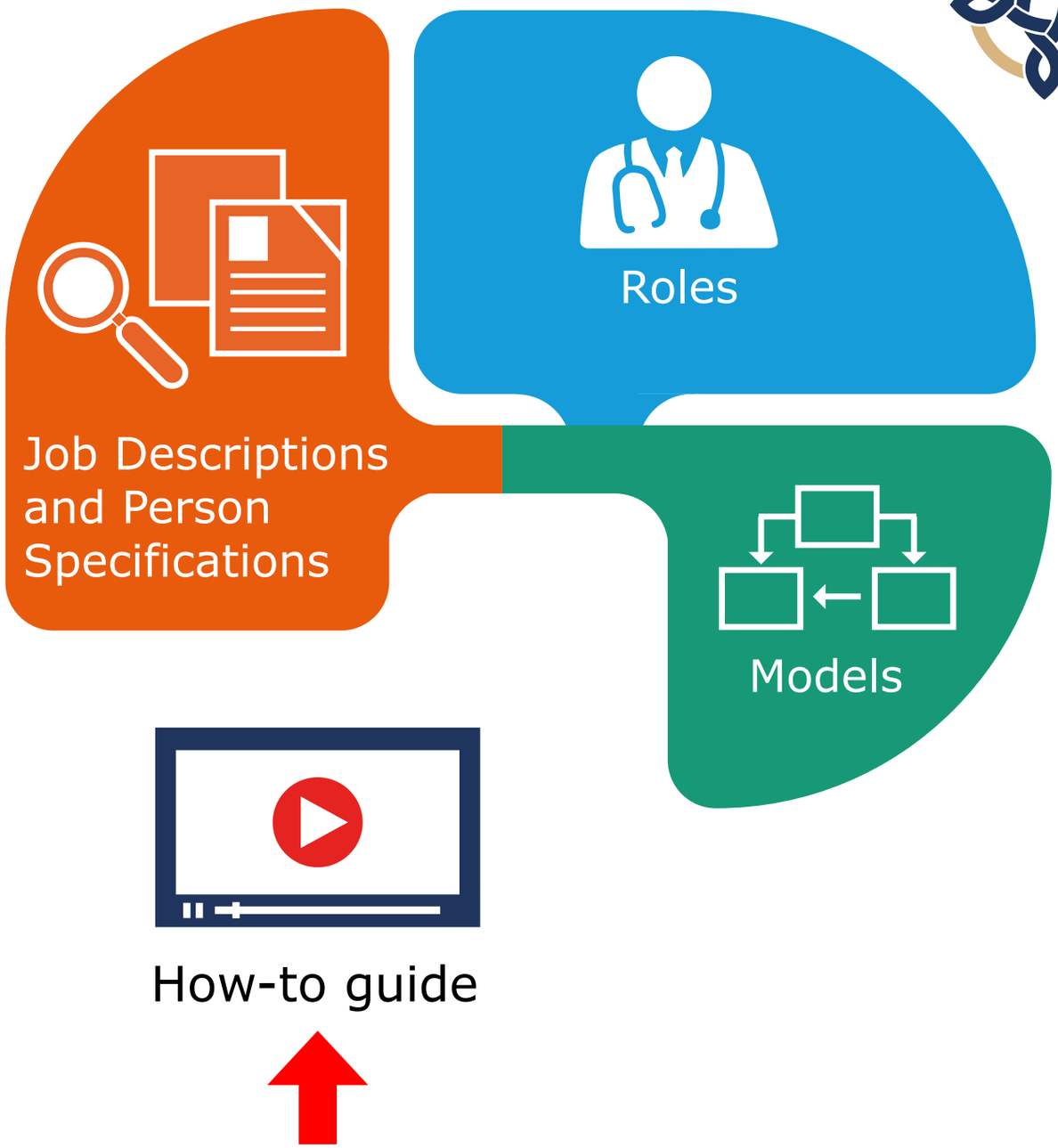
# EMERGING ROLES AND MODELS IN PRIMARY CARE




This is an interactive PDF. To navigate, use the arrow buttons on either side of each page or locate a specific section using the tool bars within the document.

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Gweithlu, Addysg a Datblygu
Shared Services Partnership
Workforce, Education and Development Services

# Job Description and Person Specification

Feedback & Queries

- Administration
- Audiology
- Communications
- Dietetics
- GP
- Healthcare Support Worker
- Social Care
- Speech & Language Therapy
- Mental Health
- Nursing
- Occupational Therapy
- Welsh Ambulance Service
- Pharmacy
- Physiotherapy
- Physicians Associate
- Podiatrist
- Practice Manager
- Project Manager
- Third Sector & Wellbeing
- Workforce Planning
- Role Redesign in NHS Wales

- Useful Reading
- JD Evaluation Flowchart
- SHARING JDs: Guidance & Template
- eLearning Coming Soon
- AfC Standard

Feedback & Queries

## List of Roles

4 Cluster Pharmacists

5 Healthy Lifestyle Advisor

6 Primary Care Workforce Planning Manager

7 Communications Officer

9 Physiotherapy / Occupational Therapy Technician

11 Proactive Care – Occupational Therapy in a General Practice

14 Advanced Practice MSK Physiotherapist

15 Advanced Physiotherapy Practitioners in Primary Care

16 Frailty Nurse

18 Physicians Associates (PAs)

20 Early Years Worker

22 Advanced Nurse Practitioner, GP Out of Hours

GIG CYMRU NHS WALES

# Cluster Pharmacists

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

## Problem

Clusters have been provided with funding by Welsh Government. 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

Managing the recruitment process and appointment of 6 individuals who were not part of the team on behalf of the clusters was a pressure on time. The new trac system should be more stream lined. Employment of the individuals by the health board has meant all the HR responsibility sat with the locality pharmacy teams, 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. To prevent a feeling of isolation for those pharmacists who have moved to Primary Care and to ensure peer support is readily available.

## Final Catchphrase

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

### 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
- There are now 13 WTE (16 staff) in post (September 2017)

### Document Library

1. Pharmacists and GP surgeries
2. Pharmacists in Practice: Communities of Practice
3. Models of Care for Pharmacy within Primary Care Clusters

# 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.***

**Lucie- Jane Whelan** – lucie-jane.whelan@wales.nhs.uk
**Dr Richard Bury** – richard.bury2@wales.nhs.uk
**Kirsty Gilling** – kirsty.gilling@wales.nhs.uk
**Public Health Wales**

## Problem

Big Challenge was around the recruitment. It was decided then that a Practice would employ the advisor with a Service Level Agreement (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 Advisers 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 will employ the Healthy Lifestyle Advisor.

Delay with the JD from the practice. The post needed an 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."*

## Document Library

1. Healthy Lifestyle Advisors – An Holistic Approach To Health
2. Healthy Lifestyle Advisor Job Description (Not subject to Agenda for Change)
3. Healthy Lifestyle Advisor Project - Evaluation Questionnaire
4. Healthy Lifestyles Leaflet
5. Healthy Lifestyle Advisors Poster
6. Measures Update
7. Healthy Lifestyle Advisor – Protocol

# 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 workforce planning 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. Workforce, Education and Development Services  workforce planning network facilitated communications and relationships to encourage uptake of the post.

**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.

## 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!

## 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
2. Developing the Workforce Elements of Integrated Plans
3. Focus on GPs and their Practice Workforce

# Communications Officer

***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

## Problem

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.

## 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

## Communications Officer - Continued

***Development of Cluster Communications Officer post to promote the Rhondda Valley and improve recruitment and retention of health professionals in the area.***

### 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.

### 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. Challenges

# Physiotherapy / Occupational Therapy 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

## Problem

The 2Ts (Tywi/Taf) Cluster has a significantly higher older population at 22.1% compared to the Welsh average of 18.7%. There are long waiting lists for Occupational Therapy / Physiotherapy 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 Occupational Therapy / Physiotherapy Technician to support GP practice multi-disciplinary working and undertaking of lower level assessments.

Every patient is considered at multi disciplinary team meeting for discussion and/or a home visit by the Physiotherapy/Occupational Therapy Technician.

## 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

## Document Library

1. The Contribution of Occupational Therapy to GP Services

# Physiotherapy / Occupational Therapy Technician - Continued

***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.***

## 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.
- Patient information is currently stated on both the Local Authority and NHS system, which are not compatible. Work is underway to enable shared records and information.

