EMERGING ROLES
AND MODELS IN
PRIMARY CARE

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EMERGING ROLES AND MODELS IN PRIMARY CARE

Job Description and Person Specification

Done
Administrative Support
Audiology
Communications
Dietetics
GP
Healthcare Support Worker
Medicines Management
Mental Health
Nursing
Occupational Therapy
Pharmacy
Phlebotomy

Physicians Associate
Physiotherapist
Practice Manager
Primary Care Support Team
Project Manager
Service Development
Third Sector & Wellbeing
Welsh Ambulance Service
Workforce Planning
EMERGING ROLES AND MODELS IN PRIMARY CARE

Models

- **Stable Primary Care**
- **New community services including complex & specialised care**
- **New Cluster Model**
- **Reduced ED & hospital admissions**

New and Emerging Models of Primary Care

- **Self Care & Healthy Living Promote, Resource, Support**
- **Community Assets e.g. Social Prescribing**
- **Motivated professionals**
- **Improved access + quality of care**
Cluster Pharmacists

*Employment of pharmacists to work under the remit of primary care clusters*

Karen May – Karen.may2@wales.nhs.uk

**Pain**

Clusters have been provided with funding by WG. GP Workload is a particular issue in primary care and employment of pharmacists was considered to be able to remove some of that workload – applying prudent principles.

**Vision**

Clusters who wanted to employ pharmacists were identified. The number of WTE varied according to finances. The vision was to have clinical pharmacists in post providing services within GP practices, seeing patients face to face.

**Solution**

The recruitment process was long and cumbersome. Getting JDs approved is a barrier as we were not able to use JDs approved and banded in other organizations, for the same job, within this organisation. Recruitment took longer than expected, specifically pre employment checks and receipt of contracts once people were in post, with a need to check progress. Interviews were held in July and the first pharmacists were in post in October.

**Lessons Learnt**

As above – managing the recruitment process and appointment of 6 individuals who were not part of my team on behalf of the clusters was a pressure on my time. I think the new trac system should be more stream lined. Employment of the individuals by the health board has meant all the HR responsibility sits with my team – this has been an added pressure. Individuals working in clusters are quite isolated and so support needs to be provided and individuals need to be self sufficient and mature.

**Final Catchphrase**

Feedback from patients is that they value the time the pharmacist spends with them to discuss their medication.

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**Stats & Facts**

- **2015**: Open evening held 8th July 2015
- **2015**: Interviews held July 28th/ Aug 3rd 2015
- **2015 - 2016**: 4.8 WTE pharmacist appointed August 2015 and in post October 2015 – January 2016
- **Additional 1 WTE appointed October 2015 and in post January 2016**
Healthy Lifestyle Advisor

The role of the Healthy Lifestyle Advisor is to manage a caseload of clients who require support to make changes to their lifestyle that will improve their health.

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Dr Richard Bury – richard.bury2@wales.nhs.uk
Kirsty Gilling – kirsty.gilling@wales.nhs.uk

Public Health Wales

Pain

Big challenge was around the recruitment. It was decided then that a Practice would employ the advisor with a SLA

Vision

The Adviser will support the client (and their family where appropriate) to make positive and sustained changes towards healthier lifestyle choices.

The main focus of the Adviser’s caseload will be on weight management (including diet and physical activity) and smoking cessation, with additional input to the Immunisation and Vaccination agenda for both seasonal campaigns (e.g. season flu vaccination) and targeted interventions (childhood immunisations).

Additional support will be provided to patients around improving their mental well being, and to support healthy ageing.

Advocates within practice – supported through Public Health Wales.

Solution

SLA with the practice

Lessons Learnt

Recruitment Process – A Practice from within the Cluster is going to employ the Healthy Lifestyle Advisor.

Delay with the JD from the practice. (not out to advert as yet June 2016).

The post needed a SLA.

Stats & Facts

• To provide smoking cessation support to clients who wish to stop smoking.
• Enhance Health improvement activity within GP practice.
• Lifestyle Changes for patients
• Seasonal Campaigns (flu)
• To deliver health education through one to one and group activities as appropriate.
• Working with Public Health and Lifestyle Advocates.

