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Archwilydd Cyffredinol Cymru
Auditor General for Wales

Primary care services in Wales

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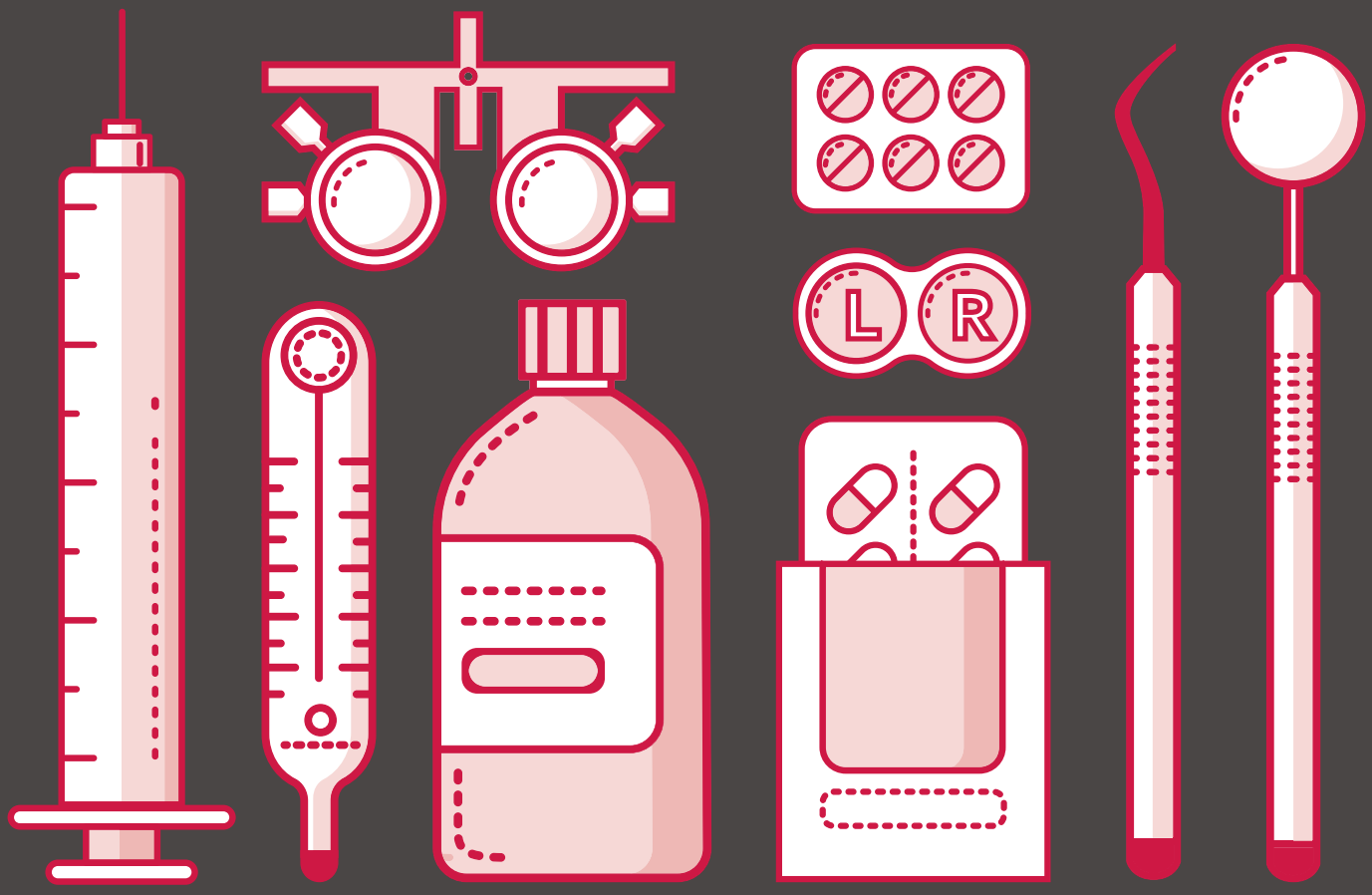

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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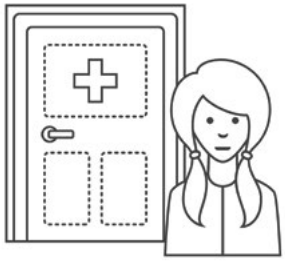
Summary report

Background

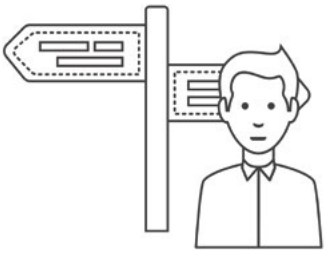
1 Primary care encompasses a wide range of services, delivered in the community by GPs, pharmacists, dentists, optometrists, as well as other professionals from the health, social care and voluntary sectors. Primary care services play a vital role in the system of health and care, as shown in Exhibit 1.

Exhibit 1 – why is primary care important?



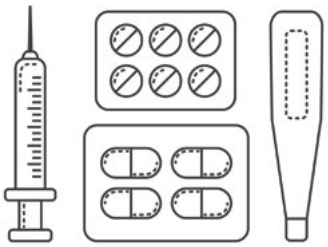
First point of contact

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



Coordinating care

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



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.

Source: **Wales Audit Office report, A picture of primary care in Wales**, which provides more background and summary statistics about primary care services.

2 For many years Wales has had plans that aim to rebalance the system of care by moving resources towards primary and community care. The national primary care plan[1], which ran until March 2018 set out a 'social model' of care to promote physical, mental and social well-being. The core principles in the plan were: planning care locally; improving access and quality; equitable access; a skilled local workforce; and strong leadership. Delivery of that plan was supported by the following developments:

a **National workforce plan**[2]: expected health boards to build multi-professional teams for patients to access as a first port of call (see Exhibit 2).

b **Primary care clusters**: these are groups of neighbouring GP practices, other primary care services and partner organisations. There are 64 clusters and their role is to ensure planning and provision of services that are locally-led by people who understand local needs. In October 2017, the Assembly's Health, Social Care and Sport Committee published a report and made 16 recommendations following an inquiry into clusters[3].

c **National Primary Care Fund**: introduced by the Welsh Government in 2015-16, the fund supports implementation of the national primary care plan. Between 2015-16 and 2017-18, the fund allocated around £120 million to health boards towards their integrated medium-term plans and workforce development plans for primary care, and pacesetter projects. Clusters were also allocated funding that they could decide how to invest. Some of the fund is retained centrally to support national action. Since 2018-19, the Welsh Government has continued to distribute around £43 million across the health boards' annual allocations.

1 Welsh Government, **Our Plan for a Primary Care Service for Wales up to March 2018**, February 2015

2 Welsh Government, **A Planned Primary Care Workforce for Wales**, 2015

3 National Assembly for Wales, Health, Social Care and Sport Committee, **Inquiry into Primary Care: Clusters**, October 2017

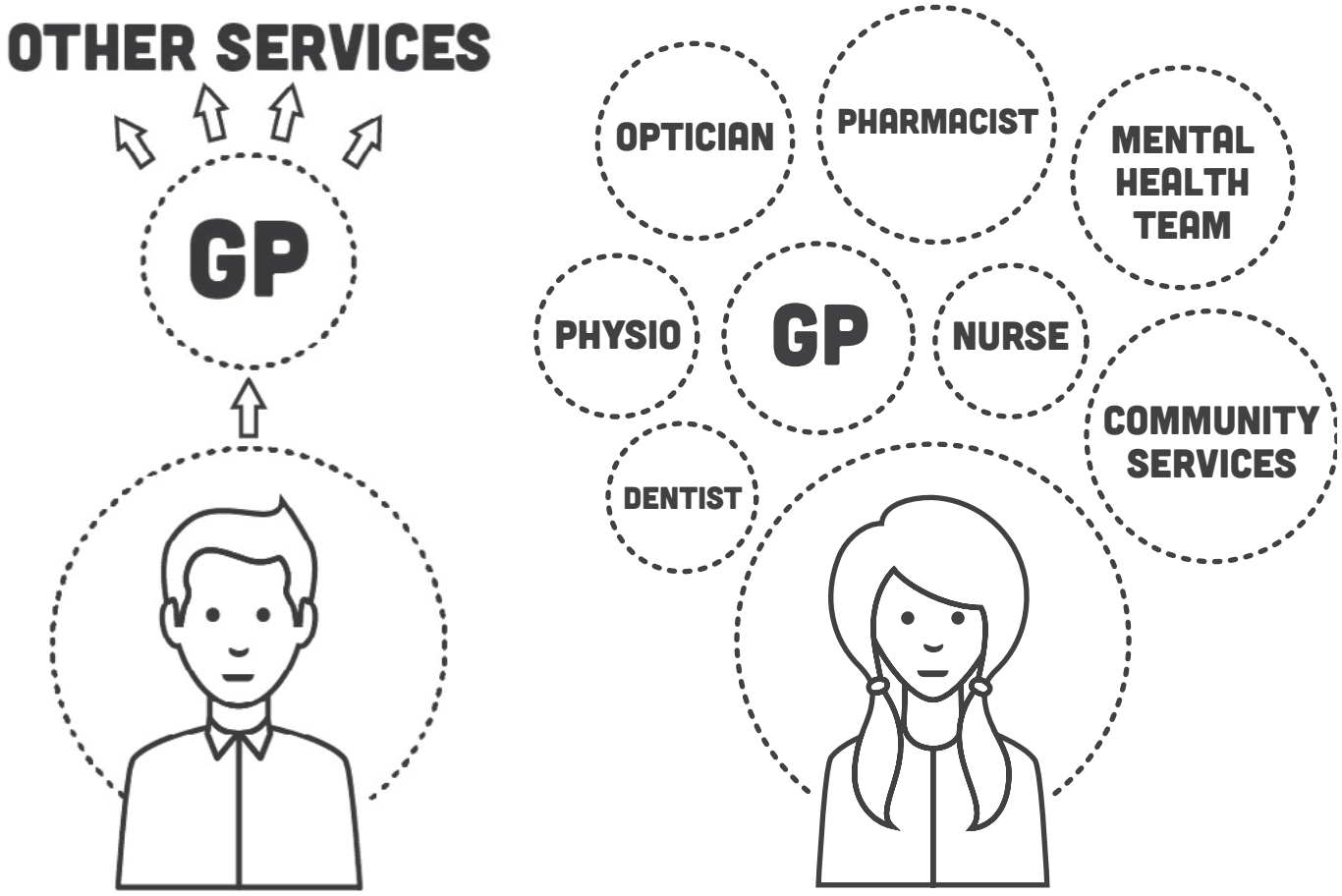
Exhibit 2 – the future model for primary care relies on building multi-professional teams

In the past

Patient goes to the GP as first port of call. The GP acts as a gateway to other services

In the future

The GP will continue to provide the first port of call for some patients. Patients will also be able to directly access many other services, thus freeing up GP time to see the sickest patients and those with complex chronic conditions.



