PRIMARY CARE POPULATION HEALTH NEEDS ASSESSMENT: ENGAGEMENT REPORT

PHW Primary Care Division | June 2018 v2a

TABLE OF CONTENTS

EXECUTIVE SUMMARY

SITUATION

This document reports on the outcome of Stage 1 of the Integrated All-Wales Primary Care Needs Assessment (IAWPCNA) proposal, which involved engagement with key stakeholders to provide recommendations to Primary Care Hub Board on the desirability/ feasibility of committing to further investment in IAWPCNA beyond Stage 1.

BACKGROUND

IAWPCNA is the working title of a project proposal from the Public Health Wales (PHW) Primary Care Hub seeking to transform the way we do primary care needs assessments in Wales. If implemented, IAWPCNA would intend to build on existing good practice and information resources, presenting key information about local needs together with evidence on effective interventions. By adopting a once-for-Wales approach, IAWPCNA would offer an efficient means to develop cluster needs assessments that are comparable and aligned to the strategic priorities that will ultimately drive quantifiable improvements in cluster population health.

Alongside this internal context, there have been changes to the contractual ask on clusters with relaxation of the requirement for a Cluster Action Plan, while at the same time the *Parliamentary review of health and social care in Wales* emphasises the importance of assessing local needs, responding to them and utilising preventive opportunities and *A healthier Wales* indicates these (no longer mandated in QOF) assessments/ plans should feed into regional assessments and Area Plans.

ASSESSMENT

A primary care needs assessment informed by these engagement workshops might include the following broad topic areas: Demographics; Non-communicable disease prevention; Screening; Infectious disease prevention; Wider determinants of health; Mental ill health & well-being; Social care and carers; Frailty; Sensory impairment; Oral health; Life-course topics; and Service use. Within these broad headings there are a number of higher-priority sub-topics that could be selected to support iterative development of a needs assessment solution. Selection also needs to take account of various contextual factors such as the availability of existing indicators; data resolution; intelligence provider access to primary care data; potential to impact on population health outcomes; etc. A prototype would help demonstrate the potential value of a needs assessment solution. A proposed schedule for phased topic development is provided in Annex C; selection for Phase 1 is based on both workshop participant views in conjunction with a rounded assessment of wider context.

A primary care needs assessment informed by these engagement workshops might include the following broad functionality considerations: Primary purpose; Primary audience; Components; Features; Timings; Implementation; Format; Content; and Design. Within these broad headings there are a number of higher-priority functionality aspects that could be selected to support iterative development of a needs assessment solution. Selection also needs to take account of various factors such as costs; availability of expert resource; impact on existing intelligence provider work plans; effectiveness of collaboration between providers; etc. A proposed schedule for phased functionality development is provided in Annex D; again, selection for Phase 1 is based on both workshop participant views in conjunction with a rounded assessment of wider context.

RECOMMENDATIONS

RECOMMENDATION 1

The Primary Care Hub Board should approve the phased development of a national template supporting primary care needs assessment. This would involve an interim release utilising available analyses led by Public Health Wales and delivered by March 2019 for each health board. Feedback on this interim solution and work on a pathway approach to diabetes intelligence will together inform the design of a longer-term automated needs assessment solution for primary care audiences.

RECOMMENDATION 2

The Primary Care Hub Board should identify mechanisms to effect improved access to primary care data for named intelligence providers supporting cluster-level needs assessment.

1. INTRODUCTION

Integrated All-Wales Primary Care Needs Assessment (IAWPCNA) was the working title of a project proposal put to the Public Health Wales (PHW) Primary Care Hub Board seeking to transform the way we do primary care needs assessments in Wales. If fully implemented, IAWPCNA would build on existing good practice and information resources, presenting key information about local needs together with evidence on effective interventions. By adopting a once-for-Wales approach, IAWPCNA would offer an efficient means to develop cluster needs assessments that are comparable and aligned to the strategic priorities that will ultimately drive quantifiable improvements in cluster population health.

This document reports on the outcome of Stage 1 of the IAWPCNA proposal (Annex A), which involved engagement with key stakeholders to provide recommendations to Primary Care Hub Board on the desirability/ feasibility of committing to further investment in IAWPCNA beyond Stage 1.

2. CONTEXT

2.1 PRIMARY CARE HUB PROPOSAL

In the National Assembly *Inquiry into primary care: clusters* (Oct 2017) PHW are quoted as noting "The Primary Care Hub is working with others to improve access to relevant and timely health intelligence. We encourage clusters to take a broad view of data describing population needs and to integrate intelligence arising from professions other than general practice. As well as reflecting population needs, cluster plans should be informed by evidence on effective interventions, and we intend to strengthen our support for this." Furthermore, "Local public health teams play a vital role in helping clusters interpret population health status, prioritise action and select best value interventions— but tailoring this for 64 clusters challenges capacity."

This position reflects a paper to Primary Care Hub Board in September 2017 that outlined IAWPCNA (Annex A). In summary, the IAWPCNA "pitch" is captured in the following graphic, as shared during the engagement events referred to below:

The accompanying narrative began by outlining traditional approaches to needs assessment:

- *All of these approaches need a source or sources of data. In Wales we have a number of different providers, each typically offering a variety of products. As a result, navigating this fruit salad of offerings to find the cherries you want can be intimidating.*
- *What's more, we have potentially 64 clusters looking at all this fruit, each in their own way. That's a lot of variation, inefficiency and incomparability. Does anybody not recognise this? Why would we want to solve the same challenge 64 different times when we could do it once and well? This is why we are here.*
- *Wouldn't it make sense if we avoided much of this by deciding nationally what a cluster-level needs assessment looks like and templating it. Instead of asking cluster leads to look over individual products and then decide what to pull from them, we could just gift them the key deliverable. 64 separate efforts would become a once-for-Wales process. This still leaves room for clusters to ask what their own patients or community think; to consider what local assets they can make better use of; and to add in extra local data in reflection of cluster-specific concerns.*

2.2 RELATED GMS CONTRACT PLANNING REQUIREMENTS

At the time of the above proposal, the 2017/18 GMS Contract Cluster Network Domain (CND 009W) required:

- An annual plan informed by evidence of local needs: "The contractor reviews and updates the previous year's Cluster Network Action Plan giving due consideration to local population needs and service development for the population served by cluster network for the next three years."
- The need for strategic alignment: "…alignment of the Cluster Network Action Plan with the Local Health Board three year Integrated Medium Term Plan or annual plan as appropriate."

At the time of the engagement workshops described below, this requirement had altered, with the GMS Contract for 2018/19 indicative of a more "light touch" contractual environment:

- The changes were "to reduce the operation of QOF to disease registers and two flu indicators, alongside the cluster network domain to be simplified to five engagement meetings during the year. This will alleviate workload pressures and allow clusters to mature in line with their own development needs."
- QOF guidance for the GMS Contract 2018/19 states "There are no specific indicators for previously defined activities such as updating practice development plans… however these are activities which are of benefit to practices and health boards. Practices when agreeing their cluster work programme for the year will need to consider these activities and the benefit to their practice and whether to include in the cluster plan."

2.3 THE PARLIAMENTARY REVIEW & WELSH GOVERNMENT RESPONSE

Prior to the announcement of GMS Contract changes, the *Parliamentary review of health and social care in Wales* (2018) had emphasised the importance of assessing local needs, responding to them and utilising preventive opportunities:

- "The needs of populations differ hugely across Wales, and health and care resources must be designed locally to meet those needs."

- "Welsh Government should revise national contracts with GPs, community pharmacists and other independent community practitioners to support delivery of enhanced community-based provision within localities that ensures effective seamless and prompt responses to health and care needs."
- "Performance management and inspection does not currently incentivise prevention: they must."

In response, Welsh Government published a long-term strategy in the form of *A healthier Wales*, noting "Local cluster needs assessment and service plans should feed into regional assessments and Area Plans developed by RPBs".

3. ENGAGEMENT APPROACH

3.1 ENGAGEMENT INTENTIONS

Stage 1 of the IAWPCNA proposal centred around engagement workshops. These workshops were intended to inform the topic and functionality scope of the IAWPCNA proposal, leading to national agreement on the way forward. Workshops were arranged for Conwy (15 May & 5 June) and Swansea (17 May & 7 June 2018). Via a "save the date" communication, participation was sought from the following stakeholder groups, including those involved the development of cluster plans or supporting cluster needs assessments:

Stakeholder group	Role representation
Primary care representation	• Cluster leads • Cluster support staff (invited via Cluster Leads) • General Practitioners, Royal College of General Practitioners, British Medical Association, Local Medical Committees • Nurses – practice, community, district, Royal College of Nursing • Health visitors • Practice managers • Community pharmacists/Royal Pharmaceutical Society • Eye health • Oral health
Local health board representation	• Heads of primary care • Primary care managers • Associate medical directors (AMDs) in primary care • Cluster development managers and those in similar roles (invited via Heads of Primary Care) • Heads of information & performance • Heads of quality & audit • Director of Primary, Community & Mental Health (DPCMH) representative • Director of Public Health representative • Director of Nursing representative • Director of Planning representative
Public Health Wales representation	• Primary Care Division • Local public health team staff who support primary care colleagues (invited via LPHT primary care leads) • Health Intelligence Division: Observatory Analytic Team (OAT); Observatory Evidence Service (OES); Welsh Cancer Intelligence and Surveillance Unit (WCISU) • Health Improvement Division

	• Health Protection Division: Communicable Disease Surveillance Centre (CDSC); Vaccine Preventable Disease Programme (VPDP) • Screening Services • 1000 Lives Improvement Division	
Other NHS Wales representation	• NHS Wales Informatics Services (NWIS) • NHS Wales Shared Services Partnership (NWSSP) • Welsh Analytical Prescribing Unit (WAPSU)	
Welsh Government representation	• Lead for Primary & Community Health Statistics • Primary care policy representative	
Academic representation	• SAIL • PRIME	

The stated overarching aim of the workshops was to address the question "*What information does a cluster need to support planning health improvements for local populations of 30–50k?*" The objectives for the first workshop were to:

- Generate a long list of topics for inclusion;
- Generate a long list for solution functionality.

The first workshop included several materials designed to stimulate table-based discussion. These included the IAWPCNA proposal, topic and functionality "primers" and survey findings on public health issues considered to contribute most to poor health and well-being from *Stay well in Wales: The public's views on public health* (Bangor University/ PHW 2018).
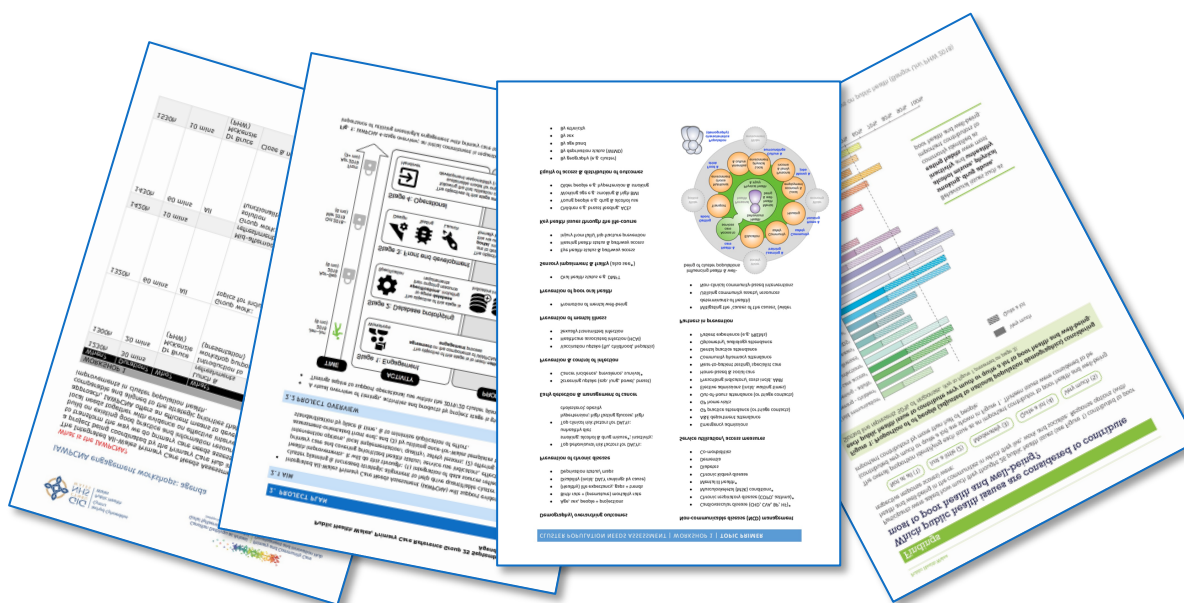
The objectives for the second workshop were to:

- Refine/ prioritise topic lists via electronic voting;
- Refine/ prioritise functionality specification via electronic voting.

Voting was carried out using Optivote hand-held electronic keypads. Participants were familiarised with the use of the devices and each new question type was explained in advance of polling. Polling results were displayed on-screen and participants were invited to comment on these where time permitted.

3.2 FIDELITY OF ENGAGEMENT

Workshops were offered in Conwy and Swansea with 50 places each (including facilitators); participants were asked to commit to attending both workshops in either location. In terms of numbers of participants:

- As there were approximately two applications for every place in Swansea, and Conwy was under-subscribed, a combined total of 79 confirmed participants were expected.
- Attendance was higher at the first event (Conwy 24; Swansea 41) excluding two facilitators at each but including deputies & unexpected participants; 31 places were thus unfilled.
- Attendance was lower at the second event (Conwy 16; Swansea 23) excluding two facilitators at each but including deputies & unexpected participants; 57 places were thus unfilled.
- A total of 67 unique participants attended at least one workshop; there were 39 unique voting participants at the second workshop.
- Participation at the workshops was at 68% and 41% of the planning intent for the first and second workshops respectively, with a 27% fall-off in participation by the second workshop.
- Note that these numbers do not fully reconcile with the electronic voting counts, suggesting some inaccuracy in the event registers.

In terms of breadth of participants, the following table of participant counts illustrates the level of engagement by organisational affiliation (where identified):

Organisational affiliation	Attended at least 1 workshop
Abertawe Bro Morgannwg UHB	8
Aneurin Bevan UHB	6
Betsi Cadwaladr UHB	16
BMA Cymru Wales	1
Bro Taf LMC	1
Cardiff & Vale UHB	4

Community Pharmacy Wales	1
Cwm Taf UHB	3
Hywel Dda UHB	2
Powys THB	1
Public Health Wales	19
SAIL	1
Sign Sight Sound	1
Welsh Government	3

The type of roles contributing to the electronic voting was as follows:

Stakeholder group	*Roles contributing to voting*
Primary care representation	• Cluster Lead • General Practitioner/ GP Principal • Practice Manager • NCN Dental Advisor • Associate Director, CPW • Local Medical Committee
Local health board representation	• Information Manager • Cluster Development Manager • Senior Primary Care Manager • Community Director • Network & Communities Manager • General Manager Community & Primary Care • Planning & Commissioning manager primary care • Informatics & Communications Lead Health Visitor • Professional lead for occupational therapy mental health • Deputy Head of Pharmacy, Primary & Community Care • Clinical Lead Pharmacist • Transformation Lead for Primary Care • Orthoptist
Public Health Wales	• Consultant in Public Health • Consultant in Dental Public Health • Principal Health Promotion Specialist • Principal in Public Health • Principal/ Senior Public Health Practitioner • Principal Public Health Intelligence Analyst • Public Health Intelligence Specialist • Analyst/ Advanced Analyst
Other NHS Wales representation	• *Nil*
Welsh Government representation	• Nursing Officer, Primary & Community, Integration & Innovation
Academic representation	• Data Scientist (SAIL)
Third sector	• Business Development Director

Most participants who evaluated the events at the second workshop felt that:

- The purpose of the workshops was clear from the outset (79% Conwy [11/14]; 71% Swansea [17/24]).
- The networking opportunity was of additional value (100% Conwy [13/13]; 76% Swansea [19/25]).
- The utilisation of electronic voting (with live feedback) was good or extremely good (100% Conwy [14/14]; 88% Swansea [22/25]).
- Participation in the workshops enabled a personal contribution to discussions around primary care intelligence issues (agree or somewhat agree; 86% Conwy [12/14]; 84% Swansea [21/25]).

Key message

The level of engagement secured was lower than the planning intention. This mirrors similarly low levels of engagement over the IAWPCNA proposal itself when circulated to selected stakeholder groups.

Implication

Confidence that the findings of this report reflect a national consensus view cannot be high.

4. VIEWS ON TOPICS FOR INCLUSION IN A SOLUTION SPECIFICATION

4.1 CLUSTER POPULATION DEMOGRAPHICS

Demography describes how the population is made up in terms of characteristics such as age, sex and ethnicity. It typically also looks at relative social deprivation by geography and high-level measures of (and inequalities in) population health status, such as life expectancy.

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:

Category	Percentage
Rural vs urban classification	2%
Veterans and currently serving personnel	0%
Deprivation status / maps	23%
Disability (inc. DALY rankings by cause)	8%
(Healthy) life expectancy, gaps, trends	23%
Cause of death	12%
Birth rate & (premature) mortality rate	6%
Age, sex, persons (inc. projections)	26%
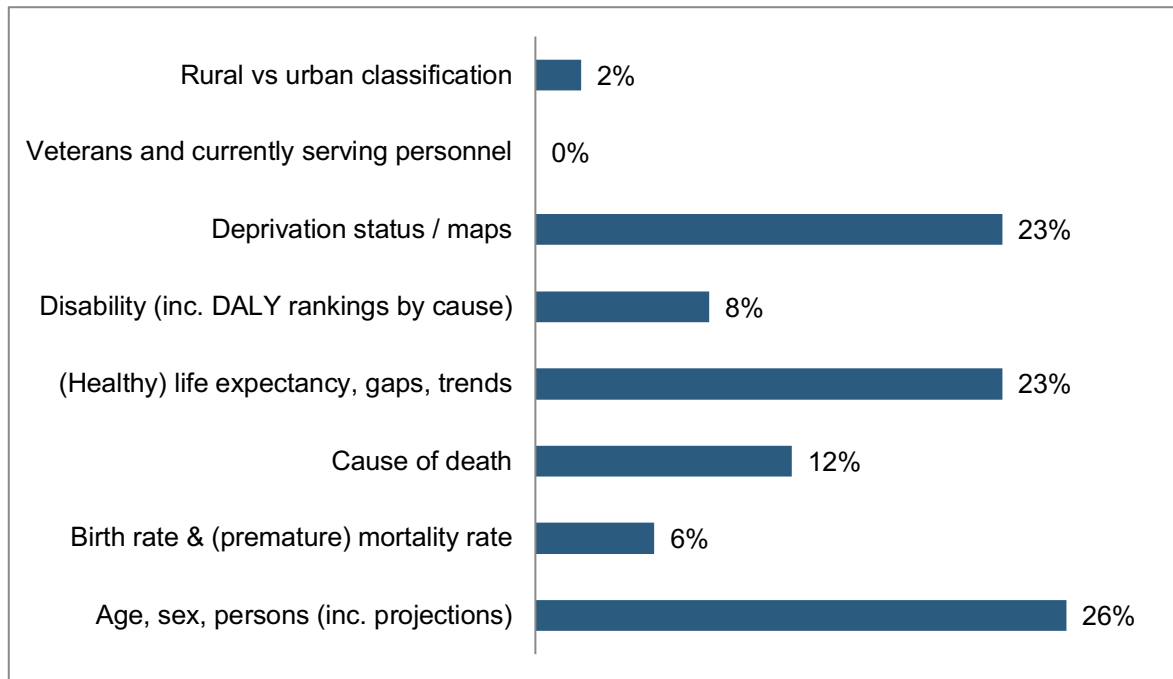
4.2 NON-COMMUNICABLE DISEASES

4.2.1 PREVENTING LONG-TERM CONDITIONS: BEHAVIOUR RISK FACTORS

At the first workshop participants had sight of the following slide, outlining the ranked contributions of identified behavioural risk factors contributing to potentially avoidable disability-adjusted life years (DALYs), a measure of the "burden of disease" that encompasses both morbidity (disease) and premature mortality (early deaths):

Top 20 Global Burden of Disease identified risk factors for disability-adjusted life years (DALYs), count of DALYs, all persons, all ages, Wales, 2016
Produced by Public Health Wales Observatory, using Global Health Data Exchange (IHME)

Risk factor	Count of DALYs
Smoking	108,966
High systolic blood pressure	90,497
High body-mass index	72,128
Alcohol use	44,097
High total cholesterol	43,626
High fasting plasma glucose	39,773
Diet low in fruits	24,964
Diet low in whole grains	24,323
Drug use	20,909
Ambient particulate matter pollution	18,921
Diet low in nuts and seeds	18,773
Diet low in vegetables	15,252
Low physical activity	14,901
Impaired kidney function	13,829
Occupational exposure to asbestos	13,794
Diet low in seafood omega-3 fatty acids	11,313
Diet low in fibre	9,613
Diet low in legumes	8,131
Low bone mineral density	6,812
Occupational ergonomic factors	5,694

Participants were presented with the question "Information on which behavioural risks would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:

Behavioural risk	Percentage
Diet	22%
Inactivity	22%
Alcohol & drugs	19%
Smoking	37%
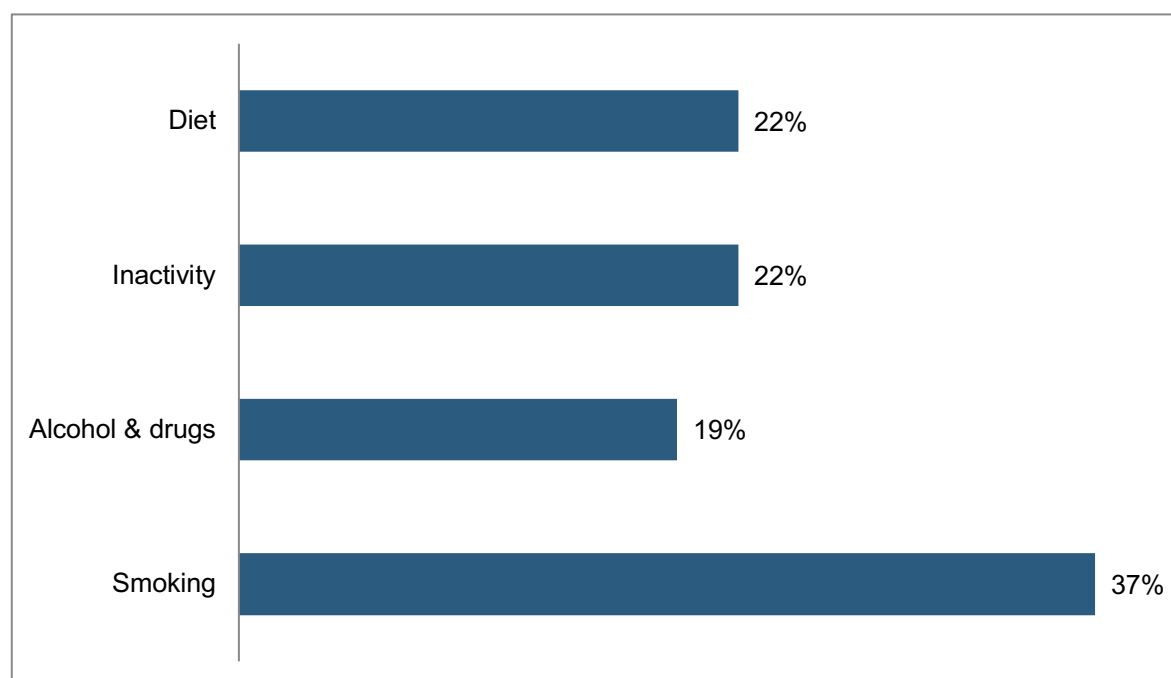
A further question arose due to recognition that traditional intelligence on prevalence of behavioural risk factors generally depends upon high-level survey findings. Participants were presented with the question "What kind of data are needed on behavioural risk prevalence? (smoking, alcohol & drugs, inactivity, diet (Select one option)" and voted as follows:

Not necessary to include	5%
Cluster level data (Audit+)	72%
Local authority survey level data	23%

Key message

Participants expressed a clear preference for cluster-derived data on behavioural risk factor prevalence.

Implication

There is some evidence of a discrepancy between survey-estimated prevalence and primary care-derived prevalence estimates (for example, SAIL found smoking prevalence using GP calculated values was approximately 7% higher than Welsh Health Survey values; see *BMC Med Inform Decis Mak*. 2017 Jan 5;17(1):2. doi: 10.1186/s12911-016-0400-6). While such a discrepancy is liable to have service planning implications, providers of routine health intelligence to primary care do not have ready access to Audit+ data to supply this (see 5.7.2). Furthermore, the usability of these data would strongly depend upon primary care ascertaining and coding such risk factors.

