Healthcare Improvement Scotland | ihub

GP Cluster Working Learning Cycle

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Contents

Introduction

Situation

It has been over five years since GP clusters were introduced in Scotland. With COVID-19 dramatically altering primary care, it was deemed vital to conduct a deep dive into GP clusters to reflect and inform the next steps for cluster development.

Background

GP clusters were introduced in Scotland during 2016-7 and were part of the 2018 General Medical Services (GMS) agreement between the Scottish GP Committee of the British Medical Association (BMA) Scotland and the Scottish Government. Even in this short time, cluster working had already evolved. However, COVID-19 dramatically altered primary care, and we are now working in a landscape where ways of working have changed. Processes and systems have had to adapt and technology has moved on rapidly.

Assessment

We have undertaken a learning cycle with the aim of having a better understanding of what is required for successful cluster working, what are the common barriers and enablers, and examples of good practice and/or ideas to enable successful cluster working.

Recommendation

Our aim is that the findings summarised in this report will help with reflecting on cluster working and discussing the next steps at both a local and national level. The findings from this learning cycle will inform future iterations of government policy for clusters.

How to use this report

Read the findings

This is a complex and multifaceted topic. We have layered the report and made it interactive so that you can choose the level of information you are interested in.

- The contents page outlines the content of this report. All pages in the report have an interactive button at the foot to return to this page, as seen on the bottom right of this page.
- The high level findings section gives you a one-page overview of the key themes.
- The framework is a visual summary of the key components required for successful cluster working. The framework is interactive and you can click on the specific component you are interested in. All pages in the report have an interactive button at the foot to return to this page, as seen on the bottom right of this page.
- The driver diagram builds on the framework and visually displays our findings on what 'drives' successful cluster working. You can access the key points and examples regarding specific components from here.

Reflect on the findings collectively

The list of questions for local reflection will help practice quality leads (PQLs), cluster quality leads (CQLs), Health and Social Care Partnerships (HSCPs) and NHS boards to reflect collectively on the next steps to support clusters considering their local context.

The list of areas for national reflection will help national organisations to reflect collectively on the next steps to support clusters at the national level.

The key points and the examples in each of the component sections can be helpful when considering next steps.

Overview of our work

Our aims

- To have a **better understanding** of:
  - the key components that enable successful cluster working, including intrinsic and extrinsic functions
  - the common barriers and enablers to cluster working, and
  - examples of good practice and ideas that enable successful cluster working.
- To **help reflection** on cluster working and the next steps at local and national level.

How we did it

- We applied the principles of the 90-day learning cycle methodology.

What we found

- See a summary of the **high level findings.**
- See the **framework of key components** for cluster working, with **key points** to consider under each component, including **examples.** A **driver diagram** accompanies the framework.
- See a **list of questions for local reflection**.
- See a **list of areas for national reflection**.

What is next

- **Disseminate the findings.**
- **PQLs, CQLs, HSCPs and NHS boards to reflect together** on the findings outlined in this report and discuss next steps locally.
- **Government, national organisations and key stakeholder representatives to reflect together** on the findings outlined in this report and discuss what should be done next at national level. This will inform future iterations of **policy guidance** for clusters.

Methodology

Preparatory work

We ran ten small exploratory meetings with CQLs from across Scotland. This helped us start identifying the key components for cluster working and areas to explore as part of the learning cycle. The questions we asked included:

24
CQLs engaged

- What works well in your cluster? Why?
- What doesn't work so well in your cluster? Why?
- What could help you?
- What are your expectations from the learning cycle?

Learning cycle

We followed the principles of the 90-day learning cycle methodology, combining expert knowledge and published literature.

Four members of the Primary Care Quality Improvement Faculty acted as critical friends and contributed their thoughts on emerging themes and their experiences in their local areas.

Interviews

We interviewed 21 key stakeholders to explore their perspectives on the themes from the exploratory meetings with CQLs.

21
people interviewed

Figure 1 outlines the geographical spread of the stakeholders who engaged in either the preparatory work or the learning cycle. Appendix A provides more details about the range of stakeholders.

Literature

We scanned relevant literature to inform our findings. See the Summary of Review Literature for more details.

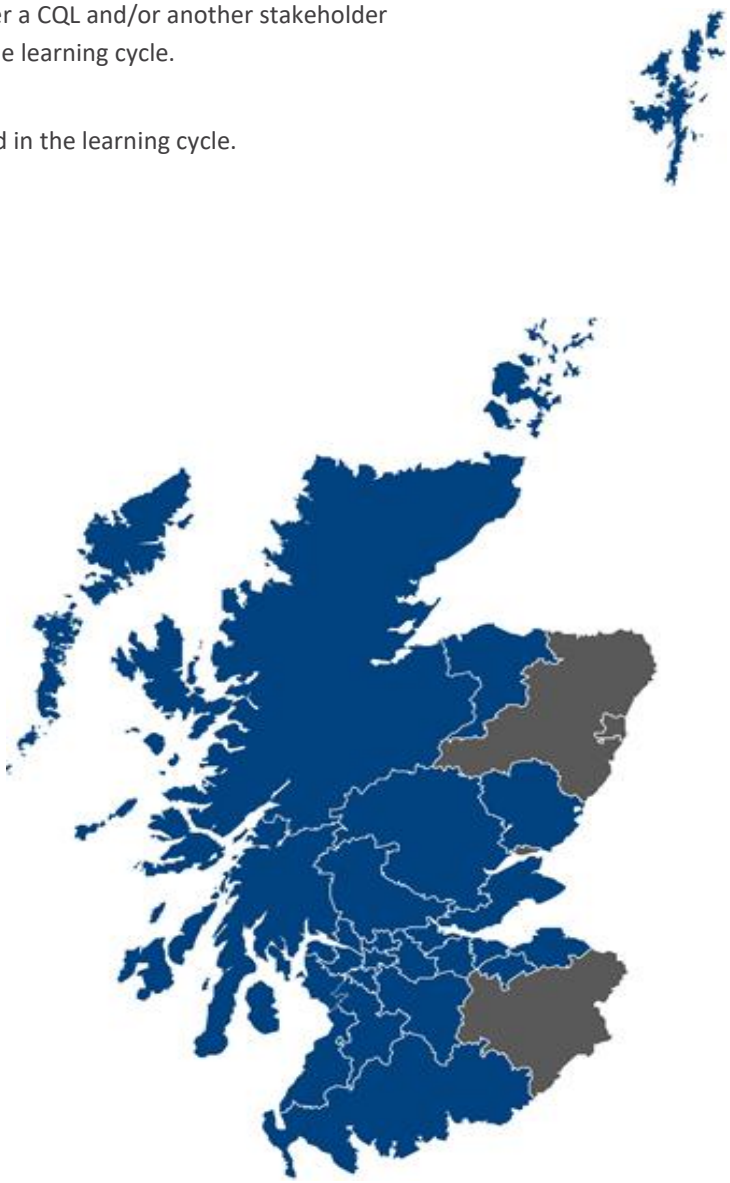
Limitations

- Validity – due to tight timescales and resources available we cannot claim to represent all views. Due to system pressures, some stakeholders were not available.
- Qualitative data are based on personal views, influenced by recent experiences.
- This report is a summary of the vast and rich information gathered in this process.

Figure 1: Geographical spread of stakeholders

Area where either a CQL and/or another stakeholder contributed to the learning cycle.

Area not engaged in the learning cycle.



High level findings

Below is a high level summary of our findings from the learning cycle.

1. Clusters are widely accepted as having **great potential** to improve the quality of care in primary care and within the whole system. However, implementation has **not** been **fully supported or prioritised**. There is **variation** across the country depending on individuals' enthusiasm and experience, support available and existing structures and relationships.

2. Overall, clusters have **achieved a substantial cultural change** as GPs are now coming together to share and discuss quality issues in a collaborative way in spite of their independent contractor status.

3. The **right conditions** need to be created first to enable successful cluster working. These include: having a shared understanding of the **vision and purpose** of clusters, having appropriate **structures** including **governance** mechanisms, providing **support** to clusters at different levels, and ensuring they have **resources** such as time, funding and IT, and also good **relationships** across the system.

4. **Quality Improvement**, **data**, **leadership** and **engagement** are the core components to ensure successful GP cluster working towards agreed **priorities**.

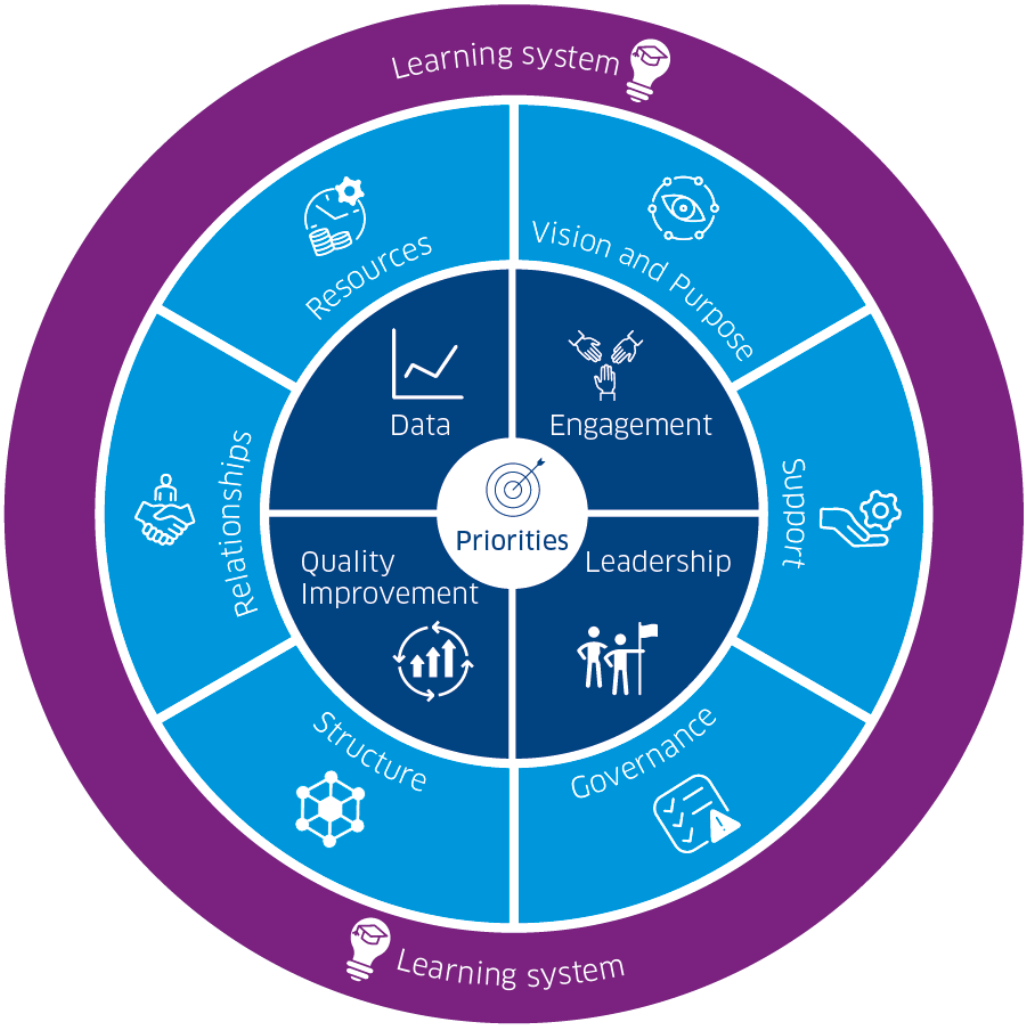
5. A **learning system** should support all the components required for successful cluster working. A learning system enables people to come together to share and learn about a particular topic, to build knowledge and speed up improvement.

6. The **main barriers** mentioned were: time limitations, lack of support for clusters, lack of availability of meaningful data, and lack of clarity or different interpretations of the purpose, roles and responsibilities of clusters, HSCPs, NHS boards and within the wider system.

