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Contents

The Health Board has a sound plan for primary care and is making reasonable progress towards implementing key elements of the national vision. Oversight arrangements are strong and performance against some indicators is above average. However, there is further scope to raise the profile of primary care, shift more resources towards primary care and to address workforce challenges.

Summary report

Background 4

Key findings 7

Recommendations 8

Detailed report

Strategic planning: the Health Board has a strong primary care plan aligned to national priorities and whilst clusters are at an early stage of development, the Health Board is taking steps to support their ongoing development 10

Investment: the Health Board has some examples of resources shifting to primary care but there are barriers to large-scale change, and the available data make it difficult to accurately calculate the overall investment in primary care 16

Workforce: workforce challenges are threatening the sustainability of some practices but the Health Board has begun workforce modelling and is in the early stages of testing solutions 22

Oversight and leadership: strong leadership and monitoring arrangements are in place and the Health Board is taking steps to improve primary care data, however, there is further scope to raise the profile of primary care 29

Performance and monitoring: the Health Board is making reasonable progress in delivering its primary care and localities plan and some aspects of performance are better than the Wales average, although a number of difficult challenges remain 33

Appendices

Appendix 1: methods 43

Appendix 2: management response 44

Summary report

Background

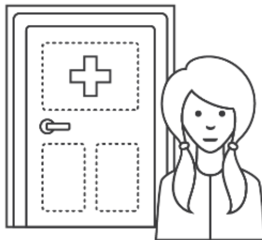
1 The national primary care plan[1] defines primary care as follows:

‘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 co-ordinating 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.

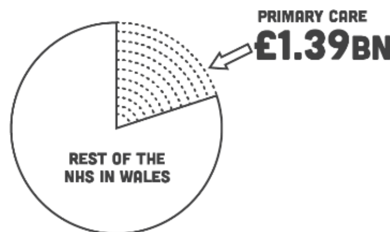
Exhibit 1: Why is primary care important in Wales?

First point of contact



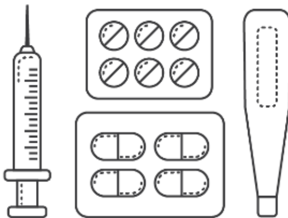
Primary care is the first port of call for the majority of people who use health services.

Spending on primary care



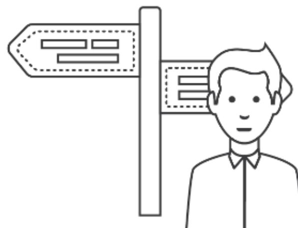
In 2016-17, the NHS in Wales spent £1.39 billion on primary care, which is around a fifth of the total NHS spending in Wales.

Prevention and early intervention



Primary care is also important because of its focus on promoting well-being, early intervention and preventing people’s conditions from getting worse.

Coordinating care



Primary care plays an important role in co-ordinating people’s care, acting as a gateway to many other services.

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. Officially there are eight clusters in Cwm Taf, but the clusters have agreed to join together to cover four localities, Rhondda, Cynon, Merthyr Tydfil and Taff Ely.

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 Transformational Model of Primary and Community Care[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 an inquiry into clusters[5].

[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.

The report noted impressive examples of progress but said that a 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].

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 **GP out-of-hours services**.

12 This report summarises the findings of work in Cwm Taf 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**: does the Health Board have effective arrangements for oversight and leadership that support transformation in primary care?
- **Performance**: 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: **The Health Board has a sound plan for primary care and is making reasonable progress towards implementing key elements of the national vision. Oversight arrangements are strong and performance against some indicators is above average. However, there is further scope to raise the profile of primary care, shift more resources towards primary care and to address workforce challenges**. 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 strong primary care plan aligned to national priorities and whilst clusters are at an early stage of development, the Health Board is taking steps to support their ongoing development: • the Health Board has a strong primary care plan aligned to national priorities and it engages with a range of stakeholders in developing its plans. • most clusters remain at a relatively early stage of maturity but cluster development will be further supported through the Health Board's new strategic planning group. We found scope to strengthen cluster leadership, membership and to improve the evaluation of cluster projects.
Investment: the Health Board has some examples of resources shifting to primary care but there are barriers to large-scale change, and the available data make it difficult to accurately calculate the overall investment in primary care: • the accounts suggest an overall real terms decrease in investment in primary care but the format of the accounts makes it difficult to say with any certainty. • the Health Board can point to some specific examples of shifting resources towards primary care, but it cannot demonstrate the extent of these shifts and large-scale change is being hampered by a range of barriers. • the Health Board has clear arrangements for monitoring cluster spending and cluster leads feel they have sufficient financial autonomy. • the Health Board is investing Welsh Government funding for health and wellbeing centres to support its primary care model, whilst supporting minor practice improvements.
Workforce: workforce challenges are threatening the sustainability of some practices but the Health Board has begun workforce modelling and is in the early stages of testing solutions: • gaps in data limit the Health Board's ability to map its primary care workforce but challenges include shortfalls in GPs and nurses and above-average patient lists. The Health Board has commissioned demand and capacity assessments in GP practices but take-up has been variable. • there are challenges to the sustainability of GP practices and the Health Board has recognised the need to strengthen the Primary Care Support Unit. • whilst the Health Board is in the early stages of implementing the national vision of multi-professional primary care teams, there are barriers to further implementing the model.

Our main findings
Oversight and leadership: strong leadership and monitoring arrangements are in place and the Health Board is taking steps to improve primary care data, however, there is further scope to raise the profile of primary care: • the Health Board has dedicated primary care representation at executive and Board level and there are clear leadership arrangements at directorate level. • primary care issues are prominent within the Health Board but some feel primary care still needs a greater profile. Primary care performance is monitored regularly and the Health Board is taking steps to improve its performance metrics. • GPs and practice managers provide cluster leadership, and they were generally positive about the support provided by the Health Board.
Performance and monitoring: the Health Board is making reasonable progress in delivering its primary care and localities plan and some aspects of performance are better than the Wales average, although a number of difficult challenges remain: • some aspects of the Health Board's performance are better than the Wales average, although the national measures do not adequately represent primary care. • the Health Board has made reasonable progress in delivering its primary care and localities plan but several challenges remain.

Recommendations

14 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 commissioned the Primary Care Foundation to carry out demand and capacity assessments in GP practices but the take-up from practices has been variable. To maximise value from the commissioned work, the Health Board should centrally analyse and collate the messages from the demand and capacity assessments and share the learning across all practices.

Recommendations
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; and 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.
The primary care workforce R3 The Health Board's workforce planning is inhibited by having limited data about the number and skills of staff working in primary care, particularly community dentistry, optometry and pharmacy. 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.
New ways of working R4 Whilst 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 learning by publicising the key messages across all clusters; c) work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments; and d) evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales.
Primary care clusters R5 We found variation in the maturity of primary care clusters, and scope to improve cluster membership and leadership. 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) review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups; and c) develop an action plan for strengthening cluster leadership.

Detailed report

Strategic planning: the Health Board has a strong primary care plan aligned to national priorities and whilst clusters are at an early stage of development, the Health Board is taking steps to support their ongoing development

The Health Board has a strong primary care plan, aligned to national priorities and it engages with a range of stakeholders in developing its plans

The Health Board's Primary Care and Localities Directorate Plan is well established and evolving and it clearly articulates the shift in focus needed to achieve transformation

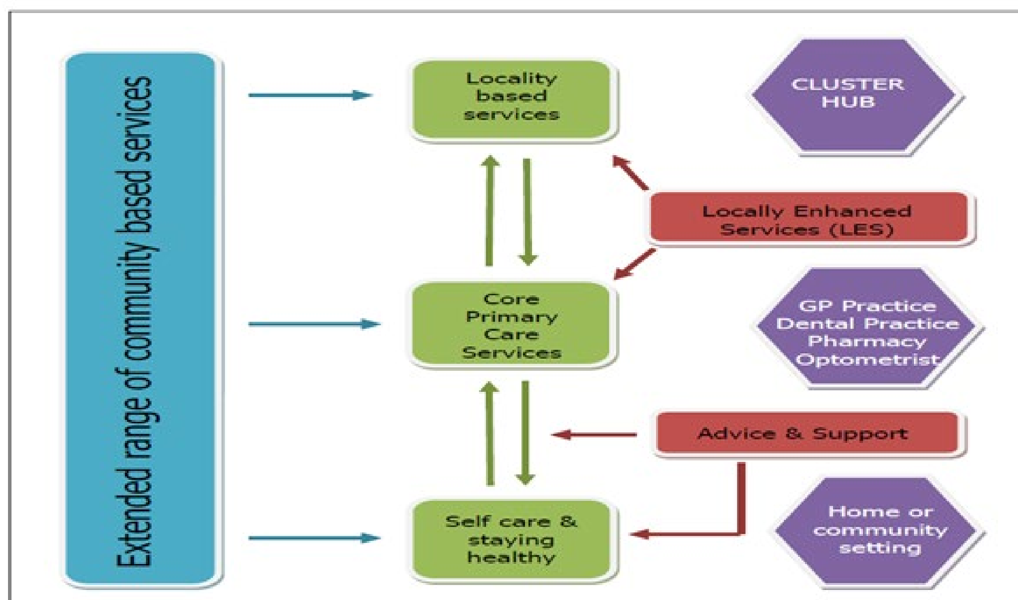
15 The Health Board has articulated its plans for primary care in its Primary Care and Localities Directorate Plan 2018-2021 (the plan), which is the directorate's three year integrated medium term plan (IMTP). The directorate's IMTP feeds into the Health Board's overarching IMTP. In 2015, the Health Board developed the Primary Care and Community Delivery Plan, which outlined its strategic intent. Each year, the directorate IMTP builds on this initial work.

