Comisiwn Bevan Commission

RCGP CYMRU WALES

Delivering a Prudent Approach to Primary Care in Wales

A joint report between the Bevan Commission and the Royal College of General Practitioners (Wales)

July 2020

Executive Summary

This paper, developed in partnership between the Bevan Commission and RCGP Wales, looks at how we ensure we have 'prudent Primary Care' in Wales.

It builds upon earlier thinking undertaken by the Bevan Commission and in particular Prudent Healthcare, which is now adopted as the underpinning philosophy for health and care policy in Wales.

It is informed by a meeting in July 2019 which brought together representatives from across health and social care. This considered what needs to be done in Primary Care to ensure a system-wide prudent approach is taken to sustain health and care, delivering services that better meet the needs of patients and local communities.

Most recently, it has been influenced by COVID 19, which whilst unprecedented, further reinforced its findings and the urgency for change.

The paper recognises the core values and real opportunities which general practice offers. It strongly recommends a number of urgent changes needed to address increased demand and raised public expectations across the whole system, further magnified by the COVID 19 situation. These include:

A clearer political commitment to rebalancing health and social care policy towards a more prudent, social model of health and care where local primary and community care services through clusters, are the main driving force for better health and wellbeing.

The level management and accountability of resources needs to be reviewed. There must be a greater commitment to invest in Primary Care, redressing the imbalance between primary and secondary care funding. This should include, **at the very minimum, an 11 %** share of the health budget dedicated to general practice.

Health and social care strategy and decision-making should be much better integrated and with devolved and flexible budgets reflecting local needs, more transparent and standardised data, and better use of local facilities.

There should be far more 'real' engagement with people and communities, valuing their assets and contribution in informing, planning and improving services, as well as finding solutions to maintaining health and wellbeing for themselves and for others.

Medical education for doctors and allied health professionals should include health literacy assessment of patients, shared decision-making skills and empowerment of patients to self-manage their conditions.

Primary Care clusters are key to implementing a prudent and social approach, engaging with local people to revitalise health in communities across Wales. It reinforces the need to expedite and resource prudent transformation across Primary Care in Wales

A digitally enabled Primary Care service should be embedded in Primary Care clusters to transform and integrate seamless services between health and social care across traditional boundaries, enabling patients to have easier access to their records and giving rapid access to wider information and other resources

The Bevan Commission and RCGP Wales call upon Welsh Government to take urgent action on these recommendations to secure a healthier Wales.

Please reference this report as:

ISBN 978-1-912334-21-6

Reports produced by the Bevan Commission are published on the Bevan Commission website at bevancommission.org/en/publications

Background

This paper reflects upon the earlier thinking undertaken by the Bevan Commission in 2013 on '*Improving Primary and Community Healthcare'*[1] and wider developments and thinking to date, including the work of the RCGP. It also reflects upon developments to date and the alignment with Prudent Healthcare[2], which now forms the underpinning philosophy for health and care policy in Wales[3]. It acknowledges the strategic intent for Primary Care, the programme of work established in Wales, and reflects and builds on it through a prudent lens.

To develop this thinking further and consider how Prudent Healthcare principles can be reinforced within Primary Care, RCGP Wales and the Bevan Commission held a meeting in July 2019:

Delivering prudent primary care: Royal College of General Practitioners (RCGP) Wales, and Bevan Commission round table, 9th July 2019

The event brought together representatives and stakeholders from health and social care across Wales (see Appendix 2 for attendees). Attendees were informed by RCGP vision papers, and previous work by both the Bevan Commission and NHS Wales, that build up a current picture of health and social care in Wales.

The purpose of this collaboration was to align all these separate pieces of policy and thinking within the framework of 'Prudent Healthcare' and using this, help drive the necessary changes needed to transform Primary Care to truly reflect its principles.

During the last six years, we have seen health and care demand grow and developments in primary and community care evolve in response to these needs. Much of this has been focused around the development of Primary Care clusters. This is a community-focused approach based on populations served by groupings of GP practices working in partnership with health, social care and third sector providers.

In 2015 the Welsh Government produced *'Our plan for a Primary Care service for Wales up to March 2018'*[4] where this policy was formally endorsed and a £43m national Primary Care fund established to help take forward the plan. Subsequently, the Integrated Care Fund[5] (£115m for 2019/20) and the Transformation Fund[6] (£100m over 2018/19 and 2019/20) have provided further opportunities for local service improvement.

'A Healthier Wales'[7], which reinforced the importance of Prudent Healthcare, also set out its vision and thinking around new models of health and care, including Primary Care. In November 2018, the 2015 document was updated by a '*Strategic Programme for Primary Care*[8]*'* to support delivery of Primary Care clusters 'at the heart of this model' promoting seamless working across the system, workforce development and an increasing role for technology. The NHS Transformation Fund was announced in 2018[6] to help encourage and change more traditional ways of working across the NHS. This included using technology, developing new roles and ways of working, and fully embracing a more prudent way of working in practice.

The RCGP has also published a number of key documents describing the future of Primary Care and general practice in particular. Specifically, in 2013 it published 'The 2022 GP: A Vision of General Practice in the future of the NHS'[9] and was followed in May 2019 by 'Fit for the Future: A Vision of General Practice'[10]. In England, RCGP was a partner body in the publication in 2016 of 'General Practice: Forward View'[11.] These documents emphasise the need to expand the capacity of the general practice workforce to meet evolving population needs, the importance of generalist–led integrated services and of multi-disciplinary team working.

High quality Primary Care also requires a focus on the science and art of consultation. Attendees at the July 2019 meeting discussed how current practice 'fitted' with the four Prudent Healthcare principles and where further work was needed to turn rhetoric into action.

