10 high impact actions to release time for care
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1: ACTIVE SIGNPOSTING
2: NEW CONSULTATION TYPES
3: REDUCE DNAs
4: DEVELOP THE TEAM
5: PRODUCTIVE WORK FLOWS
6: PERSONAL PRODUCTIVITY
7: PARTNERSHIP WORKING
8: SOCIAL PRESCRIBING
9: SUPPORT SELF CARE
10: DEVELOP QI EXPERTISE

Innovations from around England that release time for GPs to do more of what only they can do.

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@robertvarnam GPforwardview
Innovations from practices throughout around England that release time and improve care.

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10 High Impact Actions to release time for care

1: ACTIVE SIGNPOSTING

- Online portal
- Reception navigation

Innovations from practices throughout around England that release time and improve care.

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1 Active signposting

The idea

- Receptionists’ job is to connect the patient with the most appropriate service (not just book everyone with a GP).
- Train receptionists to ascertain the patient’s need. Include red flags for medical emergencies.
- Develop a directory of services, inc services outside the practice, for patients to be directed to.

Implementation tips

- Explain to patients that the aim is not to deny them access but rather to improve it, as well as allowing GPs to focus on the things only they can do.
- Involve GPs themselves in giving information and explanation, eg through the practice newsletter and in the welcome message on the phone system. Practices report this being very effective.
- Encourage receptionists to ask lots of questions, practice asking about the patient’s need and make their own suggestions for improvement and the directory of services.
- Measure closely at first, to demonstrate impact and identify areas for improvement.
- Keep the directory of services updated.

Impact

- Reduced GP appointments – estimated at 1,046 per year for a 10,000 patient practice. (Eg in W Wakefield, active signposting is saving 2.7 hours of consulting time per GP per week.)
- Patient benefits - faster access to the right service (one step in the process removed).
- Patient satisfaction – W Wakefield: 97% of patients accept suggestion about most appropriate person to see.
- Staff satisfaction – receptionists feel they’re doing a better job for patients and making bigger contribution to the practice.

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The idea

- Patients are encouraged to make the practice website or a mobile phone app their first point of contact.
- This provides access to symptom checkers, links to local sources of advice and support in the community, details of community pharmacies and self help advice for minor ailments.
- This may sit alongside e-consultation functions and transactional services for repeat prescriptions and appointment booking.

Implementation tips

- Ensure marketing is clear and attractive, and that the online option is the easiest for patients.
- Involve all practice staff in signposting patients to the online service.
- Place often-used patient information resources there and encourage clinicians to direct patients there rather than giving printouts in consultations.
- Be clear that the aim is not to deny access but rather to improve it, through allowing GPs to focus on the things only they can do.
- Keep the directory of services up-to-date. Do this in partnership with the CCG, other practices, 111 and the council of voluntary sector organisations – create the directory once, for multiple organisations to use.

Impact

- Patients increase their knowledge about how to care for themselves and are connected with community based care and support options that improve wellbeing and independence.
- Reduced GP demand for appointments – findings from inner city practices (webgp.com):
  - 60% of users use the symptom checker and self help advice
  - 20% visit pharmacy

bit.ly/GPcapacitynet1
**Staff training fund**

- £45m over 5y, weighted capitation … average £0.80/pt
- **Allocation** via CCGs, for procurement by practice / federation / CCG
  - Sept 16, Apr 17, Apr 18, Apr 19, Apr 20
- Available for **every practice**
- To pay towards costs of training reception staff for **active signposting** and clerical staff for **document management**
  - eg training costs, backfill, auditing, etc

- **Profiling:** consider pooling fund across CCGs, phasing with spread plans from early adopters
- **Alignment:** consider how to use a Time for Care programme to support implementation +/- local spread
How do patients respond to receptionists playing a more active role?

• For many, it is already normal for receptionists to act as a full member of the practice team. It is already commonplace for receptionists to need to know the purpose of an appointment when it is for a smear, vaginal swabs or travel advice, and it is usual to have to give medical details to receptionists in A&E and other hospital settings. Similarly, patients in many practices already obtain test results from a member of the reception or clerical team.

• Where receptionists in a practice have traditionally had a more limited role, it will be important to explain to patients the reason why they are now engaging more actively. In particular, patients sometimes fear that this about finding ways to deny an appointment. Practices can be confident to explain they are using active signposting for precisely the opposite reason - to make it easier for people who need a GP to get an appointment, while shortening the time it takes to connect patients with the most appropriate person.