## 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
- The Physiotherapy/Occupational Therapy Technician reinforces the interface between primary care and the local authority.

## Final Catchphrase

*GP Clusters are now recognising the benefit of investment in this role. The role is to become a permanent one within the primary care team.*

# Proactive Care – Occupational Therapy in a General Practice

***Occupational Therapists (OTs) can bring added value to general practice; this year-long pilot provides the evidence to show this professional group are part of the solution to maintaining and improving patient care within our local communities.***

## Problem

General Practice is widely acknowledged to be under significant pressure with a high number of consultations spent on non-health issues. One factor is an increasing older population with multiple and complex health and social care needs. This Health Board's Population Health Group report on Frailty and Dementia shows that age projections for the local population indicate a growing problem as the number older people living with frailty or complex needs continues to increase.

## Vision

The Royal College of General Practitioners in Wales recognises the need to expand the "general practice family" as part of addressing the significant challenges faced in general practice. The unique skills and added value of other health professionals in improving health outcomes for patients are acknowledged - embedding an occupational therapist in the practice, introduces an alternative, proactive model of care.

**Vision beyond the Pilot:**
Future opportunities identified:-

- Reducing demands on GP's by an occupational therapist visiting at home instead of a GP, where functional decline is identified as a primary concern.
- Enhancing OT knowledge to support GP's by identifying and communicating signs of ill health, avoiding escalation to point of crisis.
- Broadening remit to incorporate other identified groups

## Stats & Facts

- **68** referrals from GPs within the first 7 months of the project, compared with **13** GP referrals from the practice to the community occupational therapy service in the 6 months preceding the project.
- **104** new patients seen in the same 7 months. OT interventions undertaken with all 104 patients i.e. rehabilitation; prescription of aids & home adaptations; enablement and support; referral to others

## Solution

An alternative model of occupational therapy provision was explored with general practice clusters. Argyle Street Practice, with a patient caseload in excess of 25,000, a large centralized hub and a proactive and motivated GP workforce, was viewed as an ideal site for a pilot project.

The project commenced with funding being agreed for an experienced occupational therapist (0.9WTE) from the locality team to be embedded in the practice to undertake a period of testing an alternative way of working.

The aims of the project were defined and agreed with the practice as;

- Using the Anticipatory Care Planning approach, identify patients who are regular users to the service and increasingly frail and isolated.
- Provide proactive Occupational Therapy intervention for the identified group; frail elderly with complex presentation and multiple co-morbidities.

# Proactive Care – Occupational Therapy in a General Practice - Continued

***Occupational Therapists (OTs) can bring added value to general practice; this year-long pilot provides the evidence to show this professional group are part of the solution to maintaining and improving patient care within our local communities.***

The difference made included:

- Reduced contact with the surgery
- People able to remain at home with the support given
- Increased safety with a reduction in falls and risk of falls
- Improved confidence in ability to undertake everyday tasks leading to greater independence

## Lessons Learnt

- With increased confidence in the occupational therapist's skills, the initial GP home visit for many patients i.e. where primary concern is functional decline, could potentially be undertaken by an occupational therapist.
- There is potential for occupational therapy skills in primary care to be further enhanced to identify ill health and proactively communicate this to GP's, preventing escalation to health crisis.
- Repeat visits to patients could be minimised and attributed to the OT's knowledge and skills in assessing and supporting frail elderly patients, with faster referral to appropriate services and interventions.
- Carers', as well as patients' confidence increased in their ability to manage everyday functional activities following OT intervention.

## Final Catchphrase

Improved patient outcomes, as captured by one GP comment:

*"The OT manages frailty issues much better than me!"*

Royal College of Occupational Therapists

## Stats & Facts

## Document Library

1. Occupational therapy in a general practice
2. Occupational Therapists
3. Reducing the pressure on hospitals
4. Reducing the pressure on hospitals (Welsh)
5. Proactive Care – Occupational Therapy in a General Practice Pilot Project November 2015 – June 2016
6. Strategic Direction for Occupational Therapy in Primary Care
7. The Contribution of Occupational Therapy to GP Services
8. Living, not Existing: Putting prevention at the heart of care for older people in Wales
9. Living, not Existing: Putting prevention at the heart of care for older people in Wales (Welsh)
10. Primary Care Pilot OTs in GP – Bilingual

# Proactive Care – Occupational Therapy in a General Practice - Continued

**Primary Care Occupational Therapy services for people with frailty and multiple co-morbidities within GP clusters.**

**Background:** There are increasing numbers of frail elderly in Wales and current health & social care occupational therapy services are accessed when people are in crisis or have experienced significant changes in health. The frail elderly often experience a progressive deterioration in function when services are not immediately available and coping becomes difficult. An early intervention and a proactive approach to maintaining function would reduce demand for services that are required when dependency is established.

**Aim:** To provide Occupational Therapy assessment, support, advice, signposting and early intervention for the frail elderly with complex presentation and multiple co-morbidities. Using the Anticipatory Care Plans (ACP) approach with GP's, identify patients who are regular users to the service and are increasingly frail and isolated. Occupational Therapists would have a preliminary co-productive conversation with individuals establishing their priorities and what is important to them. This would then be continued, if appropriate, through community intervention.

**Objectives:**

1. Reduce contact with GP's by resolving underlying issues that are the root cause of regular contacts with health & social care.
2. Prevent further deterioration by maximising/maintaining independence in preferred home environment and resolving health & social issues at an early stage, therefore minimising crisis situations.
3. Re-establish or establish support and community networks to promote social inclusion, functioning & independence.
4. Undertake functional assessments – provision of any necessary equipment & adaptations.
5. Self management strategies for chronic conditions.
6. Reablement programmes/falls programmes for issues related to a physical difficulty or early onset dementia.
7. Facilitate the compliance with completing 75+ assessments.
8. Provide an interface between hospital and home/home and hospital with close links to GP/DN/CRT.

**Measureable Outcomes:**

1. Reduced visits to GP
2. Reduction of unnecessary admissions to hospital
3. Reduced length of stay for those admitted to hospital
4. Increased sustainable support in community
5. Support the compliance of achieving the target for 75+ assessments
6. Early identification of life-limiting conditions e.g. dementia
7. Measures of well-being and social inclusion
8. Reduced contacts to other services

The Royal College of Occupational Therapists calls for Regional Partnerships to ensure that Older People can live and not just exist, by deploying the occupational therapy workforce in primary and community services focused on what matters to people.

As part of the College's Improving Lives, Saving Money campaign the Living, not Existing: Putting prevention at the heart of care for older people in Wales report builds on the College's previous report 'Reducing the pressure on hospitals'. It focusses on the contribution that occupational therapists can and do make in order to give older people back their dignity and help NHS and social care services to work better together and be more efficient.

Occupational therapists can enable people to stay independent for longer carrying out the activities that matter to them. When deployed at key points of the system their intervention can delay and even alleviate the need for care – better for the person while also saving money for services. One example in the report shows how Cardiff Council made a saving of £395,279 when the occupational therapy team reviewed 227 packages of care (2015-16).

The College is therefore calling for all Regional Partnership Boards to identify a named person in three areas where occupational therapists have a key role;

- prevention or delaying the need for support
- helping older people remain in their communities
- ensuring equality of access to occupational therapy

# Advanced Practice Physiotherapist (MSK)
## Neath Port Talbot Service Delivery Unit

***Primary Care Cluster Physiotherapist –*** *delivering effective timely care, and reducing the pressures on GPs.*

### Problem - 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."*

[General Practice Physiotherapy Posts – A guide for implementation and evaluation]

THINK PHYSIO
for primary care

### Stats & Facts

- A projection of 19 weeks per year of a GP's time will be released, allowing them to increase their appointment time from 7 to 10 minutes per patient and to see the more complex medical cases.

### Document and Link Library

1. KSF Advanced Practice MSK Physiotherapist
2. Physiotherapist Authorisation Scope Of Practice
3. Data Sharing Agreement
4. Think physio for primary care: policy briefing Wales 2017 (English and Welsh)
5. cost calculator
6. Public Health England tool estimates that MSK phone triage service saves £19.30 per patient

# Advanced Physiotherapy Practitioners in Primary Care

## Betsi Cadwaladr University Health Board

***Advanced Physiotherapy Practitioners in Primary Care – a new era…***

*Cathy Wynne* *cathy.wynne@wales.nhs.uk*
*Robert Caine* *robert.caine@wales.nhs.uk*

### Problem - delays in the process were caused by….

- Difficulties in recruiting GPs
- Retention of GPs becoming a major issue
- National shortage of GPs
- 30% of a GP caseload is musculoskeletal - Advanced physiotherapy practitioners are in an ideal position to take on this workload.

