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Primary Care Services – **Powys Teaching Health Board**

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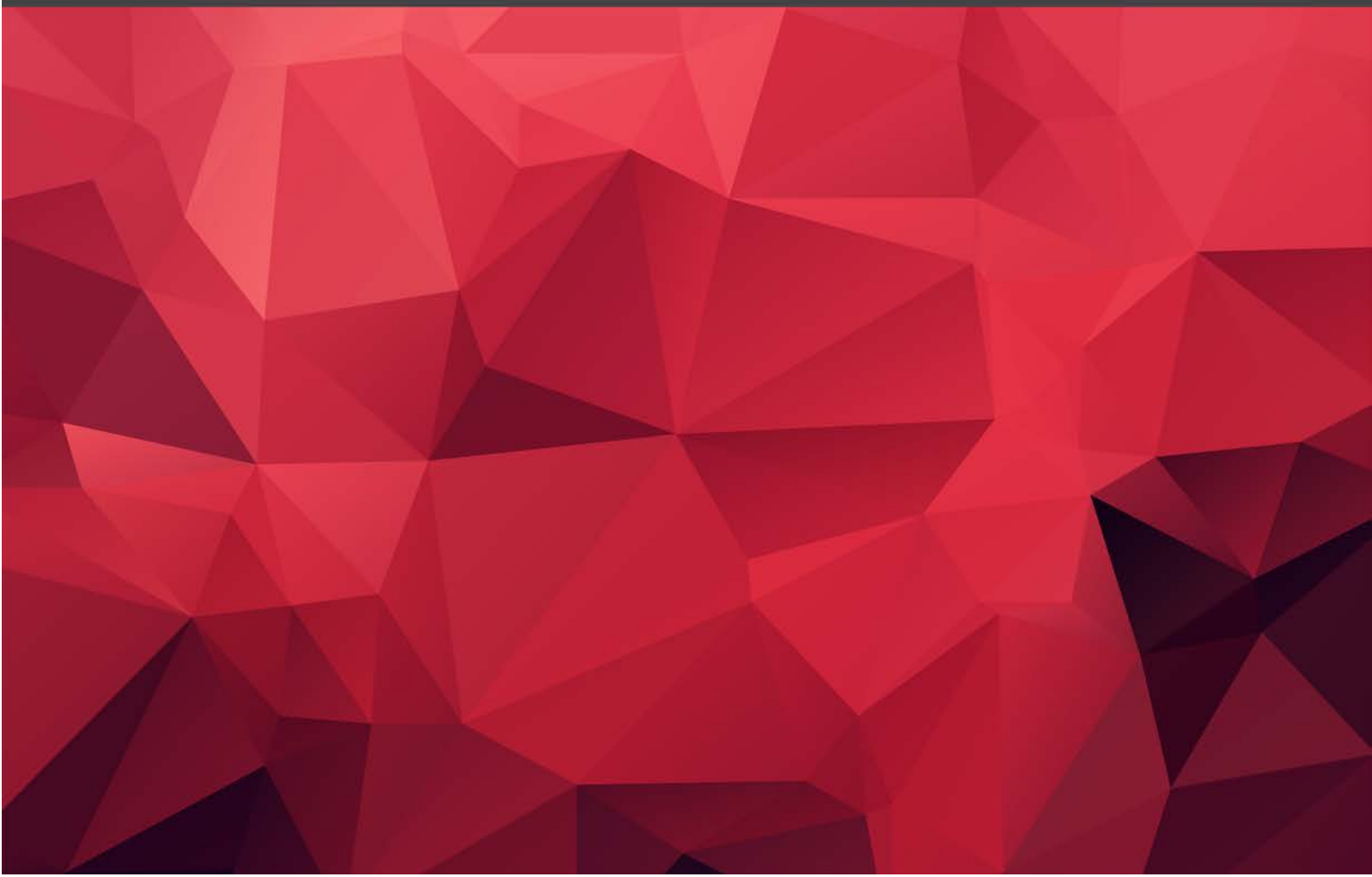


The person who delivered the work was Philip Jones.

Contents

The Health Board has clear plans for primary care and is making steady progress with implementing the key elements of the national vision. However, performance is mixed, and there is a lack of clarity about the Health Board's overall investment in primary care.

Summary report

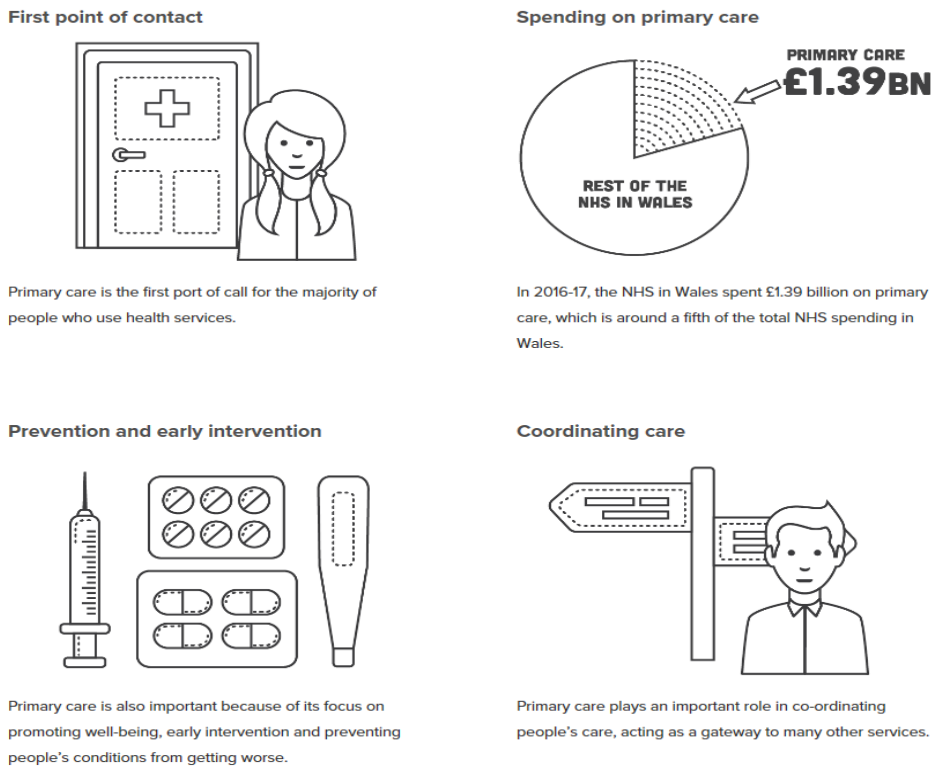
Background

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 £1.39 billion figure from the NHS accounts does not represent the totality of primary care expenditure.

[1] Welsh Government, Our plan for a primary care service for Wales up to March 2018, 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 After initially developing primary care clusters, Powys Teaching Health Board made an explicit distinction between three primary care clusters, as planners of health and wellbeing services, and three GP networks, as providers of solutions to identified planning challenges. This aimed to provide greater separation of duties and to reduce the potential for conflicts of interest and governance problems.

8 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].

[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] www.primarycareone.wales.nhs.uk/pacesetters

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

10 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.

11 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.

12 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**.

13 This report summarises the findings of work in Powys Teaching 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?

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

[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.

- **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?

Key findings

14 Our overall conclusion is that **the Health Board has clear plans for primary care and is making steady progress with implementing the key elements of the national vision. However, performance is mixed, and there is a lack of clarity about the Health Board's overall investment in primary care**. 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 Health Board has a clear primary care planning framework and is strengthening its engagement and support arrangements with primary care clusters and GP networks • The Health Board's primary care plan aligns with the key aspects of the national plan and arrangements are in place to engage with stakeholders. • All clusters and networks have plans that feed into the primary care plan and the Health Board is strengthening engagement and its support for them
Investment: The Health Board effectively monitors cluster spending although it is not able to quantify the amount of resource it has redirected to primary care and the available data make it difficult to accurately calculate overall primary care investment • The available data make it difficult to accurately calculate overall primary care investment. • The Health Board does not have targets for shifting resources towards primary care and has been unable to quantify how much resource has been moved. • The Primary Care Department monitors cluster and GP network spending but a major concern is the sustainability of funding for new models of service provision. • The Health Board is working with its partners to develop an integrated investment strategy for the primary care estate, although it is not clearly investing in ICT developments.
Workforce: The Health Board has regular contact with practices to monitor sustainability, however, gaps in data hinder workforce planning and there are barriers to the further development of multi-disciplinary teams • The Health Board recognises that gaps in staffing data are hindering its efforts to plan the workforce it needs in future. • The Health Board has regular contact with practices to monitor their sustainability and currently has no managed practices. • The Health Board has taken important steps to implement multi-professional teams but barriers to further progress include a lack of trained staff and a lack of capacity to manage these staff.

