NHS Providers

SYSTEM AIMS, AT SCALE SOLUTIONS

The contribution of at scale primary care to system working

OCTOBER 2023

SYSTEM AIMS, AT SCALE SOLUTIONS

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CONTENTS

KEY MESSAGES

- At scale providers are well-placed to contribute to key national policy ambitions set out in publications such as the Fuller Stocktake, including the development and co-ordination of integrated neighbourhood teams, increased patient access and the expansion of multidisciplinary team working.
- Working at scale provides a natural platform for engagement with other parts of the NHS. The examples below indicate some of the benefits that can only come from working at scale, although they do not represent the full diversity of models of at scale primary care that now exist.
- More locally, at scale primary care providers have sought to work innovatively with other system partners and within their own organisations to tackle longstanding challenges like workforce resilience, the introduction of technological solutions and to improve interface between primary and secondary care.
- Working at scale contributes to building integrated and blended primary and secondary care services, and to helping reduce pressures on secondary provision by helping people with conditions such as gambling addiction or diabetes before they require hospital treatment.
- These approaches can advance policy development around at scale provision in light of the commitment to explore models of general practice[1] ahead of the next iteration of the GP contract.

1 https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2/#engaging-on-the-future-of-primary-care

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INTRODUCTION

Working at scale within general practice is not new. In recent years, many practices have adopted different models, including super-practices, GP federations, primary care networks (PCNs) or through integration with other NHS providers such as trusts. Although there are many different approaches to delivering primary care at scale, common aims include: efficiencies, new ways of working above the provision of core general practice to improve quality or integrate care, and collaboration with other practices and healthcare providers to improve patient care or share resources.

Policy development has similarly reflected, and driven, consideration of the benefits of collaboration and of working at scale. Publications such as the Hewitt Review and NHS England's delivery plan for recovering primary care access recognise the need to make better use of data and technology (often applied across larger footprints), to create integrated teams of general practice staff and other health professionals, and to develop support services for multiple practices.

The Fuller Stocktake[1] of primary care and integrated care systems focuses on the collaboration and coordination of multidisciplinary teams at a neighbourhood level to tackle inequalities, build capability, and meet demand and support the health and wellbeing of communities through a population-based approach. It advocates improving personalised care services, enhancing preventative care through general practice, and focusing on workforce and data as key enablers of change.

The case studies in this briefing bring these ideas to life and demonstrate the ways in which larger scale primary care providers are, and can be, integral to NHS services working together in neighbourhoods, in place-based partnerships and in systems.

Bringing together the experiences and expertise of several 'at scale' primary care organisations, these case studies highlight how scale can benefit organisations and contribute to wider system aims.

These examples particularly demonstrate how support from 'at scale' organisations has improved access to care by freeing up clinical capacity, strengthening relationships between community and primary care teams, and using data to target those in most in need of support. The case studies also explore how to ensure best value from multidisciplinary teams and the successful introduction of population health approaches and social prescribing to tackle health inequalities and address the determinants of ill health, reducing pressures on other parts of the system.

We hope this publication proves helpful to colleagues across the health sector. We would like to thank all of our contributors.

1 https://nhsproviders.org/media/693627/otdb-fuller-final.pdf

CASE STUDY

LAKESIDE HEALTHCARE – SOCIAL PRESCRIBING

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Supporting the introduction of social prescribing through integrated approaches to care

Lakeside Healthcare (Lakeside) is a GP partnership serving more than 170,000 patients at eight practices, working in 13 local sites across Northamptonshire, Lincolnshire and Cambridgeshire. Owned and led by more than 50 partners, Lakeside employs over 500 clinical and non-clinical staff.

People's health and wellbeing are often determined by social, economic and environmental factors that a GP cannot simply write a prescription for. As part of the drive to see more people benefiting from personalised care, NHS England committed in its NHS Long Term Plan[1] to widen, diversify and increase access to the range of support available to people across the country through social prescribing.

At scale working presents the opportunity to push forward this agenda by rolling out social prescribing across multiple primary care networks (PCNs) to improve patient outcomes. With a focus on both prevention and effective intervention, Lakeside sought to alleviate the burden on NHS community services and trusts by de-escalating cases that could otherwise need immediate action by mental health teams, urgent care centres or emergency services.

The role of social prescribing empowers individuals to take control of their own health and well-being. It supports a wide range of emotional and social needs using community-centred approaches. Through collaboration and creating partnerships within communities, Lakeside has introduced social prescribing at several of its PCNs to enable patient care at a local partnership and community level.