16 The directorate's plan recognises the need for innovation and a radical approach to developing new models of care and workforce planning to meet current and future challenges. The plan sets out an ambition to move away from 'primary, secondary and social care towards integrated care, tailored to individual and community needs. The bullet points below show how the focus of the plan is evolving to achieve a fully integrated, whole system care model:

- 2015-16 – GP focus
- 2016-17 – Primary care focus
- 2017-18 – Community care focus
- 2018-19 – Integrated secondary care focus
- 2019-20 – Integrated patient centred model

17 Exhibit 4 sets out the Health Board's outline model for primary and community services. It shows a locality model which is integrated with other services. This means that patients can access a range of healthcare services close to their home. These services range from traditional primary care services and enhanced services to advice and support. The Health Board's local authority partners have replicated the locality model to make joint working easier.

Exhibit 4: outline model for Primary Care and Community Services



Source: Primary Care and Localities Directorate Plan 2018-2021.

18 We reviewed the Health Board's plan for primary care to assess whether it contained key elements that ensure alignment with the national primary care plan and transformational model. We found a number of areas which highlight particular strengths (Exhibit 5).

Exhibit 5: strengths of the Primary Care and Localities Plan

	Strengths
Strategic planning	Social prescribing and signposting: Cwm Taf recognises the value in social prescribing and signposting. This is evidenced by clusters piloting different social prescribing approaches such as Grow Rhondda and Arts based therapies sessions in Taff Ely. In terms of signposting, two clusters are piloting care navigator training.
	Out of hours and 111: Improving and remodelling the out of hours service and 111 is one of the Health Board's main vehicles for improving primary care services. This is evident by out of hours and 111 being a prominent theme in the directorate plan. Whilst there are a number of barriers to progressing this work, namely workforce, there is a clear direction for remodelling and transforming the service and implementing 111 in 2019.
Finance and resources	Modern technology: the plan lists priorities for ICT including an automated caseload scheduling system for district nursing, using ICT for triage, implementing the Vision 360 GP practice ICT system and the roll out of mobile devices for all community staff.

	Strengths
Workforce	Workforce Plan: the workforce plan for primary care is within the directorate plan. It outlines where multidisciplinary teams are already in place such as the Cynon Valley virtual ward; the enhanced primary care support unit; and how multidisciplinary working will be further developed. There is also reference to clinical triage systems, especially in terms of the out of hours service and non-clinical triage in the form of care navigators.
Oversight and leadership	Workstreams to take the plan forward: the plan outlines a model for taking the plan forward. The model is based on six themes: • Self-care and staying healthy • Advice and support • Early intervention • Rehabilitation within our community hospitals • Out-of-hours urgent care • Long-term conditions management
Performance and monitoring	The document outlines progress in delivering the 2017-18 plan. The key risk factors in delivering the IMTP are outlined at the start of the plan, with actions to mitigate the risks being discussed in later sections about service priorities.

Source: Wales Audit Office analysis of Primary Care and Localities Directorate Plan 2018-2021.

19 We found other areas of the Health Board's plan that need further development. The plan does not identify specific and costed actions to shift resources from hospitals to a community setting. The plan does include some details about enhanced services, rehabilitation of stroke patients in community hospitals and the new health parks but there is nothing explicit about moving resources. This could be because services are being transformed and remodelled, so it is not as clear cut as moving services from a hospital to a primary or community setting.

20 Neither does the plan show how the Health Board will measure the progress of shifting resources from a hospital to a community setting. Whilst the plan has a strong vision for transforming primary care, it does not include details on who within the organisation is responsible for taking forward the transformation programme, the leadership for the individual workstreams and governance arrangements.

21 We asked interviewees their thoughts on the directorate plan and there was consensus that it was a strong plan. Interviewees said the plan is well-written, ambitious, emphasises multidisciplinary team working, has links to service sustainability, service access and prudent healthcare, and includes cluster development and pilot initiatives, such as social prescribing.

22 However, some interviewees expressed concerns about the plan being too ambitious, too large and that the Health Board should concentrate on one or two big initiatives instead of many small ones. Some interviewees said the plan mainly

covers General Medical Services and that integration with other directorates could be stronger.

The Health Board engages with internal and external stakeholders in developing its plans and whilst it has not consulted the public on its entire plan, the Health Board has now introduced a dedicated communications officer for primary care

23 The Health Board regularly engages with stakeholders throughout the year. Within the Health Board, various groups such as the Performance into Action Cwm Taf (PACT) and Clinical Leadership forums give directorate managers and clinical directors an opportunity to discuss joint priorities and opportunities, reduce duplication and overcome barriers. Within the directorate, regular meetings such as monthly directorate meetings and clinical business meetings provide an opportunity to plan and monitor the directorate plan. Primary care managers meet fortnightly with business partners in finance and workforce and organisational development.

24 External to the Health Board, the Community Health Council (CHC) is involved in service planning meetings, project boards and steering groups. In addition, their executive team receives briefing reports. We spoke to the CHC and they confirmed they had been engaged in developing the directorate plan. The Health Board also engages with stakeholders by being part of (and leading on) several national peer support groups such as Directors of Primary, Community and Mental Health, and Heads of Primary Care and Assistant Medical Directors. These groups are forums to share and disseminate good practice.

25 The Health Board has a good working relationship with local authority and third sector partners. IMTP plans and progress are shared at both the Cwm Taf Regional Partnership Board and Public Service Board. Partners are represented at various strategic committees and there are a number of examples of joint working at cluster level. The Health Board also engages with the Local Medical Committee, Oral Health Advisory Group, pharmaceutical committees (via medicines management teams) and Eye Health Care Group when developing plans.

26 In terms of the public, whilst not engaging on the whole plan, the Health Board informs the public on service change through a variety of forums such as quarterly public forums held in each locality, and 50 plus forums. The public can feed back through patient participation groups, satisfaction surveys, social media, patient stories and complaints and compliments. The primary care team has appointed a dedicated communications officer, to promote primary care, for example, cluster initiatives and manage primary care social media accounts, and the team publishes a newsletter.

Most clusters remain at a relatively early stage of maturity but cluster development will be further supported through the Health Board's new strategic planning group. We found scope to strengthen cluster leadership, membership and to improve the evaluation of cluster projects

27 We looked at the way that the Health Board provides support to clusters in developing local needs assessments and cluster plans. Of the eight cluster leads responding to our survey:

- six respondents (75%) agreed that they had received helpful guidance from the Health Board when it was developing its cluster plan;
- four respondents (50%) agreed that they had received support from the Health Board to develop a needs analysis of their local population; and
- six respondents (75%) agreed that 'the Health Board listens to my cluster when it is developing Health Board-level priorities for primary care'.

28 Exhibit 6 shows the views of cluster leads on the level of maturity within their cluster. At the Health Board, five respondents said their cluster was 'stable and starting to deliver' and two said their cluster was 'mature'. Cwm Taf is one of two health boards where no leads rated their cluster as 'developmental'.

Exhibit 6: 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.

29 The Health Board supports clusters by employing cluster development managers, who have been in post since 2015. The four managers, one for each cluster, help clusters with developing cluster plans and initiatives, monitoring spending and administrative tasks.

30 Most cluster leads responding to our survey said their cluster had third-sector representation but not local-authority or lay representation. To support and advise clusters, the Health Board sends the following representatives to cluster meetings:

- Public health representative
- Dedicated finance officer to support the clusters in monitoring their spending plans
- Optometry Advisor
- General Dental Council representatives are co-opted in at various times
- Consultants are co-opted in at various times

31 To give cluster leads protected time for their role, the Health Board funds one session per week for both GP and practice manager leads. In addition, the Health Board funds backfill, so cluster leads can attend the bi-monthly cluster lead meetings. These meetings are an opportunity to share learning and good practice and discuss issues with the executive lead and Health Board managers.

32 All four clusters have a plan in place, they follow a similar format grouped under seven strategic themes. At the time of our review, the Health Board was establishing a new Primary Care Strategic Planning Group, to replace the cluster lead meeting. It was felt the cluster plans needed a more formal route into the Health Board. The new group also provides a forum for more strategic discussions and gives GPs a formal seat at the Health Board table. The meeting will be chaired by the Director of Primary, Community and Mental Health and attended by senior planning managers, the assistant medical director, finance and cluster leads amongst others.

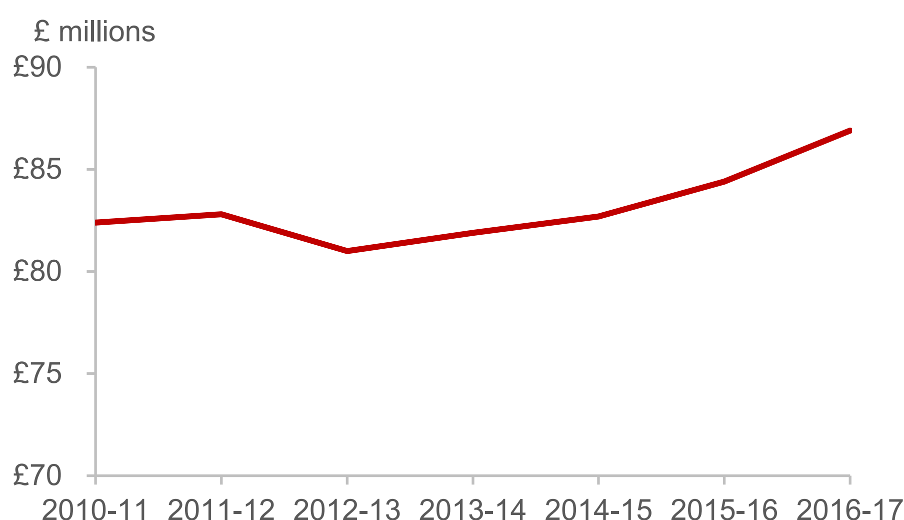
33 The majority of survey respondents, 88% (seven out of eight), agreed that the Health Board is empowering their cluster to drive innovation. Evaluation is an important part of testing innovation and 63% (five out of eight) respondents agreed that the Health Board is effectively evaluating examples of innovation in their cluster. Some cluster leads felt that evaluation was getting better, and that there was good outcome data for the Cynon Valley virtual ward. However, interviewees also said it should not be left to cluster leads to evaluate their own projects.

