INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the Welsh Government’s draft plan entitled “Our plan for a primary care service for Wales up to March 2018”.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

Specific comments:

BMA Cymru Wales offers the following specific points on the draft plan:

"Primary care is about those services which provide the first point of care for more than 90% of people’s contact with the NHS in Wales."

We would note that these 90% of contacts with the NHS in Wales overwhelmingly take place within general practice.
Page 4 – “These community services include a very wide range of staff, such as community and district nurses, midwives, health visitors, mental health teams, health promotion teams, physiotherapists, occupational therapists, podiatrists..."

We note that these staff are mostly managed within a secondary care environment.

Page 4 – “Over the next four years, we want to see a change in the way all these services work together, with health boards moving their resources towards primary care, supported by hospitals and other services, where needed, rather than continuing the traditional model where hospital-based care has attracted the lion’s share of resources and attention”

Our members observe that such a policy has been proposed in the three previous Welsh plans but has not been delivered.

Page 5 – Section beginning “The overall principles underpinning this plan are...”

We would not disagree with the proposed principles that are outlined in this section.

Page 5 – “Many things have changed since Wales’ last major policy initiative on primary care, Setting the Direction – A Strategic Development Programme for Wales, which was published in 2010”

This particular plan also promised a secondary to primary shift which was not in fact delivered.

Page 5 – “In Wales, investment in primary care has increased steadily since 2003...”

Whilst investment in primary care may have increased in absolute terms, we note that it has decreased significantly since 2003 as a proportion of overall expenditure on the NHS in Wales. The increase that has been delivered has also failed to keep pace with health service inflation.

Page 6 – “These plans, like this one, are based on the principles of prudent healthcare...”

BMA Cymru Wales reiterates its support for the philosophy behind the principles of prudent healthcare. We would similarly support the philosophy of co-production.

Page 6 – “A primary care service for Wales, based on the principles of prudent healthcare, will become the mainstay of the NHS: tackling the root causes of ill health, preventing people from being admitted to hospital unnecessarily, helping those who have been admitted to get home quickly with the right support; motivating and supporting people with chronic conditions and long-term illnesses to manage their health at home. The new primary care service for Wales will help to reshape the NHS, developing and increasing the primary care workforce to provide the majority of care close to people’s homes, accelerating the transfer of services from the hospital to the community and improving the way people can access services.”

We would endorse these aims in the way they have been expressed, but also note that they echo similar intentions that were contained in at least three previous plans.

Page 7 – “I go online to use the health record held by my GP”

We have significant concerns about agreeing to this due to issues of practicality concerning confidentiality and data protection. This would include issues concerning third party references which may be contained within a patient’s record. It would therefore need to be demonstrated that such concerns could be adequately addressed.
Page 7 – “Professionals can see my health record which is held by my GP so I don’t have to repeat my medical history”

Appropriate safeguards and limits would need to be agreed. We do not, for instance, believe this should apply to all professionals. Which professionals can have such access would therefore require to be defined.

Page 7 – “I can access most of my care from a range of professionals close to my home, a variety of facilities, including supermarkets, shopping centres, libraries, leisure centres, community centres”

It should be recognised here that the overwhelming majority of such contacts would continue to take place within GP surgeries.

Page 7 – “I can communicate in Welsh when seeking care and support from primary care.”

BMA Cymru Wales believes this should be dependent on access to a fully-funded language line service (although we would recognise that in emergency situations this may not be available).

Page 7 – “on the same day... by e-mail, instant messaging”

We would not agree with this as we do not believe it could be achieved within current staffing resources, and certainly not on a same-day basis.

Page 8 – “I can access care from a range of professionals in locations near my home, such as libraries, leisure centres and community centres”

We would question how realistic this is. As written, this statement provides expectations which we believe are wholly unrealistic. It should also be understood that this would, in any event, be far more difficult to achieve in rural localities.

Page 8 – “If my health professional refers me to hospital, they retain overall responsibility for coordinating my care and they and the hospital are in regular contact with each other and with me about my care”

We believe this should only apply in the case of out-patients.