Personalised care for patients

Lakeside's social prescribers break down patients' concerns and together they set goals, covering aspects such as mental health, financial difficulties, housing, bereavement, loneliness and isolation, social care, weight management, domestic violence, and substance misuse.

The level of support provided by social prescribers depends on the patient, with an emphasis on personalised care. Some patients may require a simple signpost to another service and not need any further support, while others whose social situations cannot be easily overcome will work with the social prescriber for up to a year.

Through the process, Lakeside has learned that there is no 'one size fits all' in its communities, but from exposure and learning it has become flexible and adapts delivery of personalised care across communities. For example, in one community where many patients feel isolated, weekly 'Wellbeing Walks' are offered. In another, they are working with the local rough sleeping outreach team to deliver medical and social care to the homeless community.

1 https://www.longtermplan.nhs.uk

This holistic approach has highlighted the benefits of system working. In addition to local programmes, Lakeside has developed pathways for personalised care teams to support patients with early cancer diagnosis through one-to-one care. When a patient is newly diagnosed with cancer at their local trust, shared clinical information allows the partnership to offer social prescribing for those who could most benefit – particularly those living with significant uncertainty in the early days of diagnosis.

Lakeside can also direct patients to the most appropriate help, including from community, charity or NHS organisations. From reviewing the success of these pathways, the partnership has established an opportunity to deliver similar care to patients with dementia or who have learning disabilities and aims to implement these.

By working at scale, Lakeside has managed to roll out the service across a much wider area than a single practice. Starting with just one social prescriber in 2019, Lakeside has now expanded the scheme across several of its PCNs, each with its own personalised care team lead who works with practices, systems and community assets to improve patient offerings and facilitate the sharing of best practice.

Lakeside's PCNs now have over 30 personalised care team members, including social prescribing link workers, health and wellbeing coaches and care coordinators.

Through effective information sharing, integrated approaches to care and a commitment to expanding the primary care team to better support patient needs, the scheme has resulted in an improved service for patients who previously felt isolated or let down by health services, building their confidence and offering support in a setting where they feel most comfortable. It presents the opportunity for personalised primary care and preventative approaches to manage people's concerns before they escalate, relieving pressure on the wider system.

CASE STUDY

HURLEY GROUP – A GAMBLING TREATMENT SERVICE

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Implementing new service models at scale

The Hurley Group is a London-based GP partnership, caring for 120,000 registered patients across 12 practices. The group also provides urgent care and out-of-hours services to 250,000 patients in Bexley and the Practitioner Health Service for GPs in England and Scotland.

Gambling addiction is an increasingly problematic area that is often challenging to uncover in patients. Many of those who gamble do so online and out of sight of even their closest family, and the addiction can have a devastating impact on the individual, their families, and the wider community.

To address these issues and improve the responsiveness of GPs to those with gambling addiction, Hurley Group has established a primary care gambling treatment service (PCGS). The PCGS improves patient outcomes for those with gambling addiction and their affected others and supports the primary care workforce in identifying and supporting them.

Working at scale has allowed Hurley Group to care for a much wider geographical area. What started as a London-based service now works effectively across the UK as a virtual service, receiving referrals from all four of the UK's nations.

Identifying problem gamblers and ensuring they, and affected others, receive treatment

Hurley Group has established a GP-led, community-based, national multidisciplinary treatment service for those who have a problem with gambling and their affected friends and family. This has involved cultivating all aspects of an NHS treatment service, including clinical records, prescribing capabilities, clinical staff and networks, and communication pathways.

Harnessing and demonstrating the potential of system working, a shared care model has been developed. It collaborates with nine third sector organisations to provide expert medical and nursing advice, as well as support and receive patients for assessment and treatment. Working together, they have established governance arrangements, referral pathways and effective, efficient, and safe care pathways. The intermediate, evidence-based treatment service aims to tend to patients' needs holistically, reducing the need for onward referrals for those with problem gambling.

As well as patients having the option to self-refer via its website, referrals are accepted from GPs, voluntary sector organisations, and through word of mouth. The service also supports GPs in improving their identification of patients with gambling disorders.

To help establish the service more widely, the medical lead for PCGS is working closely with the Royal College of General Practitioners (RCGP) to help create a curricular and

training programme for primary care to help improve GPs' skills and knowledge of gambling addiction. A competency framework has been created for GPs and primary care staff with RCGP accreditation.

