Organisational Development is essential to support systems change in primary care

Lessons from London's Primary Care Quality Academies

April 2018

Prof. Becky Malby, Nick Downham, Tony Hufflett

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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

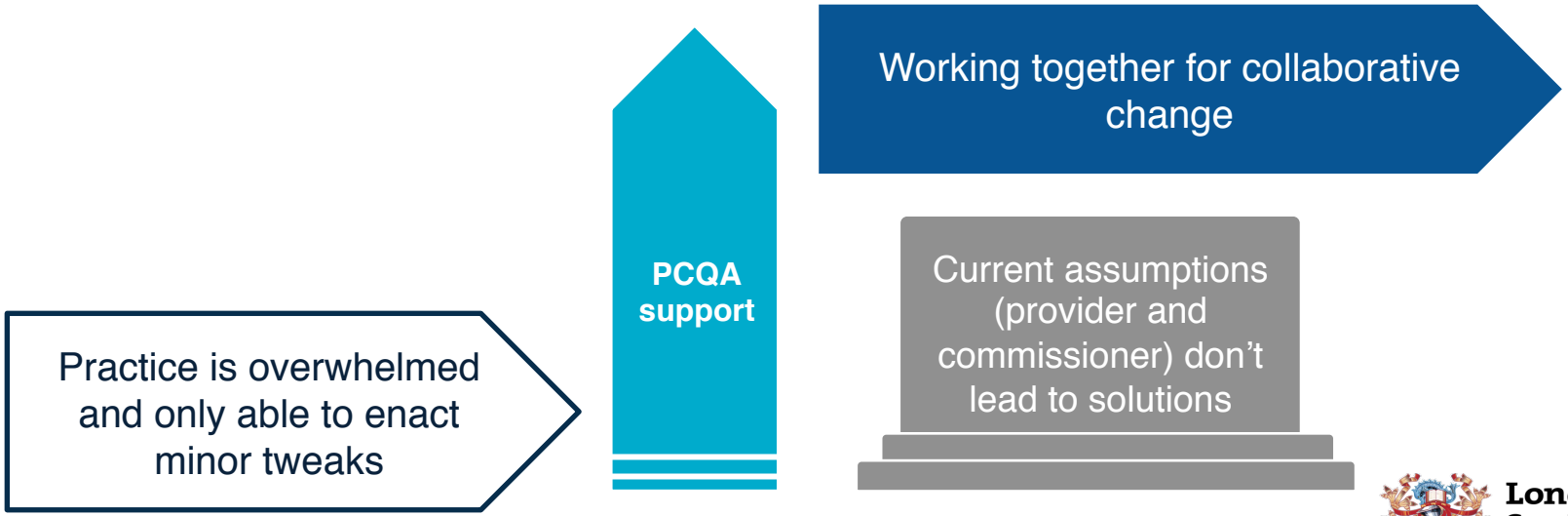
- **Use their skill sets more effectively** to meet need (diversifying their skills and offers, targeting these effectively)
- Use their **contact time with patients more effectively**
- **Improve their back-office functions** to be more efficient
- **Partner effectively** with care homes/ other practices 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)



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Transitions and Challenges

From	To
What's the matter with you?	What matters to you?
Individual	Population
Increase Access	Reduce Demand
Consumers	Partners
Hunch	Evidence based decision-making
Top Down	Self-managed teams
Hierarchies	Networks & Collaborations
Expert	Learning

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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.
6. Meet rather than manage demand.

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*

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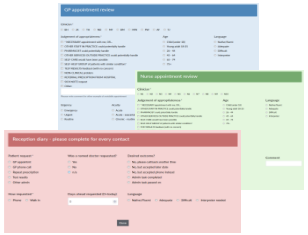
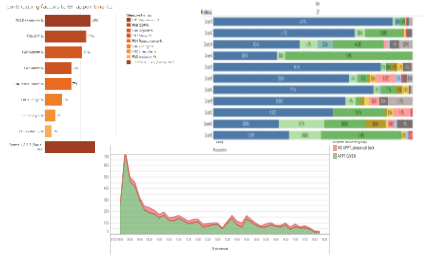
Using data and supported dialogue to catalyse inquiry and professional review

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

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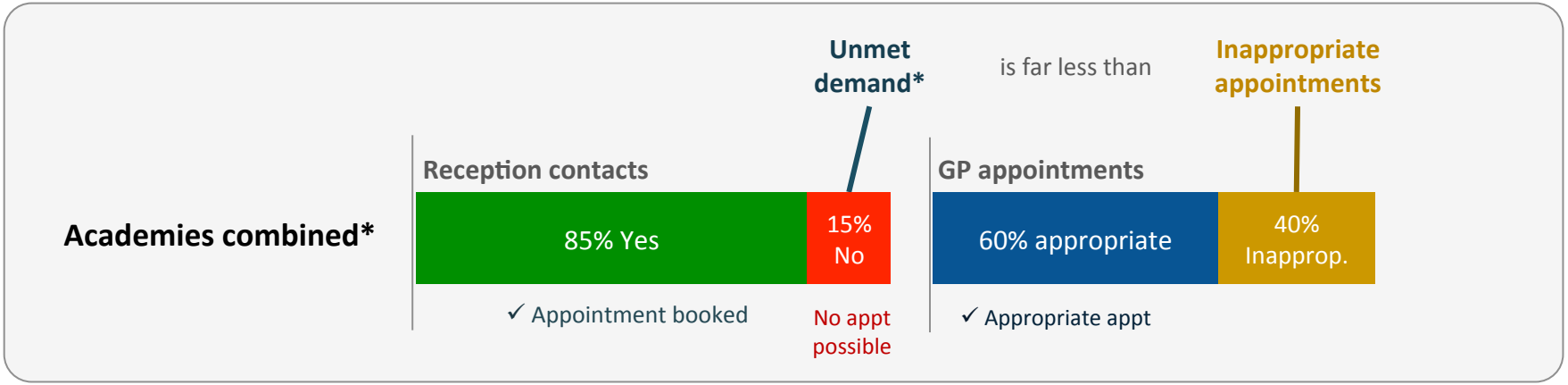
The big picture of demand vs. capacity is optimistic

