Urgent Primary Care Centre Programme (UPCC)

Developing the 24/7 Urgent Care Model 2021/22 Evaluation report

Phase 2 – Implementation Phase
(1st April 2021- 31st March 2022)

Strategic Programme - Primary Care One (nhs.wales)

Foreword

There is recognition of the need to redesign the delivery of care to meet the needs of the local population to ensure that patient pathways achieve the optimum outcome. A co-ordinated response to care will ensure that the patient journey will be managed from initial presentation through to the completed outcome.

This programme seeks to design and deliver a new model of urgent care for the population of Wales that have an urgent primary care need providing a service for people within 8 hours of contacting their local Health Board. The aim is to provide seamless care, delivered at a local level consistently regardless of organisational boundaries.

The Urgent Primary Care Centre's Programme is part of the Strategic Programme for Primary Care 24/7 work stream and sits within the Welsh Government Six Goals for Urgent and Emergency Care Programme. It is fully aligned with other existing Urgent and Emergency Care Improvement work streams including 'Think 111 First', Peer reviews for urgent primary care, the national rollout of the 111 programme and Same Day Emergency Care (SDEC).

We would like to take this opportunity to thank all those that have supported the work, both within primary care and the colleagues who we've worked with in partnership and look forward to working with you to continue the progress already made.

Richard Bowen	*Sue Morgan*
National 6 Goals Programme Director and Goal 2 Senior Responsible Owner (SRO)	National Director and Strategic Programme Lead for Primary and Community Care and Goal 3 Senior Responsible Owner (SRO)

Contents

1. Executive Summary

This evaluation report provides an overview of progress during the implementation Phase 2 of the Urgent Primary Care Centre (UPCC) Programme April 2021 – March 2022, notes the work carried out, learning, challenges and next steps. This report builds on the early findings documented in the Phase 1 December 2020 – March 2021 Urgent Primary Care Centres Pathfinder report.

- Continued commitment, adaptability, focus and resourcefulness with significant learning and rapid pace of development from the majority of participants.
- Challenges with accurately and consistently reporting aggregate patient consultation numbers due to different reporting systems which may cause an adjustment in reported numbers - but numbers still indicate increasing number of patient consultations in comparison with Phase 1.
- Evidence of move towards multi-disciplinary work to provide appropriate care to patients and a 'grow your own' staff and standards of excellence.
- Support practice/cluster resilience through short/long term cover to maintain patient services.
- Total spent was £5.1m (underspend of £1.4m primarily due to recruiting difficulties).
- UPCC Development Matrix All Wales Overview (July 2022) reported programme maturity especially in 'Service Delivery' and 'Staff' categories.
- HB local evaluations – each participating health board completed a comprehensive local evaluation for Phase 2 outlining the local programmes of work as well as their completed National UPCC Performance Reporting Framework. These evaluations contain local in depth reviews on activity and assessment of their strategies and can be found in Appendix 1. This report is based on these findings.
- Focus on alignment in Phase 3; to add full value urgent primary care centres need to integrate and to offer greater consistency with the wider urgent primary care system 24/7, ensuring wider opportunities for workforce redesign.

HB feedback showed a total population coverage in excess of 1,797,680 which covers 256 practices across 39 clusters.

Patient satisfaction rated 'Highly Satisfied' 80% and over.

Nearly 74% of patient outcomes result in medication or self-care evidencing patients were seen in the right place at the right time.

Over the 2021/2022 reporting period 8 Urgent Primary Care Centres were in operation across Wales

2. Introduction

This paper is to review and understand the progression of the Urgent Primary Care Centre Programme (UPCC) over the course of three years. The programme, commenced in winter 2020/2021 and will complete in March 2023. In Phase 1, participants planned interventions and assessed outcomes to refine models specific to local needs. Phase 2 builds on the prior learning by implementing ways to best address these needs and these findings will be reviewed in this paper. Phase 3 will be addressing the mechanisms by which Health boards (HB's) can embed and sustain urgent primary care (UPC) within a whole system response after the participants exit the programme.

The 2021/2022 Welsh Assembly Government (WG) national Urgent Primary Care Centre (UPCC) programme builds on the pilots which began in 2019/2020, funding health boards, clusters/practices and a combination of both, to lead and develop innovative urgent primary care processes and services. The priority is to enable people with urgent primary care needs to access appropriate advice, assessment and care closer to home and safely avoid the need to present elsewhere in the system. This is at the heart of A Healthier Wales (Welsh Government, 2018); Health and Social Care policy, and the Primary Care Model for Wales, which promotes supporting patients accessing treatment by the right person, in the right place as close to home as possible.

The UPCC programme and urgent primary care service links with the whole system response and seeks to direct the population to the right setting for their care needs. This is within the context of an integrated whole system response to urgent and emergency care needs with sustainable and accessible local health and wellbeing care 24/7. This vision aligns with the Welsh Government's 'Six Goals for Urgent and Emergency Care'. Specifically, the UPCC aligns with Goal 2 and 3; Six Goals for Urgent and Emergency Care, A policy handbook 2021–2026.

The 24/7 Workstream of the Strategic Programme for Primary Care (with wide representation including health boards and Welsh Government) has identified urgent primary care as one its continuing priorities. The UPCC programme is also aligned with other existing national programmes such as the 111 National Programme and the Accelerated Cluster Development (ACD) Programme.

The funding for 2022/2023 comes from the Investment Allocation Fund from the Six Goals for Urgent and Emergency Care Programme, with an investment of around £7 million already allocated for the final year Phase 3. This funding reflects the priorities and commitment from the Minister for Health and Social Services, to target investment according to local needs, aligning investment and benefits to the overarching vision of the project. That is, to co-produce, a comprehensive integrated 24/7 urgent primary care national model, which enables patients to be directed to the most appropriate healthcare professional at the time they need to access urgent health and social care, delivered on a cluster or multi-cluster footprint.

This programme, developed from the original Pathfinder initiative, was designed from the beginning to encourage testing out new ideas for proof of concept, assessing impact and refining delivery given on-going learning and analysis. The UPCC hosted the first national learning event in October 2021 for the Six Goals for Urgent and Emergency Care Programme which encouraged participants to present their local patient Centre models and findings to continue the whole system join-up.

The outcomes, as identified for Phase 2 in figure 1 below, will remain the outcomes for Phase 3. As the programme matures, each phase has provided key learnings that refine, reframe and reassess the impact and delivery of the UPCC model.

Increases in demand following the response to COVID-19 has added further pressure to delivery of health and social care across the whole system. This programme assists Urgent Primary Care Centre sites to build a foundation, or further develop, their models of care to effectively target and manage local population needs.

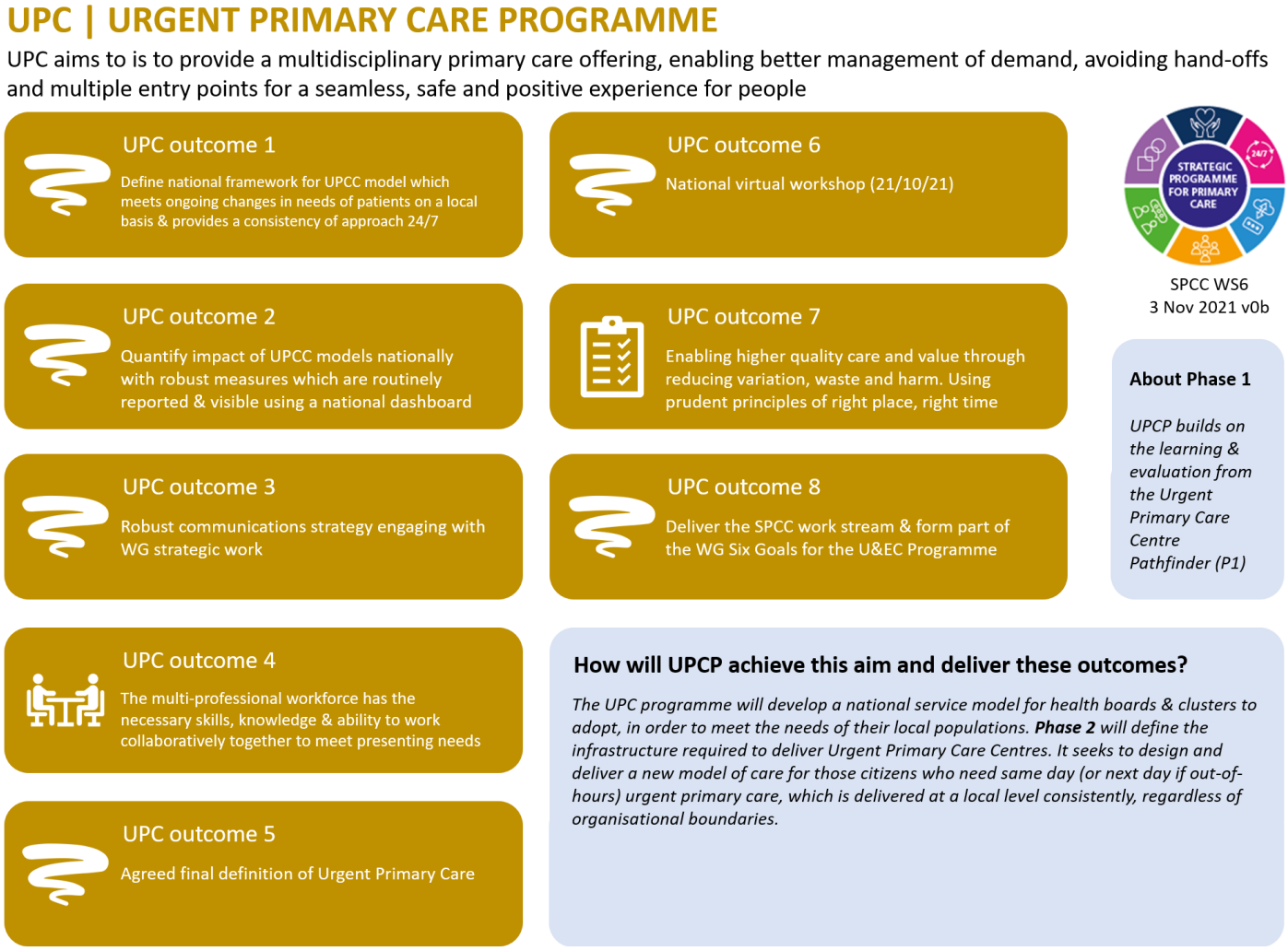

Figure 1 UPC Outcomes

3. Delivery Model

Given different populations have different needs, participants have the flexibility to design patient care based on their unique population needs, prior experiences that inform and refine approaches, and resources available. The aim is to deliver quality and safety outcomes in an integrated whole system approach. The Programme sites have been continually improving their approach. This is based on delivering local plans, reviewing impact and assessing how best to integrate into current systems with the overarching strategy of flexibly and appropriately meeting their population's needs.

Three delivery models have emerged through this programme allowing for local variation to meet the changing needs of the population:

1. Urgent primary care delivered on a **cluster (or pan cluster)** level by local General Practice workforce with some models linked to third sector mental health support. Three of the six health boards offer cluster led UPC services (Cardiff and Vale UHB, Hywel Dda UHB and Betsi Cadwaladr UHB - Central). Emphasis has been on supporting urgent GMS activity.

2. 24/7 urgent primary care centres managed by **health boards (HB)**, staffed by a mix of professional staff with the appropriate skills – three of the six participants offer this HB led UPC service (Aneurin Bevan UHB, Betsi Cadwaladr UHB – East and Swansea Bay UHB). This has been offered with a greater emphasis on managing demand linked to wider emergency /urgent care pressures across the system which includes OOHs, Emergency Departments, Minor Injury Units (MIUs) etc.

3. Hybrid Model – Both HB and Practice/Cluster led and delivered in a community hospital (Cwm Taff Morgannwg UHB).

The participants determined the best method of delivering care for their population and identified where to best focus their services. Accordingly, some provided care within clusters and others created services aligned with Emergency Departments (ED), Minor Injuries Units (MIU) and/or Out of Hours (OOHs).

4. Evaluation approach

This bottom-up approach has been reinforced by national programme tools to assist in prioritising, learning, and assessing programme impact. The aim is to minimise risk and vulnerabilities through strategising and impact assessment to respond to local needs and available resources. This is based on the work and learning accomplished during the Pathfinder Phase. In order to review progress in the following areas, frameworks and tools have been provided as the impact of efforts sometimes can be difficult to standardise due to differing needs necessitating differing impact and focus:

Clear definition of urgent primary care and emergency care.

Urgent Primary Care

Health and wellbeing issues that may result in significant or permanent harm if not clinically risk assessed and appropriately managed within the next 8 hours

Emergency Care

Health and wellbeing issues that may result in significant or permanent harm or death if not dealt with immediately

Patient satisfaction survey - Development of a once-for-Wales UPCC Patient Satisfaction Questionnaire (based on 'Your NHS Wales Experience') is complete. A collaborative effort to identify a technical solution for a national rollout is still in development. Therefore, for the purposes of this report, all participants have been asked to provide a summary of approximately 25 patient satisfaction surveys.

Staff learning and **development/Quality improvement/Clinical Governance -** An UPCC National Evaluation Framework was developed as part of Phase 1 Pathfinders collaborated with University of South Wales (USW) to develop a core dataset of 47 items (Concept Mapping) and a self-assessment matrix (the Development Matrix) that would provide possible options to address or demonstrate development and assist in strategising and prioritisation. This was to provide a fuller picture in addition to the number of patients seen, patient satisfaction and innovative processes. A matrix can be used to decide on which domains of activity to prioritise, what objectives to aim for and how key components of a Quality Improvement programme (QI) can be linked together (structure, process, resources, outcomes for example). Both local and national governance frameworks have been developed.