The hope for the future catch phrase is:

“To enhance the health improvement activity within the GP practice for patients who require support to make changes to their lifestyle that will improve their health the patient will have options.”
PT/OT Technician

Appointment of a PT /OT Generic Technician to assist managing patients more effectively and pro-actively in their own home to enhance their experience of care, improve their outcomes and reduce costs and bed days.

Menna Thomas - Menna.Thomas2@wales.nhs.uk

Pain

The 2Ts has a significantly higher older population at 22.1% compared to the Welsh average of 18.7%. Long waiting lists for OT / PT assessment in 2Ts due to lack of capacity within service and increasing demand for assessments.

Vision

Occupational Therapists and Physiotherapists promote independence and self-reliance, among elderly clients. They are also elder care advocates: They have specialist skills in assessment and re-ablement and provide evidence based exercise, education and advice programmes aimed to prevent falls, improve balance, increase self confidence, reduce fear of falling and promote active and healthy lifestyles.

Appointment of a generic technician to undertake low level assessments releases capacity for more complex assessments to be undertaken.

Solution

Cluster utilized some of their funding to employ a Generic OT/PT Technician to support GP practice MDT working and undertaking of lower level assessments.

Lessons Learnt

- Recruitment process – The post was advertised as a secondment and as a result the Generic Technician was unable to start until backfill was secured.
- Equity of provision across the cluster.
- Minimum two year contract due to employment rules and funding stream.

Final Catchphrase

Stats & Facts

- 2.9% of the population in 2Ts is over 85 years
- 10-25% of fallers will sustain a serious injury
- 139 direct GP referrals received for assessment
- 112 follow-ups for 58 patients made
- Reduction in PT and OT waiting list from 13 weeks in November 2015 to 10 weeks by the end of March 2016
- Average waiting time for assessment by = 11 days

Outcomes

- Home exercise plans put in place.
- Utilisation of 3rd sector organisations e.g red cross for wheelchair hire.
- Provision of equipment such as zimmerframes, commodes, grab rails and soft collar.
- Onward referral where required
**Pre-Diabetes Service**

**Headline / Purpose**

*Working together to prevent type 2 diabetes in North Ceredigion Cluster*

**Pain**

The diabetes delivery plan (2013) states that around 7% of adults in Wales are being treated for diabetes, 16% of those are over 65yrs. The incidence of diabetes is increasing as the prevalence of obesity is rising; diabetes among adults in Wales is predicted to rise to 10.3% in 2020 and 11.5% by 2030.

**Vision**

To identify up to 3% of the North Ceredigion Cluster population at high risk of developing type 2 diabetes and support them to make healthier lifestyle choices.

**Challenges**

- Delay in getting agreement for SLA
- Initial project idea changed
- Confusion / lack of understanding on project aim
- Continuation of the delivery of Food wise programmes for year 2 of project

**Solution**

**Project Plan in place**

SLA in place for practice payments (& English patient information documents)

Electronic template for data collection - INPS

Patient information letters / questionnaires developed and translated into Welsh

**Stats & Facts**

- 709 patients called in for a 30 minute face to face consultation
- Working with the dietetic department to Increase capacity of Food wise programmes
- 6 programmes piloted in year 1 through Practice delivery
- Working with Public Health to establish walking clubs
- Working with Local authority to scope local activity clubs
- Working with the Education for patients programme co-ordinator to recruit volunteers
- Working with Aberystwyth University to evaluate project

**Final Catchphrase**

“I’m glad my GP told me I was heading towards becoming a diabetic. I don’t want to have diabetes and now I can do something to prevent it”

Patient at high risk of developing diabetes, Tregaron surgery.
Healthy Prestatyn

A pioneering new health service for Prestatyn – a service model with four core interlinked components:
- Same day service
- Planned care
- Domiciliary and Care Home Care
- Academy

Problem

Three GMS practices, all within a few miles of each other resigned from their contracts for delivering services in a mainly urban area. A population of around 23,000 stood to lose access to essential primary care services. The multiple factors that led to these resignations included GP recruitment and retention issues. Whole service redesign was an essential only option.

