Bevan Commission

...promoting health and health services improvement in Wales

Bevan Commission - Improving Primary and Community Health care in Wales

'***Primary care is imperative for building a strong healthcare system that ensures positive health outcomes, effectiveness, efficiency and health equity. It is the first contact in the healthcare system for individuals and is characterised by continuity, comprehensiveness and coordination of care. It provides individual and family- focused and community - orientated care, preventing, curing or alleviating common illnesses and disabilities and promoting health'(Leiyu Shi 2012)***

1. Introduction

Primary and community care is a highly effective means of healthcare delivery in terms of cost and quality, however, its full potential is rarely realised. (Oldham, et al 2012) Wales needs to realise this potential, with a strong, robust and tailored primary and community care service meeting the needs of people in Wales and the Welsh NHS.

Much of the focus in health is currently on the acute sector, particularly unscheduled care and A&E, however, many of the solutions to these lie in primary and community care. Greater propriety is needed on reducing demand through prevention, protection, early intervention and on the management of chronic conditions within local communities.

Whilst this paper focuses upon primary and community care Bevan Commission members acknowledge the need for a high level holistic view across the whole system, recognising the impact and outcomes of one part of the system upon the other.

This paper draws from a range of evidence presented directly to the Commission and through its focused workshops, to identify the main issues and solutions for improving future primary and community care in Wales.

2. Background and Context

The Alma Ata (1978) defines primary care as: '***Essential care: based upon practical, scientifically sound and socially acceptable method and technology; universally accessible to all in the community through their full participation; at affordable cost and geared towards self reliance and self determination'.***

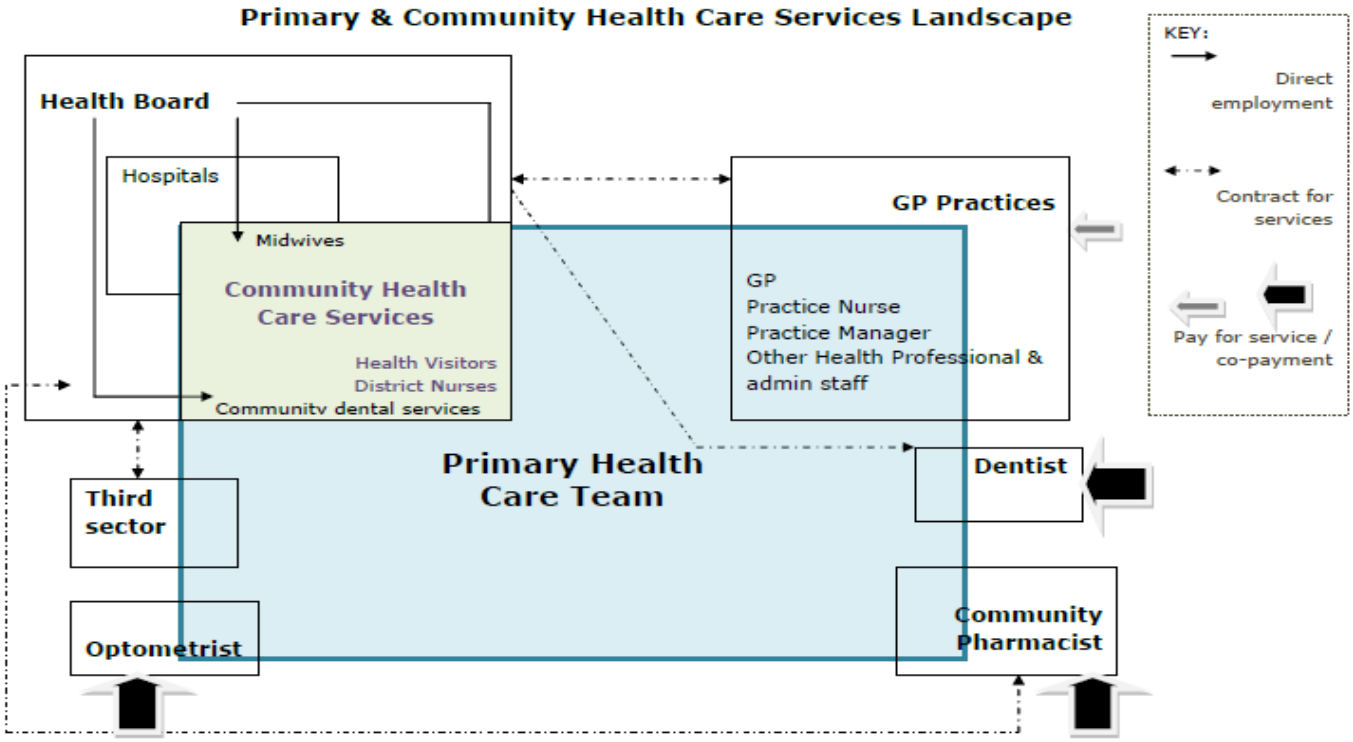
Primary care provides care throughout the life course including preventive services, access to early diagnosis, treatment and ongoing care to end of life. It is the interface between the community and health and social care. Barbara Starfield (2005) demonstrated the cost effectiveness of health care systems which are primary care led with key features as:

- Longitudinal, person centred care (not single disease focused)
- A first point of contact for most health problems
- Comprehensive holistic care in the context of the family and community
- Coordination of care for individuals

These recognise the wider factors impacting on health which are more than specific healthcare interventions delivered outside hospitals, acknowledging the importance of the community and its assets in maintaining health and well being through the wider environment, self care and support from others.

In Wales primary and community health care services are provided by a wide range of people, some managed directly by health boards, some by independent contractors and others by other service providers such as social care and the third sector. It is a complex and confusing picture for patients, carers and professionals, compounded even further when we add the interface of other services provided by the acute sector as illustrated below:

Table 1



Public Health Wales Observatory

Wales has the following designated health care professionals and 'reach' into communities:

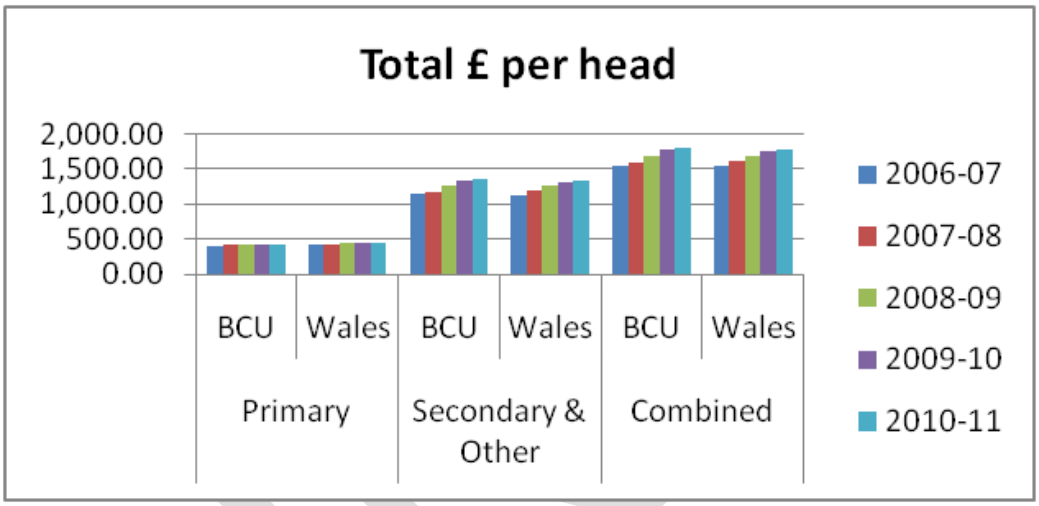
- over 2000 GP's, 710 community pharmacies, over 1000 dentists and 852 ophthalmic practitioners
- over 3, 400 nurses, midwives and health visitors in community services
- Approximately 90% of patient contacts with the NHS take place in primary care
- 94% of the population visits a pharmacy at least once a year and on average 12 times a year
- Average number of face to face consultations per week for a UK full time GP partner in 2007 was 102.3, with approximately 19 phone consultations, 6 home visits and 2 care home visits

Welsh Government Statistics

Some specialist support is also provided in the community from acute care using community consultants, for example, in geriatrics and paediatrics, as well as specialist nurses and therapists, although this varies across Wales.