Cost benefit analysis - a national framework was developed to help sites quantify the cost of each patient episode and supported sites in understanding their impact (NB due to lack of alignment nationally each site is able to quantify the cost per patient locally, but the national aggregate data is not yet consistent).

HB local evaluations – each participating health board completed a comprehensive local evaluation for Phase 2 outlining the local programmes of work as well as their completed National UPCC Performance Reporting Framework. These evaluations contain local in depth reviews on activity and assessment of their strategies and can be found in Appendix 1. This report is based on these findings.

Given the different initiatives focused on local needs, the results between sites could not be directly compared but ongoing funding, impact, value and analysis has been key to the process. The three delivery models trialled different ways of working to positively impact patient experience and were asked to provide a detailed analysis of their work. This included differences in the proposed model and the delivered model; activity, cost benefit analysis and how it links to the Six Goals for Urgent and Emergency Care Programme health board plans etc.

Those participating in Phase 2 are the same as those in Phase 1. The participating areas and details of each UPCC site are as shown below:

On Census Day, 21 March 2021, the size of the usual resident population in Wales was 3,107,500; this was the largest population ever recorded through a census in Wales.

Participants were also invited to provide proposals that would plan priorities and milestones for Phase 3 funding (2022/2023).

As shown in previous urgent primary care projects, significant effort, progress, and learning was demonstrated by those participating in the programme. Participants this year replicated these results.

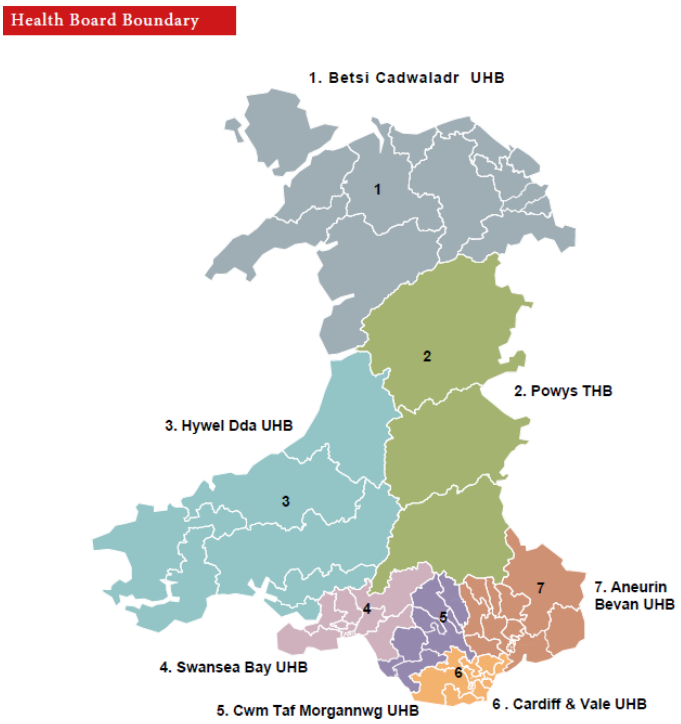

Figure 2 Health Board geographical boundaries

Health Board/Area	Population		UPC Model
Swansea Bay University Health Board	Practices Clusters Population	52 7 361,463	Health Board
Aneurin Bevan University Health Board	Clusters Practices Population	11 73 615,949	Health Board
Betsi Cadwaladr University Health Board East	Clusters Practices Population	6 39 300,436	Health Board
Betsi Cadwaladr University Health Board Central	Clusters Practices Population	1 6 61,391	
Betsi Cadwaladr University Health Board West (start May 2022)*	Clusters Practices Population		Health Board
Cardiff and Vale University Health Board.	Clusters Practices Population	3 13 132,531	Practice/Cluster
Cwm Taf Morgannwg University Health Board.	Clusters Practices Population	<1 7 out of 11 **56,000****	Practice/Cluster
Hywel Dda University Health Board.	Clusters Practices Population	7 48 301,259	Health Board

*BCUHB *West opened 30 May 2022 and therefore their activity is not included in this report*
***access Rhondda UPCC from the total cluster population of 88,000*

Table 1 UPCC participating sites

5. Learning

One of the major findings that has continued throughout the programme is the rapid pace of learning and development. The on-going commitment of programme teams to further their understanding and responding rapidly by assessing the results/impacts and piloting to test new ways of working continues to highlight the major strength of the programme, and indicates the professionalism, leadership and agility of participants. Participant efforts have resulted in significant knowledge and skill sets providing insights that can be used nationally.

5.1 Whole System Approach

Overall, the major difference between the sites this year in comparison to previous years of operation is the focus on an integrated, sustainable, whole system approach with a particular focus on workforce. There has been significant movement and learning shown by most participants, evidenced by providing significant patient care and starting to embed into the whole system.

A whole system approach adds levels of complexity not just in assessing impact but also in developing strong relationships to other community urgent care providers such as community pharmacy, social care, emergency community dental and mental health. For the patient to experience a seamless, effective and integrated service, a great deal of work, trust and communication needs to occur between the providers.

Interfacing between stakeholders has necessitated clarity and constant reassessing of the inclusion and exclusion criteria. Almost all participants identified that this is an area that is under constant review and refinement. The national UPCC Clinical Reference Group is also working on this at a national level.

HOW CAN PATIENTS ACCESS UPCC?

Aneurin Bevan Health Board	Betsi Cadwaladr Health Board	Cardiff & Vale Health Board	Cwm Taff Morgannwg Health Board	Hywel Dda Health Board	Swansea Bay Health Board
GP	GP (C&E)	GP	GP	GP /PTAS*	GP / Acute GP unit / UPCC GP
111	111 (TBC) (C&E)	111			111
ED	ED (C)				ED
MIU	MIU (C)				MIU
GMS until 6pm then OoH		OoH			OoH
	Self referral (TBC)				Self referral
Health Care Professional Call/District Nurse					AMPs / District Nursing /Acute Medicine
MISCELLANEOUS					
Nursing Home	Lymphoedema Service (C)				Extended Clinical Hub
Step Closer to home unit	SICAT **				WAST Stack on scene
Contact first					Police

*PTAS: Physician Triage and Streaming
**SICAT: Single Integrated Clinical Assessment and Triage Service

Table 2 From Digital Health and Care Wales, UPCC Feedback Workshop (22 May 2022)

The assumption that Emergency Department (ED) and Out of Hours (OOH) would embrace the support provided by UPCC was not evidenced by an increase in referrals – although there has been good progress with referrals from GP practices. The one area where referrals were significant was when UPCC's were co-located with hospitals or where Emergency Department (ED)/Minor Injury Units (MIUs) are located. The success of co-location is mitigated by the needs of the population (distribution of the population urban/rural and access) and different areas providing care in different ways. Redirecting the flow of patients to where their needs would be

best met is not straightforward, especially when patient demand is exceptionally heavy and unprecedented. It is noted that OOH's may not be able to access UPCCs because most operate Monday to Friday and not weekends or later in the day when OOHs are open which may impact utilisation.

Being physically close to other services is not always an option where populations are more dispersed. However it is clear that having a presence near other services enhances opportunities to meet and develop trust which tends to lead to larger number of referrals.

"…a community hospital which is being developed as a cluster hub means that relationships can be built with other primary care services and the centre is in a central location for patients who attend for face-to-face appointments."
Rhondda Cluster

ABUHB is moving towards a fully integrated front door model, relocated the Neville Hall Hospital (NHH) base to an integrated front door (February 2022) and continue with the development of Royal Gwent Hospital (RGH) UPCC into the Integrated Assessment model. They have noted as part of their local evaluation:
"*With Urgent Primary Care Centres located within the front door footprints of the LGH hospital sites this has enabled closer working relationships, smoother transition of patient pathway and patient care.*"

With the integration of the Front door model and UPCC's as part of the Integrated Assessment Model (IAM) ABUHB focused on ensuring:
"….*patient attends once and the patient journey follows seamlessly without patient needing to call another department, all records from initial triage follow patient electronically and are electronically sent back to the patient's own GP surgery by 9am the following morning. This ensures the patient can be followed up by their own GP the next morning.*"

SBUHB made an insightful point in their report about establishing relationships in an ad hoc way instead of establishing common agendas and goals:
"*As a result of funding, a number of services have been established over the last two years including UPCC, WAST stack review, Home visiting scheme etc. If we had known at the very start of the process that would be the case, we would have designed a fully integrated service from the start. As it is we have a number of services, which do work together, however trying to take the barriers down to integrate as one unit. This will ultimately happen and benefit us with economy of scale with staff and sustainability of cover, however it would have been easier if we had done this from the start, however timings did not allow*."

The impact of UPCC's have been examined for both benefits and possible negatives. The key question is how UPCC's impact demand; whether they divert and support primary care by providing an alternative pathway ('true' demand) or if it is stimulating demand that would otherwise not be created, a concern also raised by the University of South Wales Urgent Primary Care Development Matrix All Wales Overview report (May 2022). Initial findings seem to indicate that UPCC's are supporting other pathways and not creating demand. This is a question to be investigated further as reporting mechanisms develop and UPCC's embed into their wider patient care systems.

"Initial concern that the system would form a by-pass of patients and that this would be seen as an alternative to in-hours GMS contracted work. The pathway has realised that the patients managed via this route are patients who historically may have looped within the system, the system allows wider system change and education for patients on the correct pathway to access in future."
Aneurin Bevan HB

6. UPCC Engagement and Stakeholders

Reducing urgent primary care demand in secondary care is dependent on referrals of patients to the appropriate pathway. Given the pressure on EDs there was an assumption that referring patients (that fulfil criteria for UPCC's or other UPC care) would be viewed as helpful. This led to a second assumption – that ED's would welcome referring patients to other pathways. However, as all sites have found, there are constraints, even with those who are co-located.

Creating a collective understanding and trust is ongoing and push/pull solutions are still being created to assess interventions. GP's (in general as one participant felt UPCC's were not helpful given their population needs) were incredibly open to, embraced and utilised UPCC's to the extent that criteria and outcomes had to be reviewed.

This was not reflected in OOH, 111 nor ED/MIU referrals even when training was provided to ED triage teams, UPCC staff were embedded within ED's or when there was constant dialogue and discussion.

Key stakeholders must be part of the process, and data provides both demonstration of the success of the relationship and provides a bridge for both sides to interact. Other factors such as difficulty transferring patients from pathways that were not originally designed to signpost patients elsewhere, patients presenting later due to COVID-19 issues and lack of a cohesive model that 'glues' the different care providers create significant barriers to success even to the most resourceful and determined participants.

> *"The broad range of conditions which are seen in Urgent Care has enabled GPs in practice to see more chronic conditions daily."*
> ***Care Navigator – Ferndale Practice***

Some participants stated that UPCC's allowed GP's to release time to manage patients with chronic conditions, a comment that was also noted in Phase 1. BCUHB - East reported:

"*Its enabled our GPs to focus their time on patients with chronic health conditions and multiple complaints by enabling us to have acute patients seen in UPCC."*

7. Workforce Learning and Development

The implementation and impact of this programme relies on competent, able and motivated staff. Phase 2 (Implementation Phase) allowed sites to progress and build year on year on prior foundations of clinical and operational safety and excellence. This experience has been evidenced by the results; the more experienced participants do tend to outperform (in terms of quality indicators) those who have less experience in the programme. Most participants emphasise working as a team, sharing experiences and developing their skill sets together – all of which takes sustained time and effort.

Most sites concur that staff and staff development is the biggest resource in achieving successful outcomes for the model and ABUHB noted: "*To ensure that patients receive the best care possible a key consideration was continual CPD and ensuring high standards across the service".*

Throughout the development of the pathfinder a key element has been learning. An Operational and Clinical Governance meeting was set bi-weekly, including all key stakeholders of the Urgent Primary Care pathfinder. This included UPC staff, ED, MIU, WAST, Clinical Futures, Flow Centre and 111 representatives. Within the implementation of this meeting areas of development were discussed on a bi-weekly basis, ensuring lessons

were learnt and adjustments made, where required in real time. With the focus of this group many queries were turned around at the meeting and resolutions sought, this ensured the pathfinder was able to progress safely, both clinically and operationally, in addition to maintaining pace of delivery.

The move to a multidisciplinary model was welcomed in almost all areas. The key to successful integration appears to be evidence-based care guidelines and protocols, ongoing learning and development and strong adherence to a high level of patient care.

CTMUHB invested time and learning with practice care navigators and implemented a Care Navigator Network with a lead for each practice which "*has gotten patients more accustomed to care navigation for other situations*"

C&VUHB took the opportunity to undertake a focused piece of work to increase the utilisation of Independent Prescribers in UPCC by the Vale Lead Pharmacist supported by the National Head of Pharmacy in January 2022.

The concern that UPCC's could cause risk in the internal workforce market was mitigated by participants taking a 'grow their own' approach where they develop and support staff. Governance, development and support has therefore become a much larger part of the strategy to enhance patient care.

Estate availability is a problem; estate usage is at capacity and therefore causes issues with efficient patient flow and staff learning and development. Co-location creates opportunities for learning, increased trust, skill mix and patient ease of use. As can be seen in this report, HB's report that respiratory issues such as coughs and colds is the top condition presented by patients. With additional estate availability, nurses could see patients that otherwise would have to wait to see their GP but this option is limited by lack of rooms available.

