

Report of the National Improvement Team for Primary Care Access and Responsiveness

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Foreword by the National Director for Primary Care

David Colin-Thomé

I was asked by the Secretary of State for Health Alan Johnson to lead a team whose tasks were twofold:

- 1 to produce a report into how access can be improved in general practice
- 2 offer support to the NHS in tackling access issues.

All team members are NHS staff who work in and are hugely knowledgeable about general practice. They generously gave their time because they all feel passionately about general practice, that even the best of services can do better and, importantly, that variation in levels of service are unwarranted.

Good access to services always figures very highly in what the public wish from their NHS and, since we aspire to patient-reported outcomes of care, the NHS must have this as a priority. Specifically, during the consultation process that informed the White Paper *Our health, Our care, Our say* (2006) the general public highlighted access to general practice ‘as and when needed’ as one of their highest priorities.

The Department of Health (DH) has set standards for how easy it should be for people to book an appointment with their doctor and last year it undertook a survey on access to general practice. This was the biggest ever patient survey of its kind and, with 86% of respondents saying they were satisfied with telephone and 48-hour access, it was a vote of confidence in general practice.

But despite the overall high levels of satisfaction, detailed analysis of the survey results revealed several clear and concerning issues.

- 1 Black and minority ethnic (BME) patients, especially Bangladeshi patients, show far higher levels of dissatisfaction and are the subject of a separate and specific report as to how satisfaction for this group of patients can be significantly improved. To ensure close working together the report’s author, Professor Mayur Lakhani, is a member of my team.
- 2 16% of the population ‘not satisfied’ equates to a very large number of patients. Evidence from a separate DH tracker survey suggests the profile of the dissatisfied patient is young, in full-time employment, values convenience, and is most likely to want to exercise choice.
- 3 While there are relatively few variations in satisfaction between PCTs across the nation, the variation between practices themselves reveals major access issues. We feel this is an unacceptable variation.

Even the best can always do better. There has been a large and valid increase in resources going into general practice over the past few years. Prior to this increase, recruitment into and retention in general practice was showing worrying trends for a service that has always been popular with patients and which undertakes by far the largest majority of all NHS patient contacts with doctors and other clinicians. We now have the resources, recruitment has significantly increased and, in setting a minimum set of standards, a quality and incentive-based contract.

As a general practitioner for over 35 years and immensely proud to have been a GP I feel that professions, in order to warrant that title, must always aspire to do more than a minimum. This principle applies to accessibility as much as any other measure of quality.

The White Paper and the NHS Next Stage Review by Lord Darzi contain policies and a determination by the DH to address many of those problems that policies can address. But I feel that most improvement has to be the responsibility of a local NHS organisation and its services. This report maps out an aspiration and vision produced by local clinicians and managers, highlights existing support, levers and incentives that we need to use more optimally and that describes how important local leadership is.

As always when one visits the NHS, however high our expectations, there is always a clinician, manager and organisation already delivering excellence. Our visits to many general practices and the local NHS demonstrated that fact over and over again and showed that the key to such excellence is local and brilliant leadership. But we have always known that, so we have attempted to describe how we can make such leadership the norm. This is a challenge to us all but I have always strongly believed we must encourage and reward the excellent. Many will claim such an approach will simply increase inequity in provision but I do not want an equity that rewards low ambition and mediocrity. Let the best innovate and if it produces excellence, we must spread it so we achieve an **'equity of excellence'**.

I trust this report and the support we offer the NHS will be of use to the service in achieving an ambition of continuous improvement in the quality of the care we offer patients. We are indebted to the many practices and other NHS staff who also gave so generously of their time and knowledge, without which this report would have been so diminished. This report is above all a commitment to improve care for patients and the public whose aspirations we need to match.

Executive Summary

National and international studies¹ have consistently shown that the UK has a very high standard of primary care, of which GPs and patients can be justifiably proud.

Indeed, of 2.4 million people who responded to a national GP patient survey in January 2007, a substantial 84% said they were satisfied with access arrangements. Similar numbers were satisfied with their ability to get through to the practice over the phone and get an appointment for a routine matter within two days. That's good news.

What this also means however is that a significant minority, 16% of those who responded to the survey, are not satisfied. This doesn't include those who didn't respond or didn't have a chance to respond because they hadn't recently visited their practice.

Among the most unhappy are BME patients, especially Bangladeshi patients. The reasons for this dissatisfaction are covered in a separate report *No Patient Left Behind: how can we ensure world class primary care for black and minority ethnic people?* (January 2008).

Also, according to a separate DH tracker survey, many younger, employed people are more likely to be dissatisfied with access to GP services. They want practices to open on Saturdays and weekday evenings.

But one of the most striking outcomes of the patient survey was that patient satisfaction varied widely between different GP practices in the same PCT. This is unacceptable.

The DH has therefore identified two national priorities for primary care:

- 1 to provide more practices in the most socially deprived areas
- 2 to offer more flexible services for patients across the board by extending the hours of availability.

