Components and Characteristics of Transformational Model for Primary Care v3			
Component	**Characteristics**		
	Level 1	**Level 2**	**Level 3**
Informed Public	Case for change agreed by whole cluster team Key messages for local communication agreed, aligned to national priorities Cluster stakeholder groups identified	Cluster Communication and Engagement Strategy agreed and publicised, including vision, purpose and functions of cluster Systems and channels for public engagement/communication established, reflecting preferences of stakeholders Communication and engagement with public & service users underway	Clear understanding by public of: • Case for change • New systems of care • How to access local information, advice, support and care Cluster Communication and Engagement Strategy in active use, with wide range of communication methods and resources Clear understanding of how to access health information & advice, including self care information and use of on line symptom checkers through 111
Empowered Citizens	Options for engaging and involving service users in information / service design have been researched and agreed by cluster team Widespread support for use of behaviour change techniques by professionals Resources are available to support culture and behaviour change amongst local stakeholders All members of cluster team understand and actively promote *Making Choices Together* and *Every Contact Counts*	Systems for promoting and receiving feedback from service users are established within the cluster Active engagement and involvement of service user representatives in design of cluster services & assets All members of cluster team trained in behaviour change techniques All members of cluster team understand and actively use *Making Every Contact Counts* All members of team trained in shared decision-making and use *Making Choices Together* techniques for a few prioritised conditions	All new & redesigned local services and assets developed through co-production with service user reps Service user feedback actively used in redesign of cluster services Evidence of widespread culture / behaviour change in stakeholders, with ownership of well-being and appropriate use of services Local cluster champions in place to promote and support new initiatives Service users actively encouraged and supported to make informed choices on all care and treatments IT systems in place with designs to support decision-making Activation measures used to monitor service user motivation& empowerment

Support for Well-being, Disease Prevention and Self Care	Options for signposting and care navigation systems have been researched and understood Smart technologies that support self-care and self-monitoring have been scoped and costed	Cluster plans and business cases address gaps in local services that promote well-being and self-care Signposting and navigation systems direct service users to information and support for self-care Technologies that support self-care are included in cluster business plans	Widespread information, advice and support are available to promote ownership of health and wellbeing, esp. amongst young people Wide range of local health & wellbeing resources are available to support self-care, promoted through cluster signposting / navigation Smart technologies in widespread use to support self-monitoring and self-care, especially for long term conditions Pro active use of 111 /NHS Direct symptom checkers
Community Services	Cluster teams and Regional Partnership Boards use Population Needs & Wellbeing Assessments to fully understand community health and wellbeing requirements Cluster plans are integral to IMTPs of Health Boards and Local Authority planning mechanisms Existing cluster services and assets are scoped and analysed Gaps in cluster services and assets that support well-being, disease prevention, care and treatments within local community are actively addressed in next planning round	Cluster plans and business cases address gaps in local community services & assets through: • Prioritisation of cluster projects to address service needs • Service user reps involved in planning / design of all new services • Robust evaluation of initiatives to ensure value for money • Active consideration of factors relating to special needs, equality and health literacy is integral to prioritisation and design of services Methods and technologies enabling service users to access support & advice from healthcare teams researched Cluster services with direct access / self-referral routes are promoted e.g. community pharmacy, optometry, audiology and physiotherapy services	Comprehensive up-to-date Directory of Cluster Services published, including sources of information, advice & support in choice of formats; accessible through national Directory of Service hosted on 111 platform with links to other national directories eg. DEWIS Cymru Range of methods is available to access support, advice and treatment quickly and easily: e.g. phone, email, video-call Systems for signposting are in place to direct people to community resources easily and quickly Wide range of community services established for care and treatment, tailored to needs of the community and redressing health inequalities Systems are in place to empower people with differing levels of health literacy and sensory impairments to access advice, care and treatment