"It was found that in 95% of UPCC appointments the patient could be successfully treated by the pharmacist acting independently. The key findings:

- *The UPCC model remained the same with the introduction of pharmacists*
- *Pharmacists were able to offer the same number of clinical consultations as GPs*
- *Introducing Pharmacists did not result in an increase in f2f consultations required."*

Cardiff & Vale University Health Board

The Programme has offered learning opportunities to assist participants in expanding their knowledge and experience by presenting at the National UPCC Learning Event (October 2021); workshop on UPCC Data standards and reporting standardisation presented by Digital Health and Care Wales (May 2022); National UPCC HB Annual Review meetings (June-July 2022); External Academic Evaluation – Development Matrix (July 2022); UPCC Workforce Review Workshop (July 2022) and the ongoing national UPC Peer Review Process.

The outputs from the UPCC Workforce Review Workshop held in July 2022 will help shape the development of Phase 3 as well as the Six Goals for Urgent and Emergency Care Programme Workforce enabling work stream.

Many participants identify the National Programme Manager meetings as extremely helpful for comprehensive ideas, sharing of experience and gaining input from those who have 'been there, tried that' and can attest to the progress or otherwise of actions and initiatives. The value of learning from each other by sharing insights, asking questions and reflecting on progress is said to be: "*A significant help in collecting qualitative information during Phase 2 has been the collaborative working via the Programme Managers Group.*" (BCUHB - East).

CTMUHB noted: "*A particularly valued platform to exchange knowledge and learning from other models and the national general direction of travel."*

In addition CTMUHB found networking with C&VUHB helpful by allowing through dedicated meetings the time

to discuss ideas and opportunities for development.

Workforce, education, training and development in urgent and emergency care: immediate and longer term opportunities will be identified to support staff to work in modern, multi-professional workforce models. This will seek to enable them to use their skills in line with the prudent in practice principle to deliver the six goals, supported by excellent education, training and development; with the need to support the wellbeing of our workforce central to everything we do.

Six goals for urgent and emergency care: policy handbook for 2021 to 2026

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8. Operating Days/Times

The programme has encouraged participants to review the needs of their local populations and meet the demand resulting in a range of hours available for patient care. Weekend provision by C&VUHB has found that CAV24/7 (OOH) book 2.5% of appointments, primarily for the Saturday UPCC session in Central Vale and exploring opportunities to increase their utilisation.

Aneurin Bevan offers 24/7 service and Cardiff and Vale offer weekend availability but most UPCC's tend to offer Monday to Friday with few extended hours.

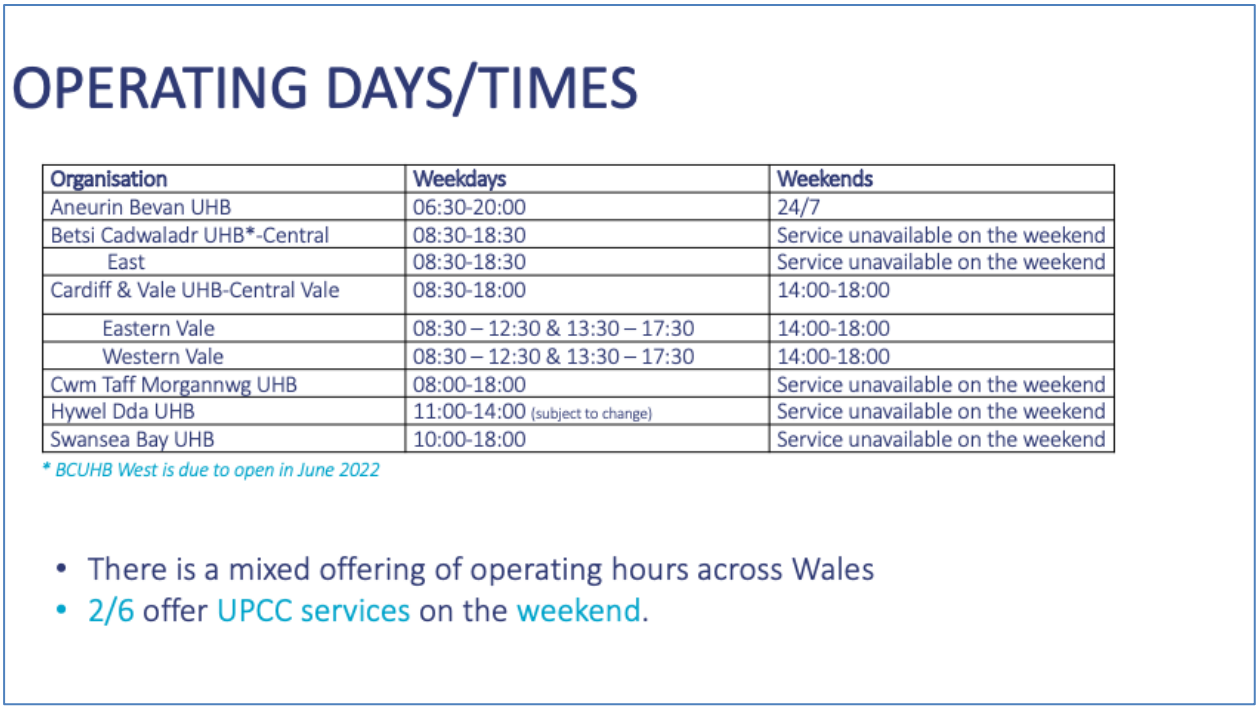

Table 3: From Digital Health and Care Wales, UPCC Feedback Workshop (22 May 2022)

Swansea noted: "*The model has been proposed with sustainability a key element, ensuring also that the introduction of in-hours provision does not cause fragility within out of hours. Through introduction of the model, the GP shift fill within out of hours periods has remained at 91% or above for 10 months, the most sustainable out of hours rota that has been achieved in many years*."

Some proposals for Phase 3 reflect the intention to increase accessibility by increasing provision for more hours, including 24/7 or weekends.

9. Measurement

Last year the wide-spread use of remote patient triage primarily via telephone was identified as an asset. The impact of Covid-19 has made this method acceptable to most patients and it is a helpful tool for treatment. It is also a vehicle for triage, with patients invited for a face to face consultation if initial telephone assessment deems this appropriate. This has the advantage of reducing patients and staff from infection and adds capacity providing timely care to patients.

However, nationally patient episode data have not been uniformly measured, causing variation in reporting. Health Boards use the ADASTRA system that counts patient triage and clinical assessment/treatment as one patient episode. In contrast, GP systems use the EMIS/Vision system that identifies the triage/clinical assessment and face to face consultations as two separate patient contacts/episodes. Thought needs to be given on how urgent primary care captures activity consistently across the 24/7 period and this will be addressed in a national framework with DHCW as part of Phase 3. In addition, the aim is to reduce the burden of manual reporting on HB's.

Understanding that these are tentative results and with the possibility that the reported activity levels may change as the data is compared to a definitive criteria of measurement, the table below shows initial results:

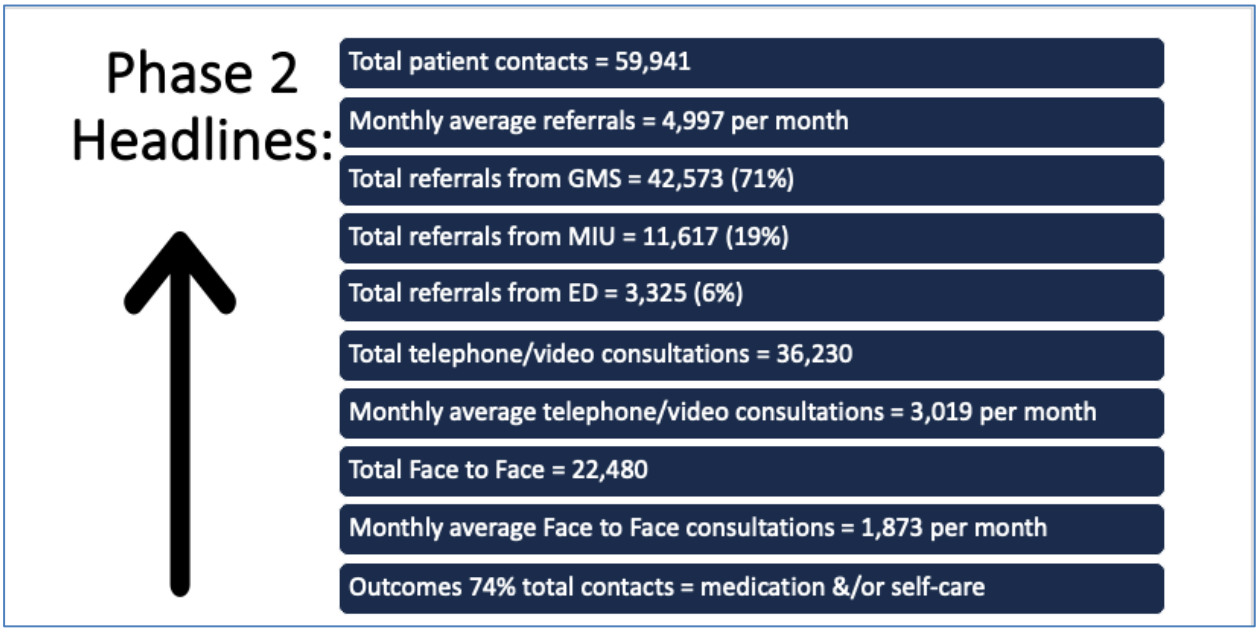

Table 4: Summary of Phase Two headlines
**Does not include HDdUHB data*

Face to face meetings have added significant additional capacity into the system. The total referrals from GMS of 42,573 – albeit yet to be confirmed – shows that significant additional capacity was provided for urgent primary care in addition to MIU and ED capacity.

Reviewing the measurement criteria and ensuring consistent data between reporting sites will delay the confirmation of numbers but the trends and indicators provide a basis on which to understand national activity:

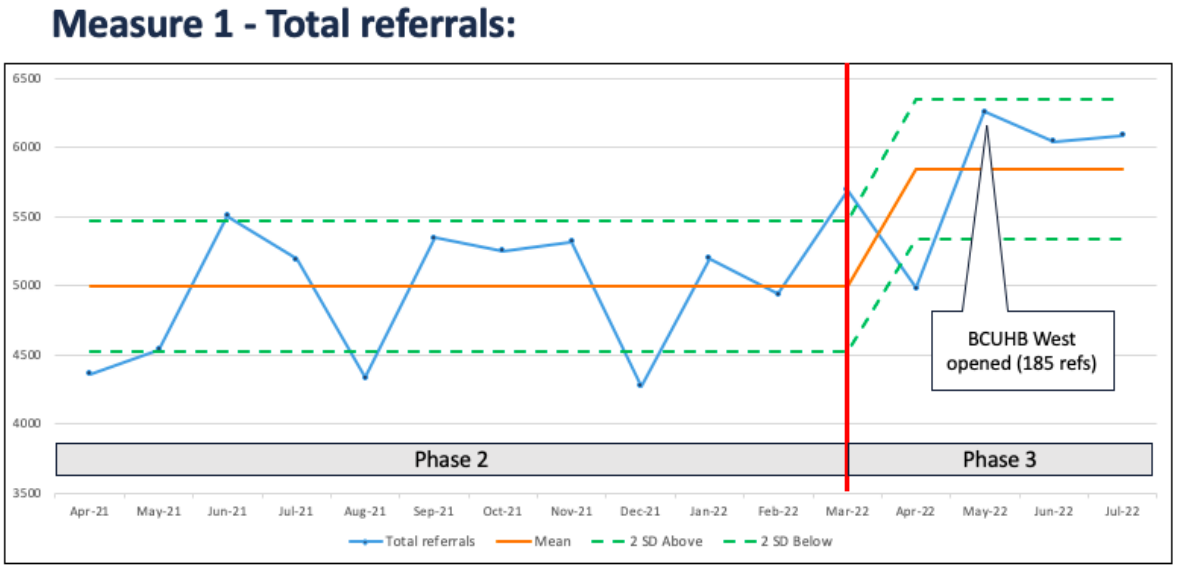

Figure 3: Total UPCC referrals

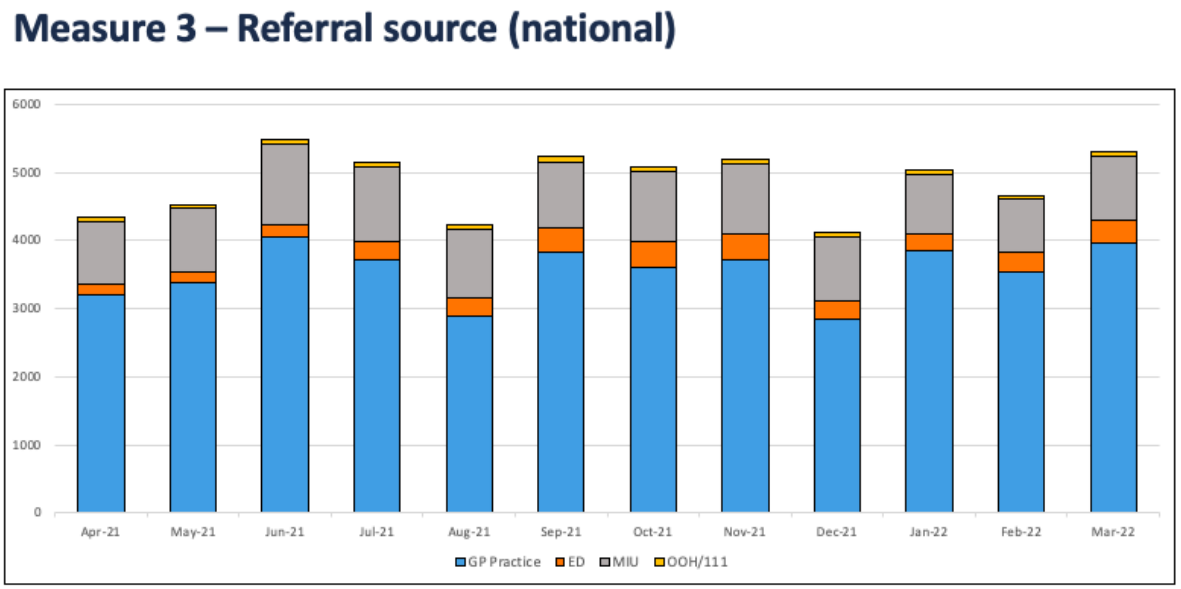

Figure 4 : Source of referrals into UPCCs

It can be seen that most referrals are from GP's, followed by MIU's.

