London Primary Care Quality Academy

April 2019

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The Dilemma

What the NHS Experiences

- Increasing complexity
- Desire to create control and simple solutions
- The need for certainty in an uncertain environment

Based on experience in leading in transactional cultures

What the NHS needs

- Adaptive capability
- Creative solutions
- New capacity and resources
- Experimentation

Requiring leadership through relational culture

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Networks

“Networks have become the predominant organizational form of every domain of human activity” Castells (2011)

“Networks are cooperative structures where an interconnected group of individuals, coalesce around a shared purpose and where members contribute as peers on the basis of reciprocity and exchange (in turn based on trust, respect, and mutuality).” Malby & Anderson-Wallace (2016)

Useful For

- Generating creative and innovative solutions
- Rapid learning and development
- Amplifying the effectiveness of individual members

Networks Work When:

- There is clear shared purpose and identity
- They are creative and innovative
- They meet member needs
- They are supported by adapted leadership
- They have strong relationships and ties
- They generate helpful outputs

Typology of Networks

Delivery/ Development Networks	• Collaboration and Coordination • Boundary Spanner • Hub and Spoke
Learning & Support Networks	• Shared and New Knowledge • Distributed Leadership • Passion and Commitment
Agency/ Advocacy Networks	• Amplification and Advocacy • Dynamic Leadership • Democratic engagement

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ROBUST GENERAL PRACTICE

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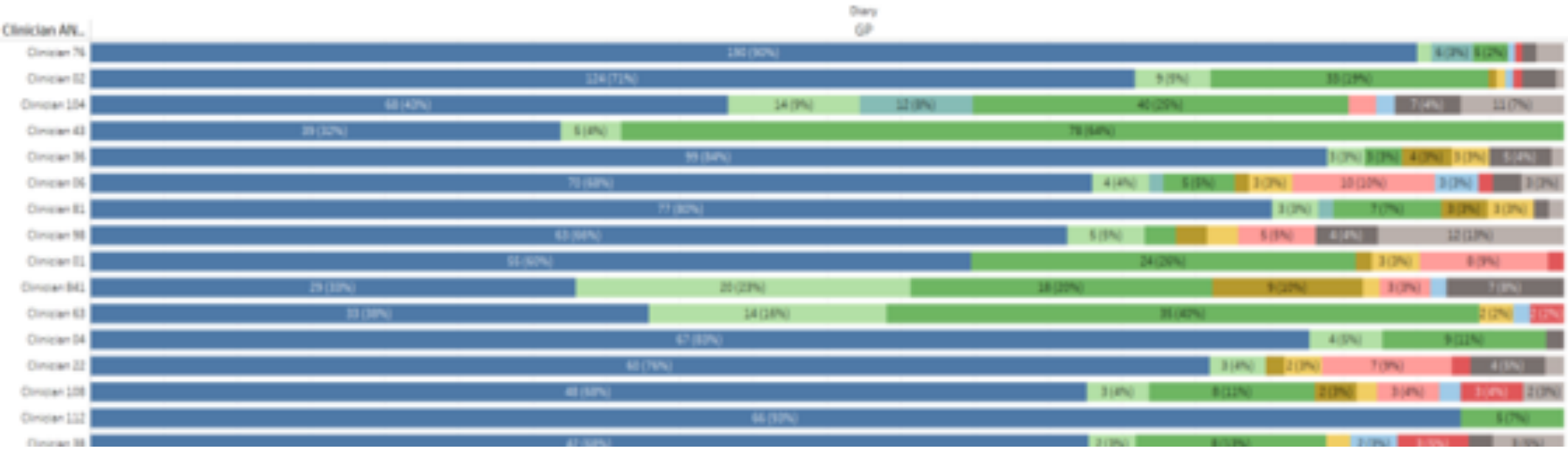
Critical Themes in High Performing Systems Adapted from Baker & Denis 2011

Leadership & Strategy	Organising Design	Improvement Capabilities
Quality and systemic improvement as a core strategy	Robust primary care teams at the centre of the delivery system	Proactive approach to building skills for quality improvement across the system
Leadership activities embrace common goals and align activities throughout the system / network of care	More effective integration of care that promotes seamless transitions	Information as a platform for guiding improvement
Clinical leadership is supported by professional management	Promoting professional cultures that support teamwork, continuous improvement and patient engagement	Effective learning strategies and methods to test and scale up across the system
Shared decision-making with patients and families	Providing an enabling environment buffering short-term factors that undermine success	Engaging patients in the their care, and in the design of care

What is The Work of General Practice?