- 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

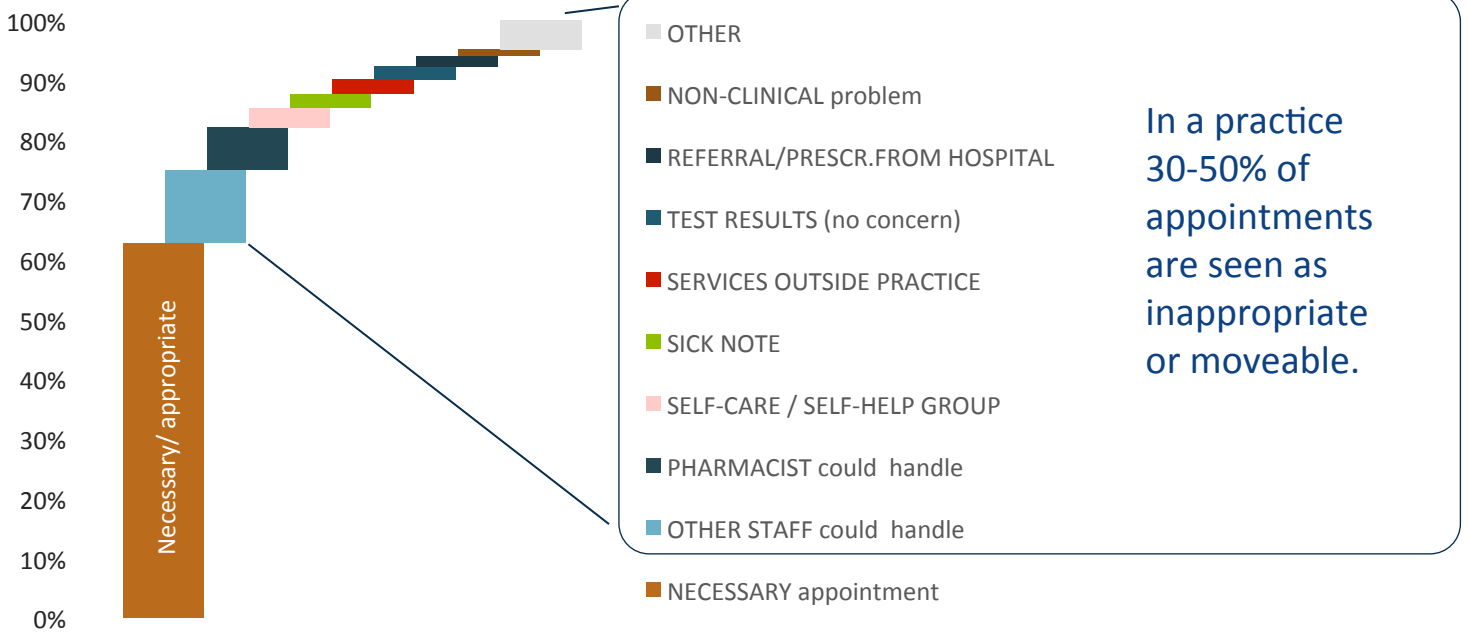


* Over 10,000 contacts / appointments
** Not including missed calls

We illustrate GPs own assessment of appropriateness of appointments

Question to GPs: **Should this patient be here today?**

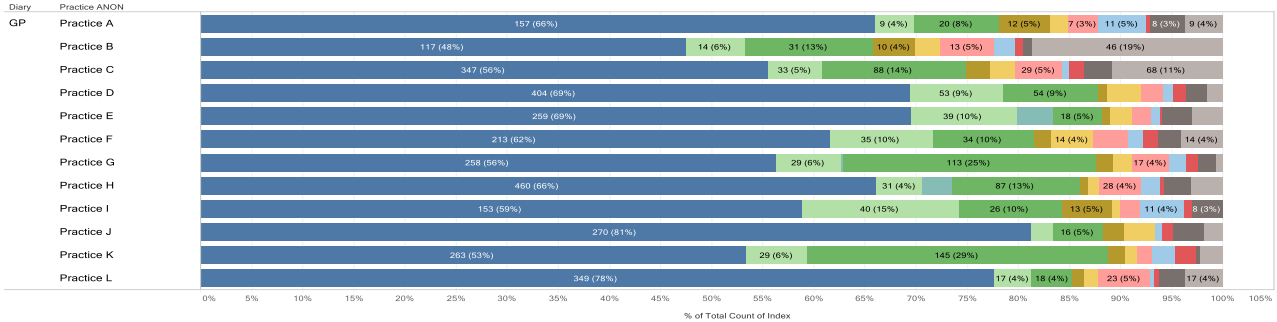
Answer from GPs: **40% of the time 'no'**



In a practice 30-50% of appointments are seen as inappropriate or moveable.

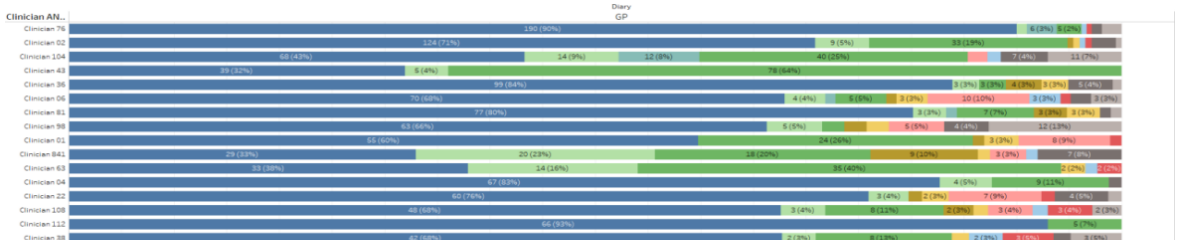
GP views: There is significant variation on what constitutes a GP appointment

Across practices….



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

Within practices….



Variation between GPS from 40% of my appts are appropriate to 90% are

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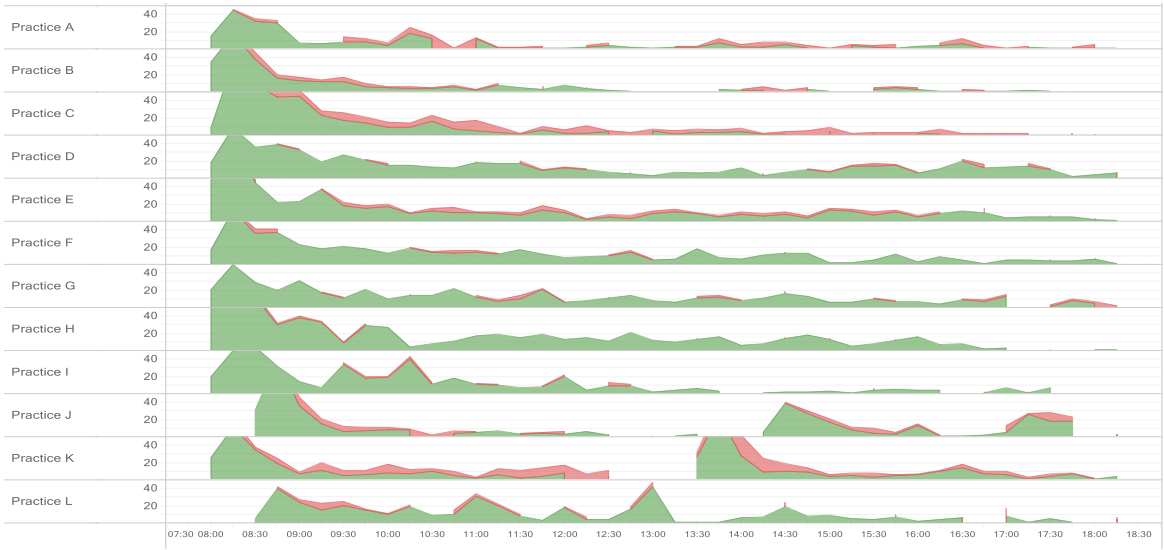
Many practices are generally unaware of the extent and profile of patients that are turned away due to lack of appointments

- 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 ⇨

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In Groups of 5 : Reviewing Sheet 1 - Appointments.