• Concerns are sometimes raised regarding the ability of receptionists to maintain confidentiality or to protect patient safety. Practices who are using active signposting make two points here:
  • receptionists should be trained to protect confidentiality and play their part in maintaining a safe service
  • a systematic approach to using active signposting will involve additional training in speaking with patients and making safe and effective decisions. In even the best practices, this is likely to actually improve patient safety.

• Active signposting is not a clinical consultation. The purpose is to connect the patient with the most appropriate person. It is not to make a diagnosis or plan treatment. Often, there will be more than one option - the patient has the final choice.
Questions for getting started…

What are the most common enquiries / problems you need to target for signposting? How much benefit are you expecting?
- Consider running a rapid audit of potentially avoidable GP consultations (bit.ly/time4caretool1) or of enquiries at reception. This will identify priority areas to address.

Where will you source information for a directory of services? How can you avoid duplicating effort?
- You could use the directory of services held by the local 111 provider as a starting point, or contact the council of voluntary sector organisations.
- Additionally, ask clinicians to log the most common patient information they give out in consultations, and put that on the portal.

How will you arrange training for receptionists? Do you have preferences about the training being entirely face-to-face or including e-learning as well? Which other practices could you partner with to undertake the training and follow-up?

How will you engage the Patient Participation Group to help with marketing and to give honest feedback on ways to improve the portal and how staff encourage patients to use it?

How will you measure the impact of the change?
Innovations from practices throughout around England that release time and improve care.

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2 New Consultation types

The idea

• The phone is used to consult (not just triage).
• Patients can be offered an appointment with their usual GP or with any available GP.
• Many follow-ups can be done on the phone as well as new problems.

Impact

• 60-70% of consultations can be handled entirely on the phone, in an average of 4-6 minutes. This improves productivity for GPs (on average, workload that once took 3 hours can be handled in 2 hours – a 50% improvement)
• Where face-to-face consultation required, GP usually decides in first 2 minutes. Some face-to-face consultations are then much shorter (e.g., examine rash).
• Access improves, especially for carers & people in work.
• DNAs fall up to 80%.
• Interpreters usually don’t need to be prebooked for telephone consultations.

Implementation tips

• Measure actual demand and adjust supply of appointments as it varies during week (Monday often 40-60% busier) and year.
• Provide training in clinical skills to ensure safety and productiveness of phone consultations.
• When moving to a ‘demand led’ rather than ‘supply led’ approach, plan how to account for current unmet need.
• Use alongside ‘active signposting’ to reduce demand.

bit.ly/GPcapacitynet2

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Online consultation systems

- Better service for patients
- Connects to the most appropriate help
- Gives patients more control

#GPforwardview
Online consultation systems

- Information about symptoms and treatments
- Find local services
- Ask a query, send a clinical consultation

#GPforwardview
Online consultation systems

- £45 million over three years
- Available for every practice
- Part of wider digital transformation

#GPforwardview
Online consultation systems

→ Support for planning and procurement

→ Advice for practices to maximise benefits

→ Materials and support to engage patients

#GPforwardview
Online consultation systems

bit.ly/gpfvonlineconsultations

#GPforwardview
FAQs

• Do patients use online consultation systems?
  • There is evidence that some practices achieve only very low use by patients. However, many others have seen around 40% of patient contacts move online.
  • For some patients, phone and online consultations are immediately welcomed and they will need no further explanation or encouragement to use them as first line in future. The experience of early adopters is that there are a number of ways to improve use.
    • Make the online consultation option very easy to find on the practice website.
    • Inform patients about the new way to contact the practice – eg through the practice newsletter, using target mailshots, in the new patient pack
    • Signpost patients to the online service in the welcome message on the phone system. This is most effective if a well-known GP records the message.
    • Ensure patients receive a good service when using the system, with a timely and appropriate response.
    • Support the whole practice team to take every opportunity to encourage patients to use the system
  • Some patients may never particularly like remote consultations, even for the most simple or transactional queries. No solution works in every situation, and staff should be prepared for this.