### Vision

This service aims to simplify the musculoskeletal (MSK) pathway by making Advanced Physiotherapy Practitioners (APP) the first point of contact for MSK conditions in primary care thereby relieving GPs of this caseload.

The underlying principle of this new model of patient centered care is to deliver an excellent integrated service, close to the patient's home without unnecessary delay.

### Solution

Currently we are achieving a 40% first point of contact across BCUHB & are in 64 practices across North Wales with 14 wte physiotherapy staff.

- We have developed JDs for both 8a Advanced Practitioner & B7 Clinical Specialist in primary care
- Training all staff in extended scope skills – prescribing / injection therapy, bloods requesting and interpretation and diagnostics.

### Lessons Learnt

- We need to be in the practices for more clinical sessions to ensure we can increase the 1st point of contact.
- Data capture – the need to make sure we can capture data from the primary care IT systems

### Stats & Facts

Patients seen since August 2016

Extended Scope Skills

Service Expansion

What patients felt about the service

### Final Catchphrase

*This is the way forward, providing patient centered care, close to the patients' home in the community.*

# Frailty Nurse

***Primary Care Nurse for Older People (PCNOP)***
***North Cardiff GP Cluster (N&W Locality)***
***Cluster employed nurses who work with frail older people.***
***Contacts for more information: Community Resource Team***

**Nurses** - Christine Crompton & Sally Kempson;
**Community Support workers** - Holly Bird & Joanne Churchill;
**Professional Lead** (CRT) – Ruth Cann

## Problem

The North Cardiff Cluster Plan recognises a large elderly population. The Cluster has identified a need for supporting the highest risk frail elderly population and as a result is using part of their allocated funding to employ 2 nurses and 2 community support workers to provide patient facing support in practices.

## Vision

The Primary Care Nurse for Older people aims to:

- Minimise the need for multiple referrals/Hospital appointments
- Coordinate integrated Health & Social Care to Older People
- Aid effective, efficient and personal centred services
- Enhance Team Working
- Reduce the risk of acute hospital admissions
- Help create an individualised plan for future care
- Prevent a crisis or hospital admission
- Reduce anxiety experienced by a carer or relative
- Individualised goal setting in collaboration with the patient and carers if appropriate

**Stats & Facts**
benefits include:

- Prevention of hospital admission
- Advanced care planning and accessing DNAR status
- Linking in with third sector support
- Reducing GP telephone consultations
- Supporting carers/families
- Future plans to access Vision remotely
- Improved relationships with GP Practices
- Opportunities to expand the service

## Solution

Having support from the nurses helps improve patients' quality of life. Before these staff were in post patients reported they felt they were "floating" - primary and secondary care is fragmented with focus on individual conditions rather than whole person.

- GPs now proactively identify patients at risk of failing at home and being admitted to hospital. The PCNOP provides support to try and prevent the crisis that often results in a hospital admission.
- Patients struggling at home have moved directly into respite or care home beds, rather than being admitted into secondary care.
- The PCNOP engages patients in advanced care planning, helping them plan for their future care.
- The PCNOP is a multi-skilled expert generalist working across health and social care to coordinate services around the patient.

# Frailty Nurse - Contunued

***Primary Care Nurse for Older People (PCNOP)***
***North Cardiff GP Cluster (N&W Locality)***
***Cluster employed nurses who work with frail older people.***
***Contacts for more information: Community Resource Team***

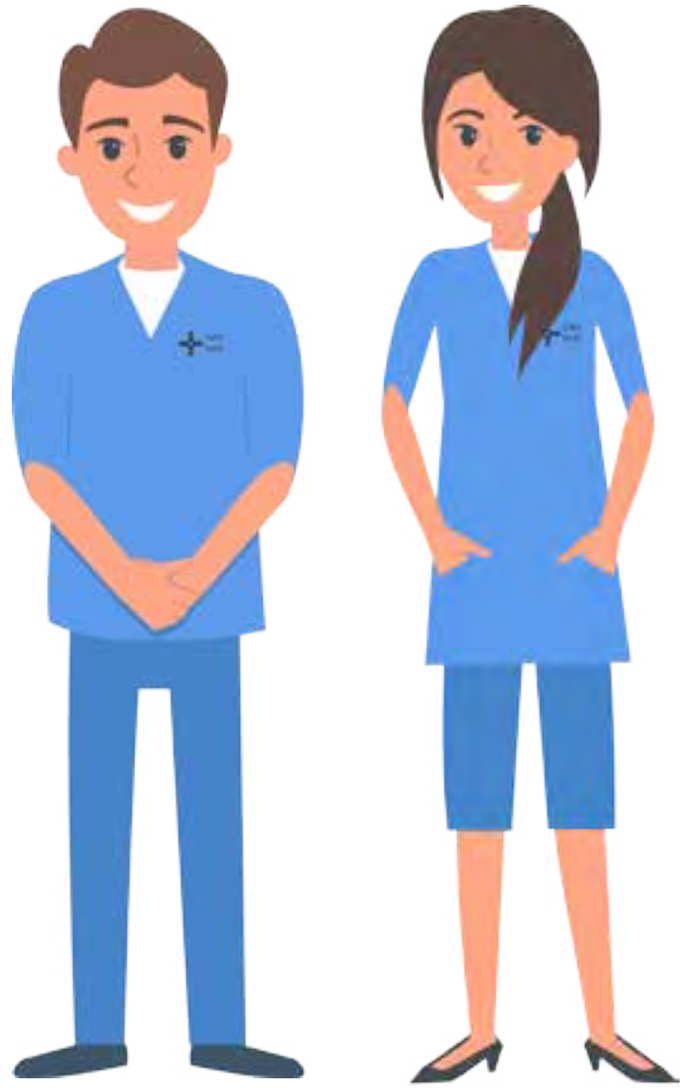
## Lessons Learnt

- Cross cluster working has its challenges and PCNOP is a developing role.
- GPs are currently in discussion to ensure fair allocation of patients to the nurses (per GP practice); current agreement is 1 patient per 1000 patient population.
- An Operational Policy is in place to help nurses organise and prioritize their work, now that caseloads are full. Further developments are underway for effective prioritisation of urgent calls.
- The PARIS digital software system, that helps streamline the delivery of integrated care, aids management of PCNOPs' workload. A further challenge now, is how to measure outcomes
- entering details of discharge end involvement onto the PARIS system will help generate outcome measures

## Final Catchphrase

*"Since meeting the PCNOP everything moves like clockwork, much happier in myself " ...without the support from the PCNOP I would have ended up in hospital" ... "the support has been invaluable and has improved my quality of life".*

**Patient/Relative feedback**



## Document Library

1. Primary Care Nurse for Older People (PCNOP)
2. Fraily Nurse leaflet

# Physicians Associates (PAs) in Primary Care tackling mental health issues

***Changing the shape of the primary care future workforce with Physician Associates.***

## Problem

Practices are facing recruitment issues - there is insufficient workforce in the NHS to meet demand resulting in ever-increasing difficulty in recruiting and retaining GPs

Mental health issues are rising with ageing population and medical time to deal with these patients is limited. As generalists with the ability to develop areas of interest PA can provide effective MH care in a primary care setting.

There are challenges in introducing and having acceptance of the role. There are also limitations not currently regulated (but consultation in process and regulation expected by 2020);

- not able to prescribe;
- unable to request ionising radiation examinations

## The PA Option

Since early 2015, Powys Teaching Health Board has been leading the way in Wales in the development of the Physician Associate role.
A qualified PA is a graduate who has undertaken full-time post-graduate training for a further two years. The training is based on a competence and curriculum framework and consists of intensive theoretical learning in medical sciences, pharmacology and clinical reasoning as well as over 1,400 hours of clinical placement experience in both community and acute care settings. The Physician Associate is a rapidly growing healthcare role in the UK, working alongside doctors in hospitals and in GP surgeries. Physician Associates support doctors in the diagnosis and management of patients. They are trained to perform a number of roles including: taking medical histories, performing examinations, analysing test results, and diagnosing illnesses under the supervision of a senior doctor.

