Primary care services – **Cardiff and Vale University Health Board**

The person who delivered the work was David Poland.

Contents

Primary care is a growing priority, the Health Board is making progress towards delivering its ambitious plans and workforce pressures are less acute than in some other areas. However, primary care performance is mixed and a number of difficult challenges remain.

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?

First point of contact
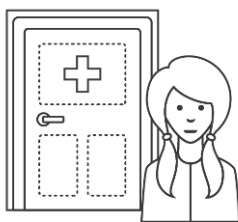
Primary care is the first port of call for the majority of people who use health services. (But NHS Wales doesn't have good data on the number of appointments each year).

Spending on primary care

PRIMARY CARE 1.4BN

REST OF THE NHS IN WALES
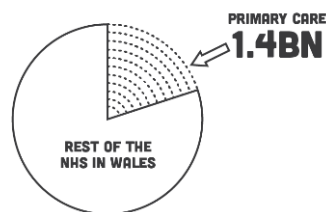
In 2016-17, the NHS in Wales spent £1.4 billion on primary care, which is around a fifth of the total NHS spending in Wales.

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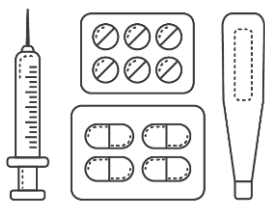
Primary care is also important because of its focus on promoting well-being, early intervention and preventing people's conditions from getting worse.

Coordinating care
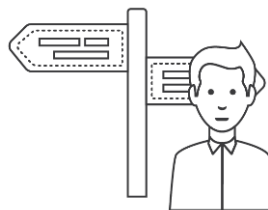
Primary care has an important role in coordinating people's care. Primary care is the gateway to many other services.

Source: Wales Audit Office

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

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

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.

4   The national primary care plan and the NHS Wales planning framework place an expectation on health boards to set out their 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. Each plan should also cover the key principles from the national plan (as shown in the bullets below) and the priority areas for action.

- prevention, early intervention and improving health;
- co-ordinated care between experts and generalists;
- actively involving public, patients and carers in decisions about their care;
- planning services at a community level; and
- prudent healthcare.

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

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

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

8   Since the national primary care plan was published in 2014, there have been several developments. In October 2017, the National Assembly's Health, Social

[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

Care and Sport Committee published a report following an inquiry into clusters[5]. 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 **Primary care out-of-hours services**.

12   This report summarises the findings of audit work in Cardiff and Vale University Health Board (the Health Board) carried out between March and May 2018. The audit 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?

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[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**: 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?

Key findings

13 Our overall conclusion is: **Primary care is a growing priority, the Health Board is making progress towards delivering its ambitious plans and workforce pressures are less acute than in some other areas. However, primary care performance is mixed and a number of difficult challenges remain**.

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

Exhibit 2: our main findings

Our main findings
Strategic planning: The Health Board's ambitious plan aligns with the national plan and is informed by cluster plans but there is scope to improve consultation and a need to take population growth into account.   - The Health Board's primary care plan is part of a wider strategy to move care closer to home. The plan aligns with the key elements of the national plan although there is scope to strengthen consultation.   - The Health Board has supported all clusters to develop plans that feed into the overall primary care plan but cluster maturity varies and representation from some stakeholders is limited.
Investment: The Health Board has made some progress in shifting resources to primary care but there are challenges to be overcome to increase further investment.   - The format of the accounts make it difficult to accurately calculate the Health Board's overall investment in primary care.   - The Health Board can point to some specific examples of shifting resources towards primary care, but large-scale change is being hampered by a range of barriers.   - The Health Board closely monitors cluster spending, but cluster leads raised concerns about delayed financial decision making and problems securing funding to mainstream successful pilots.
Workforce: Workforce challenges are less acute than in some other areas but are increasing and while the Health Board is implementing a number of new roles, there are barriers to further progress.   - Workforce pressures are less acute than in other parts of Wales but the Health Board's mapping does suggest a shortfall of GPs and an ageing nurse workforce.   - Unlike many parts of Wales, the Health Board is not directly managing any practices although sustainability issues are increasing. The workload of the Health Board's GP Support Unit is mainly reactive to requests for help from individual practices. This means there is a risk that the unit only provides support to practices once they begin to experience significant issues.   - The Health Board has made progress with implementing multi-professional teams but there are some barriers to progress including limited evaluation of new roles.

Our main findings
Oversight: Primary care is a growing priority in the Health Board but performance reporting continues to focus more on secondary care. • Senior leaders are proactive in promoting primary care as a growing priority. • Primary care performance is reported at various levels in the Health Board, but secondary care is a greater focus. • GPs provide leadership to all clusters and these leads gave positive views about the Health Board's oversight. However, leads feel they do not have enough time to lead the clusters effectively.
Performance: Primary care performance is mixed and several difficult challenges remain. • There is a mixed picture in terms of the Health Board's current performance and there is scope for improvement in many areas. • There are several barriers that need to be overcome to ensure further progress is made to improve primary care.

Recommendations

Recommendations
Strategic planning
R1   The Health Board has developed an ambitious plan for primary care, but the plan does not consider the impacts of projected population growth as a result of housing developments in Cardiff. The Health Board should therefore revisit its primary care plan to ensure it includes specific actions to meet the needs of the projected population growth in Cardiff.
R2   The Health Board's plans for primary care have been developed with only limited consultation and collaboration with some key groups of stakeholders. The Health Board should therefore develop the necessary consultation and communications plans to ensure meaningful public and stakeholder engagement in any further development / refinement of its primary care plans.
Investment

R3   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
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.   Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund.   d.   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.
Primary care clusters
R5   We found variation in the maturity of primary care clusters. 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.   c.   Ensure all cluster leads attend the Confident Primary Care Leaders course.
Oversight of primary care
R6   We found scope to improve the way in which primary care performance is monitored and reported at Board and committee level. The Health Board should: a.   Ensure the contents of its Board and committee performance reports adequately cover primary care.   b.   Increase the frequency with which Board and committees receive performance reports regarding primary care.   c.   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.

Detailed report

Strategic planning: The Health Board's ambitious plan aligns with the national plan and is informed by cluster plans but there is scope to improve consultation and a need to take population growth into account

The Health Board's primary care plans is part of a wider strategy to move care closer to home. The plan aligns with the key elements of the national plan although there is scope to strengthen consultation

The Health Board's primary care plan is part of a wider strategy to move care closer to home

15   The Health Board has articulated its plans for primary care in the following documents:

- Shaping our Future Wellbeing Strategy 2015-2025;

- Primary, Community and Intermediate Care (PCIC) Clinical Board Integrated Medium Term Plan (IMTP) 2017-2020;

- Cardiff and Vale University Health Board 2017-2018 Plan; and

- Cardiff and Vale Emerging Model Canterbury, September 2017.

16   The Health Board's overall strategic direction is set out in 'Shaping our Future Wellbeing' Strategy which was launched in 2015. The strategy aims to 'achieve joined up care based on "home first", avoiding harm, waste and variation, empowering people and delivering outcomes that matter to them'. The Health Board's aim is to work with partners to establish hospital and community-based care networks. The Health Board aims to establish within each locality 'Health and Wellbeing Centres'. These will provide a central point for a network of clinical services and facilities. They will support the sustainability of general medical practice and community care to improve overall accessibility to services.

17   The direction of travel for primary care is set out in the PCIC Clinical Board IMTP 2017-2020. This sets out the key drivers for the plan, which were identified as part of planning process. These include:

- Welsh Government's primary care plan up to 2018 and the supporting Primary Care Workforce Plan. The implementation of this plan is considered pivotal to the Clinical Board and, in turn the Health Board.

- The national Primary Care Model arising from the national pacesetter projects. The Clinical Board is closely aligned to the implementation of the model and is tracking the development of primary care in Cardiff and Vale against the model.

- GMS (General Medical Services) sustainability is a well-documented key risk across Wales. In 2017-18, Cardiff and Vale experienced unprecedented GMS sustainability pressures and is now the Clinical Board's highest risk area. This will be a key area of focus for the Clinical Board during 2018-19 – 2020-21 and is a central element of the national Primary Care Model.