Source: Wales Audit Office

3 Recent years have seen well-documented risks to the sustainability of primary care services, in particular GP practices. There are problems recruiting and retaining GPs, practice closures and perceptions of increased workload and poor work-life balance. There have been particular challenges with primary care out-of-hours services with our July 2018 report showing that out-of-hours services were strained and not meeting targets.

4 In June 2018, the Welsh Government published a plan for health and social care called A Healthier Wales. The plan builds on previous ambitions to shift care closer to people's homes and to bring health and social care closer together. The Welsh Government has set up a £100 million transformation fund (£50 million a year over the two years 2018-19 and 2019-20) to support projects that aim for closer working between health and social care.

5 In response to A Healthier Wales, the NHS, working with Welsh Government, has developed a Strategic Programme for Primary Care building on the work done to implement the national primary care plan since its publication in 2014. The programme consists of a strategic document, workstreams and action plans aimed at 'shifting the focus to a social model of care, ensuring timely access to primary care services when required and working seamlessly across the whole system'.

6 The Strategic Programme for Primary Care was launched in November 2018 and supports the implementation of the Primary Care Model for Wales. The model aims to ensure a whole systems approach to service redesign by setting out the key components that a good primary care system should contain. These key components include informed and empowered citizens, self-care, stronger community services, new first points of contact for patients including triage to ensure they are seen by the appropriate healthcare professional, better urgent care arrangements and stronger multi-disciplinary working. Paragraph 1.6 provides more detail on the model.

7 During 2018, the Wales Audit Office reviewed primary care services in all health boards in Wales[4]. We focused on strategic planning, investment, workforce, oversight and leadership, and performance. In early 2019, we carried out interviews and document reviews to assess the national leadership and governance arrangements for improving primary care. This report describes the main issues and areas of progress we found.

4 Reports on primary care in each health board can be found on our website at www.audit.wales.

Main findings

8 While the NHS and Welsh Government are taking a range of steps to strengthen primary care, change needs to happen at greater pace and scale to tackle longstanding challenges and ensure sustainability of these vital services.

The NHS and Welsh Government are taking a range of steps to strengthen primary care

9 While there have been plans to change primary care for many years, progress in implementing these has been limited and primary care has not always had a high enough profile within the NHS in Wales. Recent developments would suggest that the profile of primary care is increasing at both the national and local level, bringing with it, fresh opportunities and impetus for transformation.

10 A National Primary Care Board was established in March 2017 and the Primary Care Model for Wales has evolved during the past three to four years, before being formally endorsed by the National Primary Care Board in March 2018. An underpinning strategic programme was launched in November 2018. National lead roles have also been created to drive implementation of the model and the strategic programme. However, the model and the strategic programme are in their infancy so need to be kept under review.

11 Provision of innovation funding, to pump-prime change, has been a positive step. Health boards are using Welsh Government national primary care funding to test new ways of working. More work now needs to be done to spread good practice, improve evaluation of new approaches and ensure that once schemes prove themselves to be successful, they begin to receive sustainable, ongoing funding.

Change needs to happen at greater pace and scale to address longstanding challenges and ensure strained primary care services are made fit for the future

12 Despite considerable investment and many plans for primary care transformation over the years, change has not happened as quickly or as widely as intended. There remains growing pressure on the traditional model of primary care and patients are experiencing continued difficulties in accessing appointments at GP practices.

13 The Primary Care Model for Wales promotes the development of multi-professional primary care teams, to reduce the current pressures on GPs and to improve access and services for patients. However, progress on implementing the model is patchy and the pace of change needs to be increased. There is also not yet a clear approach to quantifying the extent of progress in implementing the model, and there is only limited data on the numbers and roles of staff employed in primary care.

14 The NHS in Wales aims to shift resources towards primary care. While there is evidence of some resource shifting in this way, change has not been at pace and scale. We also found that, for many reasons, it is difficult to measure exactly how much money is spent on primary care, which complicates efforts to measure progress.

15 Faster progress is needed to improve the way that performance and activity is measured. The available data suggests mixed performance across Wales. But the data are limited and the current performance measures do not provide a clear picture of how well primary care services are performing and how much activity is happening within services. Activity monitoring and planning is complicated by difficulties standardising data from independent primary care contractors.

16 Health boards have created clusters to drive local leadership and planning of primary care. An inquiry by the Health, Social Care and Sport Committee made 16 recommendations to improve clusters. Public Health Wales subsequently developed a framework to improve cluster governance[5]. We found that much work remains to be done to ensure clusters have a clear remit, sufficiently broad membership and can drive change at pace and scale.

17 More needs to be done to involve the public in changes to primary care. While some elements of the Primary Care Model for Wales have been consulted upon with the public at a local level, there has not been formal consultation or public involvement in the overall model at a national level. Now that the model is beginning to be implemented, there is also a risk that the public will not understand or agree with the new ways of working.

5 Public Health Wales, **Cluster Governance Framework: A Good Practice Guide**, October 2018

Recommendations

18 The table below sets out our national-level recommendations. We have already made local level recommendations through our reports at each health board.

Recommendations
Improving primary care data Monitoring of primary care performance and activity is limited. Current performance measures do not give an effective overview of whether patient outcomes are improved by primary care. Activity monitoring and planning is complicated by difficulties obtaining standardised data from independent contractors. **R1** The Welsh Government should work with the National Primary Care Board to agree robust measures of patient outcomes in their suite of performance measures for primary care, and in doing so, they should look to collaborate with experts in measuring whole-systems outcomes. **R2** The Welsh Government should work with independent primary care contractors to ensure the NHS in Wales has ongoing access to standardised information about their activity, to contribute to better planning and design of services.
Implementing the Primary Care Model for Wales The Primary Care Model for Wales and the Strategic Programme for Primary Care provide a direction of travel but there is not yet a clear approach to quantifying the extent of progress in implementing these changes, and data on the numbers and roles of staff employed in primary care is limited. The Welsh Government should: **R3** Strengthen its performance management of primary care within health boards by developing a method for quantifying each health board's progress in implementing the Primary Care Model for Wales. **R4** Collect and regularly publish data on the number and type of staff working as part of multi-disciplinary primary care practice teams, with a view to monitoring the implementation of the multi-professional model.

Recommendations

Keeping the strategy under review

The Strategic Programme for Primary Care is in its infancy and partnership with social care and the third sector, through Regional Partnership Boards, will be crucial to transformation. The National Primary Care Board should:

R5 Publish a review of progress in delivering the strategic programme in 2020-21. The review should seek opinions on progress from all key partners, including the Regional Partnership Boards.

Strengthening clusters

The Health, Social Care and Sport Committee's cluster inquiry made 16 recommendations. Public Health Wales subsequently led the development of a good practice guide for cluster governance. Much work remains to be done to ensure clusters have a clear remit, broad membership and are able to drive change at pace and scale. The Welsh Government should:

R6 Undertake and publish a stocktake of progress against the recommendations from the cluster inquiry and in implementing the cluster governance framework, with a view to supporting further development and maturity of clusters.

Recommendations

Shifting resources to primary care

From the existing data, it is difficult to quantify exactly how much the NHS in Wales is spending on primary care, and to assess whether health boards are succeeding in shifting resources towards primary and community care. A Welsh Health Circular[6] from July 2018 set out a new financial framework for supporting such shifts.

R7 The Welsh Government should consult with health boards, to agree an approach to clarifying and standardising the way that primary care expenditure is recorded and reported.

R8 The Welsh Government should work with health boards to evaluate, and if necessary, improve the effectiveness of the financial framework in supporting a shift in resources towards primary and community care.

R9 As part of the Joint Executive Team process, the Welsh Government should require health boards to report annually on their progress in shifting resources towards primary care. The coverage of these reports should not be limited to financial resources and should include other resources such as staff and services. Through this process, the Welsh Government should hold to account the entire executive team of health boards, not just the executive directors for primary care.