Out of hours (OOH) services also play a key part of the services, although the fragmentation of OOH between primary and acute care and the reluctance to risk manage can contribute to additional pressure on A&E. Other support services such as the use of volunteer patient education support and third sector services also play a key role in helping people self manage their conditions and also to remain at home longer. The table below indicates the relative spend between primary and acute care illustrating a significant differential over time:

Table 2 **Total NHS spend by primary and secondary care**



Source: Kathrin Thomas / Programme Management Unit, Public Health Wales

Wales has an urgent need to address the growing health inequalities and associated 'Inverse Care Law', particularly in deprived communities which have morbidity and mortality rates amongst the worst in the UK. (Welsh Government, CMO Report 2013) A high proportion of premature mortality, disease and disability is related to the environment that people are born into, their family, community and wider society. (Marmot et al. 2010). Community Orientated Primary Care (Gillam. S. Schamroth. A. 2004) will therefore need to be a key consideration in future approaches in Wales.

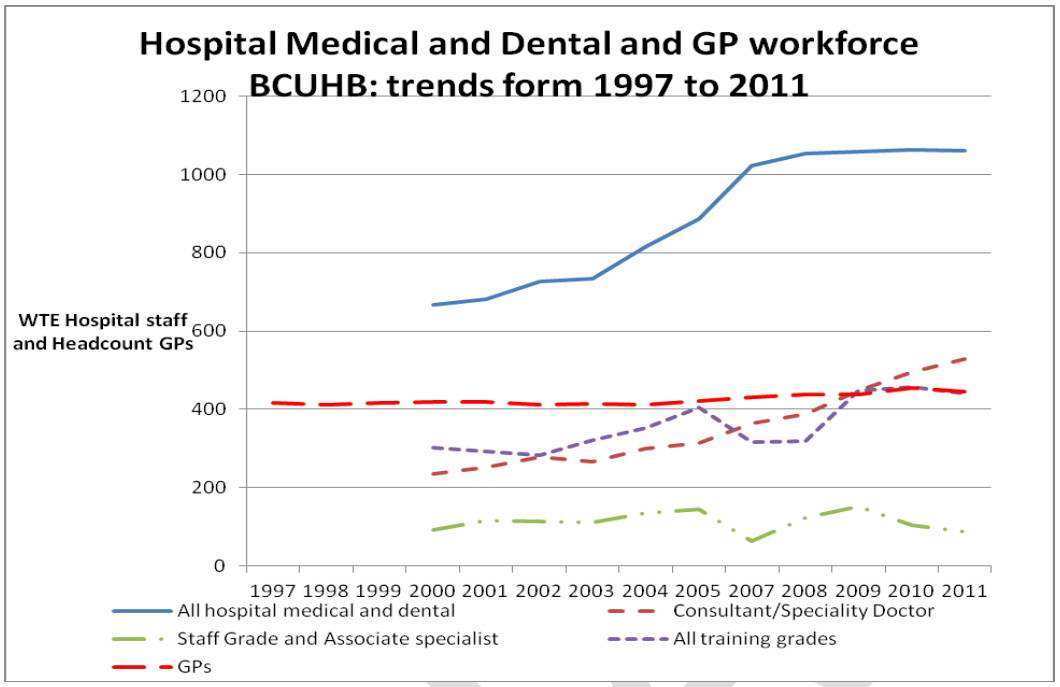
Health care services worldwide are facing rising costs, with increasing unscheduled secondary care, insufficient care delivered in the community and the over-provision of care that is not cost effective. Wales needs to urgently reconfigure a new approach to health and well being and the provision of care in the community to achieve greater sustainability, whilst recognising the longer term ecological, social, demographic and economic challenges ahead.

3. Evidence overview

Evidence clearly supports the significance of primary care on the health of populations and studies suggest that the supply of GPs and family physicians improves health outcomes, including all cause, cancer, heart disease, stroke, infant mortality; low birth weight ; life expectancy and self-rated health (Pierard E.2009). Atum (2004) and Starfield et al (2005) found that '*strong primary care systems not only improve population health but also reduce health inequities at lower cost than healthcare systems that rely more extensive on secondary and tertiary care'*. This is reinforced by Julian Tudor Harts findings related to the Inverse Care Law. (Tudor Hart,J.1992)

Evidence (Kringos et al 2013, Haggerty et al 2013) also indicates that strong primary care was associated with better population health; lower rates of unnecessary hospitalisations; relatively lower socio-economic inequality and a slower growth in healthcare spending but higher spending generally. They identified that numbers of specialists alone does not appear to improve health outcomes in general: areas with a higher level of specialists spend more but rate lower on quality and outcomes. Despite this, the majority of funding is allocated towards secondary care. Evidence in Wales (Wales Deanery, NLIAH 2012) indicates that investment in specialist consultants in acute care has continued to rise whilst GPs have remained constant but with an increasing workload, in contrast to New Zealand (Timmins, N., Ham, C 2013) for example where GPs have increased by 24% since 2005. The Deep End Report (Glasgow University 2013) went further to recommend one additional GP session/week/1000patients in very deprived areas.