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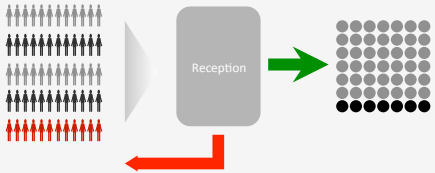
Sorting the work

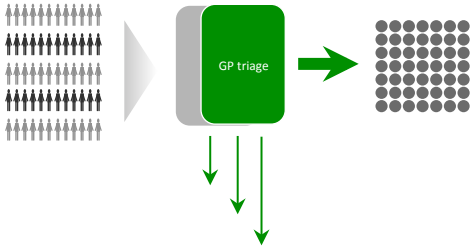
Assembling our knowledge and planning change

We help practices explore **different models** of care.=

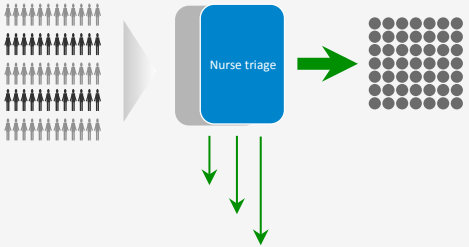
Classic



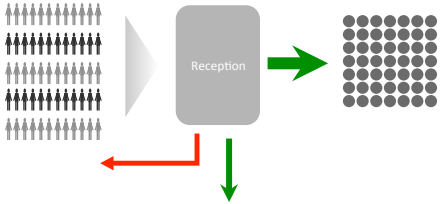
GP based triage



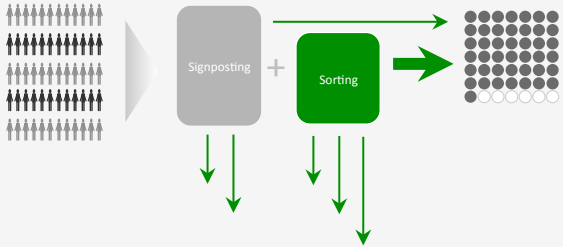
Nurse based triage



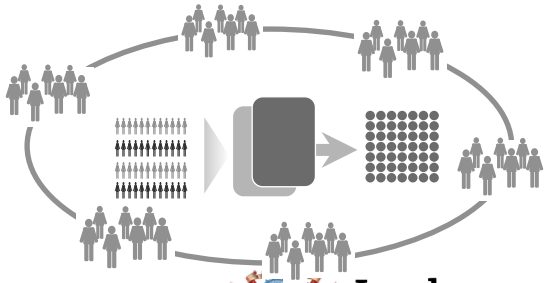
Reception signposting



Signposting + sorting



Collaborative practice



Many options: appt systems adjustments ● duty doc ● stay/wait ● skill mix adjustment ● online ● phone ● face to face ● one to many …

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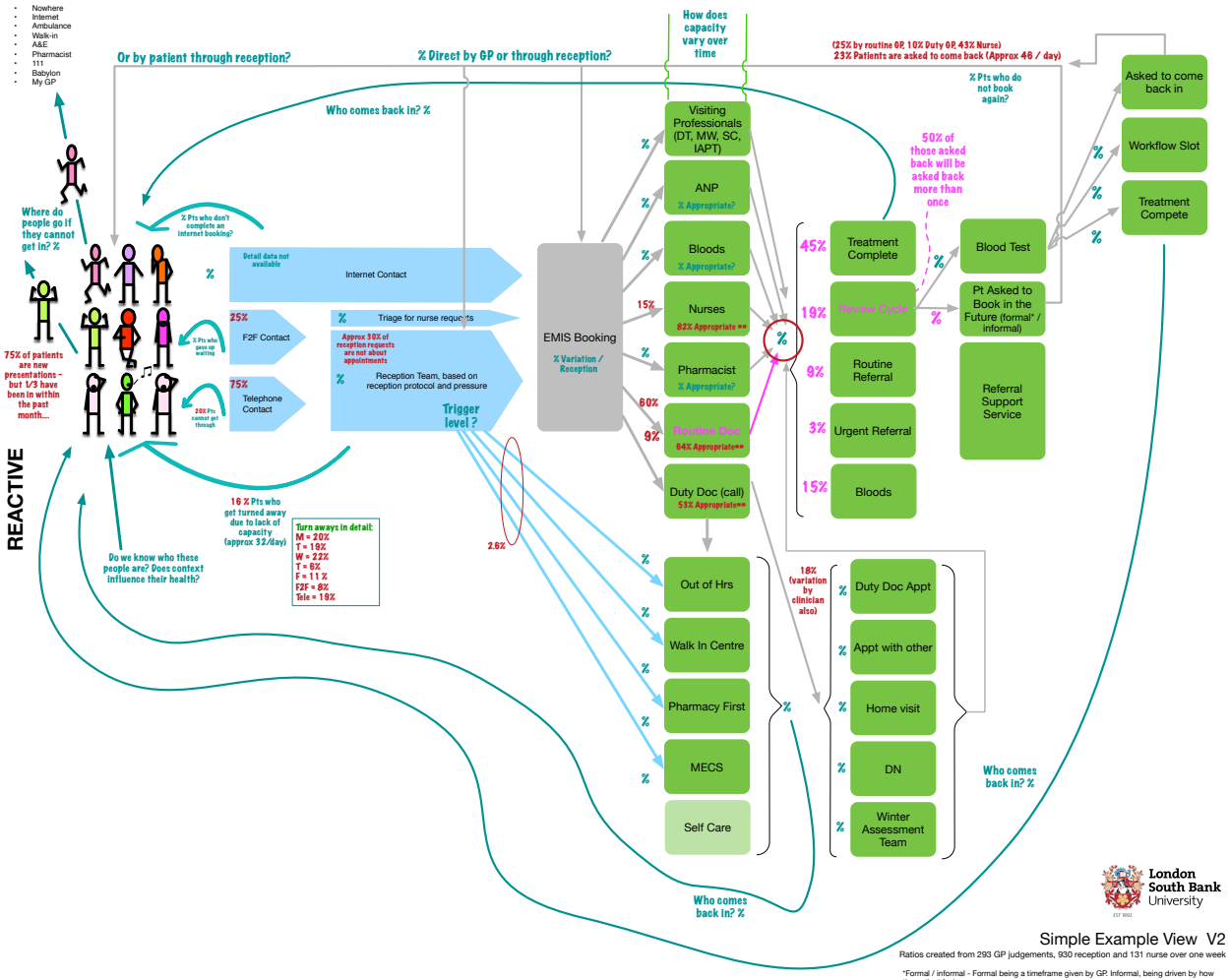
We help practices understand their practice as an **interconnected system** – and that GPs do have a role in generating their own demands.

- 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.



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Simple Example View V2

Ratios created from 293 GP judgements, 930 reception and 131 nurse over one week

*Formal / informal - Formal being a timeframe given by GP. Informal, being driven by how the patient feels.

