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Foreword

It gives me great pleasure to present this primary care strategy for consultation. In February 2001, I launched the new plan for the NHS in Wales – *Improving Health in Wales: a plan for the NHS with its partners*. This document is part of our work in implementing that Plan. Primary care services are the first port of call for the majority of people who use health services; some ninety percent of patients' first experience of the health service is through primary care. It is a vital public service. This consultation document introduces new ideas and recommendations for developing primary care in Wales to meet the challenges of this century.

There is much to be proud of in our present primary care system. In recent surveys of public opinion, the vast majority of people reported very positively about their experiences of primary health care. But this is against a background of an increasingly difficult working environment for those delivering the service. Demands are great and keeping up with the pace of change has been difficult. The resilience of the primary care services in the face of these growing pressures has been remarkable. Staff working in primary health care have maintained high quality services, often in difficult circumstances.

Now, we wish – in partnership with them – to build on their success, and to face the challenges that lie ahead in maintaining and improving the health of the people of Wales and in tackling the causes of ill health in our population. This will involve equipping primary care so that it can meet the opportunities provided by technology and the increasing range of care that can be provided in the community by primary care teams. We must also find imaginative and innovative ways of dealing with the increasing burden of work falling on primary care. The integration of all primary care professionals into strong and well supported teams is one of our main aims.

We have shown our commitment to developing primary care through additional funding during 2001. £3.1 million has been set aside to help develop primary care teams, GP recruitment, out of hours provision and welfare rights services. £1 million has been set aside from the Health Inequalities Fund for dental services, and we are working with the profession on ways to use this money, including a free fissure sealant programme, targeted at children in areas of high dental decay.

There are also challenges to be faced in relation to the geographical and age distribution of GPs, General Dental Practitioners, nurses and PAMs throughout Wales. It is often the case that communities experiencing the most severe health problems are disadvantaged in relation to health care provision – an *inverse care law* first identified by Professor Julian Tudor-Hart in the 1970s which still persists in
areas of Wales. We will address these and other issues by looking at new ways of recruiting and retaining our workforce and of rewarding their dedication and skills. We must attract more doctors, nurses and other health professionals to primary care and the expansion of medical and nurse training in Wales, and the adoption of new curricula forms part of our strategy. We must regenerate these vital services.

The introduction of primary care resource centres and the renewal of the primary care estate is essential. A Primary Care Action Plan is now being prepared to ensure that the essential steps needed to strengthen and develop the service can be put in place.

The strategy looks to develop consortia of practices and to introduce primary care resource centres. This will help to provide support to single-handed practitioners and offer a wider range of services to their patients.

Our aspiration is to turn the objective of a 'primary care led' health service into a reality through investment in and development of primary health care teams throughout Wales.

Jane Hutt
Minister for Health and Social Services
The purpose of this document is to set out what we believe our strategy for primary care in Wales and what our aims should be to strengthen and develop services and to help and support primary health care teams in the vital work they undertake and on which we all depend.

We hope that you will tell us what you think about the proposals in this document. In addition please give us your view on priorities and what needs to be done to deal with the challenges we face.

Please send your comments by Friday 19 October 2001 to:

Mike Ponton
Health and Well-Being Strategy and Planning Team
National Assembly for Wales
Cathays Park
Cardiff
CF10 3NQ
Executive Summary of Key Themes and High Level Objectives

1. Our aim is to ensure that the relative under-development of primary care in Wales over the past 20 years will be reversed. There will be systematic investment in staff development, capital projects and organisational development. Reward systems will be put in place to attract the highest calibre professionals into the sector and to place a value on the continuity and the stability of the service.

2. Primary care doctors will operate with smaller lists than now (and personally provide care for a reduced number of people due to improved triage and management by other members of the team) and will spend significantly increased time with each patient in each consultation. New models for nursing and for the Professions Allied to Medicine will be developed as part of the redesign of the primary care workforce, as key professionals in the primary care team.

3. Well developed primary care teams, working closely with public health, health promotion and an appropriate secondary/tertiary service, are an essential part of our plan to deal with the determinants of health, health inequalities, and to build a socially, environmentally and economically sustainable Wales aimed at delivering equity of provision and social justice.

4. The overall focus will be to build on the broad model of primary care designed around the core need to deliver generalist based care to the vast majority of people. The NHS patient ‘list’, 24 hour responsibility of the primary care team, professional continuity and stability of service provision will be the foundation for developing primary care in Wales, together with the adoption of core standards of primary care across Wales.

5. The strategic development of primary care will be conducted within a long-term (10 year) time frame. However, some priority areas will need speedy attention to ensure the retention and recruitment of key health professionals. A Primary Care Action Plan will be put in place by April 2002 to implement this part of the strategy.

6. We will develop primary care resource centres to support the existing practice model of primary care by providing local services (dietetics, physiotherapy, chiropody, speech therapy, occupational therapy etc) that require larger scale organisation for support. Resource centres will enable the development of new models of primary care, for example salaried GPs, nurse practitioner based services.

7. The current inequality in service provision requires targeted investment if it is to be halted and reversed. Generalist care will be delivered by an extended and
integrated team of primary care professionals and a range of other health care and support staff. They will work in close partnership with social care and the voluntary sector. The team will be the gateway to more specialist services provided either in the community or in hospital through agreed protocols and standards.

8. We will invest in restructuring professional training and the development and dissemination of best practice.

9. Practitioners who have been isolated or overworked in challenging areas will be supported through a variety of local and wider schemes to enhance their continuing professional development and service to patients.

10. There are now multiple entry points for health care and the strategy seeks to enable easier access to services for patients in a variety of settings. NHS Direct will play an increasingly important role in co-ordinating access to primary care through professional nurse based triage. This must be developed in line with the core principles and standards of practice for primary care.

11. Information is crucially important in the effective management of patient care, the continuity of care and the assessment of quality. We will prioritise the development of primary care information, information technology and communication systems infrastructure, as part of the National IM & T Development Plan for the NHS.

12. We will support and develop an evidence based learning culture within primary care in Wales to improve service effectiveness and to act as a powerful incentive for recruitment. The National Assembly is committed to the enhancement of NHS research and development and the effective evaluation of innovation in health or social care.

13. We will encourage more flexible interpretations of the existing contracts and work with national processes to reform the remuneration (contract) for GPs and other primary care professionals to ensure the high status of a career in primary care. A variety of contractual options will co-exist to facilitate flexibility in the development of a revitalised primary sector and to meet the diverse needs of primary care professionals, with due regard to work-life balance for all members of the team.
Chapter 1 - A New Vision for Primary Care in Wales

Introduction

The purpose of this strategy is to explore new and innovative ways of strengthening and developing primary health care to meet the changing needs of patients, their families and the communities in which they live. We seek to build on what has been shown to work well in Wales but we must also address the issues that clearly need to be tackled to take the service forward.

We must nurture and better support those skilled and committed individuals and teams which already exist in Wales. In that way primary care will be a rewarding and professionally stimulating service for which we can continue to attract and retain top class health professionals. We want primary care to be a career of first choice for the best people of all disciplines.

A part of any strategy must be to provide a long-term view, geared to deliver the sustainable improvements needed in the NHS in Wales and in the services it provides. But we also need to make early progress in addressing the issues that we know need attention and which will hamper progress if they are not resolved.

Defining Primary Care

To help the discussion in this document a common understanding of the term 'primary care' will be necessary. Starfield’s definition is used for this purpose:

“first contact, continuous, comprehensive and co-ordinated care provided to individuals and populations undifferentiated by age, gender, disease and organ systems.”

This is based on a core set of principles which are central to the approach to primary care proposed in this strategy. It envisages that the principles of primary care are to:

- Provide effective first contact services;
- Offer continuity of care;
- Provide comprehensive services;
- Co-ordinate services;
- Offer personal care;
- Improve population health.

These core principles have international credibility and are fundamental to an improved and better-balanced system of national health care in Wales. The Plan, Improving Health in Wales applied these principles to our local circumstances. It set out the following objectives for primary care in Wales:
It is a founding principle of this strategy that primary care must adopt both a population and an individual focus. In the new health environment these are not mutually exclusive. This strategy is built upon the work of the World Health Organisation in its document *Health 21* which states that “the improvement of health and well being of people is the ultimate aim of social and economic development”. In policy terms this means:

- Adopting strategies which draw different organisations together so that they can tackle the determinants of health;
- Investing in programmes which focus on *health outcomes*;
- Integrating family and community orientated primary health care;
- Developing services which promote participation in the way in which our health service develops;
- Strengthens primary care to take on its health promoting role in collaboration with other sectors.

The National Assembly has a clear focus on social justice, delivered in a socially, environmentally and economically sustainable Wales. The NHS generally, and a well-developed primary care sector specifically, is well placed to help deliver that agenda.

It is essential that primary care has a clear focus on improving public health, community health and well being as well as on delivering tangible improvements in the overall quality of primary care across Wales.
Principled primary care is a service judged and regulated against the generic principles articulated here and when professional groups put the ‘principles’ before professional interests.

**The starting point**

In painting a principled vision for the future it is important to emphasise the need to retain many of the key elements of our current system.

A wholesale retreat from the model that has independent contractors and the legal partnership at its core is not envisaged in the strategy. However, there is considerable scope to build on this model by developing the roles of all professional groups in primary care and, where appropriate, by utilising alternative employment models. This is now possible with the introduction of Personal Medical Service and Personal Dental Service Schemes and the new management frameworks that will become part of the development of Local Health Groups.

Primary care needs to build on its traditional role at the front end of the system, focussing on its core principles. It also needs to be better positioned to manage and co-ordinate care for patients on a whole system basis to suit the individual needs of patients for support and care across the range. In part, this will be discharged by the development of Local Health Groups which will be both commissioners and providers of services. But the extent to which LHGs should commission more specialised services is a complex issue. This will need to be shaped around the ideas expressed in *Access and Excellence*, particularly with regard to developing a higher level, health economy focus for the planning and commissioning function within NHS Wales.

**The Primary Care Team of the Future**

The development of primary care teams has been at the heart of health policy for a number of years but the situation across Wales remains patchy. Within some areas there are well developed and integrated teams, whilst elsewhere practitioners continue to work largely in isolation. The advantages of team working are many. In particular, it provides the opportunity to bring a wider range of skills and expertise to meet complex patient needs. It also offers practical opportunities to provide integrated care in a more efficient way. Team working reduces professional isolation and provides greater opportunity for peer support and challenge.