Our main findings
Oversight: There is scope to increase the focus on primary care in performance monitoring and Board business • Leaders are committed to transforming primary care but oversight has recently focused on out-of-hours services rather than wider primary care and cluster development. • There is a limited focus on primary care within the Health Board's performance dashboard and within the business of the Board in general. • GPs lead most of the clusters and networks and there is mixed evidence about the support provided to clusters by the Health Board.
Performance: The Health Board is making steady progress in delivering its plans but primary care performance is mixed and several difficult challenges remain • The Health Board's primary care performance is mixed when compared with the Wales average. • The Health Board is reporting steady progress in delivering its plans for primary and community care but it recognises that a number of difficult challenges remain.

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
Primary care clusters R1 We found variation in the maturity of primary care clusters, and scope to improve cluster leadership and support. 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. b. Ensure all cluster leads attend the Confident Primary Care Leaders course.
Investment in primary care R2 While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should: a. Calculate a baseline position for its current investment and resource use in primary and community care. b. Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.

Recommendations
Oversight of primary care R3 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. R4 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. Review the contents of its Board and committee performance reports to ensure sufficient attention is paid to primary care. b. Increase the frequency with which Board and committees receive performance reports regarding primary care. c. Ensure that reports to the 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 R5 The Health Board's workforce planning is inhibited by having limited data about the number and skills of staff working in primary care. The Health Board should therefore develop and implement an action plan for ensuring it has regular, comprehensive, standardised information on the number and skills of staff, from all professions working in all primary care settings.

Detailed report

Strategic planning: The Health Board has a clear primary care planning framework and is strengthening its engagement and support arrangements with primary care clusters and GP networks

The Health Board's primary care plan aligns with the key aspects of the national plan and arrangements are in place to engage with stakeholders

The Health Board has a primary care plan as part of a wider vision for health and social care and is establishing a Primary Care Programme to lead further improvement of these services

16 The Health Board differs from the other health boards in that it is predominantly a commissioner, buying services from a range of providers, including primary care contractors, care homes, ambulance services, and hospitals. The Health Board directly provides other services including a network of community hospitals, a health and social care centre, community services such as district nursing, midwifery and health visiting, therapies, mental health and services for people with a learning disability.

17 Increasingly, services in Powys are jointly provided by the Health Board and Powys County Council. The One Powys Plan paved the way for joint planning between the key stakeholder bodies in the Powys Local Services Board. Subsequently, Powys became the first county in Wales to develop an integrated long-term (ten-year) health and social care plan to set out a vision and strategy for the future of services up to 2027. These plans are translated into short to medium-term plans such as the Integrated Medium Term Plan (IMTP).

18 The 2015-16 IMTP set out 12 strategic objectives which impact on primary care. The most specific was 'Strategic Objective 3 – Increase the capacity and resilience of primary and community care to promote self-care and support care closer to home'. It set out a vision for the development of core primary care services through independent contractor arrangements, which covered general practice but also greater integration between primary and secondary care.

19 The 2018-19 IMTP includes an updated and more mature vision for primary care services. It includes updated priorities for general medical service provision, general dental service provision, eye care and medicines management. The IMTP also describes the Health Board's planning approach as a three-fold process, including development of primary care cluster plans 'bottom up' by individual primary care clusters; directorate plans and crosscutting, organisation-wide plans.

The Health Board's directorate plans, which sit beneath the IMTP, are intended to ensure that detailed milestones and measures are in place in order to monitor performance against plans and achievement of national and local measures.

20 A summary plan for primary care for 2018-19 onwards is included as an appendix in the current IMTP. It sets out a series of priorities shaped by national and local drivers. They include the continuation of the development of individualised care, promotion of healthy living, de-medicalisation of wellbeing, and exploration of the use of Community Connectors[9] as part of the Community Resource Team to improve access to resources through social prescribing. The introduction of clinical triage is helping to ensure timely access and is a key action within the summary plan. Community Resource Teams are being enhanced to help improve preventative, proactive and co-ordinated care.

21 The summary plan also refers to the development of a Primary Care Cluster Development Framework to ensure that health and wellbeing goals are identified and met across all communities. The Framework will require agreement between the Health Board and the clusters on population segmentation; desired Health and Wellbeing outcomes for each segment; and the development of Health and Wellbeing Plans for each Primary Care Cluster.

22 In order to help deliver this objective the Health Board has made an explicit distinction between:

- three primary care clusters, in line with national policy and as planners of health and wellbeing services; and
- three GP networks, as providers of solutions to identified planning challenges.

23 The aim is to provide greater separation of duties and to reduce the potential for conflicts of interest and governance problems.

The Health Board's primary care plans align 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. While the national plan for primary care is not explicitly referenced in the Health Board's 2018-19 IMTP, there are references to the pathfinders and pacesetters, as well as references to a transformational

[9] The Community Connector Service helps people in Powys (aged 18+) and their families or carers, to access community-level services and activities that will help them maintain independent lives and which help prevent their circumstances deteriorating to a point where they might need higher level health or social care services. The service can also help support people when they return to home from hospital by helping other Third Sector services, such as the Red Cross, identify additional local services that may be needed.

approach in commissioning. There is mention of an emerging model although not explicitly in relation to the Primary Care Model for Wales.

25 A number of areas in the Health Board's IMTP highlight particular strengths:

- informing planning through population needs assessments, and the intention to carry out local needs assessments for particular conditions, to map existing work and identify gaps eg for cancer, diabetes, and mental health;
- acknowledgement of the need to strengthen communication and engagement, and to increase the use of co-production with other agencies and the public for specific issues e.g. mental health, and substance misuse;
- recognition of the place of 111 in the overall model of care for Powys and a plan to roll out a Powys-wide 111 Pathfinder with WAST in 2018-19;
- the plan refers to a number of existing strategies which have at least some relevance to primary and community care;
- the need to develop and build on existing social prescribing initiatives; and
- references to improving signposting of patients to services.

26 Other areas of the Health Board's plans for primary care need further development:

- a lack of clarity as to how the Health Board is spending its allocation from the Welsh Government's Primary Care Development Fund; and
- a lack of clarity as to how improvements in primary care will be measured and reported, including tracking the shift in resources from secondary to primary care.

27 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 joint Planned Care and Unscheduled Care Improvement Plans with Powys County Council. They are based on keeping people living healthily and independently at home for as long as possible, and if they need acute care, to get them back home as quickly as safety allows. The Health Board also operates two theatre suites in Community Hospitals that focus on day case surgery, and an outpatient service. All are focussed on providing care closer to home. As part of the plan, the Health Board will establish steering groups for ophthalmology, orthopaedics, ENT, and urology. Each one will include primary, community, and secondary care practitioners, as well as patients and service users.

28 The Health Board's summary primary care action plan identifies several ways in which it wants to shift care into the community, including:

- revision of care pathways to ensure that more care can be provided closer to home, including identifying the top five shared care opportunities;
- development of local diagnostic and assessment services to ensure that more care can be provided locally;

- development of Powys-based Maxilo Facial and Restorative Dentistry Services to improve access to services and provide more care closer to home;
- revision of the glaucoma pathway to improve access to services and provide more care closer to home; and
- continued deployment of primary-care-based Wet AMD to improve access to services and provide more care closer to home services.

29 It has also developed an Invest in Your Health Programme and provides support for community-based Homecare services. There is increased use of step up facilities in Community Hospitals and the Health Board has split GP Networks and Primary Care Cluster roles. There is increased use of Enhanced Service agreements to support local service provision.

The Health Board can provide examples of engagement with stakeholders in developing its plans

30 It is important for health boards to collaborate with stakeholders in developing their plans. The Health Board's Primary Community and Mental Health Directorate and its corporate directorates for strategy and governance were fully involved in the long-term planning for health and social care in the county, which resulted in the One Powys Plan (see paragraph 17).

31 The Health Board engages and collaborates with key local stakeholders through a joint management group, 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. The Health Board engaged with Powys Council to set up the planning framework that led to the publication of the Health and Care Strategy for Powys, produced by the joint Health and Care Strategy Programme Team. The strategy was based on engagement with over 1,000 members of the public, staff and other stakeholders. The first stage of the process included 21 mini workshops, a health and care staff event and a public, staff and stakeholder visioning event. A draft strategy was produced and taken through a second stage of engagement events and social media activity in order to revise the strategy ready for its approval and launch.

32 There is a formal Joint Partnership Board which is currently progressing the North Powys Regional Rural Centre. It is distinct from the Regional Partnership Board and the Partnership Services Board. The intention is that this board will become a key body in relation to joint planning, although it is likely to become part of the Regional Partnership Board in future.

33 The Health Board provides the Community Health Council (CHC) with regular informal updates, as well as more formal updates given at council meetings. While primary care is high on the CHC's agenda, it was not formally involved in the development of the Health Board's primary care plans. There are very good working relationships between the CHC and senior Health Board staff. Priorities

may have shifted in recent months because of the significant risks arising out from problems with GP out-of-hours arrangements and with the advent of some interim roles. As a result, the CHC has had less focus on primary care other than out-of-hours services.

