PC 37

Ymchwiliad i ofal sylfaenol

Inquiry into primary care

Ymateb gan: Sefydliad Bevan

Response from: The Bevan Foundation

HEALTH SOCIAL CARE AND SPORT COMMITTEE INQUIRY INTO PRIMARY CARE

SUBMISSION BY THE BEVAN FOUNDATION

1. The Bevan Foundation is an independent, non-political charity that develops new ideas to make Wales fair, prosperous and sustainable. We are submitting evidence to the Committee because we are in the early stages of what we hope will be a major project to establish patients' views about primary care and to develop alternative models of delivering care.

2. We welcome the Committee's inquiry because there is a striking lack of evidence on primary care in Wales, and in particular there is a lack of evidence from a patient perspective. The most recent data on patient satisfaction with their G.P. [1] is based on surveys undertaken over 2014-15, meaning that even the simplest of measures is nearly three years out of date. Evidence is also limited in scope: for example the findings on ease of making an appointment do not distinguish between routine or urgent appointments or explain *why* 37% of people said making an appointment was difficult. And there is virtually no evidence on other primary care providers.

3. The paucity of evidence means that it is very difficult to monitor performance and satisfaction with primary care from a patient perspective. The principle of introducing primary care clusters appears sound, building on the idea of 'family care networks' advocated by the Kings Fund and others. However in the absence of any baseline information or monitoring of outputs and outcomes (at least in the public domain) it is difficult to assess whether the remodelling of provision will result in improvements for patients.

4. We have the following general points we ask the Committee to consider.

5. First, in respect of demand, we urge the Committee to recognise that the pressures on general practice are the result of multiple and interrelated drivers, not only a result of patient demand. Pressures come from three main areas identified in recent research by the Kings Fund:[2]
    - **Patient pressures**: in respect of expectations of rapid access or face-to-face consultations; continuity of care; expectations re treatment options; increasing complexity of health conditions; deprivation and diversity; and a reduction in 'self-caring'.

[1] National Survey for Wales 2014/15 **GP Services** https://statswales.gov.wales/Catalogue/National-Survey-for-Wales/2014-15

[2] Beccy Baird, Anna Charles, Matthew Honeyman, David Maguire, Preety Das (2016) **Understanding pressures in general practice,** Kings Fund

- **System pressures**: such as the introduction of new services (new medicines, new clinical guidelines, public health campaigns, non-NHS work) and relationships with other NHS services (mental health, social care, secondary care, third sector etc.) including so-called bureaucracy.
- **Supply-side pressures:** including workforce issues, funding, the role of the wider community care team, and regulation and contracts.

6. Unless there is a clear understanding of where the pressures on primary care come from and efforts are made to address them, simply remodelling delivery into clusters is unlikely to achieve sustainable improvements for patients. Indeed it is feasible that clusters could reduce pressures from patients by diverting demand to other primary care providers yet also increase other pressures, such as those from the system. It is a moot point whether this amounts to an improved service.

7. Second, we note that a key element in the cluster model is co-production. We support the principle of patients co-producing their care with healthcare professionals, but we are concerned that the implications of co-production of care, e.g. on appointment times or treatments, have not been fully considered. These factors need to be modelled into cluster provision. Indeed there is a risk that pressures on primary care could increase, for example as a result of patient expectations, if a co-produced approach is not adequately planned and resourced.[3]

8. Third, we are concerned that in allowing health boards and clusters to make their own arrangements for implementation there could be duplication, competition and a lack of comparability between areas. For example, several cluster plans have identified marketing initiatives as a way of recruiting GPs, with the result that clusters could compete with each other to attract applicants. Similarly some clusters are developing their own data collection systems, which could mean that valuable intelligence is not comparable between areas.

9. Autonomy is important, not least so that clusters can reflect the specific needs and circumstances of their population and workforce, but there also needs to be effective co-ordination between clusters and across health boards and some common standards.

10. And last, and definitely not least, we urge the Committee to maintain its focus on achieving better outcomes for patients, not least as the provider voice in the NHS is very strong.

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[3] Jonathan Richards (2015) **Is co-production possible in the National Health Service?** Exchange Issue no. 1, p.18, Bevan Foundation