

# **Multi-Professional Roles within the Transforming Primary Care Model in Wales**

## **Executive Summary**

August 2018

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## Foreword

The development of this publication has provided an invaluable opportunity to hear from the wider multidisciplinary team in primary care in relation to how they are currently working and how they can contribute to transforming the future National Health Service (NHS) in relation to primary and community care in Wales.

The multidisciplinary responses have provided rich evidence, commentary and narrative that will be useful in shaping how services develop following the publication of the Welsh Government's 'A Healthier Wales: our Plan for Health and Social Care'. I would like to thank everyone who has contributed to this important work.

**Dr Liam Taylor**

**Chair of the Primary and Community Care Reference Group**

## Executive Summary

The request for an evaluation of multi-professional roles within the Transforming Primary Care Model was made by the 'Transforming Primary Care Group' (TPCG) and led by the 'Primary and Community Care Reference Group' (PCCRG). The outcomes will be useful to the TPCG, the PCCRG, the National Primary Care Board (NPCB) and the Ministerial Task Force on Primary Care in understanding professional requirements for primary care transformation.

This report provides an analysis of a questionnaire designed to engage all professional / practitioner groups that provide input to the wider multi-disciplinary teams in the 'Transforming Primary Care Model'. The key aim of the work is to capture the potential of the wider multidisciplinary team to transform care, treatment and access to services within primary and community care, thereby improving the experiences and outcomes for service users, their carers and the public.

The survey is also an opportunity to ensure a greater familiarity amongst the professional groups working in primary care and the community with the emerging vision for health and social care in Wales and, in particular, the 'Transforming Model for Primary and Community Care' that includes the drive towards extended multi-professional teams.

A questionnaire was distributed through the PCCRG to over 25 professional groups. Responses were received from medical and dental, nursing and health visiting, pharmacy, therapies and healthcare scientists, social care and other practitioner roles delivering services in primary and community care (Appendix 1). The questionnaire can be found in Appendix 2. Responses have been collated and summarised within this report, with each section of the report addressing a different question around:

- Transforming services in relation to the primary care model
- Improving access to primary and community care and measures for access
- Roles already operating in primary and community care
- Barriers and challenges to change
- Employment considerations
- Professional requirements

At the end of each section, a summary of key messages highlights the main points raised by contributors, with a set of recommendations to provide a steer on actions required to address the issues highlighted by the questionnaire.

Further analysis has enabled these recommendations to be grouped into themes to facilitate future planning and development.

Relevant references and publications included by professional groups and practitioners in their responses can be found in Appendix 3. The views of contributors have been provided

through citations in Appendix 4 and there is an opportunity to examine full individual professional /practitioner group survey responses via the Primary Care One website.

## Recommendations by Theme

Key themes for recommended actions have emerged from the contributors' responses and these recommendations have been collated below for ease of reference and planning purposes. It should be noted that some recommendations cut across several themes.

The key (listed below) for the multidisciplinary team (MDT) themes identified follows the recommendations summarised below.

### Key for MDT Themes

**Evidence (E)** = Evidence for improving access and quality of care

**Finance (F)** = Investment in MDT roles, new ways of working, resource shift

**Planning (P)** = Workforce planning, embedding in Integrated Medium Term Plans (IMTPs) / planning processes

**Infrastructure (I)** = Estates, facilities, information, management and technology (IMT) systems, digital solutions

**HR (HR)** = Employment issues, contractual and governance arrangements

**Training (T)** = Education and training, supervision and mentoring, career structure

**Communications (C)** = Communication and engagement, organisational development (OD), cultural change

**Measures (M)** = Measures, datasets and evaluation

### 1. Evidence for improving access and quality of care

- Effective technologies and methodologies used by primary care professionals / practitioners to improve access to advice, support and care should be collated and analysed, alongside the relevant international evidence. The outcomes will enable resources to be targeted at the most effective access solutions. **(E/F)**
- The evidence provided by MDT professional groups on their ability to improve access should inform future investment in new roles and ways of working in primary and community care settings. Investment should reflect the potential contribution made, now and in the future, by all professional roles. **(E)**
- A review of the range of successful methodologies used by MDT professions to facilitate access to local advice, support and care would inform future investment into equipment, facilities and IT systems. **(E/F/I)**
- Evidence from MDT professional groups, alongside international evidence, will indicate which cluster roles and services have the greatest potential to improve access, demonstrate effectiveness and reduce demand on the health and care system, thereby informing future investment into cluster teams. **(E/F)**

