Improving Continuity of Care with Microteams: Frequently Asked Questions (FAQ)

Thank you for attending the NHS Confederation Primary Care Network webinar on 19th March, 12-1pm.

Please see below FAQs with answers to outstanding questions which were not able to be answered on the webinar from the chair Dr Joe McManners and three speakers from the Living Well Partnership, Southampton. The answers below provide insights into how the Living Well Partnership Southampton transformed its approach to delivering continuity of care through microteams.

If you would like to contact the speakers directly to discuss in more detail, please use the following contact details:

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- Moira Wright (Care Coordinator): m.wright29@nhs.net

Q. If there was some reluctance in a surgery to change, could you create one 'team' within the team, as way to pilot it with some staff/ patients? (I presume this was partly inspired by NUKA?)

A. I can’t see why it could be tried as a process but it maybe harder to implement, as the patients would need somehow to be funnelled into the ‘microteams’ depends on how the practice ‘allows’ patients appointments to be booked.

Q. Were there any discrepancies in the UPC score within the different microteams?

A. Yes, there were some discrepancies in the UPC scores across different microteams. This is something worth exploring further to understand the underlying reasons. It is important to consider that microteams are based at different sites, and local variations in patient demographics, staffing, and operational factors might contribute to these differences. However, these discrepancies also provide a valuable opportunity to identify specific challenges and apply targeted interventions.

Q. Practically, how do you clearly separate the patients into mini-lists?

A. We did lots of number crunching in the background to try and be as equitable as we could for each team. Essentially geography was the biggest factor to ensure local delivery of care for local patients. We then looked at frequency of attendances, QoF registers, Care Homes, frailty, housebound etc. to try and ensure the microteams were as equitable as we could be

Q. I'm really interested in how you manage the contacts from patients and how you ensure patients are booked with their team?

A. Our funnel process is essentially a big scale triage. Our patients are encouraged to do complete their 'anima' similar to e-consult. Where they are unable to do so we have trained staff to support. The anima is assigned to the GP team lead for the microteams. All our teams of every area are set up as pyramids. The GP team lead is either a partner or a senior GP who holds that registered list. They will 'sift and sort' to the most appropriate skill mix to deal with that patients issue. The microteams care coordinator will also help with 'sifting and sorting' animas for admin tasks, or those animas that have come in that they recognise/know will be for their team to pick up. The booking in can be as simple as sending a booking link, getting our urgent care admin to bring the patient down for today at an convenient time or getting the care coordinator assistant to bring a patient down for a specific person at the most convenient time for them both.

Q. Can I ask about your urgent care team, I assume this might be AHP's? do they work as a team, but across sites? and co-ordinated by the duty doc? you've also mentioned a team lead - could you elaborate a bit more on that role?

A. Each function area eg Care coordinators, care coordinator assistants, GPs, practice nursing, front desk, Urgent Care, Medicines team, call handling etc etc etc are all set up as 3 tiered pyramids. At the top of the pyramid is the most senior to support strategic direction, below which will be middle grade to support line management and lower tier the running of the organisation. Above all the pyramids are the 8 partners. Our non-clinical partner will take most of the senior management team reporting however this is dependant on the functioning area eg the senior pharmacist for clinical direction will report to the prescribing lead partner. Each functioning team will meet regularly to share learning, support and coordinate activities. All teams (except call handling) are disseminated through the organisation at our various sites providing a base for individuals. This too is the case for the urgent care team which are predominately AHP. They will have a link GP at their base site to support them with any queries.