Investment: the Health Board has some examples of resources shifting to primary care but there are barriers to large-scale change, and the available data make it difficult to accurately calculate the overall investment in primary care

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

34 Exhibit 7 is based on data from the Health Board's annual accounts and sets out the long-term expenditure on primary care. The total includes spending on General Medical Services (GMS), Pharmaceutical Services, General Dental Services (GDS), General Ophthalmic Services (GOS) and 'Other Primary Health Care' expenditure[9]. The exhibit shows that the Health Board spent £86.9 million on these primary care services in 2016-17.

Exhibit 7: the Health Board's spending on primary care services



Source: LHBs' Annual Accounts

Note: The vertical axis does not begin at zero. We have excluded expenditure on 'Prescribed drugs and appliances' due to the variable nature of this expenditure, partly as a result of drug price fluctuations. 'Other Primary Health Care' is a gather-all category in the accounts, used to record spending on numerous primary care items that do not fit into the other categories.

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

35 In 2016-17, the Health Board had a mixed picture of underspends and overspends in different spending categories, when compared with the allocations provided by the Welsh Government. The Health Board's explanations of these variations are set out below:

- the General Medical Services overspend was due to the cost of locums to maintain the Health Board's four managed practices. The £45.4 million allocation was overspent by £900,000.
- Pharmaceutical Services spend and allocation have remained largely consistent in recent years. In 2016-17, the allocation increased from £18.1 million in 2015-16 to £18.6 million, and the Health Board spent £17.3 million.
- the General Dental Services underspend was largely because in 2015-16, 15 dental practices underperformed against their contracted units of dental activity (UDA), and the repayments for this underperformance were made in 2016-17. The £17.1 million allocation was underspent by £1.7 million.

36 After considering the effect of inflation, the Health Board's overall spending on primary care decreased in real terms by 3.8% between 2010-11 and 2016-17. Over the same period, expenditure on General Medical Services, General Dental Services and Pharmaceutical Services decreased in real terms but increased in General Ophthalmic Services and 'Other' primary care expenditure.

37 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. However, the Health Board told us that the figures recorded in their accounts represent all primary care spend, including the £4.956 million they received in 2016-17 from the Welsh Government through the Primary Care Development Fund. The Health Board allocated the fund in the following ways:

- £1.071 million to support pacesetter projects, an enhanced primary care support unit and the Your Medicines, Your Health public information campaign;
- £1.017 million for clusters to develop initiatives based on their plans;
- £1.030 million to support service redesign (out of hours and older persons' mental health services);
- £494,000 to develop and implement community and localities services to help manage long-term conditions;
- £373,000 to fund primary care management and leadership;
- £360,000 on work to reverse health inequalities;
- £262,000 on training and development of future roles;
- £230,000 on other projects (such as a cancer diagnostic clinic, primary care estates and research and evaluation); and
- £119,000 on preparation for the 111 service.

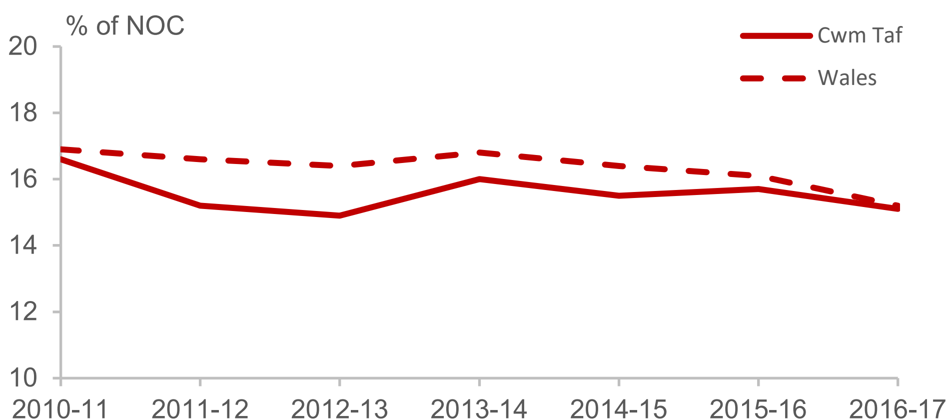
38 In March 2018, the pacesetter projects were mainstreamed meaning they are now funded through the directorate's core budget. This has allowed the Health Board to invest in new projects for 2018-2020. The focus of which will be on workforce and skills development within primary care through developing multi-professional advanced training practices in each cluster.

The Health Board can point to some specific examples of shifting resources towards primary care, but it cannot demonstrate the extent of these shifts and large-scale change is being hampered by a range of barriers

39 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]. However, issues with the format of NHS accounts (see paragraph 37) make it difficult to say whether health boards have secured such shifts.

40 Exhibit 8 shows the Health Board's expenditure on primary care as a percentage of its total expenditure. The figures exclude expenditure on prescribed drugs and appliances. The exhibit shows that despite national priorities for shifting resources towards primary care, across Wales as a whole, primary care spending has not kept pace with health boards' total spending. The trend for the Health Board is similar to that of Wales, although the percentage in the Health Board has been consistently below the all-Wales level.

Exhibit 8: 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 vertical axis does not begin at zero.

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

41 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, and 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.

42 The general consensus amongst those we interviewed was that small pots of money have moved from primary to secondary care and some enhanced services are now delivered in a primary care setting, but they have not seen a large-scale shift. The bullet points below show some specific examples from the Health Board where services and resources have shifted towards primary and community care:

- minor oral surgery is now delivered from the Dental Teaching Unit in Porth and only complex cases are seen in hospital.
- some eye care services have moved from secondary to primary and community care, for example, post-operative cataract care, monitoring of patients with stable glaucoma or ocular hypertension, and there is a community-based wet age-related macular degeneration service.
- all opticians in Cwm Taf are accredited to provide a low-vision service, so patients with eye health issues can visit their optician instead of their GP or secondary care. The Health Board reported that take-up for this scheme was so successful that they had to invest an extra £200,000.
- the Health Board is introducing community and locality-based services to help people manage their long-term conditions closer to home. For example, lung conditions, musculoskeletal conditions, diabetes, cardiology, wound management, and warfarin and anticoagulation management. At present, some of these services are offered on a cluster basis.

43 We asked interviewees what barriers stood in the way of moving more services from secondary to primary care, barriers included:

- directorates within the Health Board working in silos;
- secondary care unwilling to release budgets into primary care services;
- secondary care being so overstretched that there is no money to release into primary care;
- lack of primary care funding and resources;
- cluster innovation constrained by annual funding regime where unspent monies cannot be rolled over into the following financial year; and
- the recognition that when moving services into primary care, it is not just picking and lifting services but doing things differently, transforming services.

The Health Board has clear arrangements for monitoring cluster spending, and cluster leads feel they have sufficient financial autonomy

44 Health boards need to strike the right balance of giving autonomy to clusters whilst at the same time overseeing their spending. Our findings suggest the Health Board has a good approach to overseeing cluster spending. Each cluster has a dedicated cluster development manager, who supports the development of cluster initiatives and monitors cluster spending. Each month, these managers meet with finance to ensure spend against cluster plans is on track. Managers reported that these meetings have improved over the last 18 months. Cluster funds cannot be rolled over into the following year, so clusters now have slippage plans to prevent underspends. Finance partners reported that clusters spend most of their monies, and this year they forecast that all monies will be spent. In addition, cluster spend is monitored at cluster meetings and at regular and ad-hoc meetings between cluster leads, cluster development managers and the financial business partner for primary care.

45 At management level, cluster spending is monitored at fortnightly Localities and Primary Care Management Team meetings and by exception at monthly Clinical Business Meetings. At Board level, spend is overseen at the quarterly Primary and Community Care Committee. For national monitoring, the Health Board has to send regular updates to the Welsh Government alongside their other delivery agreements.

46 In our survey of cluster leads, we found all eight respondents agreed that the Health Board monitors its cluster expenditure effectively. And seven (88%) agreed that their cluster spends all the funding it receives and that the Health Board gives their cluster sufficient financial autonomy. Five out of seven respondents (63%) agreed that their cluster is able to spend its funding quickly once it has decided how to allocate it.

47 Cluster leads suggested that once an innovative project has proven successful, cluster budgets should not be used for ongoing funding for these projects. An example was given of a cluster funding three full-time pharmacists for four years, using approximately 70% of their budget. Cluster leads said they prepare business cases to submit to the Health Board but there are no guarantees that initiatives will be funded. Cluster leads also raised concerns about the length of time it takes to recruit, quoting an example of it taking nine months to recruit a cluster pharmacist.

The Health Board is investing Welsh Government funding for health and wellbeing centres to support its primary care model, whilst supporting minor practice improvements

48 A core part of the Health Board’s primary care model is to support cluster working. In doing so they will be developing a health park in each of the four localities. Merthyr Tydfil already houses the Kier Hardie Health Park. In 2017, the Welsh

Government announced support for the development of health and wellbeing centres with a capital value of around £68 million. With this support the Health Board will be developing health parks in the remaining three areas:

- Rhondda: Tonypandy Health Centre, refurbishment and reconfiguration
- Taff Ely: Dewi Sant Phase 2 Development (Pontypridd), refurbishment
- Cynon Valley: Mountain Ash Primary Care Centre, new build

49 Some interviewees raised concerns about a number of practices still running out of small and ageing buildings. This leaves little room for expansion of premises and services. Whilst the Health Board is not able to use capital monies to fund primary care buildings, it supports minor improvements at GP practices through improvement grants for adaptations to meet Disability Discrimination Act (DDA) requirements.