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

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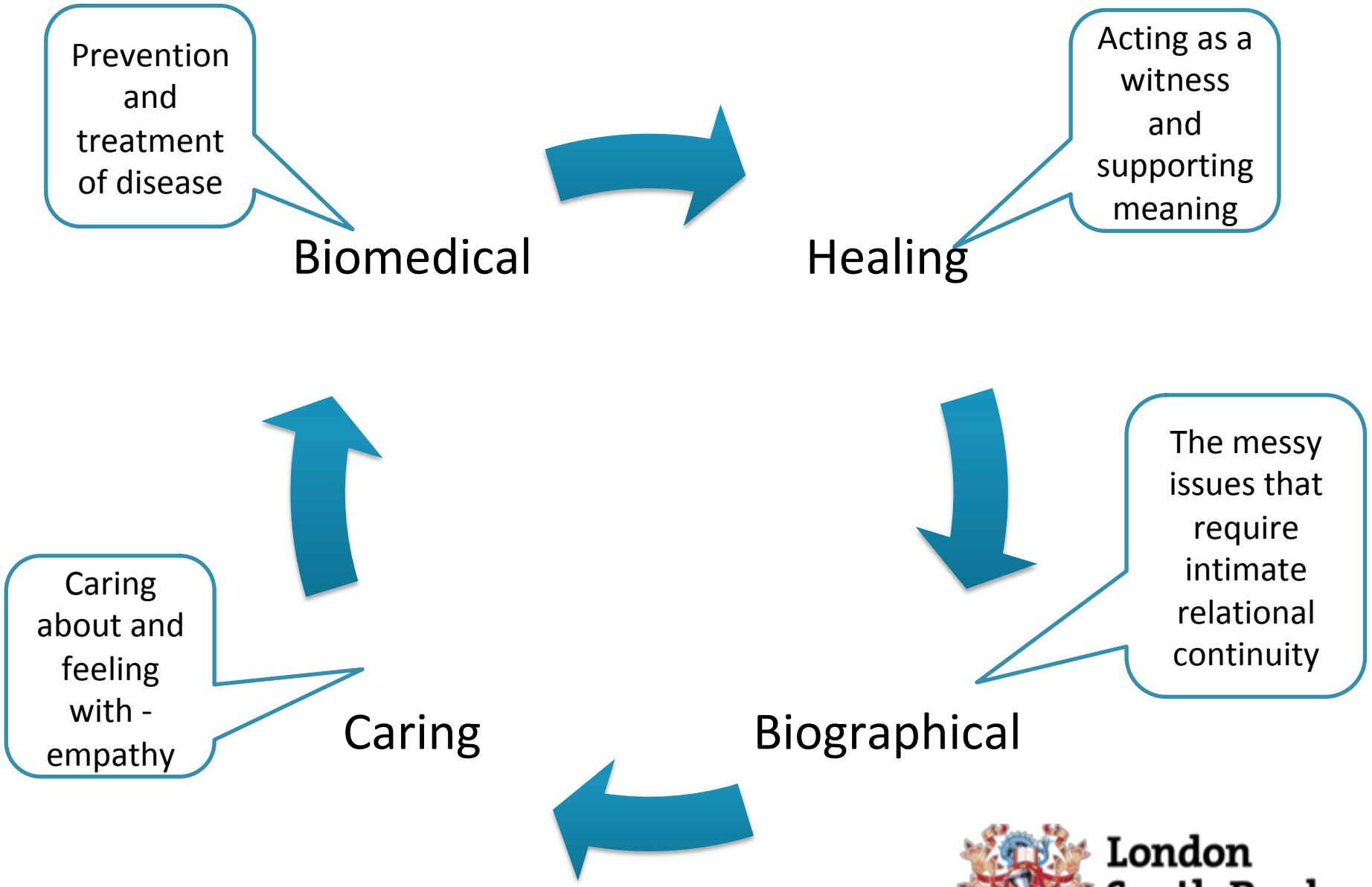