Nick Downham

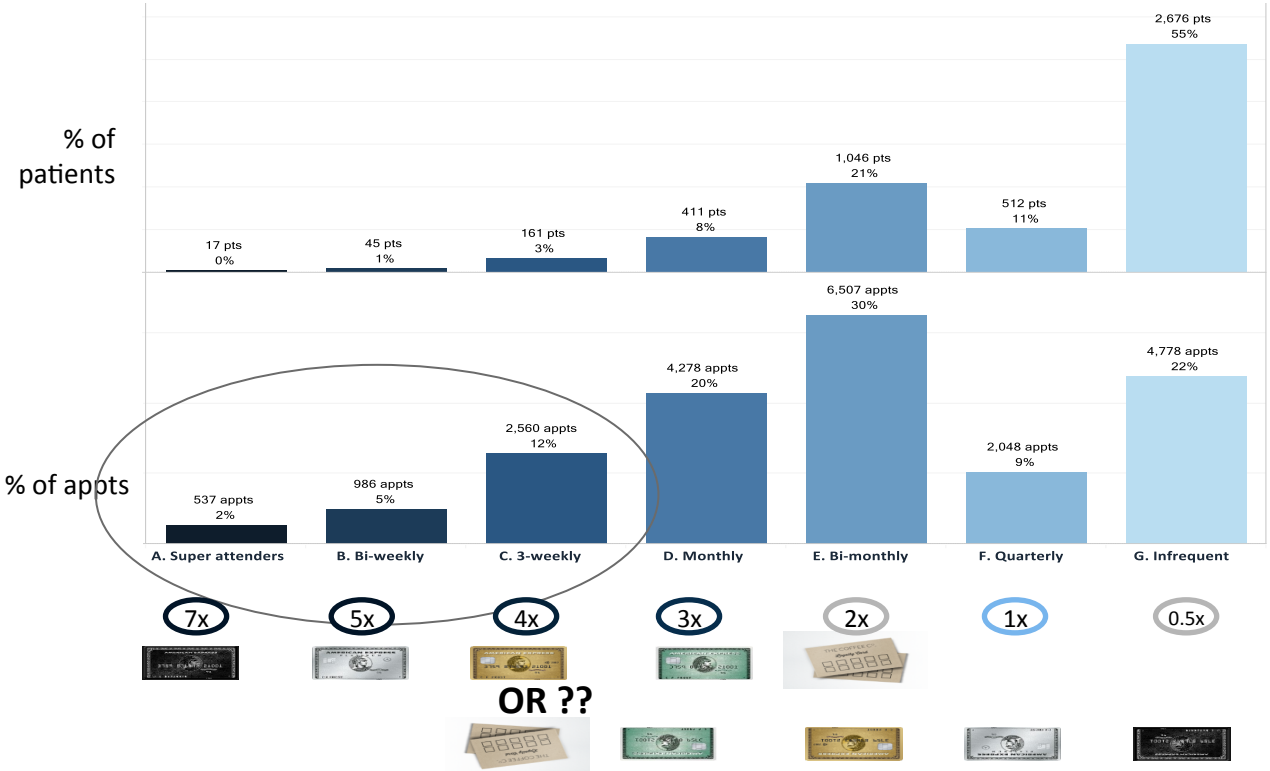
In Groups of 5 : Reviewing Sheet 2 – The Practice System

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.

Example from a small practice, one year of appointment data

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

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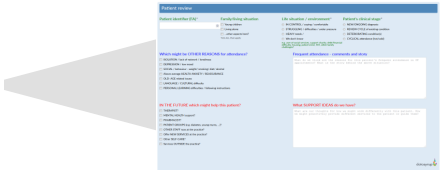
We **guide** GPs through case review and categorisation

- 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.

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

TOOLKIT: a webform prompts consideration of:

- Patient's life situation
- The real drivers of high attendance
- New services / skills and ideas



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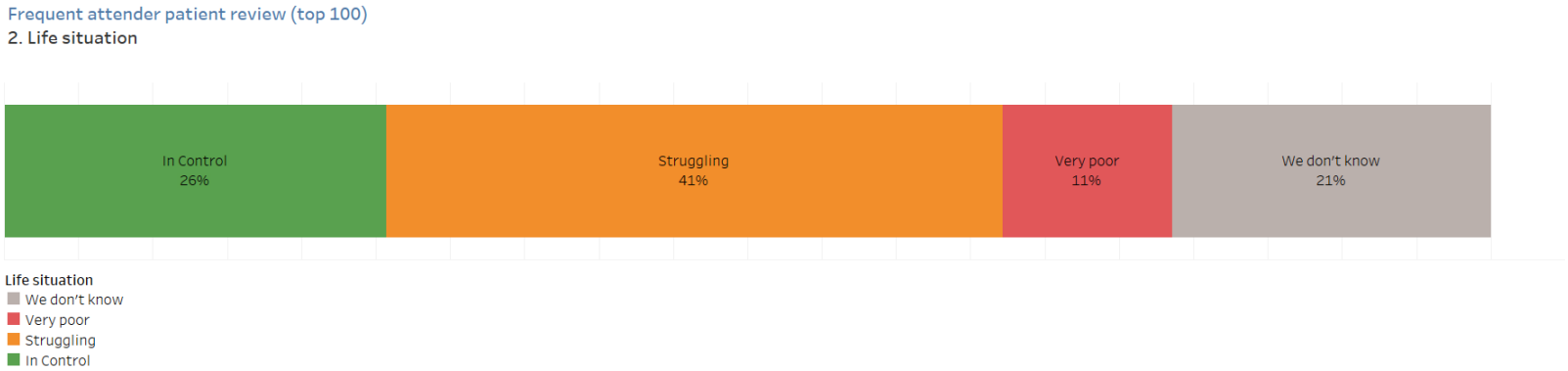
Frequent attender review (top 100)

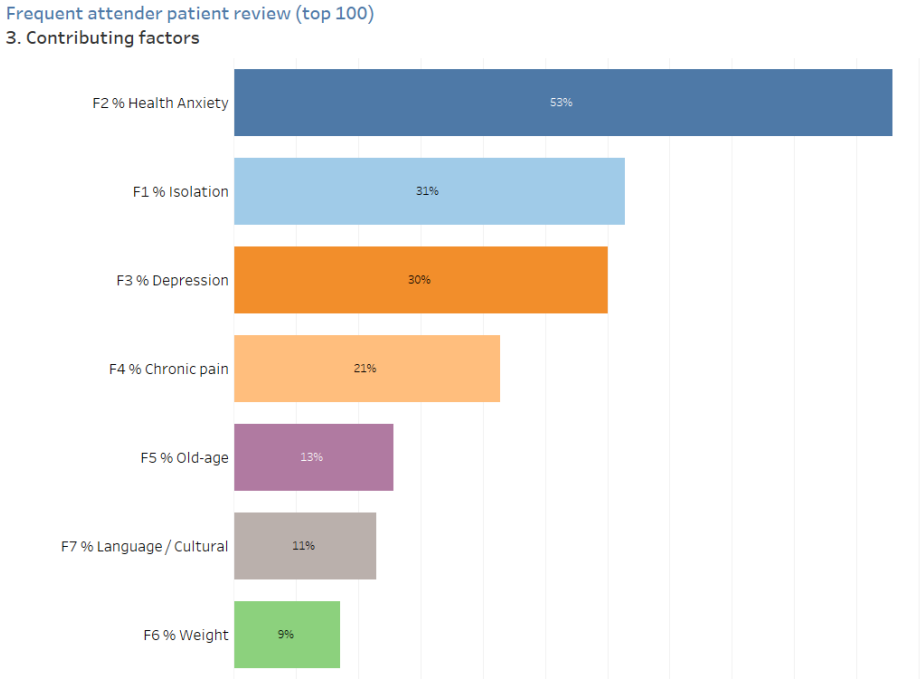
Life situation:

Over half are known to be in a struggling or chaotic life style



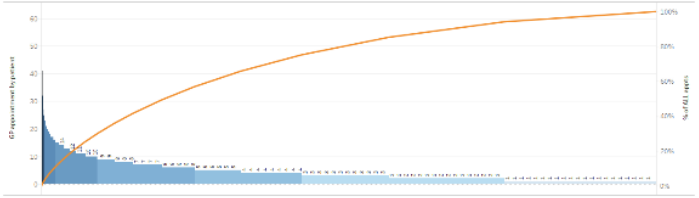
Frequent attender review (top 100)