• What about patients who do not speak or read English very well?
  • In the case of the phone, consultations are improved because it is possible to use an interpreting service without having to book ahead. This should allow 100% of consultations that require a professional interpreter to have one, improving patient safety, increasing the value of the consultation and reducing wasted appointments.
  • Encouraging more people to use the practice’s website will allow more patients to access online information leaflets and videos in their own language. However, it is unlikely they will use online consultations.
Questions for getting started…

- How much benefit could you get from using different consultation types?
  - What proportion of consultations is for a short physical examination?
  - How many consultations are for a largely clerical issue – eg checking on progress of a referral or investigation? How many are for brief clinical queries – eg should the treatment be continued given there are no side effects?
  - For conditions like diabetes and COPD, how much time is spent per patient each year repeating information or answering questions about the condition and correct management? (information could be given in a group consultation)
  - How many patients would you like to have a longer appointment, if only there was time?

- Do you want to have all your clinicians starting this at the same time, or could you pilot it first – iron out any issues before roll out?

- For what situations could you create standard patient information, for faster responses and better patient recall?

- How will you arrange training for clinicians? Are there already some who are experienced in the new way of working, who could support others?

- How will you measure the impact of the change? How will you engage the Patient Participation Group to help with evaluation and improvement?
Innovations from practices throughout around England that release time and improve care.

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3 Reduce DNAs

The ideas

• Make it easy for patients to cancel.
• Send appointment reminders (text/email) → 10% reduction.
• Patients write their own booking → 18% reduction.
• Patients read-back appointment details → 4% reduction.
• Report how many appointments were kept last month rather than DNAs → 14% reduction.
• Reduce 'just in case' booking by improving same day access → up to 70% reduction.

Implementation tips

• These are additive - implement several of them for best effect.
• Measure DNAs periodically to identify any needs for additional solutions.
FAQs ...

• Don’t clinicians benefit from the occasional DNA, to catch up during a clinic?
  • Practices sometimes note that, for busy clinicians, a DNA may provide a welcome opportunity to catch up, write notes or take a quick comfort break. That is often true - however, increasingly, practices are recognising that, if it’s important for clinicians to have time for those things during a clinic, they should be included in a planned way, rather than leaving it up to chance.

• Aren’t practices already doing everything they can do reduce DNAs?
  • Almost every practice has done at least something to try to reduce DNAs. However, the evidence shows that it’s usually necessary to do several things, and that some of the common approaches need adjusting in order to be successful.
  • By far the most effective means of reducing DNAs appear to be rearranging the appointments system to reduce 'just in case' booking ahead by patients - the DNA rate for these can be as high as 25%. If patients have confidence that, when they need help, they can call on the day, DNAs almost disappear.
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4 Develop the team

Clinical pharmacist in practice

The idea

• A pharmacist (usually with community experience) works as a full member of the practice clinical team.
• They undertake consultations for new and ongoing issues as well as taking a lead on administration of repeat prescribing and improvement in quality and safety of prescribing.
• Pharmacists are highly trained clinicians, able to provide a wide range of care. Evidence suggests they manage repeat prescribing more safely than GPs.

Impact

• Typically, GP workload is reduced, prescribing performance improves, errors are reduced and fewer patients with asthma and COPD experience exacerbations.
• One major area where the pharmacist reduces workload for GPs is clinical administration relating to prescribing:
  • repeat prescription queries
  • discharge medication reviews
  • audit, improvement and training
• They also have their own consultations with patients:
  • minor ailments service medication use reviews and patient education (eg inhalers, injectables, longterm repeat items, self-adjustment)
  • home visits and care home rounds

Implementation tips

• Provide support, if required, for a new pharmacist to obtain the independent prescriber qualification for them to add the most value for patients and the team.
• Ensure the receptionists are confident about the range of issues which the pharmacist can deal with.
• Allocate a senior GP as a supervisor and mentor, to help a new pharmacist in the practice adjust to a different team culture and ways of working.

bit.ly/GPcapacitynet4
The idea

- Approx 20% of GP appointments are for musculoskeletal complaints
- Patients presenting with a new musculoskeletal problem from a predetermined list are offered an appointment with the physio rather than a GP.
- Physio has 15 minute appointments with patients. Full access to GP record.
- Assessment of the problem and advice on exercises and self management. If required, onward referral for longer therapy / prescription request / refer to GP

Impact

Example from West Wakefield practices:

- 70% of presentations fully dealt with in a single 15 minute appointment.
- Waiting time for physio reduced by at least 4 weeks.
- Reduced pressure on GP appointments (at least 5%)
- Patient satisfaction very high (100% 'good' / 'very good')

Implementation tips

- Ensure the service is provided by appropriately experienced physiotherapists, confident in making rapid assessments of musculoskeletal problems in primary care. This usually also means using senior staff.
- Training for receptionists helps them to make appropriate judgements about signposting patients to a service like this. In West Wakefield, training increased use of the physiotherapy service by 40%.
FAQs

