

Longer, healthier lives for  
all the people in Croydon

**NHS**

**Croydon**

***Clinical Commissioning Group***

# Reducing Variation in Primary Care Strategy

September 2014



# REDUCING VARIATION IN PRIMARY CARE STRATEGY

## 1. Introduction

The Reducing Variation in Primary Care Strategy should be seen as one of the enabling strategies that will further strengthen primary care to enable the delivery of the CCG's Primary Care and Community Strategy. It also supports the provision and delivery of primary care services within Croydon as one of the enabling elements for a significant proportion of the Quality, Innovation, Productivity and Prevention (QIPP) projects being undertaken within the Borough and South West London region.<sup>1</sup> Existing and developing services will benefit where optimisation and standardisation of practice is possible. Evidence shows that Croydon has some areas of wider variation in practice than some of its peers and this should be seen as an opportunity to improve the overall experience for the people of Croydon and consequently in reducing spend.<sup>2, 3</sup>

National and local context supports the development of this work with a strong case for focussing on consistent high quality services and an integrated approach focussed around the patient.

The major risks to this programme are around skills and capacity within both the CCG and practices to deliver this programme and the wider systemic problems within Primary Care which may frustrate rather than support effective delivery of accessible, consistent high quality care that satisfies patients.

There will always be some variation in healthcare due to the complexity of variables that produce it (for example, characteristics of the individual patient, complexity of disease or unpredictability of symptoms). Such variation is reasonable and, even expected. However, the unwarranted variation in healthcare is the area for concern. What is unwarranted variation in care and why is it important to tackle it?

The most widely accepted definition of unwarranted variation is that conceived by John Wennberg:

*“(Unwarranted variation is) variation in the utilization of health care services that cannot be explained by variation in patient illness or patient preferences.”<sup>4</sup>*

The Wennberg's definition mostly relates to unwarranted clinical practice variation. Besides this there are different types of unwarranted variation in healthcare, such as in access to care and utilisation of services, variation in outcomes and quality, variation in activity and productivity<sup>5, 6</sup>. Quite often different types of variations intersect and cluster making it more difficult to identify and reduce the unwanted variation in care.

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<sup>1</sup> South West London 5 Year Strategic Plan (2014) South West London Collaborative Commissioning

<sup>2</sup> The NHS Atlas of Variation in Healthcare 2011. Available at: <http://www.rightcare.nhs.uk/index.php/nhs-atlas/atlas-downloads/>

<sup>3</sup> Health Profiles 2014, Public Health England. Available at:

<http://www.apho.org.uk/resource/view.aspx?RID=50215&SEARCH=croydon&SPEAR=>

<sup>4</sup> Wennberg JH (2010) *Tracking Medicine. A Researchers Quest to Understand Health Care*, OUP

<sup>5</sup> The NHS Confederation (2004) *Variation in Healthcare*, UK

<sup>6</sup> Department of Health (2010). *NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value and improve quality*. Available at: [www.rightcare.nhs.uk/atlas/](http://www.rightcare.nhs.uk/atlas/)

Unwarranted variation in primary care remains widespread in the healthcare of the population whose health care is commissioned by Croydon CCG, and this was evidenced a couple of years ago.<sup>7,8</sup> The quality of most primary care is good, yet there are wide variations in performance, quality and accessibility of primary care across Croydon. Some patients find it hard to get a convenient appointment with their GP and the services available are inconsistent. There are wide variations in quality and outcomes measures between different practices<sup>9,10</sup>.

The research indicates that unwarranted variation yields sub-optimal clinical outcomes and significant financial burdens.

*“If all variation were bad, solutions would be easy. The difficulty is in reducing the bad variation, which reflects the limits of professional knowledge and failures in its application, while preserving the good variation that makes care patient centred. When we fail, we provide services to patients who don’t need or wouldn’t choose them while we withhold the same services from people who do or would, generally making far more costly errors of overuse than of underuse.” (p341)<sup>11</sup>*

Despite this challenge Croydon CCG remains committed to improving the consistency of care for its population.<sup>12</sup>

The key driver is to improve the outcomes for all patients as part of their strategic goal for longer healthier lives. Potentially patients can benefit from:

- Reduced inappropriate hospital admissions resulting in better patient outcomes and experience for those exposed to those preventable admissions;
- Less duplication of tests and diagnostics from improved systems and processes resulting in better clinical outcomes and patient experience;
- More robust prescribing processes, delivering better patient safety and experience;
- Improved quality of referral and more targeted referral process means increased patient safety and better clinical outcomes. Equally this could result in a smoother experience for patients with quicker access to the right care and support.