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 on top 200



FA group	# patients in group	Avg. GP appts	% of all patients	# GP appts	% of ALL GP appts	# of all appts (incl nurse)	Avg. Age	Est VALUE of GP appts (@£40/appt)	Cumulative value
A. Weekly (35+ / yr)	11	44 appts	0.1%	479	1.0%	538	52	£19,160	£19,160
B. Bi-weekly (24-34)	35	27 appts	0.2%	938	2.0%	1,127	51	£37,520	£56,680
C. 3-weekly (16-23)	197	18 appts	1.2%	3,628	7.9%	4,333	51	£145,120	£201,800
D. Monthly (10-15)	740	12 appts	4.6%	8,731	19.0%	10,730	50	£349,240	£551,040
E. Bi-monthly (6-9)	1,722	7 appts	10.6%	12,402	27.0%	15,721	47	£496,080	£1,047,120
F. Quarterly (4-5)	1,897	4 appts	11.7%	8,405	18.3%	11,175	42	£336,200	£1,383,320
G. Infrequent (2-3)	3,578	2 appts	22.0%	8,694	18.9%	12,252	39	£347,760	£1,731,080
H. Annual (1)	2,694	1 appts	16.6%	2,694	5.9%	4,668	35	£107,760	£1,838,840
I. Non-GP attender (Other)	777	appts	4.8%	0	0.0%	1,517	40	£0	£1,838,840
J. Zero-attender (any)	4,590	appts	28.3%	0	0.0%	0	32	£0	£1,838,840
Grand Total	16,241	3 appts	100.0%	45,971	100.0%	62,061	38	£1,838,840	£1,838,840

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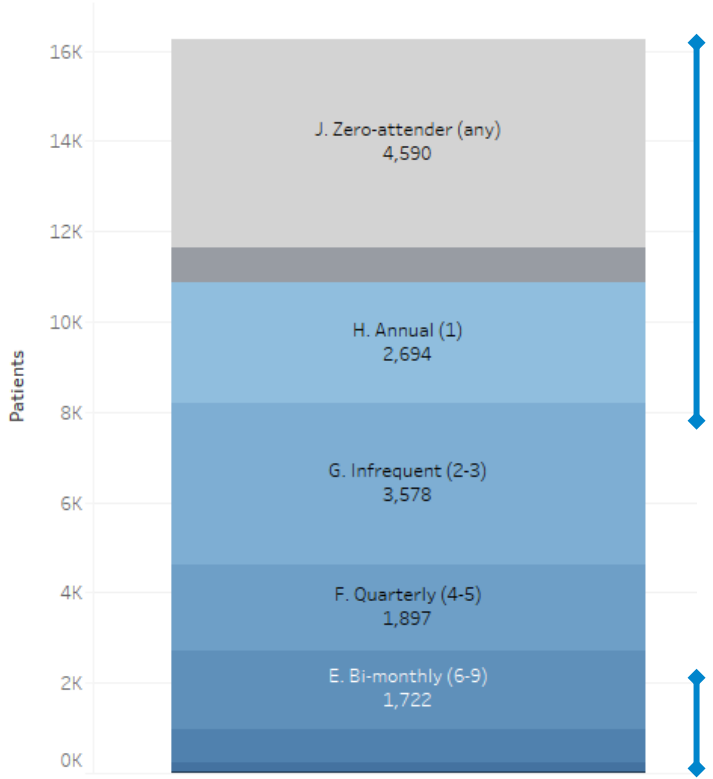
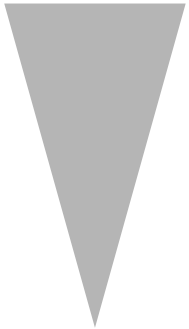
Challenge1: Managing resources to frequent attenders and offering more appropriate services to them
Challenge2: Looking after your revenue from infrequents (in the face of digital competition)



50% of your income comes from zero/single attenders



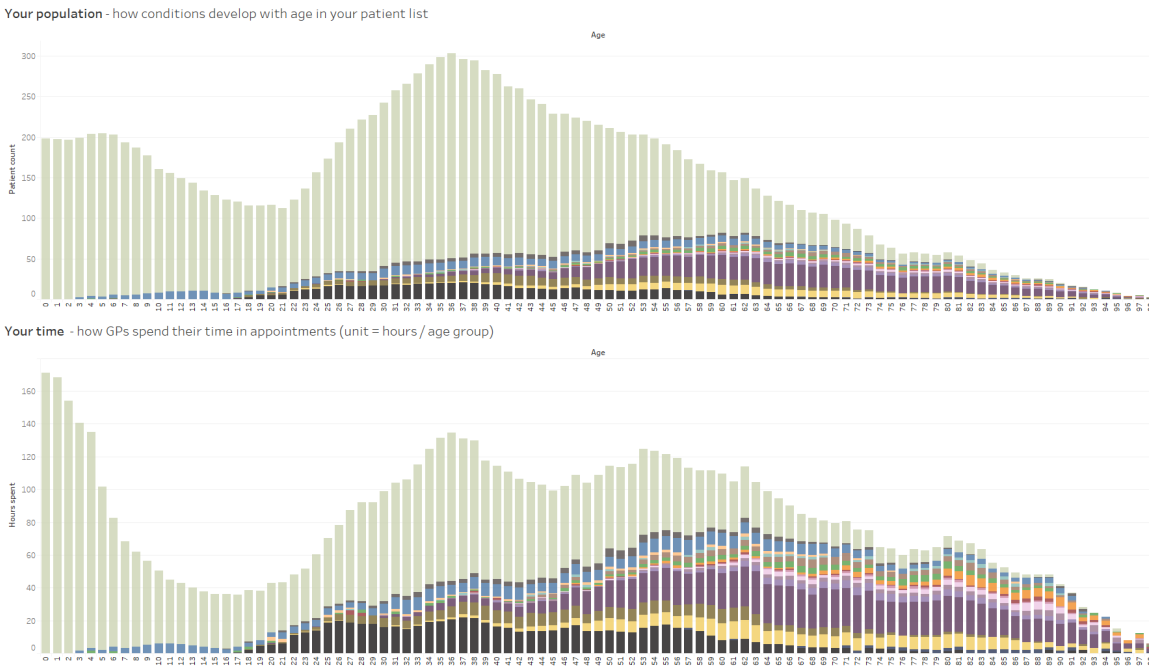
And is used by the top 15% of attenders

Standing back and looking at the whole practice population – example from one practice.

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

LTC occurrence by patient

Proportion of GP appts taken by long- term conditions



Age 0 -100 years ⇨

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Case Study (1)

The immediate impact of team development and sorting

Case: impact – CQC ratings

November 2015 (prior)

Overall rating for this service	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Requires improvement

January 2018 (during)

Practice List Size 14,000.

The practice is in the 7th most deprived borough in London and the 35th in England.