• Will patients want to see someone other than a GP?
  • Practices are sometimes concerned that patients will not adjust to new roles and will only want to speak to a GP. Those who have introduced new roles recently make two observations:
    • As when practices started employing nurses in the 1970s, or adding advanced nurse practitioners or healthcare assistants more recently, the majority of patients very quickly get used to having more options when they contact the practice. For many, it becomes normal to see someone else in the team after the first or second consultation with them.
    • As with other changes, it is important to ensure that receptionists and other clinicians are confident in signposting patients to the most appropriate person and in answering common questions about new staff.
    • Recommendation from a GP is reported as very influential for patients who are initially reluctant to consult a new member of the team.

• Is clinical indemnity cover available for new roles?
  • Indemnity providers are working to understand the new roles that practices are introducing, and updating their products to ensure they meet the needs of changing teams. When contacting their provider, the practice will need to be clear about the clinical governance system in place and any arrangements for clinical supervision of new staff. Practices in the GP Access Fund found it helpful to shop around if they did not believe new premiums to be competitive.
  • NHS England and the Department of Health are actively engaged at a very senior level with indemnity providers and the insurance market to accelerate the development of indemnity products which fully meet the needs of primary care teams working in innovative ways.
Questions for getting started…

- What do you want to achieve? What are the priority areas of work in the practice you wish to address?

- How could you benefit from collaborating with other practices in the process of training staff and implementing new roles?

- Are there other workforce developments in the area which you could join with?

- What other support would you want, for example from Health Education England or other workforce redesign experts?

- How can you involve the Patient Participation Group in explaining the change to patients and helping them get the best from it?

- What information, training or support will receptionists need to be able to explain the new system confidently to patients and answer common questions?

- How will other clinicians and staff be informed and supported so that new staff are incorporated safely and effectively into the team, and made best use of.

- Which GP will lead on supervising staff and auditing the new system?

- How will you measure the impact of the change?
10 High Impact Actions to release time for care

5: PRODUCTIVE WORK FLOWS

- Matching capacity and demand
- Efficient processes
- Productive environment

Innovations from practices throughout around England that release time and improve care.

bit.ly/gpcapacityforum
5 Productive work flows

The idea
• Identify common tasks / processes and measure them to find priorities for improvement.
• Use tools and techniques from Improvement science to design and implement improvements (eg 5S, Lean).

Implementation tips
• Don't overlook the impact that relatively small improvements to frequent tasks can make.
• Use team techniques that examine everyday processes from a different perspective - you'll often find completely new improvements you could make.

Impact
• The impact of improving workflows and physical layout depends on the specific changes made. Typical benefits include:
  • reduction in staff time spent on a task
  • reduction in errors
  • reduced frustration for staff
  • improved care for patients
  • a more positive culture in the team

Examples
• A Cheshire practice spent a couple of half days with a Productive General Practice facilitator, focusing on the repeat prescribing process. They freed an estimated 556 hours per year.
• A Yorkshire practice reduced time spent hunting for prescriptions by 82%, saving 12.5 hour per week.

Efficient processes

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The idea
- Redesign the appointment system to be more flexible in meeting patient demand as it presents.
- For most practices, this includes:
  - varying the supply of appointments to meet varying demand during the day, the week and the year
  - more flexibility in the type of appointments available (e.g., more access to nurse appointment and a variety of GP appointment lengths)
  - having first contact for patients with a GP on the phone, allowing about 70% of issues to be resolved in a shorter appointment on the same day the patient contacts the practice

Implementation tips
- Don't overlook the impact that relatively small improvements to frequent tasks can make.
- Use team techniques that examine everyday processes from a different perspective - you'll often find completely new improvements you could make.

Impact
- Matching supply with patterns of demand avoids queues building up of patients who wait several days for their appointment. The impact is:
  - improved patient safety (fewer people wait for a clinical opinion)
  - improved clinical effectiveness (more people start treatment early)
  - reduced frustration for patients and staff
  - reduced DNAs (DNAs generally less than 5% for same day working)

Examples
- A Cheshire practice spent a couple of half days with a Productive General Practice facilitator, focusing on the repeat prescribing process. They freed an estimated 556 hours per year.
- A Yorkshire practice reduced time spent hunting for prescriptions by 82%, saving 12.5 hour per week.

bit.ly/GPcapacitynet5
5 Productive work flows

The idea

• Clerical staff code incoming clinical correspondence. Following training, they refer to agreed protocols to decide what action to take with each letter. Duplicates and letters with incomplete information are handled by the clerical staff without going to the GP.
• The majority of data entry and coding about the letter will be undertaken by the clerical staff. Some letters will be forwarded to another member of the team for action.
• A minority of letters is sent to the GP.