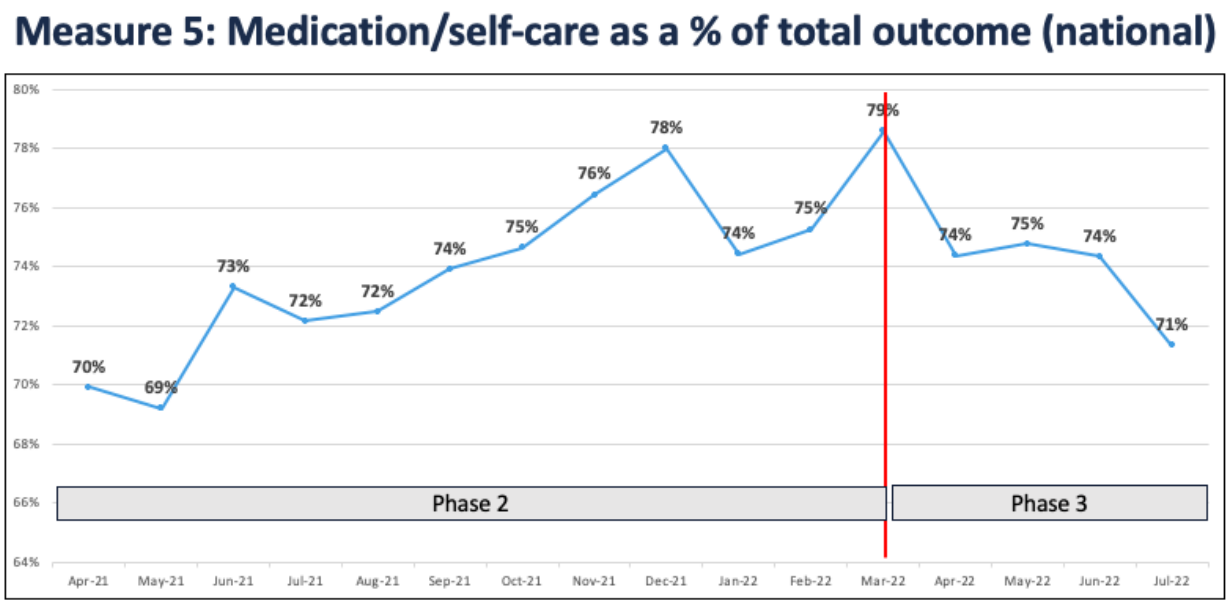

Figure 5: Medication/self-care as a percentage of outcomes

Measure 5 indicates at the end of Phase 2 nearly 80% of patient outcomes result in medication or self-care. This is an important finding, showing the quality of consultations is appropriate with patients being seen in the right place, first time.

From the available data, C&VUHB (Central Vale Cluster) have been able to demonstrate a link with a reduction in patients from their area presenting in ED. However, overall the system wide approach creates challenges in identifying how UPCC's contribute to patient care within the wider context of demand. Last year produced exceptional results and increased access to patient care, with the overall results for Phase 2 continuing to show impressive impact. Measuring impact when integrating and aligning with the wider system creates the need for a more complex and multi-faceted approach. Assessing how patients come into the system, determining how to create/maintain sustainable and robust procedures indicates a more standardised approach around protocols and measurement would be helpful. This work is on-going.

Having access to timely and accurate information helps leadership decisions and increases the opportunity to rapidly pivot if the data indicates a change is necessary. The key question is how UPCC's impact demand; whether they divert and support primary care by providing an alternative pathway ('true' demand) or if it is stimulating demand that would otherwise not be created.

The Concept Mapping Exercise (Pathfinder Phase 1) developed as part of the National Evaluation Framework has been used as the foundation of the development of the quality indicators in Phase 2. The programme has taken two complimentary processes to implementing the outputs from the Concept Mapping – the current state and future state. The current state is an interim manual system represented by the quality measures as indicated below:

9.1 National UPCC Performance Reporting Framework

Measure 1 – Total Number of Contacts broken down by face to face / virtual
Measure 2 - Total Number of Contacts dealt with by UPC Pathway
Measure 3 - Total number of contacts split by source of referral
Measure 4 - Total number of appointments available against how many utilised
Measure 5 - Total number of contacts split by outcome
Measure 6 - Total number of referrals from Practice/Cluster
Measure 7 - Top 5 most seen conditions

In parallel, Digital Health and Care Wales (DHCW), are assisting the programme in developing a set of metrics that will produce information in a way that is consistent with data definitions and standards (i.e. reviewing the future state). The move from current approach of collecting data manually forms part of the wider work of the national Six Goals Urgent and Emergency Care Programme, Data and Digital Enabling Workstream. This will provide the programme with a digital solution for participants to report local projects using a dashboard. It is anticipated this will be available for participants during the third phase of the programme, but work continues in defining consistent urgent primary care data definitions and standards. The aspiration for the dashboard is to have real time quality indicators as determined for the programme, in addition to integrating data from ED, OOH and 111 to assess if UPCC initiatives have impacted the wider system. This is currently in an exploratory state therefore no date is possible for digital resolution at this time.

The UPCC Development Matrix All Wales Overview (July 2022) reinforced the work and recommended providing a data collection mechanism to enable staff to complete the Matrix tool easily and provide access to compare results over time.

As we look ahead 10 years, many of these technologies and practices are unknown fully and still emerging, so we need to provide a system that can respond with urgency and agility to these new opportunities.

A Healthier Wales Policy 2018

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10. Patient satisfaction survey

Of those Health Boards that provided feedback from patient surveys, the vast majority reported 80% and above of patients were highly satisfied with their care. When patients were asked where they would have gone for treatment if the UPC service was not available, answers were quite different in each region. Responses ranged from a high of 36% to a low of 8% indicating they would have contacted OOH; 30% -12% would have approached ED and 40% - 8% would have gone to their own General Practice the next day.

PREM (Patient Reported Experience Measure) is being developed to ensure patient voices are heard and can influence outcomes. A national IT platform is currently being sought to host the surveys.

If time and resources are available, a deep dive into a national analysis of results could occur. Overall, it is clear that UPCC's provided care to patients that 1) patients appreciate and 2) that patients would have otherwise sought support from areas already under pressure.

11. Development matrix

The matrix was developed in the Pathfinder Phase 1 as part of the development of a National UPCC Evaluation Framework by the University of South Wales. This was in response to the programme learnings that indicated more support in prioritising, strategising and tracking annual improvements would be helpful. As it is a self-report tool, this is for development purposes only. This is the second year that it has been utilised by programme participants.

C&VUHB provided an insightful perspective in how the matrix supports participants especially where there are different expectations.

The UPCC Development Matrix All Wales Overview (July 2022) reported:

"(The Matrix) is useful also to reflect on the purpose for completing the matrix – whether it is for reporting, for evaluation, or for learning. These are not mutually exclusive of course, but it is worth being clear for those completing the matrix as to why they are doing so. Crucially, the matrix is about development of the service and should not be used for performance management and validation of activities."

"There are marked differences in approaches between HB models across Wales and a difference between clusters. The Matrix has been reported to aid learning and prioritising by providing clarity about sharing best practice, what progress looks like and providing a model that can be adapted to local needs. Comparing results over time with self-evaluation can indicate progress and highlight in the areas they have identified as priorities."

Cardiff & Vale University Health Board

The report noted that of the three domains, 'service delivery' has shown most progress, followed by 'staff'. 'system wide issues' remain an area for development. Overall:

"…*The trends that are mirrored at the individual site level, that urgent primary care centres are able to show a positive journey from more transactional forms of practice to transformational forms as defined by the matrix. This is precisely the sort of change that was anticipated and hoped for, and the matrix is a useful vehicle for demonstrating that change over time*."

For C&VUHB we see this with the Vale UPCC - a very different understanding and approach to the UPCC agenda/direction of travel between the 3 clusters. Adopting a dual maturity matrix demonstrates the flexibility of this tool that: "*There are marked differences in approaches between HB models across Wales and also a difference between clusters in interpreting and aligning to national agendas…. and hopefully is of further benefit both locally and nationally in understanding the pace of growth and 'maturity' for the UPCCs."*

URGENT PRIMARY CARE CENTRES – DEVELOPMENT MATRIX [ALL-WALES FREQUENCY DISTRIBUTION, July 2021/2][6]

Year	Number of Health Board responses against the statements					
2021						
TOTAL	79	73	48	44	22	18
PROPORTION OF RESPONSES (%)	27.8%	25.7%	16.9%	15.6%	7.7%	6.3%
2022						
TOTAL	110	108	72	62	29	12
PROPORTION OF RESPONSES (%)	28.0%	27.5%	18.3%	15.8%	7.4%	3.1%
Change – 2021 to 2022						
DIFFERENCE (n=)	+31	+35	+24	+18	+7	-6
DIFFERENCE (%)	+0.2	+1.8	+1.4	+0.2	-0.3	-3.2

Table 5: All-Wales Frequency Distribution (July 2021/22)

12. Top five presenting conditions

The top five conditions reported by participants varied according to location and local IT systems and coding but generally the trends were:

1. Chest infection/cough
2. Limb/joint Pain
3. Earache
4. UTI
5. Skin issues

As Swansea noted:
"*…. the top five conditions are what one would normally expect to see in primary care. The fact coughs predominate is in part due to its prevalence as a common symptom, however the pandemic has obviously had an impact also. It would be interesting to review the Sore throat / Skin / Ear pain cases as it would seem to suggest that alternative services such as community pharmacies are being under-utilised*."

ABUHB noted "*Interestingly the top condition is skin/subcutaneous infections and on further analysis of this data there is an interesting split between childhood rashes and adults with cellulitis type conditions."*

13. Challenges

Some challenges still remain since the inception of the Programme, despite some progress being made. Infrastructure and staffing still create difficulties that require ongoing time and resources to mitigate the impacts. In addition, the focus of this years' programme – that of adopting a whole system approach – has provided learning and challenges.

13.1 Staffing/workforce

The national challenges in recruiting were reflected in the Programme, resulting in underspends to some budgets.

STAFFING

Aneurin Bevan Health Board	Betsi Cadwaladr Health Board	Cardiff & Vale Health Board	Cwm Taff Morgannwg Health Board	Hywel Dda Health Board	Swansea Bay Health Board
	GP (C&E)	GP (C, E & W)	GP	GP	GP
	ACP / ANP / APP	ANP (C)	ANP		
	Admin Manager (E)	Operational Manager (C)			Receptionist
	Physiotherapy (E)	Physiotherapy (C & E)			
	Ongoing recruitment for BCUHB West				
RECRUITMENT					
	Admin / HCA				
	ANP/APP/Nurse Prescribers				

Table 6: From Digital Health and Care Wales, UPCC Feedback Workshop (23 May 2022)

Most sites reported some self-employed locums will not apply or work when paid via health board IR35 processes (there is a possibility that IR35 rules could change in April 2023, but currently there is no information or guidance in this area). In addition, it can cause confusion to those who expect the GP practice of pension contributions to be processed through locum GP routes. With funding having a finite date, many potential recruits did not want to apply for a temporary position. Taking a whole system approach, participants were concerned that a GP reliant model could create competition for locums and negatively impact other areas. Most of the participants in the programme indicated they would prefer to avoid depending on Bank staff if they were able to. Many areas had difficulties in recruiting in certain professions such as GP's and Physiotherapists.

Multi-disciplinary teams and creative contractual solutions have been explored and implemented with very positive impacts. C&VHB have a team of GP's, ANP's, MSK's and outsourced MH with an operational manager, and will be adding Pharmacists in Phase 3. Their inter-disciplinary team aims for a full complement of

administration support, GP's, ACP/ANP/APP, MSK and Independent Prescribers. BCUHB Central built resilience into the UPCC through an agreed hosting practice agreement, to cross cover during sickness, annual leave and provide staff a mix of Practice and UPCC work. Swansea utilised the *ad hoc* model as used by GPOOH and has also been part of cross cover with 111 Contact First and the Acute GP Unit (AGPU) to cover shortfalls in staffing. This close alignment has the goal of developing an overall Acute Hub that seamlessly deals with appropriate cases.

Some participants acknowledged that whilst the UPCC have supported practices during a very challenging time, there is always the risk that this strategy could potentially undermine the regular locum supply to individual practices and OOHs.

13.2 Infrastructure

The recent national outage of ADASTRA systems (August 2022) has demonstrated the resilience of UPCC in terms of governance and Standard Operating Procedures. The manual systems ensured that patient care remained safe and resilient throughout the outage.