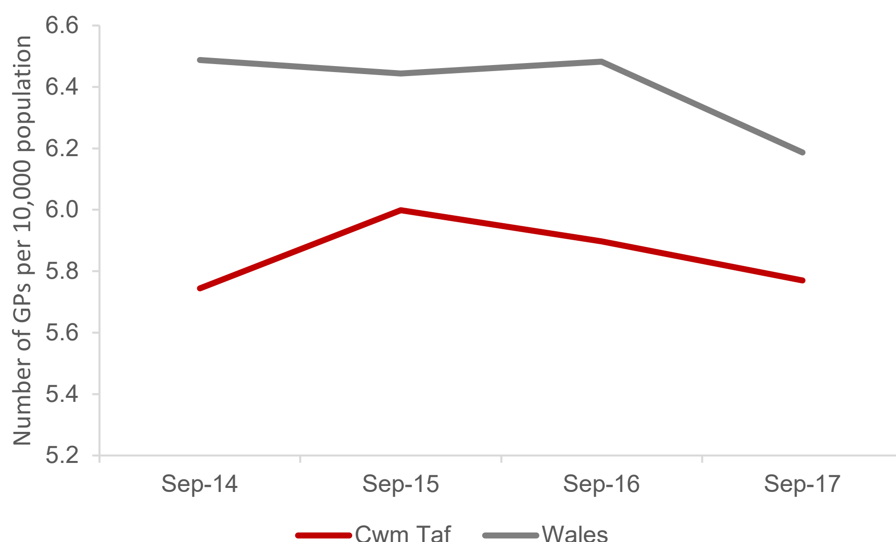
50 The NHS Wales Informatics Service leads on most ICT developments related to primary care, but the Health Board has ownership of ICT systems for GP practices and is responsible for the continued operating and maintenance costs and replacement IT systems where needed. The Health Board has identified priority areas for ICT which are outlined in the directorate plan. These include purchasing of Vision 360 to support sharing of clinical records and software such as My Health Online to improve access to primary care.

Workforce: Workforce challenges are threatening the sustainability of some practices but the Health Board has begun workforce modelling and is in the early stages of testing solutions

Gaps in data limit the Health Board’s ability to map its primary care workforce but challenges include shortfalls in GPs and nurses and above-average patient lists. The Health Board has commissioned demand and capacity assessments in GP practices but take-up has been variable

51 The Health Board has a lower number of GPs per 10,000 population (5.8) than the Wales average (6.2) (Exhibit 9). The number of GP partnerships has reduced from 46 in September 2014 to 42 in September 2017, and the percentage of partnerships with just one partner (21%) is nearly double the Wales average (11%).

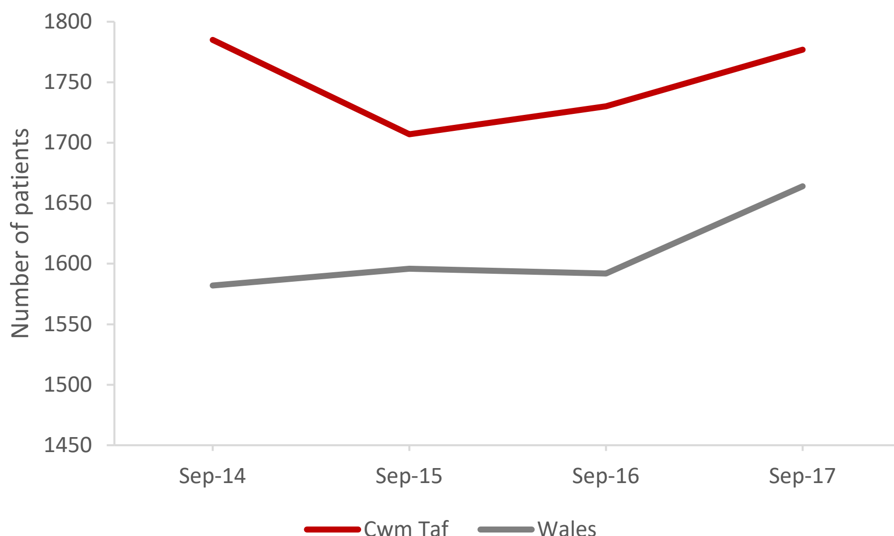
Exhibit 9: number of GPs per 10,000 population



Source: Welsh Government, September 2017.

52 As shown in Exhibit 10, since September 2015 the average patient list size per GP in the Health Board has increased. At September 2017, the Health Board’s average list size per GP was 1,777 patients, which is 113 patients higher than the Wales average.

Exhibit 10: average list size per GP



Source: Welsh Government, September 2017.

53 Exhibit 11 shows that the proportion of GPs aged over 55 and the proportion of GPs that are female in the Health Board is slightly lower than the Wales average.

Exhibit 11: demographics of GPs by age and gender

	Cwm Taf University Health Board	Wales
• Aged over 55	21%	23%
• Female	53%	54%

Source: Welsh Government, 30 September 2017.

54 At the Health Board, the number of dentists offering NHS care fluctuates year on year. In 2017, the Health Board had 220 General Dental Services contractors. The number of optometrists offering NHS care increased from 66 in 2014 to 77 in 2017.

55 The national primary care plan requires health boards to map its workforce. The Health Board's primary care workforce plan is within the directorate's IMTP. The workforce plan includes some workforce data, namely the age profile of GPs, which shows the majority of GPs in Cwm Taf are in their mid to late 40s. It also highlights that the Taff Ely locality has the largest number of GPs in their 50s, which leaves the locality vulnerable should GPs decide to retire around the same

time. The workforce plan also highlights a similar issue with practice nurses, recognising the need to attract more primary care nurses.

56 The workforce plan also shows the profile of the GP workforce (as at October 2017). This shows the total number of whole-time equivalent (WTE) GPs by locality. The data is then further split to show how many GPs are partners, salaried, regular locums and on a retainer scheme. It also details the number of WTE non-medical staff, for example: advance nurses, practice nurses, healthcare assistants, pharmacists and administrative staff.

57 However, the Health Board does not hold information on the number or skill mix of staff working in community pharmacy, community dentistry or community optometry.

58 We assessed what health boards are doing to model the future capacity and skills they need in the primary care workforce. In 2017, the Health Board commissioned the Primary Care Foundation to carry out GP practice demand and capacity assessments. Assessments were offered to GP practices on a voluntary basis and the offer is continuing into 2018 because early participation was variable. Generally, there has been a good response from the Rhondda and Taff clusters, but less so in the Merthyr and Cynon clusters. Individual practice assessment reports will feed into practice development plans, which in turn inform wider cluster plans.

59 The directorate and Heath Board IMTP includes some workforce modelling for GPs and practice nurses. The Royal College of General Practitioners recommends one WTE GP per 1,500 patients. The Health Board used this ratio to analyse the workforce gap of GPs and practice nurses. Based on this assessment, there is a shortfall of 60.5 GPs and 18.5 practice nurses across Cwm Taf. To alleviate the risks of this shortfall, the Health Board modelled an alternative multidisciplinary approach that would support one GP per 2,000 patients and one practice nurse per 4,000 patients. Exhibit 12 shows that if this approach was taken forward it would reduce the shortfall to 19.46 GPs and 9.06 practice nurses.

Exhibit 12: GPs and practice nurse shortfall based on revised workforce model

Cluster	GP Shortfall (WTE)	Practice Nurse Shortfall (WTE)
Cynon	4.37	3.69
Merthyr Tydfil	2.25	1.43
Rhondda	8.12	1.59
Taf Ely	4.72	2.35
Total	**19.46**	**9.06**

Source: Health Board IMTP 2018-2021.

There are challenges to the sustainability of GP practices, and the Health Board has recognised the need to strengthen the Primary Care Support Unit

60 The Health Board reports that there is increasing pressure on general medical services, which is compounded by the workforce issues highlighted in the previous section. From our interviews and on reviewing the directorate IMTP it is clear that recruitment and retention of GPs and practices nurses are a significant challenge for the Health Board. We asked the Health Board what factors were making it difficult to recruit, they told us:

- newly qualified GPs do not want to be partners, preferring to work office hours and have a more flexible career;
- many GPs are deciding to be locums rather than salaried or partner GPs;
- Cwm Taf's geography might not be appealing to younger GPs;
- pension changes may push some GPs to take early retirement, leaving some areas vulnerable and younger GPs without mentors;
- the new roles to compliment GPs are also in short supply, plus recruiting to these new roles may leave gaps in other parts of the system as staff move to primary care; and
- difficulties in persuading nurses to choose to begin their career in primary care, rather than moving to primary care after a career in secondary care.

61 Many health boards have developed primary care support units (although the names of these vary across Wales). These units assist GP practices to overcome threats to their sustainability. Cwm Taf has had a Primary Care Support Unit (PCSU) since 2002 and enhanced[11] the unit as part of the pacesetter programme.

62 Between 2015-16 and 2017-18 the number of staff employed by the unit increased from 34.86 (WTE) to 50.21 (WTE) and subsequently the unit's budget rose from £1 million to £1.5 million.

63 In the past, the PCSU supported unstable independent GP practices, enabling issues to be dealt with early on. Consequently, very few practices got to the point where they needed to submit a formal application through the GP sustainability framework[12]. However, recently the unit's resources have concentrated on the Health Board's four managed practices[13]. But the unit is also experiencing the

[11] The Enhanced PCSU is a multidisciplinary team, comprising, locality clinical director lead for PCSU, two PCSU support managers, two practice development and improvement managers, 18 salaried GPs (equating to ten WTE), ten nurses, 1.30 healthcare support workers, 1.80 pharmacist, an occupational therapist, two practice nurse professional educators, and is awaiting approval for two physician associates.

[12] Welsh Government, **Revised GP Sustainability Assessment Framework: 2017/18**, 21 April 2017.