### 2. Investment in MDT roles, new ways of working, resource shift

- Executive teams of health and care organisations should be advocating the potential impact of the Cluster MDT, and investing in these roles to improve access to primary and community care services, offering greater flexibility and responsiveness to population needs. **(F)**

- Decisions on the future allocation of budgets, including transformation funds, should include consideration of the potential impact of the key MDT services ‘delivered at scale’ on successful transformation. Needs assessment and skills required will inform where investment should be made. **(F)**
- Fundamental changes to the financing model are required to ensure allocative savings can move around the system to support the transformation agenda. This whole system approach to financial redesign is imperative to facilitate and drive transformation. **(F)**

### **3. Workforce planning, embedding in IMTPs and planning processes**

- Investment in MDT professional capacity should be focused on roles that relieve current workload pressures and thereby improve access to clinical and non-clinical services. It will be essential to see a real reduction in demand on the health and care system from primary care transformation. **(P)**
- Service reviews into the current range of cluster MDT professional roles and community based MDT services should be undertaken by all Health Boards, providing a baseline for the future transformation programme and the opportunity to share learning / service provision. **(P)**
- Health and care organisations, through Regional Partnership Boards and Public Service Boards, should reach agreement on joint strategies that promote community partnership working and inform / involve the public in the future design of services. **(P)**

### **4. Infrastructure: Estates, facilities, IMT systems, digital solutions**

- A national review of current cluster facilities, diagnostic services and IT systems should be undertaken and analysed against a set of agreed standards to promote effective MDT working. **(I)**
- An integrated IT system is required across health and care organisations for reliable, real time data that can be shared seamlessly to inform evaluations, service redesign and prevent duplication of work. **(I)**
- A review of the range of successful methodologies used by MDT professions to facilitate access to local advice, support and care would inform future investment into equipment, facilities and IT systems. **(E/F/I)**

### **5. HR / Employment issues, contractual and governance arrangements**

- Sound governance arrangements must underpin all MDT services and pathways and be operational from the outset. **(HR)**
- Health Boards should consider the professional benefits of a model of Health Board employment for roles in primary and community care. The preferred model of MDT respondents is to be employed by Health Boards to work within community teams or clusters. This addresses: sustainability and a ‘Once for Wales’ approach; employment rights/pension/pay and progression; indemnity issues; risk and governance management; standardisation of training. **(HR)**

- It is critical that Health Boards establish sound systems and processes that provide assurance around recruitment procedures and timeframes to avoid delays in employing cluster staff. **(HR)**
- Health Boards will need to address human resource issues such as development of job descriptions and the range of terms and conditions considerations for integrated MDT roles that cut across primary, community care and secondary care services. **(HR)**
- Job descriptions for new and extended/enhanced professional roles should be standardised, including development of flexible working models. There is an opportunity here for competency based role profiles and a 'Once for Wales' approach. **(HR)**
- Information and advice on the scope of practice, potential contractual options and career pathways for MDT members working in Primary and Community Care should be easily accessible. **(HR/T)**
- The necessity to develop supervision and mentorship should be recognised and addressed. Study leave and CDP requirements should be included in all MDT professional contracts. **(HR/T)**