7. Clusters have proved to be **invaluable in responding to the COVID-19** pandemic. The focus of clusters changed to accommodate COVID-19 requirements. However, this may have contributed to **widening the different interpretations of clusters' role**. At the same time, COVID-19 has generally helped clusters as it brought people together to work towards a shared aim. It also accelerated the roll out of MS Teams, which has enhanced communication.

8. The above findings suggest the requirement for **local and national reflections** about the future of clusters. **Action plans** should be agreed based on the findings from this exercise to ensure clusters can reach their full potential. There is an **opportunity** to have a **refresh** of clusters once the pandemic permits.

Framework showing the components of successful cluster working



This framework provides a visual, interactive overview of the key components required for successful cluster working based on our findings. Click on the specific component you are interested in.

Building on the framework, we developed a driver diagram for successful cluster working. See the interactive driver diagram on the next page.

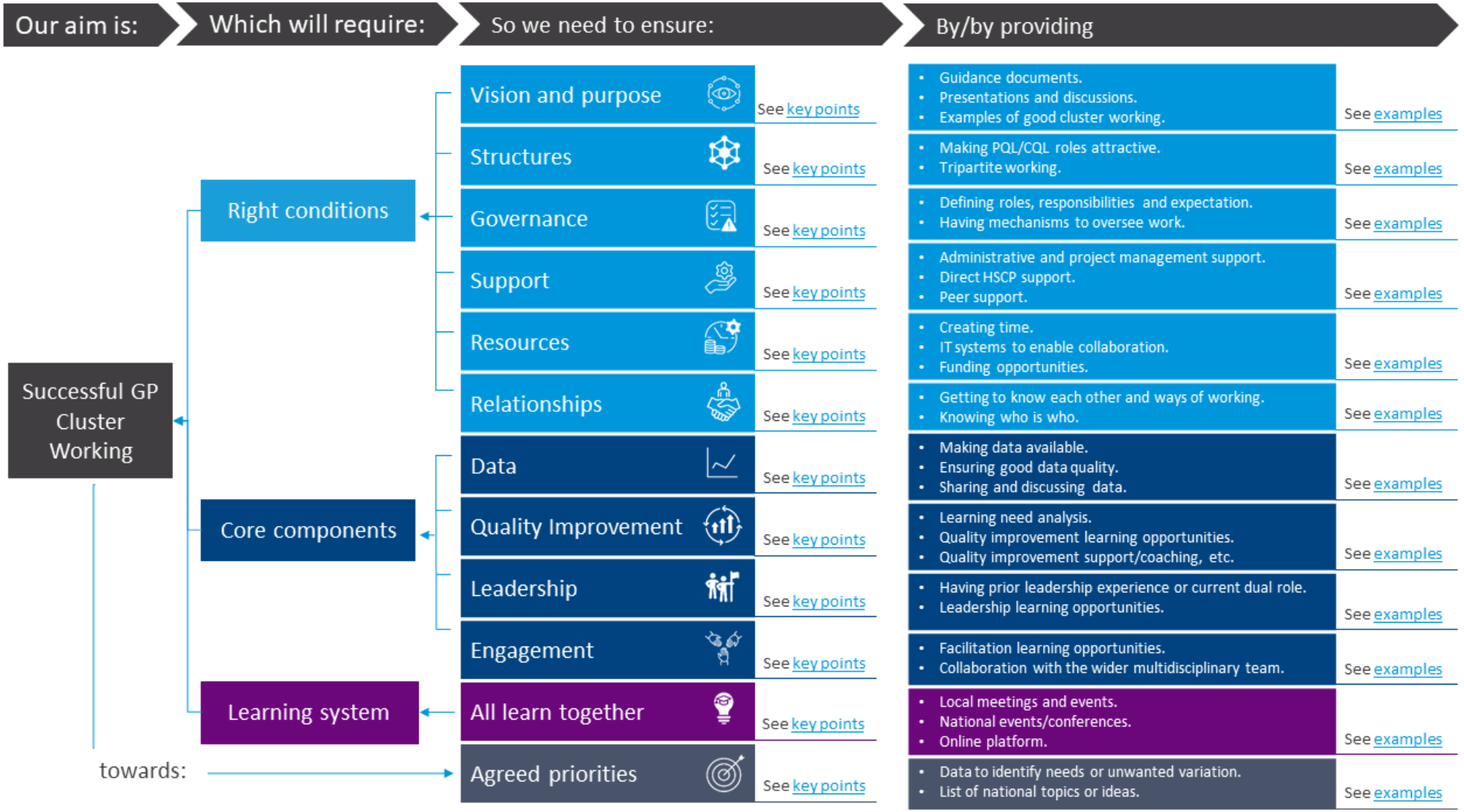
Learning System: Mechanisms that enable people to come together to share and learn about a topic, to build knowledge and speed up improvement.

Conditions: Pre-requirements that should be in place to support successful cluster working.

Core: Essential requirements for successful cluster working.

Contents

Successful GP cluster working driver diagram



Vision and Purpose

Why is it important?

- It is important to have a shared vision to **guide actions and decisions** and to **understand everyone's roles and responsibilities**.
- Communicating the vision effectively will help people **understand what good looks like**. This will help clusters to make improvements as envisaged and successfully influence the wider system to improve outcomes for patients.

Key points

- Improving Together (2017) states that the **purpose of clusters** is to provide a mechanism whereby **GPs** may engage in peer-led quality improvement activity within and across practices and also contribute to the oversight and development of care within the wider healthcare system. These purposes are often described as intrinsic and extrinsic **quality roles.** The intrinsic function of clusters seems to be more developed than the extrinsic function.
- Improving Together was a **big shift from the Quality Outcomes Framework (QOF) approach**, which took a single-disease approach and incentivised quality based on indicators for certain chronic diseases. Overall, clusters have achieved a substantial cultural change as GPs are coming together to share and discuss issues in a collaborative way in spite of their independent contractor status.
- Some mentioned that the clusters were initially loosely setup to allow them to **grow organically** but some CQLs felt **directionless**.
- Sometimes there seems to be **confusion** or **different interpretations** within clusters, the executive and wider management structures, on **what clusters should be focusing on, expectations and roles and responsibilities**. Improving quality is interpreted differently (eg small QI projects versus (vs) whole system working vs audit vs meeting standards, population health needs vs sustainability issues, efficiency, safety, staff wellbeing).
- The National Guidance for GP Clusters (2019) provided more guidance on the expectations and support required. However, the guidance has **not been widely implemented**. There is an **opportunity to have a 'refresh'** and **provide more clarity** on the roles, responsibilities and expectations of everyone involved in cluster working.

> *Improving Together offers an alternative route; facilitating collaborative relationships; learning, developing and improving together for the benefit of local communities.*
>
> (Improving Together, p7)

> *I think we shouldn t undervalue the cultural shift that's occurred here … So, I think there is already a lot of success, you ve got GPs from other practices sitting down together discussing shared problems, using data and intelligence to enact change*

> *So, the clusters are kind of like little boats floating around doing their own thing. They're all doing something, but what that adds up to, and what good looks like, is very unclear to them. And, I think, to be honest, to probably most of us.*

> *I don t know what's happened in other areas, but in [area] some of the cluster work has related to the GP contract issues but I think they've tried really hard to keep those things separate and to not allow cluster work to only be dominated by the issues within the GP contract*

> *To me that they're the same thing, so I don t think you can have the Primary Care Improvement Plan without the cluster.*

Vision and Purpose

Key points (continued)

- There are different views on **what successful cluster working** looks like. Some consider that success is having GPs working together while others consider there should be tangible outcomes and outputs.
- Developing into a successful cluster is a journey. A **roadmap for clusters** could help guiding clusters towards the vision. It would also help assess progress depending on the starting point as it was variable across the country.
- Clusters have been **invaluable in responding to the pandemic**. Having the clusters in place has been very helpful in terms of enabling peer support, sharing information, developing new pathways and local action to ensure delivery of services during the pandemic.
- Some argue that the pandemic has **opened new possibilities** for clusters while others think that clusters' work has **deviated from their original purpose** and that this should be corrected given their limited capacity.
- Clusters cannot be seen in isolation but as **part of the bigger picture.** (Namely, primary care reform, GP contract, expansion of the multi-disciplinary team (MDT), health and social care integration and the National Care Service among others).
- There should be a clear and shared understanding of the vision and purpose of clusters and **how cluster working contributes to the national and local strategic priorities**.
- The increased **fragility of the system** due to the pandemic should be considered when discussing the future of cluster working.

> *"We ve got back into that situation where we re calling people CQLs, they're all doing entirely different roles and entirely different engagement with things. [...] And so there s something for me about what is the expectation of that PQL, what is the expectation of that CQL? [...] And, actually, what's our expectation of our HSCP colleagues to support that wider structure there?*

> *"We all know it s a journey, so you can t reach success overnight. And COVID has come along slap bang in the middle of it.*

> *"Over the last 18 months the clusters have had a really different role, which has also been a good practice role but not quite the same way in terms of quality improvement programs, because they've had a real pastoral role and a role in bringing people together to just keep things going. And that's been great, actually, I don t think we would have got through all of this without the cluster setup. But it's clearly slightly different from a more traditional quality improvement role that we might have envisaged early on.*

> *"There s pre COVID clusters and then there s pan COVID 19 clusters which are a completely different kettle of fish and I think it s a shame because I think clusters have taken quite a while to really find their feet [...] but I think a lot of them were a bit lost in the beginning and didn t really know what to be doing and they were only really beginning to start understanding and being able to shape their role just when COVID 19 came in and so I think that's probably put clusters back a good six months or longer as well so it s a bit of a shame.*

Vision and Purpose

Questions for local reflection

- Is there a common understanding of what clusters should be working on?
- Is there a common understanding on what good looks like?
- What could help develop a common understanding of cluster work?

Areas for national reflection

- Additional guidance for clusters around vision and purpose.
- Regular discussions on the vision, purpose and future of clusters with PQLs and CQLs.

Examples of vision and purpose for Clusters

Guidance documents for clusters. These should be provided, and explained if needed, as part of the induction of any new person involved in cluster working. See some examples below:

- Scotland – Improving Together (2016), National Guidance for GP Clusters (2019).

  Wales – set of handbooks for clusters: Summary and quick read, Resources to help develop your cluster, Working in Wales: Policy and Strategic Context, About you as a leader).

A roadmap showing the journey or stages towards successful cluster working (See example of a Self-assessment Tool for Communities of Practice).

Presentations and discussions on the vision for clusters at national and local meetings. Wales held the event 'Accelerated Cluster Development: An exciting future ahead' in February 2022 to present and discuss the vision for clusters.

Illustrating how good looks like by using examples of good cluster working (eg presentations, videos, podcasts, case studies)

Agreeing a common mission at cluster level. A West Lothian (East) CQL worked with their cluster PQLs to develop a 20-word mission statement to guide their own vision, after doing a piece of reflective work internally about what they thought worked well, what didn't, their purpose and how that might be achieved.

Structure

Why is it important?

- The **transition from** the **QOF** to quality clusters is the vehicle to ensure continuously improving the quality of care, the health and wellbeing of the Scottish population requires **different structures and support** being in place.