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Case study: intervention list

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

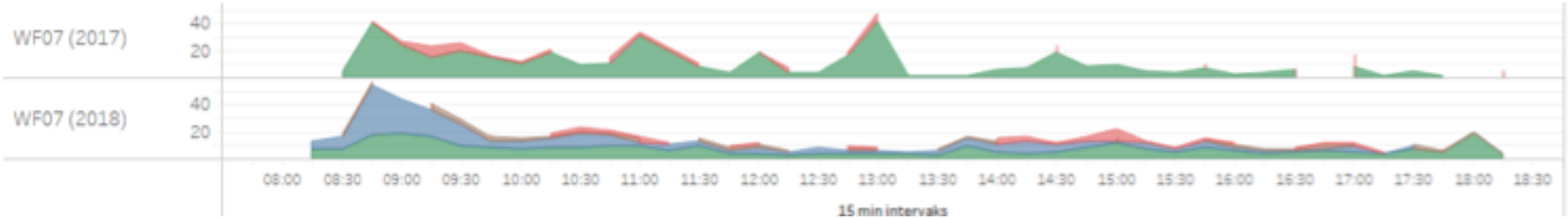
Case study: Benefits 6 months in

- 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.

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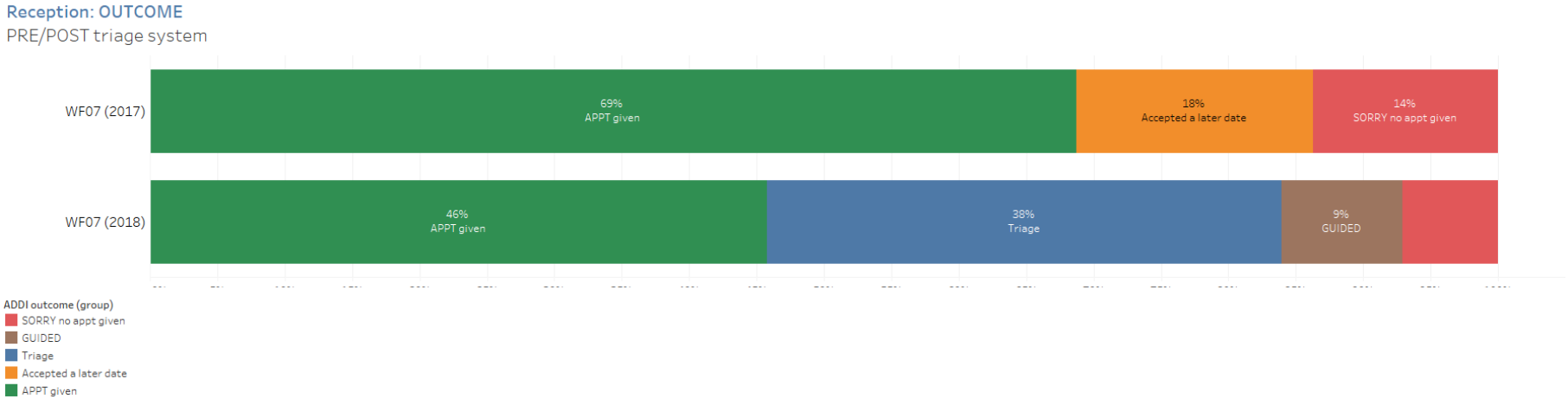
Reception: pre/post triage impact

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 a 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.**

> *"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**

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'*.

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robinlane
health & wellbeing centre

*"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

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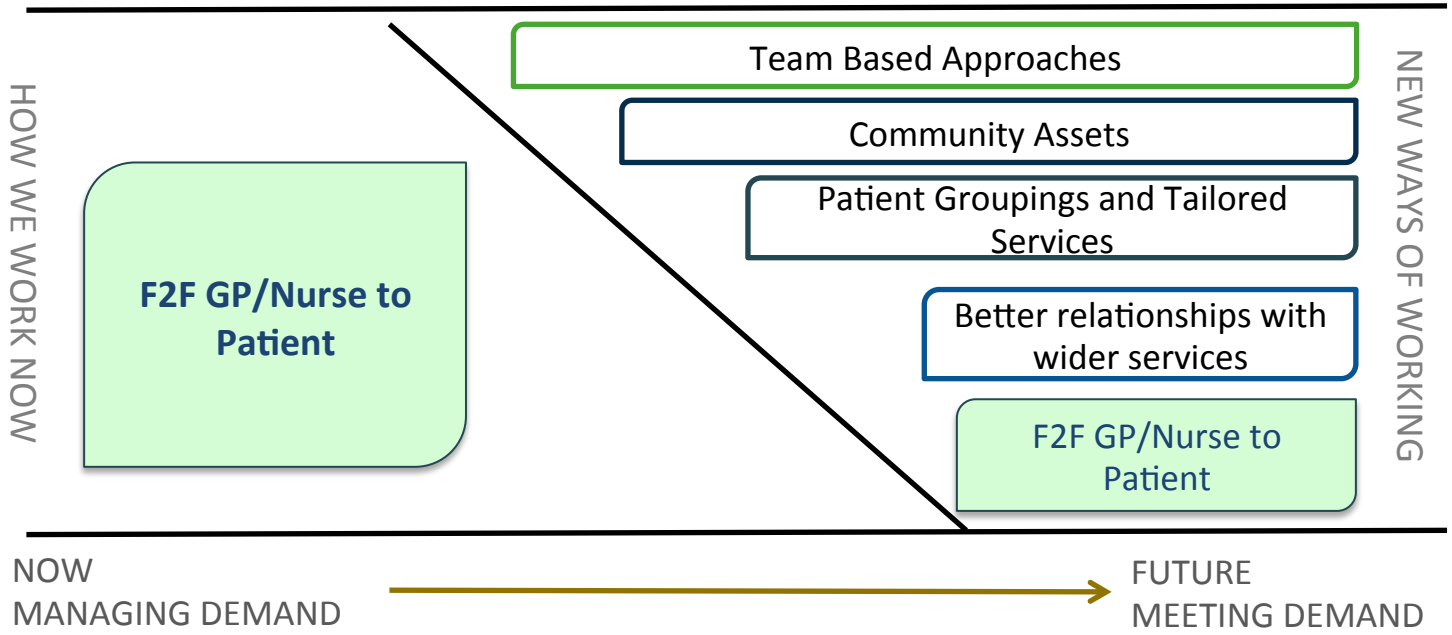
How all this comes together at practice level

Moving to a new, ‘mixed’ model

Primary Care Quality Academy



FOUNDATIONS

- Data foundations
- Creating the Practice Approach (reducing variation of clinical approach)
- Signposting and organising
- Partnering with Community

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The Ideal Primary Care System