Impact

• Typical reduction of 60-80% in the number of letters sent to GPs.
• Time is freed for GPs to spend doing what only they can do.
• GPs are less likely to rush letter processing, reducing stress and the potential for error.
• Clerical staff typically report a significant boost to their job satisfaction

Implementation tips

• Partner with other practices in working up your own protocols, to reduce the time it takes.
• Appoint a GP to support the clerical staff in the early stages, and introduce a system of regular audits thereafter, to detect any areas for improvement.
• Seek training that includes support to develop your own systems including protocols, a system of supervision and regular audits. Ideally it you should also have the opportunity to learn from other practices’ examples.

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Questions for getting started...

- How much time do your GPs spend currently processing incoming clinical documents?

- Consider auditing current documents. What proportion of documents:
  - is a duplicate? (should never go to a clinician)
  - is incomplete? (should never go to a clinician)
  - is an update about a longterm condition (probably requires coding only)
  - requires a change to repeat medication? (best to go to a pharmacist)
  - requires a clinical decision about management? (likely to need GP review)

- Who in the staff would you train?

- How will you arrange training for clerical staff? Do you have preferences about the training being entirely face-to-face or including e-learning as well? Which other practices could you partner with to undertake the training and follow-up?

- Which GP will lead on supervising staff and auditing the new system?

- How will you measure the impact of the change?
Innovations from practices throughout around England that release time and improve care.

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6 Personal productivity

The idea

• The computer is used in 100% of GP consultations, the stethoscope in approx 5-15%.
• ‘Hunt and peck’ typing is slower than touch-typing, with more need to look away from the patient.
• Typical readers read 1/3 as fast as proficient speed readers.

Impact

• In a typical GP day, a proficient touch typist (65 wpm) saves an average of 10 minutes, with a fast typist (95 wpm) saving 17 minutes.
• Touch typists do not have to look down at the keyboard, creating fewer interruptions to patient communication.
• Speed reading techniques estimated to double reading speed for clinical documents (faster for others).

Implementation tips

• Train yourselves in touch typing and speed reading.
• Have a team focus with input from secretaries.
• There are many free & paid apps, books and courses available.
Australian Medical Association 8 tips to build your personal resilience:

1. Make home a sanctuary
2. Value strong relationships
3. Have an annual preventive health assessment
4. Control stress not people
5. Recognise conflict (and distress / upset) as an opportunity
6. Manage bullying and violence assertively
7. Get our medical organisations to work for us
8. Create a legacy

Tools & guides
- www.stepsforward.org/modules/improving-physician-resilience
- ‘How Resilient Are You?’ resiliencyquiz.com
- ‘Test Your RQ’ www.testyourrq.com

bit.ly/GPcapacitynet6
Questions for getting started:

- How easy is it for people to raise questions of personal productivity and resilience in your team? Are there regular opportunities to talk together about how work is going?
- Who in your team seems to get things done quickest? (If in doubt, ask the practice manager and the clerical team – they usually know how clinicians manage their work.) Could they share some of their learning with others about how?
- How many of your clinicians can touch type and speed read?
- Could you use MDTs as an opportunity for colleagues to see each other using the computer system and learn from each other’s shortcuts?
- Do you review how individuals are managing with their workload as part of personal reviews/appraisals?
- How often do you staff have the opportunity to refresh their knowledge of the most efficient ways to use the clinical system?
Innovations from practices throughout around England that release time and improve care.

bit.ly/gpcapacityforum
The idea

• Community pharmacies are conveniently located and often open longer than other primary care providers.
• They can provide additional services such as minor ailments, emergency repeat medication supply and medicines management input.
• All of these are enhanced by giving access to the full GP record (with the patient’s consent).

Implementation tips

• Engagement of all professionals early on is essential. Ideally pharmacists and project managers need to meet with practices in person.
• If securing pharmacy commitment is slow, consider launching in phases.