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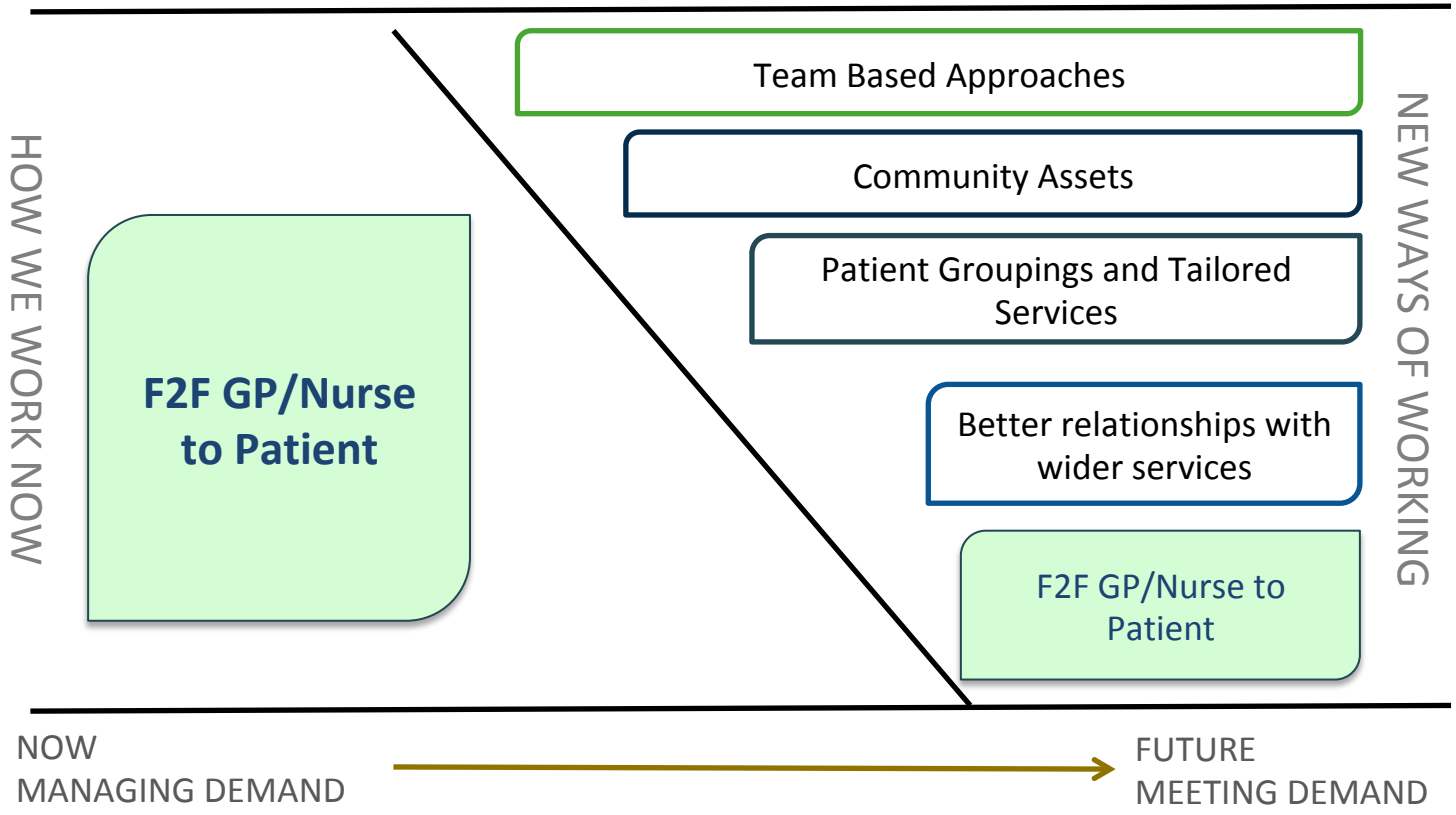