Since the service was launched at the start of the Covid-19 pandemic, waiting times for care have been reduced from 12 months to two weeks, and problem gambling referrals have increased from zero to around 60 per month. The service is expected to expand further, highlighting the opportunity for primary care to treat gambling addiction in the community.

CASE STUDY

SYMPHONY HEALTHCARE SERVICES – CENTRALISATION AND STANDARDISATION

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Standardising and centralising shared functions to improve resilience

Symphony Healthcare Services (Symphony Healthcare) is a wholly owned subsidiary of Somerset NHS Foundation Trust, providing NHS services through the management of 17 practices over 22 locations, predominantly in Somerset. It supports the care of approximately 134,000 patients and contributes to the work of 10 primary care networks (PCNs), one of which solely consists of Symphony Healthcare surgeries. It uses its expertise from working at scale to work closely with other PCNs, other large scale primary care bodies and trusts to learn and share best practice.

General practice has faced increased demand in recent years. This has led to heavier workloads alongside financial constraints due to insufficient funding, exacerbated by workforce pressures, particularly relating to recruitment and retention. To combat these pressures, Symphony Healthcare has developed a model to support its sites in having greater resilience and sustainability for the future. Working at scale has allowed Symphony Healthcare to cut operational costs by standardising and centralising shared functions.

The model focuses on skills and expertise and has involved the centralisation and standardisation of several key functions. These include:

- **Human resources:** Functions such as payroll, recruitment, employee relations and training and development.
- **An in-house locum agency:** This doubled the number of available bank staff in less than a year.
- **Finances and facilities management:** With a dedicated finance team and an automated invoice payment/approval system.
- **Procurement:** For example, procurement of energy and consumables to leverage scale and drive cost effectiveness.
- **Data performance:** Safety and performance scorecards, that are easily accessible to manage performance and maximise financial returns from funding streams such as the quality outcomes framework.
- **Digital innovations:** For instance, a standardised cloud-based telephony platform.
- **Document management:** 80% of clinical administration managed through a central hub, freeing up time for GPs (approximately four hours per day per practice, equating to an extra 4,000 appointments annually across the organisation).
- **Preparedness for Care Quality Commission inspections:** A dedicated team to prepare practices for inspections and support standardisation of high-quality care and processes across all the practices. Upon acquisition by Symphony Healthcare, most practices were rated as requiring improvement or inadequate but are now all rated good, with one rated outstanding.

- **Training and Education:** To support development at undergraduate and postgraduate level. In addition to GPs, student training is provided to nurses, paramedics and other clinicians. Symphony Healthcare aims for all its practices to become training practices.

Overall, the organisation has realised an estimated £500,000 in savings by centralising these key back office functions while improving processes and support to practices.

Symphony Healthcare's standardisation and centralisation of key shared functions demonstrate the opportunities of at scale working to improve resilience in primary care settings, particularly in the face of growing pressures.

CASE STUDY

SYMPHONY HEALTHCARE SERVICES – HIGH RISK MEDICATION MONITORING

5

Centralising systems and standardisation

The combination of growing demand, financial restraints and workforce pressures presents an increasingly tough challenge for practices to maintain standards of care. Working at scale provides the opportunity to improve processes and focus on patient outcomes without draining resources from individual practices, supporting greater resilience in primary care settings. With Care Quality Commission inspections on the horizon, Symphony Healthcare Services (Symphony Healthcare) sought to ensure its practices are compliant with regards to their high risk medication monitoring.

Improving processes around high risk medication monitoring

Some medicines prescribed by GPs, such as insulin for diabetes or lithium for some mental health conditions, are considered 'high risk'. This means they could cause patients harm if not prescribed, monitored, and administered with due diligence.

At scale working allows Symphony Healthcare to detect areas for improvement in high risk medication monitoring at its practices and address them, share best practice, and develop standard operating procedures. Using the searches available in its clinical system as a base, Symphony Healthcare has created a scorecard to provide a snapshot of performance across multiple indicators. These include high risk medications, safety alerts and possible missed diagnoses of conditions such as diabetes.

Practice performance is reviewed at monthly meetings, and where indicators are below target, actions are put in place to improve. These actions include:

- **Drug monitoring:** The majority of these indicators require up to date tests to ensure the medication is providing the right intervention and there are no adverse effects. Some patients require medication reviews to discuss usage. A standard operating procedure for recalling patients has been developed, which covers proactively inviting them in when monitoring tests are due and reactively reminding them when issuing prescriptions. It also includes reducing prescription length for non-responders.
- **Missed diagnosis:** Patients are reviewed by a clinician and informed of new diagnoses if appropriate.
- **Long term health conditions:** Some patients are recalled to ensure monitoring is in line with the most up to date guidance. Others are reviewed by long-term condition nurses to ensure their condition is well managed.
- **Safety Alerts:** Patients are reviewed and prescriptions either stopped, switched to an alternative or informed of the risks of taking the medication.

