Organisational Development is essential to support systems change in primary care

Lessons from London’s Primary Care Quality Academies

April 2018

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We know that practices that are adapting are:

- **Using data** to review their activity and improve flow within their practices and across the system.
- Looking for examples and ideas to manage and meet demand **from outside their practice**.
- **Working collaboratively** with local citizens in an asset based approach to reduce inappropriate demand.
High performing practices and primary care teams

- **Use their skill sets more effectively** to meet need (diversifying their skills and offers, targeting these effectively)
- **Use their contact time with patients more effectively**
- **Improve their back-office functions** to be more efficient
- **Partner effectively** with care homes/other practices to manage the health of frail elderly in care and reduce hospital admissions
- Work with **Multidisciplinary Teams to flag at risk people** and to solve complex needs.
- **Co-produce new services** with communities
To adapt practices need

• **Data to catalyse inquiry**, review unwarranted variation, inform demand management and work towards meeting demand.

• **Team development** to secure collective decisions that stick and to hold fast on prototypes

• **Knowledge about quality tools** and how to partner with communities. Learning provided through programmes and on-site using real issues/real-time data as case material.

• **Help** to view their practice as an interconnected system.

• Support to **prototype changes**
The principles of our work

• The development process is equally as important as the data
• We need to engage fragmented groups and work as a system
• Data from the practice itself is the most compelling
• We are ‘Agnostic’ in approach (open to all solutions)
## Transitions and Challenges

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>What’s the matter with you?</td>
<td>What matters to you?</td>
</tr>
<tr>
<td>Individual</td>
<td>Population</td>
</tr>
<tr>
<td>Increase Access</td>
<td>Reduce Demand</td>
</tr>
<tr>
<td>Consumers</td>
<td>Partners</td>
</tr>
<tr>
<td>Hunch</td>
<td>Evidence based decision-making</td>
</tr>
<tr>
<td>Top Down</td>
<td>Self-managed teams</td>
</tr>
<tr>
<td>Hierarchies</td>
<td>Networks &amp; Collaborations</td>
</tr>
<tr>
<td>Expert</td>
<td>Learning</td>
</tr>
</tbody>
</table>

Malby R 2018
Rules of thumb that shape the NHS behaviour

At the founding of the NHS
1. Can do should do
2. Doing means treatment
3. Treatment means cure
4. I am responsible

Currently
1. Private managers practices are more effective [than public service managers]
2. Outcomes can be measured easily
3. Human services are like manufacturing processes
4. Professionals always resist change

In High Performing Health Systems
1. Partnering with People as Owners secures better health
2. We are responsible - partnership means everyone contributing
3. Do what matters and demand drops (People’s health is contextual)
4. Health is relational
5. You have to know what’s really going on (real-time data) in order to adapt and do better.
Many practices hold numerous hypotheses that shape their current work

- Demand is rising
- We are just meeting it but can’t carry on – we don’t turn people away
- We don’t have enough capacity and we need more staff/ money
- Frequent attenders all have more than one chronic disease
- Secondary care shifts the burden onto us
- Social care is failing
Using data and supported dialogue to catalyse inquiry and professional review
DATA #1 Understanding demand
Finding out what’s really going on
PRACTICE DIARIES are online webforms used to measure demand (met and unmet) and capacity (appropriateness)

1. • APPOINTMENT appropriateness
   • APPOINTMENT outcomes (next steps)
   • RECEPTION outcome of appointment requests

2. • Process and report
   • Rapid turnaround

3. • Discuss
   • React, Plan
The big picture of demand vs. capacity is optimistic

- While typically **15% - 20%** of appointment requests can’t be meet at reception in a practice
- This is far less than the **40% of GP appointments** that are seen as inappropriate – unnecessary, avoidable or potentially moveable within the practice