34 The Local Medical Committee (LMC) representative is consulted on Health Board plans including IMTP planning processes. However, the LMC has difficulty providing representatives to attend meetings because of general practice commitments and the distance to be travelled. The LMC representative said the Health Board is more focused on primary care than some other health boards, due to it having no district general hospitals. He regarded their approach to sustainability funding as being proactive and helpful.

All clusters and networks have plans that feed into the primary care plan and the Health Board is strengthening its engagement and support for them

35 As mentioned above (see paragraph 22), the Health Board has three Primary Care Clusters which focus on planning activities for primary care services in each area. The three GP Networks focus on the practicalities of delivering the GMS contract and other primary care services through local practices. The Health Board made this change because it wanted to:

- engage front line clinical teams in capturing patient experience in order to feed that into the commissioning assurance process;
- maximise the potential to improve systems of care and target activities to improve public health outcomes; and
- develop comprehensive needs assessments at local population levels.

36 Each cluster has a Cluster Board chaired by a primary care clinician, who is the Cluster Lead. The Chief Executive, Assistant Director of Primary Care and the Head of Primary Care are engaging with cluster leads and they have access to a range of support functions. The Cluster Board brings together a range of community representatives and local service providers to plan services for their local population. This aims to move the focus from health care service delivery, to one geared around individual and population health.

37 Clusters, acting in a planning advisory function, use a combination of formal health needs assessments, service performance assessments, budgetary information and local knowledge to produce an annually updated cluster plan, which is agreed with the Directorate of Primary, Community and Mental Health Services Board. The Health Board recognises that this will require further strengthening of the collaborative relationship between all partners and stakeholders to allow Health Board and locality priorities to be properly addressed.

38 The clusters are supported by the South and North Locality Management Teams to help them plan, develop, implement and monitor cluster initiatives. The intention is

that these plans will form the basis of the Directorate's contribution to the Health Board's three-year IMTP.

39 The GP Networks act as a support mechanism for the development of stronger inter-practice working and collaboration and as a mechanism for trialling new ways of working to support increased sustainability. Their aim is to develop a role as a Primary Care Support Network, facilitating a collaborative approach to GP practice sustainability and delivery issues, and facilitating increased working between practices with the sharing of resources where appropriate. They also have a role in strengthening business continuity planning and emergency response arrangements to contribute to local emergency action plans.

40 The networks produce a three-year business plan setting out any services that they plan to develop in response to the needs identified by individual Primary Care Clusters in their cluster plans. These business plans also set out proposals for new models of working that require pump priming funding, via the Primary Care Development Fund. The networks also contribute to the work of the clusters through the Network Lead.

41 GP Networks sit outside of the formal management structure of the Primary. Community and Mental Health Services Directorate but help to inform clusters and are supported by the Assistant Director and Head of Primary Care.

42 We looked at the way that the Health Board provides support to clusters and networks in developing local needs assessments and cluster plans. We found that all have formulated plans and identified priorities for action, which aim to align with the IMTP. However, our cluster/network lead survey found that there were mixed views about whether effective support is provided to clusters by the Health Board. For example, they told us they had not had sufficient support to develop population needs assessments. And we heard that the Health Board's support tends to focus on the production and alignment of plans and process issues, rather than supporting clusters to implement change.

43 An internal audit report in May 2018 focussed on the Health Board's engagement with primary care providers. IT reported consistent feedback from cluster leads that meaningful engagement with primary care had fallen to a low level over the previous 18 months. The report pointed to a need to increase connections to the primary care clusters. Further, the report said that clusters needed more assistance to mature their own plans and to ensure the link across to the Health Board's plans, such as the IMTP. They found that cluster maturity varies and recommended focused developmental work with facilitated meetings between cluster leads. The Chief Executive put in place a series of actions to ensure that various aspects of the situation could be addressed quickly, and which were being implemented at the time of this review.

44 Exhibit 4 sets out our findings from our survey of cluster leads, further suggesting that clusters in Powys are at different stages of maturity.

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[10]	**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.

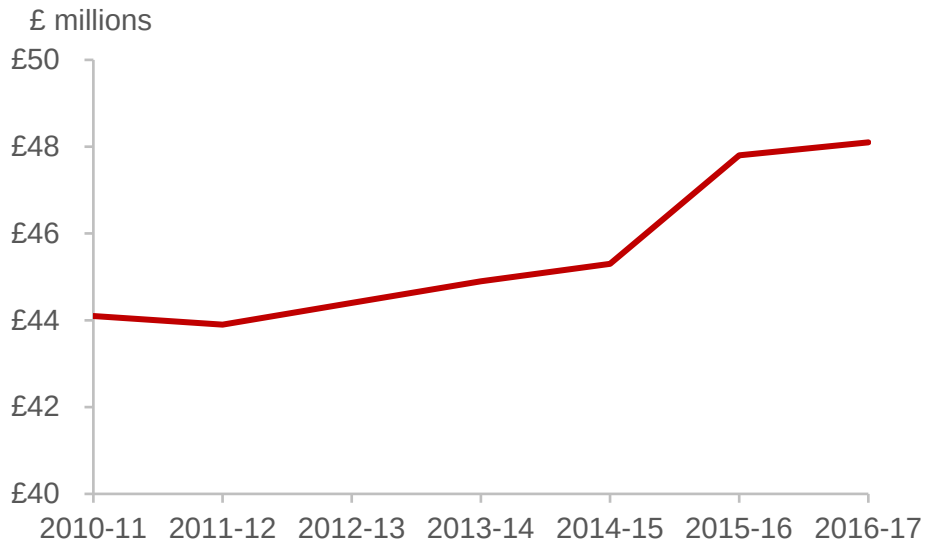
[10] Responses received from two Primary Care Cluster leads and one GP Network lead.

Investment: The Health Board effectively monitors cluster spending although it is not able to quantify the amount of resource it has redirected to primary care and the available data make it difficult to accurately calculate overall primary care investment

The accounts suggest a real-term decrease in investment in primary care but the format of the accounts makes it difficult to say with any certainty

45 The Welsh Government allocates money to health boards in a range of primary care categories. Exhibit 5 is based on data from the Health Board's annual accounts and sets out the Health Board's long-term, overall 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[11].

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



Source: LHBs' Annual Accounts

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

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

46 Exhibit 5 shows that the Health Board spent £46.1 million on primary care services, excluding prescribed drugs and appliances in 2016-17. The trend shows broadly consistent spending from 2010-11 to 2014-15, followed by a small increase until 2016-17. However, after accounting for the effect of inflation, the Health Board's spending on primary care services decreased in real terms by 0.5% between 2010-11 and 2016-17. 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.

47 We compared the Health Board's allocated primary care funding from the Welsh Government with its actual primary care spending (2010-11 to 2016-17). In 2016-17, the Health Board spent £2.6 million (8.5%) more than its allocation on general medical services; £2.4 million less (50%) on its pharmaceutical services; and £0.3 million (3.4%) less on general dental services. The Health Board explained that it has invested additional resources in Community Resource Teams, and Virtual Wards in North Powys, to reduce avoidable demand on the more acute elements of the system. It said that success of this approach is evident in its unscheduled care metrics which show lower rates than other health boards for emergency admissions, A&E attendances, Welsh Ambulance Services NHS Trust transports, admissions included in the 'Basket of 8'[12] measures, emergency average length of stay, and so on.

48 In addition to the primary care funding allocation described in paragraph 47, in 2016-17, the Health Board received £1.874 million from the Welsh Government through the Primary Care Development Fund. The Health Board gave £453,000 of this funding to clusters. It allocated the remainder to IMTP and Workforce development (£1.16 million), Pathfinders (£172,000), Wet AMD services (£79,000), and Occupational Health for GPs (£10,000).

49 The Health Board invested in a number of initiatives using finance from primary care funding and pathfinder funding, such as:

- provision of a multi-disciplinary, one-stop-shop, Wet AMD service based in Brecon Hospital, serving the greater part of the Mid and South Powys population;
- investing in a Your Health Programme to promote self-management of long-term conditions;

[12] A basket of eight measures used in relation to the following chronic conditions, ie Alzheimer's, Atrial Fibrillation, Cardiovascular Disease, Stroke, Diabetes, Musculoskeletal, Neurological and COPD.

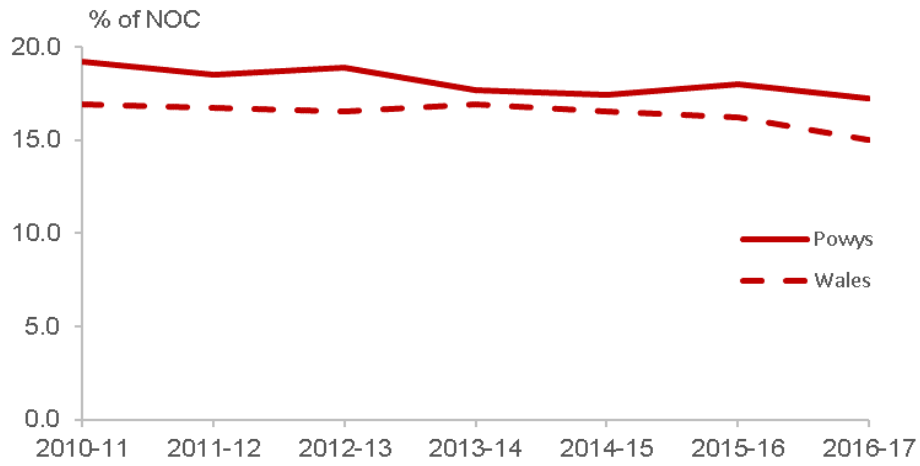
- roll out of Community Resource Teams and Virtual Wards in North Powys, which, amongst other things, represents a systemic change in the management of unscheduled care pathways between primary and secondary care in Powys; and
- a GP social-enterprise-led in-hours call-handling service and the Red Kite nurse triage project across the South Powys cluster.