Vision

- Changing the culture of how people access their GP, who is not necessarily the right person to see. Patients are offered flexibility and choice to help decide who is best to see and to make sure all care delivered is coordinated ensuring the best possible service.
- More resilient Primary Care services
- Less medicalised focus on problems originating in lifestyle choices
- Reduction in admissions to secondary care
- A healthier population
- A more engaged population

Solution

The service began operating clinically in April 2016, providing care to approaching 23,000 patients in the Prestatyn and Rhuddlan area of central North Wales. The initial phase was aimed at underpinning the inherited service, to ensure a robust daily Primary Care service. Alongside this, a team structure, built around KeyTeam pods of approximately 5,000 patients was implemented, bringing in a range of new professionals to each pod alongside GP colleagues, including:
- Clinical Pharmacists,
- Occupational Therapists,
- Advanced Nurse Practitioners,
- Advance Practice Physiotherapists,
- Audiologist

and importantly, KeyTeam coordinators who make sure each KeyTeam is able to function efficiently, provide a point of contact for patients with specific requests, and process as many administrative tasks as possible to ensure clinical professionals are able spend more time providing clinical care. (This role is very similar to the "Medical Assistant" role which the NHS England/RCGP General Practice Forward View has since proposed).

Stats & Facts

Widespread process mapping of inherited systems has led to a wide suite of measures though it is early days and computer software changes mean data collection is still in its infancy

Following this underpinning, there is an ambitious workstream to capitalise and evolve the model

1. Formal launch of a Patient Council
2. Launch of our Patient Academy, as a beacon of good practice for social prescribing and non-medicalised interventions, which will act as a nucleus around which a growing array of better and more coordinated services are made accessible.

Lessons Learnt

Still learning! So far, so good, though:
- Really strong public engagement was hugely valuable
- Change of culture and systems had a huge impact upon resources
- Staff must have the “head room” to plan, pilot and change to new ways of working.
- Pump priming and flexible use of resource is critical
- Strong medical leadership essential
- Estates and IT a constant challenge
- Organisational Change Process is essential in establishing the optimum workforce configuration but the process is slow and time consuming
- Right to focus upon some quick wins

Final Catchphrase

Be patient, stay focused on goal, things always take twice as long as you would want but in the end the goal is worth it.
**Enhanced MDT Working**

*Creating an integrated health and social team to improve access to domiciliary care in a rural area*

**Pain**

Little provision, and difficulties in the supply of domiciliary care for residents in the rural Gower area of Swansea meant that residents were disadvantaged. Patients living in the area were waiting in hospital beds for packages of care despite being medically fit for discharge. More were waiting at home for support to be put in place. This problem was leading to long delays in hospital discharges, people struggling to cope at home often with end stage complex health problems and also people not being able to return home to die in the terminal stages of an illness.

The rural nature of the Gower area necessitates long driving distances between patient calls. There were 4 different health and social domiciliary care teams working within the area. These teams were criss-crossing one another when visiting patients and there was an obvious waste of resources and an inefficient way of working. Something different had to be done with the winter season looming.

**Vision**

*A responsive team of health and social care staff* with a reablement focus on care provision. The team would deliver a joined up service and one without duplicated effort. Discharges from hospital would be without delay and those in crisis at home would be able to access care in a way which would prevent unnecessary hospital and long term care admission. The care would be free to all for an initial 6 weeks and provided thereafter based on a full needs assessment.

**Solution**

All stakeholders including patients, carers, HCSW staff from all teams, team managers, human resources and staff side representation were consulted and the need for change was clearly communicated.

The difference in health and social care team processes such as documentation, staff rotering, shift patterns and travelling arrangements

**Lessons Learnt**

The importance of following a change process has been key to the success, involving all stakeholders early was also important in gathering support.

The key lesson learnt was that not all problems can be solved at the outset; many issues follow a PLAN, DO, STUDY ACT (PDSA) cycle of change. All members of the team are still learning and implementing changes as the service evolves over time.