Table 3 **Betsi Cadwaladr Health Board Medical and Dental Workforce**

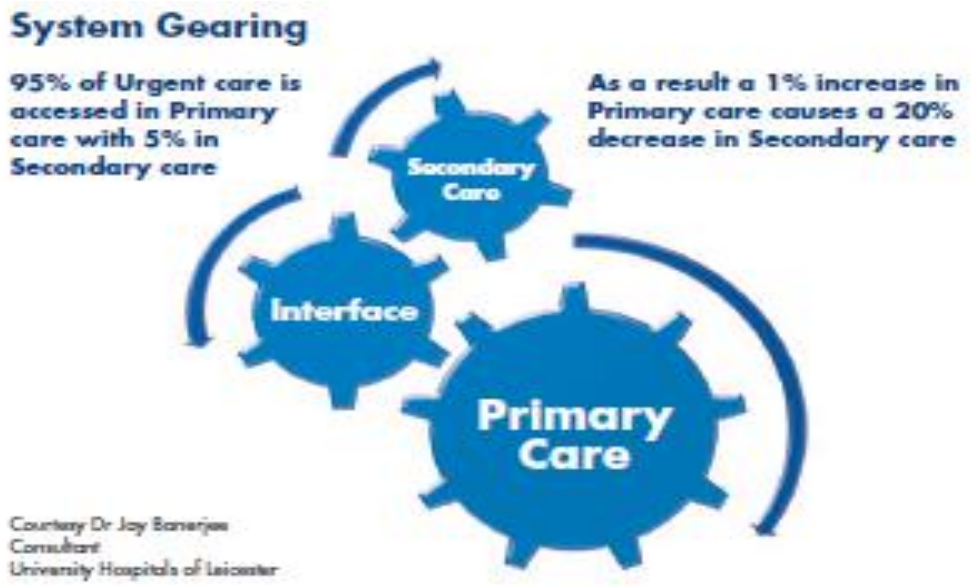


Source: Kathrin Thomas, Public Health Wales, data from StatsWales

In 2008, NHS England's Centre for Workforce Intelligence (CFWI) recommended that GP training post numbers in England be increased by about 30% to match the demand largely related to the population changing demography, rises in unscheduled care and shifting care into the community. There has been no similar decision in Wales, however the Wales Deanery and NLIAH Report (2012) examined several scenarios to inform workforce planning, all requiring increases in the number of GPs, some substantial.

Further evidence suggests a powerful relationship between the investment in primary care upon secondary care, as indicated in the system gearing below by Jay Bararjou.

Table 4



The RCGP (2011, 2013) suggests that services may work better if they become more generalist, based upon holistic, patient centred care, with opportunities for health promotion and the protection from tests and treatment with limited benefit. The Kings Fund report Health Improvement in General Practice in England (Boyce T.2010) also recognised the *'enormous potential for general practice to take a more proactive role in ill-health prevention and public health'.* They have also more recently identified the growing pressure on primary care and the new models evolving to meet these challenges and develop more sustainable general practice.(Smith.J.et al. 2013).

Experiences from Canterbury, New Zealand (Timmins, N., Ham. C 2013) and the NUKA model in Alaska (Gottlieb et al 2008) both reiterate the importance of engaging all staff in helping to find solutions in providing patient-centred care. NICE (2003, 2004, 2004) also recognises the importance of enabling people to develop more control over their lives and there is emerging evidence as to the effectiveness of practitioner led interventions in supporting individuals to make positive changes.

The Report of the Primary Care Working Group (Oldham. J et al. 2012) identified seven challenges to help realise its potential of which, incentives, IT and quality standards/ regulation were considered to be those that governments could most consistently influence.