Involving the public

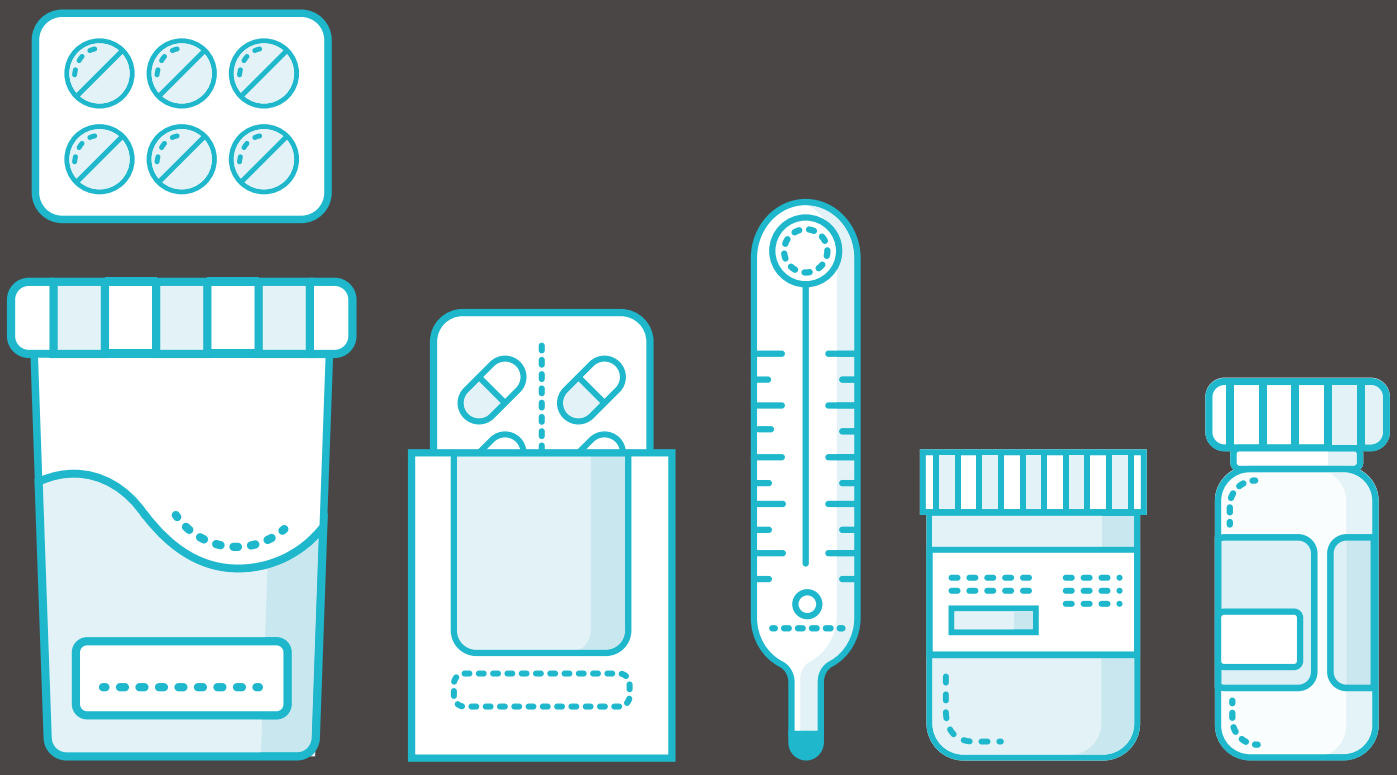
More needs to be done to involve the public in primary care changes. There is a risk that people will not understand or agree with the new ways of working. A centrally funded and led communication strategy is now in development and the Welsh Government has allocated each health board £20,000 a year since 2018-19 to improve public messaging about the model. The National Primary Care Board should:

R10 Involve the public and/or bodies that represent the public in evaluating the approaches taken by health boards to improve their public messaging on primary care, with a view to sharing learning to inform the forthcoming communication strategy.

6 Welsh Government, **Improving Value through Allocative & Technical Efficiency: A Financial Framework to Support Secondary Acute Services Shift to Community/ Primary Service Delivery, Welsh Health Circular WHC (2018) 025**, July 2018

Part 1

The NHS and Welsh Government are taking a range of steps to strengthen primary care



Primary care is becoming a greater priority for the NHS in Wales, which provides an important opportunity for transformation

1.1 Previous national plans for primary care acknowledged that primary care does not always have a high-enough profile. The 2010 document, Setting the Direction, talked about an agenda 'dominated by the acute hospital'.

1.2 Despite health boards being integrated primary and secondary care organisations since 2009, there is still some way to go until primary care has an equal profile to secondary care. However, we found evidence that primary care is becoming a greater priority. For example, two health boards have recently strengthened their leadership arrangements, meaning five health boards now have a dedicated, Board-level director for primary care[7]. Whilst this is a positive step, there is also a risk that health boards will rely too much on these directors to deliver change in primary care. If health boards are to successfully transform primary care, this will require joined-up action from all members of their executive teams.

1.3 The introduction of the National Primary Care Board, alongside the more established boards for planned care and unscheduled care, has been a positive development in raising the profile of primary care. The primary care board was set up in March 2017, has representation from many stakeholders and is providing positive, collaborative leadership of change. The board reports to the NHS Wales Executive Board and oversees the work of the Directors of Primary and Community Care Group[8].

1.4 The Welsh Government and other national bodies have taken a number of steps to raise the profile of primary care and to strengthen services. Box 1 summarises some of these steps.

7 Aneurin Bevan, Betsi Cadwaladr, Cwm Taf Morgannwg, Powys and Hywel Dda have Board-level directors responsible for primary care. Chief operating officers have responsibilities that include primary care in Cardiff and Vale and Swansea Bay.

8 The Directors of Primary and Community Care Group is a peer group of primary care directors. It has a role in implementing national primary care priorities and providing leadership for transformation in primary care.

Box 1 – Summary of national steps to address the challenges facing primary care

Pacesetter programme – The Primary Care Pacesetter Programme began in April 2015, aiming to stimulate innovation and promote primary care redesign. Twenty-four pacesetter projects were initially set up by health boards using £3.8 million a year from the National Primary Care Fund. Many of the projects employed different practitioners, like pharmacists and physiotherapists, to work in GP practices and tried out different ways for patients to contact their local practice. Fifteen additional pacesetter projects started in 2018-19 and are expected to run for two years. Further projects are being considered for pacesetter funding for 2020-2022.

Ministerial Taskforce on Primary Care Workforce – was established in 2016 to address problems with recruitment of GPs and other primary care professionals. The Minister for Health and Social Services brought together members from across all professions and took action regarding GP pay/ conditions and training and recruitment across primary care. It recently stood down as the work programme is being taken forward as part of the Strategic Programme for Primary Care.

Indemnity scheme – the Welsh Government introduced a Future Liabilities Scheme in April 2019 to try to address GP concerns about the cost of professional indemnity. The scheme covers clinical negligence liabilities that could occur due to actions of GPs and any other staff who provide primary medical services.

GP contract increase – in September 2018, GP partners received a 4% increase backdated to April 2018. Salaried GPs and dental practitioners received a 2% pay rise. Other benefits included more support for mentoring and coaching and a commitment to explore access to health board employment benefits.

Box 1 – Summary of national steps to address the challenges facing primary care

Train/Work/Live Wales campaign – launched in May 2017 to attract and train more GPs, nurses and other professionals. In addition to showcasing Wales as a great place to live, incentives of £20,000 are offered to GP trainees accepting places to train and work in hard-to-recruit areas. All trainees receive around £2,000 towards exam costs. The number of GP training places remained static at 136 for many years and until recently there were problems filling places. Almost all places were filled in 2018 and Health Education and Improvement Wales will increase the number of trainee places to 160 from 2019[9].

Primary and Community Care Development and Innovation Hub – the Hub was set up by the Primary Care Division, Public Health Wales, to coordinate support for health boards and clusters in delivering national primary care priorities. The Hub has played a major role in developing the Primary Care Model for Wales and hosts the Primary Care One website, a single point of access to important information for clusters.

Standards on access to general medical services – a set of national standards that all GP practices are expected to comply with, to develop innovative solutions and learn lessons from other practices in their cluster, to drive improvements to access[10]. The Welsh Government launched the standards on 20 March 2019 and expects GP practices to meet these standards by 31 March 2021[11].

Source: Wales Audit Office

9 Welsh Government, **Plans to increase GP training places in Wales**, June 2019

10 Vaughan Gething, Minister for Health and Social Services, **Written Statement: Access to General Medical Services**, March 2019

11 Welsh Government, **New standards for GP practices to raise and improve level of service for patients in Wales**, March 2019

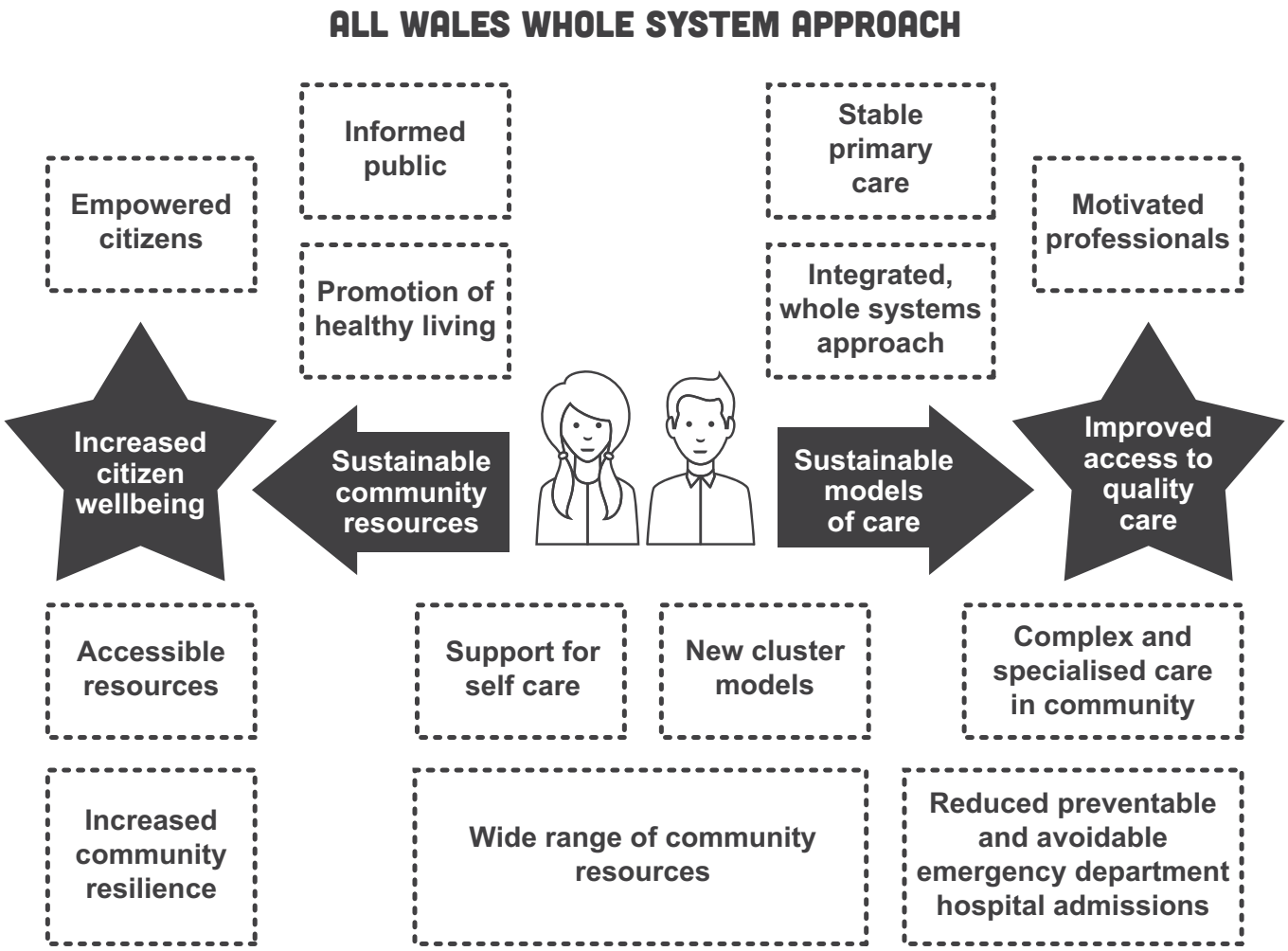
The NHS is strengthening primary care planning through a specific model, a national strategic programme and dedicated national leadership roles

1.5 The NHS in Wales is taking steps to strengthen the planning and delivery of strategic change in primary care. The NHS has introduced a tiered approach where primary care planning is happening at a national level, health board level and cluster level.