- Cluster development and the role clusters play in the health and wellbeing system. Cluster networks are key to both GMS sustainability and the future development of the wider primary care system of the future.

- The Cardiff and Vale Shaping our Future Wellbeing Strategy and applying the home first principle wherever it is appropriate to do so.

- Canterbury Healthcare – understanding the integration work undertaken by the Canterbury District Health Board and what lessons can be applied in Cardiff and Vale to accelerate the pace of change.

18   The nine Cardiff and Vale cluster plans fed into the PCIC Clinic Board IMTP. Service leads were then tasked with inputting to various sections of the PCIC IMTP documents. The PCIC Clinical Board IMTP feeds into the overall Health Board IMTP.

The Health Board's primary care plans align with the key elements of the national primary care plan

19   We assessed the Health Board's plan for primary care to see whether it contained key elements that ensure alignment with the national primary care plan and national Primary Care Model.

20   We found that the Health Board's plans for primary care generally align with the national plan and the overall strategy. We also identified strengths in the Health Board's primary care planning process, including the fact that cluster plans feed into the PCIC IMTP process. We were also told by cluster leads that the PCIC Clinical Board is putting clusters at the forefront of planning.

21   Reported weaknesses of the planning process include difficulties caused by the current financial climate and the fact that available funds are only known for the short term. We also found that cluster engagement varies and we heard concerns during some interviews that the Health Board's overall plan is just too ambitious. Our fieldwork has also raised issues with robustness of data available to inform primary care planning and that there is no agreed, effective methodology for the evaluation of new ways of working.

22   A further weakness is that the current plans do not include an assessment of the impact of future significant population growth within Cardiff due to known housing developments. It states in the IMTP that the increase in population in Fairwater, Cardiff could be 21,000 and that there will be a significant shortfall of 8,000 patients who will require access to medical services. In addition, there are other developments planned for Lansdowne (Ely Paper Mill) and St David's (North East

Cardiff). It is unclear how the full impact of these proposals has been factored into current plans for developing primary care and the impact on future sustainability.

Internal and external stakeholders feel that the Health Board's engagement on primary care has been more about informing them about future plans rather than genuine consultation and exchange of ideas

23 It is important for the health boards to collaborate with stakeholders in developing their plans. The Health Board has engaged with a range of stakeholders in developing its primary care plans, both internally, and externally.

24 Internally, the PCIC Clinical Board IMTP was developed by a wide range of primary and community care staff and stakeholders via several development sessions. These sessions included presentations to staff which outlined recent progress in developing primary care and future plans. The objective was to get ownership of the plan from frontline staff through raising awareness. It also allowed staff to challenge plans.

25 Externally, the Health Board has been working with a range of stakeholders to develop its primary care plans. The Board met with the Community Health Council in February 2018 to discuss the 'Canterbury Model' and the Board's plans for primary care. It has also engaged with other health boards through its input into national events and discussions regarding the national Primary Care Model. It also attended Pacesetter Appraisal Workshops on lessons learnt for transforming primary care in Wales in January 2018. In addition, the Health Board representatives attend the monthly All Wales Directors of Primary, Community and Mental Health meetings.

26 The Health Board has engaged with the Regional Partnership Board and the Public Service Board through discussions on the IMTP. It has held a PCIC IMTP development session with local authorities and discussed priority schemes included in the IMTP.

27 The Local Medical Committee has taken part in GMS Sustainability Workshops and have presented at these events. Some professional groups feel that the Health Board engages well and that they have an opportunity to input into the Health Board's plans. However, others feel that the opportunities to engage are not consistent and they feel unable to contribute to the local cluster agenda.

28 There has been limited engagement with the public and patients and this area will need to be reviewed to ensure that this important group are involved in the process. There have been a number of cluster based 'Health Fairs' but this have been focussed on promoting immunisation and screening services rather than consulting on plans for the future.

The Health Board has supported all clusters to develop plans that feed into the overall primary care plan, but cluster maturity varies and representation from some stakeholders is limited

29 We looked at the way that health boards provide support to clusters in developing local needs assessments and cluster plans. Each cluster has an appointed cluster lead community director, who is employed by the Health Board on a sessional basis to lead the cluster and its development. The cluster lead is supported by the locality management team within which the cluster falls, and a primary care team member is dedicated to supporting each cluster with contractual advice.

30 In April 2017, an internal audit report on the IMTP process found that while all clusters had a three-year development plan (2014-17), none had a business plan that sets out the future vision for the cluster. The report also highlighted delays in achieving key milestones within the clusters, mainly due to current working arrangements and recruitment difficulties. The report made five recommendations affecting primary care, which have been agreed and which have been or are in the process of being implemented.

31 In our survey of cluster leads, one cluster lead told us their cluster had not yet developed a three-year Cluster Network Action Plan setting out strategic priorities. However, since our work was completed the Health Board has confirmed that all clusters now have plans. The latest cluster plans cover the period 2017-2020. Clusters develop their plans with support from the locality team and wider stakeholders, for example public health.

32 Individual GP practices submit a practice development plan to the Health Board as part of the practices' contractual obligation. These plans are then used to collate a cluster-wide plan. The cluster plans are then fed into the clinical board and used to inform the PCIC IMTP. If plans do not fit strategically or financially with the objectives of the Clinical Board then further discussions are held between the practice and the GP Support Team (GPST). Ongoing support and advice is provided by the GPST throughout the planning process.

33 Our survey of cluster leads found that most clusters (6 out of 7) have undertaken a needs assessment of the local population. Most respondents (5 out of 7) agreed that they received support from the Health Board in the development of their needs assessment.

34 Five out of seven cluster lead respondents agreed that their cluster had received helpful guidance from the Health Board in developing its cluster plan. And four out of five agreed that the Health Board takes account of the cluster when it develops Health Board level priorities for primary care.

35 Our survey found that the maturity of the clusters is variable. Most clusters (five out of eight) report being at a 'stable' stage of organisational development with ongoing support required and full potential yet to be reached. Two clusters assessed themselves as being 'mature' with all members fully engaged. One

cluster assessed themselves as being in the developmental stage, that is, in an 'early stage of development with significant support required; not all cluster members fully engaged'.

Exhibit 3: 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

36   In our survey, we found that only one of the seven respondents said that they had local authority representation at the cluster meetings, three had third sector representation and none had lay representation.

Investment: The Health Board has made some progress in shifting resources to primary care but there are challenges to be overcome to increase further investment

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

37   Exhibit 4 is based on data from the Health Board's annual accounts and sets out the 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. It excludes prescribed drugs and appliances. The exhibit shows the Health Board spent £135.6 million in cash terms on primary care in 2016-17.

Exhibit 4: the Health Board's spending on primary care services
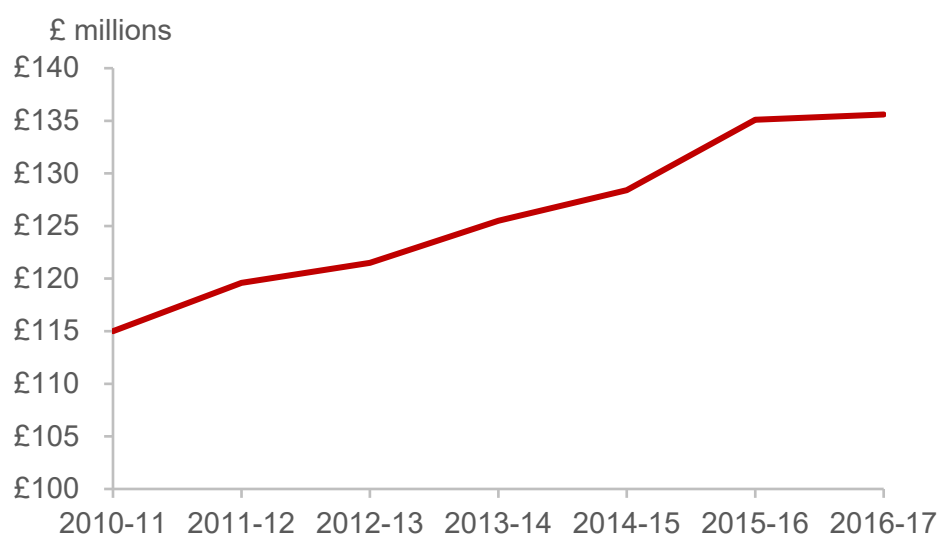
£ millions

Source: LHBs Annual Accounts

38   Exhibit 4 shows that between 2014-15 and 2015-16 total primary care spending increased from £128.4 million to £135.1 million (+5.2%). Between 2015-16 and 2016-17 spending reduced to £135.6 million (-0.3%). The increase in expenditure between 2010-11 and 2015-16 is partly reflected in the number of registered patients increasing from 489,000 to 511,000 over the six-year period.