The GP has traditionally been at the core of the primary care team working closely with practice nurses and community nursing, Midwifery and health visiting services. In future we see the essential core of the primary care team as clinical generalists and a comprehensive ‘nursing’ team operating within a single organisational framework. We believe there is great potential to develop a new model of nursing in primary care to complement the more specialist roles of existing community nursing disciplines, building beyond the role of practice nurses. This concept of
changing and developing roles will enable all the members of the primary care team to make the most of their skills and expertise and to support each others’ special contribution to patient care.

It is a key strategic objective to ensure that this basic model is operating throughout Wales. At a local level there must be clearly agreed protocols that clarify roles and responsibilities in order to achieve principled co-ordination between different professional groups. Everyone within Wales should receive primary care services from a team based model within the next five years.

Primary care should drive the development of network of clinical and care services given its unique position at the interface with specialist health care services, social care and self-help.

As primary care becomes more developed it will be essential to protect its personal front-line relationship with patients and their families. It will be necessary to embrace more formally the notion of a core team of doctors and nurses and an extended primary care team involving other key health professionals. These will include the professions allied to medicine, dentistry, pharmacy and optometry. Close working relationships with colleagues in public health, social care, housing and education and across the voluntary sector are also important and will be underpinned by the new strategic partnerships between Local Health Groups, Local Authorities and other stakeholders.

By working together, new approaches to identifying and meeting unmet needs in the community can be developed. A key element of this strategy is the responsibility of primary care to play its full part in the prevention and early detection of disease and ill health. The Welfare Rights Initiative in primary care will also help in dealing with the wider determinants of health.

Members of core primary care teams operate largely through personal contact with their patients. The creation of large and unwieldy teams is not envisaged here and the importance of maintaining a small, human scale organisation at the front of the NHS is recognised. Each team should have locally agreed core membership with clearly defined protocols for access to more specialised services or specialist teams. In this way it should be possible to retain the benefits of genuinely small-scale personal organisations with the benefit to the patient of access to specialists. In this way, no practitioner should operate in isolation and specialist care should be accessed through the local clinical generalist teams rather than by by-passing them.

Practitioners who wish to operate as independent single handed contractors must be able to demonstrate that their patient populations are cared for to modern standards. Local agreement should be reached about the development of a primary care team in support of their work and appropriate arrangements for peer review will need to be put in place. Over the strategic (10 year) period we would expect the development of tighter specifications for core primary care services.
The Primary Care Resource Centre

A key part of this strategy is the development of primary care resource centres to support general practices or PMS/PDS. They will provide a base for many of the more specialised services to support primary care in the locality. Their precise configuration will be based on local needs and circumstances. In some cases they will include access to 24 hour primary care, minor casualty services, more complex diagnostic and therapeutic services or a facility where salaried general practitioners work and train. Where resource centres are linked with community hospital or nursing home developments the possibility of access to beds will arise.

This proposal does not represent a return to the health centre model of the 1960s but is intended as being complementary to and supportive of a decentralised model of local practices. There will be no attempt to force the movement of practices into shared premises.

Resource Centres will be established by Local Health Groups and will develop managerial and clinical services serving a population focus of about 50,000 people. They should be seen as part of community wide and whole-system service development plans that link primary care to developments in intermediate and secondary services. They will become the hub of local professional education and governance activities in collaboration with local practices.

The provision of extended primary care services will promote a rich and diverse mix of supporting services. Resource centres should not be seen as a model for centralisation, but rather an opportunity to support local services and enable the decentralisation of secondary care currently locked within a hospital model. The balance between services provided in resource centres and local practices will need to be different in urban and rural settings. In some cases, it may not be sensible to provide a whole range of services from one physical location. A network approach can deliver additional services in a way consistent with a resource centre philosophy. Full use of modern information technology offers many opportunities to achieve virtual integration in more scattered communities.

Funding will be through mainstream capital processes, including PF/PPP. In some cases resource centres will be purpose built; in other cases they will be developed through the re-modelling of existing facilities including large health centres, community hospitals, or perhaps local authority premises. All centres must provide stable, long-term and unrestricted primary care services to the local community.

Primary Care in partnership

A formal merger of health and social care is not proposed in this strategy. The organisational and service turbulence created would be too severe for both sectors.
The engagement of local authority and voluntary sector members on LHG boards will bring with it a requirement to develop a joint agenda without compromising the core principles of primary care. The development of new proposals for Strategic Partnerships as part of the implementation of *Improving Health in Wales* will bring NHS trusts, LHGs, local government and their voluntary and independent sector colleagues into a new era of partnership with a vision for tackling the local determinants of ill health and securing improvements.

Local Health Groups will play a major role in developing seamless multi-sector services. The same rigour must be applied to the development of approaches to the networking of integrated community based care as is taking place in clinical networks, for NHS based services.

**Intermediate care**

The emphasis of intermediate care will be on the maintenance of independence, on caring rather than curing, and in providing the basic social and clinical services people often require to avoid slipping into long-term care in institutional settings or inappropriate acute care.

This will develop as a vibrant new sector over the next ten years. It will reduce pressure on secondary care by preventing unnecessary admissions, will facilitate discharge, and will have a strong rehabilitative role.

- The Assembly will develop a comprehensive intermediate care strategy for Wales as part of the implementation of *Improving Health in Wales*.
- Local Health Groups are ideally placed to take the lead role in developing integrated approaches to intermediate care in the future. They should review the considerable resources available in the independent sector, funded through both private and local government sources, as part of a strategy for their catchment area.

The development of specific community based support services and care-at-home schemes will feature prominently in a future model and there is a growing evidence base pointing to the effectiveness of alternative models of delivery. There are also new pressures. The provision of services to highly dependent individuals in community settings will be a growing feature of this sector in the future.
**Carers**

Relatives, friends, neighbours and volunteers play a vital role in looking after dependent people in their own homes. Carers form a major part of care in the community.

The National Assembly’s Carers Strategy identified that physical injuries such as a strained back, as well as stress related illnesses were common health problems suffered by carers. It is a key strategic issue for primary care teams to identify carers within the population, to be aware of their potential health problems and to provide them with appropriate care and support.

**Managing demand**

Primary care will play an expanded role in the management of demand in the future. The leadership role for primary care is in part related to its ability to intervene early and to have a positive impact on the performance of the rest of the health and social welfare system. In future the performance of primary care must be assessed on its ability not only to improve the experience of patients within primary care settings, but also in terms of its impact on wider health system issues. These would include its ability to reduce the rise in emergency admissions to secondary care, its achievement in the reduction of inappropriate attendance of patients to Accident and Emergency departments and a reduction in the upward pressure on hospital beds across Wales. It is important to emphasise that managing demand is not synonymous with rationing health care. A balanced approach to demand management is concerned to develop approaches that allow services to better cope with presenting demand, to modify inappropriate demand and also to create demand for more effective alternatives.

**The evidence base**

It is vital that the primary care service is developed and delivered on a strong evidence base. The development of care protocols, clinical networks, managed care pathways and disease based programmes of care must be underpinned by the national and international evidence on effectiveness. New resources will need to be invested to ensure that evidence is implemented. The culture of evidence based care should be strengthened across primary care together with an understanding of the science of implementation.

**Managing and rewarding performance**

We need to exercise radically different approaches to performance management and individual reward across primary care to reinforce the achievement of the health outcomes and service improvements that we seek. The National Assembly is involved in the national (UK) negotiations underway on the new GP contract and new opportunities for primary care nurses are being developed.
Local health groups are key players in delivering primary care in Wales and will need support, development and resources to deliver the programme of work.

The Townsend review of resource allocation in Wales is taking place at the same time as the development of this strategy. It is important that the distribution of health monies in the future will enable primary care to move forward on improving community based services in particular.

**Information and communication**

The primary care system must be underpinned by an effective, common communications and information technology platform.

All GP practices, and all locations where primary care services are delivered, must be connected to the central information network.

This is essential to help practitioners to exchange and share clinical information, to access decision support systems and to utilise remote diagnostic and consulting technologies. We must also develop a single electronic health record with appropriate levels of access to the GP, individual primary care team members and patients themselves. Considerable opportunities exist to utilise the information infrastructure, for supporting basic clinical purposes and added value functions including training and education and routine communications with staff.

New information technology has the potential to revolutionise the way first line advice is given. The development of the E-health sector is likely to be a major consideration over the next ten years and has the potential to alter radically (and positively) the way in which people access healthcare services and gain health information.

It is essential that a co-ordinated, quality assured approach to the availability of E-health resources is developed by the NHS in Wales.

It will be essential to work in partnership (with NHS Direct and other providers), to ensure that the population of Wales can be assured that there are freely available, quality assured, sources of information available for their use.

**Managing the change**

The new LHGs will have an important role in nurturing and developing primary care and community health services. They will be responsible for assessing local health care needs and securing services for their local populations. This, and the new
structures required to support LHGs are being considered as part of the implementation of *Improving Health in Wales* and will be the subject of consultation starting in July 2001.

**Conclusion**

The aim of this vision of primary care is that by 2010 the public and health professionals will report greater satisfaction with the primary care experience. Long-term careers in primary care will be seen as the first choice for clinicians and managers. A new integrated primary care sector will have equal status with other parts of the NHS and real improvements in population health will have been delivered. We will have moved forward to create health and social care systems that are fully engaged and operating within a radically modernised framework of top quality public sector services.
Chapter 2  The Challenges Ahead

Current context

In some parts of Wales, primary care is under considerable pressure and teamwork remains underdeveloped. In other areas, primary care systems are working well and effectively. It is no surprise that the system is under most pressure in those areas marked by high levels of economic and social exclusion. In response to this, Better Wales³, the Assembly’s strategic vision for Wales over the next decade emphasises the drive toward greater social, economic and health equality, job opportunity, improvements in housing and the environment. Developing a strong and universal primary health care sector is a fundamental part of that vision. Properly developed, well resourced primary care can deliver most care to most people in the most cost effective way. Shifting the emphasis in the NHS from secondary to primary responses must be a key element of building a fairer, more sustainable Wales.

The basic architecture of the UK primary health care system was laid down in 1948 and has remained largely intact ever since. Key features of our existing model include:

- The independent contractor status of medical, dental, pharmacists and ophthalmic practitioners;
- The legal partnership and ‘the practice’ as the basic unit of organisation;
- The individual general practitioner’s list as the basis of patient registration;
- Community nursing services, health visitors and midwifery to work with general practitioners in the community.