FOUNDATIONS

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

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Transactional (Practice)

Purposeful (Practice)

Purposeful (PCN)

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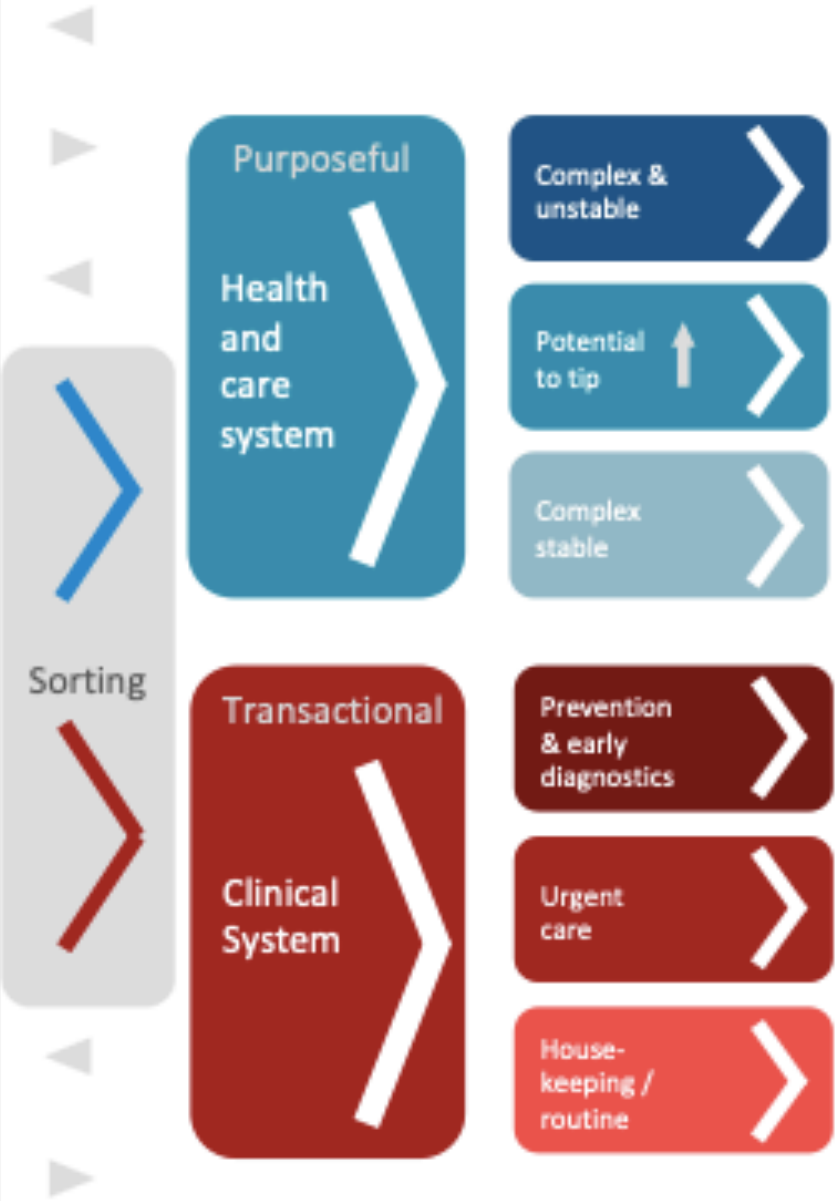
An ideal primary care system

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

Possible categories of Complex need

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



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

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

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

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The Bedrock - Resourceful Communities