The Health Board does not have targets for shifting resources towards primary care and has been unable to quantify how much resource has been moved

50 For many years, the NHS in Wales has planned to shift resources towards primary care, to reverse the 'relative under-development of primary care'[13]. However, issues with the format of NHS accounts (see paragraph 46) make it difficult to say whether health boards have secured such shifts.

51 Exhibit 6 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, despite above average primary care expenditure as a percentage of total expenditure when compared to the Wales average, there has been an overall decline in this figure over the period shown.

Exhibit 6: the Health Board's expenditure on primary care as a percentage of its total expenditure (Net Operating Cost, 2010-11 to 2016-17)



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

Source: LHBs' Annual Accounts.

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

52 We asked whether the health boards are taking specific actions to achieve a shift in resources towards primary care. We found that none of the health boards have set targets for moving resources towards primary care.

53 We also asked health boards if they have quantified the total amount of resource moved towards primary care since the inception of the national primary care plan in 2014. We found that none of the health boards has made that calculation. The Health Board was not able to provide any recent evidence of the extent of to which secondary care activity has shifted into the community as a result of planning and service developments.

The Primary Care Department monitors cluster and GP network spending but a major concern is the sustainability of funding for new models of service provision

54 The national primary care plan talks about clusters being a way of achieving local autonomy for leadership, collaboration and innovation. Health boards need to strike the right balance of giving autonomy to clusters whilst at the same time overseeing their spending. GP network expenditure is monitored by the Primary Care Department, which is part of the Directorate of Primary Community and Mental Health. All cluster funding is released to the clusters for expenditure against local priorities and is also monitored by the Primary Care Department.

55 In our survey of cluster/network leads, we asked them to respond to statements that their cluster was able to spend all of the funding it received; that it was able to spend the funding it received quickly once it has had decided on its priorities; that it had financial autonomy; and that the Health Board had monitored cluster spending effectively. In each instance, two out of three respondents agreed or strongly agreed with the statement.

56 In our survey of cluster/network leads, we heard that sustainable funding issues are always at the forefront of cluster discussions. There are concerns that practices are benefitting from new models of working and incorporating them into their daily work, but with the risk that they may cease due to no agreement of ongoing funding.

57 The Mid-Powys cluster has developed a small pharmacist team in Llanidloes to carry out medication reviews, care home reviews, and implementing medication optimisation and discharge reconciliation. Savings have been identified and activity is being logged and analysed for evaluative purposes. However, there is a small team and they indicated that they are unable to expand as they have not been able to find funding following the pilot.

The Health Board is working with its partners to develop an integrated investment strategy for the primary care estate, although it is not clearly investing in ICT developments

58 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. The 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.

59 The Health Board intends to develop, along with its local partners, a long-term estates strategy during 2018-19, to build on the ten-year Health and Care Strategy published in March 2018. It wants to ensure the best use of the current built environment and to take opportunities to deliver modern fit for purpose facilities across the public sector in Powys. They will consider the broader provision of public sector services and the future ambition for the people of Powys. The intention is to take this a stage further to consider rural regional centres providing integrated primary, secondary and social care facilities. Funding implications and options for doing so will be explored with partners and the Welsh Government during 2018-19. This could include the proposal to develop a pathfinder Rural Regional Centre in Newtown and a Community Well-being Hub in East Radnorshire.

60 The bullet points below summarise some recent primary care estates developments in the health board area:

- full business case approval was received from the Welsh Government in October 2017 for new development at Llandrindod Wells Community Hospital. Work is underway on site to develop and reconfigure clinical services to enable patients to be treated closer to home.
- scheme development and scoping is underway to enhance the clinical service environment at Ystradgynlais Community Hospital. The scheme will facilitate the development of an urgent care environment in collaboration with local GPs, who currently provide the service from unsuitable accommodation in GP practices.
- the Health Board made an improvement grant application in January 2017 to improve facilities at Newtown Medical Practice. The proposal was based on the need to improve the practice's ability to develop for the future and to provide a wider range of services on-site. Other benefits envisaged included improved succession planning for healthcare professionals in the area, as new recruits will potentially be attracted to work in the practice.

61 In 2017, the Welsh Government announced support for the development of health and wellbeing centres with a capital value of around £68 million. This is a key commitment in Taking Wales Forward. Health boards are looking to work with a

range of delivery partners, including local authorities, housing associations and the third sector, to bring together a range of public services into community hubs. Two schemes were included in this initiative for Powys:

- the Health Board submitted an outline business case in November 2017 to develop a project at Machynlleth Community Hospital to enable integrated primary care, secondary care, social care and third sector services on the hospital site. The work will also include the provision of a new palliative care suite.
- a new Llanfair Caereinion Primary Care Centre will replace the existing GP Practice and provide health and care services by 2020-21.

62 The national primary care plan stresses the importance of effective, integrated ICT systems to support better use of information by the public and primary care professionals. The NHS Wales Informatics Service leads on most ICT developments related to primary care. The Health Board and Powys County Council were the first support the roll out of the Welsh Community Care Information System (WCCIS) across health and social care and further work is planned to maximise its potential. However, the Health Board was unable to provide further evidence of what it was doing to ensure that primary care ICT systems are fit for purpose, apart from supporting practices to maintain their systems.

Workforce: The Health Board has regular contact with practices to monitor sustainability, however, gaps in data hinder workforce planning and there are barriers to the further development of multi-disciplinary teams

The Health Board recognises that gaps in staffing data are hindering its efforts to plan the workforce it needs in future

63 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'.

64 The Health Board's revised Primary Care Workforce Plan (April 2017) describes actions to secure, manage and support a sustainable primary care workforce shaped by local population needs and by prudent healthcare principles. In order to achieve the priorities set out in the plan for a primary care service for Powys the Health Board recognises the need for a planned whole system approach.

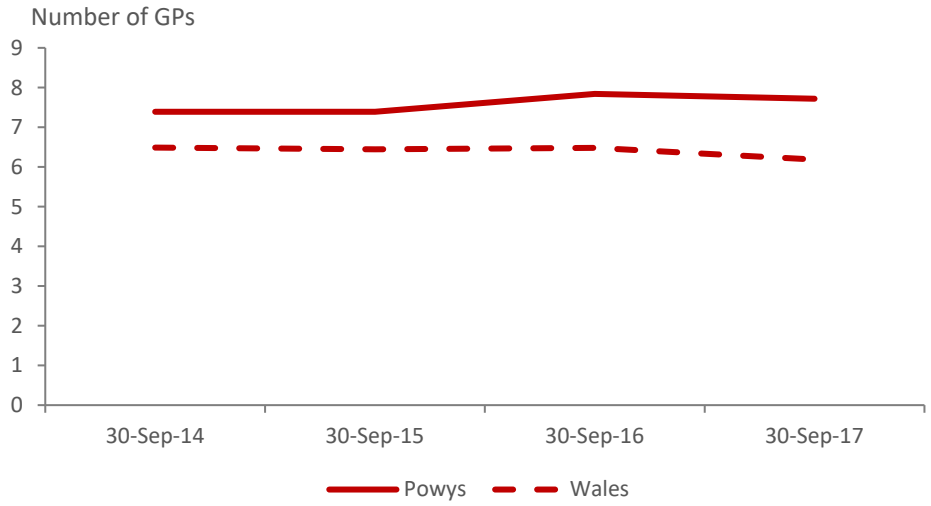
65 The workforce plan builds on actions and themes identified as part of a Medical Workforce Strategy workshop held in July 2014 and incorporates the five priority areas for action from the All Wales Primary Care Workforce Plan.

66 However, the workforce plan acknowledges that there are gaps in data and knowledge of the existing workforce. The action plan associated with the workforce plan sets out the need to establish a baseline by mapping the numbers and mix of skills of the current primary care workforce, by cluster and by practice. It identifies the need for the Primary Care Department to establish a working relationship with practice managers in order to achieve this.

67 The Health Board was not able to provide us with any clear analysis of data in relation to general practice staff and had no data on workforce numbers and skill mix in community pharmacy, dentistry and optometry. It acknowledges the need for further clarity about these services if it is to understand the type of workforce required in the long term.

