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Primary care services – **Betsi Cadwaladr University Health Board**

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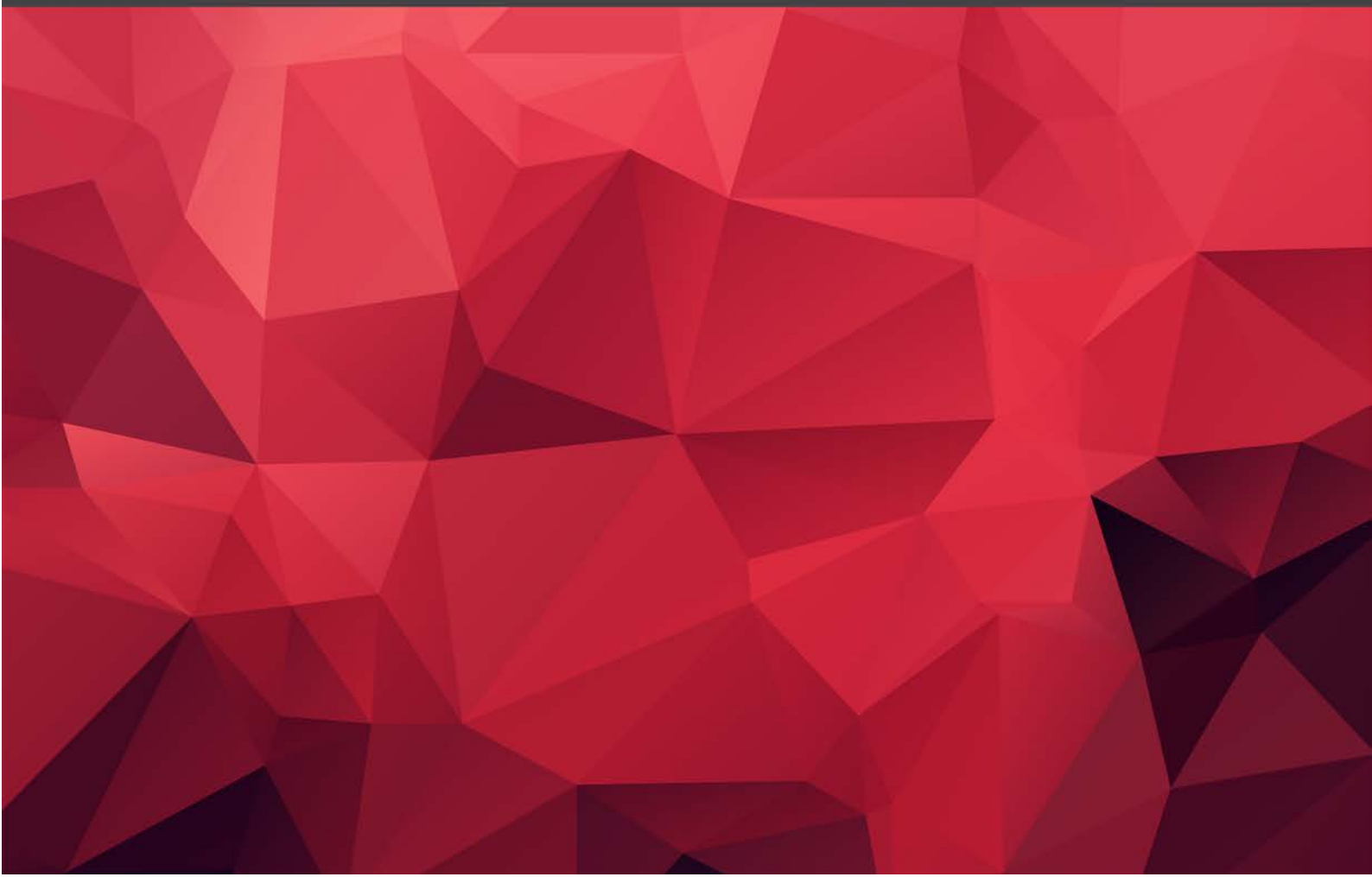

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The person who delivered the work was Urvisha Perez.

Contents

The Health Board is making reasonable progress in delivering its recently developed plans for primary care, but many aspects of performance remain worse than average and significant workforce and financial challenges remain.

Summary report

Background

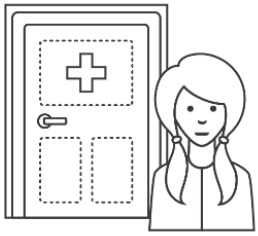
1. The national primary care plan[1] defines primary care as follows:

   "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.

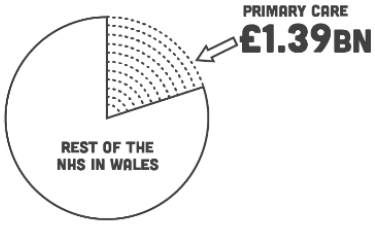
Exhibit 1: Why is primary care important in Wales?

First point of contact



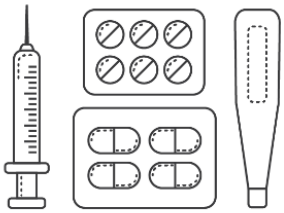
Primary care is the first port of call for the majority of people who use health services.

Spending on primary care



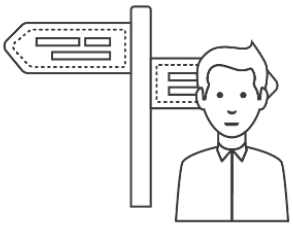
In 2016-17, the NHS in Wales spent £1.39 billion on primary care, which is around a fifth of the total NHS spending in Wales.

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

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

3. Wales has had plans for many years that stress the importance of primary care. The plans aim to rebalance the system of care by moving resources towards primary and community care. The national primary care plan aims for a 'social model' that promotes physical, mental and social wellbeing, rather than just an absence of ill health. The core principles in the plan are: planning care locally; improving access and quality; equitable access; a skilled local workforce; and strong leadership.
4. The national primary care plan and the NHS Wales planning framework place an expectation on health boards to set out plans for primary care as part of their integrated medium-term plan. Each plan should explain how the health board will develop the capacity and capability of primary care services.
5. To support the implementation of the national plan, NHS Wales issued a workforce plan[2]. Health boards are expected to put in place actions to secure, manage and support a sustainable primary care workforce shaped by local population needs and by prudent healthcare principles.
6. Primary care clusters are the main mechanism for planning services at a community level and were 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. Within the Health Board area there are 14 clusters, six in the East, four in the West and four in the Central 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 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] 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 **Primary care out-of-hours services**.

12. This report summarises the findings of work in Betsi Cadwaladr 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. Successful GP recruitment campaign to continue – Vaughan Gething

[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 is making reasonable progress in delivering its recently developed plans for primary care but many aspects of performance remain worse than average and significant workforce and financial challenges remain.** Exhibit 2 sets out our findings in more detail.

Exhibit 2: our main findings

Table detailing our main findings.

Our main findings
Strategic planning: The Health Board has a planning framework for primary care but not a detailed delivery plan. Health Board capacity is stretched in supporting clusters, which are at an early stage of development • The Health Board's recently developed Care Closer to Home Framework is aligned to the national plan but there is no detailed delivery plan and some stakeholders did not feel engaged in developing the plan. • The Health Board supports clusters well in some ways, but support capacity is stretched and most clusters remain at a relatively early stage of maturity.
Investment: Data issues make it difficult to monitor primary care investment and there are barriers to shifting resources. Financial management in clusters is hindered by procurement processes and delayed decisions • The accounts suggest a 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 several factors are hampering large-scale change. The Health Board has not quantified the total amount of resource redirected to primary care. • Processes are in place to monitor cluster spending but unclear procurement processes and delayed decision making cause difficulties for clusters in managing their finances.
Workforce: Workforce challenges pose a significant threat to the sustainability of practices and the Health Board is being stretched by directly managing a large number of practices • The Health Board has carried out some work to model the workforce it requires but there are gaps in data. Available information suggests a shortfall in GPs and growing list sizes. • There are significant challenges to the sustainability of GP practices and the Health Board is being stretched by having to directly manage an increasing number of practices. • The Health Board is in the early stages of implementing multi-professional primary care teams, but there are barriers to further progress including a shortage of non-medical professionals.
Oversight: The Health Board has recognised the need to strengthen primary care leadership and performance monitoring and scope remains to improve the support provided to cluster leads • The Heath Board has recruited a Director of Primary and Community Care, which is a positive step to addressing concerns that primary care needs stronger representation at Board level. • There is no dedicated primary care committee, there is scope for more regular consideration of primary care at Board and committees and the Health Board has developed a new dashboard to strengthen monitoring of performance.

Our main findings
• GPs provide leadership of most of the clusters, and they feel the Health Board could further support them in their role.
Performance: The Health Board is making reasonable progress in delivering its primary care plans although many aspects of performance are worse than the Wales average and a number of difficult challenges remain • Many aspects of the Health Board's performance are worse than the Wales average, however, the available measures do not give a comprehensive picture of primary care performance. • The Health Board has made reasonable progress in delivering the primary care actions from its annual operating plan but there are significant barriers to progress, in particular recruitment, retention and training, increased demand and financial challenges.

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 has recently developed a Care Closer to Home Framework but has not yet described how this framework will be implemented. The Health Board should therefore develop a costed implementation plan to support delivery of its Care Closer to Home Framework.
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 gaps in data about the number and skills of staff working in primary care in particular, community dental, optometry and pharmacy providers. 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.

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; and 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, and scope to improve cluster leadership, procurement processes, decision making and representation. 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. support clusters to improve their procurement processes. Actions could include nominating individuals in the procurement team to link with specific clusters, and developing specific procurement guidance for clusters to clarify timescales, accountabilities and processes; d. clarify and publicise the governance and leadership arrangements for clusters, to ensure better understanding of the responsibilities for decision making; e. ensure all cluster leads attend the Confident Primary Care Leaders course; and f. consider introducing a locum cluster lead post, to work across all clusters providing additional capacity and backfill for cluster leads. The post could also be valuable in sharing learning across clusters.
Oversight of primary care R6 We found scope to raise the profile of primary care in the Health Board, particularly at Board and committee level. There is also scope to improve the way that primary care performance is monitored and reported at Board and committee level. The Health Board should, therefore, develop an action plan to ensure the Board and committees are adequately informed on the following key issues: a. primary care performance; b. delivery of primary care plans; c. key risks to primary care, including GP practice sustainability; and d. patient experience of primary care.