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**Academies combined***

<table>
<thead>
<tr>
<th>Reception contacts</th>
<th>GP appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>85% Yes</td>
<td>60% appropriate</td>
</tr>
<tr>
<td>✓ Appointment booked</td>
<td>✓ Appropriate appt</td>
</tr>
<tr>
<td>15% No</td>
<td>40% Inapprop.</td>
</tr>
<tr>
<td>No appt possible</td>
<td></td>
</tr>
</tbody>
</table>

* Over 10,000 contacts / appointments
** Not including missed calls
We illustrate GPs own assessment of appropriateness of appointments

Question to GPs:
Should this patient be here today?
40% of the time ‘no’

Answer from GPs:

In a practice 30-50% of appointments are seen as inappropriate or moveable.
GP views: There is significant variation on what constitutes a GP appointment

Across practices....

Within practices....

Variation between practices from ‘80% of our appts are inappropriate’ to ‘less than 50% of our appts are appropriate’

Variation between GPS from 40% of my appts are appropriate to 90% are
Many practices are generally unaware of the extent and profile of patients that are turned away due to lack of appointments

• Some practices are unable to offer appointments to 25% or more of requests
• Some practices can fulfil nearly all requests
• Practices learn from peer comparison

Green = appointment booked
Red = appointment not available

⇒ Shown across the working day from 8am to 6pm ⇒
In Groups of 5 : Reviewing Sheet 1 - Appointments.
Sorting the work
Assembling our knowledge and planning change
We help practices explore **different models** of care.

Many options: appt systems adjustments • duty doc • stay/wait • skill mix adjustment • online • phone • face to face • one to many …
We help practices understand their practice as an interconnected system – and that GPs do have a role in generating their own demands.

- We create a system map of each practice.
- We help practices move from tinkering around the edges of change (things like correspondence management) to fundamentally challenging their system of work.
In Groups of 5 : Reviewing Sheet 2 – The Practice System
DATA #2 Reducing reactive care

Example: developing pro-active services by looking at frequent attenders
We **simplify** analysis for practices by using segments. We help them **understand** the people who attend most frequently.

- The top 5% of patients may be using 20% of GP resources at the practice
- The practice may not be thinking in a joined-up way about how it is spending this resource
We focus attention by illustrating the resources involved in helping people who attend the most.

- Thinking about groups in terms of £ value is motivating for a practice.
- We encourage practices to think about other ways of spending this money to help high attenders.

<table>
<thead>
<tr>
<th>Frequent attender groups</th>
<th>range (appts/yr)</th>
<th># patients</th>
<th># GP appts</th>
<th>% of attenders</th>
<th>% of appts</th>
<th>Ave appts/yr</th>
<th>Value*</th>
<th>Cumulative Value</th>
<th>£/head</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Super attenders</td>
<td>25+</td>
<td>17</td>
<td>537</td>
<td>0.3%</td>
<td>2%</td>
<td>32</td>
<td>£26,850</td>
<td>£26,850</td>
<td>£1,500-£3,000+</td>
</tr>
<tr>
<td>B. Bi-weekly</td>
<td>20-24</td>
<td>45</td>
<td>986</td>
<td>1%</td>
<td>5%</td>
<td>22</td>
<td>£49,300</td>
<td>£76,150</td>
<td>£1,000</td>
</tr>
<tr>
<td>C. 3-weekly</td>
<td>15-19</td>
<td>161</td>
<td>2,560</td>
<td>3%</td>
<td>12%</td>
<td>16</td>
<td>£128,000</td>
<td>£204,150</td>
<td>£800</td>
</tr>
<tr>
<td>D. Monthly</td>
<td>9-14</td>
<td>411</td>
<td>4,278</td>
<td>8%</td>
<td>20%</td>
<td>10</td>
<td>£213,900</td>
<td>£418,050</td>
<td>£500</td>
</tr>
<tr>
<td>E. Bi-monthly</td>
<td>5-8</td>
<td>1,046</td>
<td>6,507</td>
<td>21%</td>
<td>30%</td>
<td>6</td>
<td>£325,350</td>
<td>£743,400</td>
<td>£300</td>
</tr>
<tr>
<td>F. Quarterly</td>
<td>4</td>
<td>512</td>
<td>2,048</td>
<td>11%</td>
<td>9%</td>
<td>4</td>
<td>£102,400</td>
<td>£845,800</td>
<td>£200</td>
</tr>
<tr>
<td>H. Infrequent</td>
<td>1-3</td>
<td>2,676</td>
<td>4,778</td>
<td>55%</td>
<td>22%</td>
<td>2</td>
<td>£238,900</td>
<td>£1,084,700</td>
<td>£90</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>4,868</td>
<td>21,694</td>
<td>100%</td>
<td>100%</td>
<td>4.5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Example from a small practice, one year of appointment data