68 The Health Board has a higher number of GPs per 10,000 population (7.72) than average in Wales (6.19) (Exhibit 7). However, the number of GP partnerships has remained constant at 17 between September 2014 and the time of our audit, and the percentage of partnerships with just one partner (5.88%) is around half the Wales average (11%).

Exhibit 7: number of GPs per 10,000 population



Source: Public Health Wales

69 Exhibit 8 shows that the proportion of GPs that are female in the Health Board is the same as the Wales average, while the proportion of GPs aged over 55 is slightly above the Wales average.

Exhibit 8: demographics of GPs by age and gender

	Powys Teaching Health Board	Wales
• Aged over 55	26%	23%
• Female	54%	54%

Source: Welsh Government, 30 September 2017.

70 The Health Board had 67 General Dental Services contractors in 2017, down from 77 in 2014. Optometrist numbers increased, from 30 in 2014 to 34 in 2017.

The Health Board has regular contact with practices to monitor their sustainability and currently has no managed practices

71 The Health Board 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.

72 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

Primary Care Department. The Health Board employs 12 staff at different grades to support GMS practices as well as dental and optometry primary care services. At present there are no managed practices.

73 The Primary Care Department has worked with Shropdoc[14] to examine the potential to develop GP consultation and remote clinical triage. Shropdoc also has a history of working with the Health Board to develop and provide in-hours services which effectively link their out-of-hours services. The Health Board is building on that relationship by discussing how Shropdoc can support its work to ensure local GP sustainability by helping to bring general practice resources and community teams together to deliver new models of care. At the time of our review the pace of this work was being affected by the well-known issues currently affecting the Shropdoc out-of-hours service.

74 The Health Board has used the GP sustainability framework issued by the Welsh Government[15]. Using the framework as a basis, the Primary Care Department developed a Sustainability Toolkit which all practices must complete each year. The Health Board is committed to using the toolkit to ensure practices remain viable and sustainable.

75 Each practice has a practice plan, which is assessed twice yearly. Any practices evaluated as being at high risk are offered targeted support directly by the Primary Care Department and through application to the Sustainability Panel[16]for additional resources. All practices receive regular visits from the Primary Care Department during the year and there is ongoing dialogue between them about what is required to help prevent sustainability risks from increasing.

[14] Shropdoc is an independent provider of GP out-of-hours services. It is contracted to provide most of the out-of-hours services in Powys.

[15] Grant Duncan, Welsh Government, Revised GP Sustainability Assessment Framework: 2017/18, 21 April 2017.

[16] The Sustainability Panel was set up in line with Welsh Government guidance regarding the roles and responsibilities of Local Assessment Panels, which include:

- considering all requests from GP practices for any support in accordance with an agreed evidence based assessment;
- considering and deciding on the case for any practice support within six weeks of receipt of a completed GP practice application for assessment; and
- notifying the practice on the decision for any practice support.

The Health Board has taken important steps to implement multi-professional teams but barriers to further progress include a lack of trained staff and a lack of capacity to manage these staff

76 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.

77 The Health Board has placed multi-disciplinary, multi-agency Community Resource Teams at the centre of its primary care provision, so that each GP Practice can provide a comprehensive and co-ordinated local response to individual health and wellbeing needs. Practice leads can use a range of diagnostic, treatment, and support options provided in community or local Community Hospital settings. This whole system approach involves primary care, acute care, the local authority and the third sector to work to together to address patient needs in a multi-disciplinary way. This in turn helps prevent referral and/or admission to more remote secondary care settings.

78 There have been several significant developments in respect of introducing a multi-disciplinary approach. For example, the Health Board has introduced the role of physician associate. Physician associates work under the direct supervision of a doctor and carry out many similar tasks, including patient examination, diagnosis and treatment. Eight physician associates have been recruited, and more are being recruited to the Health Board (six from the University of Birmingham and two from Swansea University). The Health Board is also in the early stages of a relationship with the University of Wolverhampton to attract some of their physician associate students to work in Powys. 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.[17]

79 The Newtown Practice has a Service Level Agreement for a Specialist Orthopaedic Practitioner for Musculoskeletal therapy. At the time of our fieldwork, the practice manager was due to present the benefits of the service to the North Powys Cluster to see if other practices were interested in using this service.

[17] http://www.gpone.wales.nhs.uk/opendoc/293958

80 In conjunction with Shropdoc, the Health Board has established an extended Urgent Care Practitioner[18] scheme across four practices in North Powys and one in Mid Powys. It also plans to increase training and development opportunities for practice nurses, health care assistants and practice managers. The Health Board plans to encourage student nurses to consider primary care as a career by creating placement opportunities in Powys.

81 As mentioned previously (see paragraph 28), the Health Board has a revised glaucoma pathway that uses primary care optometrists to manage out-of-hospital care, as well as continued deployment of primary care based wet age-related macular degeneration (AMD) services. This will improve access to services and provide more care closer to home services.

82 The IMTP refers to the increasing contribution of services provided by general dental services practices. For example, the deployment of a mobile dental clinic will improve access to services and provide more care closer to home.

83 The IMTP also foresees an increasing role for community pharmacy services. The Health Board is strengthening its Choose Pharmacy signposting initiative to ensure that more patients are directed to, or avail themselves of, services provided by community pharmacists.

84 An acute physiotherapy service is available two sessions a week in a practice in South Powys. The service discharges 48% of patients who accessed this service with advice. These patient contacts would otherwise have resulted in a GP consultation if the service had not been available.

85 Clinical triage in hours is being operated in most practices. The approach varies depending on practice resources and need. Some practices use their advance nurse practitioner staff, and some use unscheduled care practitioners to provide triage. Other practices use physician associates. In a small number of cases, GPs themselves carry it out. In the cases where a member of the practice team undertakes clinical triage, the duty doctor acts as the team lead, providing advice and co-ordination.

86 The Health Board has identified a lack of availability of suitably skilled staff in most of the groups mentioned above. However, not all practices have the same needs and may not require the same resources. Another complication with the multi-professional team model in Powys is that practices do not always have the leadership capacity or the competency to manage different staff groups or to ensure that their professional needs are met.

[18] Urgent Care Practitioners (or Emergency Care Practitioners) generally come from a background in paramedicine and most have additional academic qualifications. They have enhanced skills in medical assessment and extra clinical skills over and above those of a standard paramedic, qualified nurse or other ambulance crew such as technicians.

Oversight: There is scope to increase the focus on primary care in performance monitoring and Board business and the Health Board has recognised it needs to improve its support to clusters

Leaders are committed to transforming primary care but oversight has recently focused on out-of-hours services rather than wider primary care and cluster development

87 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 Vice Chair is very experienced and has a strong commitment to strengthening primary and community care. She chairs the Out of Hours Assurance Group, which is working with Shropdoc and other partners to help resolve well documented and urgent issues in relation to the out-of-hours service and to provide assurance for the Health Board. The Health Board acknowledges that this required a significant amount of managerial input, and that it diverted attention from other priorities.

88 We found slightly varying arrangements between health boards in the executive-level responsibilities for primary care. At the Health Board the Executive Director of Primary, Community and Mental Health left in December 2017. The Director of Nursing has moved in the interim to take on the Executive Director of Community and Mental Health element of that role, while the Chief Executive has taken on the primary care element.

89 As mentioned previously (see paragraph 43), the Health Board recognises that support for cluster development has not been as focussed as it would have liked. Key factors affecting the situation include the interim arrangements in relation to the post of Executive Director of Primary, Community and Mental Health. Also, the need to focus on resolving problems with out-of-hours services with support from the Assistant Director of Primary Care. From 2019, primary care will return to the portfolio of the Director of Primary, Community and Mental Health and a new interim will be appointed.

90 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 Health Board has a Directorate of Primary, Community and Mental Health for operational delivery, and corporate directorates for strategy and governance. The Primary Care Department, which is part of the Directorate of Primary, Community and Mental Health, is now working across both primary and community care. The Chief Executive, the Assistant Director of Primary Care, and

the Head of Primary Care have been working closely with the senior managers for HR, planning and performance and finance to increase the focus on the primary and community care agenda.

91 The Health Board is establishing a dedicated Primary Care Programme team during 2018-19. It is comprised of managers from the Primary Care Department and led by a Programme Director (who is the Assistant Director of Primary Care) with the objective of bringing greater focus to primary care development and delivery. They will focus on four main areas:

- cluster development;
- primary care delivery and sustainability;
- primary care development; and
- efficiency improvement.

92 The Programme will have a multi-agency oversight group to provide strategic direction and high-level decision making for Clusters. Clusters will in turn seek to deliver the Health and Wellbeing Strategy at a local level through improved design and integration of services across the patient pathway.

93 The Executive Committee has indicated that it will continue to support the separation of Primary Care Clusters and GP Networks (see paragraph 22) on the basis that there is further clarification of their roles and functions and that they become firmly located within the wider health and social care planning and delivery mechanisms, rather than just within the primary care function.