4. Where are we now? – the services, problems and barriers

- With an increasingly ageing population the challenge is to not only manage chronic conditions better, but to manage more complex elderly care, particularly co-morbidities, alongside other complex health, emotional and social problems. These are often compounded in more deprived communities, where the solutions are not to be found in the more traditional models of care, but in more community orientated primary care. Primary and community care in Wales is under pressure to meet these increasing needs and other associated problems including; Imbalance of primary and secondary care capacity
- Changing demography and managing more complex needs
- Removal of GP 24 hour responsibility
- Medicalisation of the results of social and financial deprivation
- Fragmentation of health /social care services in the community
- Increased hospital referral/ admission
- Disempowering people and patients
- Increased focus on specialisation and less on generalism

The Bevan Commission has taken evidence from a range of individuals (Appendix 1) to inform its views both in its meetings and through workshops.

Initial feedback identified the following key issues which are summarised below. A fuller explanation of these can be found on the Bevan Website (www.bevancommission.org).

Early Issues Identified

- **Valuing and strengthening primary and community care** – currently undervalued and under resourced and not a priority compared to acute care, but held many of the solutions.
- **Preventing illness, and co – producing health** – recognising the need to maintain health not just treat illness, better support self care, co producing health with people and with communities.
- **The medicalisation of social care –** understanding the wider society impacts on health and opportunities to help address these differently.
- **Joint locality planning and delivery across health and social care -** making current localities work in practice with devolved budgets/ responsibility and accountability.
- **Generalist and Specialist Care –** working effectively together as one system to best meet the needs of patients.

- **Whole System working 24/7** – reduce fragmentation of care with GPs/ PC holding and coordinating care for their patients both in and out of hours.
- **Training and Professional development** –as health needs change so will the skills and development needs of health/other professionals.
- **Improve other supporting services**- primary care is interdependent on services such as nursing homes, ambulances, which need consideration.

Further detail was also drawn from the workshops held with GPs and other stakeholders to consider the services, barriers and solutions to a new approach for primary and community care in Wales, which is summarised below. A full report can be found on the Bevan Commission website:

a) What services should be delivered?

Services that help keep people well and manage illness, from conception to grave, through medical and other key community services:

- Maternal / child health
- Elderly care / End of life
- Learning difficulties/ mental health patients
- Chronic disease management (including mental health)
- Community Nursing care
- Acute GP care services such as minor injuries, dermatology etc
- Public health / health improvement and health protection

b) What are the barriers?

- **Current focus on acute care not primary and community care**
- **Inadequate capacity to meet increasing need**
- **Variable access to and quality of services** (greater problems in more deprived areas where demand is greatest – Inverse Care Law evident)
- **Lack of continuity of care** across the system
- **Lack of good, easy to use and accessible information**
- **Long delays in getting tests / appointments**
- **Lack of routine services outside office hours** eg diagnostics 24/7
- **Funding mechanisms - limitations of the new contract / QOF etc**
- **Potential threat of localities** -not engaging GP practices appropriately
- **Frustrations at good ideas not delivered or trusted to deliver Cultural tensions between LHBs and independent contractors**
- **Premises are often a problem –** too restrictive

- **Difficulty in moving resources around the system**
- **Signposting and co ordination of care**
- **People not grasping the opportunity to shape or improve services**
- I**neffective communication** with patients, professionals and systems
- **Professional cultures, boundaries, governance, financial and managing clinical 'risk'**
- **Public expectations of primary care**

c) What are the opportunities and solutions?

- **Better understanding/ sign up to common aims across the 'whole system'** -'one budget' based upon better patient care
- **Large scale, meaningful change re focussing effort (resources/ service) from hospital into the community and on the** person
- **Opportunity cost / benefit of primary care maximised**
- **Better access to diagnostics** etc
- **Greater transparency and better quality information** allowing comparisons and peer review
- **Encourage and performance manage, service improvement, collaboration and partnership working throughout the system**
- **Review GMS/ QOF to encourage and incentivise GPs to work together (co-operatives)to realise GP 'hubs' and their values.**
- **Use GP specialist skills to address some out of hospital care** including OOC / 24/7 care, minor injuries, dermatology etc)
- **Devolve budget and management responsibility for integrated care to localities/ cooperatives based on population health needs**
- **Create space, capacity and incentives to develop new primary care models suitable to areas of high deprivation e.g.** Social Enterprise, Community Interest Company, Community Cooperatives
- **Co-locate and Co-produce health with others e.g. leisure, schools**
- **Develop a joint 'road map' with short , medium and long term outcomes** based on a 'hub' with a single point of contact and directory
- **Support GP leadership and review workforce planning in PCC**
- **Increase access to EPP and other third sector support services**
- **GPs should hold the continuity of care for patients**
- **Reduce limited value tasks -** things that don't add value/not effective
- **Micro management reduced** trusting PC to deliver jointly agreed outcomes, supported by peer review and clarity on governance
- **Engage patients in service planning/ delivery/ improvement**