39   After taking into account the effect of inflation, the Health Board's overall spending on primary care increased in real terms by 7.5% 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.

40   We also looked at whether health boards were spending more or less than the funding allocated to them by the Welsh Government. The Welsh Government allocates money to health boards in a range of primary care categories. In 2016-17, the Health Board spent more than its allocation on General Medical Services (+£8.2 million), less than its allocation on Pharmacy (-£0.9 million) and the same as its allocation on General Dental Services. Since 2012-13 the Health Board has consistently spent above the allocation it has received from Welsh Government for General Medical Services. The Health Board told us this overspend primarily relates to increased vaccine programmes, enhanced services, rates (business rate rebates estimated to be £1.1 million were not applied until 2017-18), dispensing costs, premises inflation, Quality and Outcomes Framework (QoF) rules relaxation[9] and out of hours services.

41   In addition to the primary care funding allocation described above, in 2016-17, the Health Board received £5.807 million from the Welsh Government through the Primary Care Development Fund. The Health Board gave £1.414 million of this funding to clusters. The remainder was spent on IMTP and Workforce (£3.8 million); Pathfinders (£0.54 million) and Occupational Health for GPs (£0.03 million).

42   In 2016-17, the Health Board spent its Primary Care Development Fund allocation after submitting several Delivery Agreements. These agreements were approved by the Welsh Government before the commencement of the financial year. The funding provided by the Welsh Government is separate from the funding provided for 'pathfinder' projects or for cluster development. The aim of the agreements is to provide a frame of reference for action by health boards, trusts and partner organisations. They seek to develop clinical leadership throughout the health service and set a common direction for service improvement. Agreements in 2016-17 related to the following projects:

- Community Resource Team expansion
- Diabetes
- Eye Care
- Family Planning and STI services
- Pathway Transformation
- Stoma Clinics

[9] From January to March 2018 the Welsh Government relaxed the QoF rules for GMS to reduce workload on GPs due to winter pressures. At the year-end for each indicator practices will be paid the better of the points achieved in 2017-18 or the points used for payment at the end of 2016-17.

- Workforce Planning
- Phlebotomy
- Prescribing Teams
- Pulmonary Rehabilitation Programme
- Wellbeing Coordinators

The Health Board can point to some specific examples of shifting resources towards primary care but large scale change is being hampered by a range of barriers

43 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 39) make it difficult to say whether health boards have secured such shifts.

44 Exhibit 5 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.

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

% of NOC
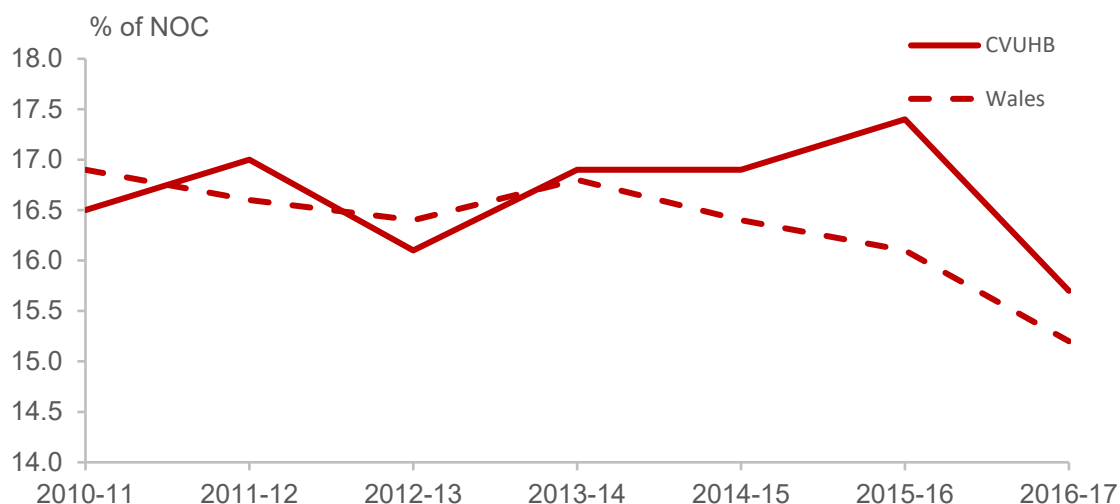
Source: LHBs' Annual Accounts

45   The Health Board's expenditure on primary care as a percentage of its total expenditure (15.7%) in 2016-17, remains above the average for the whole of Wales (15.2%). This has been the case since 2014-15. The Health Board told us that the trend in this graph is partly explained by the Health Board's total expenditure increasing from £761.113 million in 2015-16 to £832.034 million in 2016-17.[11]

46   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 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.

47   Despite having no specific targets for moving resources, the Health Board is using the 'Shaping our Future Wellbeing' Strategy 2015-2025 to design sustainable services closer to patients' homes. The following are priority service areas to move closer to patients' homes by transferring them to Health and Wellbeing Centres: cancer; dementia; dental and eye health; long-term conditions; maternal health; mental health and stroke services.

[11] The increase in primary care expenditure specifically between these years is £3.523 million excluding drugs and appliances linked to; GMS enhanced services, vaccines programme changes, Intermediate Care funding, Cluster funding and GP Out of Hours services.

48   Our fieldwork has revealed that, despite some examples of services being
      transferred to primary care, progress has been limited. Examples of service
      moves include community-based audiology and INR (International Normalised
      Ratio) anti-coagulation monitoring and management. In addition, musculoskeletal
      services and mental health assessment and liaison services have been
      transferred into primary care. During 2018, the Board will be using a resource
      transfer framework to try and quantify the shift in resources for the two latter
      services.

49   There are also cluster-based examples of service shifts. For example, diabetes in
      the South and East Locality, where the cluster has employed Diabetes Specialist
      Nurses to work at a cluster level. Also, the Pulmonary Rehabilitation Service,
      which has been developed at a cluster level for primary care patients, to avoid the
      need to refer to the hospital-based service for that practice population.

50   During our interviews, we were told about a willingness to move resources
      towards primary care but interviewees said it was difficult to achieve in practice.
      Challenges include understanding the mechanisms for transferring funding
      across budgets and service areas. The need to move resources is gaining
      recognition but there is a need to change attitudes as some perceive that work is
      being transferred to primary care without the financial or staffing resources. There
      is also evidence that at times of pressure, staff who are community based can be
      recalled back to the secondary sector.

51   Our fieldwork has also revealed some other barriers to moving resources towards
      primary care. These barriers include the current financial deficit facing the Health
      Board, which makes it difficult to identify funding streams for transfer to primary
      care. There is a view that secondary care protects their resources and are
      unwilling to transfer funds from their budget as they will then lose control of the
      funding. Limitations on budgetary guidance on how to transfer funds is also seen
      as a barrier.

52   This is exacerbated by the lack of planning of the financial impact of service
      transfers prior to implementation of schemes. Reasons for this lack of planning
      are the variation in the maturity of clusters to plan efficiently and that GPs are too
      preoccupied with work pressures to oversee planning within practices/clusters.

The Health Board closely monitors cluster spending, but cluster leads raised concerns about delayed financial decision making and problems securing funding to mainstream successful pilots

53   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.

54   The Health Board's approach to overseeing cluster spending is that cluster
      funding is allocated to clusters ahead of the start of the financial year. Plans are

requested by a set date and approved by the senior team within primary care, which includes the Director of Operations, Clinical Director, Head Nurse, Head of Workforce and Organisational Development, Finance representative and the Assistant Director.