4.2.2 PREVENTING LONG-TERM CONDITIONS: CLINICAL RISK FACTORS

At the first workshop participants had sight of the following slide, outlining the ranked contributions of identified clinical risk factors contributing to potentially avoidable DALYs:

Top 20 Global Burden of Disease identified risk factors for disability-adjusted life years (DALYs), count of DALYs, all persons, all ages, Wales, 2016
Produced by Public Health Wales Observatory, using Global Health Data Exchange (IHME)

Risk factor	DALYs
Smoking	108,966
High systolic blood pressure	90,497
High body-mass index	72,128
Alcohol use	44,097
High total cholesterol	43,626
High fasting plasma glucose	39,773
Diet low in fruits	24,964
Diet low in whole grains	24,323
Drug use	20,909
Ambient particulate matter pollution	18,921
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Low physical activity	14,901
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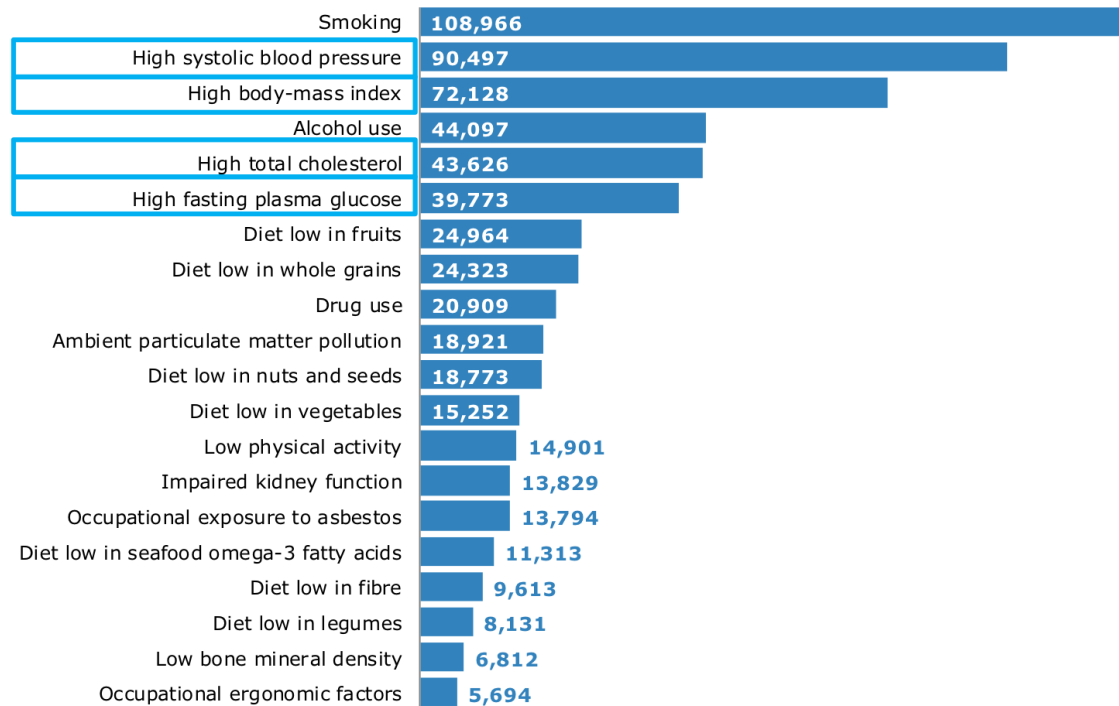
Participants were presented with the question "Information on which clinical risks would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:

Clinical risk	Percentage
High BMI/obesity	33%
High fasting glucose	15%
High cholesterol	15%
Hypertension	37%
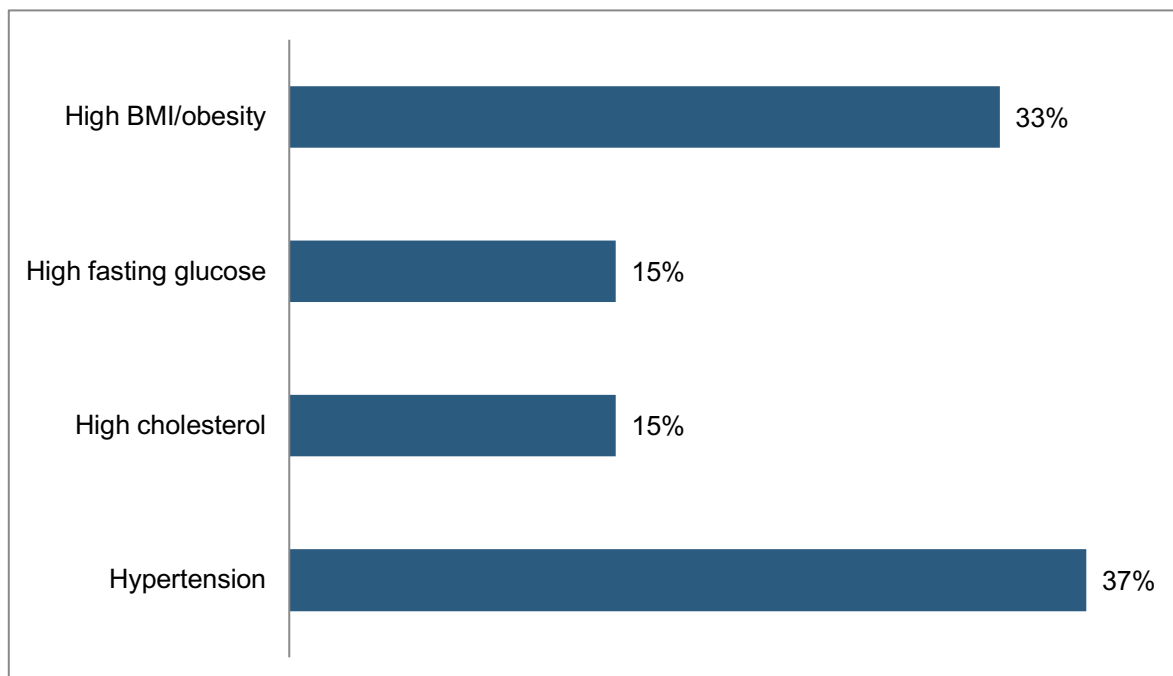
4.2.3 EARLY DETECTION & CONDITION MANAGEMENT: CANCERS

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:
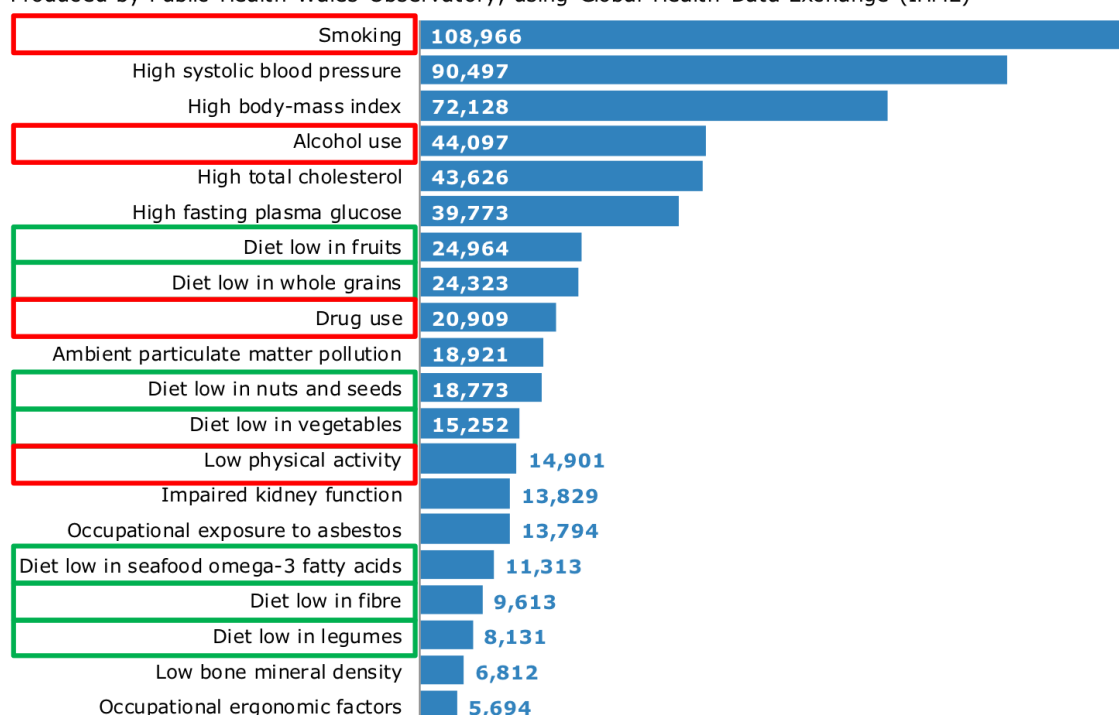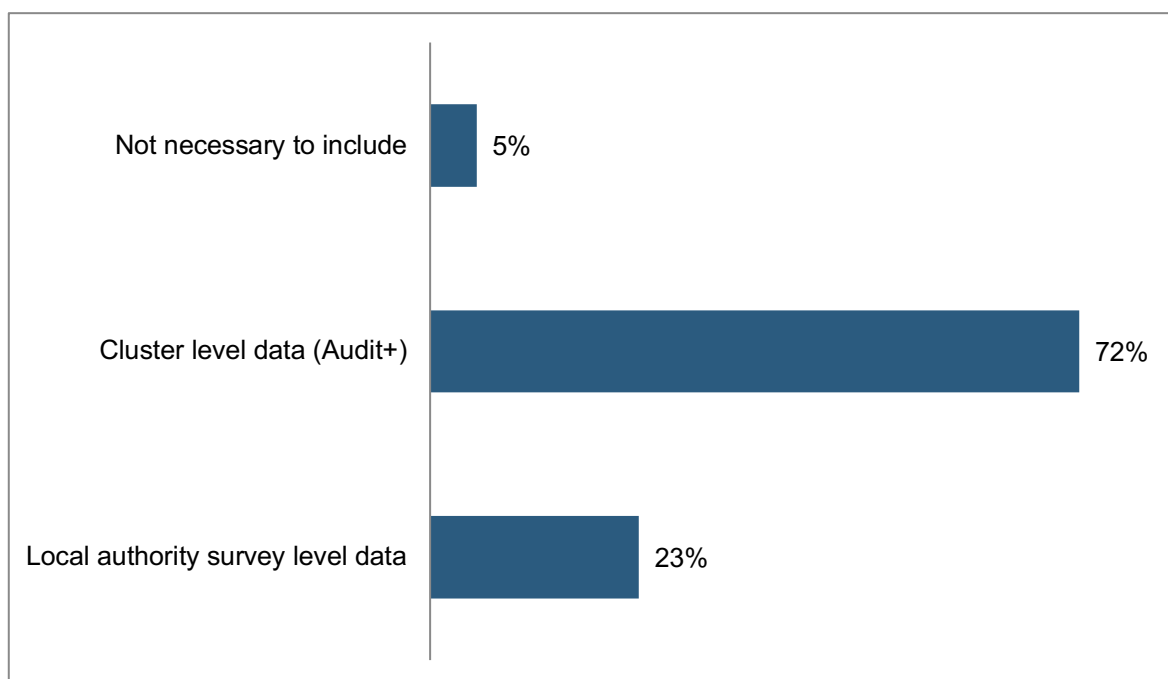
Category	Percentage
Care pathway access metrics	11%
Cancer stage at diagnosis	25%
Incidence, prevalence, survival	30%
Screening uptake (bowel, breast, cervical)	34%

4.2.4 EARLY DETECTION & CONDITION MANAGEMENT: NON-CANCERS

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:

Category	Percentage
(School sight tests)	4%
New-born blood spot	10%
New-born hearing	9%
Antenatal screen	25%
Diabetic eye disease	30%
Abdominal aortic aneurysm (AAA)	21%

> **Key message (4.2.1–4.2.4)**
>
> Participants recognised the value of preventive approaches to improving local population health.
>
> **Implication**
>
> Opportunities to progress the prevention agenda through local cluster action must not be lost in the context of a clear strategic steer in this direction with coincident relaxation of the cluster planning requirement.

4.2.3 LONG-TERM CONDITION PREVALENCE & MANAGEMENT

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:

Condition	Percentage
Palliative care (specifically not cancer related)	5%
Co-morbidities	12%
Dementia	17%
Diabetes (inc. pre-diabetes)	24%
Chronic kidney disease (CKD)	2%
Musculoskeletal (MSK) conditions	4%
Chronic respiratory disease (COPD, asthma)	13%
Cardiovascular disease (CHD, CVA, BP, HF)	24%

Participant(s) noted:

- Practices "already have this information" via QOF
- Palliative care needs in relation to non-cancerous long-term conditions is a rising concern.

Note that a few participants did suggest potential indicators of optimal clinical management for long-term conditions, however, this level of detail is best captured via subsequent engagement activities should this be indicated.

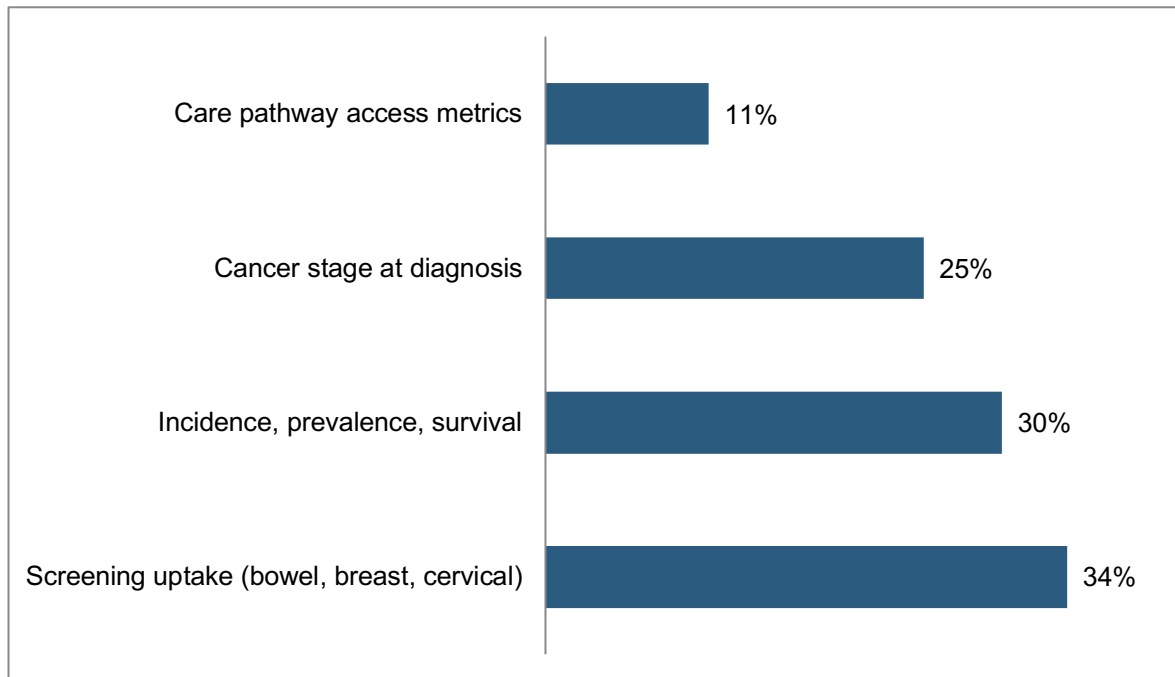## 4.3 PREVENTION & CONTROL OF INFECTION

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:
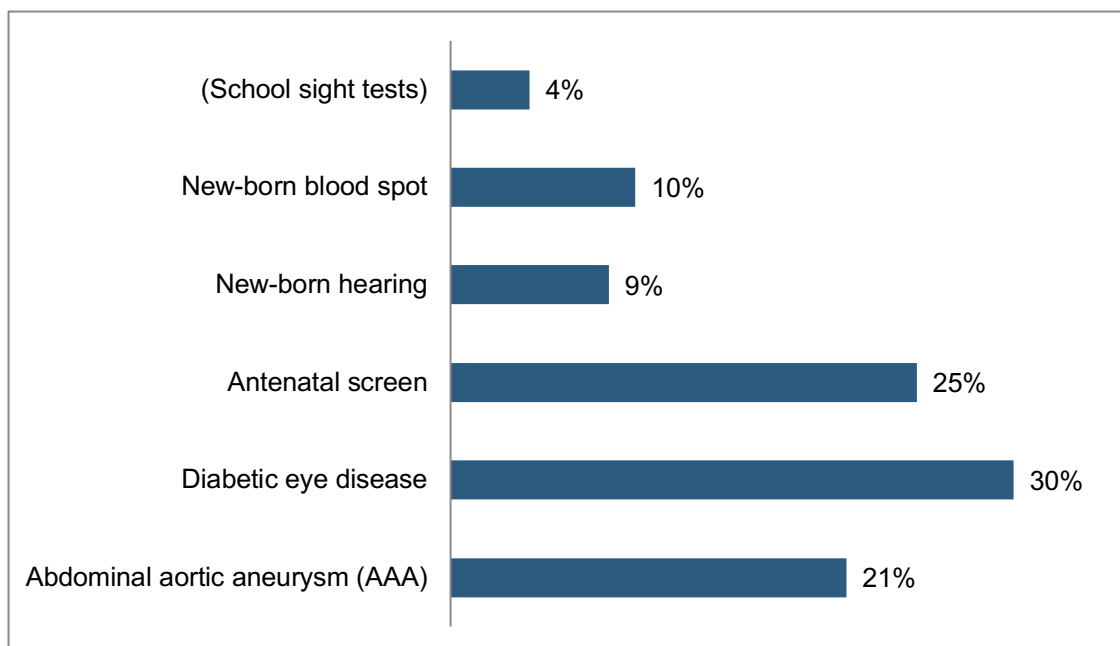
Equity of uptake (age, sex, deprivation, area) — 27%

Outbreak reporting — 7%

Sexually transmitted infection prevalence — 5%

Healthcare associated infection prevalence — 4%

Hepatitis prevalence — 2%

Childhood scheduled vaccination uptake — 30%

Flu vaccination uptake — 26%

4.4 MENTAL (ILL) HEALTH & WELL-BEING

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:

Suicide and self-harm — 10%

Access to mental health services (inc. tier 0) — 22%

Learning disabilities — 3%

Depression & anxiety — 21%

Loneliness — 15%

Life satisfaction — 4%

Measures of mental well-being — 24%

Participant(s) noted:

- Measures of access to mental health services should include "tier zero" or community-level services.

4.5 SOCIAL CARE & CARERS

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:
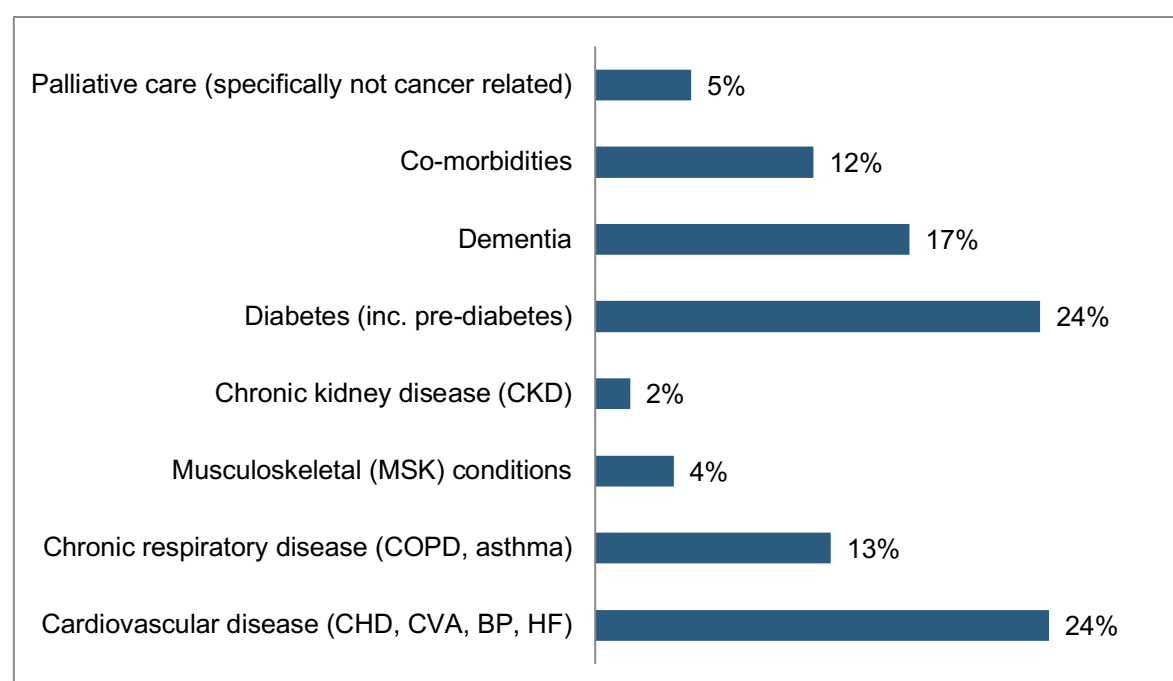
Category	Percentage
General social care info (e.g. via Daffodil)	9%
Carer needs	22%
Persons in care homes (residential)	8%
Persons in care homes (nursing)	13%
Persons receiving home care (paid or unpaid)	21%
Persons providing unpaid care / on register	27%

Note that there was not the opportunity to explore what types of data participants felt would describe carer needs.

4.6 FRAILTY

Although not unique to older age, the prevalence of frailty is strongly correlated with various long-term conditions and sensory impairment in particular. Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:
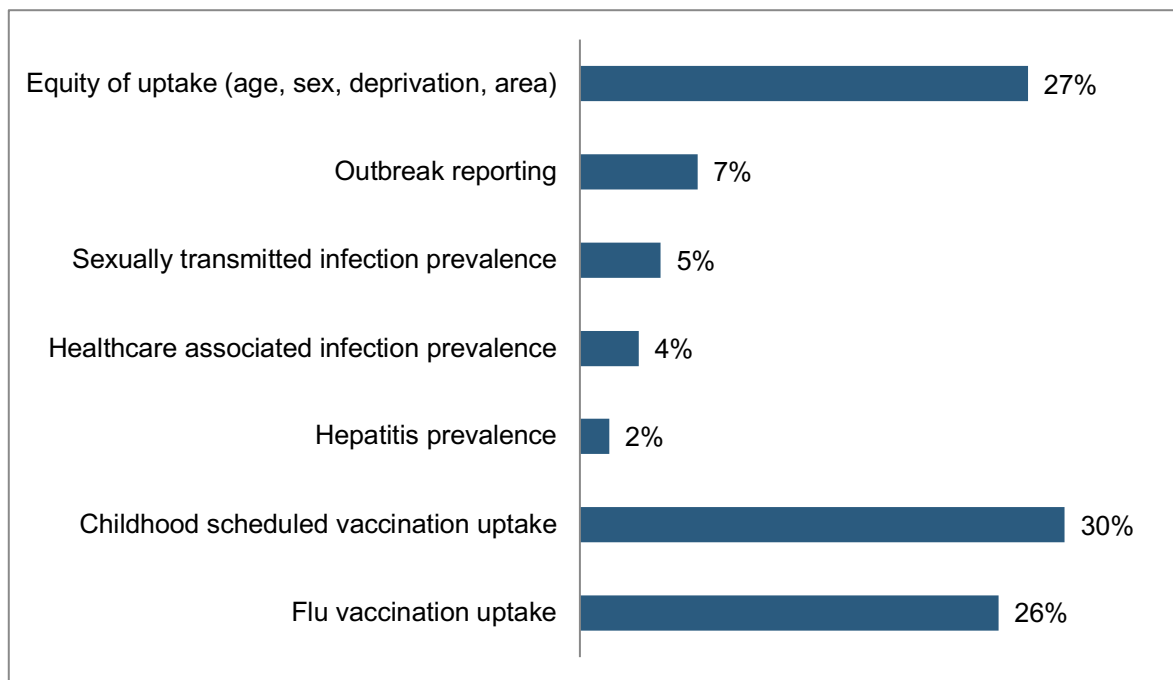
Frailty score	20%
Pressure ulcer incidence	2%
Social isolation / carers	29%
Frailty-linked condition prevalence	18%
Falls prevention uptake	10%
Injury from falls / hip fracture	21%

4.7 SENSORY IMPAIRMENT
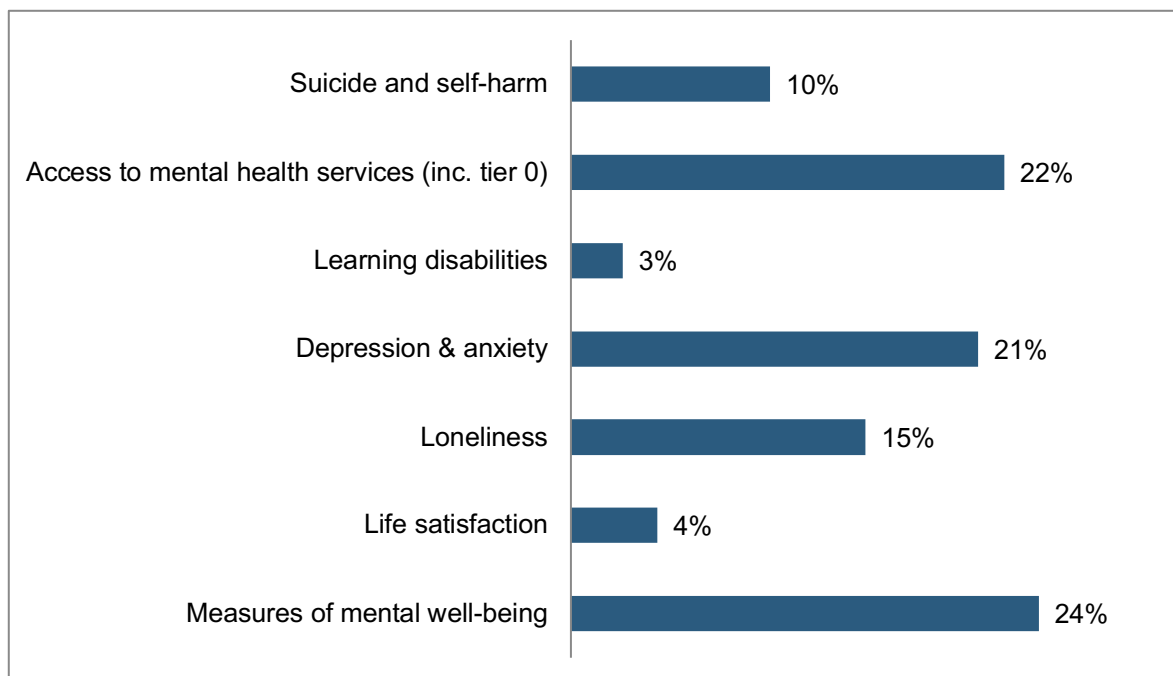
Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:

Accessibility of health information	16%
Hearing health pathway access	12%
Hearing health status (e.g. prevalence)	20%
Eye health pathway access	20%
Eye health status (e.g. prevalence)	32%
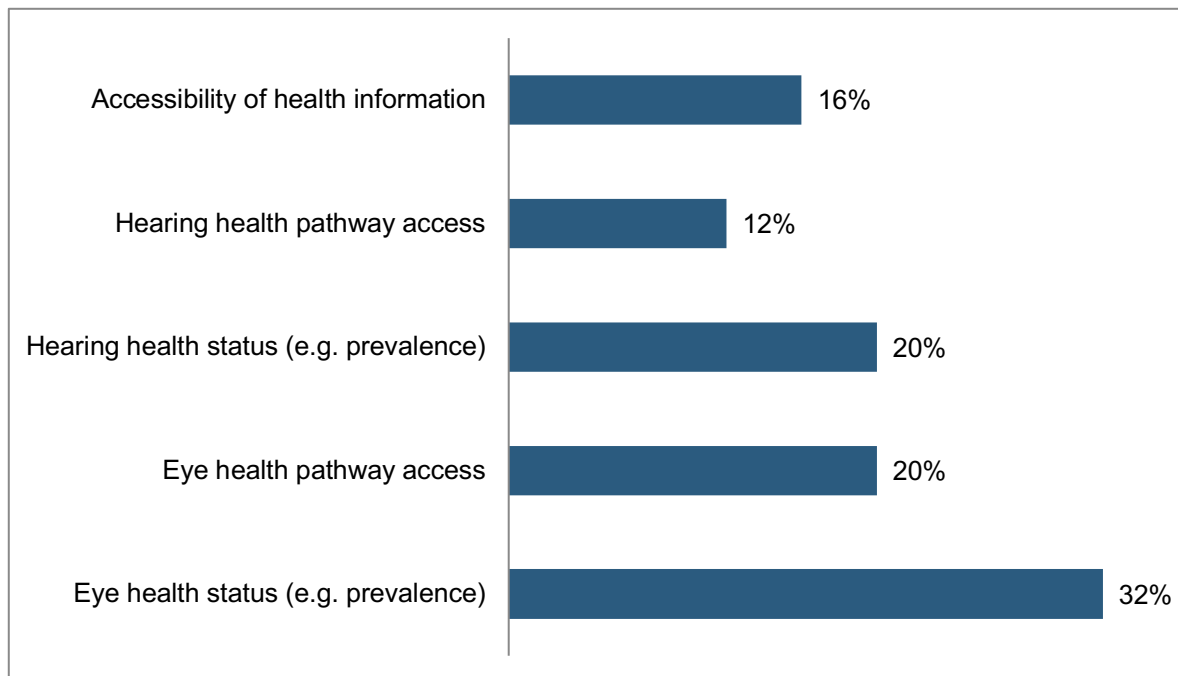
4.8 ORAL HEALTH

