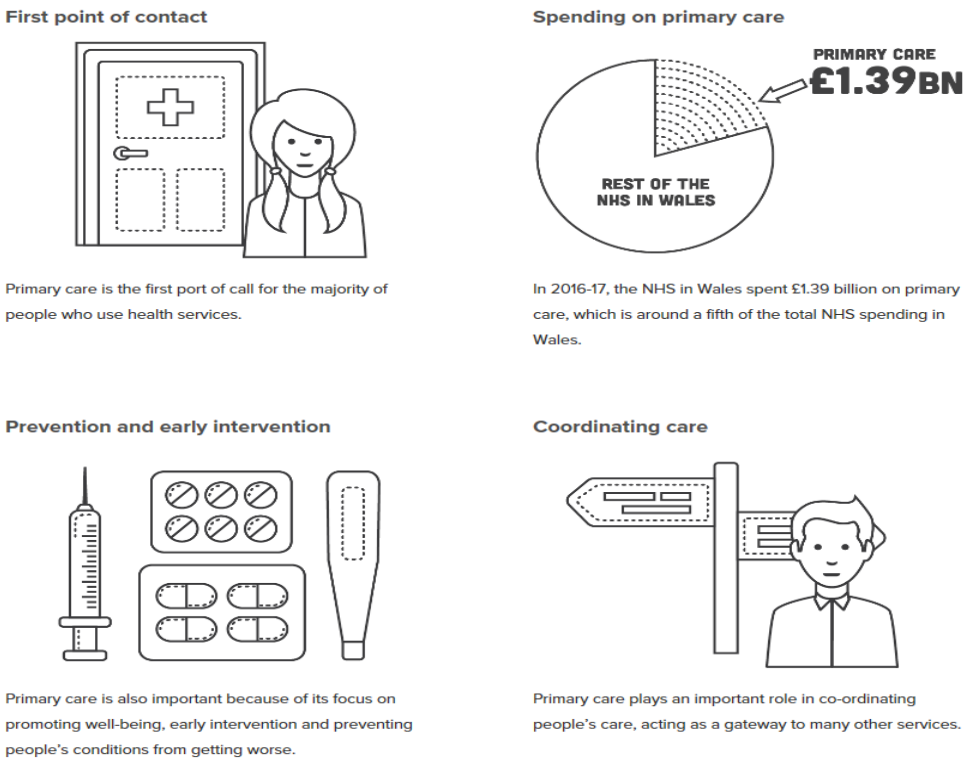
Background

1 The national primary care plan[1] defines primary care as follows:

‘Primary care is about those services which provide the first point of care, day or night for more than 90% of people’s contact with the NHS in Wales. General practice is a core element of primary care: it is not the only element – primary care encompasses many more health services, including, pharmacy, dentistry, and optometry. It is also – importantly – about coordinating access for people to the wide range of services in the local community to help meet their health and wellbeing needs.’

2 Exhibit 1 shows the important role that primary care plays in Wales.

Exhibit 1: why is primary care important in Wales?



Source: Wales Audit Office. Note: Primary care expenditure is not consistently categorised by health boards. As such, it is likely that the £1.39bn figure from the NHS accounts does not represent the totality of primary care expenditure.

[1] Our plan for a primary care service for Wales up to March 2018. Welsh Government. February 2015.

3 Wales has had plans for many years that stress the importance of primary care. The plans aim to rebalance the system of care by moving resources towards primary and community care. The national primary care plan aims for a 'social model' that promotes physical, mental and social wellbeing, rather than just an absence of ill health. The core principles in the plan are: planning care locally; improving access and quality; equitable access; a skilled local workforce; and strong leadership.

4 The national primary care plan and the NHS Wales planning framework place an expectation on health boards to set out plans for primary care as part of their integrated medium term plan. Each plan should explain how the health board will develop the capacity and capability of primary care services.

5 To support the implementation of the national plan, NHS Wales issued a workforce plan[2] . Health boards are expected to put in place actions to secure, manage and support a sustainable primary care workforce shaped by local population needs and by prudent healthcare principles.

6 Primary care clusters are the main mechanism for planning services at a community level and they were first established in 2009[3]. Clusters are groups of neighbouring GP practices, other primary care services and partner organisations such as the ambulance service, councils and the third sector. There are 64 clusters (also known as neighbourhood care networks) in Wales. Their role is to plan and provide services for their local populations. The national primary care plan requires health boards to prioritise the rapid development of the clusters in their area.

7 To support the national primary care plan and encourage innovation, the Welsh Government introduced the national primary care fund in 2015-16. And in 2016-17, the fund totalled £41 million. Cluster development was provided with £10 million and health boards were allocated £3.8 million for pathfinder and pacesetter projects, which aimed to test elements of the primary care plan. The projects funded in this way have produced some new ways of working that have been collated into the Primary Care Model for Wales[4].

8 Since the national primary care plan was published in 2014, there have been a number of developments. In October 2017, the National Assembly's Health, Social Care and Sport Committee published a report following their inquiry into clusters[5]. The report noted some impressive examples of progress but concluded that a major step-change is required if clusters are to have a significant impact. The

[2] NHS Wales. Planned Primary Care Workforce for Wales: Approach and development actions to be taken in support of the plan for a primary care service in Wales up to 2018. July 2015.

[3] Welsh Government. Setting the Direction Primary & Community Services Strategic Delivery Programme. 2009.

[4] http://www.primarycareone.wales.nhs.uk/pacesetters

[5] National Assembly for Wales, Health, Social Care and Sport Committee. Inquiry into Primary Care: Clusters. October 2017.

Welsh Government has continued to support the cluster approach through its programme for government[6].

9 However, at the same time as health boards are introducing new ways of working in primary care, there have been difficulties with recruitment and retention of GPs and other professionals. While there have been recent successes in recruiting GP trainees[7], in many areas more GP partners are retiring and there are particular difficulties in recruitment in rural areas.

10 The Welsh Government is planning to respond to the Parliamentary Review of Health and Social Care in Wales[8] with a £100 million transformation fund. It will be used to improve population health, drive integration of health and care services, build primary care, provide care closer to home, and transform hospital services.

11 It is timely for the Auditor General to review primary care services in Wales. We have published two national reports on primary care this year. In April 2018, we published **A picture of primary care in Wales**. This provides a factual snapshot of primary care in Wales and contains background information that is not detailed in this report. And in July 2018, we published **Primary care out-of-hours services**.

12 This report summarises the findings of work in Abertawe Bro Morgannwg University Health Board (the Health Board) carried out between March and May 2018. We considered whether the Health Board is well placed to deliver the national vision for primary care as set out in the national plan. Appendix 1 shows our methods. The work focused specifically on:

- **Strategic planning**: Is the Health Board effectively driving implementation of the national primary care plan at a local level?
- **Investment**: Is the Health Board managing its finances to support transformation in primary care?
- **Workforce**: Is the Health Board well placed to deliver key aspects of the national primary care workforce plan?
- **Oversight and leadership**: Does the Health Board have effective arrangements for oversight and leadership that support transformation in primary care?
- **Performance and monitoring**: Is the Health Board effectively monitoring its performance and progress in implementing its primary care plan?

[6] Welsh Government. Prosperity for All: the national strategy. September 2017.

[7] The Welsh Government reported that 91% of Wales' GP training places were filled in 2017. 16 October 2017. http://gov.wales/newsroom/health-and-social-services/2017/gprecruitnew/?lang=en

[8] The Parliamentary Review of Health and Social Care in Wales. A Revolution from Within: Transforming Health and Care in Wales. Final Report. January 2018.

Key findings

13 Our overall conclusion is that the Health Board has clear plans for primary care coupled with strong leadership and oversight of clusters but financial recovery and secondary care are taking focus from primary care planning and performance is not strong.

14 Exhibit 2 sets out our key findings in more detail.

Exhibit 2: our main findings

Table detailing our main findings.

Our main findings
Strategic planning: The local primary care strategy reflects the national plan but other priorities impede delivery • The Primary and Community Strategy aligns with the national primary care plan although the pace of delivery is impeded by other priorities. • Cluster plans reflect wider strategic plans but clusters are frustrated because they are unable to mainstream pilot projects.
Investment: The Health Board has some examples of resources shifting closer to home but the available data make it difficult to calculate overall investment in primary care and there are concerns about the lack of ongoing funding to sustain successful projects. • The format of the accounts makes it difficult to accurately calculate the Health Board's overall investment in primary care. • The Health Board can point to some examples of shifting resources towards primary and community care and has established a mechanism to oversee shifts in resource and investment. • The Health Board routinely monitors cluster spending but cluster leads have significant concerns about the lack of ongoing funding for the transformation of primary care. • Development of an estates strategy is clearly linked to the Primary and Community Services Strategy which includes investment priorities for primary care buildings and ICT needs.
Workforce: Practice sustainability is well managed although gaps in staffing data hinder workforce planning, and a lack of suitably trained staff is a barrier to the development of multi-disciplinary teams • The Health Board has gaps in staffing data which will hinder its efforts to plan the workforce it needs in future. • The Health Board has regular contact with practices and monitors their sustainability and there is one directly managed practice. • The Health Board is taking action to implement multi-professional primary care teams but a lack of suitably trained staff is a barrier to further progress.
Oversight: The Health Board has strong leadership arrangements and clear oversight of clusters but data limitations affect performance monitoring and there is scope to focus more on primary care at Board level • The Chief Executive and Vice Chair are strong advocates of the Primary Care Model for Wales and there is clear oversight of clusters and of GP practice sustainability.

Our main findings
• There is recognition that the Board will need to focus more on primary care, and while a dashboard of indicators enables the monitoring of primary care performance, it is hampered by difficulties in obtaining relevant data. • Clusters regard Health Board support as generally effective although GP's find it difficult to focus on cluster planning.
Performance: The Health Board is making some progress in delivering its plans but it is not performing strongly and several difficult challenges remain • The Health Board's primary care performance is at or below the Welsh average on a number of key measures. • The Health Board is making some progress in delivering its plans for primary and community care but needs to address some difficult challenges.