## Stats & Facts

- 450 PAs in UK/Wales
- <75 PAs in primary care in UK & <20 in Mental Health
- Predominantly female

## Vision

- Alleviate demand pressures by increasing capacity
- Need to address demands on mental health service provision
- 50-60% of graduating PAs are needed to work in primary care but currently only 15% of graduates starting first job in primary care.

# Physicians Associates (PAs) in Primary Care tackling mental health issues

***Changing the shape of the primary care future workforce with Physician Associates.***

## Solution

"…a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision". DoH, England

Generalist with medical education that works alongside the GP

www.pulsetoday.co.uk/physician-associates-can-do-gps-work-more-cheaply/20009818.article

Papers:

- Lewis DM, Naidoo C, Perry J, Watkins J. The Roundhouse: an alternative model for primary care. Br J Gen Pract 2016 -04-28 16:05:24;66(646):e364.

B'ham MH Trust one of largest employer of PAs in mental health in UK…

Making primary care an attractive option for PAs – career progression… growth in earnings for both PA and the practice as an SME (via increased service delivery, etc)

Appeal of the role…to individuals; general practice; mental health

There are currently 2 qualified PAs employed directly by medical practices in Powys, all providing valuable assistance to medical practices keeping pace with the needs of their patients. Have your colleagues specialised in a similar way to your MH specialist interest? My colleague has a n interst in Paeds.

In an early collaboration between the University of Birmingham and the Mid Wales Health Care Collaborative, the 3 PA students were offered bursaries to support them with the cost of their studies. In return theys have undertaken both primary care and acute placements in Mid Wales and will, post-qualifying, come back to Mid Wales for a minimum period of time.

The health board is providing direct support to a PA student at the University of Birmingham. On qualification in 2018, they will work in the Mid Powys area for a minimum of two years.

## Lessons Learnt

- Peer support
- Career structure

## Final Catchphrase

*"I think you PAs are brilliant, for the first time in years it seems like someone has had time to listen to what I had to say … time to Care"*

**Montgomery Patient**

## Document Library

1. All Wales Physician Associate Governance Framework
2. Who are Physician Associates?
3. Physician Associates In Primary Care & Secondary Care

# Early Years Worker

## *Giving every Child the best start in life and Reducing Health Inequalities:* *Introducing the Role of the 'Early Years Worker' to Primary Care*

*Dr Dan Sartori – Cluster Lead Penderi Cluster Network.* ***Tel:*** *01792 581666*
*Jo Edwards - Early Years Development Worker* ***Tel:*** *01792 635400*
*Tony Kluge - Cluster Development Manager* ***Tel:*** *01792 601825*
*Debra Morgan - Planning and Partnerships Support Manager* ***Tel:*** *01792 601876*

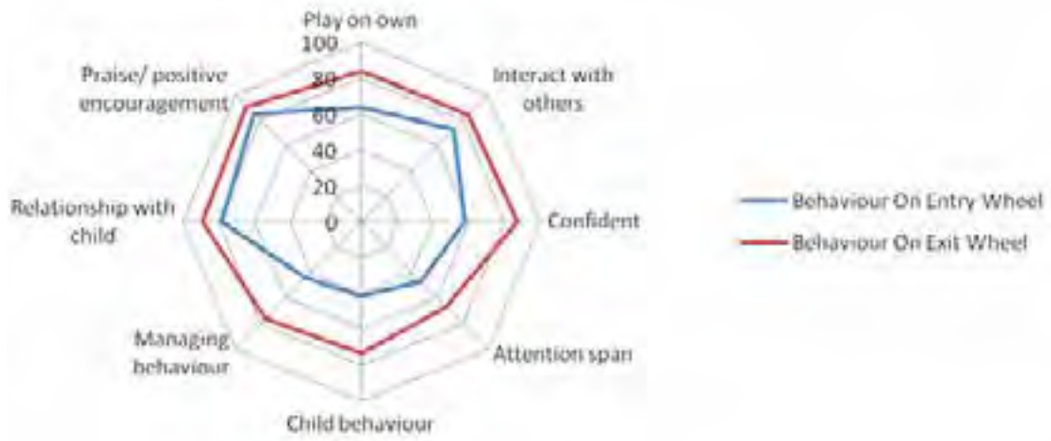
### Problem

In 2012 out of 1200 primary school children in Swansea under the age of 3, data showed that 75% were not achieving the expected developmental milestones. A local primary school reported that 40% of reception children had limited speech, 20% were dependent on dummies and 36% unable to brush their teeth. According to the Marmot Review (2010) 'giving every child the best start in life is crucial to reducing health inequalities…what happens during these early years has lifelong effects on many aspects of health and wellbeing'. The Penderi Network opted to invest in a Primary Care Early

### Vision

The pilot project aimed to 'give every child the best start in life' ensuring children were 'school ready' and narrow the health equalities gap. Swansea Council's response to the Marmot Review highlighted a lack of support for families living outside 'flying start' catchment areas. To plug the gap, a team approach working across organizational boundaries was adopted. A primary Care Early Years Worker was appointed to develop a service that would respond to requests made by GPs and generic health visitors to provide interventions meeting identified needs of young children and their parents/carers in relation to three key areas: Child mental health and behavior, parental anxiety and depression, child developmental delay. Through social prescribing, evidenced based approaches/interventions and the building of community cohesion and resilience, the work aimed to develop a pathway of support to enable families to reach their fullest potential.

**Total Child Behaviour scores on entry and exit wheels**




### Stats & Facts

During the first 12 month pilot:

- 392 beneficiaries supported
- Out of 392, 84% say that if similar support needed in future they would approach the EYW not the GP Practice
- 100% of beneficiaries report an improvement in circumstances enhancing their family wellbeing
- An estimated 705 GP appointments have been repurposed for other patients demonstrating opportunity cost benefits
- 99% of families reported a decrease in parental anxiety/depression
- 100% of families reported an improvement in child behavior
- 46% of families have been linked to and received additional support from the wider Early Intervention Team
- Referrals made by the GP/Health visitor added kudos to the service and subsequently engagement rates were high.

Swansea Healthy City Healthier Future
Abertawe Dinas Iach Dyfodol Iachach

Cyngor Abertawe
Swansea Council

# Early Years Worker

## Solution

Meeting families immediately after a referral meant they were motivated, ready to engage and responsive to support. This was instrumental in developing a 12 week offer of support provided in the families' homes. This facilitated holistic work with the whole family on a bespoke action plan to build on current strengths, enhance resilience and increase confidence and self-esteem. Triage clinics were also run from surgeries within the cluster. This enabled identification of need, an offer of appropriate intervention and prevention of escalating circumstances. It was noted that in many cases families also had additional support needs other than those noted on the referral form.

## Lessons Learnt

Throughout the intervention an exit plan is created so families have resources and strategies relating to community based support and are less likely to return to their GP when faced with future challenges.
As the role involves seamless working between partner organizations, close working relationships needed to be developed. Services met regularly to review development of the pilot, consider current trends and troubleshoot any issues.

The success of the team approach and lessons learnt from the pilot has resulted in a further expansion of the team and a revised service model, currently being rolled out to a further 2 Cluster Networks

## Final Catchphrase

*"Before this role was created, GPs had little or no option over where to send parents because they were worried about parenting. It has been such a success in our area. I hope it will be taken up by local Health Boards as a model for other areas".*

**[Dr Daniel Sartori, Cluster Lead]**

*"I was out of my mind when I went to the doctors. When Jo came to my house she offered me information that made sense to me".*

**[Penderi Patient Feedback]**

## Document Library

1. Primary Care Child & Families Wellbeing Service Referal Form (English)
2. Primary Care Child & Families Wellbeing Service Referal Form (Welsh)
3. Lead Primary Care Children's Wellbeing Worker Job Description
4. Revised Primary Care Early Years Model (Effective from April 2018)

# Advanced Nurse Practitioner, GP Out of Hours

***SUSTAINABILITY AND IMPROVEMENT:*** *AN INNOVATIVE APPROACH TO WORKFORCE DEVELOPMENT WITHIN PRIMARY CARE & THE GP OUT OF HOURS SERVICE*
*"Growing our own Advanced Nurse Practitioners"*

*Fiona Wood, Senior Nurse & Clinical Nursing Lead*

## Problem

In keeping with other areas of the UK, sustaining a skilled and effective Primary Care & Out of Hours (OoHs) workforce continues to present a challenge. At a local level this includes difficulty recruiting & retaining medical staff & advanced nurse practitioners; difficulty covering shifts in OoHs (particularly on the weekend); difficulty covering OoH sites.