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:
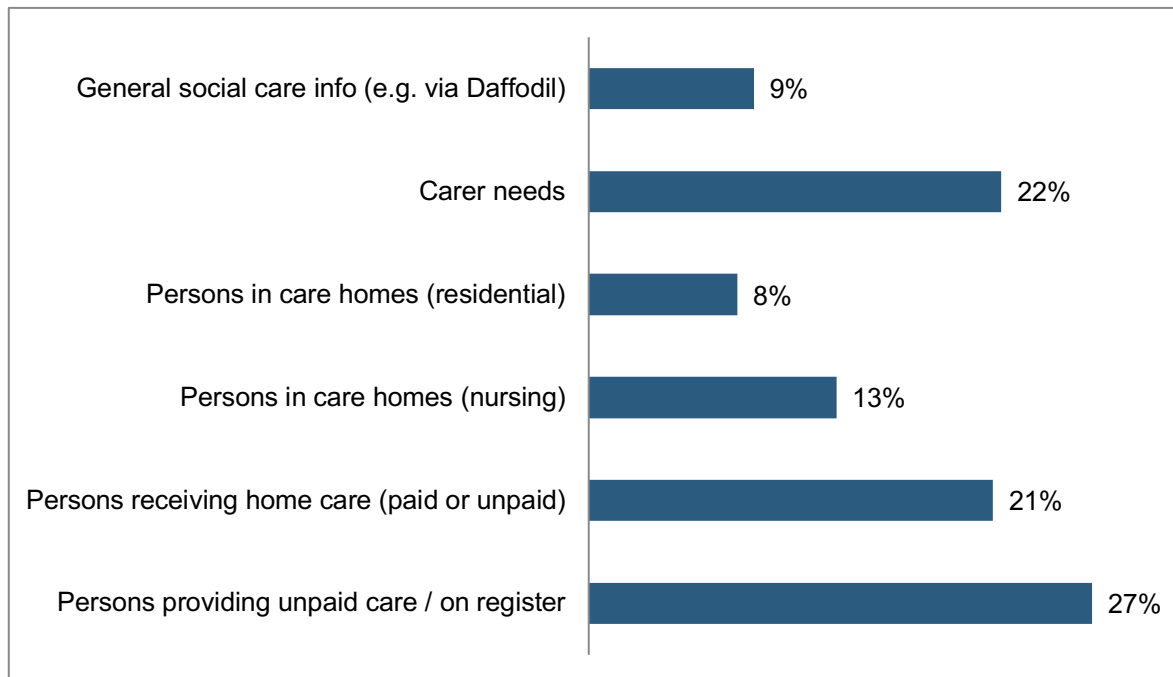
Category	Percentage
Extractions / GAs in children	15%
Measure of preventative intervention	15%
Oral cancers	13%
Dentures	1%
Dental access	23%
Oral health status (e.g. DMFT)	34%

4.9 HEALTH ACROSS THE LIFE COURSE

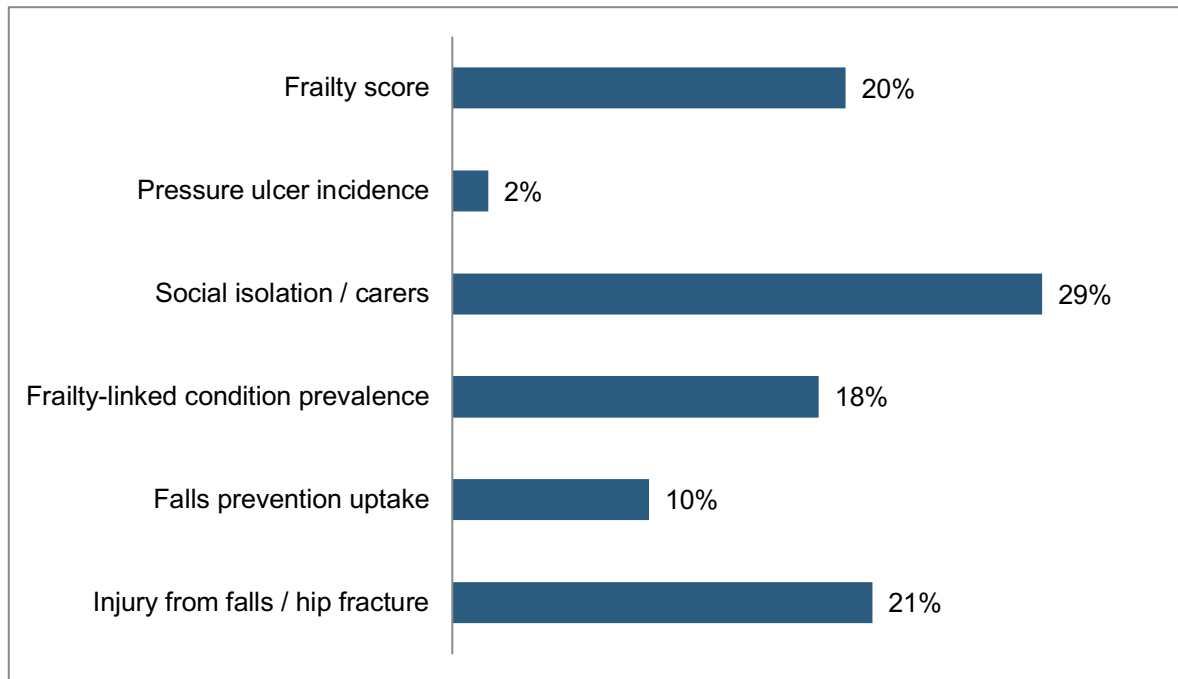### 4.9.1 HEALTH ISSUES AMONG CHILDREN (INCLUDING PREGNANCY)

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:

Single parents	2%
Toilet training at reception age	0%
School readiness	11%
Antenatal care	11%
Perinatal care	4%
Prenatal care	3%
Safeguarding issues	21%
Adverse childhood events (ACEs)	32%
Breast feeding	16%

4.9.2 HEALTH ISSUES AMONG YOUNG PEOPLE

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:

Obesity	21%
Smoking	20%
Substance misuse	15%
Abortions	2%
Teenage conceptions	12%
Transition from child to adulthood issues	12%
Safeguarding issues	18%

Participant(s) noted:

- Self-harm is an important issue not on the list for voting.

4.9.3 HEALTH ISSUES AMONG PEOPLE OF WORKING AGE

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:
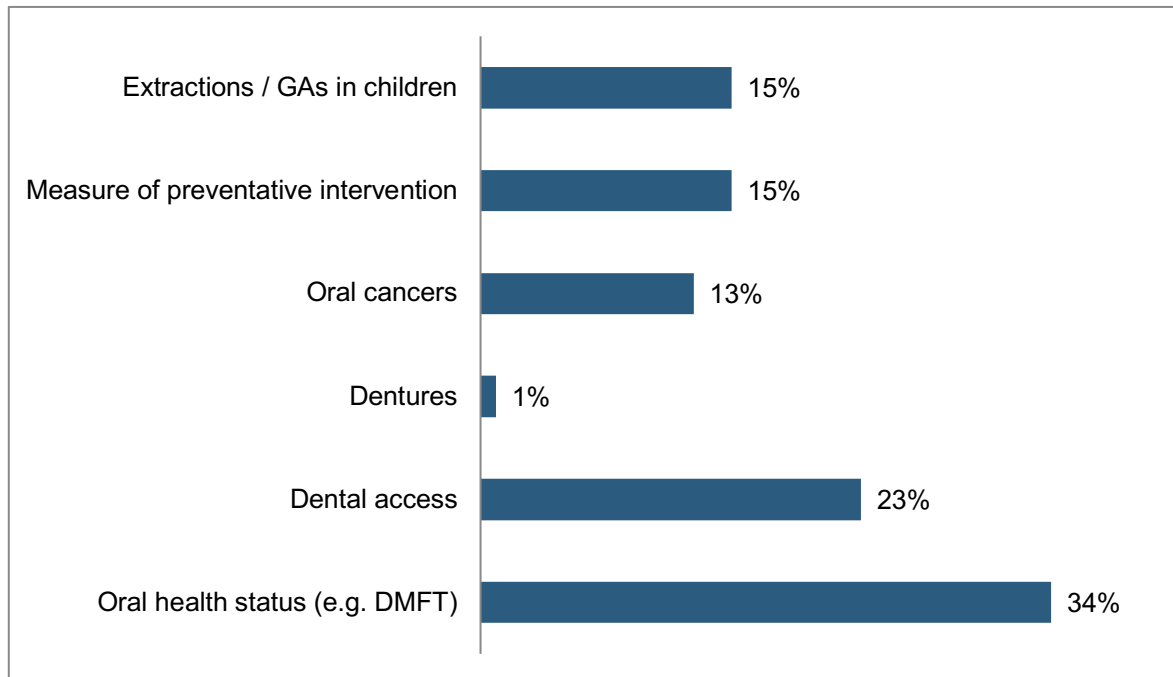

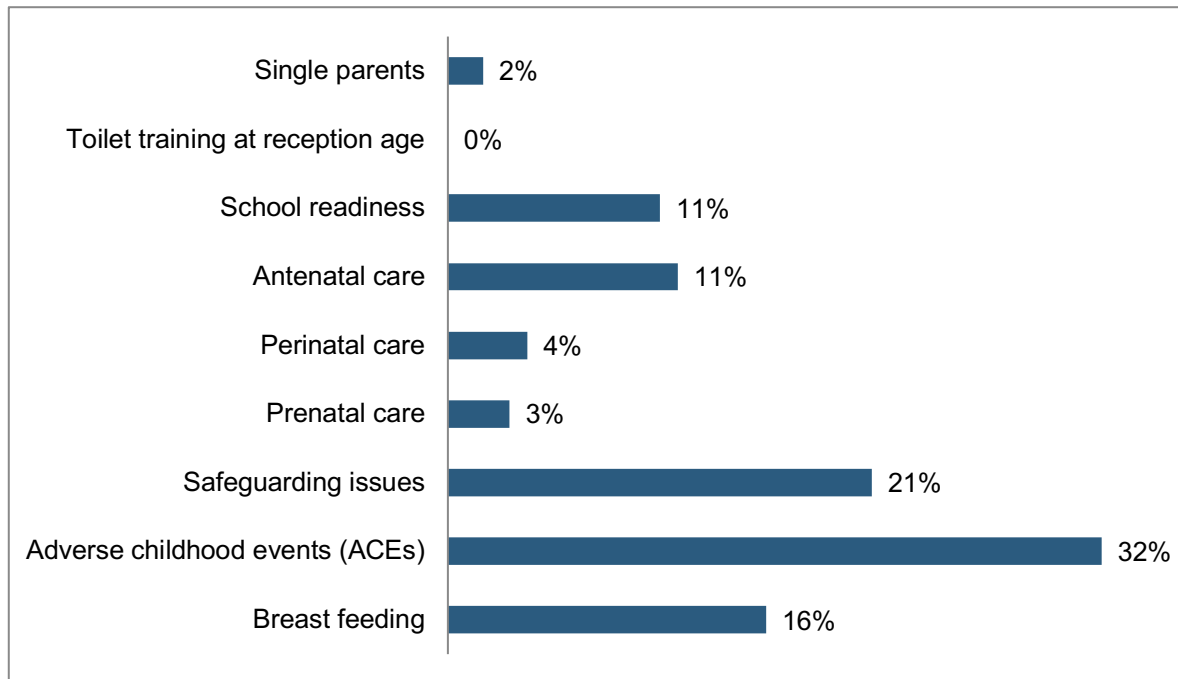### 4.9.4 HEALTH ISSUES AMONG OLDER PEOPLE

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:

Category	Percentage
Hypertension	14%
Smoking	8%
Nutrition	4%
Frailty/risk register	21%
Medication reviews undertaken	5%
Social isolation	25%
Urinary tract infection (UTI)	3%
Change in frequency of attendance	7%
Safeguarding issues	12%
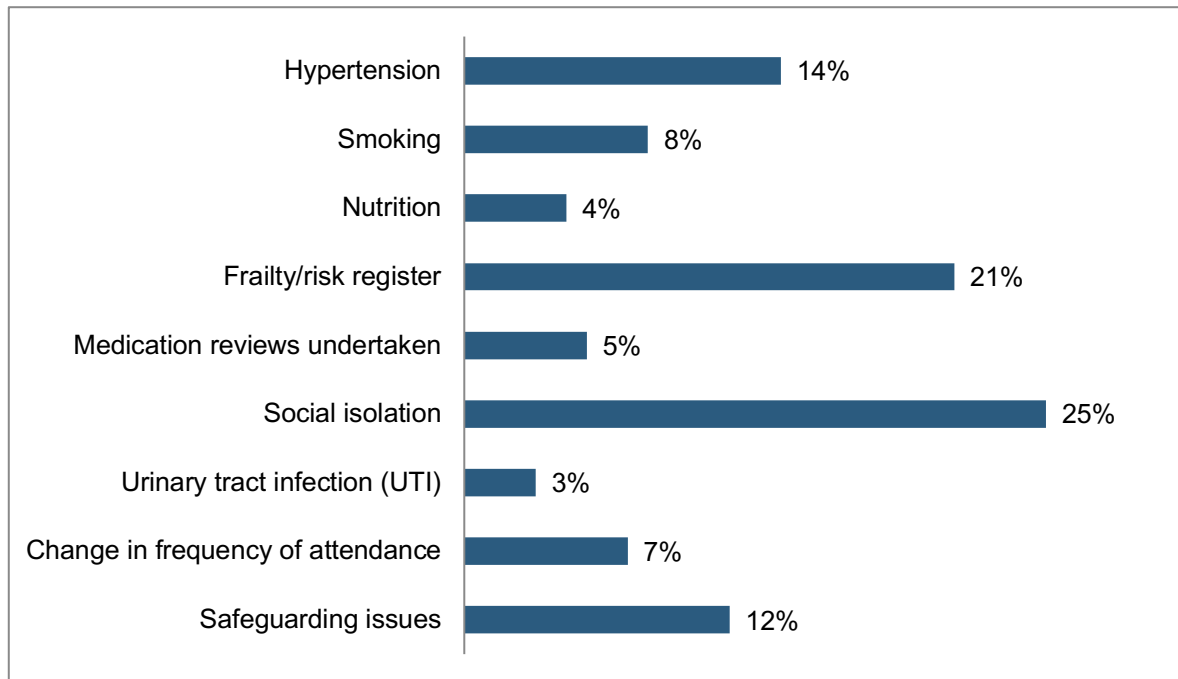
Participant(s) noted:

- Social isolation is important but not unique to older age groups.

4.10 MEASURES OF HEALTHCARE DEMAND

4.10.1 SECONDARY CARE UTILISATION

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:
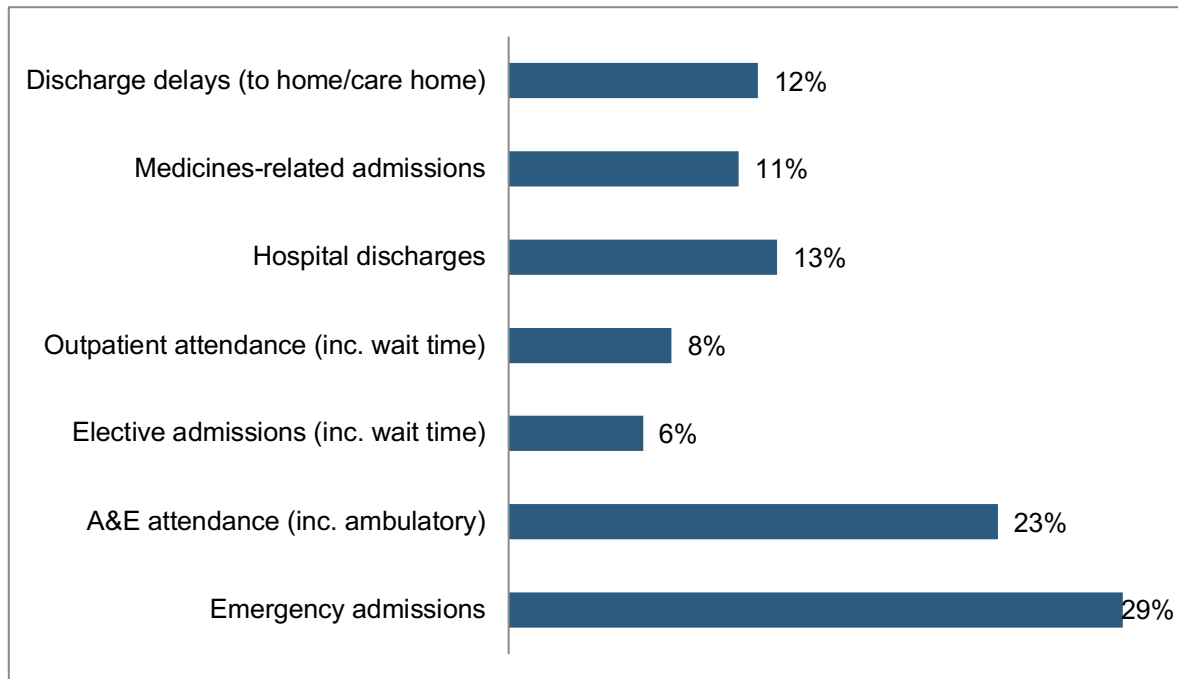
Participant(s) noted:

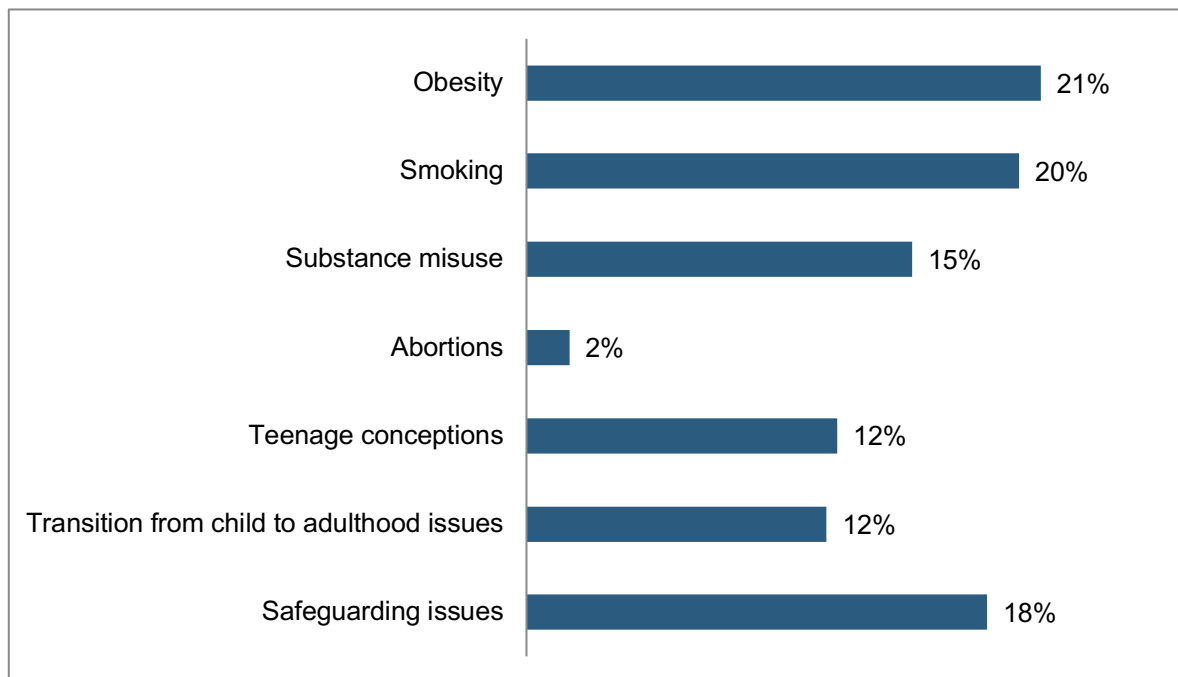- The listed measures of secondary care demand are all important, so it is hard to rank them.

4.10.2 GENERAL MEDICAL PRACTICE UTILISATION

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:
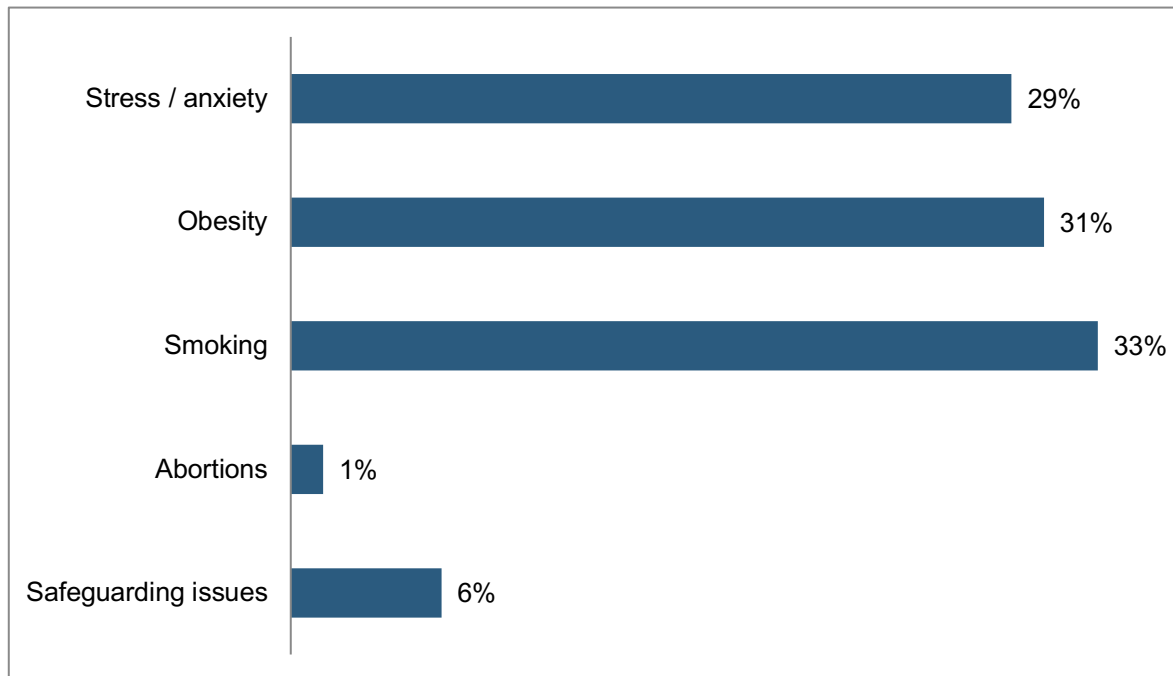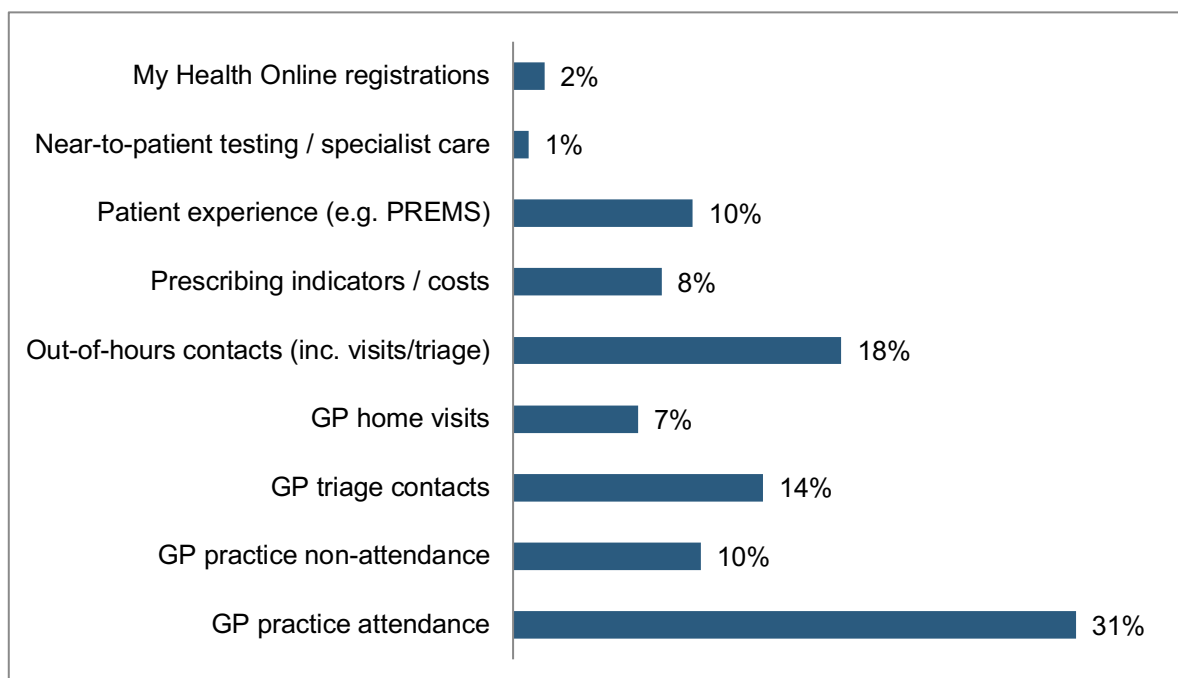
Participant(s) noted:

- Medication reviews are not the right measure for prescribing activity, but there is need for an indicator that a cluster is an outlier in terms of use of medicines.
- GP attendance: need to be able to evidence demand

4.10.3 WIDER PRIMARY CARE UTILISATION

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:
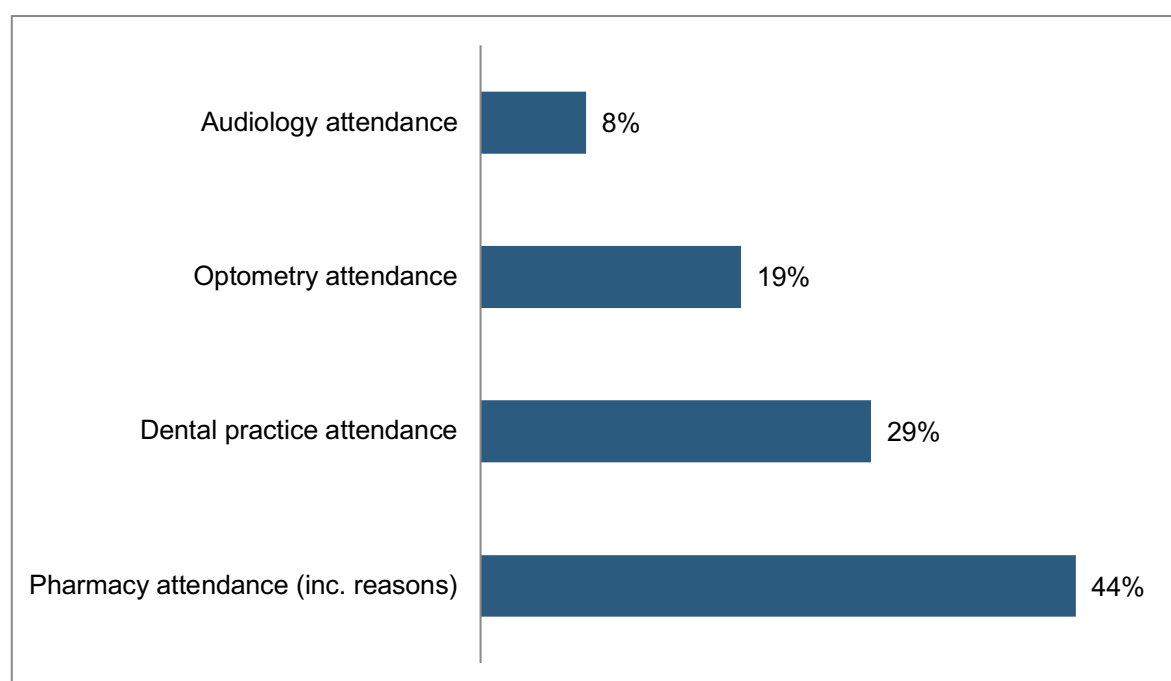
Participant(s) noted:

- Data on reasons for attendance in wider primary care settings are likely to be less developed than for GP contacts.