Non-attenders Est. -> 2,500
### We guide GPs through case review and categorisation

- The top 5% of patients may be accessing 20% of GP resources at practices.
- It is usually assumed the people who access the practice frequently are elderly / people with multiple chronic disease. However this is not always the case. We help practices understand real need, rather than assumed.

<table>
<thead>
<tr>
<th>Identifier</th>
<th>Age</th>
<th>Gender</th>
<th>GP appts</th>
<th>Nurse appts</th>
<th>Attender category</th>
<th>GP #1 %</th>
<th>GP #2 %</th>
<th>QOF registers</th>
<th>QOFs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>64 yrs</td>
<td>Female</td>
<td>46</td>
<td>5</td>
<td>Super attender</td>
<td>30%</td>
<td>20%</td>
<td>1</td>
<td>CHD,</td>
</tr>
<tr>
<td>2</td>
<td>49 yrs</td>
<td>Female</td>
<td>39</td>
<td>2</td>
<td>Super attender</td>
<td>62%</td>
<td>15%</td>
<td>1</td>
<td>obesity,</td>
</tr>
<tr>
<td>3</td>
<td>51 yrs</td>
<td>Female</td>
<td>35</td>
<td>6</td>
<td>Super attender</td>
<td>86%</td>
<td>14%</td>
<td>3</td>
<td>cancer,mental_health,obesity,</td>
</tr>
<tr>
<td>4</td>
<td>97 yrs</td>
<td>Female</td>
<td>35</td>
<td>1</td>
<td>Super attender</td>
<td>54%</td>
<td>46%</td>
<td>1</td>
<td>atfib,</td>
</tr>
<tr>
<td>5</td>
<td>52 yrs</td>
<td>Male</td>
<td>34</td>
<td>4</td>
<td>Super attender</td>
<td>38%</td>
<td>26%</td>
<td>1</td>
<td>depression,</td>
</tr>
<tr>
<td>6</td>
<td>23 yrs</td>
<td>Male</td>
<td>33</td>
<td>4</td>
<td>Super attender</td>
<td>67%</td>
<td>12%</td>
<td>1</td>
<td>learning_disability,</td>
</tr>
<tr>
<td>7</td>
<td>47 yrs</td>
<td>Female</td>
<td>33</td>
<td>0</td>
<td>Super attender</td>
<td>70%</td>
<td>15%</td>
<td>0</td>
<td>CVD,hypertension,</td>
</tr>
<tr>
<td>8</td>
<td>64 yrs</td>
<td>Female</td>
<td>33</td>
<td>4</td>
<td>Super attender</td>
<td>33%</td>
<td>27%</td>
<td>2</td>
<td>stroke_tia,</td>
</tr>
<tr>
<td>9</td>
<td>72 yrs</td>
<td>Female</td>
<td>32</td>
<td>7</td>
<td>Super attender</td>
<td>56%</td>
<td>16%</td>
<td>1</td>
<td>asthma,</td>
</tr>
<tr>
<td>10</td>
<td>37 yrs</td>
<td>Female</td>
<td>30</td>
<td>9</td>
<td>Super attender</td>
<td>27%</td>
<td>23%</td>
<td>1</td>
<td>asthma,CVD,hypertension,</td>
</tr>
<tr>
<td>11</td>
<td>62 yrs</td>
<td>Male</td>
<td>29</td>
<td>5</td>
<td>Super attender</td>
<td>28%</td>
<td>28%</td>
<td>3</td>
<td>diabetes,</td>
</tr>
<tr>
<td>12</td>
<td>63 yrs</td>
<td>Female</td>
<td>28</td>
<td>2</td>
<td>Super attender</td>
<td>46%</td>
<td>29%</td>
<td>1</td>
<td>asthma,CVD,hypertension,</td>
</tr>
<tr>
<td>13</td>
<td>48wks</td>
<td>Male</td>
<td>26</td>
<td>3</td>
<td>Super attender</td>
<td>38%</td>
<td>23%</td>
<td>0</td>
<td>depression,</td>
</tr>
<tr>
<td>14</td>
<td>61 yrs</td>
<td>Male</td>
<td>26</td>
<td>1</td>
<td>Super attender</td>
<td>23%</td>
<td>23%</td>
<td>3</td>
<td>asthma,cancer,depression,</td>
</tr>
<tr>
<td>15</td>
<td>46 yrs</td>
<td>Female</td>
<td>26</td>
<td>0</td>
<td>Super attender</td>
<td>73%</td>
<td>27%</td>
<td>2</td>
<td>depression,</td>
</tr>
<tr>
<td>16</td>
<td>56 yrs</td>
<td>Female</td>
<td>26</td>
<td>2</td>
<td>Super attender</td>
<td>54%</td>
<td>19%</td>
<td>0</td>
<td>CKD,dementia,</td>
</tr>
<tr>
<td>17</td>
<td>96 yrs</td>
<td>Female</td>
<td>26</td>
<td>2</td>
<td>Super attender</td>
<td>65%</td>
<td>27%</td>
<td>2</td>
<td>depression,</td>
</tr>
<tr>
<td>18</td>
<td>48 yrs</td>
<td>Male</td>
<td>24</td>
<td>2</td>
<td>biweekly</td>
<td>46%</td>
<td>17%</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**TOOLKIT:** a webform prompts consideration of:
- Patient’s life situation
- The real drivers of high attendance
- New services / skills and ideas
Frequent attender review (top 100)