Although there has been general progress, there continues to be difficulties with infrastructure. The impact of different systems being employed by general practice and health boards continue to cause dissonance although more understanding and visibility has occurred in this area since the original Phase 1 Pathfinders. All sites reported difficulty with data access, consistency in reporting, inter-accessibility between different care providers and ability to access raw data to track impact and provide real-time, accurate and informative information that participants can use to make informed decisions. In addition, the lack of electronic prescribing continues to be a national source of frustration.

Figure 6 outlines the different IT systems used nationally.

C&VHB noted:
"*In C&VUHB, Adastra (as used by OOH) has no interface with some practice or cluster ICT's, and of those that do, unexpected daytime system updates creates pressure and reduces capacity. Some are unable to utilise AccuRx yet which held with sending direction information or request images*."

One participant (Rhondda Cluster) found a work-around solution by purchasing DHCW managed IT equipment and using DHCW as a point of contact for support. In addition they have developed and implemented a Vision 360 shared appointment book which allows UPCC clinicians to view and access the vision appointment book.

UPCC clinicians have full access to the Vision 3 patient record. Whilst it is not a seamless system with separate logins for each practice both UPCC clinicians and Care Navigators have adapted very quickly to the use of the system. The Welsh Clinical Communications Gateway (WCCG) referral platform is, however, a helpful link between secondary and primary care.

In addition, DHCW is assisting with UPCC to determine the best way to collect and provide data relating to the Quality Indicators for next year to ensure a standardised, streamlined methodology.

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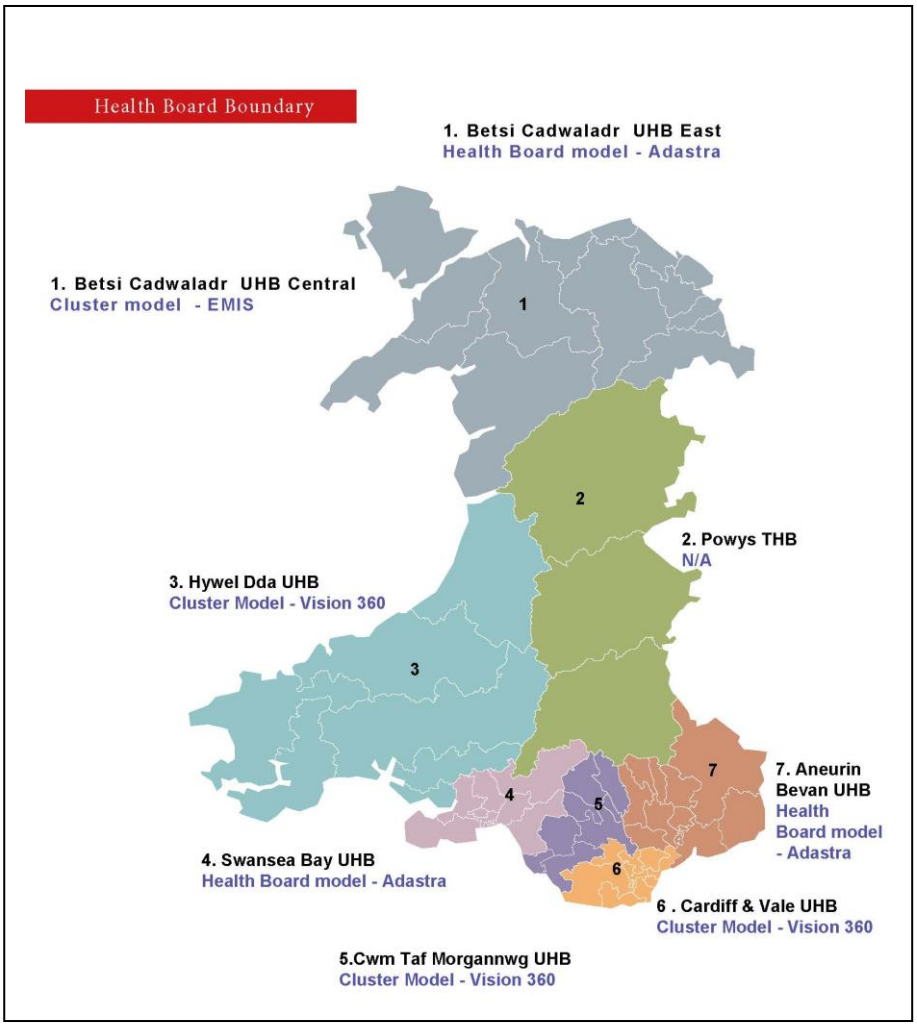


Figure 6: IT systems used nationally (From Digital Health and Care Wales, UPCC Feedback Workshop 22 May 2022)

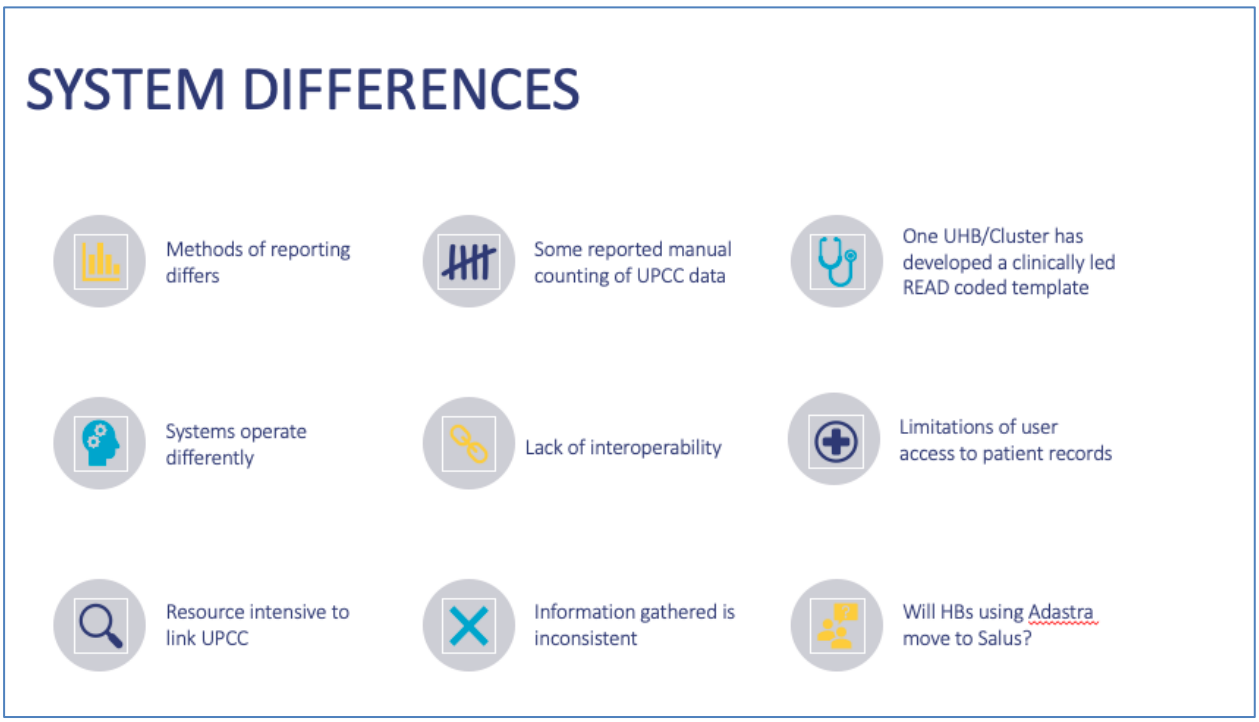


Figure 7: From Digital Health and Care Wales, UPCC Feedback Workshop (23 May 2022)

14. Conclusion

The dedication, and determination of participants - collaboratively building models by designing, delivering, assessing data and re-iterating the model at their local level - has created an opportunity in which rapid learning can evolve to sustain and embed delivery. The past two years, funded by Welsh Government, has been focused on building a strong foundation to enable innovation and adaptability to improve care so patients are seen in the right place as close to home as possible.

Strongly focused within the context of the 6 Goals Urgent and Emergency Care Policy, the aim of increasing access in urgent primary care builds supply in the service to promote access and meet urgent care demands. The establishment of a service at cluster level potentially enables GPs to have more time managing patients with chronic conditions and address the clinical long term condition backlog.

Adjustments made to parts of the whole system could cause unforeseen issues or advantages, and understanding what creates value, and how this can be accounted for, is both creative and challenging. Participant contributions do not stay static; with each phase there is a trend for teams become more cohesive and effective in their impact. The complexity of whole system is only realised by what comes before, with each re-iteration of learning.

A significant learning from Phase 2 was the differing ways of capturing and measuring data between the health boards. IT system architecture variation meant that in some areas patient episodes were captured as one event and in others each consultation was captured as discrete events. DHCW will be aligning systems to produce a consistent measurement with the anticipation that this could bring significant opportunities for granularity with tracking patients throughout the system.

The results (not including Hywel Dda) show significant patient satisfaction and alignment with seeing the patient in the right place and the right time (74% of patients are provided medication or self-care). However, it is very important to note that all reported activity is tentative at this time and could be revised given the IT measurement issues.

Trusted relationships were key to interfacing between services. Programme leadership had no formal power to encourage engagement, but influence stakeholders through discussion, negotiation and compromise. This maturing partnership working is a shoulder-to-shoulder effort, without contracts and a philosophy of a ‘memorandum of understanding’ with key stakeholders. For those working with ED, MIU and OOH, the mechanics of collaboration – clarity, trust, discussions and open resolution of conflicts – is, by necessity, time consuming. The effectiveness of this approach develops and grows with each phase of the programme, but it is clear that trust only occurs over time and when positive patient outcomes are proven.

The participants found co-location helpful in increasing referrals; a facet of trust developed by continued interaction. However, many participants found difficulty in persuading ED’s/MIUs and OOH’s to refer patients to them but it is noted that many UPCCs were open Monday to Friday 9:00-18:30pm and peak demands times such as during Sundays UPCC’s would not have been available. The impact on overall system resilience is one which is still to be fully tested and explored, and the importance of a 24/7 approach is becoming clearer. Given the pressure that each area is under, taking time to develop trust and influence becomes very difficult due to time pressures.

Estate availability is insufficient and additional services are unable to operate due to the lack of additional capacity.

Most participants report they have suggested or completed pilots to divert UPC cases from MIU’s and ED’s to

improve flows. The Six Goals Urgent and Emergency Care Programme has been invaluable for participants as a strategy that can support the interaction to discuss how UPCC's can support the whole system approach. Persistence, adapting to changing circumstances and good data analysis are distinct advantages in delivering the programme. In addition, staff experience has shown to be an advantage for impact as demonstrated by participants who have been with the programme since the Pathfinder Phase 1.

Many participants were not able to fulfil the strategic goals as identified in their proposals due to staffing shortages, which reflects the national recruiting profile. The concern that UPCC's could cause risk in the internal workforce market was in part resolved by some participants taking a 'grow their own' approach where they develop and support staff. The use, and recognised value, of multi-disciplinary teams is emerging as a strength in providing appropriate and enhanced patient care. Governance, development and support has therefore become a much larger part of this strategy.

There has been a review of Urgent Primary Care (OOH) peer review over the last six months which has included the review of urgent primary care functionality. Although this is currently ongoing there are some wider learning which will also be taken forward as part of Phase 3 and the delivery of a consistent model 24/7. Workforce sustainability remains critical. OOHs providers remain concerned that there needs to be closer integration with UPCCs so that they can build an enhanced resilience and offer to patients, particularly at weekends, when demand is at its highest but UPC capacity is at its lowest. There is also a perception that there is an increasing drift of staffing from OOH periods into UPCCs – where demand and clinical risk is more manageable and the financial incentives remain the same regardless of operating hours. This will therefore need to be carefully managed by HBs going forward but perhaps there are lessons from Swansea and Powys – where there is now increased focused on a Friday, Saturday, Sunday and Monday model to match peaks in demand.

Building on prior learnings stimulates the quality measures which in turn impacts the working practices and philosophy. This has allowed the programme to mature and understand the relationship between performance and data more effectively. This has led to the identification of consistency challenges when collecting data between different computing systems and for different populations, recognise the importance of 'true' demand, timely information, and pinpointing which data is key to identify impact.

Providing support to practices and clusters was an unexpected but valuable pivot; these are short term interactions provided enough resiliency that patient care continued.

The strategic function of health boards and clusters continues with opportunities highlighted by the participants to develop the wider conversation around UPC and how best to serve and resource local population needs during the planning cycles for 2022 and 2023. With connecting with wider stakeholders through the National UPCC Learning Event (October 2021) and ongoing learning from each other, data sharing and impact analysis, the participants, in general, are committed and action oriented, optimising the opportunities to develop and progress. The key will be to resource a sustainable model, embedding their remarkable work into core services, alignment with Accelerated Cluster Development, and whole system approach models that ensure rapid and appropriate responses to patient needs. Involving stakeholders earlier in planning would be highly beneficial in aligning initiatives.

It is clear from data that tangible benefits have been made in Phase 2, as can be seen from the positive patient responses, the number of patient encounters, greater engagement of GP's, the innovative and flexible approaches and the focus on optimising the patient journey. From available data, C&VUHB (Central Vale) have been able to demonstrate a link with a reduction in patients from their area presenting in ED through external data analysis, a very encouraging result.

15. Next steps

Phase 3 will be designed to build on the foundations of the Pathfinder (Phase 1) and the Implementation Stage (Phase 2). The focus will be on sustaining and embedding the local work of the programme and supporting health boards and clusters with their exit strategies to ensure they are aligned and form part of their annual planning cycle.

There also needs to be a greater focus on consistency of approach 24/7 with greater focus on periods of peak demand. The challenge for participants is to deliver a consistent UPCC offer across the footprint of the health board for all citizens.

