Healthy London Partnership

NHS

Next steps: a vision for strengthening general practice collaboration in London

Online guide

START

Contents

Introduction

This **maturity framework** and **toolkit** is intended to accompany the **Next Steps: A Vision for Strengthening General Practice Collaboration in London**. It has been designed as a **repository of useful information**, relating to characteristics of 'good' general practice at scale, as described in the Next Steps document.

For **each of the seven characteristics** (Population-Based Comprehensive Care, Systems and Information, Quality Improvement, Organisational Capabilities, Workforce and Wellbeing, Effective Governance, System Partnerships), a **range of material** has been collated that **describes, exemplifies or supports** good general practice at scale.

Each of the seven characteristics has a corresponding chapter within this toolkit and, for ease of navigation, each chapter is ordered in the following way: **report/ article, point of view, tool and case study**. **If you have any recommendations** regarding additional content to include, **please contact** england.londonprimarycaretransformation@nhs.net.

Report/article

Point of view

Tool

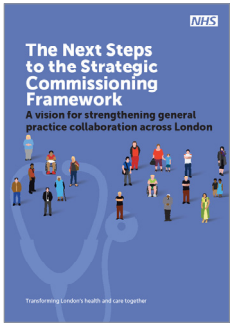
Case study

The next steps to the strategic commissioning framework:

A vision for strengthening general practice collaboration across London

The next steps

The next steps to the strategic commissioning framework: A vision for strengthening general practice collaboration across London.



This document highlights experience and case studies that illustrate the opportunities associated with collaborative general practice.

The 'Next Steps' defines a vision for London with regards to larger scale general practice as a key enabler to delivering high quality, resilient primary care that can participate effectively in the leadership of Integrated Care Systems.

Larger-scale general practice represents a vital means of delivering whole-person care that is proactive, accessible and coordinated. By collaborating at scale, it's possible to develop the core services and multi-disciplinary workforce that truly meets the needs of local populations based on their specific circumstances and achieves greater consistency of both care provision and outcomes.

What this means for patients – care is accessed more easily, delivered by a multi-disciplinary team with the combined skills to meet their specific needs, and is more consistent across London.

What this means for staff – clinicians can draw upon the expertise they need to deliver effective care, work in a collaborative environment, doing the things they were trained to do with individuals making the most appropriate use of their specific skills, ensuring they have a fulfilling role.

The document also outlines characteristics of what 'good' at scale working looks like across key areas: comprehensive population-based care, systems information and quality improvement, organisational capabilities, effective governance and stewardship, building collaborative system partnerships.

The next steps

Next Steps maturity framework

Context

- This maturity framework is based on characteristics of 'good' larger-scale general practice, as outlined in The Next Steps to the Strategic Commissioning Framework: A vision for strengthening general practice collaboration across London, which has been developed with extensive engagement of clinical leaders across London, and oversight from the Transforming Primary Care Clinical Cabinet.
- The framework articulates increasing states of maturity for larger-scale general practice organisations (LGPOs) against specific themes identified in The Next Steps document, and includes a clear state of high organisational maturity to which LGPOs can aspire.
- The framework is underpinned by 'foundations' that represent the key assets and processes that are integral to the development of all themes, at all stages.
- As STPs develop plans to accelerate collaboration in general practice, in particular through transformation fund allocations, they are encouraged to use this framework to identify in a broad sense how mature their respective LGPOs are currently, and the areas on which they may wish to focus in order to further develop organisations.

What the maturity framework is not

- Whilst the maturity framework is intended to provide structure and direction to the use of transformation funds, it is not the architecture for an assurance process for, or a 'measurement' of, organisations' maturity now, or in the future.
- The maturity framework is purposefully high-level and indicative. It does not describe an organisation precisely and comprehensively, and LGPOs will find that they are at different stages of development for different themes, and may lie between the stages described in some areas.

The next steps

Definitions

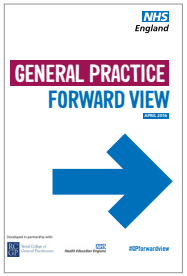
Larger-scale General Practice Organisations (LGPOs)
These organisations consist of multiple practices working via formal collaborative arrangements across a large, geographically coherent population. This enables them to develop and train a broad workforce, and to create shared operational systems and quality improvement approaches, including use of locally owned data. It also creates opportunities to support the delivery of collective back office functions that reduce waste and enhance efficiency, develop integrated unscheduled and elective care services for the whole population, and provide professional leadership through which a strong voice for general practice can be heard across boundaries. These organisations are not intended to replace practices, or diminish practice autonomy, but should support a number of vital functions that can best be achieved at this larger scale. In London, these are, for the majority, at the scale of a borough. Though most organisations in London are federations, there are multiple forms for such organisations.

Primary Care Networks (PCNs)
These networks are formed by practices coming together with other community providers, local people and the voluntary sector, to serve populations of approximately 30,000-50,000 people. Those that do exist currently in London are largely at an early stage of development. They are intended to bring together groups of practices, likely formed around local communities, with other community based health and social care services. Through these arrangements, comprehensive, team-based, multi-disciplinary care can be provided for people with enduring, complex health and care needs, who require close collaboration between service providers, and long-term care coordination.

Context

Context

General Practice forward view



The General Practice Forward View (GPFV), published in April 2016, commits to an extra £2.4 billion a year to support general practice services by 2020/21. It will improve patient care and access, and invest in new ways of providing primary care.

NHS England is investing £500 million in a national sustainability and transformation package to support GP practices, which includes additional funds from local clinical commissioning groups (CCGs). It includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development programme to speed up transformation of services. We are committing to an increase in investment to support general practice over the next five years.

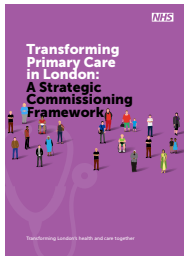
The plan was developed with the Royal College of General Practitioners (RCGP) and Health Education England (HEE) and contains over 80 specific, practical and funded steps to:

- channel investment
- grow and develop the workforce
- streamline the workload
- improve infrastructure
- and support practices to redesign their services to patients.

Source: NHS website. Available at https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

Context

Transforming primary care in London: a strategic commissioning framework



The Strategic Commissioning Framework provides both a new vision for general practice, and an overview of the considerations required to achieve it.

Transforming primary care is a concept that is rapidly gaining momentum as a key priority in the NHS – both nationally and in London. Two important pieces of work were published in the latter part of 2014, which set the platform for building on this energy and achieving the ambitions that are developing:

1. NHS Five Year Forward View,
2. Better Health for London, The London Health Commission.

This document, developed by commissioners across London, is both a new vision, and in effect a response to the NHS Five Year Forward View and London Health Commission publications. It details a specification for Londoners in the future, and begins to articulate how these changes fit within the wider out-of-hospital context. The document also considers how this specification might be delivered with regard to cost, workforce, contracts, and other key enablers.

The Strategic Commissioning Framework aims to support primary care transformation across the capital. It sets out an ambitious and attractive vision of general practice that operates without borders, and in partnership with the wider health and care system. The Framework focuses on 'function' not 'form' and sets out a new patient offer for all Londoners that can only be delivered by primary care teams working in new ways and by practices forming larger primary care organisations.

At the core of the Framework is a specification for general practice that sets out a new patient offer. This specification is arranged around the three aspects of care that matter most to patients:

1. Proactive care,
2. Accessible care,
3. Coordinated care.

Source: NHS website. Available at https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2015/03/lndn-prim-care-doc.pdf

Context

Five Year Forward View

The NHS Five Year Forward View was published in October 2014 and sets out a new shared vision for the future of the NHS based around the new models of care.

The NHS Five Year Forward View has been developed by the partner organisations that deliver and oversee health and care services including Care Quality Commission, Public Health England and NHS Improvement (previously Monitor and National Trust Development Authority).

Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers.

Source: NHS website. Available at https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Context

Better health for London

This report is about better health for London – mental health and physical health, each as much as the other. It rests on the foundational belief that London – its people, its institutions, and its political, economic and cultural leaders – has an obligation to help and support one another to achieve better health.

The Mayor set up the London Health Commission in September 2013 to review the health of the capital, from the provision of services to what Londoners themselves can do to help make London the healthiest major global city.

This report proposes tough measures to combat the threats posed by tobacco, alcohol, obesity, lack of exercise and pollution, which harm millions of people. Together the proposals amount to the biggest public health drive in the world. It contains over 60 recommendations and sets out 10 ambitions for the city with targets.

If we are to achieve the aspiration to be the world's healthiest major global city, we must improve the lives of all Londoners.

It sets out ten aspirations:

1. Give all London's children a healthy, happy start to life
2. Get London fitter with better food, more exercise and healthier living
3. Make work a healthy place to be in London
4. Help Londoners to kick unhealthy habits
5. Care for the most mentally ill in London so they live longer, healthier lives
6. Enable Londoners to do more to look after themselves
7. Ensure that every Londoner is able to see a GP when they need to and at a time that suits them
8. Create the best health and care services of any world city, throughout London and on every day
9. Fully engage and involve Londoners in the future health of their city
10. Put London at the centre of the global revolution in digital health

Source: NHS website. Available at https://www.england.nhs.uk/new-care-models/about/

Context

New models of care: vanguard sites

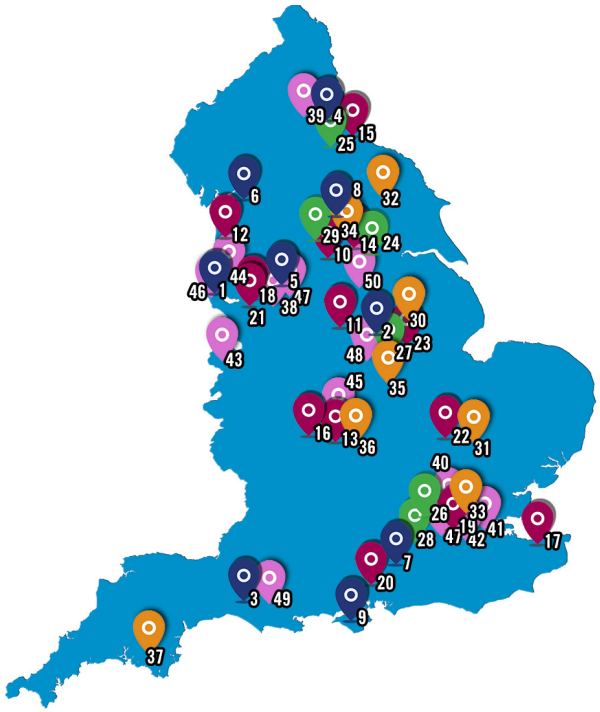
Between January and September 2015, 50 vanguards were selected to take a lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.

What this means for patients

The vanguards are improving the care received by millions of people across England. Through the new care models programme, complete redesign of whole health and care systems is being considered. This means fewer trips to hospitals with cancer and dementia specialists holding clinics in local surgeries, having one point of call for family doctors, community nurses, social and mental health services, or access to blood tests, dialysis or even chemotherapy closer to home.

They are also joining up the often confusing array of A&E, GP out of hours, minor injuries clinics, ambulance services and 111 so that patients know where they can get urgent help easily and effectively, seven days a week.

The full list of vanguard sites can be found on the NHS website (see link below).



Source: NHS website. Available at https://www.england.nhs.uk/wp-content/uploads/2016/04/vanguard-funding.pdf

Characteristics of good general practice at scale

1 Population based comprehensive care

2 Systems and information

3 Quality improvement

4 Organisational capabilities

5 Workforce and wellbeing

6 Effective governance

7 System partnerships

1 Population based comprehensive care

This section focuses on how larger-scale general practice organisations provide care for their population. They are formed by multiple practices coming together to support care delivery at practice and network levels that reflects population needs, reduces inequalities and improves outcomes for local people. Hover over each bubble for more information.

Click here to see the full component sections

I'm on my own

I work with others

We work as an informal team to understand local population needs

We work as an integrated team to reduce inequalities and improve outcomes for our population

General practice of the future


breaking boundaries

nhsalliance
connecting, engaging, innovating

General practice of the future

Can general practice retain its best features while adapting to the demands of a changing health service? David Colin-Thomé and Brian Fisher argue the case for new models.

Can general practice retain its best features while adapting to the demands of a changing health service? David Colin-Thomé and Brian Fisher argue the case for new models.

Little and big

It is not, in fact, an either/or choice. For general practice to fulfil its potential it must be both 'little and big', both local and strategic. We need a new model of care provision that moves away from provision centred on the hospital to one centred on primary care.

A 'Primary Care Home' would be an integrated, population-based provider organisation commissioned on a devolved, population-based, holistic NHS budget to disburse on the 'make or buy' principle – either it provides the service the patient needs or refers them to another provider. It would be a home not only for general medical practitioners and their teams but also for all primary care independent contractors and their staff (pharmacists, dentists, optometrists), community health service and social care professionals.

In the Primary Care Home, constituent organisations would retain their autonomy, subject to two-way accountability. It could be managed by whoever is the suited to the task locally. It could compete with other NHS-funded organisations. So general practice can be big and small, strategic and locally operational, working together and alongside community providers to change the way health services are delivered to populations.

Source: NHS Alliance website. Available at https://www.gponline.com/viewpoint-general-practice-adapt-survive/article/1174844

Primary care home

There are currently more than 200 Primary Care Home sites across England, covering eight million patients – 16 per cent of the population.

Primary care home is an innovative approach to strengthening and redesigning primary care. Developed by the NAPC, the model brings together a range of health and social care professionals to work together to provide enhanced personalised and preventative care for their local community. Staff come together as a complete care community – drawn from GP surgeries, community, mental health and acute trusts, social care and the voluntary sector – to focus on local population needs and provide care closer to patients' homes.

Primary care home shares some of the features of the multispecialty community provider (MCP) – its focus is on a smaller population enabling primary care transformation to happen at a fast pace, either on its own or as a foundation for larger models.

Source: National Association of Primary Care website. Available at http://napc.co.uk/primary-care-home/

Using case finding and risk stratification: A key service component for personalised care and support planning

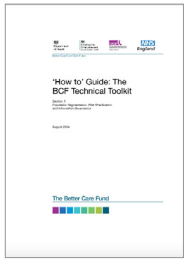
This handbook describes current thinking and provides practitioner insights into case finding and risk stratification to support personalised care and support planning – both of which are key elements of the vision and outcomes in the NHS Five Year Forward View.

The handbook contains advice on issues such as fair processing of data and Information Governance (IG), as well as linking to practical guidance, case studies and theory from organisations who are closely involved in this area. The purpose of this handbook is to share the learning from these organisations more widely. The handbook also acts as a resource to sign-post the diverse published literature on risk stratification and case finding.

Case finding and risk stratification are evolving disciplines and this resource is the first step of an on-going dialogue with a field of experts, some from the Year of Care and Integrated Care Pioneer programmes. We intend to draw on collective experience and help to move others to a similar level of understanding. We acknowledge there is more to learn in the future as case finding and risk stratification are sufficiently complex to comprise a significant challenge to widespread implementation.

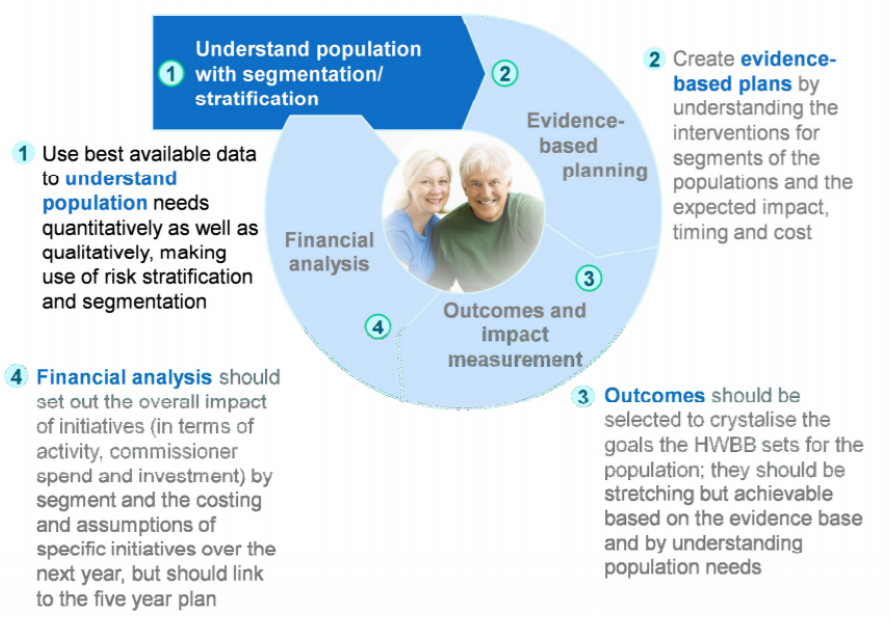
Source: NHS website. Available at https://www.england.nhs.uk/wp-content/uploads/2015/01/2015-01-20-CFRS-v0.14-FINAL.pdf

‘How to’ guide: the better care fund technical toolkit



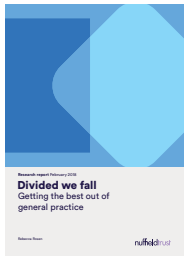
Population segmentation, risk stratification and information governance.

This document provides an explanation of population segmentation, risk stratification and information governance. The diagram below illustrates four steps for robust planning.



Source: NHS website. Available at https://www.england.nhs.uk/wp-content/uploads/2014/09/1-seg-strat.pdf

Divided we fall: getting the best out of general practice



How best to balance the proliferation of GP services prioritising speed and convenience with the traditional view of general practice based on deep knowledge, community-based understanding and continuity of care.

The prevailing narrative about general practice is of an out-of-date cottage industry which needs to be pulled into the 21st century, with its model of repeated face-to-face consultation fundamentally reformed. New models are emerging that split out different services for different groups of patients: easy access schemes like walk-in centres for those who prioritise speed and convenience, and more intensive care for frail patients with many illnesses and complicated needs.

This report asks what might be lost as doctors and patients are reallocated to these services, especially those focused on easy access. The traditional model of general practice, sometimes called 'medical generalism', involves GPs developing a relationship with a patient, and understanding their social and family background. It can make them more able to decide when medical treatment is not helpful or necessary, and to manage patients safely outside hospital. Are we at risk of losing the value this delivers to patients and the wider NHS? It concludes by looking at what GPs and national NHS bodies can do to get the best of both worlds.

Source: The Nuffield Trust website. Available at https://www.nuffieldtrust.org.uk/research/divided-we-fall-getting-the-best-out-of-general-practice

Realising the full potential of primary care: uniting the 'two faces' of generalism

Rethinking the how and what of healthcare delivery.

Faced with an unprecedented mismatch between presented health needs and resources available, we must rethink both how we deliver healthcare and what care we deliver. Work has already started on the 'how': notably with efforts to strengthen access and integration — improved coordination of the comprehensive care needed to meet a diverse range of needs. It is defining 'what' to deliver that is proving more challenging.

To address emerging problems of over- and under-treatment associated with the undue specialisation of healthcare, we need to strengthen delivery of generalist medical care. This means that we need to bolster the capacity to decide if and when medical intervention is the right approach for this individual (whole person) in their lived context. We need to put the intellectual interpretive expertise of the medical generalist back at the core of our primary healthcare systems.

Our 'United Model of Generalism' recognises the important contribution of both 'Integrated' and 'Interpretive care' in the delivery of whole person generalist medical care. Here, we describe our framework for primary care redesign and discuss the implications for subsequent actions.

Source: British Journal of General Practice website. Available at http://bjgp.org/content/67/660/292

National Institute for Health and Care Excellence, Health Technologies Adoption Programme, Mapping Care Pathways

Introducing new care pathways following technology change.

Introducing new technologies into existing care pathways may require additional training, and there may be potential staffing and organisational changes if care pathways need to be changed to accommodate the technology. However, redesigning care pathways may provide opportunities for cost savings and more efficient processes to be adopted, as well as potentially leading to better quality of care.

Process mapping is a well-established method of not only finding the best fit for a technology in a care pathway, but also identifying opportunities for improvement in the existing pathway. It provides an opportunity to capture each part of the patient journey in detail and to understand the technology's potential impact on both patients and the organisation.