## **6. Education & training, supervision & mentoring, career structure**

- There should be a needs based assessment to identify the cluster skills and competencies required to meet population needs. This evidence will inform training curricula and commissioning numbers for MDT roles. **(T)**
- HEIs and HEIW should ensure pre-registration training programmes for MDT roles are 'fit for purpose' and address future cluster workforce needs within the transformational model. **(T)**
- High quality mentoring and supervision for all MDT professionals are key to the development of the MDT and need to be developed further as the transformational model progresses. It is important to recognise that these responsibilities add to the workload pressure of those providing supervision and mentoring for extended MDT roles. **(T)**
- The additional skills and training needed for effective working within the primary and community care cluster MDT should be identified for inclusion within undergraduate and postgraduate training programmes. **(T)**
- The importance of suitable training and working environments for cluster team members must be recognised, with practice-based learning opportunities available to give the necessary clinical experience in primary and community settings at undergraduate and post-graduate level. **(T)**
- A focus on developing career pathways, with standardised education and training within primary and community settings, is required. **(T)**
- Clear and consistent career progression frameworks should be established for the full range of MDT professional groups, improving motivation and retention of the cluster workforce through a greater range of career opportunities for all disciplines in primary and community care.
- Job plans must include appropriate time allocations for CPD and other professional development requirements. Study leave and CDP requirements should be included in all MDT professional contracts. **(HR/T)**



- Information and advice on the scope of practice, potential contractual options and career pathways for MDT members working in Primary and Community Care should be easily accessible. **(HR/T)**

## 7. Communication and engagement, OD, cultural change

- A fundamental change in how the public perceive and access primary and community services is essential. The public needs to understand that the MDT can provide accessible, high quality care. **(C)**
- Communication and engagement strategies within health and care organisations should raise awareness, understanding and appreciation of the benefits and status of different professional / practitioner roles working within primary and community care, and their ability to drive the transformation agenda across Wales. These strategies need to be targeted and tailored to target audiences (professions and the public). **(C)**
- The range of behavioural change techniques used by primary care professionals / practitioners to promote prevention, early intervention and citizen empowerment should be collated and analysed alongside relevant international evidence. The outcomes should then inform investment in evidence-based training programmes into behaviour change across Wales. **(C)**
- Involvement of the public and all professionals in the transformation agenda will require strong leadership and proficient use of behaviour change techniques across health and care organisations. **(C)**

## 8. Measures, datasets and evaluation

- Regular audits of MDT services are required to evaluate effectiveness. **(M)**
- Measures for access to MDT services should be taken forward and include:
  - **Access:** Waiting times, number of assessments and treatments
  - **Patient experience:** Patient stories, case studies, PREMs and PROMs
  - **Workload:** Number of referrals, assessments, administrative tasks, diagnostic tests and treatments by MDT professionals
  - **Impact on other services:** Data on GP demand, outpatient services and admissions. **(M)**
- Robust evaluation processes must be in place to underpin primary care and community transformation processes. There will need to be 'whole system' analysis to inform debate about allocative savings and the financial investment model. **(M)**

# Multi-professional Roles within the Transforming Primary Care Model in Wales

## 1. Introduction

The request for an evaluation of multi-professional roles within the Transforming Primary Care Model was made by the 'Transforming Primary Care Group' (TPCG) and led by the 'Primary and Community Care Reference Group' (PCCRG). The outcomes will be useful to the TPCG, the PCCRG, the National Primary Care Board (NPCB) and the Ministerial Task Force on Primary Care in understanding MDT professional requirements for primary care transformation.

## 2. Background

A transformational programme of change across 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 framework takes a whole system approach to redesign, driven by national quality standards but with the flexibility to respond to local community needs. The model has a set of principles and includes a range of considerations such as ensuring an informed public, empowered citizens, support for self-care, a range of community services, cluster working, greater use of multidisciplinary team members, clinical triage, out of hours care and complex care in the community.

As part of cluster working, a range of new models has been piloted that make use of the wider multidisciplinary team members. Pacesetter pilots and other innovations in primary and community care are showing how multidisciplinary developments can transform service provision and improve the experience for service users and their families. Developments utilising a multidisciplinary approach will help to deliver stable primary care as part of the holistic emerging vision for the NHS in Wales.

## 4. Aim

The key aim of this piece of work was to capture the potential of the wider multidisciplinary team to transform care, treatment and access to services within primary and community care, and thereby inform the transformational programme of change across primary care and the community.