Impact

• Demand for GP appointments is reduced. (eg Devon GP Access Fund, working with 134 pharmacies, saved estimated 7,000 GP appointments + 2,600 OOH consultations + 360 A&E attendances).
• Better collaborative relationships with local pharmacies improves other aspects of medicines management for practices and patients.

bit.ly/GPcapacitynet7

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The idea

- The majority of practices are now in a collaborative arrangement with others. These collaborations take a variety of forms and legal underpinnings, ranging from loose networks to tightly integrated federations. A growing number of practices are also merging to form much larger practices or ‘superpartnerships’. These vary in the extent to which the identity of individual practices or sites is maintained.

- In addition to creating new possibilities for service development, working at scale offers benefits for practices through sharing resources and releasing capacity. Increasingly, collaboration and mergers are being used to achieve efficiencies in purchasing, development of policies, administration, staff pooling, human resources and continuous professional development.

- With commissioners increasingly looking to procure innovative at-scale primary care, many GP federations are rethinking their purpose, and developing more comprehensive approaches to their functions, processes and capabilities.

- The General Practice Forward View includes support for the continued development of at-scale working, aiming both to sustain and transform services in primary care. Additionally, from April 2017, practices will have the option to join a Multispecialty Community Provider (MCP), collaborating with others such as the local community trust, mental health provider and social care to provide a more joined-up service to the registered list of patients. In many cases, it is expected that an MCP will be composed of several smaller ‘hubs’ built around a population of about 50,000.
## The benefits

- Working at scale makes it easier to provide a comprehensive range of services in the community, and also offers benefits for practices and staff, including the potential to release pressure on GPs.

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<thead>
<tr>
<th>Resilience</th>
<th>Skillmix</th>
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<tbody>
<tr>
<td>Services can be more resilient to fluctuations in demand or unexpected changes in staffing. This can be realised through pooling of staff and arranging overflow support.</td>
<td>It is easier to broaden skillmix when working at scale. It is usually easier to employ new staff across several practices than to have part-time roles in each practice. For the staff themselves, working for a larger employer will often be more attractive.</td>
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<tr>
<th>Economies of scale</th>
<th>Innovation and improvement</th>
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<tbody>
<tr>
<td>Economies of scale can be realised in areas such as purchasing supplies and services, shared functions, and more efficient approaches to specialist functions such as HR, finance, clinical governance, IM&amp;T and business intelligence.</td>
<td>Working at scale makes it easier to build expertise and systems for service redesign, patient engagement, analytics and project management. This supports faster and more sustainable improvement, allowing staff to improve through working smarter not harder.</td>
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<tr>
<th>System partnerships</th>
<th>Staff development</th>
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<tbody>
<tr>
<td>Operating at scale makes it easier to form effective partnerships with other organisations in the health and care system such as acute and community trusts and the voluntary sector, and allow primary care providers to have a significant input into strategic planning.</td>
<td>It is easier for larger organisations and networks to provide an enhanced employment experience for staff. Expert HR staff and shared resources enable a strong focus on professional development and create opportunities for a more diverse career.</td>
</tr>
</tbody>
</table>

Most of these benefits are not automatic – leaders need to take action to realise them.
Doing the right thing at the right scale

Sustainability and Transformation Partnership: 0.5-3m
System partnerships for large scale change
Workforce & infrastructure planning
Major partnerships & shifts in priority

Area network: 100-900k
- Strategic partnerships
- Organisational development infrastructure
- Corporate support
- Career development
- Population wellbeing

Local network: 30-60k
- Acute care
- Shared MDT
- Population management
- Business functions

Team: 4-30k
- Place of belonging

Microteam: 2-500
- Personal continuity of care
Questions for reviewing your external partnerships:

- What existing at-scale arrangements are you currently a part of? Is their purpose clear? Is it one you are proud of?

- What other organisations provide services to your patients? Where are the current overlaps or gaps in service? How could quality, safety or productivity be improved by collaborating more closely?

- Who could you share CPD with?

- What would be the best scale at which to:
  - provide personalised multidisciplinary care for complex patients
  - improve access when continuity is less important than waiting time
  - increase resilience through pooling or sharing of staff or services
  - work in partnership with local NHS trusts, the local authority and voluntary sector
  - employ new staff such as specialist nurses, pharmacists, physiotherapists and paramedics
  - create more diverse and flexible careers for clinicians
  - enable staff to feel they belong and have a contribution to make to the team

- What individual or team capabilities would you need to build in order for your practices to create and run innovative new services in the community?
Innovations from practices throughout around England that release time and improve care.