Though policy developments over the last fifty years have emphasised teamwork and the development of alliances for health, the system remained relatively unchanged until the introduction of fund-holding in the 1990s. As we seek to unpick the fund-holding system and the competitive ethos associated with it to develop a new and effective primary care for the twenty-first century, the following challenges will need to be faced.

- **Pressures on primary care.** The health of primary care nationally is variable: at the extreme, poor premises, large list size, recruitment difficulties, too few community nurses and an increasingly complex workload lead to low morale amongst professionals. The professionals are aware that they cannot achieve the best for their patients amid the mounting pressures and this places them in intolerable ethical and moral positions.

- **Changes in clinical practice** are in some cases reducing the need for hospital beds and bringing about changes in the way hospital care is organised. At the same time, however, overall demand is rising, placing
pressure on the whole system – including primary care. Rapid technical turnover of patients does not always meet their needs for personal care, nor does it provide adequate attention to the complex health problems that have become common clinical currency in an ageing society.

- **The new policy environment.** Primary care is charged, in *Improving Health in Wales*, with playing a significant role in shaping local health services. This will require a more balanced approach to the development of primary, community and secondary health care services. *Better Health: Better Wales* also recognises that factors that affect people’s health are not always within the direct control of individuals. The strategy for health improvement is one of joined-up working between the NHS, local government, the voluntary sector and other bodies interested in the well being of communities and the provision of universally accessible primary care services.

- **The human geography of Wales** presents particular challenges. The population is more concentrated in the south-east. There are large rural areas with limited road and rail communication and a regional distinctiveness north and south. This is a highly diverse country with many specific local needs.

- **The social and economic history of Wales** has resulted in poor levels of health, high levels of morbidity and high demand. The health service has underlying financial deficits and significant use of cross border services for populations in North, Mid and South-East Wales.

- **Imbalances in general practice and primary care.** There exist considerable imbalances within Wales in the distribution of general medical practice. This makes it difficult to make sure that everyone has an equal chance of access to high quality primary care. The same can be said for dentistry.

- **Changes in the population** where new groups within the population present high levels of need, but have difficulty in accessing and using primary care services effectively.

There are considerable reported variations in gaining access to GPs. Access to GDPs is also variable. For some there are appointment systems, some have open access with no appointments. Reported waiting times to see a GP vary between 24 hours to several days for a GP of choice. Women often view access to women GPs as being particularly problematical due to the relatively low number of women GPs in practice leading to particular delays if a specific GP was requested.

At health authority level the data indicates significant differences in the expenditure on primary health care services per head of population across each of the health authorities ranging between £274 per head in Iechyd Morgannwg Health Authority to £320 in Dyfed Powys Health Authority.
While the main focus of the consultation document ‘Access and Excellence’ published in the summer of 2000 was the secondary and tertiary health sectors it also emphasised a number of important issues that have shaped the approach to developing the primary care strategy. Taken together they set out the integrated vision for the NHS established in *Improving Health in Wales*.

Some of the key issues identified by these two documents are:

- The key to tackling the major systemic problems of the NHS in Wales is the need for us to re-conceive the health care system as an integrated whole;
- In order to progress we need to join up our planning activity across organisational and sectoral boundaries and look to develop comprehensive plans and investment strategies at the level of health economies;
- Effective and efficient use of the hospital system is crucially dependent upon developing primary care and requires a fundamental shift of mind set amongst professionals, policy makers and the public to prioritise investments in the relatively low technology, people focused primary care services;
- The expansion in the number of entry points, including Accident and Emergency Departments, to expensive secondary care for patients requires different solutions when viewed from the perspective of principled primary care. The notion of the GP as the single gatekeeper to the system has become an organisational myth in recent years because the expansion and specialised fragmentation of the hospital service has had a systematic impact on primary care in many speciality areas. The traditional gates from primary care are swinging wide open under these pressures;
- The potential for technological developments that will also reshape health care;
- Areas where the proportion of women GPs is low;
- Areas where the primary care team is poorly developed.

People bring a great variety of problems to primary care and we aim to provide a system which can deal effectively with the full spectrum of needs. Designing services of this sort must be undertaken locally because the structure of primary care teams and local priorities for action will vary across Wales to meet local demands.
Little robust data is available to enable meaningful comparisons to be made at a local level, or to articulate clearly what happens in primary care, or to base judgements of operational efficiency or the quality of service outcomes. In the absence of robust information we cannot answer basic questions about the performance of a sector that is responsible for nearly a third of the total health spend in Wales. At current costs this amounts to approximately £1 billion of public expenditure per year, a significant percentage (14%) of the total expenditure of the National Assembly.

Data on the use of primary care services at the aggregate level is very limited. We know from the most recent Welsh Health Survey in 1998 that people make very high use of primary care services. The strategic significance of this information is that it clearly shows the vast majority of the population comes into very frequent contact with formal health care services. The experience people have of the NHS is likely therefore to be more guided by their primary care experience than their use of specialist services which is more limited. The opportunity these high levels of contact represent for health care screening and health promotional activities is immense if primary care is properly resourced.

The number of GP consultations in Wales continues to rise. This rise in demand, which appears to be contrary to national (UK) trends, needs detailed research to

A well-developed primary health care system has a number of well-researched facets:

- The ability for the front end of the health system to deal with most health problems, including a complex range of undifferentiated health problems and co-morbidity that is not neatly packaged into speciality compartments;
- An understanding of the specialist services available to meet specific needs and the mechanism for appropriate onward referral;
- The ‘patient-list system’ that facilitates chronic disease care, preventive interventions and a personal relationship between doctor and patient and between the patient and core members of the practice based primary care team;
- A gateway to specialist high cost treatment, providing the first line of demand management in a system offering universal coverage but with finite resources;
- An internationally accepted focus for personal preventive care and health promotion, this demands a population perspective in addition to traditional individual/family perspectives;
- An underpinning value base that avoids over-medicalising the response to presenting problems and a contractual responsibility to meet need as locally as possible 24 hours a day, 365 days per year.

The information requirements in support of the planning, delivery and review of primary care need to identified as part of the review of information underway as part of the implementation of Improving Health in Wales.
discover the reasons for it, in order to inform our future plans for primary care. It is also important to note that demand for primary care fuels demand for secondary care.

We have no insight into the small but significant numbers of the population who do not routinely access conventional primary health care services and very often, these may be people in the greatest need. The homeless, refugees, and the dispossessed come into this group. In the future the provision of services we must aim to meet the needs of high-risk groups. Well-staffed resource centres should go a long way towards achieving this aim.

Data from the GP morbidity database shows that the most prevalent diagnosis (30%) is in relation to respiratory system diseases including, upper respiratory infection, throat infection, tonsillitis, chest infection, acute bronchitis and asthma. Significant differences occur within and between local practice populations. A wider analysis of data points to the great variation of clinical need in primary healthcare and shows how a primary health care system must deal effectively with the full spectrum of differentiated and undifferentiated problems. It would be very difficult to prescribe from the centre detailed service arrangements to be delivered on a local basis given that the variance in what conditions present to general practice can be so marked.

From a policy perspective, it is noted that the high incidence of respiratory disease in primary care sits outside the current framework of health priorities such as cancers and coronary heart disease. UK health policy in recent years has tended to prioritise those diseases which are seen as the major killers in society rather than those diseases which may place greatest the workload on the NHS and cause considerable disability amongst the general public. Future health policy must ensure that there is a balance in prioritisation to take account of those problems that place the greatest burden on the public and on primary care. This will in turn enable a more efficient whole system response in other areas such as cancers and coronary heart disease and avoid the external distortions of local services that can be caused by high level strategic priorities that over-ride local clinical needs.

Data from the GP morbidity database provides an invaluable source for understanding what is happening in primary care. The development and detailed validation of the database is required to provide data that will be of value to practices and policy makers alike.

The GP morbidity database is an asset to be developed and treasured within NHS Wales. Action will be taken to place the project on a quality assured, permanent and sound financial footing.

Practice nurses and community nurses undertake a major proportion of the primary care workload though there is no comparable data to make easy comparisons between professional groups.
Of the major groups of community nurses the district nursing service is the most significant in contact volume terms (although health visiting has a bigger caseload). The Audit Commission report of March 1999 entitled, First Assessment - A Review of District Nursing Services in England & Wales identified that the district nursing service as a demand led service, defined mainly by the referrals that it attracts.

The report identified that the two main sources of referrals to the district nursing service were by GPs 40% and then hospital staff 29%. The remaining 31% came from a variety of sources including self and carer referral, other district nurses, practice nurses, health visitors and social care.

There are a number of issues of strategic interest from the information we have available about referrals to the district nursing service. Firstly, the number of referrals from social services is very small at only 3%. This is a suitable area for multidisciplinary team review to help achieve improvements in seamless care.

Secondly, the data clearly demonstrates that less than a third of referrals for the community nursing service come from hospital staff and over two-thirds from other community oriented services, mainly within a primary care context. The integration of community nursing services (organisationally) with hospital services could be seen as counter-intuitive in this context.

Thirdly the Audit Commission data shows us that about 80% of district nursing workload is task oriented with the largest workload being for wound checks, dressings and venepuncture. These data suggest potential for work redesign processes to be applied to community nursing services to look at the most appropriate ways of organising the workforce to deal with care that is relatively routine alongside high intensity cases such as palliative care and profound disability. At the same time a growing pressure being reported in Wales for community services to support more complex cases in the community requiring intensive input, including such care for children and young people. The cost of resources per case can be such that even a few patients on a local caseload can severely affect the capacity of the service and at an aggregate level the potential spiralling of costs raises complex policy questions. Access to specialist skills such as children’s nursing and palliative care teams remains a problem for a service geared mostly to long term care of older people.

The issues discussed in this chapter give an indication of what needs to be addressed in the strategy and the action needed to implement it.
Chapter 3 Building Quality

Improving clinical quality and developing organisational arrangements to ensure the quality of services has been a central theme of government health policy since the implementation of the 1998 White Paper Putting Patients First.

