Releasing capacity in general practice

Policy opportunities and Ten High Impact Actions for practices

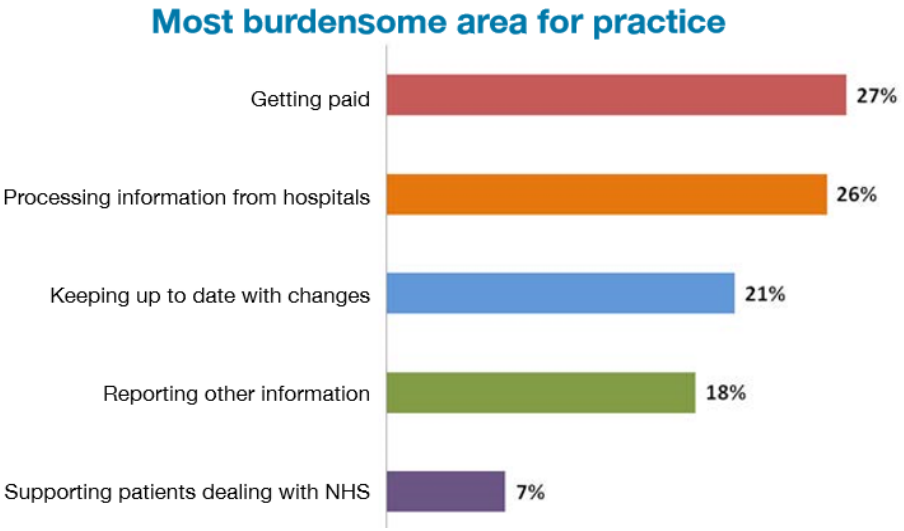
General practice is under considerable pressure right now. Recent years have seen rising volume and complexity of workload, and rising running costs, while the workforce and investment have not kept pace with other parts of the NHS. NHS England is committed to stabilising and supporting general practice, to allow it to fulfil more of its potential at the heart of the NHS.

Sources of workload for practices

In 2015, a study was commissioned to identify the chief areas where reducing bureaucracy and reshaping demand could help practices in England. The results of the study are available at www.nhsalliance.org/making-time-in-general-practice/

A survey of practice managers was undertaken, to estimate the time taken by different types of externally mandated work. Results were provided by 250 practice managers. An audit of GP consultations was also undertaken, with results provided from over 5,000 consultations with 56 GPs across England. The quantitative results were then discussed in detail through qualitative interviews and focus groups with clinicians and managers, including a roundtable event with NHS Providers. The results and recommendations were reviewed by a steering group comprised of senior leaders from national professional bodies.

a) Sources of bureaucracy



Interviews with practice managers have indicated that the top 3 most burdensome issues were:

- 'getting paid'. This has become a much bigger burden under the new system, with CCGs and local authorities commissioning services from practices, as well as NHS England. The use of different systems for reporting, claiming and reconciliation has exacerbated this. They also highlighted ways in which the CQRS system for automated processing could be improved to reduce manual workload.

- keeping up to date with incoming information from commissioners and other bodies, particularly at a national level. Managers reported that this was particularly problematic when later trying to retrieve information sent by email, letter or bulletin.

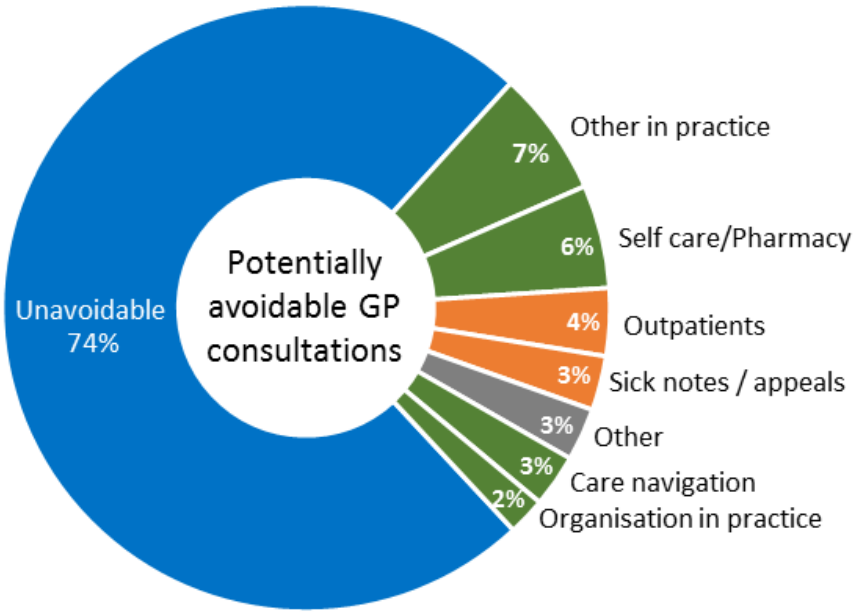
- reporting for contract monitoring or regulation. Here, interviews revealed frustration caused by multiple requests for similar information, sometimes from different teams in the same organisation (particularly NHS England), often at very short notice (eg 24 or 48