[13] GPs retiring or resigning from small or single-handed practices is the main reason for practices giving notice. The Health Board made the strategic decision to manage the four practices, one of which is a merger of three single-handed practices.

same workforce issues as independent contractors, such as having to rely on locum GPs, making it unable to offer the same level of support as before. However, the Health Board has reviewed arrangements, and from July 2018 the focus of the PCSU will be to help practices modernise and become more sustainable. To achieve this, the PCSU will support larger, stronger practices to transform smaller less stable or failing practices. The PCSU will also be further developed into a multidisciplinary team. In 2018-19, the Health Board's priority is to transfer the four Health Board managed practices back to independent status.

64 Expenditure on managed practices has increased over the last three years. The cost of running four managed practices in 2016-17 was £3.1 million, with £790,000 attributed to the PCSU.

Whilst the Health Board is in the early stages of implementing the national vision of multi-professional primary care teams, there are barriers to further implementing the model

65 The national 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 find opportunities for these professionals to improve access by providing the first point of contact for patients.

66 The Health Board and cluster leads described several examples of alternative first points of contact. Some are well established and available across the Health Board, whilst others are at early stages, being piloted or only being run in certain clusters or practices. The following examples were given:

- patient signposting and education – such as the Choose Well campaign, training practice receptionists to become care navigators so they can better signpost patients, educating patients at public forums, and an education video is being developed.
- services offered at a cluster and/or practice level – such as MIND offering low-level counselling, direct access to physiotherapist and occupational therapists at GP practices, and clinical pharmacists supporting GPs with annual medication reviews.
- wellbeing and lifestyle support – such as General Practice Support Officers, Wellbeing Co-ordinators and Lifestyle Co-ordinators who can offer advice and signposting to appropriate services. Patients can self-refer or be referred by another professional such as a pharmacist.
- Minor Ailment Pharmacy Scheme – patients can be referred or can self-refer to pharmacies who can advise and prescribe for an agreed set of minor conditions.
- Welsh Eye Care Scheme (WECS) – where appropriate, patients with an eye problem are directed to an optometrist in the community, which has been accredited by WECS.

67 The Transformational Model highlights the importance of enhanced multi-disciplinary teams. In particular, the model stresses the need for these teams to provide a shared resource for all practices in a cluster. At Cwm Taf there are a number of examples of clusters sharing resources, for example, pharmacists, occupational therapists, initial response nurseS, counselling services provided by MIND and Care and Repair resources. Clusters are also a basis for sharing support and mentorship, with experienced GPs and practice managers mentoring those less experienced within their cluster and well-established and stable practices providing GP support to those less stable.

68 In the Cynon Valley, there is a virtual ward, which is a multidisciplinary, multi-agency team that is formed around four practices. The ward targets those in the community who are frail and have multiple and complex health and social care needs. The ward has been running for two years and those we interviewed reported that it works well and produced some good results. As such, the virtual ward model is being used as a basis to bid for Welsh Government transformational monies.

69 Between December 2016 and December 2017, the Health Board held four sustainability engagement workshops with GPs and practice managers. Each of the workshops had a different theme and aimed to explore issues facing primary care and solutions moving forward. At the workshops all clusters developed their own sustainability model. The common theme that runs through all of the models is multidisciplinary working, meaning clusters recognise the value of multidisciplinary working to secure the sustainability of primary care. The feedback from these workshops will feed into the Health Board's clinical services strategy.

70 We asked the Health Board what barriers stood in the way of implementing a multi-disciplinary workforce model for primary care. Barriers included some GPs taking a while to recognise that the funding for new roles needs to come from within their budgets. For example, if a practice has a GP vacancy and they recruit a physiotherapist, the funding set aside for a GP salary could be spent on the physiotherapist. However, some practices are funding their own physiotherapists and pharmacists. Indemnity for new roles might also be putting GPs off investing in new roles and a number of GPs are close to retirement so change at this time could be daunting. Other barriers included the GMS contract not supporting practices to work differently and the availability of a trained workforce.

71 In terms of making changes in primary care, interviewees felt that whilst GPs are contractors, in reality the Health Board does not have many levers over them to effect change. It is easier for the Health Board to change services around primary care, but they cannot force practices to change. However, a consistent message from interviewees was that the primary care team has a good relationship with GPs.

72 The Transformational Model also highlights the need for shared systems of triage for members of the primary care team. The Health Board reported that the majority of clinical triage systems are currently practice based and that they have undertaken a survey of systems in place to map their use. Whilst the Health Board recognises that clinical triage has its benefits they would not force a GP practice to implement it where access is good or where there are sustainability issues.

Oversight and leadership: Strong leadership and monitoring arrangements are in place and the Health Board is taking steps to improve primary care data, however, there is further scope to raise the profile of primary care

The Health Board has dedicated primary care representation at executive and Board level and there are clear leadership arrangements at directorate level

73 To transform primary care, health boards need clear and effective arrangements for oversight and senior leadership. Health board vice chairs have a specific responsibility for championing primary care issues. Cwm Taf's vice chair, who has been in post for approximately two months, chairs the Primary and Community Care Committee, which reports to the Board. She represents the Health Board nationally through groups such as the National Vice Chairs Group and through quarterly meetings with the Cabinet Secretary for Health and Social Services. Locally, she visits GP practices, primary care services such as the PCSU, attends locality meetings and attended the recent sustainability workshops.

74 The Director of Primary, Community and Mental Health is the Health Board's Executive Lead for Primary Care, there is also a deputy director. He is also the lead for the national Primary Care Directors Group. The former director is now the interim Chief Operating Officer so has a good background in the service area.

75 Operationally, the Primary Care Team is led by the Head of Primary Care, who reports to the Director of Primary, Community and Mental Health. Beneath the Head of Primary Care are service development managers and support staff for the various parts of primary care: General Medical Services; Dental and Optometry; Clusters; Primary Care Support Unit; Out of Hours; and cardiovascular disease health checks.

76 Clinically, there is an Assistant Medical Director for primary care and a clinical director for each of the four localities/clusters. The Assistant Medical Director also chairs the national Assistant Medical Directors' Group.

77 The Health Board has a business partner model and so the primary care team is supported by finance, planning and workforce and organisational development colleagues. The primary care team, apart from out of hours, is co-located with social services and public health at Kier Hardie Health Park. Those we interviewed felt the team was well resourced, but still developing. At the time of our review, the team held two vacancies and was recruiting a deputy to support the Head of Primary Care, so she can focus on strategy and transformation.

Primary care issues are prominent within the Health Board but some feel primary care still needs a greater profile. Primary care performance is monitored regularly and the Health Board is taking steps to improve its performance metrics

78 The Health Board has a Primary and Community Care Committee, the committee meets quarterly and provides assurances to the Board. Where appropriate, items are also identified for escalation or sharing with other sub-committees such as the Clinical Governance Committee, Finance and Performance Committee and Audit Committee as well as the Executive Board. The Board receives copies of committee minutes and there are regular agenda items such as the operational delivery report, which updates the Board on key operational issues and IMTP deliverables, both of which include primary care. In addition, the Board and Finance and Performance committee review the integrated performance dashboard which includes national measures related to primary care and a small number of local measures. Those we interviewed felt primary care has a prominence at Board level.

79 The Primary and Community Care Committee has a number of standing agenda items aimed at monitoring primary care progress. Each quarter the committee receives an update on the primary care IMTP deliverables. Detailed narrative is provided for actions that are not on target, so members are sighted of the issues causing slippage. The committee also receives updates on initiatives funded through the primary care development fund. The cover report updates on the current spend against each project and an explanation of any slippage, appended to the report is the quarterly monitoring report submitted to the Welsh Government. In addition, the committee has regular updates on cluster initiatives, with one cluster reporting at each meeting and progress against the eye care and oral health and anticoagulation services.

80 Operational monitoring takes place at the monthly primary care clinical business meetings. This group receives primary care update reports and finance and workforce reports. The directorate has service development managers for dentistry, optometry and GMS who are responsible for day-to-day contract management and monitoring of independent contractors. For optometry, there is no general contract so monitoring takes place through post payment verification visits, optometry services are also being monitored by Public Health Wales.

81 There was general consensus amongst those we interviewed that primary care is a priority for the Health Board, but it is not on an even keel with unscheduled and scheduled care. Whilst there is recognition that primary care should be a higher priority, interviewees said there are external pressures which keep the focus on secondary care. For example, reporting to the Welsh Government is focussed on secondary care which has national targets and a need to manage media coverage on issues such as long accident and emergency waiting times. In terms of funding, it was felt that primary care is not on a par with secondary care, whilst primary care

gets Welsh Government funding, it is short term and ring fenced. Interviewees felt a lack of investment in primary care leads to firefighting in secondary care.

82 Overall, those we interviewed felt that there is a wealth of data within primary care, but it is held within several unintegrated systems. In addition, there can be difficulties getting information from independent contractors. However, the Health Board is trying to improve primary care data and has a data analyst specifically for primary care. The directorate is also developing new primary care measures for the integrated performance dashboard and starting to discuss collating patient experience data for primary care.

GPs and practice managers provide cluster leadership, and they were generally positive about the support provided by the Health Board

83 Exhibit 13 sets out the professional backgrounds of the cluster leads across Wales. In the Health Board the cluster leads are GPs and practice managers. Each cluster has at least one GP lead and one practice manager lead. Compared to other health boards, Cwm Taf has the largest number of non-GP cluster leads. Since our fieldwork the Health Board has seen some movement of cluster leads, it now as 13 cluster leads in total, seven GP leads, and six practice manager leads.

Exhibit 13: 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 cluster leads: GPs	Number of cluster 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 has more than one lead for each of its four clusters.

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

84 Public Health Wales, through its 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. Our survey of cluster leads found that 25% of respondents (two out of eight) had attended the Confident Primary Care Leaders course and both agreed that it helped them improve as cluster leads.

85 Cluster leads told us that the support provided to them by the Health Board has been effective, with 75% (six out of eight) of respondents agreeing that the Health Board provided them with effective support to undertake their cluster lead role. But 63% (five out of eight) of respondents felt they did not have enough time in their day to focus on cluster development.