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8 Social prescribing

The idea

- Signpost patients to care and support services which increase wellbeing and independence.
- Examples include leisure and social community activities, befriending, carer respite, dementia support, housing, debt management and benefits advice, one to one specialist advocacy and support, employment support and sensory impairment services.
- The service may be external to the practice, taking referrals, or there may be closer integration within the practice team, for example through team meetings or locating peer coaches or service navigators within the team.

Impact

- Reduced demand for GP & other appointments (eg Shropshire, 48% reduction in GP consultations, 33% reduction in A&E attendances and 58% reduction in unscheduled hospital admissions).
- Improved quality of life for patients and carers.
- Satisfaction and empowerment for volunteers (many of them former high users of GP practice).

Implementation tips

- Start by building a close working relationship with local voluntary sector groups, and involve them in shaping the work. and involve them in shaping the work.
- Maintain ongoing close relationships, for staff and volunteers to identify gaps and duplication in services, as there is usually room for improvement in collaboration in many directions.
- Aim to include plans for using savings (eg from reduced unscheduled care and admissions) to sustain the scheme.

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8 Social prescribing

The project
• Practices refer patients consulting frequently with a large component of complex social needs.
• Navigator coaches patient through agreeing support package addressing the chief risks to their wellbeing and independence. Package of direct support delivered by the Navigator or health trainer.
• 78% under 65y. Issues include domestic violence, housing and welfare problems, poverty, loneliness, caring challenges, substance misuse, limited capacity to manage a longterm condition, mental health problems and frailty.

Impact
• 48% accept referral.
  • 6% unsuitable
  • 15% referred to health trainer
  • 26% complete partial package of support
  • 53% complete full package
• Significant / partial reduction in risks for 71% of patients
• 25% reduction in GP consultation rate
• GPs are very happy with service, believing it to be a more appropriate means of meeting non-medical demand presenting to the practice.
• Patients report increased self-resilience and awareness of appropriate help-seeking.
• 1/3 cheaper than GP care (paid staff used because of unexpectedly complex nature of the needs referred)

Implementation tips
• start with a clear definition of what the service is aiming to achieve
• ensure navigators have a detailed knowledge of local services from the health, social care and voluntary sector
• take care to build close collaborative relationships between practices and the social prescribing team
• match staff training and support to the complexity of patients' needs being referred – or rethink the target group

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Social prescribing models vary in the following key areas:

- **Population segment** - who is the service aimed at / it open to?
  - specified demographics / specified health needs or social situation / no formal criteria
- **Location** – where does the link worker work? Are they employed? By whom?
  - volunteer based in practice / employed by practice / based elsewhere but attached to practice / based elsewhere and 'referred to' by practice
- **Route of entry** – how do patients get into the service?
  - self-referral / referral by GP / referral by any clinician / any staff
- **Identification of patients** – how are eligible patients identified for referral?
  - ad hoc (eg during consultation) / proactive case-finding
- **Pre-consultation work** – does the worker obtain any additional information about the person?
- **Input from navigator** – what does the worker do for the patient?
  - information-giving (signposting +/- coached needs assessment process) / direct support (care coordination, health coaching, befriending, mentoring, advocacy)
- **Longevity of contact** – how long is contact maintained with the link worker?
- **Person specification** – what are the personal requirements for link workers?
- **Links with community groups** – how proactively do workers connect with providers?
- **Recruitment and training** – how are link workers recruited and trained?
  - led by practice / CCG / NHS Trust / voluntary sector
- **Funding for service** – how is the service funded?
  - resourced by voluntary sector / employed by practice or CCG +/- expenses / fee-for-service paid by practice or CCG / outcomes-based contract with practice or CCG NHS +/- non-NHS funding (eg social impact bond)

It is worth discussing all of these when designing your own service.
Questions for getting started:

- What links do you already have with local care and support services?
- What proportion of patients could benefit from additional non-medical care and support in the community?
- Is there already a local care navigation or signposting service to help connect patients with care and support?
- How could you ensure there is sufficient capacity to signpost and support additional service users?
- What sort of a service would be most beneficial? In particular, where do you want it to be on the spectrum from “someone based within the practice” to “external service to refer to”?
- Who could you connect with to learn more?
- How would a new or expanded service be sustained?
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Innovations from practices throughout around England that release time and improve care.