## Vision

Against this background, the Health Board in partnership with four GP Practices embarked upon a new and innovative workforce development initiative. The primary aim being to "grow" our own Advanced Nurse Practitioners (ANPs) to work within General Practice & the Out of Hours service.

## Solution

- Workforce development framework & funding agreed to appoint four Advanced Nurse Practitioner Trainees June 2017.
- Trainees appointed and commenced 25th September 2017.
- All four trainees commenced MSc in Advanced Clinical Practice October 2017(Cardiff University) – 3 year programme.
- Six week induction programme included practice based visits to meet participating Designated Supervisory Medical Practitioners (DSMPs) and participating Advanced Nurse Practitioner (ANP) mentors.
- Lead GP developed handbook for GP Mentors & Trainees.
- Placements within General Practice commenced 30th October 2017.

Dr M Semmens, GP & Designated Supervisory Medical Practitioner, Sian Rees, Advanced Nurse Practitioner & ANP mentor Joanna Cook, ANP Trainee

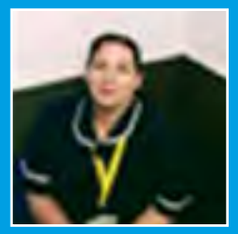
## Stats & Facts

- 2 days per week with DSMP
- 1 day per week with designated ANP mentor

The 4 participating GP Practices are:-

- Morlais Medical Practice
- Pontcae Medical Practice
- Forest View Medical Practice
- Abercwmboi Medical Centre

The 4 Trainees :-



# Advanced Nurse Practitioner, GP Out of Hours

## Lessons Learnt

- Securing 4 places on the MSc Advanced Clinical Practice needs to be planned in advance – failure to do this will result in staff not be being able to commence the relevant training in a timely manner
- Securing 4 DSMPs is critical to the success of the initiative and again this needs to be planned for in advance of the trainees commencing the role
- Planning an effective and meaningful Induction programme is an essential component of any workforce development initiative and should be allocated sufficient managerial resources and time as again this has been critical to the initial success of the project

## Final Catchphrase

*"I feel that I have been thoroughly supported throughout the past 3 months. A complete awareness of the changes I have undertaken in terms of a new band, new role, commencing an MSc, change of manager and the addition of mentors into our day to day routine..... this could have been very overwhelming if I had not felt fully supported."*

**[ANP Trainee]**

## Document Library

1. ANP Trainee Poster
2. Workforce and Development Framework

Feedback & Queries

## List of Models


25 Pre-Diabetes Service

26 Neath Primary Care Hub

28 Community Pharmacy – Triage & Treat Service

29 Pharmacy: Seasonal Flu Vaccination Service

31 Healthy Prestatyn

33 Active Monitoring (AM)

35 GP Practice Based Social Workers Pilot

37 Lymphoedema Network Wales

39 GP Out of Hours Skill Mix

41 Care Navigation – Signposting Skills for Primary Care

43 Educational Learning Placements in Primary Care


GIG CYMRU NHS WALES

## Models

# Pre-Diabetes Service

### Headline/Purpose

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

### Problem

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 Service Level Agreement (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

- 130 patients called in for a 12month review post intervention - 34% had reduced their risk enough to come off the scale.
- 6 programmes piloted in year 1 through Practice delivery. But now delivered through EPP team and Dietetics
- 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 the project. Full report due September 2018

### 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.**

### Document Library

1. SLA
2. Patient invite template
3. Pre-diabetes screening leaflet (Welsh Version)
4. Local Resources
5. Starting The Conversation: Diet
6. International Physical Activity Questionnaire
7. Participant invitation letter
8. Pre Diabete Interim Report Poster
9. Referral Options For Lifestyle Advisor

## Models

# Neath Primary Care Hub

*Better Demand Management in Primary Care*

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

***Project Leads:*** *Dr Heather Potter, Skewen Surgery*
*Owain Gimblett, Neath Primary Care Hub Operational Manager*

## Problem

The 8 GP practices 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).

*Dr Heather Potter, Project Lead*

## Stats & Facts

**Triaging practices are seeing**

- a reduction in the number of patients needing to see GPs face to face
- an increase in the number of patients being managed with telephone advice only
- patients needing to see GPs face to face having same day appointments

Total Physiotherapy slots completed in 12 months – 2021

Total Wellbeing slots completed in 12 months – 416

**For Pharmacy between July 2015 and July 2017**

- 2208 face to face consultations including medication review, chronic disease management, minor illness etc.
- 679 telephone consultations
- 12,235 other recorded activities including medication review using the records, third party consultations with relatives, re-authorisations, reconciliations including hospital discharges, queries, liaising with other health professionals e.g. social services, community pharmacies.

## Neath Primary Care Hub - Continued

*Better Demand Management in Primary Care*

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

### Lessons Learnt

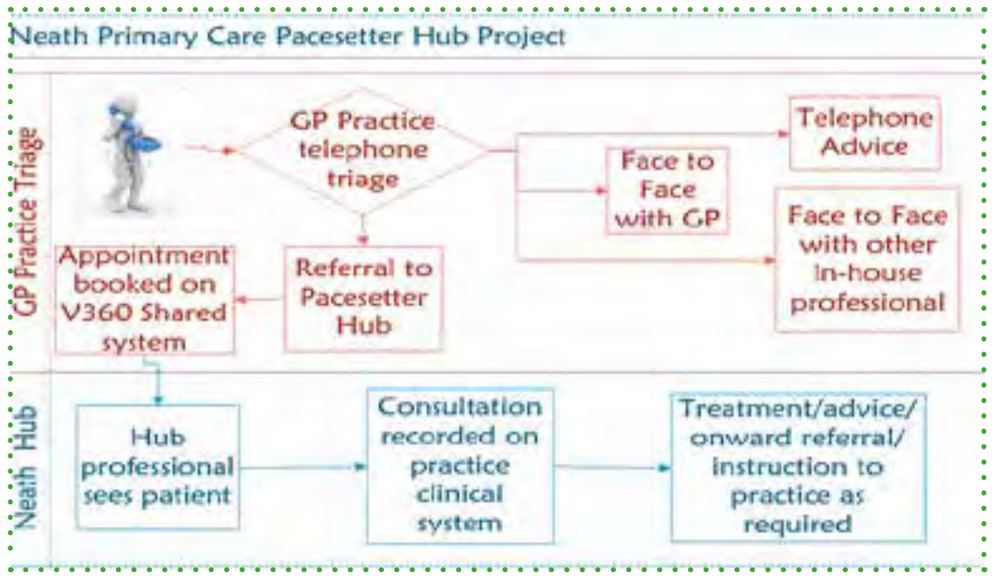
- Changing Culture (GPs and patients) takes time
- Challenge of building trust in the development of new pathways
- Greater lead in time for IT development essential
- Data analysis support due to complexity of primary care practice systems essential
- Project management essential
- Lack of scale/ size/ volume limiting the HUB's impact on GP workload

### Final Catchphrase

*"Called Medical Centre had call-back from Dr Potter - unusual pain in knee on impact. Sent to see (Hub Physiotherapist) in Neath Primary Care - absolutely brilliant, he diagnosed a tear/rip in the membrane that surrounds the tendon, which was causing the sharp pain in contact. Really clever guy, plenty of time to go through the symptoms and explain the cause. From contact with Dr Potter to diagnosis/ remedial advice with the Physiotherapist 65 minutes ! Wonderful"*

### Document Library

1. KSF Community Development Worker
2. Outcome Measures
3. National Primary Care Conference Presentation



# Community Pharmacy – Triage & Treat Service

***An assessment and treatment service for Low Level Injuries provided within Community Pharmacies***

## Problem

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

# Pharmacy: Seasonal Flu Vaccination Service

## *A GP Cluster organized 'Seasonal Flu Vaccination Service' based in the local community- Cardiff West*

*Farzana Mohammed (Cluster Pharmacist)*
*Farzana.mohammed@wales.nhs.uk*
*Tracey Enright (Practice Manager)*
*Tracey.enright@wales.nhs.uk*

### Problem

Increasing flu vaccine uptake to meet Welsh Health Circular targets for 2017/2018

- Actively offering flu vaccination to 100% of those in eligible groups.
- Protecting those aged 65 years and over and achieving a minimum of 75% coverage. Increasing capacity to deliver flu vaccinations by promoting multidisciplinary team working.