hours), and often formulated in ways which differed from how the information was stored. NHS England and CQC were described as frequently asking for information about the same aspect of the practice, but in different ways, at different times, and in a series of requests rather than a single one.

Processing information from other providers comprised a significant proportion of administrative time, and managers reported this has increased in recent years. Supporting patients to navigate the health and care system was also an area where practice workload was increasing.

b) Potentially avoidable clinical demand

Data submitted by 56 GPs for over 5,000 consultations are summarised below. In total, 26% of appointments were judged to have been appropriate for diversion or handling differently.



The most common potentially avoidable consultations were amendable to action by the practice, often with the support of the CCG. The biggest three categories were where the patient would have been better served by being directed to someone else in the wider primary care team, either within the practice, in the pharmacy or a so-called 'wellbeing worker' (eg care navigator, peer coach, health trainer or befriender). Together, these three, which could be improved by more active signposting and new support services, accounted for 16% of GP appointments. An additional 1% were to inform a patient that their test result was normal and no further action was needed. A further 1% of appointments would not have been necessary if continuity of care or a clear management plan had been established.

The second most common issue lay within the control of hospitals. Demand created by hospitals accounted for 4.5% of appointments. The largest category, creating 2.5% of appointment, comprised problems with outpatient booking (either a lapse in the outpatient booking process, such as failure to send a follow-up appointment, or a patient failing to attend an appointment, necessitating an entirely new GP referral and, incidentally, allowing the hospital to charge twice for the appointment. The other, creating 2%, was the result of hospital staff instructing the patient to contact the GP for a prescription or other intervention which was part of their hospital care.)

National support

NHS England is now taking action to address the issues identified in this landmark study and reiterated by the BMA, Royal College of General Practitioners and others.

Simon Stevens, Chief Executive of NHS England, in welcoming the increased investment being given through the GP contract in 2016/17, reaffirmed NHS England's commitment to doing more to support general practice.

> "Today's welcome agreement between NHS England and the BMA provides GPs with some stability and support, and shows what can be achieved through sensible and constructive negotiation. However this contract is only one small element of a far wider package we're jointly developing to help practices with workload, workforce and care redesign. That will require radical new options, including further support for GP recruitment and return to practice, funding for additional primary care staff, new options for practice premises, a reduction in paper-based red tape, alternative approaches to indemnity cover, and redesigned out of hours, 111 and extended hours arrangements, to name just a few – all underpinned by much greater team working across individual practices."

Ten high impact actions for practices

The 'Making Time' study also points to the fact that there is much GP practices can do themselves to help address their workload pressures. A growing number of practices are already making use of these, but it is clear that many are not. Practices tell us that it is often difficult to learn about promising innovations that could benefit them and their patients, or that implementing change is difficult or risky. There is a role for NHS England in helping to spread knowledge of successful innovations and supporting practices and federations to adopt them.