4.11 EQUITY OF HEALTHCARE ACCESS & OUTCOMES

Inequalities are observed as social differences in health status (e.g. in disability-free life expectancy) or in access to the determinants of health (e.g. in education attainment). Because many inequalities are also unjust and avoidable, they are sometimes referred to interchangeably as health inequities. Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:

By ethnicity	7%
By age band & sex	24%
By deprivation status (WIMD)	39%
By geography (or cluster)	30%

4.12 INFLUENCING THE WIDER DETERMINANTS OF HEALTH

The *determinants* of health are broader, population-level influences on health and well-being (as opposed to the *causes* of ill health, which tend to be visible on an individual basis). Workshop participants were reminded of this relationship via the following diagram during the opening presentation and in the topic "primer" on tables:
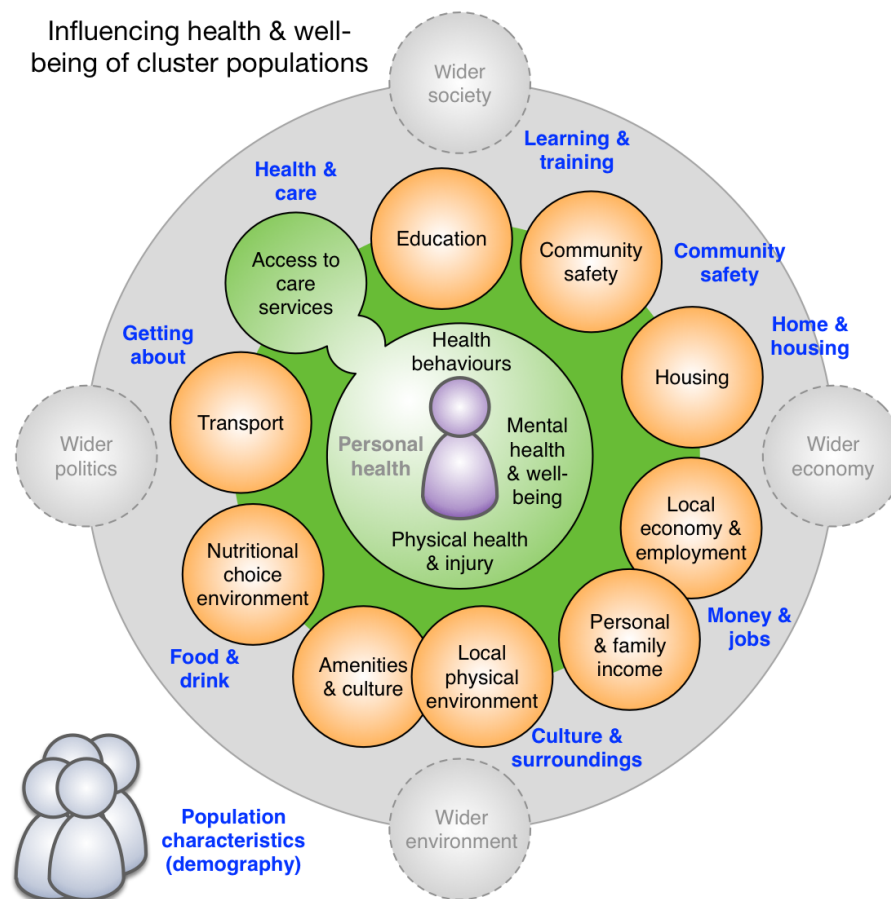
Influencing health & well-being of cluster populations

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:
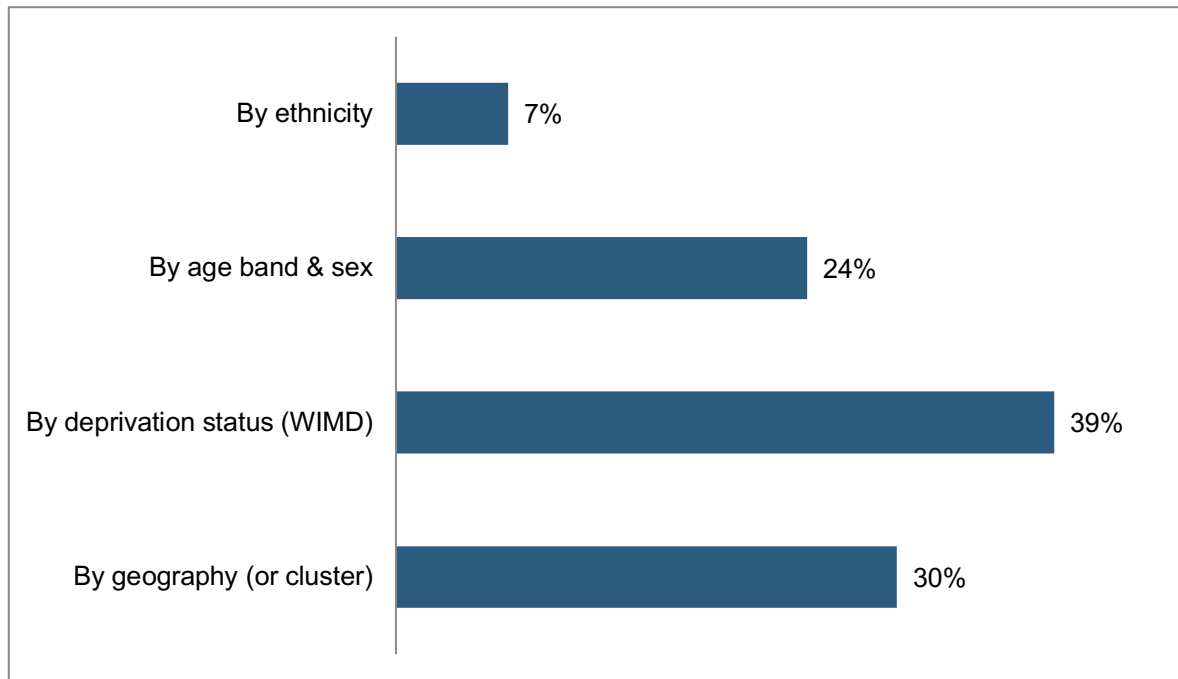

Category	Percentage
Getting about (e.g. car access)	7%
Food & drink (e.g. licensing)	6%
Culture & surroundings (e.g. green space)	3%
Money & jobs (e.g. benefit entitlement)	18%
Home & housing (e.g. single occupancy)	18%
Community (e.g. cohesion/resilience)	14%
Community safety (e.g. violent crime)	3%
Education & training (e.g. health literacy, NEET)	29%

Participant(s) noted:

- Education is the most popular determinant because clusters need to support behaviour change/ make access to behaviour change support more accessible; this links to prudent public concept.
- Are clusters able to identify opportunities for working with schools?
- "Sphere of influence" is important; at what level can something (e.g. wider determinants) be changed?
- The wider determinants are "bread & butter" s they support community development.

4.13 MISCELLANEOUS TOPICS FOR POTENTIAL INCLUSION

Participants were presented with the question "Information on which of the following would be most important to CPNA? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:
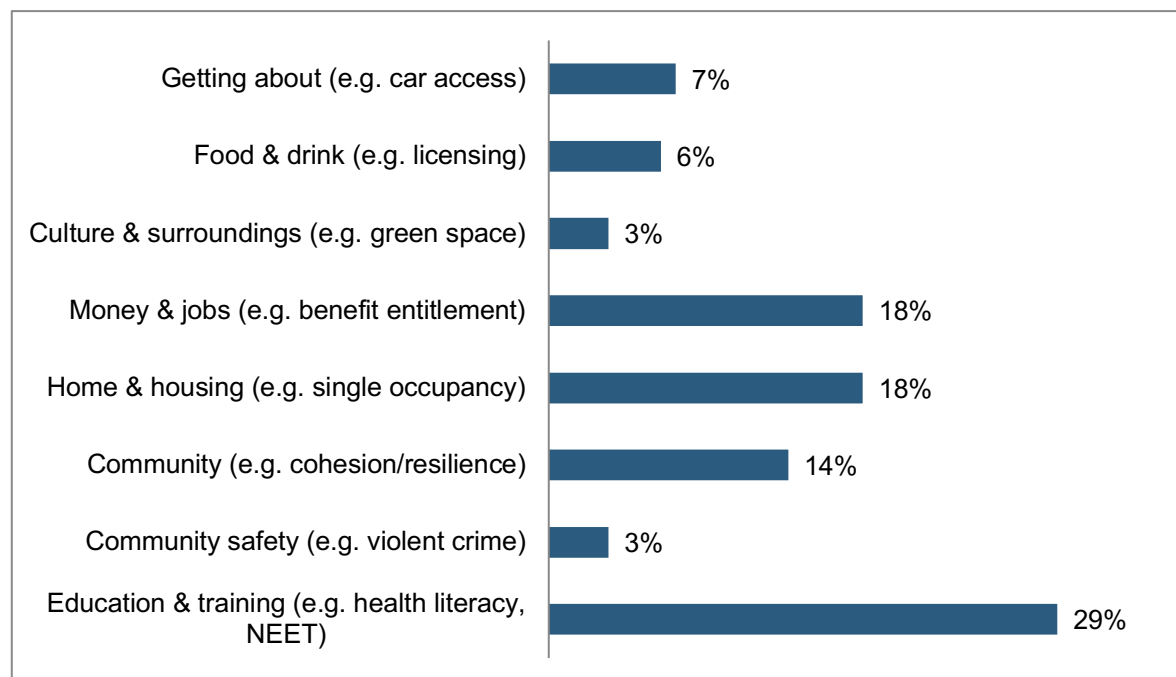
Topic	Percentage
Measure of sustainability	25%
Data linking referral, attendance, and outcome	32%
Awareness of prudent h/c principals	7%
Euthanasia	4%
Domestic violence	33%
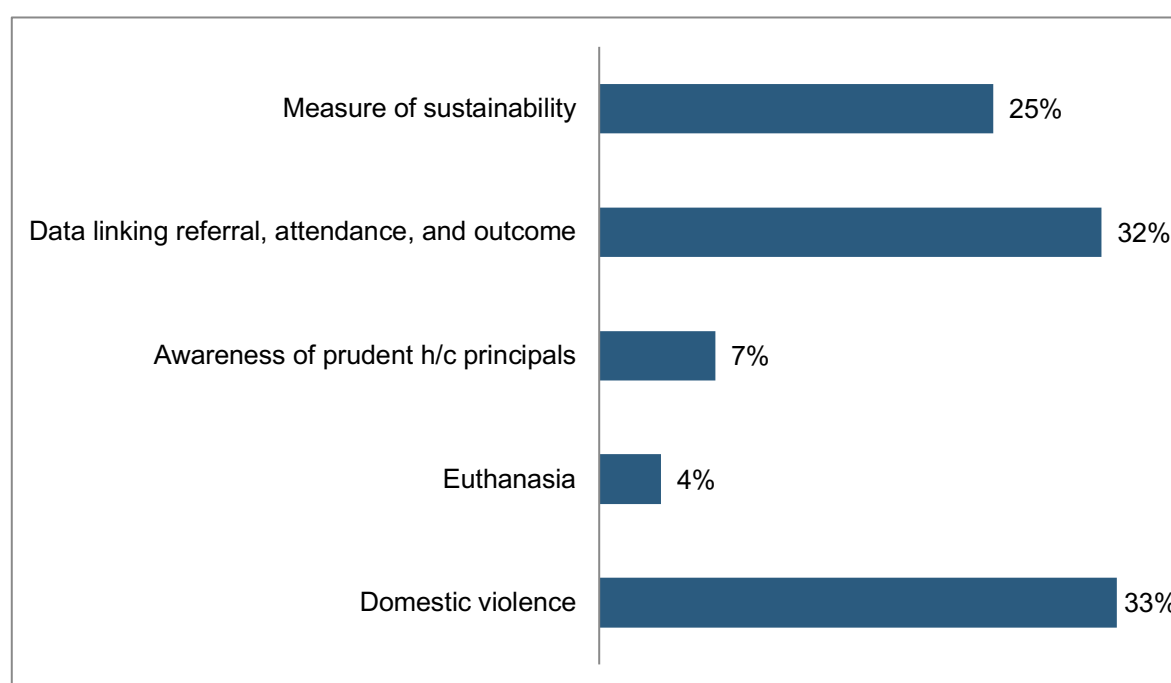
Participant(s) noted:

- It was not clear exactly what the captured participant topic suggestion of "data linking referral, attendance, and outcome" referred to.

Note that data on domestic violence might be reportable in relation to ACEs as a recognised risk factor. While interest in measures of primary care sustainability is understandable, this would not provide commentary on local population health needs.

5. VIEWS ON FUNCTIONALITY ASPECTS OF A SOLUTION SPECIFICATION

5.1 PRIMARY PURPOSE OF NEEDS ASSESSMENT

Participants were presented with the question "What is the primary purpose of cluster-level needs assessment? (Select each important option)" and voted as follows across two voting screens:
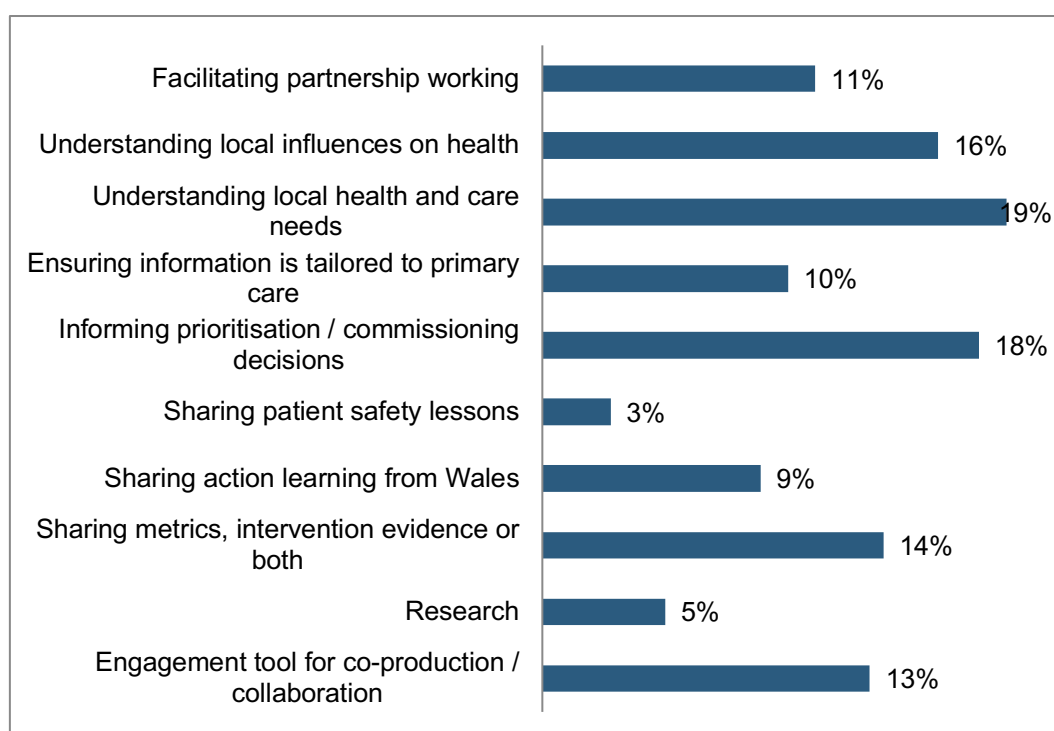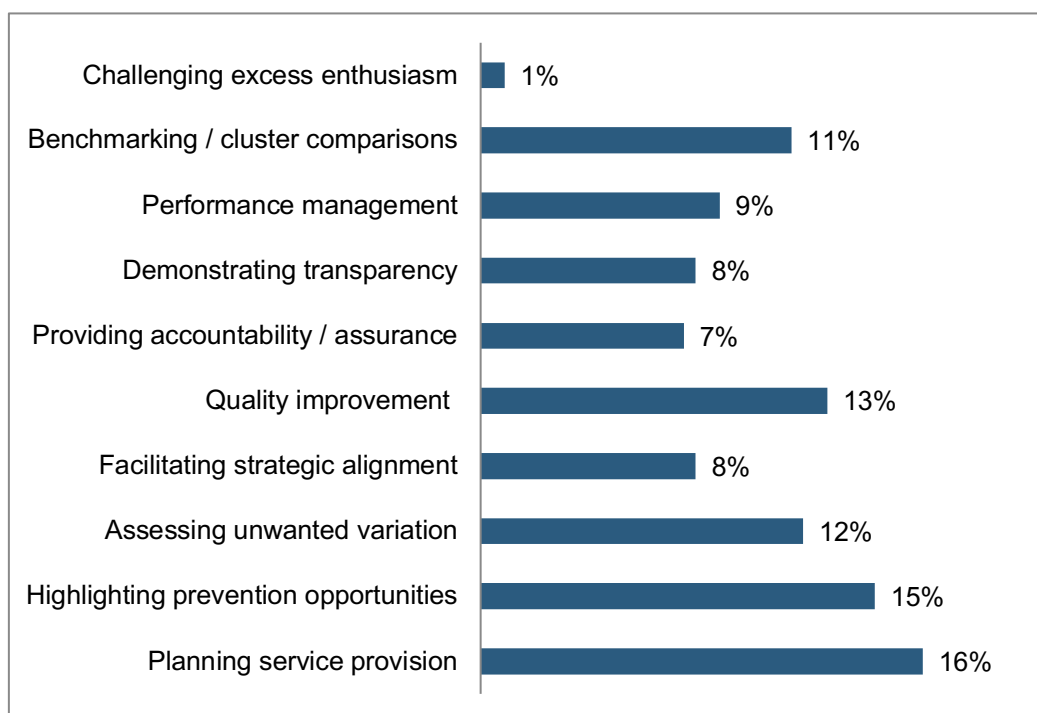
Participant(s) noted:

- Prioritising action is a key purpose but "It's difficult to get money for good ideas".
- Information about patient safety lessons might constitute duplication, since systems already exist to share these [this point was also contested].

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Key message

There is a lack of consensus on the primary purpose of cluster-level needs assessment. Although 20 potential primary purposes were identified (& many are inter-related), the more popular suggestions were understanding local health and care needs; informing prioritisation/ commissioning decisions; planning service provision; understanding local influences on health; and highlighting prevention opportunities.

Implication

This lack of consensus may relate to an apparent lack of stakeholder clarity on the role of clusters in planning for health improvement (Annex B). Some consensus on *primary* purpose will be required to ensure needs assessment is able to deliver what is needed.

</div>

5.2 NEEDS ASSESSMENT AUDIENCE

5.2.1 PRIMARY AUDIENCE

Participants were presented with the question "Who are the primary audience for utilising cluster-level needs assessment? (Select each important option)" and voted as follows:

Audience	Percentage
Public	4%
Cluster patients	4%
3rd sector partners	7%
Partnership boards (e.g. PSB, RPB)	12%
Welsh Government	12%
Health boards / NHS Trusts	25%
All primary care professionals within the cluster	27%
All GPs within the cluster	10%
Cluster leads only	5%
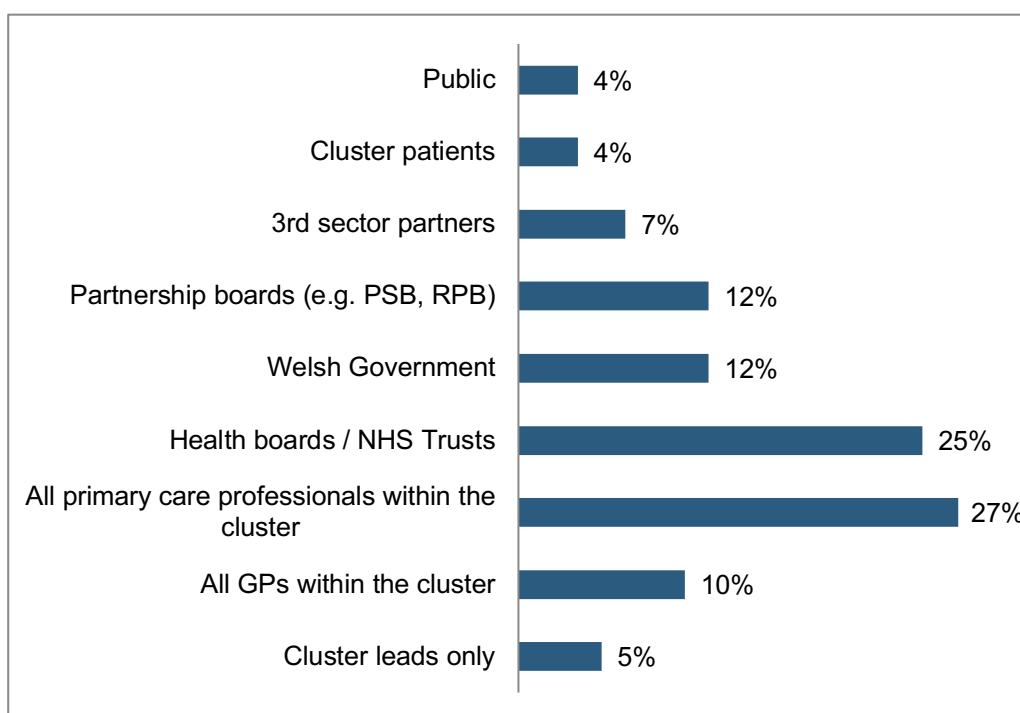
Participant(s) noted:

- The primary audience must be wider than cluster leads, as decisions should be made by the cluster, not the lead alone.
- "All primary care professionals within the cluster" should read "all those engaged within the cluster".
- An additional audience could be a National Management Board for Primary Care [this organisation does not currently exist].
- The time constraints barrier for cluster leads & other cluster participants needs highlighting, as there is little resource within the cluster to act on the data.