### Vision

Our vision was to organize two flu vaccination days in easy to reach areas of the cluster (Earl Hague Club, Whitchurch and Insole Court, Llandaff) to enable citizens to access the seasonal flu vaccine at the start of the flu season without the need to make an appointment in the GP practice. Thereby freeing capacity in the 8 Practices. Three Cluster Pharmacists were given the opportunity to attend Flu Champion training days before working with Practice nurses under the direction of a Patient Group Direction (PGD) to provide the service in October 17.

### Solution

We engaged with the Healthboard Immunisation Co-ordinator to deliver training sessions to the pharmacists. Competency assessments were completed at the Flu day with a designated practice nurse. Data on vaccinations provided would be captured using a Consent Form and a questionnaire was devised to allow for patient feedback. A Patient Information letter/leaflet was produced to promote the service.

### Stats & Facts

**In 2016**

- Invited over 75's in Cardiff and West Cluster to 1 Flu Day
- 232 Vaccinations + Beat Flu Primary Care Award 2017

**In 2017**

- Invited 10,490 patients-all over 65's in Cardiff and West Cluster to 2 Flu days
- 2000 Vaccinations , Day 1 1050, Day 2 950

**Pharmacist contribution 2017**

- 2 pharmacists attended each day
- 100 vaccinations per pharmacist per day
- 20% of patients were seen by a pharmacist

**Patient Questionnaire:** 167 forms complete

## Models

# Pharmacy: Seasonal Flu Vaccination Service - Continued

***A GP Cluster organized 'Seasonal Flu Vaccination Service' based in the local community- Cardiff West***

### Lessons Learnt

High demand for service resulted in running out of vaccine and consumables at various points during session- nearest GP practice was utilized for top up supplies. Bottle neck of patient flow in venue and car park (higher demand 10am-12, compared with 12-2pm) - Practice managers dealt with patient flow and queries. Less availability of nurses on Day 1: Results identified a minimum of 6-8 vaccinators required to meet demand.

### Final Catchphrase

- *Vaccinated 18% of >65's registered in Cardiff West*
- *Patient satisfaction survey showed 92% of respondents will attend again next year*

### Document Library

1. Training sessions
2. Consultation Form
3. Questionnaire
4. A patient information leaflet
5. PGD for influenza vaccine
6. WELSH HEALTH CIRCULAR: The National Influenza Immunisation Programme 2017
7. WELSH HEALTH CIRCULAR: Ordering flu vaccine for the 2018

# Models

## 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,

### 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

- 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).
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.

## Healthy Prestatyn - Continued

***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

### 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.*

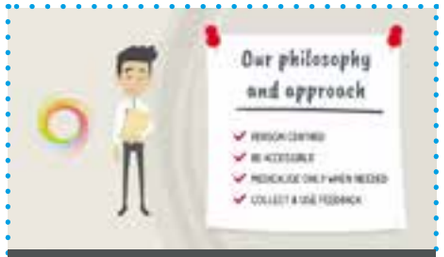
### Document Library

1. Weekly Dataset
2. In a first for Wales Prestatyn to unveil pioneering health service (Press Release)
3. Patient Booklet

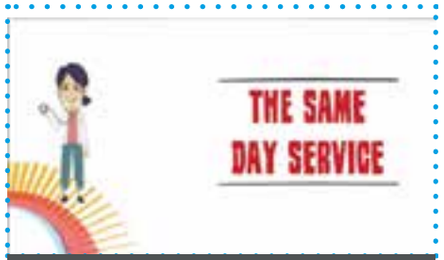
Healthy Prestatyn Iach

### Video Library

Play Video




Play Video




Play Video

Play Video

## Models

# Active Monitoring (AM)

***Active Monitoring (AM) is a self-directed psycho-educational programme made up of 5 face to face interventions over an 8 week period with a total of 2.25 hours of face to face support. The service is offered to people presenting to GPs with a range of symptoms associated with common mental health problems such as anxiety, mild depression, stress and worry and low confidence and self-esteem.***

Cwm Taf overall had statistically higher levels of mental illness in the combined 2012-2013 Welsh Health Survey compared with Cardiff and Vale UHB.

This Service enables people to engage with a support service immediately on referral from a GP. There is no other national service offered during this 'watchful waiting' period, the alternative is for the person to wait for the 'watchful waiting' period to end and then return to the GP. Whilst people are waiting to return, or for other services, it is likely that their mental health will decline which can result in a higher level of intervention being required when they do gain access – higher level intervention can include services provided by the GP and Local Primary Care Mental Health Support Services.

The service is collaboration between CT UHB and MIND. It provides support for all adults who are experiencing mental health problems. The service aims to increase the patients' wellbeing, self-esteem and confidence and reduce their likelihood of needing to access further primary and secondary mental health services.

The service supports people who are attending GP appointments for the first time with symptoms of common mental health problems including anxiety and depression and also supports individuals with mental health problems to improve their emotional and mental health and to make positive choices in their lives.

## Stats & Facts

There have been a total of 580 referrals since April 2017 to end of June 2017

**139 patients have completed at least 4 face to face appointments:-**

**Level of general anxiety at start of active monitoring:-**

Minimal 1%, Mild 8%, Moderate 19%, Severe 72%

**Level of anxiety after attending 4 face-to-face appointments:-**

Minimal 21%, Mild 25%, Moderate 21%, Severe 33%

**Level of depression at start of active monitoring:-**

Minimal 1%, Mild 8%, Moderate 19%

**Level of depression after attending 4 face-to-face appointments:-**

Moderate/Severe 25%, Severe 47%, Minimal 24%, Mild 22% Moderate 16%, Moderate/Severe 16%, Severe 22%.

## Models

## Active Monitoring (AM) - Continued

The service is delivered by Active Monitoring Practitioners who are employed by MIND. Each patient that completes at least 4 face-to-face appointments with an Active Monitoring Practitioner completes 2 sets of wellbeing monitoring questionnaires. These data are compiled to provide an evaluation of the monitoring of patients' mental health. The questionnaires include:

- GAD7 to determine their level of anxiety
- PHQ9 to determine their level of low feelings (depression)
- Warwick Edinburgh Mental Wellbeing Scale to determine their wellbeing

3 clusters have entered into an SLA with MIND to provide this service. Two clusters have a service running out of every practice within their cluster whilst the 3rd cluster is networking the service due to room constraints within the practices. This means that patients attend a surgery that they are not registered with to access the service, but this has not proved to be an issue. There is regular feedback from MIND on how the service is performing to each of the clusters.

No particular barriers identified. MIND has been very accommodating and has been open to all suggestions made by the practices on how the service could be developed in the primary care setting.

### Final Catchphrase

*"If it wasn't for this service, I wouldn't be alive now! Being able to see someone straight away and talk about what is going on in my life has been amazing".*

*Service user quote*

### Document Library

1. SLA
2. WEMWBS Form
3. Mental Health in Primary Care (England)

# 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 –*
***email**: howels2@caerphilly.gov.uk*

## Problem

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.