Detailed report

Strategic planning: The Health Board has a planning framework for primary care but not a detailed delivery plan. Health Board capacity is stretched in supporting clusters, which remain at an early stage of development

The Health Board's recently developed Care Closer to Home Framework is aligned to the nation plan but there is no detailed delivery plan and some stakeholders did not feel engaged in developing the plan

The new Care Closer to Home Framework is a vision for primary and community care but there is no detailed implementation plan and we heard concerns about the challenges of delivering the framework

15. In 2015, the Health Board was placed in special measures under the NHS Wales escalation framework. As part of these arrangements, the Cabinet Secretary for Health and Social Services set out five key areas in which the Health Board must show tangible improvements. One key area was GP and primary care services (including out-of-hours services). The criteria that the Health Board must meet to be considered for de-escalation are set out in a Special Measures Improvement Framework. The framework sets out a series of actions the Health Board must progress over three phases. One of the expectations in phase two is that a clear integrated strategy for primary and community care exists and the health board understands risks to local sustainable service delivery.

16. In November 2016, the Board approved the Integrated Primary and Community Services Strategic Framework, thereby meeting the criterion described above. This strategic framework was a baseline paper developed as a precursor to the Care Closer to Home Framework. The Integrated Primary and Community Services Strategic Framework mainly sets out the key drivers for change, outlines the scope for the future model of care and intentions to engage with stakeholders in developing the final strategy.

17. In March 2018, the Board approved a ten-year strategy; Living Healthier, Staying Well. The strategy is structured around three main programmes: Health Improvement and Health Inequalities; Care Closer to Home; and Care for More Serious Health Needs. Primary care fits under the Care Closer to Home programme. At the time of our review, the Health Board had developed a framework for Care Closer to Home, but it was yet to gain Board approval. However, as Care Closer to Home is a programme in the Living Healthier, Staying

Well Strategy the Board is cited of and has approved the approach and strategic direction.

18. Care Closer to Home is wider than just primary care. The framework states that the scope of the future model of care includes all services and support delivered in the community. This ranges from prevention, education and self-care to support from an emergency department or services required on discharge from hospital to a community setting or a GP.

19. The plan has five key work streams, these are:

- **Cluster Development** – Support the development of clusters to enhance their role in designing and delivering primary and community services.
- **Service Model** – Improve access to sustainable primary and community care services. Through expanding the number of integrated multi-disciplinary community teams and developing staff to engage with individuals to deliver support which reflects 'what matters' to them.
- **Primary Care Workforce** – Build on work done to date to introduce a broader range of health and social care professionals including specialist nurses, pharmacists and therapists into independent and managed GP practices. These will include new roles such as paramedics, physician associates and a sustainability team.
- **Health and Well-being Centres** – Develop an estate strategy for primary care.
- **Digital Healthcare and Technology** – Improved access to digital technology in the community, IT equipment, telehealth, supported self-management.

20. As the framework is new, the Health Board has not yet developed a detailed implementation plan. However, the draft framework and the Living Healthier, Staying Well strategy set out the high-level priorities for the next three years, the intended outcomes and the performance indicators to measure progress. A high-level delivery framework is also set out in the Health Board's three-year plan for 2018-21 and its Annual Operating Plan (AOP)[9] for 2018-19.

21. We heard mixed views about the Care Closer to Home Framework. Some thought it was a strong plan which is aligned to the national primary care plan and priorities. However, we also heard concerns about the challenge of developing robust actions, lack of action plan, ownership and resources to deliver it. Interviewees also raised concerns about the difficulties in delivering the plan within the constraints of the current general medical services contract and about strained relationships between GPs and the Health Board.

[9] The Health Board does not have an approved three-year Integrated Medium Term Plan (IMTP) and is working to an annual operating plan.

The Health Board's annual and three-year operating plans could be improved although they echo the priorities in the Care Closer to Home framework and generally align with national priorities

22. The integrated medium term plan (IMTP) is the key strategic planning document for health boards. Betsi Cadwaladr does not have an approved IMTP, instead the Health Board has an annual operating plan. However, the Health Board recognised the need to plan over a longer period. And so, in March 2018, the Board approved a three-year operating plan from which a detailed annual operating plan for 2018-19 has been developed. We reviewed both documents to assess whether they contained key elements that align with the national primary care plan and transformational model. Both documents align with the Care Closer to Home Framework and plans for primary care were detailed under Care Closer to Home. Exhibit 4 outlines strengths and areas for improvement for both plans. The annual operating plan pulls out the key deliverables for 2018-19 so in some respects is less detailed than the three-year plan. However, in general, we found the plans align with national priorities. The main areas for improvement are listed in the bullet points below but Exhibit 4 also highlights other areas where there is scope to provide further details:
    - lack of detail about measuring and actioning the shift of resources from secondary to primary and community care;
    - lack of clarity about how the primary and community care plans integrate with other relevant health board plans and strategies for primary and community care; and
    - lack of clarity about the leadership arrangements for primary care transformation.

Exhibit 4: annual operating plan and three-year plan strengths and areas for improvement

We reviewed the health board's plans to assess whether key aspects from the national vision were covered. The table below describes our findings.

	Included in AOP	Included in three-year plan
Strategic planning		
Developing clusters: Cluster development is one of the five priority work streams for the Care Closer to Home programme.	Yes	Yes
111 and out-of-hours services: There is some reference to both of these services in the documents, mainly in reference to developing a virtual clinical hub with these services and the ambulance service.	Yes	Yes

	Included in AOP	Included in three-year plan
Integration with other relevant health board plans/strategies for primary and community care: Both plans align with Care Closer to Home, which is a work programme within the Health Board's Living Healthier Staying Well strategy, however, it is unclear how the primary care section aligns to other Health Board plans and strategies.	No	No
Finance		
Resource shift services from hospitals into community settings: There are no explicit actions in either document.	No	No
Measuring progress of shift from hospital to primary/community settings: Whilst the three-year plan states the Health Board's intention to measure the shift out of hospital secondary care settings, it does not say how.	No	No
Spending Welsh Government's Primary Care Development Fund: The annual operating plan includes a breakdown of how the Primary Care Investment Fund, Pacesetter Funding and the Integrated Care fund has been allocated. It also includes planned initiatives yet to be allocated funding.	Yes	No
Spend on any other innovation funding such as invest to save: No details on how other funding will be used in either document.	No	No
Primary care estate strategy: Whilst neither document includes an estate strategy the three-year plan states that an estates strategy for primary care will be developed to support Care Closer to Home. In addition, the plan also details plans to develop health and wellbeing centres.	No	No
Workforce		
Workforce plans: Both documents set out high-level priorities and actions for primary care workforce, this is also a priority work stream for the care closer to home programme.	Yes	Yes
Clinical triage systems and multi-professional teams: Both documents state the Health Board's intention to expand multidisciplinary working, this is part of the Care Closer to Home service model work stream. The three-year plan also states the Health Board's intention to introduce navigation and triage systems to improve primary care.	Yes	Yes
Oversight and leadership		
Leadership of transformation of primary care: There is nothing explicit in either plan about leadership. There is mention of a primary care transformation group and a care closer to home transformation group but no explanation of what these are.	No	No

	Included in AOP	Included in three-year plan
Performance and monitoring		
Monitoring the implementation of delivery plans: Both documents state that implementation of the operating plan will be monitored as set out in the Board's Performance and Accountability Framework.	Yes	Yes
Measuring and reporting primary care improvements: Both documents list the performance indicators which will be used to monitor primary care. The three-year plan includes a wider range of indicators than the annual operating plan.	Yes	Yes
Evaluating the impact of any primary care service changes: The Gantt charts included in both documents include actions for evaluating various initiates, but neither describe how initiatives will be evaluated.	Yes	Yes

Source: Wales Audit Office analysis of Health Board Annual Operating Plan 2018-19 and Three-year Plan 2018-21

The Health Board can provide various examples of engagement and collaboration with stakeholders in developing its primary care plans although some groups do not feel engaged

23. It is important for the health boards to collaborate with stakeholders in developing their plans. The Health Board told us it regularly engages with a wide range of internal and external stakeholders throughout the year. Internally, planning away days are held in each of the areas to allow for joint planning across divisions. The East area's primary care team meetings also have representation from other directorates to engage them in strategic planning.

24. External to the Health Board, senior managers responsible for planning meet regularly with the Community Health Council (CHC) to update them on primary care and Living Healthier, Staying Well. The CHC representatives explained that they work with the Health Board and GP practices to make sure patients' views are heard where there are contract variations. The Health Board meets with local councillors on specific planning and local issues and the leadership group are members of the Local Authority Directors of Social Services and Health Board Directors group.

25. Regionally, the Vice Chair and Chief Operating Officer are members of the North Wales Regional Partnership Board. Health Board Area Directors chair the Public Service Boards in their areas and executive leads are also assigned to each Public Service Board.

26. Nationally, the Health Board engages with other health bodies through groups such as Heads of Primary Care and Directors of Primary Care and Mental Health meetings, the National Primary Care Conference and through ad-hoc visits to share good practice and ideas.

27. When establishing new models for managing practices for example Healthy Prestatyn[10], the Health Board consults with the public and patients. The Health Board also held a number of public engagement events throughout 2017 on their Living Healthier, Staying Well strategy. Over 100 events are listed on their engagement plan, which range from meeting community and third sector groups, to representation at community events and bespoke public and staff engagement sessions. Planning department staff also attended cluster meetings across North Wales to present the Care Closer to Home framework and discuss the future model of primary care. In addition, Care Closer to Home is an agenda item for the Primary Care Transformation groups, which at the time of our review were in the process of being stood-down in favour of a Care Closer to Home Project Board.

28. To promote the Care Closer to home framework the Health Board has published a public facing version of the strategy on the Health Board website. They are also in the process of developing an easy read version, poster, flyers and promotional video for staff and the public. There will also be broader staff engagement to develop the detail behind the Care Closer to Home framework.

29. The Health Board told us that it engages with local medical, dental pharmaceutical and optometry committees when developing its plan. However, the dates submitted by the Health Board show there has been no engagement for two years or longer for some committees.

30. From our interviews we heard mixed views about the Health Board's engagement and consultation on primary care. Most acknowledged that there had been good engagement on the plans with a wide range of stakeholders, but we also had comments about not everyone feeling engaged. In terms of how the plans were received, we were told that some staff attending the engagement sessions felt wary of the proposal because the model is different to how they are used to working. The medical committee received a presentation on Care Closer to Home. We were told their feedback was that they felt it was important to sustain what is currently in place, and whilst they felt innovation is positive it is unlikely in the near future. The CHC representatives commented that engagement on the Living Healthier, Staying Well Strategy was good initially, but was not as good towards the end. The CHC received feedback from the third sector, who were keen to understand whether the strategy will be put into action.