Life situation:
Over half are known to be in a struggling or chaotic life style
**Frequent attender review (top 100)**

Over half are seen as having “health anxiety” – but this is of course the doctors’ view rather than the patients.
Frequent attender groups: an uneven use of resource

Over £50,000 of resource on the top 40 patients
Over £200,000 of resource on the top 200

<table>
<thead>
<tr>
<th>FA group</th>
<th># patients in group</th>
<th>Avg. GP appts</th>
<th>% of all patients</th>
<th># GP appts</th>
<th>% of ALL GP appts</th>
<th># of all appts (incl nurse)</th>
<th>Avg. Age</th>
<th>Est VALUE of GP appts (@£40/appt)</th>
<th>Cumulative value</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Weekly (35+ / yr)</td>
<td>11</td>
<td>44 appts</td>
<td>0.1%</td>
<td>479</td>
<td>1.0%</td>
<td>538</td>
<td>52</td>
<td>£15,160</td>
<td>£19,160</td>
</tr>
<tr>
<td>B. Bi-weekly (24-34)</td>
<td>35</td>
<td>27 appts</td>
<td>0.2%</td>
<td>938</td>
<td>2.0%</td>
<td>1,127</td>
<td>51</td>
<td>£37,520</td>
<td>£56,680</td>
</tr>
<tr>
<td>C. 3-weekly (16-23)</td>
<td>197</td>
<td>18 appts</td>
<td>1.2%</td>
<td>3,628</td>
<td>7.9%</td>
<td>4,333</td>
<td>51</td>
<td>£145,120</td>
<td>£201,800</td>
</tr>
<tr>
<td>D. Monthly (10-15)</td>
<td>740</td>
<td>12 appts</td>
<td>4.6%</td>
<td>8,731</td>
<td>19.0%</td>
<td>10,730</td>
<td>50</td>
<td>£349,240</td>
<td>£551,040</td>
</tr>
<tr>
<td>E. Bi-monthly (6-9)</td>
<td>1,722</td>
<td>7 appts</td>
<td>10.6%</td>
<td>12,402</td>
<td>27.0%</td>
<td>15,721</td>
<td>47</td>
<td>£496,080</td>
<td>£1,047,120</td>
</tr>
<tr>
<td>F. Quarterly (4-5)</td>
<td>1,997</td>
<td>4 appts</td>
<td>11.7%</td>
<td>8,405</td>
<td>18.3%</td>
<td>11,175</td>
<td>42</td>
<td>£336,200</td>
<td>£1,383,320</td>
</tr>
<tr>
<td>G. Infrequent (2-3)</td>
<td>3,578</td>
<td>2 appts</td>
<td>22.0%</td>
<td>8,694</td>
<td>18.9%</td>
<td>12,252</td>
<td>39</td>
<td>£547,760</td>
<td>£1,731,080</td>
</tr>
<tr>
<td>H. Annual (1)</td>
<td>2,594</td>
<td>1 appts</td>
<td>15.6%</td>
<td>2,694</td>
<td>5.5%</td>
<td>4,568</td>
<td>35</td>
<td>£107,760</td>
<td>£1,838,840</td>
</tr>
<tr>
<td>I. Non-GP attender (Other)</td>
<td>777</td>
<td>appts</td>
<td>4.9%</td>
<td>0</td>
<td>0.0%</td>
<td>1,517</td>
<td>40</td>
<td>£0</td>
<td>£1,838,840</td>
</tr>
<tr>
<td>J. Zero-attender (any)</td>
<td>4,550</td>
<td>appts</td>
<td>28.3%</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>32</td>
<td>£0</td>
<td>£1,838,840</td>
</tr>
<tr>
<td>Grand Total</td>
<td>16,241</td>
<td>3 appts</td>
<td>100.0%</td>
<td>45,971</td>
<td>100.0%</td>
<td>62,061</td>
<td>38</td>
<td>£1,838,840</td>