Key points

- CQLs and PQLs are **GPs** within the practices leading on the improvement work. There are different views on the level of involvement of the **MDT** should have in cluster working and if so, how best to do it. See more details about involvement of the MDT in cluster working in the Engagement section.
- CQLs and PQLs are the key drivers for the improvement work. When asked what was the main **motivation** for becoming CQLs, over 56% of the CQLs we engaged with confirmed they had either been nominated or volunteered because no one else wanted to do it. Consideration should be given **to making the CQL role more attractive** as a professional development opportunity.
- The GP Clusters - Scotland - A One Page Guide for GP Practices for 2016-7 outlines the key points regarding definition, size, timescales, meetings and functions when clusters were set up in 2016. In terms of **size**, a 'typical cluster' includes 4 to 8 practices. Some mentioned that having bigger clusters (up to 12 practices) made engagement more difficult. Some reported **boundary issues** across different localities.
- **Practices** within the same cluster **can be very different:** urban vs rural, single-handed vs large, 2C vs GMS practices, deprived vs affluent population, vacancies within different staff groups). Cluster diversity can be an asset. However, this can **impact** upon the ability to find common areas of interest and get engagement (see Priorities and Engagement sections).
- **Tripartite working** aims to be a key mechanism to deliver the extrinsic function of clusters and to ensure collaboration among the three GP leadership structures (CQLs, GP subcomittee, HSCP/NHS board clinical leads). What good looks like in tripartite working is **unclear** and its implementation is at **very early stages** and patchy.
- Existing **local structures** should be considered to see how they could support and enable cluster working.
- Resources and **support** should be provided and governance arrangements be in place to enable cluster working (see Resources, Support, Data, Quality Improvement and Governance sections).

> *It s about making the role valued, so it shouldn t have to be sold. That people are really wanting to do it. So, what reward is there? And there are lots of rewards other than financial.*

> *I think a CQL if you re going to volunteer for that role you would do it because you feel that you can make a difference, you can bring people together, that you ve got something to bring to it and that the system is there to support you rather than you just being there to tick a box or to have someone to blame if it doesn t go right.*

> *We ve got[…] like [name] cluster is really big it's got eight or nine practices in it, which is a challenge, some clusters are a bit too big […]. We had a really good cluster lead but he was exhausted trying to co ordinate what I think is nine different practices.*

> *You do worry that the way it's set up, it s almost set up a bit to fail, that they're not getting the support, not the data support and not the QI support, the other leadership training and things like that as well which I think they probably need.*

> *The tripartite groups with the CQLs, the clinical directors, and the GP subcommittee, which are really important for that external part of the activity, and they're intended to provide a consistent, coherent GP voice to the system, I don t think many areas have got that very well developed.*

Structure

Questions for local reflection

- What could you do to make the PQL and CQL roles attractive?
- Are there structures in place for the MDT to contribute to cluster working? If not, would that be helpful?
- How are you involving clusters to influence the continuously changing strategic landscape? Is it through tripartite working?
- Could the current structures (eg in terms of mixture of practices, cluster size and boundaries) be better?

Areas for national reflection

- How to make PQL and CQL roles more attractive.
- Explore tripartite working in more detail.
- Explore how the MDT could best contribute to cluster working.
- Additional guidance for clusters around structure and set up.

Examples of cluster structure

Making PQL and CQL and roles attractive

- *'If it was a role that was seen as having a bit more power and a bit more say (and possibly a bit more pay than a normal GP session) then people might think, and also that it fitted in with their ways of working so rather than all the meetings from the Health and Social Care Partnership being at 9 o'clock on a Monday morning.'*
- Considering rates of pay for independent, sessional, salaried and employed PQLs and CQLs, promise of protected time, training or coaching support.

Multi-disciplinary team

- In Scotland, clusters are GP-led. The involvement of the wider MDT depends on the practices' and local cultures and relationships. See Engagement section.
- In Wales clusters are mainly led by GPs. However, some clusters started to involve the wide MDT more and more, and as a result some clusters are now non-GP led.
- In Switzerland, quality circles are organised by profession. (For example, GPs and nurses have their own quality circles.) When the topic requires multidisciplinary collaboration, the relevant quality circles merge and work together until the projects are completed.

Local structures to support the intrinsic function of clusters,

- Since 2018 about 95 (85%) practices from across Lothian have been supported each year to undertake their own innovative QI project. These fit the needs of their own practice and practice population, via the annual Lothian Quality Improvement Enhanced Service (QI SESP). See more details in Cluster Working in Lothian.

Local structures to enable the extrinsic function of clusters

- In NHS Lothian, the quality subgroup developed into the tripartite quality subgroup. Meetings of this group had representation from CQLs, the four HSCPs, the Lothian GP subcommittee, and the NHS board. See more details in the paper Cluster Working in Lothian.
- In Shetland *'we have the foundations in that we now have a chair of the GP sub and a CQL and the AMD for primary care, so we have all the ingredients which we haven't had before[…] we now have three separate people.'*
- CQLs could be part of the strategic planning forums.
- CQLs in Angus HSCP are consulted on their locality's strategic plans.

Governance

Why is it important?

Having governance structures **helps** to:

- Ensure progress in the right direction
- Ensure accountability
- Identify areas where support is required
- Support sharing the learning
- Have mechanisms to address and overcome issues (eg escalation of difficulties)
- Gather evidence of successes, increase cluster work visibility and raise their profile widely
- Drive forward the work, as it shows that the work is important and helps to see the progress and impact
- Understand everyone's roles, how everything is connected locally and to the wider system
- Make decisions such as supporting spread of successes

Key points

- Governance should be considered **at all levels**: practice, cluster, HSCP, NHS board and national organisations.
- **Improving Together** laid out the governance process for clusters. It was suggested a requirement for an '*accessible multi-disciplinary approach fully integrated into local NHS Health Board and HSCP arrangements*'. Designated clinical leads should hold overall clinical governance responsibility.
- The **improving together advisory group** was set up to support implementation of Improving Together from a national perspective.
- Cluster governance is currently **poorly defined.** If increasing governance of clusters, this should be done very carefully given the **fragility** of general practice at the moment. There could be **unintended consequences** (eg putting people off taking on PQL and CQL roles).
- While there are local and national reporting mechanisms for the primary care implementation plans (PCIPs), in most areas there are **no reporting mechanisms** to capture cluster activities. Cluster quality plans are not commonly used. Reporting systems should be very **simple** and not overly bureaucratic.
- Before increasing governance, there has to be **more direction and clarity** around expectation, roles and responsibilities of all involved (see Vision and Purpose section). Clusters should be **fully supported** as increasing their governance would add work.
- Some mentioned there is lack of clarity of **where governance sits locally** (GP subcommittee or HSCP). The governance structure must be **clearly communicated,** so everyone can see how information flows from practices to clusters, to tripartite working groups and committees and how the information is fed back.
- Having **payment structures** attached to governance (eg minimum number of cluster meetings attended) could help with engagement but it **risks** becoming a tick-box exercise like QOF.

> *I do think that's a gap that both from a sharing of good practice point of view but also from our sense of being able to identify common themes and areas where support is needed, and understanding the clusters are doing quality improvement activity.*

> *I think the governance around clusters is maybe a little bit loose at the moment, that might need clusters to tighten up for that. You don t want to make it just a complete governance fest because that turns clinicians off, but I think there s got to be some processes and systems that are there that could be adhered to give us all safety.*

> *We don t have any means of really monitoring what the activity is, and to be honest, systems don t have time to be filling out and completing things.*

> *I think there is a national dimension to it. Pretty much the only question we ever get asked about nationally is around delivery of the primary care improvement plans.*

> *I have no idea what happens to any reports or what a CQL writes, I ve no idea how they are consulted by Health and Social Care Partnership if they re considering new services or anything like that.*

Governance

Questions for local reflection

- Where do clusters fit within your governance structure?
- Is there an organisational chart and supportive information to explain the governance structure to GPs and others?
- Do you have a visible named lead to support CQLs and their development?
- Do you have a mechanism for reporting cluster activity?

Areas for national reflection

- Role of improving together advisory group to support cluster working.
- National feedback mechanisms.
- Potential for having a steering group meeting with named HSCP leads for clusters.

Examples of how enabling governance

How could there be oversight of cluster progress?

- HSCP executive team or primary care team representatives **attending cluster meetings** eg *'The medical director is also a GP and attends all meetings'.* This should be carefully considered and be based on local relationships and culture. Some might see this as being heard and valued, others as a threat.
- The HSCP clinical lead **meeting CQLs** regularly (some reported meeting weekly).
- The HSCP clinical lead **gathering information** from clusters and analysing it: *'There was an associate clinical director in post who did a lot of work with the clusters, and he pulled together quite a lot of information on the spread of projects that they were doing, but that was a couple of years ago, so we haven't replaced that.'*
- **Writing and sharing minutes** of cluster meetings beyond the cluster.
- Keeping a **tracker of cluster quality improvement plans** and updating it (eg East Renfrewshire), or having an **annual CQL/cluster report** mechanism and template (eg NHS Lothian).
- Using **self-assessment tools** to assess and reflect on progress against a **potential roadmap** for clusters (see example of a Self-assessment Tool for Communities of Practice)
- Agreeing and monitoring **measures**: *'I think the measures that I would say are success is if the meetings are still happening regularly, if they're well attended, if they're well organised, if there's data available, and if the CQLs can reflect on decisions that were made'*

How could roles, responsibilities and expectations be defined?

- Developing **job descriptions, Terms of Reference or contracts** for CQLs and PQLs (eg NHS Lothian tripartite quality subgroup has agreed standardised terms and conditions for CQLs, including induction arrangements and ongoing support, as well as quality management priorities for cluster improvement work and their practical support).
- **Stakeholder mapping exercise** to clarify and explain the roles and responsibilities of the different stakeholders involved in cluster working (eg in NHS Ayrshire & Arran a paper was drafted to help describe the roles of the different local GP leadership bodies.)
- Developing **induction packs** for PQLs and CQLs (see **handbooks for clusters in Wales**: Summary and quick read, Resources to help develop your cluster, Working in Wales: Policy & Strategic Context, About you as a leader. NHS Lothian tested an induction handbook for CQLs.

Support

Why is it important?

- PQLs and CQLs have **limited time** in which to conduct cluster work (see the Resources section). Clusters should be **supported** to ensure the **skills and limited time** of the cluster team are **used effectively.**
- Having support in place makes the cluster **roles more attractive** to GPs. Where **no support** is provided, CQLs can feel **undervalued** and have **difficulty progressing** cluster projects.

Key points

- The 2019 guidance recommended that the HSCP should **support and facilitate GP clusters** to enable them to be involved in quality improvement planning and quality improvement activity. Support available for the clusters should be clearly defined and communicated to the clusters.
- The 2019 guidance also suggested the HSCP/NHS board should provide **administrative support** for the cluster. However, there is currently variance across the country, with many CQLs reporting no administrative support, which results in CQL time being taken up with administrative tasks.
- Having **project management support**, under direction from the cluster team, can be beneficial and critical in driving cluster project work and ensuring completion of projects.
- Having **direct support from the HSCP** from the clinical director, (associate) medical director or primary care team is important to operationalise improvements, to escalate any issues, to unlock barriers and to spread ideas and successful projects.
- **Peer support** from within and across clusters was seen by many as invaluable. The HSCP and NHS board can be instrumental in enabling those connections locally and national organisations to do so at national level.
- The **wider MDT** could provide support to clusters.
- Improving Together states that a **national support network** for clusters coordinating the contributions of Healthcare Improvement Scotland, NHS Education for Scotland (NES), Public Health Scotland and Royal College of General Practitioners (RCGP) Scotland is required.
- **Data and quality improvement support** should also be provided. This will be discussed in the Data and Quality Improvement sections.