It was agreed that that national engagement of the wider Multi-Disciplinary Team (MDT) professions and practitioners involved in primary and community care, including both health and social care professional groups, would be assessed via a questionnaire. The survey provided a chance to demonstrate the impact that can be made through the extended team and to highlight some of the challenges and barriers faced by members of the extended team in contributing to the transformation agenda.

A questionnaire was designed to engage with all professional groups that provide input to the wider multidisciplinary team, working within general practice or within the wide range of community-based teams across health and social care. The survey was therefore also an opportunity to ensure a greater familiarity with the emerging vision for health and social care in Wales and in particular, the 'Transforming Primary Care Model'.

## **5. Methodology**

A questionnaire was designed in early 2018 to engage with all professions / practitioner roles providing input to the wider multi-disciplinary teams in the 'Transforming Primary Care Model'. The questionnaire enquired into: where roles are currently operating, their employment issues and professional requirements. The professions / practitioner groups also had the opportunity to highlight barriers and challenges in progressing their roles in primary and community care in Wales. The responses have the potential to inform future investment in multi-disciplinary working by creating a critical narrative and providing a bibliography of evidence (national and international) for the impact of their roles.

To facilitate the process of analysis, a request was made for a single collated response to the questionnaire per practitioner/professional group. A lead professional was identified for each group with responsibility for submitting a final collated summary for their particular profession or role.

The questionnaire (Appendix 2) was distributed via the Primary and Community Care Reference Group to all relevant professions and practitioner roles. The responses were collated in an anonymised format so individuals are not identifiable in the final report.

## **6. Results and Reports**

Over forty responses covering more than twenty-five different professions / practitioner roles were received, all of which have been included in the analysis (see Appendix 1).

References and relevant publications provided by respondent professional groups are included in Appendix 3.

The detailed responses from professions and practitioner roles have been collated (see Appendix 4) and structured around the following six sections:

- Section 1 - Transforming services in relation to the primary care model
- Section 2 - Improving access to primary and community care
- Section 3 - Roles currently operating in primary and community care
- Section 4 - Barriers and challenges to change
- Section 5 - Employment considerations
- Section 6 - Professional requirements

Responses from individual professional groups and practitioner roles in entirety are also available via the [Primary Care One](#) website.

For the purpose of this report, the term 'professional' has been replaced, where appropriate, with 'professional / practitioner role' to acknowledge the different roles in primary and community care.

## **7. Key Messages and Recommendations**

### **Section 1 - Transforming Services in Relation to the Primary Care Model.**

#### **Key Messages:**

1. There is great potential for different professional and practitioner groups, working within clusters, to drive the transformation agenda across Wales.
2. Investment in the cluster MDT approach by health and care organisations would ensure much greater flexibility and responsiveness by service providers to population needs.
3. Multi-Disciplinary Team (MDT) professionals use a range of behavioural change techniques to promote prevention, support early intervention and facilitate citizen empowerment.
4. Increasing use of new technologies and methodologies by primary care professionals is helping to improve access to medical and non-medical services, advice and support.
5. It is essential to have health facilities, diagnostic services and IT systems that are fit for purpose and the fit for the future in order to facilitate multiagency / multidisciplinary working.
6. The MDT has significant potential to improve access and quality of care delivered to service users in Primary and Community Care.

#### **Recommendations:**

1. Communication and engagement strategies within health and care organisations must focus on raising awareness, understanding and appreciation of the range of primary care professional / practitioner groups with ability to drive the transformation agenda across Wales.
2. Executive teams of health and care organisations should be advocating the potential impact of the Cluster MDT, and investing in these roles to improve access to primary and community care services, offering greater flexibility and responsiveness to population needs.
3. The range of behavioural change techniques used by primary care professionals / practitioners to promote prevention, early intervention and citizen empowerment should be collated and analysed alongside relevant international evidence. The

outcomes should then inform investment in evidence-based training programmes into behaviour change across Wales.