Where process mapping is used for integrating a new technology, it generally has two stages: the first stage is to map the current state; that is, to understand what happens, where it happens and who is involved; the second stage is to determine what changes need to be made to best integrate the technology into the pathway. When process mapping, involve the entire implementation team and ensure that everyone involved is represented.

Source: NICE website. Available at https://www.nice.org.uk/media/default/About/what-we-do/Into-practice/HTAP/HTAPMappingCarePathwaysResource.pdf

Sunderland GP alliance

Sunderland GP Alliance was formed in June 2014 when local GPs realised that the NHS was changing and needed to develop a model of collaborative work at scale to provide solutions to the challenges of today's healthcare. Aiming to provide sustainable health provision the Alliance are working collaboratively at scale, to facilitate the deliverance of a proactive, system based, standard and complex health care system to the residents of the city. We live longer and with complex health issues and the Alliance aim to meet rapid changes in healthcare provision.

Sunderland GP Alliance partners with member practices to facilitate enhanced levels of care that can't be achieved by individual practices, to a population of 284,000 through five localities of 50-80,000 people. It is working with the third and public sectors to address the wider determinants of health by utilising the latest technology to deliver care to patients, and is developing workforce initiatives that address capacity issues to support flexible and resilient general practice in Sunderland.

The Enhanced Primary Care programme, for example, has involved the creation of a single, integrated pathway and referral tool, through which clinicians can determine the right point of care for the patient, at the right time. This has enabled faster clinical decision making and freed up valuable clinical time. Added to this, the Alliance has supported the introduction of workflow coordinators in each practice to optimise workloads by taking on administrative roles such as the processing of clinical correspondence from secondary care, further releasing General Practitioner capacity.

Source: Sunderland GP Alliance website. Available at http://www.sunderlandgpalliance.co.uk/

Fleetwood community care

Four general practices in Fleetwood, Lancashire, came together to collaboratively deliver primary care to the local population of 30,000. Sharing the risks associated with employing a more diverse workforce and investing in infrastructure has radically transformed the delivery of core primary care services in the area.

Following a successful bid against the Prime Ministers Challenge Fund, the Federation has been successfully delivering routine access to the full range of GP services 7 days per week, 8am to 8pm, including GP and nurse appointments, as well as minor surgery , cervical cytology, immunisations, phlebotomy and long term conditions clinics. Working in partnership with the local Out of Hospital Urgent Care provider, FCMS, access to urgent care appointments is also available 365 days per year, 8am to 10pm, directly bookable through 111. Services are based in the modern Fleetwood Health and Well Being Centre which is used as an integrated locality hub by a range of providers.

A Pharmacy First Minor Ailment scheme which was pioneered in Fleetwood has now been rolled out across the CCG. Practices are connected via EMIS Web which has been rolled out to include full read and write access to the GP record by Community Pharmacy. GPFV Vulnerable Practices funding has been used to facilitate practices working together at scale.

The skill mix of general practice has been broadened to include paramedics delivering home visits for acute patients, specialist nurses triaging all mental health patients, and clinical pharmacists providing repeat prescribing. Integrating the medical records system has enabled clinical pharmacists to take responsibility for the management of many patients with long-term conditions (e.g. COPD).

The Healthier Fleetwood Community Partnership is fully integrated within NHS providers, the police, local schools, the local authority and many others. It is championing a focus on wellness by delivering a range of social prescribing options, as well as Health Creation and Community Empowerment.

Source: NHS website. Available at https://www.england.nhs.uk/gp/gpfv/redesign/improving-access/gp-access-fund/wave-two/pilots/#14

Tower Hamlets GP Care Group

Tower Hamlets GP Care Group is a federation of the 37 general practices in Tower Hamlets who care for over 312,000 people.

Having demonstrated the large variety of unwell patients that GPs were consulting, and recognising the high proportion of part-time staff, the organisation has sought to restore continuity of care through the development of 'micro-teams'. These are groups of clinicians and administrative staff that provided direct patient facing functions, through which all patients can be assigned a named GP. They offer the opportunity for peer review of complex cases and improved safety through a second opinion. And they are also providing emotional support to staff at a time of lower resilience within general practice.

Micro-teams are providing a powerful means of maintaining the 'small is beautiful' aspects of general practice, complementing the economies of scale provided by the umbrella federation. By being both 'big' and 'small', Tower Hamlets GP Care Group is providing more coordinated, personal care, as well as a more rewarding workplace for staff.

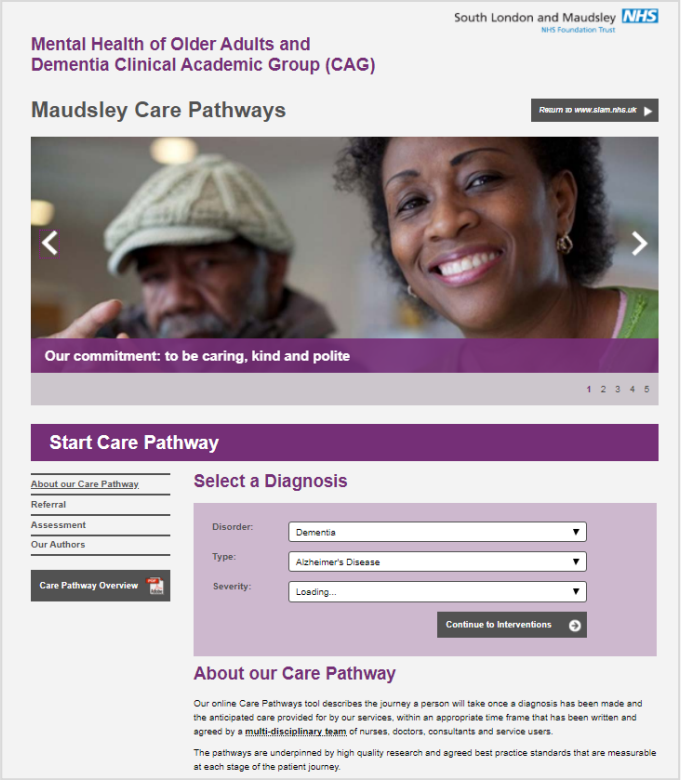
Source: Tower Hamlets GP Care Group website. Available at http://www.gpcaregroup.org/

Maudsley Care Pathways

The Mental Health of Older Adults and Dementia Clinical Academic Group (MHOAD CAG) have developed care pathways that will help guide users to respond to the needs of older people with mental health conditions such as anxiety, dementia, depression, personality disorder and psychosis.

This means that when a recognition or diagnosis has been made, staff, service users, relatives and carers will be able to access an online 'map' to identify what type of care and treatment can be provided for the condition.

Care pathways are different to patient care plans. Care pathways are underpinned by high quality research and agreed best practice standards that are measurable at each stage of the patient journey. They are designed to help clinicians to identify the appropriate resources and promote a greater understanding for service users, relatives and carers.



Source: South London and Maudsley website. Available at http://www.slam.nhs.uk/about-us/clinical-academic-groups/older-adults-and-dementia/care-pathways

Granta Medical Practices

Granta is a super-practice constituted of four practices in Cambridgeshire brought together by a shared set of values and aspirations to meet the challenge of sustainability in primary care. They have merged finances, lists, contracts, systems and buildings.

As of June 2017, Granta served 34,000 patients, with a fourth practice about to join, bringing the total to 45,000. James Morrow, the managing partner of the practice, regards this as optimal: "You then have about 150 staff, which is enough for everybody to know everybody. Management theorists think this an optimal number for an organisation or a unit within an organisation. Everybody knowing everybody and caring about them is central to how we work. People like working here. Patients give us positive feedback. We centre everything on patients' needs and wants."

The practices work like a company. The partners form what might be described as a board. There are two core teams, one managing operations and the other managing business development. The partners recognise the dangers of going at the speed of the slowest and accept that not everybody will agree with every decision. Some would like to go faster, some would like to slow down. Yet they rarely if ever have to resort to a vote. Once a decision is made the partners act like the Cabinet and support the decision within the organisation and outside.

The practice is using its scale to create a truly patient-centred service, responding flexibly where possible to key patient concerns. Through listening to the patients both informally and formally, the team understood that many patients were willing to accept seeing any GP so long as they could see a GP when they wanted to. So the practices have introduced a system that any patient with an urgent problem can be seen that day. They can ring at any time and will be seen that day between the contracted hours of 8am to 6pm. The practices also regard punctuality as essential for being patient centred. They discussed with patients when a wait becomes unacceptably long—and the patients said after 15 minutes. Granta has focused on reducing average waiting times and the current wait now averages 4.6 minutes.

Collaboration has also enabled a renewed focus on quality. Named doctors oversee clinical standards, reviewing extensive data on performance, and working with clinicians whose practice seems to be struggling. A diversified workforce, including paramedics, has allowed home-visits to be moved to the morning, avoiding hospital admissions from late referrals. Clinical staff have also been released to look after complex patients, including an annual notes review of those with long-term conditions.

Source: The BMJ Opinion website. Available at http://blogs.bmj.com/bmj/2017/06/06/richard-smith-where-general-practice-is-flourishing/

2 Systems and information

This section focuses on the importance of accurate, meaningful data and strong information systems as we move towards at scale collaboration in general practice. Hover over each bubble for more information.

Click here to see the full component sections

I'm on an information island

I've enabled limited sharing of data to enable access

We share to put in place proactive care

We use information transparently to help our PCN/LGPO plan services and improve quality

The digital patient: transforming primary care?

This paper reviews the evidence that exists on digital technology and its impact on patients in primary care and the NHS.

The paper explores the impact of seven types of digital services offered by the NHS:

1. Wearables and monitoring technology
2. Online triage tools
3. Online sources of health information and advice, targeted interventions and peer support
4. Online appointment booking and other transactional services
5. Remote consultations
6. Online access to records and care plans
7. Apps

The report finds that patient-facing technology is already showing promise that it can improve care for patients and reduce strain on the stretched health service, particularly for people with long-term conditions such as diabetes or COPD. However, this rapidly evolving market comes with risks. Many apps, tools and devices have not been officially evaluated, meaning that their effectiveness is unknown. In some cases, technology can increase demand for services, disengage staff and have the potential to disrupt the way that patients access care.

Moreover, the report warns that policy-makers and politicians should avoid assuming that self-care-enabling technology will produce significant savings, at least in the short term. The report also presents a series of lessons and recommendations to NHS professionals, leaders and policy-makers about how best to harness the potential of technology and avoid the pitfalls.

Source: The Nuffield Trust website. Available at https://www.nuffieldtrust.org.uk/files/2017-01/the-digital-patient-web-final.pdf

Online consultations

NHS England is using technology to empower patients and make it easier for clinicians to deliver high quality care and enabling patients to seamlessly navigate the service as part of its digital transformation strategy. The Online Consultation programme is a contribution towards this ambition.

As part of the General Practice Forward View, a £45 million fund has been created to contribute towards the costs for practices to purchase online consultation systems, improving access and making best use of clinicians' time.

This funding is part of the General Practice Development Programme building capacity for improvement through free training, spreading innovations from around to country using the 10 High Impact Actions and funding for new ways of working.

Benefits of online consultations

Recent years have seen rapid development of a number of online consultation systems for patients to connect with their general practice. Using a mobile app or online portal, patients can tell the practice about their query or problem, and receive a reply, prescription, call back or other kind of appointment. They can also access information about symptoms and treatment, supporting greater use of self care.

In early adopter practices, these systems are proving to be popular with patients of all ages. Many enable the patient to access information about symptoms, conditions and treatments, and connect to self help options. They free up time for GPs, allowing them to spend more time managing complex needs. Some issues are resolved by the patient themselves, or by another member of the practice team. Others are managed by the GP entirely remotely, with about a third of online consultations being followed up with a face to face consultation.

As well as improving the service for patients, evidence to date indicates that online consultation systems can free up time for GPs to spend more time leading complex care for those who need it. Whilst the focus here is on primary care the connection with urgent and out of hours GP services is an important consideration. The ultimate ambition is that we create an integrated digital experience that supports patients to access appropriate services based on their needs.

Source: NHS website. Available at https://www.england.nhs.uk/gp/gpfv/redesign/gpdp/online-consultations-systems-fund/
Source: NHS Networks website. Available at https://www.networks.nhs.uk/nhs-networks/releasing-capacity-in-general-practice/messageboard/2-new-consultation-types

One Care Consortium

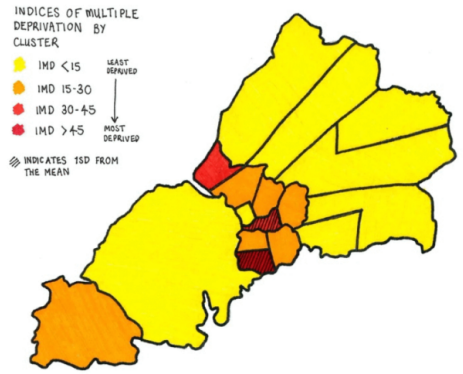
Though not a large-scale general practice organisation itself, One Care Consortium – a collaboration of over 100 practices in South West England – has shown what can be achieved through intelligent use of data. Having signed data sharing agreements with practices, a number of indicators were developed to best reflect care and the impact of clinical decisions. These included patient experience, demographics, demand, disease burden and prescribing, amongst others. Easy to digest reports are prepared for each practice, showing where it stands against peers, and workshops held to explore the relationship between activity, decision-making and the impact on other care settings.

This data has highlighted variations in practice (for example consultation rates for elderly patients) and identified real opportunities for improvement. The organisation is now building its own business intelligence platform, supporting practices to standardise data quality and management, and instilling a culture of information-based transformation. For further information, see the One Care Consortium website which outlines, in detail, the analytics and digital agenda.

- **Analytics agenda:** general practice analytics.
- **Digital agenda:** EMIS optimisation, telephony and One Care Portal powered by GPTeamNet.
- **Think data is boring? think again! case study**

This graphic shows Bristol, North Somerset and South Gloucestershire split into the three CCGs, six localities and 16 clusters with deprivation levels shown for each. Deprivation (measured here by Indices of Multiple Deprivation 2015) is associated with increased utilisation of local health services. Evidence from the stock take project shows that deprivation is associated with increased A&E attendance and emergency admissions.

Data reports are published to practices so they are able to see their position compared to their local and national peers on a huge amount of metrics (practice activity, secondary care,



telephony, out of hours, QOF, prescribing metrics, surveys, workforce metrics and more). The ability to deep dive into certain metrics that may be of interest to practices, such as the relationship between deprivation and secondary care activity or practice activity is also available. Understanding practice activity and demand can inform how staff are deployed, which in turn can contribute to improved patient access. Clusters and localities are also given the opportunity to request collective reports. Understanding the similarities and differences between practices can inform collaborative working.

Source: One Care website. Available at http://onecare.org.uk/
Source: One Care website. Available at http://onecare.org.uk/think-data-is-boring-think-again/

Central London Healthcare CIC

Formed in 2006, the GP Federation, Central London Healthcare (CLC) is a community interest, not for profit company which is owned and run by local primary care clinicians. The federation brings together the strong values of local general practices with the advantages of working at scale and the ability to collaborate on services which cannot practically be provided in smaller settings. Support provided by the federations includes:

- Acting as the employer for wider skill mix
- Developing back office support
- Hosting contracts
- Providing specialised primary care
- Centralised training for all practice staff with maintained records and overview to enable staff to work across practices
- Locum bank
- IT system to collect activity data on outcomes
- Enabling QI and direct booking across practices

Challenges faced during the move to a large-scale organisation have included:

- Alignment of staff terms and conditions, salaries and incentives
- Write access to records
- Maintaining geographic alignment
- Clusters of smaller practices may need support from more mature networks
- Sharing staff and resources
- Keeping the new structures lean

CLH provides SystmOne (GP clinical system) support to all practices under the GP Support Unit with focus on building relationships with member practices and supporting them with their clinical system. The Service provides:

- day-to-day SystmOne support
- monitoring of KPI and data quality reports to ensure the quality and safety requirements for all commissioned services are adhered to
- practice visits to resolve more advanced SystmOne queries
- data collection through SystmOne upon request
- monthly audits on practices with commissioned services to guarantee valid activity is being provided to their patients in a safe and effective manner
- assistance in creating templates and reports
- liaison with the Central London Clinical Commissioning Group
- other services on IT related issues and new incentives.

SystmOne workshops are set up in collaboration with the CCG to provide GP practices with an opportunity to learn and raise queries regarding the clinical system.

Source: Central London Healthcare website. Available at https://www.centrallondonhealthcare.co.uk/

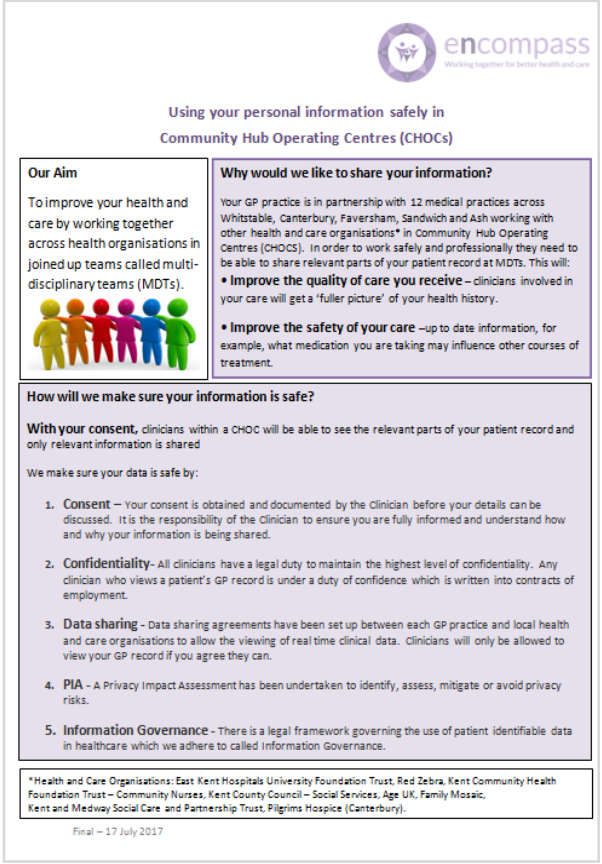
Encompass, Data Sharing

Encompass consists of 14 medical practices in Whitstable, Faversham, Canterbury, Ash and Sandwich in Kent. Their aim is to ensure health and social care is integrated and based around local needs so that patients can receive more of their treatment in their communities, rather than having to travel to hospital.

All five hubs in the Encompass area are now sharing patient records. This allows all the organisations involved in the multi-disciplinary teams to communicate and input data outside of the meetings where they discuss the patients. This has greatly improved efficiency and the ability to see more patients.

Data sharing agreements are in place to allow all people involved in the person's care to see records regardless of who originally created them (as long as the patient gives consent).

They can also add to those records immediately during the multi-disciplinary meetings so that, for example, if the patient's specific GP isn't at the meeting, the team can see exactly what happened and what the recommendations are.



encompass

Working together for better health and care

Using your personal information safely in Community Hub Operating Centres (CHOCs)

Our Aim

To improve your health and care by working together across health organisations in joined up teams called multi-disciplinary teams (MDTs).

Why would we like to share your information?

Your GP practice is in partnership with 12 medical practices across Whitstable, Canterbury, Faversham, Sandwich and Ash working with other health and care organisations* in Community Hub Operating Centres (CHOCS). In order to work safely and professionally they need to be able to share relevant parts of your patient record at MDTs. This will:

- **Improve the quality of care you receive** – clinicians involved in your care will get a 'fuller picture' of your health history.
- **Improve the safety of your care** –up to date information, for example, what medication you are taking may influence other courses of treatment.

How will we make sure your information is safe?

With your consent, clinicians within a CHOC will be able to see the relevant parts of your patient record and only relevant information is shared

We make sure your data is safe by:

1. **Consent** – Your consent is obtained and documented by the Clinician before your details can be discussed. It is the responsibility of the Clinician to ensure you are fully informed and understand how and why your information is being shared.
2. **Confidentiality**- All clinicians have a legal duty to maintain the highest level of confidentiality. Any clinician who views a patient's GP record is under a duty of confidence which is written into contracts of employment.
3. **Data sharing** - Data sharing agreements have been set up between each GP practice and local health and care organisations to allow the viewing of real time clinical data. Clinicians will only be allowed to view your GP record if you agree they can.
4. **PIA** - A Privacy Impact Assessment has been undertaken to identify, assess, mitigate or avoid privacy risks.
5. **Information Governance** - There is a legal framework governing the use of patient identifiable data in healthcare which we adhere to called Information Governance.