The overall aim of the meeting was to discuss **how we can ensure we have a prudent Primary Care system in Wales and how we can all contribute to this**. The aim of this paper is to develop an overarching system-wide approach, which embraces the future delivery of Primary Care in Wales. This includes addressing a breadth of issues which are included within the strategic programme, such as:

- the way in which we develop an approach to population health
- the organisation of general practice and other community–based services, workforce and workload issues, and 24/7 health and social care
- the way in which we use the skills and assets of people and local communities to shape the delivery of quality services designed for and around their needs.

This paper summarises those discussions. It also provides the following challenges;

- Is real change happening?
- If it is, to what extent is it in the right direction?
- Are the changes fast or radical enough?

It concludes with some key recommendations, considered imperative to ensure Wales responds to the changing needs of its communities in a way that is consistent with Prudent Healthcare principles.

Primary and Community Care in Wales is under immense pressure

Primary and Community Care has long been considered the bedrock of the NHS' success. The UK model of Primary Care has often been cited as one of the NHS' most admirable features - both by domestic and international critics - providing the first point of contact for health services for the population. Its importance was summed up in a BMJ editorial[12], which stated '*If general practice fails, the whole NHS fails'.*

In the last few years, general practices in Wales have been grouped into informal working 'clusters' with small financial incentives. These have recently been increased[13] and reinforced as 'here to stay' by the Minister for Health and Social Services[14]. They have been encouraged to work together to manage the demand and

increase community service provision. The workforce is expanding and diversifying to include community pharmacists, occupational therapists, physiotherapists, physician associates, paramedics and wellbeing co-ordinators, although their distribution is patchy. This contrasts with England, where practices are being contractually incentivised to work together in well-defined (and funded) Primary Care Networks to produce back-office economies of scale and opportunities to expand the range of services offered.

In the 2018 British Social Attitudes Survey[15] for England and Wales, public satisfaction with GP services stood at 63% - the lowest level since the survey began in 1983 and a drop of 17% on 2009 when it stood at 80%.

Although 86% of people in Wales rated the overall care provided by their GP as positive[16] this was down 4% on 2016/17 and there were specific concerns, particularly about the time it takes to get an appointment to see a GP with 42% of respondents stating they had found it difficult to get an appointment at a convenient time. Overall, satisfaction with Primary Care is higher in Wales than with the NHS overall (which at 53% was 9% lower than the last survey undertaken in 2010) but the overall downward trend is worrying.

To some degree this reflects concerns within Primary Care itself, with staff complaining of ever-increasing demand and clinical complexity as the population ages, rising bureaucracy and stress. This results in a workload that many are finding unmanageable. This, together with changes to the way NHS pensions are taxed, is directly contributing to staffing problems. Amongst general practitioners, early retirement, increasing part time working / portfolio careers and falling job satisfaction has led to severe difficulties in recruitment for many practices. Wales has a better ratio of GPs per 100k population than England (63 per 100k versus 58 per 100k in England) but less than both Northern Ireland (67 per 100k) and Scotland (76 per 100k)[17]. The workforce problem is severe, especially in rural parts of the country where there has been a series of practice closures.

To summarise the issues:

- In the UK, data on Primary Care consultations are not routinely collected (which is a problem in itself), but what studies there are[18] would indicate that the volume of patient contacts in general practice across the UK is greater than it was ten years ago, but GP numbers have not kept pace with that growth. By contrast, whole-time equivalent hospital doctors per 1000 people has risen by 72% over the same period[19]. All parts of the NHS make claims for investment but investing in secondary care at the expense of Primary Care is ultimately counterproductive, and in the opposite direction to strategic intent to move the bulk of patient care into community settings.

- Patients are increasingly presenting with multiple and complex conditions, reflecting in part the ageing population profile and the increased prevalence of conditions such as diabetes (which reflects the growing proportion of obese/morbidly obese patients and other unhealthy behaviours). Advances in

clinical practice, genomics and technology lead to additional questions, investigations, and management guidelines. In some cases, it also results in over-diagnosis and its consequences.

- Practices are being incentivised to identify chronic diseases, establish registers and undertake a growing list of risk modifying interventions. (The prudent approach encourages a more holistic, patient-centred approach, with increased sharing of information and support for informed patient choice).

- In the UK 92% of GPs say they are under high or considerable pressure as a result of increasing workloads and 58% of younger GP's say they are referring more cases compared to two years ago as a direct result of higher workloads[20,21]. GP's have increasingly less time to deal with patient issues. A 2013 study found that an average GP consultation involves a discussion of two and a half different problems across a wide range of disease areas in just 12 minutes[22].

- A 2018 survey, (Transforming general practice: Building a profession fit for the future[23]) undertaken by RCGP Wales of its GP members, reported that 31% of respondents said that at least once a week they felt so stressed they felt unable to cope. Twenty-three per cent believed it was unlikely they would be working in general practice in five years' time. They had a mixed view of clusters, with 39% feeling they were not having an impact. Given the above, it is unsurprising that many feel unable to work more than six sessions / week and take on other roles to complement their income and to give resilience to their work/life balance.

- The proportion of NHS spending on Primary Care has declined in recent decades, while at the same time care has been moving from hospital to community settings. In its 2019[24] report the Welsh Audit Office (WAO) identified a small (0.4%) increase between 2014/15 and 2018/19 but it also stated that '…it is difficult to quantify exactly how much the NHS in Wales is spending on Primary Care'. RCGP (Wales) in Transforming General Practice[23] stated that in 2016/17 only 7.3% of the NHS Wales budget was spent on general practice versus 8.88% for the UK and called for Welsh Government to commit to increasing it to 11%.

