Resource Pack 2 - Components of Transformational Model for Primary and Community Care

A transformational programme of change to primary care and community services is underway to safeguard the health and wellbeing of the people of Wales, building on the excellent services currently provided by professionals across the country. The new model takes a whole system approach to redesign, driven by national quality standards but with flexibility to respond to local community needs (see diagram Appendix 1).

1. Principles of Primary and Community Care Transformational Model

The citizen is central to the new model, with inclusion of all ages and demographics. Access will ensure the right care is available at the right time from the right source, at or close to home. The model is founded on:

- Service developments based on population need, with planning and transformation led through local primary care Clusters
- Promotion of healthy living and the demedicalisation of wellbeing
- A population focus as the basis for service planning and delivery across local communities
- A more preventative, pro-active and co-ordinated primary care system which includes general practice and community service provision through community resource teams (CRTs) or frailty services
- A whole system approach through the integration of health, local authority and voluntary sector services, facilitated by collaboration and consultation
- Holistic care for citizens that incorporates physical, mental, and emotional wellbeing, linked to healthy life style choices
- Integrated, streamlined care on 24/7 basis, focusing on the sickest patients during out of hours
- Greater community resilience through empowered citizens and access to a range of community assets
- Advice and support available to help people remain healthy, with easy access to local services for care when people need it
- Strong multi-professional leadership across sectors and agencies to drive quality improvement
- Technological solutions to improve access to information, advice & care and support self-care

2. Informed Public

A shared understanding of the case for change, setting out what good looks like and explaining the benefits, is critical to success. Cultural change requires information, education, motivation and inspiration of the public to empower people to take ownership of their health. Communication strategies require a strong primary and community care focus to inform both public and professionals of the new models and service developments. Cultural differences between geographical areas may require different approaches to change behaviour. Involving children and young people in understanding the importance of self-responsibility is a key enabler for future change. Healthcare professionals use brief interventions and approaches including making every contact count (MECC) to make an impact on lifestyle behaviours and choices

3. Empowered Citizens

Including people in the design of their local services, using feedback on user experiences and giving people active roles in the change process, all promote public empowerment. Local champions can share the value of primary and community care innovations through their own

positive experiences. Motivational interviewing and coaching techniques have been found to be effective in supporting behaviour change. Patients and service users are encouraged to make informed choices together with their health and social care professionals.

4. Support for Self Care

People are assisted to take responsibility for their health by building their knowledge, skills and confidence. Self-care and taking responsibility is key to transformational change, with active involvement of people and carers in decisions about their care, and a range of local resources available to promote self-care and self-referral. Smart technology assists with monitoring, self-care and communications.

5. Community Services

The model incorporates the ability for healthcare professionals in general practice to refer to a greater range of community services and pathways, with up-to-date information and advice on health and wellbeing. The model also includes non-clinical care and support in addition to clinical services. An increasing range of options for help and advice includes conversations with local health teams by phone, email or video call. Systems are designed to support decision-making and ensure there is access to the best professional or service when necessary. Community resources may be accessed through self-referral or by telephone triage acting as a social prescribing mechanism, with the use of Link Workers, Social Prescribers and technology to support signposting. It is essential that these local services are easily accessible, sustainable and meet the needs of the community.

6. Cluster Working

Employment of staff to work across Clusters increases efficiency and ensures the local population has good access to clinical, social and managerial expertise. Cluster teams recruit professionals including pharmacists, physiotherapists, social workers, paramedics, physicians' associates, occupational therapists, mental health counsellors, dieticians, third sector workers and other local authority staff to increase capacity for managing the everyday needs of the local population.

PCOne Primary Care Roles

General practice stability lies at the heart of the new model and is essential to ensure that local health services are sustainable and can respond to future demands. Local support from health boards helps to stabilise vulnerable GP practices and effective local workforce planning will ensure sustainability in the longer term.