- **Joint system of managing risk and governance between** GP's /consultants with accountability frameworks /peer review

5. What is the organisational model that best serves these functions and local variation?

There was overall a general consensus on what the model should look like in the future, with some minor differences in detail. This proposed a model which strengthened locality based services, based upon a 'cooperative'/ 'confederation' of GPs working together, with others, at a community level to deliver primary and community care (GMS and non GMS). It was recognised that the levels would vary from area to area but could operate above locality level, possibly 50 000 or above.

This would plan and organise local services based upon population health needs, with local people and through an integrated, devolved budget, including community nursing, therapists, pharmacists, third sector, step up, care of the elderly etc. This would be accountable to the Director through a local board (clinicians, patients, third sector etc). A number of possible models were identified, recognising that details vary from area to area depending on local circumstances, including:

a) Loose agreement
b) 'John Lewis' co-ownership model
c) Patient confederation
d) Community Interest Company/ Social Enterprise

This approach would help create a Community 'Hub', building upon existing local services (e.g. education, police, voluntary), infrastructures and community networks. There was clear recognition of the need for different models, particularly in deprived areas such as Communities First, which engaged with communities and used local assets. Models such as Social Enterprises (Bromley by Bow) and Community Interest Companies (Pathfinder Healthcare Development) allow more flexible approaches and included; training, housing advice, employment, use of local volunteers etc. (Shepherd. M. 2013) addressing the wider determinants of health and maximising opportunities for other sources of funding.

Whilst there is a growing movement and awareness of the need to change the way general practice is run across the UK (Kings Fund 2013) there was recognition of the need for incentives and capacity for change. This could include a range of options; professional job satisfaction, flexible working, devolved services such as community nursing and other out of hospital

services and more specialist medical support in the community, all of which will need to be more fully explored.

There was also recognition of the need to ensure easily accessible and consistently high quality care across Wales and the need for mechanisms to support this, such as peer review. Creating a high quality primary care system in Wales was also seen as crucial in attracting a high quality workforce. Opportunities for greater integration of public health in primary care was identified, using their knowledge and skills more effectively to identify population needs and help translate into services and support the community.

6. Where do we want to be? – vision, values, actions and enablers

Wales needs a clear vision setting out its own distinct approach, along the following lines - *'Wales aims to develop a primary and community led NHS, preventing illness, managing and coordinating care and co producing health with all partners to improve health and reduce inequalities '.*

Wales also needs to determine the values and principles which underpin this. The following were consistently raised with stakeholders and we suggest they are used to underpin future approaches to primary and community care:

- **People-centred local care, actively engaged in their health and well being and in local service provision.**
- **Needs-based population health/ care services, reducing inequalities.**
- **Proactive health promotion, protection, early intervention, predicting risk.**
- **Clinically-led, Integrated, local health and social care services, effectively coordinated and managed.**
- **Continuity and coordination of care with cooperative local solutions.**
- **Easy access to high quality services with rapid response 24/7.**
- **Consistently high quality generalist care supported by specialist services.**

The following table summarises the Commission findings as key actions and enablers needed to improve primary care in Wales. Transformation is needed to move from a reactive, fragmented service to a proactive, dynamic and integrated service with people at the centre, as set out in Appendix 3

Wales should use this opportunity to create the motivation and momentum for change, building on the consensus to date to create a new collective community environment for improving health and well being in Wales.