- The Wales Audit Office (WAO) 2019 report[24] on progress made by Health Boards in implementing the Primary Care Model for Wales, concluded that the rate and scale of change was insufficient to ensure strained Primary Care services were being made fit for the future. It 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. Some confusion remained about the role and remit of clusters and the degree of equitable attention given to Primary Care by Health Boards.

- Feedback from the workshop indicated limited awareness of the Primary Care Model for Wales amongst GP's and therefore little engagement with it.

- The public are dissatisfied with the length of time they have to wait to access Primary Care services, especially to see a GP. Long waits undermine the entire rationale of Primary Care as the first point of contact for those seeking care and advice.

- The public are also dissatisfied with the short consultation lengths. The UK average is currently 9.2 minutes, one of the lowest amongst economically advanced nations[25].

- The public want accessible, joined up care and Primary Care is struggling to provide this. There remains a divide between health and social care, while patients often need input simultaneously from both. Social problems caused by poverty are often medicalised, while lower socio-economic groups also suffer from higher rates of chronic illness and higher mortality rates, leading to decreased life expectancy and greater morbidity[26].

- Primary Care premises are often inadequate for the tasks we now need them to perform. A number are in poor condition, with maintenance problems, and are often too small for the purposes for which they are now needed.

- Health inequalities remain largely entrenched and the historical gains made on life expectancy are flattening out and, in some areas, even reversing[27].

The Welsh Primary Care context

Primary Care clusters remain at the heart of the Welsh Primary Care strategy. At an All-Wales level, the National Primary Care Board is charged with providing leadership to support and translate this into practice.

There are also national Pacesetter Programmes, funded by Welsh Government to stimulate innovation and promote the redesign of Primary Care services. The first cycle of 25 Pacesetter projects began in 2015 whilst a further 15 projects commenced in 2018.

In 2017, the University of Birmingham was commissioned to undertake a review of the Pacesetter Programme. Its report in June 2018[28] 'Critical Appraisal of the Pacesetter Programme' concluded that:

- Whilst those directly involved in delivering or overseeing Pacesetter projects understood this overall vision, national stakeholders who had little direct engagement with the programme were often unclear as to its overall purpose and in some instances did not know that it existed.

- It was common for Health Boards to view the Pacesetter funding as part of the general investment by Welsh Government in Primary Care rather than as a discrete grant with particular objectives. This resulted in some Health Boards effectively pooling the funding with other grants.

- The purpose and objectives of the programme were not well defined and communicated to those who were not directly involved. As a consequence, the potential contribution of the Pacesetters was not fully recognised or understood by many stakeholders.

- Those leading projects were not clear about what was expected of them and what would need to be demonstrated to secure mainstream and long-term funding.

- No evaluation framework, process or connected baselines were set at the beginning of the programme, which precluded robust assessment of benefits. Health Boards were not generally confident in evaluating the impact of innovations and project leads struggled to identify how best to gather and analyse data.

- Learning from the projects was not consistently shared between Health Boards with some concerns that open sharing would not be encouraged.

It is unclear whether and to what extent NHS Wales has taken on board these lessons. It is envisaged that clusters, supported by Health Boards, will roll out the innovations trialled in the Pacesetter Programme and be both a driving force for modernisation and a focus for local action, based on a social model of health. However, clusters currently have little funding or back-office administrative support.

Prudent Healthcare Principles and Primary Care

The Bevan Commission formulated a set of Prudent Healthcare Principles[2], which now underpins Welsh Health policy. These principles formed the basis of discussion as they map well to the principles of Primary Care with its emphasis on individualised holistic care, based upon early personal contact by a generalist gatekeeper.

Report summarising discussions in the July 2019 Prudent Primary Care stakeholder meeting

This section of the paper reflects the themes explored at the workshop, organised around these four principles, and informed the recommendations for further action.

Prudent healthcare principle 1: Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production

The discussion group felt that Primary Care should be at the forefront of driving a prudent and social model of health and care in communities. It wanted a system wide holistic and cultural shift away from a reliance on the traditional 20th century biomedical model of healthcare / disease-based need and delivery, towards a genuine social partnership model of health (not just illness). This was imperative, as the group recognised the extent to which social factors determine health and wellbeing, and the relatively small contribution biomedical factors play. The group suggested a shared language and values framework (developed by publicising and discussing the Prudent model between public, patients and professionals using lay terminology that all can easily understand). The current lack of understanding and shared discussion is a fundamental block for the agenda to move forwards.

Paradoxically the 'medicalisation' of the population has seen increasing demand, expenditure and public expectations, further aggravating access problems and reducing consultation times. This compromises a holistic, person centred approach to dealing with the issues being raised.

The 'partnership' and inter-professional approach should include the wider primary and community care team, including community pharmacists, counsellors, social workers, advocacy, and the third sector. It should also include the public, patients and community leaders.

The 'dominance' of, and 'dependence' upon general practitioners within the current Primary Care model contributes to rising workload and pressure to accommodate additional consultations. Currently demand is relatively undifferentiated and as a result, patients are directed to see a GP for things that other members of the Primary Care team could deal with (and may be better equipped to deal with). Redesigning roles and ways of working of the Primary Healthcare Team, with the introduction of some new roles in Primary Care such as physician associates, clinical pharmacists, occupational therapists, physiotherapists and care-co-ordinators allows GP time to be prioritised to spend more time with those with greatest need.

A mixture of 'custom and practice', risk aversion, funding problems, and historically based 'rules and regulations' tend to constrain Primary Care to operate in this way. What is needed is radical change and a reorientation of public and professional expectation that many Primary Care issues will not require direct GP input. This is desirable and necessary if we are to create more time for GP consultations.