- Connecting people / creating meaningful activities / generating self-esteem

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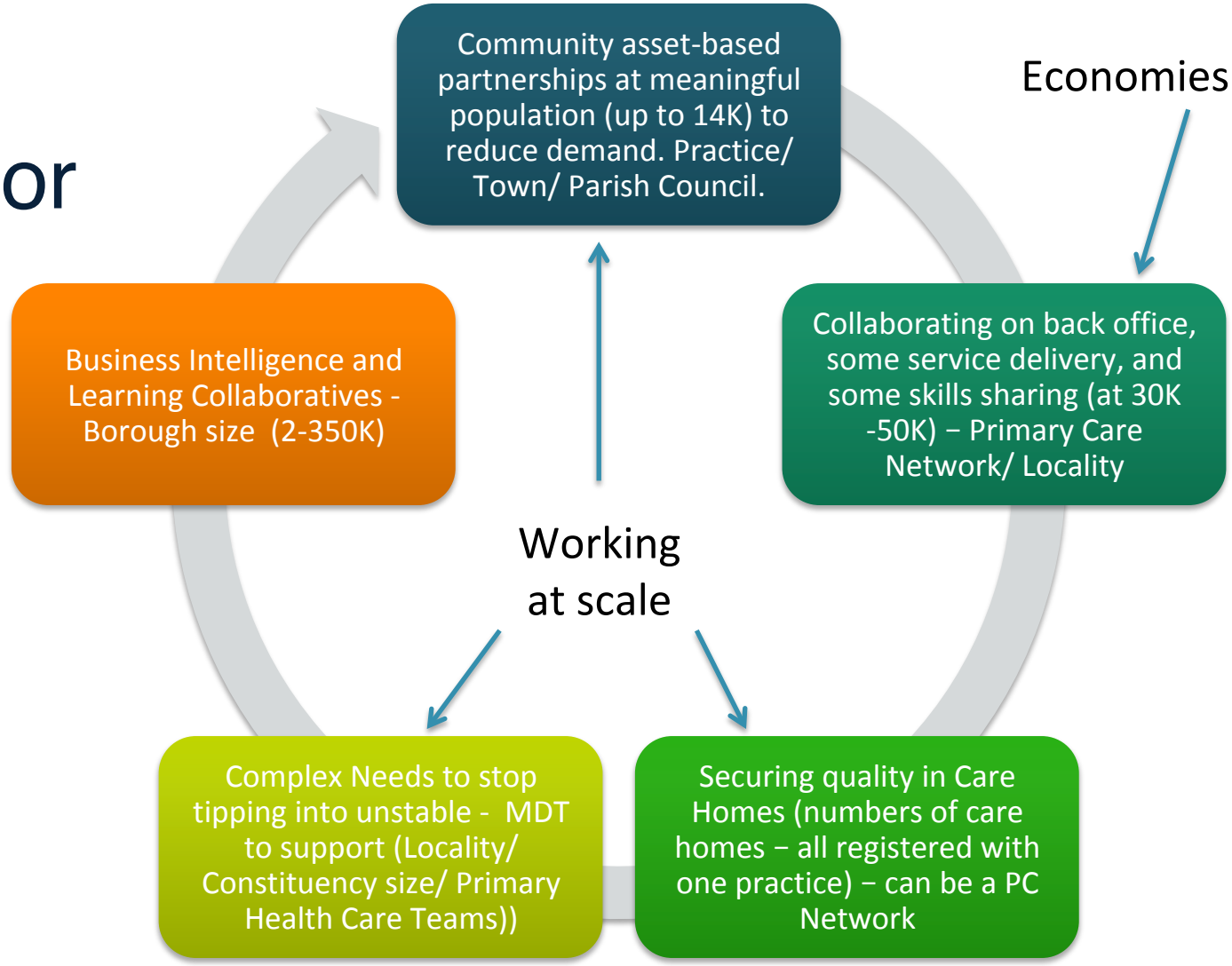
What Scale for What Work?



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ECONOMIES OF SCALE/ WORKFORCE REDESIGN