What and How? – Actions and Enablers

Table 4

WHAT?	HOW?
Establish GP Cooperatives - GPs working together to provide an extended and complementary range of local services including, OOH/ 24/7 care, minor surgery and other specialist care, such as dermatology.	− Welsh Government develop framework for GP co operatives engaging with RCGP/ LMC/GPC etc − Review GP contract and other methods of funding and incentives to align with core values and responsibility for population health − Provide local access to diagnostics and other relevant support − Ensure easy access to and use of information − Align with acute specialists to support shared care in the community, particularly paediatricians and geriatricians − Introduce "one call will solve it" in primary care telephone appointments systems
Integrated, Locality Teams with needs based services and support – GP led local services supported by integrated health and social care staff, third sector and patients. Services based upon local needs, particularly chronic conditions management and resources (re)aligned proportionate to need	− Devolve / pool budgets / staff linked to jointly agreed outcomes and proportionate to need − Identify options for co locating, within health/other public services − GPs to ensure coordination and continuity of care particularly for chronic conditions / co morbidities and complex care − GP lead dedicated time with care coordinator support responsible for local health outcomes − Patient representation and engagement process established − Population health profiles and clinical data used to inform services
Promote and co-produce health,	− Public health / services fully

WHAT?	HOW?
prevent illness and de-medicalise care – ensuring that greater emphasis is placed on maintaining health and well being within primary care and linked to wider community determinants	integrated within primary care - Strengthen incentives and other opportunities to promote health and prevent illness - Use predictive risk tools/ shared data to prevent /delay illness and proactively manage care - Identify opportunities and support to strengthen self care/ EPP - Engage with local stakeholders/ public to help co produce health
Develop and test new Innovative (co-production) models of primary care in Communities First areas – actively engaging with local people and local services	- Identify resources for clinical leadership to create capacity for new innovative models of care (Welsh Government/NHS/Communities First/ HB) - Align incentives and create momentum for change - Establish R&D support/ proposal to assess impact (NISCAR) - Create a network/learning set for change/development - Identify backfill and training to support sustained innovation
Transparent Information Sharing and use of IT - actively used to inform and improve service planning, strengthen communication and improve population health outcomes	- Develop consistent pro forma and data set for localities, including publication/ sharing requirements - Use local health profiles and other clinical data / information to inform service planning, delivery and improve outcomes - Use datasets which allow comparison to aid reflective practice and decision making between providers (peer review/ benchmarking) and support consistently high quality services - Strengthen use of IT to support care closer to home (telehealth, telecare,

WHAT?	HOW?
	telemedicine), better information and communication
Workforce fit for the future - planning and training needs aligned	− Develop comprehensive workforce planning strategy − Review capacity needs for GPs /other pc/community support − Make 'generalism' attractive to professionals in Wales − Identify opportunities for co-production of health with local people/ volunteers − Strengthen integrated working between GPs and consultants across all disciplines − Strengthen GP / clinical leadership skills − Review and revise Training Programmes to meet needs
Local governance and performance management supporting transformational change	− Local governance systems reviewed to reflect proposals − Outcome based performance system established across Wales − Performance management of health professionals (acute and PC) aligned and actively reviewed − Primary Care developments identified as a Welsh Government Tier 1 priority and progress reviewed regularly − Use peer review process to ensure greater consistency of care − Ensure service improvement and collaboration are key performance management indicators for all staff

7. In summary – Achieving change in primary care

Wales has a real opportunity to make a difference and the time is right. With increasingly different healthcare systems evolving across the UK, combined with changing workforce needs and expectations, stakeholders should continue to work together to maintain the motivation and momentum to deliver a unique approach to primary and community services that are fit for Wales and its future (Appendix 3).

General practice remains in a model which served an earlier era, and the power of the GP contract has not been fully utilised with missed opportunities to galvanise change in response to changing needs. Opportunities to use the contractual levers to ensure wider distribution of services in primary care, whilst retaining financial and performance management, have been missed. The development of less medicalised models, in more deprived areas that build on local assets, social enterprise and co production is needed to help reduce inequalities, engaging the passion and compassion of all concerned.

The success of a health service is strongly governed by the success of primary and community services. They deal with the majority of health related contacts, coordinating timely care in the best place and by the right person. Health Boards must make locality teams work in practice, working as integrated teams, including social care, with the needs of the patients central. Wales must make the practice of 'generalism' attractive to ensure it has the skills to meet the growing needs in the community, avoiding hospitals overwhelmed by inappropriate problems.

Health boards have responsibility to promote health and wellbeing alongside the provision of comprehensive health services which includes primary and community care. To date there has been focus and investment on hospital based care at the expense of primary and community care. This needs to be re focused on the community and its assets as the central pivot for sustaining health and well being.