Page 8 – Section beginning “Timely, safe, effective and individual treatment and ongoing care close to home”

We cannot see anything within the aims listed in this section with which we would disagree.

Page 9 – “Our seven health boards in Wales are responsible for identifying the health and wellbeing needs of their populations and planning and providing services to meet that need. We believe this work is best done at a local community level, drawing in all those who can help. We want more local autonomy so leadership, collaboration and innovation can flourish, and shared goals can be more easily agreed and people’s needs can be better met”

We would note that this narrative provides support for the concept of localities.

Page 10 – “Health boards need to prioritise and resource the rapid development of each of the clusters in their area”

In our view, there should be a more explicit reference to the need for devolved budgets to support clusters.
Page 10 – “for improving access to and the quality of primary care to deliver improved local health and wellbeing and reduced health inequalities”

It should be noted that such improvement will clearly require adequate resourcing in financial terms.

Page 10 – “It is about making the best use of buildings to promote professionals working together”

There should, in our view, be a reference within this sentence to the need for a realistic premises strategy for primary care.

Page 11 – “They will increasingly use their health record online”

We would echo the concerns we have previously expressed about this, and would also question what precisely this statement is intended to mean.

Page 11 – “other sources of information, advice and assistance to make informed choices about their own care, using high-quality reliable information and advice in formats that meet their needs”

We believe that this statement requires a fuller explanation.

Page 11 – “Continuous monitoring in… mental health”

Exactly how it is intended this would be achieved needs to be properly explained.

Page 11 – “While the General Medical Services contract model, which is negotiated nationally, for contracting services from independent GPs, who usually come together in partnerships to form a GP practice, will remain the principal model in Wales, health boards need to consider the use of other options. These options include contracting care at a community level as well as at individual practice level, employing GPs directly themselves and using the alternative provider medical services contract model to secure services from GPs not set up as a traditional practice partnership. To be sustainable now and in the future, some practices will need to consider merging with another one, or establishing federations. As well as using a range of contracting options, we want health boards to agree flexible career structures and portfolio roles to meet local needs”

We note that much of what is written here mirrors the recent strategy for general practice published by BMA Cymru Wales.¹

Page 11 – “To support the coordination of care, health boards should consider and develop joint contracting arrangements with multiple service providers, including local authorities and the third and independent sectors. The current model of enhanced general practice service specifications, which has proved effective in focusing care on vulnerable groups, will be reviewed each year and further developed to support this”

We have concerns about how this might be implemented and what this might mean for existing core funding streams.

Page 12 – “referral protocols”

We would be concerned as to how this might be implemented. It needs to be recognised that attempts to manage referrals in this manner presents an element of risk that would need to be carefully considered.

Page 12 – “Continuous improvement”

This cannot be achieved if the primary care workload increases without being matched by appropriate additional investment.

Page 13 – “All professionals providing primary care services need access to…”

As we have referred to in previous comments, we would have concerns about this applying to all those who might be regarded as professionals providing primary care services. For instance, we do not believe it should apply in the case of support workers, or those working for third sector organisations or local authorities. It should also not necessarily apply in the case of community pharmacists, dentists or optometrists. A properly defined list should be agreed to make it clear to whom such access should apply.

Page 13 – “By April 2017, health boards will provide people with online access to their health record“

How this will be achieved needs to be made clear, particularly in view of the concerns we raised in previous comments.

Page 13 – “From 2015-16, health boards, local authorities, the third and independent sectors will begin using a shared IT system to collect and share information to support primary care”

We believe that this will require very careful handling to overcome the concerns to which we have already referred, including those in relation to patient confidentiality and data protection. Such considerations may impact on the achievability of this proposed aim.

Page 13 – “or discharge”

We would not support this. We do not think it is appropriate to expect GPs to co-ordinate in-patient care.

Page 14 – “When people are referred to hospital-based services for further investigation or treatment, health boards will ensure they receive timely care and their referring health profession or service in primary care is notified of progress. This will avoid primary care services, including GP practices, losing valuable time in chasing up referrals“

This could achieved by producing full discharge summaries at the time a patient is discharged.