[10] In 2016 the Health Board introduced Healthy Prestatyn health and wellbeing centre, which is a new model for primary case based on a multidisciplinary workforce. The innovative model emerged because three practices gave notice at the same time, so the Health Board needed to develop a way to manage the practices.

The Health Board supports clusters well in some ways but support capacity is stretched and most clusters remain at a relatively early stage of maturity

31. 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:
    - two respondents (25%) agreed that they had received helpful guidance from the Health Board when it was developing its cluster plan;
    - four respondents out of seven (54%) agreed that they had received support from the Health Board to develop a needs analysis of their local population; and
    - three respondents (38%) agreed that 'the Health Board listens to my cluster when it is developing Health Board-level priorities for primary care'.

32. Exhibit 5 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 respondents said their cluster was 'developmental' and one said their cluster was mature. The Central Area Primary Care Team developed a cluster maturity matrix to review cluster working and their aspirations. At a cluster event in May 2016, the majority of cluster members identified that they were at level one or two (established or developing), with aspirations to move to level three (performing) and potentially level four (advanced) in future.

Exhibit 5: 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

33. Clusters membership should be wider that GPs and other clinical representatives. Six out of eight respondents said that their cluster had third sector representation. However, the majority of respondents (5 out of 7), said there was no local authority representation and (6 out of 7) said there was no lay representation. Interviewees told us that representation varies by cluster, but we were told that clusters are becoming more inclusive.

34. The Health Board employs three senior cluster coordinators, one for each area and a further six cluster coordinators. The cluster leads we interviewed spoke highly of their cluster coordinators, who support them with developing and implementing their cluster plans, with administrative support and bring a wealth of Health Board knowledge for example on policies. However, the coordinators are shared amongst clusters and cluster leads would like to have a dedicated coordinator. Coordinator capacity is an issue where there are managed practices as this takes up coordinators' time, especially senior coordinators.

35. Cluster coordinators represent clusters at relevant Health Board meeting and feed into strategy planning meetings. And the Health Board also facilitates monthly pan North Wales joint cluster lead meetings to share updates. Other support available to clusters includes guidance on developing practice plans through provision of data from the primary care support unit (public health data and primary care dashboard).

36. All fourteen clusters have plans in place, which all follow a standard set of strategic themes[11]. All plans set out the projects or initiatives, the key partners, targets completion dates, intended patient outcome and space to summarise progress. There is no formal peer review of cluster plans but the plans are discussed at cluster lead meetings. We heard some mixed views about how the cluster plans align with Health Board's primary care plans. Some felt that this alignment is improving, whilst other felt that instead of Health Board priorities coming from cluster plans, the approach was too top down.

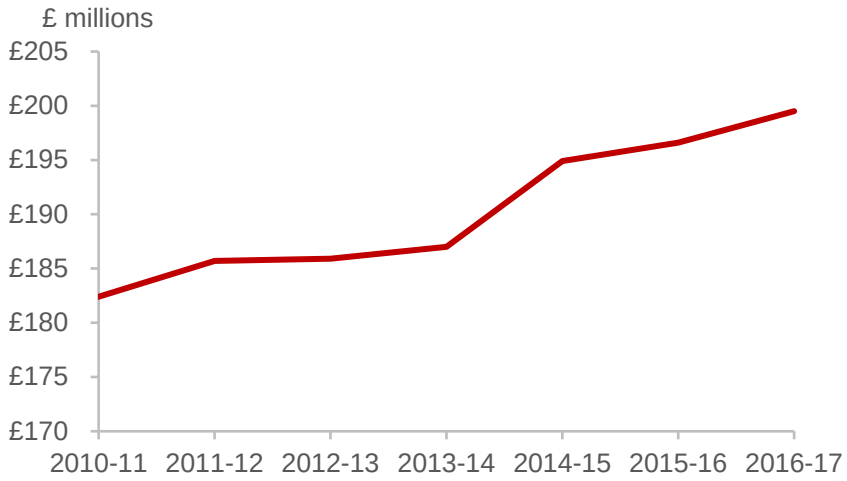
[11] Meeting population need, sustainability and access, planned care, urgent/winter/emergency, national priorities, local priorities, clinical and information governance.

Investment: Data issues make it difficult to monitor primary care investment and there are barriers to shifting resources. Financial management in clusters is hindered by procurement processes and delayed decisions

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

37. Exhibit 6 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[12]. The exhibit shows that the Health Board spent £199.5 million on primary care in 2016-17, an increase of £17.1 million when compared with 2010-11.

Exhibit 6: the Health Board's spending on primary care services



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

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

38. Our analysis highlighted some variation between the amount of funding the Welsh Government allocated for primary care in the Health Board, and the amount of money that the Health Board actually spent on primary care. The bullet points below summarise the Health Board's explanation about this variation in 2016-17:

- An overspend on General Medical Services was due to the provision of enhanced services, premises and increase in dispensing expenditure. In 2016-17 the allocation was £115.6 million, and the Health Board overspent by £2 million.
- For pharmaceutical services, the Health Board's allocation includes a Non Cash Resource (NCR), this relates to costs for medicines that are prescribed in Wales but dispensed in England. The Health Board explained that the full allocation is used, but the cost for medicines dispensed in England is subtracted from the total spend. In 2016-17 the allocation was £33.6 million and the Health Board underspent by £2.5 million.
- The General Dental Services allocation of £35.7 million was underspent by £3.3 million. There has been a year on year underspend because of the unavailability of contractors meaning it is difficult to commission dental services.

39. After taking into account the effect of inflation, the Health Board's overall spending on primary care services decreased in real terms by 0.2% 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.

40. 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. The Health Board gave us the following examples of services that are not categorised as primary care in the accounts:

- Voluntary organisation contracts, such as palliative care.
- Minor injury units and treatment centres, which move activity into the community from secondary care and GP practices.
- Outpatients appointments in community settings.

41. In 2016-17, the Health Board received £8.743 million from the Welsh Government through the Primary Care Development Fund. The Health Board allocated £2.210 million of this funding to clusters, but the full allocation was not spent. We were told that the slippage was caused by Health Board bureaucracy and delays and issues with recruitment. Clusters in the east area collectively had the largest slippage. The Health Board allocated £5.648 million for IMTP and workforce deliverables, this allocation was also underspent by £2.1 million. This funding was used to support primary care initiatives, new roles and infrastructure such as:

- alternative first points of contact and advanced practitioners for primary care;
- Common Ailment Scheme and further development of the community pharmacist role;
- management of long-term conditions such as diabetes and heart failure,
- Health and Social Care Support Workers and out of hours community nursing;
- Community Navigator training;
- Treatment Room Clinic;
- Consultant Pharmacists;
- Practice Nurse Development Team;
- Health Technology; and
- Primary Care Support and Infrastructure.

42. In addition to the above, the Health Board allocated £840,000 to support their pacesetter projects, which were the outstanding GP development programme, advanced physiotherapists practitioner in primary care and embedding clinical pharmacists in GP practices. The allocation for the pacesetter projects was underspent £221,000; the Health Board reported this was because they only had a short time to put together the plans and rollout the projects. Instead of having a proper plan with a baseline and evaluation methodology from the beginning, they are now retrospectively trying to understand the impact of the projects. For 2018-19, the Health Board's pacesetter projects are; home visiting services, to provide advanced paramedic support into out of hours services and a review and redesign of pharmacy.

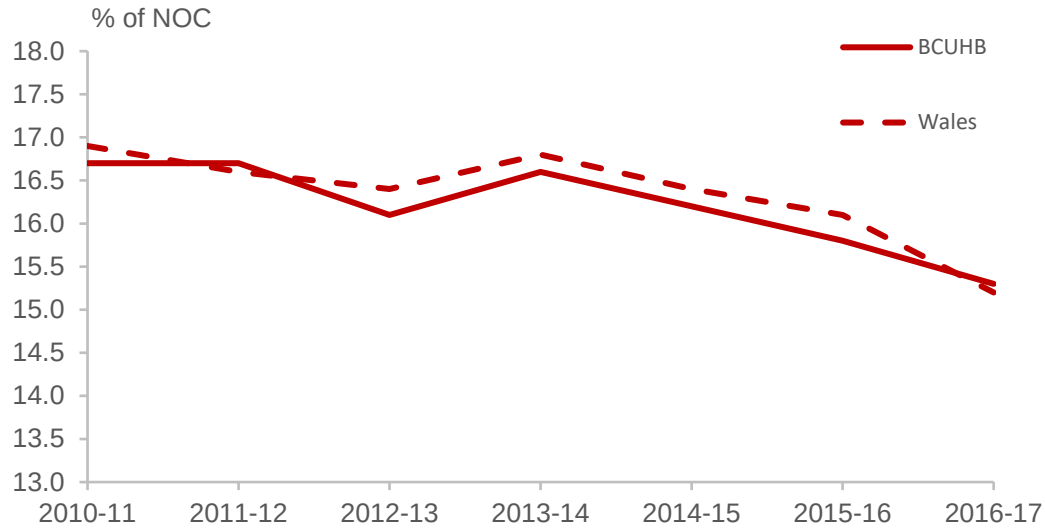
43. We asked cluster leads whether they felt the Health Board was empowering their cluster to drive innovation, just three out of eight cluster leads responding to our survey agreed with this statement. Evaluation is an important part of testing innovation and three out of eight respondents disagreed that the Health Board is effectively evaluating examples of innovation in their cluster. Some cluster leads commented that they have not received support to evaluate projects even though the need has been identified. Interviewees told is that there is no process to evidence projects, little evaluation and little Health Board support to evaluate projects. Clusters want to release cluster funds so they can invest it in other projects but there is little evidence, so it is hard to apply for funding from elsewhere.

The Health Board can point to some specific examples of shifting resources towards primary care but several factors are hampering large-scale change. The Health Board has not quantified the total amount of resource redirected to primary care

44. For many years, the NHS in Wales has planned to shift resources towards primary care, to reverse the 'relative under-development of primary care'. However, issues with the format of NHS accounts (see paragraph 40) makes it difficult to say whether health boards have secured such shifts.

45. Exhibit 7 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 the trend for Wales as a whole. The Health Board reported that overall expenditure has increased at a higher rate due to factors such as increasing demand and referral to treatment (RTT) target pressures.