A Straw Man – starting from needs

The Building Blocks for Integrated Care Systems

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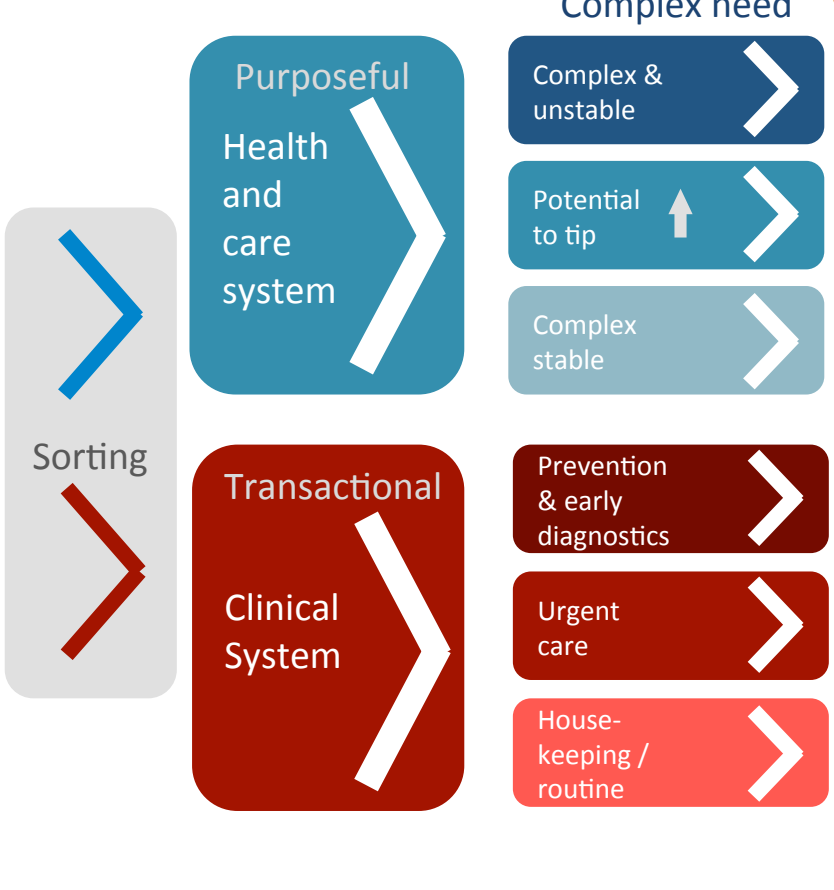
RESOURCEFUL COMMUNITY connecting people / creating meaningful activities / generating self-esteem

An ideal primary care system



Possible categories of Complex need

Frail older people | Elderly with multiple needs | Trouble with life | MH and Physical Health | Children & Young

Purposeful

Complex & unstable

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

Potential to tip

Assessment for Early warning flags

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

Complex stable

REQUIRES: Continuity of GP/team
REVIEW & PLAN: MDT Reviews
ASSESS: E-record flags
Comprehensive assessment at home

Transactional

Prevention & early diagnostics

ASSESS : E-record flags
REVIEW: of potential for complexity

Urgent care

MINOR
ACUTE & DIAGNOSE
ACUTE & IMMEDIATE ESCALATE

House-keeping / routine

PAPERWORK
PAYMENT SERVICES
ROUTINE DIAGNOSTICS

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In summary:

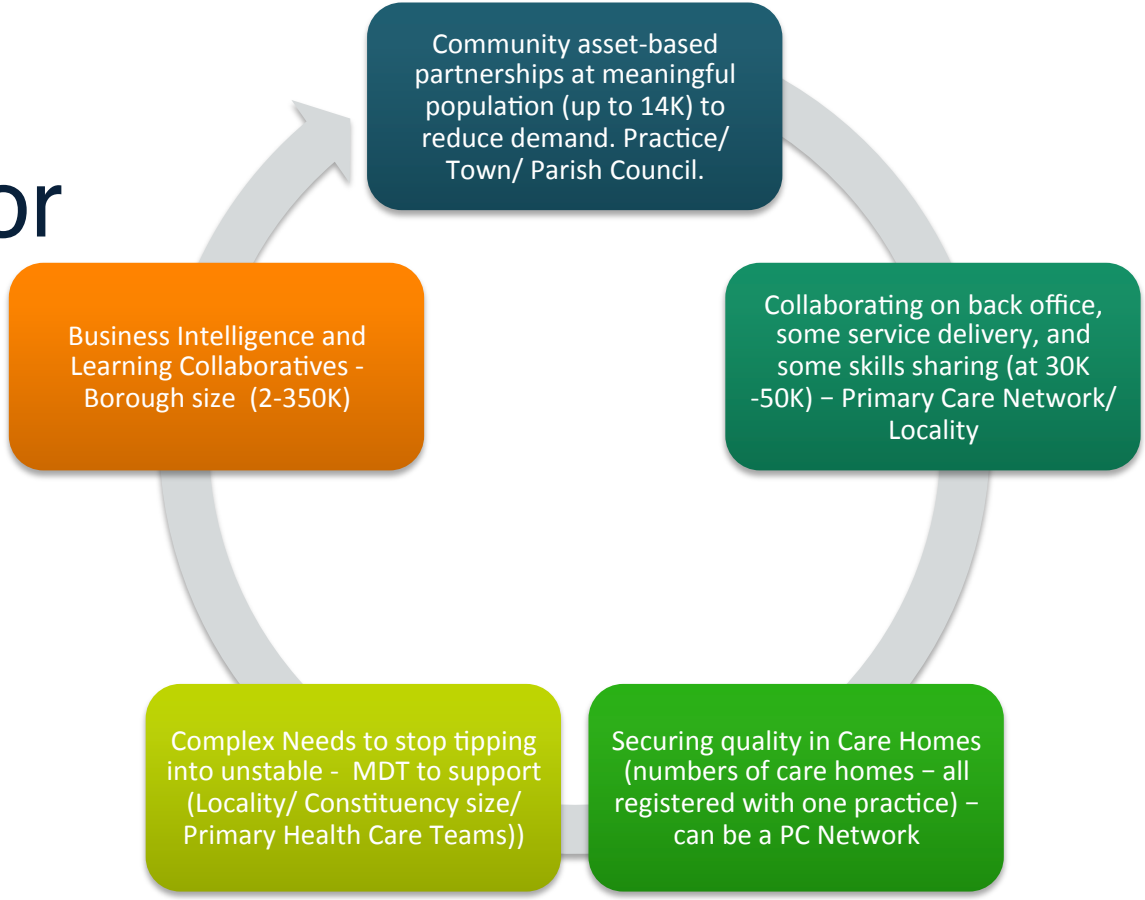
Economies of Scale thinking comes from study around VERY simple and bounded processes. For example pin making.

- 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?