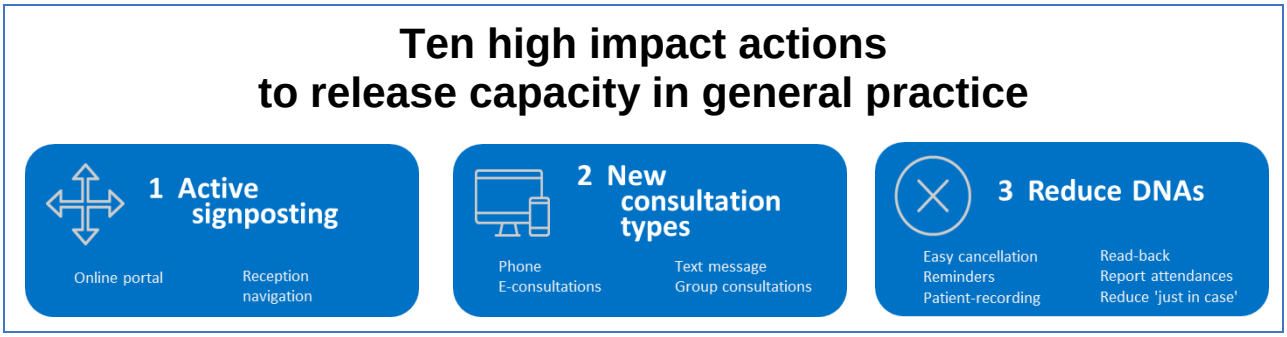
Building on evidence gathered through the Making Time report and the PM's GP Access Fund, ten areas have been identified where action can be taken to release capacity in GP practices. In each area, there are several specific changes which could be implemented to make a difference. In addition to helping the practice serve its patients better through releasing staff time, many of these innovations offer a direct improvement for the patient.

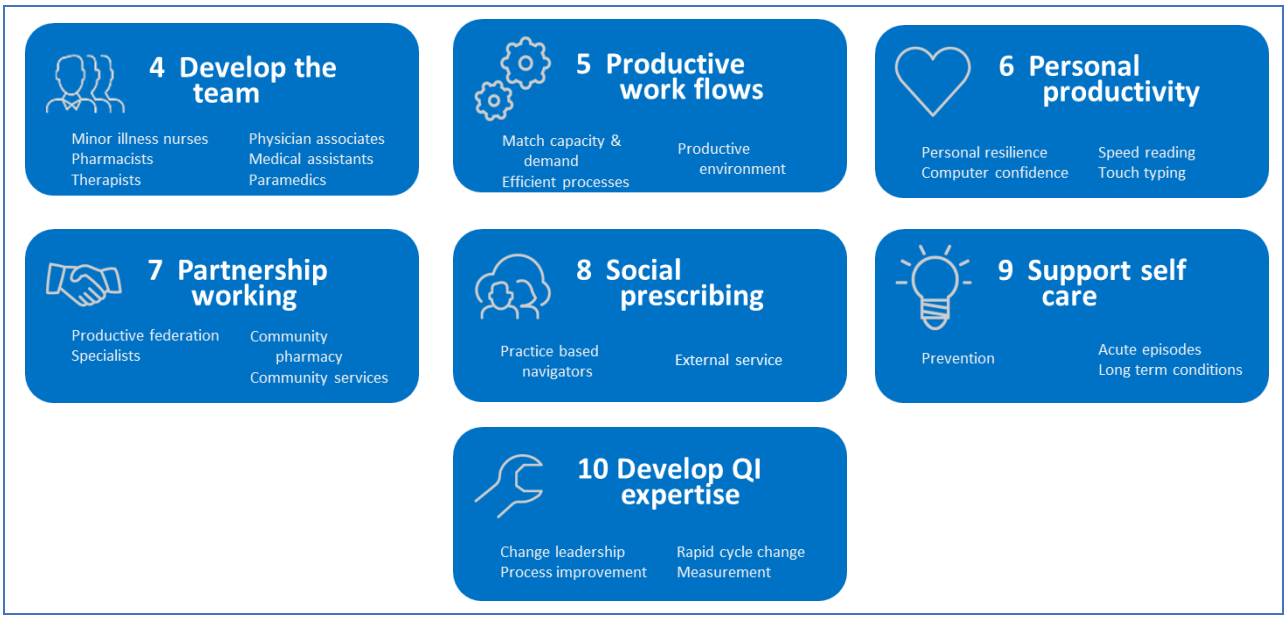
Crucially, this is about sharing the what practices in England are already doing to release capacity and improve care. It is not about NHS England telling practices how to organise themselves. Case studies are being collected, along with resources and acitivites to support local implementation.