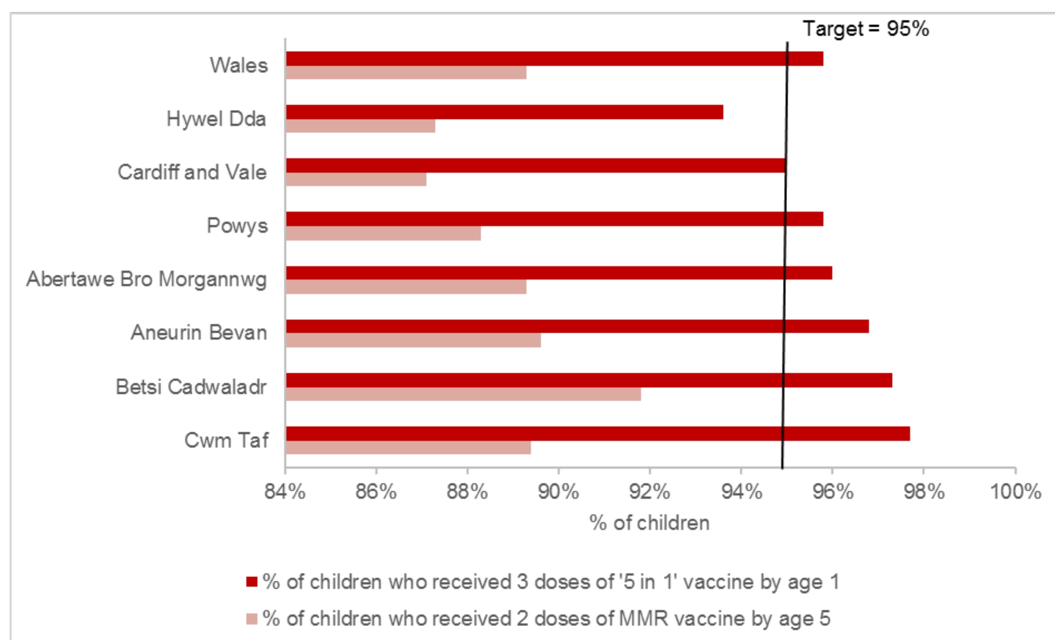
Performance and monitoring: The Health Board is making reasonable progress in delivering its primary care and localities plan and some aspects of performance are better than the Wales average, although a number of difficult challenges remain

Some aspects of the Health Board's performance are better than the Wales average, although the national measures do not adequately represent primary care

87 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 Integrated Performance Dashboard. However, national measures do not cover the entirety of primary care. The National Primary Care Board is developing a set of national primary care measures.

88 Exhibit 14 shows the Health Board's childhood immunisation rates between January and May 2018. It is meeting the target for '5 in 1' vaccines and performs better than the other health boards and the Wales average. While it is below target for MMR vaccinations, none of the other health boards are meeting it either.

Exhibit 14: childhood immunisation rates for the quarter January to March 2018

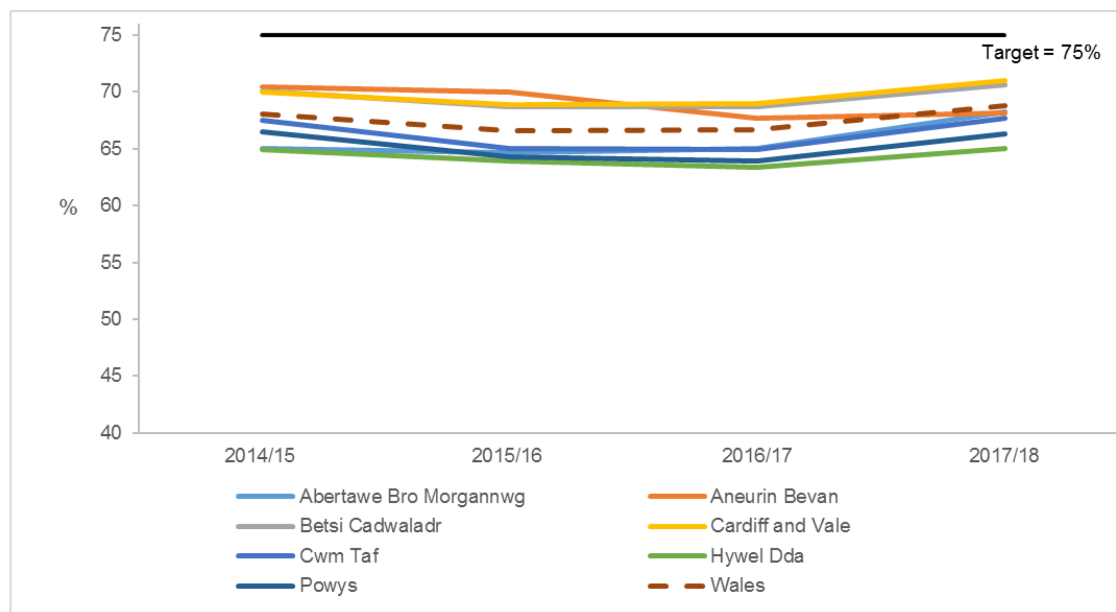


Note: '5 in 1' vaccine protects against diphtheria, tetanus, pertussis (whooping cough), polio and hib infection. MMR protects against measles, mumps and rubella infections. These results are for children living in the Health Board area in March 2018 and who reached their first and fifth birthdays during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

Source: Public Health Wales.

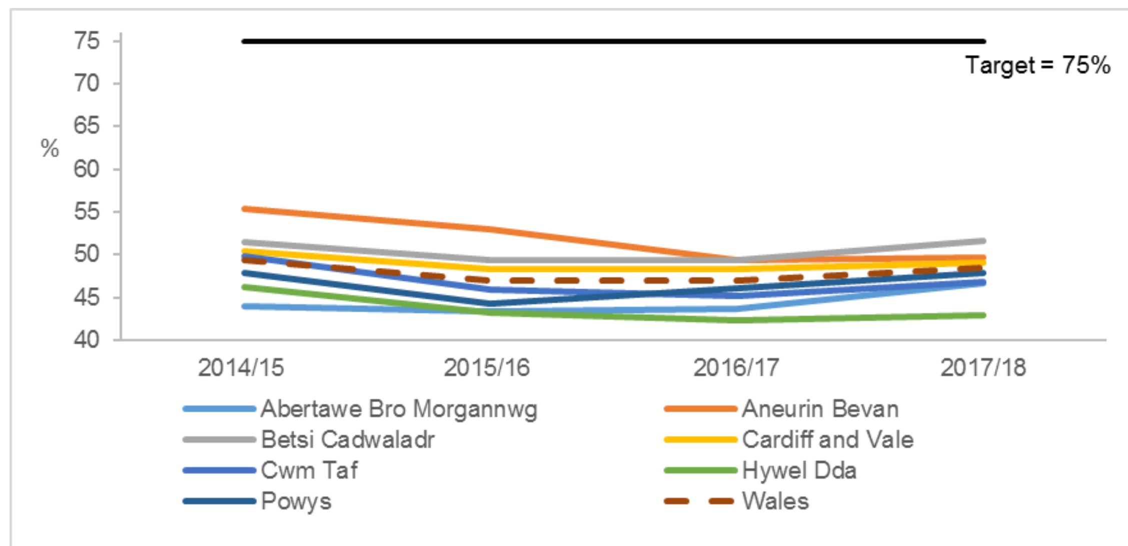
89 For adults, flu vaccinations are recommended for people aged 65 and over, as well as people with other risk factors such as asthma. The target for both groups is for 75% of those populations to receive the vaccination each year. Exhibits 15 and 16 show that the Health Board has not met the targets for flu vaccinations. The Health Board's flu vaccination uptake in patients aged 65 and over and younger than 65 at risk is below the Wales average. The Health Board's integrated performance dashboard also shows flu vaccination rates for pregnant women and health care workers. As at April 2018, none of the flu vaccination targets were being met.

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



Source: Public Health Wales.

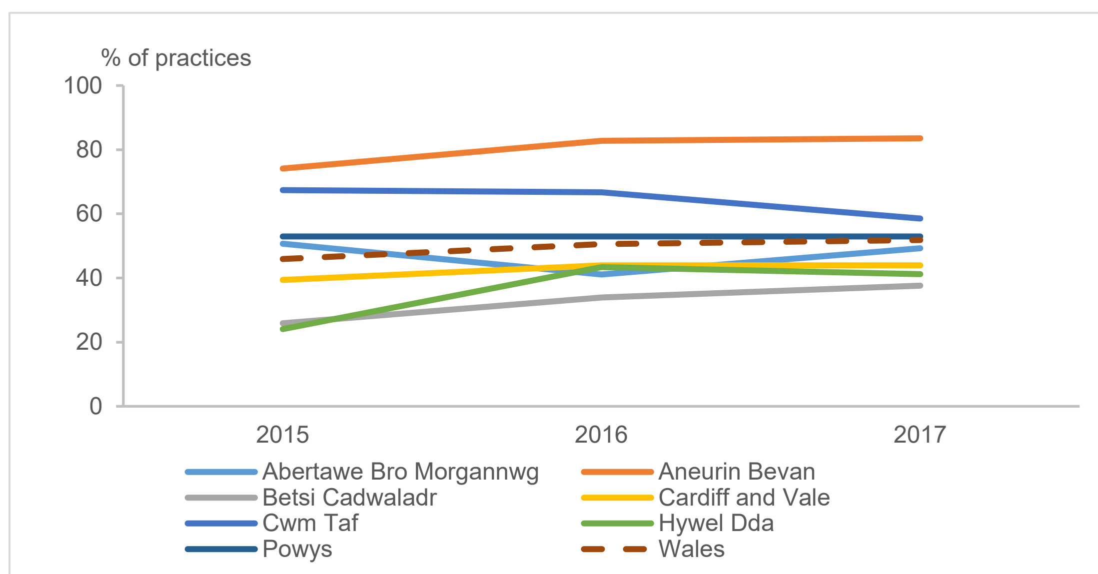
Exhibit 16: trends in uptake of flu vaccination 2014-15 to 2017-18: uptake in patients younger than 65 who are at risk



Source: Public Health Wales.