> *It seems crazy to me that we're having highly paid clinicians doing admin type work, it s madness and really needs to stop*

> *I should go saying we have extremely good admin support as well, [name] who is our minute taker and organises the meetings and stuff is really good, and she chases us up for things to make sure we've done what we said we were going to do and get ourselves organised, so that really helps as well.*

> *I had to fight to bring my practice manager to ours [our cluster meeting] by saying that I'll forget this the moment I leave this meeting so I need someone here to keep me right.*

> *Had fantastic support from the HSCP because they've got a primary care services manager who has built up relationships over many, many years with them and is very supportive. So, they have a direct route for moaning and complaining but also influencing, so they feel valued, they feel listened to and heard.*

> *What would help? Supportive and fair MDs and CDs. The links between your medical and clinical directors are very important.*

> *What we always do is build in time for those sessions just for them to talk to each other. So, it probably spreads a bit of good practice, it's more that kind of peer support of how are you doing this? How do you engage your PQLs? and how that's working for you.*

Support

Questions for local reflection

- Do clusters in your area get administrative support? How is this provided?
- Do you have project management skills within your clusters? Have you considered providing or getting project management support for cluster working?
- Is it clearly defined and communicated who, in the HSCP or NHS board structure should support PQLs/CQLs/clusters in different circumstances (eg QI support, relationship issues, conflict)?
- What opportunities does your HSCP or NHS board provide for PQLs/CQLs to enable peer support?
- How are PQLs/CQLs supporting each other within your cluster or area?

Areas for national reflection

- Assess the support provided to clusters and update the minimal requirements laid out by the 2019 Guidance.
- Monitor implementation of the guidance for cluster working.
- Consider a national support network for clusters.
- Consider national project management guidance and templates for cluster working.
- Consider opportunities to enable peer support at national level.

Examples of support provision

How administrative support is/could be provided

- Several interviewees mentioned **funding** is provided **towards administrative support:** '*I think every practice manager who was supporting, we funded the practice £2,000 a year and it was to provide administrative support to whoever the CQL was at that moment in time.*'
- In one area the personal assistant of the clinical director, who is also a CQL, provides administrative support.

How project management support is/could be provided

- In Wales all clusters have **cluster development managers** to some extent. They provide project management support. Funding of these posts varies.
- **HSCP/NHS board providing project management support**: '*In* Shetland *we've developed effectively a sort of project management group who support project management throughout the health board.'*
- There may be **members of the cluster or the wider MDT with project management skills**:
'*We've had really good support from our LIST analyst … and he's helped us to improve, if you like, I suppose the best way to describe it is the project management type of approach'*
- A CQL stated that **providing guidance and templates** for the different stages of the project would be helpful.

How direct HSCP support is/could be provided

- CQLs from several areas reported having **regular meetings with their clinical directors or (associate) medical director.** In small HSCPs and NHS board the clinical director/associate medical director can also be the CQL, having easier access to HSCP support.
- In NHS Ayrshire & Arran a **representative of the primary care team attends cluster meetings** and is able to act on and feedback issues highlighted by the cluster.

How peer support is/could be provided

- Some CQLs have set up their own **WhatsApp group**
- **Local networking and developmental sessions** for CQL and PQLs enable peer support (eg NHS Greater Glasgow and Clyde, NHS Lothian, NHS Tayside).
- Existing **local groups or networks** (eg GP forum).

Resources

Why is it important?

- Having **time and the headspace** for cluster working is **key** to achieving results. Lack of time was the **most frequently mentioned barrier**.
- Having **funding for additional support or resources** to implement changes can help clusters achieving results (see Support section).
- Having **appropriate IT systems can** help to accelerate collaboration and save time. Data IT systems are also key for effective cluster working. See Data section.

Key points

- The **2019 Guidance** recommends **CQLs** to have a **minimum of four sessions (16 hours) per month**. This is funded by the HSCP. It also recommends **PQLs** have **two sessions (eight hours) per month**. This is fully funded by the PCIP funding.
- There is **variation in the time CQLs have** for cluster working. Based on the exploratory meetings we had with CQLs across Scotland, a number of CQLs have less than the one session per week.
- Time is required to **prepare and attend meetings** but also to **do QI work in the practice**. This could include gathering and reviewing data and engaging with key people.
- **Attending different meetings**, particularly considering the CQLs' extrinsic role, can take up a considerable amount of time.
- **Protecting time for cluster working can be difficult** given the capacity constraints in general practice and clinical priorities. Cluster work is considered **important but not urgent**, which means cluster work has not been fully supported or prioritised.
- There may be **staff capacity issues** within the **HSCP** or **NHS board** to support clusters.
- Having support from non-clinical staff alongside the rest of the **MDT** could help with the lack of PQL and CQL time (see Support section)
- **Funding** from HSCP, NHS board or external organisations can be key to enable the implementation of improvement ideas.
- The pandemic helped to accelerate the roll out of **MS Teams** and support collaboration locally. However, currently CQLs and PQLs are not digitally connected on a national level.

> *It s time. Can t get it. Time and staff and workload […] So, we've got to find other ways, we ve got to find cleverer ways, to facilitate it. And that's going to be around employing appropriate non clinical people at project management level to facilitate it and to be able to do it.*

> The biggest barrier is time and demand and capacity, and it s very difficult when the Government or anybody else says okay, we ll support you and you ve got this many sessions to do it , that is meaningless because for me to say okay, well I've got two sessions in the partnership , they ll say well actually we re a person down .'

> *Partners in practice are supportive but as everyone is at maximum capacity they cannot lose [CQLs] for sessions. Locums are hard to get a hold of they have had to offer a locum a salary contract.*

> *There is some protected time but not very much. I would have thought a cluster lead should have a day a week at least and a practice lead should have half a day a week. The practice leads need to be much more active if it's actually going to change within the practice. Unless it s something simple. So, that's a finance issue.*

> *There was lack of video conferencing tools as a result of rural location and bad broadband width. COVID was the driver for this to change as it became necessary.*

> *The HSCP primary care team are usually very good in supporting the cluster but have been unable to as they were the pandemic response and vaccination response. They just can t do it.*

Resources

Questions for local reflection

- How many sessions do your CQLs and PQLs have for cluster working? Is it enough to achieve meaningful cluster work?
- What resources do they have in terms of IT to support their communication and collaboration?
- What support and resources do clusters have to help them drive successful improvements?
- Do clusters know how to bid or request funding from HSCPs to implement ideas or get analytical support?
- Are clusters aware of external funding opportunities?
- Do clusters have help to apply for available external funding?

Areas for national reflection

- Review the minimum time recommended for PQLs and CQLs.
- Consider assistance for obtaining external funding.
- Monitor implementation of the guidance for cluster working.
- Review national support in terms of resources for cluster working.

Examples of how to ensure enough resources

Time

- **If backfill available, increase CQL and PQL time** for cluster work.
- Doing **more QI work** to do things more efficiently could help to reduce workload and streamline processes.
- **Practice managers could help GPs to protect time** for cluster working.
- **Spread the workload to other members of the team** as much as possible (eg through workload optimisation - See Workflow Optimisation Toolkit for more information)
- Get support from the **MDT staff** for cluster working (see Support, Data and Quality Improvement sections).

IT

- **MS Teams** has helped cluster work (eg saving time on travel, having better engagement as PQLs not in surgery can still join and some members were unable or unwilling to travel, having a good system for sharing files and documents easily).
- **WhatsApp group** has helped arrange meetings and share information.
- Setting up **distribution lists** via IT helps with communication.

Funding

- Getting **external funding** could help cluster work (eg Midlothian HSCP got funding from the Health Foundation, through its Advanced Analytics programme, for a dedicated senior information analyst to support their Frailty project). Having a good **understanding of different funding opportunities** and **support to bid** for funding could help clusters.
- **Funding from the East Ayrshire HSCP** to create a position of a funded young person counsellor was key to the success of the project. Similarly, East Ayrshire funded a project to have a community palliative care bed in a care home to be accessible by anyone in the cluster.
- NHS Lothian practices undertake their own innovative QI project via the annual **Lothian Quality Improvement Enhanced Service** (QI SESP). See Cluster Working in Lothian.
- Having **primary care transformation funds** – each cluster in NHS Greate Glasgow and Clyde got £5,000 for tests of change and improvement projects – helped the cluster to organise PLT sessions and get PQLs and practices engaged.
- Having an **HSCP representative in the cluster meetings** can be helpful as they can ask questions and fully understand the needs of the cluster, and therefore request funding from the relevant sources in the HSCP or external sources.

Relationships

Why is it important?

- Cluster working is **collaborative work**, which requires CQLs and PQLs to work with other care professionals and non-clinical individuals from the wider system. Building relationships is the basis of engagement and collaboration.
- Developing good working relationships, where there is **trust** and **good understanding of each other's needs and ways of working**, is important for any successful collaborative work, including cluster working.

Key points

- Relationships need to be built **within the cluster** (GP to GP), **within the wider MDT, within the wider system of HSCP or NHS board** and **with tripartite working group**.
- Clusters had **different starting points**, with some areas already having good relationships built while others inheriting historical tensions or difficult relationships.
- Developing relationships and trust is especially important given that GPs are mainly **independent contractors** and in **competition with each other**.
- Collaborative culture and relationships **cannot be built overnight.** They require **time, effort and leadership** from PQLs/CQLs. It also requires **soft skills** (eg interpersonal skills, problem solving, communication skills) and an **open mind.**
- The first step is to **know who is who and how they can help and be contacted**. HSCPs/NHS boards can help to make the connections between clusters and different teams/people within the HSCP and NHS boards. The Cluster Guidance recommended that '*GP Clusters should have, as a minimum, named links and methods of access*' for a number of areas.
- The **HSCP/NHS board size** may affect the opportunities for PQLs/CQLs to develop relationships beyond their practices. In bigger areas developing relationships may require more support. In the smaller areas, building relationships is easier, and often one person can have multiple roles, however this makes the system very person dependent.
- **Staff turnover** will also affect cluster working as new relationships will need to be built.
- Different **contractual models** (GMS vs 2C) and **different access to services** may also affect relationships as the support they receive might be seen perceived as unequal.
- **Getting to know each other**, the language each profession uses, their priorities and **appreciating the different skills and experiences** that people bring to the table is key in developing good working relationships.

> *The feedback I get from cluster leads, really reflects good relationships. So, good things come out of good relationships.*

> *So, I think it was right for the first couple of years it was a very softly softly approach and to allow practices to develop the relationships, because that is a huge shift.*

> *I think it shows the lack of involvement of the partnership in the clusters and I really don t quite understand how they all communicate with each other up and down the way.*

> *The Lothian HSCP 90 day indicated that the development of relationships between the practices, the CQLs and the HSCPs was determined by the skills, knowledge and personality of the individual CQLs and the leadership within the HSCP.*

> *So it's understanding also that there are many different tribes within the GP world, and speaking to those tribes in a language that each of them understand.*

> *I think to be honest the stability of general practice in our area is probably the number one thing […] so we've got stable practices, we ve got well functioning practices.*

Relationships

Questions for local reflection

- Do your PQL and CQL know who is who within your system and who to approach for different issues?
- How would you assess the current working relationships within your area?
- How do you help your clusters to develop positive working relationships across the system?
- Have you considered how you can use technology to facilitate relationships?
- Do you have mailing lists to help with communication? If not, you could discuss whether these would be helpful.

Areas for national reflection

- Promote implementation of the guidance for clusters in terms of relationships and their importance.
- National meetings for PQLs and CQLs and for the HSCP leads supporting clusters
- Mailing lists for CQLs, PQLs and HSCP contacts for clusters.

Examples of supporting relationship building

Knowing who is who and how they can help

- The list of named people could be **part of the induction packs** for PQLs and CQLs.
- Having the HSCP/NHS board key contacts for clusters on an **intranet** could help clusters to make connections.
- **Word of mouth** can also be powerful: '*the cluster that we've engaged with a lot in the past, they've been really good and let the other clusters know as well of what we could do.*'
- **Networking sessions** where PQLs/CQLs hear directly from key people from the HSCP/NHS board about how they could help PQLs/CQLs and how to be contacted could enable relationships.
- Having **conversations** to understand others' perspectives, priorities, language and ways of working helps to build relationships.

Connecting people

- The **HSCP lead person for clusters** could also facilitate connections by introducing people and explaining the support available.
- **National and local meetings/sessions**, including local/NHS board CQL/PQL network and groups, can also help in connecting people and enable peer support (see Support section).
- **Mailing lists** can be a simple and useful way of connecting people, enable peer support and sharing the learning. The creation of mailing lists (eg CQL mailing list, PQL mailing list, cluster mailing list, HSCP contact for clusters mailing list) could be a helpful means of communication (see Resources section)
- **Technology** (eg MS Teams, WhatsApp) could also facilitate building relationships.