<td>£1,838,840</td>
</tr>
</tbody>
</table>
**Challenge 1:** Managing resources to frequent attenders and offering more appropriate services to them

**Challenge 2:** Looking after your revenue from infrequents (in the face of digital competition)

50% of your income comes from zero/single attenders

And is used by the top 15% of attenders
Standing back and looking at the whole practice population – example from one practice.

- Long term condition register (QOF) - occurrence by age/across appts
Case Study (1)

The immediate impact of team development and sorting
Case: impact – CQC ratings

November 2015 (prior)

<table>
<thead>
<tr>
<th>Overall rating for this service</th>
<th>Requires improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are services safe?</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services caring?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services responsive to people’s needs?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Requires improvement</td>
</tr>
</tbody>
</table>

Practice List Size 14,000.
The practice is in the 7th most deprived borough in London and the 35th in England.

January 2018 (during)

Overall Good

- Safe: Good
- Effective: Good
- Caring: Good
- Responsive: Good
- Well-led: Good

Read overall summary
## Case study: intervention list

<table>
<thead>
<tr>
<th>What we did</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Readiness – the first data diary on appointments</td>
<td>June 2017</td>
</tr>
<tr>
<td>3 day Core Concepts of Quality Course for 5 members of the practice</td>
<td>June 2017</td>
</tr>
<tr>
<td>9 days of onsite development – practice team relationship development;</td>
<td>September to present.</td>
</tr>
<tr>
<td>coaching the lead partner; QI, flow; measurement, new triage;</td>
<td>Implementation of prototypes from November 2017</td>
</tr>
<tr>
<td>workshop facilitation, coaching the team to implement prototype;</td>
<td></td>
</tr>
<tr>
<td>keeping the heat up with data reviews; frequent attender review; moving</td>
<td></td>
</tr>
<tr>
<td>from meeting to managing demand to the aim to reduce demand.</td>
<td></td>
</tr>
<tr>
<td>Communities of practice sharing the granular details of how to change the</td>
<td>September to present x 3</td>
</tr>
<tr>
<td>practice system</td>
<td></td>
</tr>
</tbody>
</table>
Case study: Benefits 6 months in

• Reduction in required GP resource - salary of £71,000 plus 12.8% National Insurance contributions and 14% employer's superannuation – a total of about £90,000. Currently reviewing how to invest this in meeting rather than managing demand.