1.6 At a national level, the Primary Care Model for Wales aims to ensure a whole systems approach to service redesign. As summarised in Exhibit 3, key components of the model include informed and empowered citizens, self-care, stronger community services, new first points of contact for patients and stronger multi-disciplinary working. The model has emerged from the new ways of working that have been successful in the pacesetter programme. The model has evolved over the last three to four years, with its name changing at least twice.

1.7 During 2019-20, the Welsh Government is funding the development of a national evaluation framework to be used locally to report on the impact of the Primary Care Model for Wales. The evaluation is intended to provide interim assurance of progress in implementing the model. The Primary and Community Care Development and Innovation Hub will share learning across Wales from 2020.

Exhibit 3 – the Primary Care Model for Wales



Source: Wales Audit Office adaptation of a diagram from the **Strategic Programme for Primary Care**, November 2018

1.8 The Strategic Programme for Primary Care[12] has been established to provide key workstreams to support the implementation of the primary care model. The National Primary Care Board recognises that the model needs to evolve again to focus more on prevention and wellness, and to move towards the social model of care described in A Healthier Wales. To improve coordination and delivery of change, the strategic programme has six workstreams[13], each jointly led by a director of primary and community care and a professional lead who has specific expertise in the area of work. Each workstream is developing an action plan focused on critical areas that need further development in order to deliver the vision.

1.9 The Welsh Government has strengthened senior leadership arrangements to drive change. The chief executive of Aneurin Bevan University Health Board has lead responsibility for primary care, including primary care out-of-hours services and the 111 service[14]. There is a National Director and Strategic Programme Lead for Primary Care and a programme manager was appointed in March 2019 to drive the strategic programme. There is also a national professional lead for primary care. These arrangements are a positive step as they increase the capacity and skills dedicated to driving change in primary care.

1.10 The Welsh Government provides direction to the health boards through its guidance on the health board integrated medium-term plans. Our local work found that health board primary care plans aligned with the key aspects of the national priorities. We also found that all clusters had plans setting out priorities for improving primary care in their local area, and all health boards had primary care plans that were, to some extent, fed by the cluster plans.

1.11 Analysis by the Primary and Community Care Development and Innovation Hub, on behalf of the Directors of Primary and Community Care Group, was undertaken to review the focus on the Primary Care Model for Wales by health board executive teams and boards. The findings indicate that primary care and community services have greater prominence within health boards' integrated medium-term plans for 2018-19 than in previous years[15].

12 National Primary Care Board, **Strategic Programme for Primary Care**, November 2018

13 1. Prevention and well-being, 2. 24/7 Model, 3. Data and Digital Technology, 4. Workforce and Organisational Development, 5. Communication and Engagement, 6. Transformation and the Vision for Clusters.

14 The Welsh Ambulance Services NHS Trust has responsibility for the service delivery and provision of 111 call handling and triage.

15 Public Health Wales, **Review of Health Board IMTPs (2018-19): Primary Care Transformation Perspective**, November 2018

New ways of working are emerging but there is a need to spread good practice, improve evaluation and ensure sustainable funding for successful schemes

1.12 The Primary Care Pacesetter Programme began in April 2015, aiming to stimulate innovation. In 2015-16, as part of the £43 million National Primary Care Fund[16], the Welsh Government allocated £3.8 million to health boards, on a recurring basis, for the projects which make up the national pacesetter programme. Twenty-four projects were initially set up to test out new ways of working in primary care. Many of the projects employed different practitioners, like pharmacists and physiotherapists, to work in GP practices and tried out different ways for patients to contact their local practice. Fifteen new projects were started in 2018-19 and are expected to run for two years[17]. Further project are being considered for pacesetter funding for 2020-2022.

1.13 Our work in health boards highlighted three main issues with pacesetters:

- **Slow spread of good practice** – we found that health boards and clusters were piloting new ways of working but in many cases, good practice had not spread far beyond the original pilot.
- **Limited evaluation of new ways of working** – we found limitations in approaches to evaluating new ways of working, such as a lack of a standardised methodology to provide evidence of positive outcomes and to inform decisions on whether to expand these ways of working.
- **Difficulties in mainstreaming funding** – we found that health boards can struggle to sustain and mainstream successful schemes once the pacesetter programme funding ends.

16 The main items within the £43 million fund included £26 million to support the delivery of health board plans for primary and community care, £10 million for the clusters, and £3.8 million for the pacesetters. There was also funding to encourage specific services, such as anticoagulation services and services for wet age-related macular degeneration, to shift from hospitals to community settings.

17 The list of all projects can be found at the following links: **www.primarycareone.wales.nhs.uk/projects** and **www.primarycareone.wales.nhs.uk//page/95999**

1.14 In June 2018, the University of Birmingham published an independent appraisal of the pacesetter programme, commissioned by the Primary and Community Care Development and Innovation Hub on behalf of the Directors of Primary and Community Care Group. It concluded that the programme had been a 'valuable experience' for those leading individual projects, and for health boards. The appraisal also found a need for:

- greater clarity about the objectives and sustainability plans for each project;
- better governance for the programme, involving a wider range of stakeholders;
- more time for health boards to develop their project proposals;
- more patient and community input when designing the projects;
- project management and evaluation support for those leading projects;
- a better evaluation framework for the projects; and
- more structured opportunities for sharing learning between health boards.

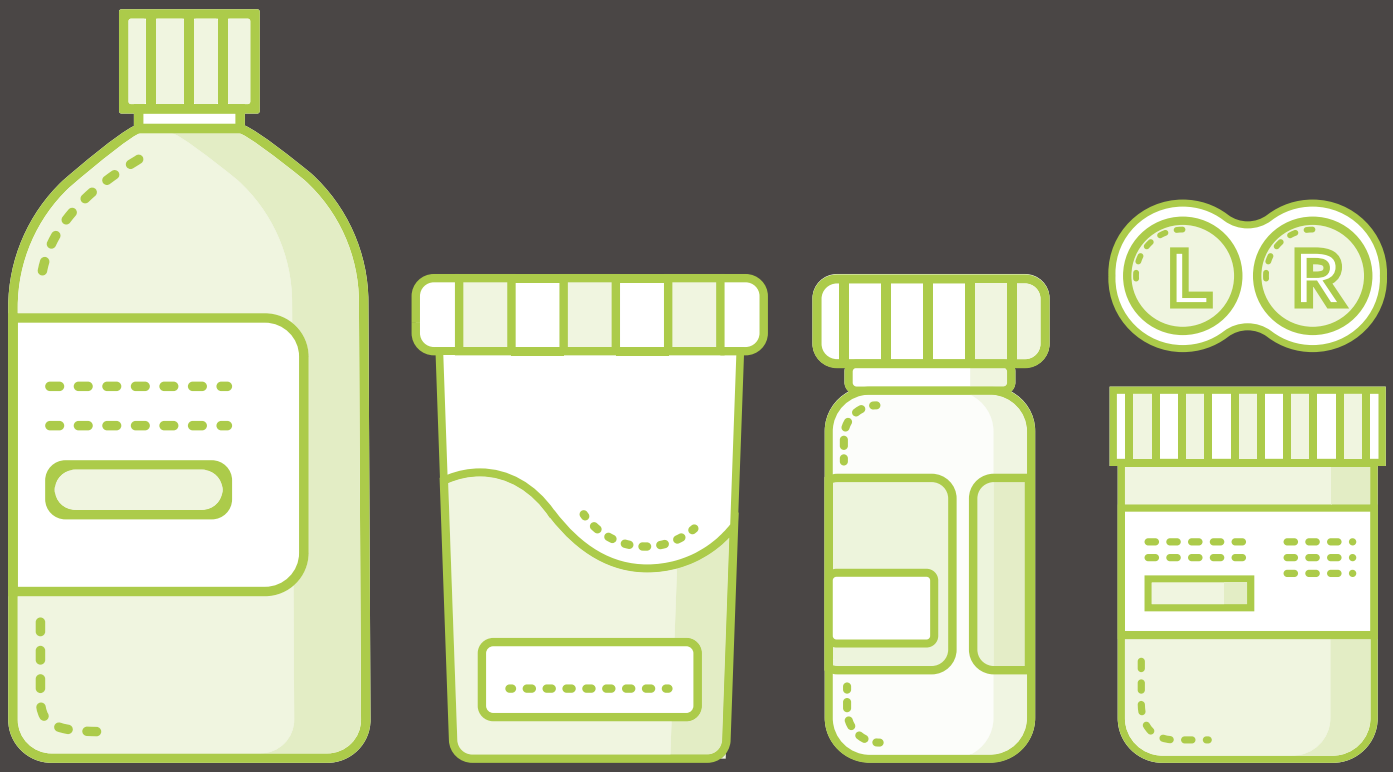
1.15 The appraisal led to an all-Wales learning event and a workshop, where key messages were explored with various stakeholders at the Regional Partnership Board level. Building on the findings of the appraisal, and at the request of Welsh Government, the Directors of Primary and Community Care Group undertook its own evaluation of pacesetters, specifically to support the roll out of the 2019-20 pacesetter programme. The group assessed whether the pacesetters covered all of the themes in the Primary Care Model for Wales and aligned with the three aims of the National Primary Care Fund, namely sustainability, improved access and increasing the availability of care in the community. The evaluation concluded that all components of the model have been covered by the pacesetters although some elements have had greater emphasis, such as multi-disciplinary working.