Symphony Healthcare has used other at scale provisions, such as its medicines management hub, to monitor indicators on behalf of the practice and act on them by, for example, reducing doses or switching medications.

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The medicines management hub team comprises prescription clerks, medication optimisation assistants, apprentice pharmacy technicians and pharmacy technicians. They work closely with the practice and primary care network pharmacists. The hubs process prescription requests for the practices, reconcile medications, and conduct medication reviews.

Best practice is shared across sites. For example, patient information letters on certain medications have been imported into each clinical system for practices to send.

In using its data and analytics capacity to enhance the support available to patients, hundreds of patients have been appropriately monitored, reviewed, and informed of any risks relating to their medication, helping to reduce unwarranted variation across practices.

The effective management of high risk medicines demonstrates the opportunities available in primary care to treat and manage conditions such as diabetes. This benefits the wider health and social care system by reducing the likelihood of additional treatment in acute settings.

CASE STUDY

MODALITY PARTNERSHIP – HEALTH COACHING

6

Increasing access to lifestyle management and support services

Modality Partnership (Modality) is an NHS GP super-partnership with 130 partners, providing primary healthcare to 450,000 patients and community services across nine regions of the UK. It provides community services for trusts, promoting out of hospital solutions during increased pressure in secondary care.

A significant volume of patients requiring personalised care planning, goal setting, management and support can be seen by highly skilled non-clinical roles. At scale working presents opportunities to adopt a population health approach, drawing on wider primary care teams to prevent ill health and improve patient outcomes. Modality has implemented a new strategic approach to workforce planning and increasing patient access and support.

An international, remote health coaching service

Modality has collaborated with a market leading provider in Mumbai to design and implement an innovative remote coaching service that offers personalised care to patients requiring lifestyle management and support. This could relate to diet, physical activity, mental wellbeing, and long-term conditions.

The international coaches, working across multiple time zones to provide patients with a flexible and convenient service, have been trained, inducted and developed locally to align with NHS pathways.

The team of 22 qualified multi-lingual coaches work to provide a flexible and convenient service to patients, with one whole-time equivalent coach providing around 400 appointments per month.

Referrals are taken from GPs and other clinical team members working in primary care. Patients are proactively monitored and reviewed to ensure progress and support are in place, supervised remotely by an experienced clinician.

Through targeted engagement with both practice teams and patients, the key focus has been to break down barriers and foster acceptance of a 'new' workforce, demonstrating agile working, flexibility, role redesign and innovation.

The new model has alleviated day-to-day operational pressures and provided workforce resilience, increasing staff satisfaction and reducing administrative burden for practices. It has freed up time for GPs to offer appointments for more complex patients with multiple conditions and needs. For patients, it has improved health and wellbeing outcomes and GP access, with medication use reduced in 85% of patients accessing the coaching service.

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A longitudinal review of A&E attendances throughout the coaching service suggests that presentations by frequent attendees were reduced, indicating the opportunity for system-wide savings and the reduction of pressure on secondary providers.

By focusing on preventing issues such as social isolation and poor mental health, the project has demonstrated how at scale working can contribute to population health management approaches and provide out of hospital solutions for people with long-term conditions.

CASE STUDY

MODALITY PARTNERSHIP – ROBOTIC PROCESS AUTOMATION

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Investing in new technology to drive efficiency, workforce resilience and patient access

Processing lengthy email consultation forms is one of the more burdensome tasks involved in running a general practice. Due to the time taken, it affects both staff morale for those processing and reading the forms, and patients' timely access to appointments. Administrative teams ensure individual email consultations are matched to patient records and appointments are allocated, while clinicians are responsible for reading the entire form before an appointment to understand the nature of the request. Working at scale provides the opportunity to afford large-scale investments in new technology to address such issues.

With the volume of email consultations increasing at its practices, Modality Partnership (Modality) has invested in new technology to drive efficiency, workforce resilience and patient access.

A digital solution to operational pressures

Modality has designed, built and implemented a robotic process automation (RPA) system across 49 sites across England. With the automation, a bot transfers pertinent information from the consultation form to patient notes and allocates the case to the most appropriate team member for action. This reduces administrative burden and ensures clinician time is maximised per consultation.

