The Same Day Access Model of Care
Key Principles

The new model of care sees the introduction of **'Same Day Access Hubs'** in NWL. There are certain high-level design principles which are fundamental for the hubs to run effectively and meet patient demand.

This is a journey, and a balance between having a consistent approach, and meeting the needs of each local area through having flexibility around the design, staffing and the appropriate phasing of implementation during 2024/25 will be essential.
Nine Design Principles and the new model of care:

1. **Ability to triage same day demand at scale** i.e. PCN or borough-level function
   - Functionality.
   - For local to determine the scale but not at a level smaller than PCN
   - Aim to increasing volume of triage over time
   - Flex in level of traffic and how they do it will depend on lots of factors depending on what workforce they have available etc.
   - Expectation is that the quantum of triage will start at a low level and build incrementally over time as PCN teams develop trust and expertise.

2. **Staffed by Multidisciplinary extended primary care team**, according to patient need
   - Skill mix will be determined by the PCN and depends on the scale of the model
   - Models could use ARRS roles, but must include senior clinical decision makers who will be responsible for patient safety and on the day clinical governance.
   - ARRS roles cover a range of different disciplines, the principle is not prescriptive but suggests that care navigators will support the clinician in patient direction and some clinical ARRS team members may benefit from spending time supporting the at scale working.
   - Care navigators can process incoming queries, collate information and support the senior clinical decision maker around who is best to deal with the presentation.
   - Administrative and non-clinical queries can be managed by other team members.
   - Clinical presentations can be allocated for delivery within the access centre, at the GP practice or referred / signposted to other primary care providers such as community pharmacists (including CPCS and Pharmacy First), dentists, ophthalmologists
   - Allocation and filtering should aim to the support the patient interacting with right person depending on the presenting condition
   - Staffing model will not be prescriptive around what should be – should be determined by the PCN.
   - As models develop it may be useful to consider a competency-based framework approach rather than qualifications for triage component. This recognises the diverse and impressive skill set that many of our workforce have and that working in new ways requires support, training and supervision

3. **Ability to manage low complexity patients both face to face and remotely**
   - This is not dependent on a single physical hub, it could be in one place (practice), or dispersed across practices and utlising existing resources to support care pathways.
   - Based on connectivity and integration.

4. **Ability to accept all 111 dispositions**
   - The timeframe for introduction will be down to the PCN/Borough, but would need to use a worklist approach.

5. **Ability to accept and triage online consultations**
   - This could be incremental build – it could be easier to start with online consultations as the information is already at hand.

6. **Ability to order diagnostic tests and issue prescriptions**
   - ICB needs to provide the functionality to do this. Discussions have commenced.

7. **Ability to book appoints with patient's home' practice for those with complex needs**
   - It is down to the ICB to ensure that there is an appropriate risk stratification tool
   - ICB is looking to enable the appropriate connectivity / interoperability to support this.
   - PCNs/Borough will need to identify which patients would benefit from continuity within the practice.

8. **Referral to other primary, acute, mental health and community care services as needed**
   - Community services referrals take place via email. SystmOne hubs could make referral, EMIS – need EMIS community/or task back to practice.
   - Two-week wait referrals – eRS functionality is now in place for the hub to make a referral, i.e. doesn't have to be the registered GP, but do still need to work through the process.
   - ICB discussion around C2C referrals for primary care clinicians in the hub to refer to mental health and acute.
   - Conversations with community and mental health services planned.

9. **Ability to provide appointments at a minimum between 8am-6pm,** and seek opportunities to integrate with core, enhanced, and out of hours services to the design principles.