

Health, Social Care and Sport
Committee

Inquiry into Primary Care: Clusters

October 2017



National Assembly for Wales
Health, Social Care and Sport Committee

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The Committee was established on 28 June 2016 to examine legislation and hold the Welsh Government to account by scrutinising expenditure, administration and policy matters, encompassing (but not restricted to): the physical, mental and public health and well-being of the people of Wales, including the social care system.

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Chair's foreword

Primary health care provides patients with their first point of contact with the healthcare system. It was for this reason that this Committee undertook a review into Primary Care Clusters. We wanted to take a close look at whether this model of working is delivering improved services to patients and whether it is on track to make the systemic changes we know are needed within primary care.

The evidence we have heard suggests there is still some way to go if the Welsh Government is to realise its ambitions for systemic change in order that primary care meets local needs. During the inquiry we have heard about impressive examples of work in individual GP practices and in specific clusters across Wales. Much of this appears to be driven by the enthusiasm and commitment of staff working within them, leading to a concern that the cluster model may be over-reliant on key individuals. There were also clear concerns from some professional groups that they are not being included in cluster work as much as they should be.

We heard from many GPs and other health professionals that they struggle to be involved in clusters because of their challenging work pressures and the risk that their participation in cluster work could reduce their clinical contact time. It is clear that clusters have a long way to go before they deliver on the Welsh Government's ambitions for them to play a significant role in planning the transfer of services and resources out of hospitals and into local communities. We have heard that this is a missed opportunity and there has been little engagement between clusters and secondary care professionals.

Some of the main challenges to emerge were practical difficulties. This included concerns that the short term nature of cluster development money is making it difficult to recruit and retain staff and challenges in relation to employment issues and indemnity arising from the fact that clusters are not legal entities. Other significant practical barriers were that the current primary care estate and digital infrastructure are not fit for purpose to accommodate the cluster model of working.

I am grateful to all those who have helped the Committee with this important review by providing written and oral evidence. Members were particularly grateful to those professionals who took time to come and speak to us at the focus groups we held in Caernarfon and Carmarthen. We also spoke to professionals in Wrexham. Their frontline experience has shaped our thinking and helped us to identify the range of recommendations that we have made.

There must be a major step-change if clusters are to have a significant impact and a role in delivering the Welsh Government's ambitions for primary care. I trust that the evidence we have gathered and the recommendations we have made will contribute towards delivering the solutions needed to address this issue.

Dr Dai Lloyd AM,
Chair

Recommendations

Recommendation 1. The Welsh Government should publish a refreshed model for primary care clusters which restates a clearly defined vision for them from the beginning of the new financial year. Page 21

Recommendation 2. The Welsh Government should publish guidance for primary care clusters to accompany the refreshed model [Recommendation 1]. This should include good practice and should set out: a basic governance framework; example terms of reference; suggested core membership; quorum requirements for meetings; suggested decision making processes. Page 21

Recommendation 3. The Welsh Government should set out its expectation that primary care clusters function in a more agile way rather than being constrained by health boards' decision making processes. The guidance [Recommendation 2] should set out a clear process for delegating decision making to clusters. 21

Recommendation 4. The Welsh Government should set a timescale for the publication of primary care cluster plans to promote transparency and to enable scrutiny in a timely manner. Page 22

Recommendation 5. The Welsh Government should develop and action a national campaign aimed at patients which supports and promotes the primary care cluster model. Building on the 'Choose Well' campaign, it should be aimed specifically at changing attitudes and promoting the view that all primary care professionals have equal value in their areas of expertise. Page 34

Recommendation 6. The Welsh Government's guidance [Recommendation 2] should set out practical ways and examples of how primary care clusters and secondary care staff should engage with each other in order to deliver on the existing expectations for clusters to have an impact on secondary and unscheduled care. Page 34

Recommendation 7. The Welsh Government's guidance [Recommendation 2] should clarify its expectations for clusters both with regard to their impact on local health inequalities and also the extent to which they should be taking forward preventative work. It should also include good practice examples.Page 34

Recommendation 8. As a matter of urgency the Welsh Government must work with relevant stakeholders to resolve the problems relating to the employment status of cluster staff, indemnity, pension, and funding issues. This should include exploring the potential for primary care clusters to have their own legal status. Page 44

Recommendation 9. The Welsh Government should set out a framework to establish professional parameters for clinical staff which reflect new and developing roles and responsibilities. It should also set out its expectations regarding clinical supervision arrangements within primary care clusters.Page 44

Recommendation 10. The Welsh Government should put in place a national lead to co-ordinate training and development needs within clusters. It should also set out its expectations as to how training needs will be identified systematically at a local level..... Page 44

Recommendation 11. The Welsh Government should ensure that cluster development money is allocated to individual clusters on a three year rather than a one year basis. Page 53

Recommendation 12. The Welsh Government should undertake a review to identify current primary care funding streams in order to work towards rationalising and maximising the impact of the total available funding. Page 53

Recommendation 13. The Welsh Government should work with health boards and cluster leads to establish clear decision making processes for quickly evaluating and scaling up successful models and ceasing funding for less successful initiatives. Page 53

Recommendation 14. The Welsh Government should work with health boards to undertake a review of the primary care estate with a specific reference to the physical capacity for multi-disciplinary working and the capital funding requirements to support the new models of care. Page 58

Recommendation 15. This Committee has already included scrutiny of the ICT Infrastructure supporting the NHS within its forward work programme. The interim report of the Parliamentary Review of Health and Social Care set out the need for better exchange of data within NHS Wales and to other service providers; a key element of which will be the need to better link health and social

care ICT. These are key issues to underpin cluster working and Welsh Government must set out a plan in response to the final Parliamentary Review report. Page 58

Recommendation 16. Evidencing whether primary care clusters are an effective model and deliver value for money is crucial. As a matter of urgency, the Welsh Government must ensure there is a much clearer and more robust mechanism for evaluating cluster work. Despite the clear challenges, there must be attention given to how evaluation mechanisms can begin to measure the impact of cluster work on patient outcomes. Page 64

01. How the inquiry was conducted

1. Primary health care provides the first point of contact in the healthcare system. In the NHS, the main source of primary health care is general practice. Primary care clusters (also known as GP clusters) are groups of general practitioners working with other health and social care professionals to plan and provide services locally.

2. Our inquiry focused on the role of clusters as a means of transforming primary care. The inquiry's terms of reference were:

- How GP cluster networks in Wales can assist in reducing demand on GPs and the extent to which clusters can provide a more accessible route to care (including mental health support in primary care).
- The emerging multi-disciplinary team (how health and care professionals fit into the new cluster model and how their contribution can be measured).
- The current and future workforce challenges.
- The funding allocated directly to clusters to enable GP practices to try out new ways of working; how monies are being used to reduce the pressure on GP practices, improve services and access available to patients.
- Workload challenges and the shift to primary prevention in general practice to improve population health outcomes and target health inequalities.
- The maturity of clusters and the progress of cluster working in different health boards, identifying examples of best practice.
- Local and national leadership supporting the development of the cluster infrastructure; how the actions being taken complement those in the Welsh Government's primary care plan and 2010 vision, Setting the Direction.
- Greater detail on the aspects being evaluated, the support being supplied centrally and the criteria in place to determine the success or otherwise of clusters, including how input from local communities is being incorporated into the development and testing being undertaken.

3. From 2 December 2016 to 3 February 2017 we ran a public consultation. We received 47 written responses, representing a range of health care organisations, professional groups and individual clinical staff. In addition, we heard oral evidence from a number of witnesses. The schedule of oral evidence sessions is published on the Assembly's website.

4. Committee members also met with GPs, Practice Managers and other representatives from clusters and LHBs at events held in Carmarthen, Caernarfon and Wrexham. The group discussions focused on the maturity of clusters, cluster development, workforce, funding, patient satisfaction, and accountability.

5. The Committee would like to thank all those who have contributed to its work.

02. The background to primary care clusters

6. There are 64 primary care clusters across Wales, serving populations of between 30,000 and 50,000 patients. The geographical area that a cluster covers is determined by individual local health boards. The intention is that clusters are used as local planning mechanisms by grouping several adjacent GP practices together to plan services for the specific population registered with them.

Why were primary care clusters created?

7. The Welsh Government set out the concept of GP services being co-ordinated on a “locality basis” in ‘Setting the Direction (2010)’,¹ its “primary and community services strategic delivery programme”. Referring to the position of primary care and community services in 2010 the document stated:

“Although there are examples of good practice in the delivery of primary and community services within Wales, there is limited evidence of whole-system changes that are delivering significant shifts in the overall models of care, and associated resource and staffing flows. Without this, the agenda will continue to be dominated by the acute hospital. It is also apparent that no single vision for the way in which sustainable services could be delivered in the future - across rural, urban and city environments - has been developed. In the absence of a clear strategic framework, change continues to be small scale and piecemeal and existing service tensions remain.”

8. It went on to say “the status quo [was] not an option” and set out a “proposed system which is predicated on the co-ordination of services on the basis of ‘localities’”, with indicative populations of around 30,000 to 50,000. The intention is that GPs play a key role in supporting these clusters, working with partners to assess and meet local need.

9. The General Practitioners Committee (GPC) of BMA Cymru Wales (BMA) agreed a new contract deal with the Welsh Government effective from April 2014 which resulted in the clusters being established. On this basis, LHBs developed formal arrangements for GP practices to work collaboratively to develop services in their locality.

10. In 2015, the Welsh Government published “Our plan for a primary care service for Wales up to March 2018”.² It emphasised “planning care locally” as one of the five priority areas of its approach and set out a specific aim for clusters, saying:

“As well as planning and delivering more primary care services to meet local need, primary care clusters will play a significant role in planning the transfer of services and resources out of hospitals and into their local communities for the benefit of their local populations.”

11. The 2015 plan went on to say:

“Health boards have already created local planning mechanisms by clustering several adjacent GP practices together using their combined registered

¹ Welsh Government, [Setting the Direction](#), 2010

² Welsh Government, [Our plan for a primary care service for Wales up to March 2018](#), 2015

populations to create a small local planning population. There are 64 of these primary care clusters across Wales, although they are still relatively immature structures, which have focused so far on promoting collaboration between local GP practices. The annual changes to the national GP contract are being used to encourage GP practices to agree and deliver action plans to ensure the sustainability and quality of their services.”

Roles, responsibilities and support for clusters

12. A number of organisations and post-holders have roles and responsibilities to deliver the Welsh Government’s ambitions for clusters, including health boards, Public Health Wales (PHW), GPs and a wide range of NHS, health and social care bodies.

13. The Welsh Government’s 2015 primary care plan³ states:

“Each cluster needs a leadership team with the capacity and capability to fulfil that function, and to agree action plans and key milestones, including the devolved management of services, from 2015-16 which develops its ability to respond to and be accountable for the health and wellbeing outcomes of their local populations.”

“Health board directors of primary, community and mental health will lead cluster development and support this work at a national level by securing a programme of organisational development from Public Health Wales and developing a national set of core governance requirements for cluster working.”

“We want the primary care clusters to develop three-year plans which in turn will shape and underpin the health board level integrated medium term plans. Both the primary care cluster and health board plans will set specific goals and actions for improving access to and the quality of primary care to deliver improved local health and wellbeing and reduced health inequalities.”

14. The health board Directors of Primary, Community and Mental Health (DPCMH) told us they meet monthly on an all Wales basis to work on matters within their remit, including cluster issues. The original expectations for health board support to clusters were extensive, involving:

- Providing support to each cluster network through locality clinical and managerial leads.
- Working with clusters to enable single handed and small practices to engage either through having GP/Practice Manager attending or “buddying” with larger practices.
- Providing information to support needs assessment and service improvement plans.
- Facilitating appropriate links to enable GP cluster network development.
- Ensuring effective and efficient GP cluster network meetings, with actions identified and progress monitored.
- Expanding the delivery of community based services to support care closer to home.
- Promoting cluster review of key priority areas.

³ “Our plan for a primary care service for Wales up to March 2018”

- Ensuring any issues in relation to GP cluster network delivery are considered by the LHB.
- Ensuring that progress and constraints highlighted by GP cluster networks and responses to those issues are fed back to Welsh Government.
- The active support of this agenda, addressing health inequalities and enabling more integrated health and social care at a GP cluster network level.

15. The PHW Primary and Community Care Development and Innovation Hub (the Hub) also has a number of key roles relevant to clusters, specifically to:

- Coordinate support for LHBs and clusters, at a national level, in the delivery of the national plan for primary and community care in Wales.
- Facilitate coordinated delivery on a range of primary care projects.
- Provide support to other projects within the overall work programme for DPCMH.
- Support and enable the evaluation of clusters and Pacesetter projects.
- Work with Other national PHW teams work in partnership with Hub staff to deliver these projects.

16. It is intended that local public health teams also work with the Hub, supporting clusters directly in health board areas, and contributing local knowledge and skills to the national work programme.

17. The PHW Observatory **produced a set of profiles** to support the development of primary care clusters, including: **2015 Practice Profile indicators**, building on Cluster Profiles **published in 2013**; Coronary Heart Disease modelled prevalence analysis (2015); and GP chronic disease population profile 2016 updates.

Pacesetter projects

18. The evidence received by the Committee made extensive references to the **Pacesetter projects**, funded by Welsh Government from 2015-16 onwards.⁴ These are twenty four primary care projects that aim to test elements of the primary care plan, to stimulate innovation, and to promote the redesign of primary care services.

19. The Pacesetter projects focus particularly on new roles within the primary care team which aim to increase capacity within the practice team and develop alternative ways to deliver services through enhanced cluster working, and can be grouped under **four broad themes**:

- referral and demand;
- primary care support;
- pharmacy roles; and
- new models for primary care.

20. The Welsh NHS Confederation⁵ states that the Pacesetter Programme “promotes innovation across primary care”. It acknowledges that the projects are still developing but says:

⁴ Written evidence, PC 21

⁵ Written evidence, PC 24

“The outcome of individual projects inform an emerging model for primary care with the potential to drive transformational change across the NHS in Wales.”⁶

21. Grant Duncan, the Welsh Government’s Deputy Director of Primary Care told us PHW were due to issue a contract in June 2017 to evaluate the work of Pacesetters, with the report due back in February 2018.⁷ The submission from PHW outlined that the areas the evaluation would be looking at would include:

- The contribution clinical triage services and multi-disciplinary teams can make to the management of the primary care workload.
- Integration of out of hours services in ensuring continuity of care.
- Approaches to the internal configuration of clusters.
- The central role of workforce planning in facilitating service transformation and enabling sustainable primary care services.
- The organisation and function of primary care support units, especially in supporting the short-term sustainability of primary care.⁸

⁶ Written evidence, PC 24

⁷ RoP, 7 June 2017, paragraph 42

⁸ Written evidence, PC 20

03. The pace and nature of cluster development

This chapter deals with five key issues which emerged in the evidence:

- The maturity of clusters;
- Cluster leadership;
- The autonomy and governance of clusters;
- The potential for clusters' success to be dependent on key individuals; and
- Whether the necessary organisations and stakeholders are involved in clusters.

22. There were a number of key messages about cluster development in the evidence the Committee received:

- Clusters are at very different stages and levels of development, not just across Wales but also within individual health board areas.
- There are different views on the value and maturity of clusters.
- According to some respondents there is a large degree of reliance on the energy and enthusiasm of individual GPs, GP Practices or cluster leads in terms of driving development in some clusters, and that this is not a sustainable long term model.
- A suggestion from some organisations and professions, such as pharmacy, dentistry and therapies, that clusters are not engaging with them to the extent they would like.
- A belief amongst some key organisations, especially the health boards, that the clusters are working well and have the potential to grow and develop further. At the same time, there is evidence that the continued pressure on primary care services, the ability to recruit, the challenging financial position and time pressures are all real barriers to cluster progress.
- There is a need for a stronger, more settled and local support infrastructure, and a clearer view on the future shape, accountability, powers and structure of clusters.

Maturity

23. The evidence to the Committee suggested that clusters are at different stages of development and maturity, across Wales and within health board areas. In turn this results in some clusters being seen as much more effective than others.

24. Health boards reported that clusters are developing well and have the capacity to mature further. The Directors of Primary, Community and Mental Health told us that a range of cluster models are emerging across Wales at differing paces and rates of maturity. The Directors explained that this is to suit differing local needs and such variety appears to be effective, provided there are standardised outcomes and governance frameworks. They also believed that health boards have strongly prioritised cluster support and development.⁹

25. In oral evidence, representing the DPCMH, John Palmer said:

⁹ Written evidence, PC 21

“[...] at the two-year point, we’re broadly seeing a system that’s maturing faster than we would have expected it to. There’s loads of variation, because we set out to experiment and that means that we’ve seen lots of different things happen from community to community.”¹⁰

26. The BMA stated:

“[...] it is clear that the pace of cluster development has not been uniform across the country and that the new money released by Welsh Government in April 2016 has not yet truly transformed services across Wales. Where there has been some transformative development, [...], it is important that there is a renewed effort to embed that change; we do not know how sustainable the changes will be in the future without renewed effort.”¹¹

27. The Welsh Ambulance Services NHS Trust (WAST) share the widely held view about the varied stages of cluster development across Wales, which is reflected in the varied speed and manner with which WAST has been able to take forward work with clusters. At the same time, WAST note that all GPs acting as cluster leads have been “receptive to suggestions of joint working”.