Much greater effort needs to be put into sharing responsibility of care with patients, and in increasing public health literacy, skills, confidence and awareness of the role they can play in their own health and in supporting others. High quality resources, to inform patient understanding, should be developed to support this. Only then can we really operate informed, shared decision-making, a prerequisite of working in genuine partnership and co-production with patients. We have to empower patients to understand the nature of their health journey, and to participate in wellbeing goal

setting. This will help to meet needs most effectively, raise standards in health and social care, and improve outcomes for patients. Some patients will find this uncomfortable (and conversely find medical paternalism comforting) but over time this cultural shift needs to occur.

This should be assisted by a drive to provide everyone with electronic access to their medical records, results and allow electronic updating of their own health status and achievement against goals (e.g. weight loss, change of diet, prescribing concordance) This brings with it a feeling of genuine partnership and a sense of shared responsibility. The electronic record should be integrated across health and social care, to allow best use of the information it stores and high-level communication across traditional boundaries of primary, secondary, tertiary and social care.

We should also give further thought to the role of patients in informing and shaping services within Primary Care. Patient panels and other mechanisms are important to ensure we engage local voices and involve people in supporting and shaping local Primary Care services.

Prudent healthcare principle 2: Care for those with the greatest health need first, making the most effective use of all skills and resources.

This group discussed caring for those in greatest need. They felt it implied prioritisation and knowing how 'greatest need' is defined and identified. GP's are well placed to know their communities, families and their needs, but an important contribution can also be made by high quality data to describe the needs of the most vulnerable individuals and groups.

'Health need' (within the context of prudent health) is more than 'sickness', it also presents a challenge to addressing inequalities in health and the 'inverse care law'[29]. Local knowledge of community / locality needs should be assisted by a flexible approach to the way resources are allocated and managed by clusters, including an ability to move funds between budgets. The group agreed that funding issues should not be allowed to cloud planning and thinking. This is a political imperative.

Current access problems can compromise the aim of ensuring that those with greatest 'need' (however defined) get seen promptly and also that subsequent care (from other services, such as secondary care) takes place quickly. There is a need to engage patients much more closely and openly in this debate, possibly through patient forums or liaison groups.

People sometimes present in Primary Care with an expectation of a 'medical' solution to a problem with its roots in their social/economic position. For example, requests to be put on anti-depressants, which whilst modifying mood, often do not address the cause(s) of that depression. These may relate to a number of issues including adverse childhood experiences, loneliness, debt, relationship issues or job loss, and require additional approaches to remedy them, other than, or in addition to, medication.

Primary Care has to operate within a wider network of services to provide long-term solutions to such problems and not just medical 'sticking plasters'. There is a growing role for social prescribing as a means of accessing such support.

Rebalancing the social/medical model means that Primary Care will increasingly provide a menu of support and advice beyond the traditional core of GP's and practice nurses. This could include other services such as psychology, yoga or debt advice for example.

Expanding the 'role and reach' of Primary Care has implications for the type of premises required for the delivery of health and care, and where they should be located. Enhanced Primary Health Care Teams need to have sufficient physical space and facilities to be utilised to their full potential.

Making best use of resources also requires greater staff flexibility in terms of job roles. The changes to roles and skill mix that Dr Arfon Williams led in his practice in North Wales provide an indication of what can be done[30]. It reflects the importance of successful changes needing to be communicated, led and supported from the top.

Prudent healthcare principle 3: Do only what is needed, no more, no less; and do no harm

Group 3 recognised that doing only what is 'needed' implied a differentiation between 'wants' and needs' and also that judgements have to made as to what constitutes an appropriate intervention. Who should decide this? The group felt that a conversation was needed about who is responsible for the use of resources and how they are used. Local communities need to have trust in the integrity and competence of those making these decisions to maintain equity and fairness. It is important to understand that need varies according to locality and may need local individualised responses.

The issue of making decisions relying on good information was also discussed in this group, and it was agreed that it is impossible to have a good conversation without good information and / or data. This data should be both qualitative (narrative) as well as quantitative - personal narratives are important, alongside 'Big Data' and quantitative measures. It is important that data is presented appropriately - for example, using absolute risks rather than relative risks, to give clearer indications of actual risks that are less open to misinterpretation and easier for the public to understand.

The vast majority of healthcare professionals want to do the right thing. However, we continue to have problems with the way care is delivered, with over-diagnosis and over-treatment, and managing patient expectations. There are a number of common reasons why the care provided either does not meet, or exceeds, that 'required'. These include:

- Time constraints – seeing complex patients in ten-minute appointment slots.
- Inaccurate/insufficient information.
- Anxiety or fear of missing something important.
- Risk aversion (fear of complaints, or that decisions will not be supported by others).

- Patients seeing the wrong person – where seeing the right person can reduce unnecessary investigations/prescriptions.
- Pressure from patients/relatives, health service guidelines, contractual requirements to prescribe, investigate or refer.
- Not understanding patients' wants and needs, and not working in collaboration to ensure they know and understand what is happening to them.

Consistency is important, in the context of need varying according to locality and community. Again, there is a need for standards and definitions to measure this.

As with Group 2, Group 3 also discussed the importance of flexibility between budgets, as some interventions may cost more to start with, but can reduce costs downstream. An example given was the use of psychologists in multi-disciplinary teams (Diabetes Cymru / Wrexham information), reducing admissions to mental health services.

There needs to be a sustained effort to 'de-medicalise' the population. The rise of clinical workload is partly driven by demographic changes but is also driven by a growing dependency on clinical intervention. In effect the 'bar' for seeking medical advice appears to be lowering, often for problems that are either medically self-limiting (colds, or minor abrasions for example) or whose underlying causes are social and not medical. This can also be driven by media advice to seek medical help for a widening range of common, self-limiting problems.

