Asesu Anghenion Gofal Sylfaenol Integredig Cymru Gyfan - Pecyn 14

Situation analysis

1.1 Where do we want to be?

- Acceptance that healthcare is best organized at small population level was a basis for creating 64 clusters in Wales, each serving 30–50k registered GP practice populations, to permit joint working on development of services
- To achieve this, cluster plans should be informed by evidence of **population needs** & evidence on **effective interventions**
- This in turn is contingent upon overcoming major sustainability pressures contributing to health needs assessment capacity & capability constraints

1.2 Where are we now?

Cluster end user issues:

- A number of intelligence providers may each offer a variety of products; navigating this myriad of offerings to find the information you want can be intimidating
- Multiple products create information overload & don't offer a single source of truth
- A GP/ clinical focus is understandable, yet wider primary care, well-being & wider determinants also impact population health status

Health board/ local public health team (LPHT) user issues:

- It's not possible to compare one cluster needs assessment to another (or track improvements across time) without some standardisation
- Cluster plans may lack reference to evidence on interventions explicitly linked to needs
- LPHTs have adopted a 'hunter-gatherer' role, sourcing what data are obtainable or traditionally provided, in the absence of widespread agreement on what is actually needed

Intelligence provider issues:

- Some products come out too late to inform cluster plans; timings may need adjustment
- Limited assurance on whether individual products are used to inform decision making
- Products utilised in silo, with limited cross-provider data integration to tell a coherent story

Systems working issues:

- Lack of a shared needs assessment/ solutions process inhibits alignment of priorities across clusters, health boards, Public Health Wales & Welsh Government, with examples of existing effective practice not visible at the point of decision making
- The duplication of effort involved in 64 disparate needs assessments/ 7 LPHT supporting activities is an inefficient use of limited capacity resource & creates unhelpful variation
- Existing cluster & LPHT capability solutions may not fully reflect the optimal contribution these roles can make to the needs assessment process (e.g. periodic workshop attendance may not translate to ability to undertake robust needs assessment)

Project plan

• Aim

- Integrated All-Wales Primary Care Needs Assessment (IAWPCNA) will support evidence-informed cluster planning & increased strategic alignment to help drive quantifiable cluster population health improvements. It will do this through: (1) integration of data sources reflecting wider primary care and covering prioritized health status/ service use indicators, effective intervention options, local implementation/ quality/ safety lessons; (2) offering an easy-to-use assessment-orientated front end; and (3) by utilising once-for-Wales templates to effect standardisation by place & time, & to minimise duplication of effort.

• Project overview

- A visual overview of timings, activities and products by project stage is given in Fig. 1
- Timings aspire to support operational use within the 2019/20 cluster planning cycle