In October 2007 Lord Darzi's interim report on the NHS Next Stage Review committed the DH to making five key improvements to primary care. These were: to extend opening hours; create 100 new GP practices; develop 150 GP-led health centres; link NHS payments to GPs with patient satisfaction; and make information about GP practices available on the NHS Choices website.

In order to get a better picture of access to primary care services, the DH asked the National Improvement Team (NIT) to visit GP surgeries across the country and work with patient representatives, practice staff, PCTs and SHAs to find out what factors make the best practices outshine the rest.

¹ K. Davis, C. Schoen, S. C. Schoenbaum, M. M. Doty, A. L. Holmgren, J. L. Kriss, and K. K. Shea, *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*, The Commonwealth Fund, May 2007

The NIT came up with a list of 10 common factors and behaviours displayed by the best GP practices and their PCTs.

- 1 Being responsive to patients and the public: listening to what patients say and then acting on it and backing action with evidence.
- 2 Good relationships between PCTs and practices: working together towards the same goals.
- 3 Strong PCT management of poor performance: identifying poor performers and helping them improve.
- 4 Opening at the right times: in the evenings and at weekends as well as routinely during weekdays.
- 5 Information for patient choice: giving patients information about the range and quality of local services available.
- 6 Increasing capacity of general practice: PCTs boosting patient choice by contracting with commercial, voluntary and mutual providers.
- 7 Positive approach to new models of care: being willing to explore new ways of delivering primary care services.
- 8 Capacity planning within practices: planning capacity and designing services to reflect the needs of registered patients and getting the most out of invested resources.
- 9 Development of talent and innovation: welcoming new technologies and skill mixes.
- 10 Strong leadership and teams with vision: having inspirational leaders (GPs and other clinicians) and developing a clear vision for how the whole practice team will work to improve services.

Poorer performing practices could make rapid improvements in patient satisfaction if they focused their efforts on one or more of these factors. Equally PCTs, whose responsibility it is to commission primary medical services on behalf of their local population, should have a strong focus on quality, effectiveness and value for money of these services.

There is also an onus on PCTs to encourage and spread good practice. Indeed, if they could bring the worst two practices in their area up to the England average, national performance would improve by almost 1% in a single year. There are currently three strands of work that will support PCT's efforts in this area.

- 1 Practice based commissioning (PBC). This provides practices and PCTs with valuable feedback on the performance and value of the service providers they use and as such is a vital component of world class commissioning (WCC). Importantly, it will also enhance general practice provision.
- 2 WCC: developing commissioning that will strengthen PCTs as commissioners and help them shift the emphasis from spending on diagnosis and treatment for individuals towards also having a focus on prevention and health promotion for their entire local population.
- 3 Managing the system for the benefit of patients. The DH has published *Principles and rules for Cooperation and Competition* and will soon publish an overarching *Framework for Managing Choice, Cooperation and Competition*. Along with other key guidance on procurement, promotion and corporate transactions, these key documents will help PCTs build coherent local healthcare systems that use choice and competition to drive up quality for the benefit of patients.

Recommendations

The report recommends a series of actions by the DH, SHAs, PCTs and individual practices to ensure equity of access and responsiveness in primary care.

Practices

- 1 Use examples of good practice identified in the report to consider how to make the services they provide more accessible and responsive.
- 2 Work more collaboratively with the PCT to ensure patients have access to services that respond to their needs.
- 3 Segment the practice population based on need and then design services and clinics around this.
- 4 Build an extended healthcare team to make it easier for the practice to be responsive to patient need and be cost effective.

PCTs

- 5 Foster an environment that breeds good practice, rewarding and using innovation and driving continuous improvement.
- 6 Work to embed WCC and PBC in commissioning activity.
- 7 Target the worst performing practices and focus on improving patients' satisfaction.

SHAs

- 8 Build on current good practice by ensuring the WCC programme addresses the capacity, capability and information needed to commission responsive primary care services.

DH

- 9 Build on current good practice by ensuring the primary and community care strategy (being developed as part of the NHS Next Stage Review) fosters an environment where practices are supported and incentivised to provide continuous improvements in access and responsiveness.
- 10 Resource a national support team and development programme to help the local NHS implement good practice. This should cover both PCT commissioning and the capability of general practice.
- 11 Work with other agencies (such as the Improvement Foundation, NHS Alliance, National Association of Primary Care, NHS Institute for Innovation and Improvement and others) to champion success and support development.

Introduction

In 2007, the DH conducted the first national GP patient survey. It was sent to five million people who visited their GP in a single week in January 2007. Nearly half of them (2.4 million) responded, making it the largest ever survey on patient satisfaction in primary care.

Overall the results showed:

- 86% of respondents were satisfied with telephone access
- 86% of respondents were satisfied with access within 48 hours
- 84% of respondents were satisfied with current opening hours
- 75% of respondents were satisfied with advance booking
- 88% of respondents were satisfied with their choice of GP.