This translates into an unsustainable rise in workload. In England, for example, the annual consultation rate per person increased by 10.51% between 2007/8 and 2013/14[31]. There is a severe danger that Primary Care services will reach saturation point but crucially many of these referrals to GP's have the potential to be avoided or be seen more appropriately by someone else.

Prudent healthcare principle 4: Reduce inappropriate variation using evidence-based practice consistently and transparently

This group discussed the need to include 'what actually matters to the patient' across the health and care system. Alongside discussion with the patient about what outcome is desired, a greater use of Patient Reported Outcome Measures (PROMS) is required to build up a comprehensive understanding of how patients actually viewed the success (or otherwise) of particular interventions. The whole health and social care pathway needed consideration, with awareness that there are different levels and types of evidence, with all having some value.

With regard to reducing inappropriate variation there have been too many initiatives for changes in health service delivery that have not been sustained, with the result that they are confusing to staff and patients alike, and ultimately wasteful. As a result, Wales remains in the position of considerable variation in practice, even within localities. It also does not often have access the information that enables choices or action to reduce inappropriate variation when it occurs. The Quality and Outcomes

Framework (QOF) and its newer format, the Quality Assurance and Improvement Framework (QAIF), together with other measures of practice are not currently readily available to the public in an interpretable format. Wales also has no patient-based feedback measures for Primary Care.

Prescribing remains an area where further advances can be made in terms of tackling evidence of unexplained variation, both in terms of absolute levels of prescribing between doctors, or practices and of type of drugs prescribed. However good prescribing practice is, unless there is appropriate patient compliance to the prescribing regime, the effectiveness of the intervention is likely to be compromised. Technology has the potential to play a considerable role by facilitating an interactive partnership between the practice and the patient in terms of monitoring medication and uptake, reporting side effects and outcomes and tackling drug wastage. The potential gains are considerable.

For example, 6.5% of all admissions could be attributed to, or associated with, adverse drug reactions, with up to two-thirds of these being preventable[32.] In a practice of about 1,000 patients over the age of 65, this is equivalent to approximately 14 preventable adverse drug events per year and five of these will be serious[33]. Patients in care homes have a roughly 50:50 chance of having a preventable adverse drug event each year[34]. Between one-third and a half of all medicines prescribed for long-term conditions are not taken as recommended[35-38].

Stakeholder Plenary Discussion and Reflections

The stakeholder group proceeded to discuss what transformation was needed to the programme of work already being delivered in Wales, viewed through a 'prudent' lens.

None of the group discussions centred on the specific issues of Out of Hours care, pressure on emergency services, or patient journeys across primary and secondary care boundaries. Instead the focus was on patient-centred care in community and general practice settings, in the belief that if this could be implemented well, there would be ripple effects for healthcare services across primary and secondary care.

The following points summarise a wide-ranging discussion:

- **There should be real engagement with people and communities**, valuing their potential contributions to maintaining health and wellbeing for themselves as well as for others.

- **Health and social care thinking, and decision-making should be much better integrated.**

- **Medical Education for doctors and allied health professionals** should include health literacy assessment of patients, shared decision-making skills and empowerment of patients to self–manage their conditions.

- **Digital and IT development is urgent and imperative**

Recommendations

1. A prudent social model of health and care

- There must be a much clearer political commitment to rebalancing health and social care policy towards a more prudent, social model of health and care where local primary and community care services through clusters, are the main driving force.

- Welsh Government needs to refocus Health Board attention on Primary Care, holding them to account for rebalancing financial and service delivery from secondary care.

- The cluster model should continue to be the vehicle to drive change in Primary Care but must be driven at greater speed, with more devolved funding, responsibility and infrastructure. Funding for clusters must be sustainable over time.

- Clusters must be empowered and resourced properly to respond to local health and care needs in an integrated, responsive and coordinated way, working with alongside local people.

- A simple and transparent general practice Prudent Quality Framework should be developed, based on prudent Primary Care principles, (including health and wellbeing as well as management of disease), to replace the current Quality Assurance and Improvement Framework (QAIF).

2. Engaging the public

The public need to be fully engaged in the design and development of Primary Care services. People should be encouraged and supported to share responsibility for their own health, their families and friends, and to get involved in findings ways to do this.

Although policy documents may be clearly written, both frontline healthcare professionals and the public still find it hard to understand current plans and engage in their care. In order to facilitate this engagement;

- There needs to be greater ownership of a shared vision for a prudent approach to Primary Care that fully engages the public in the planning, needs assessment, delivery and performance of primary and community based services. This should take the form of a range of lay/patient engagement at cluster level to include representation at each level in the decision-making

process (for example patient panels representing their communities). Patients and the public should be equal partners in decision-making.

- We should invest in existing schemes and services that support the social model such as; health literacy, social prescribing, Making Choices Together and the Education Programmes for Patients (EPP Cymru).

- Patients and communities need to be enabled, encouraged and incentivised to help themselves, as well as to help each other, with each person seen as an 'asset' and not a 'problem'.

- There should be more openness and transparency in the publication of data and information, which should be made more easily accessible to the public.

- Standardised metrics should be used that can inform understanding, choices and analysis of regional variations.

- National targets for prudent primary and community care should be revised, refocused and prioritised to reflect clear and transparent prudent Primary Care provision with outcomes relevant to local people and communities.

- They must be easily measured, understandable and owned by the public. Patients' priorities should be valued and measured through Patient Reported Outcome Measures (PROMs).