Exhibit 7: the Health Board's expenditure on primary care as a percentage of its total expenditure (Net Operating Cost, 2010-11 to 2016-17).



Source: LHBs' Annual Accounts
Note: The y-axis does not begin at zero.

46. 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.

47. The general consensus amongst those we interviewed was that whilst small pots of money have moved, in general the resource shift toward primary care has not been very successful. The bullet points below show some specific examples from the Health Board where services have shifted toward primary and community care:

- Integrated Heart Failure Programme, which provides community-based care for heart failure patients. The programme has been developing steadily in North Wales over the last ten years and is run in all three areas.
- Advanced practitioner audiologists in GP practices, they remove the need for many patients with tinnitus, hearing and balance conditions to see their GP. The service has been running for approximately two years and is currently available in 31 practices, but the Health Board is looking to extend the service to all practices.
- Advanced physiotherapists in primary care, where people presenting with musculoskeletal problems are seen locally by an Advanced Physiotherapy Musculoskeletal Practitioner as an alternative their GP. The scheme has been running since 2015 and the Health Board expected 80 practices to have access to the service by March 2018.
- Dermatology, Sexual Health, Rheumatology and Atrial Fibrillation services are delivered in a variety of community settings across each Area of North Wales.

48. The areas teams control the budgets for primary care, but they also control budgets for some hospital delivered services. These include diabetes (endocrine), sexual health, neurology, rheumatology, dermatology and immunisation. As stated above some of these services are delivered in a community setting, but not consistently. It is up to the area teams how and where best to deliver these services. For example, cluster teams in the east have asked to meet with consultants to discuss how some of these hospital services can be moved into the community. One of the Wrexham clusters will be piloting dermatology services in the community. This is at the planning stage, but they have one consultant invested in working with them. And in the West some work has been done to move diabetes nurses into the community including the budget, this started about 2-3 years ago and now benefits are starting to be seen in secondary care, this is now being replicated.

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

- the Health Board has a large financial deficit and therefore has a focus on ensuring secondary care services are delivered effectively whilst managing their financial position;

- some of the Health Board's secondary care services are stretched because of limited resources and increasing demand, so it would not be practical to move these resources into primary care;
- there needs to be a change in culture where there is greater recognition that patients can be better managed in a community setting instead of in hospital;
- the capacity of consultants to deliver services within a community setting and how the work would fit into their agreed job plans; and
- difficulty in moving resources because it is impractical to shut a service down first. Instead it was suggested that transitional funding was needed to keep primary and secondary care services running in tandem until the function matures.

Processes are in place to monitor cluster spending but unclear procurement processes and delayed decision-making cause difficulties for clusters in managing their finances

50. Health boards need to strike the right balance of giving autonomy to clusters whilst at the same time overseeing their spending. The Health Board's has several approaches for overseeing cluster spending. During the financial year clusters have to submit project proposals which need to be agreed with their respective area manager. The cluster support teams monitor each project and then expenditure is paid and spend collated on a monthly basis. This is reported back to the clusters, through cluster meetings and cluster leads meetings. Funds that were not spent in the previous years were re-provided to clusters and additional plans have been put in place to use this funding as it will not be available the following year. The Health Board has developed templates and forms to support clusters to manage their funds.

51. In our survey of cluster leads, we found that five out of eight respondents (63%) agreed that the Health Board effectively monitors their cluster's expenditure. Only three out of the eight respondents (38%) agreed that their cluster spends all the funding it receives. And the majority (seven out of eight, 88%) of respondents, disagreed that their cluster is able to spend its funding quickly once it has decided how to allocate its funding and that the Health Board gives their cluster sufficient financial autonomy.

52. We found that clusters need more support and guidance from the Health Board around procurement and decision making. Cluster leads and Health Board managers, expressed frustrations about the length of time procurement processes take, lack of guidance, conflicting advice given by the procurement team, and complications of procurement rules, especially when more than one cluster is tendering for similar services. There was a perception that the procurement and finance teams were not well versed with cluster monies. Interviewees told us they do not understand how decisions are made, who you need to approach to make progress, who you appeal to and who has final say. This was true for cluster

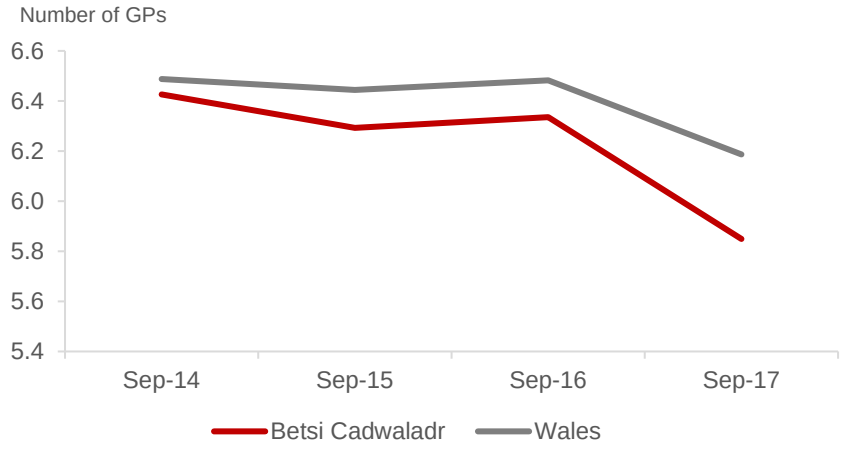
monies as well some confusion about internal pots of funding for primary care. To overcome this barrier cluster leads and assistant medical directors said they go straight to the Chief Operating Officer for approval. But even after the Chief Operating Officer has approved projects there are still delays with procurement and finance processes.

Workforce: Workforce challenges pose a significant threat to the sustainability of practices and the Health Board is being stretched by directly managing a large number of practices

The Health Board has carried out some work to model the workforce it requires but there are gaps in data. Available information suggests a shortfall in GPs and growing list sizes

53. The Health Board has a lower number of GPs per 10,000 population (5.8) than the Wales average (6.2) (Exhibit 8). The number of GP partnerships has reduced from 114 in September 2014 to 107 in September 2017, and at 18%, the percentage of partnerships with just one partner is higher than the Wales average (11%).

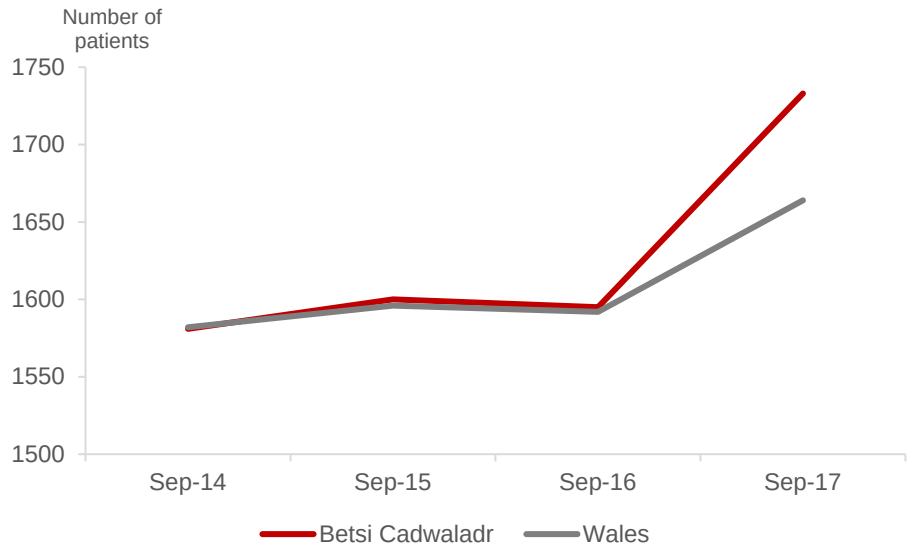
Exhibit 8: number of GPs per 10,000 population



Source: Welsh Government, September 2017

54. As shown in Exhibit 9, since September 2016 the average list size per GP in the Health Board has increased. At September 2017, the Health Board's average patient list size per GP was 1,773, which is 69 patients higher than the Wales average.

Exhibit 9: average list size per GP



Source: Welsh Government, September 2017

55. Exhibit 10 shows that at the Health Board, the proportion of GPs aged over 55 is slightly higher than the Wales average and the proportion of GPs that are female is slightly lower than the Wales average.

Exhibit 10: demographics of GPs by age and gender

	Betsi Cadwaladr University Health Board	Wales
• Aged over 55	24%	23%
• Female	52%	54%

Source: Welsh Government, 30 September 2017

56. The number of dentists offering NHS care within the Health Board area is steadily increasing. In 2017 there were 323 General Dental Services contractors, up from 313 in 2014. However, the number of optometrists offering NHS care is falling, from as high as 230 in 2013 to 182 in 2017.

57. The national primary care plan requires health boards to map its workforce. The Health Board holds information on the age of all GPs and has a good understanding of the number of whole time equivalent (WTE) GPs. However, because practices are not obliged to notify the Health Board of any changes, the Health Board reported that this data may not be fully accurate. The Health Board

also periodically collates information about practice staff other than GPs, which they analyse using the practice development plans. The data we reviewed was from September 2017 and shows the number of contracted hours and headcount for the professions shown below, split by practice and showing comparative data from the year before:

- advanced level nurses
- extended role and specialist nurses
- practices nurses
- those offering direct patient care
- administrative and clerical staff

58. The forms we reviewed for the three areas had varying levels of detail. The most detailed was the West area which showed disaggregated information about professionals offering direct patient care, for example: audiologist, advanced paramedic and clinical pharmacist. This gives the West Area a better understanding of the shape of their primary care workforce and identify gaps and opportunities.

59. In terms of other primary care services, the Health Board does not collate information about the number or skill mix of those working in community pharmacy and optometry. And whilst the Health Board holds information about their staff offering community dental services, they hold limited information about general dental service contractors. This means that the Health Board does not have a full understanding of the numbers and range of skills of those working within primary care services within the Health Board area. Having a complete picture would prove valuable when planning future services.

60. We assessed what health boards are doing to model the future capacity and skills they need in the primary care workforce. The Health Board's Care Closer to Home framework details the Health Board's vision for service provision on a cluster basis. It includes an example model cluster serving a population of 50,000. It sets out the expected services within each cluster such as, two health and wellbeing centres, 25 GPs, six opticians and seven dental surgeries. The framework also includes an example of the group of professionals that would work in the health and wellbeing centres core team and surrounding virtual team. But the number of professionals needed in each cluster or centre has not been profiled. Those we interviewed acknowledged that there had been attempts at modelling the workforce. For example:

- When planning Healthy Prestatyn, the Health Board developed a workforce plan to help establish which professionals will be needed, demands on the services such as the number of likely consultations, consultation timings and the types of patient requests.
- In November 2016, the Health Board sent the Welsh Government a workforce estimation to help them identify the future size and shape of the wider primary care workforce in Wales. The Health Board based their estimation on the Healthy Prestatyn model and predicted that if the model

was rolled out across North Wales a total of 207 GPs amongst other professional would be needed, meaning this model would half the number of current GPs[13].