*Health and Care Organisations: East Kent Hospitals University Foundation Trust, Red Zebra, Kent Community Health Foundation Trust – Community Nurses, Kent County Council – Social Services, Age UK, Family Mosaic, Kent and Medway Social Care and Partnership Trust, Pilgrims Hospice (Canterbury).

Final – 17 July 2017

Source: Encompass website. Available at http://www.encompass-mcp.co.uk/

eConsult, Southampton

eConsult is an online triage and consultation tool. It gives patients access to self-help, allows them to complete administrative tasks such as requesting a sick/fit note remotely, and makes it easier for GPs to assess what medical care the patient needs. Hedge End Medical Centre is one of a growing number of practices seeing its benefits, with a Care Quality Commission quality report praising its online services.

The problem. Three years ago, Hedge End changed its on-day system from a duty nurse to a duty team that operated a triage list which ensured that those with the greatest need could be seen on the day. Meanwhile, the practice continued to accept pre-bookable appointments. While the system worked well, demand continued to increase and appointments became more difficult to book, increasing stress for both receptionists and patients. The system worked up to an 'at capacity' level which saw all of Monday's appointments being booked within the first 45 minutes of the practice opening.

Solving the problem. Having persuaded the team to try using online consultations for a year, Hedge End Medical Centre needed to embed it as a core way of working for the future. The practice paid for the service using money that would otherwise have been spent on paying one session a week of a salaried doctor. As the service is simply added on to a practice's website, the crucial implementation step is making sure that the new service is well publicised and well-used. Hedge End produced leaflets and flyers, as well as putting a banner on their website to notify patients of the platform. EMIS Health provides all the publicity materials.

eConsult was developed by the Hurley Group of fifteen practices in London as an internal scheme to help provide primary care in a timely manner. Following its success, it spread to practices in Tower Hamlets and then across the UK, with over 300 practices now using it. The company is made up of a clinical team and a technical team, working closely with EMIS Health.

Source: England NHS website. Available at https://www.england.nhs.uk/wp-content/uploads/2017/10/e-consult.pdf

Midlands Medical Partnership

MMP overview

- 13 sites across Birmingham
- Single GMS contract
- Single IT database
- Focus on care delivery and access
- Collect patient feedback through a variety of mediums
- Growing patient services

Governance

- Management board
- Senior business manager
- Staff include: 200 clinical and non-clinical staff, 15 salaried GPs, 30 nurses and HCAs, advanced nurse practitioners, specialist nurses (diabetes and respiratory), functional areas, executive management board, 20 partners
- 3 x teams: functional areas (operations, IT, compliance, finance), clinical teams (SGPs, registrars, ANPs, PNs, HCAs), non-clinical teams.

MMP delivery model

- Fully integrated business and clinical working model
- MMP management board/ partnership structure
- Centralised MMP management team
- Centralised MMP in house functions, HR, Finance, IT
- Centralised MMP performance target teams – monthly clinical performance reports
- Centralised MMP call centre
- MMP standardisation of service
- MMP benchmarking to achieve clinical excellence

Benefits

- Use data to improve the quality of service
- Positive patient feedback
- QOF rating 'outstanding'
- Offer extended access, patients can book by phone or website

Source: GP At Scale RCGP website. Available at https://gpatscale.rcgp.org.uk/wp/wp-content/uploads/3.-GP-perspective-MMP-sunando-ghosh.pdf

3 Quality improvement

This section focuses on the need for larger-scale general practice organisations to improve quality and services using shared expertise and data. Hover over each bubble for more information.

Click here to see the full component sections

I look at quality issues when things go wrong

I'm working with others to think about quality improvement

We have a shared approach to QI, and collaborate to improve

QI is a core principle of the learning system within our network

Quality improvement science: Evidence-based healthcare and quality improvement


Quality improvement science
Evidence-based healthcare and quality improvement

This is the tenth in a series of articles about the science of quality improvement.

The article explores how evidence-based healthcare relates to quality improvement, implementation science and the translation of evidence to improve healthcare practice and patient outcomes.

Evidence-based practice integrates the individual practitioner's experience, patient preferences and the best available research information. Incorporating the best available research evidence in decision making involves five steps: asking answerable questions, accessing the best information, appraising the information for validity and relevance, applying the information to care of patients and populations, and evaluating the impact for evidence of change and expected outcomes.

Major barriers to implementing evidence-based practice include the impression among practitioners that their professional freedom is being constrained, lack of appropriate training and resource constraints. Incentives including financial incentives, guidance and regulation are increasingly being used to encourage evidence-based practice.

Source: Primary Care website. Available at https://www.ncbi.nlm.nih.gov/pubmed/24865339

Quality improvement in general practice

Most general practice professionals are committed to providing a high-quality service to their patients, yet quality improvement is not routinely embedded in general practice, and various barriers need to be overcome to create a culture in which quality improvement is recognised as central to the provision of good general practice services.

This paper reviews approaches to quality improvement and their current usage in general practice, examines the barriers to adopting new quality improvement methods and the factors that promote it, and makes recommendations for action at multiple levels of the health system to nurture and support improvements in quality in general practice. The paper draws on published literature as well as the authors' experience in training and coaching general practice teams in quality improvement.

Successfully promoting quality improvement and embedding it within mainstream general practice is likely to need a broad package of activity, enacted at different levels of the NHS and sustained over several years. This requires an environment that predisposes, enables and reinforces the adoption of a continual quality improvement paradigm.

The key recommendations for commissioning consortia are to:

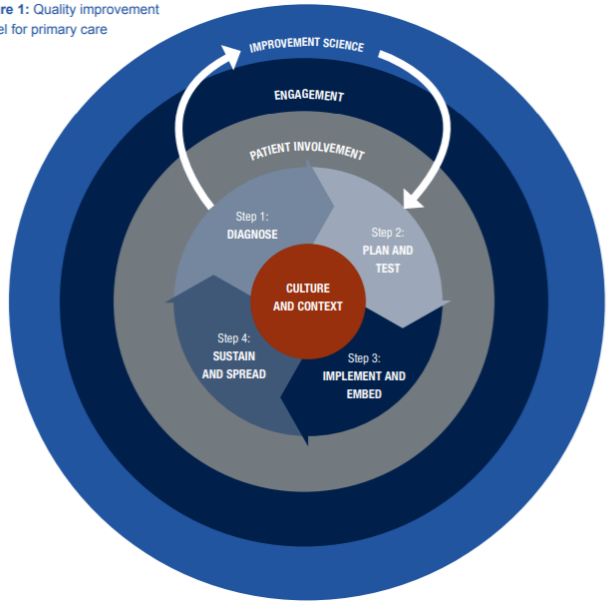
- build effective relationships
- establish vision and values for improvement
- involve patients as partners in evaluating and improving care
- lead a culture of improvement and innovation
- use information to drive improvement
- create opportunities for engagement and sharing
- invest in skills
- invest in quality improvement time
- establish a quality improvement support team (QIST)
- incentivise improvement in every practice
- establish clear and strong clinical governance.

Source: The King's Fund website. Available at https://www.kingsfund.org.uk/sites/default/files/field/field_document/quality-improvement-gp-inquiry-discussion-paper-mar11.pdf

Quality improvement for general practice

GPs strive to deliver the highest quality of care to patients. There is a pressing need to address this aim with 'evidence-informed' quality improvement (QI). This guide aims to make the principles and tools of quality improvement as accessible as possible for GPs and their practices' teams.

Figure 1: Quality improvement wheel for primary care



Introducing the QI wheel for primary care

We have created a simple visual representation of quality improvement for primary care to give you an overview of your quality improvement journey. It illustrates the main elements for you to consider in the design, delivery and evaluation of a QI project and acts as a guide to the stages you will work through during implementation.

The QI wheel is made up of five rings:

1. Culture and context. Helps you to create the right conditions for a successful project.
2. QI cycle. Guides you through project implementation.
3. Patient involvement. It provides ideas on harnessing vital patient input for successful improvements.
4. Engagement. It provides ideas on which stakeholders to engage and how to involve them.
5. Improvement science. Provides you with the big picture context that your QI work fits into.

Source: Royal College of General Practitioners. website. Available at http://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement/quality-improvement-guide-for-general-practice.aspx

Is bigger better? Lessons for large-scale general practice, booklet 4. Improving quality

This research report is drawn from a 15-month study of large-scale general practice organisations in England. The study examined the factors affecting their evolution and their impact on quality, staff and patient experience. It was informed by an extensive literature review, which will be published separately, and combined national surveys with in-depth case studies of contrasting, large-scale general practice organisations and analysis of 15 quality indicators.

Three actions to help improve quality of care

1. **Set clear quality improvement goals**
- Identify specific quality improvement objectives (that are relevant to local health needs and/or commissioner priorities) on which to focus quality improvement work
- Work with commissioners to attach targets to objectives at network levels and encourage contracts to be in place long enough to see a potential return on investment in quality
- Choose appropriate process and outcome metrics to track your progress, as this will influence behaviour. Capture baseline data as early as possible and choose appropriate follow-up times for measurement of change
- Make change meaningful – people may have an incentive to do the wrong thing if it will improve the metric score.

2. **Regularly revisit goals and progress**
- Use organisation-wide support systems (for example, administrative target reviews, clinical case discussions, IT-enabled quality and performance dashboards) to support quality improvement initiatives
- Evidence suggests clinical case discussions within networks and administrative target reviews can improve process and outcome measures
- Take advantage of the opportunities of scale to deliver education and training (for example, using web technologies) and skills development
- Use standardised processes to improve delivery of initiatives to improve quality.

3. **Provide central support to member practices to improve quality**
- Identify practices performing less well on quality measures and offer them support to improve care
- Clinical leaders who work in member practices act as powerful role models to other staff, so they need to model good practice
- Training and education delivered through web-based technologies can provide an efficient way to develop skills in clinical and non-clinical staff.

Source: The Nuffield Trust website. Available at https://www.nuffieldtrust.org.uk/files/2017-09/4.-improving-quality.pdf

Making time in general practice

This report was commissioned by NHS England as part of its wider work to deliver the New Deal, strengthening primary care and releasing capacity to introduce new care models. The report focuses on freeing GP capacity by reducing bureaucracy and avoidable consultations, managing the interface with hospitals and exploring new ways of working.

The report summarises work carried out by the Primary Care Foundation and NHS Alliance during 2014/15 on reducing bureaucracy and shaping demand in general practice in order to make more time for GPs to do what only they can do. It reports on a survey of general practices to identify where the burden of bureaucracy lies and identifies changes in contracting and monitoring that would reduce practice time spent on bureaucracy.

The report details an audit of GP appointments to understand how avoidable consultations with GPs arise and where they could have been better directed. It includes recommendations for improving the primary-secondary care interface developed jointly by senior clinicians and managers from both sectors. Finally, it concludes with a series of articles and thought leadership pieces commissioned in pulling this report together.

Source: Primary Care Foundation website. Available at http://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading_Reports/PCF_Press_Releases/Making-Time-in_General_Practice_FULL_REPORT_28_10_15.pdf

Releasing time for care: 10 high impact actions for General Practice

Developed by Dr Robert Varnam and aimed to help practices manage their workload better. New ways of working can help release staff time.

1. **Active signposting:** Provides patients with a first point of contact which directs them to the most appropriate source of help. Web and app-based portals can provide self-help and self-management resources as well as signposting to the most appropriate professional.
2. **New consultation types:** Introduce new communication methods for some consultations, such as phone and email, improving continuity and convenience for the patient, and reducing clinical contact time.
3. **Reduce Did Not Attend (DNAs):** Maximise the use of appointment slots and improve continuity by reducing DNAs. Changes may include redesigning the appointment system, encouraging patients to write appointment cards themselves, issuing appointment reminders by text message, and making it quick for patients to cancel or rearrange an appointment.
4. **Develop the team:** Broaden the workforce in order to reduce demand for GP time and connect the patient directly with the most appropriate professional.
5. **Productive work flows:** Introduce new ways of working which enable staff to work smarter, not harder.
6. **Personal productivity:** Support staff to develop their personal resilience and learn specific skills that enable them to work in the most efficient way possible.
7. **Partnership working:** Create partnerships and collaborations with other practices and providers in the local health and social care system.
8. **Social prescribing:** Use referral and signposting to non-medical services in the community that increase wellbeing and independence.
9. **Support self care:** Take every opportunity to support people to play a greater role in their own health and care with methods of signposting patients to sources of information, advice and support in the community.
10. **Develop QI expertise:** Develop a specialist team of facilitators to support service redesign and continuous quality improvement.

Source: NHS website. Available at https://www.england.nhs.uk/expo/2016/11/14/releasing-time-for-care-10-high-impact-actions-for-general-practice-dr-robert-varnam/
Source: NHS Networks website. Available at https://www.networks.nhs.uk/nhs-networks/releasing-capacity-in-general-practice/documents/the-10-high-impact-actions-overview-slides

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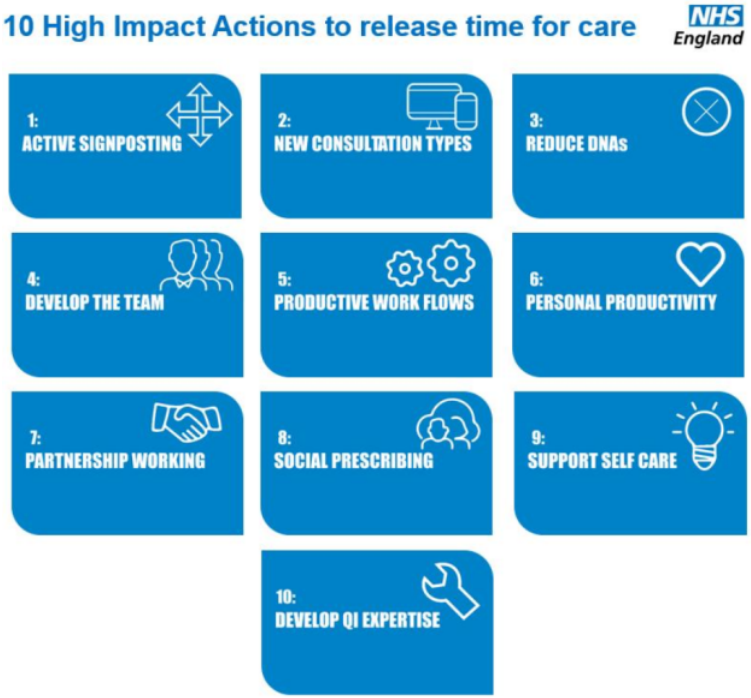


Source: NHS website. Available at https://www.england.nhs.uk/expo/2016/11/14/releasing-time-for-care-10-high-impact-actions-for-general-practice-dr-robert-varnam/
Source: NHS Networks website. Available at https://www.networks.nhs.uk/nhs-networks/releasing-capacity-in-general-practice/documents/the-10-high-impact-actions-overview-slides

Making the case for quality improvement, The King's Fund

Quality improvement, the use of methods and tools to continuously improve quality of care and outcomes for patients, should be at the heart of local plans for redesigning NHS services. NHS leaders have a vital role to play in making this happen as leadership and management practices have a significant impact on quality.

Improving quality and reducing costs are sometimes seen as conflicting aims when they are in fact often two sides of the same coin. There are many opportunities in the NHS to deliver better outcomes at lower cost (improving value), for example by reducing unwarranted variations in care and addressing overuse, misuse and underuse of treatment. The potential benefit is even greater if quality improvement techniques are applied consistently and systematically across organisations and systems. However, this is not currently the case. To deliver the changes that are needed to sustain and improve care, the NHS needs to move from pockets of innovation and isolated examples of good practice to system-wide improvement.

10 lessons for NHS leaders:

1. Make quality improvement a leadership priority for boards.
2. Share responsibility for quality improvement with leaders at all levels.
3. Don't look for magic bullets or quick fixes.
4. Develop the skills and capabilities for improvement
5. Have a consistent and coherent approach to quality improvement.
6. Use data effectively.
7. Focus on relationships and culture.
8. Enable and support frontline staff to engage in quality improvement.
9. Involve patients, service users and carers.
10. Work as a system.

Source: The King's Fund website. Available at https://www.kingsfund.org.uk/publications/making-case-quality-improvement

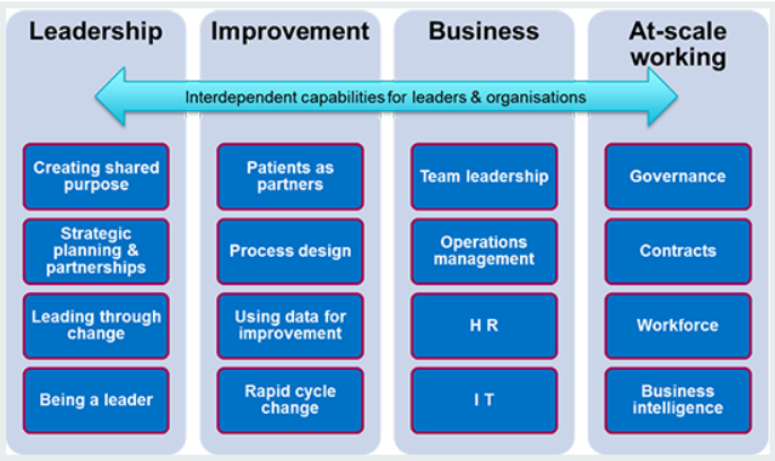
Building capability for improvement

A clear picture is emerging of the kind of capabilities which practices and at-scale collaborations such as federations will need in order to innovate, improve and transform services. These are presented in the capability framework below.

Having clinicians and managers with quality improvement skills is key to successful change. Free places are provided on the General Practice Improvement Leader training programme from NHS England's Sustainable Improvement team. This is a successful personal development programme with small cohorts of up to 30 people to build confidence and skills for leading service redesign in your practice or federation.

The programme incorporates interactive training workshops, personal reading and reflection, and action learning as participants lead a change project in their own workplace. Participants gain new perspectives, skills and confidence in using improvement science in general practice, and leading colleagues and teams through change.

The programme is for those working in general practice including, GPs, practice managers, nurses, project managers, reception managers and facilitators. Delegates will need to bring an improvement project to work actively on during the programme. There is a self assessment tool to complete ahead of hosting a Time for Care programme.



Source for Building Capability for Improvement: NHS website. Available at https://www.england.nhs.uk/gp/gpfv/redesign/gpdp/capability/
Source for self assessment tool: NHS website. Available at https://www.england.nhs.uk/publication/hosting-a-time-for-care-programme-readiness-self-assessment/

Quay Health Solutions GP Federation

A federation of 20 member practices in South East London, Quay Health worked in partnership with NHS England's Sustainable Improvement team to implement a quality improvement change programme. The federation created a team of service improvement leaders made up of GPs, nurses, practice managers and reception staff. The move was seen as a vital way to build capability, capacity and confidence in quality improvement within all 20 member practices, with a goal to help achieve sustainable improvements and build confidence in managing change across the federation. 17 of the practices nominated an improvement leader to participate in the programme and a Service Level Agreement was put in place between the federation and the practices to release their time, including attendance at workshops and capacity to spread their learning with colleagues. Each leader not only was equipped with tools to run their own project, but also supported other practices in the federation.

On completing the programme, each leader:

- Returned to their practice to deliver the improvement project they had chosen and share what they had learned with their practice team.
- Supported other practices in the federation they had been mapped to, either to get them going with their improvement projects or generally share tools and techniques that help drive quality improvement.
- Helped the federation deliver the Time for Care learning sessions. This included facilitation support, leading table discussions and providing general learning in quality improvement.

Implementation tips

- Communication and engagement was vital to bringing member practices on board. The service improvement and communications teams took every opportunity to discuss the programme with practices to help secure buy-in, for example, engaging with the Quay Health Solutions board, attending member practice meetings, attending the local Practice Manager's Forum and Nurses Forum, as well as speaking to staff during practice visits.
- A Service Level Agreement set out what the federation 'ask' was of member practices and what they received in return. This clearly set out expectations on both sides for the time and commitment required to make the programme succeed.
- The federation's service improvement team helped provide support to those practices where there was no service improvement lead, ensuring improvement was driven across the whole federation.