The RPA bots have also freed up clinical time to provide more appointments, reducing the time a clinician spends reviewing an email consultation by summarising key points into the patient records. The reduced administrative burden for GPs is equivalent to 1.5 whole-time equivalent GP time per practice (based on a caseload of 30,000 patients) per month. Pre-automation, the clinical time spent per email consultation was 10 minutes, and the administrative time was six minutes. Post automation the administrative processing time is eight and a half minutes, and the administrative processing time is three and a half minutes. The resulting reduction in staffing costs has achieved a 200% return on investment.

By removing human error, processing accuracy has also improved, and clinical variation has been reduced. Modality expects improved decision-making and patient satisfaction, with an additional 270k appointments already delivered to date thanks to the improved use of clinician time.

Staff satisfaction has also increased, with day to day operational pressures alleviated and the volume of manual, burdensome work decreased. This has helped to maintain services and increase workforce resilience.

The RPA system highlights the benefits of investing in new technology to relieve everyday pressures in general practice, boost workforce morale and reduce clinical variation.

CASE STUDY

INTRAHEALTH – SHARING STAFF AND EXPERTISE

8

Deploying staff across sites according to need

IntraHealth is a limited company and at scale provider of NHS primary care and community services, operating 10 practices and five community pharmacies in the north east of England and providing community care across the Midlands and north of England. It serves a patient population of 54,000.

Staffing shortages across the wider healthcare system have impacted service provision and workforce morale.

IntraHealth has maximised the benefits of having clinicians working across its various sites, particularly for smaller practices. It sought to upskill and support greater resilience in its workforce, and has achieved this through a variety of methods:

Sharing learning

For example, a larger practice develops a medication protocol then teaches smaller practices how to adopt it successfully. IntraHealth also encourages clinicians with specific interests to develop bespoke training, such as a module on interpreting blood test results, which can then be shared with other practices and the wider organisation.

Sharing staff across smaller sites

This means that support is available for individual practices struggling to deliver training and development. This provision of support has been well-received by staff and creates opportunities for sharing skills, which helps to embed a learning culture across practices. It enables teams and individuals to solve problems in new environments and aids their personal development.

Sharing staff between clinical services and primary care teams

IntraHealth has a clinical services division and a primary care division and often uses staff from one to support the other. This helps with staffing shortages at key points during the year. During the pandemic, the clinical services team took over Covid-19 vaccinations for IntraHealth practices, releasing pressure from primary care staff at a critical time.

By taking advantage of how at scale working can support system goals alongside day-to-day primary care activity, Intrahealth has maximised both their GP workforce's capacity and ensured patients can be seen by those best placed to support them.

CASE STUDY

OPEROSE HEALTH GROUP – A CUSTOMISABLE DASHBOARD PLATFORM

9

Deploying new technology at scale

Operose Health is a directly owned subsidiary company of Centene[1] that provides NHS primary care to 640,000 patients, operating 66 practices across England. As part of its commitment to work with the wider health and care system, Operose Health collaborates with trusts across the country to, for example, reduce emergency department attendance.

Improved data analysis and interpretation is a nationwide priority across the NHS and presents the opportunity to drive improvements for patients, populations, and systems. However, staff time and funding can be limiting factors in establishing data driven projects, particularly at smaller GP practices. Working at scale can support practices by providing the time, capacity and expertise to use, interpret and implement data-driven change.

Operose Health has developed a customisable dashboard platform called EZ Analytics (EZ-A) to drive improvements across all primary care areas. It can identify areas of variation, benchmark practices against local and national outcomes, tackle inequalities and optimise clinical and operational activity.

New technology at scale to manage population health

EZ-A had to be deployed at scale to manage population health across a primary care network or wider region effectively. It allows practices to use a structured and organised data-driven approach to deliver better experience and care for patients. This drives efficiency for the practice, reduces the likelihood of further complications, and streamlines practice operations, saving valuable time for staff.

EZ-A was developed in house by Operose Health and was launched in 2017. It was designed to incorporate key performance data from all clinical systems and is now firmly embedded across the group and is used by other primary care providers and local authorities. Some of its benefits include:

- Benchmarking performance across a set of clinical indicators.
- Gaining insight into improving long-term condition management.
- Improving practice sustainability.
- Optimising and improving medicine safety.
- Improving immunisation performance.
- Accessing financial reports to make improvements based on profits and losses and simplify payments to GP providers.
- Identifying and proactively managing patients with multiple morbidities.
- Monitoring performance, setting goals and supporting decision making.

