URGENT PRIMARY CARE

Development Matrix

for National Urgent Primary Care Pathfinder Panel

Professor Mark Llewellyn and Professor Jonathan Richards

Welsh Institute for Health and Social Care · University of South Wales

May 2021 – FINAL VERISON AND ALL-WALES OVERVIEW

Canolfan PRIME Cymru
PRIME Centre Wales

University of South Wales
Prifysgol De Cymru

wihsc
SILVER ANNIVERSARY • PEN-BLWYDD ARIAN
ESTABLISHED 1995 • SEFYDLWYD 1995

CONTENTS

1. INTRODUCTION

From the outset of our work to develop an overall evaluation framework, we recognised the value of utilising the 'Maturity Matrix' concept within the context of the national Urgent Primary Care (UPC) Pathfinder Programme. This document contains the final version of the 'Development Matrix for Urgent Primary Care' which has been developed and iterated in partnership with the six UPC sites and the National Urgent Primary Care Pathfinder Panel.

Maturity matrices are the foundation of the Clinical Governance Practice Self-Assessment Tool, used by all general practice teams in Wales as a component of the Quality and Outcomes Framework. 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 can be linked together (structure, process, resources, outcomes for example). An example of a general practice Maturity Matrix (figure taken from Elwyn G et al, 2004)[1] is provided below:

Clinical Records	Audit of clinical performance	Clinician access to clinical information	Use of guidelines
50%	50%	50%	50%
Written records only. No computerised information.	Audits not undertaken	No clinical information available in practice	Guidelines not used within the practice
Registration data on computer.	Data collection exercises completed but failure to meet full audit cycle criteria.	Textbook access, limited locations.	Guidelines discussed but no policy to follow any particular guidelines agreed
Registration and repeat prescribing system on computer.	Less than one audit per year that meets full audit cycle criteria.	Peer reviewed journals e.g. BMJ and similar available to all clinicians.	Guidelines discussed and adapted to use in the practice
Electronic records kept for registration and prescriptions.	Regular audit cycles completed but only few clinical areas.	Peer reviewed journals and digest publications such as Bandolier, Effective Healthcare Bulletins, Drug & Therapeutics Bulletin available to all clinicians.	Guidelines are incorporated into clinical information systems and used as clinical tools.
Mix of electronic and paper records	Regular full audit cycles undertaken in key clinical areas (asthma, diabetes, hypertension)	On-line access to internet based databases available to all clinicians at limited locations.	Use of guidelines audited.
Majority of clinical encounters coded electronically by clinicians (i.e. searchable).	Regular full audit cycles undertaken in key clinical areas (asthma, diabetes, hypertension) and information regarding audits published for external peer review, e.g. to audit groups.	On-line access to information at clinical desktops.	Care pathways developed and implemented.

[1] Elwyn G, Rydderch M, Edwards A et al (2004) Assessing organisational development in primary medical care using a group based assessment: the Maturity Matrix™ *BMJ Quality & Safety* **13:**287-294 http://qualitysafety.bmj.com/content/13/4/287

The scoring, and the patterns of responses can inform discussions between different teams and with managers and commissioners who wish to have an overview of what is happening and the progress that is being made or that can be anticipated. Flexibility and iteration are key with a mature approach to measurement and a sophisticated understanding of the complexities of delivering services in the real world.

CONTEXT

When the Welsh Government made available £4m to provide community UPC services, six health boards were successful in making applications for this money which was distributed across Wales. The 2020-2021 workstream builds on earlier UPC pilot work across Wales[2] and the work of the Strategic Programme for Primary and Community Care.

Over time, the focus has moved from the broader context, through urgent primary care (UPC) and most recently to urgent primary care centres (UPCC). There has been a degree of flexibility in how different areas interpreted different aspects of their new services, and the six sites all took different approaches to the nature of what had been achieved in previous initiatives, the current needs of each locality, contemporary service provision, current IT provision and other, local, factors – one service model size did not fit all. This flexibility was 'built in' in order to achieve the objective of the pathfinder aims to define a definition and describe a national model. Further, there was an asymmetry in the starting points and history of such services across Wales. Accordingly, those delivering services started to collect data on the impact of their services without clear guidelines, and as such there was no consistency of approach between the six services.