28. Some respondents were very positive about their local experience. For example the South West Cardiff GP Cluster reported that it has been “working very successfully over the past 2 years with engagement from all 11 GP practices”.¹² However it, and the Wales Cancer Network, and Cardiff Third Sector Council supported the view that there is variability between clusters.

29. Some participants of the Committee’s focus group in Carmarthen reported that their local cluster models were well established and supported, suiting the needs of their areas. However they also felt there was a lack of understanding at a senior level in health boards about clusters.

30. Some participants of the Caernarfon focus group told us there is not enough impetus or buy-in to drive significant changes via the cluster model and that staff are not clear enough about the vision, expected outcomes and the drivers for change. They also said that the funding is not sufficient to be a motivating factor and that GPs are too busy ‘fire-fighting’ to deliver services and keep practices open.

31. Dr Kay Saunders, a GP in Cardiff for 22 years, told us she has been “greatly disappointed by the cluster developments”. She referred to them as a “very amateur structure”, and argued that the overall impact of the approach would be “minimal”, based on her experience to date:

“The plans to which my practice has contributed have made no difference at all. It has been a demoralising, time consuming tick box exercise.”¹³

32. In 2015, the Welsh Government’s assessment of clusters was that they were “still relatively immature structures” which had focused on “promoting collaboration between local GP practices”.¹⁴ The Government acknowledged that cluster working was “progressing at different rates across Wales” and said:

¹⁰ RoP, 3 May 2017, paragraph 87

¹¹ Written evidence, PC 41

¹² Written evidence, PC 04

¹³ Written evidence, PC 44

¹⁴ Welsh Government, [Our plan for a primary care service for Wales up to March 2018](#), 2015

“To a certain extent this is to be expected as the challenges presented in collaborating to meet local need will be varied. For clusters to work effectively however, it is essential they are owned, managed and operated autonomously with their working practices, workforce capacity and skill mix being determined through partnership working between professionals drawn together on the basis of serving the needs of a local population.”¹⁵

33. The Welsh Government therefore set out clear expectations for clusters in its **plans for primary care up to 2018:**

“Health boards need to prioritise and resource the rapid development of each of the clusters in their area. This will involve identifying and drawing in all planners, coordinators and providers of local services and other community resources and local people, becoming increasingly directly accountable for the health and wellbeing of the communities they serve and the use of available financial, workforce and other resources. Each cluster needs a leadership team with the capacity and capability to fulfil that function, and to agree action plans and key milestones, including the devolved management of services, from 2015-16 which develops its ability to respond to and be accountable for the health and wellbeing outcomes of their local populations.”

34. The Cabinet Secretary for Health, Well-being and Sport told the Committee “the pace and scale at which the clusters are maturing varies between and within health boards”. However he also said:

“Through the national primary care plan, cluster working is now progressing beyond a collection of GP practices into fully functioning arrangements.”¹⁶

Cluster leadership

35. Evidence to the Committee pointed to a clear need for effective leadership of clusters, and for it to be structured, supported and sustainable. It also showed there were clear differences of opinion about the extent to which this was happening in different parts of Wales.

36. The DPCMH emphasised that health boards have made significant efforts to support cluster development and stressed the key importance of clinical leaders in educating, advising, supporting and leading innovation.¹⁷

37. Abertawe Bro Morgannwg University Health Board (ABMU) states that “there is clear leadership within each of the 11 cluster network teams from GPs in particular [...]”.¹⁸

38. The Welsh NHS Confederation identified “leadership and support to develop” as one of the main cluster development needs. It referred to the ‘Confident Primary Care Leaders Course’ commissioned from PHW which is aimed at cluster leads and aspiring cluster leads across Wales.

39. Rosemary Fletcher of PHW told us:

¹⁵ Welsh Government, **A planned primary care workforce for Wales**, 2015

¹⁶ **Health, Social Care and Sport Committee, 7 June 2017, Paper 1**

¹⁷ Written evidence, PC 21

¹⁸ Written evidence, PC 07

“The confident leaders programme [...] has taken in excess of 40 of the cluster leads through a development programme in two cohorts. There are nine modules and they’ve been meeting on a monthly basis. That’s providing a networking opportunity for the cluster leads so that they can share and also they’re learning and developing together.”¹⁹

40. The Royal College of General Practitioners (RCGPs) emphasised that consistent leadership and sharing of good practice is essential for cluster development.²⁰

The autonomy and governance of clusters

41. There were mixed views in the evidence we received about the autonomy of clusters. Several responses argued strongly for less health board involvement, more autonomy for the clusters, and increased clinical leadership. A number of responses stated that the need for health board involvement during the initial stages of establishing clusters has reduced and that clusters now need greater autonomy in decision-making and control over cluster funding.

42. The BMA called for the “necessary governance frameworks” to be put in place to enable clusters to “act autonomously and at arm’s length from Local Health Boards”²¹ and become “true legal entities with clearer governance and financial frameworks”. It referred to a survey conducted in 2015:

“Some respondents cited the involvement of health board management as serving to dilute the effectiveness of local plans. Members also reported a general sense that clusters in practice needed to obtain health board approval before proceeding with plans...”²²

43. Dr Ian Harris, also representing the BMA, went on to say:

“We are such agile, innovative people as GPs, because we run our own businesses, that we’ve only got a certain degree of patience with these initiatives, I think, and the danger, if we don’t see quick wins and meaningful change through clusters over the next year or two, is that GPs will disengage from that cluster process.”²³

44. Bro Taf Local Medical Committee (LMC) recommended that “the necessity for Primary Care Clusters to be overseen /controlled by the Health Boards is reconsidered”,²⁴ claiming that:

“In reality, the relative immaturity of clusters and their reliance on existing Health Board processes to implement has stifled the innovation.”²⁵

45. In contrast, the Bevan Foundation pointed to the potential drawbacks of each cluster “going its own way”, and the need to avoid duplication, competition and the potential loss of comparability between clusters. It explained that although autonomy is important in enabling clusters to “reflect

¹⁹ RoP, 3 May 2017, paragraph 89

²⁰ Written evidence, PC 46

²¹ RoP, 3 May 2017, paragraph 89

²² Written evidence, PC 41

²³ RoP, 3 May 2017, paragraph 112

²⁴ Written evidence, PC 17

²⁵ Written evidence, PC17

the specific needs and circumstances of their population and workforce”, there also needs to be “effective coordination between clusters and across health boards and some common standards”.²⁶

46. There were differences between some of the health boards in terms of planning and decision-making processes in respect of clusters. Some of the health boards refer to the arrangements in their area. For example Betsi Cadwaladr University Health Board (BCUHB) states that its executive team agreed in July 2016 that within the following two years, all clusters in its area would have “agreed a governance framework within the Health Board which clarifies their decision making processes, authority to act and accountability arrangements”.²⁷ Similarly Cwm Taf University Health Board said “terms of office and election procedures have been agreed. The Cluster terms of reference to include the decision making process have been ratified.”²⁸

47. The Cabinet Secretary told the Committee:

“The national primary care leadership team has undertaken work on the governance required to enable successful cluster development. As learning surfaces, further national and local work will be needed to support the development of each cluster in line with its own development needs.”²⁹

A reliance on key individuals?

48. Some of the evidence pointed to significant concerns about the lack of capacity for GPs to be involved in cluster working and the reliance of clusters on a small number of key individuals to sustain the model.

49. We heard that some GPs are under extreme pressure to keep practices running and to deliver services to patients. In turn, this meant that being involved in cluster working could not be a priority for most GPs. For example Bro Taf LMC said:

“[...] one of the reasons that clusters have largely failed to meet their true potential is the lack of ‘head space’ for the GPs involved.”³⁰

50. Some participants of the Committee’s focus groups in Caernarfon expressed concern that there was a reliance on one or two key individuals within clusters. Some said that only a small number of GPs and Practice Managers are involved and engaged in clusters and that attendance at meetings can be a “tick box” exercise. We heard that other staff are too busy doing their “day jobs” and therefore do not engage in the feedback from colleagues about cluster meetings. Some participants also suggested there was inconsistent attendance at cluster meetings which made it difficult to take projects forward. They highlighted a need for clearer overall leadership and vision as to what clusters should deliver.

51. Cardiff Third Sector Council told us:

“The maturity of clusters appears to depend on one or two key individuals, often the leads for the cluster, there is the risk that if the cluster relies too

²⁶ Written evidence, PC 37

²⁷ Written evidence, PC 30

²⁸ Written evidence, PC 45

²⁹ [Health, Social Care and Sport Committee, 7 June 2017, Paper 1](#)

³⁰ Written evidence, PC 17

heavily on these individuals that if they move on or are unable to continue in the role that the cluster will slip backwards instead of progressing.”³¹

52. The BMA indicated some concerns about the difficulties practices experience, especially the smaller ones, in participating in cluster development:

“Where clusters have succeeded, it is largely where individuals have shown proactive leadership to develop and operate a successful model. This under-resourced time commitment is additional to other practice and clinical responsibilities and most cluster leads, we understand, are not remunerated for this role despite the level of responsibility and commitment it entails. [...] LMCs have revealed frustration around the timeliness of feedback and with regard to seeing actual movement on projects, leading to a general perception that cluster work will not lead to a return in value.”³²

Whether the right organisations are involved

53. A number of respondents expressed concerns about how effectively the full range of partners are being involved in cluster work. This point was reiterated by evidence from specific groups of professionals who told the Committee they were not being included in clusters as much as they should be. The Committee was also told that clusters still need to increase their focus on the wider primary and community care team, rather than primarily on the role of GPs.

54. Some evidence highlighted what was believed to be good practice. For example, participants at the Committee’s focus group in Carmarthen highlighted that there is a WAST representative involved in their cluster meetings. As stated previously, WAST itself also said that “all cluster leads were receptive to joint working”.³³

55. The Royal College of Nursing (RCN) also said there are real examples of what it believes is good practice in terms of securing nurse involvement in cluster work, and drew particular attention to Cardiff and the Vale and Betsi Cadwaladr UHBs.³⁴ It also said that clusters should work to ensure that stakeholder engagement is as wide as possible, and cluster activities should not focus consistently on the same people and groups, which can pose difficulties for practice nurses “due to time and workload constraints”. It makes the point that the timing of cluster meetings is equally important, as clinical commitments can limit attendance during normal working hours.³⁵

56. The Committee heard strong concerns that clusters were reluctant to, not engaging with, or ignoring dentistry, optometry and pharmacy.³⁶ CPW told the Committee:

“[...] it is disappointing and somewhat perplexing that local community pharmacists and other members of the pharmacy team find themselves unable to contribute to the local cluster agenda”.³⁷

³¹ Written evidence, PC 18

³² Written evidence, PC 41

³³ Written evidence, PC 25

³⁴ Written evidence, PC 10

³⁵ Written evidence, PC 10

³⁶ Written evidence PC 09, 11, 13, 19, 28

³⁷ Written evidence, PC 09

57. The British Dental Association (BDA) said that “clusters are solely focused on primary medical care, rather than primary care”.³⁸ The Welsh Dental Committee said “it may be unrealistic to expect General Dental Practitioners to be part of every Primary Care Cluster” but there should be scope to address issues that dental teams have in common with other primary care practitioners and to link in with cluster work.³⁹

58. PHW itself highlighted the need for wider professional involvement saying it is “aware of variation, ranging from inclusive arrangements to clusters that have a general medical practice focus”.⁴⁰

59. There was a view raised by a number of respondents that initial use of the terminology ‘GP clusters’ was unhelpful and had inhibited their development. The move to using the term ‘primary care clusters’ was welcomed.

60. Aneurin Bevan University Health Board already refer to clusters as Neighbourhood Care Networks (NCNs) to reflect the broader role. It also says that they are “genuine partnerships”, demonstrated by the fact that one cluster is being led by a Public Health Specialist and another by a Senior Nurse (rather than by GPs).

61. Some participants at the Committee’s focus group in Caernarfon expressed concern that there was a lack of integration between the clusters and social care professionals. These issues were raised by the Care Council for Wales, now Social Care Wales. In its written evidence it focused on the role of social care within clusters, emphasising the important role of social work and domiciliary care in supporting the shift to increased support at home and within communities and away from hospitals and residential care.⁴¹

62. John Palmer, of Cwm Taf UHB, pointed to some challenges around having the involvement of a wider group of stakeholders from the outset. He told us:

“[...] one of the issues for my own patch, and I know for others, has been that some clusters grew too big, too quickly. So, what they ended up with was loads of stakeholders around the table and then an almost completely unmanageable agenda because, just like we have big meetings with lots of stakeholders around the table at Government level, health board level and delivery level, clusters were sort of entering into that space and trying to get consensus.”⁴²

63. In oral evidence, Dr Richard Lewis, the Welsh Government’s National Clinical Lead for Primary Care, referred to the make-up of clusters and stated:

“[...] in terms of the multidisciplinary content of clusters, we’ve now moved from 64 per cent to 80 per cent having a broader range of primary healthcare team membership over 12 months. So, we are moving in the right direction. Also, it’s pleasing to note that we’ve got more clusters with local authority representation on them, in terms of making those moves to work with local government, and also increased number of clusters with third sector and lay

³⁸ Written evidence, PC 13

³⁹ Written evidence, PC 38

⁴⁰ Written evidence, PC 20

⁴¹ Written evidence, PC 27

⁴² RoP, 5 May 2017, paragraph 87

representation as well. So, it's, again, early days, but it seems as if the trend is that we're moving in the right direction to truly primary care clusters, rather than just GP clusters."⁴³

Our view: The pace and nature of cluster development

- There is significant variation in the maturity of the 64 clusters and their stages of development. Whilst variation is not in itself a negative, the Committee wants to be assured that this is as a result of responding to local needs, rather than because of a lack of consistency in the pace of development.
- There are differing views about the purpose of clusters and we believe this adds to the variation in how they are developing. Whilst some are very effective at bringing key delivery partners and stakeholders together, in other areas they appear to be primarily seen as a vehicle to apply for funds.
- There is a definite risk of the cluster model's success being dependent on the drive of a few key individuals, with the potential of them focusing on their areas of interest. This is not sustainable. All relevant professionals need the time and space to be meaningfully involved. In the current climate this is a major challenge.
- A key theme that has emerged during the inquiry is that not all the right stakeholders are involved and that some clusters still have a focus on general medical practice. This may be partly because of the lack of national direction, but we acknowledge that clusters are still maturing. Whilst accepting the dangers of clusters becoming unwieldy from having an agenda which is too broad, there must be a point of integration between the clusters and social care professionals.
- We agree with the Welsh Government's premise that primary care services should have a strong focus on local planning and delivery of services to meet the identified health needs of the population. Therefore we support the view that clusters need autonomy. However this must be positioned within a much more defined and structured governance framework. There is a need for a clearer view on the future shape, accountability, powers and structure of clusters. Without this there is a danger of a variety of ad hoc local approaches which will not deliver sustainable change.

Recommendation 1. The Welsh Government should publish a refreshed model for primary care clusters which restates a clearly defined vision for them from the beginning of the new financial year.

Recommendation 2. The Welsh Government should publish guidance for primary care clusters to accompany the refreshed model [Recommendation 1]. This should include good practice and should set out: a basic governance framework; example terms of reference; suggested core membership; quorum requirements for meetings; suggested decision making processes.

Recommendation 3. The Welsh Government should set out its expectation that primary care clusters function in a more agile way rather than being constrained by health

⁴³ RoP, 7 June 2017, paragraph 73

boards' decision making processes. The guidance [Recommendation 2] should set out a clear process for delegating decision making to clusters.

Recommendation 4. The Welsh Government should set a timescale for the publication of primary care cluster plans to promote transparency and to enable scrutiny in a timely manner.

04. Are clusters delivering Welsh Government’s ambitions for primary care?

This chapter sets out six key issues which emerged in the evidence:

- Whether clusters are reducing the demand on GPs and improving access to care.
- The extent to which they are alleviating pressures on secondary care.
- Where they are improving access to mental health support.
- How the cluster model aligns with delivering services that meet the needs of patients.
- The extent to which clusters undertake preventative work and work to address health inequalities.
- The extent to which clusters are using local health data to informing their priorities.

64. There was broad support for the concept behind clusters and the principles of multi-disciplinary team working and greater collaborative working across GP practices. The BMA noted the potential for clusters, if developed properly, to support individual practices:

“Across the medical profession it is clear that there is widespread support for the concept of cluster working as a means to determine and meet the health needs of the local populace.”⁴⁴

65. The BMA also pointed to the GPC Wales’ strong support for the principles behind cluster working, saying:

“GPC Wales is fully committed to cluster networks. For the last two years we have worked with Welsh Government to embed cluster working in the GP contract - and especially in terms of cluster plans which should be closely aligned to HB integrated medium term plans, therefore (in theory) helping health boards to facilitate the transfer of resources towards primary care.”⁴⁵

66. In oral evidence, Dr Charlotte Jones, representing the BMA, stressed that there were some caveats to this support:

“[...] we have a national strategic policy that we’re all signed up to, and we can see the benefit of it—there’s lot of evidence to support working in this way from within the UK and outside of the UK—but that’s not translating into real, transformative change on the ground level for patients, and that’s what we’re all here to do.”⁴⁶

67. Alongside the evidence in support of the concept of clusters, there were concerns about:

- How effectively they are working in practice.