Data

Why is it important?

- Data is important to drive **quality improvement** and to **support decision making**. It helps clusters identify local needs and assist with **prioritising work** and **quality planning** (see Priorities section). Data also helps to demonstrate if changes are improvements and whether they are sustained over time.
- Data can help to identify **outliers** within data sets, **prompt discussion** on reasons for variation and potential QI work, and **get clusters engaged**. This can lead to **reducing unnecessary variance** within and across clusters.
- Data is important to **influence**. It allows clusters to generate buy-in from cluster members and from HSCP/NHS board members, as it highlights needs and can support the case for change and potential investment.
- Data helps **tell the story, supports the sharing of the learning** and evidences that changes have led to improvement.

Key points

- There are long-standing issues with primary care data. Existing data are **not easily accessible** and when accessible, there are often **data quality issues**. There is a national group looking at data and intelligence in primary care.
- Available data may **determine the focus** of the cluster and may skew QI work. Availability of data can also influence MDT involvement (see Engagement section). **Relevant national datasets for primary care**, rather than secondary-focused data, would be helpful for comparison at different levels and to provide direction to some clusters that require more support.
- There needs to be a good understanding of the **data available and how they can be used**. Support is also required to **interpret and present the data in a meaningful way.**
- There are some examples of **locally developed data systems** to enable the collection and extraction of data. A **national data system** like Scottish Primary Care Information Resource (SPIRE) would help cluster working. There is a **feeling of inequality** in terms of investment in **primary care data systems** in comparison with secondary care data system.
- Sharing and discussing data requires an **environment of trust** and a culture of continuous improvement. There are examples of clusters and NHS boards starting to share their data.
- **Engagement with Local intelligence support team (LIST) analysts** is **variable** across the country and often depends on the relationships locally (see Relationships section). Whilst some CQLs praise their LIST analysts, others have never met theirs or are not fully aware of the support on offer.
- **LIST analysts support a wide range of work**, including PCIP implementation and cluster work (sometimes their work is prioritised in other areas).

> *You need easy access to data and the data needs to be the right sort of data for us that the practice will be interested in.*

> *Emergency departments can snap their fingers and say "this is the number of patients we see, this is what we do , we don t do it so we look stupid, and think general practice is doing nothing*

> *It is really difficult to start saying other services need to change if you can t demonstrate some of those improvements.'*

> *So what would help us? I think if there were very straight forward datasets for various areas that were easily compared across clusters, regions, nationally [...] Datasets could give direction to some clusters.'*

> *The data those analysts provide is kind of epidemiology type stuff, and for the GPs it s like okay, but what do we do with that?" What are we meant to do?*

> *To realise this potential fully requires support; relevant and timely data; analytical expertise to assist in its interpretation; facilitation of constructive conversations; and implementation of appropriate improvement strategies. Without these components, there is a credible risk that they will fail in their intention.'*
>
> *Improving Together (p7)*

Data

Questions for local reflection

- What data are available locally and nationally to your PQLs/CQLs?
- Are the PQLs/CQLs aware of the data sources and support available?
- Have you considered developing local reports to enable data extraction?
- Do you consider capacity/funding for manual data collection if required?
- What training and support is available to ensure good data quality?
- What opportunities are there for PQLs/CQLs to increase their knowledge on data?
- How are PQLs/CQLs/LIST analysts enabled to build good working relationships?
- Is the role of LIST analysts clearly understood?
- Have you considered having a dedicated contact within the HSCP for LIST analysts to facilitate good relationships?

Areas for national reflection

- Development and communication of national datasets that are relevant and with the appropriate level of detail for clusters.
- Data systems for primary care and interim arrangements.
- Support for data extraction and interpretation.

Examples of how data can enable cluster working

Outlining the data and support available

- The Spark Page explains how can help clusters can access data and analytical support. The Data sources section in Improving Together interactive also outlines data sources available in Scotland.

Gathering/extracting additional data

- Practices in NHS Ayrshire & Arran were given access to **automatic searches around highly topical patient safety topics** (eg certain drugs that had not had standard monitoring leading to significant adverse events).
- **e-Health facilitators** can develop **local reports.** Capacity of the e-health facilitators should be considered.
- When there are no reports from the GP medical information systems and data are required, it needs to be collected **manually**. Practice managers are the data gatekeepers and are key in enabling this.

Using data for planning and quality control

- NHS Greater Glasgow and Clyde developed a **cluster intelligence report** on different clinical areas. Building on this work, a national dataset on diabetes for clusters is being developed and tested. NHS Greater Glasgow and Clyde also set up an NHS board-wide **primary care intelligence group**, with various members, including public health, that looked at data and what analysis would be useful for clusters.
- The NHS Lothian LIST data analysts developed a new **cluster profile dataset** which provides aggregated cluster level data, benchmarked against their HSCP, across various demographics, unscheduled care, out-patient referrals, and prescribing metrics. The data profile will be tested by CQLs (see Cluster Working in Lothian).
- Angus North West cluster **agreed a set of six indicators** to improve the relevance of data gathering. PQLs and their clinical teams were asked to identify current clinical priorities, and the quality control measures were agreed. See Developing the Tayside Primary Care Quality Improvement Network.
- Practices from a cluster in East Ayrshire **share their prescription data** and **discuss it at cluster meetings.**

Using data to demonstrate impact and spread good practice

- A cluster in East Ayrshire created a position of a funded young person counsellor to bridge the gap between school nurse and Child and Adolescent Mental Health Service. The referral data showed that in their area, they had less mental health issues than projected for their area, and they decided to roll out the model.

Quality Improvement (QI)

Key Points

- Quality Improvement (QI) is key to **tackle unwarranted variation in care, harm and waste** and can ensure a **more personalised approach to care and equality and equity of care** within our health and care system. It can also help to free up time by introducing more efficient processes.
- PQLs and CQLs have the **responsibility and protected time for quality improvement leadership** role in their practices and at cluster level, respectively.
- Using appropriate QI tools and methodologies can **help to identify what** parts of the process are **not working**, the **root cause** of the problem, what **changes** are required, **iteratively test** new change ideas and confirm whether the changes were **effective.**

Why is it important?

- There are **different interpretations of what QI** means (eg audit, meeting standards, etc.)
- Cluster members need to have **QI skills.** The 2019 guidance recommends that every CQL should have accessed QI training opportunities and completed them within 18 months of CQL appointment. However, there is variation in the QI skills and training received by CQLs.
- A **wide range of learning opportunities** would be required **to fit people's needs** in terms of level (beginners vs advanced), time required (courses vs bitesize modules) and learning style (toolkit vs course).
- There are **national educational programmes** available. Few areas provide **QI training locally**. Learning about QI as a team and working on a project with guidance from QI experts would be beneficial for clusters.
- **National QI collaboratives** can also help with the development of QI skills and facilitate local QI support.
- PQLs/CQLs may not be experts in QI. Having **access to QI coaching support** could help them progress with their improvement projects. All NHS Lothian CQLs rated the coaching they received locally as extremely or very valuable, and would recommend it to other CQLs.
- There is **variation on the availability of local QI support** for clusters, with the majority not having any access. There is a **feeling of inequality** in terms of QI support available for quality improvement work in comparison with secondary care, where clinicians are usually support by QI advisors.
- **Other members of the MDT** could have QI skills that could be beneficial to the cluster (see Support section).
- There should be easy access to a **suite of QI resources** to help with QI.

> *The primary care development officers that we ve got, there is so much going on around primary care improvement plans and contractual changes and just the day to day running and management of all the issues that come up around practices, and some of the previous quality improvement support resources that we had through big national programs like SPSP is no longer there. So, if you look across the possible capacity to support quality improvement in general practice an awful lot of that has either diminished or got other priorities at the moment*

> *I think what we all felt was that we were lacking that improvement expertise, so we had lots of good ideas about things we wanted to look at but we didn t have the skills to really know the most effective way of doing improvement projects because we're GPs and nobody has ever really taught us.*

> *There s also huge variability across Scotland in improvement advisors assigned to clusters and if you think if this was anything in secondary care, the front line clinicians would not be the ones doing everything, they would have an improvement advisor supporting them*

> *And I completely agree about the multidisciplinary approach. I think we're massively missing a trick, not just in terms of different perspectives, but actually capacity to do quality improvement work […] we re not harnessing that through our clusters.*

Quality Improvement (QI)

Questions for local reflection

- What QI knowledge and skills do your cluster members have?
- Have you considered doing a learning needs analysis of clusters?
- What QI development opportunities do clusters have?
- What QI support do clusters have access to locally?
- What QI resources do clusters have access to locally?
- Do PQLs/CQLs know where/ how to seek QI support, training, or tool templates?
- Do other members of the primary care team have QI skills that could contribute to cluster QI projects?

Areas for national reflection

- National educational opportunities for clusters.
- National educational opportunities for clusters.
- National QI coaching support for clusters.
- Local QI support for clusters.
- Agree the future of Improving Together interactive or alternative online platform for QI resources.

Examples of QI in cluster working

How QI knowledge and skills are/could be developed?

- There is a range of educational opportunities for health and social care staff (eg educational programmes, bitesize learning resources, guides and toolkits). NES could run **'train the trainer' Scottish Coaching and Leading for Improvement programme courses** to enable HSCPs to train their primary care team members.
- Wales encourage their cluster leads to undertake a basic QI course (**Bronze QI package**) in their first year and to progress towards the Silver one.
- There could be **local QI training courses** (eg CQLs in NHS Lothian undertake the Lothian Primary Care QI Network QI Essentials course and/or the Lothian Quality Academy Planning for Quality course, within 18 months of starting their role). For more details see Cluster Working in Lothian.
- A **CQL needs analysis** was conducted when the Tayside PCQI network was established in June 2020. Of the respondents, 43% agreed to having 'adequate knowledge and skills in QI'.
- Participating in **national QI collaboratives** such as the Practice Administrative Staff Collaborative can help develop QI skills of the cluster while working on a specific project.

How QI support is/could be provided?

- **Local QI support** could be made available for clusters:
  - In one board, two practice managers were funded a day a month to take on a quality facilitator role so they could support practices in their quality improvement work.
  - The Tayside PCQI network started developing PQL and CQLs' skills internally through coaching from a local QI advisor and a clinical lead.
  - A small team of improvement advisors and
  - GP clinical lead deliver QI training and coaching session(s) to practices that undertake their own innovative QI project via the annual Lothian Quality Improvement Enhanced Service (QI SESP). They also get financial support. For more details see Cluster Working in Lothian. Separately, CQLs get additional QI coaching sessions.
  - Local QI leads supported clusters in their improvement work as part of the Practice Administrative Staff Collaborative.
- Healthcare Improvement Scotland tested the concept of a **Primary Care Quality Improvement Faculty** to provide tailored and responsive support to primary care services and develop local links across Scotland.
- Improving Together interactive started hosting a **suite of QI resources** to support primary care teams.

Leadership

Why is it important?

- Strong leadership skills are essential to **guide** the clusters, create a positive **trusting and collaborative culture** and **achieve goals.**
- Leadership skills are important for **effective engaging** with the wider system, including tripartite working and ensuring an effective representation of clusters' voice.