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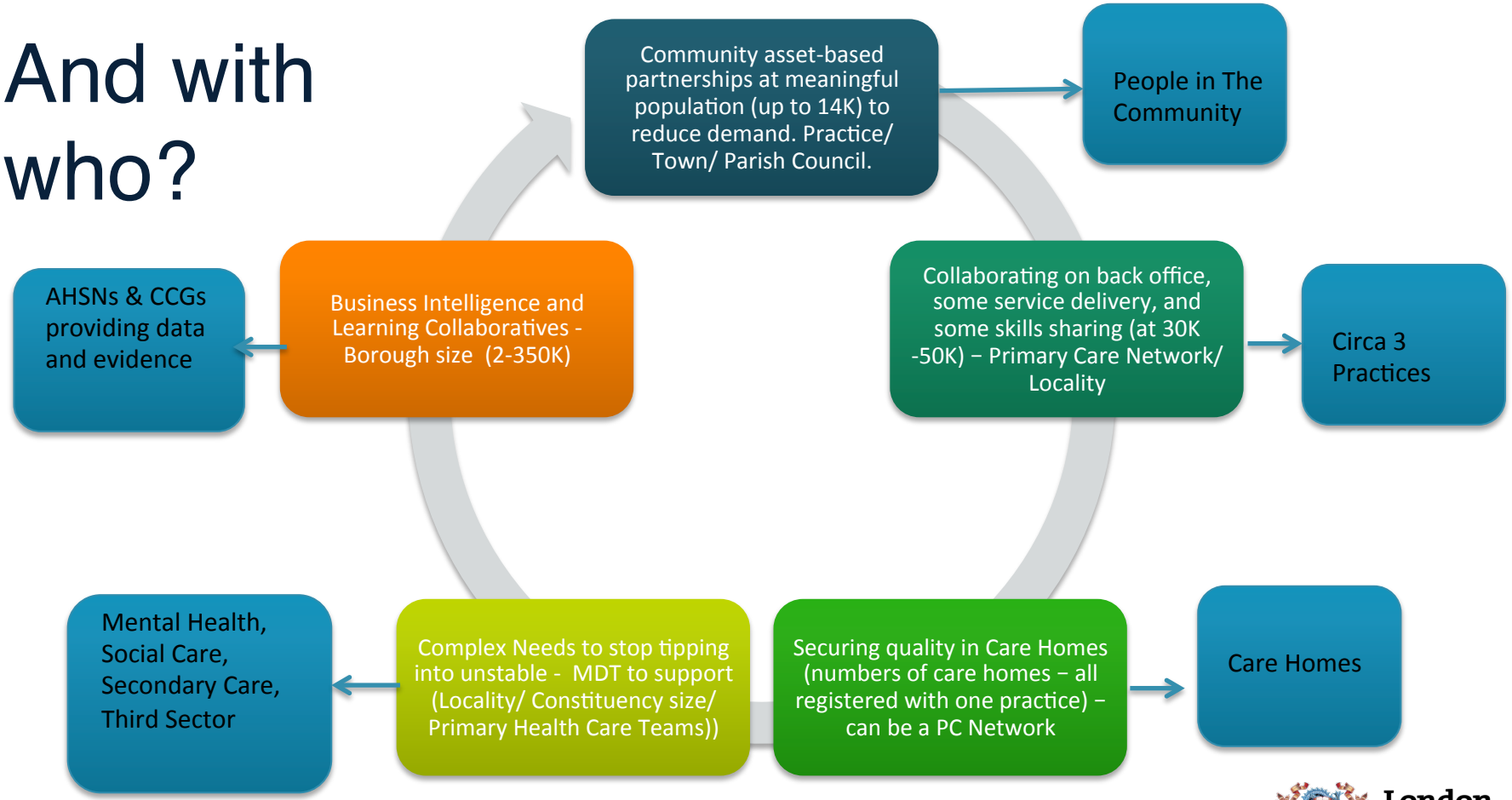
And with who?



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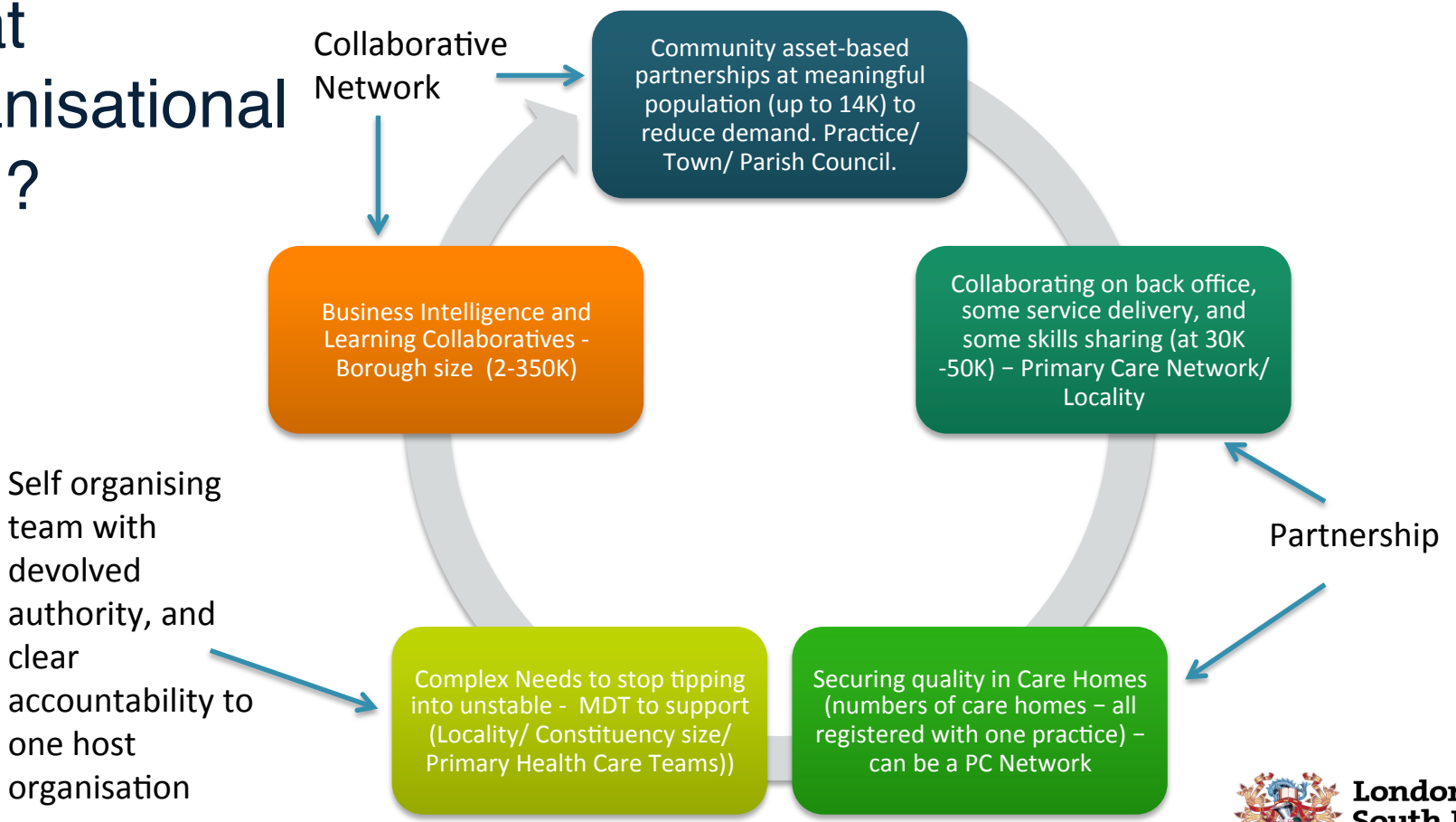
What organisational form?



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What it Takes

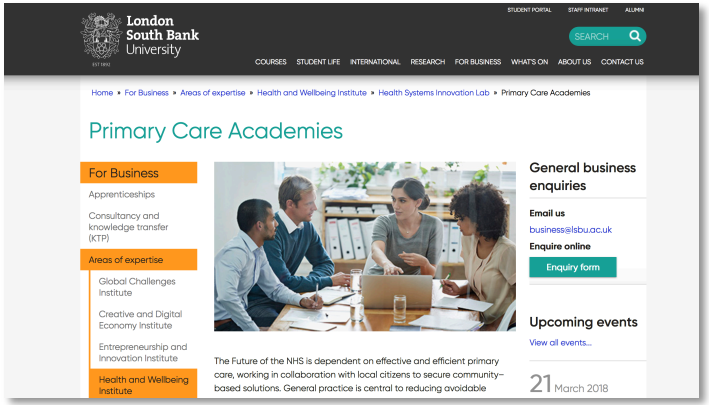
To do this work

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.



https://beckymalby.wordpress.com/

r.malby@lsbu.ac.uk

@BeckyMalby

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