⁴⁴ Written evidence, PC 41

⁴⁵ Written evidence, PC 41

⁴⁶ RoP, 3 May 2017, paragraph 101

- Whether there is a robust evidence base about their impact.
- What their future shape and potential could be.

68. The Cabinet Secretary told the Committee:

“[...] there’s going to be no—from my point of view—walking away from clusters. The idea that we’d say, ‘We don’t think clusters work so we’re going to break them up and start them again’—I think that’d be hugely disruptive and the wrong thing to do for staff and the citizens who rely on the service. So, it’s about how we make clusters work, not about saying we’re prepared to tear it all up and start again.”⁴⁷

Reducing demand on GPs and improving access to care

69. Whilst there was strong evidence in support of the great potential clusters have to reduce demands on GPs, there was limited data to show this is actually happening on the ground. Evidence set out examples which were currently in place, suggestions of new ways of working, and also the challenges that still remain due to the significant demand on GP time.

70. The BMA and the RCGPs refer to the need for caution on the level of cluster impact on demand for primary care services. The BMA said “we have not seen the change on the ground at the pace or scale of what is required to deal with the unprecedented pressures and challenges currently faced by GPs across Wales”. It goes on to say that “we believe that greater and sustained momentum is needed”.⁴⁸

71. The BMA also referred to a survey it conducted in 2015 in which 69.1% of survey respondents said that “cluster work had adversely affected their clinical time”. It also said that “engaging in cluster work thus has a consequence on direct clinical contact, and any engagement in such work must therefore have a demonstrable benefit to practices in addressing wider pressures”.⁴⁹

72. We received considerable detail about the services that clusters have put in place in an effort to support reduced demand on GPs and improve the accessibility of care. For example:

- Additional posts based at GP Practices, for example pharmacists, specialist nurses, and primary care counsellors. However there was limited evidence that these reduced GP workloads. It was also not always clear which posts were CDM funded, as opposed to from other funding streams, such as individual practices or other primary care funding.
- Both PHW and the DPCMH set out that evaluation of the Pacesetter projects has, and will, examine the contribution that can be made to reducing primary care demand through MDT working, clinical triage, better management of complex care needs and better continuity in out of hours care. However, again, there is limited data at this stage to evidence this.⁵⁰
- There were several references in the evidence to social prescribing. Cardiff and Vale UHB indicates that joint working with the third sector on Well-being Co-ordinators has had an impact on demand saying “early indications suggest this resource has helped reduce GP appointments where alternative Third Sector and non-statutory input has been able to be

⁴⁷ RoP, 7 June 2017, paragraph 123

⁴⁸ Written evidence, PC 41

⁴⁹ Written evidence, PC 41

⁵⁰ Written evidence, PC 20

utilised through the use of local community activities e.g. referral to leisure/housing/welfare/community wellbeing activities”.⁵¹

- WAST recognised the value of integrated working between its staff and clusters in supporting “the emerging model for a sustainable primary care service in Wales” and offered a number of examples where WAST is working with clusters.⁵²
- Cardiff and Vale UHB said that “Clusters have also been able to assist in reducing demand on GPs via working with secondary care hospital directorates and specialities via developing new pathways, challenging traditional models and designing more integrated primary/secondary care pathways”.⁵³
- The Emlyn Surgery said “cluster work can reduce the demand on GPs for instance by the excellent work of pharmacists and frailty nurses in some areas [...]”. It goes on to say however “the patients are certainly getting better care and the work may be reducing in acute hospital admissions but the overall effect is not one of reduction in demand for GP time etc”.⁵⁴

73. Several responses acknowledged the potential that clusters have to reduce demand on GPs and also to improve access to care. Examples included:

- The BDA say “Clusters need to acknowledge that they are also the key to maintaining access to dental, optometric and pharmacy services in these challenging times”.⁵⁵
- The Chartered Society of Physiotherapy (CSP) and the DPCMH report that musculoskeletal (MSK) services within cluster teams are resulting in reductions in GP consultations for MSK conditions.⁵⁶ However whilst many of the clusters have invested in additional physiotherapy services, there was limited hard evidence to prove that this has directly reduced the pressure on GPs.
- The evidence suggested that not much cluster funding has been targeted at Occupational Therapy and Speech and Language Therapy services.
- Cymorth Cymru refers to the need to integrate primary care with local authority and third sector services and say the cluster model can “benefit those with complex needs and the most vulnerable in our society”. It recommended better integration with local authority and third sector services that support people to deal with social and economic issues such as housing and welfare reform. It believes “the cluster model can meet many of these needs, whilst also reducing pressure on GPs”.⁵⁷
- Glamorgan Voluntary Services also emphasise the need for the third sector to be integrated into clusters, emphasising how this sector can relieve pressure on general practice and the wider health care sector.⁵⁸

⁵¹ Written evidence, PC 33

⁵² Written evidence, PC 25

⁵³ Written evidence, PC 35

⁵⁴ Written evidence, PC 05

⁵⁵ Written evidence, PC 13

⁵⁶ Written evidence, PC 08

⁵⁷ Written evidence, PC 23

⁵⁸ Written evidence, PC 02

- Some participants at the Committee’s focus group in Carmarthen believed that the emphasis in primary care should not necessarily be about improving faster access, but more on continuity of care and enabling patients to see the same healthcare professional.

74. Many respondents highlighted the challenge to clusters that they are developing their work against a backdrop of continued high pressure on primary care. For example:

- The Welsh NHS Confederation say that “demand on primary care continues to be high” and that clusters “have a key role to play in re-shaping the response to demand through identifying training needs and opportunities at a very local level and identifying local gaps in the service”.⁵⁹
- Bro Taf Local Medical Committee stated that “workload in primary care is rising exponentially”. It also says “there is a great degree of variance between the effectiveness of Primary Care Clusters. There are certainly examples of outcomes arising from individual clusters which are thought to have a positive impact on demand in General Practice”.⁶⁰
- The North Cardiff Cluster is the largest cluster in Wales with 11 practices and a population of 107,000 patients. In written evidence, it said “there were mixed feelings about the wider purpose of the cluster with some feeling that the cluster generates more work”. It also said that GP services remain the “first port of call” and that “demand continues to rise with schemes allegedly developed to reduce GP workload (e.g. NHS Direct, Community Pharmacy schemes) having little if any impact”.⁶¹

75. The Bevan Foundation urged the Committee “to recognise that the pressures on general practice are the result of multiple and interrelated drivers, not only the result of patient demand”.⁶² It refers to recent research by the Kings Fund⁶³ identifying “system pressures” (such as public health campaigns and the introduction of new services and also “supply-side pressures” (such as workforce issues and funding).⁶⁴ The Bevan Foundation argued that:

“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.”⁶⁵

76. The Cabinet Secretary suggested that clusters could be impacting positively on GP capacity:

“This extended general primary care team model is resulting in better access ensuring people are directed to the right professional within the team without unnecessary delays. It also releases GP capacity to improve access for those who do need to see a GP including those people with more complex needs. Aneurin Bevan University Health Board has reported in a three month period, pharmacists replaced 1842 hours of GP time.”⁶⁶

⁵⁹ Written evidence, PC 24

⁶⁰ Written evidence, PC 17

⁶¹ Written evidence, PC 42

⁶² Written evidence, PC 37

⁶³ Beccy Baird, Anna Charles, Matthew Honeyman, David Maguire, Preeti Das (2016) Understanding pressures in general practice, Kings Fund

⁶⁴ Written evidence, PC 37

⁶⁵ Written evidence, PC 37

⁶⁶ Health, Social Care and Sport Committee, 7 June 2017, Paper 1

77. He challenged the concept of “reducing the demand”:

“I think that’s probably the wrong way to look at it, if we’re just being perfectly honest, because there will always a demand for how people are dealt with, whether it’s about making sure they go to a pharmacist instead of coming into a GP surgery for an appointment.”⁶⁷

Moving demand from secondary care

78. In 2015, the Welsh Government emphasised that clusters would:

“[...] play a significant role in planning the transfer of services and resources out of hospitals and into their local communities for the benefit of their local populations.”

79. The Royal College of Physicians (RCP) emphasised the importance of a future model of care which involves more specialised services being delivered in or close to the community:

“[...] the system must operate in a far more joined up fashion if we are to prevent unnecessary hospital admissions.”

“GP clusters must also be encouraged to focus on unscheduled care rather than scheduled care from next year. We acknowledge that the problems in unscheduled care are far trickier to solve, and they understandably haven’t been the focus of GP clusters so far. However, the system must operate in a far more joined up fashion if we are to prevent unnecessary hospital admission.”⁶⁸

80. Lowri Jackson representing the RCP told us it has 1,200 members in Wales most of whom are based in hospitals dealing with unscheduled care. She went on to say:

“An overwhelming number of them said that they’d had very little engagement with GP clusters. Actually, even the specialty leads in certain areas said they hadn’t had that much engagement with the clusters. So, there’s a huge missed opportunity there to join up those two sectors.”⁶⁹

81. Cardiff and Vale UHB emphasise that clusters have a significant collaborative role to play in planning the transfer of services into the community, but say that the cluster agenda is becoming so demanding there is limited time to develop networks and generate new ideas.⁷⁰

82. Specific practices suggest there is very limited engagement between clusters and secondary care, for example Morfa Lane Surgery stated there is “poor engagement with some Secondary Care Services”.⁷¹ We were also told by a practice in BCUHB that as secondary care appeared under significant pressure, staff based within it did not have time to come to cluster meetings if invited, for example to discuss decisions relating to urgent potential cancer referrals.

⁶⁷ RoP, 7 June 2017, paragraph 7

⁶⁸ Written evidence, PC 12

⁶⁹ RoP, 11 May 2017, paragraph 8

⁷⁰ Written evidence, PC 33

⁷¹ Written evidence, PC 01

83. We heard about a number of examples where clusters could support moving demand from secondary care:

- The CSP pointed to the potential benefits of self-referral/direct access and community-based physiotherapy, with the latter focusing especially on falls prevention, reablement and community pulmonary rehabilitation.⁷²
- The Royal College of Psychiatrists (RCPsych) argued there is still the risk that secondary care will remain under pressure because of the lack of capacity within primary care to address mental health issues.⁷³
- The Royal College of Speech and Language Therapists (RCSLT), referring to speech and language therapists, stated “significant additional opportunities exist to utilise SLTs to support the shift from hospital to community care”.⁷⁴
- The National Community Hearing Association argued that making hearing a primary care service in Wales could reduce pressures on GP practices and hospitals.⁷⁵
- The Wales Cancer Network suggested there should be more effective integration between primary and secondary care and that “this should be a matrix approach – laterally how Clusters link together their constituent practices and clusters themselves and vertically with secondary and tertiary services”.⁷⁶

84. The Cabinet Secretary’s written evidence to the Committee stated:

“Each cluster, as it matures, has the potential to enable and support coordinated care across the whole health and care system. The cluster can work with hospital based colleagues to develop new care pathways and better use of technology, making referrals only when necessary and returning people to the care of the primary care team as soon as possible. Multi professional teams and new professional roles can contribute significantly not only to the sustainability of primary care, and also impact on the unprecedented demand and pressures on unscheduled and scheduled care services in the acute setting.”⁷⁷

Access to mental health services

85. Professor Keith Lloyd, representing the RCPsych, cited RCGP data from 2014 saying:

“[...] out of every 1,000 people who go to see their GP, about 300 have a mental health problem: 230 will be seen, 24 will be referred on to secondary mental health services and six will eventually be admitted to either psychiatric hospitals or crisis teams. So, the vast burden of that workload falls on the primary care team.”⁷⁸

⁷² Written evidence, PC 08

⁷³ Written evidence, PC 22

⁷⁴ Written evidence, PC 15

⁷⁵ Written evidence, PC 31

⁷⁶ Written evidence, PC 32

⁷⁷ Health, Social Care and Sport Committee, 7 June 2017, Paper 1

⁷⁸ RoP, 17 May 2017, paragraph 6

86. In its written evidence, Mind Cymru also refer to the prevalence of mental health issues within the GP workload saying the “vast majority (81%) of people first come into contact with mental health services via their GP, and it is estimated that one third of GP appointments involve a mental health component”.⁷⁹

87. The RCPsych’s written evidence suggests the development of Local Primary Care Mental Health Support Services (LPCMHS) has been “patchy” across Wales.⁸⁰ As a result, the RCPsych believe that many GPs are over-prescribing antidepressants, often due to a lack of available psychological interventions. It stated:

“GPs have expressed concern that they cannot deal with the increase in the mental health workload and that they are feeling less confident in managing complex cases, particularly where external social factors such as debt or unemployment are causing mental health issues.”⁸¹

88. Cluster investment in mental health link workers and community dementia support workers was highlighted in the responses from the Welsh NHS Confederation, Cardiff North Cluster, Cardiff and the Vale UHB; and Cwm Taf LHB. BCUHB pointed specifically to its Primary Care Counselling Service which it says has expanded and developed rapidly as a result of investment from two clusters.⁸² The DPCMH written evidence states:

“It is clear that rapid access to appropriate and locally driven mental health provision is becoming a strong theme in emergent cluster plans around Wales. The second year of cluster plans across Wales shows evidence of clusters commissioning MIND and other providers for in-practice mental health clinics.”⁸³

89. Whilst health board directors told us that mental health was very much part of cluster plans, we also received some evidence that this hadn’t yet had an effect at local level. For example Morfa Lane Surgery stated “cluster meetings have little impact on mental health generally”.⁸⁴

90. The Cabinet Secretary described cluster level working as “an excellent way” for partners to work together to plan local primary mental health support services.⁸⁵

Patients’ experiences

91. A key theme in the evidence was the challenge of changing patients’ perceptions about which professional they should be seen by when they contact the GP Practice. This is seen as a barrier to the development of cluster working.

92. Some participants at the Committee’s focus groups with cluster professionals in both Caernarfon and Carmarthen emphasised the need to change patient expectation in terms of the appropriateness of seeing a range of primary care professionals rather than always seeing the GP.

⁷⁹ Written evidence, PC 36

⁸⁰ Written evidence, PC 22

⁸¹ Written evidence, PC 22

⁸² Written evidence, PC 30

⁸³ Written evidence, PC 21

⁸⁴ Written evidence, PC 01

⁸⁵ [Health, Social Care and Sport Committee, 7 June 2017, Paper 1](#)

Examples were given of patients insisting on an appointment with a GP, despite there being other staff such as a practice nurse who it may have been more appropriate for them to see.

93. We were told by some participants in the Carmarthen focus group that whilst some patients are moving to a preference of seeing a nurse practitioner, older people in particular have a continuing preference to be seen by a GP, even when they may not be the most appropriate person. They referred to work by the Older People's Commissioner for Wales which suggests that older people prefer not to be "triaged" by a non-clinical member of staff.

94. We were told by some participants in the Caernarfon focus group that there needs to be a clear strategy to move forward patient's attitudes and expectations to match the drive for primary care services to be multi-disciplinary. They recommended that Welsh Government take forward a national campaign that takes into account the demographic of the range of target audiences, and therefore not based entirely on social media.

95. This call for a national campaign was strongly supported by PHW and RPS.⁸⁶ The need to change public perceptions was emphasised by Alan Lawrie, representing the DPMCH.⁸⁷

96. The Bevan Foundation said "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" and says the most recent data on GP satisfaction⁸⁸ is "nearly three years out of date". It goes on to say:

"The paucity of evidence means that it is very difficult to monitor performance and satisfaction with primary care from a patient perspective. [...] 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."⁸⁹

97. The Committee did not receive evidence that there was patient or community involvement in cluster planning and decision-making.

98. The Cabinet Secretary's written evidence referred to the importance of the patient experience:

"Critically, and common to all these examples of change, is the need to involve and work with local communities, families and individuals in a range of different ways. This helps explain the changes and their rationale and to support people to know how and when to access services."⁹⁰

Preventative work and addressing health inequalities

99. The Committee wanted to find out how effective clusters are in addressing health inequalities and developing service provision outside the traditional medical model. We also wanted to see the extent to which they are taking forward the preventative agenda.

100. There was support amongst responses for the value of clusters taking on a prevention role and supporting more non-medical model solutions such as social prescribing. However, respondents

⁸⁶ Written evidence, PC 20 and 28

⁸⁷ RoP, 3 May 2017, paragraph 36

⁸⁸ 1 National Survey for Wales 2014/15 GP Services <https://statswales.gov.wales/Catalogue/National-Survey-forWales/2014-15>

⁸⁹ Written evidence, PC 37

⁹⁰ [Health, Social Care and Sport Committee, 7 June 2017, Paper 1](#)

raised concerns about capacity and argued that clusters could not take sole responsibility for tackling these issues.