Key points

- Leadership **skills** are required. Improving Together states: 'The cluster quality leads have an important role in the GP cluster, in particular by demonstrating leadership in how discussions and activity here link to the wider clinical priorities, quality structures and to the locality management team.' Improving Together recognised there was a need for leadership training to be made available to support CQLs in running productive meetings.
- There is **variation** in the level of leadership skills CQLs have. Some CQLs mentioned they would welcome more **training** on leaderships skills. This may provide the basic soft skills required for a leadership role. However, additional **ongoing support** should be available to improve their confidence.
- CQLs should be supported to fulfil their leadership role, especially their extrinsic function. Some CQLs commented that it would help them to be **more integrated in HSCP conversations.**
- There should be **more clarity and guidance** on the PQLs/CQLs' leadership **role** and **their scope and limitations** as there would be for other GP leadership roles already in place (see Structure section) to prevent tensions and confusion.
- Having a good understanding of the **decision-making process** in different groups could help PQLs/CQLs in their leadership roles.
- Some CQLs have **dual roles** and they may have more influence as they already have a seat at HSCP/NHS board meetings and have a better understanding of the wider context, how things work and how best to influence.

> *"It's not part of their GP training to be leaders […] So, we probably need to seriously look in terms of supporting that training element, how do we train people to become leaders in the system.*

> *"you may well find that a number of CQLs and PQLs also have other roles where they get the training and education that they need from those other roles so they can do the CQL and PQL role more effectively and more efficiently, and they can meld their time.*

> *"I think they [clusters] just struggle to navigate through what they need to take forward as priorities, it becomes a bit of a talking shop at times, but they are very passionate about certain things but they just don t seem to know how to navigate and take it forward, and it s how do we support them to do that, because we don t have the capacity.*

> *"Clinical lead and CQL role has enabled [CQL] to influence work in HSCP work in relation to [topic] piloted in [location] that may not have happened had they not had those roles.*

> *"It can be difficult when wearing more than one hat but it allows you to have oversight of all issues.*

Leadership

Questions for local reflection

- What leadership skills do your PQLs and CQLs have?
- Have you considered doing a learning needs analysis of clusters?
- What leadership development opportunities do your PQLs/CQLs have? Are they aware of these?
- How does the HSCP/NHS board support the development of the PQLs/CQLs' leadership skills?
- Are there existing leadership networks that the CQLs could join?

Areas for national reflection

- National leadership development opportunities for CQLs.
- National leadership coaching support for CQLs.

Examples of leadership skills and development

Leadership learning opportunities

- Improving Together interactive lists a range of educational opportunities **including leadership training courses** and **modules** available. Completing the course 'You as a collaborative leader' delivered by NES having one-to-one coaching as part of this was found to be helpful by some CQLs and recommended to others.
- **Advanced QI courses** such as the Scottish Quality and Safety Fellowship Programme or Scottish Improvement Leader Programme have a big emphasis on leadership, change management and soft skills.
- Other **national leadership programmes** include:
- Project Lift, a leadership programme to develop leadership skills at all levels, in all roles, for all who work in health and social care in Scotland.
- The School for Change Agents is aimed at anyone in the UK who works in health and care, at whatever level and whether they are in a clinical or non-clinical role. It is open to everyone and all are welcome. The School offers participants the opportunity to take their desire to see change happen and make it a reality.
- Cluster leads in Wales are provided with the About you as a leader **guide** as part of their induction pack. They have also run several cohorts of **leadership courses**.
- **Increasing self-awareness** through NES Leadership Capability Feedback Tool.
- CQLs could develop their skills through **coaching** (eg in NHS Lothian leadership skills was regularly selected by CQLs for their coaching sessions).

Experience from other leadership roles or current dual roles

- Some CQLs had **dual roles** (eg HSCP clinical lead, locality clinical lead, LMC member, GP subcommittee chair/member, managed clinical network clinical lead, associate medical director).

Engagement

Why is it important?

- The Improving Together framework is based on **facilitating collaborative relationships**.
- Good engagement with GP practice staff, wider MDT, cluster, HSCP/NHS board representatives is essential for successful cluster working as **everyone's input is required**. A whole-team approach is needed.

Key Points

- **Cluster meetings** are taking place and they seem to be well attended. However, there are **varying degrees of input and enthusiasm** from those involved in cluster and practice improvement work.
- Sometimes it is **challenging to get engagement** from colleagues and cluster members. PQLs and CQLs do not have any authority and may **feel disempowered**.
- Having **clear roles and responsibilities** for all, **understanding the vision** and **seeing the impact** of clusters could help with the engagement of practices and clusters (see Vision and Purpose section).
- PQLs/CQLs should have **facilitation skills**, as they are key to facilitate communication and collaboration. Good facilitation helps people to reach decisions, resolve issues, generate creative ideas and progress.
- Due to COVID-19, cluster meetings are mainly happening through **MS Teams.** This has **increased the opportunities** to join cluster meetings and engage in conversations (see Resources section).
- Also, **comparing data** can ignite curiosity and get people more engaged and work collaboratively.
- A **systems-approach** should be adopted in improvement work. Engagement with all those involved in the **patient's journey**, including the patient, should be considered as every person will bring a different perspective. Others (eg interface leads, realistic medicine leads) could be helpful.
- The **engagement of the MDT** in cluster meetings is **variable.** They are often guests and not part of the core team. Some are GP-only clusters while others have members of the wider MDT and across the system. There are clusters where practice managers deputise for GPs and/or attend as part of the core cluster team.
- It seems that **NHS board pharmacists** have had easier access to clusters than other professions as they could provide **prescribing data** and it was a win-win situation. **Other professions** such as nurses have not had easy access to clusters. Their work can provide qualitative, rather than quantitative data. Different professions have different priorities and reaching an agreement on priorities may require more effort.
- Engagement with **LIST analysts** is **variable** (See Data section).

> *"It s really well attended, the Cluster Chair is really good, the GP who s the Chair of Cluster, he s got a really good approach. For me, honestly, it s the best meeting that I go to in the month.*

> *"Practice leads are happy to come to meetings but not to do any solid work. Cluster colleagues are too apathetic and happy to just let [CQL] do what they want.*

> *"Certainly you would expect where if there was going to be a project on a particular area of prescribing that the community pharmacist would be involved in that […] I suspect it isn t always done, but it should be.*

> *"The cluster meetings they have at cluster level vary but I think all clusters now involve practice managers […] because their role in this is key because it tends to be the practice team who do much of the data mining or counting or changing.*

> *"And we've been clarifying the links with the rest of the system […] they may not be coming with a particular ask for us […] but they're coming to tell us about what they're doing so we can then think oh, hang on a minute, that links up, we hadn t really thought of that, maybe we should be looking at those things. So, that's starting to work quite nicely.'*

Engagement

Questions for local reflection

- How confident are the PQLs and CQLs in using facilitation skills?
- Have you considered doing a learning needs analysis of clusters in relation to facilitation?
- What facilitation development opportunities do clusters have locally?
- How do you engage and work collaboratively with the MDT?
- How do you engage patients to make their voices heard and contribute to cluster work?
- Before starting a project, do you consider and engage with all professionals involved in the patient's journey?

Areas for national reflection

- Provide clarity around roles and responsibilities for all involved in clusters.
- Showcase examples of good cluster engagement across the system.
- Consider minimum level of national facilitation training required by CQLs.

Examples of enabling engagement

Providing facilitation training

- Developing facilitation skills through coaching sessions.
- In Switzerland, quality circle facilitators/leads complete a 3-day course. They also attend an annual quality circle facilitators' conference for all professions.

Finding common interests through data

- A CQL from NHS Tayside commented how agreeing a cluster dataset that was important to them and comparing data among themselves helped to increase interest and engagement with cluster work.

Building effective ways of working within the cluster

- Clusters could agree their ways of working and/or ground rules for the cluster. '*I think they've got a good system where people will come forward, discuss a topic, people will agree whether they think it's important and something that we should be taking forward in cluster, and then quite often one of the practices will agree to either pilot or scope something out, they'll go away and do a bit of a pilot and then they'll come back and report back and everybody else will probably have done a little bit of scoping and searching of things in the meantime and then come back and say; "okay, this is what we learned from our pilot" and either everybody is going to go forward, everybody is going to do it, or actually this issue has arisen or that issue has arisen, so there's quite a steady approach.*'
- Organisational development teams could help clusters to develop as a team by providing team building activities/sessions.

Engaging with professionals across the system

- Having guest speakers at cluster meetings is a common way of engaging with other professionals. There were several examples of how referral issues led to engaging with relevant professionals, presenting at the meetings and collaborating on improvement activities. There were also examples on specific conditions such as diabetes or frailty.
- MDT professionals could be included in the cluster membership (see Structure section).
- All relevant professions should be working together on specific topics - see examples of collaboration between pharmacists and clusters and example of collaboration across the pathway. (For example, in the Western Isles, the Realistic Medicines Lead, who was also the Interface Lead, shared data on the endoscopy pathway with the cluster.)

Engagement with patients

- A practice patient group in NHS Western Isles gathered feedback on patients' views on GP access. They produced a report and this is reviewed in the practice meetings to address the recommendations progressively.
- Healthcare professionals could record feedback from patients to improve improvement work (see community pharmacist example).

Learning System

Why is it important?

Having mechanisms to identify, capture and share the learning helps to:

- **prevent 'reinventing the wheel'** by building on the learning of others going through similar experiences or working on the same areas
- share success and failure, to build on **all** learning, and spread successes
- **inspire others** and spark ideas
- **enable peer support** by connecting people and learning from each other
- **motivate people** by demonstrating the value and impact of cluster working, and
- **increase support and buy-in** from HSCP/NHS boards as they see the impact of clusters.

Key points

- There are **pockets of good practice and successes** across the country. However, these are **not widely shared**. There is also a lost opportunity to celebrate the good work that is happening.
- Sharing the learning **requires time** (eg to write a summary, attending meetings) but given its importance, appropriate resources **and/or support** should be invested.
- **A variety of mechanisms should be in place** to enable the sharing of learning **at local and national level**.
    - **Identifying learning** – mutual benchmark, discussions, reflective practice, research, deep dives on specific topics.
    - **Capturing the learning** using different formats – reports, publications, videos, off-the shelf projects/toolkits, case studies, webinar recordings, posters.
    - **Sharing the learning** – meetings, events, groups, networks, national conference, webinars, induction, shadowing, journals, newsletters, online platforms hosting resources, training, induction, project surgeries, and networks.
- An effective learning system requires a **learning culture** that values and welcomes all learning, both from successes and from things that have not worked out as planned. A learning culture should not **be judgemental** but focus on learning.
- Some CQLs mentioned that **sharing worked examples with other clusters** and **easy to find resources** would help them.

> *I don t want to be overly bureaucratic, but how are we capturing all that extremely amazing work that's happening there? Because it s being missed. And how do we celebrate that?'*

> *I think there does need to be lots of ways to share it but I just don t think people have the time and capacity to do that the way things are set up at the moment, and that's the biggest problem.'*

> *The cluster has been able to work on a few small QI projects separately and share the learning. Cluster was a good mechanism for discussions and sharing learning when pandemic hit.'*

> *It s also easy to forget what is out there. Where are all the resources that you can tap into so that you can take this into your own cluster and not recreate the wheel.'*

> *Some of the innovations have been extraordinary, but again not shared widely, or people have always got […] and maybe this is just general practitioners, but they've always got a viewpoint; that'll not work in our place or where s the evidence around that? So, quite a judgemental environment. And it was supposed to be anything but judgemental.'*

Learning System

Questions for local reflection

- What opportunities or mechanisms are there for the PQLs/CQLs to share learning and learn from others?
- How is the learning from clusters shared within the HSCP, NHS board and nationally?
- What support is available to help with capturing the learning from clusters?
- What else could be done to improve sharing of experiences and learning?

Areas for national reflection

- National CQL events.
- Online platform for CQLs and PQLs.
- National induction pack for CQLs and PQLs.
- Guidance for sharing the learning (eg templates, format, etc).

Examples of how learning is captured and shared

Meetings (For example, cluster meetings, local CQL meetings with or without their clinical director or associate medical director. In Wales, they hold externally facilitated cluster lead meetings, followed by a record of the discussion).