Behind the numbers

The good news is the majority of patients expressed satisfaction with access to GP services. The downside however is the remaining 16% – a significant minority – were dissatisfied. The NHS must be fair and accessible as it responds to the challenges of the 21st Century.

A detailed analysis of the survey results picked out several worrying trends.

BME patients are less satisfied

The survey showed that BME patients, especially Bangladeshi patients, were on average significantly less satisfied with all aspects of access to primary care.

After seeing the results, the Secretary of State for Health asked Professor Mayur Lakhani to lead a separate review into the reasons for this worrying variation by ethnicity. Professor Lakhani's conclusions are now available in the report *No Patient Left Behind: how can we ensure world class primary care for black and minority ethnic people?* (January 2008).

Younger, employed people are less satisfied

The GP patient survey showed a big variation in satisfaction, particularly with regard to opening hours, between older and younger patients. 23% of under 35s were not satisfied with current opening hours, compared to just 9% of those aged over 65. This is supported by data from a separate DH tracker survey, which suggests that patients who are younger (aged 20 to 35) and in full-time employment are also more likely to be dissatisfied with access to GP services.

Patients who fit the profile of this younger group tend to value convenience and choice most highly. Almost half of them (46%) said they would welcome GP practices opening on Saturday mornings and more than a quarter (26%) would like to see weekday evening openings.

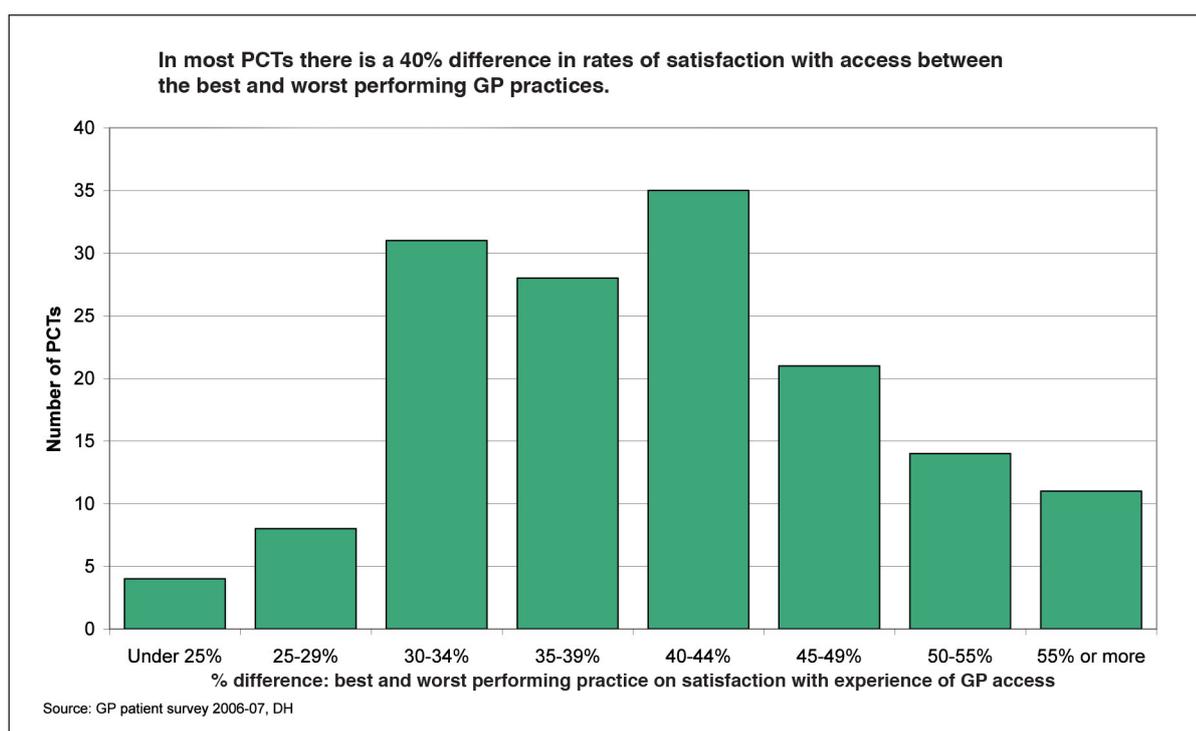
This supports the view that greater access to weekend and evening appointments is likely to have a significant impact on improving access and responsiveness for a number of patient groups.

Variation between practices

The survey reveals another striking reality: differing levels of satisfaction between different GP surgeries within the same PCT.

Many areas have practices that are excellent in responding to the needs of patients and which innovate to improve patient care. But many also have poorly performing practices that provide minimum levels of service.

The graph below illustrates the variation that exists within PCTs. For the majority, there is a 40% difference between the best and worst rates of satisfaction.



The variation can be better illustrated with specific examples. In Heart of Birmingham PCT the average rate of satisfaction with access was 73%, yet six practices were above 90%. Conversely, Dorset PCT had an average satisfaction rate of 90% even though five practices had satisfaction rates lower than 75%. Cornwall PCT had a GP practice in both the 10 highest and 10 lowest rated practices in the country in terms of access experience.