4. Effective technologies and methodologies used by primary care professionals / practitioners to improve access to advice, support and care should be collated and analysed, alongside the relevant international evidence. The outcomes will enable resources to be targeted at the most effective access solutions.
5. A national review of current cluster facilities, diagnostic services and IT systems should be undertaken and analysed against a set of agreed standards to promote effective MDT working.

## **Section 2 - Improving access to primary and community care and measures to demonstrate improved access**

### **Key messages:**

1. There are opportunities for MDT professionals / practitioners to improve access to care and treatment through seven-day community services, with the potential for extended hours opening, using new technologies and methodologies.
2. The increased scope and diversity of professional / practitioner roles within the MDT is well placed to meet the complex health and care needs of clients, delivering services within a wide range of community settings.
3. Many MDT professionals / practitioners have particular expertise in prevention, early intervention and self-management. They are adept at addressing many of the issues that underlie frequent primary care contacts.
4. The multi professional team has the skills and knowledge to signpost clients to a range of statutory and third sector organisations, reducing demand on traditional medical services.
5. Sound governance arrangements are essential to ensure the safe delivery of all new MDT services and pathways.
6. There is great variation in the range of MDT roles and services across Wales at present. There is significant inequity in MDT service models and access models.

### **Recommendations:**

1. The evidence provided by MDT professional groups on their ability to improve access should inform future investment in new roles and ways of working in primary and community care settings. This should reflect the contribution that all roles can make.
2. There should be a needs based assessment to identify the skills and competencies required to meet population needs. This evidence will inform training curricula and commissioning numbers for MDT roles.
3. Investment in MDT professional capacity may need to be focused on roles that relieve current workload pressures and thereby improve access to clinical and non-clinical services. It will be essential to see a real reduction in demand on the health and care system from primary care transformation.
4. A review of the range of successful methodologies used by MDT professions to facilitate access to local advice, support and care would inform future investment into equipment, facilities and IT systems.
5. Sound governance arrangements must underpin all MDT services and pathways and be operational from the outset.

### **Measures that could be (or are being) used to demonstrate improved access to roles**

#### **Key Messages:**

1. Consistent, reliable, integrated IT systems across Wales are required to collect real time, relevant electronic data.

2. Some professionals / practitioner roles use the following information as a basis for service evaluation:
  - How much did we do?
  - How well did we do it?
  - Will anyone be better off?
3. The use of patient related outcome and experience measures (PROMS and PREMS), case studies, satisfaction surveys and patient stories are all methodologies that can be used to evidence impact on access and quality of care.
4. Regular audits provide a methodology for measuring against standards.
5. Therapy Outcome Measures (TOMS) provide data on the impact services have on individuals in relation to:
  - Impairment
  - Activity
  - Participation
  - Well-being.
6. Data on GP demand, outpatient services and hospital admissions can all assist in assessing the impact of the MDT.

#### **Recommendations:**

1. An integrated IT system is required across health and care organisations for reliable, real time data that can be shared seamlessly to inform evaluations, service redesign and prevent duplication of work.
2. Regular audits of MDT services are required to evaluate effectiveness.
3. Measures for access to MDT services should be taken forward and include:
  - **Access:** Waiting times, number of assessments and treatments
  - **Patient experience:** Patient stories, case studies, PREMs and PROMs
  - **Workload:** Number of referrals, assessments, administrative tasks, diagnostic tests and treatments by MDT professionals
  - **Impact on other services:** Data on GP demand, outpatient services and admissions.

### **Section 3 - Where roles are currently operating in primary and community care in Wales**

#### **Key Messages**

1. Many professionals / practitioner roles operate in both primary and community care settings across Wales, working in partnership with community or voluntary sector services. Some services are already co-located within GP practices or clusters.
2. MDT professional groups may be located within Health Board premises, GP practices or in shared premises with local authorities.
3. Primary care professionals / practitioner roles are working within a range of community services including community resource teams (CRTs), long-term condition management teams and acute clinical teams, providing a rapid response service within the community and at the community/hospital interface.