In undertaking the research for this strategy a number of central themes have emerged:

- An open, sharing and learning culture needs to be driven from the highest levels of the health service. Professionals must feel safe to examine practice and admit mistakes. The approach to governance must be driven by a desire to improve practice, to learn from error and to support professionals to get it right;
- There is a general acceptance of the need to drive for higher quality and a recognition that current variations in clinical standards and service availability are unacceptable;
- It is acknowledged that clinical governance is everybody’s responsibility and the establishment of lead roles and committees by itself will not bring about change;
- Current practice is often not underpinned by clinical evidence. Developments in education are beginning to impact on this situation but specific initiatives that enhance the availability of evidence to health professionals are also important. For example, the Gwent based ‘Attract’ project aims to respond rapidly to GP queries on the evidence base, and the UWCM based CeRes project which supports research in primary care;
- There is a need to consider medical/legal aspects of healthcare with the increasing number of litigation claims and the real potential for NHS resources to be lost in settling claims for service failings. We need quality assurance strategies that enable us to get it right first time in the context of highly valued health care;
- We need to share experience and work toward greater consistency of standards across Wales;
- Clinical governance reviews need to be integrated into the mainstream performance management process;
- Developing comprehensive and consistent approaches to clinical supervision for all staff is essential. There is considerable scope for community based staff to become professionally isolated;
- There is a need for better multi-disciplinary clinical pathways/frameworks across the scope of practice which are developed with the professions and patients and are appropriately resourced. The importance of the development of formal clinical networks to improve service delivery and also to support staff within larger peer groups is as important in primary care as in secondary care.
- Staff need to invest time into producing service standards within which the professions can develop, reflectively evaluate their practice and undertake development activity that will lead to continuous improvement.

- LHGs need to develop implementation strategies for national and local guidelines and NSFs - the National Assembly recognises the additional workload NSFs are placing on primary care and the need for resources.

- An all-Wales policy will be developed to make explicit the mechanism for identification and investigation of poor performance. The framework for poorly performing doctors should be implemented and should be seen as a model for other professions. Developing high quality professional leadership roles and HR support to primary care are essential pre-requisites for this;

- Ongoing training and conduct for clinical governance must be resourced. Clinical governance must be seen as a thread running through all educational programmes and not just an isolated topic;

- The status and remuneration of Clinical Governance Leads needs to be reviewed, and guidance needs to be produced on their responsibilities and accountabilities.

All NHS organisations are developing formal strategies for clinical governance, which attend to the underpinning structures, processes and organisational culture. At a national level the government has established the Commission for Health Improvement to examine and aid the development of quality within the NHS and also the National Institute for Clinical Excellence, which synthesises the evidence base on the effectiveness of clinical interventions and issues guidelines to the NHS.

The National Assembly is party to England - and Wales-wide arrangements for both NICE and CHI and is currently establishing a new national infrastructure to support this work. Much has already been done in health authorities and LHGs to establish the basic components of the clinical governance framework for primary care with identified governance leads, governance committees and work programmes at LHG level. CHI will systematically review arrangements in Wales as part of a rolling forward programme and has recently completed a first review of clinical governance arrangements in Gwent covering the Health Authority and primary care.

A history of corporate working and well developed institutional infrastructure is virtually missing in primary care. The hospital and community services are better equipped in these respects. The requirements of the modern NHS will require us to give a high priority to building these arrangements for primary care over the next few years.

One of the real complexities for governance in primary care is the extent to which service quality is in multiple hands with many core staff being employed by other organisations, some outside the NHS. Developing clinical governance is a partnership exercise and there is a need for shared approaches with NHS trusts and local government; sometimes this will need service level agreements. LHGs will
take on a lead role in intermediate care and they will need to discuss with local government colleagues the potential for the development of joint care governance arrangements.

Within the NHS General Dental Services the Assembly intends to introduce three new terms of service requirement, to enable dentists to undertake a minimum level of clinical audit activity, establish and operate a practice based quality assurance system, and make an annual return in respect of that system. The Assembly has negotiated levels of remuneration for such activity.

The results of an all-Wales audit of clinical governance are due to be published and will provide a baseline of information and highlight ways of strengthening clinical governance in Wales. The National Assembly will separately publish a new clinical governance strategy later this year, which will include the development of performance indicators and the introduction of a new Assembly-based Clinical Governance Support and Development Unit. There are a number of specific issues that will need to be reflected in that strategy.

- The CHI review framework for primary care must be used by local organisations to self-review. We should not wait for the CHI work programme to undertake reviews;
- The abolition of Health Authorities in Wales will mean that greater responsibility falls on Local Health Groups and they will need the capacity to take on the leadership role on primary care governance;
- We should look to develop a partnership approach to quality improvement initiatives across Wales and lead roles to address common priority areas on behalf of the wider community need to be agreed;
- No health professional should be able to operate in isolation or to develop idiosyncratic practice outside a formal review mechanism. The development of primary care resource centres could act as the locus for governance activities locally and the place where all staff can access support and CPD;
- Each LHG should publish an annual clinical governance report to an accepted format and these will be publicly available;
- Community Health Councils will be given the same rights of access to primary care services in Wales as for other parts of the NHS.

These developments must be pursued within the principles of primary care.

The scale of the development agenda is such that consideration will need to be given to the development of innovation teams, as a part of the Innovations in Care programme, within and between LHGs who can rapidly develop and promulgate best practice.
Research and Development

Historically most medically orientated research has been conducted from secondary/tertiary health care institutions with a strong bias towards university centres. Public health has been involved in community population-wide studies but this is a small part of the research spend in the UK.

Research in and on primary care has grown steadily and a climate for progress in UK primary care research has been created during the closing decade of the 20th century.

Scientific reasons for supporting research in primary care include:

- The extrapolation of clinical evidence from studies conducted from secondary (referred) care to primary (unselected) populations introduces a major selection bias that is unacceptable;
- Evidence for the efficacy of an intervention is no proof of its implementability in the service. The 'science of implementation' is a major development area and primary care has contributed to this academically as well as being the sector of the health service where most implementation occurs;
- Public participation in the understanding of science and in weighing up the risks and benefits of a therapy on offer are important developments for health care in the 21st Century. The science underpinning these elements is 'risk communication' and 'information sharing';
- The implementation of clinical trials and other studies in primary care requires distinctive skills that are quantitatively and qualitatively different from secondary care research. Even the clinical epidemiology of common conditions differs and much basic primary care research remains to be done;
- Multidisciplinary research teams involving clinicians and scientists are the norm in most academic departments of primary care. A majority of these teams depend on soft project money. The sustained development of a critical mass of experienced primary care researchers will depend on more career posts, studentships and fellowship programmes.

Primary care research in the NHS has not been given the support and encouragement that specialist sectors have enjoyed. Research and development is the life-blood of any big organisation. It informs decision-making, attracts inward investment, facilitates the development of staff & generates income from other sources. The resulting publications and publicity send out a clear message of forward thinking values and progressive planning. Primary care in Wales will not flourish and be attractive to external recruits of the highest calibre without the strategic injection of resources and skills.
Through the forthcoming strategy for Research and Development the National Assembly for Wales will make a serious long-term commitment to the enhancement of NHS research and development;

Primary care will be a high priority area for research funding and capacity building through enhanced research networks, studentships, fellowships and properly resourced responsive grant award schemes;

The aim will be that funding for R&D should be at a level that compares well with the rest of the UK;

NHS policy research should be subjected to peer review in the same way as response mode funding. Policy driven research should also be used to extend the value of investment in primary care resource centres and of any PMS or PCAP projects in Wales;

Proposals that address the points outlined in the paragraph on **scientific reasons for supporting research in primary care** should be given a priority to enhance the evidence base of the discipline;

NHS Wales should look to expand the network of primary care research practices perhaps using the resource centre concept as a locus for local activity. Established research quality assurance mechanisms should be used.
Chapter 4 Developing the Team

The development of the members of the primary care team and all its supporting staff is crucially important to achieving the aims of the strategy. The recruitment, retention and continued development of all health professionals must be a central plank in our work to ensure the strengthening and development of primary care. All aspects of good employment practice must be implemented, and all staff given the opportunity to extend their skills and practice in a supportive and rewarding environment.

GPs

Recruitment

Wales can be more attractive to young graduates. The current expansion of training in Wales is welcome, but by itself this will not be enough. Wales is likely to remain a net importer of medical staff and nurses for the next 10 years. They will only come if they are confident of excellent training, good working conditions and career prospects.

Research will be undertaken to find ways of attracting young graduates but there is an urgent need for a co-ordinated approach to promoting Wales as a place to live, train and develop professionally. This means investment in training, work environments, employment flexibility, opportunity for advancement and social support of immigrant staff.

Possible short-term options to improve recruitment include:
- Supported living packages for short term recruits;
- Primary care support teams to enable tired or flagging practitioners to have a sabbatical and participate in Continuing Professional Development. New recruits would then know that they would have support to maintain their CPD;
- As a priority effective occupational health services must be developed and made available to all primary care staff;
- Salary enhancements in priority areas;
- Developing supportive policies in the workplace for all staff with family responsibilities;
- Imaginative use of the Red Book and PMS options to develop salaried alternatives to independent contractor status. About 15% of the medical workforce is likely to be employed on a salaried basis by 2010;
- Prioritisation of investment in primary care resource centres and practices so work conditions in high need areas are rapidly enhanced;
Pay and reward is an important issue. In Wales we aim to develop ways of rewarding staff which draw directly on their own views and in the longer term exploration of a more radical approach to pay and conditions of work is needed.

The lifelong earnings profile for GPs is very different from that for hospital doctors. GPs reach the peak of earnings relatively early in their career and then plateau at an average level significantly below the pay of top earning hospital doctors. Nurses and professions allied to medicine have had to relinquish clinical posts and become managers to be adequately rewarded.

One of the main contentions in this document is the need for us to raise the status of primary care generally and to raise the status of the clinical generalist more specifically. In this context a system of incentives/payments should be investigated to encourage general practitioners, nurses and other professionals to engage in a broader range of activities without relinquishing clinical duties. This would recognise their contribution to areas such as research, teaching, developing the next generation, contributing to the development of the profession itself, service development (possibly linked to specific goals) and burden of service.

One of the strengths of such incentives/payments is that it would recognise career-long contributions and would reward the long-term development work that is necessary to bring about many of the changes envisaged in this strategy. Short-term approaches to recruitment, retention and performance management will not have the same impact.

Remuneration systems are a UK wide issue and not in the direct control of the National Assembly. But through direct involvement in national discussions we must seek to influence their development to ensure that they accommodate the approaches we need to meet the specific requirements of Wales.