61. But the majority of interviewees felt the Health Board had not done any formal workforce modelling or gap analysis. The Care Closer to Home Framework recognises that 'understanding the size and shape of the workforce for integration is paramount'. We agree with this statement as without a clear picture of the current workforce, current and future service planning is hindered.

There are significant challenges to the sustainability of GP practices and the Health Board is being stretched by having to directly manage an increasing number of practices

62. Health Board's Integrated Primary and Community Services Strategic Framework highlights significant sustainability issues facing primary and community care services. These issues include GP retirement, insufficient training places for GPs and allied health professionals and recruitment issues in rural areas. These issues are threatening the current GP model and are barriers to new ways of working. In addition, recruitment and capacity issues are compounded by increasing patient demand and expectation and the variable quality of the primary care estate hinders expansion of services. These issues were echoed by those we interviewed.

63. The Health Board uses the GP sustainability assessment framework developed by the Welsh Government to help support and target struggling practices. Prior to the national framework, the Health Board had developed its own risk matrix to identify practices likely to struggle within 12-18 months. In addition, area teams use practice sustainability returns, required as part of the GMS contract, and local intelligence to target their support. Such support can include providing staff such as salaried GPs, physiotherapists or pharmacists.

64. 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. At the time of our review, the Health Board was in the process of reorganising its Primary Care Support Unit (PCSU) to better align with and support the areas teams. The PCSU was established in 2010 as a corporate function. The PCSU was responsible for primary care contract and performance management and providing clinical governance support. The areas teams are responsible for primary care provision, development, sustainability and support for contractors. As at 2017-18, the unit employed 25 staff and cost £1.09 million. However, from 1 April 2018, the PCSU's clinical governance structure (eight members of staff) transferred into the area teams, with the contractual function remaining part of corporate finance.

[13] In 2017, there were 407 GPs working in the Health Board area.

65. The Health Board has 12 directly managed practices, with more practices at risk of giving notice. Over the years, the Health Board has experienced several practice resignations. More recently, however, there has been an increase in the number of long-term managed practices. This is because of difficulties in attracting new independent contract holders when GPs retire. The Health Board recognises that the future of primary care in North Wales will be a mixture of managed and independent practices, with practices moving between the two statuses. And that this brings opportunities for testing new models of care and innovation. For example, Healthy Prestatyn was developed after three GP practices gave notice around the same time.

66. Expenditure on managed practices has increased over the last three years. The Health Board has undertaken some work to understand the costs of supporting managed practices. But they reported that it is difficult to the cost of running an independent practice with that of a managed practice because practices are run differently so there are a number of variances in cost.

The Health Board is in the early stages of implementing multi-professional primary care teams but there are barriers to further progress including a shortage of non-medical professionals

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

68. The Health Board and cluster leads described a number of alternative first points of contact developed in North Wales. The schemes, funded using the Primary Care Development Fund and Integrated Care Fund, are at varying stages of development and coverage. We reviewed a series of internal business cases requesting schemes continue to be funded or extended. Some examples include:

    - Locality based diabetes specialist multi-disciplinary scheme established in some localities;
    - Out of Hours district nursing in all areas;
    - Common Ailment Scheme with community pharmacy, which aims to reduce GP practice workload associated with the management of common ailments, and unscheduled supplies of repeat medication, particularly for temporary residents; and
    - Advanced Pharmacist Practitioner within primary care.

69. The Health Board also has a special holidaymakers clinic on the Lleyn Peninsula, where they can access pharmacy, medical care and prescriptions. In addition, the various clusters are developing alternative first points of contact, for example three

of the Wrexham clusters are working on sign-posting projects which are linked to Dewis Cymru.

70. Whilst it is positive that the Health Board has in place and is developing alternative first points of contact, some issues were raised through our cluster lead survey and interviews. Whilst cluster leads were positive about working with other professionals, they stressed that unless the alternatives are robust, patients will turn back to their GPs as their first point of call. They raised concerns about non-medical professionals being in short supply, as well as GPs being in short supply. They also raised concerns about an unequal offer of services between different clusters.

71. Those we interviewed felt that whilst patients might have initially been suspicious of alternative points of contact they have now become used to them. However, there is still some work to do to educate and inform people about the role of these new points of contact.

72. The Transformational Model highlights the importance of enhanced multi-disciplinary teams providing a shared resource for all practices in a cluster. As stated earlier, Healthy Prestatyn is a multidisciplinary primary care model where a range of professional work together to make sure patients receive appropriate care. The service has been running for over two years, and those we interviewed agreed that the model and direction is right but the service is not without its challenges. However, many of the challenges faced are not uncommon across the Health Board and nationally, for example, difficulties recruiting GPs, nurses and administrative staff and having to use locum doctors.

73. The Health Board is also in the early stages of introducing other multidisciplinary teams. For example, community resource teams are being developed in Gwynedd. Also, as mentioned earlier, the Health Board is introducing alternative professionals to work with GP practices such as clinical pharmacists, advanced physiotherapists and paramedics so that more conditions can be managed within the community, negating unnecessary access of secondary care services. But there are barriers to mainstreaming a multidisciplinary model of care, these include:

- Most advanced practitioners start their careers in a secondary care setting, but there a different set of skills is required work in a primary care setting. Currently there not enough advanced practitioners trained in a primary care setting.
- There are recruitment issues across professionals these being GPs, nurses and allied health professionals.
- The training placements for medical, nursing staff and therapists are not sufficient to meet current capacity gaps. This means that different services are competing for the same staff.
- High demand in practices but not enough professionals to meet the demand.

- There is an aging workforce especially for GPs, which risks shrinking the primary care workforce further.
- Overreliance on short-term, non-core funding for primary care modernisation and service change. This is not sustainable as it does not allow for long-term planning and for new ways of working to become embedded.

74. The Transformational Model also highlights the need for shared systems of triage for members of the primary care team. The Health Board has collaborated with Glyndwr University to develop care navigator training which has been offered to all administrative staff at GP practices in North Wales. The training is a four-module accredited certificate, which gives receptionists in primary care the skills and tools to sign post patients more effectively to community services and other health professionals.

Oversight: The Health Board has recognised the need to strengthen primary care leadership and performance monitoring and scope remains to improve the support provided to cluster leads

The Heath Board has recently recruited a Director of Primary and Community Care, which is a positive step to addressing concerns that primary care needs stronger representation at Board level

75. 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. At the time of the fieldwork, Betsi Cadwaladr's vice chair, told us her role was to have strategic oversight of primary care. She discharges her duties through attending engagement events, supporting work such as social prescribing and initiatives to reduce health inequalities. Generally, those we spoke to felt the vice chair was supportive, had innovative ideas and was an advocate for primary care.

76. There were mixed feelings about whether executives and non-executive members had a good understanding of primary care issues. Those we interviewed felt there could be greater representation of primary care at Board level. Until recently, the Chief Operating Officer had executive responsibility for primary care but also had responsibility for several other service areas. The Chief Operating Officer post has since been removed and the Health Board has now appointed an executive director for primary and community care who will report directly to the chief executive. The executive director for primary and community care will raise the profile of primary care at executive and Board level. We understand that the individual taking up this new role has recent experience in primary care service transformation and is a GP by background.

77. The three area managers have delegated responsibility for primary care. The area managers work alongside the area medical directors who are all GPs. There is a primary care team within each area which is made up of:

- assistant area directors for primary care
- nurse leads for primary care
- assistant medical directors
- cluster coordinators
- information analysts

78. Enablers such as workforce officers, project managers and planning, commissioning and transformation leads provide support to all three areas. Interviewees told us the Health Board had invested in the primary care teams and

that these teams are supportive. But because of capacity constraints, we were told the team is not doing enough to support some services, such as dental and pharmacy. The team is also stretched in areas where there are a number of managed practices.

There is no dedicated primary care committee, there is scope for more regular consideration of primary care at Board and committees and the Health Board has developed a new dashboard to strengthen monitoring of performance

79. The Board receives regular progress reports against their special measures framework and this includes primary care. The integrated performance report also includes some primary care measures. Aside from this the Board receives ad-hoc reports about primary care services and initiatives, such as such as updates on Healthy Prestatyn and the Living Healthier Staying Well strategy, which includes Care Closer to Home. But there is no primary care standing item on the Board agenda.

80. The Board does not have a dedicated primary care committee. Instead, scrutiny is split across several committees, these are detailed below. We reviewed the terms of reference for these committees and found that none of them have a specific remit to scrutinise primary care:

- The Strategy Partnership and Population Health Committee, which receives quarterly updates on annual operational plan deliverables, including primary care.
- The Quality, Safety and Experience Committee, receives a performance report with measures assigned to the committee. However, the majority of measures are related to secondary care.
- The Finance and Performance Committee scrutinises the integrated performance report, which includes some primary care measures.

81. The above committees also receive ad-hoc primary care update reports and papers for decisions. Whilst we appreciate that primary care matters are brought to the attention of the Board and committees, given the sustainability issues facing the service and the fact the service is considered across several committees it would be preferable to have a standing item at Board or one of the committees to ensure there is regular focus and scrutiny. However, the Care Closer to Home Framework outlines draft governance and decision-making arrangements for the ten-year strategy. This shows that each of the three programmes, including Care Closer to Home will have its own project Board which feeds up an executive level board, which reports up to the Strategy Partnership and Population Health Committee. These arrangements will ensure there is greater focus on the delivery of the care close to home programme.

82. Area teams have monthly and quarterly executive accountability meetings. And from August 2018, the Health Board introduced east, central and west accountability meetings, which include both the Area teams and the hospital management teams. The aim of this is to help support more joined up accountability and decision making.

83. There was a mix of opinions about whether the Health Board considers primary care as important as other service areas. Some feel primary care is not as high up the Health Board agenda as it should be, feeling discussion and agenda are still very much secondary and acute care focused. Whilst other think primary care is high on the health board agenda, with more primary care papers being taken to the Board. But both sides of the argument agree that the balance is shifting towards primary care, although there is a barrier caused by the secondary care focus of the national targets.