PURPOSE OF THE MATRIX

Our aspiration in developing a matrix was to produce a tool that clinicians, managers, commissioners and other key stakeholders would find helpful. It was initially designed to:

- Describe what is happening with 'face validity' for the key stakeholders;
- Facilitate a description of what is happening in a way that enables comparison between sites across Wales;
- Illustrate what 'good' looks like with steps to suggest and/or demonstrate development; and
- Enable teams to discuss *amongst and for themselves* how they perceive their current circumstances and agree on the next steps to be taken, as this is how such tools work best.

The study team reviewed the most recent publications on UPCC that had been issued including the '20200928 Letter to COOs and DPCMH' and 'Urgent primary care programme 2019_20 learning to date'. A spreadsheet was developed to reflect the wording in the letter to inform the interviews with managers and front-line clinicians, structured by a series of the key features that were to be part of these projects:

[2] The earlier pilot work has been reviewed in two reports: Davies C and Esain A (2019) *Welsh Urgent Primary Care Programme*; Urgent Primary Care Programme Year 2 (2020) *Learning to Date: Observations and Reflections November 2019-May 2020*

Objectives in Welsh Government letter
Function
an extension of GP OOH/111 service
access to a wide range of professionals
a wide range of presenting conditions
extension of capacity for same day appointments
Staff
GP
ANP
MSK Practitioner
Paramedic
Pharmacist
wellbeing/Mental health practitioner
Social/Community Connector or Social Worker
Purpose
meet demand in hours
meet demand out of hours
practice
cluster
multi-cluster
pathway based
presentation based
alternative to ED presentations
links to front end 111 services

Functions
screening
assessment
clinical management
telephone support
senior support
IT and data
integrated with general practice
access to general practice
access by general practice
access to ED/Secondary Care
access by ED/Secondary Care
Measures
user satisfaction short
user satisfaction long
standard flow dataset
standard activity dataset
bespoke flow dataset
bespoke activity dataset
Outcomes
simplification of health provision
improve access
single point of access
avoid hand-off
meet demand

In this context where it was clear that there could be different priorities for each locality and for each health board, the study team went through a series of stages that the before arriving at the matrix as described in this document.

DEVELOPING THE MATRIX

Ahead of initial meetings with the programme managers, we read the documentation provided. We then had conversations with six of the health board teams, speaking with either project managers, clinician leads or both. The conversations were informed by other projects that we have worked and our understanding of how the NHS has always differed from one part of Wales to another. The history and context of each project fitted precisely with this experience. We could begin to see how the activities and plans in each locality/cluster/health board fitted with the materials provided and

what we understood to be the anticipated outcomes together with what was expected of us in producing the matrix.

The preliminary interviews, some with programme managers and some with clinical leads informed the development of the matrix. It became clear that the Development Matrix should include a number of domains, each with a particular focus for the commissioners and stakeholders, for health boards, for cluster leads, for clinicians in primary care and for patients.

It was recognised that measures like the numbers of patients seen, investigations carried out, and interventions performed within each health board do not tell the whole story about the transformative opportunities provided by the new resources made available in this initiative. The quantitative measures that will be determined as part of the core dataset needed to be complemented by a more qualitative form of assessment of impact. The study team developed the matrix to address this gap.

2. THE URGENT PRIMARY CARE DEVELOPMENT MATRIX

The matrix provides a framework for a qualitative assessment to be made of progress. The matrix is designed so that the services can determine which of the cells in the matrix best describes their progress to date against different dimensions within three domains. It is intended that the services could compare their progress over time, and also to potentially compare their service with others in Wales. One of the benefits of the matrix is that services can use it to assess their progress in relatively short order – services would not need to engage in detailed data collection exercise to make a determination of progress against the matrix.