Capability and capacity in quality improvement is being enhanced across the federation, rather than being concentrated in a few individuals. Projects are, as a result being unblocked and advanced; one practice has for example, released the equivalent of 6 sessions of appointments per year through a focus on just 11 frequently-attending patients.

Source: Quay Health website. Available at https://www.quayhealthsolutions.co.uk/about-us/
Source: NHS website. Available at https://www.england.nhs.uk/gp/case-studies/building-capability-for-quality-improvement-across-a-gp-federation/

South Warwickshire GP Federation

South Warwickshire is made up of 34 practices covering 270,000 patients. The organisation has been using Learning in Action as part of NHS England's Time for Care programme.

A series of workshops have been held in which practices have the 'headspace' to share their experiences, share insights and learn from each other, whilst creating a community in which practices are supportive of each other to make change happen. Resources coming out of the workshops, including those developed by the practice themselves (e.g. standard operation procedures) were shared across the federation. Practices on the programme were also introduced to a number of quality improvement tools and techniques to help unblock change, and then supported to embed them in order to create a culture of continuous improvement.

Practices are seeing tangible benefits as a result. Improvements to signposting at one medical centre, for example, have reduced inappropriate appointments, whilst the time taken to deal with paperwork has fallen at another. Securing the buy-in of all practices in the endeavour through a focused clinical communications campaign was vital in the federation's successful implementation of the programme.

Impact deep dive

- Active signposting has helped the practice release 11% of inappropriate GP appointments, this is 80 appointments per week equating to 13 hours of GP time.
- The freed up appointments have given GPs more time to focus on those patients that need their time (e.g. those with more complex care needs), as well as improving access for patients who need to be seen.
- Feedback from the PPG has been very positive, results for the friends and family test have improved by 5%.
- Staff feedback has been very positive, with most pleasantly surprised by how positively patients have received the change and their willingness to share clinical detail.

Implementation tips

- It is important to have clear aims, objectives and measures for any project of change you embark on.
- Engaging and motivating staff to support and endorse the change is essential.
- It is important to inform and educate patients about the changes and the rationale. You need to make sure communications are clear and impactful.
- There is great value in working collaboratively with fellow managers on these problems, sharing learning and resources. It helps speed up the process of change and improvement.

Source: NHS website. Available at https://www.england.nhs.uk/gp/case-studies/active-signposting-frees-up-80-inappropriate-gp-appointments-a-week/

Tower Hamlets GP Care Group

Tower Hamlets adopted QI methodology to address key operational issues, which in turn helped create financial stability. Initial analysis suggested that approximately 45% of patients seen by GPs could be seen by an alternative staff member or the patient could self-manage. The first step taken was to shift suitable work to practice nurses, which made a small saving but freed up GP time to focus on other patient issues. In order to enable change, Tower Hamlets rely on a QI methodology, taking the best from global evidence in change approaches.

The following steps were key:

- Identify quality issue,
- Understand the problem,
- Develop a strategy and change ideas,
- Test,
- Implement and sustain the gains.

Tower Hamlets recognise that QI alone isn't enough to drive sustainable change. Five focus areas have been identified for a two year programme:

- QI training and coaching,
- Team and individual development,
- Comparative data and training,
- Centralised resource for change,
- Development collaboratives.

Cross practice collaboration is being used to accelerate the pace of change, incorporating interventions such as: monthly sessions to share lessons learned from recent pilots/ changes, annual QI show and tell exhibitions.

Source: The Health Foundation website. Available at http://www.health.org.uk/newsletter/building-culture-improvement-takes-years-careful-nurturing
Source: Quality Improvement East London Foundation Trust website. Available at https://qi.elft.nhs.uk/about-us/

Making the Case for Quality Improvement, Example 1, Identifying and managing patients at risk of chronic disease exacerbation, Heart of England NHS Foundation Trust

What was the problem? Around one in eight people will develop chronic kidney disease at some point in their lifetime. It is more common among older people and those with diabetes and hypertension. While most cases of chronic kidney disease are mild or moderate and can be managed at home or in primary care, around 60,000 people in the UK have end-stage kidney disease that requires 'renal replacement therapy' – usually dialysis or transplantation. As well as having a major impact on patients' quality of life, treatments are expensive. The annual cost of dialysis per patient is around £25,000. Preventing or delaying end-stage kidney disease depends on the early identification of patients whose kidney function is deteriorating. As symptoms related to kidney disease usually occur only when the disease is advanced, the main way of detecting declining kidney function is through a blood test. The Heart of England NHS Foundation Trust aimed to develop a surveillance system that would allow trained clinical laboratory staff to identify people at risk of end-stage kidney disease using existing laboratory data.

What did they do? Starting in 2004, a kidney consultant at the trust used the nephrology department database to generate graphs of all the results from patients with diabetes who had been newly tested in the previous week. Patients with declining kidney function were assessed for their need to be seen in the specialist clinic. This enabled the clinical team to identify patients at risk of end-stage kidney disease at an early point. Having seen the benefits from using the system among people with diabetes, the trust was awarded a grant by The Health Foundation in 2012 to extend the system to cover the entire population served by the trust's pathology service.

What impact has it had? The surveillance system has been instrumental in enabling it to stabilise the number of patients having renal replacement therapy at a time when it is on the rise across the rest of the UK. UK Renal Registry data from 2012–14 shows a 4 per cent fall in the number of patients starting renal replacement therapy in the trust, compared with a national increase of 8 per cent. The system has also helped the trust to become the first one to achieve a late presentation rate – the proportion of patients presenting to a renal specialist less than 90 days before the start of their renal replacement therapy – of less than 5 per cent. In contrast, the average rate across England is 18 per. The success of the trust's surveillance system has prompted the development of a new programme, ASSIST-CKD, aimed at spreading the approach across up to 20 UK pathology laboratories and their surrounding GP networks.

Source: The King's Fund website. Available at https://www.kingsfund.org.uk/publications/making-case-quality-improvement/example-1

Making the Case for Quality Improvement, Example 2, Acute-led development of an ambulatory care service, University Hospitals of North Midlands NHS Trust

What was the problem? Heart failure currently affects around 900,000 people in the UK. It causes or complicates about 5 per cent of all adult emergency admissions and is the commonest cause of admission in people aged over 65. Admissions are expected to rise over the next 20 years as the population ages and survival rates increase. As well as being resource-intensive and expensive – the average length of stay for a heart failure patient is 13 days and the typical cost is around £3,800 – a hospital admission is often not what patients want. Many heart failure patients are frail older people who would prefer to remain at home. The University Hospitals of North Midlands NHS Trust aimed to reduce the need for some hospital admissions by making specialist treatment, which had previously only been accessible to inpatients, available on an outpatient basis. The project team estimated that around 30 per cent of heart failure admissions to the trust could be avoided by redesigning the service in this way.

What did they do? In 2011, a nurse-led, consultant-supported ambulatory heart failure clinic was set up at the City General Hospital in Stoke. The clinic compresses a full day of inpatient care into a single session lasting a few hours, avoiding the need for overnight stays. As well as the usual range of outpatient services, the clinic offers emergency 'same day' care and 'next day' slots for specialist review. It also offers self-management advice and psychological support for patients who could manage their condition at home with the right support. The launch of the clinic means that someone with chronic heart failure living at home can avoid a hospital admission at points when their condition becomes unstable. After a rapid review and diagnosis from a cardiologist, a care management plan covering the patient's ongoing care and medication needs is produced, with the aim of keeping them at home whenever possible. People with worsening heart failure can also be referred to the clinic directly from the emergency department, rather than being admitted, while inpatients can now be discharged home at an earlier stage via the clinic.

What impact has it had? The clinic is now an established service within the trust. It has negotiated its own tariff with the local clinical commissioning group and is getting referrals from both primary and acute care. An analysis by the project team of the outcomes of all patients referred to the clinic in 2015/16 suggested that, by preventing the need for some heart failure patients to be admitted to hospital, the clinic had freed up the equivalent of 12 inpatient beds. The clinic's 30-day readmission rate was also comparable to that of heart failure patients discharged by hospitals across England. Moreover, only 2 of the 383 patients referred to the clinic opted for inpatient care over the ambulatory model of care during the year. This suggests that providing specialist care in an ambulatory setting is safe, popular with patients and can release some acute capacity for other purposes. However, this impact is contingent, the team believes, on the presence of a comprehensive and integrated local heart failure pathway that allows patients to be referred from both primary care and secondary care in a timely way.

Source: The King's Fund website. Available at https://www.kingsfund.org.uk/publications/making-case-quality-improvement/example-2

Making the Case for Quality Improvement, Example 3, Medicines optimisation and polypharmacy, Northumbria Healthcare NHS Foundation Trust

What was the problem? Polypharmacy – the concurrent use of multiple medications by one individual – is common in care homes. It can be harmful if poorly managed and can also affect the individual's quality of life. But it is not always standard practice to review medicine usage and stop inappropriate medicines. Many prescribing decisions in care homes are taken without the involvement of residents or their families. This project, led by the Northumbria Healthcare NHS Foundation Trust's pharmacy service and transformation team, aimed to develop a method of improving medicines management while ensuring that residents were involved in decisions about their medicines.

What did they do? Prior to the project, reviews of the medicines of 37 residents in a care home in North Tyneside were carried out by a pharmacist, a general practitioner (GP) and a nursing team. They found that two-thirds of residents were taking medicines that were no longer performing a medical function or were inappropriate when other co-morbidities were taken into account. A total of 114 medicines were stopped as a result. Building on this pilot, a project team designed and tested an intervention with three main components. After a detailed medicines review by a pharmacist, a multidisciplinary team involving a GP, a care home nurse and a pharmacist met to consider whether the medicines were still needed and beneficial. Following the meeting, residents were asked for their views before any final decision was taken. The intervention was refined over time, in part to reflect residents' differing levels of capacity and the extent to which their family members were able to be involved. In some cases it made sense to engage residents or family members at an early stage of the review process. In other cases, however, neither the resident nor a family member was in a position to be involved, and it was therefore appropriate to bring in an independent advocate to act on their behalf instead.

What impact has it had? Over a 12-month period, the medicines of 422 residents in 20 care homes were reviewed. Almost 20 per cent of medicines prescribed to residents were stopped as a result of the project. In most cases this was because they were not medically useful (57%), or because residents no longer wanted to take them (17%). A small number of medicines were stopped because of safety concerns (6%). By reducing overprescribing and inappropriate medication, the project generated a net annual saving in the medicines budget of £77,000, or £184 for each resident reviewed. Building on the success of the pilot, the trust has rolled the model out to care homes across Northumberland through a service commissioned by Northumberland Clinical Commissioning Group and the Vanguard Pharmacy team. The model has also been developed further with the help of Vanguard funding: all new and discharged patients are identified weekly and reviewed by a technician, who refers complex patients on to a pharmacist or a multidisciplinary team. Medicine use reviews are also now being carried out by community pharmacists with support from the Vanguard Pharmacy team.

Source: The King's Fund website. Available at https://www.kingsfund.org.uk/publications/making-case-quality-improvement/example-3

Making the Case for Quality Improvement, Example 4, Improving safety and quality through multi-professional training, North Bristol NHS Trust

What was the problem? Good teamwork and communication is crucial in ensuring high-quality care and avoiding errors during obstetric emergencies. An awareness of the importance of effective teamworking has led to a shift in the focus of maternity staff training over the past 20. A leading example is Practical Obstetric Multi-Professional Training (PROMPT), a programme developed by a group of professionals based in maternity units in south-west England. It was first implemented at North Bristol NHS Trust in 2000 and has since spread to maternity units across the UK and around the world.

What did they do? The PROMPT programme is based on the idea that teams that work together should learn together, and that the best place to learn is in the maternity unit itself, not on an off-site training course. At Southmead Hospital in Bristol, PROMPT consists of a one-day course involving a mix of workshops and team-based emergency drills, using patient actors and props in a clinical setting. Over the past 17 years, the course has become an established and highly valued part of the maternity unit's practice. It has strong support from maternity, obstetric and midwifery leads, who are committed to ensuring that staff are released to attend the course and that there are enough trainers to deliver it.

PROMPT is designed to ensure that teams have the technical competence to respond in the right way in any given emergency: it is about making the 'right way, the easy way' and is as much a social intervention as a technical one. The course helps teams to work together to identify and achieve their own shared goals and do their best for each mother and baby. It also seeks to foster a learning ethos within the unit, founded on a collective commitment to continuous improvement and critical reflection. One of the key behaviours that PROMPT seeks to embed is 'problem sensing', where staff use both real-time data and soft intelligence to spot emerging safety and quality challenges and review their practices accordingly.

What impact has it had? PROMPT has had a significant and sustained impact on Southmead Hospital's perinatal outcomes. Since its introduction in 2000, injuries to babies caused by a lack of oxygen have reduced by 50 per cent, while there has been a 100 per cent reduction in permanent brachial plexus injuries to babies. By improving the safety of its service and the outcomes and care experiences of mothers, babies and their families, the hospital has also saved the NHS money. For example, litigation claims have gone down from £25 million before the launch of PROMPT to around £3 million in the 10 years that followed.

Source: The King's Fund website. Available at https://www.kingsfund.org.uk/publications/making-case-quality-improvement/example-4

Making the Case for Quality Improvement, Example 5, Whole-pathway improvement involving collaboration between the primary, acute and community sectors, NHS High Weald Lewes Havens Clinical Commissioning Group

What was the problem? Sussex has more people living with dementia than anywhere else in England yet a local clinical review conducted prior to a project carried out by NHS High Weald Lewes Havens Clinical Commissioning Group found that their care experiences were often poor. Access to information and support was fragmented, primary care was frequently ill-equipped to manage slow-declining dementia and post-diagnostic support was limited. The aim of the project was to redesign the dementia care pathway to provide a more co-ordinated and responsive service in the community, while allowing secondary care mental health services to concentrate resources on more complex cases.

What did they do? Over the course of six months, a core project team – working closely with partners across the health and social care system, including people with dementia and their carers – built up a detailed picture of how care was being delivered and what needed to happen to improve people's care experience and quality of life. After securing buy-in from senior leaders in local primary care, community care, acute care, social care and voluntary sector organisations, a series of project groups, involving clinicians and people with dementia and their carers, was set up to design and develop the core aspects of a new care model. This new care model was then piloted in one GP practice in Buxted in Sussex in 2015 for three months. Through this model, the patient is referred by their GP to a multidisciplinary team, who then allocate an appropriate professional to carry out a comprehensive assessment in the patient's home, rather than in a hospital memory clinic. The multidisciplinary team then meet to consider the person's diagnosis, which is delivered in the patient's home, and a 'Golden Ticket' is issued, aimed at providing the patient with a co-ordinated package of care in the community, built around their needs and preferences. A weekly GP clinic has been set up to co-ordinate rapid interventions for people with dementia seen to be at risk of deterioration, while peer support and signposting to other services are available through a memory café. Also, a new 'dementia guide' role has been created to support people and their carers through their entire care journey.

What impact has it had? The results from the pilot in Buxted were encouraging. The new model had a positive impact on the emotional and physical wellbeing and quality of life of people with dementia and their carers. People involved in the project also reported that they felt more able to live independently and had better access to information and advice. A reduction in GP consultations and acute care attendances and admissions was also reported. However, given the small number of patients involved in the pilot, the full impact of the new model will only become apparent once its planned roll-out to other practices within the clinical commissioning group's area is complete.

Source: The King's Fund website. Available at https://www.kingsfund.org.uk/publications/making-case-quality-improvement/example-5

4 Organisational capabilities

This section focuses on how closer collaboration can help us build better organisations through economies of scale. This should result in greater financial and legal security, enhance system value, and create happier, more resilient teams. Hover over each bubble for more information.

Click here to see the full component sections

I try to do everything alone

I'm working with other to collate and simplify our work

We collaborate, plan and share

We act together in a formal and organised way

Is bigger better? Lessons for large-scale general practice, booklet 2. Sustainability

The research report is drawn from a 15-month study of large-scale general practice organisations in England. The study examined the factors affecting their evolution and their impact on quality, staff and patient experience. It was informed by an extensive literature review, which will be published separately, and combined national surveys with in-depth case studies of contrasting, large-scale general practice organisations and analysis of 15 quality indicators. Key lessons captured in four booklets published in September 2017.

Three activities can help practices remain sustainable in a larger group:

1. Create operational efficiencies
2. Use technology
3. Develop the practice and network workforce

For further details, please refer to the booklet.

Source: The Nuffield Trust website. Available at https://www.nuffieldtrust.org.uk/files/2017-09/2.-sustainability.pdf

Provider development support kit

This kit aims to support provider organisations to develop and understand their requirements to grow in maturity and readiness.

This kit aims to support provider organisations to develop, and to understand their requirements in order to grow in maturity and readiness. It contains:

- Background to the new model of care
- Provider readiness – what is the development journey?
- New provider models – what are the benefits and challenges of each type of model?
- Self assessment tool
- Appendix Case studies providing examples of providers working at scale

Source: Healthy London Partnership website. Available at https://www.healthylondon.org/resource/provider-development-support/

Harness GP cooperative federation

Covering a network of 21 practices in North West London with a combined list of 115,000, Harness GP Co-operative has been evolving in its maturity since 2008, increasingly towards a super-practice model.

As well as providing extended access 08:00-20:00, 7 days a week GP hubs, a GP-led health centre and Local Authority-contracted public health services, Harness has also developed a range of organisational capabilities. It has built in-house contract and project management expertise to support quality and performance. In particular, a range of measures are now in place to introduce new members of the workforce and support existing employees.

These include:

- mapping current competencies and conducting a skills gap analysis
- comprehensive policies and procedures
- an award winning apprenticeship scheme with 40 graduates to date
- developing new roles for HCAs and to support social isolation, working with the third sector enhanced induction, continuous personal development, supervision and mentorship

As a combined result, Harness has been able to ensure a high fill-rate of posts, take on a wider range of services and develop new models of care.

Source: Nuffield Trust research report, Harness case study. Available at https://www.nuffieldtrust.org.uk/files/2017-01/large-scale-general-practice-web-final.pdf

5 Workforce and wellbeing

This section focuses on how to build an organisational model that delivers effective patient care, enhances resilience, brings joy to the workplace and puts general practice at the heart of systems of integrated care. Hover over each bubble for more information.

Click here to see the full component sections

I try to do everything alone

I'm sharing with others to build consistency and resilience

We work as an extended team with the right support

In search of joy in practice: a report of 23 high-functioning primary care practices


In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices

Report highlights primary care innovations gathered from high-functioning primary care practices, innovations believed to facilitate joy in practice and mitigate physician burnout.

To do so, 23 site visits were made to high-performing primary care practices and focused on how these practices distribute functions among the team, use technology to their advantage, improve outcomes with data, and make the job of primary care feasible and enjoyable as a life's vocation.

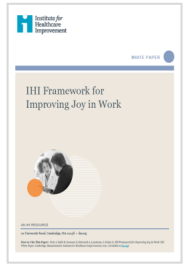
Innovations identified include:

1. Proactive planned care, with pre-visit planning and pre-visit laboratory tests
2. Sharing clinical care among a team, with expanded rooming protocols, standing orders, and panel management
3. Sharing clerical tasks with collaborative documentation (scribing), non-physician order entry, and streamlined prescription management,
4. Improving communication by verbal messaging and in-box management
5. Improving team functioning through co-location, team meetings, and work flow mapping.

Observations suggest that a shift from a physician-centric model of work distribution and responsibility to a shared-care model, with a higher level of clinical support staff per physician and frequent forums for communication, can result in high-functioning teams, improved professional satisfaction, and greater joy in practice.

Source: Annals of Family Medicine website. Available at http://www.annfammed.org/content/11/3/272.full.pdf+html

Institute for healthcare improvement framework for improving joy in work



With increasing demands on time, resources, and energy, in addition to poorly designed systems of daily work, it's not surprising health care professionals are experiencing burnout at increasingly higher rates, with staff turnover rates also on the rise.