No single action is a silver bullet. Each has been found by practices to be beneficial, but we encourage people to consider multiple solutions in order to achieve the greatest benefit for themselves and their patients.

The first nine actions are 'the what' of releasing capacity – the changes practices could make. The tenth is about 'the how'. This is actually where success or failure often lies. It's also the reason why experiences of the same innovation can differ so greatly between practices. Most practices are not able to draw on the kind of leadership, service improvement and programme management capabilities that other NHS providers take for granted.

There needs to be investment in building these, through a learn-while-doing approach, if practices are to implement this package of changes successfully and sustainably. There is a role for CCGs in investing in leadership and organisational development capabilities in local general practice, in order to achieve their sustainability and transformation goals.




4 Develop the team
Minor illness nurses
Pharmacists
Therapists
Physician associates
Medical assistants
Paramedics
5 Productive work flows
Match capacity & demand
Efficient processes
Productive environment
6 Personal productivity
Personal resilience
Computer confidence
Speed reading
Touch typing
7 Partnership working
Productive federation
Specialists
Community pharmacy
Community services
8 Social prescribing
Practice based navigators
External service
9 Support self care
Prevention
Acute episodes
Long term conditions
10 Develop QI expertise
Change leadership
Process improvement
Rapid cycle change
Measurement

The Ten High Impact Actions at a glance

Action	Description	Benefits for practice	Benefits for patients
1 Active signposting	Provide 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.	Frees GP time. Makes more appropriate use of each team member's skills. Reduces internal referrals.	Improves appointment availability. Reduces low-value consultations and onward referrals. Shorter wait to get to see the most appropriate person.
2 New consultation types	Introduce new communication methods for some consultations, such as phone and email. Where clinically appropriate, these can improve continuity and convenience for the patient, and reduce clinical time per contact.	Shorter appointments (eg phone consultation average 50% shorter, 66% dealt with entirely on phone). More opportunities to support self care with e-consultations, text message follow-ups and group consultations.	Greater convenience, often no longer requiring time off work/caring duties. Improves availability of appointments. More opportunities to build knowledge, skills and confidence for self care.
3 Reduce 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.	Free GP time. Easier to avoid queues developing, through more accurate matching of capacity with demand.	Improves appointment availability.
4 Develop the team	Consider broadening the workforce, to reduce demand for GP time and connect the patient more directly with the most appropriate professional. This may include training a senior nurse to provide a minor illness service, employing a community pharmacist or providing direct access to physiotherapy, counselling or welfare rights advice.	Frees GP time. Makes more appropriate use of each team member's skills. Reduces internal referrals. Improved job satisfaction for administrative staff undertaking enhanced roles.	Improves appointment availability. Reduces low-value consultations and onward referrals. Shorter wait to get to see the most appropriate person.
5 Productive work flows	Introduce new ways of working which enable staff to work smarter, not just harder. These can reduce wasted time, reduce queues, ensure more problems are dealt with first time and that uncomplicated follow-ups are less reliant on GPs consultations.	Frees time for staff throughout the practice. Reduces errors and rework. Improves appointment availability and patient experience.	Improves appointment availability and customer service.

Action	Description	Benefits for practice	Benefits for patients
6 Personal productivity	Staff are the most valuable resource in the NHS. We have a duty to nurture them as well as providing resources and training to ensure they are able to work in the most efficient way possible. This may include improving the environment, reducing waste in routine processes, streamlining information systems and enhancing skills such as reading and typing speed.	Frees clinicians to do more in each consultation, with fewer distractions and frustrations. Improves staff wellbeing and job satisfaction.	Improved quality of consultations, with more achieved. Reduced absence of staff.
7 Partnership working	For a number of years, practices have been exploring the benefits of working and collaborating at greater scale. This offers benefits in terms of improved organisational resilience and efficiency, and is essential for implementing many recent innovations in access and enhanced longterm conditions care. Increasing the scale of operations beyond the traditional small practice team requires considerable planning and leadership, as well as attention to the need to maintain the personal aspects of care which are the bedrock of effective primary care for many patients.	Frees GP time, makes best use of the specific expertise of staff in the practice. Creates economies of scale and opportunies for new services and organisational models.	Access to expanded range of services wrapped around the patient in the community. Reduces delays introduced by referrals to different providers.
8 Use social prescribing	Refer or signpost patients to services which increase wellbeing and independence. These are non-medical activities, advice, advocacy and support, and are often provided by voluntary and community sector organisations or local authorities. 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.	Frees GP time, makes best use of their specific medical expertise.	Improved quality of life. Improved ability to live an independent life.
9 Support self care and management	Take every opportunity to support people to play a greater role in their own health and care. This begins before the consultation, with methods of signposting patients to sources of information, advice and support in the community. Common examples include patient information websites, community pharmacies and patient support groups. For people with longterm conditions, this involves working in partnership to understand patients' mental and social needs as well as physical. Many patients will benefit from training in managing their condition, as well as connections to care and support services in the community.	Frees GP time, makes best use of their specific medical expertise.	Improved ability to live an independent life.