USING THE MATRIX

It is important to note that there is an underlying logic in how the statements build on one another across the matrix. The statements are incremental – moving along the boxes presupposes that forms of practice under the previous statement are included in the next one. For example, in selecting S2 for domain 1.3, people completing the matrix are suggesting that first assessments are undertaken 'by a triage call handler (Care Navigator)' **in addition to** 'a medical receptionist (Care Navigator)'. It was clear in discussions with each site, that not every component within each line is present in every setting. On some occasions it is not required, in others it is not currently an option. Therefore, there is an opportunity to provide context around the statements in the box underneath the matrix. There is also an 'N/A' option which can be used if the domain is determined to be outside of the current remit of the service model, is not required in that locality or if there is capacity elsewhere in the system that can be drawn upon.

Different levels of 'development' have been determined through the piloting of the matrix. It is now possible for those completing the matrix to use darker shading against statements where there is greater evidence that the statement has been fully achieved. Lighter shading is an indication that some progress has been made in this domain, but that it remains a 'work in progress'.

Whilst not wishing to be overly prescriptive about the way in which the matrix should be used, it is important to note that it can be deployed variously within different health boards. There should, of course, be one 'composite' matrix that is completed at health board level, but this single matrix can be an amalgamation of a number of different matrices that have been completed by operational teams, managers, clinical directors and others either in combination or completing it alone. This is how such a matrix is designed to work – it can be considered to be similar to a balanced score card.

It is crucial though that having established a local approach, the same method is repeated the next time the matrix comes to be completed to ensure comparability over time. It 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.

Date of completion:	**Site**:	**Person/s completing the DM**:

Scope of answers given (tick as appropriate):	These answers are based on the UPC service / UPC centre only	☐
	These answers are based on the broader context within which the UPC service / UPC centre sits	☐
Status of answers given (tick as appropriate):	These answers are based on the current operational model of the UPC service / UPC centre	☐
	These answers are based on the agreed and planned model of the UPC service / UPC centre	☐

Domain	**Descriptors: For each of the dimensions below, which statement below (S1-S5) best describes your current position?** *It is important to note that there is an underlying logic in how the statements build on one another across the matrix. The statements are incremental – **moving along the boxes presupposes that forms of practice under the previous statement are included in the next one**.* *Darker shading against statements indicates that there is evidence that the statement has been fully achieved. Lighter shading is an indication that some progress has been made in this domain, but that it remains a 'work in progress'.*					
1. SERVICE DELIVERY	*S1*	*S2*	*S3*	*S4*	*S5*	*N/A*[3]
1.1 | Focus of the service	Supporting patients (directly or indirectly) contacting the GP (primary care in-hours)	Supporting patients (directly or indirectly) contacting the OOH service	Supporting patients (directly or indirectly) contacting 'Contact First'	Supporting people (directly or indirectly) who might otherwise have contacted ED/MIU	Supporting people (directly or indirectly) contacting WAST	
1.2 | Method of service provision	A remote (telephone or video) consultation	Face-to-face with a GP	Face-to-face with MSK, MH or other practitioner (e.g. physio)	Signposted to support service (incl. voluntary sector social prescribing)	Signposted (where necessary) to other services	
1.3 | First 'assessment' *Where is the triage decision made?*	By medical receptionist 'Care Navigator'	By triage call handler 'Care Navigator' (e.g. from 111 or Contact First)	By a clinician 'Care Navigator' (in primary care or ED/MIU	Within the UPC/At the UPCC hub	Direct referrals from primary care	
1.4 | IT systems used *Select one or other of the two paths as they run in parallel not series*	GP systems in practice only (Vision)		GP systems in Cluster (Vision 360)		System offering further and fuller advantages (e.g. Vision Anywhere, Symphony, Indigo)	
	ADASTRA (incl. Individual Health Record)		ADASTRA aligned with other systems (e.g. (CWS, Welsh Clinical Portal, SALUS, Radius C3)			
1.5 | Visibility / 'amend-ability' of patient record (interoperability)	The patient records cannot be seen (within primary care or without)	Records can be seen (within primary care)	Records can be seen and amended (within primary care)	Records can be seen (between primary care and other parts of the system)	Records can be seen and enhanced (between primary care and other parts of the system)	

[3] The 'N/A' option should be selected if the domain is determined to be outside of the current remit of the service model, or it is not needed because of capacity elsewhere in the system.