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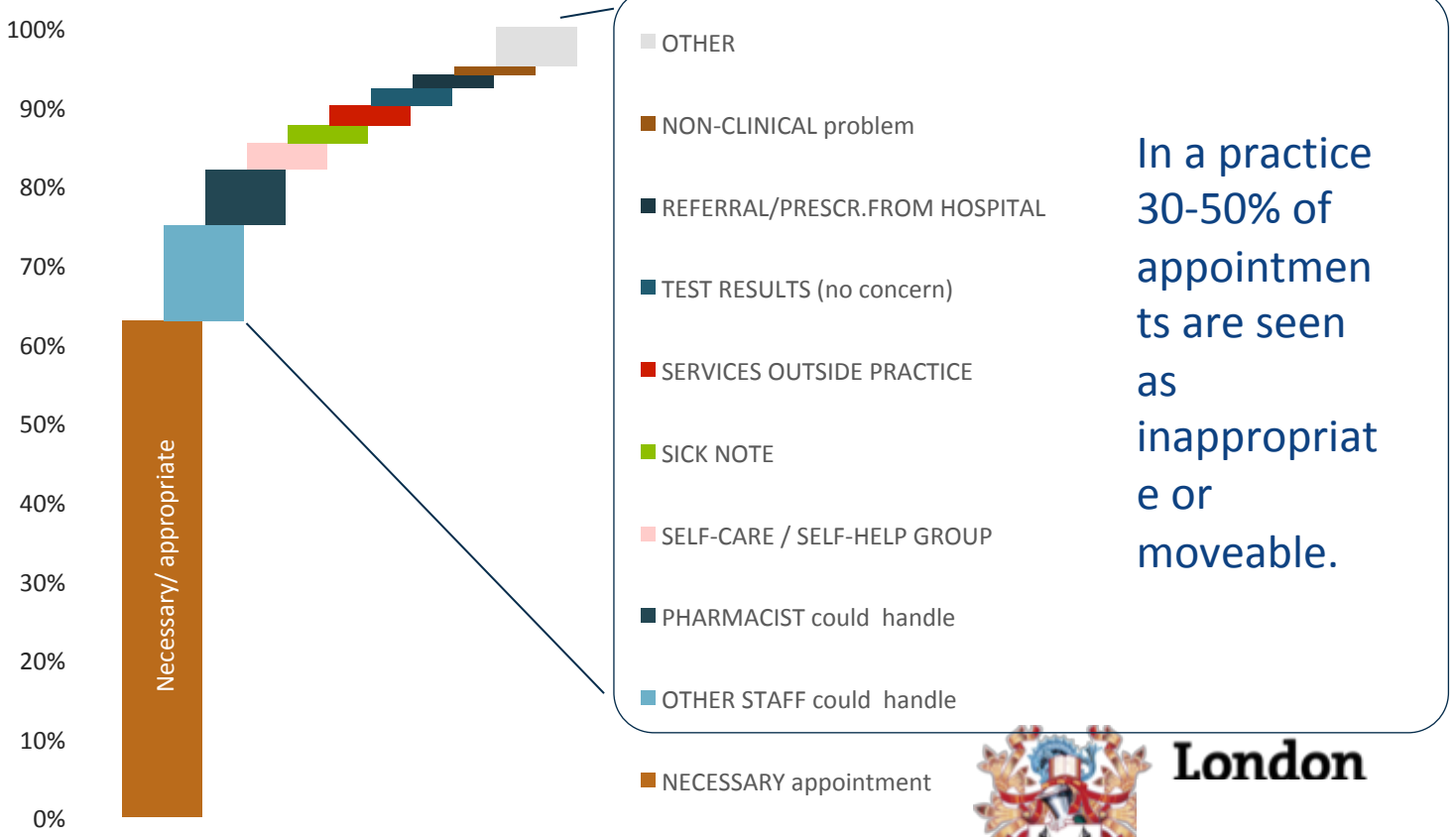
We illustrate GPs own assessment of appropriateness of appointments

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.

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Nick Downham	Economies of Scale	Working at Scale
What is it driven by?	Driven by classic economic and industrial thinking from the 1700s, 1800s and early 1900s. Four driving principles: • Division of Labour (Adam Smith) • Functional Specialism (Max Weber and Adam Smith) • The role of Market (Adam Smith and many more) • Unit costing	Driven by a support, service or innovation need that can only be achieved at a certain scale. • To support the maintenance of a certain technical expertise. • To provide depth and quality of collaboration network. • To reflect natural sizes of communities. • To support team based approaches**