84. Those we interviewed felt that there is a lot of data in primary care, especially held by GP practices but the Health Board is unable to access this data. Also, it was felt the performance measures reported at Board and committee level are secondary care focused. However, the Health Board is trying to address this issue and has recently developed a primary care dashboard. The dashboard allows secondary care data to be broken down at cluster, practice and patient level. Practices have access to the dashboard and the Health Board is encouraging them to use it. It has been developed as a single access tool for primary care teams, practices and clusters to use to help them understand demand and the needs of the patients. The dashboard is still evolving but the types of reports available include:

- Inpatients – admissions, readmissions and inpatients by practice and chronic admissions and readmissions.
- Emergency department – attendance including out of hours data, emergency department attendance verse wales rates and frequent attenders.
- Outpatients – Summary of outpatients, referrals heat map, referrals trend by practice and referral rates versus Wales rates.
- Incidents and concerns data.
- Waiting list – Referral to treatment and diagnostic and therapy.

GPs provide leadership of most of the clusters and they feel the Health Board could further support them in their role

85. Exhibit 11 sets out the professional backgrounds of the cluster leads across Wales. In the Health Board, the cluster leads are mainly GPs, with two cluster leads from other professional backgrounds, namely an advanced nurse practitioner and third sector representative. This is in line with other health boards in Wales where most cluster leads are also GPs.

Exhibit 11: professional background of the cluster leads

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

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

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

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

86. Public Health Wales' Primary and Community Care Development and Innovation Hub has developed a Confident Leaders Programme, which has been attended by 40 cluster leads who continue to learn from each other through a community of practice. In our survey, two out of eight responding cluster leads had attended the programme, with one agreeing that it has helped them improve as a cluster lead, the other neither agreed nor disagreed.

87. Only three out of the eight cluster leads responding to our survey agreed that the Health Board provides them with effective support to undertake their role. And seven out of the eight respondents disagreed with the statement 'I have enough time in my day to focus on cluster development'.

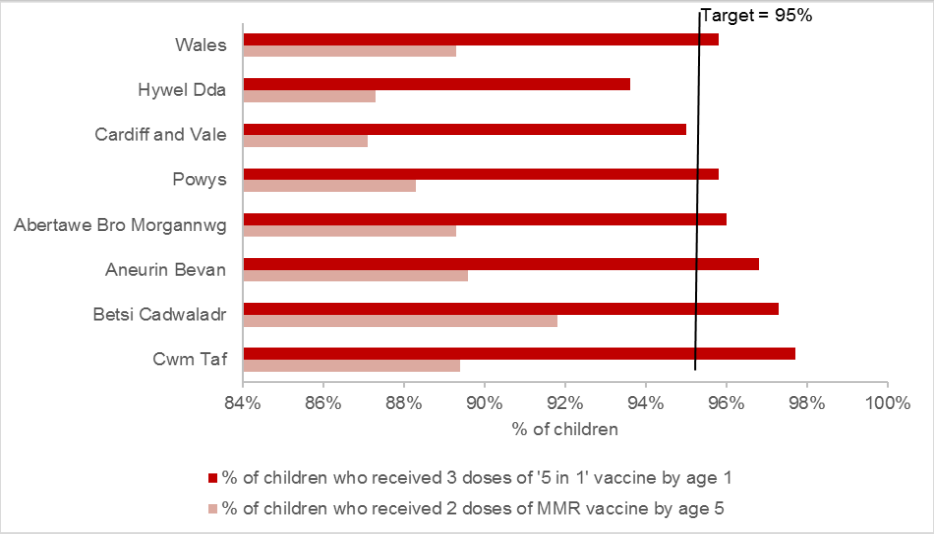
Performance: The Health Board is making reasonable progress in delivering its primary care plans although many aspects of performance are worse than the Wales average and a number of difficult challenges remain

Many aspects of the Health Board's performance are worse than the Wales average, however, the available measures do not give a comprehensive picture of primary care performance

88. 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 Report. However, national measures do not cover the entirety of primary care. The National Primary Care Board is in the process of developing a set of national primary care measures.

89. Exhibit 12 shows the Health Board's childhood immunisation rates between January and March 2018. The Health Board is exceeding the target for '5 in 1' vaccines and it has the second best performance compared to other health boards. The Health Board is below target for MMR vaccinations but this is the case for all health boards. The Health Board's performance on this measure is better than the Wales average. The Health Board's integrated quality and performance report also includes an extended range of local measures for childhood immunisation. The May 2018 report shows data from quarter three 2017-18, where the local childhood immunisation targets (95%) had been exceeded.

Exhibit 12: childhood immunisation rates for the quarter January to March 2018

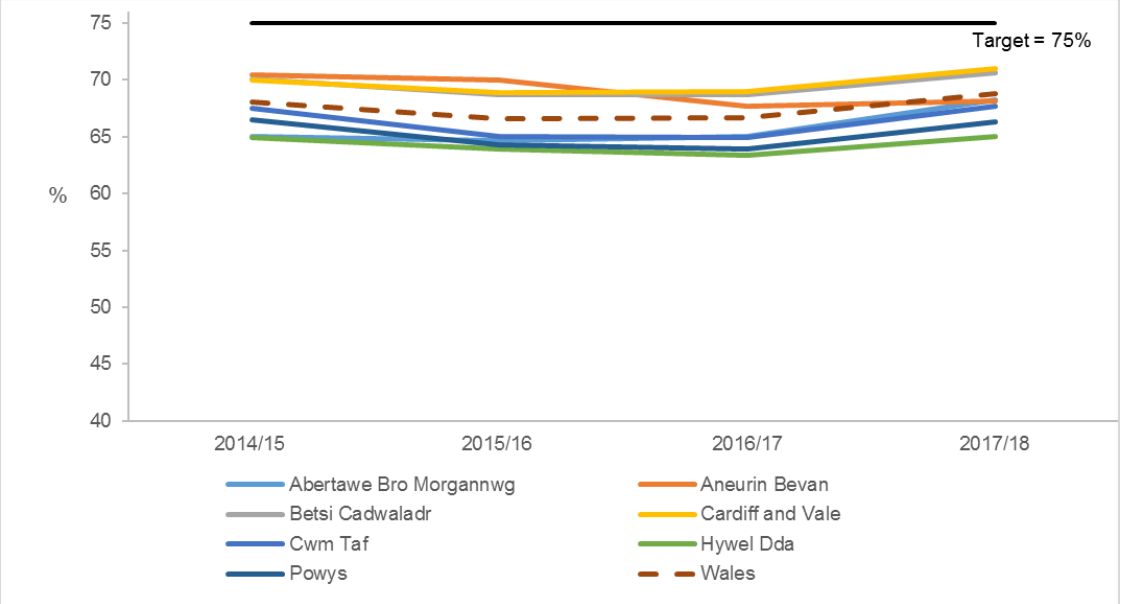


Note: '5 in 1' vaccine protects against diphtheria, tetanus, pertussis (whooping cough), polio and HIB infection. MMR protects against measles, mumps and rubella infections. These results are for children living in the Health Board area in March 2018 and who reached their first and fifth birthdays during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

Source: Public Health Wales

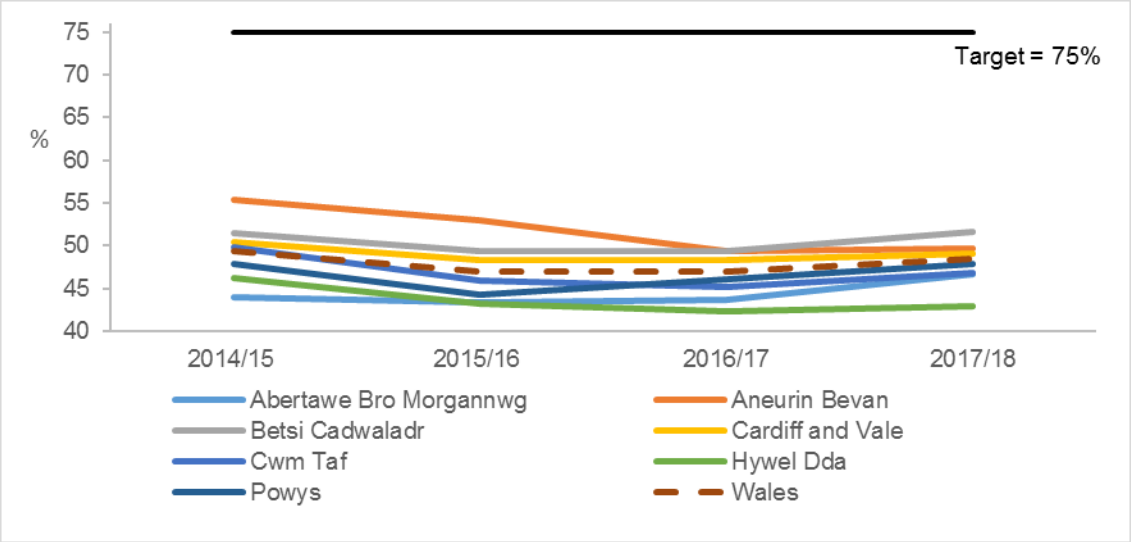
90. For adults, flu vaccinations are recommended for people aged 65 and over, as well as people with other risk factors such as asthma. The target for both groups is for 75% of those populations to receive the vaccination each year. Exhibits 13 and 14 show that across Wales the Health Board has not met the targets for flu vaccinations. However, the Health Board's flu vaccination uptakes are better than the Wales average.

Exhibit 13: trends in uptake of flu vaccination 2014-15 to 2017-18: Uptake in patients aged 65 years and older.