Domain	Descriptors: For each of the dimensions below, which statement below (S1-S5) best describes your current position? *It is important to note that there is an underlying logic in how the statements build on one another across the matrix. The statements are incremental – **moving along the boxes presupposes that forms of practice under the previous statement are included in the next one**.* *Darker shading against statements indicates that there is evidence that the statement has been fully achieved. Lighter shading is an indication that some progress has been made in this domain, but that it remains a 'work in progress'.*					
2. STAFF	*S1*	*S2*	*S3*	*S4*	*S5*	*N/A*
2.1 | General practitioner input	Fully engaged local GPs on rota (on sessional basis in addition to 'normal' workload)	Cluster salaried or locum GPs (on sessional basis in addition to 'normal' workload)	UHB employed salaried GPs	GPs working remotely for telephone support	OOH or MIU/ED clinical staff	
2.2 | Responsibilities of staff team: specialist nurse (ANP)	Clinical assessment only	Clinical assessment and test requests	Clinical assessment, managing test results	Clinical assessment, testing and face-to-face prescribing	Full responsibilities of consultant nurse	
2.3 | Responsibilities of staff team: MSK, MH or other practitioners	Clinical assessment only	Assessment and referral to diagnostics	Assessment, management and treatment	Assessment and onward referral into other services	Advanced clinical practitioner/practice	
2.4 | Responsibilities of staff team: healthcare assistant (HCA)	Supporting patients to the UPC service/UPCC	Completing referral forms	Identifying potential patients to flag to triage team	Undertake observations within ED prior to entry with UPC service/at UPCC	Undertaking enhanced functions (e.g. phlebotomy / signposting onwards)	
2.5 | Relationship with pharmacists in supporting UPC team	Resolving medication difficulties without patient contact	Resolving medication difficulties with patient contact	Simple prescribing	Independent prescribing	Follow up outside of the UPC/UPCC	
2.6 | Support and education for UPC service / UPCC practitioners	No additional UPC-specific support or education provided	Incorporated into standard educational programme	Education and support provided (teaching only)	Education and support provided (incl. feedback and clinical/peer review)	Education and support provided (incl. audit and feedback)	
2.7 | Extent of 'in house' and 'in reach' staffing of UPC service/UPCC staff team	UPC service/UPCC wholly dependent on 'borrowing' staff support (as above) from other clinical services	UPC service/UPCC partly dependent on 'borrowing' staff support (as above) from other clinical services	Mid-point between dependence and independence of staff support (as above) from other clinical services	UPC service/UPCC nearly independent without need to 'borrow' staff support from other clinical services	UPC service/UPCC wholly independent without need to 'borrow' staff support from other clinical services	