1.16 The evaluation also reported that health boards are working on how successful schemes can be adapted and adopted across Wales through the integrated medium-term planning process. Further work is now planned to strengthen evaluation and facilitate the roll out of successful programmes into other areas[18].

18 Directors of Primary and Community Care Group, **Review of 2018/19 Pacesetter Programme and Proposals for 2019/2020 Programme**, January 2019

Part 2

Change needs to happen at greater pace and scale to address longstanding challenges and ensure strained primary care services are made fit for the future



There are increased pressures on the traditional model of primary care and continued difficulties in accessing appointments

2.1 There are a number of trends that suggest growing pressure on the traditional GP practice model. Appendix 1 describes these trends in detail and the bullet points below summarise the key points:

- a the number of GP partnerships[19] in Wales has reduced. In 2014 there were 462 partnerships but in 2018 this had reduced to 420. This is partly due to mergers of partnerships to create larger practices but is also due to closures when practice lists are dispersed to other practices.
- b the number of GP practitioners in Wales has fluctuated but in 2018, there were 42 fewer GPs than in 2014. The number of GP locums increased by 144 between September 2015 and September 2018, suggesting a shift of service provision that relies more on temporary staff.
- c the number of GPs per 100,000 population in Wales has fallen slightly from 63.2 in 2014 to 62.6 in 2018. This is higher than England (58) but much lower than Scotland (76)[20].
- d the age profile of GPs has been raised as a concern for the sustainability of services because older GPs are more likely to retire in the near future. The data show that between 2014 and 2018, the proportion of GPs aged over 55 has actually reduced slightly while the proportion of GPs in the 30-44 age group has increased.

2.2 There are limitations in the current data relating to numbers of GPs, for example there is no recording of how many hours each GP works, with many working part-time. Whole time equivalent data has not been available since 2013. The Welsh Government has launched the Wales National Workforce Reporting System to secure better data which should in future create a clearer picture of the GP workforce, and the pressures it is facing.

2.3 The General Practitioners Committee Wales has highlighted some of the increasing pressures on GP workload. The committee says these include changes to the Personal Independence Payment scheme requiring additional letters from GPs; local authorities increasingly requiring a mobility assessment for disabled people to support applications for a Blue Badge; and patients on hospital waiting lists being re-referred back to the GP in order to expedite appointments.

19 Welsh Government, **General medical practitioners: as at 30 September 2018**, March 2019
20 Nuffield Trust, **Is the Number of GPs Falling Across the UK?** May 2019

2.4 There are also some financial issues that threaten the sustainability of the traditional GP practice model because they could potentially persuade GPs to retire early. These issues are summarised below:

- **NHS Pension Scheme changes** – the amount of pension that GPs can accrue over their career and the annual amount of pension they can accrue without being taxed have both reduced. This is reported to be contributing to doctors retiring at a younger age and is persuading some doctors to cut back on the number of sessions they work. The UK Government is considering how to respond to these challenges.
- **Last person standing** – GP partnerships share financial liabilities (and any benefits) across all partners. If several partners retire or leave for other reasons, one partner may be left with outstanding liabilities[21] of the practice. If the remaining partner cannot find other doctors to take on the partnership, they may decide to close the practice. The Welsh Government is now considering steps to address this.

2.5 Ongoing changes to national IT systems are also adding to the pressure on some GP practices. Around half of the practices in Wales have had to change the supplier of their practice IT system after the original supplier's contract ended. There have been delays in implementing the new systems and some affected GPs have expressed concerns at the significant disruption involved in these changes

2.6 When a GP practice is at risk of closure, the health board follows a formal process to decide whether or not to maintain that practice's services by taking over the direct management of the practice. The number of directly managed practices in Wales fluctuates but at the time of our fieldwork in 2018, there were 24 practices managed directly by five health boards. While some health boards have used primary care support units for many years to provide short-term support to prevent GP practices from failing, we found that health boards are increasingly using these units to take over the management of practices.

2.7 In many areas in Wales people are experiencing difficulties getting an appointment with a GP. The proportion of people finding it difficult to get an appointment decreased slightly from 42% in 2017-18 to 40% in 2018-19 although this level remains of concern and varies around Wales (Exhibit 13)[22]. Exhibit 14 and Exhibit 15 suggest a small improvement in GP practice opening hours. There has also been an increase in the overall rate of satisfaction with care received at GP appointments, from 86% in 2017-18 to 93% in 2018-19[23].

21 Such liabilities could include leases on rented buildings, outstanding mortgage, negative equity on buildings and redundancy payments.

22 Welsh Government, **National Survey for Wales 2018-19: Hospital and GP Services**, June 2019

23 Welsh Government, **National Survey for Wales 2018-19: Hospital and GP Services**, June 2019

Progress is patchy in delivering a multi-professional primary care model

2.8 The NHS in Wales is working on long-term solutions to sustainability in primary care by increasing the number and range of other professionals working in primary care settings. This is partly about relieving the pressures on the current GP-centric model of care, but it is also about creating a better model of care where patients have improved access to a wider range of professionals. Box 2 summarises some of the new roles that are supporting the move towards implementing the multi-professional model.

Box 2 – Examples of steps taken towards implementing the multi-professional model

Physiotherapists – direct access to physiotherapy aims to reduce the need for GP appointments and provide more timely assessment and treatment for musculoskeletal conditions. The Chartered Society of Physiotherapy has guidance[24] including costings to support clusters considering employing physiotherapists.

Pharmacists – pharmacists are undertaking wider roles in practices, such as providing prescribing advice, undertaking annual reviews of patients' medication and independent prescribing. These pharmacists can be employed by the practice, or the health board and may work in an individual practice or across several practices or clusters.

Advanced nurse practitioners – have had additional training to allow them to diagnose, prescribe medications and treat a wide range of acute illnesses and chronic conditions within their scope of practice.

Physician associates – clinically trained healthcare professionals who work with a dedicated medical supervisor but can work autonomously with appropriate support.

Lifestyle support, social prescribers and community connectors – because health is influenced by social, economic and environmental factors, social prescribing aims to help people access different activities. These professionals go by different names but are being piloted in a number of clusters.

Source: Wales Audit Office

24 Chartered Society of Physiotherapy, **General Practice Physiotherapy Posts: A Guide for Implementation and Evaluation in Wales**, July 2017

2.9 Despite these positive steps, we found that progress in implementing the multi-professional model has been patchy. Our local work found a number of barriers[25] to expanding the model, as summarised below:

- filling vacancies can create gaps elsewhere as professionals are recruited from other parts of the health and care system.
- many of the new roles require supervision, training and mentoring. This can mean the new roles are not immediately autonomous, and there can be a significant time commitment from those providing the oversight, which can make it more difficult to meet patient demand.
- more needs to be done to share and spread good practice to ensure these extended roles are implemented at pace and scale.
- there needs to be more strategic thinking about the development of these new roles. For example, there could be benefits from introducing more standardised training, job descriptions and specific career paths for these professionals.

2.10 The NHS in Wales is now taking steps that attempt to address some of the issues listed above. The Welsh Government recognises that implementation of the Primary Care Model for Wales is inconsistent and expected health boards to respond to this in their integrated medium-term plans[26] covering 2019-20 to 2021-22. In addition, a national compendium of role descriptors has been developed. Clusters considering employing staff can now use the descriptors to prevent unhelpful variation in the roles and remits of these professionals across Wales[27].

2.11 The Strategic Programme for Primary Care workstream on workforce is pulling together learning from the pacesetters to address issues related to pay and employment and to make primary care a more attractive place to work. The workstream is also developing a cluster workforce planning tool and important work is ongoing between Health Education and Improvement Wales and Social Care Wales to develop a workforce strategy to cover all of health and care by November 2019.

25 The August 2018 report by the Primary and Community Care Reference Group entitled Multi-Professional Roles within the Transforming Primary Care Model in Wales, provides more detailed evidence about these barriers and issues.

26 Welsh Government requires all health boards and NHS trusts to submit an integrated medium-term plan setting out how resources will be used over a three-year period. The plan must: address areas of population health need; improve health outcomes and quality of care; and ensure best value from resources.

27 NHS Wales Shared Services Partnership, Workforce, Education and Development Services, **Emerging Roles and Models in Primary Care**

Progress has been slow in shifting resources towards primary care although it is difficult to quantify exactly how much is spent on primary care

2.12 Exhibit 4 provides basic analysis from the NHS accounts of expenditure on contracted primary care services. When inflation is accounted for, the figures suggest a small (0.4%) real terms increase in primary care spending by health boards between 2014-15 and 2018-19[28]. Within this overall figure are large increases in general medical services and ophthalmic services.

Exhibit 4 – the NHS accounts suggest a small increase in primary care spending in Wales but limitations in these data make robust trend analysis difficult

	£ millions				
	2014-15	2015-16	2016-17	2017-18	2018-19
Prescribed drugs and appliances	511.8	522.3	519.6	523.9	507.7
General Medical Services	476.1	486.7	487.2	517.6	550.1
General Dental Services	172.5	173.0	173.9	178.2	185.2
Pharmaceutical Services	151.7	148.7	150.1	150.5	151.4
General Ophthalmic Services	32.0	32.6	39.0	41.6	42.0
Other Primary Health Care expenditure	25.7	31.4	29.6	34.7	36.3
Total	**1,369.7**	**1,394.6**	**1,399.3**	**1,446.4**	**1,472.7**

Source: Wales Audit Office analysis of the health boards' annual accounts.

28 For an explanation of the categories of spending see the Wales Audit Office report, **A picture of primary care in Wales**.

2.13 However, Exhibit 4 does not provide a particularly robust picture of primary care spending because it does not include spending in relation to the National Primary Care Fund (see paragraph 2c), nor does it include spending in relation to other central funds that are indirectly relevant to primary care. These funds include the £100 million transformation fund (see paragraph 4), the Integrated Care Fund and the Efficiency Through Technology Fund.