To reduce unexpected or unwarranted variation in primary care, we need to identify the sources and work to reduce their impact on patient care and experience.

## **2. Purpose**

Consistency acts as a driver for quality care; therefore, managing variation is an essential quality improvement tool<sup>13</sup>. However, the complex interactions of the

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<sup>7</sup> Operating Plan 2013/14. Croydon Clinical Commissioning Group

<sup>8</sup> 5 Year Strategic Plan 2014 /19 & 2 Year Operating Plan 2014 / 16. NHS Croydon Clinical Commissioning Group

<sup>9</sup> Health Profiles 2014, Public Health England. Available at:

<http://www.apho.org.uk/resource/view.aspx?RID=50215&SEARCH=croydon&SPEAR=>

<sup>10</sup> Data from Outcomes benchmarking support packs: CCG level (2013) and Primary Care Web Tool

<sup>11</sup> Mulley, AJ. (2010) *Improving productivity in the NHS*.BMJ

<sup>12</sup> Croydon Clinical Commissioning Group Annual Report 2013-14

multiple causes of variation pose challenges in designing and implementing an effective strategy and action plan to deal with unwarranted variation. Transforming Primary Care focuses on driving quality improvements and establishing how data sets, information and indicators can be combined with evidence-based good practice to more effectively improve and assure quality and equality in general practice delivered care, and consequentially reduce variations of quality across the Croydon health and social care economy.

The core goals of the Reducing Primary Care Variation Strategy for NHS Croydon CCG are to:

- Improve the quality of care and increase accountability;
- Improve health outcomes;
- Reduce operational costs;
- Reduce health care inequalities;
- Improve accessibility and patient satisfaction;
- Improve performance across all primary care providers for the people of Croydon, working in partnership with all appropriate stakeholders including the local authority to drive up service quality and reduce variation.

The CCG has 3 primary roles in reducing primary care variation:

### **1) Partnership Role**

- The CCG has a role in supporting the member practices in reducing variation in outcomes and activity and improving care quality in primary care. We need to support primary care teams in taking a proactive approach that ensures patients are identified to prevent ill health and ensure that their conditions are effectively managed to improve their independence and well-being; reduce unscheduled hospital attendance and admission; and improve health outcomes. We will drive improvements in care and reduction in unwarranted variation by providing clinicians with more timely and accurate data, information and knowledge they need to identify and prioritise areas for quality improvement, support for best practice implementation and development to meet the ever increasing need and complexity of population healthcare.

### **2) Improvement role**

- Many general practices are engaged in quality improvement initiatives and are proactive in seeking to deliver improvements in care. However, quality improvement is not yet routinely embedded as a way of working. Practices need to be supported in creating an environment within which quality improvement can flourish.
- GPs are often unaware of the variations in quality that exist within and between their practices and those of their peers. Making clinicians aware of such variations is a first step to encouraging them to explore the reasons for variable

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<sup>13</sup> The NHS Confederation (2004) *Variation in Healthcare*, UK

performance, and to act accordingly. Therefore, the CCG has a role to play in creating a learning environment that supports general practice in its quest for quality.

### 3) QIPP

- Good quality care generally costs less especially where it is well coordinated and meets the needs of the patient first time. Many of the individual components of the CCGs plans will deliver savings in the long term although it is likely that a period of investment to support the transformation and integration of services will be required.
- Reducing variation and increasing the use of best practice will optimise the delivery of quality care improving the cost of delivering the whole package of care to each patient

## 3. National context

Transforming primary care is an emerging national strategic picture, particularly in light of the development of the Call to Action for General Practice in November 2013 published by NHS England<sup>14</sup>. The change document highlights the increasingly unsustainable pressures that general practice and wider primary care services face such as:

- An ageing population, growing co-morbidities and increasing patient expectations, resulting in large increase in consultations, especially for older patients,
- Increasing pressure on NHS financial resources, which will intensify further from 2015/16
- Growing dissatisfaction with access to services.
- Persistent inequalities in access & quality of primary care, including twofold variation in GPs and nurses per head of population between more and less deprived areas
- Growing reports of workforce pressures including recruitment and retention problems