**Medical Education in Wales**

It has been beyond the scope of this strategy to undertake detailed reviews of education and training issues for all staff groups. There are plans in development, however, for medical education that will have a profound effect on the ability of the service to deliver new models of primary care and the availability of doctors over the next few years and it is important to make reference to those developments here.
Undergraduate Medical Education

Following the University of Wales College of Medicine’s implementation of its integrated curriculum, the delivery of medical undergraduate education within a primary care setting has already increased significantly, in line with the recommendations in "Tomorrow’s Doctors”, GMC, 1993 and within the guidelines on Good Practice in NHS/Academic Links, HEFC(UK) 1999.

The wider expansion of medical undergraduate education, in which primary care and other community settings will play a full part, has been proposed by Ian Cameron. This will increase the volume of teaching in primary care as student numbers increase. In the light of very positive feedback and high level of student achievement during the general practice final year clinical placements, there is the intention to extend the clinical placements in primary care and the community setting and therefore further contribute to medical undergraduate education. This will increase the time spent learning in primary care settings for all students.

Vocational Training for General Practice

The vocational training programme is governed the Vocational Training Regulations which prescribe a set pattern of training. Change has been widely advocated in order to ensure that future general practitioners are sufficiently skilled to deliver a full range of services in primary care. Any changes adopted in Wales must be consistent with UK developments but Wales should seek to influence the national scene to ensure that high quality clinical generalists are trained for the NHS of the future.

Higher Professional Education

After accreditation, upon completion of Vocational Training Scheme, all new practitioners should have the option of undertaking a period of higher professional education, supported by experienced educators/trainers. This programme should be supported by a Masters’ programme in Primary Care for Wales. Such a model could link with the community attachment expansion of undergraduate medical education, with groups of training practices providing high levels of clinical and educational provision with enhanced clinical competency and with the development of leadership skills.

Investment Requirements for Undergraduate Education and Postgraduate Training

With the planned expansion of both undergraduate and postgraduate medical education in Primary Care in Wales, it is likely that a doubling of the number of practices involved regularly in training will be required. Investment in the infrastructure for learning within the primary care setting is necessary for this growth and to sustain quality.
A development plan must be put in place to develop teaching staff in medicine, nursing and practice management. In addition, teaching facilities and technology must be developed. Local consortia of LHGs should contribute to the development of teaching facilities in practices/resource centres, e.g. to provide additional seminar room space, teaching equipment and other resources. It will also be appropriate for local consortia of LHGs to consolidate training budgets to deliver co-ordinated training for primary care staff. There will be a coherent plan across Wales for Postgraduate Education for Primary Care, to include long-term funding of educational units.

A programme for preparing GPs for educational roles, and developing teaching capacity across the Primary Care team will need to be designed and implemented. The current development programme for teachers in primary care also needs to be further enhanced.

Primary care premises will need enlarging for teaching purposes: the majority of medium sized and larger practices involved in teaching will need designated teaching space, such as a seminar room, and relevant equipment including books and literature, IT, and diagnostic and therapeutic tools is required in all settings. The primary care resource centres will again be helpful in this context.

**Continuing Professional Development for General Practitioners**

There are now a number of clear imperatives for the future development of CPD for general practitioners. We should ensure that practitioners undertake personal professional development that is planned and documented in a personal development plan. Such a plan will make a fundamental contribution to the annual appraisal for GPs (‘Maximising clinical performance’) and to the process of 5-yearly revalidation.

Multi-professional team development in conjunction with all other professionals within the team needs to be developed. The network of CPD co-ordinators should be further developed and resourced, and Continuing Medical Education (CME) associates appointed on a substantive basis.

In addition to practice-based education, specific CME events will be required to ensure that practitioners are informed about new clinical developments.

A framework will be required to provide support or retraining for doctors whose performance is called into question by appraisal or following referral to the GMC. A central resource should be available to support and retrain doctors who have special educational needs.
Primary care support units should be planned by each LHG so general practitioners and their primary care colleagues can be properly supported to undertake personal development and revalidation processes. These support units should be multidisciplinary and enable skills mix changes to occur. Sometimes sabbaticals will be essential to restore overworked health professionals.

**Multidisciplinary Learning**

Primary care will provide exceptional opportunity for undergraduate and postgraduate clinical students to learn in appropriate multidisciplinary environments and in multidisciplinary groups of students. Resource centres will be exceptional in this regard provided they are planned and developed as learning environments as well as service environments. The associated general practices/PMS/PDS that are networked into each resource centre will sometimes be well-equipped teaching practices and sometimes less well equipped for this function. It is vital that each LHG should keep the needs of education and training on their agendas as innovative forward plans develop.

**Nursing**

The demand for a quality patient centred service over the past years has led to significant changes in the way in which the various elements of primary care services have been developed, with an increasing emphasis on the provision of care provided through a general practice based team. The impact of policy, organisational and clinical pressures has led to changes in the practice and structure
of the primary health care team with increasing recognition by GPs and other professionals, over the past decade, of the significance of the nursing, health visiting and midwifery contribution.

For their part, nurses, midwives and health visitors have recognised that some of their roles, responsibilities and caseloads have had to change, and as a result there has been a trend towards the development of an integrated service as their skills are used appropriately to meet the needs of individuals and communities.

The Cumberlege Review (1986) challenged the ‘separate, traditional ways of working in which health visitors and district nurses appeared to be trapped’. It promoted the concept of neighbourhood nursing in which services would be more responsive to the needs of the community, and which would form the basis for more effective collaboration between all community health care workers. This early reference to an integrated team has continued to develop in many areas across Wales, despite the issue of separate employers and the potential boundary that this creates. Primary care nurses and health visitors have developed partnerships and joint working, and a review of specific areas of patient care, in an attempt to streamline services being provided for individuals in the community. However, this has tended to be informal rather than formal, and linked to specific areas of provision and it would appear that many difficulties still exist. If such a team is not focused on a population basis, then it still excludes the unregistered and can make access more difficult for disadvantaged groups.

Changes in the overall service have impacted on the work and role of nurses in recent times. For example the renewed emphasis on prevention of disease and the promotion of health has brought with it many changes in secondary prevention schemes, including 3 yearly health checks for those over 75. This, coupled with immunisation and cytology targets, has led to a significant rise in the number of practice nurses to cope with the increasing workload within the general practice setting. Practice nursing has thus become a significant workforce but it has taken some time for the role of the general practice nurse to be academically and professionally recognised alongside the qualifications of district nurses and health visitors and midwives.

Changes in primary care services in recent times have also brought changes within the primary care nursing workforce in which there has been an increase in numbers of qualified nurse practitioners and health care assistants. These developments have facilitated greater substitution and delegation of care/tasks right across the primary care workforce, and in particular between GPs and practice nurses. But such challenges need to be supported by appropriate training and continuing professional development. With today’s strong emphasis on clinical governance and the quality of care, a review of multi-professional opportunities for shared learning and working inevitably is needed, including consideration of the specific recommendations made as a result of the review of Health Visiting and School Nursing services in Wales.
The "Challenges for Nursing and Midwifery in the 21st Century" (1995) outlined eight strategic issues for consideration, that remain relevant to this strategy. These are:

- the contribution of the nursing professions to the individual;
- the context of nursing;
- team working;
- role substitution;
- education and training (continuing professional development);
- authority, responsibility, accountability;
- regulation;
- the public perception of the nursing professions.

These are consistent with the established principles for primary care outlined in this document which must remain as the guiding principles for individual professional groups as they work to develop their unique contribution.

The general shift of patient care to primary care means that the role of nurses will be very different in the future. Nurses, midwives and health visitors will play a significant role in targeting health and social needs, and in community developments. This will build on the existing experience of nurses and health visitors in primary care who already play a key role in health needs assessment, community profiling, the provision of care to vulnerable groups and dealing with the sociological, cultural and other factors impinging on the health of the individual.

The best and most effective outcomes for patients and clients are achieved when professionals work together, learn together, engage in clinical audit of outcomes together, and generate innovation to ensure progress in practice and service. But this integrated approach does not lessen the need for individual professional and contractual accountability.

Increasingly it has become recognised that some aspects of care can be addressed by the substitution of one profession for another: for example, expert nurses are developing new roles and improving the quality of patient care. However, it is essential that where substitution occurs, there has first been an understanding of the task in hand, and a clear supporting rationale. Nursing tasks can be delegated to many different grades of nurses, but the assessment of health needs, the re-assessment, the evaluation of prescribed nursing care, the monitoring of standards, counselling, teaching, health education and promotion and referral to other agencies, requires the expertise and knowledge of a higher grade professional.
It is the specialist elements of the various disciplines of nursing that cannot easily be replicated by other disciplines and it is these elements that make their contribution unique. Thus, in this context, the development of the generalist nurse must not be seen in the context of the loss of skills and autonomy but as the development of multi-skilled individuals who are qualified to offer a wider range of care within the community. The specialist skills that nurses, health visitors and midwives contribute to the promotion of patient care in a complementary way must also continue to be recognised and facilitated.

We will conduct a review of roles and responsibilities of nurses within primary care to include consideration of the ‘new roles’ within primary care such as nurse practitioners, the family health nurse, consultant nurses, and health care assistants.

Education is fundamental to the management of change and development. It needs to prepare nurses for constant change, to analyse problems, challenge current ways of thinking, and respond appropriately to individual patients. From pre-registration to post-registration development and lifelong learning, nurses need access to the professional education that will equip them to fulfil the changing roles within primary care. Enhanced opportunities need to be available in the pre-registration period to allow student nurses at undergraduate and post graduate levels to ‘experience’ work in the primary care setting and to undertake elements of supervised practice.

We must ensure that:

- Training practices are identified and supported for nursing and health visiting placements that offer high quality mentoring and training in specific areas of care such as community development roles, public health work, chronic disease management and cervical screening;
- All nurses working in primary care have access to appropriate accredited specialist training programmes including appropriate prescribing modules;
- There is improved access for practice nurses and school nurses to the specialist community degree programme. This should recognise and accredit those courses / modules specific to the role of the nurse in the full range of primary care;
- National and local strategies are prepared for the education and development of nurses and health visitors within primary care in association with health organisations and their academic partners;
- The new standards for the education of health visitors, primary health care nurses, school nurses that are to be specified and achieved in Wales are developed in partnership with the profession.