55   Monthly details of expenditure for the period to date and forecasts for the year and following year are provided by the PCIC finance team to each cluster/locality. Where there is any slippage in implementation of schemes, further schemes are considered. The Health Board has, in previous years, re-provided slippage to the next financial year, although for the year 2017-18 this is reported as minimal. In addition to the above, the Health Board provides cluster updates to the Welsh Government on a quarterly basis, including spending.

56   Our survey of cluster leads found that most (6 out of 7) agreed that their cluster spends all the funding that it receives. However, only one out of the seven respondents agreed that they can spend its funding quickly once it has decided how to allocate it. Only two clusters agreed that the Health Board gives their cluster sufficient financial autonomy.

57   Most (4 out of 7) respondents agree that the Health Board is providing ongoing funding to successful pathfinder/pacesetter schemes and the majority (6 out of 7) agree that the Health Board effectively monitors their clusters expenditure.

58   Respondents to the survey stated that the Health Board's processes cause delays in decision making particularly in the areas of recruitment and procurement. It should be noted that both recruitment and procurement services are provided by the NHS Wales Shared Services Partnership.

59   Although the timeliness of financial reporting was raised as an issue during the field work, the audit did confirm that financial reports are produced monthly for primary care. No issues have been flagged directly to the finance department regarding the timeliness of reports.

60   Clusters also believed that if a project was shown to be successful following evaluation then the funding would be made permanent, subject to the Health Board's investment processes. The initial funding would then be released back to the cluster for further investment in innovative schemes. This, however, has not happened which leaves no funding available for developing further innovative ideas. There is a lack of understanding of how clusters should agree permanent funding for successful projects upfront and the rules surrounding funding of projects and their sustainability generally.

Workforce: Workforce challenges are less acute than in some areas but are increasing and while the Health Board is implementing a number of new roles, there are barriers to further progress

Workforce pressures are less acute than in some other parts of Wales but the Health Board's mapping does suggest a shortfall of GPs and an ageing nurse workforce

61   The number of GPs in the Health Board area has remained constant since September 2014 and the average GP list size has increased only marginally from 1,620 in September 2014 to 1,651 in September 2017. These trends are at odds with the trends at an all-Wales level. The number of GPs per 10,000 population in the Health Board area is 6.3 which is above the All Wales figure of 6.2. This is illustrated in Exhibit 6. The average list size for GPs in the Health Board in September 2017 was 1,651, slightly below the All Wales figure of 1,664.

Exhibit 6: number of GPs per 10,000 population
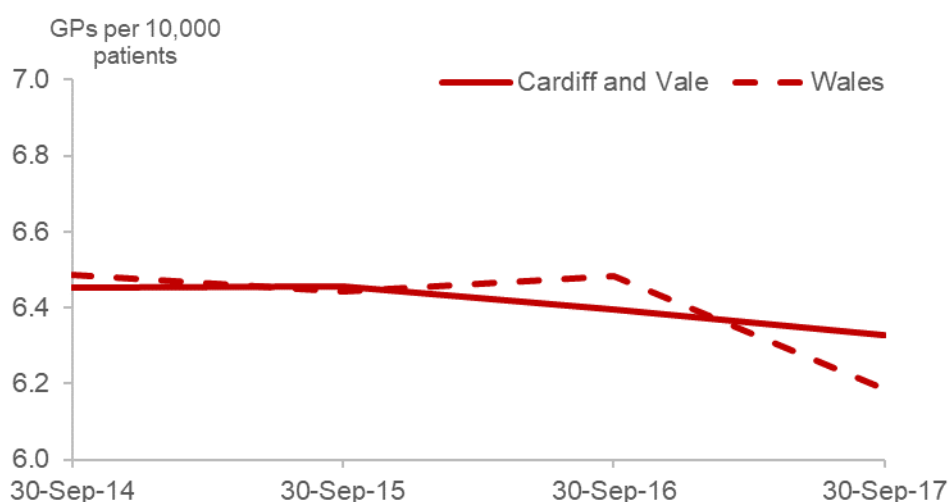
Source: Welsh Government

62   We found that 22% of GPs in the Health Board area are aged 55 and over, compared to an all Wales average of 23%. The percentage of female GPs in the Health Board rose from 52% in September 2014 to 57% in September 2017. This is above the Wales average of 54%.

63   The number of dentists in the Health Board area has increased slightly from 306 at the end of March 2014 to 317 at the end of March 2017. Dentists in the Health Board continue to see more residents than the Wales average as they treated 56% of residents in 2017 compared with the Welsh average of 55%.

64   There has been an increase from 170 to 185 in the number of NHS ophthalmic practitioners and optometrists in the Health Board between 2013-14 and 2016-17. Activity for all sight tests paid for by the NHS increased from 111,875 to 117,304 in the same period.

65   The national primary care plan requires health boards to map their workforce. Health Board's mapping covers GP partners, salaried GPs, returners and retainers, practice nurses and other health care support workers. Data on the number and skill mix of all staff working in GP practices was collected in October 2017. This shows the number of staff in post by practice and the number of hours worked. There is no data on the number and skill mix of staff working in community pharmacy, dentistry or optometry. The Health Board has also analysed the age profile of GPs and it collects data on the extent to which all GPs are working part time or full time. Information on whole time equivalents is available by cluster and individual practice.

66   The PCIC IMTP contains information on the age profile of all staff employed in primary care. This shows that for the age profile for the directly employed, 54% of the workforce are aged over 46. As nursing is the biggest staff group (43%) and the current age profile shows 44% are aged 51 or over, this presents a significant risk to workforce sustainability. The plan acknowledges that improvements in recruitment practices and processes to attract, whilst continuing to promote 'retire and return' and improved engagement, will be key in retaining the current workforce.

67   The Health Board considers primary care workforce issues through its Primary Care Workforce and Organisational Development Group. The Health Board has taken the following actions to model future workforce needs:

- The Board has employed workforce planning and organisational development expertise to support the establishment of baseline workforce data and the ambitions of clusters and practices for their future workforce based on population needs.

- At the time of our review, a skills analysis of the general practice nursing workforce was underway to identify a baseline of skills that will support proactive targeting of skills development/investment in conjunction with the Primary Care Education Team. In addition, facilitated workshops have taken place to support clusters and practices to develop their thinking around future business models and service priorities to start modelling the future workforce.

68   The Health Board's modelling of future requirements shows that the number of GPs required by 2020 will increase from 252.85 whole time equivalent (WTEs) to 289.52 WTEs as shown in Exhibit 7.

GP (WTE) Workforce projections:2020
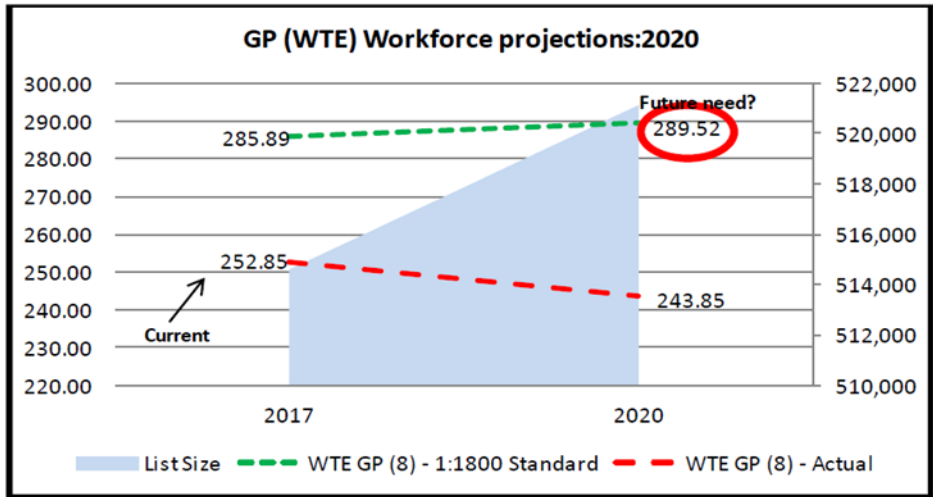
Source: Health Board self-assessment

Unlike many parts of Wales, the Health Board is not directly managing any practices although sustainability issues are increasing

69   Unlike many other areas in Wales, the Health Board is not directly managing any GP practices. However, the PCIC IMTP states that General Medical Services in the Health Board area have become increasingly fragile over the last year and the workforce and organisational development expertise have a key role in supporting sustainability. It has several actions planned for 2018-19 designed to support delivery of an efficient, sustainable and engaged workforce.