Cluster teams are breaking down artificial barriers within local health and social care systems to promote integrated care around the needs of the local population. Integrated working and cultural change are facilitated by joint contracts, shared learning sessions, co-location of staff and opportunities for professionals to rotate between different sectors. The emergence of various models that promote collaborative Cluster working, such as Federations, Social Enterprises and the Primary Care Hub, are aligned to this integrated multi-professional approach.

6. Clinical Triage / Telephone First Systems in General Practice

Safe and effective call-handling and clinical triage systems at the front door of primary care are designed to direct people to the most appropriate professional / service, moving away from the current system in which the GP filters the majority of patient contacts. Telephone advice is appropriate for a significant proportion of people's requests and, if given by a suitably experienced professional, can safely and effectively reduce the number of face-to-face consultations. This telephone first model, incorporating call handling (or care navigation) and clinical triage, has the potential to direct or signpost people beyond the multi- professionals around the GP.

The telephone first / triage model is also about ensuring access to the right care from the right service in a timely way, directing people to:

- Clinical professionals integrated within the local multi-professional Cluster team, including optometric and dental professionals to manage eye, tooth and oral health problems; community Pharmacists to manage common ailments and medication-related problems and physiotherapists to manage musculoskeletal problems
- Non-clinical community services when appropriate, with referrals assisted by link workers or social prescribers who are integrated within the local multi professional team

7. 111 and Out-of-Hours Care

The redesigned 111 Service ensures appropriate management of people with urgent needs in the out-of-hours period, with good communication systems to ensure that professional teams have access to contemporaneous clinical records. This is essential for seamless care across in- and out-of-hours, especially for patients with complex conditions and / or at the end of life.

111, supported by a national virtual directory of services, also acts as a social prescribing mechanism to signpost people 24/7 to local services and sources of help.

8. Direct access

People can directly access a range of local health services that include: community pharmacists for advice and treatment for a range of common ailments; optometrists for advice and treatment of routine and urgent eye problems; dentists for toothache and oral health; physiotherapists for Musculo-skeletal problems; audiologists for hearing problems. Some of these services may not be available yet everywhere but they are developing and transforming over time.

9. People with Complex Care Needs

As a result of effective triage and enhanced multidisciplinary Cluster working, GPs and Advanced Practitioners have more time to proactively care for people with more complex needs at home or in the community - often the elderly with multiple co-morbidities. Significantly longer consultation times are required to assess, plan and coordinate anticipatory care.

People who present with both health and social care needs can be supported by seamless care from community resource teams, frailty or other integrated local health and care teams. Complex issues arising from welfare, housing and employment problems can be better managed through a whole system, multi-professional approach. The Cluster team is also well placed to support care of the acutely ill within Virtual Wards and Community Hubs, working alongside specialist colleagues to care for those who would otherwise be admitted to hospital and risk losing their independence. Such community teams can also facilitate prompt discharge from hospital.

This holistic multidisciplinary model therefore offers a more proactive and preventative approach to care, with people managed earlier in their care pathways when they respond better to education and support for self-care. The result is better outcomes and experiences for people and carers.

The model has the potential for a wider range of planned care to be undertaken in the community, including outpatient appointments and treatments, and diagnostic tests. It could also reduce referrals to secondary care and unscheduled care admissions, allowing hospital staff to focus resources on the very sick and on planned specialist care.

10. Infrastructure to support Transformation

The Primary Care Transformational Model must be underpinned by an infrastructure that is fit for purpose and designed to facilitate enhanced MDT working. Local health facilities, informatics and telephony systems need to be flexible and responsive to future changes, supporting multi-professional working and telephone first/triage components. Digital options to seek and receive

care need to become commonplace. Direct access to diagnostic services in the community by Cluster clinicians is essential to the delivery of quality care closer to home.

11. Anticipated Outcomes National and international research, taken alongside the evidence emerging from the Pacesetter Programme, indicates the potential benefits of the transformational model for primary and community care:

- Improved citizens' health and wellbeing
- Greater community resilience
- Better practitioner morale, motivation and wellbeing
- Increased recruitment and retention of primary care and community staff
- Sustainable models of care

Useful References

NHS Wales Planning Framework 2018/21

Prosperity for All