Primary Care will have a much stronger role, as part of a more integrated system of out-of-hospital care, by reducing the use of secondary care for basic healthcare provision and in improving population health. Radical change is required to transform the delivery of care, reduce variation and improve quality, increase capability and productivity further, and to create capacity within primary care. Thus, this strategy will underpin delivery of NHS England's national objectives for general practice around variation which are:

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<sup>14</sup> NHS England (2013) *Transforming Primary Care in London: General Practice A Call to Action*

- 1 – Proactive co-ordination of care, particularly for people with long term conditions and more complex health and care problems;
- 2 - Providing holistic care by addressing people’s physical and mental health needs and social care prerequisites;
- 3 - Ensuring fast, responsive access to care and preventing avoidable A&E attendances and emergency admissions;
- 4 – Promoting health and wellbeing, reducing inequalities and preventing ill-health and illness progression at individual and community level;
- 5 – Personalising care by involving and empowering patients and carers to manage their own health and care;
- 6 - Ensuring consistently high-quality, cost-effective and high-value care.

The national objectives are delineated in the King’s Fund paper “Securing the future of general practice” (2013) which highlighted that to be fit for the future, general practice needs to be capable of fulfilling the five following functions<sup>15</sup>:

- Improving population health
- Managing short-term, non-urgent episodes of minor illness or injury
- Managing and coordinating the health and care of those with long-term conditions
- Managing urgent episodes of illness or injury
- Managing and coordinating care for those who are nearing the end of their lives

#### **4. Local context**

Locally primary care faces the following challenges:

- The Croydon population is growing, more people are living with multiple long term conditions or complex health needs<sup>16</sup>
- The prevalence of conditions affecting the ageing population is increasing, including dementia and falls
- General practices are being required to be more productive overall and provide more access flexibility to services, including a GP of patient’s choice
- Croydon has wide variation in key areas of emergency attendance, admission and outpatient referral
- A significant number of practices are outliers on national indicators
- Under diagnosis in key conditions, such as COPD and dementia

Croydon CCG 5 year plan defines the following priorities:

- Reduce differences in life expectancy between communities
- Support children and young people to achieve their full potential
- Improve patient experience in hospital and primary care
- Increased planned and urgent care services provided closer to home

<sup>15</sup> Smith J, Holder H, Edwards N, Maybin J, Parker H, Rosen R & Walsh N (2013) *Securing the Future of General Practice: New models of primary care*. London: The King’s Fund and the Nuffield Trust

<sup>16</sup> JSNA on the Croydon Observatory. Available at: <http://www.croydonobservatory.org/jsna/chapters201213/>

- Increasing the proportion of older people living independently at home following discharge from hospital
- Improve the health related quality of life of people with long term conditions and vulnerable adults

The priorities drive the Integrated Strategic Operating Plan with Reducing Variation in Primary Care initiative acting as an enabler to achieve and deliver the CCG priorities.

Croydon CCG is working towards the goal to address health inequalities across the whole borough. As such this is a key aspect of how the CCG is making a contribution to addressing the issues that have been identified in the JSNA<sup>17</sup>. The issues highlighted in the JSNA reflect directly through to several of our commissioning priorities highlighted in this strategy. The CCG's contribution to reducing the health inequality gap is addressed by tackling some of the lifestyle issues and causes of premature death that are identified in the JSNA. The CCG has prioritised improving access to cardiology services, improving diabetes services, and improving stroke care – all of which contribute to reducing mortality from cardiovascular disease.

## **5. Priorities**

A comprehensive range of data have been gathered and analysed from a variety of sources (available separately). Four priority areas have been identified from this analysis:

### **1 – Primary Care Variation**

There are wide variations in patient experiences in terms of access to care, continuity of care, and patient engagement. Patients remain poorly engaged in making decisions about their own health and more could be done to support patients to make choices, to be engaged in decision-making, and to care for themselves.

### **2 – Access to Care**

Improving access to quality primary care is at the heart of this strategy. Improving access means providing care at convenient times and offering a wider range of services delivered in a flexible way that meets the specific needs of our patients. We will continue to improve access by providing care at convenient times and offering a wider range of services delivered in a flexible way that meets the specific needs of our patients.

### **3 - Community Based Services**

Significant potential exists for reducing the number of emergency hospital admissions for conditions that could have been managed in primary care. Currently, many of our patients are being admitted to hospital when well-coordinated community services could care for them effectively in their own homes. In the future, more patients will be supported at home and in the community instead of having to go to hospital.