4. Some MDT professionals / practitioner roles are integrated into consultant-led specialist services, with community based specialists working within a primary / community MDT.
5. Many MDT services provide domiciliary visits to patient's homes, including residential and nursing homes.
6. There are examples of triage and telephone assessment services being scaled-up to facilitate direct access to MDT services. Single points of access help to streamline assessment and treatment.



## Recommendations

1. Service reviews into the current range of cluster MDT professional roles and community based MDT services should be undertaken by all Health Boards, providing a baseline for the future transformation programme and the opportunity to share learning / service provision.
2. Evidence from MDT professional groups, alongside international evidence, will indicate which cluster roles and services have the greatest potential to improve access, demonstrate effectiveness and a reduced demand on the health and care system informing future investment into cluster teams.
3. Robust evaluation processes must be in place to underpin primary care and community transformation processes. This will need to be 'whole system' analysis in order to inform debate about allocative savings and the financial investment model.

## Section 4 - The Barriers and Challenges to Change

### Key Messages:

1. There is lack of awareness within primary care of the range of MDT practitioner roles and their benefits. Smaller professional groups in particular feel their size poses challenges for recognition of their potential contribution. There is a perceived lack of respect and status for wider MDT professional / practitioner groups within primary care.
2. There is a need for strategic commitment to resolve funding issues in relation to resources following work moving from secondary to primary care, funding across sectors and the sustainability of primary and community services.
3. There is a lack of a recognised career pathway for MDT professionals / practitioners working in primary care that can be a disincentive to recruitment and retention. Standardisation is required for MDT training, with more opportunities to gain experience and for joint training in primary and community settings. 'On the job' support, mentoring etc., and sufficient primary care staff to provide this, are critical.
4. It is essential for the public to be engaged and involved if there is to be general acceptance of an alternative care model to seeing the GP. There is a need for strong leadership to facilitate behaviour change amongst the public and professionals.
5. Current workload pressures on primary care means that there is little time and space to 'step out' and plan for a future model, despite recognition of the need for transformational change. Specific requirements cited for the new model include planning for population needs; professional support and networking; skilled and flexible workforce.
6. There should be a focus on the self-care agenda in order to ensure the MDT profession /practitioner roles can truly transform services and have capacity to deliver for patients.
7. Maximizing the benefits of IT systems is seen as vital, working across organisational boundaries to facilitate communication, share information and support evaluation.
8. There is a need for a 'diagnostics everywhere' approach to health care, providing diagnostic services as close to home as possible - including self-management and self-testing.

9. Appropriate governance structures are essential to minimise risk and provide clarity required around indemnity arrangements, budgetary arrangements and legislation in relation to some of the newer roles.
10. The ability to maximise opportunities from changes to medicines legislation is highlighted, allowing non-medically qualified professionals to train to be independent prescribers.

### **Recommendations:**

1. Communication and engagement strategies within health and care organisations should raise awareness, understanding and appreciation of the benefits and status of different professions / practitioner roles working within primary and community care. These strategies need to be targeted and tailored to target audiences (professions and the public). A fundamental change in how the public perceive and access primary and community services is essential. They will need to understand that the MDT can provide accessible high quality care.
2. Health and care organisations, through Regional Partnership Boards and Public Service Boards, should reach agreement on joint strategies that promote community partnership working and inform / involve the public in the future design of services.
3. Decisions on the future allocation of budgets, including transformation funds should include consideration of the potential impact of the key MDT services 'delivered at scale' on successful transformation. Needs assessment and skills required will inform where investment should be made.
4. Involvement of the public and all professionals in the transformation agenda will require strong leadership and proficient use of behaviour change techniques across health and care organisations.
5. A focus on developing career pathways, standardised education and training within primary and community settings is required with high quality mentoring and supervision for all MDT professionals are key to the development of the MDT.
6. Robust governance structures should underpin the employment model adopted. The preferred model of MDT respondents is to be employed by Health Boards to work within community teams or clusters. This addresses: sustainability and a 'Once for Wales' approach; employment rights/pension/pay and progression; risk and governance management and standardised of training.
7. Fundamental changes to the financing model are required to ensure allocative savings can move around the system to support the transformation agenda. This whole system approach to financial redesign is imperative to facilitate and drive transformation.