2.14 A key finding from our work is that it is difficult to quantify exactly how much the NHS in Wales is spending on primary care, and how much this is changing over time. We reached this conclusion because:

a spending on some aspects of primary care is not consistently categorised across health boards, making comparisons difficult across organisations.

b accounting changes over time make trend analysis difficult, and complicate efforts to monitor whether the NHS is achieving its ambition of shifting resources toward primary care.

c primary care services and primary care transformation can be funded from multiple sources, making it difficult to track and compare the totality of investment in primary care.

d some health board primary care activities are not included in the primary care section of their accounts, meaning the accounts do not represent the totality of spending on primary care. Examples include contracts with voluntary organisations and spending on health board staff that support primary care services.

e in some services and specialties, elements of service provision are provided in primary care, whilst other elements are provided in hospital. The cost of the primary care elements is often difficult to define.

2.15 We assessed whether health boards are taking specific actions to achieve a shift in resources towards primary and community care. The bullet points below suggest health boards are taking some actions but faster progress is required:

- all health boards have examples of some secondary care services now being delivered in primary or community settings (ie shifting certain audiology services into GP practices, employment of diabetes nurses in primary care, and shifts in physiotherapy and occupational therapy services). However, these are fairly isolated examples rather than examples of a wholesale shift at pace and scale.
- no health boards have set targets for moving resources towards primary care.
- no health boards have quantified the total amount of resource moved towards primary care since the inception of the national primary care plan in 2014.
- health boards' plans for transforming primary care have limited detail about how changes will be afforded.
- overall financial deficits can complicate efforts to shift funding and silo working within health boards can result in departments protecting their budgets.

2.16 In July 2018, Welsh Government issued a financial framework to help support the shift of secondary acute services to primary and community delivery[29]. The framework provides detailed guidance for health boards on developing a business case approach to service change and financial savings without jeopardising the quality of care. This report includes a recommendation for the Welsh Government to work with health boards to evaluate, and if necessary, improve the effectiveness of the financial framework.

29 Welsh Government, **Improving Value through Allocative & Technical Efficiency: A Financial Framework to Support Secondary Acute Services Shift to Community/Primary Service Delivery, Welsh Health Circular WHC (2018) 025**, July 2018

Monitoring of primary care performance and activity is limited and the available data suggest mixed success

2.17 We found that performance monitoring in health boards was being hampered by difficulties in obtaining and standardising important primary care data. For example, activity data, such as numbers of appointments and time taken during appointments, could be helpful in planning and monitoring the workload of primary care services. However, GPs, community pharmacists, dentists and optometrists are independent contractors, so the NHS does not have automatic rights to their data. There are also difficulties in ensuring the data collected by independent contractors is standardised and comparable.

2.18 We found weaknesses in the national targets, which can have an influence on where health boards invest their time and resources. Current targets[30] for primary care cover things that are easily measurable, such as numbers of immunisations, quantities of prescribed medicines, and opening times of GP surgeries. Appendix 2 sets out the performance achieved by the health boards against these national targets and shows a mixed picture of performance. A report[31] on attainment of quality improvement measures by Primary and Community Care Development and Innovation Hub in December 2018 found similar variation across health boards and at cluster level. However, the current suite of targets does not provide an effective overview of whether patient outcomes are being improved by primary care.

2.19 The Welsh Government reviews the overall performance of health boards through twice-yearly Joint Executive Team meetings with NHS bodies. Primary care is only a small part of these arrangements. The Welsh Government is looking to strengthen the oversight of primary care through the development of delivery milestones for the Primary Care Model for Wales and by increasing the number of primary care measures considered as part of monitoring arrangements. The Welsh Government is also planning to improve scrutiny of primary care performance by publishing an annual, national report on primary care performance.

30 As described in the NHS Wales Delivery Framework and Reporting Guidance 2018-2019.

31 Public Health Wales, Primary Care Division, **Primary Care Measures: National Variation Report**, December 2018

2.20 In addressing a national primary care conference in November 2018, the Minister for Health and Social Services acknowledged weaknesses in how primary care is monitored. He urged consideration about what is measured and proposed an indicator based on the time that people spend at home, as opposed to measuring the time they spend in hospital.

2.21 Work is underway to introduce more meaningful primary care measures. The Primary and Community Care Development and Innovation Hub developed a set of revised measures for which information is readily accessible[32]. These measures were made available to health boards on the Primary Care Information Portal in March 2018 and as a report in December 2018[33]. From 2018-19, the Welsh Government required health boards, through clusters, to use the measures to inform their primary care plans. The data and digital technology workstream of the strategic programme is developing additional measures.

Much work remains to be done to ensure primary care clusters have a clear remit, broad membership and are able to drive change at pace and scale

2.22 Primary care clusters (described in paragraph 2b) were established in 2010 but as shown in Exhibit 5, very few cluster leads considered their clusters to be 'mature'.

32 These measures include GP practice indicators such as measuring alcohol consumption and medication reviews; public health indicators around screening and circulatory disease mortality rates; and dental indicators such as access to dental care for children and adults.

33 Public Health Wales, **Primary Care Division, Primary Care Measures: National Variation Report**, December 2018

34 Welsh Government, **Phase 2 – primary care quality and delivery measures, Welsh Health Circular WHC (2018) 026**, July 2018

Exhibit 5 – only nine cluster leads thought their cluster was at a mature stage of development

The table shows how cluster leads rated the maturity[35] of their cluster.

	Developmental	Stable and starting to deliver	Mature	No response
Abertawe Bro Morgannwg	1	4	2	4
Aneurin Bevan	1	6	0	5
Betsi Cadwaladr	2	5	1	6
Cardiff and Vale	0	5	2	2
Cwm Taf	1	5	2	4
Hywel Dda	0	4	1	2
Powys	1	1	1	2
Wales	**6**	**30**	**9**	**25**

Note: We sent an online survey to leads at all 64 clusters in Wales in April 2018. The overall response rate was 64% (45/70). A total of 70 responses were received reflecting returns from both cluster and GP network leads in Powys, and more than one lead for each cluster replying in Cwm Taf.

Source: Wales Audit Office survey of cluster leads

35 'Developmental' was defined as 'Still at early stages of development with significant support required: not all cluster members fully engaged'. 'Stable and starting to deliver' was defined as 'Starting to deliver some benefits but still early days, ongoing support required and full potential yet to be reached'. 'Mature' was defined as 'All cluster members fully engaged; delivering across a number of areas in line with the cluster plan'.

2.23 Some confusion remains about the role and remit of clusters. During our fieldwork, we heard how the work of some clusters remains too focused on GP practices rather than the wider primary care system. And we heard how the membership of some clusters needs to broaden. Our cluster lead survey revealed that while the majority of clusters had third sector representation, approximately half had local authority representation, and very few had a lay member.

2.24 Our fieldwork also revealed some concerns about the effectiveness of clusters in driving change at pace and scale. Some interviewees told us that clusters can struggle to take timely decisions, particularly around spending and procurement, which can delay service changes. We also heard mixed views about whether or not clusters should have more or less financial autonomy from their health boards.

2.25 In October 2017, the Health, Social Care and Sport Committee reported on its inquiry into primary care clusters. The report concluded that clusters had achieved many positive developments but highlighted issues with the pace and nature of clusters, including the need for a broader membership base. Funding arrangements, ICT, workforce and premises were also highlighted as areas where faster change was required. The committee also suggested work should be undertaken to raise public awareness of the benefits of changes to service models. The committee made 16 recommendations although the Welsh Government rejected five, saying that they did not want to limit the autonomy of clusters to develop based on their local circumstances by being too prescriptive.

2.26 In October 2018, the Primary and Community Care Development and Innovation Hub coordinated production of a governance framework for primary care clusters. The framework was developed with the aim of addressing some of the recommendations from the cluster inquiry and covers key areas such as employing staff, financial arrangements and quality assurance. This is a positive development, although it is too soon to know whether the framework is being used effectively.

2.27 Clusters remain an important aspect of the future of primary care although transformation will require effective joint working between many organisations and groups. A Healthier Wales sets out a vision for seamless health and social care, building on foundations of local innovation, 'including through clusters of primary and community care providers'. A Healthier Wales says that Regional Partnership Boards[36] will 'occupy a strong oversight and coordinating role' and are at the heart of driving change. The Regional Partnership Boards have been allocated monies from the £100 million transformation fund. The National Director & Strategic Programme Lead for Primary Care has a schedule of attendance at Regional Partnership Boards and health boards to provide primary care representation. The NHS in Wales will need to keep in view its engagement with Regional Partnership Boards, to ensure primary care transformation is driven by all relevant stakeholders.

More needs to be done to involve the public in changes to primary care to ensure that people understand how the model will work

2.28 Our local work found variation in the extent to which health boards engaged with the public when developing their plans for primary care. For some health boards we found little or no evidence of public engagement. The approach taken by the rest of the health boards ranged from consulting the public when developing their plan, to engagement on specific projects or service changes.

2.29 The development of the Primary Care Model for Wales has been a gradual evolution that has incorporated good ideas and successful new ways of working as they have arisen. While some elements of the model have been consulted upon with the public at a local level, there has not been formal consultation or public involvement in the overall model at a national level.

2.30 At the national primary care conference in November 2018, the Board of Community Health Councils talked about the importance of public involvement. They stressed that the public care deeply about primary care, although they do not always fully understand what their local services are. The presentation also stated that people fear change they do not understand.

36 In April 2016, seven statutory regional partnerships came into being through the Social Services and Well-being (Wales) Act 2014. Their purpose is to drive the strategic regional delivery of social services in close collaboration with health.

2.31 The findings of our work suggest that given the lack of involvement of the public, there is the potential for confusion and disagreement with the proposed new ways of working in the model. There is also a need to increase awareness, understanding and support for the model amongst NHS staff, who can guide patients to the right service and can act as advocates for the new ways of working.