Recommendations

15 As a result of this work, we have made a number of recommendations which are set out in Exhibit 3.

Exhibit 3: recommendations

Table outlining our recommendations to the Health Board.

Recommendations
Strategic planning R1 The Health Board's plans for primary care are not supported by detailed financial analysis meaning it is unclear how the implementation of the plans will be funded. The Health Board should therefore develop clear a financial cost analysis to support its primary care plans to ensure its plans are affordable and to set how it will fund any planned changes.
Primary care clusters R2 We found variation in the maturity of primary care clusters, and scope to improve cluster leadership/procurement processes/etc. The Health Board should: a. review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary; and b. ensure all cluster leads attend the Confident Primary Care Leaders course.
Investment in primary care R3 The Health Board cannot demonstrate a shift in resources from secondary to primary and community settings, apart from small service changes. The Health Board should adopt the financial framework recently issued by Welsh Government to support the implementation of its primary care and wider service transformation plans.

Recommendations
Oversight of primary care R4 We found scope to raise the profile of primary care in the Health Board, particularly at Board and committee level. The Health Board should therefore develop an action plan for raising the profile of primary care in the Health Board. Actions could include ensuring a standing item on primary care on Board agendas. R5 We found scope to improve the way in which primary care performance is monitored and reported at Board and committee level. The Health Board should: a. ensure the contents of its Board and committee performance reports adequately cover primary care; and b. ensure that reports to Board and committees provide sufficient commentary on progress in delivering Health Board plans for primary care, and the extent to which those plans are resulting in improved experiences and outcomes for patients.
The primary care workforce R6 The Health Board should explore and implement ways to extend its use of existing workforce information, and examine how it can gather and use additional workforce data about the wider primary care team.
New ways of working R7 While the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should: a. work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models; b. centrally collate evaluations of new ways of working and share the key messages across all clusters; and c. subject to positive evaluation, begin to fund these new models from mainstream funding rather than the Primary Care Development Fund.

Detailed report

Strategic planning: The local primary care strategy reflects the national plan but other priorities impede delivery

The Primary and Community Strategy aligns with the national primary care plan although the pace of delivery is challenged by other priorities

The Health Board's plans for primary care are set in the context of financial recovery and the move of Bridgend services to Cwm Taf Health Board, which is challenging the pace of delivery

16 The Health Board does not currently have a formal IMTP. We reviewed the Health Board's Annual Plan for 2017-18 which set out organisational objectives for that year. The section relating to primary and community care gives little in the way of detail. However, it refers to the development of the five-year strategy for primary care.

17 The Health Board's Primary and Community Strategy, 2017–2022, describes its intentions for the development of separate Primary and Community Services Units across Bridgend, Neath Port Talbot and Swansea over a five-year period. It sets out a vision for the development of primary care services with general medical practices working together in cluster networks, integrated with care teams from the community, secondary care, social care and the third sector. It includes five key components: access, workforce, quality, information technology, and estates. The Strategy is accompanied by an implementation plan which sets out the priorities for each of the components over the five-year period.

18 To drive transformation and to support the planning and management of primary care, health boards need sufficient numbers of skilled staff within their primary care teams. The Primary and Community Services Unit is responsible for strategy and governance. Their Unit IMTP submission for 2017-18 identifies several overarching strategic priorities as a focus for work and use of resources:

- supporting the sustainability of service delivery;
- improving the cost-effectiveness of community and continuing healthcare;
- ensuring delivery of contractual services and only paying for services delivered;
- ensure the appropriate use of our physical and ICT assets as service changes are rolled out; and
- support the reduction of inappropriate prescribing and dispensing, to reduce harms and wastage.

19 The Primary and Community Services Unit set out a series of nine specific draft IMTP deliverables for 2017-18, to ensure that these key priorities can be achieved. It also provided a high-level progress commentary on these deliverables in October 2017.

20 In the short to medium term, the Health Board's priorities for primary care will need to be delivered in the context of financial recovery and the move of Bridgend services to Cwm Taf University Health Board. The Primary and Community Services Unit will be challenged to deliver significant cost reductions by the end of 2018-19. The current expected Unit shortfall in funding for 2018-19 is in the range £3.2 million to £4.8 million. It will also need to accommodate Welsh Assembly Government's desire to transfer the health care delivery of the Bridgend resident population to Cwm Taf Health Board.

21 The 2017-18 submission is clear that in order to ensure a strategic focus for delivering these twin objectives, other development needs will have to be de-prioritised. Otherwise the Primary and Community Services Unit risks not delivering any key objectives if it tries to achieve too many short-term goals. However, it is not clear which development needs are to be de-prioritised.

22 In addition to delivering the key actions in the Primary and Community Services Strategy Implementation Plan for 2018-19, the Unit has identified six principal objectives for delivery in the coming year; all of which will have some impact on the operating efficiency of the other Units across the Health Board:

- focus the efforts of the community nursing teams on areas that will have the greatest impact;
- review and remodel services from the current model of delivery in Gorseinon and Maesteg Community Hospitals;
- investment in pharmacy delivered care;
- recommission general practice enhanced services;
- rollout 'hub' model of integrated services; and
- out of hours redesign.

23 However, the Health Board does not have a detailed financial analysis to set out how the implementation of the plans will be funded.

The Health Board's Primary and Community Strategy aligns with the key aspects of the national primary care plan

24 We reviewed the Health Board's plans for primary care to assess whether they contained key elements that ensure alignment with the national primary care plan and Primary Care Model for Wales.

25 The Health Board's Primary and Community Strategy (see paragraph 17) was written in the context of The Social Services and Well-being (Wales) Act and is linked to 'Our Plan for Primary Care Service for Wales' up to March 2018. It also refers to the key points raised in the Nuffield Trust report, 'Securing the future of general practice' (2013).

26 The Primary Care Model for Wales is a key feature of the Strategy. It was adopted following the learning from the national pacesetters, which included seven programmes within the Health Board. The Neath Hub contributed to the development of a clinical triage model utilising multi-disciplinary team working. Other initiatives being pursued in the early years of the Strategy are:

- testing an ideal cluster workforce model;
- rolling out the Neath Hub;
- launching the Telephone First model;
- development of GP Acute Clinical Outreach; and
- establishment of the Bridgend GP Federation.

27 We found a number of areas in the Health Board's Primary and Community Strategy that highlight particular strengths:

- clear reference to elements of the Primary Care Model for Wales as part of local plans;
- ways in which the capacity and capability of clusters can be developed;
- recognition that practices will need to work in federations, networks or merged partnerships to increase their scale, scope and organisational capacity;
- references to multi-disciplinary working, including use of optometrists, physiotherapists and community pharmacists, as well as the development of new professional roles;
- recognition of the importance of collaboration between health boards, local authorities, and universities on a range of issues;
- plans to strengthen communication and engagement, and to increase the use of co-production with the public and other agencies, particularly in relation to managing health and wellbeing; and
- reference to the potential for signposting and social prescribing initiatives.

28 We found other areas of the Health Board's Primary and Community Strategy that need further development:

- little mention of the use of needs and wellbeing assessments used to inform partnership plan developments;
- no reference to engaging the public in primary care planning.

29 The national primary care plan requires health boards to develop a priority list of secondary care services which in future it plans to deliver in primary or community settings. The Health Board has identified opportunities to shift services from secondary to primary care, highlighting the need to redesign of pathways for chronic disease management and planned care. The aim is that patients will be able to successfully manage chronic diseases, such as Diabetes, Chronic Obstructive Pulmonary Disease and Asthma at home with support from primary care teams and specialist advice when necessary. It recognises unwarranted existing variation in how support is provided and where it is provided across the Health Board.

30 The Health Board's Primary and Community Strategy also recognises a wide range of opportunities for shifts from secondary to primary care for other planned care pathways such as oral health and eye care. Many patients are receiving screening, assessment or follow up treatment in hospital settings when designated high street optometrists are qualified and able to undertake the work. The Health Board also has plans for further promotion of direct access physiotherapy and podiatry services, together with evidence-based self-referral mechanisms in order to promote self-management and ease of access, and to avoid the need to contact a GP.

The Health Board has engaged with stakeholders to develop its plans for primary care

31 It is important for the health boards to collaborate with stakeholders in developing their plans. The Health Board's Primary and Community Strategy has been developed during 2017 and 2018 through consultation and engagement with other service delivery units, corporate staff and the executive team. Further development and implementation was conducted through:

- the Primary Care Development Group;
- several strategy development workshops and three oral health-specific workshops;
- cluster development workshops and cluster leads' meetings with Unit medical directors; and
- patient participation groups, carers' groups and the Carers' Partnership Board.

32 The Community Health Council (CHC) said that the Health Board had not engaged with them at an early enough stage in the development of the Strategy. Their own engagement with the public on the Health Board's intentions had to commence at a point when plans were already at an advanced stage of development. More intensive Health Board engagement with the public from the outset would have informed and strengthened the planning process and identified any issues at a much earlier stage.

33 Local Medical Council Executive representatives, the CHC and the third sector representatives participated in the events outlined above. While the Local Medical Council acknowledges that engagement occurs, they are doubtful as to its value. They also referred to recent issues which were said to have diminished GP confidence in the Health Board's ability to establish local agreements in relation to Directed Enhanced Services (DES).

34 The Health Board has engaged and collaborated with key local stakeholders through the Regional Partnership Board and the Public Services Board. Regular reports are presented in these forums and feedback is integrated into Health Board plans as appropriate.

35 The Health Board Local Dental Committee participated in the strategy and oral health-specific workshops. The Committee meets at least bi-monthly and has been

updated on progress with plans at every meeting. Community Pharmacy Wales representatives participated in the engagement events and workshops.

36 South West Wales Optometry Committee members participated at strategy implementation engagement stage. A local Optometry advisor was involved throughout the process.

Cluster plans reflect wider strategic plans but clusters are frustrated because they are unable to mainstream pilot projects

37 There are 11 clusters in the Health Board area covering 3 local authority geographical areas. Each cluster is led by a designated cluster lead for one session per week over 46 weeks each year. Each lead is recompensed through a service level agreement with the Health Board. The Health Board has appointed two Cluster Support Managers and 11 Cluster Support Officers to support the cluster leads. It also hosts a variety of meetings and forums to facilitate the cluster agenda.