Action	Description	Benefits for practice	Benefits for patients
10 Build QI expertise	Develop a specialist team of facilitators to support service redesign and continuous quality improvement. Such a team will enable faster and more sustainable progress to be made on the other nine high impact changes. The team could be based in a CCG or federation. They should ideally include clinicians and managers, and have skills in leading change, using recognised improvement tools such as Lean, PDSA and SPC, and coaching GP practice teams. All of these will help practices to work smarter rather than harder, and to more rapidly introduce new ways of working.	Improved ability to achieve rapid, safe and sustainable improvements to any aspect of care. Increased staff morale and sense of control.	Assurance of continuous improvement in patient safety, efficiency and quality of care.

1 Active signposting

Provide 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.

1.1 Online portal

Patients are given access to a web portal or mobile app. This can provide a number of services, including booking or cancelling appointments, requesting repeat prescriptions, obtaining test results, submitting patient-derived data (eg home blood pressure readings), obtaining self help advice, viewing education materials and consulting a clinician.

1.2 Reception care navigation

Reception staff or volunteers are given training and access to 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. This adds value for the patient and may reduce demand for GP appointments.

2 New consultation types

Introduce new communication methods for some consultations, such as phone and email. Where clinically appropriate, these can improve continuity and convenience for the patient, and reduce clinical time per contact.

2.1 Phone

Use of the telephone for consultations is growing rapidly in general practice. Some practices have been offering this kind of consultation for ten years or more, but interest has grown significantly since about 2012. From a starting point of treating phone contacts as brief triage encounters, practices are increasingly recognising the feasibility and value of fully addressing the patient's need in a single phone contact where appropriate. Experienced consulters generally find phone consultations are half the length of face-to-face ones, and that approximately 75% of consultations can be fully concluded on the phone. This releases GP time, reducing waiting times for patients, and making it easier to offer better continuity and longer face-to-face appointments for patients who need it. Most practices implement phone consultations as part of other changes, for example the introduction of active signposting and redesign of systems to create more productive workflows, particularly with a focus on matching capacity with patterns of demand through the week.

2.2 E-consultations

Using a mobile app or online portal, patients can contact the GP. This may be a follow-up or a new consultation. The e-consultation system may be largely passive, providing a means to pass on unstructured input from the patient, or include specific prompts in response to symptoms described. It may offer advice about self care and other sources of help, as well as the option to send information to the GP for a response.

2.3 Text message

In addition to sending reminders, text messaging can be used for more interactive two-way communication between patients and their practice. Systems exist to help automate this, allowing for quite sophisticated packages of education, reminders and support self-care.

2.4 Group consultations

For patients with longterm conditions, group consultations provide an efficient approach to building knowledge and confidence in managing the condition, which includes a peer-led approach as well as expert input from professionals.

3 Reduce 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.

3.1 Easy cancellation

Rapid access is provided for patients who wish to contact the practice to cancel an appointment. Common approaches include having a dedicated phone number, a text message service and online cancellation functionality.

3.2 Appointment reminders

Patients are sent a text message to remind them about a forthcoming appointment. A reminder is included about how to cancel the appointment if it is no longer wanted.