90 Exhibit 17 shows that in 2017, 59% of GP practices in Cwm Taf opened for 100% or more of their weekly core hours. This is better than the Wales average of 52% and is the second highest percentage after Aneurin Bevan.

Exhibit 17: percentage of practices open for 100% or more of weekly total core hours, by Health Board, 2017



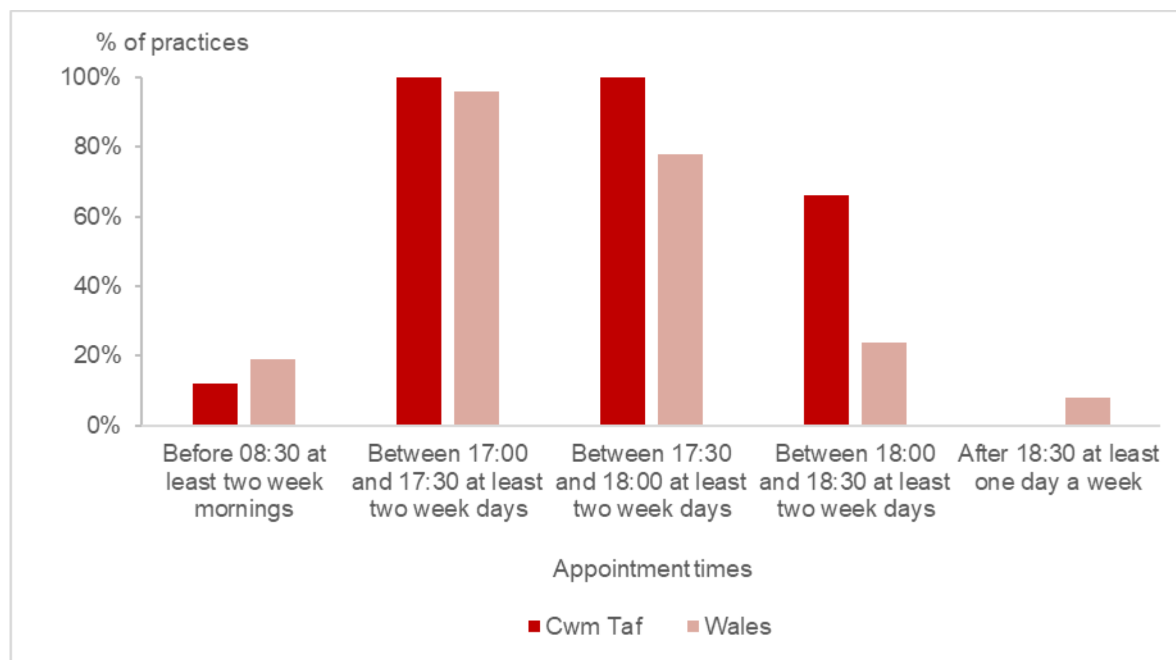
Note: total weekly core hours equals 52 hours and 30 minutes.

Source: Welsh Government.

91 Exhibit 18 shows various measures related to the provision of GP appointments at different times of the day. Except for appointment times before 8.30 am and after 6.30 pm, the Health Board performs better than the Wales average. Exhibit 19 shows how Cwm Taf compares to heath boards. Cwm Taf has the highest percentage of GPs offering appointments between 5 pm and 6.30 pm. But along with Powys has the lowest number of practices offering morning appointments, between 8 am and 8.30 am. Cwm Taf is one of five health boards where no appointments are offered after 6.30 pm.

92 Within the performance dashboard, the Health Board also has two local measures relating to GP practices. The first being, the number of GP referrals to secondary care, which stood at 9,779 at May 2018. The total is also broken down by cluster, with the target being a reduction in referrals. This measure was first reported to the Board in July 2018, so at the time of our review we are not able to comment on whether the Health Board is meeting this target. The second local measure is the percentage of patients registered as receiving palliative care with their GP practice, which was 1.41% of the cluster total in 2016-17. Again, while the dashboard shows the number of patients by cluster, a target for this measure is yet to be decided. The dashboard also includes a measure for the percentage of patients who did not attend a GP appointment, but the figure included in the Board papers for July 2018 was from February 2016.

Exhibit 18: extended appointment times at GP practices, 2017



Source: Welsh Government.

Exhibit 19: extended appointment times at GP practices, 2017

Percentage of practices offering appointments.

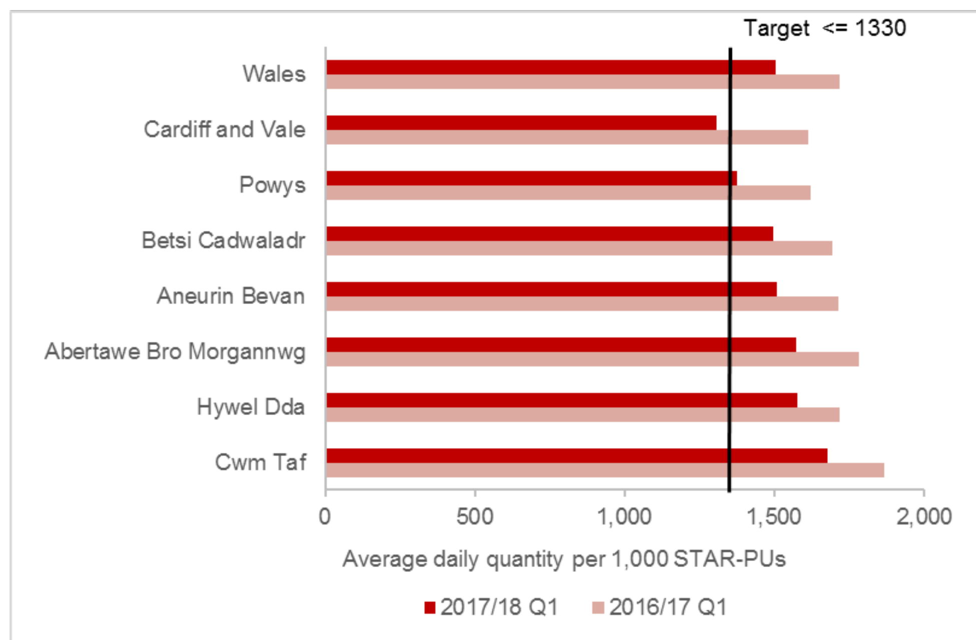
Health Board	Before 08:30 at least two week mornings	Between 17:00 and 17:30 at least two week days	Between 17:30 and 18:00 at least two week days	Between 18:00 and 18:30 at least two week days	After 18:30 at least one day a week
Abertawe Bro Morgannwg	14%	93%	77%	22%	0%
Aneurin Bevan	23%	97%	99%	25%	41%
Betsi Cadwaladr	15%	94%	56%	11%	0%
Cardiff and Vale	23%	95%	74%	12%	0%
Cwm Taf	**12%**	**100%**	**100%**	**66%**	**0%**
Hywel Dda	31%	98%	80%	37%	10%
Powys	12%	100%	76%	18%	0%
Wales	19%	96%	78%	24%	8%

Source: Welsh Government.

93 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 20 shows the Health Board has reduced its prescribing in the previous 12 months (by 10.2%). However, its performance shows less of a decrease than the Wales average (12.3%) and it has higher prescribing rates compared to other health boards.

Exhibit 20: 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).

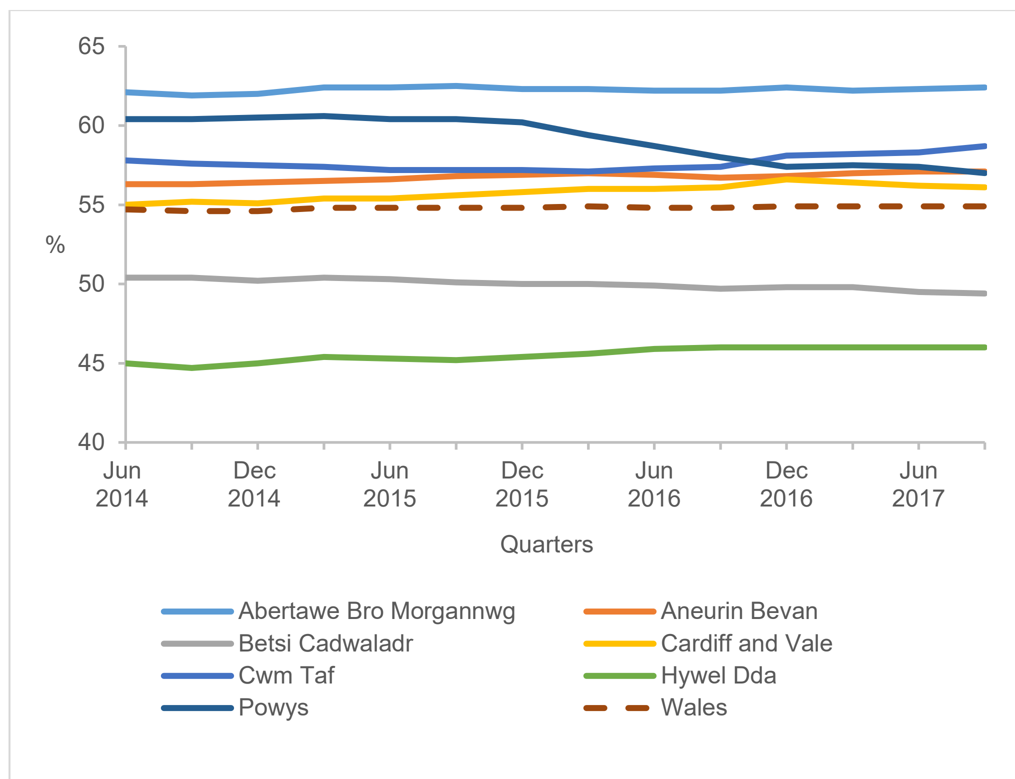


Target = <1,330

Source: Welsh Analytical Prescribing Support Unit

94 Exhibit 21 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 achieved. At September 2017, Cwm Taf had the second highest percentage (59%) of patients treated at an NHS dental practice, in same month the Wales average was 55%.