The table below sets out the aspiration of each of the outcomes as detailed in section 1 for Phase 3:

Outcome No.	Definition:	Proposed Outcomes:
1	Define national framework for UPCC model which meets ongoing changes in needs of patients on a local basis & provides a consistency of approach 24/7	• Co-production of a national framework for UPCC model 'what good looks like' (November/ December 2022) • Focus on integrated, whole system approaches to serve local populations • Build on Phase 2 work with: ED/MIU, OOHs and other stakeholders: community services, ambulance, social care and third sector partners to develop new pathways • Explore 7 day working to meet local population demand • Continue conversations around UPC access/front end
2	Quantify impact of UPCC models nationally with robust measures which are routinely reported & visible using a national dashboard	• Current State – build on manual data baseline quality indicators using the learning from Phase 2 • Future State – DHCW work to define a consistent 24/7 reporting framework with national definitions & standards • Contribute to work on national urgent and emergency care dashboard (6 Goals Urgent & Emergency Care Programme) • Alignment of infrastructure and inter-operability • Consistent and robust reporting mechanisms • Quantify 'true demand' • Quantify impact on GPs, ED/MIU & OOHs
3	Robust communications strategy engaging with WG strategic work	• Continue work aligned with 6 Goals for Urgent & Emergency Care Policy and other national programmes • Develop national UPCC Community of Practice (CoP) to ensure sharing of best practice, continued development and resiliency after Phase 3
4	The multi-professional workforce has the necessary skills, knowledge & ability to work collaboratively together to meet presenting needs	• Align with wider UPC workforce strategy (6 Goals for Urgent & Emergency Care Programme) • Move to sustainable multi professional workforce • Explore developing themes highlighted by health boards/clusters as part of their local evaluations (Phase

Outcome No.	Definition:	Proposed Outcomes:
		2) including community pharmacies/independent prescribers • Ongoing training, collaboration, development and governance
5	Agreed final definition of Urgent Primary Care	• Review and validate working definition as part of national programme exit strategy
6	National virtual workshop (21/10/21)	• Completed • Plan final event to share programme findings at the close of the programme (Summer 2023)
7	Enabling higher quality care and value through reducing variation, waste and harm. Using prudent principles of right place, right time	• Utilise products developed by the pathfinder national evaluation framework, includes: - Quality indicators - PREMS - Concept Mapping - Development Matrix
8	Deliver the SPCC work stream and form part of the WG Six Goals for the Urgent & Emergency Care Programme	• Continue the programme as a Ministerial priority for 2022/2023 • Funded by the Six Goals Investment Fund (Phase 3)

16. Appendix One - Health Board Summaries

Taken from local evaluations Phase 2.

16.1 Aneurin Bevan University Health Board

ANEURIN BEVAN UNIVERSITY HEALTH BOARD (ABUHB):	
Total Population:	**615,949**
Number of Clusters:	**11**
Number of Practices:	**73**
Reported Activity:	**Total of 15,967** patients treated from several pathways: Re-directions **7,861** Step Closer to Home Unit **64** Think 111 First **5,923** 111 daytime Pull **892** In hours escalation **1,227**
	7,861 patient re-directions from MIU/ED: **4,433** face to face consultations **(79% MIU** & **21% ED**)
	1,227 patients seen from Practices in Escalation in-hours
Headlines Reported by HB:	✓ Launched support for in-hours escalation both short & longer term
	✓ Wider partnership engagement saw Mental Health practitioners & MSK team playing active part in designing the model
	✓ January 2022 - launch of the Step Closer to Home Unit (10 beds) medical support from UPCC GPs & Nurses. Supported clinical governance & acute medical support to facilitate better patient flow in acute & community sites particularly when shortages of community packages of care. Model's 24/7 cover is unique & links into 6 Goals Framework (Goal 2)
	✓ Frailty Service running at weekends - weekend service reduced duplication of work
	✓ 5,923 patients transferred to UPC Hub & received telephone advice from the UPC team: - 33% of these patients seen/managed within UPC - 35% directed to the most appropriate MIU - 12.8% referred to GUH ED - remainder of patients followed community services or secondary care pathways

Qualitative headlines as reported by ABUHB:
Qualitatively, the greatest benefit reported by ABUHB: "*Has been the team ethos and determination for system wide thinking……During Phase 1 ABUHB set out to plan for an integrated flow to provide a 'front door' system that integrated multiple services. The end of Phase 2 reveals a clear model is emerging demonstrating links with Urgent Care, the Clinical Review Hub, 111, ED, MIU and 999*." Funds were used to identify possible services within the existing UPCC Service already integrated within the 111 service. These included exploring support in a pilot scheme with daytime 111 pull, assisting practices when staffing issues disrupted care, and providing support to facilitate better patient flow, assist safe discharges, and discharge of patients safely with reduced packages of care with the Step Closer to Home Unit.

As ABUHB reported**:**

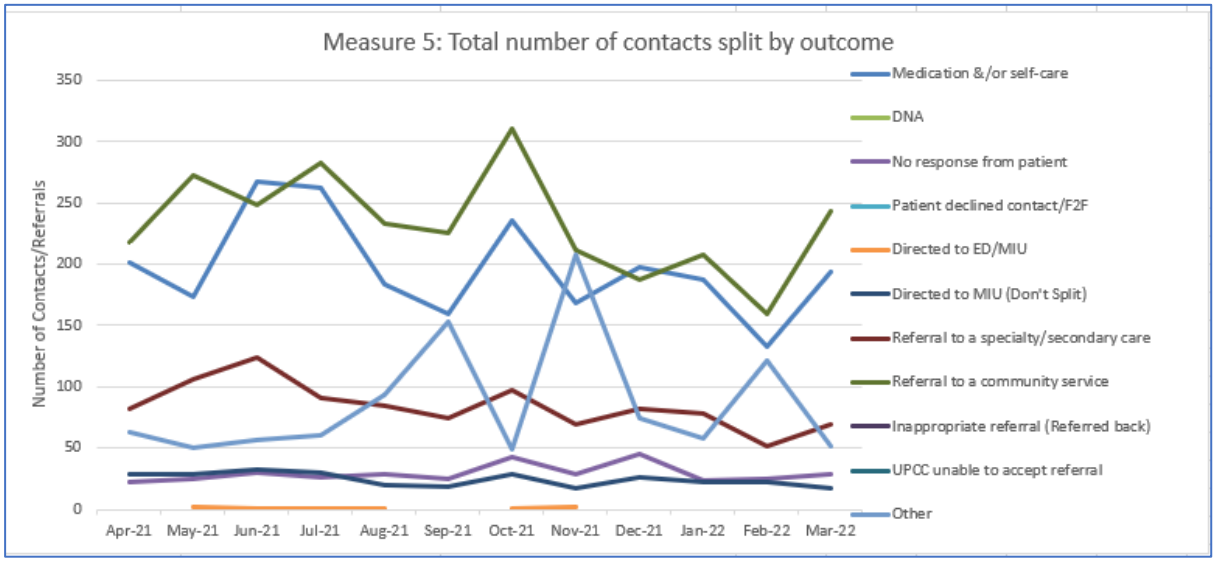
"*It was identified that it was imperative when developing the model that the whole system position was considered. This was particularly pertinent in the development of the mental health practitioner and physiotherapist roles, acknowledging that recruiting to these positions solely for UPCC could see a detrimental impact on the wider system recruitment and sustainability and a positive move forward was to work closely with the mental health and therapies services, in order to develop robust pathways into the services from UPCC, where resource can be managed more efficiently and robust clinical supervision and governance is in place, within the area with specialist knowledge*."

In a two-week pilot during December/January 2022, WAST 111 and The Gwent Urgent Primary 24/7 Service agreed to the Gwent UPC team to pull any GP suitable calls from the WAST 111 First Advice Queue (FAQ). The patients were offered treatment/assessment pathway options utilizing the resources already in place. 892 were managed through this pathway with 88% of calls were closed by UPC 24/7 through telephone advice or F2F visit. 65% of patients were managed with self-care advice or redirected to their own GP without needing to be seen F2F on the day.

The UPCC supported in reducing the pressure on acute hospitals and decrease the attendances within the Emergency department, leaving other parts of the system free to treat the most serious cases.

ABUHB worked to provide a platform where the patient would experience a seamless course of treatment. As ABUHB indicated:

"*The graph below… Demonstrates the total number of contacts split by outcome, as identified there are very few patients that were referred inappropriately via this pathway, or that were unable to be accepted. This is due to the extensive work undertaken across UPC and MIU/ED staff groups on appropriateness of referrals and discussions around any changes needed in relation to the pathway/criteria in real time, through the governance and operational group. The two highest outcomes were referral to a community service or medication / and or self-care. I think this element clearly demonstrates the importance of the UPC service, particularly in relation to goal 2 signposting, ensuring that patients have the appropriate treatment in the right part of the system*".



Closer links have been made with the flow Centre and the C3 WAST stack work, supporting patients awaiting ambulances within the community, with the ABUHB pilot starting in April 2022.

16.2 Betsi Cadwaladr University Health Board - Central Area

BETSI CADWALADR UNIVERSITY HEALTH BOARD (BCUHB) – CENTRAL AREA:	
Total Population:	**61,391**
Number of Clusters:	**1**
Number of Practices:	**6**
Reported Activity:	**Total of 346 referrals - 99%** with UPCC clinician
	Utilisation grew from **27% in December to 91% in March**
	December 2021 - January 2022 average of **29 referrals per month** (6 practices) increased almost five-fold average **to 143** referrals in February & March 2022
Headlines Reported by HB:	✓ UPCC service hosted by BCUHB Managed Practice: Healthy Prestatyn Iach (HPI)
	✓ UPCC launched December 23rd 2021 – March 2022 (due to staffing issues & hosting difficulties)
	✓ Patient Satisfaction: 96% of the patients surveyed scored 8 or above out of 10
	✓ UPCC daily capacity of 34 appointments (virtual/F2F) ✓ MIND service weekly capacity 76 patients

Qualitative headlines as reported by UHB:

As BCUHB indicated:

"*The cost per case in Phase 2 is reflective of the Service being in early stages of implementation and development, with UPCC clinicians still training and underutilization of the service by the Cluster Practices initially. In Phase 3, planned recruitment, increased Service utilisation and increased capacity of the UPCC Clinicians (as the service progresses) will see an improvement in the Cost per Case, moving towards the predicted spend/utilisation cost of £42.06 per case, or potentially less when other clinicians are recruited."*

BCUHB Central developed a wide range of partnership connections such as Community Resource Teams, District Nurses, third sector and mental health. It also provides access to MH support (76 patients). This element is not funded by the UPCC programme as already established with MIND.

The model delivery of the UPCC was disrupted due to recruiting difficulties.

As BCUHB reported:

"*The Central Area approached the staffing of the UPCC in such a way as to maximise the use of available experienced staff. Due to the cluster-based model including an agreed hosting practice arrangement, the intention is to supplement the existing Healthy Prestatyn Iach (HPI) practice team (local initiative) with additional skilled staff, in order to release sufficient skilled staff time to deliver the UPCC service. Using this approach will build resilience into the UPCC through potential cross cover during sickness and annual leave, and by including a mix of Practice and UPCC work, staff gain variety in their job plan*."

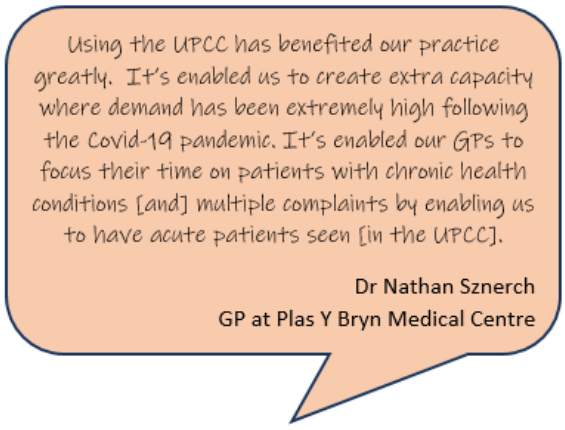
16.3 Betsi Cadwaladr University Health Board - East Area

BETSI CADWALADR UNIVERSITY HEALTH BOARD (BCUHB) - EAST AREA:	
Total Population:	**300,436**
Number of Clusters:	**6**
Number of Practices:	**39**
Reported Activity:	**Total of 12,099** patient episodes (average of 1,008 referrals per month - increase from 619 in Pathfinder Phase 1)
	72% utilisation (November 2020 – March 2021)
Headlines Reported by HB:	✓ 93% of cases received a consultation with a UPCC clinician
	✓ 94% patient survey rated overall experience as excellent or very good
	✓ Questionnaire revealed 24% of patients would have self -referred to ED/111 & 20% would have contacted GPOOH if GP appointment or UPCC not available
	✓ 88% patients dealt with at UPCC, 3% referred to a specialty or secondary care service with 4% inappropriate referrals
	✓ Wednesday are busiest day followed by Tuesday & Monday respectively

Qualitative headlines as reported by UHB:

The funding enabled supporting other care pathways, providing support in key areas.

A Central GP practice in March had significant issues in providing cover for patients. East BCUHB UPCC provided cover for remote consultations to provide ongoing patient care. In addition, when no prescribing clinician was available within the Lymphoedema service, East BCHUB UPCC was able to step in and support.



Most referrals accessing assistance were received from GP practices, followed by MIU. Referrals from ED is low, and negligible from 111/WAST. The team therefore has been reviewing referral criteria, streamlining referral process and meeting with ED management team and triage teams to increase referrals. Initiatives included trial use of UPCC HCA's working with the ED triage team. However, this did not have desired outcome of increasing referrals which was attributed to the HCAs feeling unable to challenge the triage team to refer to the UPCC. Further discussions, co-operation and investigating new ways of working together are being investigated.