Page 14 – “Examples of services include smoking cessation, weight management, exercise referral, mental health teams, structured self-care education, rehabilitation, reablement, virtual wards, community nursing and therapy, support groups and end-of-life care”

We would note that much of this is already undertaken within general practice.
Page 14 – “To support people being able to receive the majority of their diagnostic tests, treatment and ongoing care close to home, hospital-based staff will provide much more specialist support to primary care by telephone, email, virtual review, video call, telemedicine technology and in local clinics.

It must be recognised that more staff are required for all of these tasks to be undertaken and this will require to be appropriately resourced.

Page 14 – “Their health and wellbeing needs may be appropriately met by seeing another health professional, such as a nurse, a pharmacist, and optometrist”

We would question how realistic such a statement is in practice.

Page 15 – “Flexible facilities mean using each community’s assets to deliver a much wider range of care from different professionals. As well as more professionals and services being offered in GP surgeries, community pharmacies, dental practices and optometry practices”

As we have referred to in an earlier comment, such an aim will be dependent on an effective premises strategy. We would refer to the comments contained within chapter 5 of the BMA Cymru Wales strategy for general practice. ²

Page 15 – “we want to see much more use made of local community facilities like leisure centres, community centres, supermarkets, the high street and shopping centres”

In our view, this proposal generates significant governance concerns, other than perhaps for screening purposes.

Page 15 – “referral protocols”

We would reiterate the concerns we expressed earlier in this response regarding how this might be implemented, and that it needs to be recognised that such attempts to manage referrals will present an element of risk that would need to be carefully considered.

Page 17 – “A co-ordinated multi-professional response to agreeing with individuals about how to manage that risk through their care plan is then needed to ensure continuity of care designed to prevent poor health and exacerbations”

We would question how this statement sits with the concept of prudent healthcare. This may therefore require further consideration.

Page 17 – “developing a national set of primary care quality and delivery standards and measures by December 2014”

We would seek clarification as to whether these proposed new standards will be subject to consultation prior to being implemented.

Page 18 – “The public will be able to easily find out how their GP practices are doing in meeting their needs”

Before this is implemented, BMA Cymru Wales would seek appropriate engagement with Welsh Government regarding the indicators that will be used.

Page 18 – “Equitable access to primary care is about a proactive, proportionate and individual approach to improving the physical and mental health and wellbeing of individuals, families and communities”

We are unclear as to what exactly this statement is intended to mean.

Page 19 – “To promote equity, through their annual refresh of their three-year integrated medium term plans, health boards are required to demonstrate how they will take action, supported by Public Health Wales NHS Trust and other partners, to meet local need better by tackling the inverse care law and reduce inequalities in health”

There seems to be some confusion in this sentence. Health inequity and health inequality are not the same. If we are seeking to promote equity then surely we should be seeking to reduce inequity.

Page 19 – “we expect this will result in more people routinely reporting they have been able to communicate in Welsh when seeking care and support from primary care”

We would again reiterate that providing this will be dependent on having access to a fully-funded language line service.

Page 19 – “Health boards also need to provide primary care services which are accessible to and address the individual needs of people who have diverse language and cultural needs; people with physical and learning disabilities; people with sensory loss, people with low health literacy and frail older people”

We welcome the fact that it is clearly identified that this responsibility should lie with health boards.

Additional general comments:

BMA Cymru Wales notes that there is no mention in the proposed plan of out-of-hours (OOH) services despite the fact they operate for more hours of the day than in-hours services. We feel there should be a reference to the need for OOH services to be appropriately staffed and of high quality.

We similarly note that there is no specific mention of primary care teams. Members have suggested that there should be a reference to the need for effective, integrated primary care teams, ideally co-located on the same site and including a community nursing team, a practice nursing team, a health visitor and a midwife. The inclusion in the team of a mental health counsellor is also desirable. Having such effective, integrated primary care teams is key in our view to ensuring that a significant majority of patients can be effectively managed within a primary care setting.

GP members believe that the importance of the rapid transfer of information from secondary care to primary care cannot be over-emphasised. On too many occasions, at present, they find themselves having to attempt to second guess a patient’s diagnosis on the basis of their discharge prescription from secondary care. This is clearly far from satisfactory.