70   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. The Health Board's unit is called the GP Support Team (GPST) and its budget has increased from £229,000 in 2015-16 to £504,000 in 2017-18[12].

71   The main responsibilities and activities of the GPST are:

- Carrying out a visiting programme to practices;
- Practice nurse mentoring, training and education;
- Clinical support and review of systems and processes;
- Action planning for practices where issues have been identified;

[12] A proportion of the £504,000 goes on funding the GPST but the funding is also used to fund and test innovative GP out-of-hours posts.

- Workforce and organisational development support, including carrying out a baseline workforce assessment across practice teams; and
- Developing bespoke specific packages of support to aid sustainability.

72   The GPST aims to work proactively with practices to put support in place when sustainability issues are first recognised. Sustainability issues have only started to be raised within the last 18 months and are now taking up time for the Health Board and the GPST.

73   The Health Board encourages practices to complete the Welsh Government's GP Sustainability Framework where significant issues are identified, particularly if there are financial pressures within the practice. However, The Health Board reports that most of the GPST's contact with practices to date has been done informally with practices approaching the GPST for advice and support. The Health Board has only received two formal Sustainability Framework applications since the framework was launched. The issues that were brought to the attention of the Board were concerning recruitment difficulties. Both practices were asked to meet with the team to discuss the issues further. However, one of them has declined to engage any further.

74   Other actions taken by the GPST in relation to practice sustainability are summarised below:
- Two GMS sustainability workshops were held in February 2018, including promotion of the GPST and the support they can offer practices.
- The team has supported a practice merger and is working with another four practices who are looking to merge into two sets of two. Reasons for the mergers are retirements of GPs or partnerships being dissolved.
- The team are currently developing a public-facing recruitment and retention website. This will mainly advertise practice vacancies and promote living and working in Cardiff and Vale.
- A Recruitment and Retention Project Group and a Communications Group have been established to ensure that the work of the team is 'branded' and standardised wherever possible.
- Work is also ongoing to identify external companies who can be commissioned to provide support to practices where they need more specialist support and advice eg capacity and demand management; development of a medical administrator model etc. as part of a proactive approach.

75   In April 2018, the Chief Executive wrote to all cluster leads informing them of his immediate plans for supporting primary care resilience and sustainability. The following immediate measures were proposed:
- Investment in IT infrastructure to enable practices to better connect to each other, to external services and clusters;
- Fund an increase in capacity for the GPST;

- Fund and procure demand and capacity modelling software capability ('Ask my GP') for all practices;

- Fund care navigation training for reception staff;

- Introduce a GP Fellowship scheme;

- Work with the LMC on a range of supportive measures for improving sustainability, including include boundary changes, list closure processes, merger support and an active recruitment and retention programme for GPs; and

- Funding the roll-out of musculoskeletal and mental health liaison schemes across clusters.

The Health Board has made progress with implementing multi-professional teams but there are some barriers to progress including limited evaluation of new roles

76 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.

77 At the Health Board we found several examples of progress in developing new roles. For example, cluster pharmacists are now employed in eight clusters. Each pharmacist works across the practices within the cluster, undertaking poly-pharmacy reviews and audits intended to release GP time. A community physiotherapy service level agreement is also in place between the Central Vale Cluster and the Health Board to provide the first point of contact for the musculoskeletal physiotherapy service.

78 Other initiatives include:

- A cluster hosting a paramedic pilot, funded by the Welsh Ambulance Services NHS Trust (WAST), undertaking home visits on behalf of the GP to reduce demand on WAST and GPs.

- A primary care mental health pilot is underway in Cardiff East Cluster to provide the first point of contact and support for mental health conditions within the community.

- A primary care nurse for older people (PCNOP) has been established in Cardiff North Cluster. The nurse's remit is to provide proactive holistic care to individuals who are frail and/or have chronic conditions, co-ordinating care around the needs of the individuals using networking skills across sectors.

- Wellbeing co-ordinators roles created and delivered by the third sector with 257 referrals onto community and third sector organisations, 309 targeted

service user contacts regarding immunisation and 89 targeted service user contacts regarding screening.

- Social prescribing initiatives have been developed/piloted by Cardiff South West Cluster. Additional clusters are recognising the need to and benefits of up-skilling front line reception staff to support signposting to other services, including Dewis Cymru[13] and Cardiff Council Independent Living Services.

79   The development of new roles has progressed at different rates across the nine clusters and our work identified several barriers to further progress. These are summarised below:

- Delays in recruitment caused by the need for job evaluation for new roles and delays caused by the recruitment process.

- Clarification of employment arrangements for new roles such as who is responsible for risks and liabilities of staff (the HB or individual practices).

- Problems providing supervision and mentorship for staff in new roles.

- Difficulties in ability to scale up successful schemes and to ensure new roles become business as usual, due to financial constraints.

- Limited public awareness about how to make best use of primary care services, including new roles.

- The timely allocation of funding and the impact of changes to the GMS contract also impact on the appetite for pursuing opportunities.

- The development of skills and competencies of staff transferring from secondary to primary care also needs to be addressed.

- It has been difficult to embed the MDT approach when staff are only working one day a week in a practice/cluster.

80   Only two out of seven respondents to our cluster lead survey agreed that the Health Board effectively evaluates examples of innovation in their area. Cluster leads told us that evaluation skills are currently not available within clusters, and where evaluations have taken place, they have been retrospective rather than an integral part of projects.

81   We found that demands on practices and clusters leave little room for strategic thinking time for cluster leads. The lack of access to project management, business analyst skills and resources has also been challenging and is a barrier to making progress.

82   The national Primary Care Model also highlights the need for shared systems of triage for members of the primary care team. It is reported that within the Health Board, nothing has currently been set up, but opportunities are being explored.

[13] A web based resource providing information or advice on well-being from over 6,000 local and national services across Wales

Oversight: Primary care is a growing priority in the Health Board but performance reporting continues to focus more on secondary care

Senior leaders are proactive in promoting primary care as a growing priority

83   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, the Vice Chair has only been in post since October 2017 but is regarded as being proactive in relation to primary care. He meets regularly with key primary care staff and receives reports and briefings on primary care issues.

84   Across Wales we found slightly varying arrangements between health boards in the executive-level responsibilities for primary care. At the Health Board executive responsibility for primary care rests with the Chief Operating Officer, although his remit is broader than just primary care. Chief Operating Officer is the Executive lead for Primary care services so takes an active interest in promoting primary care issues and the Director of Public Health has primary care expertise, having served as the interim Director of Primary Care and Mental Health.

85   Operational management rests with a Director of Operations for Primary, Community and Intermediate Care who is supported by a senior Assistant Director. The clinical lead for the Primary Care Board is the Clinical Board Director for Primary, Community and Intermediate Care.

86   Our fieldwork suggests that primary care is increasing as a priority although there is scope for more progress in this regard. Four out of seven respondents to the cluster lead survey agreed that the Health Board gives sufficient high priority to transforming primary care. Respondents felt there had been an increase in the profile of primary care since the arrival of the new Chief Executive. Our fieldwork also revealed opinions that whilst the Health Board is undergoing a process of service change and attitudes to primary care are changing, this change needs to happen at a faster rate.

Primary care performance is reported at various levels in the Health Board but secondary care is a greater focus

87   We were interested in the frequency with which the Board and committees consider agenda items related to primary care. We found that primary care issues are presented to the Board regularly. Issues are reflected in a range of Board Reports such as the Performance 'Boardbook', the Chief Executive's Report, the Finance Report and reports of the Patient Safety, Quality and Experience Sub Committee. There is no standalone primary care report on the Board Agenda,

although there is an Annual Report to the Board on primary care, which over recent years has been an All Wales Primary Care Annual Report, which the Health Board and all other Health Boards feed into.