101. A number of submissions, especially from NHS Wales bodies, echoed the view of the Welsh NHS Confederation, who stated that:

“The MDT approach to Cluster working, with a workforce based on population health needs, offers opportunities to focus on prevention and early intervention. In planning for future services, it will be essential to factor in services that support self-care, social prescribing and the promotion of health and well-being outside the traditional medical model.”⁹¹

102. However Dr Shore-Nye, representing the RCGPs, said that whilst there may be a role for clusters to address health inequalities, the issue was wider than just within the cluster team.⁹² Dr Charlotte Jones, representing the BMA, supported this view. Referring to clusters aims to increase uptake of some screening programmes amongst “vulnerable and more hard-to reach areas” she said:

“I haven’t seen any evidence to say that, actually, having that in a cluster report and a cluster discussion has led to a real change in uptake rate. I would argue that it’s not always the responsibility of the cluster and the practices [...]”⁹³

103. Health boards provided examples of efforts in their areas:

- BCUHB referred to capacity issues, indicating that the ability of primary care to deliver on the preventative agenda could be limited by workload demands on individual GP practices. It referred to two clusters in its area identifying obesity as a priority and that one had worked with Public Health and Dietetic services to develop a service model and pathway for referral.⁹⁴
- Aneurin Bevan UHB also reported an increasing focus on prevention and early intervention to avoid hospital admissions and promote well-being, giving examples in its area.⁹⁵
- Alan Lawrie, representing the DPCMH, referred to examples in Powys THB saying “[...] identifying health inequalities across the patch is a little harder, but the issues of rural isolation are certainly an issue for us in mid Wales”.⁹⁶
- Cardiff and Vale UHB point to the “introduction of Well-being Co-ordinators who work at the interface between GPs and the community, with a focus on delivering public health priorities for the cluster population, and enhance the social model of care (social prescribing), through their use of community networks”.⁹⁷

104. Other examples were also provided, such as:

- The Welsh Dietetic Leadership Advisory Group points to the link between health inequities and poor diet and says there are opportunities for “primary prevention work to be

⁹¹ Written evidence, PC 24

⁹² RoP, 3 May 2017, paragraph 179

⁹³ RoP, 3 May 2017, paragraph 178

⁹⁴ Written evidence, PC 30

⁹⁵ Written evidence, PC 43

⁹⁶ RoP, 3 May 2017, paragraph 83

⁹⁷ Written evidence, PC 33

undertaken at cluster level by trained workers who understand the barriers and opportunities in that community”.⁹⁸

- CPW, the CCA and the RPS all emphasise strongly the role pharmacists can play in both prevention and improving health outcomes for example smoking cessation, emergency contraception and needle exchanges.⁹⁹
- This emphasis on the importance of the wider MDT and service partnerships is noted by the Cardiff Third Sector Council who set out that primary prevention in General Practice is not necessarily dependent on GPs, with the third sector able to work with clusters through neighbourhood partnerships.¹⁰⁰
- Cymorth Cymru’s view on the benefits of the Supporting People Programme, which provides housing-related support to vulnerable people, and social prescribing, involving referral to community groups or non-medical support.¹⁰¹
- The social prescribing approach supported by MIND Cymru, Cardiff and the Vale UHB, Cardiff Voluntary Sector Council and BCUHB.¹⁰²

105. An issue raised by a cluster lead in BCUHB was the important question of how you divide up cluster funding to tackle the health inequalities agenda. So, for example, if the cluster employ a physiotherapist, then should their time be divided equally across the practices? Or should it be divided half and half between the two practices with the biggest need for the service?

106. The Cabinet Secretary argued that “primary care cluster working can support primary prevention, both through provision of services and through appropriate signposting”. He also said:

“The shift of greater resources into primary care allows for even more targeting of efforts and outreach work that enables more early intervention.”

107. We asked the Cabinet Secretary whether there is hard evidence that clusters are working systematically to tackle health inequalities, or whether the money is being allocated across GP practices in a very general way. He told us:

“Well, part of what we’ve done in creating these is that groups of health professionals can come together to plan their service to meet the needs of their local population. It isn’t simply about splicing up the money to make sure that each GP practice can say, ‘We’ve got a share of the money’. It’s actually about how you meet the need within that population.”¹⁰³

Using local health data to inform cluster priorities

108. The Welsh Government’s ambitions are for health intelligence to inform cluster action plans. Its NHS Wales ‘GP One website’ states:

⁹⁸ Written evidence, PC 34

⁹⁹ Written evidence, PC 09, 19 and 28

¹⁰⁰ Written evidence, PC 18

¹⁰¹ Written evidence, PC 23

¹⁰² Written evidence, PC 18, 30, 33 and 36

¹⁰³ RoP, 7 June 2017, paragraph 133

“Robust primary care cluster action plans will be informed by evidence on population health needs and evidence on effective interventions to improve health and reduce inequalities. Evidence requires careful interpretation; potential actions require prioritisation and implementation plans will need evaluation. The local public health teams embedded within health boards have a key role to play in supporting clusters to undertake these tasks.”¹⁰⁴

109. PHW emphasised the importance of clusters having good intelligence about their local population, highlighting areas of deprivation and health inequality:

“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.”¹⁰⁵

110. However, it highlighted the significant workload challenge associated with this:

“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.”¹⁰⁶

111. The BMA questioned the extent to which public health data is informing cluster plans:

“While each cluster does maintain links with Public Health Wales and receives information on public health issues, the interface could be improved. As a result we remain to be convinced this aspiration has become reality, or that it is driving cluster working or priorities.”¹⁰⁷

Our view: Are clusters delivering Welsh Government's ambitions for primary care?

- There must be a major step-change if clusters are to have a significant impact and a role in delivering the Welsh Government’s ambitions for primary care.
- We support the Welsh Government’s view that primary care planning and delivery should be undertaken at a local level. General practice is clearly a core element of primary care, but increasingly a wide range of other services and professionals have a vital role in its delivery.
- The cluster model does have the potential to reduce pressures on GPs and secondary care in many different ways and ultimately improving patient’s experiences. There is very limited evidence that these potential benefits are being realised to a significant extent at this time. This is a concern.

¹⁰⁴ GP One website

¹⁰⁵ Written evidence, PC 20

¹⁰⁶ Written evidence, PC 20

¹⁰⁷ Written evidence, PC 41

- We fully support the Welsh Government’s aim for clusters to play a significant role in planning the transfer of services and resources out of hospitals and into their local communities. This will not happen without an increased impetus and focus on how secondary care professionals can be meaningfully involved in cluster working and how clusters can engage in the very big challenges around reducing unscheduled care. The Welsh Government must set out a clear plan as to how this aspect of cluster work will be taken forward.
- There are many practical barriers that prevent clusters reducing the significant GP workload including: the lack of time for professionals to properly engage with clusters, and numerous practical and HR issues dealt with later in this report. One concern is that GPs end up with less capacity for their clinical work due to an increasing management role for the new multi-disciplinary staff teams.
- We support the need for a national campaign, building on the existing Choose Well Strategy, to increase patient’s understanding and support for the increased multi-disciplinary team approach.
- It is clear that GP’s workload includes treating a significant percentage of patients experiencing mental health difficulties and that clusters have a key role to play in providing support. Whilst some Cluster Development Money has been targeted at mental health, there is limited evidence to date of improved access to care.
- There are some examples of clusters taking forward preventative work, but it is not clear that clusters have the capacity and drive to take forward this substantial agenda. Similarly there is limited evidence to date of clusters prioritising tackling health inequalities. However, we accept that this work is at an early stage and this cannot be an agenda for clusters alone.
- The Welsh Government’s ambitions for primary care are clear, but evidence of whether they are being delivered and the extent to which progress can be attributed to clusters is limited.

Recommendation 5. The Welsh Government should develop and action a national campaign aimed at patients which supports and promotes the primary care cluster model. Building on the ‘Choose Well’ campaign, it should be aimed specifically at changing attitudes and promoting the view that all primary care professionals have equal value in their areas of expertise.

Recommendation 6. The Welsh Government’s guidance [Recommendation 2] should set out practical ways and examples of how primary care clusters and secondary care staff should engage with each other in order to deliver on the existing expectations for clusters to have an impact on secondary and unscheduled care.

Recommendation 7. The Welsh Government’s guidance [Recommendation 2] should clarify its expectations for clusters both with regard to their impact on local health inequalities and also the extent to which they should be taking forward preventative work. It should also include good practice examples.

05. A workforce to deliver the cluster model

Much of the evidence on clusters focused on issues related to staffing. It highlighted the many practical issues and challenges in securing the right workforce to deliver the cluster model.

These issues are referred to in more detail in this chapter and include:

- The benefits of multi-disciplinary team working and the associated challenges.
- Challenges arising from the shortage of GPs and other health professionals.
- Governance, employment of cluster staff, and clinical supervision.
- Workforce training and skills development for the new cluster model.

There were also significant concerns about the short term nature of cluster funding and a view that it makes it difficult to recruit and retain staff. This evidence is dealt with in more detail in chapter 6 relating to funding.

The multi-disciplinary team and associated challenges

112. The Welsh Government plans for primary care identify the multidisciplinary team (MDT) as a key element required to delivering future services:

“Collaboration through primary care clusters creates better opportunities to take an innovative approach to designing primary care. Innovation in primary care is about generating new funding models, new service models and workforce roles, new ways of contracting and new partnerships with communities and the third and independent sectors.”

113. The Committee heard that cluster funding had been used to put in place a wide range of additional posts, including: Pharmacists; Advanced Nurse Practitioners, Specialist Nurses; Extended Scope Physiotherapists; Paramedic Practitioners; Counsellors; Physician Associates; third sector Wellbeing Co-ordinators; and Advanced Paramedic Practitioners.

114. There was overwhelming support in the evidence for this move towards more MDT working in primary care. For example participants in the Committee’s focus group in Carmarthen emphasised the need to change ways of working in primary care, with health professionals other than GPs taking more of a role.

115. Health boards and their directors of primary care were also supportive of the MDT approach. The DPCMH highlighted the importance of effective collaboration with both local authorities and the third sector:

“There are significant opportunities to manage primary care demand through an MDT approach, matching cluster workforce expertise with the needs and demands of the local population.”¹⁰⁸

¹⁰⁸ Written evidence, PC 21

116. The RCP set out clear support for the MDT philosophy, envisaging additional investment in a number of services and significantly changed roles:

“It is becoming increasingly clear that the community-based health and social care workforce will need to change and diversify in the future. Primary care should include more specialty clinics in the community which work with advanced nurse practitioners, specialist nurses and physician associates, for example. Optometry and podiatry services should be more widely commissioned in primary care, nursing shortages should be addressed, and innovative models of staffing involving allied health professionals such as occupational therapists and physiotherapists should be promoted. Pharmacists must play a bigger role in treating more complex patients with long term conditions. Paramedics must be an integral part of these teams, helping to assess patients at an early stage of their treatment journey.”¹⁰⁹

117. This type of approach was endorsed by a range of agencies and stakeholders with an emphasis on the importance of including specific professional groups, seen as integral to effective delivery of primary care.¹¹⁰ Respondents also highlighted the benefits of cluster MDT working as: being able to test new and alternative service models, without the potential risk to single practices; the provision of holistic care based on local needs; and the potential for sharing skills.

118. PHW stressed that there needs to be attention paid to how successful MDT pilots are transformed into sustainable and established models of care. The Welsh NHS Confederation noted the wide range of professionals playing key roles in primary and community care, but emphasised:

“There is a strong desire from our members for Clusters to have multi-disciplinary workforce model and future collaboration between practices depending on local need and geography because one size does not fit all.”¹¹¹

119. Some health boards and the Welsh NHS Confederation cautioned that the increased involvement of other professions may have an impact in terms of increasing the complexity of the GP workload, alongside the additional responsibilities of managing an expanded MDT.¹¹² This was echoed by a number of other respondents, and some of these issues are discussed in chapter 4.

120. John Palmer, representing the DPCMH, highlighted challenges around clarity about the scope of professional practice and the potential for role overlap between members of the MDT. Alan Lawrie, also representing DPMCH, referred to “some issues with GPs in terms of having manage this growing multi-disciplinary team and feeling confident to be able to manage a growing number of health care professionals [...]”.¹¹³

Challenges arising from the shortage of GPs and other health professionals

121. There were clear concerns that the development of clusters is set against persistent and significant workforce challenges, with real difficulties in recruiting and retaining GPs and other key health professionals. Some of the evidence suggested that the limited number of appropriately skilled

¹⁰⁹ Written evidence, PC 12

¹¹⁰ Written evidence, PC 06, 09, 10, 14, 15, 16, 22, 25, 28 and 43

¹¹¹ Written evidence, PC 24

¹¹² Written evidence, PC 24

¹¹³ RoP, 3 May 2017, paragraph 22

staff means that clusters risk creating an “internal market”,¹¹⁴ with several organisations being in pursuit of the same limited number of staff. In principle therefore, the MDT and cluster model, involving greater sharing of skills, was seen as key to tackling some of these hard to tackle workforce issues. In practice, it was suggested that some aspects of cluster development could be amplifying them.

122. The difficulties in recruitment and retention for primary care were highlighted by many respondents, and are explored in more detail in the Committee’s recent report¹¹⁵ on medical recruitment.

123. Aneurin Bevan UHB stated that nearly 20% of its GPs are likely to retire in the next 10 years. Both Betsi Cadwaladr and Hywel Dda health boards pointed to the increasing number of practices which are directly health board managed, largely due to workforce and sustainability issues. Hywel Dda UHB also says that it expects 30% of its GPs to retire in the next five years and that recruitment is increasingly hard because of the geographical location of some of its practices. It also highlighted that 24 of the 53 GP practices in its area have registered populations of below 7,500 which make them increasingly fragile and unsustainable.¹¹⁶

124. The Welsh NHS Confederation also pointed to the “fragility of many practices across Wales”:

“The rapidly shrinking GP workforce is one of the most challenging aspects of primary care, with increased workforce pressures, unstable practices and risks to the quality of patient care.”¹¹⁷

125. Participants at the Committee focus group in Carmarthen also raised this issue, indicating that because there were insufficient staff trained to undertake the roles required, practices and clusters were often competing for the same staff. This view was reiterated by WAST.

126. In oral evidence, representing the DPCMH, Alan Lawrie said¹¹⁸:

“[...] there is the same quantum of physiotherapists, pharmacists, nurses and so on and so forth. The jobs that we’re creating are interesting and exciting jobs, so therefore people are attracted to those. That’s going to create potential recruitment problems elsewhere in our system, whether that’s in our community hospitals or in our district and general hospitals, potentially, et cetera, because they see an exciting job working in a practice or at cluster level.”

127. Referring to the workforce, Dr Ian Harris, representing the BMA, said:

“[...] there is a fixed resource around bringing people into clusters because you are moving the resource—moving the deck chairs around the Titanic, if you like.”¹¹⁹

¹¹⁴ Written evidence, PC 25

¹¹⁵ [Health, Social Care and Sport Committee report on medical recruitment – June 2017](#)

¹¹⁶ Written evidence, PC 06

¹¹⁷ Written evidence, PC 24

¹¹⁸ RoP, 5 May 2017, paragraph 44

¹¹⁹ RoP, 3 May 2017, paragraph 145

128. The submissions from RPS, CPW and CCA express significant concerns about workforce issues relating to pharmacists, arguing that there is a danger of insufficient number of available pharmacists being spread too thinly across GP practices, with most of the 100 working in clusters being drawn from secondary care. It is also suggested that cluster investment is being targeted at recruiting additional pharmacists without first identifying capacity amongst existing pharmacists.¹²⁰

129. BCUHB indicated that 12% of the current nursing and midwifery staff are above retirement age and that there is no evidence to suggest this will not be the case within the primary care nursing group. It says that “a shortage of appropriately trained and experienced nursing staff will present a significant challenge to developing new models of care”.¹²¹ The RCN emphasised that treating increased numbers of patients in home and community settings needs sufficient investment in the primary and community care workforce.

130. Similarly the COT, CSP and RCSLT all had concerns about the difficulties in recruitment and retention in relation to the staff they represent. The RCSLT called for a strategic approach, without which it said there would be a risk of inequity of service, and a “new era of shortage of supply”.¹²²

131. However the DPCMH suggested the development of the MDT approach and shared expertise across the clusters was a way of addressing staff shortages stating:

“The fragility of many practices across Wales has a range of causes including increased volume and complexity of workload, and difficulties in recruitment. The rapidly shrinking GP workforce is one of the most challenging aspects of primary care, with increased workforce pressures, unstable practices and risks to the quality of patient care. There is an urgent need to increase capacity in the system, with new workforce roles and alternative models that do not simply move existing resources around the healthcare system.”¹²³

132. The DPCMH submission emphasised the need for co-operative working, saying:

“The enhanced cluster team offers flexibility and responsiveness to changing conditions and demand, promoting sustainability, resilience and improved economies of scale.”¹²⁴

133. Several responses pointed to the Welsh Government’s Ministerial Taskforce on Primary Care. For example, Dr Charlotte Jones, representing the BMA, told us:

“Certainly, the ministerial taskforce, and the fact that the Minister chairs that, has made a difference with respect to looking at general practice recruitment specifically, and the initiatives around paying for the examination for GP specialty trainees across Wales, and the additional moneys for those going into hard-to-recruit areas, is showing benefits this year in terms of increased applications for those areas, and to Wales.”¹²⁵

¹²⁰ Written evidence, PC 09

¹²¹ Written evidence, PC 30

¹²² Written evidence, PC 15

¹²³ Written evidence, PC 21

¹²⁴ Written evidence, PC 21

¹²⁵ RoP, 3 May 2017, paragraph 148

134. The Cabinet Secretary’s written evidence referred to the Welsh Government’s ‘Primary Care Workforce Plan’ 2015:

“As well as supporting cluster working, the plan includes a number of actions to stabilise core sections of the workforce, including GPs and nurses, by supporting people who want to return to practice or work part-time; exploring how training and working in general practice can be encouraged in areas of greatest need and communicating the opportunities afforded by general practice in Wales.”¹²⁶

135. When questioned about the potential dangers of clusters creating ‘an internal market’ competing for the same range of primary care staff, the Cabinet Secretary said:

“Well, there’s an honest challenge here about how we get our whole service to plan and work together, so that you’re not pinching from different parts of the service and just shifting different pressures around [...]”