• Lower use of locums over Christmas. GPs taking the usual Xmas holidays so no change in practice staffing.

• Appointment demand spread over the day more evenly and now only 7% patients turned away (because they don’t want what is offered) – everyone is seen or given an appointment (Telephone triage /GP/Other service).

• Seeing 35% more patients a week.

• DNAs reducing.

• Improved CQC from Requires Improvement to Good across all aspects

Additionally

• PPG very supportive of the changes, and staff say stress levels are down.
Data results

Illustrating it takes time for a practice to develop the skills in new models.
Reception: pre/post triage impact

PRE TRIAGE: 30% of appt requests were not possible or on a much later date
POST TRIAGE: Nearly all requests are either granted, triaged or signposted
Case: The Practice Next Steps

- Considering bringing in walk in (removes the sorting step),
- Social (contextual) focused proactive work on super attenders
- Community Collaboration – working with their community as assets by helping to develop networks
- Developing stronger relationships with formal services in the community
- Skill mix development (team based)
Collaborative Practice

Examples of what we are expecting to gain from previous experience.
Impact

Evaluation of work in 30 General Practices, drawing on evidence from the UK Government’s Foresight Project and the New Economics Foundation, shows that 216 ‘types’ of Practice Health Champion-led activities brought about improvements in patients’ wellbeing, resilience and ability to adapt, cope and live well with long term conditions as well as gaining a better understanding of how to use services.

The evidence tells us that when it works for patients we see significant improvements in mental health and wellbeing and overwhelming support from practice staff to sustain the work:

- **94%** of patients surveyed had improved mental health and wellbeing
- **95%** of staff surveyed recommend and want to continue after the funded period has ended

We found that having champions as part of the practice family changes the nature of the family and both coevolve to do things differently. This in turn leads to benefits for patients, champions and the practice and a new collaborative community centred model of general practice emerges.

New relationships between champions and Practices become embedded and are sustainable into the long term without ongoing funding. Champions becoming part of the practice ‘family’ and, simply, ‘how we do things round here’.

“It feels like we’re a GP Practice within a larger organisation. There’s the General Practice Primary Care bit which is wrapped around with a much bigger range of things going on.”

Dr Linda Belderson
GP, Robin Lane Medical Centre, Leeds
“We have increased our patient list by 4,500 people, that’s a 57% increase, and we have seen no increase in demand for either primary or secondary care consultations because we do things differently.”

Mev Forbes, Managing Partner, Robin Lane Medical Centre
How all this comes together at practice level

Moving to a new, ‘mixed’ model
NOW MANAGING DEMAND

HOW WE WORK NOW

F2F GP/Nurse to Patient

FOUNDATIONS

Data foundations

Creating the Practice Approach (reducing variation of clinical approach)

Signposting and organising

Partnering with Community

NEW WAYS OF WORKING

FUTURE MEETING DEMAND

Team Based Approaches

Community Assets

Patient Groupings and Tailored Services

Better relationships with wider services

F2F GP/Nurse to Patient

Primary Care Quality Academy
The Ideal Primary Care System
A Straw Man – starting from needs
The Building Blocks for Integrated Care Systems
An ideal primary care system

<table>
<thead>
<tr>
<th>Purposeful Health and care system</th>
<th>Possible categories of Complex need</th>
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<tbody>
<tr>
<td></td>
<td>Frail older people</td>
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<td></td>
<td>Elderly with multiple needs</td>
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<td>Trouble with life</td>
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<td>MH and Physical Health</td>
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<td>Children &amp; Young</td>
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MDT @ home – the number of visits/meetings can probably be pre-determined by type of need and forms the pathway. Tele-health to secondary care