3.3 Patient-recorded bookings

Patients are asked to write their own appointment card for their next appointment, rather than having it done for them. This encourages recall, reducing subsequent DNAs.In one study, practices found that switching from the nurse writing the appointment card for follow-up appointments to having the patient do it reduced DNAs by 18% (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3308641/). It seems this is beneficial partly because the act of writing the appointment adds to the patient's ability to recall the details, and partly because it represents a more firm public commitment to attend the appointment than passively receiving the appointment card. Psychological research consistently confirms the power of publicly stated commitments to increase the likelihood that we will undertake an action.

3.4 Read-back

The patient is asked to repeat the details of the appointment back, to check they have remembered it correctly. If receptionists ask the patient to repeat back to them the appointment date and time, the patient is more likely to attend the appointment. In one study, this simple addition to receptionists' habit reduced DNAs by 3.5% (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3308641/).

3.5 Report attendances

Publish information, for example in the practice waiting room, about the number or proportion of patients who do keep their appointment, with an encouragement to cancel unwanted appointments. This is more effective than reporting the proportion who DNA.

3.6 Reduce 'just in case' booking

Creating an appointment system and booking experience which is straightforward and responsive, giving patients confidence that they will be able to obtain help when they need it. This can reduce booking of appointments a long way in advance, which is associated with a much higher DNA rate.

4 Develop the team

Consider broadening the workforce, to reduce demand for GP time and connect the patient more directly with the most appropriate professional. This may include training a senior nurse to provide a minor illness service, employing a community pharmacist or providing direct access to physiotherapy, counselling or welfare rights advice.

4.1 Minor illness nurses

A nurse with additional training in diagnosis, management and prescribing, provides a service for people with minor ailments. Patients are directed to the service by an active front end, such as a mobile app, online portal or a triage protocol operated by receptionists. This ensures that only clinically appropriate problems are seen in the minor ailments service.

4.2 Practice pharmacists

A pharmacist works in the practice as an integral part of the team. They may perform a wide range of duties, including service audit and improvement, longterm condition medications management, discharge medication reconciliation, medicines use reviews and minor ailments clinics. Additional training in diagnosis, management and prescribing may be necessary for some of these.

4.3 Direct access therapists

The practice has access to book patients directly into appointments with a physiotherapist or mental health practitioner for patients presenting with a defined range of problems. This avoids delays created by a referral system and, with an appropriate Active signposting, can also avoid the need for a GP consultation, with triage by the online system or receptionist.

4.4 Physician associates

Graduates with a science degree undertake a two year training programme to develop skills in diagnosis, investigation and clinical management. Physician associates then work under the direct supervision of a doctor.

4.5 Medical assistants

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. These may include tasks such as processing incoming hospital correspondence, ordering tests, chasing results and outpatient referrals, liaising with other providers and explaining care processes to patients. In some practices, the medical assistant works very closely with the GP, sitting alongside them during telephone clinics.

4.6 Paramedics

An emergency practitioner is attached to a practice or group of practices. They undertake urgent home visits, supported by full access to the GP record and rapid access to the patient's practice in order to discuss cases with a GP. They may also be involved in seeing patients with acute illness attending the practice, including those with minor injuries.

5 Productive work flows

Introduce new ways of working which enable staff to work smarter, not just harder. These can reduce wasted time, reduce queues, ensure more problems are dealt with first time and that uncomplicated follow-ups are less reliant on GPs consultations.

5.1 Match capacity with demand

Appointment systems and staff rotas are designed in order to ensure sufficient capacity is available to match patterns of demand as they vary through the week and the year. This requires an ongoing system of measuring demand and adjusting capacity accordingly. It may also involve scheduling routine work (eg annual reviews and clinical audit) for less busy times of the year. The benefits are a reduction in delays for appointments, less stress for staff and patients, and better access.

5.2 Efficient processes

The application of Lean principles to measure, understand and improve common processes in the practice, in order to reduce waste and errors. Typical targets include clinical follow-up protocols, processing of letters and test results, requests from patients, staff messages and team decision making. Staff themselves often have a wealth of ideas about ways in which processes could be improved to release time. Practices who take a systematic approach to identifying and testing these generally find that this improves care for patients as well as freeing staff time for other things. The use of pre-prepared plans for managing common simple follow-up processes can improve their reliability and efficiency, freeing GP time. Common examples include management of hypertension, monitoring of tests after the initiation of new medication, and adjustment of medication doses to reach a target.