88   The main Health Board Performance Report, which is contained in the Boardbook, contains 65 measures. Finance and nursing information is reported separately. However, secondary care data dominates the performance report. Most of these measures are not primary care related, with greater prominence given to measures of mortality, mental health, unscheduled care, out-of-hours services, stroke, cancer, elective access, healthcare acquired infections and finance.

89   Not all the key indicators included in the NHS Wales Delivery Framework are reported in the main Health Board Performance Report. In the May 2018 Boardbook, there was a clear description of the performance of the GP Out of Hours performance but none of the other key Welsh Government primary care targets. This may be due to some primary care performance issues being reported to the PCIC Clinical Board, but a clear mechanism is required to provide assurance to the main board on primary care performance issues so that these are discussed and actioned.

90   At committee level, the Health Board has a dedicated PCIC Board although this is not a sub-committee of the main Board. The main primary care performance report to this forum is the PCIC Clinical Board Performance Report. As well as information on primary care workforce and finance this Report contains information on:

- Immunisation rates (flu and childhood rates)
- Emergency admissions and readmissions
- Referrals to the Community Resource Team and District Nursing activity
- Sexual health activity
- Prisons and homelessness activity
- Primary care practice issues
- GP out of hours services
- Medicines management

91   The Health Board told us that other performance information is available via the primary care information portal although our fieldwork suggests that it is not widely used.

GPs provide leadership to all clusters and these leads gave positive views about the Health Board's oversight. However, leads feel they do not have enough time to lead the clusters effectively

92   All cluster leads in the Health Board have a professional background as GPs. Exhibit 8 shows that across Wales only two Health Boards have GPs as leads in all their clusters. The remainder all have at least one lead from another profession.

Exhibit 8: professional background of the cluster leads

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

Note: While the total number of clusters is 64, the total number of cluster leads is 67 because Cwm Taf has both GP and other professional leads for its clusters.
Source: Wales Audit Office, Health Board self-assessment returns

93   In our survey of cluster leads, the majority (four out of seven) of respondents agreed that the Health Board provided them with effective support to undertake their cluster lead role. However, only two agreed that they have enough time in their day to focus on cluster development. During fieldwork we heard that decisions are sometimes taken that have an indirect impact on clusters, but the cluster is not involved in the decision-making process.

94   Cluster leads are recruited following open competition. The Health Board will seek 'expressions of interest' and candidates are then invited for interview to ascertain their understanding of the role.

95   Leadership development for cluster leads is underway but takes time to embed considering the significant agenda they are facing. Public Health Wales's Primary and Community Care Development and Innovation Hub has developed a Confident Leaders Programme, which has been attended by 40 of the cluster leads from across Wales. The cluster leads continue to share and learn from each other through a community of practice. However, our survey of cluster leads found that none of the seven respondents in the Health Board had attended the course.

96   Progress of clusters is monitored through the regular monthly PCIC Board meetings and there are regular meetings of cluster networks and the quarterly review of the Clinical Board's IMTP. In addition, there is a Primary Care Plan Actions and Progress Report. There is therefore regular contact between the Health Board and the clusters.

97   In April 2017, an internal audit report on the IMTP process highlighted some issues with cluster governance. The report found that there were no terms of reference for cluster meetings and therefore there was scope to clarify approval structures and roles and responsibilities.

98   Since the report was published the Health Board report the following progress (Exhibit 9) has been reported:

Exhibit 9: recommendations and responses to the Internal Audit Report

Recommendation	Progress/Response
A business plan should be established for each cluster that sets the future vision and developments of individual clusters.	Cluster plans in place for all clusters and these align and feed into the PCIC IMTP three-year business plan.
Cluster governance needs to be reviewed, to ensure future sustainability.	Community Directors Forum Terms of Reference (ToR) updated to reflect stronger focus on cluster development and governance. Several clusters have agreed or are in the process of agreeing their ToR.
Key milestones/delivery measure, should be achievable, with appropriate mechanisms will be in place at a locality level, to monitor the outcomes.	IMTP Project Opportunity Documents (PODs) and progress against key milestones are updated using the quarterly tracker. Updates are discussed at Service Delivery Group meetings and at Executive Performance Review.
Considerations should be given to providing targeted project management support for the development and sustainability of the clusters.	Part actioned: Cluster resource/support staff document developed and shared with clusters.

Recommendation	Progress/Response
Governance arrangements to be reviewed and updated appropriately.	Part completed: Governance review as part of the Clinical Board Development session postponed. Service Delivery Group ToR have been reviewed and updated. Executive Director of Planning attendance at Clinical Board meetings has improved recently.

Performance: Primary care performance is mixed and several difficult challenges remain

There is a mixed picture in terms of the Health Board's current performance and there is scope for improvement in many areas

99   Exhibit 10 shows how the Health Board performed against key Welsh Government indicators as reported in the Board's Performance Report for May 2018. As noted above, information and narrative on primary care performance is light. The data shows that the Health Board has made improvements in some areas and Welsh Government targets were met in three out of six indicators. The Health Board failed to meet a further two and there is no data reported for the sixth.

Exhibit 10: reported performance against national indicators

Indicator	Target	All Wales	C+V	Target met?
Percentage of GP practices open during daily core hours or within 1 hour of the daily core hours	Annual Improvement	87%	88%	Yes
Percentage of GP practice offering daily appointments between 17:00 and 18:30 hours	Annual Improvement	84%	92%	Yes
Out of Hours Services – % urgent calls logged & patient started definitive clinical assessment <=20 mins of call being answered Feb 18	98%		68%	No

Indicator	Target	All Wales	C+V	Target met?
Out of Hours Services – % very urgent patients seen<= 60 mins following clinical assessment	98%		85%	No
Percentage of the heath board population accessing NHS primary dental care	Annual Improvement	54.9%	56%	Yes
Percentage of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that they received at their GP/family doctor	Annual Improvement	89.7%	No data	No data

Source: Health Board Boardbook, Performance Report, May 2018

100   Exhibit 11 shows that the Health Board's child immunisation rates are amongst the lowest in Wales. The Health Board achieved the target for immunisations by the age of 1 but did not meet the target for MMR vaccinations.

Exhibit 11: child immunisation rates as at 31 March 2018
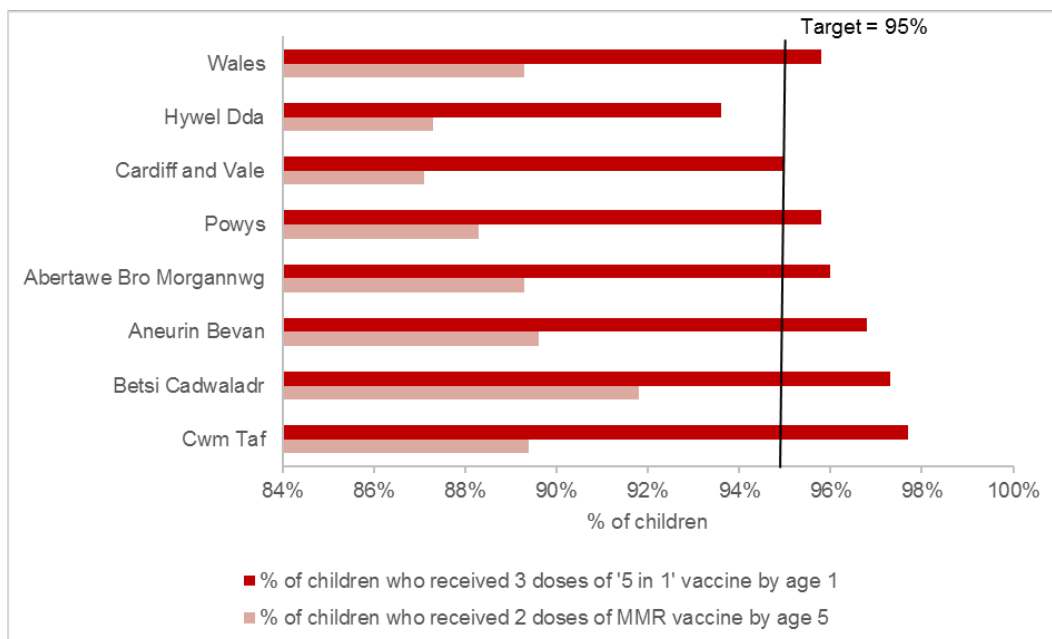
Note: '5 in 1' vaccine protects against diphtheria, tetanus, pertussis (whooping cough), polio and hib infection. MMR protects against measles, mumps and rubella infections. These results are for children living in the Health Board area in March 2018 and who reached their first and fifth birthdays during the quarter 1 January to 31 March 2018.