Lifelong learning is vital to the continuous personal and professional development of all staff and must be available to all primary care nurses. They will be expected to approach their development through personal and practice development plans,
which will identify and balance personal, educational and professional
development needs. Appropriate educational support, access to appraisal,
objective setting and clinical supervision must be available to all staff by April 2003.

We will work with education and health care providers in Wales to put in place:

- The ‘Health Care Support Worker Initiative’ to enable access to Healthcare Assistant and pre-registration nursing courses;
- Opportunities for career development and progression for all nurses and health visitors in primary health care;
- Nurse, Midwife, and Health Visitor Consultant posts in primary care to ensure the development and retention of expert practitioners in clinical practice;
- Nurse and health visitor specialist posts, including those of nurse practitioners in primary care are supported through relevant, accessible training programmes;
- Education and training programmes for new roles such as the Family Health Nurses is available via a common development programme;
- Leadership programmes for all staff including those within the nursing profession.

The public will increasingly demand accountability of health care professionals, including nurses, health visitors and midwives, within primary care. The NHS in Wales aims to improve services and to improve accountability through the framework of clinical governance and a new range of public service accountabilities which will form an integral part of the performance management process.

Regulation and accreditation are different processes and mean different things to individual practitioners, organisations and in statute. Self-regulation by the nursing, midwifery and health visiting professions must continue and be effective to protect the public. The establishment of the new Nursing & Midwifery Council will continue to strengthen this role.

We must ensure that:

- Nurse and Health Visitor Managers and leaders within primary care teams must monitor their own work and the work of their team;
- Clear lines of accountability exist. Nurses, midwives and health visitors must be trained in the process of appraisal and objective setting;
- Appraisal systems for nurses, health visitors and teams in primary care should be in place by April 2003;
- Clinical supervision must be accessible to all nurses and health visitors in primary health care work and reports should be made available annually to Trust Boards and the Boards of LHGs by April 2003.
The public reactions to the changing roles of nurses and health visitors in response to changing face of health and social care will depend on the marketing of any new roles and the quality and effectiveness of service provided.

Nurses and health visitors in primary care have an important role in:

- Ensuring greater involvement of patients in decisions about their care and the provision of adequate evidence to help patients make informed decisions;
- Providing clarity for patients and the public regarding the level of qualification and experience held by the practitioners who are providing their care;
- Helping to improve access for patients and the public through a range of initiatives such as nurse triage, nurse led PMS pilots, and nurse prescribing;
- Involvement in the development of joint strategies between LHGs and Social Services to help ensure the optimum contribution of primary health care nursing and health visiting expertise for patients at home and in the community;
- Developing a patient centred NHS that is meaningful and in which the contribution of primary care nurses and health visitors will be monitored and evaluated against clinical standards and patient outcomes.

The nursing and health visiting professions must be at the heart of the debate around the future provision and management of primary care and community services and their strategic direction. We must provide an opportunity for all professionals to review their various roles and functions in the team and to take on new responsibilities.

Practice Managers

The role of Practice Manager is key to the smooth running of practices and the effectiveness of the business and administrative processes involved. Practice managers have an important part to play in developing and strengthening the supporting services on which the service depends.

We will review the role and training requirement of the Practice Managers and their administrative teams and put in place new and comprehensive development programmes to meet changing requirements.

Pharmacy

The future for pharmacy within primary care lies in its ability to make the best use of the complementary skills of the whole of the Pharmacy Family, that is community pharmacists, hospital pharmacists, pharmaceutical and prescribing advisers and pharmacists working in specialised areas. It also includes their support staff. The main areas where we see the pharmacy family developing its contribution in primary care are as follows:
Adopting a more strategic approach to medicines management through:

(a) advisory support services for GPs including practice medicines management, formulary development, prescribing advice, prescribing quality assurance and audit;

(b) direct support for clients and patients - providing information about and use of medicines, assisting concordance, offering self-help advice for minor ailments;

(c) repeat dispensing thereby reducing the need for people to visit their GP on every occasion;

(d) development of a partnership approach to medicines management between the patient, the GP and the pharmacist;

(e) risk reduction by using patient medication profiles that reflect all medication (prescribed and purchased).

Closer working between GPs and community pharmacists to ensure that skills are used in a complementary and synergistic way.

Development of Local Pharmaceutical Services to encourage new ways of working.

Linking in to NHS Direct using community pharmacies as access/delivery points.

Closer working with Social Services, and other healthcare professionals, to support patients in domiciliary and care settings.

Promotion of health and well being through LHG led activities such as smoking cessation schemes, substance misuse services, contraceptive services.

Development of the LHG led prescribing role of the pharmacist in respect of repeat prescribing, substance misuse harm minimisation/reduction schemes, the management of minor ailments.

Improved out of hours arrangements to ensure timely access to services.

In order to support the development of pharmaceutical services in the future it will be necessary to develop a number of initiatives e.g.

- Joint training, accreditation and continuous professional development of primary care health professionals
- Development of the role of pharmacists as trainers;
- Explore the potential for new models of pharmacy contract to allow community pharmacy to develop in a sustainable way;
- Review the pharmaceutical workforce and its skills mix;
- Develop the underpinning IM&T for primary care to allow essential information exchange;
- Develop pharmacy premises to enable the provision of a wider range of services in a confidential way;
- Harness the potential of e-pharmacy to support the provision of pharmaceutical services.
We have frozen prescription charges since October 2000 and since April 2001 we have introduced free prescriptions for people under 25.

**Dentistry**

Good oral health makes a valuable contribution to the general health and well being of everyone in Wales. We believe that securing improvements in oral health will be best delivered in an environment where it is considered an integral component of the general health needs of individuals and communities.

The key challenges facing NHS dentistry in Wales are:
- Contributing to the creation of greater equity in oral and general health in Wales.
- Improving the quality of service delivered to the patient.
- Improving the availability of NHS dental services.
- Integrating NHS dental services with the wider NHS family.
- Utilising the whole dental team to best effect in the interest of patient care.

Despite improvements in the dental health of the population of Wales there are still unacceptable variations. Even in areas where the overall prevalence of dental decay is low there remain pockets of disease frequently associated with deprivation and social exclusion.

Improving oral health and reducing health inequalities are priorities for the Assembly. The highest priority in preventing dental disease is for children. Improvements in oral health are achievable and health gain deliverable.

The Assembly has already taken action in key areas through the introduction of free dental checks for the under 25s and over 60s, and the freezing of the maximum patient charge at its April 2000 level. It has also agreed that a fissure sealant programme aimed at children in areas of high dental need will be funded from the additional £1 million for the Health Inequalities Fund announced in February.

NHS dental services are currently provided by a wide range of practitioners including Independent Contractors in the General Dental Services (GDS), dentists employed by NHS Trusts in the Community Dental Service (CDS), and hospital based services. Consultants in Dental Public Health also have a key role to play in assessing, planning and developing dental services that meet local needs and public health priorities.

The majority of primary care dentistry is delivered through the GDS. In recognition of this we have introduced commitment payments that reward those GDPs who have remained loyal to the NHS. We will continue to work with the profession to refine this system.
The Welsh Dental Initiative continues to attract new dentists into those parts of Wales where they are most needed and the National Assembly intends to build on this success and the initiative will be continued and enhanced, also funded from the additional £1 million for the Health Inequalities Fund announced in February. A flexible approach has been taken in recent years to enable CDS employed dentists to deliver general dental services where there has been a need or shortfall in GDS provision. Through this trial we have demonstrated our commitment to a flexible approach in the provision of primary dental care. We now have the possibility of greater innovation in clinical and employment models through Personal Dental Services (PDS) and, in the future, expect LHGs to make imaginative use of the opportunities provided by PDS.

For dentistry to become more closely integrated within the wider NHS, dentists need to be involved in the development and integration of NHS dentistry at the local level. Within Wales dentists are already involved in the policy making procedures of Local Health Groups.

A key priority for dental services must be ensuring equity in the availability of routine and emergency services for the whole population. New models of service provision will be encouraged, new approaches to currently unregistered patients will be developed and areas of greatest need will be targeted.

A strong CDS must complement the General, Personal and Hospital Services. We must avoid fragmentation of this service to enable it to deliver dental health promotion programmes. These will include the provision a full range of treatment to patients who would not otherwise seek treatment from the general dental services (e.g. patients with special needs). We must also ensure screening of children in state funded schools, epidemiological field work, and the provision of facilities for a full range of treatment to patients who have experienced difficulty in obtaining treatment in the GDS.

Like the other components of primary care services the provision of premises and capital is a priority issue and it is also essential that the all Wales Information Management & Technology (IM&T) strategy is developed to incorporate all contractor professions and the current separation of dentistry must be addressed.

Dentistry in Wales must also embrace the clinical governance agenda and the need to improve performance and quality. Continuing professional development for all, a revitalised role for the General Dental Council will underpin the commitment of dentists to improve service quality. We intend to introduce a new clinical audit and peer review scheme that will improve the service and care provided to patients. All dentists working within the NHS GDS will be able to take part in the scheme. We also propose to provide funding for the establishment of quality assurance systems in every general dental practice in Wales.

Oral health should feature in all health improvement plans but particularly where there is a need to make a real impact in areas of poor oral health.
Postgraduate dental education has established a solid base in Wales, and has a crucial role to play in ensuring the delivery of quality dental services. Building on the success of the existing dental vocational training schemes we intend to commence a further general dental professional training scheme in 2002. We are providing extra financial support for GDPs in continuing professional development and reforming the system by which GDPs are reimbursed for such activity.

Wales has a world class teaching institution in the Cardiff Dental School. Securing the workforce of the future will be central to any detailed dental strategy, and the school will have a vital role in this. Once the Dental Workforce Review has reported we will look at the possibilities of expanding the training of Professions Complementary to Dentistry to further encourage a whole dental team approach to providing dental care in Wales.

Finally, NHS Direct Wales can be expected to play a greater role in securing access to NHS dental services offering advice to callers on the availability of dental services in their areas both routinely and out of hours.

**Optometric Services**

The problems associated with impaired vision and failing eyesight are a key issue in primary care and the health and well being of a wide range of people. Optometric services are provided by a wide variety of professionals operating within different settings some in the NHS community services for people with special needs (children in particular) and within the specialist hospital services. In the main, however, services are provide by independent contractors providing either private services or NHS services under the GOS contract.