5.3 Productive environment

The physical layout within the practice is assessed for its effect on staff's productivity, and improvements are introduced which reduce wasted time. The Lean technique of 5S is the best known approach for doing this. Additionally, work can be undertaken to ensure that staff can access information needed to support their work quickly. This reduces time spent searching for information and can improve patient safety as well.

6 Personal productivity

Staff are the most valuable resource in the NHS. We have a duty to nurture them as well as providing resources and training to ensure they are able to work in the most efficient way possible. This may include improving the environment, reducing waste in routine processes, streamlining information systems and enhancing skills such as reading and typing speed.

6.1 Personal resilience

Supporting staff to be happy and productive in their work through the way they respond to pressure. The maintenance of an engaged organisational culture through deliberate leadership of the team and systems can have a significant impact on resilience and productivity. A wide range of activities may help build staff resilience, including training, mentoring and peer support schemes, as well as more intensive support for staff experiencing difficulties.

6.2 Computer confidence

Provision of initial and ongoing support to staff to ensure they are able to make the best and most efficient use of practice computer systems. Specific opportunities may be created for staff to discuss their use of systems and to share tips, or this may feature as part of other team sessions.

6.3 Touch typing & speed reading

Training for staff in typing and reading at speed. This frees staff time, and reduces frustration and distraction, making it easier to devote attention to other things.

7 Partnership working

For a number of years, practices have been exploring the benefits of working and collaborating at greater scale. This offers benefits in terms of improved organisational resilience and efficiency, and is essential for implementing many recent innovations in access and enhanced longterm conditions care. Increasing the scale of operations beyond the traditional small practice team requires considerable planning and leadership, as well as attention to the need to maintain the personal aspects of care which are the bedrock of effective primary care for many patients.

7.1 The productive federation

A growing number of practices are entering into collaborative arrangements with others. These collaborations take a variety of forms and legal underpinnings, ranging from loose networks to tightly integrated federations. Historically, much of the drive behind collaboration has been a desire to win contracts for services such as minor surgery, community dermatology or outpatient monitoring. Some collaborations were originally established with a less clearly defined purpose of protecting practices from commercial competition or difficult financial circumstances. These networks and federations do not necessarily provide a platform for service provision at scale or for supporting practices to improve quality or innovate in core services. With commissioners increasingly looking to procure innovative at-scale primary care from GP federations, many are rethinking their purpose, and developing more comprehensive approaches to their functions, processes and capabilities.

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.

7.2 Specialists

Developing closer and more seamless collaboration with specialist colleagues. This may involve new protocols and processes for sharing care, clarifying responsibilities for different parts of the patient journey and reducing gaps and duplication. Direct access to advice is increasingly being provided, to reduce the need for some patients to be referred out of primary care. Specialists may also be brought into more community-facing roles, providing training, advice and care outside hospital. These measures have clear benefits for patients as well as general practices.

7.3 Community pharmacy

Community pharmacies provide a wide range of expert advice about episodic and ongoing needs. A growing number of GP practices are building closer collaboration with their community pharmacies, particularly in the areas of minor illness and medication reviews.

7.4 Community services

Form new collaborative relationships with community service providers. This offers the potential to provide more joined-up care for patients, especially those with longterm conditions, where fragmentation of services is common and impacts on the safety, effectiveness, efficiency and experience of care.

8 Social prescribing

Referral and signposting to services which increase wellbeing and independence. These are non-medical activities, advice, advocacy and support, and are often provided by voluntary and community sector organisations or local authorities. 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 operate quite separately from the GP practice, accepting referrals in the same way as other providers, 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.

8.1 Practice based navigators

Volunteers or staff members are attached to a GP practice, to provide a source of expertise about local voluntary and community sector services. They will often meet directly with patients and carers, identifying needs and opportunities, and supporting them to engage with services.

8.2 External service

Practices have access to a service run by another organisation, such as a council of voluntary sector agencies, who can signpost patients and carers to sources of support in the local community. They will take referrals from the practice, and will usually also provide support directly to local residents without referral.