**Stats & Facts**

1. Number of patients waiting in hospital beds for care packages, including length of stay in days. Before the implementation, 15 patients were waiting in hospital with length of stays ranging from 6 – 12 weeks.

2. Number of patients waiting in the home setting for care packages – The number of patients waiting in August 2013 was 20.

3. Time taken to implement care delivery from time of referral – This would range from 6 weeks with some instances of patients never receiving the care package they required.

**Final Catchphrase**

*Embrace the health and social care integration agenda, planning future community services in partnership with local authority colleagues can bring about an end to fragmentation and duplication of services.*
Primary Care Development Project

**GP Practice Based Social Workers Pilot**

**Caerphilly County Borough –**

**PHASE 1:** 3 Social Workers, 3 GP Practices (Pilot)

**PHASE 2:** Social Workers covering all 25 GP Practices

Stephen Howells, Service Manager, Caerphilly County Borough Council –
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**Pain**

Primary care plays a central role in providing integrated health and social care to the population it serves. However, working in an integrated way across organisational boundaries is challenging, despite the common goal of all concerned – to provide seamless, efficient and appropriate care for a person’s health and wellbeing.

**Vision**

The project is piloting the use of social workers within GP practices to become part of the community multi-disciplinary team (MDT):

- Improve outcomes for residents
- Improve the patient experience
- Save GP time

**Solution**

- Social workers are now embedded in general practice
- Significant improvement on the outcomes of patients
- The medication reviews have improved the quality of life of patients and delivered financial savings
- Single interventions reduced waste and produced savings
- Patients have been diverted from hospital admissions and discharged from hospital earlier.
- GP's have been unanimous in their support for the pilot
- The service user / patient experience has been overwhelmingly positive.

**Lessons Learnt**

Funding – Short-term grant funding available with limited notice compresses planning time and employs temporary staffing causing instability in core services. Agreement between partners is core to effective working – funding for this project is via a combination of Local Authority, Neighborhood Care Network and Intermediate Care Funds

Although the pilot evaluated positively the barriers faced in the up-scaling of the original pilot for 2016/17 are the same i.e. negotiations must continue for effective partnership working. Do not underestimate the need for clear communications.

**Stats & Facts**

- 3 social workers in 3 GP Practices
- 500+ referrals (50% from GP's / 75% from MDT)
- 70% referrals for older people
- 94% had wellbeing support
- 6% formal care package
- Medication reviews with Community Pharmacist delivered financial savings – an estimated £326.08 p.a. for each patient
- Patients have been diverted from hospital admissions and discharged from hospital earlier – circa £300 per bed day

To minimize complications the project leads worked hard to avoid negotiation of complicated agreements, SLA's etc. The focus was on professionally qualified staff working together to try to achieve the same goals in the best interest of citizen’s, and so far people have signed up to that.

Trying to integrate IT across organisations is problematic; previously there was no provision for NWIS to support the purchase of equipment from local authorities resulting in delays - the IT provision is now purchased from NWIS via the Local Health Board.

**Final Catchphrase**

“Having the social worker attached to our surgery has been the biggest innovation in the last 10 years” – GP Risca Surgery.
EMERGING ROLES AND MODELS IN PRIMARY CARE

Neath Primary Care Hub
Better Demand Management in Primary Care

Changing a 20th Century Primary Care model to meet 21st century patient demand

Pain

The 8 GP clusters which make up Neath Cluster Network were seeing increased demand for face to face GP appointments and recognised that the traditional method of every patient seeing a GP in every case was proving to be unsustainable.

Vision

- Better access to healthcare for patients
- Patients seen by the most appropriate professional
- GP capacity saved through better call management/telephone triage
- GPs doing today’s work today
- GPs having time to deal with more complex cases
- Improved patient satisfaction

Solution

The Cluster set up a project with two key elements:

- Channelling patient demand for primary care through telephone triage
- Managing demand more appropriately by deflecting appropriate cases to a wider range of shared professionals within the cluster (Physiotherapists, Mental Health Support Worker and Prescribing Pharmacist)

To make this happen, the cluster commissioned V360 (a shared appointment and clinical system).