38 Each cluster lead receives dedicated support from a cluster development manager and/or a primary care manager, together with their associated teams. The support is provided under the supervision of area clinical directors and heads of primary Care. The Primary Care support team for non-general medical services (e.g. Pharmacy) also supports cluster agendas.

39 Clusters are comprised of a wide range of members across organisations and sectors, all contributing to the delivery of the cluster agenda. Those involved in directly supporting clusters have a key role in liaising with partner members for the delivery of cluster plans and work programmes.

40 The cluster plans were developed within the framework of strategic objectives set out by the Health Board. In 2017, the Quality and Outcomes Framework set out the need to shift towards the development of three-year plans. Clusters have developed their plans with the intention of undertaking annual refresh exercises.

41 All 11 cluster plans were developed using a range of information sets to ensure that each plan considers specific local population, patient and service needs which, where appropriate, can then be addressed through cluster action plans.

42 Cluster leads expressed frustration with a perceived lack of prioritisation of primary care. They said that they have been unable to mainstream locally based solutions to help transform services. They told us that there is no clear project evaluation approach and no mechanism to allow the Health Board to provide mainstream funding for effective projects. We were told that, despite representations to the Health Board, none of the projects within individual clusters has been adopted. Part of this challenge is that cluster funding for projects is for two years rather than three. The Health Board recognises that two-year funding does not provide sufficient brokerage to ensure that projects become fully operational. However, for successful projects lasting long than two years, fixed term employees gain

permanent rights of employment. This is not recognised in the Health Board's IMTP.

43 Exhibit 4 sets out our findings from our survey of cluster leads, suggesting that clusters in the Health Board are at different stages of maturity. There is a mix of experience amongst the eleven cluster leads.

Exhibit 4: cluster leads' assessment of the level of their organisation's development

The table provides the number of clusters at each of three levels of maturity (see note).

	1 = Developmental	2 = Stable and starting to deliver	3 = Mature
Abertawe Bro Morgannwg	**1**	**4**	**2**
Aneurin Bevan	1	6	0
Betsi Cadwaladr	2	5	1
Cwm Taf	0	5	2
Cardiff and Vale	1	5	2
Hywel Dda	0	4	1
Powys	1	1	1
Wales	6	30	9

Note:
1 = Developmental: still at early stages of development with significant support required; not all cluster members fully engaged.
2 = Stable and starting to deliver: Starting to deliver some benefits but still early days, ongoing support required and full potential yet to be reached.
3 = Mature: all cluster members fully engaged; delivering across a number of areas in line with the cluster plan.

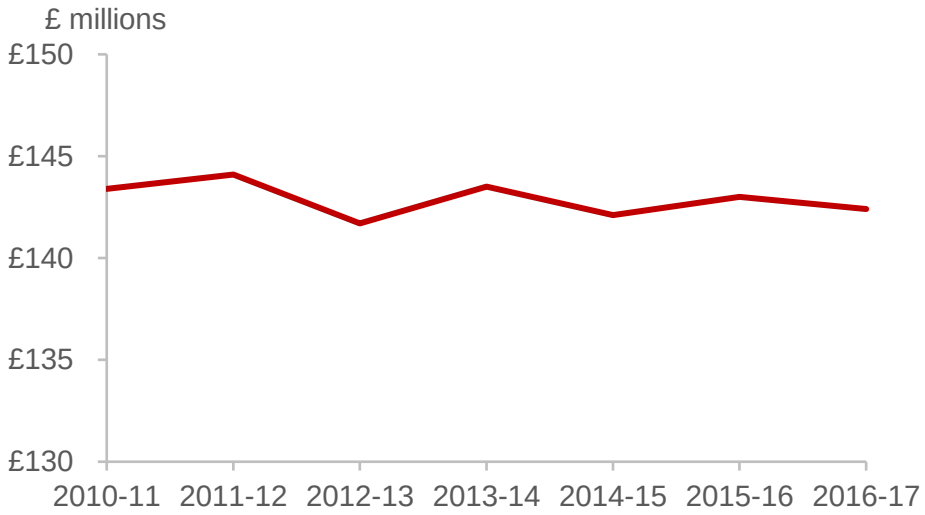
Source: Wales Audit Office survey of cluster leads, April 2018

Investment: The Health Board has some examples of resources shifting closer to home but the available data make it difficult to calculate overall investment in primary care and there are concerns about the lack of ongoing funding to sustain successful projects.

The format of the accounts makes it difficult to accurately calculate the Health Board's overall investment in primary care

44 Exhibit 5 is based on data from the Health Board's annual accounts and sets out the Health Board's long-term expenditure on primary care. The total includes spending on General Medical Services, Pharmaceutical Services, General Dental Services, General Ophthalmic Services and 'Other' Primary Health Care Expenditure[9]. The exhibit shows that the Health Board spent £142.4 million on these primary care services in 2016-17.

Exhibit 5: the Health Board's expenditure on primary care services



Source: Abertawe Bro Morgannwg UHB Annual Accounts

Note: The y-axis does not begin at zero. We have excluded expenditure on 'Prescribed drugs and appliances' due to variable nature of this expenditure, as a result of drug price fluctuations.

[9] Excludes spending on 'Prescribed drugs and appliances'.

45 Exhibit 5 shows that overall spending remained largely the same between 2010-11 and 2016-17. After accounting for the effect of inflation, the Health Board's spending on these four categories of primary care services appeared to have fallen in real terms by 9.4% over this period. However, this figure does not account for differences in the way that expenditure was categorised in different years. Also, the Health Board has received funding for primary care from other sources (see paragraph 50). In addition, other factors need to be taken into account in order to arrive at a more accurate picture in relation to expenditure on primary care.

46 There was a reduction in GMS expenditure between 2015-16 and 2016-17 because a review by the Valuation Office Agency reassessed the business rates due for GP practices based on a lower valuation over several years. This resulted in a reduced budget allocation for GMS in 2016-17 by £3.5 million based on non-recurrent rates rebates for that year. Therefore, in effect, actual GMS expenditure was higher by same amount. Other similar adjustments in 2016-17 led to a reduction in budget allocation, including £3 million of accounting changes related to non-cash limited Pharmacy and £2 million due to the centralisation of GP registrar training costs.

47 The budget allocation for pharmaceutical services is the cash limited value allocated to Health Boards, and spending figures we have referenced were after non-cash limited services had been accounted for. The Health Board receives a net credit for the difference between prescribing and dispensing, and cross-border flows have to be taken into account for true comparative purposes. The Health Board has indicated that when its cash limited allocation is compared to the cash limited expenditure it shows that, for the years 2010-11 to 2014-15, expenditure either exceeded or been broadly in line with the cash limited allocation.

48 In more recent years, the level of cash limited expenditure was lower than the cash limited allocation. Welsh Government reduced the practice payment to community pharmacies, with the expectation that health boards will increase the range of enhanced services it will commission. There have been delays in implementing national agreements for these services. The true underlying position over the last three years is that the Health Board spends around £2 million a year less than the allocation. This is being addressed through the contract reform process from 2017-18 onwards, and it is planned that expenditure will increase following the commissioning of a range of new or expanded enhanced services.

49 Across Wales we found issues with the way that primary care expenditure is recorded in the accounts. Spending is not consistently categorised by health boards and the figures recorded in the accounts often do not represent the totality of primary care expenditure. Also, some health boards may provide a service through primary care whilst others may provide the same or a similar service through community care. Since 2010-11, the Health Board told us that its revenue allocation for non-primary care items has increased by £145 million. This reflected general uplifts to support pay awards and other inflationary effects, changes in technology and demand growth. In addition, there were specific allocations to support service changes and developments across primary and community

services, Mental Health and Learning Disabilities, Child and Adolescent Mental Health Services and Intermediate Care.

50 In 2016-17, the Health Board received an additional £9.9 million funding for primary care from the Welsh Government:

- voluntary organisation service level agreements LAs (£2.3 million in 2016-17)
- section 28a agreements (£0.9 million in 2016-17)
- delivery plan agreements (£4.3 million in 2016-17)
- cluster network expenditure ((£1.7 million in 2016-17)
- Pacesetter expenditure (£0.7 million in 2016-17)

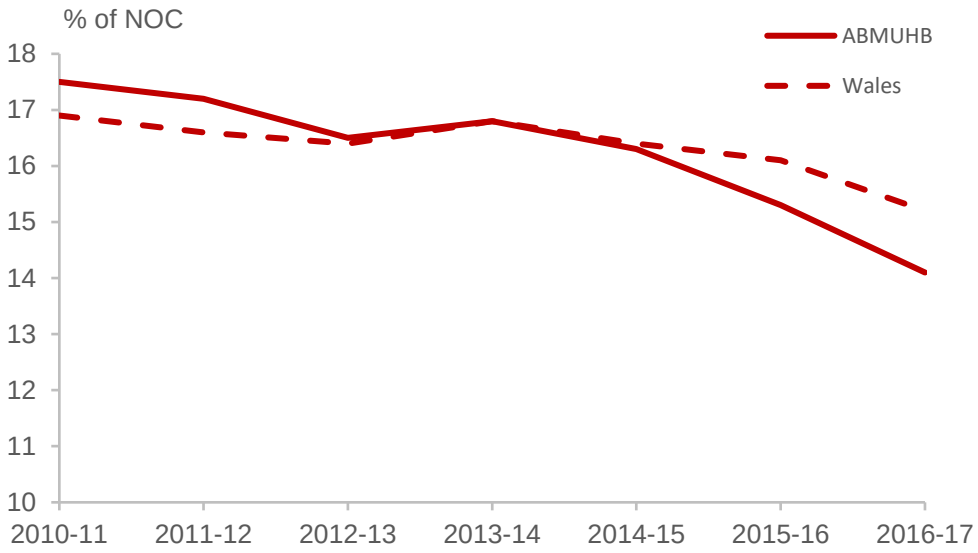
The Health Board can point to some examples of shifting resources towards primary and community care and has established a mechanism to oversee shifts in resource and investment

51 For many years, the NHS in Wales has planned to shift resources towards primary care, to reverse the 'relative under-development of primary care'[10]. The current national primary care plan again stresses the importance of 'health boards moving their resources towards primary care'.