Domain	Descriptors: For each of the dimensions below, which statement below (S1-S5) best describes your current position? *It is important to note that there is an underlying logic in how the statements build on one another across the matrix. The statements are incremental – **moving along the boxes presupposes that forms of practice under the previous statement are included in the next one**.* *Darker shading against statements indicates that there is evidence that the statement has been fully achieved. Lighter shading is an indication that some progress has been made in this domain, but that it remains a 'work in progress'.*					
3. SYSTEM-WIDE ISSUES	*S1*	*S2*	*S3*	*S4*	*S5*	*N/A*
3.1 | Extent of strategic connection *Select one or other of the two paths – top row for cluster-based projects, bottom row for health board projects*	Project working in relative isolation in primary care locality/cluster		Fully integrated with relevant partners in locality/cluster and region		Fully integrated within national planning and developments	
	Integrated within health board and partners' strategic planning in region		Key priority for development across the whole system in region			
3.2 | Clinical governance overview	None. Reliance on each clinician's understanding and practice of their professional duties	Limited data collection, no reflection or analysis	Routine data collection, limited analysis	Routine data collection and analysis, limited reflection	Established system of governance in place with appropriate oversights	
3.3 | Incident reporting	Limited/no collection of process or incident data	Minimal process data relying on ad hoc incident reporting	Some process data with systematic incident reporting in place	Most process data available with safety netting	Effective 'good practice' system in place for incident reporting	
3.4 | Engagement in quality improvement / service development	Engagement with and participation from full UPC team	Engagement with and from cluster clinical leads	Engagement with and from Local Medical Committee	Engagement with and from ANPs, AHPs and MH practitioners	Engagement with and from patient groups (incl. CHC & data from PREMs)	
3.5 | Pathways	Developed local pathway	Piloted, tested and learned lessons about the local pathway	Developed health board-wide pathway	Pilot, test and learn lessons about the health board pathway	Development of national/network pathway	
3.6 | Sustainability	Of general practice: demand and workload	Of general practice: recruitment and retention	Of OOH or of WAST	Of ED and/or MIU	In preventing secondary care admissions / utilising secondary care services	
3.7 | Understanding impact	Data providing understanding of PREMs and project level outputs	Data providing understanding of broader system impacts at project level	Data comparing project level PREMs, outputs and broader system impacts with others within UPC in Wales	Data controlling for variation in models (e.g. different staff mix) to analyse differences within UPC in Wales	Data allowing comparison between impacts of Welsh UPC and other similar services (inter)nationally	
3.8 | Understanding the counterfactual *What would have happened across the system in the UPC service / UPCC hadn't existed?*	Limited data providing understanding what would have happened in lieu of UPC service	Intermediate stage between limited data and 'good enough' data	'Good enough' data providing understanding what would have happened in lieu of UPC	Intermediate stage between 'good enough' data and excellent data	Excellent data providing understanding on what would have happened in lieu of the UPC service	

Domain	Descriptors: For each of the dimensions below, which statement below (S1-S5) best describes your current position? *It is important to note that there is an underlying logic in how the statements build on one another across the matrix. The statements are incremental – **moving along the boxes presupposes that forms of practice under the previous statement are included in the next one**.* *Darker shading against statements indicates that there is evidence that the statement has been fully achieved. Lighter shading is an indication that some progress has been made in this domain, but that it remains a 'work in progress'.*					
TOTAL CELLS PER COLUMN of 20	**S1** Darker = Lighter =	**S2** Darker = Lighter =	**S3** Darker = Lighter =	**S4** Darker = Lighter =	**S5** Darker = Lighter =	**N/A** =

Explanatory narrative (if needed) to contextualise the choice of descriptors above

3. OVERVIEW OF MATRIX RESPONSES

In order to provide an overview of the six health boards responses that have been made to date, two tables are provided below.

ALL-WALES MODAL DISTRIBUTION

The first table identifies the modal value for the responses given across the three domains, and the statements within each. This data has been presented on an all-Wales basis. For each row in the Table, a shaded cell indicates the modal value within that distribution. On occasion there are two modal values identified (as the numbers are equal in value).

The distribution of data in this Table provides a good indication of how respondents have made assessment against the statements. Within Domain 1 ('Service Delivery'), the distribution of responses tends to be weighted towards Statement 3 and above, indicating that this is an aspect of the developmental work done by sites which has reached a relative state of maturity. A similar pattern of responses is found for Domain 2 ('Staff') with a series of modal values around Statement 4. For Domain 3 ('System-Wide Issues') there is a more heterogenous distribution, with higher modal values for 3.2 and 3.3 for example, but lower modal values for the remainder. It is instructive that much of Domain 3 focuses on understanding how local data relates to system impact, so perhaps unsurprising that this area needs development at this stage.