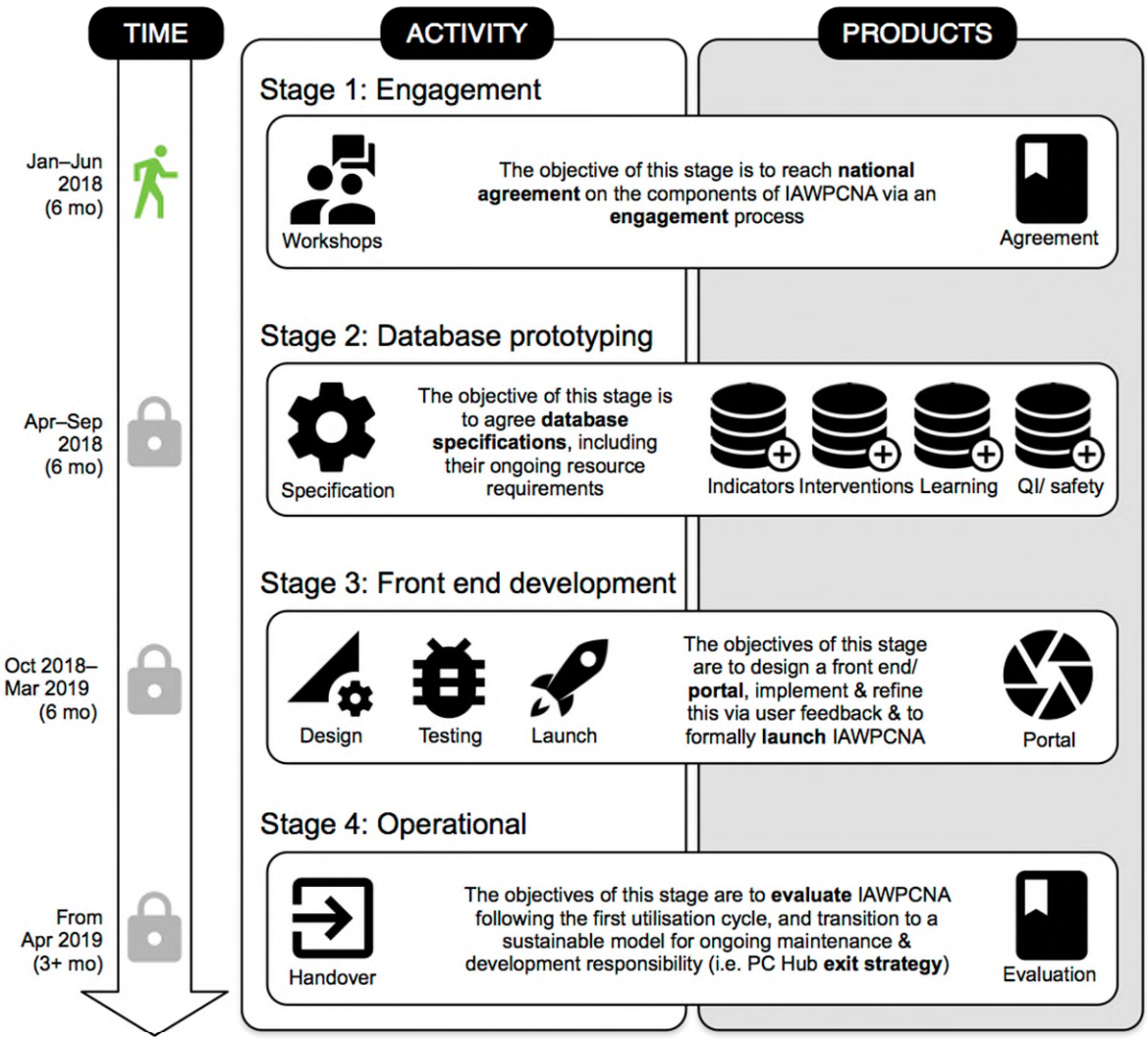

Fig. 1: IAWPCNA 4-stage overview; an initial commitment is requested to Stage 1 only, recognizing the importance of utilising meaningful engagement with primary care to design subsequent stages

2.3 Stage 1 objective, activity & product

- Objective: reach national agreement on the components of IAWPCNA via engagement
- Activity: engagement workshops
- Output: written agreement on IAWPCNA components
- Stage 1 is detailed further below (section 4)

2.4 Stage 2 objective, activity & products

- Objective: agree database specifications, including ongoing resource requirements
- Activity: database specification, which is likely to involve additional engagement
- Outputs: databases (and curation processes) for health status/ service use indicators (metrics); evidence statements on effective intervention options by indicator group; synopses of learning from local implementation/ best practice; & potentially synopses of learning from quality improvement activity or patient safety issues where applicable

2.5 Stage 3 objectives, activity & product

- Objectives: design a front end/ portal; implement & refine this via user feedback; formally launch IAWPCNA
- Activities: portal design (coding/ web development); end user testing; launch planning
- Output: an easy-to-use portal to support cluster plan preparation

2.6 Stage 4 objectives, activity & product

- Objectives: evaluate IAWPCNA following the first utilisation cycle; transition to a sustainable model for ongoing maintenance & development responsibility
- Activity: negotiation of project handover
- Output: end-of-project evaluation report to guide ongoing development within business-as-usual in the care of an appropriate sponsor

Anticipated project benefits

Benefits to clusters:

- Focuses on the key deliverable (needs assessment), not on individual intelligence products (cluster can remain provider/ product naïve)
- Compatible with a disease pathway approach that is familiar to clinicians & emphasises the primacy of prevention; also allows integrated consideration of wider determinants data
- Creates an explicit link between evidence on needs & evidence for responsive action
- Facilitates the joining up of population health (e.g. PHW) & healthcare public health (e.g. LHB) intelligence to tell a coherent story

- Incorporation of analysis based on individual-level data (via Audit+) should enable assessment of co-morbidities (rather than examine conditions in isolation, as is traditional)

Benefits to public health teams:

- Refines the LPHT value-added contribution to interpretation/ prioritisation assistance via a structured conversation around the needs assessment (LPHT don't have to provide the data)
- Releases LPHT capacity to assist clusters with any local assessment topics beyond IAWPCN

Benefits to health boards:

- Ensures cluster plans are informed by data/ assessments reflecting wider primary care
- Templating provides a measure of quality assurance that may be difficult to replicate within one-off unstructured needs assessments
- Templating permits a baseline to spot variation between clusters & across time (including monitoring plan effectiveness in improving population health)

Benefits to health intelligence providers:

- Should IAWPCNA not progress beyond Stage 1, engagement still informs product development/ new product priority
- National agreement increases the likelihood that data products feeding into IAWPCNA would be better aligned to cluster planning cycle timeframes

Benefits to the wider system/ systems working:

- As clusters are at different stages of maturity, IAWPCNA can help normalise consideration of data through a holistic lens (e.g. well-being, wider primary care, wider determinants)
- A once-for-Wales template maximises efficiency by making the most of each party's value-added contribution
- Shared underlying health intelligence provision and a shared process for sifting evidence on best-value interventions positions LPHTs and Primary Care Support Units to help bring alignment to health & well-being goals & to encourage synergistic health improvement approaches at various levels
- IAWPCNA can enhance visibility of whole-system concerns e.g. antimicrobial resistance

[For more information on primary care health intelligence]