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<sup>17</sup> JSNA on the Croydon Observatory. Available at: <http://www.croydonobservatory.org/jsna/chapters201213/>

#### 4 - Integration and Care Coordination

There is considerable scope to improve the quality of care co-ordination for patients with long-term chronic and mental illnesses, for those at the end of life, and in maternity care. Links between general practice and other services need to be strengthened in areas where patients with complex problems receive care from multiple providers.

Reducing Variation in Primary Care can be split using the QIPP domains as the signposts to map the objectives of the strategy. The domains and overarching themes encompass the criteria of the efficient and high quality care associated with improved patient satisfaction, reduced urgent care activity and emergency attendances, minimised care variation, lower health inequalities and better value for money.

The following nine domains formed the framework to determine the areas of consideration and priority for the Reducing Variation in Primary Care strategy:

1. **Diagnosis** – Current variation in diagnosis means there is scope to reduce delays and errors in the diagnostic process and focus on assessing and improving the quality of diagnosis
2. **Referral** – Current variation in referral pathways means there is scope to improve the appropriateness and quality of referral practice and decision-making
3. **Prescribing** – Current variation in prescribing practice means there is scope to reduce medication errors, improve adherence, and rationalise prescribing practices
4. **Acute illness** – Current variation in practice means there is scope to focus on appropriate and effective diagnosis and develop efficient acute illness management
5. **Long term conditions** – Current variation in practice means there is scope to focus on developing proactive preventative activities and management strategies
6. **Health promotion** – Current variation in health promotion means there is scope to target childhood immunisation, be proactive about smoking cessation, weight management and other health and well –being incentives
7. **Accessibility to services** – Current variation in practice means there is scope to rationalise consistent access and availability of clinicians by reducing urgent care activity, for example.
8. **Continuity of care** – Current variation in the continuity of care means there is scope to enable patients to see the same doctor and other clinical staff and develop an effective and therapeutical relationship with them
9. **Patient engagement and involvement** – Current variation in patient engagement and involvement means there is scope to empower and involve patients in all decisions about their care and treatment and to proactively seek feedback on their experience

Additionally the above domains or priorities should be seen alongside the following overarching themes and should be embedded within them:

- *Comprehensive services* – care provision with ability to meet the majority of patient’s physical and mental health care needs
- *Patient-centred care* – holistic approach to care management, interactions concern the whole person
- *Co-ordination of care* - support the co-ordination of health and social care to people with long term conditions, mental illness and those at the end-of-life

## 6. Enablers

To support the change and the delivery of our Primary Care Variance Reduction Strategy we have identified key enablers:

- Integrated working with all providers in health and social care
- Comprehensive knowledge of evidence-based practice
- Quality and competence of the primary care workforce
- Education and training for the workforce
- Reliable and well understood information sources and data sets
- Better and smarter use of information tools and technology

## 7. Benefits and Outcomes

The Reducing Variation in Primary Care strategic framework is anticipated to deliver the following benefits:

<p><b><i>Reduced variation resulting in improved and more consistent health outcomes</i></b></p>	<p>A transformational change in the way primary care operates as both a commissioner and as a provider of services so there is a reduction in variation and patients can benefit from improved health outcomes. A set of standards and evidence-based clinical pathways for care outside hospital will be developed. These standards and pathways will provide a mechanism for reducing variation across primary care and measuring and, more importantly, improving quality. The CCG members will consistently provide high quality and safe care as evidenced through appropriate quality assurance systems and the production of transparent, publicly available benchmarking data. We will utilise the CCG Dashboard tool to identify outliers within the practices and develop action plans to improve quality of care and reduce inequalities. Comparative variation data, when used to study practice patterns, can improve the quality of care.</p>
<p><b><i>Patient involvement and empowerment with resulting</i></b></p>	<p>Efficient and understandable care pathways will be provided, developed and will transform patients experience such that the patient is always at the centre. Patients will have access to their own care records and be provided with evidence</p>