Assessment for Early warning flags

REQUIRES: Continuity of GP/team

REVIEW & PLAN: MDT Reviews

ASSESS: E-record flags

Comprehensive assessment at home

ASSESS: E-record flags

REVIEW: of potential for complexity

MINOR

ACUTE & DIAGNOSE

ACUTE & IMMEDIATE ESCALATE

PAPERWORK

PAYMENT SERVICES

ROUTINE DIAGNOSTICS

Additional reviews based on need: Clinical; Social; Poly pharmacy
In summary:

**Economies of Scale** thinking comes from study around VERY simple and bounded processes. For example pin making.

- The very real risk is that the end result of applying this thinking to purposeful and relational services is that we create failure demand. By either not meeting or delaying the meeting of need. We shift cost to elsewhere or later.

**Working at scale** is about enabling a technical expertise or team, network or community innovation that genuinely cannot be achieved without a certain scale.

- They speed up the meeting of need, rather than delay or possibly not meet it.
What Scale for What Work?

Community asset-based partnerships at meaningful population (up to 14K) to reduce demand. Practice/Town/Parish Council.

Collaborating on back office, some service delivery, and some skills sharing (at 30K-50K) - Primary Care Network/Locality

Securing quality in Care Homes - numbers of care homes - all registered with one practice - can be a PC Network.

Complex Needs to stop tripping into unstable - MDT to support (Locality/Constituency size/Primary Health Care Teams))

Business Intelligence and Learning Collaboratives - Borough size (2-350K)
And with who?

- Community asset-based partnerships at meaningful population (up to 14K) to reduce demand. Practice/Town/Parish Council.
- Collaborating on back office, some service delivery, and some skills sharing (at 30K-50K) – Primary Care Network/Locality
- Securing quality in Care Homes (numbers of care homes – all registered with one practice) – can be a PC Network
- Business Intelligence and Learning Collaboratives - Borough size (2-350K)
- Complex Needs to stop tipping into unstable - MDT to support (Locality/Constituency size/Primary Health Care Teams)
- People in The Community
- Care Homes
- Circa 3 Practices
- AHSNs & CCGs providing data and evidence
- Mental Health, Social Care, Secondary Care, Third Sector
What organisational form?

Community asset-based partnerships at meaningful population (up to 14K) to reduce demand. Practice/Town/Parish Council.

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Complex Needs to stop tipping into unstable - MDT to support (Locality/ Constituency size/ Primary Health Care Teams))

Securing quality in Care Homes (numbers of care homes – all registered with one practice) – can be a PC Network

Collaborative Network

Self organising team with devolved authority, and clear accountability to one host organisation

Partnership

London South Bank University
What it Takes

To do this work
What it takes to do this work (principles)

• **A neutral non-judgmental academic partner** willing to walk alongside the practices as they develop; but also rigorous and challenging/critical friendship

• **We start with what’s really going on in the practice using data and system maps** to understand the patterns of behaviour

• **We work with their real time current issues** – we start where they want to start

• **We sort and filter all the advice available** to general practice on quality and change

• **We work with the practice as a system** not a series of parts that can be fixed mechanistically - we start anywhere and go everywhere
  – across **appointment systems** and how people move through the system;
  – clinical and management **variation** in signposting,
  – **referral and clinical decisions**;
  – **skill mix** – who does what work;
  – building the **assets of the communities**; working with the folk who are struggling
What it takes in practice

• Our team has expertise across all the emerging needs of the practice, with a portfolio of primary care specific methods – QI methods, Data, Citizen engagement and asset building; team development and peer decision-making; clinical variation; working as a system.

• We build the relationships that enables them to decompress – we listen (for hours) meaningfully to their experience, assumptions and opinions.

• We reframe the issues so that they relate directly to the practice’s business

• We respect their learning and creating headspace and a learning environment

• We secure pace and spread through Communities of Practice

• We work with the top of the system to generate accountability for the issues that reside at the whole system level

• We walk practices through their challenges. Depersonalising and de-externalising them.