1 https://www.centene.com

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EZ-A has effected large and sustained improvements in medication monitoring in more | than 30 high risk drugs and many long-term conditions. The group has also seen significantly increased detection rates across various long-term conditions. The platform highlights the benefits of harnessing new technology at scale to adopt a population health approach and improve patient outcomes while driving efficiency in general practice.

CASE STUDY

OPEROSE HEALTH GROUP – A 12-MONTH HEALTH INEQUALITIES PROJECT

10

Improving long-term condition management

Hypertension, or high blood pressure, is often referred to as a 'silent killer', with the British Heart Foundation and Stroke Association attributing around 50% of heart attacks and strokes to hypertension. With its much higher prevalence in ethnic minorities and deprived groups, the NHS' National Healthcare Inequalities Improvement Programme has included hypertension as one of five clinical areas of focus which require accelerated improvement.

The London borough of Lambeth has a deprived and highly diverse population, whose black community has more than double the hypertension rate seen in the white population. Operose Health launched a 12-month programme at two of its practices in the borough to challenge some of the organisational and social factors contributing to this healthcare inequality.

Tackling inequalities in blood pressure control

A 12-month project was initiated at two of Operose Health's practices, Edith Cavell Surgery and Streatham High Practice, to improve overall control of hypertension for all patients – with a particular focus on patients from black African and black Caribbean backgrounds.

The programme was led by a senior GP and primary care network (PCN) manager who organised an approach involving centralised recall and pharmacist teams working alongside practice-based pharmacists and health care assistants (HCAs).

The team used Operose's data analytics platform, EZ Analytics, to identify those most at risk, and monitor real-time progress. Identified patients were contacted directly, and staff with language skills or interpreters helped the programme maximise its reach.

Once contacted, the team arranged for patients to provide a home blood pressure reading or attend the practice or local pharmacy for assessment. If repeated readings gave cause for concern, patients were booked in for an appointment in a dedicated pharmacist clinic to receive guidance and education around self-care and information about lifestyle approaches and medication.

At the start of the project, across the Lambeth PCN, 67% of white and only 55% of black patients aged under 80 with hypertension were being treated, representing a 12% inequality gap. Over the course of the 12 month project, this inequality gap in blood pressure treatment between black and white patients was eradicated. In addition, over 300 patients from the local community were newly diagnosed, and over 2,000 NHS health checks were carried out by the HCA and nursing team in 12 months.

The Lambeth hypertension programme demonstrates the opportunities available in primary care to identify, focus on and address health inequalities in local communities. This benefits the wider health and social care system by reducing the likelihood or acuity of additional treatment, for example, due to the incidence of stroke and heart attack.

CONCLUSION

These case studies demonstrate how working at scale has enabled primary care to overcome long-standing challenges, including workforce resilience, the use of data and technology, and the introduction of population health approaches in order to better support patients and reduce system-wide pressures.

As working across footprints larger than single practices continues to mature – whether via primary care networks, federations, integration with trusts or through super practices – these case studies help to illustrate the opportunities that exist in harnessing the benefits of scale.

At scale working can help to support the primary/secondary care interface, both via multidisciplinary teams spanning primary and community care, or through the ability to collect, interpret and use data to keep people healthy and out of hospital. These case studies show how at scale working has benefited both patients and the wider system by managing clinical risk in the community.

Through adopting preventative approaches and addressing patients' needs by using both technology and an expanded skill mix, working at scale can help improve population health and support the development of integrated neighbourhood teams, as promoted in publications such as the Fuller Stocktake.

We hope the case studies presented help to provide some insight into how these approaches have been successfully adopted to deliver real outcomes for both patients and organisations, and demonstrate how working at scale can continue to address national policy priorities.

ABOUT THE AT SCALE PRIMARY CARE NETWORKING GROUP

The At Scale Primary Care Networking Group brings together the leaders of an influential group of large-scale primary care providers to share information, resources and ideas to help advance the development of primary care.

The group includes thought leaders from several well-known large-scale practices covering significant patient populations across the country, all with an interest in and commitment to innovation which improves patient care.

Suggested citation

NHS Providers (October 2023),
System aims, at scale solutions – The contribution of at scale primary care to system working.

Interactive version

This report is also available in a digital format via:
www.nhsproviders.org/at-scale-primary-care-report

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