There is a limited focus on primary care within the Health Board's performance dashboard and within the business of the Board in general

94 The main focus of Board business is on the IMTP and secondary care, rather than primary care. The Board does receive some updates relating to problems with out-of-hours services. And the quarterly progress reports on the IMTP that are taken to the Board include a section on the transformation of primary care. However, there were no Board papers on primary care practice developments and sustainability, and none on cluster and GP network and achievements. The Finance Planning and Performance Committee and Board get in-committee updates on specific practice issues. However, we did not see any updates of this nature in recent committee papers.

95 The Board and the Executive Committee review 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 the Board.

96 The Primary, Community and Mental Health Directorate produces a quarterly progress report on the Health Board's implementation of the primary care national plan, which goes to the Finance, Performance and Planning Committee. The Primary Care Department discusses cluster level emergency admission rates by specialty with each cluster lead. They find emergency admission rates to be an accurate and helpful indicator of performance in the absence of other cluster indicators.

97 As mentioned previously (see paragraph 64), the Workforce and Organisational Development Committee produced a revised Primary Care Workforce Plan, which was agreed by the Board in April 2017. The Board also receives summaries of Board Joint Committee and Partnership Activity through the year. There are some references to primary care developments within the broad scope of these papers.

98 The Health Board told us it does monitor primary care performance at a number of boards, including the Unscheduled Care Programme Board, Planned Care Programme Board, Directorate Board and Oral Health Board. The Health Board could further strengthen its ability to plan and develop new services in primary care if it were to request performance and progress reports from GP practices, other community providers, and clusters. However, no such information is provided at present.

GPs lead most of the clusters and networks and there is mixed evidence about the support provided to clusters by the Health Board

99 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.

100 Exhibit 9 sets out the professional backgrounds of the cluster leads across Wales. In the Health Board[19], two of the three cluster leads are GPs. The other cluster lead is a nurse practitioner who is also a practice partner.

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: Total number of cluster leads is 67 because Cwm Taf supplied contact details for more than one lead for each cluster.

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

101 The Health Board recognises that local delivery of the Primary Care Model for Wales is dependent on effective leadership, professional engagement, community involvement and a workforce committed to new ways of working. Further investment in leadership development in the clusters and networks will be critical to the delivery of their plans to transform primary care.

102 Public Health Wales, through the Primary Care Hub, has developed a Confident Primary Care 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. Our survey of cluster/network leads found that none had attended the programme.

103 Two of the three cluster/network leads told us that the support provided to them by the Health Board has been effective. The same number agreed with the statement ‘I have enough time in my day to focus on cluster development’. However, evidence from a recent internal audit report (see paragraph 42) indicated that the Health Board had not provided effective support for cluster leads.

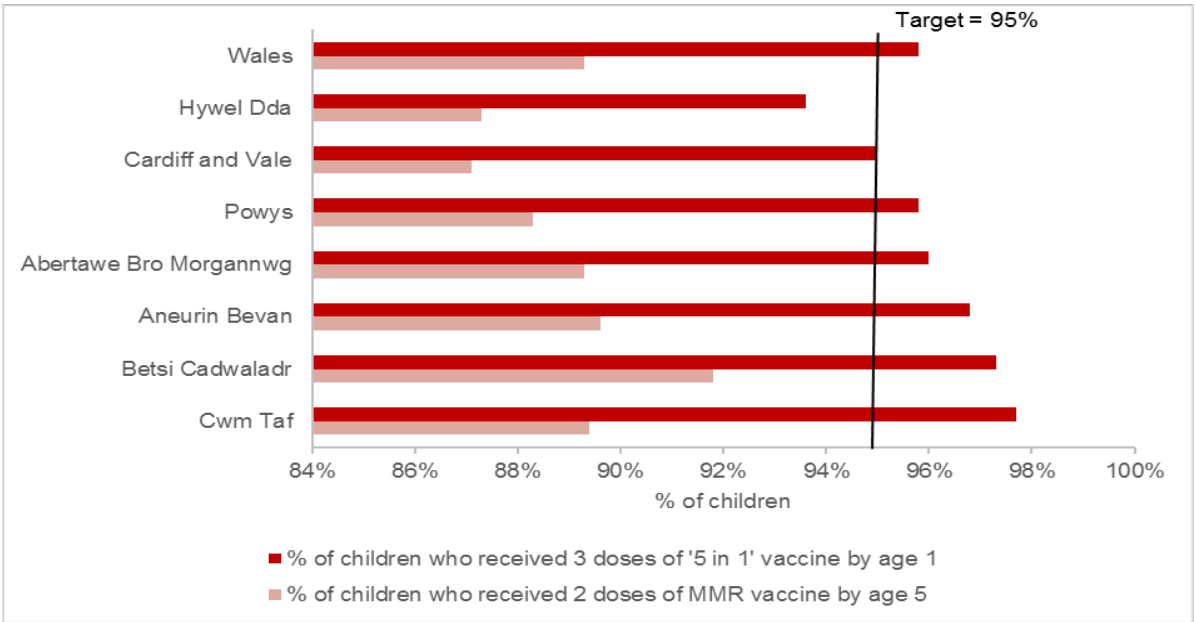
Performance: The Health Board is making steady progress in delivering its plans but primary care performance is mixed and several difficult challenges remain

The Health Board's primary care performance is mixed when compared with the Wales average

104 In this section of the report we summarise the Health Board's performance against the Welsh Government's Outcome and Performance Measures.

105 Exhibit 10[20] shows that while the Health Board is meeting the target for '5 in 1' vaccinations, it is under target for the MMR vaccinations.

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



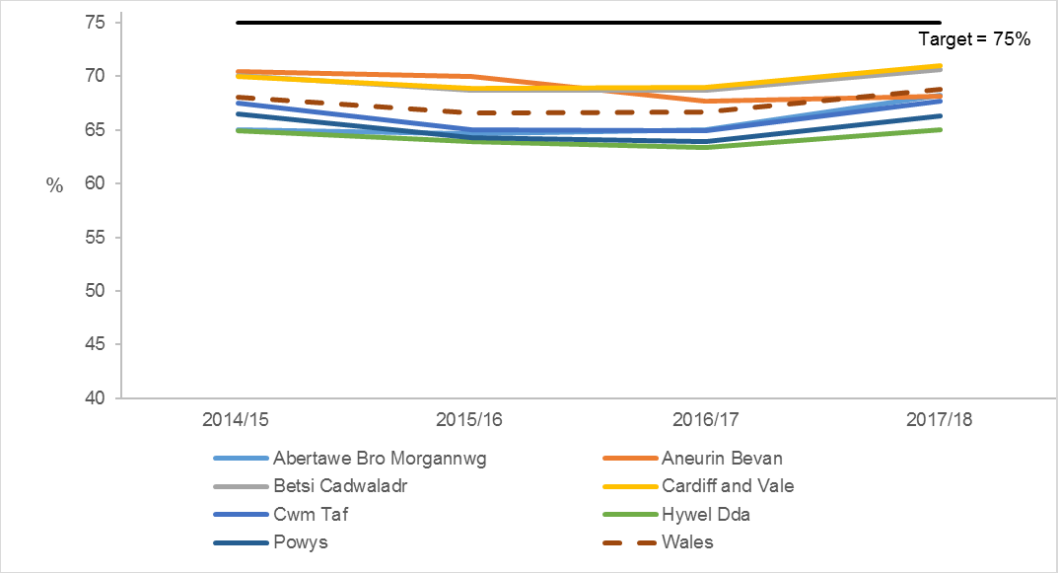
Note: '5 in 1' vaccine protects against diphtheria, tetanus, pertussis (whooping cough), polio and hib infection. MMR protects against measles, mumps and rubella infections. These results are for children living in the Health Board area in March 2018 and who reached their first and fifth birthdays during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

Source: Public Health Wales.

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

106 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 Health Board's rate of flu vaccinations in patients aged 65 years and older is below the all-Wales position and has not changed significantly over the four-year reference period, having never met the target[21].

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

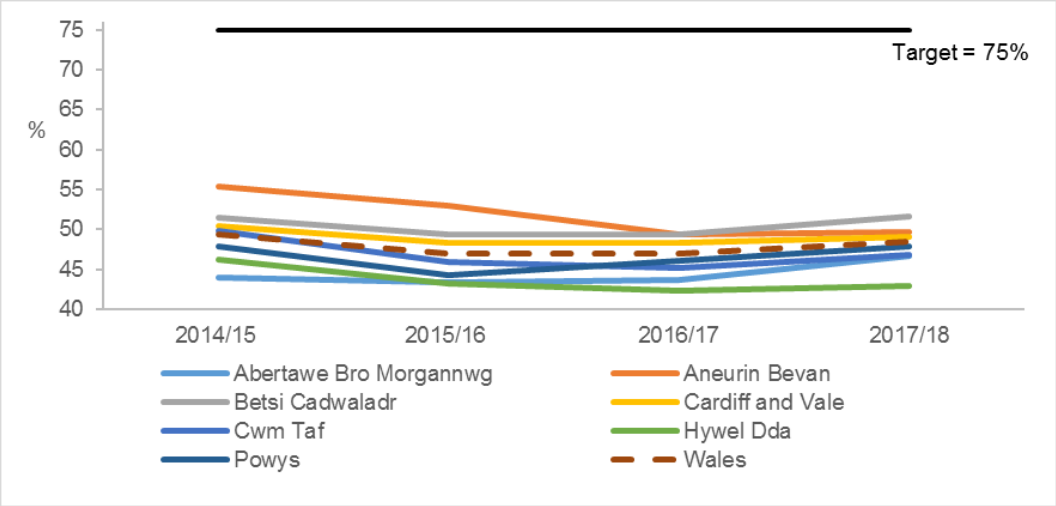


Source: Public Health Wales.