Cluster Working	Joint agreement by integrated cluster team on vision, purpose and functions of their cluster Cluster strategy has been drawn up, shaped by cluster data and intelligence Cluster Lead in post Code of conduct and Terms of Reference is agreed by Cluster Stakeholder Team Cluster workforce plans drawn up, based on assessment of population needs and cluster skills/capacity requirements.	Cluster operational model agreed through use of options appraisal, with legal advice sought as necessary. Cluster governance framework in place, with robust processes for cluster decision-making, risk management and accountability for all partner organisations. Integration and partnership working actively promoted within cluster Cluster recruitment / sustainability plans agreed to ensure stability of Primary Care services Primary Care training placements are established for cluster staff	Cluster model in operation to promote multidisciplinary approach & integrated care Cluster partnership working is promoted through co-location of staff, joint contracts, shared learning, staff rotations, etc. Range of professionals in post to increase capacity and expertise of cluster team, delivering holistic care closer to home Contractual arrangements for cluster staff in place to ensure effective lines of accountability, robust indemnity and pension arrangements All cluster professionals are supported by appropriate training, clinical supervision, mentorship arrangements GP practices and Primary Care services are stable and sustainable, employing a workforce trained in cluster environment
Call-handling, Signposting, Clinical Triage / Telephone First Systems	Clear understanding of cluster call-handling, signposting, clinical triage / Telephone First systems & processes by cluster team: • Purpose of each system • Benefits to service users & staff • Potential problems and challenges • Systems and processes required • Cost and infrastructure implications • Training and supervision requirements Service users involved in designing feedback systems to evaluate call-handling, signposting and triage systems	Use of service user feedback to design signposting, call-handling, triage systems Agreement by cluster team on operational models for call-handling, signposting, clinical triage systems IT systems installed to support safe and effective call-handling / triage processes Guidance and protocols in place for all cluster call-handling and triage systems Training and refresher courses attended by all staff involved in cluster call-handling & triage systems / processes Regular risk assessment & audits for all cluster call-handling and triage systems	Safe and effective cluster call-handling & triage systems in place to assist service users in accessing right information, advice & care from clinical and non-clinical services Non-clinical referrals are assisted by link workers, social prescribers, care navigation, etc and citizens are signposted using the national Directory of Service Robust protocols, guidance and support are in place for all cluster call-handling, signposting and triage systems Service user feedback, monitoring, significant event analysis & audits inform redesign of systems Regular refresher courses attended by staff delivering call-handling/triage services

111 and Out-of-Hours Care *Given that 111 is not fully rolled out across Wales, should 111 be separated from OOH – especially as 111 is a 24/7 service whereas OOH isn't?*	Systematic patient feedback systems embedded in 111/GPOOH services Flexible boundaries to allow patients to be assessed in service closest to home (not where they are registered) Equitable access to emergency/urgent dental conditions in line with national specification Flexible workforce solutions that allow professionals to work remotely Consistent policies on management of home visits	OOH advice & care delivered by multi-professional team including core disciplines available to all services – eg. pharmacists, nurses, doctors, paramedics Standardised pathways for common issues – eg. management of blocked catheters, end of life care	Excellent communication systems across in- and out- of-hours interface with handover of care through effective sharing of 'Special Patient Notes' and Anticipatory Care Plans OOH and 111 Staff have access to relevant, up-to-date records through Welsh GP Record People effectively signposted to appropriate advice & care by use of MDT in OOH period, with potential for scheduling into alternative pathways (eg. community services) by 111/GPOOH service without hand-off back to own GP Specialist skills available during OOH period through regional working (eg. Mental Health Specialists) Use of digital technology to improve patient experience and efficient service delivery Integrated pathways between 111/GPOOH and 999 service
People with Complex Care Needs	People with more complex needs are identified by use of benchmarking, disease registers, risk stratification tools, admissions data, etc Analysis of cluster professional capacity and skills to deliver complex care undertaken, e.g. GPwSIs, ACPs, Community Resource Team, Frailty Team, Integrated Health & Care team, specialist teams Increased emphasis on disease prevention for long term conditions in cluster community, using LPHT support / expertise, PNAs and PWBAs	Multi-professional teams increase cluster capacity and tailor consultation times to the needs of more complex patients Cluster Outreach Services deliver specialist care through an MDT approach, closer to home Community diagnostic services support complex care closer to home	CRTs, Frailty and Integrated Health & Care teams support complex care through MDT approach within primary care / community settings Virtual Wards and Community Hubs are used to care for acutely ill people, with hospital specialists working alongside cluster teams Increased range of planned care delivered within the community, with local access to specialist expertise and diagnostics

Infrastructure to support Transformation	Good understanding by cluster team of infrastructure requirements for effective cluster working: estates & facilities, IT systems, community diagnostic services, etc. Support and expertise is readily available to promote and support cluster working, e.g. • PNAs and cluster planning • Business case development • Data analysis, IT systems, new technologies	Cluster infrastructure scoped to identify development needs, with prioritisation Appropriate channels, mechanisms and support are used to escalate significant deficiencies in cluster infrastructure, with clarity on risks to safe, effective cluster working Where appropriate, business cases address deficiencies in infrastructure and facilities, e.g. community diagnostic services, smart technologies.	Local estates and facilities are fit for purpose, sustainable and support multi-professional team working and training Informatics and telephony systems in place with designs that support and promote multi-professional working Digital options that enable service users to access care quickly and easily are commonplace Direct access to range of diagnostic services is available to cluster teams