Burnout leads to lower levels of staff engagement, patient experience, and productivity, and an increased risk of workplace accidents. Lower levels of staff engagement are linked with lower-quality patient care, including safety, and burnout limits providers' empathy — a crucial component of effective and person-centered care.

So, what can health care leaders do to counteract this epidemic? IHI believes an important part of the solution is to focus on restoring joy to the health care workforce.

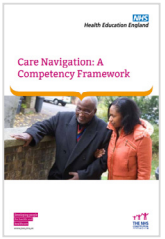
This white paper is intended to serve as a guide for health care organizations to engage in a participative process where leaders ask colleagues at all levels of the organization, "What matters to you?" — enabling them to better understand the barriers to joy in work, and co-create meaningful, high-leverage strategies to address these issues.

The white paper describes the following:

- The importance of joy in work (the "why")
- Four steps leaders can take to improve joy in work (the "how")
- The IHI Framework for Improving Joy in Work: nine critical components of a system for ensuring a joyful, engaged workforce (the "what")
- Key change ideas for improving joy in work, along with examples from organizations that helped test them
- Measurement and assessment tools for gauging efforts to improve joy in work.

Source: Institute for Healthcare Improvement website. Available at http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx

Care navigation: A competency framework



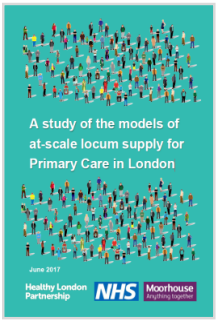
Effective navigation is a key element of delivering coordinated, person-centered care and support. This document describes a core, common set of competencies for care navigation.

Charting stormy uncertain seas requires good navigation – with purpose and direction. Similarly, most people at some point in their life may benefit from 'navigation' through encounters with different health services, agencies and professionals, across an often confusing seascape of health, social and community care. And it's not just an issue for service users, there is broad consensus from healthcare professionals that such systems can be complex and difficult to navigate.

The core competencies identified are brought together in a tiered competency framework, recognising three successive levels; essential, enhanced and expert. This will help provide a coherent benchmark or set of standards for care navigation, to help ensure relevant staff receive the necessary education, training and support to work effectively. This framework may be used by employers, education providers and individuals to inform education and training needs. It will also help lay the foundations for a career pathway framework for non-clinical staff, within primary and secondary care sectors. This is important to secure a sustainable current and future workforce, offering opportunities for development.

Source: Health Education England website. Available at https://hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf

Staff bank feasibility study



In order to work effectively, the future market model must satisfy the needs of both providers and locums to ensure a stable and efficient marketplace. This report doesn't look to reduce or remove a need for locums in Primary Care, but instead looks to find solutions for locum supply that maximise benefit for both groups, by solving each respective problem statement in the most mutually beneficial way.

Workforce recruitment, retention and development is a core work stream within the General Practice Forward View (GPFV). As part of their GPFV Provider Development Plans created in late 2016, half of the Clinical Commissioning Groups in London expressed an interest in developing staff bank functions and at scale recruitment for their Primary Care services.

Report objective:

- Review options to optimise the use of locum and temporary staff in General Practice
- Understand the feasibility of developing workforce banks for Primary Care.

The research looked at a number of models either proposed or currently in use, including: locum agencies, GP chambers, informal locum networks, workforce banks, and digital platforms. It is recommended that there are two feasible workforce bank models which would maximise benefits;

1. Primary recommendation: Digital platform – Lowest cost and fastest implementation, a digital platform, for example Lantum, meets all principles and provides greater ease of use in comparison to other models. Implementation has zero cost and typically takes 3-6 months.
2. Secondary recommendation: Provider-run workforce bank – Higher cost, but offering added control, a provider-run workforce bank requires a pre-existing at-scale provider organisation to manage it, and can be run as a brokerage model or a salaried bank model. Implementation costs are ~£50k, and typically takes up to 12 months.

Please contact Fiona Erne (f.erne@nhs.net) for further information.

General Practice resilience programme and case studies

The General Practice Resilience Programme was announced as part of the General Practice Forward View. The programme will provide £40 million over four years (until 2020) to support GP practices and to build resilience into the system.

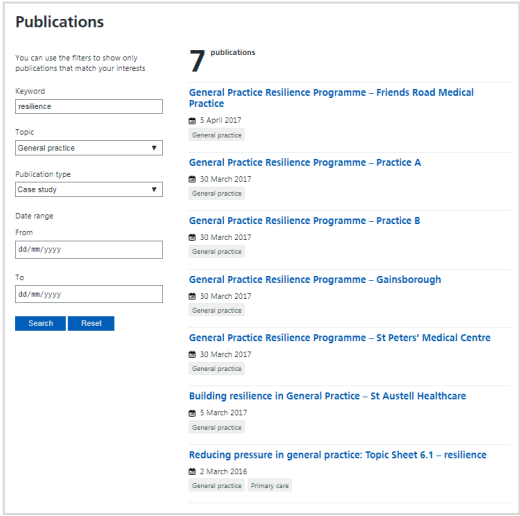
The purpose of the fund is to deliver a wide menu of support that will help practices to become more sustainable and resilient, better placed to tackle the challenges they face now and into the future, and securing continuing high quality care for patients.

The resilience programme allows support to be extended to not only the most at risk GP Practices, but also to their neighbouring practices that may be at risk of struggling if a practice in the vicinity becomes unable to cope. By building resilience into the system we reduce the risks to practices working at capacity, supporting them to better respond to the workload pressures that are widely recognised in general practice.

Support ranges from helping to stabilise practices at risk of closure through to more transformational support, including, if appropriate helping practices to explore new models of care.

This could include:

- Diagnostic services to quickly identify areas for improvement support
- Specialist advice and guidance e.g. human resources, IT
- Coaching/Supervision/Mentorship
- Practice Management Capacity Support
- Rapid Intervention and management support for Practices at risk of closure
- Co-ordinated support to help practices struggling with workforce issues
- Change management and improvement support to individual practices or group of practices
- Support is available to individual practices as well as being available on a greater scale to groups of practices in localities.



Source: NHS website. Available at https://www.england.nhs.uk/gp/gpfv/workload/resilience/

Training for reception and clerical staff

As part of the General Practice Forward View, a £45 million fund was created to contribute towards the costs for practices of training reception and clerical staff to undertake enhanced roles in active signposting and management of clinical correspondence.

Active signposting by reception staff

This provides patients with a first point of contact which directs them to the most appropriate source of help. Web and app-based portals can provide self-help and self-management resources as well as signposting to the most appropriate professional. Receptionists acting as care navigators can ensure the patient is booked with the right person first time. Reception staff are given training and access to a directory of information about services, in order to help them direct patients to the most appropriate source of help or advice. This may include services in the community as well as within the practice.

- **Benefits for practices:** frees up GP time, releasing about 5 per cent of demand for GP consultations in most practices. It makes more appropriate use of each team member's skills and increases job satisfaction for receptionists.
- **Benefits for patients:** It is easier for patients to get an appointment with the GP when they need it, and shortens the wait to get the right help.

Correspondence management by clerical staff

A member of clerical staff in the practice is given additional training and relevant protocols in order to support the GP in clinical administration tasks. All incoming correspondence about patients from hospitals is processed by a member of the clerical team. They have received training to deal with most letters themselves. Working against standard protocols developed in-house and refined through continuous improvement, the member of the team reads the letter, enters details into the patient's record and takes appropriate follow-on action. In some cases this involves other members of the team, or booking the patient an appointment.

- **Benefits for practices:** Using this system, 80-90 per cent of letters can be processed without the involvement of a GP, freeing up approximately 40 minutes per day per GP. For the clerical team, job satisfaction is often increased as well.
- **Benefits for patients:** Practices report they are often able to take speedier action on some issues. More detailed coding of clinical information in the GP record results in improved monitoring and management of certain conditions.

Source: NHS website. Available at https://www.england.nhs.uk/gp/gpfv/redesign/gpdp/reception-clerical/

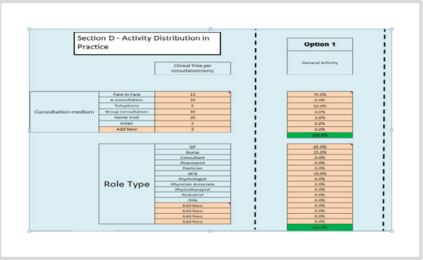
Primary Care Future Workforce Modelling Tool

A workforce modelling tool, collaboratively developed by HLP, HEE, and STPs in London.

Previous workforce modelling approaches have been built upon to further enhance the ability to look at large and small population groups (e.g. STP to local network), whole populations and clinical subsets (e.g. LTC). The tool has also been developed to be able to calculate indicative relative workforce costs, thus enabling a comparison of current and future ways of working. The ability to model a whole person perspective is currently being developed (e.g. elderly frail, multiple co-morbidities).

Using a combination of population data (existing and growth), HEE supply data, and local information on service use and who does what (currently and in the future), the modelling tool can show future workforce profiles, thus informing requirements around the supply of new and existing roles. This is a valuable planning asset that enables organisations to consider workforce implications of new ways of working and service transformation activities, both strategically and locally.

Input sheets, that tool users fill in, have been designed to be easy to complete and functions have been automated where possible to minimise the need for manual input. Further automation with provider systems is also being explored. Once input is complete, the information is turned into scenarios and easily interpreted graphics at the press of a button. A number of test sites have been identified and the tool is now available for use by commissioners, primary care networks, federations, workforce networks, service development groups, e.g. LTC.



For further information please contact: Paul Roche (paul.roche@nhs.net), Stewart Weller (stewart.weller@nhs.net), Dominic Hunt (dominic.hunt.hee.nhs.net), Jonathan Sampson (jonathan.sampson@nhs.net)

Practice Manager Development Programme

The Practice Manager Development Programme consists of a programme of five workshops.

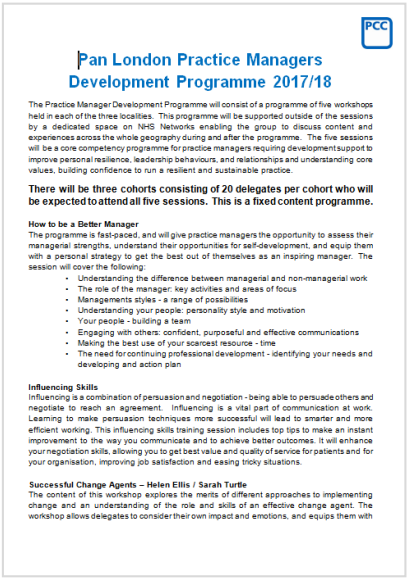
This programme will be supported outside of the sessions by a dedicated space on NHS Networks enabling the group to discuss content and experiences across the whole geography during and after the programme.

The five sessions will be a core competency programme for practice managers requiring development support to improve personal resilience, leadership behaviours, and relationships and understanding core values, building confidence to run a resilient and sustainable practice.

The five sessions are:

1. How to be a better manager
2. Influencing skills
3. Successful change agents
4. Appraisal training
5. The leader as a coach

There will be three cohorts consisting of 20 delegates per cohort who will be expected to attend all five sessions. This is a fixed content programme.



PCC

Pan London Practice Managers Development Programme 2017/18

The Practice Manager Development Programme will consist of a programme of five workshops held in each of the three localities. This programme will be supported outside of the sessions by a dedicated space on NHS Networks enabling the group to discuss content and experiences across the whole geography during and after the programme. The five sessions will be a core competency programme for practice managers requiring development support to improve personal resilience, leadership behaviours, and relationships and understanding core values, building confidence to run a resilient and sustainable practice.

There will be three cohorts consisting of 20 delegates per cohort who will be expected to attend all five sessions. This is a fixed content programme.

How to be a Better Manager
The programme is fast-paced, and will give practice managers the opportunity to assess their managerial strengths, understand their opportunities for self-development, and equip them with a personal strategy to get the best out of themselves as an inspiring manager. The session will cover the following:

- Understanding the difference between managerial and non-managerial work
- The role of the manager: key activities and areas of focus
- Managements styles - a range of possibilities
- Understanding your people: personality style and motivation
- Your people - building a team
- Engaging with others: confident, purposeful and effective communications
- Making the best use of your scarcest resource - time
- The need for continuing professional development - identifying your needs and developing and action plan

Influencing Skills
Influencing is a combination of persuasion and negotiation - being able to persuade others and negotiate to reach an agreement. Influencing is a vital part of communication at work. Learning to make persuasion techniques more successful will lead to smarter and more efficient working. This influencing skills training session includes top tips to make an instant improvement to the way you communicate and to achieve better outcomes. It will enhance your negotiation skills, allowing you to get best value and quality of service for patients and for your organisation, improving job satisfaction and easing tricky situations.

Successful Change Agents – Helen Ellis / Sarah Turtle
The content of this workshop explores the merits of different approaches to implementing change and an understanding of the role and skills of an effective change agent. The workshop allows delegates to consider their own impact and emotions, and equips them with

For further information please contact: Paul Roche (paul.roche@nhs.net), Stewart Weller (stewart.weller@nhs.net), Jane Lindo (jane.lindo1@nhs.net), Dominic Hunt (dominic.hunt.hee.nhs.net), Jonathan Sampson (jonathan.sampson@nhs.net)

Sunderland GP Alliance

The Practice Manager Development Programme consists of a programme of five workshops.

Sunderland GP alliance has demonstrated an effective leadership development approach, comprised of four key domains;

1. **Individual effectiveness of the leader:** Myers-Briggs Type Indicator personality preference, 360 degree feedback.
2. **Relationships and connectivity:** coaching to explore the health of relationships and connections across the system with specific work on strengthening relationships that add value to the service user.
3. **Innovation and improvement:** explore the skills and capacity of the staff to problem solve, service improve, and signpost to developments already available within the system.
4. **Learning and capacity building:** coaching around how new ideas, research and skills could be diffused and shared within and between the five locality teams across the city.

Some of the beneficial outcomes identified so far include:

- Greater understanding of different roles and increased collaboration.
- Staff more satisfied with quality of care and support they can offer patients.
- Improved sense of pride.
- Increased sense of unity and a feeling of being one team.

Source: Sunderland GP Alliance website. Available at http://www.sunderlandgpalliance.co.uk/

Brighton, Workflow Optimisation

Workflow Optimisation was born from the Extended Primary Integrated Care (EPiC) programme in Brighton and Hove, which was part of the first wave of the Prime Minister's Challenge Fund. Workflow optimisation aims to release GP time and increase their capacity to be able to provide greater patient care.

Approach: GP practice clerical teams were given training that enabled them to read, code and action incoming clinical correspondence, according to a framework, based on practice protocols. GPs were only presented with letters that required clinical input or action. During an offsite training course, administrators learned where the areas of risk were, and a standard way to interact with a letter to ensure that all the key actions, read codes, and medication changes were detected and enacted. In addition to administrators, a GP was nominated to act as a Workflow Lead, responsible for supporting the administrator(s) and collating feedback from partners.

Challenges: The biggest challenge for GPs was letting go, putting trust in colleagues and handing over control of letters and other documents. As there was no consistent approach to handling incoming letters, there was also a need to develop a defined protocol that the workflow team would adopt and implement. Another challenge was investment. In order for the workflow changes to be successful, administrators' hours had to be increased to allow for the new work to be done, and support their development by enabling them to participate in training.

Outcomes: Within six weeks, the number of letters each GP saw every day had reduced by around 50%, and within 18 weeks, 80% of incoming correspondence was processed in its entirety by the administrative team. This released approximately 40 minutes per day, for every GP. Workflow optimisation has also sped up how long a letter spends in the system, and enhanced data quality. There is now a trained team capturing pertinent clinical information in a timely and consistent way. As a consequence of the robust approach to data collection from incoming correspondence, QOF also increased. This was because data was captured from letters first time, using a template within the clinical system designed specifically with incoming correspondence in mind.

Source: Pulse Today website. Available at http://www.pulsetoday.co.uk/your-practice/how-a-workflow-administrator-saved-us-40-minutes-a-day/20035876.article
Source: NHS Networks website. Available at https://www.networks.nhs.uk/nhs-networks/releasing-capacity-in-general-practice/messageboard/5-productive-work-flows/695446443

Larwood and Bawtry Primary Care Home

Larwood and Bawtry Primary Care Home covers several villages in Nottinghamshire and South Yorkshire. Two practices wanted to build a new primary care team to care for their local populations and work in partnership with other organisations to ensure services improved and remained sustainable.

The primary care home is improving the way the practices work together and bringing in new partners to improve services to patients. It has three aims: to improve staff support and wellbeing so they can cope and stay well doing an increasingly difficult job, improve patient outcomes particularly by identifying issues before they become acute and find increasingly efficient ways of working.

The two GP surgeries have created integrated teams co-locating community and voluntary services in the practices. Community matrons and community nurses work with practice nurses in integrated neighbourhood teams. The practices provide administrative support to the community service staff, resulting in better exchange of information between GPs, practice nurses and the community teams.

Community advisors funded by the voluntary sector now work from the surgeries, running citizens advice clinics signposting patients to voluntary and non-medical services in the area. They provide a vital link to services that can address some of the underlying causes of anxiety and depression including debt and unemployment. Close working with the district council has led to improved support in care homes and for people with housing needs. Social care clinics are held on site enabling patients to receive quicker needs assessments.

There's been a 5 per cent reduction in prescribing costs following the appointment of an in-house practice pharmacist who carried out medicine reviews for care home residents. Analysis over a seven-month period found a significant reduction in prescribing costs and projected £229,000 annual savings, as well as reducing the risk of side-effects for patients. Emergency admissions dropped by 8 per cent over the same period with the clinical commissioning group estimating savings of £277,000.

Staff are working together better and find work more fulfilling (87 per cent of staff surveyed felt the PCH way ofworking had improved job satisfaction). Patient care has improved with better information among staff and care plans integrated across services.

Source: national Association of Primary Care website. Available at http://napc.co.uk/primary-care-home/rapid-test-sites/larwood/

Clinical Pharmacists in Wallingbrook Health Group, Devon

By placing a clinical pharmacist in the group has reduced the need for patient GP appointments by 30%, making a significant impact on GP workloads and patient outcomes.

Karen Acott has been a clinical pharmacist at the Wallingbrook Health Group in Devon since 2004. She is a full partner in the group, which covers practices in Chulmleigh and Winkleigh. As a prescribing pharmacist, she sees patients in clinics and delivers telephone consultations, handling all aspects of medication management. Over the years, her work has reduced the need for patient GP appointments by 30%, making a significant impact on GP workloads and patient outcomes. A 2016/17 audit of workload impact showed that having a pharmacist working four sessions a week resulted in over 400 hours of GP time was saved over the course of the year.

Karen explains: "My focus is on patients whose conditions and medication are reasonably well controlled and stable and our aim is to improve self-management. Within my consultations I also devote time to help patients learn how to self-care and give them confidence and information that empowers them."

While the role of the clinical pharmacist in general practice has been developing for some time, it is now an integral part of a transformation in GP services by harnessing the skills of the wider workforce. Karen is able to support GPs by highlighting where, for example, NICE guidelines have changed, by looking at how best practice is integrated into care processes. She is also able to provide guidance on medicines' optimisation and care for patients with long term conditions.

Karen works together with the local healthcare community to design more efficient and effective ways of working. "I also look at all the agencies and health professionals involved in that patient's care and try to ensure we are all working in harmony. A patient might also be receiving cognitive behavioural therapy or treatment for glaucoma at the secondary care level and I will check if those agencies are still in contact, what treatment they have had, while ensuring their repeat prescription is up-to-date and integrated into their care plan."

Previously, GPs would run joint clinics with nurses for chronic disease management where nurses would carry out initial observations, such as blood pressure and breathing tests, and the GP would finish the review amending medications if necessary. In the early days, Karen would step in where traditionally a GP appointment would have been needed. As a trained prescriber, she is able to monitor trends using blood results focusing on potential harm that can come from long-term use of medicines or poor compliance.

Source: NHS website. Available at https://www.england.nhs.uk/gp/case-studies/wallingbrook-health-group/

The physician associate will see you now – new role to assist patients in primary care

By 2020 there could be as many as 1,000 physician associates working in primary care, but regulation of the profession is seen as crucial in the development of this new role.