5.2.2 WIDER AUDIENCE

Participants were presented with the question "Who should have sight of cluster-level needs assessment? (Select each important option)" and voted as follows:

Category	Percentage
Public	10%
Cluster patients	11%
3rd sector partners	11%
Partnership boards (e.g. PSB, RPB)	13%
Welsh Government	13%
Health boards / NHS Trusts	15%
All primary care professionals within the cluster	15%
All GPs within the cluster	8%
Cluster leads only	3%
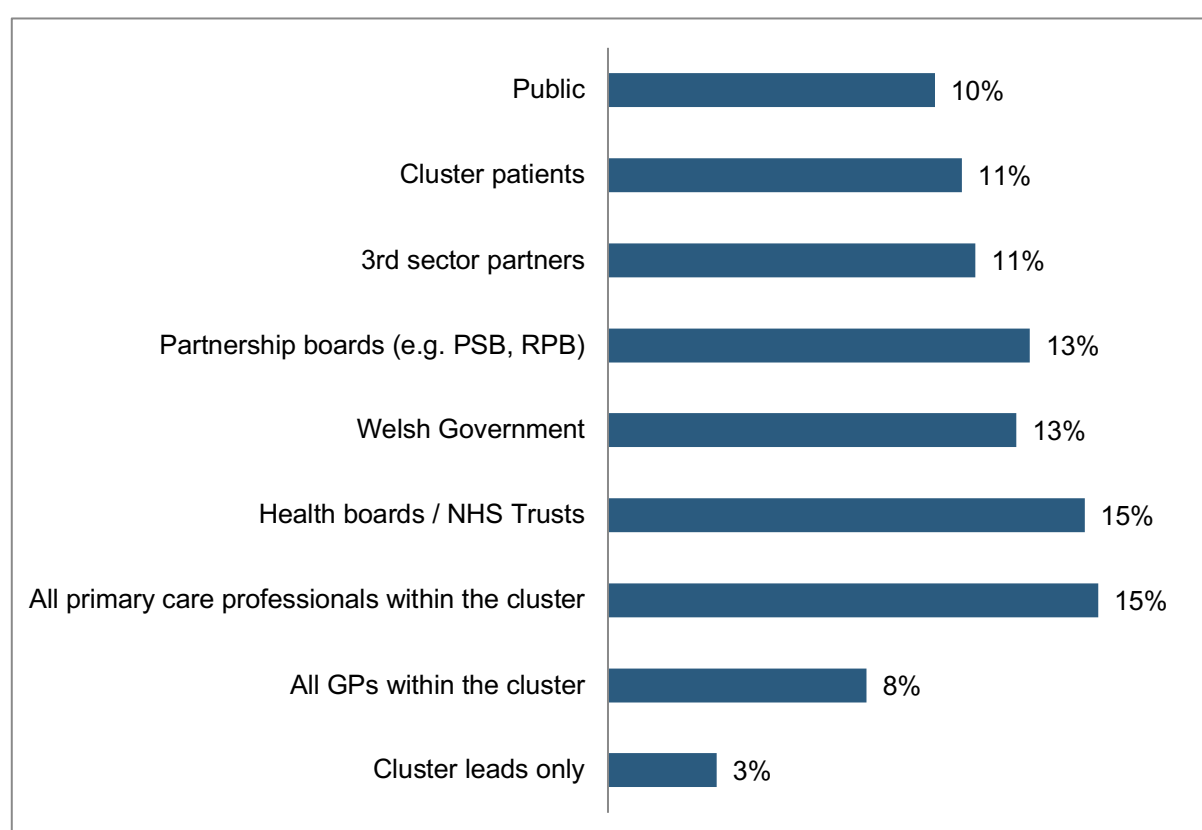
Participant(s) noted:

- Wider audiences may need tailored views on the data.
- The wider audience needs to include sight by private sector partners.

Key messages (5.2.1–5.2.2)

Participants felt that the primary audience for utilising cluster needs assessment was all those engaged within the cluster itself and health board staff. It was recognised that a much wider audience should have sight of the assessment.

Implication

A preferred solution may need to incorporate differing levels of access and/ or "windows" on the needs assessment content for a variety of reasons.

Key message

Significant concerns were repeatedly expressed during the workshops over cluster capacity to absorb and act on needs assessments.

Implication

In deciding how best to procced with primary care needs assessment, consideration will need to be given to providing mitigation of cluster capacity concerns.

5.3 SOLUTION COMPONENTS

5.3.1 GENERAL ELEMENTS

The first workshop had explained that traditionally health needs assessment (HNA) can involve one or more of three approaches. An epidemiological approach seeks to 'triangulate' incidence & prevalence, (cost-)effectiveness and baseline services. The comparative approach compares local services +/- routine health data with that of similar populations. A corporate approach seeks views on need, supply & demand. Most HNAs are a pragmatic blend of these three approaches, and some will also take account of community assets—focusing on the things you have, rather than what you don't have, to improve local health and well-being.

Participants were presented with the question "Which components of cluster needs assessment are best coordinated once (All-Wales) & well? (Select each important option)" and voted as follows:

Category	Percentage
Interpretation/ implications for service redesign	13%
Sharing what works/ implementation lessons	15%
Evidence on effective intervention options	15%
Drivers for change (e.g. NICE, Gov. policy)	13%
Utility of local assets (e.g. cooking class)	4%
Corporate perspectives (e.g. patient voice)	8%
Comparative metrics (e.g. referral rates)	15%
Epidemiology (e.g. demographics, prevalence)	17%
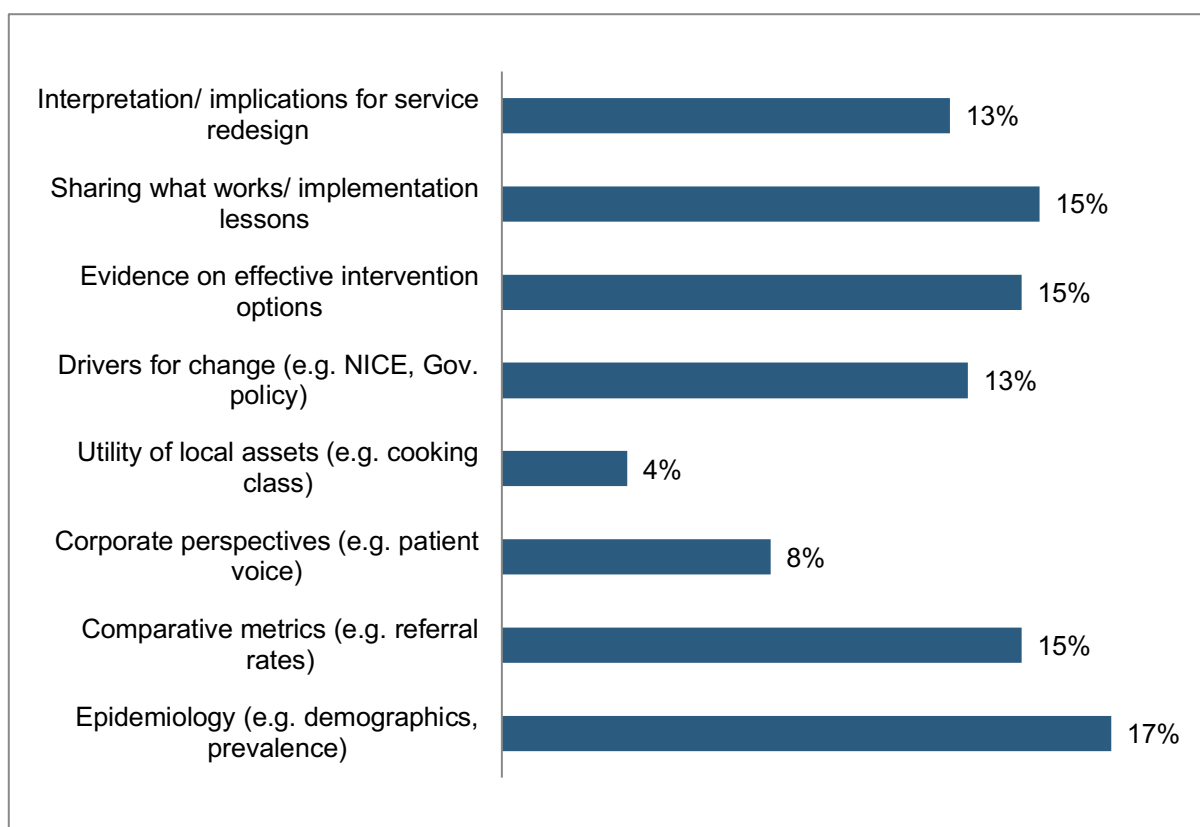
Participant(s) noted:

- Capturing the corporate perspective would be too hard on a once-for-Wales basis.

5.3.2 PRACTICALITY OF INCLUDING NON-CLINICAL COMMUNITY ASSETS

Given the recent resurgence of interest in social prescribing, it was felt a little more attention to community asset mapping/ collation was warranted. Thus, participants were presented with the question "Is it appropriate and practical to include information about non-clinical local assets (e.g. for social prescribing) in a once-for-Wales CPNA template? (Select one option)" and voted as follows:
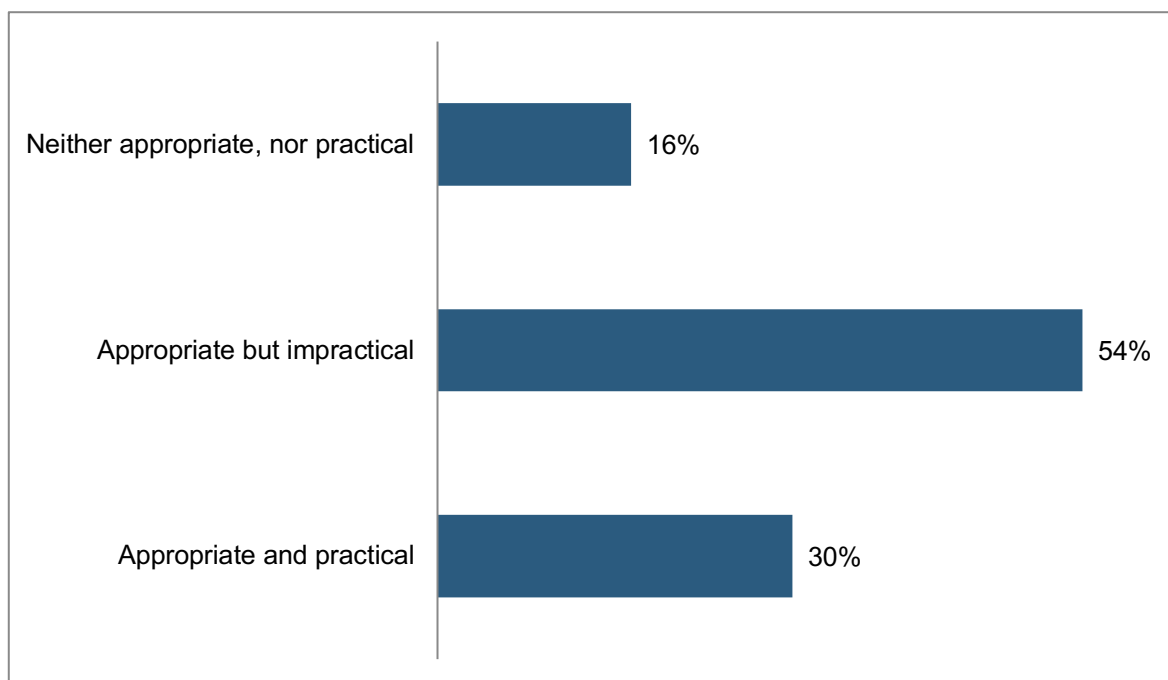
Participant(s) noted:

- Collating local assets is a separate project—too large for incorporation into CPNA.
- Community assets are not organised by cluster, but it makes sense to collate some data at national/ regional level and allow input to this from local level i.e. some sort of coordination/ curator role is needed.

Key messages (5.3.1–5.3.2)

Participants de-emphasised national approaches to information about local assets and incorporation of the patient voice on local primary care services. While considered desirable, a once-for-Wales approach to collating local non-clinical assets was felt to be impractical.

Implication

Corporate and asset-based components of local needs assessment would be best coordinated locally. However, this need not preclude a national steer on options/ tools for effecting this.

5.3.3 SOLUTION NAME

Participants were presented with the question "What should an all-Wales CPNA be called? (Select one option)" and voted as follows:

Feature	Percentage
Cluster Population Information for Planning (CPIP)	26%
Cluster Population Needs Profile (CPNP)	26%
Cluster Population Needs Assessment (CPNA)	13%
Primary Care Needs Assessment (PCNA)	18%
Clear Review of Authority Profile (CRAP)	3%
Cluster Well-being Assessment (CWBA)	13%

5.4 GENERAL SOLUTION FEATURES

Participants were presented with the question "Which features should be included in cluster-level needs assessment? (Select each important option)" and voted as follows across four voting screens:

Community perspective on needs — 12%
Info on intervention cost / RoI — 10%
Evidence on priority areas — 12%
Data on priority areas — 15%
Signposting to services / care navigators — 11%
Facility to record public health discussion — 7%
Facility to record cluster-level discussion — 8%
Export functions — 10%
Intuitive, simple, designed for end-user — 15%

'Easy read' public view vs professional view — 14%
Single point of access for all audience types — 10%
Data relevant to wider partners — 10%
Data relevant to community nursing — 13%
Data relevant to optometric practices — 10%
Data relevant to community pharmacies — 14%
Data relevant to dental practices — 12%
Data relevant to GP practices — 17%

Chart 1

Category	Value
Interactive maps of services	11%
Facility to monitor the impact of previous actions	14%
Cluster-to-cluster (peer) comparison	13%
Cluster-to-cluster (any) comparison	11%
Cluster-to-Wales comparison	12%
Clarification of top (10?) issues for action	15%
Clarification of link between needs and plan	11%
Consistent format year-to-year	13%
Health professional training records	1%

Chart 2

Category	Value
Heat maps	8%
Search facility	10%
Aggregate cluster reports to area or LHB	11%
Ability to compare intervention options	11%
Meaningful measures of impact (cf. incidence)	17%
Meaningful measures of demand	15%
Sharing best practice (e.g. implementation lessons)	17%
Incorporation of complaints or compliments	3%
Sharing information as a way of building trust	7%

5.5 TIMING-RELATED FEATURES

Participants were presented with the question "Which time-related considerations are most important? (Select each important option)" and voted as follows:

Fit to the cluster planning cycle — 30%

Updates following intelligence product releases — 22%

Live (real-time) updating for ad-hoc reports — 24%

Preparation of an annual profile — 23%

Participant(s) noted:

- How often would a cluster-level needs assessment be conducted?
- Contract submission timeframes for Cluster Action Plans do not support strategic alignment with health board IMTP timeframes.

> **Key message**
>
> Participants felt it was most important that needs assessment availability was timely in relation to the cluster planning cycle.
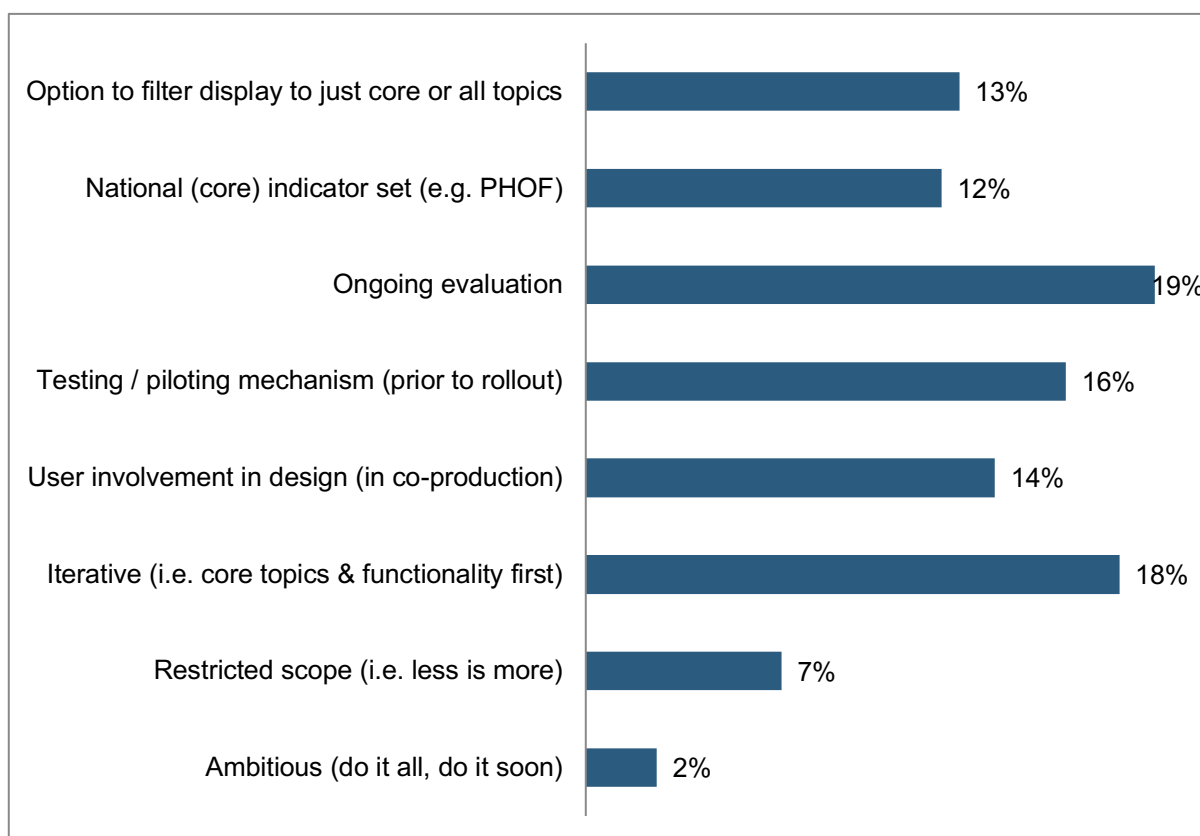>
> **Implication**
>
> This consideration may be less relevant given changes to the planning requirement in the GMS Contract for 2018/19. Questions remain over the optimal frequency for refreshing primary care needs assessments (i.e. need it be annual?) and whether there is scope to better align GMS Contract and health board IMTP key planning milestones.

5.6 IMPLEMENTATION ASPECTS

5.6.1 IMPLEMENTATION APPROACHES

Participants were presented with the question "Which approaches to implementation would be essential? (Select each important option)" and voted as follows:

| Approach	Percentage
Option to filter display to just core or all topics	13%
National (core) indicator set (e.g. PHOF)	12%
Ongoing evaluation	19%
Testing / piloting mechanism (prior to rollout)	16%
User involvement in design (in co-production)	14%
Iterative (i.e. core topics & functionality first)	18%
Restricted scope (i.e. less is more)	7%
Ambitious (do it all, do it soon)	2%

Participant(s) noted:

- The solution needs to be flexible/ able to respond to end-user feedback.
- There needs to be a mechanism for requests to add datasets as well as functionality.
- There needs to be a mechanism to challenge the validity of data presented.
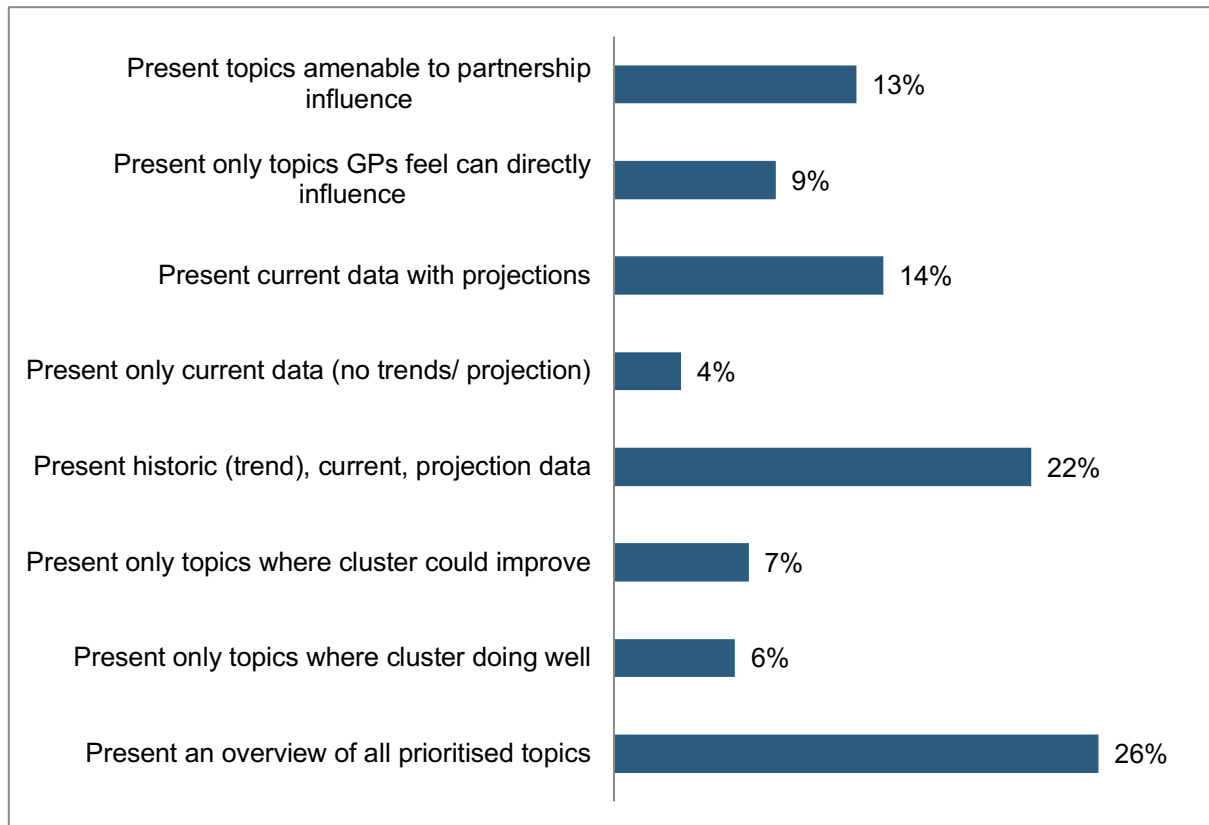
5.6.2 SOLUTION FORMAT

Participants were presented with the question "What format should standardised cluster needs assessment take? (Pick up to 3 in order of importance)" and voted via priority ranking as follows:
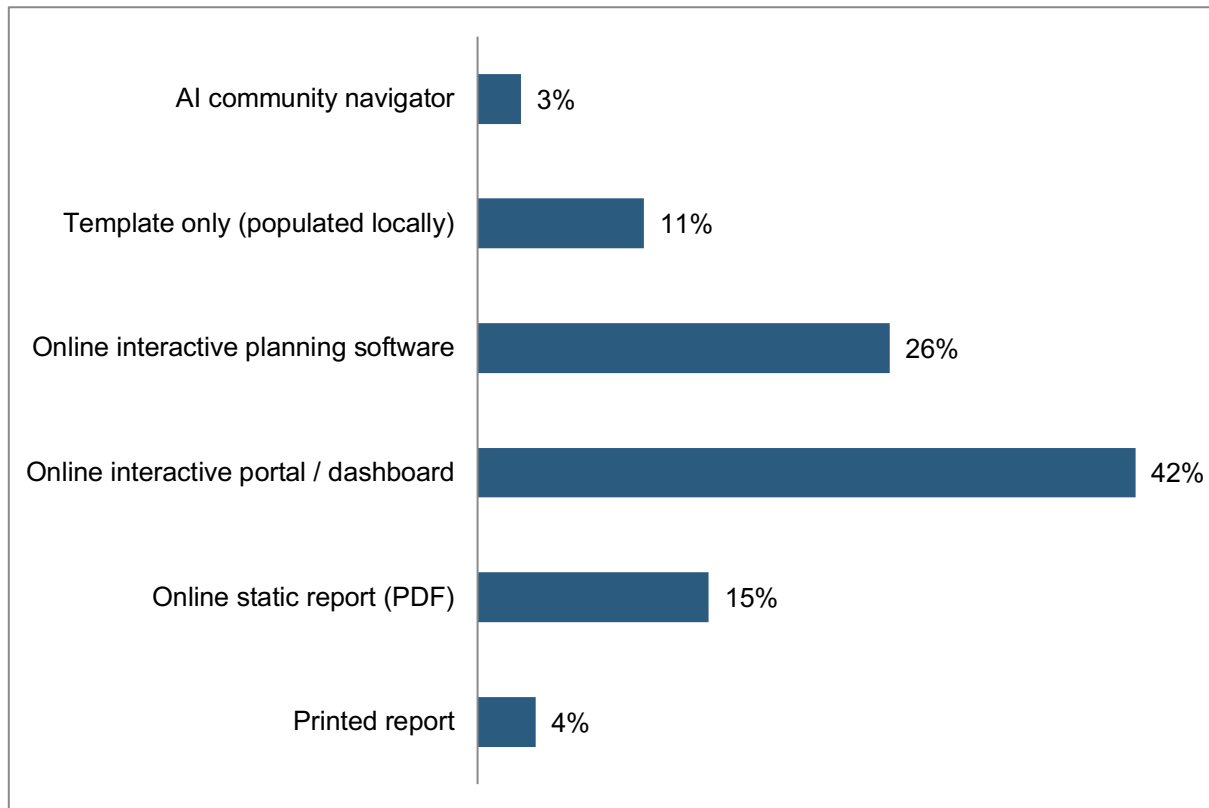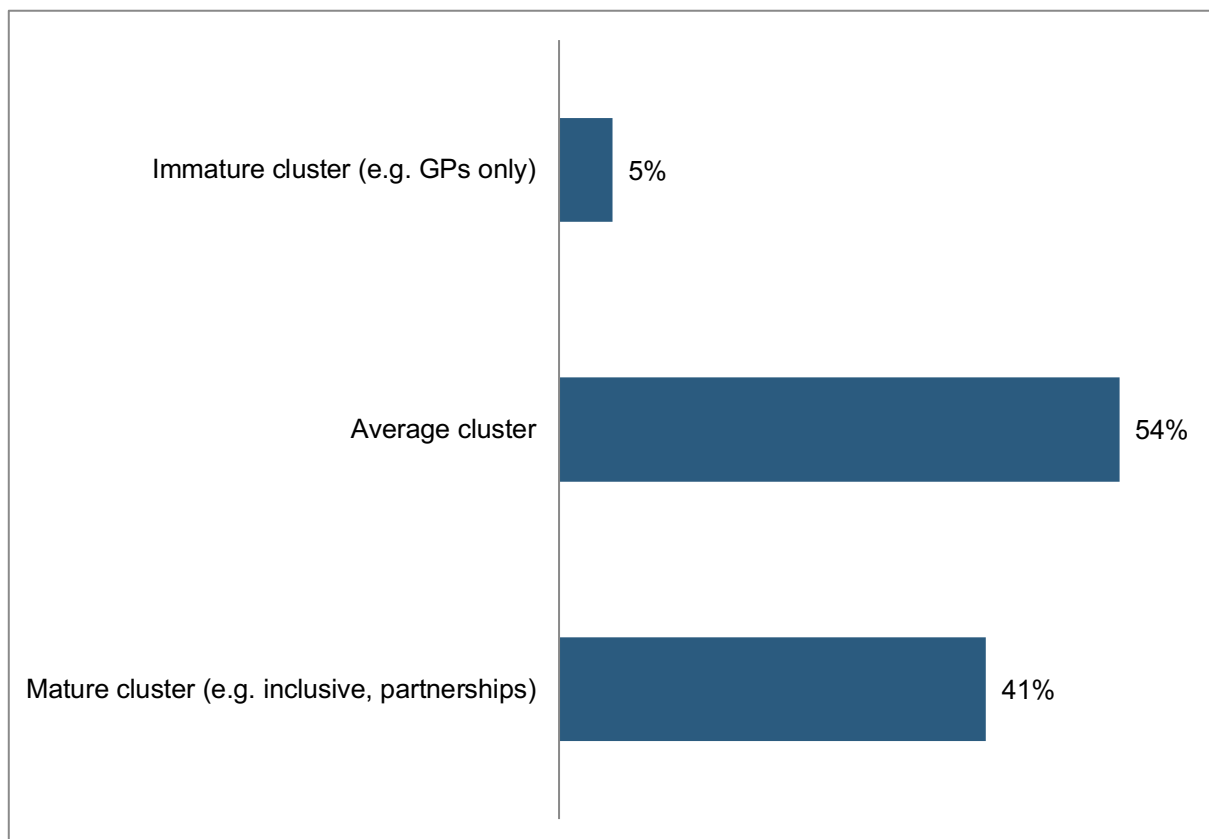