## **Section 5 - Employment considerations**

### **Key Messages:**

1. Employment considerations, including contracts and job descriptions, need to be looked at in relation to the scope of all MDT roles.

2. Fixed term contracts due to short term funding are a consistent challenge for teams, projects and service sustainability.
3. Many practitioners highlight the importance of stability of employment, with clear professional, governance and support structures.
4. Sound governance arrangements lie at the heart of key decisions around contracts, identification of the employer, line management and professional accountability. The preferred employer model identified by a wide range of professions is Health Board employment, working in clusters and community based services. Clinicians working within the GMS MDT need clear line management, professional management, supervision and mentorship relationships must all be clear.
5. Within multi agency teams, health and social care professionals are often working to different terms and conditions, with differing salary scales. This must be resolved to give equitable contractual arrangements.
6. The MDT professionals highlight the importance of job descriptions, with consistent banding, to ensure the team has the appropriate skills and competencies matched their roles. Job descriptions may need to include lone-working and medicines administration. Several professional groups highlight the need for flexible working.
7. Professions and practitioner roles highlight the need for high quality mentoring and supervision. There needs to be protected time for CPD for all MDT professionals.
8. Indemnity issues are critical within the team, with clearly defined professional responsibilities for discreet episodes / elements of care at any particular time within an episode of care.
9. Although there was little reference to pension issues in responses, there was reference to the benefits of retaining access to the NHS pension and that this helps with recruitment.

### **Recommendations:**

1. Health Boards should further consider the preferred employment model for primary and community care in order to make the very best use of resources and provide assurance for the public. This will also help to address governance, indemnity, pay progression and other employment issues. It is critical that Health Boards provide assurance around the recruitment process to avoid delays.
2. Health Boards will need to address human resource issues such as development of job descriptions and the range of terms and conditions considerations for integrated MDT roles that cut across primary, community care and secondary care services.
3. HEIs and HEIW should ensure pre-registration training programmes for MDT roles are 'fit for purpose' and address future cluster workforce needs within the transformational model.
4. High quality supervision and mentoring are essential to support professionals working within the MDT and need to be developed further as the transformational model progresses. These responsibilities add to the workload pressure for those providing supervision and mentoring for extended MDT roles.
5. The additional skills and training and skills needed for effective working within the primary and community care cluster MDT should be identified for inclusion within undergraduate and postgraduate training programmes.

6. Clear and consistent career progression frameworks should be established for the full range of MDT professional groups, improving motivation and retention of the cluster workforce through increased career opportunities for all disciplines in primary and community care. Job plans must include appropriate time allocated for CPD and other professional development requirements.

## **Section 6 – Professional Requirements**

### **Key Messages:**

1. Greater opportunities for practice-based learning within the primary care setting for the undergraduate workforce are required, with opportunities for career development opportunities including advanced and extended scope practitioner roles.
2. Some MDT roles in primary and community care are clinicians working at advanced practice levels and with extended scope to the top of their license. Many professional groups highlight the need to hold advanced level qualifications for example BSc or Masters level qualifications, and to be registered with a regulatory body. Community Resource Teams (CRTs) have a wide skills mix across all grades.
3. The MDT professionals highlight the need for appropriate competencies to deliver clinically focussed care for patients. Non- medical independent prescribing and referral rights are identified as key skills for several professional groups, requiring specific post-graduate training and experience.
4. Information and advice on the scope of practice, potential contractual options and career pathways for MDT members working in Primary and Community Care should be easily accessible.
5. Assessment skills and specific competencies to support individuals to remain at home, including reablement/therapy competences, are seen as valuable by several professional groups.
6. Amongst those who work as autonomous practitioners, appropriate supervision arrangements and access to mentors are essential to avoid professional isolation, provide training and support. Professionals are encouraged to engage in evidence based practice and to support research agendas.
7. As part of the wider multidisciplinary workforce, practitioners should have access to study leave and appropriate CPD opportunities, with training needs identified through the relevant appraisal / PDAR process.