- Health literacy should start early, in primary schools, with flexibility for local influences and issues, connected to public health as well as to Primary Care.

3. Resources

The level, management and accountability of resources needs to be reviewed.

- There must be a greater commitment to invest in Primary Care, promoting prudent health and wellness across the community. The imbalance between primary and secondary care funding needs to be addressed. This should include, **at the very minimum, an 11 %** share of the health budget dedicated to general practice.

- There should be devolved budgets at cluster level with the **ability to use these proportionately and flexibly to reflect local needs**, supported by Health Board governance. Budgetary considerations should not be allowed to cloud issues of need and local variations.

- Investment must include provision of suitable premises, estate capacity and communications technology that can accommodate the expansion of the practice team and the co-location of a wider range of properly equipped services, to enable patients to access the best possible care.

- There needs to be better utilisation and connection with local facilities, including planning for multi-use premises and wider assets e.g. Local authorities, and third sector.

4. Technology

- A digitally enabled Primary Care service should be embedded into Primary Care clusters to improve seamless integration between health and social care
- Standardised databases must be developed further for consistent and all Wales use, giving rapid access to information and resources used for planning and delivery of services
- Technology, including the single IT system, should continue to be developed and made increasingly 'user friendly' to enable easier access to records, services and health and care information, for both patients and professionals.

Conclusion

The core values of general practice are rooted in localities, delivering essential and valued services to protect and promote people's health and wellbeing.

A prudent approach to primary and community care addressing all four principles and delivered through clusters working alongside people, is fundamental to the future health of local communities. COVID 19 has been a stark reminder of this, reinforcing the essential role that people play in their own health as well as in the well-being of people around them. The response to the COVID 19 crisis has resulted in practices working together in new ways to meet the challenges, which have also forged new alliances both across practices as well as between practices, community services and the community itself. In the wake of this pandemic things must and will change. This paper reinforces the need for a serious commitment and refocus on primary and community care at policy and Health Board level to ensure we maximise the opportunities and considerable potential this offers.

We must be bold and seize this opportunity to make these recommendations a reality. We have the potential to deliver a dynamic and sustainable primary health and care service which is meaningful to local people and which involves them in managing their own health, and that of their families and friends.

The Bevan Commission and RCGP Wales calls upon Welsh Government to take urgent action on these recommendations to secure a fairer and healthier Wales.

References

1. Bevan Commission (2013) *Improving Primary and Community Healthcare*' Bevan Commission, Cardiff 1st December 2013

2. Bevan Commission (2015) *A Prudent Approach to Health: Prudent Health Principles.* Bevan Commission, Cardiff. 1st February 2015

3. Drakeford M. (2015). *Keynote address by Minister for Health and Social Services to the Welsh NHS Confederation Conference*, Cardiff, 28.1.15

4. Welsh Government (2015) *Our Plan for a Primary Care Service for Wales up to March 2018'.* Welsh Government http://www.wales.nhs.uk/sitesplus/documents/986/our%20plan%20for%20primary%20care%20in%20wales%20up%20to%20march%202018.pdf (accessed 15th August 2019)

5. Welsh Government (2019) *Integrated Care Fund: Revenue Capital and Dementia Guidance Effective 1st April 2019* https://gweddill.gov.wales/docs/dhss/publications/integrated-care-fund-revenuecapital-and-dementia-guidance.pdf (accessed 15th August 2019)

6. Welsh Government (2018) *Welsh Government Transformation Fund: Health and Social Services Transformation Fund 2018-2020* https://gov.wales/health-and-social-servicestransformation-fund-2018-2020 4. (accessed 15th August 2019)

7. Welsh Government (2018) *A Healthier Wales: our plan for health and social care*. Welsh Government. 8th June 2018. https://gov.wales/healthier-wales-long-term-plan-health-and-social-care (accessed 15th August 2019)

8. NHS Wales (2018) *Strategic Programme for Primary Care*. National Primary Care Board. November 2018. http://www.primarycareone.wales.nhs.uk/sitesplus/documents/1191/Strategic%20Programme%20for%20Primary%20Care.pdf (accessed 30th August 2019)

9. Royal College of General Practitioners (2013) *The 2022 GP: A Vision of General Practice in the Future of the NHS.* Royal College of General Practitioners. 7th May 2013. https://www.rcgp.org.uk/campaign-home/~/media/Files/Policy/A-Z-policy/The-2022-GP-A-Vision-for-General-Practice-in-the-Future-NHS.ashx (accessed 13th November 2019)

10. Royal College of General Practitioners (2019) *Fit for the Future: A Vision of General Practice*. Royal College of General Practitioners. May 2019.

https://www.rcgp.org.uk/-/media/Files/News/2019/RCGP-fit-for-the-future-report-may-2019.ashx?la=en
(accessed 13th November 2019)

11. NHS England (2016) *General Practice: Forward View* NHS England. April 2016. https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf (accessed 13th November 2019)

12. Roland M, and Everington S. (2016) *Tackling the crisis in general practice.* BMJ 352:i942. 17th February 2016. https://www.bmj.com/content/352/bmj.i942 (accessed 14th November 2019)

13. Goodall A. (2020) *Additional £10m Primary Care Fund*. Director General Health and Social Services: Letter to Health Board Chief Executives 13.01.2020

14. Gething V. (2019) *Minister of Health and Social Services: Keynote Address.* Report of the 4th National Primary Care Conference Clusters: past, present and future. November 7th 2019.http://www.primarycareone.wales.nhs.uk/sitesplus/documents/1191/2019%20National%20Primary%20Care%20Conference%20Report.pdf (accessed 10th March 2020)