52 Exhibit 5 shows the Health Board's expenditure on primary care as a percentage of its total expenditure (Net Operating Cost, 2010-11 to 2016-17). The figures exclude expenditure on prescribed drugs and appliances. The exhibit shows that despite national priorities for shifting resources towards primary care, primary care spending has not kept pace with health boards' total spending. This is the case at the Health Board where, it has fallen below the Wales average since 2013-14 and was in decline for almost all of the period between 2010-11 and 2016-17.

[10] Welsh Government, Improving Health in Wales: The Future of Primary Care, July 2001.

Exhibit 5: the Health Board's expenditure on primary care as a percentage of its total expenditure (Net Operating Cost, 2010-11 to 2016-17)



Source: LHBs' Annual Accounts

Note: The y-axis does not begin at zero.

53 We asked whether health boards are taking specific actions to achieve a shift in resources towards primary care. We found that none of the health boards has set targets for moving resources towards primary care. We also found that none of the health boards has quantified the total amount of resource moved towards primary care since the inception of the national primary care plan in 2014. The Health Board acknowledges that while it needs to shift resources from secondary to primary and community settings, it can currently only demonstrate this shift in small service changes e.g. vasectomy services being delivered in primary care.

54 A Financial Framework to Support Secondary Acute Services Shift to Community / Primary Service Delivery[11] has been developed by health board directors of finance working together with directors of primary and community care. The Health Board recognises that this framework methodology can support the implementation of its primary care and wider service transformation plans.

55 The Health Board's Primary and Community Strategy identifies services that may transfer over coming years, subject to formal Health Board approval processes. In 2017, the Health Board established an executive-led Investment Benefits Group which operates as the mechanism for any resource investment or shift within the Health Board. The group takes a business case approach to all decisions regarding shifting resources towards primary care. It has set out a template of rigorous information requirements for each submission; a consistent process for

[11] 54 A Financial Framework to Support Secondary Acute Services Shift to Community / Primary Service Delivery, WHC (2018) Rhif / Number 025, July 2018

consideration of each case; and robust monitoring and evaluation of investments. The overall approach generates greater confidence and assurance.

56 The Health Board recently submitted a proposal to Welsh Government for the Cwmtawe Whole System Model of Transformation, to demonstrate how a cluster can deliver at pace the Primary Care Model for Wales. The proposal was approved and is the first cluster in Wales to receive funding to develop this model. The Health Board secured £1.7m in funding and has been asked to develop plans to roll this approach out across all clusters in the new health board[12].

57 The Health Board told us that they have invested in a number of initiatives using finance from primary care funding and pathfinder funding, such as:

- the commissioning of directed enhanced services which has seen a shift to primary care of in excess of £1.2 million in the areas of anticoagulation, secondary care requested phlebotomy and diabetes care in 2017-18.
- the development of the Primary and Community Services Delivery Unit from 2016 has included the transfer of management responsibility and oversight of several services from former secondary care-based units (eg restorative dentistry, sexual health, community cardiology and pulmonary rehab services) that have allowed the unit to better meet the agenda for primary care delivery.
- the Health Board's tender during 2015-16 for the provision of vasectomy services from general practices (at around £0.8 million per annum, delivering 720 cases).

The Health Board routinely monitors cluster spending but cluster leads have significant concerns about the lack of ongoing funding for the transformation of primary care

58 Health boards need to strike the right balance of giving autonomy to clusters whilst at the same time overseeing their spending. Cluster development plans are created, agreed and signed off by cluster and network leads. The plans are translated into financial projections and budgets, which are uploaded to the Health Board's financial system. Non-pay expenditure is reviewed and authorised by cluster leads. Pay costs are coded in the same way as all other pay expenditure across the Health Board.

59 Reports are produced at least monthly and on an ad hoc basis on request by a cluster support officer. The reports are discussed at cluster network meetings. Quarterly reports on cluster expenditure, commitments and plans are submitted to the Primary & Community Services Board. They are also submitted to the Health

[12] Services in the eastern part of the Health Board, in the Bridgend area, are to become part of Cwm Taf University Health Board. The remaining services in the Health Board will constitute a new health board.

Board Vice Chair for discussion with the Cabinet Secretary and Welsh Government officials as required.

60 In our survey of cluster leads, we heard repeatedly that there is real concern about the lack of ongoing funding to embed successful transformation pilot projects and other development initiatives that have had positive results.

Development of an estates strategy is clearly linked to the Primary and Community Services Strategy which includes investment priorities for primary care buildings and ICT needs

61 The model of ownership of primary care buildings is complicated. Some premises are purpose built by a commercial developer and leased back to the NHS. Other properties are owned by GPs who receive notional rent reimbursements from the health boards. Other properties are owned by health boards who lease rooms to GPs. Welsh Government announced in 2013 that it was no longer funding primary care estates developments which would in future be the responsibility of Health Boards.

62 The Health Board has set out the need to improve the primary and community estate as part of its Primary and Community Services Strategy. The strategy indicates the challenges to be addressed and gives this work a high priority. This was informed by an Estates Position statement which was undertaken in 2016-17.

63 Development of an overarching property and estates strategy is in development, as set out in the Primary and Community Services Strategy implementation plan. This has been used to inform Welsh Government applications for practice improvement grants, capital builds in Bridgend, Neath Port Talbot, and Swansea and practice refurbishment schemes such as the Murton and Penclawdd practices.

64 The Health Board has progressed new primary care premises in Brynhyfyd, Briton Ferry, Porthcawl, Vale of Neath, as well as an integrated family and primary care centre in Mayhill. It has also secured improvement grant funding for GMS premises in Aberkenfig and Ystalyfera. It used Health Board discretionary capital to renovate Maesteg Hospital to provide fit-for-purpose GMS premises for Bron Y Garn surgery. At the time of our review, business cases were being progressed against significant primary care pipeline funding for projects in Swansea and Bridgend.

65 The Primary & Community Services Board received and considered two proposed submissions for improvement grants in its December 2017 and February 2018 meetings.

66 Oral health investment plans also include a Health Board improvement scheme through which general dental service practices are being incentivised to provide improved premises and to meet Equality Act requirements through capital investment.

67 The Primary and Community Services Strategy sets out associated ICT needs and priorities across the Health Board. Several elements have been initiated, for example:

- allocation from first phase of Welsh Government cluster funding to improve ICT and access;
- investment by clusters in Vision 360 Appointments[13] to improve cross practice collaboration; development of a shared approach to capturing and analysing patient experience data; and cluster-based websites;
- development of a primary care dashboard for real time management information (see paragraph 106);
- joint work with Welsh Ambulance Services Trust (NHS Direct/111) to support introduction of new access model for urgent dental care in and out of hours;
- piloting the 111 service and subsequent involvement in implementing systems and links between GP out-of-hours and practice systems; and
- continued investment in computer hardware and software for GP practices to extend clinical provision.

[13] Vision 360 Appointments is a cross-practice appointment viewing and booking application which enables access to, and updates of, appointments for patients at multiple practices.

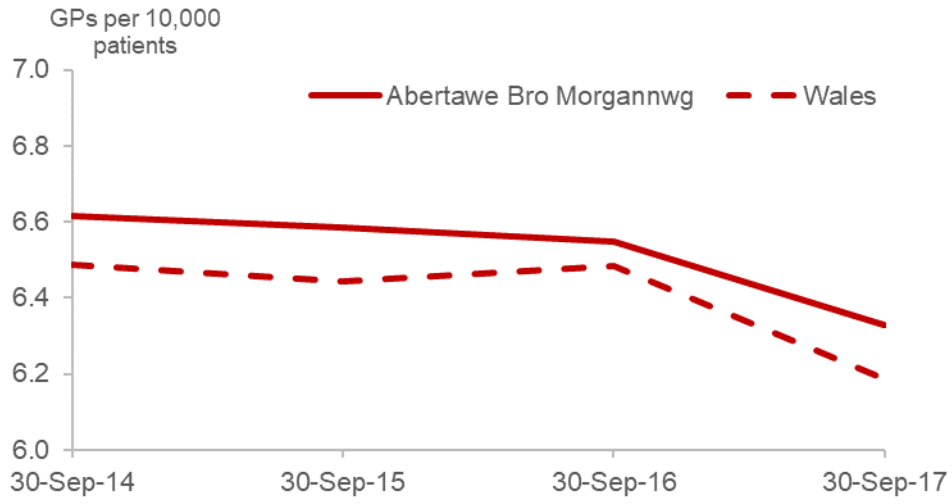
Workforce: Practice sustainability is well managed although gaps in staffing data hinder workforce planning, and a lack of suitably trained staff is a barrier to the development of multi-disciplinary teams

The Health Board has gaps in staffing data which will hinder its efforts to plan the workforce it needs in future

68 The national primary care plan sets out the need to build a skilled local workforce with the right numbers and mix of skills to meet people's needs closer to home. The national primary care plan requires health boards to 'map all available clinical, workforce, financial, and other resources'.

69 The Health Board has a slightly higher number of GPs per 10,000 population (6.33) than average in Wales (6.19). The number has declined in recent years broadly in line with the national trend (Exhibit 6). The number of GP partnerships has fallen each year from 77 in September 2013 to 68 at the time of our audit. The percentage of partnerships with just one partner is 6% which is lower than the Welsh average of 11%.