Nick Downham	Economies of Scale	Working at Scale
What does it look like in practice?	• Specialism of roles and teams. • Introduction of greater number of different, and often more specialised roles. • Greater emphasis and specification of tasks and roles (often to allow for greater division of labour). Management of services around labeled needs*. • Consolidation of organisations (often to allow for greater volumes of functional specialism) • Outsourcing of functions. • Bulk buying • Batching of work • Short contracting cycles • Introduction of greater numbers of assessments and gateways. • Concentration on intervention (unit / point / episode) costs.	• Specialist centres where there is a a genuine need for deep specialism from a technical perspective. For example specialist heart centres or Neighbourhood hubs for Spirometry interpretation (not taking). • Genuine multi-disciplinary team based approaches (for example Intermountain's primary care MH team based approach). • Autonomous generalist team (neighbourhood) based approaches such as the Nuka system or Buurtzorg approach. • More generalist competencies. • Driven by contextual (social determinants) needs of patients as well as the health needs. • Systems that seek to meet need at the earliest possible instance, rather than label and handoff. • Community networks meeting much of the population need rather than the formal services. • Understanding of end to end cost rather than intervention (unit or point cost).

What impact does it have?	• Greater number of **handoffs** in order to get 'work done'. Creating **failure demand** (more work − typically felt elsewhere). • Individuals and departments concentrate on getting their bit (their specialism) done, and then handoff. • Work is bounded by the **specification**. • Staff get **de-motivated** by only doing a limited number of tasks. • It is almost **impossible to be flexible.** • **Responsibility** for the whole **is lost.** • Individual interaction costs go down**, overall costs typically go up.** • **We lose the ability to take into account a patient's context.** • **Supply driven care.** • **Conflicting priorities.**	• **Reduction in failure demand** and thus overall system cost. • **Simpler** systems (less requirement for costly management infrastructure). • **Less system fragmentation** and thus greater communication. • **Needs** (H or S) driven **care**. • **Empowered** staff. • Greater **view** of the **whole**. • **Aligned** priorities. • **Stronger networks.** • **Stronger communities.**

*Source: Richard Davis / John Seddon (Vanguard)

** Team based approaches are not the same as broadening skill mix − which is generally a form of division of labour)

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.

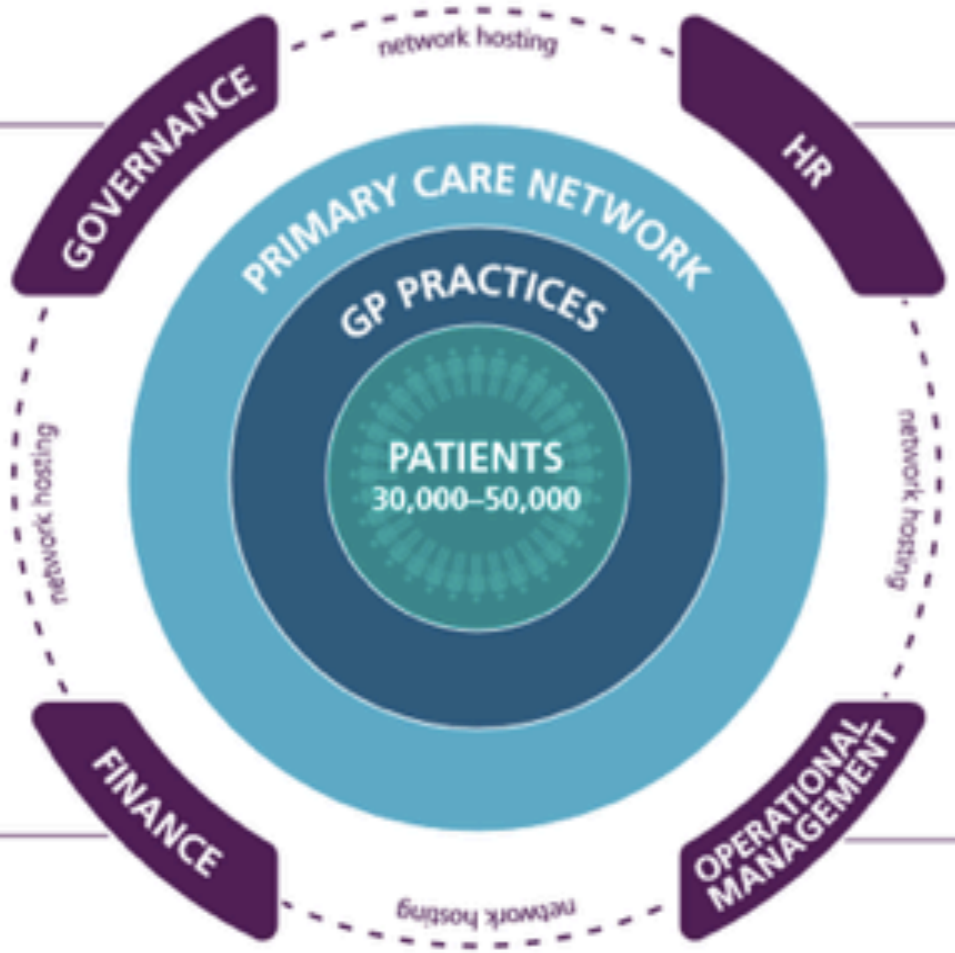
Working at scale is about enabling a technical expertise or team, network or community innovation that genuinely cannot be achieved without a certain scale.