The UPCC has two locations; one based in Wrexham and one in Mold. In Wrexham, the rooms are loaned from Outpatients and was temporarily relocated to an alternative base for 3 months during Phase 2. This impacted service capacity, and reduced utilisation by some stakeholders. Uncertainty regarding a long-term location and current limits on clinic rooms constrains expansion.

Other constraints included difficulties in administration and clinical staffing resulting in reduced capacity. However, the pressure has been managed, for example relocating a GP from Mold UPCC to Wrexham UPCC to aid accepting referrals from ED.

BCUHB reported that troubleshooting led to faster responses and implemented solutions. Although the results are not as anticipated, different ways of approaching issues are planned.

16.4 Cardiff & Vale Clusters – Central, Western & Eastern Clusters

CARDIFF & VALE CLUSTERS – CENTRAL, WESTERN AND EASTERN CLUSTERS (C&VUHB):	
Total Population:	**132,531**
Number of Clusters:	**3**
Number of Practices:	**13**
Reported Activity:	**Total 21,141** **UPCC** total **19,253** **MH** total **494** (within 24 hrs.) **MSK** total **1,394**
	UPCC referral source: - **18,819** GP Practice - **468** OOH/111 (2.5%) – majority for Saturday UPC session
Headlines Reported by HB:	✓ UPCC activity ✓ **66%** telephone triage – 12,744 ✓ **34%** face to face – 6,509
	✓ Consistently high utilisation across 3 UPCCs ranging from **85% to 94%**
	✓ **95%** of consultations are completed with selfcare / medication
	✓ **1.7%** DNA rate

Qualitative headlines as reported by C&VUHB:

As C&VUHB reported:

"*Patients are treated in the three Urgent Care Hubs, Central, Eastern and Western Vale with all Hubs now offering MSK and Mental Health services. C&V UHB are well on the way to developing an effective multidisciplinary model to deal with acute unscheduled care needs and their ambition is to expand both the scale and scope of this model. The process of integration with the out of hours service has now been achieved with further plans to strengthen these links and develop seamless pathways to the Cardiff and Vale 24/7 services*."

There are three clusters within the Vale locality. Central Vale has been building its expertise from the beginning of the programme in 2019, with Eastern Vale and Western Vale joining the programme this year. Each cluster identified one local Urgent Primary Care location to accommodate local needs.

- ✓ To support GMS sustainability, across Cardiff and Vale, the health board has invested £1.9m to increase resource and roll out First Point of Contact (First Contact Physiotherapist) and Mental Health capacity. Individual practices have also brought in additional capacity as part of the model they wanted to put in place.
- ✓ Cluster development and Pan Cluster Planning Groups within the Vale are planning a Vale Alliance based on the Canterbury, New Zealand model. C&VUHB now have a clear plan to take the alliance forward supported by an integrated team with the Head of Adult Social Services and the Vale Alliance building the foundations for this with consideration to lessons already learned.

C&VUHB exploring new ways of delivering patient care services, from pharmacy to point of care (Pocte) to assist patients with respiratory symptoms closer to home and for admissions avoidance.

As they report: "*The UPCC's have differing levels of workforce capacity with Central Vale providing services from: GP, pharmacist, independent prescriber, ANP (and an ANP trainee) physiotherapist and paramedics. Eastern and Western Vale plan to have all these services (except the paramedics) available*

in phase 3."

One of the keys to embedding services is the wider system alignment with C&VUHB reporting:

"*One of the key aims of the Vale UPCCs is to '**reduce pressure on both 'in-hours' and 'out of hours' unscheduled primary care'** ….Therefore the **21,141 patients** seen in one of the UPCCs during Phase 2 would otherwise be seen within GMS or by OOH/EU….. The priority for Phase 2 was to clearly demonstrate the wider system impact of the Vale UPCCs on CAV247/OOH/ED.*"

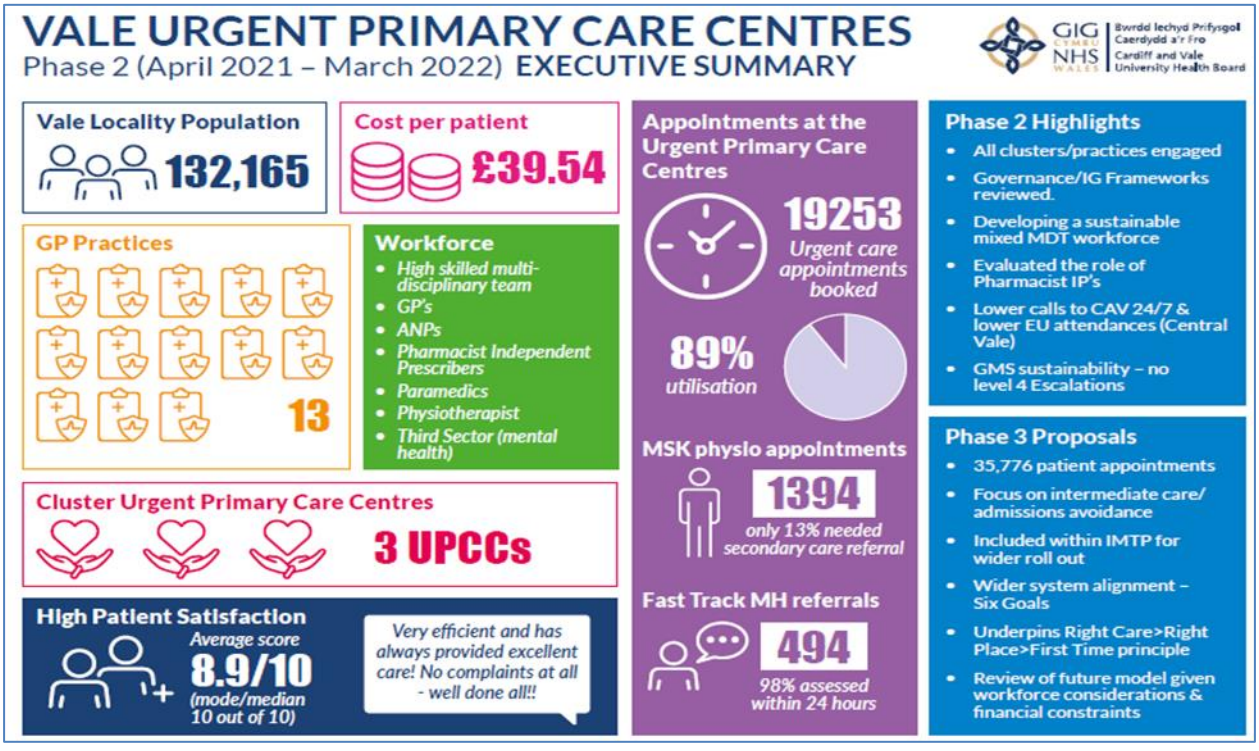
Issues on available capacity in both EV & WV UPCCs resulted in fewer UPCC appointments than proposed. "*Therefore, the focus is on CV where the quantity of patient episodes made (in excess of 12k) and a service that has routinely operated daily Monday to Saturday has provided rich insight – though noting that data needs to be interpreted with care given other factors can also impact**….** The data by month is showing a downward trend in attendances at EU from Central Vale. Feb 22 is showing lowest monthly attendances since 2016*."

With the maturity of the work of the original Central Vale Cluster, the health board has been able to breakdown data for EU attendances which shows:

- ✓ Fewer patients being discharged which may indicate more appropriate EU presentations
- ✓ More patients referred to other outpatient/primary care services
- ✓ Fewer patients being admitted to wards
- ✓ Fewer patients being admitted from EU to SAU

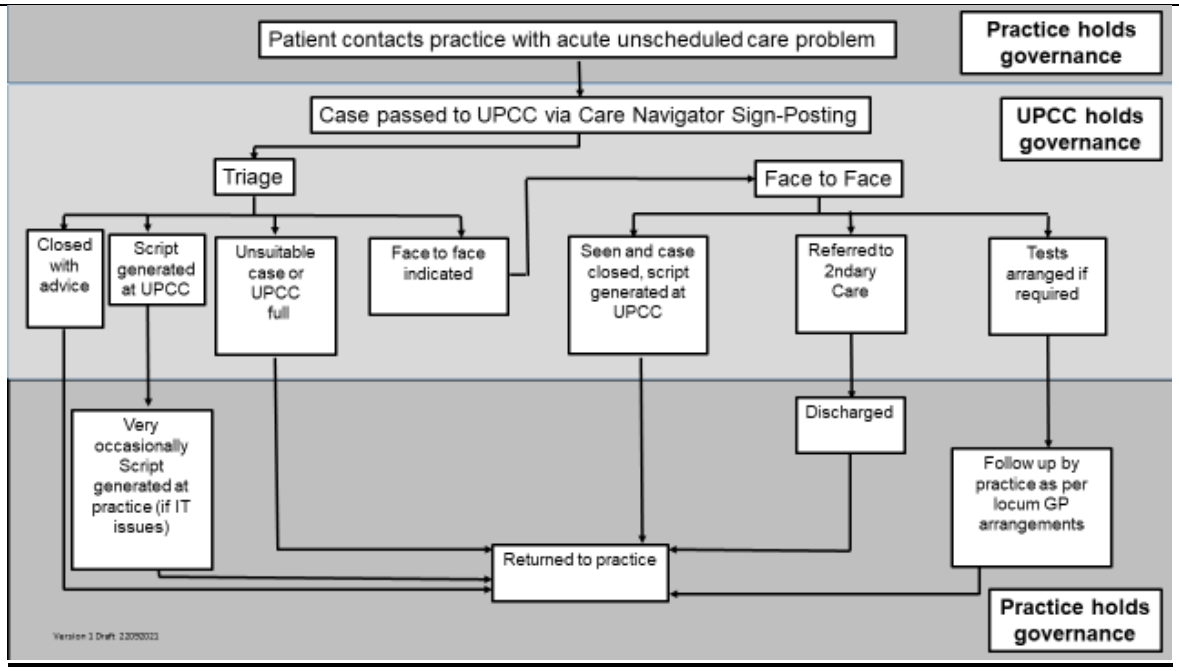
As C&VUHB noted:

"*These results do appear to show a very positive result, linking efforts to a system wide impact. Reduced demand on CAV24/7 /OOH, leading to less demand and patients receiving appropriate treatment within their local area is a significant step forward."*



16.5 Cwm Taf Morgannw University Health Board - Rhondda Cluster

CWM TAF MORGANNW UNIVERSITY HEALTH BOARD (CTMUHB) – RHONDDA CLUSTER UPCC:	
Total Population:	**56,000 patients** access Rhondda UPCC from the total cluster population of 88,000
Number of Clusters:	**<1**
Number of Practices:	**7 of 11** practices collaborating
Reported Activity:	**Total of 15,825** patient episodes - **12,934** telephone consultation - **2,891** face to face
	Average **utilisation 98%**
Headlines Reported by HB:	✓ Multi-disciplinary team (ANP, APP & Independent Pharmacy Prescribers)
	✓ Cluster lead model - in community hospital close proximity to MIU Primary Care Resource Centre in Ysbyty Cwm Rhondda, Llwynypia
	✓ Referral pathways for DVT & Respiratory Health – aim to reduce referral rate to secondary care & improve detection of DVT's in community
	✓ UPCC pilot site for University of South Wales & CTMUHB research to assess validity of D-Dimer POC testing
Qualitative headlines as reported by CTMUHB:	
The model is now operating with 7 practices signposting to UPCC and offering telephone triage and face to face appointments Monday to Friday between 9am and 6pm providing an average of 10-14 GP sessions per week plus 10-14 ANP/APP appointments. The North Rhondda UPCC model is unique since it is a practice led model based in a Community Hospital, Ysbyty Cwm Rhondda', with five of the twelve cluster practices collaborating to develop the UPCC. Being based in the community hospital had the advantage of easier access to patients, but efforts were hampered as only two rooms were available. The original start date was delayed to 7 January 2021 due to IT challenges, integration with ICT and staffing issues. Significant increase in reach in Phase 2: population in phase 1 served 30,000 with 5 practices.	
"The broad range of conditions which are seen in Urgent Care has enabled GPs in practice to see more chronic conditions daily. From a care navigator's perspective, it allowed me to navigate more efficiently, offer more patient options and develop a rapport with patients when you explain the UCC service and how it can help them" – **Care Navigator – Ferndale Practice.** *"We are initiating a pilot project with ED in the Royal Glamorgan Hospital that will allow ED to refer patients to the Rhondda Urgent Care Centre. Often the flow of patients from primary care to ED is one way. We hope to create a two-way process between ED and primary care. Our hope is that we will be able to provide the right care in the right place and avoid long unnecessary waits for patients with primary care appropriate problem who present to ED"* – ***Dr Aled Davies (UPCC Clinical Lead).***	



To support sustainability within the UPCC the initial workforce plan for Phase 2 was to use the health board's salaried clinicians who would join the team for part of their working week. Unfortunately, due to sustainability pressures within the UHB Managed Practice this structure was only part of the UPCC workforce for May and June 2021. This is reflected in the higher percentage of sessions filled. The results in September and October show a more stable workforce as a result of ANPs recruitment following completion of their earlier training and mentoring at the UPCC. November and December's shift fill is the result of the Omnicron wave.

The current model does not integrate with OOH, ED & WAST. The UHB strategic plans will direct the UPC model moving forward.