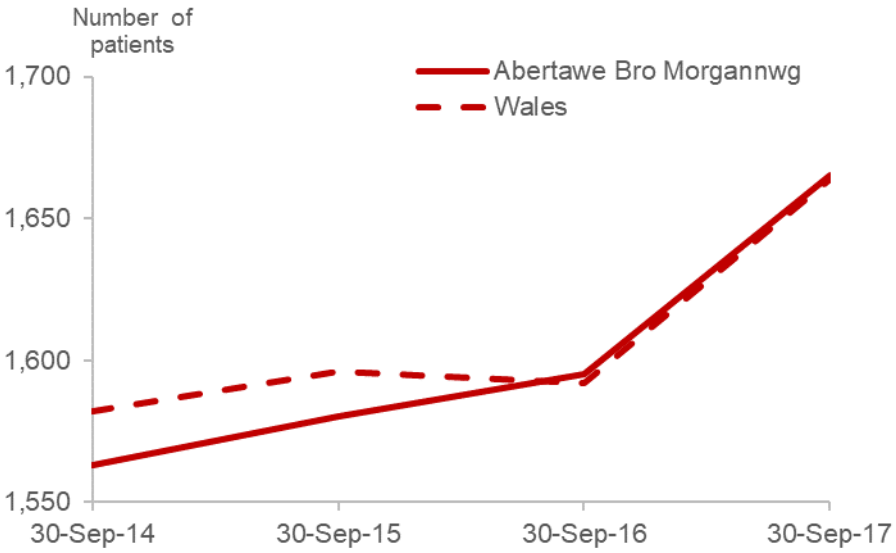
Exhibit 6: number of GPs per 10,000 population



Source: Welsh Government, September 2017

70 Exhibit 7 shows that the average list size per GP in the Health Board varied slightly over recent years and is currently in line with the Wales average.

Exhibit 7: average list size per GP



Source: Welsh Government, September 2017

71 Exhibit 8 shows that the proportion of GPs aged over 55 in the Health Board area is below the Wales average, while the proportion of GPs who are female in the Health Board is just below Wales average.

Exhibit 8: demographics of GPs by age and gender

	Abertawe Bro Morgannwg University Health Board	Wales
• Aged over 55	18%	22%
• Female	51%	52%

Source: Welsh Government, 30 September 2017

72 The Primary and Community Strategy sets out potential workforce models and professional roles that will be necessary in order to implement the new model of general medical practice. We understand discrete elements of the strategy have led to workforce reviews in specific areas e.g. the introduction of new models of oral health service in primary and community care. However, we have not seen any clear analysis of the available data.

73 The Health Board has mapped GP numbers and sessions worked and has started to collate GP vacancy information on a more regular basis. It utilises practice development plans to collate and analyse demographic information on the general practice workforce. It is unclear whether this includes information on skill mix.

74 Basic staffing data is available for other community-based practitioners. The Shared Services Partnership has advised the Health Board that 129 pharmacists work in the 125 local community pharmacies. However, this figure does not include a substantial number of locum staff and the skill mix is unknown.

75 The Health Board reports that there are 312 registered General Dental Practitioners working locally on a total of 105 general and specialist contracts, but there is no data on skill mix within practices. It also reports that there are 128 registered optometrists working across 54 local practice premises within ABMU, but again there is no information on the skill mix within practices.

76 The Health Board had 292 General Dental Services contractors in 2017, up from 245 in 2014. Optometrist numbers increased slightly from 113 in 2014 to 116 in 2017.

The Health Board has regular contact with practices and monitors their sustainability and there is one directly managed practice

77 The Health Board clearly recognises the need for sustainable general medical services, given national challenges relating to increasing demand from patients with more complex conditions, as well as recruitment and retention issues.

78 A number of practices have suffered severe sustainability challenges in recent years. In September 2016 there were 73 GMS practices in the Health Board area, and at the time of our work there were 68. The reduction was supported by the Practice Support Team (see paragraph 79) using a local practice merger framework. The framework provides discretionary financial support and encourages mergers.

79 Many Health Boards have a Primary Care Support Unit to provide support to directly managed practices and to ensure continued sustainability of practices that are not directly managed. At the Health Board this function is fulfilled by the Practice Support Team, which was initially set up during 2016-17. In April 2018 the team had 7.4 WTE which included the management team of 0.8 Clinical Director, 1 WTE Senior Nurse and 1 WTE Development Manager

80 The Team is led by the Clinical Director for Sustainability who has attended cluster network meetings to pro-actively promote the service. It consists of salaried GPs, an advanced nurse practitioner and a business development manager. The emphasis is on sustainability and promoting Prudent Healthcare. The team provides diagnostic and service transformation support to practices. The Team works closely with Primary and Community Services Units Unit, the medicines management team, as well as finance and workforce staff.

81 The Practice Support Team identifies practices at risk using the National Sustainability Framework which is completed and agreed with every practice. It proactively offers support and resources to help practices to innovate to introduce new models of care, and to develop the workforce according to local needs. This includes support for the development of cluster-based services, teams and networks.

82 All practices that have scored higher than 55 (amber and red) on the framework have received a visit. Support options are considered at Sustainability and Access meetings. The Practice Support Team's interventions are also monitored at these meetings. The Team's Clinical Director recruits and line manages Cluster Fellowship GPs (currently three in place) who work in practices which are difficult to recruit to. These roles are funded by the clusters and practices.

83 By December 2017, the Team had worked with 18 practices. Support options are considered at Sustainability and Access meetings. The Practice Support Team's interventions are also monitored at these meetings. The Team's Clinical Director recruits and line manages Cluster Fellowship GPs (currently three in place) who work in practices which are difficult to recruit to. These roles are funded by the clusters and practices.

84 The information from the framework is also used to produce vulnerability assessment maps for each cluster area which is monitored by the Access and Sustainability Forum. The sustainability framework has been incorporated into the formal Practice Governance visiting programme that addresses contractual and clinical governance issues. The aim is to maximise the value of interactions between the primary care team and the practices, and to minimise the burden of bureaucracy on practices.

85 The Heads of Primary Care, the Unit Service Director and Unit Medical Director meet with LMC and CHC representatives every three months to discuss issues of access and sustainability. The Unit, LMC and CHC also meet to consider practice applications for sustainability support using the Wales-wide agreed sustainability process.

86 Four practice mergers and one practice dispersal have taken place with appropriate engagement of patients, and CHC advice where necessary:

- 1 April 2017 – merger of Cwmavon Practice with Cymmer (Health board-managed practice) to form a single health board managed practice operating over 2 sites in Neath-Port Talbot.
- 1 June 2017 – merger of St Helens and High St practices to form the Abertawe Practice (GMS).
- 1 July 2017 – closure and dispersal of Victoria Road single-handed practice in Bridgend
- 1 October 2017 – merger of Ashfield and Newcastle surgeries to form the Bridgend Practice

- January 2018 – Merger of Clydach Primary care and Sway Road to form Cwmtawe Primary care

87 At the time of our review one practice was being directly managed by the Health Board.

The Health Board is taking action to implement multi-professional primary care teams but a lack of suitably trained staff is a barrier to further progress

88 The national primary care plan says that in future, the role of GPs will be to provide overarching leadership of multi-professional teams. These teams would include pharmacists, therapists, optometrists, paramedics, advanced practice nurses and others. The national workforce plan says that health boards must identify opportunities for these professionals to improve access by providing the first point of contact for patients.

89 A key strategic priority in the Primary and Community Services Unit plans for 2018 is the establishment of hub-based multi-disciplinary working across clusters. Cluster plans, pathfinder plans and the Health Board Annual Plan all include significant elements of workforce redesign, particularly to support the sustainability and development of primary care. The Health Board reports a significant shift in the makeup of workforce models towards a multidisciplinary approach, with each cluster engaging at least one non-medical clinical worker such as a pharmacist, independent prescriber, or advanced practitioner.

90 There are well-developed partnership models with other agencies such as the Welsh Ambulance Service NHS Trust (WAST). For example, the GP out-of-hours service has recruited paramedics who are supported by WAST. This is a key element of the ongoing redesign of the service which aims to reduce dependency on increasingly scarce GP and nurse practitioner resources. The redesign also includes greater reliance on nurse call handlers and a 111-based multi-disciplinary 'clinical desk'. Some of these approaches are also being explored by clusters.

91 Community pharmacies are being supported by both the Unit and medicines management teams to ensure they are equipped to deliver the broader range of enhanced services needed to ensure that first-point-of-contact care is as envisaged in the national strategy. The Health Board envisages that the introduction of the new contract, combined with investment in IT needs such as the Choose Pharmacy platform, will lead to greater integration of pharmacists with other primary care providers. In turn this would help to ensure general practice sustainability.

92 The range of services available at most optometry practices has been expanded. The Health Board intends to ensure that the use of this resource is maximised and supports the redesign of ophthalmology pathways. This will include making use of Welsh Government monies for optometry training.

93 The Health Board is taking a progressive approach to the provision of support for oral health. The aim is to improve access and the quality of services as well as to reduce unnecessary referrals and waits for secondary care. It has provided training and services for six pilot dental contract practices, and also employs a dentist with enhanced skills in endodontics.[14] There are further plans to enhance general dental capacity to undertake prosthodontic[15] work.

94 Trained dental nurses are being used to support the Referral Management Centre for oral health. The Centre was established in 2014 to coordinate and manage in-hours requests for urgent general dental care.

95 A variety of Telephone First access models have been introduced across the Health Board. In 2017, the Health Board's multi-agency access group formalised standards for these models. In February 2018 it launched guidance for practices who wish to implement any access model requiring patients to have a telephone consultation before an appointment is provided. All practices will be undertaking a self-assessment against these standards.

96 Other triage innovations are based on the Neath Hub model where GPs either book directly into communal appointments for clinicians. In addition, patients can contact a range of clinicians directly rather than contacting a GP first eg audiologists, physiotherapists, pharmacists, podiatrists.

97 The Health Board reports that the biggest barrier to developing these new models is the recruitment and retention of sufficient numbers of suitably qualified and experienced staff. It is engaging in joint initiatives to help overcome perceived barriers in recruitment to primary care.

98 The Health Board works with Swansea University to deliver a practice manager development programme and a practice nurse/practitioner programme. It has also secured additional loan capital to establish an Out-of-Hours 'Academi'. The Health Board' faces significant problems in maintaining staffing levels for its GP out-of-hours service. The establishment of an academy is one of the actions it is taking to address the situation.