National conferences or events (For example, National CQL Event in Glasgow in 2017, annual conference in Wales where a cluster yearbook is compiled, Swiss annual conference for quality circle facilitators representing all primary care professions).

Deep dives (Locally – NHS Lothian LMC 90 day on cluster working or nationally (this learning cycle).

Research by the Scottish School of Primary Care producing briefing papers and reviews, among others. They also publish **articles** (eg Progress of GP clusters two years after their introduction in Scotland: findings from the Scottish School of Primary Care national GP survey).

National online platforms such as Improving Together interactive to host relevant **QI resources and information** for primary care (eg case studies, posters, toolkits and relevant information on specific topics at patient level (eg dementia) or practice/cluster level (eg inequalities), events such as the Primary Care Resilience Webinars, educational opportunities and networking opportunities). Another example is the Primary Care One website in Wales.

Local online platforms such as the Lothian primary care network to host relevant QI **resources and information** for primary care, such as primary care toolkits, CQL support available, CQL resources, etc.

Podcasts and videos (eg Hospital at Home ihub podcasts, NHS Lothian Quality Academy video library).

Induction packs for PQLs and CQLs. (For example, NHS Lothian have tested an induction pack for CQLs. See also handbooks for clusters in Wales: Summary and quick read, Resources to help develop your cluster, Working in Wales: Policy and Strategic Context, About you as a leader).

Training and coaching are powerful ways of sharing learning (eg NHS Lothian CQL coaching support). See QI, Data, and Leadership sections for examples on training).

Self-assessments against a roadmap for clusters could help clusters to reflect on progress and the next steps. See example of a self-assessment tool for communities of practice.

Non-clinical staff within or beyond the cluster (eg administrative staff, project support staff, knowledge brokers) could help to capture the learning into resources.

Priorities

Why is it important?

- Given the limited resources, it is important to prioritise those areas or topics that are **relevant to practices and their population needs** where clusters can have a bigger impact.
- Agreeing priorities is also important to ensure **buy-in from everyone** in the cluster.

Key points

- Having a **shared and clear vision and purpose of clusters is key** to ensure clusters focus their work on the right areas (see Vision and Purpose section).
- Cluster priorities should be **driven by local population needs** but access to good quality and meaningful **data is limited**. See Data section.
- **Priorities** within the cluster are usually based on discussions at cluster meetings. The data available can determine the area of focus (eg prescription data being available may have influenced the decision to improve prescribing). The resources available can also influence the decision on areas to work on (eg selecting smaller pieces of work).
- Finding a common area of work can be challenging due to the **lack of homogeneity** among practices within the cluster (see Structure section).
- Sometimes there are **disagreements** on what the priorities should be (eg HSCP and some professions could be more interested in savings while clusters in clinical outcomes, contract implementation vs population health needs). The **decision-making** and **escalation process** should be explained as part of the Governance structure for clusters.
- Having a **list of topics or ideas** for clusters to choose from could provide some direction to those clusters that require it. The decision on potential topics for clusters should be **evidence-based**, not media or politically driven. Ensuring clusters keep their **autonomy** to decide their priorities locally is very important to them.
- Clusters should build their **confidence progressively**. They should start by choosing projects that guarantee success to build their confidence before tackling bigger issues.
- The agreed priorities should be recorded in a **plan** (eg Cluster Quality Improvement Plan) and progress tracked (see Governance section).

> *"We ve done all the low hanging fruit stuff, we ve looked at our prescribing.*

> *It's great that people come forward with things that they're interested in, […] but that can t be the only way that we identify things; we need to be much more systematic about are we identifying unmet needs […] [LIST Analyst] has helped us a lot with that because he s been involved in the joint strategic needs assessment for the HSCPs, so he s brought that knowledge into the cluster.*

> *I think it [list of topics] would naturally provide a point of focus for, we do have a bit of a struggle to get a clear focus and collaboration around our locality work […] I think aligning right up through the tree to a strategic plan to a needs assessment makes sense, and also contributing, putting their identification of issues and challenges at primary care and making sure they appear in the needs assessment and strategic plan.*

> *I think they need to be focused on QI […] I m very clear that is their role is QI work, they're not there for sustainability. We need others, sustainability is a huge issue, but we have other mechanisms.*

> *But GPs by and large when they're not burning out, like most healthcare professionals and certainly most doctors, are competitive and they do want to do well, they want to be seen to do well. And hence the QOF was quite good because it was clear things you could chase and there was some money involved, but it wasn t just the money, it was also doing the right thing.*

Priorities

Questions for local reflection

- How do you identify your priorities locally? Do you use data and/or intelligence?
- How do you prioritise the topics identified?
- Are you considering the patient journey when identifying priorities?
- How do you map cluster priorities to local strategic plans?
- How are decisions on priorities made if there is disagreement within the cluster or with the wider system?
- How do you record the priorities agreed and monitor progress against them?

Areas for national reflection

- Review and clarify the purpose of cluster working and expectations in the current context.
- Setting topics to prompt clusters when considering priorities (potentially with a suite of resources that could help clusters).

Examples of priority definition and agreement

Priorities could be defined based on:

Data (population health needs data, significant adverse events, cluster dataset) – See Data section:

- *'NHS Greater Glasgow and Clyde did a public health cluster report […] what was really good was the cluster was able to see what was real within their area and […] what data was being inputted into their systems so you could see what was coming out. And that allowed them to make some local decisions.'*

Discussions (at practice, cluster, HSCP and national meetings):

- *'There was a little almost lightbulb moment from the GPs which was they were a bit like 'well, frailty identification, we don't really need to do that because we already know who our frailty patients are, so what difference is it going to make if we have a frailty code?' But then, having done that system piece of work there was that thing; "actually if we do that piece of work, it's not going to be about what we do differently, it's going to be about what happens differently through the system because the rest of the system will understand that that person is living with frailty and therefore they need to respond in a different way." So, it's about helping the patient on their journey outside primary care. So, that's a project that they've just adopted and agreed is being scoped out.'*

List of suggested topics – See examples below

- GP quality circles in Switzerland are given a list of areas to work on together with a relevant dataset. Then the GPs decide what aspect of the topics to improve on:
  [We are asked to] 'have one or two quality circles on diabetes, but then we can choose the aspect of the diabetes topic, whether we want to put an emphasis on new anti-diabetes drugs, or collaboration with specialists, or collaboration with physiotherapists, etc. But, it's just one or two circles should be about diabetes, or two or three other chronic conditions. […] For instance, we developed like a huge Excel sheet on diabetes where we have an overview of the population who actually has diabetes[…]. So-and-so many patients have not taken out their drugs at a regular interval, so many patients have not measured their HPAC at least once or twice a year, etc and then you can look at how well they were administered, and then you can prioritise.'
- In Wales, clusters were required to work on a series of areas determined on an annual basis (see Basket of QI projects for 2019-20).
- In the past NHS Highland developed a list of ten sample prescribing project areas. The list was discussed with every GP practice together with their prescribing data. The GP practices would choose projects to work on based on their needs.
- *'Having primary care bundles and other quality improvement programs that could just sit as a shelf and you picked one out so that you had a ready-made framework that you could just work through'* could help spread QI work. See Learning System section.

Next steps

- **Disseminate the findings.**
- **PQLs/CQLs, HSCPs and NHS boards to reflect together** on the findings outlined in this report and discuss what should be done next locally.
- **Government, national organisations and key stakeholder representatives to reflect together** on the findings outlined in this report and discuss what should be done next at a national level. This will inform future iterations of **guidance** for clusters.

Acknowledgements

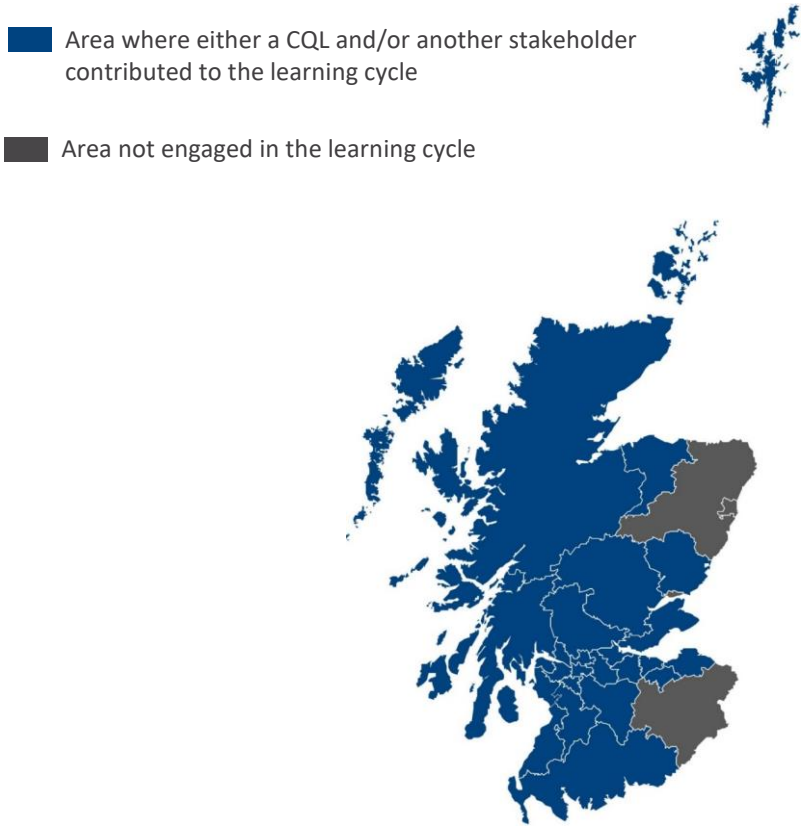
We would like to thank all those who have shared their experience, best practice examples and time without which this report would not be possible. This includes:

- the four Primary Care Quality Improvement Faculty members that acted as critical friends and contributed their thoughts on emerging themes and their experiences in their local areas
- the 24 cluster quality leads that contributed to the exploratory work, and
- the 21 professionals interviewed during the learning cycle.

Appendix A: Range of stakeholders engaged with and geographical spread

Perspective	Number of people engaged with during the
CQLs *	24
Professional representative organisations (BMA, RCGP)	2
Policy	2
Academia	1
HSCP/NHS board – medical directors/clinical directors	4
HSCP/NHS board – primary care support team	2
HSCP/NHS board – LMC	1
Special NHS boards (NES, Public Health Scotland)	5
MDT (pharmacy, nursing)	2
International (Wales, Switzerland)	2
Grand Total	**45**

**Some CQLs were LMC representatives*



Appendix B: Questions for local reflection

Vision and Purpose

1. Is there a common understanding of what clusters should be working on?
2. Is there a common understanding on what good looks like?
3. What could help developing a common understanding?

Structure

1. What could you do to make the PQL/CQL roles more attractive?
2. Are there structures are in place for the MDT to contribute to cluster working? If not, would that be helpful?
3. How are you involving clusters to influence the continuously changing strategic landscape? Is it through tripartite working?
4. Could the current structures (eg in terms of mixture of practices, cluster size and boundaries) be better?

Governance

1. Where do clusters fit within your governance structure?
2. Is there an organogram and supportive information to explain the governance structure to GPs and others?
3. Do you have a visible, named lead to support CQLs and their development?
4. Do you have a mechanism for reporting cluster activity?

Support

1. Do clusters in your area get administrative support? How is this provided?
2. Do you have project management skills within your clusters? Have you considered providing/getting project management support for cluster working?
3. Is it clearly defined and communicated who in the HSCP/NHS board structure should support PQLs/CQLs/Clusters in different circumstances (eg help with improvement projects, relationship issues, conflict)?
4. What opportunities do your HSCP/NHS board provide for PQLs and CQLs to enable peer support?
5. How are PQLs/CQLs supporting each other within your cluster/area?