Source: Public Health Wales

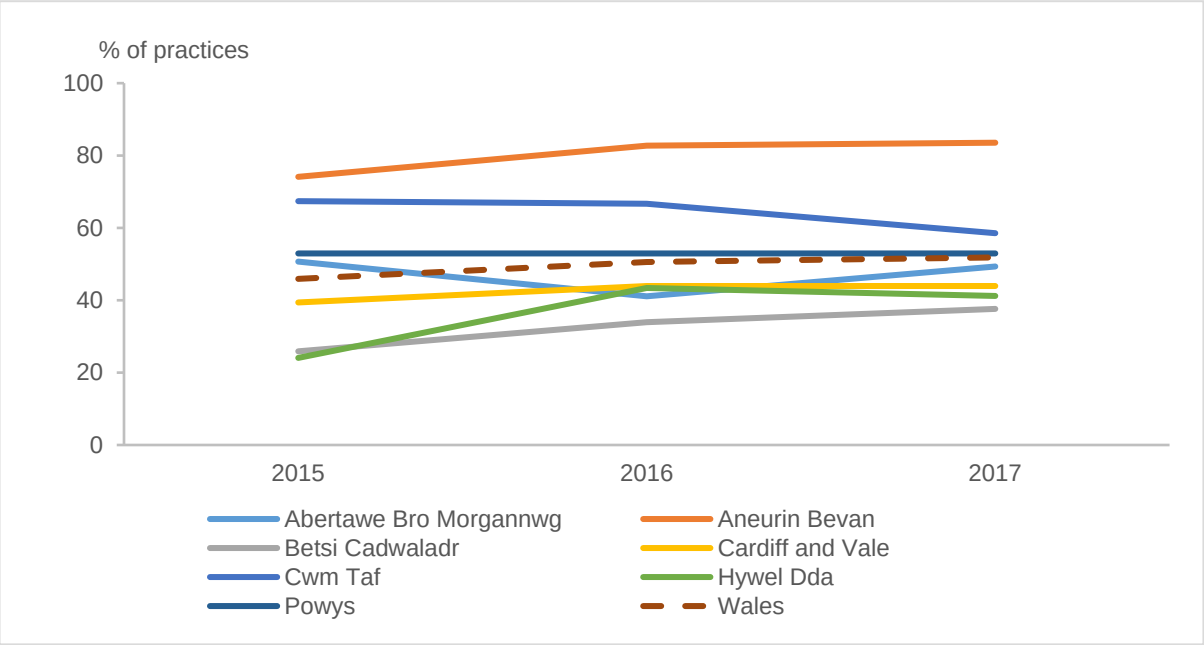
Exhibit 14: trends in uptake of flu vaccination 2014-15 to 2017-18: Uptake in patients younger than 65 who are at risk



Source: Public Health Wales

91. Exhibit 15 shows that in 2017, just 38% of GP practices in Betsi Cadwaladr opened for 100% or more of their weekly core hours. This is worse than the Wales average of 52% and performance in Betsi Cadwaladr is the worst in Wales.

Exhibit 15: percentage of practices open for 100% or more of weekly total core hours, by Health Board, 2017

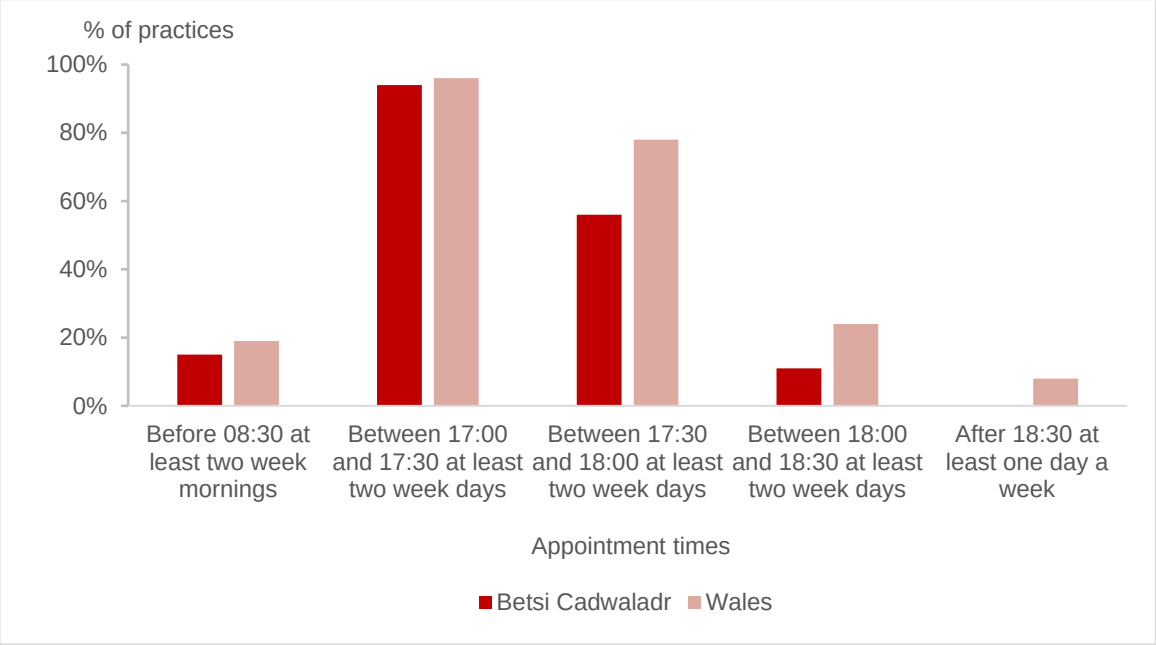


Note: Total weekly core hours equal 52 hours and 30 minutes.

Source: Welsh Government

92. Exhibit 16 shows that the Health Board performs below the Wales average for all measures related to the provision of GP appointments at different times of the day. Exhibit 17 shows how Betsi Cadwaladr compares to heath boards. Betsi Cadwaladr has the lowest percentage of GPs offering appointments between 5.30pm and 6.30pm and is one of five health boards where no appointments are offered after 6.30pm.

Exhibit 16: extended appointment times at GP practices, 2017



Source: Welsh Government

Exhibit 17: extended appointment times at GP practices, 2017

Percentage of practices offering appointments.

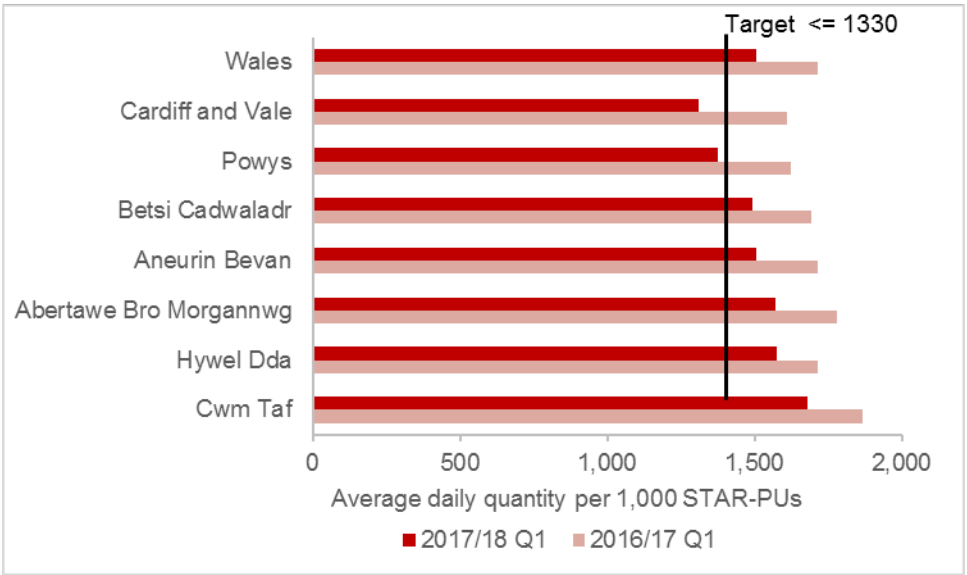
Health Board	Before 08:30 at least two week mornings	Between 17:00 and 17:30 at least two week days	Between 17:30 and 18:00 at least two week days	Between 18:00 and 18:30 at least two week days	After 18:30 at least one day a week
Abertawe Bro Morgannwg	14%	93%	77%	22%	0%
Aneurin Bevan	23%	97%	99%	25%	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 nonsteroidal anti-inflammatory drugs (NSAIDs) to reduce the risk of complications. Exhibit 18 shows the Health Board has reduced its prescribing in the previous 12 months by 11.8%. However, the Health Board has shown slightly less of a decrease than the Wales average of 12.3%.

Exhibit 18: 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).

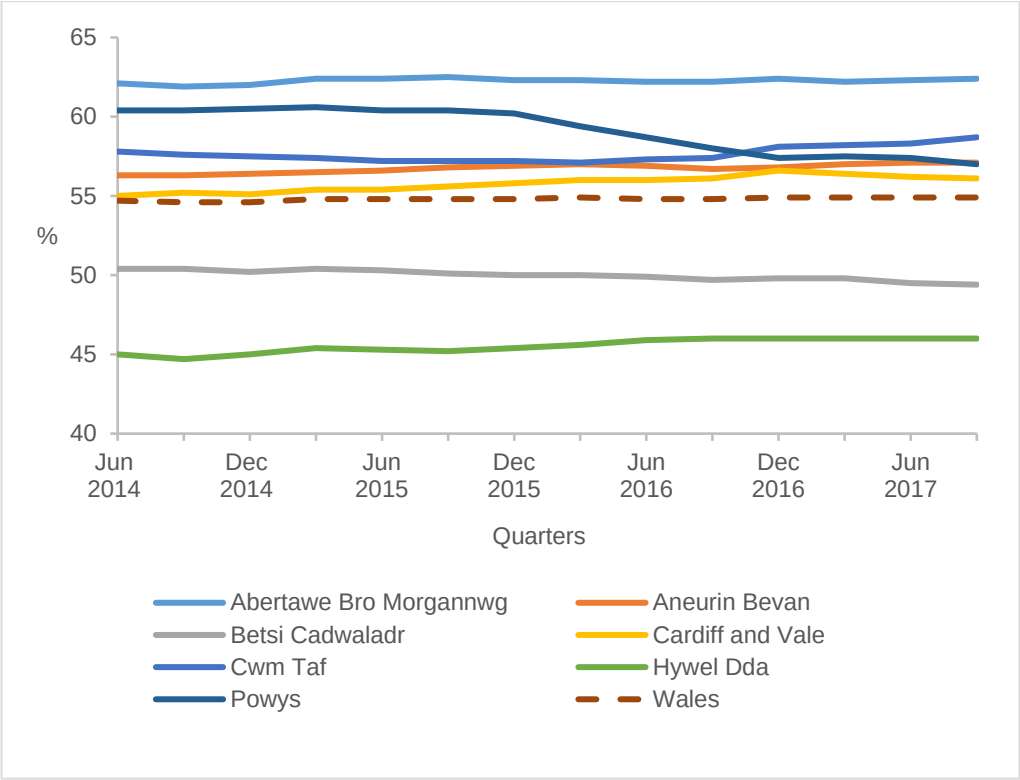


Target = <1,330

Source: Welsh Analytical Prescribing Support Unit

94. Exhibit 19 shows the percentage of the population regularly accessing NHS primary dental care in the previous 24 months as at 30 September. The target is for annual improvement, which the Health Board has not achieved. At September 2017, Betsi Cadwaladr had the second lowest percentage (49%) of patients treated at a NHS dental practice, in the same month the Wales average was 55%.