## 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

# GP Practice Based Social Workers Pilot - Continued

***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 –*
***email**: howels2@caerphilly.gov.uk*

## 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.

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."*

## Document Library

1. Expression of Interest Senior Practitoner
2. Practice Based Social Workers FAQ
3. GP Pilot Report
4. Partners for Better Care
5. Practice Based Social Workers 1st Quarter Evaluation
6. Practice Based Social Workers 2nd Quarter Evaluation
7. Practice Based Social Workers 3rd Quarter Evaluation
8. Practice Based Social Workers 4th Quarter Evaluation
9. Social Worker Older People JD

## Models

# Lymphoedema Network Wales

***Creation of the On the Ground Education Project (OGEP) and development of the Chronic Oedema "Wet Leg Pathway". Working with community nurses to raise awareness of lymphoedema and chronic oedema promoting timely referral and prompt effective management of lymphorrhoea "leaking wet legs"***

*For further information about the project, email Karen.morgan6@wales.nhs.uk*

*For further information about Lymphoedema Network Wales, please see our website*

## Problem

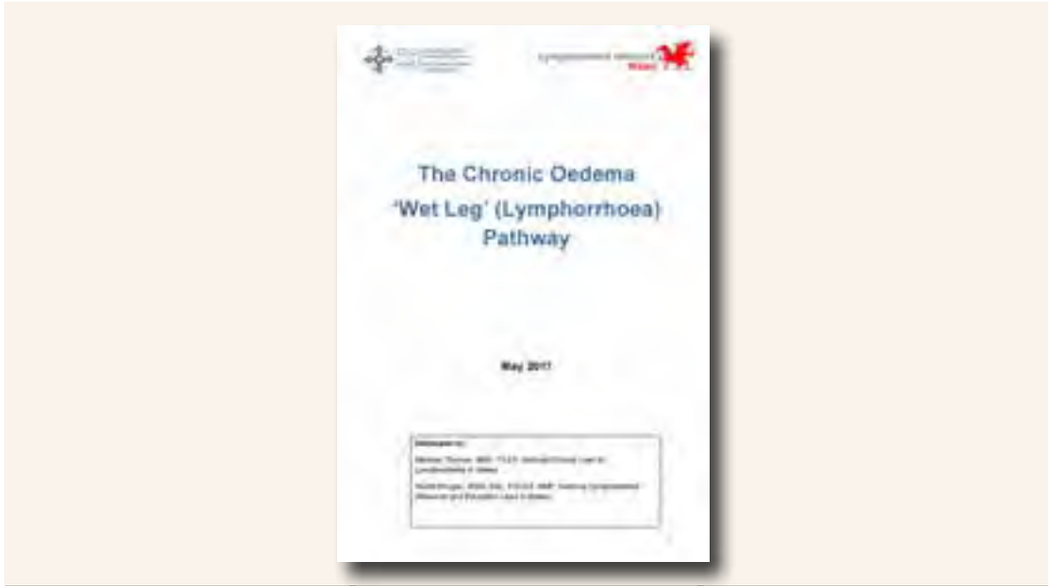
Developed Agored Cymru accredited work-based units to raise community nurses awareness and understanding of the management of chronic oedema. However, nurses were not released for education and training, consequently late referrals and ineffective management continued throughout Wales. Thus, a new education model was needed.

## Vision

All community nurses will be aware of chronic oedema and be able to offer effective and timely management of patients with "wet legs". A dedicated community chronic oedema clinical educator is employed within each Health Board in Wales.

## Solution

Successfully applied for Health Technology Funding (131k) – pilot in Cardiff & Vale UHB (population of 479,000) – OGEP was introduced employing two community lymphoedema specialists for 9 months. Provided the Agored Cymru Training and used a digital media patient story developed with Pocket Medic. Swansea University Health Economics Department ratified the purposive (n=97) data analysis. The results demonstrated a 63% reduction in dressing costs, 89% decrease in episodes of cellulitis and 54% reduced nursing visits, thus time back to care. However, this is difficult to sustain without a dedicated nursing post promoting healthy lower limbs within the community, providing values-based care. The Chronic Oedema "wet leg" pathway was an output from the project and provides evidence based guidelines for nurses to follow.




## Stats & Facts

**Articles published demonstrating the impact and savings from the project:**

Thomas M, Morgan K, Humphreys I et al (2017) Managing chronic oedema and wet legs in the community: a service evaluation. Nursing Standard. 32.

Watts T, Davies R, Chronic oedema 'on-the-ground' education programme. British Journal of Community Nursing November 2017 Vol 22, No 11.

## Lymphoedema Network Wales - Continued

***Creation of the On the Ground Education Project (OGEP) and development of the Chronic Oedema "Wet Leg Pathway". Working with community nurses to raise awareness of lymphoedema and chronic oedema promoting timely referral and prompt effective management of lymphorrhoea "leaking wet legs"***

*For further information about the project, email Karen.morgan6@wales.nhs.uk*

*For further information about Lymphoedema Network Wales, please see our website*

### Lessons Learnt

55% of the community nursing workload is treating mild to complex chronic oedema. Nurses are reluctant to apply compression to patients with chronic oedema without a Doppler reading gaining an ABPI. However, Doppler readings in chronic oedema patients are inconclusive. Consequently the patients remain ineffectively managed. Collaboration with lymphoedema services and prompt efficient management is essential in improving the current care for patients with chronic oedema.

### Final Catchphrase

*"By raising chronic oedema awareness and management strategies with the community nurses will improve patient health and wellbeing as well as saving valuable NHS funds. Roll out of this project must occur across all Health Boards in Wales".*

### Document Library

1. The Chronic Oedema 'Wet Leg' (Lymphorrhoea) Pathway

NHS Electronic Staff Record

Learning@Wales

### Learning Library

1. Education Videos
2. Agored Cymru Unit
3. NHS Wales - Lymphoedema and Chronic Oedema (ESR)
4. NHS Wales - Lymphoedema and Chronic Oedema (Learning@Wales)

Agored Cymru

## Models

# GP Out of Hours Skill Mix

***To provide a sustainable solution for the delivery of primary care out of hours (OOH) services, through an engaged and developed multi-disciplinary workforce.***

### Problem

Following the introduction of the GP Contract in 2004, which transferred the responsibility for providing Out of Hours care to patients to Health Boards, the LHB became responsible for securing GPs to work within the service.

An average of 33 GP shifts was regularly unfilled per week, and the sustainability of the service across Cardiff & Vale was deemed high risk. The ability to deliver a sustainable, clinically safe OOH service for the resident population of Cardiff and Vale, that was primarily reliant on locum GPs continued to increasingly become more challenging.

### Vision

To develop a sustainable multi-disciplinary OOH service model, using robust activity data, to include a range of available professionals who have the right skills, to deliver the right care, in the right place and at the right time.

### Solution

Utilizing the knowledge and evidence following demand and capacity exercises the service was able to categorize patient needs and demands by age, which enabled the identification of alternative professionals and skill sets that are best placed to meet patient needs, underpinned by prudent healthcare principles.

It was deemed that through the development of an MDT, where patients would have access to the most appropriate clinician for their need, this would reduce and relieve workload pressures on GPs working within the service, thus increasing the attractiveness of the model and methods of working in Cardiff and Vale, which would subsequently improve GP shift fill rates, reducing the risks associated with the service.

The MDT consisted of the following roles in its early development;

- GPs
- Clinical Practitioners (Nurse/Paramedic working to achieve Advanced Practice status)

### Stats & Facts

- Increased capacity for face to face appointments through introduction of Clinical Practitioner roles.
- Increased direct booking ability, for Practitioners where appropriate to do so in line with their level of competence.
- Increased numbers and types of clinicians working within the service
- Reduced service risk – improved stability through increased GP cover overnight and Clinical Practitioners.
- Improved morale and working environment

- Pediatric Nurse Practitioners (Bank hours only)
- Clinical Telephone Triage (Nurse/Paramedic)

The current model continues to test new ways of working and plan to introduce Minor Illness Practitioner roles, increase Pediatric skills and capacity for face to face appointments, and will support Clinical Practitioners at Masters level to achieve competencies to work across the Advanced Practice framework enabling them to deal with more complex patients and provide additional support to meet  home visiting demands on the service.

## Models

# GP Out of Hours Skill Mix

***To provide a sustainable solution for the delivery of primary care out of hours (OOH) services, through an engaged and developed multi-disciplinary workforce.***

### Lessons Learnt

- Essential to engage GPs and drip feed new roles into the service, one by one, allowing 'bedding in' time.
- Close collaboration with other professional groups to understand the scope and impact of new roles.
- Important to understand the education and development needs of the different staff groups to reduce variation in practice and to increase workforce flexibility.
- Strong leadership and support needed from the OOH Team and clinical board.
- Team working is essential to success.
- OOH is a niche area, and turnover can be challenging.
- Job descriptions, funding and governance issues for new roles to be agreed and worked through in advance to reduce confusion about responsibilities - A process to agree and sign off competencies is essential.
- Whilst the role of the Clinical Practitioner has been well recived we have had a high turnover of staff as they leave to find work 'in hours' in GP practices – Consider best methods to utilize staff both in and out of hours (placements, shared contracts, etc)

**What we achieved;**
- Multi-disciplinary working
- Reduced pressures on the GP workforce,
- Stronger, stable service model,
- Active signposting to the right clinician who best meets the patients need.
- Improved working environment

**What we can share;**
- JDs, Policies & procedures, PGDs

### Final Catchphrase

*"Team work – Innovation and sustainability is possible, by turning challenging situations into positive solutions."*

## Models

# Care Navigation – Signposting Skills for Primary Care

*Ty Elli Group Practice*
*Jamie.OGrady@wales.nhs.uk*

### Problem

Decimated by GP resignations/retirements/maternity leave over a very short space of time with 60% of GPs leaving over a period of a year; and although aware of the forthcoming changes, and despite careful planning to fill roles in advance, the situation was not conducive to easy recruitment. Unable to secure any applicants for the vacant GP posts, meant that the unpredicted changes steered a move towards a more multidisciplinary team (MDT) model of working.

