Workshop Notes - All Practice Event 31st January 2012
Workshop 2 – Locality Leadership

1. Locality Leadership
Chair: Dr Gillian Ellsbury
Note Taker: - Janie Conlin

What has worked well from practice visit process?

- Opportunity to review data and benchmark (Alicia's info was good)
- Being able to visit a high referring practice and an average practice was helpful as a comparison
- Having all the Drs at the meeting helped to implement changes in practice
- Visits more productive when practices have reviewed info pack internally prior to meeting
- Not just focusing on demand management but engaging the practice in a broader two way dialogue
- Focusing on variation in referrals and referral patterns rather than absolute amounts of referrals
- First round of minutes were generic but now need to be more targeted (does every practice need a visit that regularly?)
- Having a meeting of the locality leads prior to the visits in order to discuss the information packs and how to run the visits
- Being able to improve patient care while embracing the differences between practices and localities (shows that the locality structures are worth investing in)
- An added value of the visits is identifying potential clinical network leads

What were some of the barriers?

- Practice info pack out of date so didn't aid discussion
- Visits being too medically focused so not representing entire care pathway (eg not including nurses or discussions relevant to nurses)
- Variability in terms of who attends visit from the practice end
- Understanding role of leads and vists – performance management or performance development
- Not having QoF info or relevant info such as planned retirements in the pack
- Circulating referral information by email is a problem due to limited mail box sizes
- Need to have a Lambeth website with all the current and relevant referral information, documents and guidance and, if possible, this should include the practice information as well
- Need more information/support from the cluster (eg contracting teams) and public health (understanding referral variations) in order for leads to be more effective at visits

NHS Lambeth

How confident are you in the impact of your visits i.e. affecting behavioural changes?

- Practices seem receptive to change
- Evidence of implementation eg referral management system
- Observed noticeable changes in practice behaviour

What personal development would help you get more out of future visits?

- Supporting leads to be able to answer practice questions or signpost to information
- Support from public health to understand variation in referrals
- Skills to support changing clinical behaviour and having difficult conversations

Suggested immediate actions

- Clarification of role of leads and purpose of visits
- Review of visits to date and agreement on the structure for future visits (that is more tailored to practices)
- Development opportunities for locality leads in terms of:
  - ✓ Expert knowledge and up-skilling on commissioning issues
  - ✓ Dialogue at visits (eg skills to facilitate, challenge, coach)
- Lambeth wide information sharing forum to agree learning and bring back escalated issues which need problem solving
- Pre-meets for locality lead teams and support staff to prepare for visits
- Setting up a Lambeth website to host all referral information/documents/guidance and possibly the practice info packs (eg GP Interactive Lewisham and Croydon website)

2. Supporting Practices to Deliver

Chaired by Patricia Kirkman
Note taker: Harprit Lally & Alicia Reeves

Reflections on CaB presentation and peer reviews

1) Choose & Book
   - There are a number of issues with CAB
     - Timeliness for response to advice and guidance
     - Directory of Services – quality/content is still variable
     - Access (e.g. many locums unable to get onto CAB)
     - Local services (e.g. community services) not available on CAB
   - Need a mechanism to feedback these issues so they can be resolved in a timely manner
     - Need an identified lead to contact who can take forward issues raised. GSTT was highlighted as a particular issue

2) Peer review - what are some of the issues
   - Practices conducting peer reviews tend see an initial drop in referral levels, but this plateaus, so this should not be seen as a panacea. However, peer review of referrals aids education and professional development.
   - Implementing this in practice is dependent upon a number of things including
     i. Cultural change: reflective process which requires mutual trust. There was agreement that this can be very beneficial, with a number of practices reporting positive impact on team building, sharing of learning, greater awareness of alternatives to referral, and more thorough working up of patients within primary care.
     ii. Time/logistics: programming in weekly meetings in smaller practices or flexible working can be challenging, but some practices reported they had worked around this successfully. A range of approaches would need to be used
     iii. Implications of PMS review on ability/capacity to engage with this raised. Suggested this could contribute to re-validation.
3) Patient
   - Issue with managing patient expectations and gaining a greater understanding of their experience. Felt that would be useful to do some further work on this
   - Inequalities – need to consider implications, both positive/opportunities and potentially negative.
   - Useful to support patients to understand the resources needed for different services e.g. A&E versus SELDOC.

What actions could be put in place/the barriers?