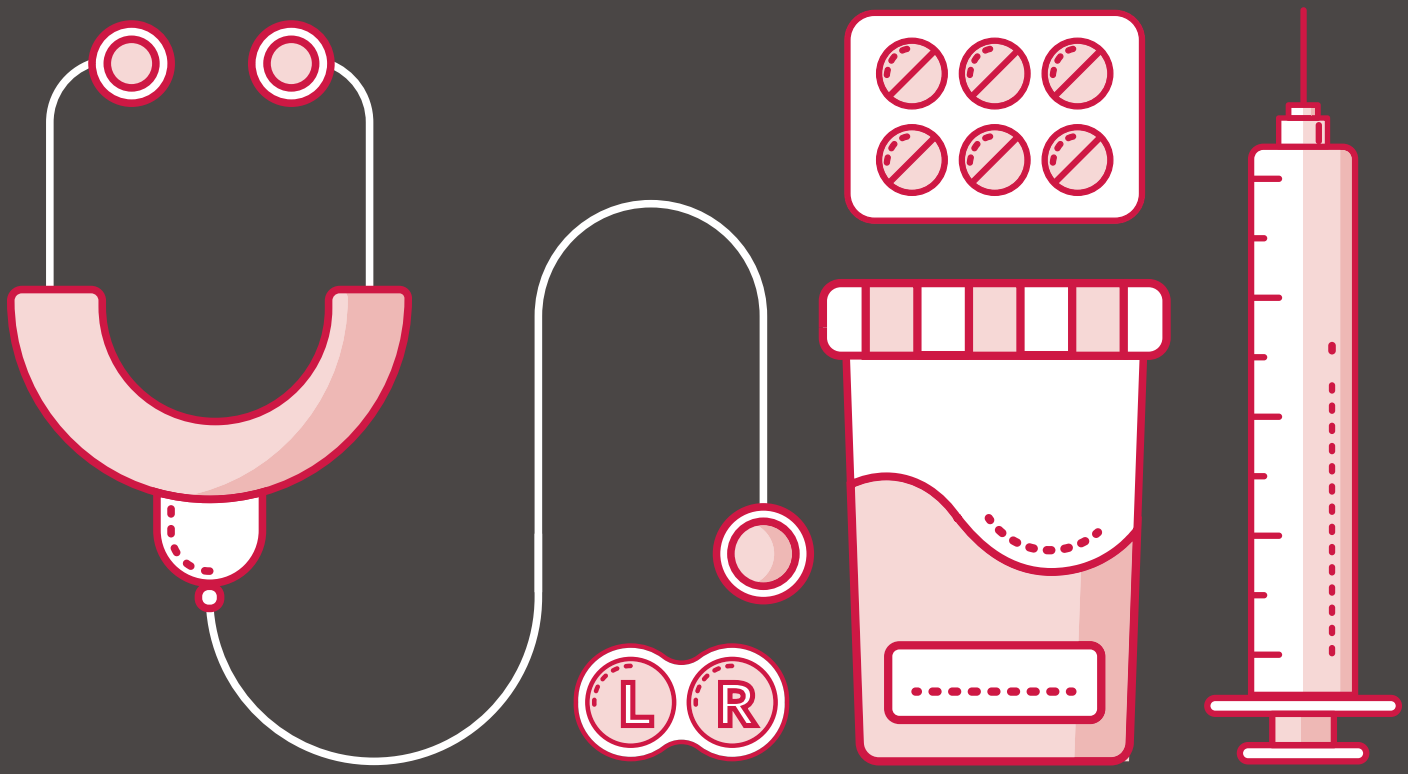
2.32 The Welsh Government has allocated each health board £20,000 a year since 2018-19 to support local activities that improve communication and public messaging about the model. The local activities are based on a national-agreed set of messages. The strategic programme for primary care includes a specific workstream for communication and engagement. This workstream has produced a national communications strategy and a national campaign in 2019.

Appendices

Appendix 1 – Workforce data

Appendix 2 – Performance data

Appendix 3 – Our methods



Appendix 1 – Workforce data

This appendix shows trends in some key data related to the primary care workforce.

There are limitations in the current data relating to numbers of GPs, such as not recording how many hours each GP works, with many working part-time. Whole time equivalent data has not been available since 2013. Welsh Government has launched the Wales National Workforce Reporting System to secure better data which will create a clearer picture of the GP workforce, and the pressures it is facing, in future.

Exhibit 6 – trends in the number of GP partnerships in Wales

There were 420 GP partnerships in 2018, a drop of 42 since 2014. This is an overall decrease of 10% although rates vary from no change in Powys to a fall of 18% in Cwm Taf.

Health Board	2014	2015	2016	2017	2018	Change 2014-2018 (Number)	Change 2014-2018 (%)
Abertawe Bro Morgannwg	76	75	73	71	67	-9	-13%
Aneurin Bevan	88	86	81	79	78	-10	-13%
Betsi Cadwaladr	114	111	109	107	105	-9	-9%
Cardiff and Vale	66	66	66	66	63	-3	-5%
Cwm Taf	46	45	42	42	39	-7	-18%
Hywel Dda	55	54	53	50	51	-4	-8%
Powys	17	17	17	17	17	0	0%
Wales	**462**	**454**	**441**	**432**	**420**	**-42**	**-10%**

Note: The table does not distinguish between resolved partnerships, ie practice lists which have been dispersed to other practices, or practice mergers ie where a new/larger partnership was formed.

Source: Welsh Government, **General medical practitioners: as at 30 September 2018**, March 2019

Exhibit 7 – trends in the number of GPs working in Wales

There has been a decrease of 42 GP practitioners since 2014 while there has been an increase in GP locums of 144.

	2014	2015	2016	2017	2018	Change 2014-2018 (Number)
All practitioners (excluding GP Registrars, GP Retainers & locums)	2,006	1,997	2,009	1,926	1,964	-42
GP Registrars (1)	220	231	232	239	230	10
GP Retainers (2)	23	25	19	17	14	-9
GP Locums (3)	---	634	684	754	778	144 (2015-2018)
Other practice staff (4)	7,192	7,379	7,341	7,299	7,505	313
Registered patients (millions)	3.17	3.19	3.2	3.2	3.14	-0.03

Note: Welsh Government obtains this data every 30 September from NHS Digital generated from the Exeter (GP payments) system. Welsh Government has concerns about the quality of the data and has undertaken validation work in 2018. In future, data will be collected through Wales National Workforce Reporting System.

Source: Welsh Government, **General medical practitioners: as at 30 September 2018**, March 2019

(1) A practitioner employed for the purpose of training in general practice and in respect of whom a training grant is paid. A GP registrar is either in their second or third year so the GP registrars are not all in the same cohort.

(2) A practitioner who provides service sessions in general practice. They undertake the sessions as an assistant employed by the practice and are allowed to work a maximum of 4 sessions each week.

(3) A GP who deputises temporarily at a GP Practice, usually to cover for an absent GP Practitioner. Such cover should last for no more than 6 months. The GP locums data includes the number of locums registered to work on the Medical Performers List, not the number who were working at that point in time, or who had completed any work during the year.

(4) Includes qualified nurses providing a wide range of services, other staff providing direct patient care who are not nurses, administrators including practice managers and other staff such as cleaners.

Exhibit 8 – trends in the age ranges of general practitioners

The number of GPs aged over 55 has decreased since 2014 but there has been an increase in GPs aged 30-44

	2014	2015	2016	2017	2018	change 2014-18 (Number)
Under 30	22	16	30	17	16	-6
30-44	830	828	879	878	886	56
45-54	686	649	655	595	625	-61
55-64	392	396	381	374	378	-14
65 and over	70	64	64	62	59	-11
Total number	2,006	1,997	2,009	1,926	1,964	-42

Note: This table does not include age data for locums, registrars or retainers listed in **Exhibit 7**.

Source: Welsh Government, **General medical practitioners: as at 30 September 2018**, March 2019

Exhibit 9 – trends in the average list size for GP practices

The average list size varies from 1,366 patients for each GP partner in Powys to 1,668 in Betsi Cadwaladr. List sizes have increased slightly on average across Wales since 2014 but there are big differences between areas with large increases in Betsi Cadwaladr and large decreases in Cwm Taf.

	2014	2015	2016	2017	2018	change 2014-18 (Number)
Abertawe Bro Morgannwg	1,563	1,580	1,595	1,665	1,545	-18
Aneurin Bevan	1,570	1,575	1,538	1,605	1,622	52
Betsi Cadwaladr	1,581	1,600	1,595	1,733	1,668	88
Cardiff and Vale	1,620	1,621	1,649	1,651	1,612	-8
Cwm Taf	1,785	1,707	1,730	1,777	1,661	-124
Hywel Dda	1,510	1,606	1,607	1,707	1,548	38
Powys	1,411	1,414	1,330	1,365	1,366	-46
Wales	**1,582**	**1,596**	**1,592**	**1,664**	**1,599**	**17**

Note: Average list size is calculated by dividing the total number of patients on lists by the number of 'All practitioners (excluding GP registrars, GP retainers and locums)'.

Source: Welsh Government, **General medical practitioners: as at 30 September 2018**, March 2019

Appendix 2 – Performance data

This appendix summarises some of the key performance data included in the NHS Wales Delivery Framework and Reporting Guidance 2018-2019.

Exhibit 10 – child immunisation rates as at 31 March 2019

The exhibit shows performance in relation to two delivery measures within the guidance:

- Delivery measure 2: Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1. Five health boards met the target of 95%; and
- Delivery measure 3: Percentage of children who received 2 doses of the MMR vaccine by age 5. No health board met the target of 95%.

	% of children who received 3 doses of '6 in 1' vaccine by age 1	% of children who have received 2 doses of MMR by age 5
Abertawe Bro Morgannwg	95.9	91.8
Aneurin Bevan	95.6	92.3
Betsi Cadwaladr	95.4	94.3
Cardiff and Vale	94.3	90.6
Cwm Taf	97.5	93.1
Hywel Dda	93.9	90.3
Powys	96.3	91.3
Wales	**95.4**	**92.2**

Note: 6 in 1' DTaP/IPV/Hib vaccine protects against Diphtheria, Tetanus, Pertussis (Whooping Cough), Polio, Hib infection and Hepatitis B.

Source: Public Health Wales, **Vaccine Preventable Disease Programme. Vaccine uptake in children in Wales; Annual report 2018-19**, June 2019

Exhibit 11 – trends in uptake of flu vaccination 2014-15 to 2018-19: Patients aged 65 years and older

Delivery measure 5i: Uptake of the flu vaccination among: 65 year olds and over. Target 75%. No health board has met the target for this measure.