<b><i>improvement in experience</i></b>	based and accessible information in order to work as partners with professionals to manage their health. Engage primary and community care health professionals to address inequalities in health and variation in access to services.
<b><i>Integrated care delivery network across providers centred around the patient</i></b>	Patients with long term conditions will have access to an integrated care team designed around their own needs to ensure their conditions are managed effectively. Pathways, both existing and new, will be developed to ensure an integrated approach is taken for the patient – primarily between primary and secondary care but also with social services for the provision of additional services for patients.
<b><i>Consistency and continuity of care is improved</i></b>	<p>Practices will be working in a more collaborative way to ensure consistency and continuity of care, utilising specialist skills where necessary so patients benefit from care closer to home.</p> <p>Best practice sharing - Supporting the development of more cohesive systems of care through innovative ways of working across the networks will provide an opportunity to share best practice. Improved and standardised information and data sharing across practices, facilitated by improved access to benchmarking information and comparative data, which will be shared across our CCG networks.</p>
<b><i>Access and Responsiveness more closely meets patient demand and expectations</i></b>	There will be easy access to high quality, responsive primary care including a rapid response to urgent needs so that fewer patients need to access hospital emergency care. Croydon CCG will facilitate the further development of robust systems to provide a consistent primary medical urgent care response. This also involves access to diagnostics and efficient structure to support the patient care pathways and urgent health needs with good coding and reporting.
<b><i>Enhanced local health services</i></b>	The task will be to standardise, where appropriate and improve the range and quality of services. Patients will access enhanced local health services within their communities easily and those services will work well together to ensure care remains within primary and community care where ever appropriate. This enabler involves creation of levers and incentives to facilitate collaboration within a range of primary medical care providers to offer an increased range of services within communities. We will encourage primary care providers to work collaboratively to share skills and resources by ensuring appropriate financial flows for outcomes delivered, monitored through agreed Key Performance Indicators (KPIs)

## **8. Delivering Change**

The CCG is seeking to understand and reduce variation in patient populations by supporting practices in analysing their baselines, generating plans and monitoring process and outcome measures, utilising data to learn from and manage variation over time. By comparing past, present, and desired performance, the CCG will seek to reduce undesired variation and reinforce desired variation.

There are four steps to reducing variation in Primary Care:

1. Undertake an analysis of current quality, variation, capacity and capability and assess against desired levels
2. Generate practice action plans to develop primary and community care to meet the strategic objectives
3. Monitor progress against plans and the outcome measures
4. Establish a process to receive feedback from patients on their experience through the programme of change

This Strategy outlines the principles which will be used to design new services and review existing ones to ensure access to all communities and individuals. Using practice population profiles it is possible to determine where there are areas of higher disease prevalence and lower life expectancy. All practices will be supported in developing systems that support local patients in managing their disease better whilst using initiatives such as Making Every Contact Count to promote healthy lifestyles and prevent ill health occurring.

By commissioning services jointly with the local authority vulnerable groups will be supported in being able to make healthy choices and in developing their own well-being. Services for other groups such as the frail elderly will be designed to put the patient at the heart of the service with agencies working together to share information and provide better wrap-around care. Encouraging a holistic approach will be critical as the number of people coping with multiple co-morbidities increases.

There are a number of performance monitoring datasets already in use and we are combining these with the National Outcomes Frameworks to enable progress to be monitored in a consistent and systematic way. Nationally available data sets provide a rich source of material for measuring quality in general practice, but they have significant gaps. Other methods of harnessing information from data held within general practices are needed to supplement national quantitative indicators.

## **9. Risks**

- GP services vary significantly depending on the type, size, contract and management of the practice in terms of access, quality, and condition of premises and range of services available which means a focus will be required on ensuring that all practices are encouraged to work on this programme

- Limited capacity to respond to urgent care needs in and out of hours, this programme will enable a broader view on urgent care needs to be assessed
- CCG is a membership organisation and not the Primary Care Commissioner which means the style of leadership for this complex programme of transformation in primary care services must be inclusive, facilitative and motivational
- Multiple demands to respond to enhanced service requirements means that there is a risk that GPs do not have the time or energy to give to this programme. This means it will be important for the engagement element of the programme to be carefully mapped to provide a level of understanding to inform the pace of delivery across GP practices
- There are a significant number of single handed GPs (9 out of 60 practices, or 15%) who will require tailored support to meet their specific needs in being able to respond to this programme
- Large programme of transformation is required to change the environment to deliver with limited delivery capacity both within the CCG and within practices, this means that a key element of the programme will be consideration of the potential for environmental restrictions to restrict maximum delivery
- Managing variation will not resolve the systemic issues of an outdated model of healthcare which doesn't fully support the efficient delivery or proactive, preventative healthcare in an accessible way. This means that consideration will be required of new, meaningful health pathways that deliver tangible improvements in health outcomes and patient experience

## **10. Overview of Implementation Plan**

The CCG implementation plan aims to support practices in improving quality of care by reducing variation in outcome and experience. Initial work commenced in 2013/2014 at the inception of the CCG to lay the foundations for a wider programme of change.