“That’s part of the conversation that we expect people to have. It is part of our expectation of being a small country and then having enough people to be able to sit down in the same room to talk through and agree on some of the challenges rather than simply going about saying, ‘Well, I’m prepared to pay more’, because otherwise we end up driving costs up in a way that doesn’t necessarily deliver a better service.”¹²⁷

Governance, employment of cluster staff, clinical supervision

136. The challenges around these issues was a key theme to emerge from the evidence. In particular we heard about the significant difficulties arising from the fact that clusters cannot employ staff themselves because they are not legal entities and have no legal status.

137. Bro Taf Local Medical Committee and the BMA both commented that the current cluster model limits the ability of clusters and individual practices to directly recruit and employ additional staff with cluster funding. The BMA response stated that:

“There is a need for greater working at scale to share costs and resources (e.g. workforce and facilities), which clusters cannot enable due to their lack of status as legal entities. Federations of practices could exist within, or between, cluster networks and could potentially offer greater flexibility in terms of employment options both for GPs and the wider primary care team such as pharmacists, physiotherapists, and advanced paramedics.”¹²⁸

138. Protracted timeframes for recruitment and delays in human resource support were cited as significant challenges by the Cluster Lead in Cardiff North and the Cardiff and Vale UHB, as well as by the BMA.¹²⁹ The Cardiff and Vale UHB response stated:

¹²⁶ **Health, Social Care and Sport Committee, 7 June 2017, Paper 1**

¹²⁷ RoP, 7 June 2017, paragraph 100 and 101

¹²⁸ Written evidence, PC 41

¹²⁹ Written evidence, PC 42 and 33

“The recruitment process is further complicated by the governance arrangements for appointing staff to work at a cluster level but be managed by the relevant health board operational team because clusters are not statutory bodies in their own right. Addressing these recruitment issues will speed up the maturity of cluster working.”¹³⁰

139. However, the evidence we heard from the allied health professionals supported the principle of those professionals being directly employed by LHBs. Dr Alison Stroud, representing the RCSLT, told us:

“Our preferred model would be that the allied health profession staff are employed by the LHB, but with a service level agreement to either one or two GP clusters, depending on what the service was going to be, because that’s a safer way of ensuring that you’ve got practitioners who are being properly developed and are safe for the public.”¹³¹

140. This view was supported by Ruth Crowder representing the COT.¹³² She told us that a “pooled approach” would enable the rotation of staff and access to LHB services, while also facilitating supervision and governance.¹³³

141. There were concerns expressed in a number of consultation responses about some of the clinical governance issues raised by the increased MDT and enhanced clinical roles amongst therapy and other staff.

142. The Wales Cancer Network also raised this issue; whilst supporting the increased involvement of a wider range of professionals in primary care, it identified the need for a supporting competency and governance framework, especially if other professionals were taking on clinical work undertaken previously by GPs.¹³⁴

143. The DPCMH also set out in their oral evidence to the Committee the need for role clarity, to avoid professional overlap, and concerns about the capacity of GPs to manage a growing MDT:

“A strong governance framework, with clear accountabilities and indemnity, is an essential foundation for new cluster models.”

144. Some representatives of the focus group in Carmarthen reported that indemnity was a big issue for GPs in the new model, and the importance of ensuring all staff were indemnified properly should not be underestimated. Hywel Dda University Health Board called for an “All Wales approach to addressing the rising costs of indemnity insurance for paramedics, community- and practice-based pharmacists and additional nurses working in the community”.¹³⁵

145. Concerns about indemnity and vicarious liability were also highlighted by the BMA.¹³⁶ Similarly, Philippa Ford, from the Chartered Society of Physiotherapy (CSP), suggested that one of the advantages with the allied health professionals remaining as health board employed was around the

¹³⁰ Written evidence, PC 33

¹³¹ RoP, 11 May 2017, paragraph 289

¹³² RoP, 11 May 2017, paragraph 315

¹³³ RoP, 11 May 2017, paragraph 320

¹³⁴ Written evidence, PC 32

¹³⁵ Written evidence, PC 06

¹³⁶ RoP, 3 May 2017, paragraphs 130, 171 and 173

area of indemnity and insurance because the health board, as the employer, would pick up the vicarious liability.¹³⁷

146. At the focus group event held in Caernarfon we were told that nurses employed by an LHB are unable to perform different roles in the community for a cluster network because those nurses wouldn't be registered with CSSIW.

147. When the Cabinet Secretary appeared before the Committee he was asked a number of questions about the operational practicalities of multidisciplinary team working within clusters, particularly with regard to the employment of the relevant professional staff.

148. The Cabinet Secretary told us that it was “no surprise” that significant amounts of cluster development funding was being used to employ new staff in order to move away from the current model of primary care service. Referring to those new staff he said “there is an active conversation on whether they should be the employer or whether health boards should be host employers”.¹³⁸ The Cabinet Secretary continued:

“Most of the time, health boards end up being the host employer, but then that person is practically managed and works within the service, and it's part of our conversation to have about do we think that we should mandate and say, ‘This is how we want it to work’ or not. And, again, that's part of the tension of saying to people, ‘Here's money. Here's the latitude to get on and do something and innovate’, and then saying, ‘Actually, looking at it from a more national level and taking a step back, do we actually think the right thing to do is to make sure that all the staff end up being employed in a different way?’ But, you know, this is part of the challenge we have already in the way that, in individual practices, staff are employed: is a practice nurse an employee of the health board or an employee of the practice? So, these are challenges that we already have, and let's not pretend this is a new thing. ... I recognise that it's a challenge and I won't tell you now that there is a single answer, because there isn't.”¹³⁹

149. The Committee questioned the Cabinet Secretary further on the issue of employment of staff for clusters. He told us that he understood completely why people would prefer a health board to be the host employer. He said:

“Often lots of GPs want the person to be hosted by the health board because there's the element of management time, as the employer, if you're employing directly another member of staff that may be hosted with you but working across the cluster.”¹⁴⁰

150. The Cabinet Secretary also said that “instinctively” he would prefer people to be employed by a health board, but that there had to be recognition that some clusters with the proper enabling legal setting may want to directly employ staff.¹⁴¹ The Cabinet Secretary added:

¹³⁷ RoP, 11 May 2017, paragraph 321

¹³⁸ RoP, 7 June 2017, paragraph 52

¹³⁹ RoP, 7 June 2017, paragraph 53

¹⁴⁰ RoP, 7 June 2017, paragraph 55

¹⁴¹ RoP, 7 June 2017, paragraph 62

“We don’t yet, I think, have an evidence base to definitely say, ‘We will say, “Do what you like. Get on with it. We’re not worried about where they’re employed in it”, or, equally, if we’re going to say, “Everyone should be, or must be, employed by the health board”’. ”¹⁴²

151. With regards to concerns expressed over the clinical supervision of professionals working in a cluster setting, the Cabinet Secretary told us that this wasn’t a “new challenge” as each individual healthcare professional has individual responsibilities and the people employing them also have a responsibility for making sure they maintain their professional competence.¹⁴³

152. On indemnity cover, the Cabinet Secretary told us:

“Indemnity is one of the reasons why some GPs say that they don’t particularly want to be the direct employer of new healthcare professionals. But there’s quite a wide-ranging indemnity conversation that is also about where are their responsibilities for staff working in their practice with their patient group, and there are challenges there about whose patient it is for individual professionals. [...] They are things that we are working through and looking at the evidence and what people are saying directly to us, because, again, different people take different views on whether they think their indemnity cover is there, whether there are risks they’re prepared to take, and in all of this there’s a risk.”¹⁴⁴

Training and skills development

153. Respondents told us that cluster working needs to be accompanied by changing roles and skills development. We also heard that a clearly identified lead for the development of new skills and roles within clusters is needed. We were told this could mitigate the need for clusters and practices to compete to appoint from a small existing pool of staff with the right skills.

154. A number of points were made in this regard:

- The need to upskill and support the professional development of the whole multi-disciplinary team, including staff who are changing roles and those who were new to primary care.¹⁴⁵
- The requirement for clear parameters to work within when developing job descriptions for ‘integrated’ job roles, including the suggestion of an ‘All Wales compendium of job descriptions for cluster roles’.¹⁴⁶
- The difficulties of transitioning secondary care staff into primary care, given most have been trained in secondary care only.¹⁴⁷
- Ensuring the primary care workforce has the skills and capacity to deliver quality mental health care and the recommendation that all staff in GP clusters have protected training time for this.¹⁴⁸

¹⁴² RoP, 7 June 2017, paragraph 55

¹⁴³ RoP, 7 June 2017, paragraph 55

¹⁴⁴ RoP, 7 June 2017, paragraph 65

¹⁴⁵ Written evidence, PC 10, 28 and 33

¹⁴⁶ Written evidence, PC 33

¹⁴⁷ Written evidence, PC 46

- The need for clusters to invest in language provision so that services can be delivered in Welsh and support languages other than English wherever practicable.¹⁴⁹

155. The Royal College of Paediatrics and Child Health (RCPCH) noted children and young people account for about 1 in 5 of a typical GP’s patients and about a quarter of a GP’s typical workload in the UK. It said “GP clusters must therefore have an appropriate focus on children and young people with expertise on child health available at each cluster”.

156. Ruth Crowder, of the COT, told us of the need to maximise the specialist skills of the cluster workforce:

“We all bring very, very separate and very different skills and it’s important to maintain that. This isn’t about having a blurred, generalist approach. For us, it’s about having very, very clear access to different professional skills, so that you have not got some general toolbox, but you can make sure that you have highly skilled interventions for the right thing for the right person.”¹⁵⁰

157. The Welsh NHS Confederation told us that some training was already in place and that health boards were:

“[...] providing a wide range of development programmes to support and develop leaders and managers at all levels, both inside and outside of the Health Boards, to improve their skills and improve staff experience.”¹⁵¹

158. Cluster leadership is referred to earlier in this report. PHW told us:

“We have supported or brokered several initiatives to develop leadership and other skills. These are the Confident Leaders Programme (for cluster leads); coaching and action learning (initially in North Wales and also aimed at cluster leads); and a series of workshops aimed at anyone working in or with clusters (initially on health needs assessment, project management and co-production). A follow-on programme is in development and will be informed by evaluation of events to date.”¹⁵²

Our view: The workforce

There are obvious and substantial benefits to the multi-disciplinary team approach on which the cluster model is based. However some of the associated practical difficulties are substantial and in our view potentially pose the most significant challenge to the future of cluster working. These include:

- The recruitment and retention of GPs and a wide range of other professionals involved in primary care.
- The question of who employs ‘cluster’ staff and the associated issues of pensions and indemnity, perhaps the most significant barrier to effective cluster working.

¹⁴⁸ Written evidence, PC 36

¹⁴⁹ Written evidence, PC 28

¹⁵⁰ RoP, 11 May 2017, paragraph 279

¹⁵¹ Written evidence, PC 24

¹⁵² Written evidence, PC 20

- The potential for GPs to spend time dealing with HR and management issues rather than on delivering clinical care.
- That the clinical supervision of the MDT is becoming diluted as staff are placed outside traditional management models and physical locations.
- The negative impact of annual funding allocations impacting on the ability to recruit and retain staff.
- Associated governance issues.
- The need for properly planned and co-ordinated workforce training and skills development for staff within this new cluster model.

We welcome the Welsh Government’s ambitions to improve primary care workforce projections and workforce planning. We also understand the rationale for allowing the clusters to develop according to local need. However the evidence provided to us makes it clear that now is the time for the Welsh Government to provide clearer guidance and practical leadership to clusters on a range of matters. It is essential there is a clearer governance framework for clusters. It is also important that there is guidance as to which professionals should be involved, so that clusters can apply this within their local setting. Clear accountability and decision making structures are needed. Issues relating to who employs cluster staff and indemnity and pensions must be urgently resolved.

Finally, there is a pressing need to ensure there is a clear structure for planning and delivering training to develop the skills needed in the new models of care.

Recommendation 8. As a matter of urgency the Welsh Government must work with relevant stakeholders to resolve the problems relating to the employment status of cluster staff, indemnity, pension, and funding issues. This should include exploring the potential for primary care clusters to have their own legal status.

Recommendation 9. The Welsh Government should set out a framework to establish professional parameters for clinical staff which reflect new and developing roles and responsibilities. It should also set out its expectations regarding clinical supervision arrangements within primary care clusters.

Recommendation 10. The Welsh Government should put in place a national lead to co-ordinate training and development needs within clusters. It should also set out its expectations as to how training needs will be identified systematically at a local level.

06. Cluster funding

159. The Welsh Government has allocated £10m to clusters in 2017-18. The Cabinet Secretary's written evidence confirmed this funding is recurrent and that this is the third year of such funding, commencing with £6m in 2015-16. His written evidence also referred to the £43m primary care fund, designed to support the Welsh Government's broader development of primary care services in Wales.

160. There was a broad welcome from all stakeholders for the Cluster Development Monies (CDM) and a consensus that a number of innovative initiatives and staff appointments have been made possible as a result. Powys THB stated that "in broad terms the direct funding of clusters (£6m) has been a success".¹⁵³ The evidence from the Cabinet Secretary, the Welsh NHS Confederation, health boards and the DPCMH indicated that year one of the funding was generally focused on set up arrangements, one off spends for equipment, while year two has seen the development of more direct service delivery initiatives.

161. Whilst there is support for the direct funding of clusters, there are a number of reservations expressed about the CDM, which are set out below.

This chapter sets out further detail on eight funding issues which emerged in the evidence:

- The amount of funding and whether it is sufficient to deliver the changes needed.
- That the short term allocation of Cluster Development Money is a significant barrier.
- Whether it is possible to track Cluster Development Money allocations.
- The processes and timing of funding allocations.
- Health Boards' role in allocation of Cluster Development Monies.
- Whether Cluster Development Money is subsidising existing gaps in primary care services rather than bringing additionality, for example in mental health services.
- The funding of local versus strategic priorities.
- Scaling up and targeting the funding of service change.

The amount of funding

162. The sums involved in the CDM are relatively small and the evidence suggests that financial rules and regulations limit clusters' ability to use them most effectively. Cardiff North Cluster told us¹⁵⁴ that the bulk of the CDM is committed through salaries. The Committee heard that around 90% of CDM funding is spent on staffing costs, leaving limited funds for any additional developmental work or extending existing successful initiatives.¹⁵⁵ This concern was echoed in a number of written responses and also in other evidence heard by the Committee. Some participants at the focus groups in both Caernarfon and Carmarthen believed that there needed to be more CDM funding made available to drive change, which they believed should enable more long-term appointments to be made and it needs to get to clusters more quickly.

¹⁵³ Written evidence, PC 14

¹⁵⁴ Written evidence, PC 42

¹⁵⁵ Written evidence, PC 42

163. Dr Isolde Shore-Nye, from the RCGP, reported that as a GP she would welcome the opportunity to develop an MDT and employ a wider range of staff, but “[...]the funding that I receive as part of the cluster moneys would in no way at all address the need to recruit those specialties, even if I could”.¹⁵⁶

164. In his evidence, Dr Ian Harris from the BMA, outlined that:

“[...] if you look at individual clusters, a couple of hundred thousand pounds doesn’t buy you many boots on the ground to deliver workforce change and workload change for GPs day to day.”¹⁵⁷

165. Alan Lawrie, representing the DPCMH, acknowledged the limitations of the CDM funding in terms of achieving change:

“[...] it is a relatively small element of the total amount of spend that happens in primary care in a particular patch, and, I think, seeing it in the round, that element can actually be the lever to change something, using it that way. If it all gets spent on lots of staff in year 2, then you haven’t got any area for innovation and development as you move forward into year 3.”¹⁵⁸

166. In response to the question as to whether clusters are reducing demands on GPs and providing more accessible routes into care, BCUHB stated:

“In providing examples of how working at Cluster level can and is leading to improvements, it is important to set that into the context that scaling up such activity, so that the impact becomes greater (i.e. beyond Cluster boundaries), would require a significant shift in how core resources and planning within the Health Board and Welsh Government are directed and utilized; Cluster funding alone would not facilitate such a development at its current level, thus limiting potential for further improvement.”¹⁵⁹

The short term allocation of Cluster Development Money

167. One of the most significant issues raised in evidence was the short term nature of cluster funding. There were major concerns about the impact of funding being allocated on an annual basis only. As the majority of the funding is spent on staffing, the annual allocations can exacerbate the existing challenges of recruiting and retaining staff when health board recruitment processes are lengthy.