Such variation in the behaviours of individual practices is unacceptable because it means the NHS isn't meeting everyone's needs. Even the best PCTs can't afford to be complacent.

Initial DH response

The DH responded swiftly to the survey results. The Director-General of Commissioning and System Management wrote to PCTs on 27 July 2007 asking them to work with practices on their patch to examine and respond to the findings and develop local action plans for improvement.

The DH also immediately established the NIT to work with SHAs, PCTs, practice staff and patient representatives to develop a deeper understanding of what makes excellent GP services, and how good practice can be best shared with and adopted by others.

In the interim report of the NHS Next Stage Review (October 2007), the DH made a series of further commitments.

- 1 Action by PCTs in working with all GP practices in their area to develop flexible opening hours so that at least half of all practices open on Saturday mornings or for one or more evenings a week.
- 2 New investment to help establish at least 100 new GP practices in PCTs with the greatest need for additional primary care services.
- 3 New investment to help PCTs develop at least 150 GP-led health centres in easily accessible locations, providing a mix of pre-bookable appointments, walk-in services and other services (eg pharmacy and diagnostic services) for the local population, whether or not they choose to register with the centre.
- 4 An increase in the proportion of NHS payments to GPs that are linked to success in attracting patients and patient satisfaction. This will take into account the ability of patients to book advance appointments and see a GP within 48 hours.
- 5 Key information about GP practices to be made available on the NHS Choices website via www.nhs.uk

The 2008/09 Operating Framework, published by DH in December 2007, sets out the health and service priorities for the year ahead, the reform levers and enabling strategies, the financial regime and the business processes.

The Improving Access section of the framework reiterates the commitment set out in the interim report of the NHS Next Stage Review in that it asks PCTs to ensure at least half of all GP practices in their area offer extended opening to patients. Furthermore, it says additional opening hours should be based on patients' expressed views and preferences on access.

Methodology

The NIT is a group of experienced primary care professionals. It was asked to work with SHAs, PCTs and practices to identify the factors inherent in accessible and responsive primary care services.

The team undertook a series of visits, targeting mostly PCTs with high levels of patient satisfaction, but also contrasting these with PCTs which had fewer satisfied patients. Bringing this collective knowledge of the NHS together, the team was able to identify 10 clearly emerging factors. This qualitative evidence, filtered through the experience of the NIT, is illustrated with case studies from the areas involved.

Factors contributing to responsive and accessible primary care

In a series of visits across the country, the NIT was able to drill down the key factors that make the best practices so good at delivering accessible and responsive care for patients, as well as the behaviours displayed by the best PCTs in supporting their practices.

The visits confirmed the survey findings that the majority of patients are satisfied with GP services, which continue to perform well, particularly on equity, quality and efficiency.

But good can always be better and, more importantly, the need remains to tackle the unacceptable disparity between practices highlighted by the GP patient survey.

Sometimes though, it can be difficult for practices or PCTs to know where to focus their efforts to make the biggest difference. To this end, the NIT has identified 10 common factors and behaviours displayed by effective GP practices and their PCTs that point the way forward for improving access and responsiveness across all practices in the UK.

1. Being responsive to patients

Practices and PCTs need to seek out the views of patients, listen to what they say and then respond by making appropriate improvements to the services they commission and provide. This will involve understanding the needs and preferences of different groups of patients, including 'hard to reach' groups such as BME patients, elderly patients and those with disabilities, including learning disabilities. Practices should be sensitive to patients' requirements and ensure their practice systems are flexible enough to accommodate a range of needs.

The best practices work hard to continually collect patient feedback and act upon the results. They are always looking to improve their performance and to tailor their services to the differing needs of their patient population. Segmenting the practice population according to need and preference will help practices design more responsive services.

How can primary care be sure it is providing and commissioning the right services for its local population, if it doesn't regularly ask them?

Case study

Central Surgery, Oadby, Leicestershire

This GP surgery with a population of 8,500 in suburban Leicestershire has a higher than average proportion of patients with chronic obstructive pulmonary disease (COPD). The practice has devised a means of supporting patients on its COPD register that has enabled it to manage their conditions and reduce non-elective acute admissions by 10% in 2007.

The practice establishes a self-management plan with patients likely to benefit. Patients keep an emergency supply of medicines and telephone the practice when they recognise the warning signs of an exacerbation. The practice receptionist then uses an on-screen computer alert to ensure the patient gets to speak to a doctor or nurse to discuss using their medicine at home and managing the episode.

Patients with particularly severe conditions also have support from community matrons: nurse case managers who ensure that patients are offered holistic care from joined up health and social care services. The focus on support for self-care and early intervention when a patient's condition begins to deteriorate has reduced the need for hospital-based care. Studies demonstrate that these services are well appreciated by this specific group of patients who have many, varied and complex needs.

2. Good relationships between PCTs and practices

Practices and PCTs are working towards a shared goal of providing accessible, efficient and effective healthcare services tailored to the needs of local people.