Source: Public Health Wales

101   Furthermore, the Health Board did not meet any of the five primary care targets reported by Public Health Wales for 2016-17. This is shown in Exhibit 12 below.

Exhibit 12: Public Health Wales primary care targets

| Indicator	Target	All Wales	Cardiff and Vale	Report Period	Target met
Bowel Screening Uptake	60%	53.4%	51.5%	2016/17	No
Breast Screening Uptake	80%	73.1%	70.2%	1/11/17	No
Cervical Screening Uptake	80%	77%	75.7%	31/3/17	No
Flu uptake over 65	75%	66.7%	69%	2016/17	No
Flu Uptake Under 65 at risk	75%	46.9%	48.3%	2016/17	No

Source: Public Health Wales

102   As shown in Exhibit 13 and Exhibit 14, the Health Board failed to meet the influenza vaccination target in either of the performance areas.

Exhibit 13: trends in uptake of flu vaccination 2014/15 to 2017/18: Uptake in patients younger than 65 who are at risk
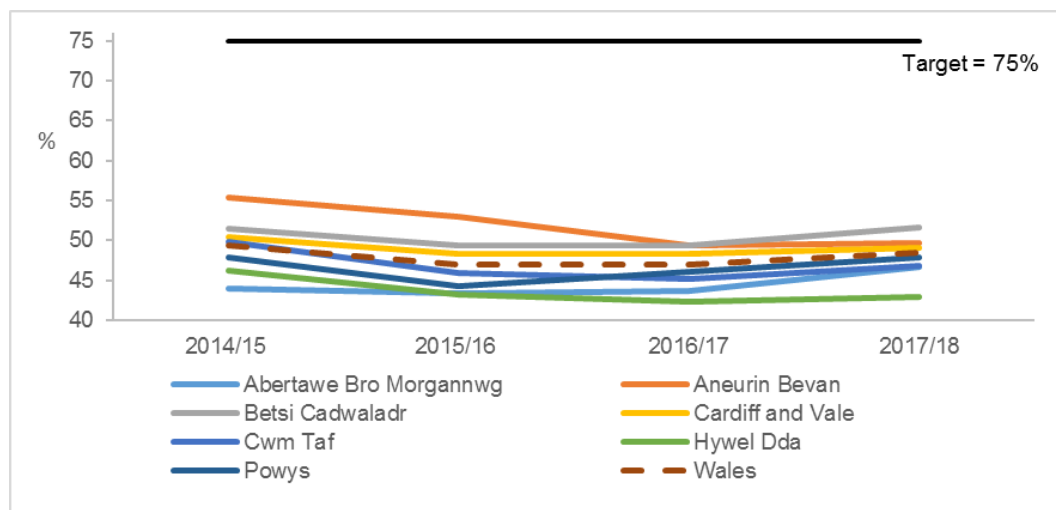
Source: Public Health Wales

Exhibit 14: trends in uptake of flu vaccination 2014/15 to 2017/18: Uptake in patients aged 65 years and older
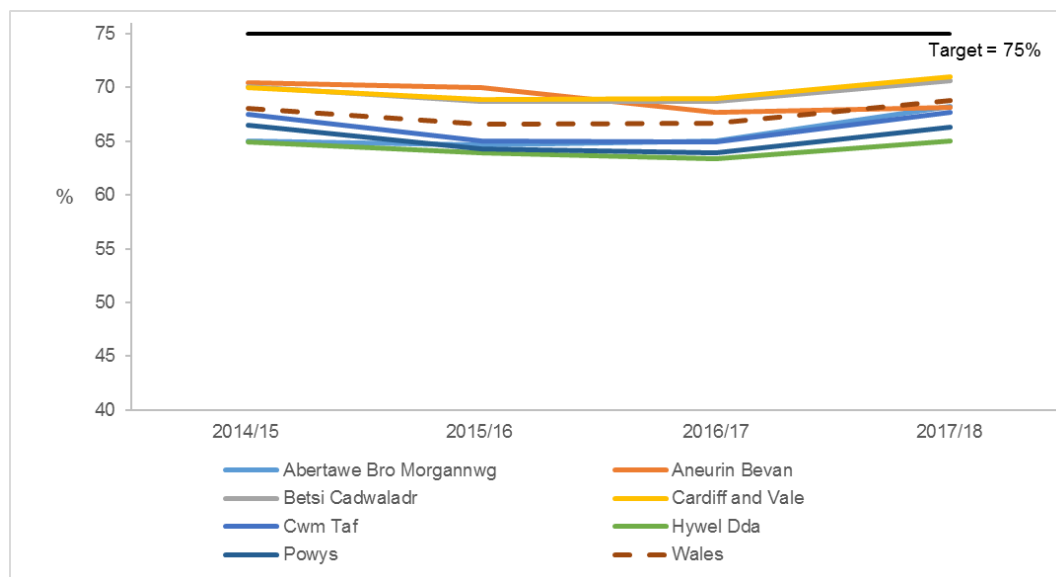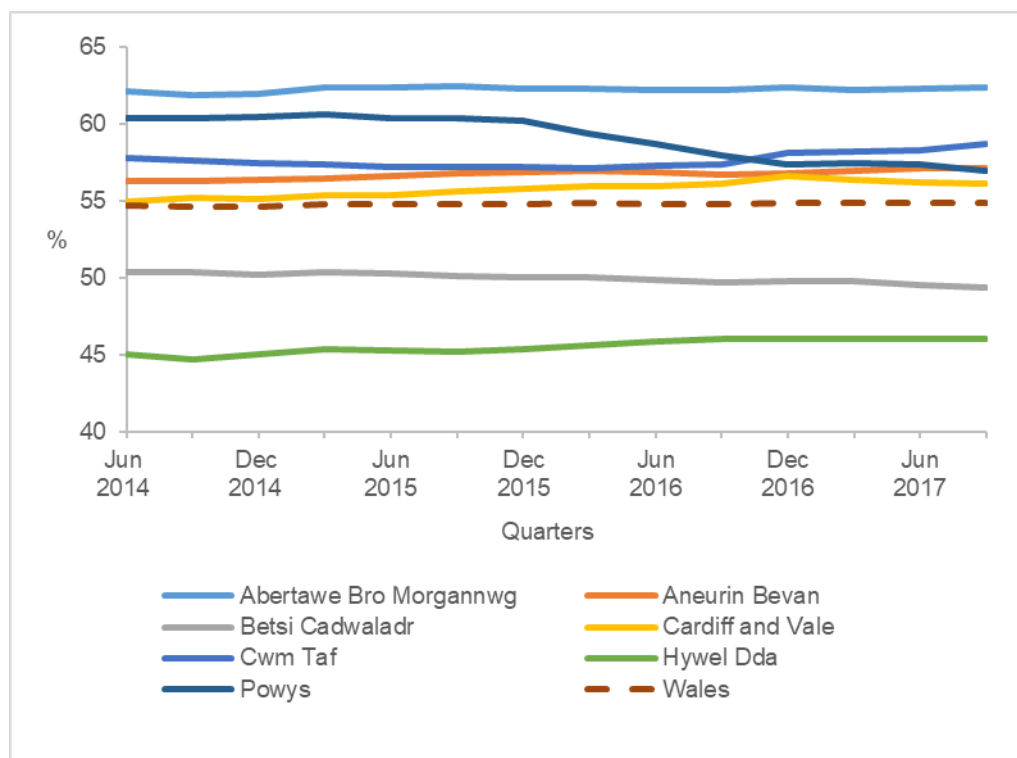

Source: Public Health Wales

103 Exhibit 15 shows the percentage of residents within the Cardiff and Vale area who were treated at an NHS dental practice in the previous 24 months. This shows that in the area 56.1% of residents were treated. This compares with a

Wales average of 54.9%. The Health Board was the fifth worst performing out of seven in Wales.