Wales must re-orientate and refocus effort and resources to improve outcomes in the areas where those costs are generated - the population not in hospital. Welsh Government and health boards will have to address this, building trust and strong partnerships to ensure a robust, high quality system, supporting more sustainable health and well being, balancing patient flows and the population needs of Wales, now and throughout the 21st Century.

Recommendations

1. **Adopt and actively drive forward a Primary and Community led NHS in Wales, supporting the identified values, actions and enablers to transform the model and approach, tailored to fit the needs of Wales.**

2. **Ensure that primary and community care is a high priority for NHS Wales, reflected in policy, planning, resource allocation and performance management.**

3. **Identify and target resources to support the transformation, particularly GP leadership, capacity and new models in more deprived communities. Recruitment of GPs and other community staff to Wales is critically important for the success of this.**

4. **Establish a Primary and Community Care Development and Delivery team with responsibility to coordinate and drive large scale change at pace across Wales in the next 12 months.**

5. **Ensure accountability for delivery across the system through performance management systems for Chairs, CEOs and Medical Directors in LHBs and their GPs and within Welsh Government.**

Appendix 1

Contributors

Attendees at Bevan Commission meeting – 8 August 2012

Surname	First name	Organisation
Jones	Chris	Chairman, Cwm Taf Health Board (ex GP)
Gully	Karen	Senior Medical Adviser, Primary Care Welsh Government
Cottom	Andrew	CEO Powys Teaching Health Board(CEO Lead for primary care)
Griffiths	Andrew	CEO NWIS
Richards	Jonathan	GP Merthyr, RCT

Workshop Invitees

Surname	First name	Organisation
Allen	Steve	Chairman of the Community Health Councils
Aylward	Mansel	Chairman, Public Health Wales / Bevan Commission
Bailey	David	BMA
Bhowmick	Bim	Bevan Commission Member
Boylan	Brendan	Cardiff and Vale
Butler	Chris	Professor of Primary Care, Cardiff University
Calland	Tony	Bevan Commission Member
Campbell	Fraser	MD Betsi Cadwaladr
Dharmasena	Helen	Salaried GP 1
Dickinson	Mark	Public Health Wales
Edwards	Dorothy	Abertawe Bro Morgannwg
Gully	Karen	Senior Medical Adviser, Primary Care Welsh Government
Hooper	Rachel	Salaried GP 2
Hopkins	Sharon	Director of Public Health Cardiff and Vale
Houston	Helen	Cardiff University
Howson	Helen	Consultant in Public Health, Public Health Wales/Special Advisor Bevan Commission
Hussey	Ruth	CMO, Welsh Government
Jones	Carwyn	GP, Hywel Dda
Jones	Charlotte	GP, Abertawe Bro Morganwwg
Jones	CDV	Chairman, Cwm Taf (ex GP)
Lang	Geoff	Acting CEO/ ex Director of Primary Care, Betsi Cadwaladr
Lewis	Malcolm	Welsh Government, Medical Advisor
Lewis	Richard	BMA
Longley	Marcus	Bevan Commission Member

Surname	First name	Organisation
Matthias	Jon	Public Health Wales
Myres	Paul	Chair RCGP Wales, Public Health Wales
Ponton	Mike	University of South Wales
Roberts	Ed	Vice Chair (ex GP) Abertawe Bro Morganwwg
Saunders	Kay	GP, Cardiff and Vale
Stanton	Naomi	Cwm Taf
Thomas	Kevin	Salaried GP 3
Thomas	Sue	RCN Wales
Whyley	Helen	Welsh Government
Williams	Alan	GP, Hywel Dda
Williams	Lynda	Director of Nursing, Cwm Taf

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Appendix 3

TRANSFORMING PRIMARY AND COMMUNITY CARE		
From…		***To…***
Individual focus	→	**Family and community context including locality health and well being**
Single disease focus	→	**Holistic care managing complex needs and co morbidities**
Often difficult to access 9 – 5 services	→	**Easy access to 24/7 services**
Treatment / illness focus	→	**Strengthening prevention and early intervention- promoting and protecting health and well being**
Reactive – responding to illness	→	**Proactive - predicting and managing risk and preserving health**
Centrally managed community care	→	**Locally planned and managed services and support including community nursing**
Central and individually managed budgets	→	**Locally devolved and pooled budgets across health and social care**
Medically dominated model	→	**Community / co produced / social enterprise model**
Professionally led / dominated	→	**Engaging patients, carers, the public and the third sector in service design and delivery**