99 The Swansea University course for physician associates has offered trainees more exposure to secondary care than to primary care. The Health Board is working with the university to establish physician associated internship programme which will provide greater exposure to multiple community-based specialities and practices. While NHS Wales has a governance framework for employing physician associates, they are not yet fully regulated by an organisation like the General Medical Council. It is important to provide good supervision and ongoing evaluation of their impact.[16]

[14] Root canal work

[15] Removable dentures.

[16] www.gpone.wales.nhs.uk/opendoc/293958

100 The Primary and Community Service Unit has supported and encouraged the establishment of Pen y Bont Health. It is the first federation of GPs in Wales and is comprised of a cluster of six GP practices in the Bridgend area. Delegates from each surgery engage with the Health Board in order to provide better health services to patients, and to promote closer working across the six GP practices in the cluster.

Oversight: The Health Board has strong leadership arrangements and clear oversight of clusters but data limitations affect performance monitoring and there is scope to focus more on primary care at Board level

The Chief Executive and Vice Chair are strong advocates of the Primary Care Model for Wales and there is clear oversight of clusters and of GP practice sustainability

101 To transform primary care, health boards need clear and effective arrangements for oversight and senior leadership. The health board vice chairs have a specific responsibility for championing primary care issues. At the Health Board we found that the recently appointed Vice Chair has a strong commitment to strengthening primary and community care. She recognises the challenge that clusters face in achieving scale in transforming new services, and the difficulty of shifting resources from secondary care to primary care. She would like more opportunity for the executive team and senior managers to focus specifically on primary care.

102 The recently appointed Chief Executive is highly committed to the Primary Care Model for Wales transformation. There are slightly varying arrangements between health boards in the executive-level responsibilities for primary care. The Health Board's Primary and Community Services Unit was created in August 2015. It is one of the six delivery units of the Health Board and is tasked with the development and delivery of safe and effective out-of-hospital services. There is a strong team in the Unit including the Service Director, Head of Primary Care, and the Unit Medical Director/Associate Medical Director. The Service Director reports to the Chief Operating Officer. There are several other leads in the team focussed on various elements of primary and community care provision. They work closely with managers for HR, planning, performance and finance to support the clusters and the implementation of their plans.

There is recognition that the Board will need to focus more on primary care, and while a dashboard of indicators enables the monitoring of primary care performance, it is hampered by difficulties in obtaining relevant data

103 At Board level, the executive team reports provide routine updates on the work being carried out by the Primary and Community Services Unit. There is general recognition that there should be more focus on primary care at Board level and in its committees. However, the main focus of the Board is on financial recovery and secondary care.

104 The Health Board indicated that it monitors primary care performance at a number of boards. The Primary and Community Services Unit Board receives a monthly update report on the unit's financial position and agrees any actions that need to be taken.

105 A monthly recovery and sustainability report for general medical and primary care services is prepared for the Performance and Finance Committee. It provides a high-level summary of the financial position, actions, risks, workforce trends and workforce indicators. A separate and more detailed Primary and Community Services Unit finance report is considered at Financial Recovery Meetings.

106 There is ongoing work by the Primary & Community Services Unit to produce a rational and robust dashboard to provide assurance for independent members of Quality and Patient Safety in Primary Care. While the current dashboard has 53 measures, difficulties in obtaining data have limited the extent to which it can be updated. The dashboard has not yet become a part of the Unit's processes and it is being updated manually until a decision is made on its future.

107 A quarterly performance review paper for the Primary and Community Services Unit is prepared and presented at executive team meetings. The Board and the Executive Committee review the quarterly and annual Integrated Performance Reports on progress against Welsh Government National Outcomes and Performance Framework. The measures related to primary care include childhood immunisation and flu vaccinations, smoking cessation, access to GP appointments, GP out-of-hours services, NHS primary dental care and prescribing indicators. However, the main focus of the framework is secondary care targets. Moreover, there are no explicit primary care indicators reported in the high-level dashboard seen at Board.

108 Individual cluster reports are presented to the Primary and Community Services Unit Board and then collated into a report for various forums, including the Primary and Community Development Group. We did not see any reports by GPs or other primary care staff on how the clusters are progressing with their projects.

109 The Unit produces a quarterly report on the Health Board's progress on implementing the primary care national plan, which goes to the Finance and Performance Committee. The Health Board Annual Primary Care Report was presented to the Board in September 2018 and describes the context within which

directly managed and contracted services have been operating and developed. It is aligned to the National Annual Report for Primary Care, and provides a summary of the key issues and achievements for that year. It is prepared in the context of the Health Board Primary and Community Strategy approved in May 2017.

Clusters regard Health Board support as generally effective although GP's find it difficult to focus on cluster planning

110 The Welsh Government sees clusters as the means of achieving local autonomy for leadership, collaboration and innovation. However, the Health, Social Care and Sport Committee's inquiry into clusters found mixed views on whether there was a need for more effective leadership of clusters. The inquiry also found evidence of reliance on a small number of individuals to sustain clusters.

111 Exhibit 9 sets out the professional backgrounds of the cluster and NCN leads across Wales. In the Health Board all eleven cluster leads are GPs.

Exhibit 9: professional background of the cluster leads

The table provides the numbers of cluster leads who are GPs and the number of cluster leads who are other professionals in each Health Board

	Number of clusters leads: GPs	Number of clusters leads: other professionals	Total number of clusters
Abertawe Bro Morgannwg	11	0	11
Aneurin Bevan	9	3	12
Betsi Cadwaladr	12	2	14
Cwm Taf	5	6	8
Cardiff and Vale	9	0	9
Hywel Dda	6	1	7
Powys	2	1	3
Wales	54	13	64

Note: While the total number of clusters is 64, the total number of cluster leads is 67 because Cwm Taf has both GP and other professional leads for its clusters.

Source: Wales Audit Office, Health Board self-assessment returns.

112 Public Health Wales, through the Primary Care Hub, has developed a Confident Leaders Programme, which has been attended by 40 of the cluster leads. The cluster leads continue to share and learn from each other through a community of practice. Cluster leads are supported through regular individual sessions with their Area Clinical Director, as well as through training programmes such as the Confident Leaders Programme.

113 The Health Board sees the development of clinical leadership in the clusters as a key priority to ensure that clusters can fulfil their functions. Our cluster leads survey found that most of the respondents had attended the national Confident Primary Care Leaders course. The majority of these either agreed or strongly agreed that the course had helped them to improve as a cluster lead. The majority also agreed that the Health Board provides them with effective support to undertake their cluster development role. However, the majority disagreed or strongly disagreed that they had sufficient time during the day to focus on cluster development.

114 We looked at the way that the Health Board provides support to clusters in developing local needs assessments and cluster plans. We found that while most clusters said they have undertaken a needs assessment, some said that they had not received support in developing one. Only two clusters agreed that the Health Board listens to them when it is developing Health Board level priorities for primary care.

Performance: The Health Board is making some progress in delivering its plans but it is not performing strongly and several difficult challenges remain

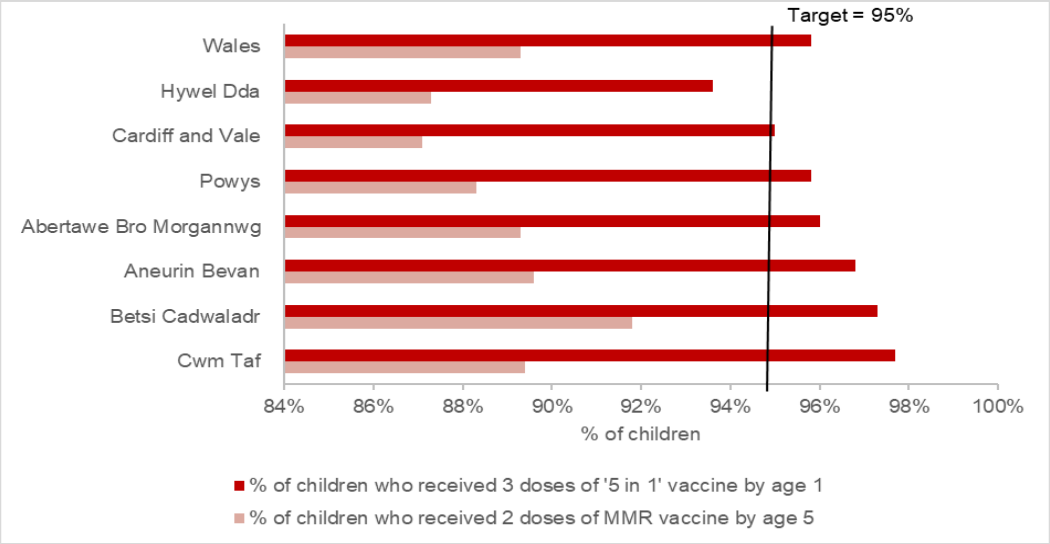
The Health Board's primary care performance is at or below the Welsh average on a number of key measures

115 In this section of the report we summarise the Health Board's performance against the Welsh Government's Outcome and Performance Measures, as described in the Health Board's monthly Integrated Performance Report.

116 Exhibit 10 [17] shows that the Health Board's childhood immunisation rate is around the Welsh average for one key vaccine and slightly above for another. While the Health Board has exceeded the target for '5 in 1' vaccines, it is under the target for the MMR vaccine, along with all other health boards.