Chris Deane's day starts like any other at the busy Warwickshire practice where he works. First he triages calls from patients, decides those who will need a home visit later in the day, and books others into free slots in his morning or afternoon surgeries.

Like his GP colleagues, he deals with around 60 patients a day, but unlike them he is not a family doctor. Instead, Deane is a qualified physician associate – a new breed of healthcare professional taking pressure off hard-pressed doctors and providing patients, especially those with long-term conditions, the continuity of care they need.

"I have my own patient list, I can diagnose and make referrals and the GPs refer patients to me as I have an interest in paediatrics and mental health," he says. "I do work in a similar way to a GP, but it's important that patients understand we have a different role, we are not doctors."

Deane, now a partner at his practice, was one of the first handful of physician associates to qualify in the UK a decade ago. Today there are approximately 350 practising in both primary and secondary care and another 550 in training, with numbers in training predicted to rise. Currently, around 20% of graduate physician associates are recruited to roles in primary care. But that is about to change. By 2020, the Department of Health and Health Education England (HEE) – the organisation responsible for NHS workforce training – want to see a total of 1,000 physician associates recruited to primary care roles.

Source: NHS website. Available at https://www.england.nhs.uk/gp/case-studies/the-physician-associate-will-see-you-now-new-role-to-assist-patients-in-primary-care/

Nursing Associate

The Secretary of State for Health announced an expansion in the numbers of Nursing Associates on 3 October 2017. Plans will see 5,000 Nursing Associates trained through the apprentice route in 2018 and 7,500 in 2019. Details of the expansion will be confirmed by HEE in the forthcoming weeks for employers, Higher Education Institutes and prospective Nursing Associate applicants.

The expansion builds on Health Education England's (HEE) current pilot project which has 35 test sites training 2,000 Nursing Associates. Early feedback from the ongoing evaluation is very positive, with employers reporting enthusiasm for the role and its potential for adding value to the work of their multidisciplinary teams.

The Nursing Associate role is designed to bridge the gap between Healthcare Assistants and Registered Nurses in England. Nursing Associates will deliver care, freeing up Registered Nurses to spend more time using their skills and knowledge to focus on complex clinical duties and take a lead in decisions on the management of patient care. Following their training, Nursing Associates will work within teams with direct or indirect supervision to deliver aspects of nursing care, complementing the work of registered nurses, not replacing them.

Employers tell us they need a more flexible workforce to keep pace with developments in treatments and interventions. The Nursing Associate role is designed to provide employers with a wider skill mix within multidisciplinary teams. The Nursing Associate role is one of many new roles emerging across the healthcare professions; Physicians' Associates, Physicians' Assistant (anaesthesia), Surgical Care Practitioner and Nursing Associates are just some of the new roles which are all designed to improve patient care and form a valuable part of a contemporary multidisciplinary workforce.

The Nursing and Midwifery Council's (NMC) recent consultation on the future nurse standards shows that the Registered Nurse of the future will be educated to plan, deliver and evaluate more complex care.

Source: NHS website. Available at https://www.england.nhs.uk/leadingchange/staff-leadership/nursing-associate/

6 Effective governance

This section focuses on how important it is for larger-scale general practice organisations to govern themselves in the right way, to enhance the involvement of patients and other stakeholders, and to develop their leaders. Hover over each bubble for more information.

Click here to see the full component sections

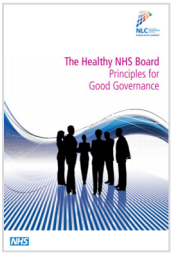
Value autonomy and concerned about relinquishing control

I understand the rationale and options for new structures

We are putting structures around the emerging collaboration

We are embedding effective and empowering structures for action

Healthy NHS Board: Principles for Good Governance



Good leadership leads to a good organisational climate and good organisational climates lead, via improved staff satisfaction and loyalty, to sustainable, high performing organisations.

This document sets out the guiding principles that will allow NHS board members to understand the:

- collective role of the board
- governance role within the wider health system
- activities and approaches that are most likely to improve board effectiveness
- contribution expected of them as individual board members.

This guidance is intended for boards of all NHS organisations. Some interpretation will be required for organisations operating at a national or regional level.

Source: NHS Leadership Academy website. Available at https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-TheHealthyNHSBoard.pdf

Patient involvement in the development of patient-reported outcome measures: a scoping review

Patient-reported outcome measures (PROMs) measure patients' perspectives on health outcomes and are increasingly used in health care. To capture the patient's perspective, it is essential that patients are involved in PROM development.

This article reviews in what ways and to what extent patients are involved in PROM development and whether patient involvement has increased over time.

A total of 189 studies, describing the development of 193 PROMs, were included. Most PROMs were meant for chronic disease patients (n = 59) and measured quality of life (n = 28). In 25.9% of the PROM development studies, no patients were involved. Patients were mostly involved during item development (58.5%), closely followed by testing for comprehensibility (50.8%), while patient involvement in determining which outcome to measure was minimal (10.9%). Some patient involvement took place in the development of most PROMs, but in only 6.7% patients were involved in all aspects of the development. Patient involvement did not increase with time.

Although patient involvement in PROM development is essential to develop valid patient-centred PROMs, patients are not always involved. When patients are involved, their level of involvement varies considerably. These variations suggest that further attention to building and/or disseminating consensus on requirements for patient involvement in PROM development is necessary.

Source: Health Expectations Journal online library. Available at http://onlinelibrary.wiley.com/doi/10.1111/hex.12442/pdf

Involving people in their own health and care

10 key actions for CCGs and NHS England on how to involve people in their own health and care.

Clinical Commissioning Groups (CCGs) and NHS England have a key role to play in ensuring that providers make individuals' personal involvement in their health and care a reality. This guidance supports CCGs and NHS England to fulfil their legal duties to involve people in their health and care, so that people experience better quality care and improved health and wellbeing, and the system makes more efficient use of resources. The guide highlights the importance of involving people, their carers and families, to improve individuals' health and wellbeing outcomes and the efficiency and effectiveness of health services. It also explains how CCGs and NHS England can meet their legal duties.

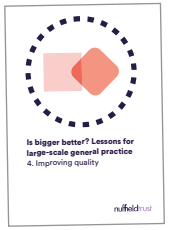
Key actions include:

- how to publicise and promote personal health budgets and the choices available to patients and carers
- how CCGs and NHS England assure themselves that providers are enabling involvement
- how CCGs and NHS England are commissioning for involvement.

To support CCGs and NHS England to address these issues, the key mechanisms for involving people in their own health and care are described, with links to a range of resources, good practice and advice.

Source: NHS website. Available at https://www.england.nhs.uk/wp-content/uploads/2017/04/ppp-involving-people-health-care-guidance.pdf

Is bigger better? Lessons for large-scale general practice, booklet 1. Leadership and governance



The research report is drawn from a 15-month study of large-scale general practice organisations in England. The study examined the factors affecting their evolution and their impact on quality, staff and patient experience. It was informed by an extensive literature review, which will be published separately, and combined national surveys with in-depth case studies of contrasting, large-scale general practice organisations and analysis of 15 quality indicators. Key lessons captured in four booklets published in September 2017.

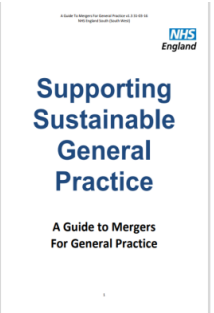
Five first steps to help practices form successful large-scale general practice organisations:

1. Develop the simplest possible governance arrangements
2. Create a leadership team
3. Create lines of accountability to members
4. Involve your members in key decisions
5. Create lines of accountability to patients

For further details, please refer to the booklet.

Source: The Nuffield Trust website. Available at https://www.nuffieldtrust.org.uk/files/2017-09/1.-leadership-and-governance.pdf

Supporting Sustainable General Practice A Guide to Mergers For General Practice



This document aims to provide guidance to General Practices considering merging into a single entity.

The 5 Year Forward View (5YFV) confirms the need for practices to come together to explore new, innovative ways of delivering Primary Care at scale. There is important learning from the experience of those primary care organisations that have already been through the process which may aid those starting the journey.

As with many issues there is no 'right answer' and the decision about the scale of joint working and whether to formally merge or simply work in a federated model will depend on local circumstances. Mergers traditionally involved two or more neighbouring practices that were confronted with similar limitations: for example the desire for larger, better equipped premises or the opportunity to increase the patient list size and practice income.

The benefit of sharing staff can also be a significant factor.

Source: The Nuffield Trust website. Available at https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/guide-mergers-gp.pdf

Improving Health Ltd

Improving Health is a federation constituted of 20 practices in South East London grouped into four clusters of around 30-40,000 patients.

Improving Health is making use of its data, structure and collective resources to enhance the health of the local population. Six-weekly meetings take place with each cluster to enable peer review and support, and identify the need for targeted interventions. This includes identifying where practices can share resources/staffing and where additional federation-employed practitioners are best deployed to improve population outcomes. Agendas cover and are informed by dashboards displaying population health activity and outcomes information by practice, cluster, and federation.

Further scrutiny takes place at the Population Health Delivery Group. Progress reports, projections and recommendations are examined at the board, on which sit four elected GPs, a practice manager and the federation managing director. During 2016/17 the federation approach achieved an additional £170k of contract income, which in turn supports investment in further improvement. The organisation is now looking at future commercial opportunities to strengthen at scale working in partnership, including the potential formation of joint ventures and alliances.

Source: Improving Health website. Available at https://www.ihlsouthwark.co.uk/

City and Hackney Confederation

City and Hackney GP Confederation was established in 2014 as a Community Interest Company with a membership of 43 GP practices and a growing registered patient list of around 307,000. The company is a not-for-profit organisation in which each of the GP practices are equal shareholders. Each pays an annual membership fee to the Confederation based on the size of their registered practice list.

The GP Confederation has an agreed constitution in place that was consulted on and agreed with GP member practices. The governing body is its Clinical Board (the Board of Directors) which is made up of five elected GPs.

On inception, a clear vision and strategic aims were defined. The vision is to make a positive difference to the quality of primary care, to influence the development and redesign of local services through a collective voice for primary care in the local care system, and to ensure that local communities have access to the best quality local healthcare.

Strategic aims are to develop:

- The role as a local provider of out-of-hospital services and local preventative services.
- The capacity and capability of the local primary workforce.
- The role in relation to public health and health promotion.

Source: City and Hackney GP Confederation website. Available at http://www.cityandhackneygpconfederation.org.uk/

Modality Partnership, Birmingham

The Modality Partnership was founded in Birmingham in 2009, starting with just two practices and subsequently expanding to over 35 sites, and now serving more than 300,000 patients.

Initial motivations to partner were to provide better general practice to a larger population and a broader range of patient services. Partnership benefits include: new patient services, a more corporate partnership to deliver on business case, improved quality metrics, happier GPs, and the ability to advise and support others embarking on the journey.

Key lessons learnt include: merging of services is a time-consuming process that requires management support and a partner to devote time, money and energy to make it happen. Throughout the process, effective communication is key, both between the partnership and staff, and their patients. Monthly newsletters and regular email updates are essential to cascade information and patient participation groups are crucial in capturing patient feedback and services they'd like to see in the future. GPs that have joined the partnership have benefited hugely from a reduced administrative burden, thus freeing up more time to enjoy general practice. Organisational change takes time so it's essential to ensure staff contracts are harmonised as soon as possible.

Source: Modality Partnership website. Available at https://modalitypartnership.nhs.uk/

Our Health Partnership, Midlands

A GP partnership of 38 practices with 45 surgeries. 186 GP partners and 50 salaried GPs in Our Health Partnership serving around 330,000 patients in Birmingham, Sutton Coldfield and Shropshire.

The partnership offers a shared administrative and management structure, cutting down the time doctors have to spend on admin. It opens up economies of scale to get best value from budgets. It has the resources to develop innovative services and effective partnerships with local hospitals and care services. And it can access new funding streams that are only available to large GP organisations. That means more choices and a quality service for patients, a secure future for the local surgeries they rely on and security and job satisfaction for our committed and capable doctors and practice staff.

Structure;

A Board and Executive Team alongside central office staff.

- **The Board:** Our Health Partnership is led by committed and experienced GPs and healthcare specialists. They share a passion for outstanding primary services and a deep practical knowledge of community healthcare. The board is made up of seven elected GP partners, two co-opted Shropshire based GP partners and three officers (a Managing Director, Operations Director and Finance Director). The Board is responsible for the central functions of Our Health Partnership, including accounting, HR, finance and CQC registration. It also investigates and shares best practice and innovation, provides a strong voice for the collective locally and nationally, manages our partnerships and is in constant communication with all our GP practices to support their individual needs.
- **Executive Board:** Comprised of a Strategic Advisor, Operations Director, and Finance Director.

As a partnership we have registered our organisation as one registered provider, which will help practices continue to provide a high standard of patient care and introduce continuity across OHP Practices. Our Statement of Purpose that has been produced as part of our registration details of the aims and objectives in providing the regulated activities (the services) at each of the OHP Practices. Each of our Practices has its own CQC ratings.

Source: Our Health Partnership website. Available at http://www.ourhealthpartnership.com/

7 System partnership

This section focuses on how, by strengthening collaboration between practices and developing their capacity to lead, we can begin to take on significant leadership responsibility and have strong influence within new Integrated Care Systems. Hover over each bubble for more information.

Click here to see the full component sections

I feel that something important is being lost

I've identified others who want to protect and champion community-based care

We are working collectively to strengthen the role and quality of general practice

We are working across professional and organisational boundaries as a single system to create new models of care

The impact of new forms of large-scale general practice provider collaborations on England's NHS: a systematic review

Over the past decade, collaboration between general practices in England to form new provider networks and large-scale organisations has been driven largely by grassroots action among GPs. However, it is now being increasingly advocated for by national policymakers. Expectations of what scaling up general practice in England will achieve are significant.

- **Aim** To review the evidence of the impact of new forms of large-scale general practice provider collaborations in England.
- **Design and setting** Systematic review.
- **Method** Embase, MEDLINE, Health Management Information Consortium, and Social Sciences Citation Index were searched for studies reporting the impact on clinical processes and outcomes, patient experience, workforce satisfaction, or costs of new forms of provider collaborations between general practices in England.
- **Results** A total of 1782 publications were screened. Substantial financial investment was required to establish the networks and the associated interventions that were targeted at four clinical areas. Quality improvements were achieved through standardised processes, incentives at network level, information technology-enabled performance dashboards, and local network management. The fifth study of a large-scale multisite general practice organisation showed that it may be better placed to implement safety and quality processes than conventional practices. However, unintended consequences may arise, such as perceptions of disenfranchisement among staff and reductions in continuity of care.
- **Conclusion** As more general practice collaborations emerge, evaluation of their impacts will be important to understand which work, in which settings, how, and why.

Source: British Journal of General Practice website. Available at http://bjgp.org/content/68/668/e168.long

Is bigger better? Lessons for large-scale general practice

This research report is drawn from a 15-month study of large-scale general practice organisations in England. The study examined the factors affecting their evolution and their impact on quality, staff and patient experience. It was informed by an extensive literature review, and combined national surveys with in-depth case studies of contrasting, large-scale general practice organisations and analysis of 15 quality indicators.

Key findings are as follows:

- This agenda is well underway across the country, with almost three-quarters of general practices already in some form of collaboration with others, almost half of which formed during 2014/15. The major reasons for forming were to 'achieve efficiencies' and 'offer extended services in primary care'.
- Larger scale has the potential to sustain general practice through operational efficiency and standardised processes, maximising income, strengthening the workforce and deploying technology.
- However, scaling up will take a lot of hard work and cannot just be left to a few heroic leaders. All GPs will need to play a part in making these new organisations successful.
- The evidence that these organisations can improve quality is mixed. Patients had differing views about the benefits of large-scale organisations. Some appreciated increased access, while others were concerned about losing the close relationship with their trusted GP.
- The case study organisations had established high-quality specialist services in the community which were popular with patients, but were delivered at relatively small scale. Trust and close engagement between practitioners and commissioners were very important for successful implementation. Clinical commissioning groups (CCGs) had to manage the tension between supporting large-scale organisations to develop while also managing conflicts of interest.
- In light of these findings, the authors argue that policy-makers and practitioners should be realistic in their expectations of the pace at which large-scale organisations can contribute to service transformation. The report offers a series of practical insights and lessons for general practitioners as well as important lessons for policy-makers, national leaders and commissioners.

The full report includes detailed insights about governance, leadership, management or change, staff perceptions and quality improvement methods used in each of our case study sites. The lessons are also captured in four booklets published in September 2017.

Source: The Nuffield Trust website. Available at https://www.nuffieldtrust.org.uk/research/is-bigger-better-lessons-for-large-scale-general-practice

Is bigger better? Lessons for large-scale general practice, booklet 3. Working with the wider health economy

This research report is drawn from a 15-month study of large-scale general practice organisations in England. The study examined the factors affecting their evolution and their impact on quality, staff and patient experience. It was informed by an extensive literature review, and combined national surveys with in-depth case studies of contrasting, large-scale general practice organisations and analysis of 15 quality indicators.

Two actions can help large-scale general practice organisations work with other organisations in their local health economy.

1. Build strong, positive relationships with your local clinical commissioning group
   - Demonstrate how you can contribute to local commissioning priorities.
   - Demonstrate that the organisation can address variations and improve quality.
   - Link (at least some of) your organisation's development priorities to evidence of local need.
   - This will help to reduce the risk of negative perceptions if a private organisation.

2. Carefully manage conflicts of interest between the general practice organisation and CCG board members
   - Directors of your organisation should not sit on the CCG governing body.
   - Find ways to contribute expertise to CCG commissioning work without participating in commercially sensitive meetings and decisions.

If your large-scale general practice organisation is planning to deliver extended services:

- Work collaboratively with local specialists to establish these services
- If you focus on easy-to-deliver parts of a care pathway without involving local specialists, this may disrupt relationships, making it harder to collaborate to fundamentally transform care
- Use the opportunity of establishing extended services to develop skills in practice workforce.

For further details, please refer to the booklet.

Source: The Nuffield Trust website. Available at https://www.nuffieldtrust.org.uk/files/2017-09/3.-working-with-the-wider-health-economy.pdf

Large-scale general practice in England: What can we learn from the literature?

This report presents findings of an extensive literature review examining the evidence of whether collaborative 'at-scale' models of general practice can really deliver what is expected of them.

This paper presents the findings of a review of the literature which contributes to the Nuffield Trust's stream of work on large-scale general practice, including the recently published findings of a 15-month mixed methods research study, Is Bigger Better? Lessons for Large-Scale General Practice.

The report, published in collaboration with the London School of Hygiene & Tropical Medicine, aims to answer the following questions:

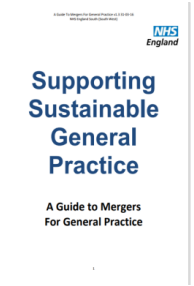
1. Which organisational form(s) have large-scale collaborations of GP practices adopted in England?
2. What are they expected to deliver?
3. What evidence is available on their impact in England?
4. What can we learn from initiatives with similarities?

Conclusions

- Broadly see four models of large-scale general practice provider collaborations emerging in England: networks, federations, super-partnerships and multi-site practice organisations. Depending on their functions and the goals of the GPs and practices participating in them, each may adopt one or more different legal forms and governance structures.
- Expectations of what these groups may be able to achieve are ambitious and include harnessing opportunities to strengthen the workforce, improve quality of care, extend services and create efficiencies. There is, however, little good quality research into these new forms of collaboration to confirm or refute whether these expectations are realistic. What evidence exists shows promising results for managed general practice networks acting on specifically targeted areas of care for improvement which received significant financial investment and management support.
- National and international experience underlines that the engagement of GPs is essential to increase the likelihood of large-scale general practice collaborations succeeding. For this, GPs must feel they have sufficient autonomy and influence over the new groups.

Source: The Nuffield Trust website. Available at https://www.nuffieldtrust.org.uk/research/large-scale-general-practice-in-england-what-can-we-learn-from-the-literature

Supporting Sustainable General Practice; A Guide to Mergers For General Practice



This document aims to provide guidance to General Practices considering merging into a single entity.