168. There were also concerns about the inability to “roll over” unspent CDM into the following financial year. BMA Cymru Wales argued that allowing the “roll-over” of unspent monies would encourage longer-term planning and avoid short-term planning decisions which “do not offer the best value for money”.¹⁶⁰ The Welsh NHS Confederation explained that:

¹⁵⁶ RoP, 3 May 2017, paragraph 151

¹⁵⁷ RoP, 3 May 2017, paragraph 154

¹⁵⁸ RoP, 3 May 2017, paragraph 63

¹⁵⁹ Written evidence, PC 30

¹⁶⁰ Written evidence, PC 41

“[...] this means money has to be spent before end of year, which can lead to short term spending decisions and lower value for money than could be achieved with longer timeframes.”¹⁶¹

169. Dr Karen Parry, GP Partner at Lansdowne Surgery, referred to the Cardiff South West Cluster:

“Uncertainty over the future of clusters and their funding leads to a lack of engagement within primary care teams.”¹⁶²

170. Grayham McClean representing WAST told us “until we get that consistency of actions, we really can’t attribute funding to sustainable services”.¹⁶³ Similarly, Suzanne Scott-Thomas from the RPS set out the need for assurance on the sustainability of funding for cluster pharmacy posts, as service change requires a degree of continuity.¹⁶⁴

171. The Cabinet Secretary told us that Cluster Development Money was to be “re-provided” by health boards. When asked to confirm whether this meant cluster underspends could be carried over to the next financial year, he said:

“We expect them to be re-provided. We expect health boards to re-provide them from within their resource envelope. That’s slightly different to saying the money is just rolled over and protected and kept over, but our expectation is that the money will be re-provided in the next year, and money spent within that year has to be spent on primary care. So, it can’t go from, ‘We haven’t spent it on a cluster this year, so we’ll put it into the bottom line’. That is not what we’ve said is going to be acceptable.”¹⁶⁵

172. The Committee received subsequent additional correspondence from the health boards which indicated that the health boards aimed primarily to ensure that clusters were able to spend their CDM allocation within the relevant financial year, but adopted a policy of effectively re-providing any underspent monies to the clusters to be spent in the following financial year, so that no available funding was lost to the clusters. ABM Health Board stated:

“The Health Board has recognised that the best interests of clusters are served by maximising the flexibility of expenditure plans. Rather than requiring clusters to utilise funding in each financial year – hence increasing the risk that short term expenditure strategies are pursued at the expense a more planned and methodical approach – the Health Board has encouraged the carry forward of unspent allocations. Carry forwards are approved upon receipt of an agreed expenditure plan for utilisation in the following financial year.”¹⁶⁶

Tracking Cluster Development Money allocations

173. The evidence the Committee received suggested there is a difficulty in tracking in detail how the CDM monies are spent and what impact they have had. The BMA stated “We strongly believe there

¹⁶¹ Written evidence, PC 24

¹⁶² Written evidence, PC 40

¹⁶³ RoP, 11 May 2017, paragraph 139

¹⁶⁴ RoP, 11 May 2017, paragraph 220

¹⁶⁵ RoP, 7 June 2017, paragraph 128

¹⁶⁶ Written evidence, PC 07

needs to be greater clarity on what cluster resources are being spent on.¹⁶⁷ CPW expressed a concern that increased devolution of CDM to clusters could make it difficult to track the impact of CDM spending.¹⁶⁸

174. The Committee heard from the CSP that therapists “are not involved in the actual management of clusters, so we’ve not really had access to funding”.¹⁶⁹ Similarly, the RCN indicated concerns about the way that funding was drawn down and allocated.¹⁷⁰ Mair Davies of the RPS emphasised the need for multi-professional involvement in both strategic and financial decision-making.¹⁷¹ Professor Keith Lloyd from the RCPsych indicated that it was difficult to be clear about how much CDM investment had found its way into mental health.¹⁷²

175. The Committee also received evidence from WAST expressing concern about how cluster funding is being deployed and whether it is being targeted effectively:

“WAST has observed occasions where funding is being dealt with at a local level as a response to a problem in recruiting GPs, practice nurses, and community nurses, rather than as a strategic choice. For example, in Hywel Dda [...] APP costs have been re-charged to the HB, with funds being released as a result of GP vacancies.”¹⁷³

176. In response to this evidence, the Cabinet Secretary told the Committee that:

“We’ve had that directly from stakeholders asking that question, and I’ve said that money can only be spent in primary care; you can’t put it into the bottom line. That isn’t what the money is there for. And for those health boards that aren’t living within their means, pinching money from clusters isn’t a smart or acceptable way to try and resolve their bottom-line issues.”¹⁷⁴

177. The Committee heard other concerns about variation between clusters in terms of CDM funding and allocation processes. The BDA¹⁷⁵ and the RPS¹⁷⁶ argued that the bulk of it is going to GPs, with less being made available to other primary care contractors, and that smaller and more rural practices had difficulty in accessing CDM funding. Other evidence provided to the Committee suggested that a significant proportion of CDM-funded schemes and Pacesetter projects have involved the development of pharmacy services, and the RPS themselves stated “Many of the clusters have funded new clinical roles for pharmacists to work alongside their doctor and nurse colleagues in general practice”.¹⁷⁷

178. The evidence received by the Committee in both consultation responses and the Cabinet Secretary’s written evidence highlighted issues around transparency, clarity of funding, processes and timing of funding allocations.

¹⁶⁷ Written evidence, PC 41

¹⁶⁸ Written evidence, PC 09

¹⁶⁹ RoP, 11 May 2017, paragraph 311

¹⁷⁰ RoP, 11 May 2017, paragraphs 377-8

¹⁷¹ RoP, 11 May 2017, paragraph 230

¹⁷² RoP, 17 May 2017, paragraph 7 and 33

¹⁷³ Written evidence, PC 25

¹⁷⁴ RoP, 7 June 2017, paragraph 119

¹⁷⁵ Written evidence, PC 13

¹⁷⁶ Written evidence, PC 28

¹⁷⁷ Written evidence, PC 28

179. The Committee wrote to all health boards asking for additional information on the allocation of CDM funding and the allocation timescale. Their responses show that the health boards have a consistent view on some aspects of funding (although this is not always consistent with the views of other stakeholders):

- All health boards reported that clusters and cluster leads are notified of the funding available at the beginning of the financial year. Clusters then agree with the health boards the schemes and investments for the forthcoming year, and funds are released thereafter as and when required.
- The health board responses indicate that they do not vet or formally sign-off these funds for approval. For example, ABM UHB reports that they have adopted the principles of ‘light touch oversight’, focusing on supporting the clusters. At the same time, Cardiff and the Vale UHB indicate that cluster investment proposals are agreed through discussion at the senior team meeting of the Primary, Community and Intermediate Care Team.
- All the health boards set out that cluster spending should be in line with Cluster Development Plans and guidance from Welsh Government in regard to access and sustainability.
- The health boards report that they hold no CDM funds centrally for providing support to clusters, with management support to clusters met out of health board core funding. Aneurin Bevan UHB report that since 2015-16 they have invested annually around £300,000 in funding twelve leads for their Neighbourhood Care Networks.

180. There does appear to be some disparity in when health boards receive final notification of funding levels:

- A number of the health boards outlined that their CDM funding was notified to them in their allocation letters for the upcoming financial year, usually received in December.
- Several other health boards reported that their notification came at the beginning of the financial year, normally around April.

181. The Committee heard evidence from a number of stakeholders about what they saw as the slow process of CDM allocation to the clusters. In particular, some participants at the focus groups in both Carmarthen and Caernarfon stated that the speed of allocating and accessing the funding was a problem, with the monies taking a long time to come through from the health boards. Similarly, the BMA stated that they had become aware of “significant delays in the release of these funds by Health Boards”.¹⁷⁸

Health Boards’ role in allocation of CDM monies

182. A number of responses, including the BMA, Macmillan Cancer Support and participants at the Carmarthen focus group called for the CDM to be allocated directly to clusters, rather than via the health boards. South West Cardiff GP Cluster argued that individual GP practices should have funds for their own population, rather than monies going to an entire cluster.¹⁷⁹

¹⁷⁸ Written evidence, PC 41

¹⁷⁹ Written evidence, PC 04

183. Several respondents believed that the health boards' role in funding allocation slowed up the process of getting CDM funding to clusters.¹⁸⁰ The RCGP stated that "at times the bureaucracy surrounding spending has been seen as restrictive".¹⁸¹ The BMA agreed that health boards slowed the process down. Giving oral evidence on their behalf, Dr Charlotte Jones set out her concerns about delayed allocation of funding:

"[...] when we have to involve the health boards, either because the person supporting the clusters isn't a decision maker or because of the request that's being made, it's not always driven by the cluster. Sometimes, it's the health board agenda, and we need to be truly looking at what the barriers are and how we can change those to enable us then to monitor it properly and see where those moneys are going."¹⁸²

Are allocations subsidising existing primary care services rather than bringing additionality?

184. The BMA said it had reports of cluster money being used "to prop up services which should be resourced by other monies" and that they expected health boards to be able to demonstrate cluster funding was being spent appropriately.¹⁸³ The Committee also heard concerns on this issue from some participants at the focus group in Caernarfon, who stated that CDM monies were sometimes used to subsidise gaps in secondary care and mental health services rather than bring additionality to primary care.

185. There were questions raised about whether CDM funded schemes represented real value for money. WAST, the BMA and other respondents commented that CDM funding is tending to go to local level in response to individual local problems, rather than taking a more strategic approach and seeking to innovate across clusters as a whole.¹⁸⁴

186. Professor Keith Lloyd expressed concern that Cluster Development Money could be plugging gaps that other primary care money should be funding, saying:

"[...] some of the stuff that's being provided from the third sector is very good. I hope it's not just being used as a cost-shifting exercise, so that care that was previously provided from the NHS or from primary care is being provided from the third sector, but some of that stuff is very good."¹⁸⁵

187. Dr Brendan Lloyd from WAST reiterated this in his evidence to the Committee:

"[...] in terms of the strategic funding, yes, we would like to see, perhaps, a bit more direction on the clusters being tasked to identify the problems and come up with some solutions to the main problems that we know we are facing as a health system. And if that was scaled up at a higher level, then I think we'd be in a better position going into winter—we'd have some more solutions that were tangible and evidence based. I think that that then comes back to the

¹⁸⁰ Written evidence, PC 41

¹⁸¹ Written evidence, PC 46

¹⁸² RoP, 3 May 2017, paragraph 112

¹⁸³ Written evidence, PC 41

¹⁸⁴ Written evidence, PC 25

¹⁸⁵ RoP, 17 May 2018, paragraph 29

second part, which is that funding needs to be somehow channelled into an area where we can make the services sustainable. Because there's absolutely no point in trying to employ a community paramedic on a 12-month contract with no guarantee of what is going to happen at the end of that."¹⁸⁶

Scaling up and targeting the funding of service change

188. The Committee heard considerable evidence about the need to focus on identifying pilot programmes that work, have the capacity to deliver change and which should be scaled up and rolled out.¹⁸⁷ Alison Davies from RCN Wales stated that:

"I think that lesson is well learnt in many other arenas, prior to clusters, where short-term funding is available. It can very much help pump prime and change, but it's the sustaining of that change and the embedding of any change into mainstream service delivery that then remains the challenge."¹⁸⁸

189. Dr Ian Harris from the BMA told us:

"There has to be a process whereby the innovation within a cluster becomes practice across the health economy, and I've not seen any evidence of health boards showing an appetite for that, let alone a mechanism for releasing it."¹⁸⁹

190. Some participants at the focus groups in Caernarfon and Carmarthen stated there was a lack of a clear vision about how the mainstreaming of successful innovation could be achieved. In particular, there was a view that once a pilot scheme was proven then the health boards should take over responsibility for funding the service, enabling cluster funding to be used for other innovative projects, which the groups felt was not happening.

191. This view was echoed in the evidence from Pen-y-Bont Health, with Dr Ian O'Connor stating that there were real difficulties in securing decisions on central funding from health boards to enable the rolling out of successful pilot schemes.

192. Philippa Ford from the CSP supported the concept of "future models with pooled budgets, joint posts across secondary and primary care".¹⁹⁰ Likewise, some of the participants in the Carmarthen focus group argued that the CDM needed to be linked with other funding sources such as the Intermediate Care Fund.

193. PHW also commented on this issue:

"General practices operate within a primary care context, and primary care within a whole system context (including secondary care and communities). It follows that funding streams to explore new ways of working should reflect this inter-dependence. Although clusters continue to evolve towards wider primary

¹⁸⁶ RoP, 11 May 2017, paragraph 138

¹⁸⁷ Written evidence, PC 10, 25 and 46

¹⁸⁸ RoP, 11 May 2017, paragraph 386

¹⁸⁹ RoP, 3 May 2017, paragraph 175

¹⁹⁰ RoP, 11 May 2017, paragraph 291

care involvement, in some cases decisions on spending these monies do not reflect this.”¹⁹¹

194. John Palmer, representing the DPCMH, acknowledged the need to identify how this scaling-up could be achieved in order to realise change, and identified that there are advantages in joining up the various available funding streams:

“Can we respond in a planning cycle to scale some of these things up actively? That’s on us. That’s our responsibility and accountability as leaders in NHS Wales.”¹⁹²

195. The Cabinet Secretary emphasised the importance of not just rolling out successful innovation, but ensuring that funding moves to support that service change and innovation. Hence, given the recurrent availability of cluster funding:

“[...] there is then this conversation between clusters and health boards about what becomes mainstream and what becomes mainstream funding, and the evaluation should help us with that as well; about understanding what we think should be mainstream provision. And there’s a challenge about how you recycle money to keep on being able to innovate.”

“[...] But, we always talk about the shift from secondary into primary care, and I’ve said consistently to stakeholders in private meetings, and in this setting as well, that the money needs to follow the service. And if you’re moving services around and there’s a need to spend money differently, you need to spend that money differently, rather than simply saying there’s a big fence between secondary and primary.”¹⁹³

Our view: funding

We recognise and acknowledge the CDM funding that has gone into supporting clusters. It is clear from the evidence we have heard that this investment is welcomed by all of those involved in cluster working, whether nationally or locally. However we note a number of issues:

- The level of specific CDM investment is relatively small, especially when set against the expectations for clusters in terms of delivering new service models.
- At the same time, CDM is only one element of a number of disparate streams of funding made available by the Welsh Government to NHS Wales. It appears very difficult to identify with certainty which funding streams the wide range of schemes referred to in evidence were funded by: whether from CDM, Primary Care Monies, the Intermediate Care Fund or investment from the health boards of GP practices themselves.
- We recognise that relatively small sums effectively invested can help in stimulating innovation. But the evidence we heard suggests that the many, small funding streams may be individually less

¹⁹¹ Written evidence, PC 20

¹⁹² RoP, 3 May 2017, paragraph 26 and 49

¹⁹³ RoP, 7 June 2017, paragraph 123

than effective in securing real strategic service change and streamlining. There is a case for more active joining-up of funding streams.

- A review of funding streams will need to be supported by a clear process for scaling-up and mainstreaming successful initiatives, but also ending the funding to less successful schemes. We saw little evidence of such a clear process, but noted the pressure for consolidated and recurring funding of all CDM-funded schemes.
- This need for focusing attention on mainstreaming success is noted in the Interim Report on the Parliamentary Review of Health and Social Care in Wales (2017), which called for a limited set of new models of care to be developed, trialled and evaluated and scaled up rapidly.
- The need for a transparent and nationally agreed financial allocation process and timescale.
- Any future process for allocation of CDM funding must be supported by a robust and effective governance framework. At the moment, clusters are not in a position to hold or allocate funds, and there is not a shared or consistent view on how monies should be held. This issue needs addressing as part of any future development of primary care collaborative working.

Recommendation 11. The Welsh Government should ensure that cluster development money is allocated to individual clusters on a three year rather than a one year basis.

Recommendation 12. The Welsh Government should undertake a review to identify current primary care funding streams in order to work towards rationalising and maximising the impact of the total available funding.

Recommendation 13. The Welsh Government should work with health boards and cluster leads to establish clear decision making processes for quickly evaluating and scaling up successful models and ceasing funding for less successful initiatives.

07. The primary care estate and ICT infrastructure

The primary care estate

196. The Welsh Government’s 2010 document, ‘Setting the Direction’, set out the imperative need for the primary care infrastructure, including buildings and IT, to be supported and developed.¹⁹⁴ Its subsequent 2015 plan referred to primary care estate and facilities in the context of flexibility and innovation. A clear message emerged from this 2015 Plan indicating that the Welsh Government believed that planning care locally and at a small population level through clusters would allow for a more flexible and creative approach to the use of facilities to provide primary care services. It stated:

“Collaboration through primary care clusters creates better opportunities to take an innovative approach to designing primary care. [...] It is about making the best use of buildings to promote professionals working together.”¹⁹⁵

197. More recently the Cabinet Secretary described to us the remodelling of the primary care estate as a “national challenge”,¹⁹⁶ and acknowledged that the pace of progress varied across the country¹⁹⁷.

198. Focus group participants in Caernarfon and Carmarthen offered many comments on the issue of the primary care estate and the practical impact it has on the primary care cluster model. Some participants in Caernarfon told us that:

- GP premises and the primary care estate are not fit for purpose for taking the cluster model forward and, without that, clusters will not deliver the Welsh Government’s ambitions for primary care.
- Many practices do not have the physical space to take forward the specific ambitions for the cluster model in their locality.
- Practices are unable to upgrade premises to provide enough space for a multi-disciplinary team to work, and being part of a cluster has not helped with applications for new premises.