[17] www.wales.nhs.uk/sites3/page.cfm?orgid=457&pid=54124

Exhibit 10: childhood immunisation rates for the quarter January to March 2018



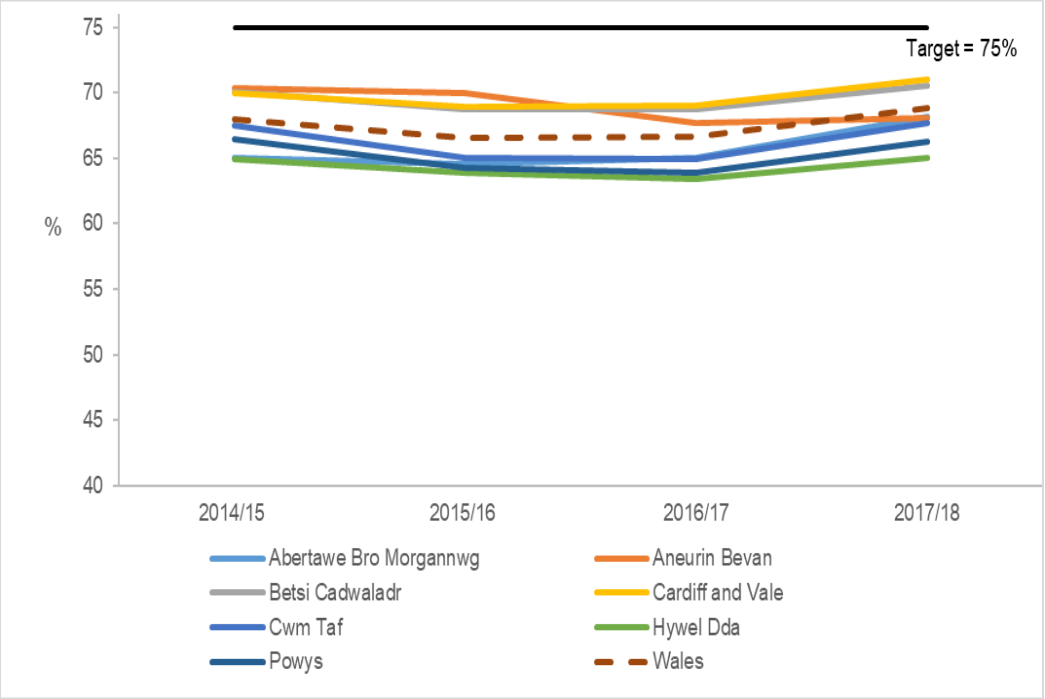
Note: '5 in 1' vaccine protects against diphtheria, tetanus, pertussis (whooping cough), polio and hib infection. MMR protects against measles, mumps and rubella infections. These results are for children living in the Health Board area in March 2018 and who reached their first and fifth birthdays during the quarter 1 January to 31 March 2018.

Source: Public Health Wales

117 For adults, flu vaccinations are recommended for people aged 65 and over, as well as people with other risk factors such as asthma. The target for both groups is for 75% of those populations to receive the vaccination each year. Exhibit 11 shows that the rate of flu vaccinations at the Health Board for patients aged 65 and older (68.2%) is just below the all Wales position. The rate in September 2017 was 3% higher than in September 2014. However, it fell in the intervening period and has never met the target[18].

Exhibit 11: trends in uptake of flu vaccination 2014-15 to 2017-18: Uptake in patients aged 65 years and older

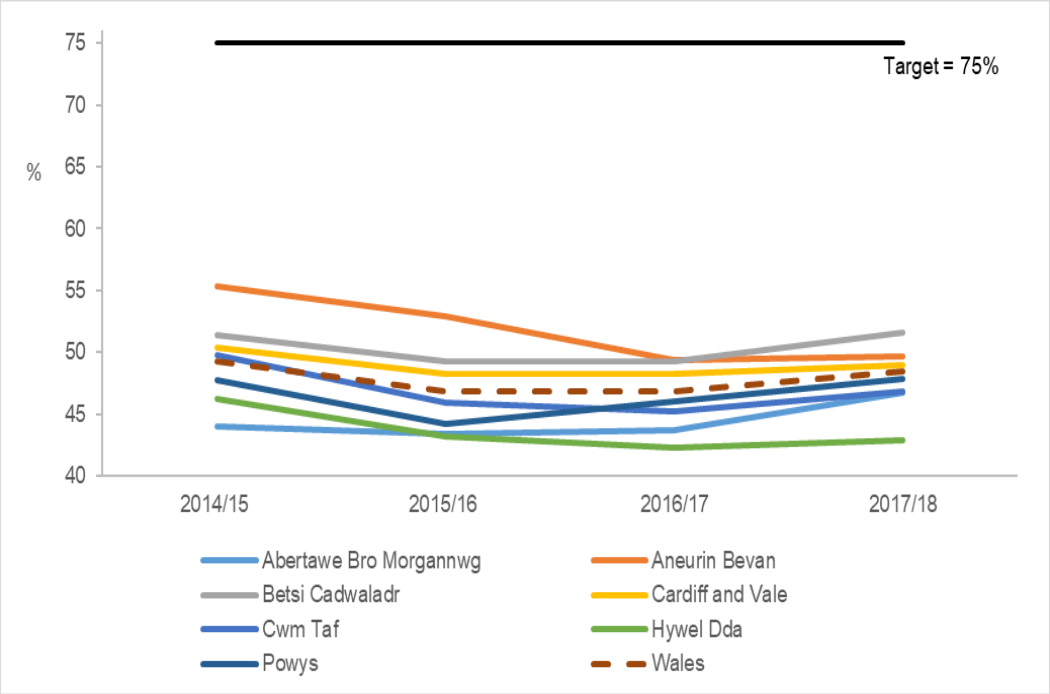
18 www2.nphs.wales.nhs.uk:8080/CommunitySurveillanceDocs.nsf/($All)/AC9851271F3475FD80258160004CF724/$File/Seasonal%20influenza%20in%20Wales%20201617_v1a.pdf



Source: Public Health Wales

118 Exhibit 12 shows that in September 2107 the rate of flu vaccinations for patients younger than 65 who are at risk was 46.7% which was below the all Wales position.

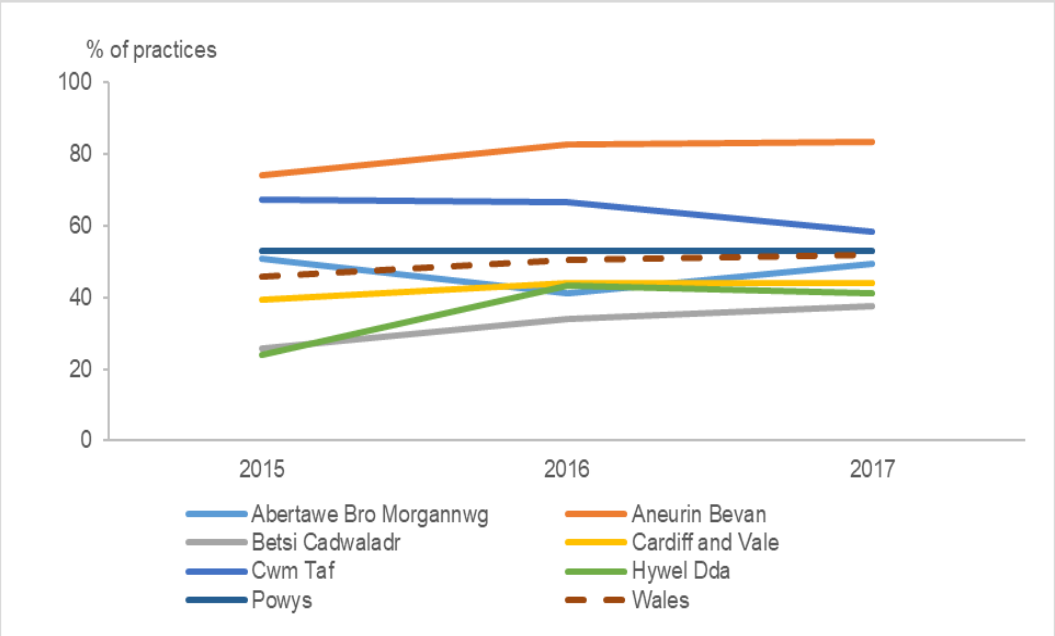
Exhibit 12: trends in uptake of flu vaccination 2014-15 to 2017-18: Uptake in patients younger than 65 who are at risk



Source: Public Health Wales

119 Exhibit 13 shows the percentage of GP practices that remained open all day[19] in 2017 was 49%. This is slightly below the all Wales average of 52%.

Exhibit 13: percentage of practices open for 100% or more of weekly total core hours, by Health Board, 2017



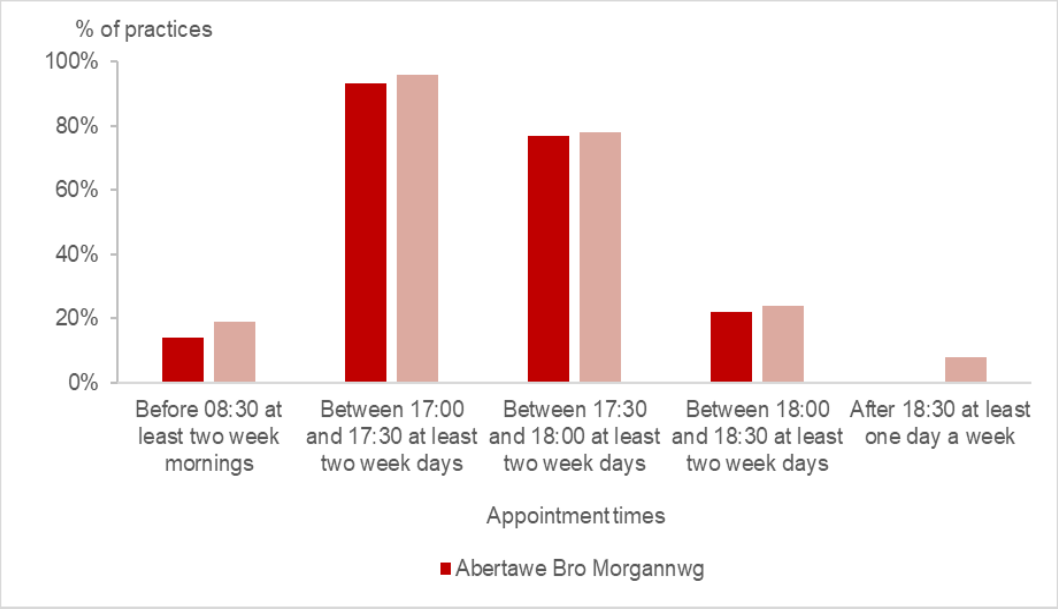
Note: Total weekly core hours equals 52 hours and 30 minutes.

Source: Welsh Government

[19] Definition: Practices open Monday to Friday from 08:00 to 18:30 each day, with no lunchtime closure (as set under the GMS contract).

120 Exhibit 14 shows that in relation to the provision of GP appointments at different times of the day, the Health Board performs below the Wales average in all respects.