5.6.3 SOLUTION CONTENT FOCUS

Participants were presented with the question "What type of focus should the CPNA have? (Select each important option)" and voted as follows:

Present topics amenable to partnership influence	13%
Present only topics GPs feel can directly influence	9%
Present current data with projections	14%
Present only current data (no trends/ projection)	4%
Present historic (trend), current, projection data	22%
Present only topics where cluster could improve	7%
Present only topics where cluster doing well	6%
Present an overview of all prioritised topics	26%

Participants were presented with the question "If aimed at the cluster, which type of cluster is the audience? (Select one option)" and voted as follows:

Immature cluster (e.g. GPs only)	5%
Average cluster	54%
Mature cluster (e.g. inclusive, partnerships)	41%

Participant(s) noted:

- Needs assessment could be regarded as an "educational tool for the immature cluster".
- As there is no consensus on determination of cluster maturity, this is a potentially contentious question.
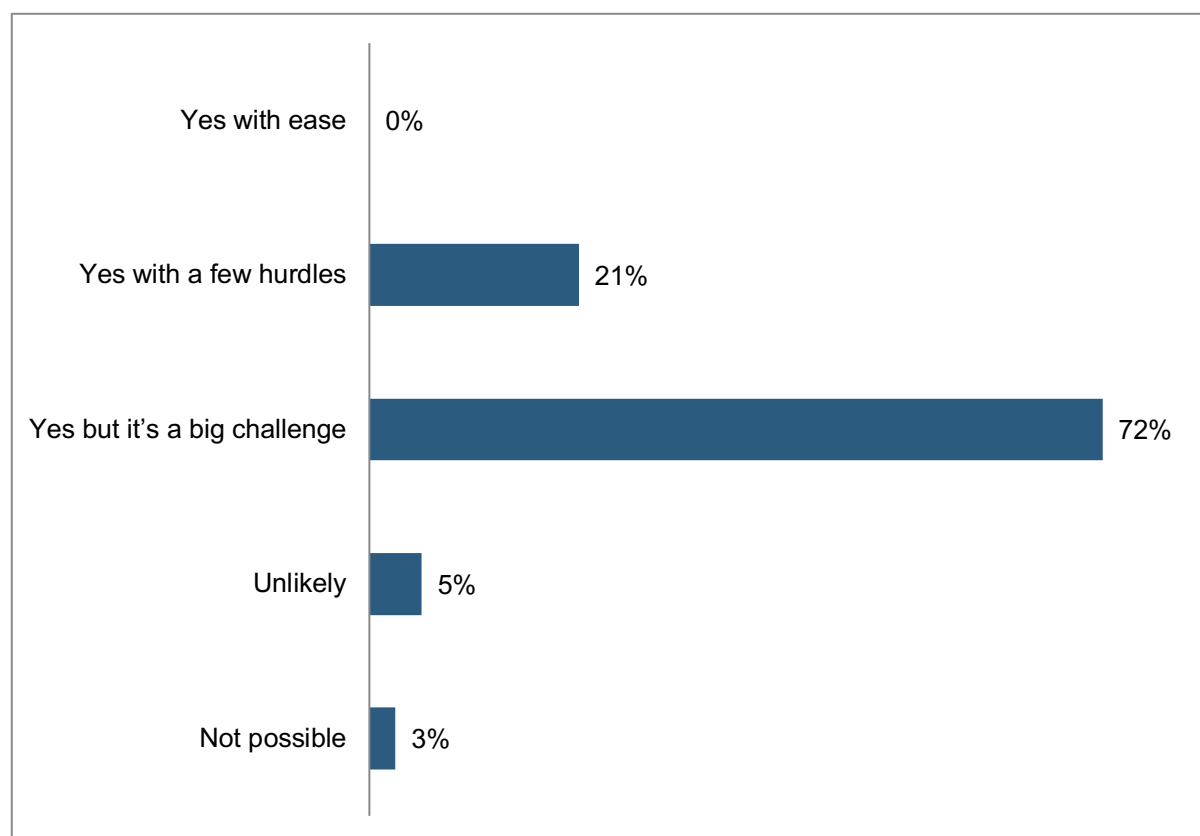
> **Key message**
>
> Participants did not feel that aiming for a "lowest common denominator" cluster had merit, with a preference for aiming for the middle ground (however defined).
>
> **Implication**
>
> There is anecdotal evidence that clusters are at differing stages of maturity, with some more than others thinking beyond healthcare to well-being, beyond the individual patient to the wider population and beyond general practice to wider primary care. All clusters could be encouraged on this journey by normalising the inclusion of more encompassing health metrics via a national template. In other words, a needs assessment that exceeds a core requirement focus could provide a "nudge" for clusters to think and act differently.

5.6.4 SOLUTION FEASIBILITY

Participants were presented with the question "Do you think an all-Wales CPNA could be realistically implemented? (Select one option)" and voted as follows:

Option	Percentage
Yes with ease	0%
Yes with a few hurdles	21%
Yes but it's a big challenge	72%
Unlikely	5%
Not possible	3%

Participant(s) noted:

- Tangible capacity within both clusters and local public health teams is needed to respond to needs assessment on the scale proposed.
- Confidence among LPHTs to have the necessary conversations with clusters is assumed to be present.
- Any solution will be highly dependent on NWIS [who were not participating in the engagement workshops].

Key message

Significant concerns were repeatedly expressed during the workshops over local public health team (LPHT) capacity and/ or capability to more effectively support clusters to interpret and act on needs assessments.

Implication

In deciding how best to procced with primary care needs assessment, consideration will need to be given to providing mitigation of LPHT capacity or capability concerns.
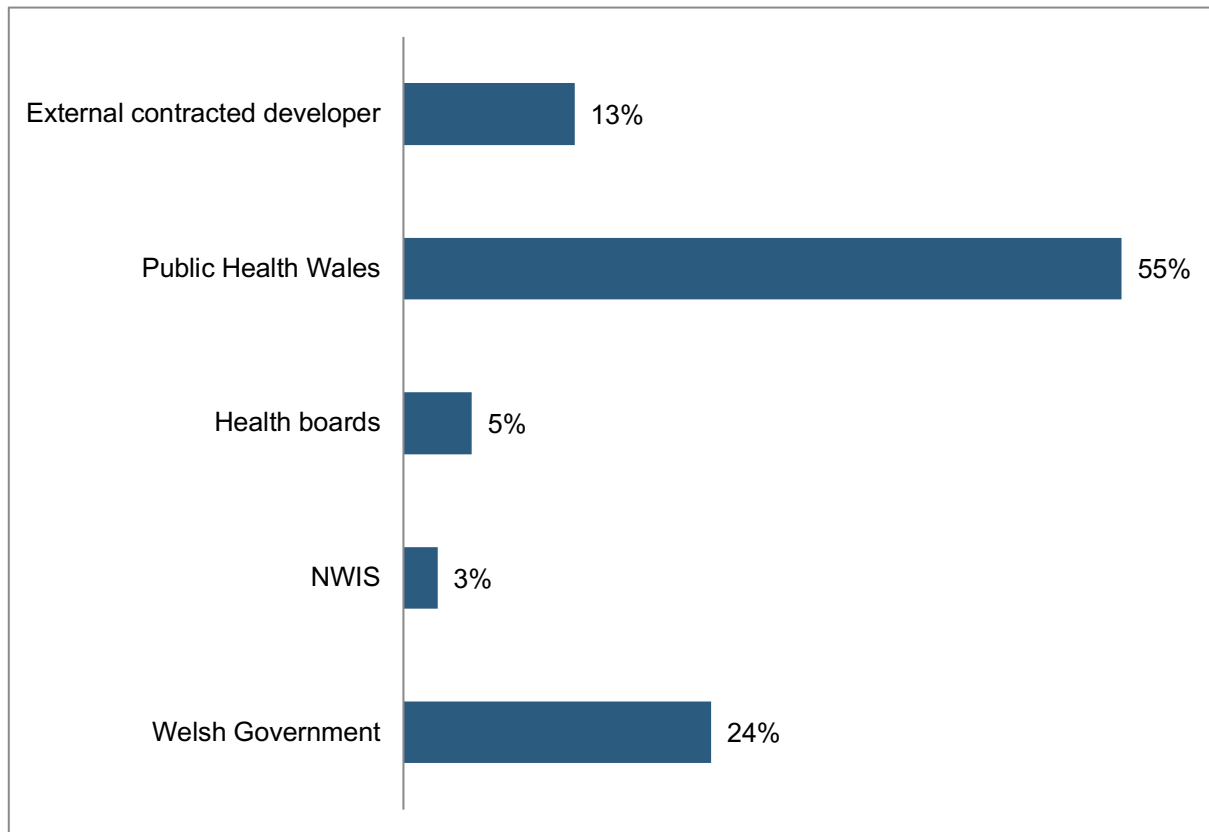
5.6.5 SOLUTION DESIGN CHARACTERISTICS

Participants were presented with the question "How digestible (information accessibility) is digestible enough? (Select each important option)" and voted as follows:

Option	%
Detailed evidence statements with signposting	19%
Bullet-point evidence synopses with signposting	31%
Detailed data tables	19%
Simple infographics where feasible	32%

5.6.6 SOLUTION HOSTING & DEVELOPMENT

Participants were presented with the question "Who should be responsible for CPNA hosting and development? (Select one option)" and voted as follows:

Category	Percentage
External contracted developer	13%
Public Health Wales	55%
Health boards	5%
NWIS	3%
Welsh Government	24%

Key message

Participants most favoured Public Health Wales to take a lead role in hosting and/ or developing a needs assessment solution, followed by Welsh Government.
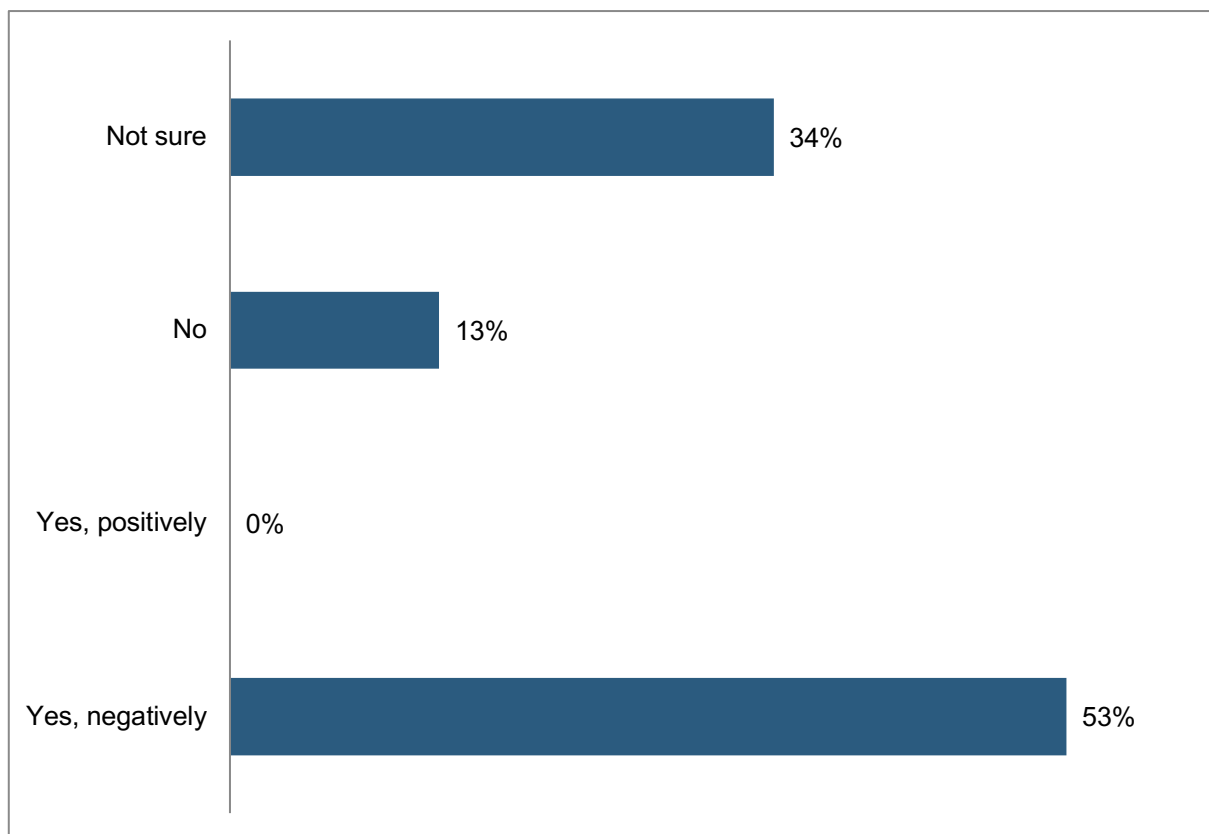
Implication

Participants may not appreciate that PHW's expertise is grounded in the intelligence *content*, not the developing the technical means to deliver it. A lead role for PHW conflicts with current limitations on primary care data access.

5.7.1 QUALITY ASSURANCE & GMS CONTRACT CHANGES

Participants were presented with the question "Is the GMS Contract reduction of QOF likely to impact clinical coding? (Select one option)" and voted as follows:


Key message

While not a given, there is majority concern that data quality will suffer as a result of relaxation of QOF.

Implication

Planning should be based on robust data sources whenever possible.

5.7.2 INTELLIGENCE PROVIDER ACCESS TO PRIMARY CARE DATA

Participants were presented with the question "Would you be in favour of named intelligence providers having better access to cluster (Audit+) data (e.g. as secondary care via PEDW)? (Select one option)" and voted as follows:
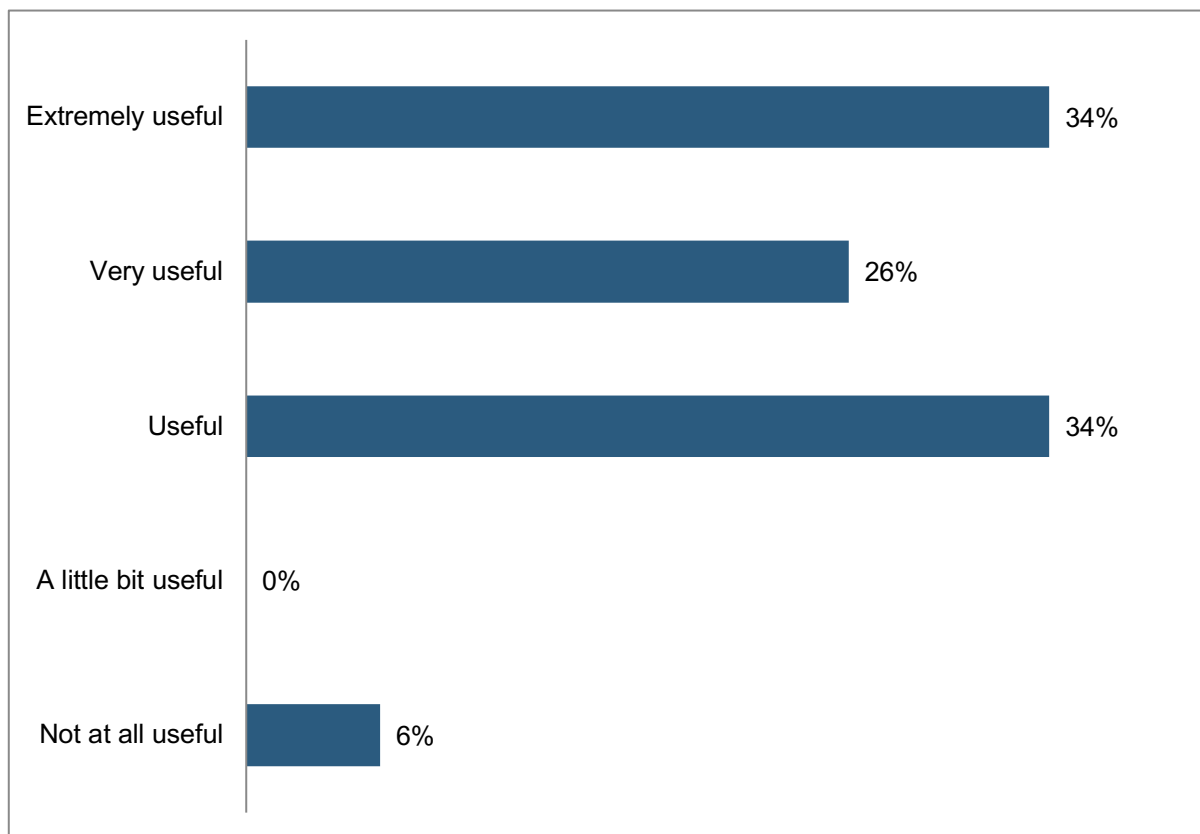
Participants(s) noted:

- Anxieties exist regarding the use of primary care data for performance management vs. planning/ quality improvement purposes.
- General practitioners have a data controller role, with associated governance implications.
- General Data Protection Regulation (GDPR) compliance may further inhibit data sharing from primary care.
- The existing DQS governance process is not fit-for-purpose.

Key message

There is a clear majority view that named intelligence providers should have better access to primary care data in order to better support primary care clusters with health needs assessment.

Implication

There is a strong argument for improving the population health/ planning utility of data originating in primary care, which is currently better utilised for research purposes. This might extend to mandating installation of agreed Audit+ modules in NHS Wales GP practices to support the production of routine health intelligence outputs.

5.7.3 DATA RESOLUTION

Participants were presented with the question "How directly relevant to the cluster population is relevant enough? (Select each important option)" and voted as follows:
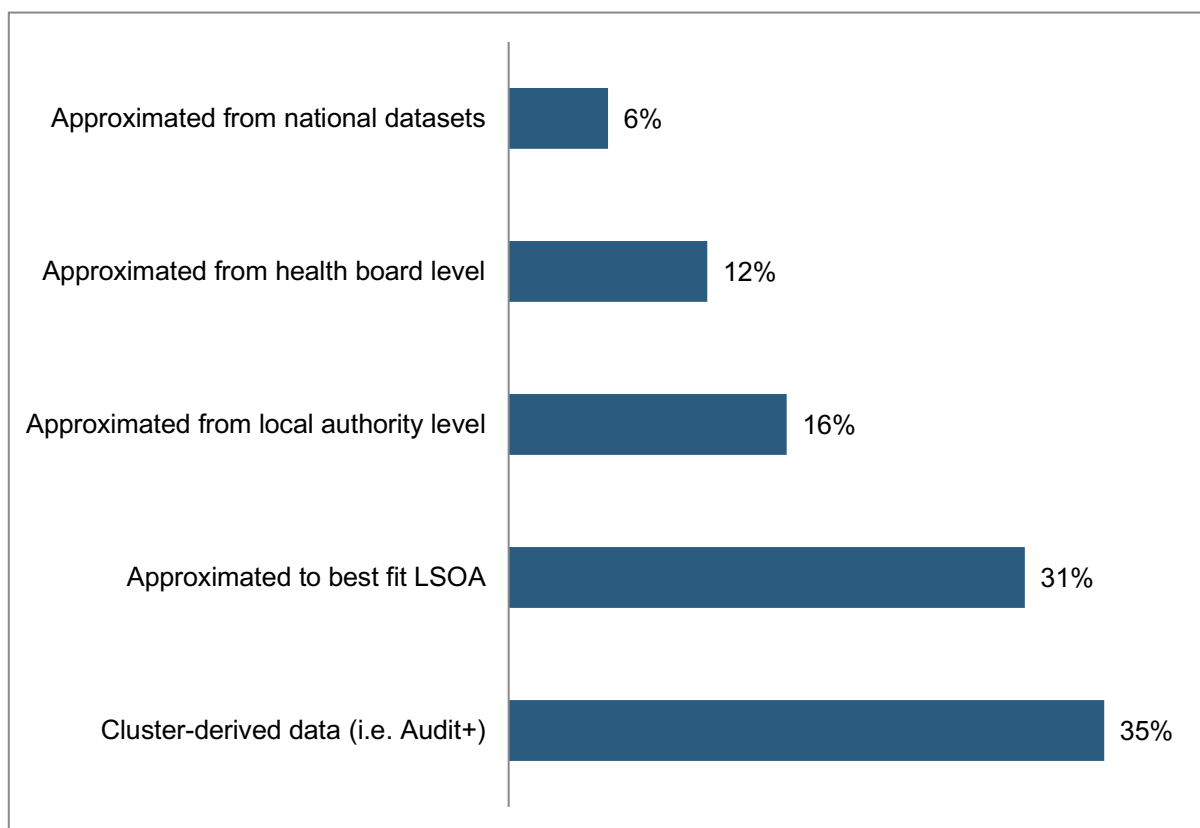

Participant(s) noted:

- Data levels are not mutually exclusive; some stuff is best at cluster level, while another source may only be available at local authority level (for example).
- While relevance to the cluster is important, multiple data levels should be included where helpful.
- Any dataset aggregation/ disaggregation should also report at local authority level, so Regional Planning Boards can utilise it.

5.7.4 CLUSTERS & GEOGRAPHIC BOUNDARIES

As "homework" from the first workshop, participants were asked to consider the utility of having geographic cluster boundaries. It was explained by the facilitator that this would allow additional survey data to be reported at a cluster level, increasing the breadth of information available to clusters about the populations they serve.

Participants were presented with the question "Would you be in favour of assigning approximate geographic boundaries to each cluster area? (Select one option)" and voted as follows:

Extremely useful	17%
Very useful	26%
Useful	37%
A little bit useful	9%
Not at all useful	11%
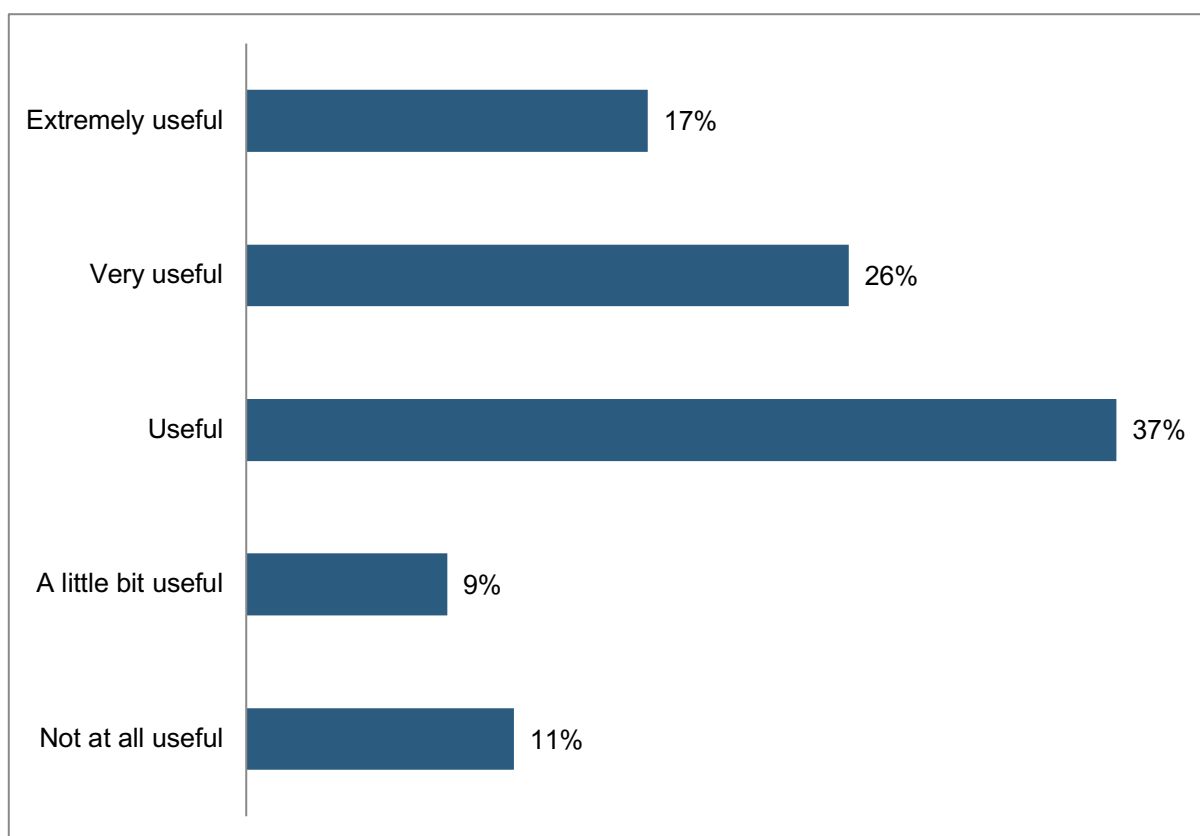
Note that subsequent to the workshop, it became apparent that clusters in ABMU do correspond to LSOA boundaries (LSOAs are aggregated so the boundaries are contiguous, and each cluster is comprised of certain LSOAs); this is not however the universal case across Wales. It was also noted that *A healthier Wales* included a map appearing to show defined geographic cluster boundaries, however, this was not produced on the basis of a shared methodology and did not take account of real working practices (e.g. official clusters operating as one entity).

Key message

There is clear majority interest in mapping clusters to a geographic boundary.

Implication

Health intelligence providers are already in conversation with a view to developing an appropriate shared mapping methodology.

6. KEY MESSAGE SUMMARY & CONCLUSIONS

6.1 ENGAGEMENT APPROACH

The level of engagement secured was lower than the planning intention. This mirrors similarly low levels of engagement over the IAWPCNA proposal itself when circulated to selected stakeholder groups. Confidence that the findings of this report reflect a national consensus view cannot be high.

6.2 TOPIC-RELATED CONSIDERATIONS

Participants expressed a clear preference for cluster-derived data on behavioural risk factor prevalence. There is some evidence of a discrepancy between survey-estimated prevalence and primary care-derived prevalence estimates (for example, SAIL found smoking prevalence using GP calculated values was approximately 7% higher than Welsh Health Survey values). While such a discrepancy is liable to have service planning implications, providers of routine health intelligence to primary care do not have ready access to Audit+ data to supply this. Furthermore, the usability of these data would strongly depend upon primary care ascertaining and coding such risk factors.