- Focus on supporting increased management within primary care or within alternative settings
  - Barriers
    - PMS/Pharmacy contract reviews and capacity/funds

        - Decommissioning/contractual mechanisms – need confidence that changes/innovations can be implemented. Eye care was one particular example. It was recognised that in addition to contractual issues, would also require a cultural change in referral behaviour in line with this.
    - Suggested solution: locality/borough based services – explore opportunities for efficiencies whilst maintaining quality.
        - Emphasised the focus on quality be maintained
        - Quality information is essential to support this work
    - Making better use of and linking in with existing resources and services
        - Patient groups
        - Services e.g. health trainers, Expert Patient Groups
- Peer review
    - Barriers:
        - Cost / value of time spent on peer review
            - Concern raised over financial implications of daily meeting
            - Concern raised over value of time spent
    - Suggested solution: Incorporate as part of continuing professional development and include peer review as part of requirements for GP appraisal process

3. Road testing the Information pack

Note taker: Sally Rickard

- The aim of the pack is to support practices to know where they are in terms of acute activity, and context against the activity in the locality, Lambeth, London and Nationally.
- Of 31 people in the group 5 had seen the pack before.
- No one in the group has seen any other examples of information packs from elsewhere.
- Of those who expressed an opinion 7/8 people felt the information contained in the pack was about right. 1 person felt there as too much information in the packs.

Question 1 – What is useful in the pack?

- The pack is useful to provide an overview of how a practice referral trend is compared to benchmarks provided.

Question 2 – What is hard to understand

- The information is presented as a lot of numbers. More graphical representation as the EPACT (medicines management) data would make the information more digestible.
- Suggestions as to areas a practice should focus on and actions a practice could take to improve should be presented along side the pack. Agreed this is part of the context of a practice visit – which the packs are intended to support. It is important to read the information packs together with the broader discussion of a practice visit.

Question 3 – What is missing

- Prescribing data – although all agreed it is important to keep the EPACT separate.
- Context of 'where we should be' rather than just benchmarks. If London / National referrals in a specialty are high, it may be practices feel their referral rate is comparatively good; however, context of expected prevalence of some conditions and appropriateness of referrals would add value to the data.
- Acute contracting data – what is included in the contracts. What is the price of activity.
- Clearly showing how the audit information has been collated including:
  - Which clinicans were involved in the audit process
  - What were the criteria for 'apprpopriateness'

Question 4 – how could the format be improved

- More graphs and less data
- A few key pointers e.g. "practice is an outlier in X and recommended action"

General comments

- At the end of a practice visit there should be
    - Action plan
    - What was useful
    - What was not useful
- Common issues should be feed back via the clinical network
- Information builds up through the visits – those with visits later in the schedule have greater benefit. Agreed this would improve over time.
- Summary of what has been agreed should be written up following the practice visits
- The practice packs and visits raise many questions – feedback is not always followed up
- Information on national tariffs and local tariffs to be shared.

4. Leadership Development through Action Learning

Note taker: Jennifer Burgess

What are action learning sets?

- Locality driven, looking at two groups per locality to get involved in fortnightly meetings, over a 3-4 month period about 3 hours per fortnight, could be 'virtual' meetings or conference calls
- Groups to determine what projects to work on
- The idea is to build a network and develop local leadership for the future
- Could be supported by:
  - Public Health
  - Integrated Care Pathway (ICP)
  - Cancer network

Potential areas to focus on:

Allied to strategic priorities:

- Immunisation
- Cytology
- HBA1C
- Alcohol
- Mental Health
- A&E
- Breast screening

Thoughts from the group

Needs to be practical and 'doable'
Outcome might not be completely achieved but will learn going through the process
Could be 1 x clinical and 1 x managerial
Needs to include all practice staff ie GPs, Sessional/Salaried GPs, Practice Managers, Practice Nurses, use Deanery for SpRs
Share good practice already happening elsewhere
An opportunity to influence future commissioning
An opportunity to develop new ways of working
Practices will need incentive to take time away
Need to be clear about resources and expectations – clear outcome description
Projects could be integrated so not working in isolation
Capacity in practice will make the timing critical to success
Need to work collaboratively for future sustainability

Examples of collaborative work

South East Practice Managers - meeting regularly, and/or via email, and problem solving, supportive

Lambeth Living Well Collaborative – working together for 18 months, changing practice and how we work together, end result is beneficial to patients and reduces workload