1. Active Signposting
2. New Consultation Types
3. Reduce DNAs
4. Develop Community
5. Reduce Reattendance
6. Increase Utilisation
7. Participate
8. Maintain
9. Support Self Care
10. Develop QI Expertise

- Prevention
- Long term conditions
- Acute episodes

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9 Support self care

The idea

• The GP contract requires practices to provide access to coded information in records.
• It is also possible to give full access.

Impact

• If 30% of patients accessed their full record online twice a year, a 10,000 patient practice would save 4,747 appointments and 8,020 telephone calls per year.
• This takes account of additional time spent giving explanations to a minority of patients.
• 76% of patients feel more involved in their care, 62% have improved understanding of consultations, 77% understood & managed their condition better.
• Medication compliance increases 42%, 64% are more likely to follow lifestyle advice better.

Implementation tips

• Play some case study videos in a team meeting: www.england.nhs.uk/ourwork/pe/patient-online/
• Give staff opportunities to raise questions & concerns early on. Compare with experience of practices already offering full access.
9 Support self care

FAQs...

• Is supported self care acceptable to patients?
  • A common concern from practices is that patients will welcome efforts at supporting self care. A 2016 survey of over 5,000 people for Self Care Week found:
    • if they understood their own NHS ‘footprint’, 80% would be more likely to seek advice from pharmacists and use over-the-counter remedies for coughs, colds and other self-treatable conditions.
    • 92% acknowledge the importance of taking responsibility for their own health in order to ease the financial burden on the NHS.
    • when made aware of the cost of self treatable conditions to the NHS, nearly one third of those who qualify for free prescriptions (29%) said they would be willing to purchase an OTC medicine for a self-treatable condition. Considering the NHS still spent more than £83 million on prescribing 22.6 million packs of paracetamol in 2014, behaviour shifts like this could have a significant impact on the future sustainability of our healthcare system.
    • There are common misconceptions worth addressing. For example, 18% believed pharmacists to be less well qualified to advise on managing minor conditions, and 23% felt entitled to visit the GP simply to obtain a free prescription.
  • Practices who have introduced a more deliberate focus on self care report that it WORKS… WITH CARE and explaining this is intended to empower people to stay well and look after themselves better, not to deny them care from the practice. Reminding patients that the practice is still there for them when they need it is important.

• Does it work
Questions for getting started…

- How much benefit could you get from this? What proportion of consultations is for:
  - illnesses that could be prevented by changes in lifestyle
  - self-limiting acute illness
  - exacerbations of a longterm condition amenable to adjustment of therapy (e.g., asthma, COPD, heart failure, ischaemic heart disease)
  - giving or reinforcing standard advice about lifestyle or disease management

- What existing resources do you use for promoting prevention, self care and self management? How much are they used by clinicians and patients?

- What other resources exist already? Consider discussing this with the local council of voluntary sector organisations and other providers such as diabetes specialist nursing team, health visitors and community COPD team. Consider discussing possibilities with local community pharmacies as well.

- Which is the first priority area to address? Could you plan a small pilot initially, with support from local experts?

- How could you collaborate on this with other practices, to reduce the workload and increase the impact?
Innovations from practices throughout around England that release time and improve care.

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10 QI expertise

The idea

• Identify common tasks / processes and measure them to find priorities for improvement.
• Use tools and techniques from Improvement science to design and implement improvements (eg 5S, Lean).

Impact

• A Cheshire practice recently spent a couple of half days with a Productive General Practice facilitator, focusing on the repeat prescribing process. They freed an estimated 556 hours per year.
• A Yorkshire practice reduced time spent hunting for prescriptions by 82%, saving 12.5 hour per week.

Implementation tips

• Don't overlook the impact that relatively small improvements to frequent tasks can make.
• Use team techniques that examine everyday processes from a different perspective - you'll often find completely new improvements you could make.

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10 Build QI Skills

What capabilities?
Questions for getting started…

- Do you already have people who lead change? How could they be supported to have a bigger impact?
- What do you see as the main differences between working smarter and working harder?
- QI is often described as tools to help us work smarter, not harder. What would be the benefits and challenges of doing that in your practice?
- Have you ever tried any of the tools of improvement science (e.g., PDSA, driver diagrams, run charts, and SPC)? What was the impact? How were they received by colleagues?
- If you were building a local QI team to facilitate service redesign and improvement, where could they be based?
- What are your top priorities for improvement and innovation? What do you know already about the size of the issue and the potential solutions?
- Have you measured the current situation? How will you know if your changes are an improvement?
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