The role of optometrists should be strengthened within the primary care team. Improving access to and the co-ordination of services to patients offers real opportunities to achieve significant improvement in the health and well-being of people with low or impaired vision. The extension of the role of the community optometrist will facilitate the delivery of patient eye care in the community thereby avoiding inappropriate and often unnecessary referrals to hospital.

The following initiatives will be explored:

- direct referral by optometrists within LHG guidelines to secondary ophthalmology services for patients requiring specialist treatment; but
- The implementation of the recommendations of the Crown Report on prescribing to enable optometrists, following appropriate further training and accreditation, to prescribe certain medications;
- A programme of eye examinations, available to ‘at risk’ groups of people in Wales, specifically designed to detect eye disease;
- An All Wales screening programme for diabetic retinopathy;
- The establishment of an all Wales low vision service;
- Co-management with the secondary sector, under agreed protocols, of certain eye conditions e.g. cataract and glaucoma.
The optometric service should look to work with other agencies to improve the uptake of services by pre-school children and the elderly and to establish protocols for the regular and comprehensive eye examinations for these groups.

Further work will be done to establish a programme of formal post-graduate education in Wales to meet the needs of optometrists for continuing professional development and the principles of clinical governance and evidence based medicine should apply equally to this part of primary care.

The optometric service needs to be supported to invest in the estate, information and equipment infrastructure to develop a wider range of services in primary and community locations. Primary care resource centres may offer a partial solution to some of these issues where services can be developed in partnership with contracted optometrists.

Finally as with all contractor professionals it is essential the ophthalmic community are actively involved in the health policy and service planning processes.

- A Primary Care Action Plan will be prepared by the end of March 2002 to inform the planning and development process for the NHS and to prioritise the needs of primary care and the contractor professions.
- Strategies for all the contractor professions will be developed as a matter of urgency to inform the Primary Care Action Plan.

**Professions Allied to Medicine (Therapists and diagnostic services professions)**

The therapists included here include physiotherapists, dieticians, occupational therapists, podiatrists (chiroprists), speech & language therapists and arts therapists. Each of these groups has a legitimate interest in the future of primary care in Wales.

Most professional members in these categories are salaried and employed by NHS trusts but private and industrial practice is well established in some groups particularly physiotherapists, chiroprists and speech therapists. Both local authorities and trusts may employ occupational therapists and the expectations of the two employers can be somewhat different.

Each of the NHS employed professional groups has its NHS interface with primary care through referral or as outreach from a trust base.

These groups have varied ambitions but a number of key issues are held in common:

- A relatively small work force spread thinly in the NHS;
- Espouse the principle of empowering people with illness or disability to be more independent of the formal services. This principle is core to primary
care generally and it is in common with many charities and voluntary
groups (Arthritis Care, Stroke Association etc);

- A tendency to become fragmented into specialist roles that map onto the
  sub-specialists in medicine;
- A need for schemes of continuing professional development and quality
  assurance;
- Developing evidence base for each discipline;
- Recruitment and retention problems.

It is clear that the average general practice cannot expect to have the in-house
services of each therapy profession. Logistics, costs, patient needs and professional
development militate against this degree of distribution. However the concept of a
primary care resource centre relating to 10 or more practices and 50-100,000
patients is a model that each of the professions could see as a feasible goal for their
involvement in the extended primary care team model.

Much work remains to be done within each of the professions to ensure that
national support for our strategic intentions can be won. This is not the task of this
strategy but our recommendations raise issues for the workforce, resource use,
governance, undergraduate training and professional development that could
revolutionise the future health service in Wales.

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<th>We must ensure that:</th>
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<td>🗼 Quality assurance and clinical governance of the work of the professions is integrated into the clinical governance programmes in the NHS;</td>
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<td>🗼 That each of the professions develop a generic career option to work from primary care resource centres in extended primary care teams and to interface with specialists;</td>
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<td>🗼 Workforce forecasting needs to be related to needs assessment. In the therapy and scientific disciplines in particular, service availability is partly a function of a very limited workforce supply;</td>
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<td>🗼 Well-evaluated programmes for rehabilitation or patient support from the voluntary/charitable sector are considered in the context of service development by therapists in primary care.</td>
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**Diagnostic services**

Laboratory and other diagnostic services e.g. pathology, medical physics, audiology,
imaging and physiological measurement in Wales are predominantly hospital based
but a shift in the provision of care from secondary to primary care will increase the
already large component of hospital based work that is routine support for primary
care (30-40% of pathology services are directed towards general practice).
Laboratory based scientists are most likely to operate from a central location and specimens or patients travelled to them. The others provided a service from a wide variety of locations and all sub-specialise.

Laboratory based scientists do not normally see patients and their key issues are:

- how to maintain quality assured standards of diagnostic tests in primary care as their number and range continues to grow; and
- avoidance of duplicate laboratory tests as patients move between primary and secondary care as well as attribution of resource use to the correct sector.

To support all of the developments in primary care there will need to be timely and accurate investigations and there will need to be more flexible access to diagnostic services. New technological developments, self diagnostic kits and imaging technologies will lead to major changes in the way patients currently access services in future.

Diagnostic tests should be further developed in order that analytical equipment can be used by non-specialist staff at the bedside, clinic or by the patient themselves. The quality assurance of laboratory biological testing procedures be extended to include the use of diagnostic tests in primary care and that good practice is explored through joint clinical governance arrangements between LHG, primary care resource centres and trusts.

This can facilitate more informed decision-making at primary consultation and an improved response time for communicable disease control. Successful introduction and usage of increased near patient testing and telemetric monitoring requires an integrated strategy involving primary care and hospital departments. The principle to test when the extension of diagnostic service extension in primary care is proposed is that the development must be more cost effective and compassionate for the patient, yet without serious opportunity costs for other essential primary care services.

In addition to population screening there are many potential therapeutic interventions for chronic diseases that could also take place in primary care environments if they fulfil the principle discussed above. Anticoagulation clinics have already been devolved to general practices in most areas; intravenous infusions, minor surgery and hospital at home schemes have been evaluated in recent years.

If clinical and diagnostic services are extended in primary care it will be essential that the following issues are considered: cost; quality assurance; record keeping; backup; health and safety and the potential loss of epidemiological data. Infection control will also become more problematical and joint arrangements will need to be developed with NHS trusts to oversee devolved arrangements.
There is no doubt that there is enormous potential to expand the range of support offered to primary care and this potential will grow as new technology is developed and the IM&T infrastructure rolls out across Wales. Quality assurance of this work will be essential and primary care services must be developed in partnership with hospital based services. The additional requirement for training, recruitment and retention of biomedical and clinical scientists and medical consultants will need to be factored in to long term workforce planning assumptions.

A strategic approach to the provision of clinical support services to primary care should be developed and in particular to examine the potential for greater access to laboratory and diagnostic services within primary care resource centres.

Developments must be planned and resourced if we are not to simply undermine the existing hospital based services.

A project will be established to examine current developments in the field and to make recommendations about the most appropriate way to support and manage the growing demands on clinical support services.

This strategy sets out to underpin primary care services by recognising that much needs to be done to nurture and develop all staff and to support them in dealing with the challenges they face. We need to extend the workforce and enable all health professionals to feel confident that they can look forward to long and rewarding careers in primary care.
Chapter 5 Developing the Infrastructure

The Primary Care Estate

The provision of high quality primary care is dependent in part upon the availability of suitable premises. Domiciliary care delivered in homes by peripatetic staff is a much valued component of primary care but the GP practice, the health centre and the primary care resource centre will remain at the core of primary care delivery.

The primary care estate across Wales is very diverse and much of it is privately owned by GPs and the other contractor professions, dentists, pharmacists and optometrists. Standards across the estate vary enormously with some practices offering state of the art, purpose built facilities incorporating space for a wide range of other professionals but in some places services continue to be delivered from sub standard, inappropriate facilities.

During our consultative work in the preparation of this strategy GP concerns over the viability of the primary care estate were raised as an issue of critical concern. In particular there are GPs facing significant problems associated with negative equity on premises investment that if not addressed will deter new GPs from investing and potentially encourage existing GPs to quit or at least badly affect morale.

A review of primary care estate has revealed that:

- In 3 out of the 5 HA areas, more than a third of premises were inadequate;
- Branch premises are generally in the worst condition and must be tackled as a priority;
- The LHGs with the best premises were Cardiff, the Vale of Glamorgan and Monmouthshire. Those with the worst were Wrexham and Merthyr;
- 69 premises in Wales stand out as being particularly deficient, 44 of which are branch premises;
- Reception areas and the overall quality of treatment rooms were the most deficient areas.

These findings demonstrate that:

- Developing a strategic approach to the management of the primary care estate is essential;
- New forms of capital funding will be required by LHGs if they are to impact on this situation;
- The distribution of problem premises means that any methodology for capital resource distribution will need to take into account areas in greatest need.
The expected growth in the numbers of salaried practitioners, the changing demographics of the GP workforce and the changing expectations of young doctors mean that there are fewer newly qualified doctors willing to take the personal risk of buying into practice premises. This undermines both the value of the personal investments made by GPs and primary care delivery.

In some parts of Wales the economics of the property market never create the conditions to support private investment at all. A situation will soon be reached when perhaps 1 in 4 GPs no longer wish to buy into premises. Existing partners will find it difficult to find new GPs willing to take on long-term financial commitments and the existing model will begin to unravel.

There is a recognised lack of flexibility in current funding mechanisms for HAs and LHGs. We will investigate the new health action zone flexibilities in England and make recommendations for the adoption of some of these in Wales. In particular we will consider:

- The introduction of a new local development scheme to allow HAs to subsidise premises projects at their discretion. This is where the project is financially unviable without extra resourcing and it contributes to the enhanced provision of services;
- The introduction of a premises indicator to the annual review process with a remedial action plan where appropriate;
- Review 15 areas of the Statement of Fees and Allowances where clarification or amendment of existing rules might stimulate more development;
- Setting up a joint working party with professional interests to explore the implications of these issues and to develop long-term proposals to support primary care practitioners.

Whatever the outcome of this process it is likely that we will need to develop arrangements for a long-term transition period toward a future in which there will be greater provision of public sector facilities or public private partnerships for primary care facilities. The National Assembly has already committed itself to seek opportunities to work with the NHS Lift scheme in England in order to explore the potential for large-scale Public Private Partnerships (PPP) approaches to primary care premises.