The Transformation programme for year 2014/15 consists of 2 key programmes:

- Urgent Care
- Planned Care

Year 2014/15 objectives so far include:

- Peer review at network level of current practice for urgent care and outpatient referral through Practice Delivery and Developments scheme (PDDS)
- Monthly performance dashboard provided by the CCG allows practices to review and analyse their activity, identify gaps and training needs
- Implementation of Urology and Gastroenterology care pathways to support best practice delivery in these areas
- CReSS referral review and management service implemented

The main challenges identified are to:

- Improve further access to primary care services by working with practices to ensure opening hours are consistent with contractual arrangements
- Continue the implementation of standardised clinical pathways for patients to enable them to receive the right care at the right time in the right place
- Increase the number of people who are able to self-manage their health in relation to long term conditions and minor illnesses through effective health education and promotion
- Identify long term conditions earlier through more timely and reasonable health diagnostics
- Health promotion and prevention of ill health through targeted health promotion and prevention
- Improve the patient experience and design a process to receive regular feedback

The implementation approach can be broken down into the following distinct steps:

- 1- *Collating all the relevant care processes and outcome data*
- 2- *Create a shared baseline to drive prioritisation of opportunities*
- 3- *Reconfigure the care processes to support the delivery of evidence based care*
- 4- *Embed the change into the primary care culture*

An evaluation framework will be designed that supports developmental progressions, facilitates continuous learning and delivers an improvement process. The measures that will be used will include health outcomes, process, patient experience and cost data that collates the range of achievements and success and ensure sustainability.

A key consideration is to identify indicators which are measurable and meaningful in General Practice and that align with CCG priorities.

Practices will provide regular performance updates, at least quarterly, as an integral element of the governance of this programme to and to maintain momentum throughout the year. Updates will be presented to the clinical networks for review and assurance that sufficient progress is being made.

The CCG will provide supportive visits through the year to assess progress and support those who need additional help to ensure their plans are on track.

A detailed action plan for the domains has been developed and is being further refined along with a delivery guide. The current available measures and metrics for each domain are also being developed.

## **11. Resources**

The Reducing Primary Care Variation strategy builds on and brings together the existing work of practices, networks, commissioners and the engagement team. The plan is predicated on the Practice Delivery and Developments Scheme (PDDS) and the ongoing work across the QIPP programme. Following a review, including a

dedicated workshop and series of discussions it is proposed that further capacity is required to build on the infrastructure that supports Primary Care engagement. This will include the supporting elements such as supporting effective clinical networks, practice support, training needs analysis and delivery, providing practice and network level data streams and reporting progress through the governance structure. Clinical Leadership capacity will also need to be further enhanced.

## **12. Recommendation**

Following the review of the strategy and outline plan for Reducing Primary Care Variation a detailed implementation plan is being developed. The Governing Body are requested to approve the following overarching actions to take this work forward at pace:

- Review the strategy for reducing variation in Primary Care
- Approve the proposed overarching actions to take this work forward namely:
  - Use the data analysis already undertaken to identify key areas of variation in Primary Care to best prioritise the areas for support and development
  - To apply a benchmarking approach that supports ongoing Peer Review
  - Support practitioners in this programme through the Development and Delivery Scheme
  - Scope and review the data and IT tools required to ensure effective and timely delivery
  - Scope and develop a business case for additional capacity to support delivery of the above processes, drawing on the engagement skills developed in the Medicines Management Team.
  - Continue to support the development of Practice Managers in skills acquisition and involvement

Commission external support as required for e.g. mentoring and coaching clinical leads, improving specific practices needing support, supporting discussions on Federated Models to ensure sustainable changes lead to the effective reduction in variation in primary care so that all people in Croydon have access to equitable primary care regardless of their General Practice

Dr Leon Douglas, Head of Clinical Engagement/ Jolanta Juskaite, Best Practice and Delivery Manager

15 August 2014