Participants recognised the value of preventive approaches to improving local population health. Opportunities to progress the prevention agenda through local cluster action must not be lost in the context of a clear strategic steer in this direction with coincident relaxation of the cluster planning requirement.

Conclusion

A primary care needs assessment informed by these engagement workshops might include the following broad topic areas:

- Demographics
- Non-communicable disease prevention
- Screening
- Long-term conditions
- Infectious disease prevention
- Wider determinants of health
- Mental ill health & well-being
- Social care and carers
- Frailty
- Sensory impairment
- Oral health
- Life-course topics
- Service use

Within these broad headings there are a number of higher-priority sub-topics that could be selected to support iterative development of a needs assessment solution. Selection would need to take account of various factors such as the availability of existing indicators; data resolution; intelligence provider access to primary care data; potential to impact on population health outcomes; etc. A proposed schedule for phased topic development is provided in Annex C.

6.3 FUNCTIONALITY-RELATED CONSIDERATIONS

There is a lack of consensus on the primary purpose of cluster-level needs assessment. Although 20 potential primary purposes were identified (& many are inter-related), the more popular suggestions were understanding local health and care needs; informing prioritisation/ commissioning decisions; planning service provision; understanding local influences on health; and highlighting prevention opportunities. This lack of consensus may relate to an apparent lack of stakeholder clarity on the role

of clusters in planning for health improvement (Annex B). Some consensus on primary purpose will be required to ensure needs assessment is able to deliver what is needed.

Participants felt that the primary audience for utilising cluster needs assessment was all those engaged within the cluster itself and health board staff. It was recognised that a much wider audience should have sight of the assessment. A preferred solution may need to incorporate differing levels of access and/ or "windows" on the needs assessment content for a variety of reasons.

Significant concerns were repeatedly expressed during the workshops over cluster capacity to absorb and act on needs assessments. In deciding how best to procced with primary care needs assessment, consideration will need to be given to providing mitigation of cluster capacity concerns.

Participants de-emphasised national approaches to information about local assets and incorporation of the patient voice on local primary care services. While considered desirable, a once-for-Wales approach to collating local non-clinical assets was felt to be impractical. Corporate and asset-based components of local needs assessment would be best coordinated locally. However, this need not preclude a national steer on options/ tools for effecting this.

There was a broad range of general requirement placed on the solution by workshop participants. To progress a primary care needs assessment, prioritisation decisions will need to be taken that reduce the scope of initial ambition for a solution.

Participants felt it was most important that needs assessment availability was timely in relation to the cluster planning cycle. This consideration may be less relevant given changes to the planning requirement in the GMS Contract for 2018/19. Questions remain over the optimal frequency for refreshing primary care needs assessments (i.e. need it be annual?) and whether there is scope to better align GMS Contract and health board IMTP key planning milestones.

Participants did not feel that aiming for a "lowest common denominator" cluster had merit, with a preference for aiming for the middle ground (however defined). There is anecdotal evidence that clusters are at differing stages of maturity, with some more than others thinking beyond healthcare to well-being, beyond the individual patient to the wider population and beyond general practice to wider primary care. All clusters could be encouraged on this journey by normalising the inclusion of more encompassing health metrics via a national template. In other words, a needs assessment that exceeds a core requirement focus could provide a "nudge" for clusters to think and act differently.

Significant concerns were repeatedly expressed during the workshops over local public health team (LPHT) capacity and/ or capability to more effectively support clusters to interpret and act on needs assessments. In deciding how best to procced with primary care needs assessment, consideration will need to be given to providing mitigation of LPHT capacity or capability concerns.

Participants most favoured Public Health Wales to take a lead role in hosting and/ or developing a needs assessment solution, followed by Welsh Government. Participants may not appreciate that PHW's expertise is grounded in the intelligence content, not the developing the technical means to deliver it. A lead role for PHW conflicts with current limitations on primary care data access.

While not a given, there is majority concern that data quality will suffer as a result of relaxation of QOF. Planning should be based on robust data sources whenever possible.

There is a clear majority view that named intelligence providers should have better access to primary care data in order to better support primary care clusters with health needs assessment. There is a strong argument for improving the population health/ planning utility of data originating in primary care, which is currently better utilised for research purposes. This might extend to mandating

installation of agreed Audit+ modules in NHS Wales GP practices to support the production of routine health intelligence outputs.

There is clear majority interest in mapping clusters to a geographic boundary. Health intelligence providers are already in conversation with a view to developing an appropriate shared mapping methodology.

Conclusion

A primary care needs assessment informed by these engagement workshops might include the following broad functionality considerations:

- Primary purpose
- Primary audience
- Components
- Features
- Timings
- Implementation
- Format
- Content
- Design

Within these broad headings there are a number of higher-priority functionality aspects that could be selected to support iterative development of a needs assessment solution. Selection would need to take account of various factors such as costs; availability of expert resource; impact on existing intelligence provider work plans; effectiveness of collaboration between providers; etc. A proposed schedule for phased functionality development is provided in Annex D.

8. RECOMMENDATIONS

Recommendation 1

The Primary Care Hub Board should approve the phased development of a national template supporting primary care needs assessment. This would involve an interim release utilising available analyses led by Public Health Wales and delivered by March 2019 for each health board. Feedback on this interim solution and work on a pathway approach to diabetes intelligence will together inform the design of a longer-term automated needs assessment solution for primary care audiences.

This proposal is informed by several notable considerations:

- Anticipated benefits of some planning on a larger footprint (e.g. planning at a population level with improved strategic alignment; deployment of needs assessment/ action planning resources at scale; identifying & realising opportunities for genuine partnership working; attracting proportionate and sustainable intervention funding, etc.);
- Strategic emphasis on the planning role of Regional Partnership Boards;
- Concerns regarding cluster capacity to absorb and act on needs assessments;
- Concern among local public health teams regarding their capacity to interpret and support clusters to act on needs assessments; and
- Concern that removal of the Cluster Action Plan obligation from the GMS Contract may negatively impact upon the cluster planning function.

Recommendation 2

The Primary Care Hub Board should identify mechanisms to effect improved access to primary care data for named intelligence providers supporting cluster-level needs assessment.

9. ACKNOWLEDGEMENTS

This report was prepared by Dr Bruce McKenzie, Consultant in Public Health Medicine and Harvey Carman, Senior Health Intelligence Analyst. The authors/ facilitators would like to thank all workshop participants for their time and thoughts.

## ANNEX A: IAWPCNA PROJECT OUTLINE

Please refer to separate document.

ANNEX B: VIEWS ON THE CLUSTER ROLE IN HEALTH IMPROVEMENT

Although not part of the original engagement intent, discussions at the first set of workshops revealed a lack of certainty on the role clusters have (or might have) in planning for local population health improvements. A number of questions were therefore put to attendees at the second workshop with the aim of understanding how such uncertainty might shape the views being expressed.

B.1 UNDERSTANDING OF THE PURPOSE & FUNCTION OF CLUSTERS

Participants were presented with the statement "I am personally clear on the purpose/ function of clusters (Select one option)" and voted as follows:
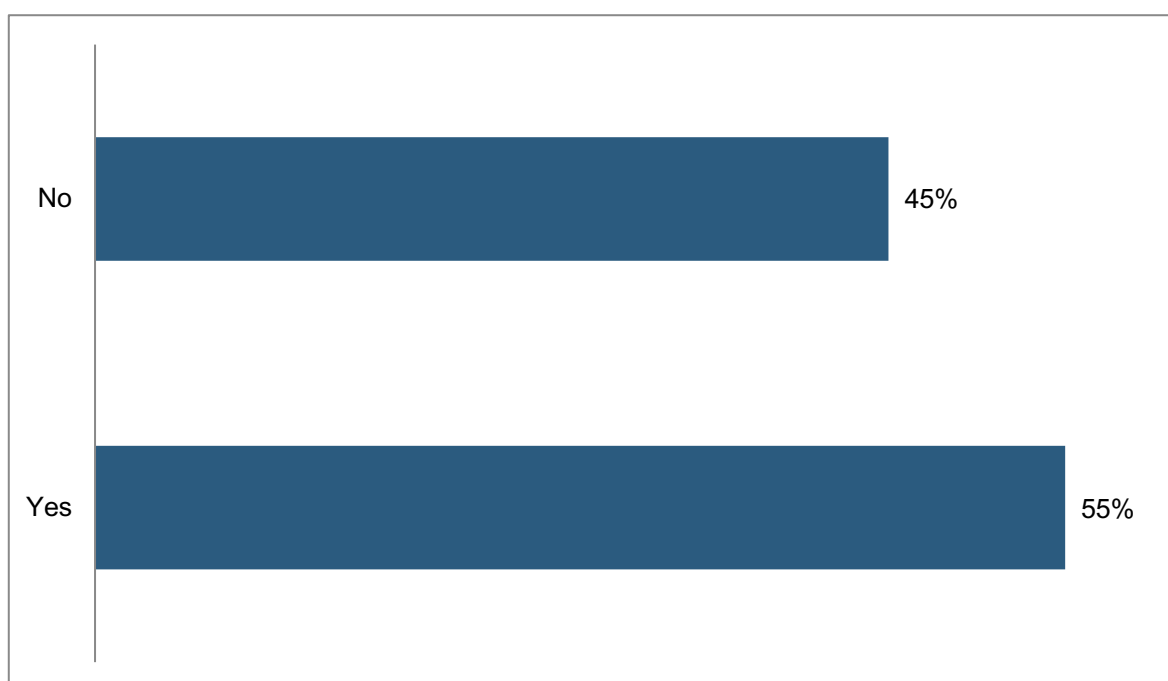
Participant(s) noted:

- There is not clarity on "who is part of a cluster".
- There have been a number of inconsistent statements made (by the same source) about the purpose of clusters.
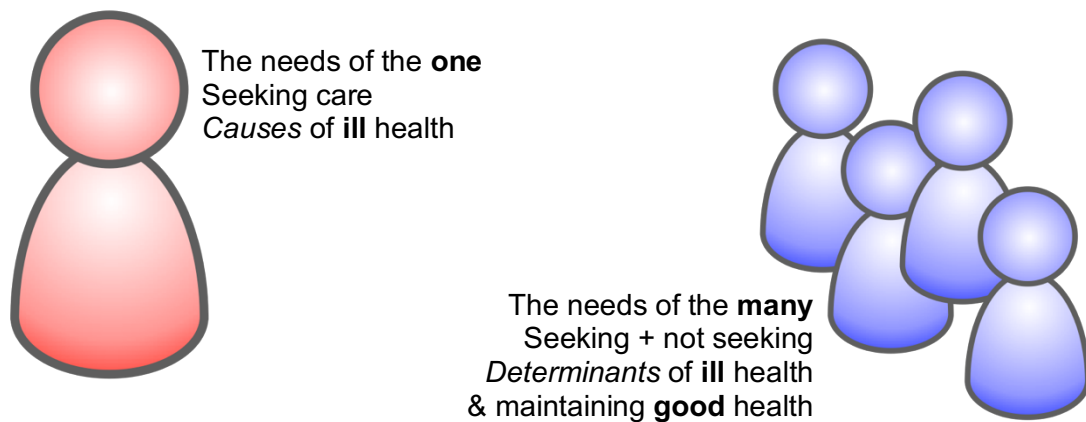

Key message

Workshop participants did not share an understanding on the purpose or function of clusters.

Implication

In the absence of a shared understanding of cluster purpose, it will be challenging to articulate a clear purpose for needs assessment & cluster planning in support of it.

B.2 UNDERSTANDING OF HOW INDIVIDUAL & POPULATION NEEDS DIFFER

At the first workshop participants were reminded that the needs of the many differ from those of the few (or the one) with the following diagram:

The needs of the **one**
Seeking care
Causes of **ill** health

The needs of the **many**
Seeking + not seeking
Determinants of **ill** health
& maintaining **good** health

Participants were presented with the statement "I am personally clear on how the needs of populations may differ from those of individuals (Select one option)" and voted as follows:


No   0.00%

Yes   100.00%

Participant(s) noted:

- It is possible sharing the above diagram influenced participant responses to this question.

B.3 APPRECIATION OF A HEALTH IMPROVEMENT ROLE FOR CLUSTERS

Participants were presented with the statement "I believe that clusters have the lead role to play in planning for local population health improvements (Select one option)" and voted as follows:

No — 63%

Yes — 38%

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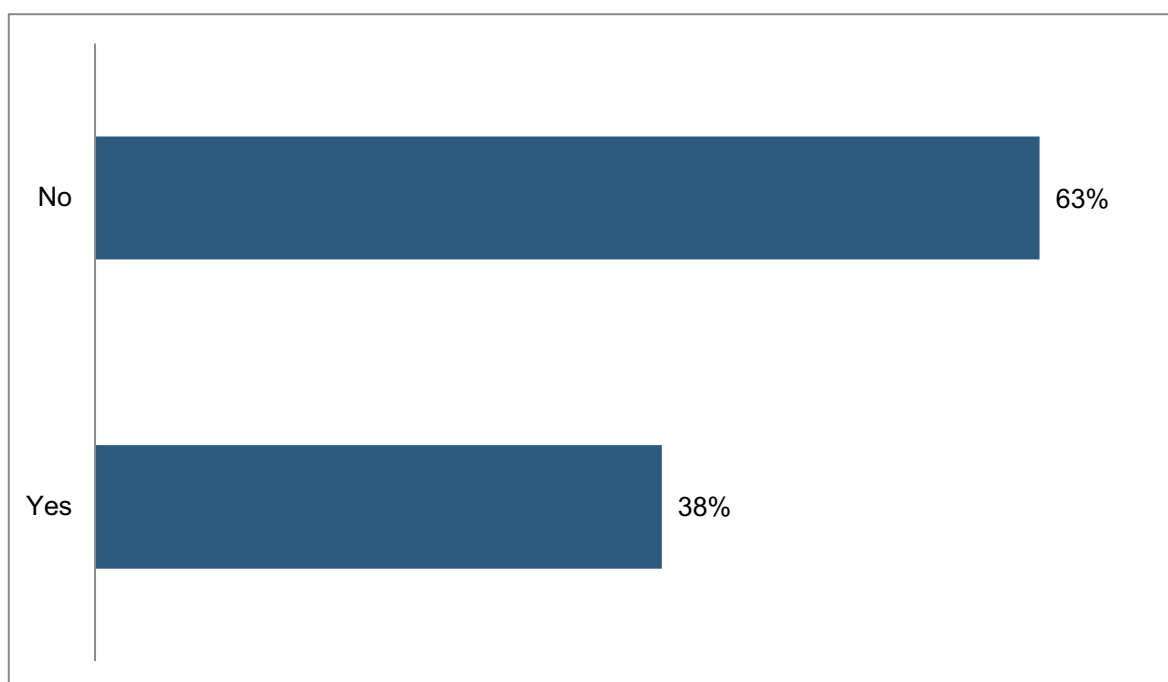
Key message

Most workshop participants did not consider that clusters have the lead role to play in planning for local population health improvements.

Implication

It is unknown what underlies this position, which may reflect factors such as perceived duplication of planning functions, lack of resource/ wider sustainability concerns (capacity), lack of opportunity to influence population-level changes (capability), lack of incentive, ambiguity of "local", etc.

</div>

B.4 SUPPORT FOR INFORMED CLUSTER PLANNING

B.4.1 ASSESSMENT OF LOCAL NEEDS

Participants were presented with the statement "Planning local services without an assessment of local health needs is feasible (Select one option)" and voted as follows:
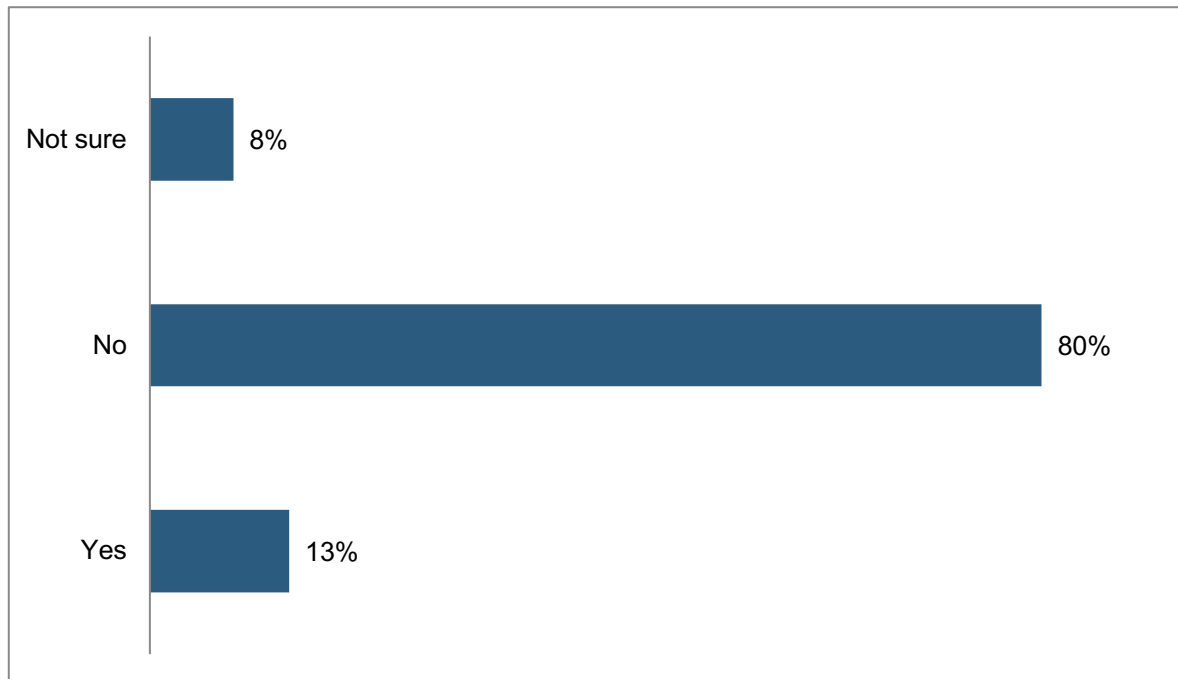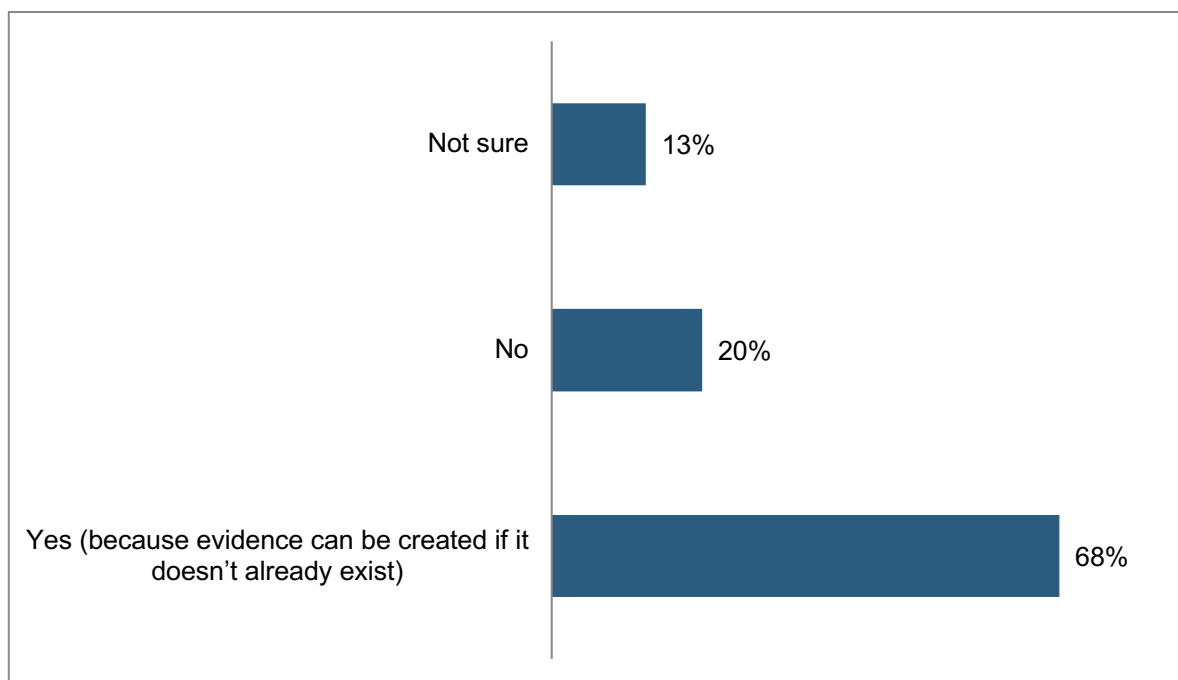
Participant(s) noted:

- Need to define "local" as this has a fluid meaning depending on type of data/ service, etc.
- What is "local" depends on service e.g. smoking cessation national but delivered locally.
- Documenting local needs requires information from different sources/ at different levels.

## B.4.2 TAKING ACCOUNT OF INTERVENTION EVIDENCE

Participants were presented with the statement "Planning local services without evidence on effective intervention options is feasible (Select one option)" and voted as follows:

Note that this question was perceived by some participants as ambiguous/ poorly worded, as thus may be unreliable.

B.4.3 CLUSTER PLANNING UTILITY

Participants were presented with the statement "For the purpose of informing cluster plans, do you think an all-Wales CPNA would be (Select one option)" and voted as follows:
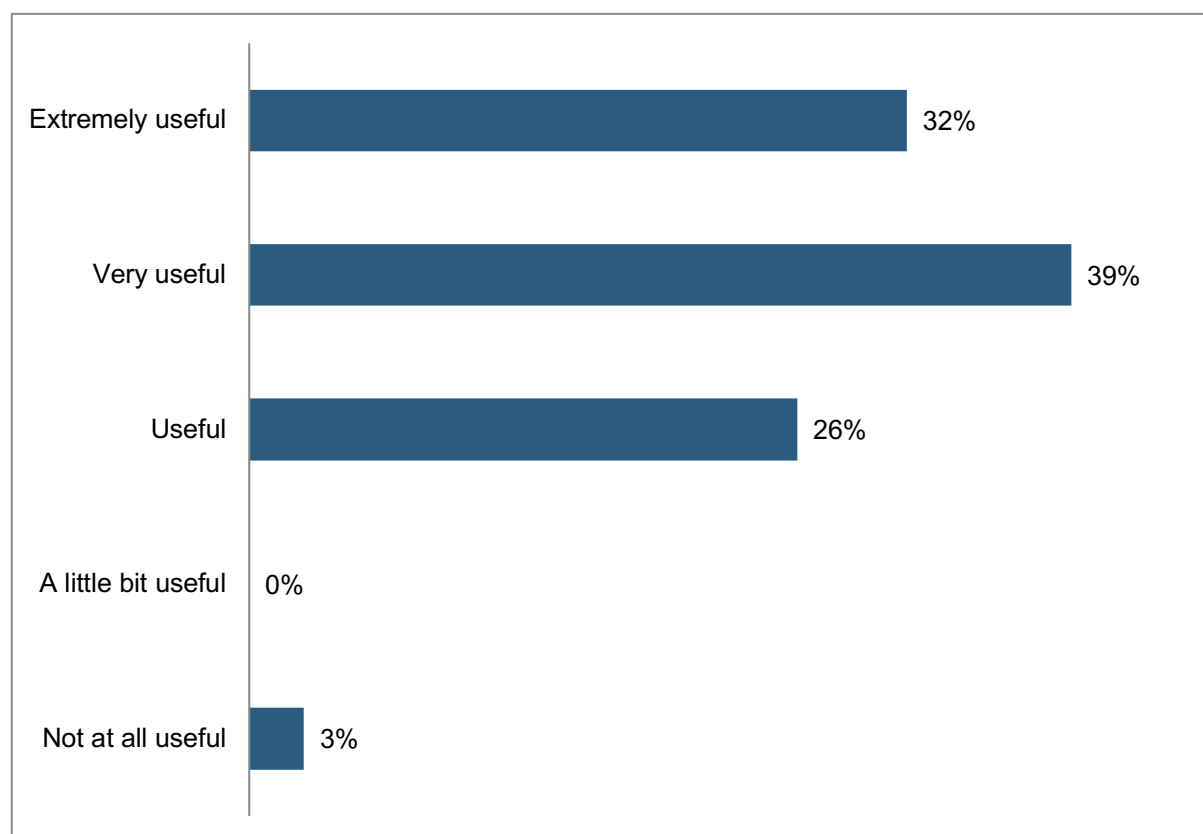
> **Key messages (B.4.1–B.4.3)**
>
> A clear majority of participants felt it was not possible to plan local services without an assessment of local health needs. Participants did not see the absence of evidence on intervention effectiveness as a barrier to making cluster plans, acknowledging that there was room to generate evidence (innovation). Almost all participants felt a nationally-templated cluster population needs assessment would be useful, very or extremely useful for informing cluster plans.
>
> **Implication**
>
> While there is broad support for nationally-templated cluster population needs assessments, it is unclear how this support can be reconciled with the position that most feel clusters don't have the lead role to play in planning for local population health improvements (B.3).

