General Practice Micro-teams in Tower Hamlets

*Fresh Doctors and Cost Effective Care*

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Declaration: No conflicts of interest
Creating the Future of General Practice Together

A programme that aims to consolidate the legacy of leadership, quality, innovation and resilience of primary care in Tower Hamlets

Our vision for General Practice in Tower Hamlets is for consistent high quality care, delivered by resilient and healthy practice teams, who work with patients and their carers to understand them and their lives, and support them to take control of their health. General Practice will work to coordinate patient control care that brings services together so that people can achieve the outcomes that are important to them.

This programme aims to:

• Create and nurture an environment of leadership and innovation for general practice to deliver patient centred care.
• Secure the role of the general practice teams as the expert generalists in the wider healthcare system, who work with other providers to integrate services for patients.
• Address the unprecedented levels of demand for general practice services, supporting practices to meet patient needs.
• Ensure that general practice in Tower Hamlets is supported by strong infrastructure to allow it to develop, grow and deliver high quality, equitable services for patients.
• Maximise what we can achieve through working collaboratively across practices and with local communities within the network arrangements.

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Drivers for establishing Micro-teams

• Case reviews in two large (>12 000 patients) high (QOF) performing practices
  – Cancer (Oct 2011): Up to 8 different GPs were involved over the course of the year, in addition to the named GP, before a diagnosis of advanced cancer (J R Soc Med 2013)
  – Dying in Hospital (April 2012): Up to 10 different GPs were involved over the course of the year prior to dying in hospital, in addition to the named GP, but no key GP or Team of GPs was identified to oversee a care plan (>20 different GPs work in this practice)
• Other
  – Obligation: Informing over 75yrs of their named GP
  – Workforce:
    • Maximise effectiveness of predominantly part time GP workforce
    • Practice size range from 20 800 - 1 303 patients (15/36>10 000 patients)
    • 1.4 M consultations/year (280 000x5/year)* Social disadvantage
    • >900 000 consultations delivered by GPs working in a 'sessional' capacity
    • ‘Back room’ function (HR, supplies etc.) and ‘front room’ function how best to manage uncertainty and risk through continuity of:
      – Information,
      – Management
      – Relationship
    • Restore ‘ownership and control’
      – >70 % (>200/300) are Sessional GPs (pilot workforce data)
      – Succession planning - age structure of workforce >10% within 5 years of retirement
## Front Office and Back Office Functions: Tower Hamlets Micro-teams in context

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>Geographical Networks established 280 000 Residents</td>
<td>36 Practices combine into 8 Networks with 4-5 practices collaborate to provide services in four geographical Localities</td>
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<tr>
<td>Nov 2013-Jan 2014</td>
<td>Tower Hamlets CCG Case for Change CCG Quality/Excellence In General Practice Strategy launched</td>
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<tr>
<td>June – Dec 2014</td>
<td>Micro-teams Rationale: safety; benefits and potential cost savings. Invitation to practices to test</td>
<td>Baseline data shows that the four practices who volunteer to test micro-teams are higher performing practices in that</td>
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<tr>
<td></td>
<td>Practice Locality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>North West</td>
<td>South West</td>
</tr>
<tr>
<td></td>
<td>Approximate List size</td>
<td>14 000</td>
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<td></td>
<td>Cohort Debate: All or only some patients?</td>
<td>High Need Integrated Care</td>
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<tr>
<td></td>
<td>Composition of team</td>
<td>Six GPs: Three teams</td>
</tr>
<tr>
<td>Sept 2014</td>
<td>GP Care Group -CIC Community Interest Company 37 Practices CEPN</td>
<td></td>
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<tr>
<td>Oct- Nov 2015</td>
<td>Micro-teams Progress Report: Leadership Recommendation QI Action Learning Set for Leads</td>
<td>Leads to be trained in QI and to test - not established at this stage</td>
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<td></td>
<td>2015 – July 2016</td>
<td></td>
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<td></td>
<td>Tower Hamlets Together</td>
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<td></td>
<td>Vanguard Status Multi-specialty Provider</td>
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<td>Nov 2016 -2017</td>
<td>EQUIP QI first wave</td>
<td></td>
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<tr>
<td>April 2017</td>
<td>29/36 Practices agree Local QOF</td>
<td>Yes</td>
</tr>
<tr>
<td>April 2018</td>
<td>25/36 Practices signed up to EQUIP</td>
<td>EQUIP</td>
</tr>
<tr>
<td>June 2018</td>
<td>Micro-teams Progress Report: Costs to be established and change ideas tested</td>
<td>Empathetic Continuity of Episode</td>
</tr>
</tbody>
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Relational Continuity

- Highly valued by:
  - most patients (Jeannie Haggerty) [http://www.annfammed.org/content/11/3/262.short](http://www.annfammed.org/content/11/3/262.short)
  - GPs - consistently selected as the most important factor

- Cost Effective - reduced costs through less: prescriptions; tests A&E attendance; hospital admissions and more (Kings Fund 2010; BMJ 2017)
If evidence so strong why have practices not embraced micro-teams?

• Variation in understanding what is delivered in General Practice
• Variation in leadership and decision making across practices
• Lack of integrated data to describe waste in the system
We illustrate GPs own assessment of appropriateness of appointments

Question to GPs: Should this patient be here today?
Answer from GPs: 40% of the time ‘no’

- NON-CLINICAL problem
- REFERRAL/PRESCR.FROM HOSPITAL
- TEST RESULTS (no concern)
- SERVICES OUTSIDE PRACTICE
- SICK NOTE
- SELF-CARE / SELF-HELP GROUP
- PHARMACIST could handle
- OTHER STAFF could handle
- OTHER
- NECESSARY appointment

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

Malby Downham and Hufflett. 2016 London Primary Care Quality Academy. London South Bank University  R.Malby@lsbu.ac.uk
**GP views:** There is significant variation on what constitutes a GP appointment

**Across practices....**

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

**Within practices....**

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

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Malby Downham and Hufflett. 2016 London Primary Care Quality Academy. London South Bank University  R.Malby@lsbu.ac.uk
Managing Uncertainty and Coproduction of Care

Realising the full potential of primary care: uniting the ‘two faces’ of generalism. BJGP 2017
Joanne Reeve and Richard Byng
Variation in leadership and decision making across practices

For 17/18 Tower Hamlets CCG offered a local alternative to QOF. Variation in how decision was made with some making the decision with

- Only GP partners
- All GPs in the practice
- All clinicians in the practice (GPs and PNs)
- The whole practice team (Clinical and Administrative)
- All the practices in the Network
Tower Hamlets Leadership Vision for Real Time Integrated Data

Primary Care Development Committee

Workstream Projects

- CO-CHAIRS
  - Isabel Hodkinson
  - Stuart Bingham

- BOARD MEMBER/
  - (SUMMIT GROUP)
  - WORKSTREAM CHAIRS

- CSM

- Primary Care Committee
  - Education
  - Service Development
  - Indemnity
  - Calibration

- Workstreams
  - Practice Population
  - National Health
  - Practice Population

- Workstream Projects
  - Prescribing
  - Area Based Monitoring
  - Workstream Projects

- Workflow Activity
  - Workstream Projects
  - Prescribing

- Workflow Activity
  - Workstream Projects
  - Prescribing

- Workflow Activity
  - Workstream Projects
  - Prescribing

- Workflow Activity
  - Workstream Projects
  - Prescribing
'Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has'

Margaret Mead - Cultural Anthropologist (1901 –1978)