	Uptake in patients aged 65 and older				
	2014-15	2015-16	2016-17	2017-18	2018-19
Abertawe Bro Morgannwg	65	64.6	65	68.2	68.1
Aneurin Bevan	70.4	70	67.7	68.1	69.7
Betsi Cadwaladr	70.1	68.7	68.7	70.6	71.0
Cardiff and Vale	70	68.9	69	71	69.1
Cwm Taf	67.5	65	64.9	67.7	67.1
Hywel Dda	64.9	63.9	63.4	65	62.9
Powys	66.5	64.3	63.9	66.3	65.5
Wales	**68**	**66.6**	**66.7**	**68.8**	**68.3**

Source: Public Health Wales, **Seasonal influenza in Wales 2018/19**, June 2019

Exhibit 12 – trends in uptake of flu vaccination 2014-15 to 2018-19: Patients younger than 65 who are at risk

Delivery measure 5ii: Uptake of the flu vaccination among: Under 65s in risk groups. Target 75%. No health board has met the target for this measure.

	Uptake in patients younger than 65 at risk				
	2014-15	2015-16	2016-17	2017-18	2018-19
Abertawe Bro Morgannwg	44	43.4	43.7	46.7	43.0
Aneurin Bevan	55.3	52.9	49.4	49.7	46.9
Betsi Cadwaladr	51.4	49.3	49.3	51.6	47.9
Cardiff and Vale	50.4	48.3	48.3	49	44.0
Cwm Taf	49.8	45.9	45.2	46.8	40.0
Hywel Dda	46.2	43.2	42.3	42.9	38.1
Powys	47.8	44.2	46	47.9	43.1
Wales	**49.3**	**46.9**	**46.9**	**48.5**	**44.1**

Source: Public Health Wales, **Seasonal influenza in Wales 2018/19**, June 2019

Exhibit 13 – percentage of people who found it difficult to make a convenient GP appointment

Delivery measure 47: Percentage of people (aged 16+) who found it difficult to make a convenient GP appointment. The target is to achieve an annual reduction. Three health boards achieved this measure in 2018-19.

In 2018-19, on average 40% of respondents across Wales who had seen their GP in the last 12 months found it fairly difficult or very difficult to get an appointment.

	2017-18 %	2018-19 %
Abertawe Bro Morgannwg	48	37
Aneurin Bevan	48	41
Betsi Cadwaladr	37	37
Cardiff and Vale	42	45
Cwm Taf	48	46
Hywel Dda	35	36
Powys	33	37
Wales	**42**	**40**

Source: Welsh Government, **National Survey of Wales. April 2018 to March 2019**, June 2019

Exhibit 14 – daily opening hours - Percentage of GP practices open during daily core hours or within 1 hour of daily core hours

Delivery measure 53: Percentage of GP practices open during daily core hours or within 1 hour of daily core hours.

Opened for daily core hours is defined as:

- practices which were open Monday to Friday from 08:00 to 18:30 each day, with no lunch time closure[37] (as set under the General Medical Services contract).

Opened within one hour of daily core hours is defined as:

- practices which were open Monday to Friday from 08:00 to 18:30 each day, but closed for one hour or less for lunch on one or more days, or
- practices which opened between 08:00 to 08:30 and closed between 18:00 to 18:30 with no lunch time closure.

	2016	2017	2018
Abertawe Bro Morgannwg	85	90	95
Aneurin Bevan	99	99	99
Betsi Cadwaladr	74	78	81
Cardiff and Vale	88	88	87
Cwm Taf	90	90	90
Hywel Dda	74	73	80
Powys	100	100	100
Wales	**85**	**87**	**89**

Note: GP practices returned data collection forms to Welsh Government in January 2019 and refer to December 2018.

Source: Welsh Government, **GP Access 2018**, March 2019 and Welsh Government, **GP Access 2017**, March 2018

37 Where practices close their premises for lunch, they often remain open to respond to phone calls.

Exhibit 15 – weekly opening hours – percentage of GP practices open for 100% of core hours or longer

While Exhibit 14 considers daily opening hours of practices, Exhibit 15 considers the total opening hours across a week. It shows that on average, 53% of GP practices are open for at least 52.5 hours a week which has increased from 51% in 2016.

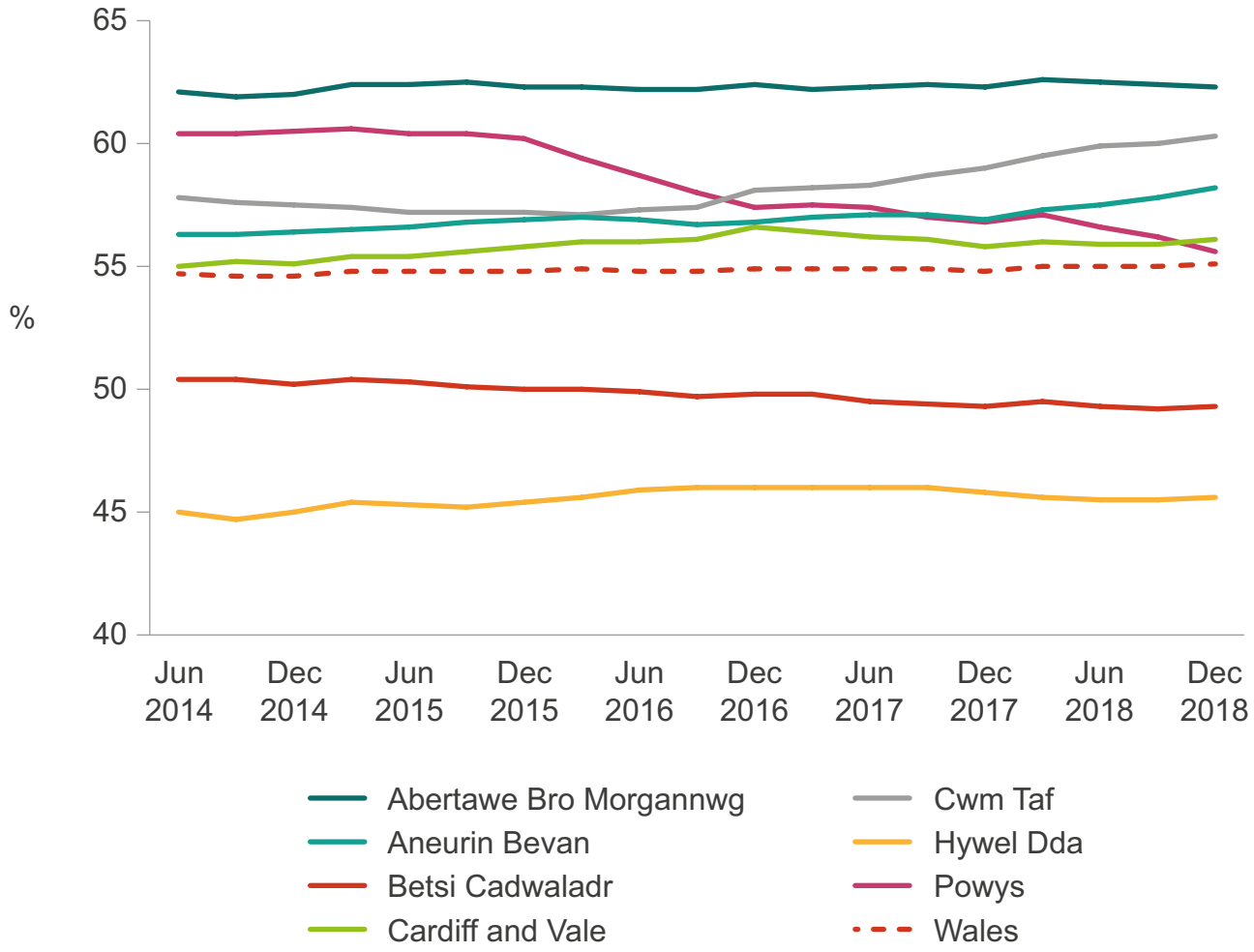
	2016	2017	2018
Abertawe Bro Morgannwg	41	49	51
Aneurin Bevan	83	84	86
Betsi Cadwaladr	34	38	40
Cardiff and Vale	44	44	45
Cwm Taf	67	59	56
Hywel Dda	43	41	41
Powys	53	53	50
Wales	**51**	**52**	**53**

Note: GP practices returned data collection forms to Welsh Government in January 2019 and refer to December 2018.

Source: Welsh Government, **GP Access 2018**, March 2019

Exhibit 16 – percentage of residents treated at an NHS dental practice in the previous 24 months, between 2014 and 2018

Delivery measure 57: Percentage of the health board population regularly accessing NHS primary dental care. Target is for annual improvement but the data shows little improvement in access rates since 2014.



Note: Data are shown for patients seen over 2 years each quarter ending 31 December 2018. The data is derived from dental activity forms submitted for payment and processed by NHS Business Services Authority Dental Services.

Source: Welsh Government, **NHS Patients Treated for Adults and Children by Local Health Board**, December 2018

Appendix 3 – Our methods

We reported on primary care services in each health board during 2018. Our local fieldwork took place between February and May 2018. We carried out our national-level fieldwork in late 2018 and mid 2019. Details of our approach are set out below.

Exhibit 17 – our methods

Method	Detail
Health board self-assessment	We used a self-assessment questionnaire to gather corporate-level data from each health board.
Document review	We reviewed key documents relating to primary care at each health board. We also reviewed documents from the National Primary Care Board and other national groups.
Interviews	We interviewed: • a range of staff at each health board including executives, senior managers, operational managers and clinical leaders; • representatives from community health councils; • representatives from the British Medical Association's General Practitioners Committee and the Royal College of General Practitioners; • staff from Welsh Government; and • a range of other people involved in planning and delivering primary care in Wales.
Cluster lead survey	We sent an online survey to all cluster leads in Wales in April 2018. The overall response rate was 64% (45/70).
Review of health boards' integrated medium-term plans	We reviewed the health boards' medium-term plans to assess the extent to which primary care is included.
Use of existing data	We used existing sources of data wherever possible such as Welsh Government and Public Health Wales statistics.

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