### Vision

Moving away from the more traditional model of care towards better team working to deliver a seam free, safe, efficient, sustainable quality service for patients.

### Solution

Re-modelling the triage system, by recognising team members' skills and capabilities to maximise capacity within the team.  This paved the way to an MDT management of appointments, as opposed to a GP only basis of appointment control.

To get the system needed meant changing, not only the working pattern, but also the mind-set of the team whereby all staff are required to answer the phone at the peak ½ hour of between 8:30-9am where around 25% of daily callers are accessing the system in that 30 minute period.

In addition, it is also important to have a monitoring system alongside and have it displayed where call handlers (receptionists) work so they can monitor and respond to peaks throughout the day.

As well as establishing the call-handling / triage system, effort was concentrated on core services;  nursing team tasks were streamlined so that they were also involved in the above rather than non-contracted GMS work.

### Stats & Facts

The GP Practice currently has the following team:

- GPs
- Nurses
- HCA
- 2 Advanced Nurse Practitioners
- 1 Triage Nurse/Nurse Practitioner
- 1 Advanced Pharmacist
- 1 Palliative Care Nurse (2 days)
- 1 Physician Associate (2 days)
- 2 Shared Social Prescribers
- 1 Shared OT
- 1 Advanced Physiotherapist (1 day)

A locality 2 day training course is undertaken with a commercial company, a UK wide organisation offering training and development for healthcare professionals. An internal course is also accessed 'From Reception to Active Signposting' via Effective PI Ltd.

# Care Navigation – Signposting Skills for Primary Care

*Ty Elli Group Practice*
*Jamie.OGrady@wales.nhs.uk*

## Lessons Learnt

To be realistic with regard to the number of GP applicants that are out there. There comes a time when a practice must resign itself to the fact that it cannot recruit GPs. This is the driver for the need to change to an alternative model – in this case, towards a more MDT based model.

One of the biggest challenges to implemention of the new way of working was to ensure that the telephone system to support it was robust and modern, and that processes were in place to accommodate the system. It is important to take on board the advice of other GP Practices with regard to this and don't get sold an inadequate system.

This is a work in progress; staff are constantly reminded to keep to their set protocols, although it can be difficult with the pressure put on call handlers by patients' expectations of who they feel they need to see and when they want to see them.

## Final Catchphrase

*"We are relatively happy with where we are at the moment but acknowledge we are not yet near the stage where the system is embedded in practice service delivery... we still have some way to go and it's important to keep the staff communications open to ensure bad habits don't get introduced."*

## Document Library

1. Practice Nurse Service
2. Minimum Data Set
3. Reception Triage Protocol
4. Enhanced Healthcare Team Care Navigation

# Educational Learning Placements in Primary Care

***CLINICAL PRACTICE EDUCATORS ROLE:*** *CREATING EDUCATIONAL LEARNING PLACEMENTS WITHIN PRIMARY CARE – THE PROMOTION OF PRACTICE NURSING AS A FIRST CHOICE CAREER*

*Fiona Wood, Senior Nurse & Lead for the established GPN pathway & the Specialist Nursing/GP pathway*

*Dr Gaynor Thomas (Lead GP for the Hub & Spoke) who first identified and championed the need for the model to be implemented within CTUHB.*

## Problem

Coordinated and facilitated by the Primary Care nursing service, student nurse placements within GP Practices (CTUHB) were first introduced in 2007. Whilst the established pathway continued to be positively evaluated, there remained limited capacity to respond to the large numbers of student nurses requiring meaningful educational learning placements within Primary Care. In addition, ongoing challenges regarding the recruitment and retention of Practice Nurses coupled with an increasingly ageing practice nursing workforce (the average age being 45 years across the 41 GP Practices) and a drop in the number of student nurses selecting Primary Care placements led to the following aims; to strengthen the existing Pre-Registration pathway for educational learning placements in Primary Care and to increase the number of available placements by introducing a new combined Specialist Nursing/GP pathway and a new Hub & Spoke model.

## Vision

This innovative project, to improve and increase training placements in general practice, is the result of collaboration between Cwm Taf University Health Board (CTUHB), the University of South Wales (USW), Pontnewydd Medical Practice (the Hub) and Specialist Nursing services.

**Pictured above:** Chris Poole, Team Leader together with members of the Primary Care nursing service who are also trained mentors.

The combined Specialist Nursing/GP pathway was first introduced in January 2018 and is coordinated by Clinical Practice Educators and mentors Rebecca Gill and Heather Owens.

## Stats & Facts

The long established GPN pathway was first introduced in 2007 via the Primary Care Nursing Service

Pathways accommodate 2nd & 3rd year student nurses for 6 or 12 week placements.

The new Hub & Spoke model (first introduced in January 2018) is based on the work of the Advanced Training Practice Scheme (Health Education Yorkshire and the Humber). The Hub & Spoke consists of one "Hub" Practice Pont Newydd Medical Centre & two "Spoke" practices, Cwm Gwyrdd Medical Centre & Morlais Medical Practice. However, work is ongoing to recruit more GP Practices.

# Educational Learning Placements in Primary Care

## Solution

- Workforce development framework produced and submitted by the Senior Nurse for ratification via the Primary Care & Localities Patient safety & Quality meeting
- Funding secured for the implementation of the Hub & Spoke model
- Educational Audit document (including the type of student to be accommodated, the placement profile and the identification of learning opportunities) completed by the Senior Nurse and the Hub.
- Student nurse handbook, teaching pack and the E- evaluation process completed by the Senior Nurse and the Hub.
- "Spoke" GP Practices recruited by the Hub
- Practice Educator (CTUHB) delivered mentorship training to those Practice Nurses who were not trained mentors
- Specialist nursing services recruited by Senior Nurse
- USW approved and signed off Educational Audit documentation for Specialist Nursing pathway and Hub & Spoke model
- GP Lead and Primary Care Development Manager visited the Advanced Training Practice scheme (Health Education Yorkshire and the Humber)
- Clinical Practice Educators - Primary Care in partnership with Team Leader for the Primary Care Nursing service coordinate placements on behalf of UHB
- Hub to coordinate placements on behalf of Hub & Spoke

## Lessons Learnt

- Effective communication between all key stakeholders has been central to the successful implementation of the project
- Planning effective and meaningful educational learning placements can be labour intensive, therefore the allocation of sufficient resources and time has been critical to the success of the project

## Final Catchphrase

*"Thank you very much for an amazing six week placement, I have really enjoyed. I feel I have learnt so much. I was made to feel welcome from day one. This has definitely been the most enjoyable and beneficial placements that I have been on so far"*

**[2nd Year Student]**

## Document Library

1. Clinical Practice Educator Role (Poster)
2. Development Framework for Bachelor of Nursing Placements within Primary Care
3. Educational Audit of Practice Learning Environment: Development Framework for Bachelor of Nursing Placements within Primary Care (Please see Appendix 2, Page 15–26)
4. Student E-Evaluation Form (for completion following a placement within General Practice)
5. Practice Nursing as a First Career Choice (Poster)
6. Student Nurse Handbook: Development Framework for Bachelor of Nursing Placements within Primary Care (Please see Appendix 3, Page 27–31)
7. Student Nurse Information Pack
8. Clinical Practice Educator Job Description
9. Pre-Registration Educational Learning Placements -Evaluation Report

## Contact

For more information or queries, please contact Workforce, Education and Development Services (WEDS):

**Address:**

4-5 Charnwood Court, Heol Billingsley, Parc Nantgarw, Cardiff, CF15 7QZ

Feedback
& Queries

GIG CYMRU NHS WALES

Partneriaeth
Cydwasanaethau
Gwasanaethau Gweithlu, Addysg a Datblygu
Shared Services
Partnership
Workforce, Education and Development Services