9 Support self care

Take every opportunity to support people to play a greater role in their own health and care. This begins before the consultation, with methods of signposting patients to sources of information, advice and support in the community. Common examples include patient information websites, community pharmacies and patient support groups. For people with longterm conditions, this involves working in partnership to understand patients' mental and social needs as well as physical. Many patients will benefit from training in managing their condition, as well as connections to care and support services in the community.

9.1 Prevention

Some practices are fostering links with their local community and launching new programmes to improve population health and prevent disease. This spans a range of activities, including health education, promoting healthy eating and physical activity, and influencing other aspects of public health. A common feature is a focus on communities helping themselves, with statutory services providing support.

9.2 Patient online

Technology changes are enabling patients to access their personal record online, through web portals and a growing number of health apps for mobile phones. This makes common transactions such as ordering a repeat prescription quicker for the patient and for practice staff. It also allows patients to become better informed about their health and care, and to play a more active role. With explanation and support, patients and their carers are able to check test results, the progress of investigations and referrals, read and share their care plan, and enter details of home monitoring, such as blood pressure, weight, and sugar tests. As well as being popular with patients, GP practices are reporting a reduction in workload as a result of patients using these online services.

9.3 Acute episodes

Practices are increasingly involved in supporting patients with minor ailments to care for themselves. This often includes providing advice and signposting to services provided by community pharmacy. Education also plays a part, with growing numbers of practies contributing to efforts to teach people about the best ways to seek help when ill. This often begins with engagement in local primary schools.

9.4 Longterm conditions

For people with longterm conditions, a more proactive approach to care is being adopted, alongside a focused effort to help people play a more active role in monitoring and managing their condition. Initiatives include supporting people to access their full medical record online, the use of health coaching in clinical consultations and the provision of training and support in the community, aiming to build the knowledge, skills and confidence for patients and carers to manage their condition. This builds patients' own assets and quality of life, as well as reducing their dependence on services such as the general practice.

10 Develop QI expertise

General practice faces important challenges and opportunities. There is growing agreement that widespread change is needed. These present an unprecedented change leadership challenge for clinicians and managers.

Although many of the high impact actions to release capacity can be described easily, implementing them is often a complex challenge of service redesign and leadership. This is particularly true when using these changes to achieve other goals such as improving access or introducing enhanced models of care.

Other sectors have benefitted from support to build capabilities for management, leadership and service redesign, allowing more rapid innovation adoption and improvements in patient experience, safety, quality and productivity. However, general practice has not seen similar investment, and it is ill-prepared to use many quality improvement, management and leadership practices which are taken for granted elsewhere.

Develop a specialist team of facilitators to support service redesign and continuous quality improvement. Such a team will enable faster and more sustainable progress to be made on the other nine high impact changes. The team could be based in a CCG or federation. They should ideally include clinicians and managers, and have skills in leading change, using recognised improvement tools such as Lean, PDSA and SPC, and coaching GP practice teams. All of these will help practices to work smarter rather than harder, and to more rapidly introduce new ways of working.

Local commissioners, academic and training bodies are asked to consider what they could do to support the development of capacity and capability for leading change and redesigning services in general practice.

10.1 Facilitated change

One popular approach to building your team's capabilities for service redesign is to undertake a programme of change with external facilitiation. This approach to 'learning while doing' focuses chiefly on the change project, often addressing something like the appointments system or repeat prescription handling. External expertise is used to guide the planning and delivery, and they provide coaching for the team and leaders through the process. The secondary aim is to build confidence in using the relevant redesign methods, thus leaving a legacy of increased capability for the future.

It is worth taking care to choose an external coach or team who will help you address a high profile need in the practice as well as build your intrinsic capabilities for the future. Purchasing external support that does not leave a legacy can end up being very costly.

10.2 Capability building

Another approach is to focus chiefly on training and coaching to develop the awareness and skills of an individual of team. This provides them with a thorough understanding of a range of approaches to leading change, the reasons why they work and how to apply them in different situations. For busy primary care staff it is usually best to apply a learn-while-doing approach to training like this, as few people are interested in committing to a more academic learning experience. Action learning with expert coaching and personal study can help develop capabilities for the future at the same time as accelerating the implementation of a live change project.