199. In written evidence we were told of inadequate buildings,¹⁹⁸ practices that are becoming unfit for business due to the historic underfunding of infrastructure,¹⁹⁹ and buildings that are not fit for purpose²⁰⁰.

200. The Cabinet Secretary acknowledged that “different parts of the [primary care] estate are in better or worse conditions”, and that historic conversions of homes into GP surgeries are part of the remodelling challenges.²⁰¹ The Cabinet Secretary also confirmed that the Welsh Government had attempted, and is still trying, to reserve capital within its budget for the remodelling of primary care.²⁰² He went on to say:

¹⁹⁴ [Setting the Direction](#)

¹⁹⁵ [Our plan for a primary care service up to 2018](#)

¹⁹⁶ RoP, 7 June 2017, paragraph 84

¹⁹⁷ RoP, 7 June 2017, paragraph 82

¹⁹⁸ Written evidence, PC 01

¹⁹⁹ Written evidence, PC 04

²⁰⁰ Written evidence, PC 18

²⁰¹ RoP, 7 June 2017, paragraph 81

²⁰² RoP, 7 June 2017, paragraph 81

“The challenge will be in planning, and there’s the attitude to risk in doing that, though, as well, which is part of the reason why we see some of the challenges we do with the old estate that we recognise is no longer fit for purpose. If you own that and that’s part of what you own as an individual professional, if you’re a partner in a practice, to move into a different building, there’s a challenge about who takes the risk for that. And if the public purse is going to provide a new building, then lots of people here would expect that the public purse would need to own the freehold of that building as well.”²⁰³

201. The Cardiff Third Sector Council told us that there are examples of multiple practices combining resources in order to share new or updated premises to deliver their services, but that it was “unclear how the success of these is being measured”.²⁰⁴

202. The DPCMH also recognised the importance of the physical estate:

“Increasingly, the design of estates needs to support [multi-disciplinary teams] MDTs working on a cluster basis.”²⁰⁵

203. This view was echoed by Powys THB and the Welsh NHS Confederation.²⁰⁶ WAST advocated the need for future estate developments put in place to support enhanced services to ensure the co-location of ambulances with primary care centres.²⁰⁷

204. The North Cardiff cluster lead commented on the growing trend for service provision in the community led by larger multi-disciplinary teams but said that these teams need “appropriate accommodation” and the supporting infrastructure has to be “appropriately funded”.²⁰⁸

205. While recognising that there is still “much to do”, Aneurin Bevan UHB highlighted its recent investment in its primary care estate, which includes new multi-disciplinary facilities at Rhymney Integrated Health and Social Care Resource Centre and the Primary Care Resource Centre in Blaenavon.²⁰⁹

206. Dr Alison Stroud of the RCSLT noted there are also examples in BCUHB where the use of bigger buildings has facilitated multidisciplinary working including the “right person at the right time” to deliver care to a patient.²¹⁰

207. The Cabinet Secretary highlighted to us a number of examples of health boards working towards constructive relationships in order to make better use of the primary care estate. He said:

“In Cwm Taf, for example, they have a very good relationship with their two local authorities, both in the way they plan their services—so, the neighbourhood planning for local authorities matches the cluster footprint, and that’s been really helpful—and they have a really constructive relationship

²⁰³ RoP, 7 June 2017, paragraph 90

²⁰⁴ Written evidence, PC 18

²⁰⁵ Written evidence, PC 21

²⁰⁶ Written evidence, PC 14 and 24

²⁰⁷ Written evidence, PC 25

²⁰⁸ Written evidence, PC 42

²⁰⁹ Written evidence, PC 43

²¹⁰ RoP, 11 May 2017, paragraph 304

about making use of the public estate between the two of them to try and remodel primary care within that area.”²¹¹

208. The Cabinet Secretary and his officials also told us of best practice examples in Prestatyn and Neath. With regards to the latter the Cabinet Secretary’s official highlighted the example of one practice in a cluster using its accommodation to provide resources to others in that cluster arrangement.²¹²

209. The Cabinet Secretary’s official also stated that some practices, particularly in Hywel Dda UHB, have accommodation issues due to rooms being occupied by old paper records, but that a “rolling programme of digitalisation” will “free up” space.²¹³

210. The Cabinet Secretary acknowledged the need for a conversation about the better use of the primary care premises and estate which “cluster working is promoting”.²¹⁴ He added:

“It’s been brought into sharper focus by wanting to have teams work together and wanting to house teams together if at all possible. But I think that, over time, we’ll see the estate being shifted to accommodate the remodelling of primary care.”²¹⁵

Primary care ICT infrastructure

211. Problems with the primary care ICT infrastructure is a theme which has emerged during the course of this inquiry.

212. During a recent Committee scrutiny session with members of the Parliamentary Review of Health and Social Care in Wales, we heard that **NHS Wales Informatics Services** (NWIS) currently supports 77 different systems across NHS Wales.

213. Some participants of the focus group discussion in Carmarthen expressed concerns about the ICT network across Hywel Dda UHB, but noted that the issues were not confined to just one health board. We were told that staff regularly face reliability and access issues with the ICT systems in place. Participants suggested that agile working across the health and social care sector would only succeed if the necessary and appropriate information technology was in place.

214. The Cluster Lead in North Cardiff said there are a number of “recognised constraints” within the cluster operating model that include “the need for comprehensive IT solutions with appropriate levels of resource for equipment, software and training”.²¹⁶

215. The Cardiff Third Sector Council also commented on the issue of IT systems as a barrier to successful cluster working. While acknowledging that larger surgeries within some clusters have the accommodation available to host cluster-wide services, those services cannot be established because different patients’ record systems are being used in the GP surgeries and the systems do not communicate easily.²¹⁷ They added:

²¹¹ RoP, 7 June 2017, paragraph 83

²¹² RoP, 7 June 2017, paragraph 84 and 92

²¹³ RoP, 7 June 2017, paragraph 92

²¹⁴ RoP, 7 June 2017, paragraph 93

²¹⁵ RoP, 7 June 2017, paragraph 84

²¹⁶ Written evidence, PC 42

²¹⁷ Written evidence, PC 18

“[] having a common system used by all GPs in Wales would solve this problem and should be a national priority.”²¹⁸

216. In 2010, the Welsh Government identified limitations in the IT system in place within primary care at that time. It said it was a system characterised by inaccessible records which was resulting in a limited exchange of information across the health service network.²¹⁹ ‘Setting the Direction’ identified the need for “investment in shared, secure and robust information systems across health and social care”.²²⁰

217. Five years later the Welsh Government’s plan for primary care similarly identified a need for primary care services to have “appropriate access to shared information, on shared IT systems”.²²¹

218. NHS Wales is currently rolling-out the Welsh Community Care Information System (WCCIS) which is designed to help health and social care professionals work together to provide care closer to people’s homes. We also note NHS Wales Informatics Services’ (NWIS) statement that:

“When fully implemented across Wales [WCCIS] will overcome the obstacles posed when organisations use different IT systems by securely storing important information covering a range of activities such as community nursing, health and social care visits, mental health, learning disabilities, substance misuse, complex care needs or social care therapy.”²²²

Our view: the primary care estate and ICT infrastructure

- The NHS needs timely and effective infrastructure to support the change to cluster working. This includes both the primary care estate and also the digital infrastructure.
- The evidence we have heard suggests that progress in this area has been minimal and the estate, in its broadest sense, remains a significant issue for the primary care sector.
- The evidence we heard suggested a consensus that the primary care estate in Wales and the Welsh NHS ICT infrastructure are practical matters which certainly are a “national challenge”. As such, they must be high on the agenda when considering the future ambitions for clusters.
- We are convinced that co-location of the multi-disciplinary teams is vital to the success of clusters. While we acknowledge the inherent difficulties with managing an ageing estate, more focus is needed to improve primary care facilities so that they are fit for purpose and can meet the needs of the cluster model of service delivery.
- We do not offer a firm suggestion of whether improvement should be obtained through a programme of redevelopment and/or renovation, or by the identification and implementation of more efficient use of building space. Solutions will of necessity vary according to local circumstances. However we do believe that the primary care estate is an issue which needs urgent attention.

²¹⁸ Written evidence, PC 18

²¹⁹ Setting the Direction

²²⁰ Setting the Direction

²²¹ [Our plan for a primary care service up to 2018](#)

²²² www.wales.nhs.uk/nwis/page/66175

- Similarly, and despite the Welsh Government’s intentions which were laid out in 2010 and 2015, the NHS in Wales does not yet have ICT systems in place to support the pace of change in primary care, and this is an area which also needs significant and rapid consideration.
- Such a high number of NHS IT systems in operation, and the necessary accompanying support from NHS staff, is not sustainable and nor is it conducive to streamlined, efficient, multi-disciplinary, multi-agency working.
- The ICT infrastructure across the local health boards and NHS trusts in Wales is an issue that has been raised with us on a number of occasions. Of specific interest is the potential for more integrated technology and the use of shared data, improving the patient experience, and issues relevant to integration across health and social care. We intend to formally undertake a piece of work on this subject in the coming months.
- The new **Welsh Community Care Information System** is to be welcomed. However, it is currently only live in Bridgend, Ceredigion and Powys, and this is disappointing. This illustrates the slow pace of change. The evidence we have heard as part of this inquiry suggests that not enough progress has been made since the launch of the Welsh Government’s 2015 plan.

Recommendation 14. The Welsh Government should work with health boards to undertake a review of the primary care estate with a specific reference to the physical capacity for multi-disciplinary working and the capital funding requirements to support the new models of care.

Recommendation 15. This Committee has already included scrutiny of the ICT Infrastructure supporting the NHS within its forward work programme. The interim report of the Parliamentary Review of Health and Social Care set out the need for better exchange of data within NHS Wales and to other service providers; a key element of which will be the need to better link health and social care ICT. These are key issues to underpin cluster working and Welsh Government must set out a plan in response to the final Parliamentary Review report.

08. Evaluation: how do we know the impact clusters are having?

This chapter sets out further details on four key issues identified in the evidence in terms of the monitoring and evaluation of clusters. These are:

- Concerns that there is limited quantifiable evidence on the impact of clusters.
- The lack of mechanisms in place to robustly evaluate clusters and their impact on patient outcomes.
- That there are not necessarily the systems in place within the health board to systematically evaluate and scale up projects which have worked well.
- The potential that the systems in place to share good practice across Wales are insufficient.

Evaluation currently in place

219. The Committee was keen to understand the evaluation mechanisms currently in place. However it was not clear the data in the evidence we received was cluster-specific, or whether it referred to Pacesetter projects or other evaluations. Much of the evidence also referred to outcomes clusters had the potential to achieve, e.g. reducing GP workloads, without necessarily showing quantifiable evidence that they were actually doing so at this point in time.

220. The Welsh Government’s 2015 Strategy for primary care states:

“From 2015-16, health board DPCMH will deliver a co-ordinated national approach to supporting innovation in primary care, including structured support mechanisms, systematic evaluation of new ideas and good practice, and prioritised funding for innovative ways of delivering care and improving access.”

221. PHW has a key role. It is tasked with supporting and enabling the evaluation of clusters and Pacesetter projects, in addition to existing processes of sharing and dissemination of learning. PHW has commissioned an academic partner (Bangor University) to:

- survey the functions and maturity of clusters in Wales;
- review measurement tools designed for comparing primary care maturity and quality;
- tailor an existing tool for within Wales comparisons; and,
- measure the ‘strength’ of primary care clusters in relation to maturity.²²³

222. John Palmer, representing the DPCMH, said it was “early days” for the evidence base on the changes brought about by clusters.²²⁴ Rosemary Fletcher, representing PHW, confirmed that the evaluation tool was at pilot stage.²²⁵

²²³ Written evidence, PC 20

²²⁴ RoP 5 May 2017, paragraph 4

²²⁵ RoP, 5 May 2017, paragraph 7

223. The Welsh NHS Confederation set out more detail on the monitoring process :

- There has been assessment and dissemination of the shared learning from both the Pacesetter and cluster programmes.
- A further external evaluation into Pacesetters is due to be commissioned by Welsh Government shortly, with 9-12 months to evaluate and produce the final report.
- Regular monitoring reports are submitted to the Welsh Government on a quarterly basis for all of Health Board funded pathfinder/pacesetter projects and the CDM funding.²²⁶

224. In their evidence, PHW refers to work being led by DPCMH on developing primary care measures, but indicated that:

“New ways of working necessitate some form of outcomes assessment to identify change that has merit and potential for adoption elsewhere through the sharing of learning. We are exploring how we can strengthen our support to clusters through coordinating access to research and evaluation expertise within and without the organisation.”²²⁷

225. The individual health boards described progress in their areas:

- BCUHB stated that “clusters are starting to quantify the impacts of the initiatives by the clusters, by understanding demand, activity, waiting lists, etc. [...]”. It goes on to say clusters are looking at ‘soft outcomes’ and that future services will be commissioned with clearer outcomes.²²⁸
- Cardiff and the Vale UHB said that “the main mechanism for measuring the cluster model in its broadest sense has been via implementation of cluster plans”²²⁹ and that “early indications show that this can be evidenced however a longer period of measurement is required before conclusions can be made”.²³⁰
- Cwm Taf UHB had “appointed a dedicated full time Data Analyst whose role is to support all the Primary Care Initiatives and this includes the Cluster programme. Going forward greater involvement of the public and communities will be sought as part of the evaluations”.²³¹
- Powys THB said “a rigorous evaluation framework is necessary” and that “PTHB has only begun to really work on the evaluation of its various schemes, concepts, deployments and so forth”.²³²

226. Dr Karen Pardy, referred to the work of the Cardiff South West Cluster, and stated:

“Outcome measures include GP appointments saved, interventions to improve patient care, patient feedback and the use of audit as a quality improvement tool.”²³³

²²⁶ Written evidence, PC 24

²²⁷ Written evidence, PC 20

²²⁸ Written evidence, PC 30

²²⁹ Written evidence, PC 33

²³⁰ Written evidence, PC 33

²³¹ Written evidence, PC 45

²³² Written evidence, PC 14

227. She went on to refer to projects that the cluster is running in collaboration with the third sector:

“The success of these schemes will be measured through reduction in GP appointments, changes in prescribing patterns and self reported well-being measures.”²³⁴

228. The WAST submission also sets out that it has been working with primary care to develop evaluation criteria for measurement of the emerging new models of care, for example a reduction in patients’ being conveyed/admitted to emergency departments by ambulance. It also indicated that its main IMTP objective is to focus on developing and evaluating the MDT models that have been put in place with clusters, including:

- Advanced Paramedic Practitioners (APPs) working as part of an MDT in Hywel Dda, undertaking home visits as part of the GP out of hours (OOH) service in Aneurin Bevan and supporting a GP practice in Aberdare by undertaking daytime home visits and supporting GP OOH.
- Linking the Rapid Response Vehicle to GP Practices in the Western Vale Cluster, to avoid unnecessary hospital admissions, although the clinical lead remains very firmly with GPs.

229. PHW and Bro Taf Local Medical Committee also emphasised the need for better sharing of examples of initiatives that had made a positive impact, and PHW highlighted the role of the [Primary Care One website](#) as a central source of information to promote collaborative working.²³⁵

Views on cluster evaluation

230. Whilst in general we heard some positive feedback about the perceived impact of cluster initiatives, there was very limited quantifiable and measurable evidence to back up these perceptions. Concerns were expressed about whether it is possible to demonstrate the impact of clusters, and about whether there are mechanisms in place to ensure the robust evaluation of what they do and the extent to which they are improving patient outcomes. Evaluation and monitoring were seen as vital not only in assessing progress but also in ensuring that successful cluster work was shared with others and rolled out where appropriate.

231. There was a strong recognition of the need for effective evaluation of developments, whether in relation to Pacesetter projects, MDT initiatives or the clusters as a whole. However, there was not a shared understanding of how this evaluation would be managed and delivered.

232. The RPS’ [Models of Care for Pharmacy within Primary Care Clusters](#) (2015) includes details of how the impact of Pharmacy initiatives could be demonstrated. Pharmacy Research Wales also set out the need for effective evaluation, involving a centralised approach to methodology, outcome measures and data collection. It said:

“This group believes there is an urgent need for Welsh Government to provide a directive on the necessity for robust research to evaluate any transformational changes within the NHS and a specific commissioned funding stream to

²³³ Written evidence, PC 40

²³⁴ Written evidence, PC 40

²³⁵ Written evidence, PC 20

support and ensure appropriate aims, quality and timeliness of research related to this enquiry.”²³⁶

233. The BMA said that a significant number of their own members reported to them in a 2015 survey that although clusters had improved local networking and peer support, it was difficult to demonstrate tangible progress on service delivery. It went on to state:

“Thus far the benefits of cluster working, in terms of transforming primary care for the benefit of the patient and GP across Wales, are not as tangible as we would expect at this stage of their existence, and productivity is hugely variable.”²³⁷

234. In oral evidence, the BMA and the RCGP²³⁸ stated that “clusters aren’t at the level of maturity where evaluation is part of their day to day business”, and that although cluster initiatives show some value for money they aren’t reducing primary care demand as much as they could.