All of the excellent practices visited by the NIT were able to demonstrate strong and mutually beneficial relationships with their PCTs. The most important factors were regular good quality communication, involvement between PCTs and practices at all levels and open and constructive dialogue between PCTs and practices.

Case study

Salford PCT and Langworthy Medical Practice

Salford PCT covers an area of high deprivation, and has relatively few clinicians for its population. The PCT recognised that to improve levels of service provision it needed to support practices with the drive to develop. It worked with Langworthy Medical Practice to expand and improve services and, as a result, the practice is well integrated with other community services and offers extended opening hours and online prescriptions.

3. Tools for PCT commissioners to manage poor performance

The results of the GP patient survey showed differing levels of satisfaction between different GP practices within individual PCTs. All PCTs must tackle such variations because poor performing practices are simply not providing the accessibility and responsiveness patients deserve.

Commissioners need to have access to detailed, comparative information so that they can readily identify variations in clinical behaviours and quality standards.

Publishing this information on a clinically-developed 'balanced scorecard', even if only for internal benchmarking, will encourage practices to compare their own performance against that of their peers and thereby take action to improve their individual standing.

It will also help PCTs identify the poorest performers in their area, enabling them to target support and drive up performance using the various levers available to them, such as regular reviews of the general medical services (GMS) contract and renegotiation of personal medical services (PMS) contracts.

If PCTs were to bring the two practices in their area with the poorest GP patient survey results up to the England average, national performance on key access indicators would improve by 0.9% in the first year and by 2.5% over three years. Improving the four most poorly performing practices in each PCT would deliver a 1.5% improvement in the first year and 3.6% over three years.

It makes sense then for PCTs to focus their attention on poor performance in the short term, but this should be done in a developmental way that encourages improvement through the continual sharing of good practice in order to make innovation the norm. Such developmental support should be given within a defined and limited time frame.

Case study

Coventry PCT

Coventry PCT, GPs and practice based commissioners are working together to develop a balanced scorecard of quality standards that will help them improve general practice. The process has been clinically led and supported by the Local Medical Council (LMC). The scorecard will enable practices to compare the services they offer with other practices in the PCT, reflect on any improvements they could make and then take necessary action. From the PCT's point of view, the scorecard is valuable in identifying which GP surgeries need their support the most to drive up overall standards.

4. Opening at the right times

Nearly half (46%) of all patients who told the GP Patient Survey they were dissatisfied with current access to GP surgeries, said they would like to be able to make appointments on Saturdays. A further 26% said they would like evening openings. Other preferences included lunchtimes (11%), more in-hours availability (9%), early mornings (7%) and Sunday appointments (2%).

The Extended Access Direct Enhanced Service (DES), recently accepted by GPs as part of changes to the GMS contract, provides a national framework to reward practices that offer additional consultation time to patients outside their current hours and core contracted hours. Extended hours will be identified as highly visible, responsive to local needs and based on patients' preferences as defined by a local survey based on a representative sample of the practice's population.

There is clearly demand for more flexible appointment times, but the overriding factor is that the practice is accessible at convenient times. It was clear from the NIT visits that the best practices are responding to their patients' requirements by extending opening hours, as well as ensuring good access to GP appointments during core hours.

In contrast, many poorer performing practices have limited availability for appointments within core hours. Where this is having a detrimental effect on the service they are providing patients and leaving needs unmet, PCTs should use existing contractual arrangements to address the issue. The aim should be to have the right balance of appointments throughout the day, bookable in advance, to meet patients' needs.

Case study

Churchill Medical Centre, Kingston

The Churchill Medical Centre in Kingston has produced an excellent leaflet that sets out the reasons why, steps towards and costings for its practice's extended opening hours, available at www.churchillmedicalcentre.com

5. Information for patient choice

There is little point telling patients they can choose between primary care services without also giving them the information that will enable them to make their choice.

Good PCTs and individual practices are working both to raise awareness about the right to choose and to provide information about the range and quality of services provided by each of the practices on their patch.

This process can also help raise overall standards by increasing competition between practices.

NHS Choices is supporting access by making comprehensive health information available through a variety of digital channels, including the internet, mobile phones and other forms of digital media. The general practice directory on NHS Choices includes information for the public on the availability of registration, plus service information such as opening times and out-of-hours services, results of patient surveys and the quality outcomes framework (QOF). It also gives practices the opportunity to highlight any special services they offer. More than half the practices in England have registered and 2,200 have completed their online profiles, ensuring that the information available to patients is up-to-date and accurate.

Case study

NHS Choices

The NHS Choices service is a comprehensive on-line healthcare information resource for patients. Its information on GP services is designed to help patients access practices with good performance ratings and suitable opening times. It also provides information on other healthcare providers such as hospitals, dentists and opticians. The fact that so many people can now access information on NHS Choices is a powerful incentive for healthcare providers to improve the services they offer. Patients who find it difficult to understand the healthcare system or to use NHS Choices can get help at a number of local libraries.