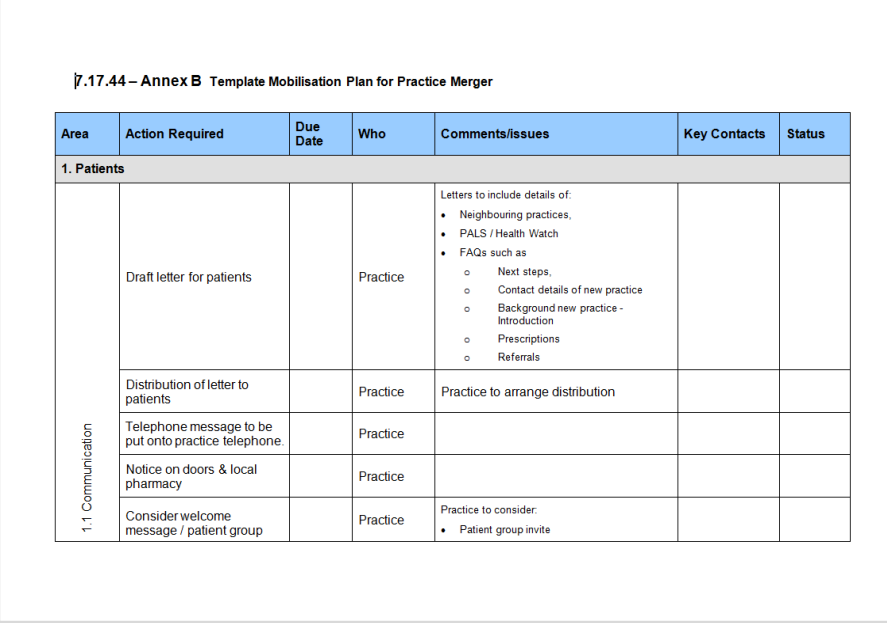
The 5 Year Forward View (5YFV) confirms the need for practices to come together to explore new, innovative ways of delivering Primary Care at scale. There is important learning from the experience of those primary care organisations that have already been through the process which may aid those starting the journey.

As with many issues there is no 'right answer' and the decision about the scale of joint working and whether to formally merge or simply work in a federated model will depend on local circumstances. Mergers traditionally involved two or more neighbouring practices that were confronted with similar limitations: for example the desire for larger, better equipped premises or the opportunity to increase the patient list size and practice income. The benefit of sharing staff can also be a significant factor.

Source: NHS website. Available at https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/guide-mergers-gp.pdf

Primary medical care policy and guidance manual: practice mergers and or contractual mergers – annexes

The Policy Book for Primary Medical Services provides commissioners of GP services with the context, information and tools to commission and manage GP contracts. These are the annexes for the Practice Mergers and or Contractual Mergers section. Annex B: Template mobilisation plan for practice mergers.



7.17.44 – Annex B Template Mobilisation Plan for Practice Merger

Area	Action Required	Due Date	Who	Comments/issues	Key Contacts	Status
1. Patients						

1.1 Communication	Draft letter for patients		Practice	Letters to include details of:
				• Neighbouring practices,
				• PALS / Health Watch
				• FAQs such as
				  ○ Next steps,
				  ○ Contact details of new practice
				  ○ Background new practice - Introduction
				  ○ Prescriptions
				  ○ Referrals		

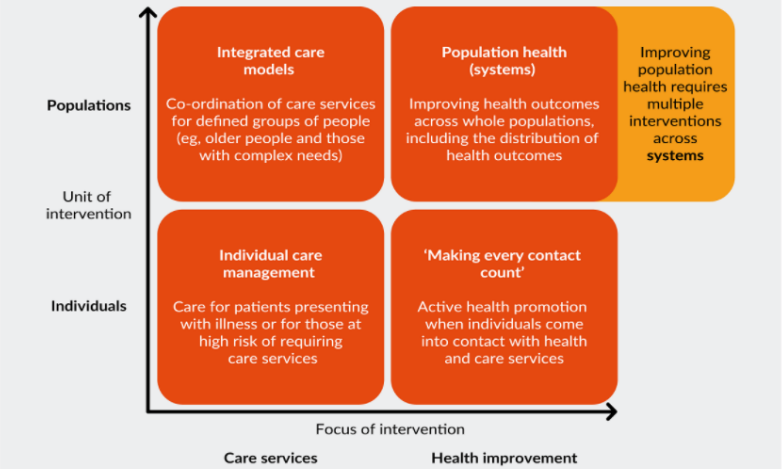
	Distribution of letter to patients		Practice	Practice to arrange distribution		
	Telephone message to be put onto practice telephone.		Practice			
	Notice on doors & local pharmacy		Practice			
	Consider welcome message / patient group		Practice	Practice to consider: • Patient group invite		

Source: NHS website. Available at https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-practice-mergers-and-or-contractual-mergers-annexes/

Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England

NHS England has recently changed the name of accountable care systems to integrated care systems, which describes more accurately the work being done in the 10 areas of England operating in this way. The King's Fund updated long read looks at work under way in these systems and at NHS England's proposals for an accountable care organisation contract.

Figure 1 The focus of population health systems



Contents

Source: King's Fund website. Available at https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems

The Symphony Programme, South Somerset

The Symphony programme is a partnership between a federation of 19 practices, acute Trusts and the local council established to address rising demand and costs, and a staffing crisis in general practice. It is chaired by a GP, with four other members of the board drawn from general practice.

Together, they have analysed the population, joined up data, and established new organisational forms to support primary care. Crucially, new models of integrated care have been developed by GP-led groups, including:

- Health coaches across practices, working in teams with GPs and other practice staff to discuss patients agree actions, and support patients to have the confidence to self-care.
- Virtual diabetes MDTs with consultants.
- Hot respiratory clinics where practices can obtain urgent expert opinion.

Throughout, GP leadership, secondary care resources, and a willingness to reflect on feedback have been integral to success.

Source: Symphony Integrated Healthcare website. Available at http://www.symphonyintegratedhealthcare.com/about-symphony/

Northumbria primary care

Northumbria Primary Care Ltd was established as a single legal entity in response to a request for support from the primary care sector, and is constituted of the local acute foundation Trust and seven general practices.

The organisation now provides practices with a range of back office support, including governance, payroll, financial services, HR, estates. Each practice continues to operate independently, providing localized care to patients. But they have also benefited from the economies of scale, increased purchasing power, and expertise sourced from their acute colleagues lowering costs and placing them collectively in a stronger position to win contracts and generate new income streams.

Patient satisfaction and CQC ratings are high. The practices have broadened their workforce to include new roles. One member practice has reported a 76% improvement in access times, whilst another has reduced monthly expenditure by £6,000.

The collaboration has forged stronger links between primary and secondary care – in and of itself, and also by facilitating the progress of the PACS vanguard project, initiated in Northumbria in 2015.

Source: Northumbria Primary Care website. Available at http://www.northumbriaprimarycare.co.uk/about-us

Dudley, multi-specialty community provider

The multi-specialty community provider model proposed by the partnership in Dudley aims to develop of a network of integrated, GP-led providers across health and social care, each working at a level of 60,000 people, collectively reaching over 318,000 people across Dudley. The vision is a front line of care working as 'teams without walls' for the benefit of patients, and all taking mutual responsibility for delivering shared outcomes. This coordinated approach aims to 'fill the cracks' so patients receive high quality care in a timely manner.

Under the new provider system, patients have care overseen by multi-disciplinary teams within the community, including specialist nurses, social workers, mental health services and voluntary sector link workers. One example of interventions used is the 24 hour rapid response and urgent care centre which provide a single, coordinated point of access as an alternative for 999 cases that are not in need or urgent, acute care.

Lessons learnt along the way include:

- Clinical leadership is vital, utilise monthly leadership sessions
- Important to consult patients on proposed and upcoming changes
- Communication is extremely important. Channels that have landed well include newsletters and patient groups
- Culture is key. People have to want to change.

Source: Dudley CCG website. Available at http://www.dudleyccg.nhs.uk/our-plans/integration/

Fylde

Fylde Coast is a vanguard comprised of 6 partner sites. The shared vision is to develop healthcare that 'wraps around' the patient, delivering more support closer to people's home and less in hospital. Together, the clinical commissioning groups have a registered population of 320,000 living across a mix of coastal towns and rural villages.

A new community based service, 'extensive care', provides proactive support for people aged 60 and over, who have two or more long terms conditions. Patients benefit from a harmonised team of health and care professionals working together to provide support required to keep them out of hospital. This includes helping people to understand and manage their health conditions and other aspects of their life that may impact wellbeing. The service is complemented by locally based neighbourhood care teams, which provide support to people who require ongoing management of one or more long term conditions, shared electronic care records and a single point of contact for all out of hospital services on the Fylde Coast.

Key benefits include:

- patients feel empowered with support to better manage their conditions and stay healthy
- health system pressure is relieved through better coordination and fewer unnecessary hospital admissions
- better patient experience as a result of streamlined care through a single point of access and agreed shared electronic care records.

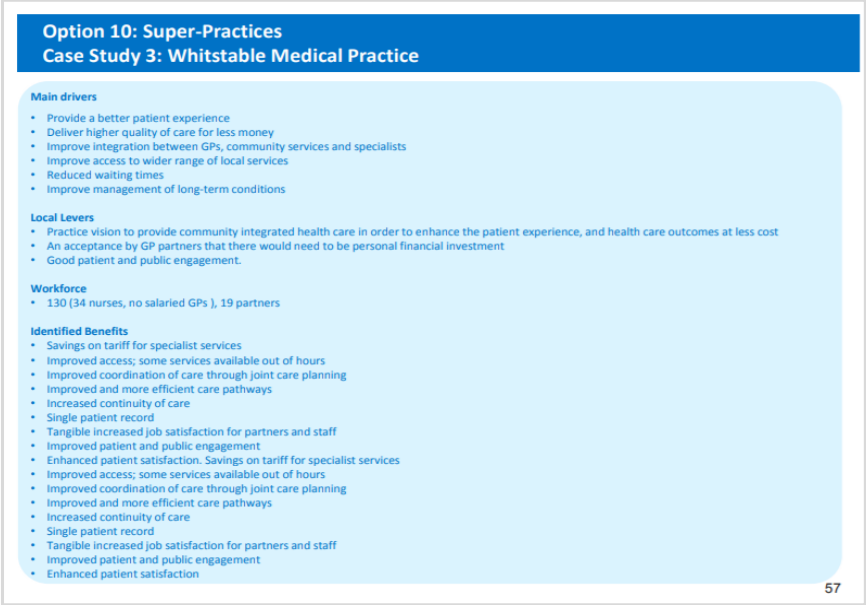
Source: Your care Our Priority website. Available at https://www.lciatestbed.org.uk/fylde-coast-vanguard

Appendix

Appendix

Accelerator Support Pack 1 Module 1: Understanding New Care Models and Workforce Implications

This support pack is designed to assist with the development of new care models.



Option 10: Super-Practices
Case Study 3: Whitstable Medical Practice

Main drivers
- Provide a better patient experience
- Deliver higher quality of care for less money
- Improve integration between GPs, community services and specialists
- Improve access to wider range of local services
- Reduced waiting times
- Improve management of long-term conditions

Local Levers
- Practice vision to provide community integrated health care in order to enhance the patient experience, and health care outcomes at less cost
- An acceptance by GP partners that there would need to be personal financial investment
- Good patient and public engagement.

Workforce
- 130 (34 nurses, no salaried GPs), 19 partners

Identified Benefits
- Savings on tariff for specialist services
- Improved access; some services available out of hours
- Improved coordination of care through joint care planning
- Improved and more efficient care pathways
- Increased continuity of care
- Single patient record
- Tangible increased job satisfaction for partners and staff
- Improved patient and public engagement
- Enhanced patient satisfaction. Savings on tariff for specialist services
- Improved access; some services available out of hours
- Improved coordination of care through joint care planning
- Improved and more efficient care pathways
- Increased continuity of care
- Single patient record
- Tangible increased job satisfaction for partners and staff
- Improved patient and public engagement
- Enhanced patient satisfaction

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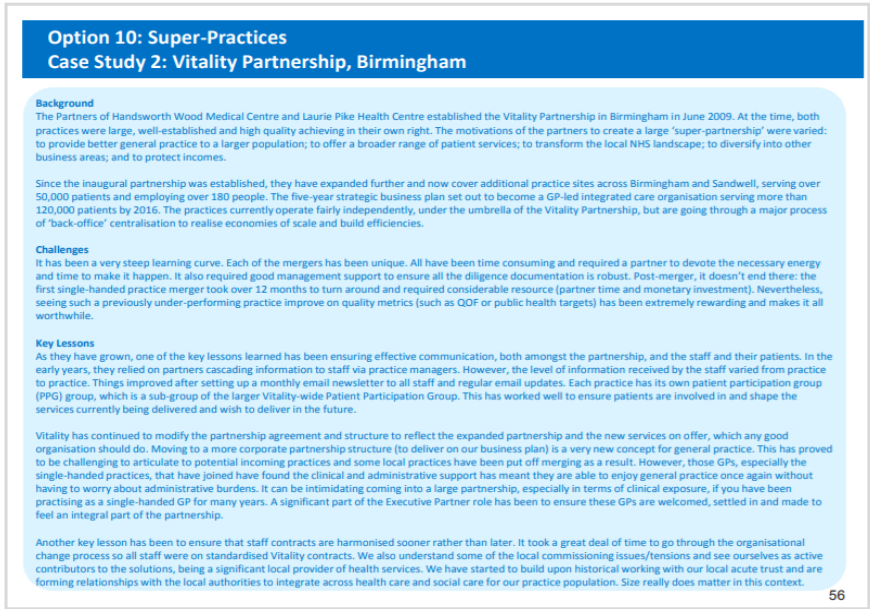

Option 10: Super-Practices
Case Study 2: Vitality Partnership, Birmingham

Background
The Partners of Handsworth Wood Medical Centre and Laurie Pike Health Centre established the Vitality Partnership in Birmingham in June 2009. At the time, both practices were large, well-established and high quality achieving in their own right. The motivations of the partners to create a large 'super-partnership' were varied: to provide better general practice to a larger population; to offer a broader range of patient services; to transform the local NHS landscape; to diversify into other business areas; and to protect incomes.

Since the inaugural partnership was established, they have expanded further and now cover additional practice sites across Birmingham and Sandwell, serving over 50,000 patients and employing over 180 people. The five-year strategic business plan set out to become a GP-led integrated care organisation serving more than 120,000 patients by 2016. The practices currently operate fairly independently, under the umbrella of the Vitality Partnership, but are going through a major process of 'back-office' centralisation to realise economies of scale and build efficiencies.

Challenges
It has been a very steep learning curve. Each of the mergers has been unique. All have been time consuming and required a partner to devote the necessary energy and time to make it happen. It also required good management support to ensure all the diligence documentation is robust. Post-merger, it doesn't end there: the first single-handed practice merger took over 12 months to turn around and required considerable resource (partner time and monetary investment). Nevertheless, seeing such a previously under-performing practice improve on quality metrics (such as QOF or public health targets) has been extremely rewarding and makes it all worthwhile.

Key Lessons
As they have grown, one of the key lessons learned has been ensuring effective communication, both amongst the partnership, and the staff and their patients. In the early years, they relied on partners cascading information to staff via practice managers. However, the level of information received by the staff varied from practice to practice. Things improved after setting up a monthly email newsletter to all staff and regular email updates. Each practice has its own patient participation group (PPG) group, which is a sub-group of the larger Vitality-wide Patient Participation Group. This has worked well to ensure patients are involved in and shape the services currently being delivered and wish to deliver in the future.

Vitality has continued to modify the partnership agreement and structure to reflect the expanded partnership and the new services on offer, which any good organisation should do. Moving to a more corporate partnership structure (to deliver on our business plan) is a very new concept for general practice. This has proved to be challenging to articulate to potential incoming practices and some local practices have been put off merging as a result. However, those GPs, especially the single-handed practices, that have joined have found the clinical and administrative support has meant they are able to enjoy general practice once again without having to worry about administrative burdens. It can be intimidating coming into a large partnership, especially in terms of clinical exposure, if you have been practising as a single-handed GP for many years. A significant part of the Executive Partner role has been to ensure these GPs are welcomed, settled in and made to feel an integral part of the partnership.

Another key lesson has been to ensure that staff contracts are harmonised sooner rather than later. It took a great deal of time to go through the organisational change process so all staff were on standardised Vitality contracts. We also understand some of the local commissioning issues/tensions and see ourselves as active contributors to the solutions, being a significant local provider of health services. We have started to build upon historical working with our local acute trust and are forming relationships with the local authorities to integrate across health care and social care for our practice population. Size really does matter in this context.

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Source: Health London Partnership website. Available at https://www.healthylondon.org/wp-content/uploads/2017/11/Case-studies-Understanding-new-care-models.pdf

Annex

Annex: Maturity Matrix Summary

Population based comprehensive care: This section focuses on how larger-scale general practice organisations provide care for their population. They are formed by multiple practices coming together to support care delivery at practice and network levels that reflects population needs, reduces inequalities and improves outcomes for local people.			
A I'm on my own	**B** I work with others	**C** We work as an informal team to understand local population needs	**D** We work as an integrated team to reuce inequalities and improve outcomes for our population
Systems and information: This section focuses on the importance of accurate, meaningful data and strong information systems as we move towards at scale collaboration in general practice.			
A I'm on an information island	**B** I've enabled limited sharing of data to enable access	**C** We share to put in place proactive care	**D** We use information transparently to help our PCN/LGPO plan services and improve quality
Quality improvement: This section focuses on the need for larger-scale general practice organisations to improve quality and services using shared expertise and data.			
A I look at quality issues when things go wrong	**B** I'm working with others to think about quality improvement	**C** We have a shared approach to QI, and collaborate to improve	**D** QI is a core principle of the learning system within our network
Organisational capability: This section focuses on how closer collaboration can help us build better organisations through economies of scale. This should result in greater financial and legal security, enhance system value, and create happier, more resilient teams.			
A I try to do everything alone	**B** I'm working with other to collate and simplify our work	**C** We collaborate, plan and share	**D** We act together in a formal and organised way
Workforce and wellbeing: This section focuses on how to build an organisational model that delivers effective patient care, enhances resilience, brings joy to the workplace and puts general practice at the heart of systems of integrated care.			
A I try to do everything alone	**B** I'm sharing with others to build consistency and resilience	**C** We work as an extended team with the right support	**D** We work as a team to enhance individual wellbeing, personal development, and organisational resilience
Effective governance: This section focuses on how important it is for larger-scale general practice organisations to govern themselves in the right way, to enhance the involvement of patients and other stakeholders, and to develop their leaders.			
A I value autonomy and I'm concerned about relinquishing control	**B** I understand the rationale and options for new structures	**C** We are putting structures around the emerging collaboration	**D** We are embedding effective and empowering structures for action
System partnership: This section focuses on how, by strengthening collaboration between practices and developing their capacity to lead, we can begin to take on significant leadership responsibility and have strong influence within new Integrated Care Systems.			
A I feel that something important is being lost	**B** I've identified others who want to protect and champion community-based care	**C** We are working collectively to strengthen the role and quality of general practice	**D** We are working across professional and organisational boundaries as a single system to create new models of care

Annex: 1 Population-Based Comprehensive Care

Domain	A	B	C	D
Key concepts	**I'm on my own**	**I work with others**	**We work as an informal team to understand local population needs**	**We work as an integrated team to reduce inequalities and improve outcomes for our population**
Practices in networks, covering 30-50,000 people	I have been working in the same practice for a number of years. I know the patients on my list and have an ongoing relationship with many of them, which they value, but is getting harder for me to maintain.	Our LGPO has helped arrange meetings with five-to-six other local practices. It's helpful to connect with others who are facing similar challenges. It feels like we can share the burden.	We are getting a bit more organised as a group; together our practices cover a population of 30-50,000 and collectively we feel more responsible for the health of patients within our local community.	We feel like a real team: practice, PCN and LGPO working together with other providers to improve health outcomes and reduce inequalities.
Collaborating to understand population needs	I see other GPs at CCG meetings and learning events. We talk about the difficulties we are all facing, but our current workload means we never arrange time to meet and think about how we might work on these issues together.	Working with other practices I can see that there are some common issues our patients and practice teams face. The LGPO is helping us to explore how else we can work with each other.	Because we have the LGPO we have been able to get extra help to look at health data. We can all see that there are significant opportunities to improve care for the population.	The LGPO gives us regular, useful information about how things are going, in terms of activity, outcomes and contracts. This allows us to demonstrate the impact of what we are doing together and identify opportunities for further improvement.
Collaborating to reduce variation in outcomes, and redesign clincial pathways	I know that other practices do things differently, but none of them seem to have a solution to the increased pressure we are all under. I don't have time to find out what they do, or how I compare. I just try to see as many patients as I can in a day.	Through the LGPO we are able to run a shared GP Access Hub, which improves patient access and takes pressure off the practice. This has taken some time to happen, but I am interested in what other opportunities there may be.	We are having really collaborative discussions about how to share staff to get new roles and services in place. It feels as though we are able to make a difference. This is invigorating: I remember why I came into general practice again.	Working this way means we are all meeting contracted requirements. With this additional income we are able to reinvest in developing new pathways of care. We are finally getting beyond physical health and addressing psychological and social needs effectively.