235. Dr Ian Harris, representing the BMA, told us:

“I’ve seen evidence of a few initiatives in my own cluster that have had an evaluation, and the results are largely qualitative. I think it’s fair to say that the data are not fantastic. Where there are data, they support the fact that certainly there are some cluster initiatives that are valuable to some extent, but if you’re looking at value for money, often they don’t reduce GP workload as much as you’d like to think they would, and they cost significantly more than, maybe, employing another GP would.”²³⁹

236. In oral evidence, the DPCMHs acknowledged that it remained “early days” for an evidence base on clusters.²⁴⁰ Cardiff Third Sector Council also say that there is very little information available on how cluster work is being evaluated, but that evaluation needs to be consistent and also cautioned about the dangers of ignoring initiatives that take longer to produce real and tangible results.²⁴¹ The RCP emphasised the need for lessons learned from cluster plans to be written up, evaluated and if appropriate, rolled out more widely.²⁴²

237. Professor Keith Lloyd, representing RCPsych, was asked whether it is difficult to measure if clusters have worked. He told us:

“I’m not saying we aren’t able to evaluate whether they’re working. I’m saying we haven’t done it yet, that I know of.”²⁴³

238. The RCPCH emphasised the importance of the patient voice:

“Proper evaluation and trials are required in the Welsh context and this must be funded appropriately. Innovative work is happening but we don’t yet have

²³⁶ Written evidence, PC 29

²³⁷ Written evidence, PC 41

²³⁸ RoP, 3 May 2017, paragraph 113

²³⁹ RoP, 3 May 2017, paragraph 114

²⁴⁰ RoP, 3 May 2017, paragraph 4

²⁴¹ Written evidence, PC 18

²⁴² Written evidence, PC 12

²⁴³ RoP, 17 May 2017, paragraph 21

the evaluation necessary to share learning and enable successful models to be scaled up. This testing must include input from families and children and young people themselves given the significant needs of children and young people and the impact on GP workloads.”²⁴⁴

239. Dr Jane Fenton-May supported the view that evidence was needed about whether care for the patient was improving. Dr Brendan Lloyd, Medical Director at WAST, told us evidence was needed as to whether patients are receiving the best care in the best environment”.²⁴⁵

240. Some participants at the Caernarfon focus group called for detailed annual evaluations of what each cluster has achieved. They also questioned how health boards can identify and scale up good practice and also how good practice was being shared across Wales.

241. The danger that effective projects would not be scaled up was raised by Dr Ian Harris, representing the BMA:

“[...] the worry we have is that you’ll have 60-odd clusters developing initiatives, which appear to be very valuable, but that innovation never becomes reality on a grander scale. I’m not entirely sure that health boards have twigged that that’s exactly what needs to happen and, you know, time will tell.”²⁴⁶

242. In oral evidence the Cabinet Secretary responded to concerns about evaluation and said:

“I wouldn’t try and pretend to you, or anyone else, either in this room or in a private conversation, that we have an evidence base in the here and now that can tell us everything that we want to do, and how we’ll do it, and what that will mean, because, as I say, it is a developing piece of work. But the point about starting off on this journey, and starting to go down the route on this journey, is that we recognise that doing nothing is not an option.”²⁴⁷

243. The Cabinet Secretary referred to the PHW commissioned work being undertaken by Bangor University saying that the evaluation tool ‘is expected to be available later this year’.

244. Referring to the outcome of the evaluation the Cabinet Secretary also told us “we expect to have an evaluation ready in the spring, and, obviously we will make that available when we’ve got it and considered it”.²⁴⁸ In oral evidence he went on to say:

“[...] the evidence base is developing—that’s being perfectly honest—because we’re relatively early in the journey on primary care clusters, and that does mean that you won’t have, and I won’t have, all the evidence we might want to see now about the way in which demand is being managed differently, and, hopefully, more successfully. And when we do get that evidence in greater

²⁴⁴ Written evidence, PC 39

²⁴⁵ RoP, 11 May 2017, paragraph 85

²⁴⁶ RoP, 3 May 2017, paragraph 134

²⁴⁷ RoP, 7 June 2017, paragraph 11

²⁴⁸ RoP, 7 June 2017, paragraph 12

number, and greater measure, we'll also learn things that haven't worked as well as we might have wanted them to."²⁴⁹

Our view: evaluation

- Whilst it is clear that there is not as yet a robust framework to evaluate cluster outcomes, we agree with the Cabinet Secretary that transformative change of primary care is needed and that “doing nothing is not an option”.
- We appreciate that evaluating improvements in primary care can be very challenging. These challenges include attribution of changes when multiple factors are involved, and measuring outcomes for patients.
- However, it is vital to ensure that mechanisms are put in place to robustly evaluate clusters and associated pilot projects, including the need to assess the impact of cluster development monies. We need to see if clusters are improving patient outcomes, delivering value for money, seeing what works and sharing best practice.
- Cluster development money is not the main funding stream for primary care but it is still significant. It is important that the Welsh Government does not find itself in a position in the future of not being able to evidence value for money.
- Whilst we note the DPCMH stated that “allowing different models to evolve, whilst ensuring standardised outcomes and governance frameworks, appears to be effective”, the evidence suggests that there is not an obvious way to collect standardised outcomes.
- We are concerned that the evaluation of the project by Bangor University will look at the process only and not outcomes.
- There is a lack of clarity about how successful projects can be subsequently scaled up and mainstreamed into primary care across the health board areas and where relevant, Wales wide.

Recommendation 16. Evidencing whether primary care clusters are an effective model and deliver value for money is crucial. As a matter of urgency, the Welsh Government must ensure there is a much clearer and more robust mechanism for evaluating cluster work. Despite the clear challenges, there must be attention given to how evaluation mechanisms can begin to measure the impact of cluster work on patient outcomes.

²⁴⁹ RoP, 6 June 2017, paragraph 9

09. Lessons from other models

Definitions: what do we mean by 'cluster' and 'federation'?

245. An increasing number of GP practices across the UK are considering entering into collaborative arrangements with other practices. GP networks go by many names, such as federations, networks, collaborations, joint ventures, and alliances. These terms are often used interchangeably to describe multiple practices coming together.

246. Powys THB told us that there are “frequent references in many documents and papers across Wales that suggest that clusters and federations are interchangeable”. It supplied its own view, setting out its intentions:

“GP Federations are and will be essential, for delivery of greater sustainability, economies of scale and robust future delivery models. GPs will need to become more collegiate as a professional group across a specific geography and in this way, it should be possible to improve access and provide an extended range of services.

Clusters are the local planning and delivery areas for Health Boards with all partners and making use of all local resources.”²⁵⁰

Catchment populations: is there a right size for clusters?

247. There are 64 cluster networks across Wales. Published statistics on GPOne report that clusters serve populations of between 30,000 and 50,000 patients. However, there is considerable variation in these numbers and several clusters serve much larger populations. For example, according to 2016-17 Cluster Plans the cluster in Cardiff North encompasses 102,250, Swansea Bay serves a population of 75,313, and Bridgend East includes 70,464. The composition of clusters is determined by individual LHBs in each area.

248. The Committee heard evidence which suggested the need to look at whether the existing pattern and number of 64 clusters was appropriate and sustainable. For example Community Pharmacy Wales questioned whether 64 clusters is too many.²⁵¹

249. We also heard questions about whether clusters are of sufficient size to secure the service changes needed and to provide the organisational scale to employ cluster staff. The RCN told us that different operating models across the 64 clusters “make it difficult to plan strategically”.

250. The Cabinet Secretary did not rule out changes to the current cluster profile if necessary, but told us that he did not see any reasons for drawing different boundaries at this point in time:

“The decision on choosing cluster areas was drawn on evidence from the Kings Fund, amongst others, about the sorts of groups of population that you can plan for and deliver improvements for locally. [...] it would have to be a really good reason to want to change the maps and the groups of the population that we’re drawing together to work in this way, because otherwise you’ll have to

²⁵⁰ Written evidence, PC 14

²⁵¹ Written evidence, PC 09

restart some of that work and the relationships that are being developed across the country.”²⁵²

251. A King’s Fund report published in 2014²⁵³ examined how primary care federations and networks were working jointly to deliver extended ranges of services.²⁵⁴ It concluded that population coverage in the range of 25,000 to 100,000 people is needed to enable federations and networks to function effectively.²⁵⁵ Professor Chris Ham reiterated this position in an **article accompanying** the report, setting out that this meant GP practices:

“[...] would have to collaborate through federations and work at sufficient scale to be able to lead the development of family care networks. This is likely to mean serving populations in the range of 25,000 to 100,000 and possibly even larger over time. The opportunity this offers is to strengthen the role of GPs primarily as providers of care, coordinating the delivery of services on behalf of their patients and working in collaboration with others to provide joined-up services in the community.”²⁵⁶

GP collaborative models across the UK

252. NHS England has been pursuing an approach based around **GP federations**. These tend to serve larger, multi-practice populations, including many of **over 250,000**. Some of the motivation for this is based on a drive to work more collaboratively or at greater scale; the aim of sharing costs and resources (for instance, workforce or facilities); or as a vehicle to bid for enhanced services contracts. There is a wide range of federations established across England. Examples include **Suffolk, Bury, Croydon** and **South Warwickshire**.

253. The **Suffolk GP Federation** is a not-for-profit Federation of 59 independent GP practices covering 580,000 patients. Members remain independent organisations, whilst collaborating in the development of local primary care and delivery of other services such as community pain, lymphoedema and diabetes services.

254. GPs in Northern Ireland are also developing federations as part of a process to ensure more people are treated outside the acute hospital setting. Federations comprise of around 20 general practices, delivering services to approximately 100,000 patients. By the end of 2015 almost all GP practices in Northern Ireland were in a federation. The **BMA Northern Ireland vision for GP federations**²⁵⁷ sets out further information on this development. This was backed by the development of multi-disciplinary teams, including pharmacists and phlebotomists in practice teams. However, the Committee heard evidence from the representatives of Pen-y-Bont Health reporting that progress in these federations was still at an earlier stage of development than clusters in Wales.²⁵⁸

255. GP clusters were **introduced in Scotland** with the 2016/17 GMS agreement between the Scottish GP Committee and the Scottish Government. The Scottish Government:

²⁵² RoP, 7 June 2017, paragraph 153

²⁵³ The King’s Fund *Commissioning and funding general practice: making the case for family care networks* (2014)

²⁵⁴ The King’s Fund *Commissioning and funding general practice: making the case for family care networks* (2014)

²⁵⁵ The King’s Fund *Commissioning and funding general practice: making the case for family care networks* (2014)

²⁵⁶ The Kings Fund *Making general practice fit for the future*, 19 February 2014

²⁵⁷ BMA *General Practice in Northern Ireland: the case for change* (2015)

²⁵⁸ RoP, 17 May 2017, paragraph 201

- Specified that GP clusters had to be operating by 1 April 2017 (although there was an expectation that most areas would be active before that date).
- Estimated that a ‘typical cluster’ might include four to eight practices covering 20,000 to 40,000 patients, although this would depend on the practice sizes and the geography of the local area.
- Prescribed that the Local Medical Committee and Health Board must be closely involved by practices in the local process of defining GP cluster groups.
- Made additional funding available to ensure every Practice Quality Lead has dedicated protected time to participate in cluster working.

The GP federation model in Wales: Pen-y-Bont Health

256. Building on the primary care cluster work in Wales, the first GP federation in Wales was **Pen-Y-Bont Health**, established in 2016. Six GP surgeries in Bridgend joined together to offer a range of new community services for their patients, including a bespoke new website just for those practices: Ashfield, Newcastle, Oak Tree, New Surgery Pencoed, Pencoed Medical Centre and Riversdale. The federation serves a population of over 70,000 patients, and engages with ABMU with the aim of providing better health services to patients, whilst promoting closer working across the six GP practices in the cluster. The GP practices in Pen-y-Bont Health are included within the **Bridgend East Cluster Plan for 2016-17**. Pen-y-Bont Health report that their focus is on delivering: better local care; more health information; new and well trained GPs and other healthcare staff.

257. While each of the surgeries remains independent, they aim to develop extra services working together as a team. As a federated cluster of GP practices, they have developed Wales’ first not-for-profit **social enterprise** consortium. This allows them to bid for public sector contracts with the aim of providing local health care solutions to local needs. The Committee heard that the practices had looked at various models of provision, with the help of the Bridgend Association of Voluntary Organisations, and received support from the Welsh Government via Pacesetter funding.²⁵⁹

258. The practices have a mix of GP Partners and Salaried GPs, with each practice having a GP principal as one of the Directors on the Board, assisted by two of the Practice Managers.²⁶⁰ Dr Ian O’Connor from Oak Tree Surgery explained to the Committee that each of the practices is also represented on the Bridgend East Cluster, and that:

“[...] where we’ve got to, essentially, is that we’ve got two entities now. We’ve got the network and we’ve got the federation. They are separate but they overlap, because the voice of the federation is what we would bring to the network.”²⁶¹

259. The federation has also set up a joint mental health counselling service for patients over the age of 18. Before this, patients were usually signposted to local charities for support, but now the federation is able to offer direct counselling services itself. The GPs are also currently in talks with

²⁵⁹ RoP, 17 May 2017, paragraph 81 and 96

²⁶⁰ RoP, 17 May 2017, paragraph 93

²⁶¹ RoP, 17 May 2017, paragraph 90 and 96

ABMU about a possible diabetes service, and have successfully tendered for the provision of GP services at Parc Prison, Bridgend.²⁶²

260. The Committee heard evidence from representatives of Pen-y-Bont Health, who set out some of the reasons for pursuing the federation model. One of the key issues was a sense that the cluster model was not one that was delivering what the practices needed and that this led to frustration and a disengagement from the process. Representatives of Pen-Y Bont Health expressed concerns about the lack of a governance structure within clusters to enable decision-making.²⁶³

261. They told us that the federation model allowed them to work towards the ‘bigger picture’. Dr Gail Price noted also that the practices had been able to share time from clinical staff who have particular expertise or interests, including in areas such as diabetes and musculoskeletal conditions.²⁶⁴

262. The Committee heard there had been considerable interest from other health boards in moving towards a federated model and Pen-y-Bont had received a number of requests to discuss their experience with others. The Committee also received evidence about proposals for a federation developed by GPs in Cardiff and the Vale.²⁶⁵

263. At the same time, Dr Price did sound a note of caution:

“I think we’ve been very fortunate that we’ve been able to take this forward because of the way we’ve gelled together in the way we think, but that wouldn’t necessarily run out across all practices in each cluster area.”²⁶⁶

264. One key issue that the federation noted is that they were unable to employ staff directly, but relied on contracts being held by individual practices.

265. Another area of concern which took time to resolve was the relationship with the health board. For example, securing a funding stream for a new project such as an enhanced service could require a service level agreement to be set up with the health board.²⁶⁷ In a similar vein, Dr Price set out the difficulties in getting timely financial drawdown from the health board and Dr O’Connor outlined the difficulties in enabling successful schemes to be consolidated:

“In our particular case, we’ve had a couple of projects that we feel have been very well received by patients, GPs, and our community at large. We believe that we’ve collected evidence and demonstrated their value, but we’re still awaiting our health board to decide whether they’re going to say, ‘Right, you’ve proven your point. We will fund this now.’”²⁶⁸

266. The BMA said:

“The exploration of alternative models, such as practice federations, is necessary to address sustainability challenges. The GPC UK document ‘Collaborative GP networks’, offers food for thought (rather than detailed

²⁶² RoP, 17 May 2017, paragraph 144

²⁶³ RoP, 17 May 2017, paragraph 77

²⁶⁴ RoP, 17 May 2017, paragraph 153

²⁶⁵ Written evidence, PC44 Annex

²⁶⁶ RoP, 17 May 2017, paragraph 196

²⁶⁷ RoP, 17 May 2017, paragraph 128 and 136

²⁶⁸ RoP, 17 May 2017, paragraph 133 and 167

guidance) for the establishment of new structures with varying levels of involvement and integration. There is a need for greater working at scale to share costs and resources (e.g. workforce and facilities), which clusters cannot enable due to their lack of status as legal entities. Federations of practices could exist within, or between, cluster networks and could potentially offer greater flexibility in terms of employment options both for GPs and the wider primary care team such as pharmacists, physiotherapists, and advanced paramedics.”²⁶⁹

267. The Cabinet Secretary acknowledged that in response to increasing demand, a variety of organisational forms for delivering sustainable and accessible care are evolving out of cluster working across Wales. He cited the Bridgend federation, and also the Red Kite social enterprise in the South Powys cluster as forming “part of the national programme of pathfinders and pacesetters projects”.²⁷⁰

Our view: lessons from other models

- It is clear there are a variety of models of collaborative working in primary care emerging across Wales and elsewhere within the UK. It is critical that Wales actively seeks out learning and good practice from this range of emerging models. This may involve changes to the existing cluster profile in the future.
- We recognise that terminology for the various models can be confusing. However it is essential to have a shared and clear understanding of what the practical distinction between the models, in terms of how they are governed, how they operate and the services they deliver to patients and the communities they serve.
- This clarity is important. Federations and clusters in Wales are distinct organisations with the single existing Welsh federation in Bridgend operating on a smaller scale to the primary care cluster. This is contrary to England, where Primary Care Federations are serving much larger patient populations.
- There is a pressing need to evaluate the impact of the different emerging models in NHS Wales and elsewhere, in terms of both the services they provide and develop, and the outcomes they deliver for patients.

²⁶⁹ Written evidence, PC 41

²⁷⁰ [Health, Social Care and Sport Committee, 7 June 2017, Paper 1](#)