Target = annual improvement
Source: Dental activity forms, Welsh Government

104   The data and monitoring information suggests a mixed picture in terms of improvement in performance and progress in transforming primary care. Progress has been made in some areas, but the overall performance reported suggests that more needs to be done to ensure that sustainable improvements are made.

There are a number of barriers that need to be overcome to ensure further progress is made to improve primary care

105   There is a growing acknowledgement within the Health Board that the primary and secondary care sectors are intertwined and that the success or failure of one will have an impact on the other. The 'Shaping our Future Wellbeing' Strategy is seen as the way forward but there is a view that the pace of change must be

faster, and the plans implemented fully to ensure the sustainability of the primary care sector and, indeed, the overall Health Board.

106   The Health Board maps progress of its primary care plan against the national plan and primary care workforce plan for Wales in the PCIC Clinical Board Progress Report. The report contains information on 60 separate actions. An implementation timeframe and a HB lead are identified for each action. A description of progress made, and the proposed next steps are included alongside a RAG (Red, Amber, Green) rating.

107   In the report provided to us dated September 2018 nearly all actions are rated as Green (19) or Amber (24). Only one action is rated as Red and this is described as 'Developing a strategic approach on securing new methods of financing service developments and facilities, including accessing funding from wider sources and ownership models'. The remaining 16 actions are unrated at the time of writing.

108   Our review has highlighted barriers that need to be removed to ensure further progress is made. We sought the views of staff through interviews, self-assessment and our cluster leads survey. Our interviews with staff indicated the following challenges remain to be overcome:

- Financial constraints, including financial controls
- Slow pace of change
- Maintaining services whilst planning for the future
- IT connectivity
- Workforce capacity amongst all staff groups not just GPs
- Lack of transparency of cluster plans

109   We asked the Health Board what the main barriers were to transforming primary care. Exhibit 16 shows that the Health Board recognises that it has several difficult issues to overcome.

Exhibit 16: the Health Board's view on the main barriers to transforming primary care

Barriers	What needs to be done to remove these barriers?
Supporting GMS sustainability and managing sustainability issues takes a lot of time and energy. Linked to this barrier is the primary care OOHs sustainability issues.	More support and resource to provide practices regarding sustainability. Consider how GMS contract negotiations can assist in stabilising general practice. Move to more regional working.
Shifting resources from secondary care to support the provision in primary / community care.	Incentive shifting care into the community; agreement of the Financial Framework.

Barriers	What needs to be done to remove these barriers?
GMS contract negotiations 2019-20 – service and financial impact.	Clarity on the future direction and impact.
Several practical issues relating to cluster working eg information governance implications.	More national advice and guidance on the impact of GDPR on cluster working.
Limited resources in place and support for clusters.	If clusters are to be a catalyst for change and new ways of working, they need to be better supported and resourced to do this. Linked to GMS contract negotiations
Public awareness around best use of primary care services.	Consistent public messaging.

Source: Health Board self-assessment

110   We sought views from cluster leads on the main challenges facing primary care in their area. Exhibit 17 shows that the main challenges they raised cover a range of workforce and sustainability issues, as well as financial and demographic pressures.

Exhibit 17: challenges described by cluster leads

Challenges
Recruitment of GPs, nurses and Physiotherapists
Financial constraints – continuous pressure
GP sustainability
Local Development Plan – population growth, demographic changes
Practice engagement within clusters
Increasing demand
Barriers to cluster working, ie delays in recruitment and procurement

Source: Cluster Lead Survey

Appendix 1

Methods

Method	Detail
Health Board self-assessment	The self-assessment was the main source of corporate-level data that we requested from the Health Board. 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%. In the Health Board it was 77.8%.
Interviews	We interviewed several staff including the following with responsibility for primary care: • Vice Chair • Director of Operations – PCIC • Medical Director • Executive Director responsible for primary care (COO) • Head of Primary Care Operations & Delivery – PCIC • Clinical Service Lead GP, General Practice Support Team (GPST) – PCIC • Assistant Director of Operations, PCIC • Clinical Board Director – PCIC • Head of Workforce and OD – PCIC • Workforce Planning Manager – PCIC • Head of Medicines Management – PCIC • Assistant Director- Finance • Director of Strategic Planning • Locality Manager • GP Cluster Lead • Community Health Council representatives
Review of the Health Board's Integrated Medium-Term Plan	We reviewed the Health Board's integrated medium-term plan to assess the extent to which primary care is considered.
Use of existing data	We used existing sources of data wherever possible such as Welsh Government and Public Health Wales statistics.

Appendix 2

Management response

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	Revisit its primary care plan to ensure it includes specific actions to meet the needs of the projected population growth in Cardiff.	To ensure plans are able to meet population projections.	Yes	Yes	The UHB is commissioning an independent assessment of the impact of population growth on the demand for services and to identify opportunities for meeting this increased demand.	January 2019	Executive Director of Strategic Planning
R2	Develop the necessary consultation and communications plans to ensure meaningful public and stakeholder engagement in any further development / refinement of its primary care plans.	To encourage public support for the primary care plans.	Yes	Yes	Communication plan to be developed and actions to be carried out this financial year, with the plan to be incorporated as a core part of the 2019-20 Primary and Community Intermediate Care Integrated Medium Term Plan (PCIC IMTP).	Plan to be developed by December 2018. Implementation throughout 2018-19 – 2019-20.	Director of Operations, PCIC

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3a	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	Financial resource shift framework developed and will be used to track investment and resource use from secondary to primary care, starting with the investment in MSK (Musculoskeletal) and MH (Mental Health).	Framework to be finalised October 2018. Ongoing monitoring.	Assistant Director of Finance
R3b	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	Build into IMTP annual review process.	March 2020	Assistant Director of Finance

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 establish a robust evidence base of benefits to help inform decision making.	Yes	Yes	Formally evaluate cluster nursing posts and cluster pharmacists. Communicate the evaluation of cluster-based nursing posts and cluster pharmacies, to inform future decision making. Ensure future cluster models (MSK, MH) have robust evaluation built into the process.	October/November 2018 November 2018 March 2020	Director of Operations, PCIC
R4b	Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters.	To support development of the clusters.	Yes	Yes	Communicate the evaluation of cluster-based nursing posts and cluster pharmacies at CD (Clinical Directors) forum. Use CD forum to help sharing and learning by publicising the key messages via Cluster Leads.	November 2018	Director of Operations, PCIC

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R4c	Subject to positive evaluation, begin to fund new models from mainstream funding rather than the Primary Care Development Fund.	To help ensure a long-term future for new models of care.	Yes	Yes	Many Primary Care funding has now been mainstreamed as core business. Cluster pilots to continue to be evaluated to assess the option of rolling out at scale, starting with MSK and MH. Subject to affordability within the resource available.	March 2019	Assistant Director of Finance
R4d	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	As per R2 – develop Communications Plan. Start communication and engagement by engaging with the UHB Stakeholder Reference Group on new ways of working.	Plan to be developed by December 2018. November 2018	Director of Operations, PCIC
R5a	Review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary.	To support development of the clusters.	Yes	Yes	Continue to prioritise the OD (Organisational Development) programme for cluster development.	March 2019	Director of Operations, PCIC

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	Discussion on cluster membership to be built into the cluster OD programme, to include an initial discussion at the CD forum on 31 October 2018.	November 2018	Director of Operations, PCIC
R5c	Ensure all cluster leads attend the Confident Primary Care Leaders course.	To strengthen cluster leadership.	Yes	Yes	We will ensure lessons are learnt from the current CDs attending the Confident Primary Care Leaders course and encourage this course for new CDs and existing CDs who have not attended.	December 2018	Director of Operations, PCIC
R6a	Ensure the contents of its Board and committee performance reports adequately cover primary care.	To increase the Board's understanding of primary care performance.	Yes	Yes	Review currently being undertaken of Performance reporting to the Board and its Committees.	November 2018	Deputy Chief Executive and Director of Transformation

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R6b	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	See R6a	November 2018	Deputy Chief Executive and Director of Transformation
R6c	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	See R6a	November 2018	Deputy Chief Executive and Director of Transformation