15. National Centre Social Research (2019) *2018 British Social Attitudes Survey 36.*https://www.bsa.natcen.ac.uk/?_ga=2.166134013.2122252749.1585312472-2145004946.1585312472. (accessed 12th December 2019)

16. Welsh Government Statistical Bulletin (2018) *National Survey for Wales 2017/18: Hospital and GP Services* https://gov.wales/sites/default/files/statistics-and-research/2019-01/national-survey-wales-hospital-gp-services-2017-18.pdf (accessed 13th November 2019)

17. Palmer B. (2019) *Is the number of GP's falling across the UK?* Nuffield Trust. 8th May 2019 https://www.nuffieldtrust.org.uk/news-item/is-the-number-of-GP's-falling-across-the-uk (accessed 13th November 2019)

18. Q Research (2009) *Trends in Consultation Rates in General Practice 1995/1996 to 2008/2009: Analysis of the Q Research database*. Final Report to the NHS Information Centre and Department of Health. 2.09.2009. https://files.digital.nhs.uk/publicationimport/pub01xxx/pub01077/tren-cons-rate-gene-prac-95-09-95-08-rep.pdf
(accessed 13th November 2019)

19. Charlesworth A and Johnson P (ed) (2018) *Securing the future: funding health and social care to the 2030s.* Institute for Fiscal Studies and The Health Foundation, May 2018. https://www.ifs.org.uk/uploads/publications/comms/R143.pdf (accessed 13th November 2019)

20. Gibson J, Sutton M, Spooner S, and Checkland, K. (2018) *Ninth National GP Worklife Survey 2017*, Policy Research Unit in Commissioning and the Healthcare System, Manchester Centre for Health Economics 2018. https://prucomm.ac.uk/assets/uploads/Ninth-National-GP-Worklife-Survey.pdf. (accessed 13th November 2019)

21. General Medical Council (2019) *The state of medical education and practice in the UK* GMC 19th December 2019. https://www.gmc-uk.org/-/media/documents/somep-2019---full-report_pdf-81131156.pdf?la=en&hash=B80CB05CE8596E6D2386E89CBC3FDB60BFAAE3CF (accessed 27th February 2020)

22. Salisbury C, Procter S, Stewart K, et al. (2013) *The content of general practice consultations: cross sectional study based on video recordings British Journal of General Practice* 2013; 2013; 63 (616): e751-e759. https://bjgp.org/content/63/616/e751 (accessed 13th November 2019)

23. RCGP Wales (2018) *Transforming General Practice: Building a profession fit for the future* Royal College of General Practitioners (Wales) December 2018 http://www.gpone.wales.nhs.uk/sitesplus/documents/1000/RCGP-transforming-general-practice-dec-2018.pdf (accessed 13th November 2019)

24. Auditor General for Wales (2019) *Primary Care Services in Wales.* Wales Audit Office. October 2019. https://www.audit.wales/system/files/publications/Primary-care-services-in-Wales-2019-eng.pdf (accessed 13th November 2019)

25. Irving G, Neves AL, Dambha-Miller H, et al. (2017*) International variation in Primary Care physician consultation time; a systematic review across 67 countries* BMJ Open 2017:7:e017902. doi:10.1136/ bmjopen-2017-017902 . https://bmjopen.bmj.com/content/7/10/e017902 (accessed 13th November 2019)

26. Public Health Wales (2018) *Health and its determinants in Wales: Informing Strategic Planning*. 2018 *Public Health Wales Observatory* http://www2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/85c50756737f79ac80256f2700534ea3/93cea84901926a258025820b0059c112/$FILE/Health&determinantsinWales_Summary_Eng.pdf (accessed 2nd August 2019).

27. ONS (2018) *National Life Tables: UK 2015*-2017 Office of National Statistics 25th September 2018 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2015to2017. (accessed 2nd August 2019)

28. Miller R, Weir C and Gulati S. (2018) *Critical Appraisal of the Pacesetter Programme.* Health Services Management Centre, University of Birmingham.

June 2018.https://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/news-events/2018/critical-appriasal-pacesetter-programme.pdf. (accessed 2nd August 2019)

29. Tudor Hart J. (1971) *The Inverse Care Law*. The Lancet 297: 405–412.

30. Bevan Commission (2019) *Improving capacity and patient access in Primary Care* in Transformation from Within: Bevan Exemplar Projects 2017-18.

31. Richard Hobbs RD, et al. (2016) *Clinical workload in UK Primary Care: a retrospective analysis of 100 million consultations in England, 2007-14* The Lancet 2016; 387:2323-30 https://www.ncbi.nlm.nih.gov/pubmed/27059888. (accessed 2nd August 2019)

32. Pirmohamed M, et al (2004) *Adverse drug reactions as cause of admission to hospital: prospective analysis of 18,820 patients*. BMJ 2004:329 https://www.bmj.com/content/329/7456/15. (accessed 13th November 2019)

33. Gurwitz JH, et al (2003) *Incidence and Preventability of Adverse Drug Events Among Older Persons in the Ambulatory Setting.* JAMA. 2003;289(9):1107-1116. https://jamanetwork.com/journals/jama/fullarticle/196099 (accessed 13th November 2019)

34. Howard, R et al (2007) *Which drugs cause preventable admissions to hospital? A systematic review* British Journal of Clinical Pharmacology 2007 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2000562/. (accessed 13th November 2019)

35. Duerden M, Millson D, Avery A, and Smart S. (2011) *The Quality of GP Prescribing* Kings Fund. London https://www.kingsfund.org.uk/sites/default/files/field/field_document/quality-gp-prescribing-gp-inquiry-research-paper-mar11.pdf. (accessed 13th November 2019)