Annex: 2 Systems and information

Domain	A	B	C	D
Key concepts	**I'm on an information island**	**I've enabled limited sharing of data to enable access**	**We share to put in place proactive care**	**Using information transparently to help the PCN / LPGO plan services and improve quality**
Principle of data sharing established across the network	I am the data controller for the records of patients on my list. With everything else going on it is hard to stay up-to-date with IG rules. But I know that I have a responsibility to keep my patient's information safe, so I minimise the number of professionals who can access it.	I am working with other practices and the LGPO so that my patients' records are visible to a clinician when a patient visits the GP Access Hub.	As part of a PCN we are all clearer about the need to share information safely to support patient care whilst respecting patient confidentiality.	Our practice, PCN and LGPO are really embracing the power of data. We are able to use de-identifiable data to improve care quality, and make our practice systems more efficient. We know much more about when and why people use our services.
Moving towards common policy (and people) to enable data sharing	Any requests for data sharing comes to me. I'm not sure what others do, but I am mostly concerned about protecting patient confidentiality, and if in doubt it is safer to say no.	Working on this together has been made easier because we have asked the LGPO to employ a specific person to deal with data and IG issues. I and other practices have a common policy around data sharing.	We have started to think about the information we need to share to establish more proactive care, through the LGPO IG lead we are putting in place agreements with other local providers, such as the hospital.	Our common approach across the LGPO means patients receive a consistent message, this is less confusing and creates confidence. We also have better resources to engage with patients and involve them in decisions.
Collaborating to invest in common systems and hardware across the network	Our practice IT systems are frustrating. We are dependent on the CCG for any improvements. I know there is a lot of talk about digital technology but I don't really know where to start, and am concerned about the impact of more change on the practice given how pressured we are already.	The GP Access Hub has demonstrated that we can be more imaginitive when it comes to GPIT. With the CCG we are thinking about how to use funding more transformatively.	This means that we can now use our own systems to look at the hospital record and vice versa; and we have dashboards for patients with identifiable risk factors.	It is transformative. Patients really appreciate how we are using digital technology to integrate the unscheduled care system, and making booking and prescriptions easier. We are better able to direct patients to other local services giving us more time to care. They feel empowered by technology, and so do we.

Annex: 3 Quality improvement

Domain	A	B	C	D
Key concepts	**I look at quality issues when things go wrong**	**I'm working with others to think about quality improvement**	**We have a shared approach to QI, and collaborate to improve**	**QI is a core principle of the learning system within our network**
Moving towards a common understanding of QI and its application in general practice and primary care	I care about the quality of my clinical work, and what happens to my patients. I try to stay up to date, and I encourage others to do the same. But it is getting harder to find the time to think about quality together, as a practice.	The five-to-six practices in my area have been meeting regularly with the LPGO. We have some interesting dicussions about quality improvement. I think we all recognise it needs to be a part of how we work, not an occassional project.	With the LGPO, practices in the PCN have looked at examples from elsewhere and we have committed to putting in place a more systematic approach to quality review and improvement. We work together, look at our data openly, and try to learn and improve.	Across our PCN we are focused on improving clinical effectiveness, and we have a genuine culture of learning. We are sharing data to identify and work on the quality issues we think matter, and we are reducing variation in patient outcomes and spreading good practice.
Developing the clinical and managerial leadership to embed QI	There are a couple of us in the practice who have been on some training about quality improvement, and we have done a couple of audits in the practice, which resulted in some changes - but these were hard to sustain.	The LPGO has appointed a designated clinical lead for quality improvement, and they are encouraging us to nominate a lead in each practice to learn more about improvement processes and the tools we can use.	There is leadership throughout the PCN, and in each practice. We take personal responsibility for encouraging others and sharing learning. The emphasis on data, evidence, diagnosis, treatment and evaluation makes clinical and business sense.	Everyone involved feels like they put a lot in and get a lot out. It is professionally and personally rewarding, and as a result there is strengthening leadership and support for it at every level of the system.
Putting resources behind the ambition, to make the right thing the easy thing	It's difficult to keep the momentum going: care is safe and we don't have time to attend multiple courses and constantly review what we do. That is what the CCG is for - I am happy to participate when they put on CPD sessions, or when their quality and medicines optimisation teams visit the practice.	We are using some of the CCG GPFV funding to put proper resources into training. We are working with the CCG clinical leads and the medicine optimisation teams. There is actually a lot of resource for this in the CCG, and working together is feeling productive.	Working together, the CCG and LGPO have invested in additional clinical leadership time and technical facilitation. We now have additional help to create simple prompts, shared templates and dashboards - so that the right thing to do becomes the easy thing to do.	We are wasting less money on ineffective treatments, enabling us to invest in QI, and the LGPO has leveraged more support from staff within the CCG. Our common QI approach makes it easier to collaboarte with the hospital and community teams. It feels like we are creating a virtuous cycle of learning and improvement.

Annex: 4 Organisational capability

Domain	A	B	C	D
Key concepts	**I try to do everything alone**	**I'm working with other to collate and simplify our work**	**We collaborate, plan and share**	**We act together in a formal and organised way**
Developing corporate functions for business administation	I have run the practice with my partners for years, and I've learnt to juggle the management tasks for the practice with my clinical work. It takes a lot of my time but we have a manager who looks after most of the day to day running of the practice, and we pay for accountancy and legal advice when we need it.	The LGPO have talked to me and other practices about our corporate support. We have mapped out what we are all doing and how much we all pay. This work has been led by the practice managers coming together in a monthly Forum. I can see a number of areas where we could get a better deal by working together.	With support from the LGPO, practices have agreed to collaborate to buy corporate services that we all need and can share. We have agreed to proceed with one or two areas where this will save us money collectively, like designating a shared Data Protection Officer.	The LGPO is a vital part of how we now operate across our PCNs. As members of the LGPO we agreed to appoint an executive officer to manage a range of corporate functions on behalf of practices and our PNCs - meaning that the practice team have more time to focus on providing great care.
Developing corporate functions for clinical governance	The partners in the practice have instituted a process for looking at clinical governance issues, and for reviewing complaints. No-one is an expert, but like other small businesses these are skills we have had to take on.	The practices in my area have looked at how we each manage clinical governance and complaints. We have identified a few opportuntiies to simplfy things and join forces a bit more so we have a common approach.	The LGPO has helped the PCN to create standard processes to support consistent clinical governance across the practices and PCN partners. Leadership of the clinical governance is closely related to the leadership of QI and we have appointed a shared clinical lead for the PCN.	This has also freed up my time to get involved in leading other aspects of the practice and PCN, including QI, service redesign, and more innovative approaches to delivering care. I feel more confident that we all have robust clinical governance processes in place - including regular reviews of adverse incidents and complaints led by our clinical lead, as chair of our PCN's joint Care Quality Review Group. This contributes to the culture of improvement and learning we have developed.
Developing corporate capacity to engage with patients and the rest of the system	There is not a lot of time to engage with patients or other parts of the system. We have a small PPG which meets every 2-3 months, and we stay connected through the bulletins we receive from the CCG.	And we talked about the potential for PPGs to meet together periodically, so that our respective practices could engage with patients together about issues affecting the local community.	With the help of the CCG, we have begun to make much more use of PPGs across the PCN. Bringing the groups together helped us to discuss things that practices could address as a network.	Our new approach to engagement with patients has really transformed our services, we have found that patients have offered constructive challenge and great insights. Many are willing to put time and effort into making improvements in our practices and the PCN - resulting in a genuinely coproductive approach.

Annex: 5 Workforce and wellbeing

Domain	A	B	C	D
Key concepts	**I try to do everything alone**	**I'm sharing with others to build consistency and resilience**	**We work as an extended team with the right support**	**We work as a team to enhance individual wellbeing, personal development, and organisational resilience**
Developing an understanding of workforce needs and opportunities	I am keen to reduce my clinical commitment but we are struggling to recruit a GP. One of my partners has taken early retirement and another is approaching this - she also has an interest in dermatology and is a trainer so will leave big gap that will be hard to fill. Young GPs seem to want to limit their clinical work and have more flexible, portfolio careers - it is hard for us to offer this in the practice.	I have begun to meet with other local practices regularly and we discuss what gaps we have and what we could do about it. Working together we have agreed one or two areas to test, like helping each other with cross-cover if someone calls in sick. Working with our GP Access Hub we are thinking about creating some variation in clinical roles and greater flexibility to support recruitment and retention.	We are now thinking about workforce needs and opportunities across the PCN. This is easier to do because we can draw on specialist HR and workforce input from the LGPO. They are helping us to identify some priorities for action and working with HEE we have created a number of new roles for clinicians to give them a broader range of experience and leadership development.	Our LGPO provides expert support across our PCN. We have a shared vision of the workforce and culture we want and need, and we have agreed priorities and actions to recruit, develop and retain staff across the network. Staff in each PCN meet regularly and value and respect the expertise each person brings to the team.
Developing common policies and support for recruitment, training & development, & management	Like most practices we don't have access to regular HR support. Our terms and conditions of employment are consistent with those advised by the BMA. We used to all meet as a practice once a week to share learning and talk about complex patients, this was also a chance to talk to other teams such as the district nurses, health visitors and palliative care team, who we still meet occassionally but it is now harder to find a day and time we are all together.	The LGPO has helped us to compare our policies and approaches to HR. Working together we have identified areas where we could become more consistent, for example so that locum staff are able to access local training. We have set up a network to provide support for sessional GPs and help them get to know each other. The CCG is supporting regular meetings between practices and other community services where we talk about how to work together more effectively.	Practices in the PCN have agreed on a common set of HR policies and have standardised terms and conditions for clinical and administrative staff. The Practice Nurse Forum has expanded to include nursing staff from local care homes, and has helped us ensure that our pay and conditions are consistent with the rest of the NHS. This has already made a difference to recruitment and retention of practice nurses.	Our shared policies mean that everyone is treated equitably, and there is the right support for training and development. We have worked closely with the local training providers to ensure trainees gain experience in primary care, and we are using CEPN funding to commission innovative additional training for existing staff that better reflects the way we now work together.
Developing a broader scope of skills and ensuring people are working at the top of their competency	I know we could manage our workload better with a broader skill mix in the practice. Our practice nurse is able to see patients with minor illness which helps, but she cannot yet prescribe independently. Other practices have started employing clinical pharmacists and this could be a good addition to the team. But I am not sure how affordable this is for us.	By working together, with the LGPO and the CCG, we have been able to test a few opportunities to share some roles, for example a clinical pharmacist is employed to help several of the practices optimise medicines management and deliver some services to patients with chronic conditions. This has freed some of us to spend more time with our more complex patients.	Across the PCN we have started to put in place 'micro teams' providing shared expertise and continuity of care for our most complex patients. Working together across the PCN we are able to share a range of roles, including a specialist nurse, a clinical pharmacist, and a community worker. We are also able to better support volunteers who help us with a range of non-clinical tasks around the practice. Everyone has access to statutory training, including an online version. Staff across the PCN feel more supported and confident. They feel more connected to each other and thir patients - bringing joy back into what they do.	The scale of our LGPO means that we have recruited to a range of shared posts that deliver services within our PCN; and staff employed this way are happy at the variation and flexibility we can provide. We feel that we are all using our specific skills, doing what we do best, but with the chance to develop and take on new challenges too. By shairng tasks amongst the wider MDT we all have more time to learn, more time to care, and for those who want it, more time to work with other providers to lead the local system.

Annex: 6 Effective governance

Domain	A	B	C	D
Key concepts	**I value autonomy and I'm concerned about relinquishing control**	**I understand the rationale and options for new structures**	**We are putting structures around the emerging collaboration**	**We are embedding effective and empowering structures for action**
Developing the form and constitution of the organisation to enable good decision-making	I know that at-scale working is becoming more popular. My practice hasn't looked into it in much detail, and I'm not sure what our options are. My partners are concerned about loosing control over the way we work. I can see the benefits of working more closely with other local practices but don't really know them well enough to feel confident about commiting to sharing decisions about risk and resources together in the way we do as a practice.	We are members of the LGPO. The federated model has allowed us to deliver some services together but the commitment and contribution of different member practice varies. We are providing additional appointments together through the GP Access Hub run by the LGPO but to really make a difference we know we need to be more innovative about how we deliver core services and share staff.	Having explored in detail the different options to organise the PCNs, practices have worked with other providers to put in place formal structures that enable decisions to be made at practice-level, PCN-level and LGPO-level. These still feel fragile and the LGPO is working with system partners and the CCG to think about how to make these new organisations feel more 'real'. Specifically they have started to discuss how they could start to hold larger budgets and take collective responsibility for delivering care to the local population.	For practices, the LGPO is operating as our shared support: we are all part of one team working to improve primary care and to deliver more for our local population. There are robust systems and processes that support clinical and corporate risk management and decision-making through our board structures. Our board is diverse: drawn from member practices in each PCN, and it includes independent public and partner representation. Adhering to the Nolan principles, we operate openly and transparently in the interests of the population we serve.
Developing a unifying leadership and articulating a strategic vision	We have regular partnership meetings with the practice manager to review our financial situation, performance against targets like QOF, and any operational or workforce issues. Recently we have been talking more about the future but are stuggling to come up with a way forward that maintains our core values as GPs, and provides financial stability.	One of my partners is on the Board of the LGPO so I know what is happening, but ensuring all member practices feel involved is hard. As a group of practices we are spending some time together to describe our hopes and fears about the future. Having discussed our strengths, weaknesses, opportunities and threats, leaders at all levels are beginning to articulate a different ambition for working together. A key part of this is the development of PCNs with other providers in the local system. We don't all have time to contribute to this but practices are supportive of clinical leads who step forward to develop our LGPO on behalf of member practices.	A new organisational form has been incorporated at LGPO level and an Executive Board has been established, with clarity about the oversight responsibilities to manage clinical and corporate risks. The Board works with member practices to formalise a strategic vision for the LGPO and PCNs, and to agree specific priorities for joint working with other providers. The Board brings together clincial and managerial representation from member practices and PCNs, with an executive team appointed by practices, and is looking to recruit two new Non-Executive Directors to provide external expertise and guidance.	We operate with a unified and distributed leadership: everyone recognises that we each play an important role in creating a postive culture within the practice, PCN and LGPO. We have a shared vision and clear objectives, and we all take responsibility for articulating and delivering the strategy. We have created formal partnerships with other providers and together we are redesigning local pathways of care and improving quality and outcomes, whilst taking collective responsibility for the resource available for parts of the population locally.
Ensuring strong engagement with member practices and the local population	As an organisation, the practice listens to our patients and staff; we know patients appreciate the care we provide and we try to act on suggestions that are made through the PPG to improve the appoointment system and other parts of the service we offer. Staff morale is low; we all feel this but struggle to know how to fix it given the pressures we are under.	With practices agreeing to work more closely, LGPO leads are dedicating time to listen to practice teams and to communicate regularly with PPGs across the local area to ensure they are informed and involved in our plans, and supported to come together periodically to discuss developments.	Member practices are formal shareholders in the new organisation, and practice representatives are brought together regularly within members meetings. The PPGs are also supported to become more formally linked with a regular PPG network meeting established. They have elected two representatives as voting memebers of the LGPO Board.	Across the network, practice staff, PCN teams and PPGs are systematically involved in the work we do, with representation at every level of decision making.

Annex: 7 System partnership

Domain	A	B	C	D
Key concepts	**I feel that something important is being lost**	**I've identified others who want to protect and champion community-based care**	**We are working collectively to strengthen the role and quality of general practice**	**We are working across professional and organisational boundaries as a single system to create new models of care**
Protecting the culture of generalism and holistic care	I came into general practice because I think that there is something unique and important about the holistic care we provide as specialistst generalists - serving local communities and trusted by our patients. I can see the benefits of working more closely with other practices but I am worried that this sort of personalised care will be lost.	Through the CCG we are meeting with people from neighbouring pratices. It has been helpful to share experiences with clinicians who value general practice as I do. I'm encouraged that there are others like me and that we are in this together. We have started talking about ways we could work together as a PCN.	By joining forces across the PCN we have been able to identify a few projects that we can do together. It feels like we are going 'back to the future' - working with other pracitces and community providers to deliver more joined up care to those patients we have identified as most vulnerable in our community. This is what I came into general practice for. We are now trying to describe what general practice and primary care needs to look like for the 21st century, making the most of the range of health and care skills on offer.	The PCN feels like a real team, we are able to deliver the sort of personalised, holistic care that our patients want and is fulfilling to provide. We share information and have open lines of communication, and we are getting the support we need from our LGPO to work effectively together, and improve quality through continued learning and feedback. In the practice we have challenged ourselves to describe and deliver an enhanced model of specialist generalist care that will serve the needs of our community.
Developing the capacity and capability to lead the improvement of the local system	I want to be more active in protecting and promoting what general practice can offer to our patients and the rest of the health and care system, but I don't have time and find most of the meetings I attend just full of management jargon. It feels impossible to influence local plans - let alone get involved in leading change.	The CCG has supported a number of clinicians and practice managers to develop leadership skills. As part of this we have been able to set out some practical steps that will strengthen our collaboration. We have formed a LGPO and all the practices in the borough are members. We have an elected Board and additional project management support from the CCG. The Chair of the Board has started to meet regulalry with the leaders of other providers in the local health and care system.	A selection of clinicians have agreed to play a more visible leadership role in the LGPO. They are helping all of us to spot opportunities for joint working, and they are able to speak to the rest of the system on our behalf. By working with the CCG and local partners we are able to draw additional nursing and pharmacist support into each of the PCNs; and we are now recruiting for physiotherapists to join the teams. This is freeing up time for us to care for our most complex patients and to lead service change within PCNs.	Our LGPO has brought together and developed clinical and managerial leaders that we all trust. They are able to help us improve how we work and they act on our behalf to lead the development of the wider care system, working with other care providers and commisioners in the STP to improve the health and care outcomes for residents, as a truly Integrated Care System.
Establishing a credible and constructive leadership voice for general practice	I'm not sure who else is interested in the problems I and my practice face on a daily basis. Raising issues feels like shouting into the wind. The rest of the system seems focused exclusively towards hospitals. I used to be able to pick up the phone and speak to colleagues in hospital or community services, and I knew many of them by name. We worked closely together to support my most vulnerable patients. This feels like a thing of the past now.	Increasingly it is clear that we have common cause, not just in general practice but across the whole system. Everyone is frustrated by working in silos. Increasingly we are hearing that others out there recognise the importance of a joined up approach if we are to solve the problems the hospital are facing. There is a shared commitment to support general practice and community care and we have been able to access additional resourcing and investment from our CCG.	Because we are setting out a shared description of the future, and matching that with some practical improvements to pathways of care such as shared templates and referral criteria, we are building new and productive relationships with local partners. They have offered to support us with access to people, IT, buildings and management skills that we would struggle to secure on our own.	Local partners see the changes we are making in the community and recognise the importance of the LGPO's leadership voice in reshaping how the system works. They have changed the way they work to align around PCNs and are working as part of our PCNs within integrated care teams, and in partnership with our LGPO to invest in new pathways of care. I have a sense of optimism about the future and am confident that the values of general practice remain at the heart of our local health and care system.

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