Exhibit 14: percentage Health Board practices open for 100% or more of weekly total core hours, compared to the average for Wales, 2017

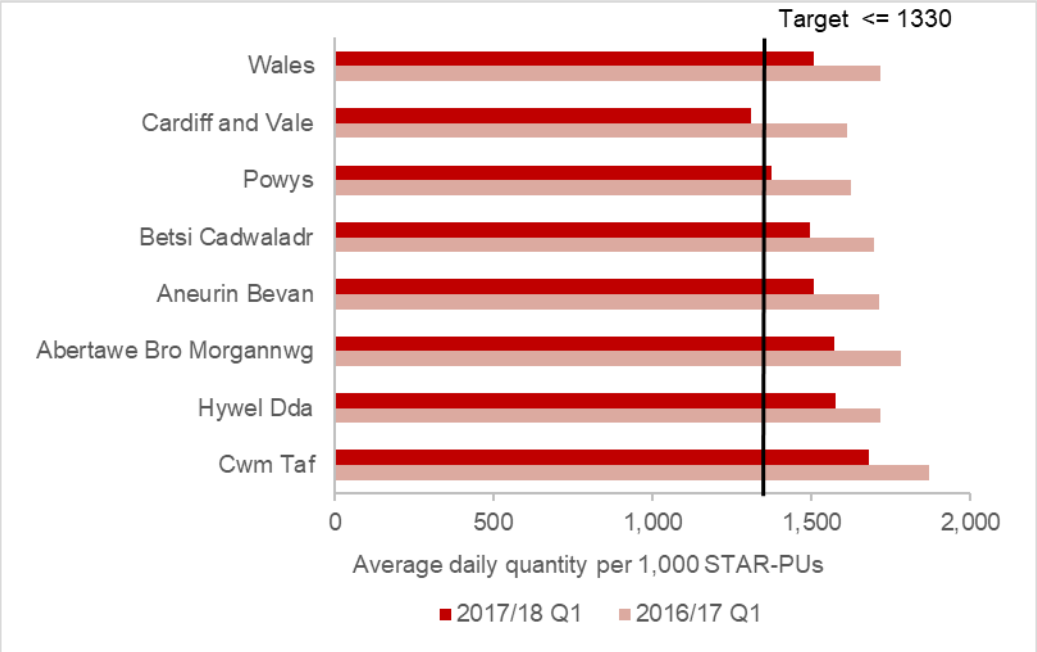


Source: Welsh Government

121 There is a target to reduce the use of painkillers like ibuprofen, known as non-steroidal anti-inflammatory drugs (NSAIDs) to reduce the risk of complications. Exhibit 15 shows the Health Board has reduced its prescribing in the previous 12 months by 12%. The Health Board's performance is below the Welsh average. The Health Board has not met the target yet, but it has fulfilled the objective of making year-on-year improvements.

Exhibit 15: prescribing levels of NSAIDs in primary care, first quarter 2016-17 and 2017-18.

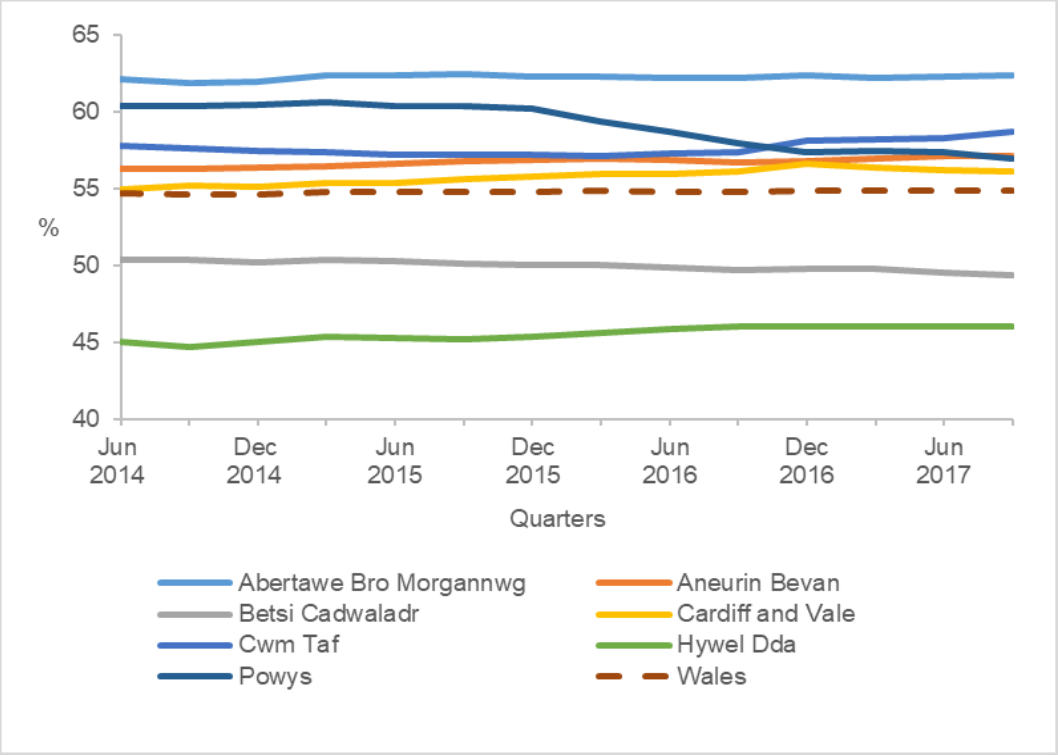
Prescribing levels in average daily quantity per 1,000 STAR-PUs (specific therapeutic group age-sex prescribing units).



Source: Welsh Analytical Prescribing Support Unit

122 Exhibit 16 shows the percentage of population regularly accessing NHS primary dental care in the previous 24 months, as at 30 September 2017. The target is for annual improvement, which the Health Board has not achieved. However, it does have the highest percentage of access in Wales (62.4%) which is well above the average (54.9%).

Exhibit 16: percentage of residents treated at an NHS dental practice in the previous 24 months



Target = annual improvement

Source: Dental activity forms, Welsh Government

The Health Board is making some progress in delivering its plans for primary and community care but needs to address some difficult challenges

123 We asked the Health Board what the main barriers were to transforming primary care. Exhibit 17 shows that there are concerns about a reduced supply of doctors and the difficulties in establishing new models of care to address the situation.

Exhibit 17: the Division's view on the main barriers to transforming primary care

Barriers	What needs to be done to remove the barriers
Lack of sufficient numbers of appropriately qualified or experienced people available locally/nationally to sustain existing models of service or – more importantly – to support the implementation of new service models	National as well as local multi-agency work with professional and general education planners and suppliers to design programmes through which appropriate staff can be identified and trained.
The challenges of introducing new models of care in the community, whilst sustaining the services they will ultimately replace. In turn it is difficult to transfer resources to primary care to follow the transfer of services, which relates to complexity of managing system changes	Introduction of Contract and Pathway Development Group plus ongoing action to tackle the issues which have resulted in the Health Board's current status
Limited capacity to pump-prime development of new or alternative services in primary care, and mainstream	Introduction of Contract and Pathway Development Group, and especially clear clinical pathways across the unit structures.
Timing issues between release of policy instructions (e.g. Directed Enhanced Services) and announcements on availability of associated funds to implement them	Longer term planning and associated finance cycles

Source: Wales Audit Office, Health Board self-assessment returns.

124 We sought views from the cluster leads on the successes of clusters/networks and main challenges facing primary care in their area. Exhibit 18 shows that among the successes is the development of a number of cluster-based services.

Exhibit 18: cluster lead survey: successes

Successes
Provision of cluster based services including cognitive behavioural therapy; open access physiotherapy; pre-diabetes screening; cluster based children and young people/ adolescent counselling services; and open access podiatry.
Development of the community pharmacist role.
Enhancing the uptake of immunisation and screening
The challenge arising from regular cluster meetings in relation to cluster activities.
Mergers of neighbouring practices.
Implementation of a new wound care system and negotiation of GP remuneration for the service.
The formation of the first Federation of GPs in Wales – Pen y Bont Health Limited.

Source: Wales Audit Office survey of cluster leads, April 2018

125 In the Health Board, cluster leads raised a number of challenges, as shown in Exhibit 19.

Exhibit 19: cluster lead survey: challenges

Challenges

Increasing workload pressures challenging the sustainability of primary care:

- a shift in secondary care services to primary care without corresponding transfer of resources;
- aging population leading to increased demand on primary care services, and increasingly complex individual health care needs;
- primary care serving as a dumping ground for external agencies; and
- practice pressures and soaring indemnity costs having a negative impact on staff health and morale, leading to more early retirements and making it more difficult to recruit new staff.

Lack of senior leadership and representation for primary care at the highest levels of the Health Board:

- primary care issues not promoted at key Health Board committees and the Board;
- cluster Network Leads have little influence within the Health Board; and
- a lack of funding to mainstream fully evaluated pilot projects means that there is slow progress in establishing the Primary Care Model for Wales.

Individuals need to take greater responsibility to manage their own health more effectively in order to achieve better long term health outcomes and to reduce pressure on the system.

Source: Wales Audit Office survey of cluster leads, April 2018

Appendix 1

Methods

Method	Detail
Health Board self-assessment	The self-assessment was the main source of corporate-level data that we requested from the Health Board in February 2018. This tool also incorporated a document request.
Survey of cluster leads	We sent an online survey to all cluster leads in Wales in April 2018. The overall response rate was 63% (45/67). The response rate for the Health Board was 67% of cluster leads.
Interviews	We interviewed a number of staff including the following with responsibility for primary care: • Vice Chair • Executive Director responsible for primary care • Head of Primary Care • Medical Director • Assistant Medical Director • Director of Finance • Director of Workforce • Director for Planning and Performance • Operational Managers • Local Community Health Council representative
Review of the Health Board's Integrated Medium Term Plan	We reviewed the Health Board's medium term plan to assess the extent to which primary care is considered.
Use of existing data	We used existing sources of data wherever possible such as Welsh Government and Public Health Wales statistics.

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