6. Increasing capacity of general practice

In some areas of the country patient choice is restricted because there are too few practices serving the local population. In these areas PCTs need to think about increasing the choice available to patients by commissioning primary medical services from a range of providers, including existing GPs, third sector organisations and independent sector providers.

The Alternative Provider Medical Services (APMS) contract is the most flexible way of introducing new services, because it enables the fullest possible range of potential providers (including existing entrepreneurial GP practices, commercial, voluntary and mutual providers) to put forward innovative proposals for new services. The APMS contract also provides maximum flexibility in specifying additional quality requirements to reflect local needs and priorities.

A greater range of primary care providers not only delivers greater choice for patients, but should also create stronger incentives for all GP practices to provide responsive services for patients.

At the beginning of 2008 two PCTs had signed Government-brokered APMS contracts with independent sector providers, delivering a range of benefits for local patients including extended opening hours.

Following the Comprehensive Spending Review, the DH has provided additional funding to support PCTs with the greatest need in establishing over 100 new GP practices. PCTs were selected on the number of existing primary care clinicians (GPs and practice nurses), relative health outcomes and patient satisfaction with GP access.

Case study

New APMS provider, Kirkby in Ashfield, Nottingham

A new primary care centre in Kirkby in Ashfield, Nottingham is providing greater access to primary care for its local population, which has significant health needs. The new provider aims to deliver against a challenging contract that includes challenging health improvement targets and enhanced opening hours. The centre is part of a modern community hospital that is being changed into a 'health village' with community nurse-led beds, a state-of-the-art rehabilitation unit and a range of voluntary and statutory services. It aims to complement GP services in addressing health inequalities in this former mining town.

7. Positive approach to new models of care

Some of the most successful examples of primary care development have come from PCTs working with GPs and other providers to develop new ways of delivering primary care services. A diverse range of providers can not only improve patient choice, but also stimulate innovation in service design and raise quality of service provision.

Successful examples of new provider models have included:

- shareholder-owned limited liability companies. Initially, these might provide additional services as part of the Care Closer to Home agenda*, but they could also provide core primary care services
- social enterprises. These are normal functioning businesses built on an ethos of public service and which reinvest their financial surpluses to fulfil their social objectives
- partnerships between existing GP practices and independent sector or third sector providers, possibly on a franchise basis, which help provide higher quality organisational management.

* http://www.dh.gov.uk/en/Healthcare/Ourhealthourcareoursay/DH_4139717

8. Capacity planning within practices

Capacity planning is important in ensuring GP practices provide the right mix of services at times that meet the needs of their patients. The best GP practices all have good capacity management processes that reflect, for instance, the optimal balance (on any given day) between on-the-day appointments, advance appointments, telephone consultations and open access slots.

Many practices have also improved capacity and responsiveness by segmenting the practice population based on its needs (for example, patients with long-term conditions, children) and then designing specific services and clinics to reflect the levels of different need. Practices particularly need to ensure they assess needs and provide services in ways that promote more equitable access to services for different groups, including patients from BME communities, patients with disabilities and patients with mental health problems.

Case study

Churchill Medical Centre, Kingston

Churchill Medical Centre has a team member dedicated to managing capacity planning. As the practice has steadily grown without a corresponding increase in consulting space, it has had to manage its space more effectively to meet patient demand.

The practice carefully monitors daily minimum appointment requirements via retrospective analysis of appointment use. At the same time it looks at the clinical staff rota to match previous activity to future demand, taking into account annual leave and meetings. The practice has a strict annual leave policy and all clinicians adhere to a minimum notice of three weeks. This facilitates planning and ensures capacity requirements are met at all times.

The practice identifies patterns of attendance from particular groups of patients and uses the information to enhance the care it provides. A recent innovation has been the introduction of urgent care late evening paediatric clinics for the large number of children and young adults in the population.

Contingency planning is a vital part of capacity management. The practice has planned the GP rota so that many clinicians work in shifts throughout the week. This gives extra support when needed. As a direct result locum cover is minimised and continuity of care enhances the patient experience.

9. Development of talent and innovation

Successful GP practices do not allow bureaucracy to stifle innovation but instead embrace new technologies and models of care where they can deliver benefits for patients.

For example, adoption of new telephone and internet appointment booking systems has been slow across the country, but those practices that have embraced the systems have found they have helped improve patient access as well as reducing 'did not attend' rates.

Successful practices also recognise that primary care provision is about much more than access to GPs and that they need to make the most effective use of the skills mix within their practice if they are to provide the most effective and responsive care for their patients.

Most of the practices visited by the NIT that had scored highly on the GP patient questionnaire had extensive nursing teams, including practice nurses, nurse practitioners, healthcare assistants, dual role administrative and support staff and other healthcare workers such as counsellors.

Case study

The Kakoty Practice, Barnsley

The Kakoty Practice in Barnsley uses EMIS computer software to enable patients to book their own appointments using the internet, interactive TV and mobile phones. The system allows patients to book same day appointments as well as appointments up to six weeks in advance. Cancellations and repeat prescriptions are also available through this method. Patients have evaluated the service as excellent. It has also reduced the number of incoming telephone calls and face-to-face consultations undertaken by the practice.