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

107 Exhibit 12 shows the percentage uptake of the flu vaccination in people younger than 65 who are at risk. The target rate of immunisation is 75% for this group of people. The chart clearly illustrates that all health boards perform at a rate which remains substantially less than that, and none achieved the target rate. The Health Board performs below the Wales average, at a rate which has remained largely unchanged over the four-year period.

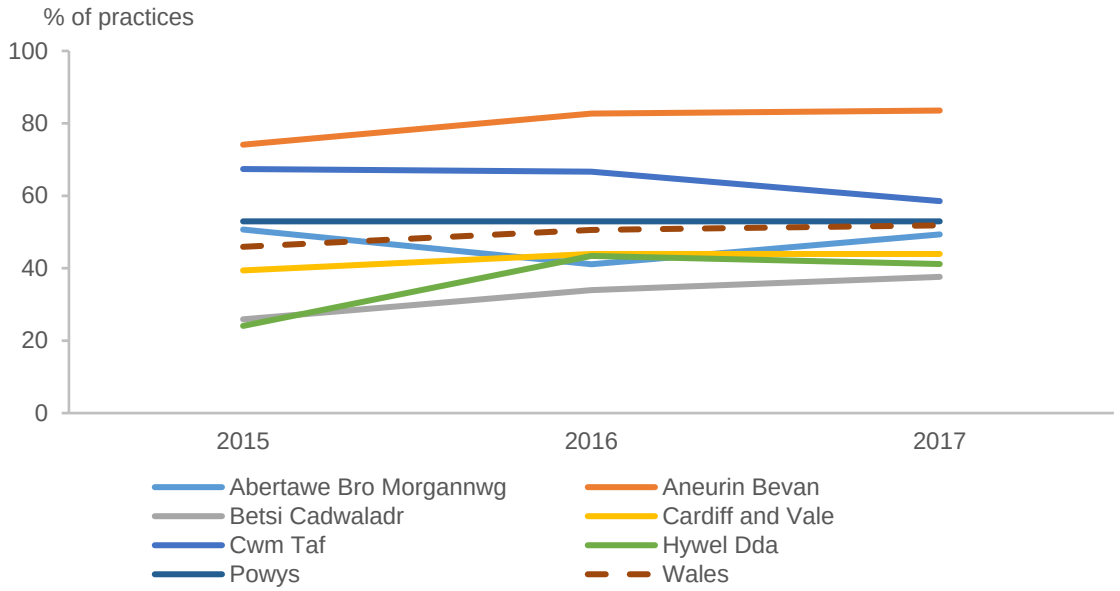
Exhibit 12: trends in uptake of flu vaccination 2014-15 to 2017-18: Uptake in patients younger than 65 who are at risk



Source: Public Health Wales.

108 Exhibit 13 shows the percentage of GP practices that remained open all day[22] in 2017 was 53%. This is slightly above the all Wales average of 51%.

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



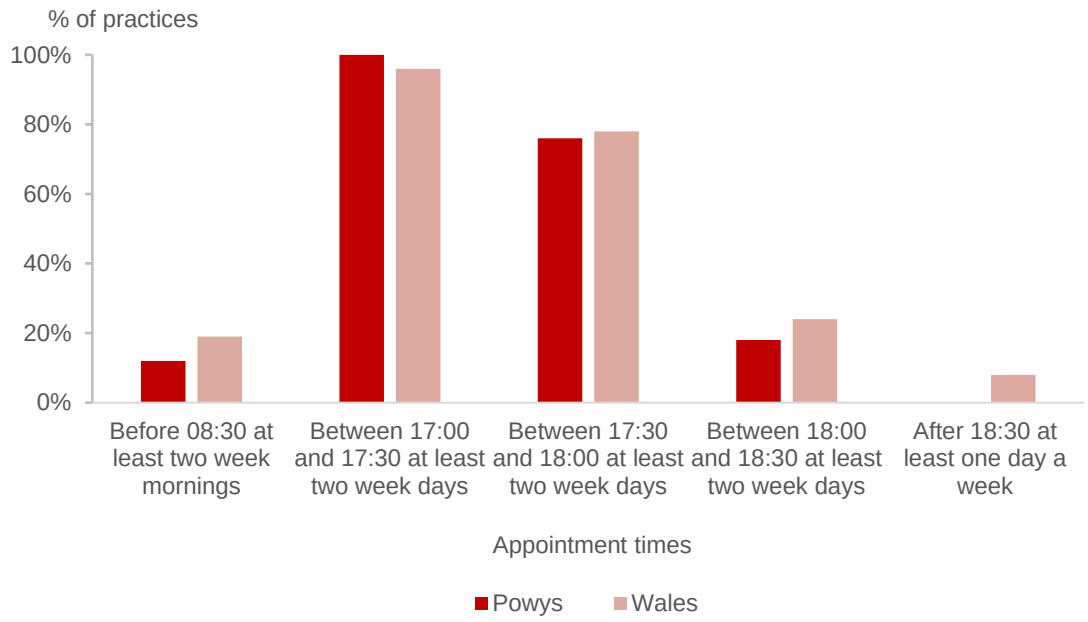
Note: Total weekly core hours equals 52 hours and 30 minutes.

Source: Welsh Government

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

109 Exhibit 14 shows that in most measures related to the provision of GP appointments at different times of the day, the Health Board performs slightly worse than the Wales average.

Exhibit 14: extended appointment times at GP practices

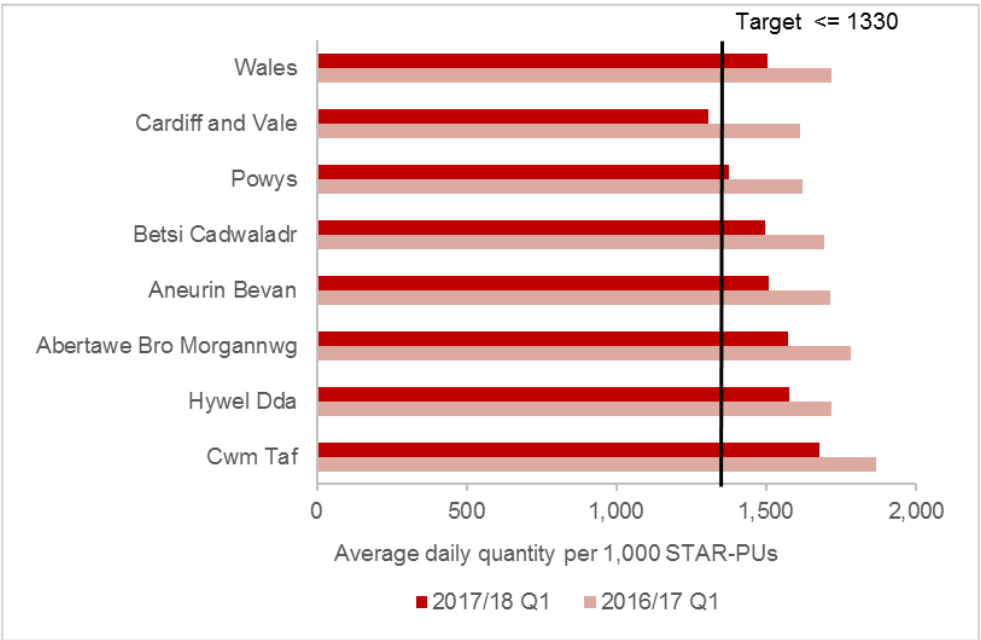


Source: Welsh Government.

110 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 15.3% and is now meeting the target. Performance in the Health Board is better than the Welsh average.

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).