B.5.1 CURRENT SITUATION

Participants were presented with the statement "The key unit responsible for planning local primary care services is *currently* (Select one option)" and voted as follows:
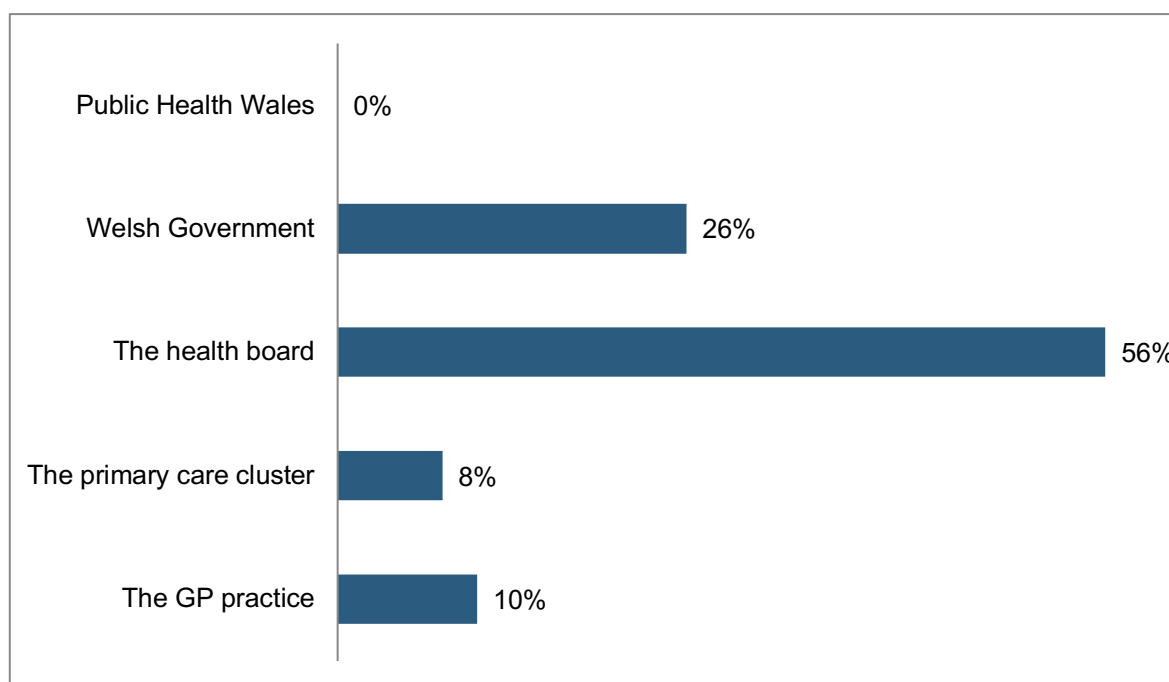
B.5.2 IDEAL SITUATION

Participants were presented with the statement "The key unit responsible for planning local primary care services *should be* (Select one option)" and voted as follows:

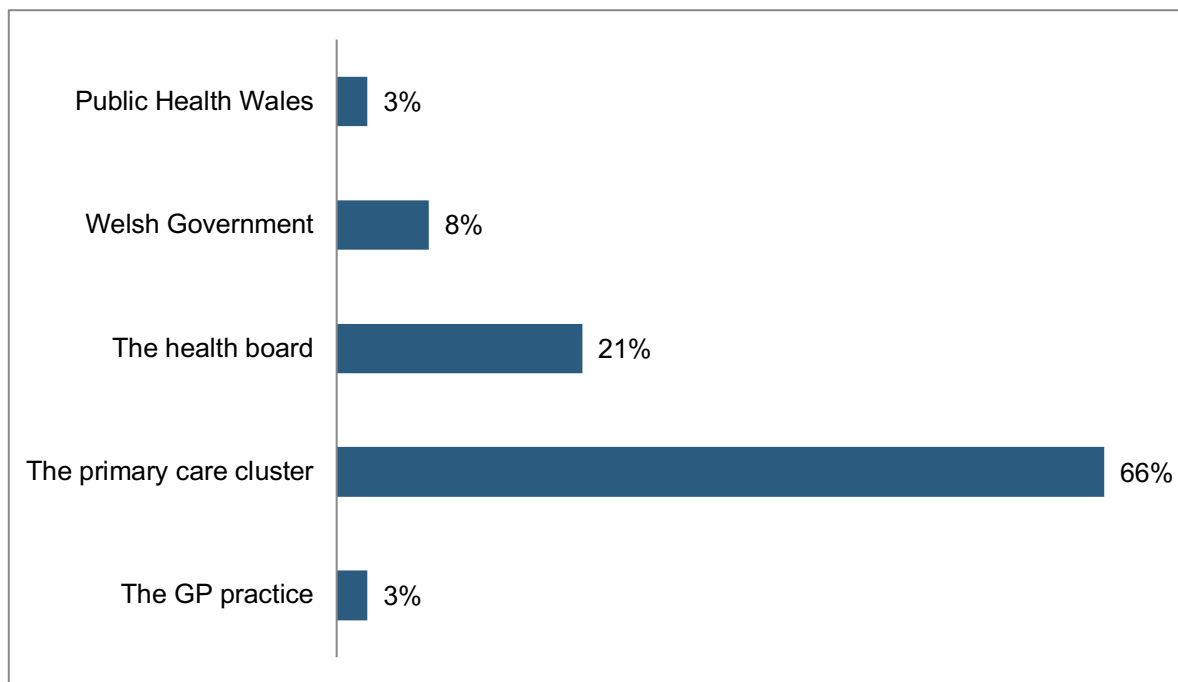|	
Public Health Wales	3%
Welsh Government	8%
The health board	21%
The primary care cluster	66%
The GP practice	3%

Key messages (B.5.1–B.5.2)

A clear majority of participants felt planning of local primary care services is currently a health board responsibility, however, a majority considered that this role should be undertaken by clusters.

Implication

While this position initially seems at odds with the majority view that clusters don't have the lead role to play in planning for local population health improvements (B.3), it may merely suggest that many participants were not equating local health improvement actions to primary care service reconfiguration or improvements in population health outcomes.

B.5.3 PLANNING FOOTPRINT

Participants were presented with the statement "At what level would primary care population needs assessment make most sense? (Select one option)" and voted as follows:

National level — 0%
Health board level — 13%
Local authority level — 16%
Cluster level — 58%
Practice level — 13%
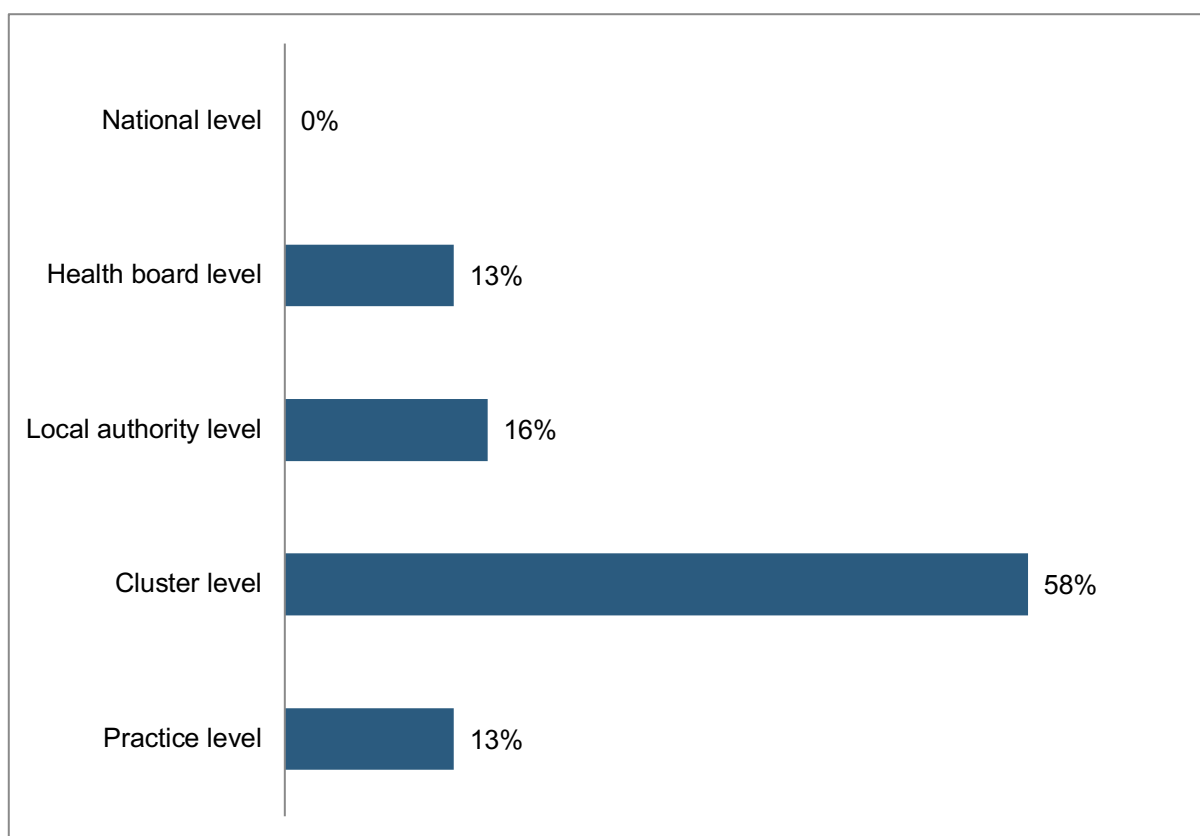
Participant(s) noted:

- This was a poorly-articulated question, as assessment makes sense at multiple levels depending upon factors such as data source availability, opportunities to influence/ partnerships, business case, etc.

Note that this aspect is revisited in the report summary in reference to planning relationships, as footprint was a "meta-theme" during the engagement workshops.

B.6 CLUSTER PLANNING INCLUSIVITY

B.6.1 CURRENT SITUATION

Participants were presented with the statement "Clusters *do currently* involve the following in planning improvements (Select each important option)" and voted as follows:
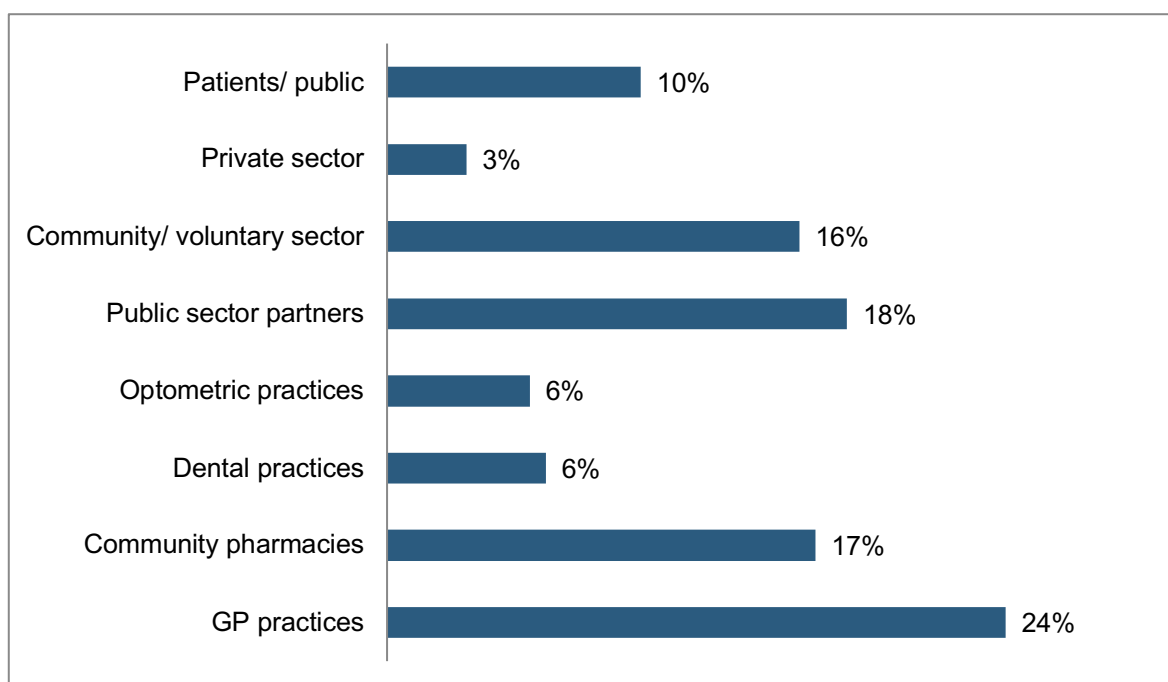
Participant(s) noted:

- This degree of current inclusivity can be contested, since "involvement" is very open to interpretation (e.g. there is a difference between extending an invitation and meaningful co-production).
- Given the suggestion that cluster are currently engaged with a variety of non-GP roles, work could be undertaken to look at how this is being achieved with a view to sharing best practice (i.e. this is a knowledge gap).
- Non-engagement is not necessarily because the offer isn't there, but those in other roles may not have the (financial) opportunity to participate or could be put off by the GMS-dominated meeting agenda or the "cluster identity crisis".

B.6.2 IDEAL SITUATION

Participants were presented with the statement "Clusters *should* involve the following in planning improvements (Select each important option)" and voted as follows:
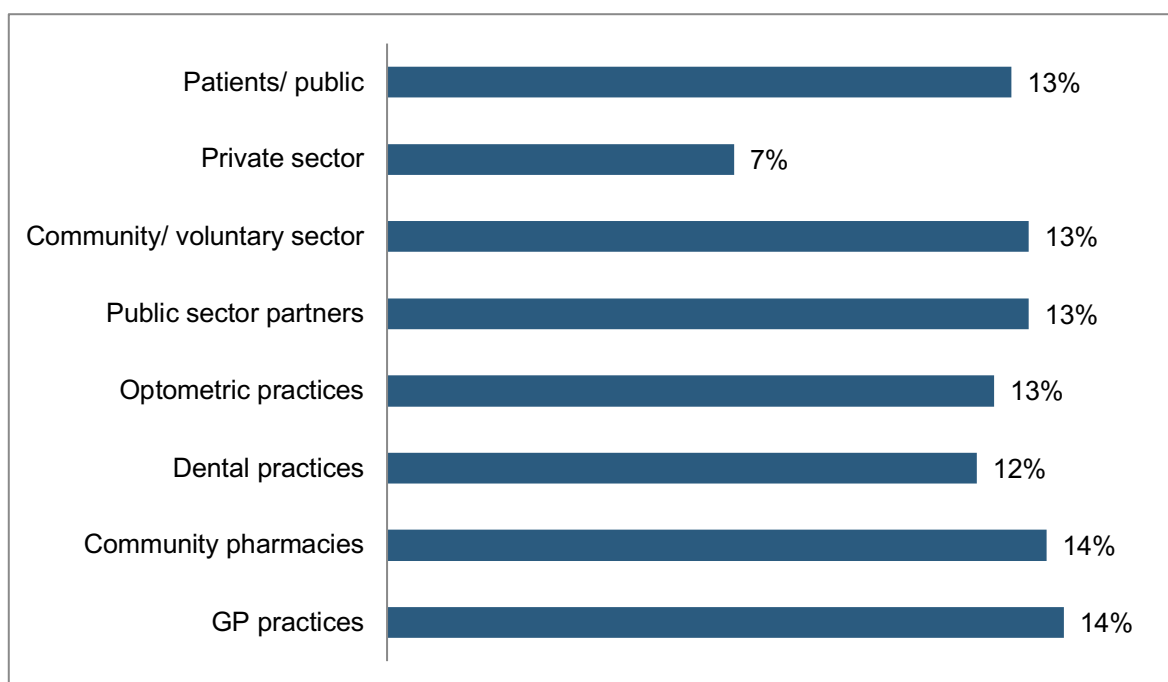
Patients/ public	13%
Private sector	7%
Community/ voluntary sector	13%
Public sector partners	13%
Optometric practices	13%
Dental practices	12%
Community pharmacies	14%
GP practices	14%

Participant(s) noted:

- Examples where a cluster might engage with the private sector include: nursing/ care homes; landlords regarding housing; Weight Watchers referral; behaviour change specialists; gyms; Farm Foods; employers regarding workplace health.

Key messages (B.6.1–B.6.2)

There is a gap between current and desirable levels of inclusivity in the cluster planning process.

Implication

While there are strong suggestions some clusters are being more inclusive, it is recognised that there is variation in practice and best practice around engagement with those in non-GP roles is not widely shared. This situation is likely linked to persisting uncertainty over "who is part of the cluster" (B.1).

B.7 INCENTIVISATION OF CLUSTER PLANNING

Workshop participants were made aware via the introductory presentation of plans (subsequently confirmed) to relax the requirement for Cluster Action Plans (CAPs). Participants were presented with the question "Is the GMS contract removal of a CAP obligation likely to impact cluster planning? (Select one option)" and voted as follows:

Not sure	21%
No	13%
Yes, positively	10%
Yes, negatively	56%
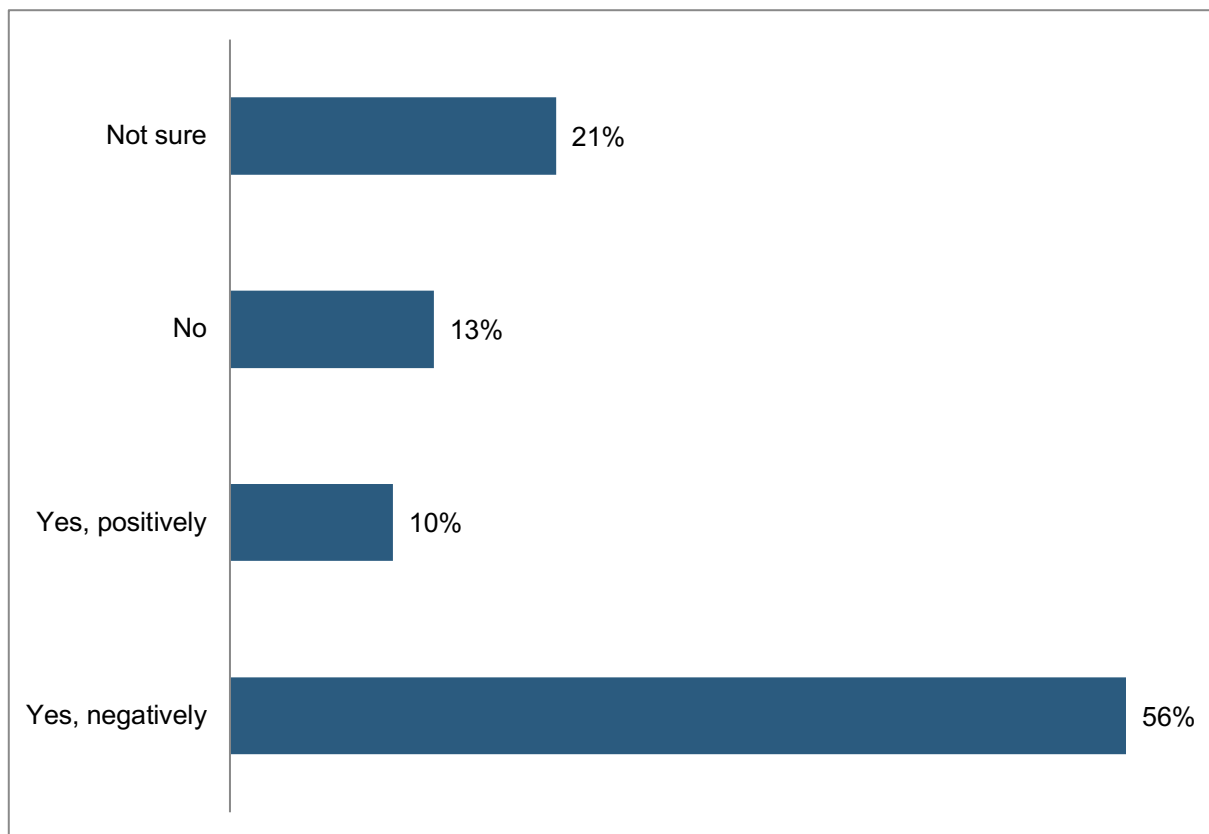
Key message

A majority of participants expressed concern that removal of the Cluster Action Plan obligation from the GMS Contract will negatively impact on cluster planning.

Implication

If on a voluntary basis (despite encouragement) clusters are less likely to make (robust) plans that articulate health improvement actions, then the case for a nationally-templated needs assessment solution to inform them may be undermined. There is unhelpful conflict between contemporary statements regarding the strategic planning role of clusters and the need to support primary care sustainability.

B.9 RELATIONSHIP TO OTHER NEEDS ASSESSMENTS & INITIATIVES

A "functionality primer" distributed to participants at the first workshop included a list of existing metrics, assessments, plans, reports and contracts. These were intended to stimulate discussion on the tables around relationships between these, hoping participants would identify how they might impact on cluster-level needs assessment. The list included:

- Quality and Outcomes Framework (QoF)
- Primary Care Measures
- National Prescribing Indicators
- International Consortium for Health Outcomes Measurement (ICHOM)
- Patient Reported Outcome Measures (PROMs)
- Patient Reported Experience Measures (PREMs)
- Pharmaceutical Needs Assessments (Public Health Act)
- Public Health Outcomes Framework (PHOF)
- Well-being Assessments (WBFG Act)
- Population Needs Assessments (SSWB Act)
- Public Services Board (PSB) Well-being Plan
- Health board Primary Care Directorate Plan
- Health board Integrated Medium Term Plan (IMTP)
- Public Health Wales IMTP
- National Delivery Plans
- National plan/ strategy for primary care
- Wider strategy e.g. Prosperity for All (Welsh Govt)
- *Parliamentary review of health and social care in Wales*
- HSCSC *Inquiry into primary care: clusters*
- GMS (medical), GDS (dental), CPC (pharmacy), optometry contracts
- *Stay well in Wales* (public views on public health topic importance)

Key message

Participants were unable to articulate the nature of potential relationships between cluster needs assessment and existing metrics, assessments, plans, reports and contracts, or did not consider this an important aspect of their discussions.

Implication

In the absence of sufficient mutual awareness to describe tangible relationships to other initiatives, the concept of strategic alignment within the health & care operating environment is largely fictitious.

ANNEX C: PROPOSED SCHEDULE FOR TOPIC DEVELOPMENT

Phase 1 would be delivered by end March 2019 and encompass the following topics areas:

Category	LHB	LA	Cluster
Demographics (via OAT)			
• Age, sex, persons (incld. projections)	Y	Y	X
• (H)LE, gap, trends	Y	Y	—
• Deprivation status/ maps	Y	Y	X
Non-communicable disease prevention (via OAT)			
• Behavioural risk factor prevalence	Y^1	Y^1	X
• Clinical risk factor prevalence	X^2	X^2	X
• Cardiovascular disease prevalence	Y	—	Y
• Diabetes prevalence	Y	—	Y
• Chronic respiratory disease prevalence	Y	—	Y
• Dementia prevalence	Y	—	Y
• Co-morbidity prevalence	X	X	X
Screening (via Screening Division)			
• Cancer screening uptake (bowel, breast, cervical)	Y	Y	Y
• Cancer incidence, prevalence, survival (bowel, breast, cervical)	Y	Y	Y
• Cancer stage at diagnosis (bowel, breast, cervical)	Y	Y	Y
• Diabetic eye screening uptake	Y	Y	?
• Antenatal screening uptake	Y	Y	?
• AAA screening uptake	Y	Y	Y
Infectious disease prevention (via VPDP)			
• Influenza vaccination uptake	Y	Y	Y
• Childhood vaccination uptake	Y	Y	Y
Wider determinants (via OAT)			
• Education & training TBC	Y	Y	—
• Home & housing TBC	Y	Y	—
• Money & jobs TBC	Y	Y	—

Phase 2 would require further scoping and significant improvements in access to primary care data:

Category	LHB	LA	Cluster	Equity	Trend
Mental ill health & well-being (OAT?)					
• Well-being prevalence	?	?	—		
• Depression & anxiety prevalence	Y	—	Y		
• Self-harm event prevalence	?	?	X		
• Social isolation prevalence	?	?	X		
Social care & carers (Social Care Wales?)					
• Persons receiving care	?	Y	X		
• Persons providing care	?	Y	X		
• Carer needs	?	?	X		
• Safeguarding event prevalence	?	?	X		
• Domestic violence prevalence	?	?	X		
Frailty (OAT?)					
• Injury from falls/ hip fracture	?	?	X		
• Frailty score	?	?	X		
Sensory impairment (Contracted providers?)					
• Sight loss prevalence	?	?	X		
• Hearing loss prevalence	?	?	X		
Oral health (WOHIU)					
• Adult dental disease (DMFT) prevalence	?	?	X		
• Child dental disease (dmft) prevalence	?	?	X		
Life-course topics (OAT?)					
• Breast feeding prevalence	?	?	X		
• ACE exposure prevalence	?	?	X		
• Teenage conceptions	Y	Y	X		
Service use (OAT?)					
• Emergency hospital admissions	Y	Y	X		
• A&E attendances	Y	Y	X		
• GP practice attendance contacts	X	X	X		
• GP practice in-hours triage contacts	X	X	X		
• Out-of-hours GP contacts	X	X	X		
• Community pharmacy contacts	—	—	—		

• Access to community mental healthcare services/ attendance	?	?	X		
• Access to optometry care/ attendance	—	—	—		
• Access to audiology care/ attendance	—	—	—		
• Access to dental care/ attendance	?	?	—		

Key and notes:

- Y = suitable, existing data; — = not feasible/ not appropriate; X = suitable but data access barrier; ? = not sure/ requires further investigation
- [1] self-reported survey only, pending primary care data access improvements
- [2] self-reported weight only, pending primary care data access improvements
- Phase 1 would have a prevention focus and reflects the datasets PHW are best placed to contribute
- Equity could be assessed using the dimensions of age band, sex, deprivation status & area of residence/ cluster of registration
- Equity and trend information may need adding to Phase 1 topic areas

ANNEX D: PROPOSED SCHEDULE FOR FUNCTIONALITY DEVELOPMENT

A solution prototype would focus on a sub-set of functionality suggested by the workshops:

Category	Prototype position	Desired end position
Purpose	Understand local health needs Deliver cluster planning utility Emphasize prevention opportunities	Incorporate additional purposes as captured during workshops/ via subsequent feedback
Audience	Health boards/ NHS Trusts All those directly engaged with clusters	Utility to a wider audience (including the general public)
Components	Comparative epidemiology Intervention evidence Discussion & decision	Add in: Topic importance/ drivers for change Local implementation lessons Local assets/ partnership potential Local community voice
Features	Topic prioritisation Simplicity of use Cluster-relevant data, where available Outcome cf. process measures, where available Demand measures, where available Implementation lessons, where available	Other features determined via subsequent feedback
Timing	Release prior to end June (corresponding to former CAP requirement) One-off prototype	Refresh at annual or 3-yearly intervals?
Implementation	Initial release in prototype form, low-tech build Iterative (agile) development Ongoing evaluation w/ stakeholders	Move to automated build
Format	Online	
Content	Summary of priority topics	Summary of additional topics Equity dimensions Time trends
Design	Bullet point evidence synopses w/ signposting Simple infographics where feasible	

Taking account of the above functionality, for each topic area, the solution would be designed along the following lines (greyed out = placeholder for implementation beyond Phase 1 prototype):

Interface component	Data resolution	Presentation	Purpose/ category
Importance/ drivers	n/a	Brief narrative	Strategic context
Local position	LHB, LA, LSOA, cluster as available	Quantitative	Measurement
Comparator position	Wales, LHB or LA as appropriate	Quantitative	Measurement
Local improvement intervention options	n/a	Brief narrative	Evidence synopses/ best practice & value
Local implementation lessons	n/a	Brief narrative	Evidence synopses/ shared learning
Local assets/ partners	n/a	Text area for entry of local narrative	Co-production/ asset utilisation
Local community voice	n/a	Text area for entry of local narrative	Co-production/ user engagement
Discussion & decision	n/a	Text area for entry of local narrative	Governance