Case study

The North Hill Practice, Colchester

The North Hill Practice in Colchester has increased its capacity and skills mix through the addition of two nurse practitioners, both of whom have authority to refer and prescribe as appropriate. The first nurse practitioner is responsible for the care of older people and is predominantly community based, covering three local residential homes. The second focuses on patients aged under 75 who have a long-term condition. She triages new patients, runs her own daily clinics and sees patients on a weekly basis via pre-booked appointments, helping them to retain their independence and better manage their conditions in their own homes.

These two members of the practice team have significantly increased the number of appointments available to patients, decreased demand for GP home visits from five a day to five a week and freed up more GP time for specialist service management.

Case study

Collingwood Health Group, North Tyneside

Collingwood Health Group practice in North Tyneside believes achieving high levels of access satisfaction cannot be separated from an overall commitment to patient-centred care delivered by an integrated primary health care team. Receptionists help improve access by offering patients the option of telephone contact with a health professional, encouraging use of the practice website for booking appointments and ordering prescriptions. They are also trained to provide additional services for patients such as phlebotomy, smoking cessation and weight management.

Healthcare assistants and practice nurses are supported to continually develop their skills with further training and to offer a wide range of appointments throughout the day.

All GPs offer telephone appointments as well as surgery consultations and each GP has their own PA who monitors and supports selected patients under their supervision, a practice that may reduce the need for some surgery appointments.

Additional staff, including a full-time mental health practitioner and a part-time pharmacist, are employed to increase the range of professionals patients can access.

There is an overall commitment within the team to deliver a service that patients want, when they need it and to continually train and support each individual member of the team so that they can deliver on this commitment to the best of their ability. The team emphasises that delivering excellent access in this way is not a 'cheap option' but requires investment in staff and training and an ethos among practice partners that quality of care is a higher priority than maximisation of practice profits.

10. Strong leadership, teams with vision

All the best practices visited by the NIT exhibited coherent, inspirational leadership and positive, forward-thinking attitudes, which translated into better access and services for patients.

Managers and clinicians with strong leadership skills and drive had helped their practices develop a clear vision or mission statement about where they wanted to be and how the whole team would work towards getting there, measuring success and reviewing outcomes along the way.

To be successful, practices need this kind of leadership and 'can do' attitude as well as excellent clinical quality, but it can come from any member of the multi-disciplinary practice team, not necessarily a GP.

The NIT also noted that practices with this team commitment and a shared ethos not only excelled at the work undertaken, it also proved more enjoyable.

PCTs and SHAs need to think about how they can encourage and develop leaders in primary care to ensure the access and responsiveness issue is taken forward. By allowing clinical leaders to develop, take risks, test and embed ideas, they will benefit from a wider breadth of knowledge and innovation for improvement.

Case study

Rowley Healthcare, Sandwell

Rowley Healthcare in Sandwell is a nurse-led health centre and a prime example of how a different model of management can be successful in providing primary care services. The centre employs two nurse practitioners, one salaried GP and two practice nurses. Several other service providers including counsellors and social services also use the space, resulting in good multi-disciplinary working. The practice performed well in the GP patient survey, not least because of its positive attitude and adherence to the advanced access principle of doing 'today's work today'.

Spreading and embedding best practice

While excellence in all 10 factors described above was in evidence across the country in high-performing PCTs and practices, the fact remains that it is not widespread across the system. If practices were to focus their efforts on one or more of the factors they could improve patient satisfaction very quickly.

The onus is not only on practices though. PCTs, as commissioners of primary care must also ensure that services meet the needs and requirements of the local population.

There are currently three strands of work that will help PCTs in encouraging and spreading good practice.

- 1 PBC.
- 2 WCC.
- 3 System management (managing the system for the benefit of patients).

1. Practice based commissioning

WCC depends critically on strong clinical involvement in making commissioning decisions, including prioritising local objectives for health and well-being and redesigning service delivery. PBC provides the basis for clinical involvement in these commissioning decisions.

PBC also helps make GPs and other primary care clinicians aware of the financial consequences of clinical decisions and provides incentives to help develop new forms of service delivery that both improve patient care and create more efficient use of resources.

Many GP practices have seized the opportunities presented by PBC to help shape local priorities and redesign patient pathways, but success continues to depend on the quality of the relationship between PCTs, GP practices and other primary care providers.

Embedding PBC is likely to be a key factor in driving continuous quality improvement both in GP services and in primary care more generally. PCTs need to ensure through PBC that they are providing sufficient support and incentives for GP practices to engage in shaping local priorities and redesigning services.

2. World class commissioning

WCC is a development of commissioning that moves the emphasis from spending on diagnosis and treatment towards also focusing investment in prevention and health promotion.