ALL-WALES FREQUENCY DISTRIBUTION

The second Table provides total numbers of responses by Domain and by statement. The broad pattern is to be expected, with the greatest number of responses made across the six sites against Statement 1, with the fewest number of responses against Statement 5. The expectation would be that over time, there is a shift within this distribution and percentage values are provided in order to indicate the proportion of responses across the statement levels.

There are some small exceptions to the broad pattern described above. Whilst the total number of responses by statement does move from highest against Statement 1 (n=73) to lowest for Statement 5 (n=22), there are occasions (within Domain 1 between Statements 1 and 2, and within Domain 2 between Statements 3 and 4) where the higher level Statement has more responses than the lower.

Taken together, these two tables represent a relatively positive baseline positive for the first assessment against the matrix, and now act as a all-Wales baseline against which further assessments can be judged and measured.

Domain		Distribution of Health Boards against the statements					
Statement levels		*S1*	*S2*	*S3*	*S4*	*S5*	*N/A*[4]
1. SERVICE DELIVERY	**1.1 | Focus of the service**	-	**2**	-	1	**2**	1
	1.2 | Method of service provision	-	1	1	-	**3**	1
	1.3 | First 'assessment'	-	-	**3**	-	2	1
	1.4 | IT systems used	1		**4**		-	1
	1.5 | Visibility / 'amend-ability' of patient record (interoperability)	-	**2**	**2**	1	-	1
2. STAFF	**2.1 | General practitioner input**	-	1	-	**3**	1	1
	2.2 | Responsibilities of staff team: specialist nurse (ANP)	1	-	-	**4**	-	1
	2.3 | Responsibilities of staff team: MSK, MH or other practitioners	-	-	-	**4**	-	2
	2.4 | Responsibilities of staff team: healthcare assistant (HCA)	**1**	-	-	**1**	-	4
	2.5 | Relationship with pharmacists in supporting UPC team	-	-	-	**3**	-	3
	2.6 | Support and education for UPC service / UPCC practitioners	**2**	-	1	1	1	1
	2.7 | Extent of 'in house' and 'in reach' staffing of UPC service/UPCC staff team	-	-	**2**	**2**	1	1
3. SYSTEM-WIDE ISSUES	**3.1 | Extent of strategic connection**	**2**		**2**		1	1
	3.2 | Clinical governance overview	-	1	1	1	**2**	1
	3.3 | Incident reporting	-	-	1	1	**3**	1
	3.4 | Engagement in quality improvement / service development	-	**2**	**2**	1	-	1
	3.5 | Pathways	-	**3**	-	2	-	1
	3.6 | Sustainability	-	1	1	**3**	-	1
	3.7 | Understanding impact	1	**4**	-	-	-	1
	3.8 | Understanding the counterfactual	1	1	**3**	-	-	1

[4] This category includes health boards who have only offered evidence of 'work in progress' towards the domains.

Domain	Number of Health Board responses against the statements					
Statement levels	*S1*	*S2*	*S3*	*S4*	*S5*	*N/A*
1. SERVICE DELIVERY	20	22	14	14	8	*1*
2. STAFF	25	20	15	19	8	*9*
3. SYSTEM-WIDE ISSUES	34	31	19	13	6	*8*
TOTAL	**79**	**73**	**48**	**44**	**22**	***18***
PROPORTION OF RESPONSES (%)	**27.8%**	**25.7%**	**16.9%**	**15.6%**	**7.7%**	***6.3%***

[5] This table only includes counts of those indications where respondents have suggested that the statement has been fully achieved ('darker' shaded responses). It does not count those where health boards have only offered evidence of 'work in progress' towards the statements.

Welsh Institute for Health and Social Care

University of South Wales, Glyntaf Campus, Pontypridd, CF37 1DL
wihsc.southwales.ac.uk · wihsc2@southwales.ac.uk · 01443 483070