36. Nunes V, et al (2009) *Medicines Adherence: involving patients in decisions about prescribed medicines and supporting adherence* NICE 28th Jan 2009 https://www.nice.org.uk/guidance/cg76/evidence/full-guideline-242062957 (Accessed 13th November 2019)

37. McGilchrist MM, et al (1993) *Primary non-compliance with prescribed medication in Primary Care* British Medical Journal 1993; 307. 2nd October 1993. https://www.bmj.com/content/307/6908/846. (accessed 13th November 2019)

38. National Institute for Health and Care Excellence (2009) Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence. National Institute for Health and Care Excellence

(NICE) Clinical Guideline CG76. January 2009. https://www.nice.org.uk/guidance/cg76/chapter/Introduction (Accessed 13th November 2019)

Appendix 1

The Bevan Commission

The Bevan Commission (hosted and supported by Swansea University) brings together a group of internationally renowned experts to provide independent, authoritative advice on health and care to Welsh Government, leaders across Wales, the UK and worldwide. The Bevan Commission identifies and shares best practice from healthcare systems around the world, building on the principles of the NHS as established by Aneurin Bevan. It provides authoritative recommendations to improve Wales' healthcare system, and supports healthcare professionals on the frontline to innovate and test out their own expert ideas. The Bevan Commission believes that good health and care is everyone's responsibility, so works with professionals and community members to ensure their views and ideas are heard in the health and care debate.

Current Bevan Commissioners

Professor Sir Mansel Aylward CB, Chair	
Professor Dame Sue Bailey	Professor Ewan Macdonald OBE
Nygaire Bevan	Chris Martin
Professor Bim Bhowmick OBE DL	Professor Sir Michael Marmot
Professor Dame Carol Black DBE	Professor Sir Anthony Newman Taylor CBE
Sir Ian Carruthers OBE	Dr Helen Paterson
Mary Cowern	Professor Phillip Routledge CBE
Professor Ilora Baroness Finlay of Llandaff	Fran Targett OBE
Professor Kamila Hawthorne MBE	Professor Hywel Thomas CBE

Professor Trevor Jones CBE	Sir Paul Williams OBE CStJ DL
Lt General Louis Lillywhite CB, MBE, OStJ	Roy Noble OBE DL O.St J

Appendix 2

Attendees at the RCGP Wales / Bevan Commission Primary Care stakeholders discussion workshop, July 12th 2019.

RCGP Wales
1. Rob Morgan, Vice Chair, RCGP Wales
2. Will Mackintosh, Chair South West Wales Faculty, RCGP Wales
3. Karen Gully, Quality Lead, RCGP Wales and Clinical Director for Primary Care, ABUHB
4. Peter Saul, Joint Chair, RCGP Wales
5. Mair Hopkin, Joint Chair, RCGP Wales
6. Suzanne Thickens, RCGP Wales Advocate for ABUHB
7. Nicola Edmunds, RCGP Wales and Republic of Ireland Manager
8. Elizabeth Czaban, RCGP Wales Patient Group Chair
9. Arfon Williams, RCGP Representative
10. Charlie Williams AiT Representative, RCGP Wales
Bevan Commission
11. Helen Howson – Director
12. Kamila Hawthorne – Commissioner
13. Sion Charles – Deputy Director
14. Fran Targett – Commissioner
15. Barbara Chidgey – Bevan Advocate
Practice Managers
16. Helen Griffith, Practice Manager, North Wales
17. Graeme Hunter, Practice Manager, South Wales
RCN
18. Sue Thomas, Primary Care Representative, RCN
RPS
19. Suzanne Scott-Thomas, Chair, Royal Pharmaceutical Society
Welsh Government
20. Cathy White, Community, Primary Care and Health Services Policy Directorate, Welsh Government
Public Health Wales
21. Zoe Wallace, Director of Primary Care at Public Health Wales

22. Mary-Ann McKibben, Consultant in Public Health at Public Health Wales
HEIW
23. Charlette Middlemiss, Head of Workforce Modernisation, HEIW
NHS Wales
24. Liam Taylor, Deputy Medical Director Aneurin Bevan University Health Board
25. Allan Wardhaugh, Assistant Medical Director for Information Governance and Technology, Cardiff and Vale University Health Board
26. Sian Passey, Head of Nursing, NHS Wales
27. Alastair Roeves, Interim Deputy Medical Director, Swansea Bay University Health Board
Occupational Therapists
28. Rhian Giles, Clinical Lead OT for Adult Physical Services, Aneurin Bevan University Health Board
Physiotherapists
29. George Oliver, Physiotherapy Service Lead - Primary Care, Cardiff and Vale University Health Board
Welsh Ambulance
30. Andy Swinburn, Assistant Director of Paramedicine, Welsh Ambulance Services NHS Trust
Health Boards
31. Hilary Dover, Director of Primary and Community Delivery Unit, Swansea Bay University Health Board
WCVA
32. Fiona Liddell, Helpforce Manager, WCVA
Mind Cymru
33. Rhiannon Hedge, Senior Policy and Campaigns Officer, Mind Cymru
Mental Health
34. Veryan Richards, Lay Representative
35. Eva Elliott, Honorary Research Fellow, Cardiff University and Lay Representative
WLGA
36. Susan Elsmore, Cabinet Member for Social Care and Health, County Council of the City and County of Cardiff
37. Phil Robson, Special Advisor, Aneurin Bevan University Health Board
Social Care Wales

38. Carolyn Wallace, Associate Professor, University of South Wales
Interlink
39. Lucy Foster, Community Coordinator, Rhondda Interlink
40. Karen Powell, Community Coordinator, Taff Ely Interlink
41. Sue Leonard