Lessons Learnt

- Changing Culture (GPs and patients) takes time
- Challenge of building trust in the development of new pathways
- Greater lead in time for IT development essential
- Data analysis support due to complexity of primary care practice systems essential
- Project management essential

Final Catchphrase

“I have seen doctors in the past and it did take a physiotherapist to find my problem. The doctors were okay but they can’t be experts at everything” [Patient]

“The reactivity of the triage service allows you to identify sick patients quickly and see them promptly” [GP]
Primary Care Cluster Physiotherapist – delivering effective timely care, and reducing the pressures on GPs.

Pain - delays in the process were caused by....

- There is currently a national shortage of GPs;
- 30% of a GP’s caseload is for musculo-skeletal (MSK) problems which could be seen by a physiotherapist.

Vision

- Patients are to be seen by the most appropriate professional for their MSK Problem;
- Improved and timelier access to healthcare for patients;
- To save and release GP capacity allowing GPs to do ‘today’s work today’;
- GPs will have the time to deal with more complex cases;
- Patients will be more satisfied with efficiency of service provision

Solution

Deflection of demand to the physiotherapist, away from the GPs

- Achieving service sustainability.

Locally delivered, readily accessible services:

- Moving services into the community.

Lessons Learnt

Ensure the software to be used is fit for purpose and all ‘read codes’ are pre agreed to enable easier reporting.

Ideally enable the physiotherapist to work both in primary care and core service

Final Catchphrase

He listened to my symptoms and spoke about the different causes of back pain and the types of treatment that may be offered. He asked a lot of questions and looked at my previous x-rays...I have seen doctors in the past but the physiotherapist found my problem.
Development of Cluster Communications Officer post to promote the Rhondda Valley and improve recruitment and retention of health professionals in the area.

Hayley Pugh, Primary Care Development Manager, Cwm Taf UHB 01685 351341
Felicity Waters, Head of Communications, Cwm Taf UHB 01443 744812
Tom Bodden, Rhondda Cluster Communications Officer 01443 741842

Pain

Over the past 12 months the number of GP practices in the Rhondda has decreased from 16 to 14 and we now have two managed practices in the area. The Rhondda cluster identified GP recruitment and retention as a particular focus of their cluster plan to address the issue of sustainability in the area.

Vision

The aim was to improve the profile of the Rhondda as a place to work in order to attract people from outside of the area. The Communications Officer was seen as a key role to develop the information, present it in an appropriate format and disseminate the information to as far reaching an audience as possible. The Communications Officer had the knowledge and expertise that was lacking within the cluster in relation to social media and website development.

Solution

The development of the RhonddaDoc website has been successful in raising the profile of the area. From the stats we have from the website there have been views as far as Scotland and London with the vacancy page being the most visited site. It has also provided the cluster with a platform to advertise the other innovative cluster initiatives taking place to showcase the Rhondda as an area of forward thinking GPs passionate about providing quality Primary Care services to the population they serve.

Lessons Learnt

The Communications Officer is hosted by Cwm Taf UHB on behalf of the cluster. The post is for a fixed term contract and the officer sits within the Communications team at the UHB to ensure appropriate line management and peer support. As the post is hosted by the UHB we had to adhere to all the job matching and recruitment requirements of the UHB which can be quite onerous.

Stats & Facts

September stats for RhonddaDoc

- 1.1K users since August 1st 2016.
- 78.4% users new visitors to the site
- 21.6% returning visitors to the site
- 20.35% visitors from Cardiff area
- 13.7% Visitors from London area
- 2.53% Visitors from Birmingham area.
- After the home page the most visited page is the job vacancy page.

Final Catchphrase

Vaughan Gething AM, Cabinet Secretary for health, well being & sport recently mentioned the RhonddaDoc website in a statement to the Senydd whilst discussing the national recruitment plans. He said, "Organisations across Wales, including health boards and trusts, will come together under the banner of NHS Wales to harness the best use of local activity such as the excellent Rhondda Docs website, and I will say if you haven't had a look at it, it's well worth having a look at what doctors are doing for themselves to market the place that they live and work in and are very proud to do so."

This template is now being used as the model on which the new corporate recruitment site is being built.