### **Recommendations:**

1. Health Boards should consider the professional benefits of a model of Health Board employment for roles in primary and community care.
2. Job descriptions for new and extended/enhanced professional roles should be standardised, including development of flexible working models. There is an opportunity here for competency based role profiles and a 'Once for Wales' approach.

3. The necessity to develop supervision and mentorship should be recognised and addressed. Study leave and CDP requirements should be included in all MDT professional contracts.
4. The importance of suitable training and working environments for cluster team members must be recognised, with practice-based learning opportunities available to give the necessary clinical experience in primary and community settings at undergraduate and post-graduate level
5. Information and advice on the scope of practice, potential contractual options and career pathways for MDT members working in Primary and Community Care should be easily accessible.

## Multi-professional Roles within the Transforming Primary Care Model in Wales

### Appendix 1 – Professions / Practitioner Roles responding

Professional Group	Profession/Practitioner Role	Role
<b>Dentistry</b>	Dentistry	Chair of WDC
<b>Healthcare Scientist</b>	Biomedical and Clinical Scientists	Point of Care Services Manager
	Clinical Scientists and Healthcare Science Practitioners	Non-Ionising Safety Lead
	Healthcare Scientists	Cedar Director and Consultant Clinical Scientist
	Audiology * 3	
	Radiography	SOR Policy Officer
<b>Medical</b>	General Practitioner	BMA Cymru Wales
	General Practitioner	Membership Officer RCGP Wales
	General Practitioner	GP/Cluster Lead and
	General Practitioner	Individual GP
	Physician Associate *3	Physician Associate (PA)
<b>Nursing</b>	Acute Clinical Team	Community Senior Sister
	Advanced Nurse Practitioner (ANP)	Advanced Nurse Practitioner
	Community Children's Nursing	Consultant Nurse
	Community Learning Disability Nursing / Community Mental Health Nursing	Lead Nurse CYPP
	District Nursing (DN)	Primary Care, Community and Independent Sector Adviser
	Health Visiting Public Health Nursing	Senior Nurse – Health Visiting Public Health Nursing
	Health Visitor	Flying Start Health Visitor
	Practice Nursing/Practice Nurse	Clinical Nurse Lead, General Practice Support Team and Clinical Practice Educator, Cardiff & Vale UHB
	Practice Nursing/Practice Nurse	Lead Nurse, Primary Care
	Practice Nursing/Practice Nurse	Primary Care, Community and Independent Sector Adviser, RCN Wales
	Practice Nursing/Practice Nurse	Practice Nursing colleagues
	School Nursing and Looked after Children	Senior Nurse School Nursing
<b>Pharmacy</b>	Pharmacist	Pharmacy Lead
	Welsh Pharmaceutical Committee	Chair
<b>Social Care</b>	Local Authority Adult Social Care	Principle Manager Adult Services
	Social Care (adult)	Service manager for social care teams (adult)
	Social Work	Professional Officer – BASW Cymru
<b>Social Prescribing</b>	Social Prescriber/Care Navigator	Social Prescriber *3
<b>Therapies</b>	Arts Therapies	Art Psychotherapist Clinical Lead, Adult Mental Health
	Child Psychologists (Primarily Clinical and Counselling)	Lead for Psychology
	Clinical Psychology *2	

	Nutrition and Dietetics	Community Dietetic Service Manager
	Occupational Therapy	Head of Occupational Therapy
	Orthoptist	All Wales Orthoptic Advisory Committee
	Paramedics, Specialist and Advanced Paramedic Practitioners	Clinical Development Lead/Advanced Paramedic Practitioner
	Physiotherapy	CSP Public Affairs and Policy Manager for Wales &
	Physiotherapy	Team Lead, (Acting) Integrated North Hub, Community Resource Service
	Podiatry and Orthotic Services	Head of Podiatry and Orthotics
	Prosthetics	Clinical Lead Prosthetist
	Speech and Language Therapy	Head of Wales Office, Royal College of Speech and Language Therapists
	Optometry Wales	Chief Executive