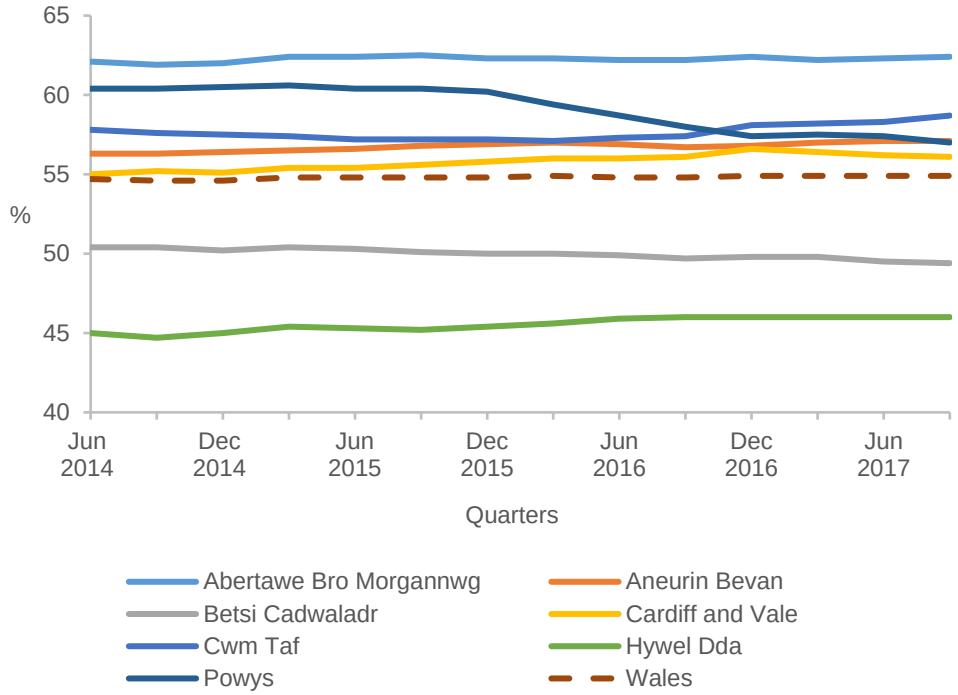


Target = <1,330

Source: Welsh Analytical Prescribing Support Unit

111 Exhibit 16 shows the percentage of the population regularly accessing NHS primary dental care in the previous 24 months as at 30 September. The target is for annual improvement, which the Health Board has not achieved.

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 reporting steady progress in delivering its plans for primary and community care but it recognises that a number of difficult challenges remain

112 In summer 2017, the Health Board's Executive Committee received a RAG-rated[23] report from the Primary Care Department on the Health Board's progress in response to the national primary care plan. The report identified nine red-rated areas and it was agreed that further work would need to be undertaken to move up to at least an amber rating. In an update to the progress report presented in January 2018, none of the nine areas were red-rated anymore. In five instances, this was due to the additional work carried out. In the remaining four instances, there was further evidence of action which had already been taken.

113 The Primary Care Department also reports annually on progress in delivering its work programme. In addition, it recently reported on its progress against Health Board-specific actions in response to the national primary care plan. The Health Board is confident that it has achieved most of the actions it set out. Exhibit 17 summarises the extent of progress by March 2018 using the RAG status derived by the Health Board. The red ratings relate to a lack of progress in sharing use of IT systems across the public and third sectors to share information that will support primary care; and a lack of consistency in linking investment to local needs to address the inverse care law[24].

Exhibit 17: progress against the national primary care plan at March 2018

National priority areas	Progress against local actions
Planning care locally	2 green 4 amber
Improving access and quality	6 green 2 amber 1 red
Equitable access	1 green 1 red
A skilled local workforce	1 green
Strong leadership	1 amber

Source: Our plan for primary care services in Wales: Progress update, Powys Teaching Health Board.

[23] RAG-rated – an evaluation based on a traffic light approach of red, amber or green.

[24] The inverse care law was originally suggested by Julian Tudor Hart in a paper for The Lancet, to describe a perverse relationship between the need for health care and its actual utilisation, ie those who most need medical care are least likely to receive it. Conversely, those with the least need of health care tend to use health services more (and more effectively).

114 We asked the Health Board what the main barriers were to transforming primary care. Exhibit 18 shows that the Division identified the need to develop medical leadership and increase managerial and primary care workforce capacity, as well as a need to find levers to shift resources away from secondary care.

Exhibit 18: the Division's view on the main barriers to transforming primary care

Barriers	What needs to be done to remove the barriers
Medical leadership capacity	Develop via cluster plans
Managerial capacity	Increase resources to increase capacity
Primary care workforce capacity	Increase resource to increase capacity
Acute service attitude and focus	Design system levers to support resource shift away from secondary care

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

115 We sought views from the cluster/network leads on the successes of clusters/networks and main challenges facing primary care in their area. Exhibit 19 shows that among the successes is nurse triage and the development of community pharmacy teams.

Exhibit 19: cluster lead survey: successes

Successes
Nurse triage
Virtual ward
Cluster pharmacy team
Physician assistants
Active monitoring partnership with MIND
Red Kite Health Solutions

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

116 Exhibit 20 shows that Health Board cluster leads raised a number of challenges for primary and community care, some of which are identified elsewhere in this report:

Exhibit 20: cluster lead survey: challenges

Challenges
Access to services
Increased staffing costs
Practice sustainability
GP out-of-hours services
Rurality leading to primary care providing secondary care without recognition
Increasing patient demand

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

Appendix 1

Methods

Exhibit 21: 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 Health Board has two Primary Care Cluster leads, two GP network leads and one who is both network and cluster lead in for their area. The response rate for the Health Board was 60% (three respondents out of five contacted).
Interviews	We interviewed a number of staff including the following with responsibility for primary care: • Vice Chair • Executive Director responsible for primary care • Acting Medical Director • Assistant/Deputy Medical Director • Finance lead • Workforce lead • Planning and Performance lead • Operational Managers • 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.

Appendix 2

Management response

Exhibit 22: management response

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1a	Review the relative maturity of Clusters, to develop and implement a plan to strengthen its support where necessary.	To strengthen and target Cluster development support.	Yes	Yes	PTHB will: • Review Clusters against the Maturity Matrix • Design Cluster Development Plan • Implement Primary and Community Care Development programme	31 March 2019	Director of Primary and Community Care and Mental Health Services

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1b	Ensure that leadership skills development opportunities are provided for Cluster leads where necessary.	To strengthen Cluster leadership.	No	Yes	Formal leadership development will be provided where skills and experience demonstrate a shortfall. Cluster leads will be encouraged to attend the Confident Primary Care Leaders course.	N/A	Director of Primary and Community Care and Mental Health Services

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2a	Calculate a baseline position for its current investment and resource use in primary and community care.	To establish a baseline from which to measure the resource shift towards primary care.	Yes	Yes	Baseline information re costs incurred (and therefore committed resources) is available as per annual accounts and costing returns. The Health Board will review to establish a summary of the baseline position to monitor against going forward.	Baseline Summary to be completed by 31 December 2018	DOF/DDOF

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2b	Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	To understand progress made in moving resources from secondary to primary care.	Yes	Yes	Specific investments are reported where link to specific funding allocations. Health Board will establish a mechanism to report changes in expenditure compared to baseline as per R2a.	Report movement between 18/19 to 19/20 post completion of annual accounts.	DOF/DDOF

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3	The Health Board should develop an action plan for raising the profile of primary care in the Health Board. Actions could include ensuring a standing item on Board agendas regarding primary care, and publishing an annual report on primary care.	To increase the Board's understanding of primary care performance.	Yes	Yes	PTHB will: • Produce an Annual Primary Care Report for consideration by the Executive Committee and the PTHB Board. In addition, PTHB will: • Develop a Primary Care Performance Dashboard that will formally update the board and PEQS committee on a regular basis, frequency to be agreed.	31 May 2019 31 March 2019	Director of Primary and Community Care and Mental Health Services

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4a	Review the contents of its Board and committee performance reports to ensure sufficient attention is paid to primary care.	To increase the Board's understanding of primary care performance.	Yes	Yes	A formal reporting mechanism is being developed in line with the PTHB Commissioning Assurance Framework (CAF) to ensure that the Board receives assurance on performance, quality and efficiency for primary care.	Work on this will begin within the month of November 2018, however, full implementation and monitoring will take a significant amount of time.	Director of Primary and Community Care and Mental Health Services

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4b	Increase the frequency with which Board and committees receive performance reports regarding primary care.	To increase the Board's understanding of primary care performance.	Yes	Yes	Through the CAF process regular reports will be submitted as part of the assurance process to the relevant committee. Frequency to be agreed as per R3 above.	Work on this will begin within the month of November 2018, however, full implementation and monitoring will take a significant amount of time.	Director of Primary and Community Care and Mental Health Services

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4c	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.	To raise Board awareness of the impact of primary care transformation on patients.	Yes	Yes	Through the CAF reporting process the categories for assessment will include Access, Finance, Quality & Safety and Patient Experience. Also regular reports will be submitted to report against primary care transformation in line with the IMTP objective: 'Increase implementation of all elements of the primary care model for Wales, to achieve equitability across all independent contractors.	30 March 2019	Director of Primary and Community Care and Mental Health Services

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R5	The Health Board should develop and implement an action plan for ensuring it has regular, comprehensive, standardised information on the number and skills of staff, from all professions working in all primary care settings.	To have a clear understanding of the whole primary care workforce, which will be the basis for current and future workforce planning.	Yes	Yes	Work has commenced to create a comprehensive data set that will provide information of the number and skills of staff and also inform the future needs of the workforce relating to the four contractor services in primary care.	31 July 2019	Director of Primary and Community Care and Mental Health Services

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