Exhibit 19: 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 the primary care actions from its annual operating plan but there are significant barriers to progress, in particular recruitment, retention and training, increased demand and financial challenges

95. The Health Board reports quarterly to the Strategy, Partnership and Population Health (SPPH) Committee against its annual operating plan deliverables, which includes primary care. The report uses a traffic light system to highlight actions:
    - Green = on track or complete
    - Amber = in progress but with some issues
    - Red = not on track and have issues

96. In July 2018, SPPH Committee received the 2017-18 year-end update on annual operating plan deliverables. Exhibit 20 shows progress against primary care actions. At quarter four, out of 98 actions, 65 were on track or complete (green), 32

were on amber and one action was red. The Health Board is making reasonable progress against their plans, however, primary care sustainability remains a high risk (red risk) on the corporate risk register.

Exhibit 20: progress against 2017-18 primary care annual operating plan deliverables

Primary Care themes	Number of actions	RAG status of actions at quarter 4		
		Green	Amber	Red
Medicines Management	30	15	14	1
Sustainable Primary Care	38	27	11	0
Improving Access	21	17	4	0
Developing Integrated Services	4	4	0	0
Referral Systems	5	2	3	0
Total	**98**	**65**	**32**	**1**

Source: Wales Audit Office analysis of Quarter 4 Annual Operating Plan deliverables, 2017-18

97. We asked the Health Board what the main barriers were to transforming primary care. Exhibit 21 shows that the Health Board identified recruitment, retention and training as the main barriers to transforming primary care. In terms of training, the Health Board not only identified the need for more training places for professions where there are shortages and greater demand. But also, the need for advanced practitioners to be trained specifically to work in primary care settings.

Exhibit 21: the Health Board's view on the main barriers to transforming primary care

Barriers	What needs to be done to remove the barriers
Recruitment and retention	• Terms and Conditions of GPs (independent and salaried) • Relocation packages • Indemnity insurances • Mitigation of premises risks • Addressing work/life balance
Training Places	Increased commissioning of training places in the right areas
Advanced practitioners not trained in a primary care setting	Bespoke training packages for primary care and funded mentorship opportunities

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

98. We sought views from cluster leads on the successes that have been achieved and also the main challenges facing primary care in their health board area. Exhibit 22 shows the cluster leads feel their main successes are the increased inclusion of allied health professionals within clusters and practices. They also feel that practices within clusters are working better together to support each other and the relationship between primary care providers and the Health Board is improving. Some felt there is now greater recognition that the traditional primary care model is unsustainable and that innovation funds are helping to test new models of care.

Exhibit 22: successes described by cluster leads in our survey

Successes	Number of clusters
Cluster, community and practice-based services	7
Improved communication and working between practices in clusters	3
Improved relationship between Health Board and providers	2
Funding for innovation and testing new models	2
Recognition that traditional GMS is unsustainable	2
Primary and secondary care interface meetings	1
Greater cluster autonomy	1
Cluster support teams	1

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

99. Exhibit 23, shows that the main concerns expressed by cluster leads were recruitment of GPs and allied health professionals, as well as increasing demand and workload within primary care services. They were also concerned about the financial challenges facing the Health Board. Some concerns were expressed about clusters not getting enough funding for large scale innovation, lack of support to help spend cluster funds, a lack of procurement support and bureaucracy.

Exhibit 23: challenges described by cluster leads in our survey

Challenges	Number of clusters
Recruitment and retention of GPs and allied health professionals	7
Increasing workload and demand	4
Financial challenges	4
Cluster support, funding and bureaucracy	3
Pressures in secondary care	2
Procurement and recruitment delays and issues	2
Low morale	1
Collapsing practices	1

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

Appendix 1

Methods

Method	Detail
Health Board self-assessment	The self-assessment was the main source of corporate-level data that we requested from the Health Board in February 2018. This tool also incorporated a document request.
Survey of cluster leads	We sent an online survey to all cluster leads in Wales in April 2018. The overall response rate was 63%. At the Health Board we sent out 14 surveys and received 8 responses, giving a response rate of 57%.
Interviews	We interviewed a number of staff including the following with responsibility for primary care: • Vice Chair • Directors responsible for primary care • Medical Director • Assistant/Deputy Medical Director • Finance lead • Workforce lead • Planning and Performance lead • Operational Managers • Community Health Council representative
Review of the Health Board's Integrated Medium Term Plan	We reviewed the Health Board's medium term plan to assess the extent to which primary care is considered.
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 24: Betsi Cadwaladr University Health Board's management response

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
Strategic planning							
R1	The Health Board has recently developed a Care Closer to Home Framework but has not yet described how this framework will be implemented. The Health Board should therefore develop a costed implementation plan to support delivery of its Care Closer to Home Framework.	To ensure that there is a clear and resourced roadmap to deliver sustainable and impactful improvements. To improve pace of primary care programme delivery.	Y	Y	The Care Closer to Home Transformation Group is being refreshed following the commencement in post of the Director of Primary & Community Care services, and part of this work involves the creation of greater detail of the steps required to implement the Framework. A key element of this Delivery Plan will be the costed implications including savings. The first draft will be completed in November 2018.	November 2018	RN

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
Investment in primary care							
R2a	Calculate a baseline position for its current investment and resource use in primary and community care.	To determine the extent of resource shift between primary, community and secondary care.		Y	In support of the financial planning for 2019-20 to 2021-22 IMTP, the extent of resources invested in primary and community care will be calculated to establish a baseline against which future investment and disinvestment decisions will be made against.	January 2019	RN
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 provide assurance on the extent of investments in care closer to home, health improvement.	Y	Y	In support of the financial planning for 2019-20 to 2021-22 IMTP the extent of resources invested in primary and community care will be calculated to establish a baseline against which future investment and disinvestment decisions will be made against. Currently, comparison between years expenditure split between secondary care, mental health and primary care is analysed as part of AGM presentation.	January 2019	RN

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
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.	To have a clear understanding of the whole primary care workforce, which will be the basis for current and future workforce planning.	Y	Y	The Health Board recognises that data related to the Primary Care contractor workforce is limited, and that the Care Closer to Home Framework would benefit from more extensive workforce data. The Health Board will continue to work with contractor service providers to improve our baseline data set and seek their help in identifying anticipated future requirements. The Care Closer to Home Framework has a number of important workforce dataset requirements, with a sub-group being convened to support workforce planning.	June 2019	CS

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
New ways of working							
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.		Y	Workstream leads have been appointed to oversee key pieces of work within the Care Closer to Home Framework, including the development of clusters, the development of Community Resource Teams within clusters, and the development of new ways of working within Primary Care. These pieces of work are complementary and will provide frameworks focused to allow the evaluation and propagation of beneficial new ways of working.	Framework agreed April 2019	CS
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.	Y	Y	Cluster coordinators are in post with workplans that are aligned to sharing good practice and experience across Clusters. Collation of evaluations will be included within ongoing work currently bringing together an Academy framework for Primary Care services.	April 2019	CD

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 these new models from mainstream funding, rather than from the Primary Care Development Fund.	To ensure that new ways of working are embedded and sustainable.	Y	Y	This will be specifically included within the work referred to in responses R1 and R2a	January 2019	RN
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. To share lessons learnt so they can be adopted across the clusters.	Y	Y	The Health Board is committed to developing opportunities built around the all Wales new model for Primary Care, and has created a major workstream within the Care Closer to Home Framework dedicated to doing this.	Framework agreed April 2019	CS
Primary care clusters							
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.	Y	Y	The Health Board is committed to prioritising and developing clusters. Work is now underway to scope out a blueprint for focused support to develop cluster maturity, led by a cluster lead, and supported by Area Teams who are exploring ways of better supporting clusters as Area building blocks.	Framework agreed April 2019	CS

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					The Health Board wishes to support clusters as multi-organisation, multi-disciplinary constructs, and has indicated a wish to work collaboratively with partners to ensure this. The development of a cluster blueprint is proceeding in partnership.		
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.	Y	Y	See response R5a. All clusters are being supported to form multi-partner, multi-disciplinary meeting structures.	Framework agreed April 2019	CS
R5c	Support clusters to improve their procurement processes. Actions could include nominating individuals in the procurement team to link with specific clusters and developing specific procurement guidance for clusters to clarify timescales, accountabilities and processes.	To improve the efficiency and value that can be achieved through effective procurement		Y	The Health Board recognises that opportunities exist to improve procurement opportunities. Guidance will be provided, and links, alongside best practice national guidance.	April 2019	CS

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R5d	Clarify and publicise the governance and leadership arrangements for clusters, to ensure better understanding of the responsibilities for decision-making.	To improve communication, coordination and lines of accountability	Y	Y	Arrangements are being clarified via the Care Closer to Home Framework, with a specific sub-group focused around the governance and leadership of clusters. This will build upon national guidance to create local clarity and facilitate decision-making in line with evolving cluster maturity.	Framework agreed April 2019	CS
R5e	Ensure all cluster leads attend the Confident Primary Care Leaders course.	To strengthen cluster leadership.		Y	Two cohorts have now attended the Confident Primary Care Leaders course, and those cluster leads that have not attended will be encouraged and supported to do so.	June 2019	CD
R5f	Consider introducing a locum cluster lead post, to work across all clusters providing additional capacity and backfill for cluster leads. The post could also be valuable in sharing learning across clusters.	To strengthen cluster leadership capacity to be able to support planning and service changes.	Y	Y	This will be discussed with existing cluster leads, in order to establish the best way forwards.	January 2019	CS

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
Oversight of primary care							
R6	We found scope to raise the profile of primary care in the Health Board, particularly at Board and committee level. There is also scope to improve the way that primary care performance is monitored and reported at Board and committee level. The Health Board should therefore develop an action plan to ensure the Board and committees are adequately informed on the following key issues: a. Primary care performance; b. Delivery of primary care plans; c. Key risks to primary care, including GP practice sustainability; and patient experience of primary care.	To ensure that board members sufficiently focuses on implementation of the health board's care closer to home strategic intent. To ensure proactive management of service sustainability issues.	Y	Y	The commencement of a Director for Primary and Community Care services, with consistent support from the Health Board vice-chair (holding a lead role to champion this area) will increase the visibility of Primary Care at Board and committee level. An action plan is being prioritised as part of the entry strategy for the new Director.	December 2018	CS

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