Resources

1. How many sessions do your CQLs and PQLs have for cluster working? Is it enough to achieve meaningful cluster work?
2. What resources do they have in terms of IT to support their communication and collaboration?
3. What support and resources do clusters have to help them drive successful improvements?
4. Do clusters know how to bid or request funding from HSCPs to implement ideas?
5. Do clusters know of external funding opportunities?
6. Do clusters have help to apply for external funding available?

Relationships

1. Do your PQLs/CQLs know who is who within your system and who to approach for different issues?
2. How would you assess the current working relationships within your area?
3. How do you help your clusters to develop positive working relationships across the system?
4. Have you considered how you can use technology to facilitate relationships?
5. Do you have mailing lists to help with communication? If not, you could discuss whether these would be helpful.

Data

1. What data are available locally and nationally to your PQLs/CQLs?
2. Are the PQLs/CQLs aware of the data sources and support available?
3. Have you considered developing local reports to enable data extraction?
4. Do you consider capacity/funding for manual data collection if required?
5. What training and support is available to ensure good data quality?
6. What opportunities are there for PQLs/CQLs to increase their knowledge on data?
7. How are PQLs/CQLs/LIST analysts enabled to build good working relationships?
8. Is the role of LIST analysts clearly understood?
9. Have you considered having a dedicated contact within the HSCP for LIST analysts to facilitate good relationships?

QI

1. What QI knowledge and skills do your cluster members have?
2. Have you considered doing a learning-needs analysis of clusters?
3. What QI development opportunities do clusters have locally?
4. What QI support do clusters have access to locally?
5. What QI resources do clusters have access to locally?
6. Do other members of the primary care team have QI skills that could contribute to cluster QI projects?

Leadership

1. What leadership skills do your PQLs/CQLs have?
2. Have you considered doing a learning-needs analysis of clusters?
3. What leadership development opportunities do your PQLs/CQLs have? Are they aware of these?
4. How does the HSCP/NHS board support the development of the PQLs/CQLs' leadership skills?
5. Are there existing leadership networks that the CQLs could join?

Engagement

1. How confident are the PQLs and CQLs in using facilitation skills?
2. Have you considered doing a learning-needs analysis of clusters in relation facilitation?
3. What facilitation development opportunities do clusters have locally?
4. How do you engage and work collaboratively with the MDT?
5. How do you engage patients to make their voices heard and contribute to cluster work?
6. Before starting a project, do you consider and engage with all professionals involved in the patient's journey?

Learning System

1. What opportunities or mechanisms are there for the PQLs/CQLs to share learning and learn from others?
2. How is the learning from clusters shared within HSCP, NHS board and nationally?
3. What support is available to help with capturing the learning from clusters?
4. What else could be done to improve sharing of experiences and learning?

Priorities

1. How do you identify your priorities locally? Do you use data and/or intelligence?
2. How do you prioritise the topics identified?
3. Are you considering the patient journey when identifying priorities?
4. How do you map cluster priorities to local strategic plans?
5. How are decisions on priorities made if there is disagreement within the cluster or with the wider system?
6. How do you record the priorities agreed and monitor progress against them?

Appendix C: Areas for national reflection

Vision and Purpose

1. Additional guidance for clusters around vision and purpose.
2. Regular discussions on the vision, purpose and future of clusters with PQLs and CQLs.

Structure

1. How to make PQL/CQL roles more attractive.
2. Explore tripartite working in more detail.
3. Explore how the MDT could best contribute to cluster working.
4. Additional guidance for clusters around structure and set up.

Governance

1. Role of improving together advisory group to support cluster working.
2. National feedback mechanisms.
3. Potential for having a steering group meeting with named HSCP leads for clusters

Support

1. Assess the support provided to clusters and update the minimal requirements laid out by the 2019 Guidance.
2. Monitor implementation of the guidance for cluster working.
3. Consider a national support network for clusters.
4. Consider national project management guidance and/or templates for cluster working.
5. Consider opportunities to enable peer support at a national level.

Resources

1. Review the minimum time commitment recommended for PQLs and CQLs.
2. Monitor implementation of the guidance for cluster working.
3. Consider assistance for obtaining external funding.
4. Review national support in terms of resources for cluster working.

Relationships

1. Promote implementation of the guidance for clusters in terms of relationships and their importance.
2. National meetings/sessions for PQLs and CQLs and for the HSCP leads supporting clusters locally.
3. Mailing lists for CQLs, PQLs and HSCP contacts for clusters.

Data

1. Development and communication of national datasets that are relevant and with the appropriate level of detail for clusters.
2. Data systems for primary care and interim arrangements.
3. Support for data extraction and interpretation.

QI

1. National educational opportunities for clusters.
2. QI skills pathway for PQLs/CQLs.
3. National QI coaching support for clusters.
4. Local QI support for clusters.
5. Agree the future of Improving Together interactive or alternative online platform for QI resources.

Leadership

1. National leadership development opportunities for CQLs.
2. National leadership coaching support for CQLs.

Engagement

1. Provide clarity around roles and responsibilities for all involved in clusters.
2. Showcase examples of good cluster engagement across the system.
3. Consider minimum level of national facilitation training required by CQLs.

Learning System

1. National CQL events.
2. Online platform for CQLs and PQLs.
3. National induction pack for CQLs and PQLs.
4. Guidance for sharing the learning (eg templates, format, etc).

Priorities

1. Review and clarify the purpose of cluster working and expectations in the current context (COVID-19 service pressures).
2. Setting topics to prompt clusters when considering priorities (potentially with a suite of resources that could help clusters in their work).

Appendix D: Examples of collaboration between pharmacists and clusters

This section provides specific examples regarding collaboration between pharmacists and clusters to illustration how relevant professions work together on specific topics as mentioned in the Engagement section.

Reducing errors in Immediate Discharge Letters (IDLs)

'Practices worked collaboratively to standardise the process of IDLs being sent to the technician led pharmacotherapy hubs to minimise the chance of errors. So, all stakeholders were involved in amending their processes to bring everything together into one process, all discussed at cluster meetings process and tested and agreed through the clusters, and then initiated at the hub and confirmed that it worked.'

Improving the patient's journey at the community pharmacy end

'The community pharmacist attended the hub in order to provide the GP partners on issues that they were identifying in the community pharmacy, so being able to explain things that the patients were saying to them but also saying things that were happening when prescriptions were coming down to them and that the practice was then able to amend processes in order to make the journey smoother for patients at the community end.'

Improving the patient's journey for long term conditions

'This one is around supporting and improving long term condition recovery and remobilisation. Improving a pain pathway. Improving pulmonary rehab. Annual medication reviews. Improving prescribing of <INAUDIBLE 34.04> and repeat prescribing guidance.'

Improving pharmacotherapy services

'Both the pharmacist and the pharmacy technician attend the monthly cluster meeting, and they are able to move towards standardised working across the cluster with things like serial prescriptions, and also looked at anti-depressant reviews and mental health triage, and GPs really understanding what's going on as a result.'

Improving follow-ups after prescription changes

'This is quarterly meetings around follow-up letters. So, where changes in prescribing had been agreed, and then follow-up letters are shared with the pharmacy team in order to ensure that the changes are made and the patients are followed up to check that any changes needed have been successful for the patient.'

Improving new initiation of opioids such as co-codamol

'The GPs designing a leaflet to support patients and as the drugs were prescribed and tracking the patient's journey to check that they were reviewed at regular intervals. And that was done by the pharmacy team, and they did some follow-up patients after the initial consultation by the GP.'

Appendix E: Example of collaboration across the pathway

This section provides an example of collaboration across the pathway to illustrate of how relevant professions work together on specific topics as mentioned in the Engagement section.

'I would say probably the ones that have shown the best examples have been often through a clinical caseload, so people living with diabetes or people living with COPD, and actually just getting their care agreed across a cluster so that all of the practices will do X, Y, and Z. They'll make sure that the resources, some of them have utilised a house of care model, so care support planning, so that all people in that area that they know and understand what their assets are and across that whole area so that social prescribing becomes much clearer.

And they then work with the diabetologist, they bring them in from the hospitals, so you're starting to see patient pathways and routes of care becoming much clearer and obvious and everybody's doing a similar… so you'll have a different conversation, but everybody having a similar ethos. And that has made quite a difference actually because people feel supported in and across their change, and the environment of which they're trying to improve, and they come together, and I have seen and heard the nurses coming together to talk about the things that they need that have made a difference […] and you can see the positive attitude that comes from some of that as well.'

Appendix F: 'Basket' of QI projects for Welsh Clusters in 2019-20

Example of list of topics for clusters in Wales

The quality improvement domain is based on the introduction of a 'basket' of quality improvement projects which are to be delivered at cluster level. The basket of projects available for 2019-20 were:

- Patient Safety Programme – Reducing medicines related harm through a multi-faceted intervention for the cluster population.
- Reducing stroke risk through improved management of atrial fibrillation for the cluster population.
- Ceilings of care/advanced care planning.
- Urinary tract infection to multi-disciplinary antimicrobial stewardship 2019-20.

The Quality Assurance and Improvement Framework (QAIF): General Medical Services contract 2019 to 2020 (page 22-32) contains a section for each project area with information about the requirements of the QI project and measurement.

Appendix G: Glossary and list of acronyms

2C GP practice	A GP practice that is run by the NHS board.
A	
Action plan	A robust plan detailing all the actions required to achieve project goals. See more details here.
B	
BMA	British Medical Association.
C	
CQLs	Cluster quality leads.
D	
Deep dive	An in-depth examination or analysis of a specified topic
Driver diagram	Tool to visually present a team's theory of how an improvement goal will be achieved. See more details here.
E	
Extrinsic Role	Role of GP clusters to contribute to the oversight and development of care within the wider healthcare system.
G	
GMS practice	Practice that has a standard, nationally negotiated contract.
GP Contract (also known as GMS contract)	It refers to the General Medical Services contract between NHS boards and GP practices run by GP partners.
GP Cluster	Professional grouping of general practices, represented at periodic meetings by Practice Quality Leads (PQL). Each GP cluster will have a Cluster Quality Lead (CQL) whose role is to facilitate and guide the members and liaise with locality and professional structures. The purpose of these clusters is to provide a mechanism whereby GPs may engage in peer-led quality improvement activity within and across practices and also contribute to the oversight and development of care within the wider healthcare system. These purposes may further be described as intrinsic and extrinsic quality roles.
GP Session	Typically the number of contracted number in a GP session is 4 hours.
H	
HSCPs	Health and social care partnerships.
I	
Improving Together	A national framework for quality and GP clusters in Scotland designed to complement the Scottish national GP contracts. See more details here.
Intrinsic role	Role of GP clusters in peer-led quality improvement activity within and across practices.
IT	Information technology.
L	
LIST	Local intelligence support team. See more details here.
LMC	Local medical committees. They are local representative committees of NHS GPs and represent their interests to the NHS health authorities.
M	
MDT	Multi-disciplinary team.
P	
PCIP	Primary care implementation plan.
PQLs	Practice quality leads.
Primary Care Quality Improvement Faculty	A group of healthcare professionals contracted to Healthcare Improvement Scotland to provide input from a clinical perspective on improvement work.
Q	
QI	Quality Improvement - the application of a systematic approach that uses specific techniques to improve quality.

QOF	Quality and Outcomes Framework – formed part of the GMS contract. QOF measured achievement against a range of evidence-based indicators, with points and payments awarded according to the level of achievement.
Quality circles	In this context, group of around 6-12 healthcare professionals that meet regularly to review and improve primary care services.
R	
RCGP	Royal College of Practitioners.
S	
Stakeholder mapping	A way of identifying, prioritising and understanding your stakeholders. See more details here.
T	
Terms of reference	Outlines the purpose, responsibilities and structure of a group, meeting or project.
Tripartite working	Collaboration between the GP subcommittee of the area medical committee, NHS board/Integration Authority GP leads and CQLs.
W	
Workflow optimisation	Workflow Optimisation, also known as document management, is a process designed to support seamless management of incoming correspondence, primarily at the point of the administration team.

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