- They speed up the meeting of need, rather than delay or possibly not meet it.

Your Primary Care Network Partner

BOLTON GPFEDERATION

- Terms of Reference/MOU/SLA
- Support and facilitate Network Board
- Financial transactions and reporting
- Quality systems
- Shared access incident reporting
- Information/data capture and reporting



- Recruit, DBS/registration check for new/TUPE staff
- Ensure training and development is delivered and kept up to date
- Annual appraisals, CPD & development
- CQC registration – statement of purpose

- Employment Liability is with Fed – not practices
- Independent 'honest broker'
- Owned by practices
- Existing financial systems and governance, Accountant lead
- Strong financial track record

- Organising network clinics/ MDTS, staff, equipment
- IT, data sharing, read/write record access all already in place
- Reporting/information processes in place
- Independent facilitation of sharing of staff
- You wont have to take a call when someone rings in sick and then manage cancelling clinics/rearranging patients
- You wont have to take the call when IT isn't working and then sort out the problem

WORKING AT SCALE

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Where to start

- Needs First
- Data enabled for Quality
- Primary Care is the starting place
- Telehealth to support
- Secure best health
- Manage complexity through MDT
- Integrated record
- Long term outcomes based contracts
- Effective peer leadership

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Transactional

Prevention	Urgent Care	Housekeeping
E-record flags	Minor	Routine diagnostics
	Acute and Diagnose	Paperwork
	Acute and escalate	Payment services

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Purposeful Work

Practice

- Complex/ Stable
- REQUIRES: Continuity of GP/ team
- REVIEW & PLAN: MDT Reviews
- Assessment for Early warning flags

PCN

- Complex/ Unstable
- MDT @ home –Pathway pre-determined by type of need
- Tele-health to / relationship with secondary care

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Key findings – what works in place-based collaboratives for quality

- Strong relationships and inter-professional working which should be linked to leadership training programmes and development.
- Culture of learning- neutral space partnership between academia and practice
- Leadership that is dedicated, focused and distributive
- Shared purpose and narrative
- Solving problems through data enabled communities of practice
- Incremental change based on repetition, reciprocity, peer leadership, collaboration with citizens

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PCNS as Learning Networks Innovating Practices

- Learning Network
- Amplify what works
- Community of practice in the PCN
- Managing the remedials???

The Tipping Point

That if you don't like the way that people are behaving, they are likely to be organising around a purpose that you don't support.

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. Access is prime.*
- *We don't have enough capacity and we need more staff/ money*
- *Frequent attenders all have more than one chronic disease*
- *Communities are populations of size or disease.*
- *The professional is the expert*
- *Secondary care shifts the burden onto us*
- *Social care is failing*
- *If we meet need demand goes down*
- *We do what the matters to the person*
- *Our work is biomedical, biographical, healing and caring*
- *The resources to meet need are in the community and in our team. Our role is to unlock that capability.*
- *Communities are people with shared identity (geography or meaning)*
- *Professional practice is collaborative. The body of knowledge is beyond the capability of an individual clinician**
- *We make our own luck with our partners in the health system*

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