The issue of discretionary capital to maintain and develop the new primary care estate and to underpin other elements of development including IM&T will need to be considered as part of the new funding proposals being considered as part of the implementation of Improving Health in Wales.
The development of estate plans for primary care will be undertaken as part of an integrated planning approach to the total network of facilities available, including hospitals, intermediate care settings, primary and other community premises. Service and estate planning should incorporate voluntary organisations, the private sector and local government.

**LHGs will be required to produce detailed estate strategies (in partnership with other organisations) that demonstrate the following:**

- A programme to ensure all primary care premises meet minimum accepted standards;
- Opportunities are taken to reduce overlap and duplication of service environments;
- Where new premises are being developed or refurbishment is taking place the environmental impact of NHS building is minimised and opportunities for cost efficiency are maximised;
- The development of primary care resource centres as part of the new NHS landscape;
- Estates strategies to bring currently disparate services together;
- Opportunities for re-providing appropriate hospital based services in local settings;
- Plans, where feasible, for primary care services to share facilities e.g. community hospitals, social services;
- New developments in the information and information technology infrastructure.

### Information and Information Technology Development in Primary Care

Through *Better Information Better Health*(1999), NHS Wales has already adopted a strategic framework for the development of information and information technology and we do not need to replicate that work in this strategy. It is however important to confirm the central importance of new technology to the delivery of our vision for primary care.

We must develop fully functioning teams to provide more services locally, to enhance the ability for health professions to work as part of a holistic care process, and develop the ability to improve joint working across sectoral boundaries without breaches of confidentiality. In order to do this we will have to develop a shared information base, improve routine communications and bring about a fundamental cultural shift in recognising the ultimate patient ownership of the clinical record.
It is possible to become mesmerised by the potential for an IM&T based revolution in the way services are delivered over the next ten years but we also need to be realistic. The current state of primary care IT systems is poor as a consequence of long-term under-investment and uncoordinated approaches to development in primary care. The technical capacity in primary care is virtually non-existent. We need to prioritise the basics e.g. putting the technical networks in place, achieving practice connectivity, training in basic skills, providing clerical support for data handling and standardising systems to meet core requirements, before we can move on to deliver the broader vision.

We must also ensure that the whole primary care community including dentists, pharmacists and optometrists have appropriate access to core IT networks and are included rather than excluded from the code of connection as at present.

There are however a number of important existing National Assembly IT initiatives in primary care which must be acknowledged:

- **The IM&T Foundation Programme** to upgrade all GP practices to the common standard for the accreditation of GP systems and for all practice systems to operate within a Windows-based environment including connection to DAWN, Cymruweb and the Internet.

- **I3PC** to improve data quality in GP systems.
- **General Practice Morbidity Database Review Project** to develop an effective, responsive GP morbidity and activity database service for Wales.

- **SCIPiCT (Sharing Clinical Information in the Primary Care Team)** is a pilot project to bring GPs, practice nurses and other members of the PHCT and social services together to work on the production of a generic system to accommodate and support the needs of all members of the whole team.

- **Telecoms 2000** will see a commercial supplier brought in to administer and support the DAWN where GP practices will be provided with capacity appropriate for their own network needs.

- **XML Protocol** (a web based protocol) will provide a common platform for the transmission of electronic data and will be phased in to create a uniform standard for the transmission of medical data.

The information and information technology needs of primary care will be included in the work now underway to implement *Improving Health in Wales*. 
Chapter 6  Managing the change

The development and monitoring of extended roles for the primary care sector will fall, to some extent, to local health groups (LHGs). They should develop minimum service specifications locally and these should be incorporated into service plans and long-term agreements.

In extending the capacity of primary care to deliver a broader agenda the following issues need to be addressed:

- Develop primary care to improve local access to high quality services. (This will include promotion, prevention, diagnosis, treatment, rehabilitation and continuing care of those with chronic disease and in need of long-term nursing and residential care).
- Limit the inappropriate flow of work into secondary care.
- Reflect local needs through the planning process.
- Promote a new partnership with the people of Wales to take greater personal responsibility for health.

In *Health 21* the World Health Organisation reviews international experience and advocates the development of integrated primary and community organisations and the development of primary care models that are close to our envisioned approach. A number of general themes emerge from the literature drawing on experience mainly from Australia, Canada, New Zealand, USA, the Netherlands, and PCG development in England that are relevant to the organisational development (OD) agenda in Wales.

- Developing primary care improves service quality and controls health care costs across the whole healthcare system;
- The need to develop corporate primary care organisations within which individual clinicians retain considerable freedom and encouragement to remain working in their communities for many years;
- The importance of such organisations balancing a concern for population health with services tailored to individuals;
- The importance of developing intermediate care as an alternative where appropriate to high cost hospital admission;
- Primary care organisations should be based on inter-sectoral networks and alliances;
- We should develop integrated clinical and corporate management;
- Recognise that professional as well as financial incentives are powerful in helping to shape behaviour and kindle vocational attitudes.
Achieving full service integration is our overarching goal. The integration of primary and generic community services to develop extended primary care teams is at the core of the strategic vision. A closer partnership with social care is also a key aim.

Clinical networks must be driven from the primary care sector. Alternative strategies must be adopted to ensure the effective organisation and delivery of care across organisational boundaries and between primary and secondary care, including joint pathway and protocol development, shared care models, primary care involvement in clinical network development, joint IM&T infrastructure development and shared clinical and care governance arrangements.

The Primary Care Action Plan will include proposals to pump prime initiatives that will be compatible with the principles of Primary Care and ensure the adoption of best UK practice. This will be put in place in April 2002 to implement this strategy, following consultation.

The pace of development of new primary care organisations in England has been different from Wales and although we are not following the same development path there are a number of important lessons to reflect upon from the English experience:

- Invest in capacity building up front and invest in organisational and leadership development.
- The change process should not be rushed.
- Changing structures by itself will not fix relationships, inadequate management or a lack of resources.
- Joint working is required to commission secondary and specialist services.
- There is still considerable professional scepticism about the concept of corporate primary care, which is seen as a central control agenda and a way of cash limiting primary care.
- There need to be new checks and balances in organisations that combine purchasing and providing

In establishing bodies we need to be clear about the range of functions devolved to them, which will influence the detailed organisational form and governance structures. New LHGs will have a number of core functions and will require new organisational structures. This is being considered by the Structures Task and Finish Group as part of the implementation of Improving Health in Wales and proposals for the new and extended role of LHGs will be the subject of consultation.
Conclusion

The National Assembly requires primary care to be a vital player in the development of a socially, environmentally and economically sustainable Wales and a means by which we might ensure equity of service provision and social justice for all in Wales. In the future, primary care will also need a clearer focus on public health, on health inequalities, and on community health development.

NHS Wales faces considerable challenges as it grapples with the growing demands on and for health care, changing public expectations and new technological possibilities. These make fundamental change in services, values and organisational arrangements timely, desirable and inevitable.

There is a growing awareness of health inequalities between communities and between different social groups. Balancing the concern for the health of the whole population and a concern for the health of individual patients represents a major clinical and managerial challenge to primary care and the whole NHS.

Wales has a very broadly based approach to primary care. It is at the heart of local communities. This reflects a recognition of the importance of meeting people’s needs in - or as close as possible to - their homes and in the most practical and effective ways available. This is achieved by using the skills of everyone working in primary care and partner organisations.

Developments in primary care are vital for Wales because, despite the targeting of significant resources in the last decade, there are variations in quality and access, and evidence of service imbalance. Primary care has an increasingly complex workload. Patients’ expectations are higher and GPs and their teams are stretched trying to provide services in the surgery, at people’s homes and elsewhere. There are potential GP recruitment difficulties in many parts of Wales and the age structure of Welsh GPs will significantly exacerbate this problem.

This strategy sets out to seize the opportunities these challenges offer to strengthen and develop primary health care to ensure that it drives the reformation and delivery of care and the delivery of health improvement in the community. We need to build on the achievements of this most vital public service and make it a career of first choice for health professionals and their supporting staff.
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Glossary

**Acute services**
Medical and surgical treatment and care mainly provided in hospitals.

**Clinical network**
A network of clinicians working across traditional boundaries of health organisations in order to provide more effective care for patients.

**Commission for Health Improvement (CHI)**
A body which investigates the NHS and provides recommendations for changes in practice to ensure high standards of care.

**Community services**
Care which is provided within the community, either within community hospitals or similar settings, or close to the patient’s home. Community services are provided by health care professionals employed by NHS Trusts.

**Digital All-Wales Network (DAWN)**
The telecommunications network for the NHS in Wales.

**Elective care**
Planned treatment, such as an inpatient, day case or an outpatient appointment.

**Health economy**
A way of recognising natural relationships between hospital services, reflecting existing clinical practices and/or known patient flows.

**Local Health Group (LHG)**
A group in every local authority area which brings together GPs, nurses, and other primary care professionals with local government and other representatives of local communities, such as members of the voluntary sector and lay people. They shape and improve the quality, delivery, accessibility and co-ordination of health and social care.

**National Institute for Clinical Excellence (NICE)**
An expert committee that recommends best clinical practice to government.

**National Service Framework (NSF)**
Bring together the best evidence of clinical and cost-effectiveness with the views of service users to determine the best ways of providing particular services.

**Primary care**
Directly accessible health care services provided by family doctors, nurses, health centres, dentists, pharmacists, optometrists and ophthalmic medical practitioners.
**Private Finance Initiative (PFI)**
PFI schemes involve creating partnerships between the public and private sectors. In the health sector, the NHS will continue to be responsible for providing high quality clinical care to patients. But, where capital investment is required, there will increasingly be a role for a private sector partner in the provision of facilities. PFI schemes aim to build long-term and mutually beneficial partnerships between public and private sector partners.

**Professions Allied to Medicine (PAMs)**
The professions that support medical services such as physiotherapists, occupational therapists, dieticians, speech & language therapists, arts therapists, chiropodists & podiatrists, orthoptists, paramedics, prosthetists & orthotists and radiographers.

**Public service accountabilities**
A range of commitments expressing clear responsibility for the delivery of services, involving the public and working with partners to agree and meet local needs and to review their effectiveness.

**Secondary care**
Health care which is normally provided within a hospital setting.

**Social services**
Personal care services provided by local authorities for vulnerable people, including those with special needs because of old age or disability, and children in need of care and protection.

**Tertiary care**
Specialist health care provided in a hospital setting.