Exhibit 21: 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 has made reasonable progress in delivering its primary care and localities plan but several challenges remain

95 The directorate reports monthly to its clinical business meeting and quarterly to the Primary and Community Care Committee on its IMTP deliverables. The report uses a traffic light system, so it is easy to see which actions are:

- Green = key milestones complete
- Amber = some milestones problematic
- Red = major problems

96 The Primary Care and Localities Directorate Plan 2018-2021 gives an overview of performance against 2017-18 deliverables. Exhibit 22 shows that as at March 2018, out of 103 actions, 80 had been completed, 22 were on amber and one was a red action. However, for the out-of-hours redesign and GP sustainability and workforce programme, the Health Board warns that whilst plans are in place to reduce and mitigate these issues, it is one of the highest risks for the directorate

and remains a high risk on its risk register. The Health Board's corporate risk register also includes the following high-rated primary care risks:

- Primary Care Workforce – Recruitment and sustainability
- Failure to continue to provide GP Out of Hours Services as currently configured
- Failure to invest in and develop Primary Care Services, across RCT and Merthyr Tydfil but particularly in the Rhondda Valleys

Exhibit 22: primary care and localities directorate progress against 2017-18 IMTP deliverables

Primary Care and Localities 2017-18 delivery programme	Number of actions	RAG status of actions at March 2018		
		Green	Amber	Red
Out of Hours Redesign	7	1	6	0
Enhanced Primary Care Support Unit (PSCU)	5	4	1	0
Cluster Hub Locality Cardiology Service	4	2	2	0
Cluster Hub Locality COPD service	5	4	1	0
Cluster Hub Locality Community Diabetes Service	7	5	2	0
Cluster Hub Locality MSK Service	4	2	2	0
Danish Cancer Diagnostic Model	6	6	0	0
Training and Development/Management and Leadership	6	6	0	0
Primary Care Cluster Initiatives	5	5	0	0
Inverse Care Law and Risk Stratification	7	7	0	0
Introduce New Primary Care Indicators	2	2	0	0
Continue to develop @Home Services	3	3	0	0
Development of Palliative Care Services	5	5	0	0
Development of 'Cluster Hubs' within each locality	3	2	1	0
Community Hospital Beds – Continue to improve flow across community hospital sites and review staffing and models	5	2	3	0
GP Sustainability and Workforce Programme	4	1	3	0
Community Eye Care Services	4	3	1	0
Lead Role for the organisation in managing with IT the testing of WCCIS.	2	1	0	1
Implement 111	4	4	0	0

Primary Care and Localities 2017-18 delivery programme	Number of actions	RAG status of actions at March 2018		
		Green	Amber	Red
Wound Cluster Service	7	7	0	0
Cost Containment of CHC	3	3	0	0
Oral Health	3	3	0	0
Primary Care Estates Development	2	2	0	0
Total	**103**	**80**	**22**	**1**

Source: Wales Audit Office analysis of Health Board's Primary Care and Localities Directorate Plan 2018-2021.

97 We asked the Health Board what the main barriers were to transforming primary care. Exhibit 23 shows that the directorate recognises that there needs to be a greater shift of resources towards primary care and that steps need to be taken to reduce locum use.

Exhibit 23: the directorate's view on the main barriers to transforming primary care

Barriers	What needs to be done to remove the barriers
Prioritisation of Health Board finances against Welsh Government priorities	Recognition that a greater shift in resources towards Primary Care needs to be made.
Standing Financial Instructions for Health Board	Standing Financial Instructions were initially a barrier when clusters were introduced. But the Health Board produced guiding principles to help inform clusters around processes such as procuring services.
Workforce issues	Need to strengthen the independent contractor status and reduce the benefits being given to locum status.

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

98 We sought views from cluster leads on the successes that have been achieved and the main challenges facing primary care in their health board area. Exhibit 24 shows the cluster leads feel their main successes are around improved collaboration, alternative services being available on a cluster and practice basis, and the increased use of technology.

Exhibit 24: successes described by cluster leads in our survey

Successes	Number of clusters
Cluster and practice-based services	8
Improved collaborative working	5
Increased use of technology	3
Intermediate care services	1
Cluster support	1
Health Board sustainability meetings	1
Rhondda recruitment website	1

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

99 Exhibit 25 shows that the main concerns expressed by cluster leads were increased patient expectation, where patients expect an instant service. Recruitment and retention of GPs, nurses and other health professionals are also a concern, along with increased demand and volume of work.

Exhibit 25: challenges described by cluster leads in our survey

Challenges	Number of clusters
Increased patient expectation	5
Recruitment and retention issues	5
Increased demand	3
Locum costs	2
Secondary care work falling to primary care and lack of funding to support it	2
Lack of mental health provision	1
Issues associated with a deprived population	1
Disparate IT systems	1

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

Appendix 1

Methods

Exhibit 26: 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%. At the Health Board we sent out 12 surveys and received eight responses, giving a response rate of 67%.
Interviews	We interviewed a number of staff including the following with responsibility for primary care: • Vice Chair • Head of Primary Care • Assistant Medical Director • Clinical Directors • 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.
Use of existing data	We used existing sources of data wherever possible such as data from the Welsh Government, Public Health Wales and the Health Board's annual accounts.

Appendix 2

Management response

Exhibit 27: management response

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	The Health Board commissioned the Primary Care Foundation to carry out demand and capacity assessments in GP practices but the take-up from practices has been variable. To maximise value from the commissioned work, the Health Board should centrally analyse and collate the messages from the demand and capacity assessments and share the learning across all practices.	To maximise the value from the demand and capacity assessments.	Yes	Yes	Currently this is being undertaken and the outcomes will be shared at Cluster meetings, the Primary Care Strategic Planning Group and reported through to the Primary Care Committee. Numerous practices have implemented changes and this will be captured and shared as a key element of this work.	December 2018	Head of Primary Care

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 the baseline from which to measure the resource shift out of secondary care.	Yes	Yes	This work has commenced and will be a crucial element in determining the baseline position for the primary and community element of the Cwm Taf Partnership Transformation Plan.	March 2019	DPCMH
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	The Cwm Taf Partnership Transformation Plan will require that a thorough assessment is made in regard to the impact of investment in primary, community and social care on the whole health and care system. This will require reporting to WG and also through the Regional Partnership Board as well as internal efficiency and productivity arrangements.	March 2020	DPCMH

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3	The Health Board's workforce planning is inhibited by having limited data about the number and skills of staff working in primary care, particularly community dentistry, optometry and pharmacy. 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.	No	Yes	The Health Board through the Oral Health and Eye Care planning arrangements will commence during 2019/20 more detailed work on the workforce issues in Dentistry and Optometry practices. In particular skill mix approaches and professional shortages. The CDS service will have been repatriated and a full workforce analysis and modernisation approach will be undertaken The Cwm Taf Transformation plan places great store on MDT working of which the role of pharmacy and pharmacists is crucial. Workforce planning in this area is key and will be worked through the Transformation Plan	March 2020 March 2020	AD (Primary Care, Localities and CYP) Chief Pharmacist/ DPCMH

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4a	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.	To support clusters to evaluate initiatives and understand whether it would be beneficial to carry on and expand or stop.	Yes	Yes	The Public Health Local Team have supported the clusters in evaluating a small number of schemes already but not all. In addition to this they have produced a template evaluation framework for clusters. The use of this template needs to be encouraged for all schemes. Detailed evaluation is an essential part of the new transformation plans to demonstrate the impact of the extended MDT team.	March 2020	Head of Primary Care

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4b	Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters.	To provide a mechanism for clusters to learn from each other's initiatives.	Yes	Yes	A Primary Care Newsletter is in existence and is produced quarterly. This newsletter is intended for professionals and is shared across the clusters, between contractors and community.	Ongoing	Head of Primary Care
R4c	Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments.	To educate the public about alternative first points of contact available.	Yes	Yes	Work has already commenced with this as part of 'know your own team campaign'. A plan for 2018/19 has been produced. Engagement with clusters is essential. Opportunities to engage will be taken via media, press, existing forums and groups and events.	Ongoing	Head of Communications

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4d	Evaluate the effectiveness of the Health Board's new primary care communications officer role and share the learning with all health boards in Wales.	To share learning with other health boards in Wales.	Yes	Yes	This process is already in place and evaluation/success measures are already detailed in the delivery agreement which is reported to the Welsh Government on six-monthly basis. Sharing of learning across Wales takes place via all Wales forum of Heads of Communication.	Ongoing	Head of Communications
R5a	Review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary.	To strengthen and target cluster development support.	Yes	Yes	Significant support is already given to clusters however they will need to evolve both as part of the strategic direction set by the Welsh Government in A Healthier Wales and to fulfil the expectations and requirements of the transformed model. In addition, a new governance framework has been issued on a national basis and will be used locally as part of the delivery of the transformation plan to support clusters in their maturity.	March 2020	AD (Primary Care, Localities and CYP)

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R5b	Review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups.	To ensure clusters have the right representation.	Yes	Yes	This has been undertaken and steps are in place to strengthen the primary care cluster structure.	March 2019	Head of Primary Care/AMD (Primary Care)
R5c	Develop an action plan for strengthening cluster leadership.	To strengthen cluster leadership.	Yes	Yes	Various options will be offered to cluster leads in order to fit their skills and experience and to provide flexibility. This will be explored at cluster leads meeting.. An array of options are already available through their PCCI Hub	March 2020	Head of Primary Care

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