Document Library

1. Communications Officer Job Description
Primary Care Workforce Planning Manager

To secure Strategic Workforce Planning expertise to support the sustainability of general practices across Cardiff & Vale for both in and out of hours.

Pain - delays in the process were caused by....

Lack of skills and expertise in the recruitment pool. The processes around development of the job description prior to active recruitment. The Primary Care Workforce Plan calls for a robust and joined-up approach to workforce planning but the provision of such expertise, specifically for primary care is sparse.

As a new role for Primary Care there is no existing job description available within Wales to benchmark against. A job description needed to be developed and job matched before recruitment could proceed.

Although Workforce Planners are recruited to Health Boards there does not appear to be anyone within Wales with both a strategic workforce planning qualification, and expertise/working knowledge of primary care. The Primary Care Workforce Planner post was advertised on 3 occasions with no suitable candidates to shortlist on 2 out of 3 of these occasions.

Vision

The Workforce Planning Manager will be key in supporting the delivery of Our Plan for a primary care service for Wales up to March 2018 and will work across the Clinical board to aid the development of workforce plans for Primary Care Clusters and individual GP practices. They will also support the Clinical Boards development by upskilling teams and acting as a Consultant to ensure that workforce planning becomes embedded as a business as usual activity.

Solution

Candidates able to meet the necessary criteria with workforce planning expertise/qualification and knowledge of Primary Care were not there. Recruitment aims had to change to overcome this shortfall; the decision was to proceed to recruit workforce planning expertise on a secondment basis, and to support the successful post holder in gaining knowledge of Primary Care whilst in post. WEDS workforce planning network facilitated communications and relationships to encourage uptake of the post

Lessons Learnt

• The length of secondment may be too short to deliver the aspirational objectives of the Clinical Board.
• Underestimation of the lack of knowledge/awareness of strategic workforce planning within the Clinical Board.
• Be prepared to work at the pace of others!

Stats & Facts

In development:

• Primary Care focused introduction to workforce planning training.
• Development of a HCSW/GPN skills, training & qualification matrix to aid skills mapping at Cluster and individual practice level.

Final Catchphrase

It's not a race, it's a journey!

Document Library

1. Our Plan for a primary care service for Wales up to March 2018
An assessment and treatment service for Low Level Injuries provided within Community Pharmacies

Pain

Following the closure of 2 local Minor Injury Units there was a need to provide some level of service within an area which doubled in population over the holiday period. Local Practices were already stretched and the nearest A&E was over 24 miles away.

Vision

We wanted to develop Community Pharmacy as an unscheduled care provider. Our vision was to set up an assessment and treat service which would enable citizens to be able to access a local service to reduce the need to travel to a hospital or make an appointment in the GP practice. The activity data from the MIUs indicated that Community Pharmacists were able to treat many of the minor level injuries with appropriate training.

Solution

We set up a steering group including key stakeholders, developed a service specification outlining what would be delivered. We engaged with our Emergency Nurse Practitioner so they could deliver training sessions and undertake competency assessments. Data on treatments provided would be captured using a Consultation Form and a questionnaire was devised to allow for patient feedback. A Patient Information leaflet was produced to promote the service.

Lessons Learnt

Competency Assessment- initially this was done by face to face assessments at pharmacies; which proved time-consuming. The process was revised in 2016 and now involves completion of an individual competency quiz at the end of the last training session.

Final Catchphrase

Health Board: “The concept came from the grass roots pharmacists - if we listen to their ideas they tend to work!”

Patient comments: “Fantastic idea; no need to trouble A&E or the doctor for a minor injury.”

Stats & Facts

- 2014: 2 pilot sites
- 2015: 12 pharmacies delivering service
- 2016: so far... 16 pharmacies delivering service
- In 2015/16: 99 patients accessed the service, 81 were treated

Top Presentations

- Minor Wounds 48%
- Minor Burns 17%
- Abrasions 16%

If the service was not available:

- 47% would go to A&E
- 38% would go to the GP

Document Library

1. Service specification
2. Training sessions
3. Consultation Form
4. Questionnaire
5. A Patient Information leaflet