"*The present appointment system is not equitable throughout the participating Practices with the main largest Practice utilising 50% of the UPCC capacity, which is 18% more than allocated based on list their list size. The remaining Practices with a total population of 38,000 share the 50% capacity. As the model is based on supporting the sustainability within General Practice it is important that the service is equitable throughout.*"

"*It is likely this reflects 4 out of the 6 practices joining later in the year which would lead to lower usage. In addition, not all cluster practices are invested in the UPCC service which means that the population in Rhondda do not have equitable access to this service*."

The location (within a community hospital) has strengthened relationships and is helpful for patients who can access other services in the same location or close by. However, space is in demand and the UPCC is located in two rooms without the opportunity to expand. The preferred hub and spoke model (determined to be the best fit for the local population due to geographical issues and lack of a natural central location for UPCC's), is not currently available due to lack of available accommodation within Practices.

Rhondda has created and maintained good working relationships with between UPCC, local Practices, Pharmacies, Urgent Primary Care Service and Emergency Department Teams.

16.6 Swansea Bay University Health Board

SWANSEA BAY UNIVERSITY HEALTH BOARD (SBUHB):	
Total Population:	**361,463**
Number of Clusters:	**7**
Number of Practices:	**52**
Reported Activity:	**Total 4,580** (April 2021 – March 2022) demand was initially low & increased monthly with colocation to exceed planned capacity in final month **2,696** telephone consultations **1,829** face to face
	28% referrals from ED **25%** referrals from GP's **8%** OOH
Headlines Reported by HB:	✓ **2 UPCC locations:** **1. Morriston Hospital** (December 2020) **2. Neath Port Talbot Hospital** (November 2021)
	✓ UPCC patient satisfaction survey: **86%** of patients rated overall experience as excellent
	✓ UPCC's used a whole system approach to interface between GP's and ED at Morriston Hospital

Qualitative headlines as reported by SBUHB:

SBUHB reports: Swansea Bay have been working towards an integrated care model. As such UPCC is co-located and integrated into the 'Acute Clinical Hub'. This hub comprises of the following Services, and is working towards co-location with the acute medical unit:

- Ambulatory care (including POCT and rapid diagnostic radiology services) including co-located medical teams
- 111 contact first
- WAST stack review
- Hot slots with OPAS (Older Person Assessment Service)
- Access to direct admission pathways agreed under contact first
- Links with ED via our 'GP in ED'

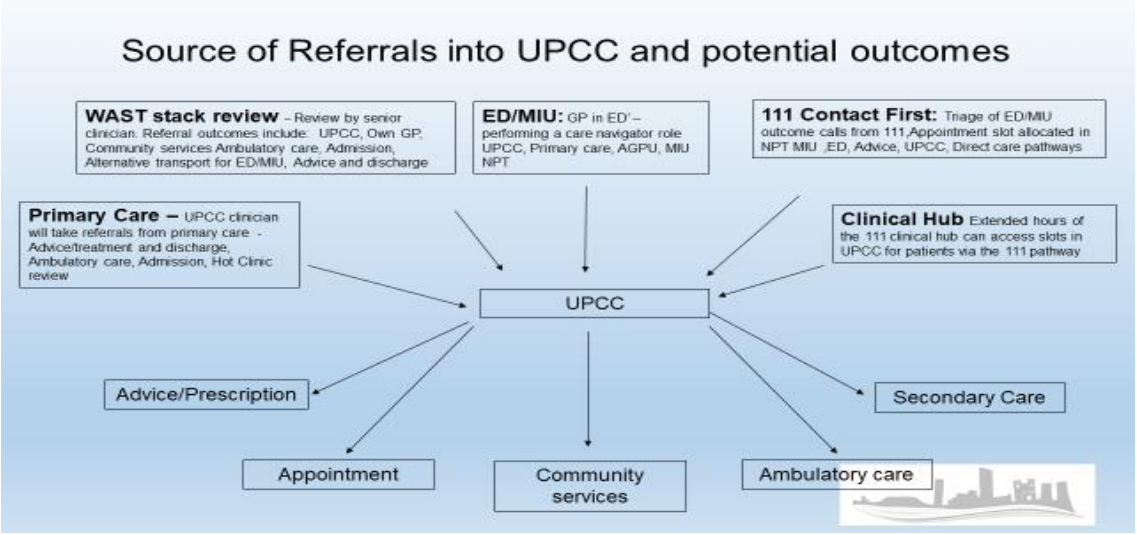
✓ The set-up of a 24/7 Mental Health pathway and the launch of the private transport pilot which will be extended to all clusters providing transport to patients requiring same day ambulatory assessment following GP home visits.

✓ Progress on the implementation of a whole system approach to tackle the increasing incidence of urgent primary care presentations is now directly impacting frontline emergency services and GP Practices.

✓ The establishment of the UPCC is now providing an interface between General Practice and the Emergency department at Morriston Hospital and the more recently opened centre in Neath Port Talbot Hospital ensuring an efficient and effective filter of all urgent primary care related cases. The UPC centres continue to link with established stakeholders to receive all redirected urgent primary care patients identified as needing to see a clinician on the same day but not falling into the emergency bracket of ED. The Centre's are also acting to filter those urgent presentations identified within General Practice that cannot be absorbed into the daily workload but identifying as patients requiring urgent on the day treatment.

- ✓ Members of the UPCC multi professional team will be working in conjunction with the Ambulatory Emergency Care team situated at Morriston and Singleton Hospitals in order to access rapid diagnostics and ambulatory care pathways.

Despite lower than anticipated utilisation, demand grew until March 2022 when demand outstripped provision. As a result, the data will be reviewed to assess if expansion of services are required or if patients are referred appropriately.



"*Swansea Bay planned for a system wide approach, focusing on the "new 'Phone First' service via 111 to receive all redirected UPC patients to avoid "unnecessary admission or routing through the Emergency Department. This would deliver a primary care service closer to the patient's home, reduced footfall at the acute sites resulting in reduced COVID-19 transmission risk for patients*."

Some benefits were expected and others emerged, as reported by Swansea Bay:

"*We have created a system of push and pull referral at all entry points into the unscheduled system. The benefit of this is redirection of primary care patients to the appropriate pathway…. the patient has a better journey as they receive the benefit from senior triage and redirection to appropriate care delivered in a timely manner in an appropriate setting by the right person. This allows resource such as ambulances, ED clinicians etc. to be utilised appropriately. This helps improve flow in already stretched services. An unexpected benefit was the utilisation by primary care. We designed the service to very much focus on the inappropriate presentation of primary care cases in secondary care, however we were also able to offer practices who felt they were struggling to have an outlet for their patients to be assessed and seen. This obviously offered a much needed lifeline to practices who were under pressure due to staff absences from COVID as well as avoiding possible presentation of those patients to secondary via WAST or ED*."

In consultation with stakeholders, colocation in Morrison was agreed (instead of original idea of collocating with GPOOH) which resulted in substantially increased referrals. The total number of appointments increased due to opening of second Centre in November 2021. It was found that co-location was key to ensuring referrals, and constant input and discussion was required to establish a level of comfort so ED would refer patients. Having GP's embedded in ED was helpful but the tension between falling into an ED role or being an expensive care navigator has been reviewed and re-assessed, identifying that a nursing post would be a more appropriate fit moving forward. Ongoing dialogue is also occurring with WAST and 111 National Programme.

16.7 HDdUHB – awaiting return

Total Population:	**301,259**
Number of Clusters:	**7**
Number of Practices:	**48**
Reported Activity:	**77% (37 GP practices)** of practices signed up to Urgent Primary Care service & utilised the funding to resource services to release GP time to manage complex patients with intermediate care needs on the 'virtual ward' & receive dispositions from '111 First' of patients presenting with primary care needs. The resource equates to two appointments per practice per day.
Headlines Reported by HB:	✓ Our UPC Service is now fully resourced against the investment received ✓ Progressing implementation of the 24/7 UPC service model in phased approach ✓ Urgent primary care response pathways are available for patients with palliative care & intermediate care needs (virtual ward) across the whole Health Board ✓ Clinical Streaming Hub established focused currently on Carmarthenshire residents. Senior clinicians working with WAST APP navigator to prevent conveyance to hospital through dispositions to intermediate care provision on the virtual ward managed by the patient's own GP. ✓ High level outcome indicator for the UPC service is reduced Conveyance & reduced presentation to ED of self-presenters to minors ✓ Our Conveyance rates have reduced a further 4% since October 2021 which corresponds with an increased number of patients being assessed and managed by primary care on the 'virtual ward'. ✓ There is evidence that self presenting minors to ED have reduced for those practices participating in the UPC pathfinder compared to those practices who have not participated
Issues & Risks	✓ Our UPC Model was developed & agreed in April 2021 based on the understanding that '111 First' would go live & 'stream' patients with primary care need presenting to 111 to our clinical streaming hub who would schedule appointment with the patient's own GP. ✓ UEC UPC funding was granted based on this proposed model ✓ 111 First has yet to 'go live' which presents a challenge to us being able to redirect patients who present to ED with primary care needs.
Next Steps	✓ To provide assurance through data analysis that the reduction in conveyance since October is not related to reduced WAST resource due to handover delays & their recommendation that patients self present to ED ✓ To undertake retrospective random analysis of self presenting minors to ED to provide assurance that UPC service is impacting in this area ✓ Roll out the Clinical Streaming Hub

Qualitative headlines as reported by HDdUHB:
The 6 Goals UEC programme mandates the development of an integrated 24/7 urgent care service. Specifically it outlines the requirement for Health Boards to implement Urgent Primary Care Centres / services which will providing a locally accessible and convenient service and offering diagnosis and

treatment for urgent care complaints, illness or injury – by April 2023. It also specifies the requirement that each Health Board or Region develop a clinical Support or Streaming Hub by April 2023.

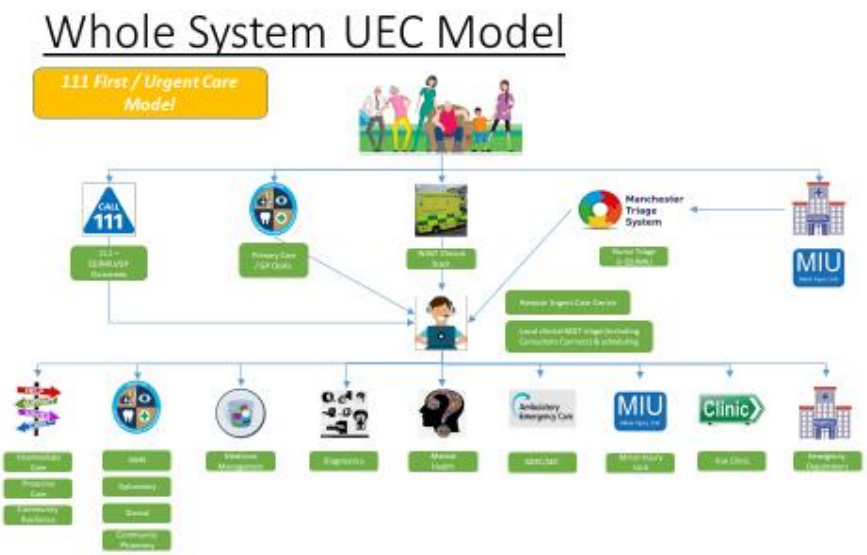
In considering our model we analysed our data. This clearly demonstrated that our frail population dominated Emergency Department (ED) demand both in terms of WAST conveyance and Health Care Professional (HCP) referrals. A random review of self-presentation demand and '111' demand highlighted primary care needs contributed to demand to the value of 2 patients per practice per day. On this basis our model recognised that any UPC service would need to ensure sufficient resource to accommodate frail patients on a 'virtual ward' while also releasing GP time to oversee these patients and accommodate primary care dispositions from ED and '111'.

We acknowledge the expectation that each Health Board develop an UPC Centre. While considering our UEC model we determined that establishing a UPCC that would benefit the Health Board's population would be challenging given its geographical expanse. In consultation with the local GPs in the model's development, we established that their preference would be to take responsibility for their own patients. They proposed that patients registered to their practices who are attending Emergency Departments or indeed accessing our emergency services (WAST) when their needs could be safely should be managed by primary care in the community. Our GPs and the Clusters agreed therefore that they will deliver the UPCC 'offer' for our Health Board as an Urgent Primary Care 'service' and hence a 'remote' UPCC.

"…we know our patients best and if they need to see a GP they should be seen by us rather than a GP in a UPCC" General Practitioner

Our Hub will provide clinical and professional advice remotely and signpost / refer / schedule patients directly to the right place, first time. Dispositions include palliative care, intermediate care, SDEC, MIU and Hot clinics. It will also accommodate dispositions from ED and '111'. The Hub will integrate our 'in hours' UPC offer with the existing GPOOH. The latter however will benefit from 24/7 multidisciplinary resource that exists in UPC provision. The Hub and its 'streaming' pathways will evolve in a phased manner but will ensure that every person with an urgent primary care need will reliably have access to the right professional or service for that need within 8 hours of contacting the NHS. This will be fully functioning according to the timescales expected by WG of May 2026.

Our Model



WG UEC funding was utilised to provide additional resource in UPC for the following areas:

- Hub Clinicians
- 'Wrap around care' for patients on the virtual ward (inclusive of therapy and care workers)
- Additional resource at GP practice level to release GP time (this was based on individual GP practice review of their workforce to determine the additionality. This ranges from locum GP sessions, ANPs, Pharmacists, Pharmacy Techs and additional admin for front door triage and navigation

Our UPC resource is now fully resourced with the investment received from WG.

Next Steps