To attain world class status, commissioners will need to show better health and well-being outcomes for local people, adding life to years and years to life by:

- ensuring the best possible health and well-being outcomes, so people stay healthier for longer and their quality of life is improved
- dramatically reducing health inequalities
- giving more choice and influence over services for people in the local population
- providing these achievements through best use of available resources.

As part of the WCC, the DH is working with a range of PCTs, GPs and other stakeholders to identify how WCC skills apply to commissioning primary care and managing contracts with GP practices and other primary care providers.

This will mean a much greater focus on PCTs engaging with and managing relationships with the GP practices and other primary care providers in their area, to help develop services that have the most positive impact on health and well-being and on patient satisfaction.

It will mean using information in a much more proactive fashion to understand patient needs, to review how effectively these needs are being met and to help drive improvements in quality of services.

The WCC programme will also support PCTs in managing performance more effectively. This includes developing strong partnerships between clinical leaders and PCT managers, using information (including patient feedback) to monitor performance, providing developmental support, and using contractual or regulatory levers to tackle unacceptable performance.

The DH is working with PCTs and other stakeholders to develop an assurance system for WCC that will hold PCT commissioners to account and help them understand areas in which they need to work to move toward WCC.

SHAs will lead on building support and development resources that will give commissioners the tools they need to ensure improvement, either by sharing services and good practice, developing NHS resources or buying in good practice. The DH will support this work by developing a national PCT support programme on governance.

3. System management (managing the system for the benefit of patients)

It is the role of SHAs and PCTs to manage the overall NHS system, including choice and competition, in ways that ensure the best outcomes for patients. The DH has worked with the NHS and other stakeholders to develop a suite of system management policy and guidance that creates a clear understanding of the roles and responsibilities of SHAs and PCTs, as well as the capabilities required to fulfil these roles and the levers available to them.

There are three main components of effective system management.

- 1 Tasks associated with building the system, such as rolling out PBC and ensuring patient choice becomes a reality.
- 2 Ensuring the system is coherent, for example making sure that key NHS objectives are reflected in contracts for services.
- 3 Making the system operate in the interests of patients.

In the context of primary care, the framework should, among other things, support SHAs and PCTs in supporting patient choice, ensuring the fair and transparent procurement of new services, ensuring promotional activity is appropriate and does not damage the reputation of the service and ensuring effective governance arrangements for PBC.

What more needs to be done?

Although the ongoing work described above will help PCTs spread and embed good practice, more needs to be done to ensure that all patients have speedy and convenient access to primary care services that respond to their needs.

By practices

- 1 Use examples of good practice identified in the report to consider how to make the services they provide more accessible and responsive.
- 2 Work more collaboratively with the PCT to ensure patients have access to services that respond to their needs.

Practices should consider the 10 factors outlined in this report that have been identified as contributing to making primary care services accessible and responsive to patients' needs. They should then work with their colleagues and employees, as well as with the support of the PCT, to look at how the service provided to patients can be more accessible and responsive. Specifically we would suggest that practices focus on increasing their ambition to provide more than the basic core services.

- 3 Segment the practice population based on need and then design services and clinics around this.

Patients' needs could include factors like patients with long-term conditions, paediatric or BME patients. Specific services and clinics can be designed in direct proportion to the demonstrated need and influenced by frequent reviews of the needs and wishes of patients, with services adjusted accordingly.

- 4 Build an extended healthcare team to make it easier for the practice to be responsive to patient need.

The 21st century extended healthcare team includes practice nurses, nurse practitioners, healthcare assistants, dual role administrative and support staff and other healthcare workers such as counsellors. Each team will be different according to the size of the practice population and some practices may wish to have team members working across practice boundaries. These teams can provide a more responsive service to the varying needs of their patients and can be more cost-effective.

By PCTs

- 5 Foster an environment that breeds good practice, rewarding and using innovation and driving continuous improvement.

PCTs should seek out and apply innovation, knowledge and good practice to improve service quality and outcomes and should ensure appropriate recognition and reward for the best performing and most innovative practices.

They should also seek to engage these practices in providing advice and practical support to other local practices and support practice managers in seeking Practice Manager with a Special Interest status.

6 Work to embed WCC and PBC into commissioning activity.

PCTs must ensure that they apply the competences of WCC to the commissioning of GP services and other primary care services.

PBC is a vital component of WCC, because clinicians at the frontline are ideally placed to help shape the priorities for local healthcare and help redesign services accordingly. However, a vibrant and effective system of PBC relies on the strength of PCTs in commissioning primary care services.

7 Target the worst performing practices and focus on improving patients' satisfaction.

PCT commissioners will already have identified through the 2007 GP patient survey which practices require the greatest improvements in access and they should already be working to support improvements in these practices.

PCTs should build on this approach to develop a fuller picture of practice performance and take action where services are not sufficiently responsive to the needs of different patients. PCTs will want to assure themselves that practices are meeting the needs of the full range of patient groups, including hard-to-reach groups, by using more in-depth patient consultation and advocacy approaches where appropriate.

Where performance does not improve, PCTs should consider a range of levers for addressing under-performance, including commissioning management support for practices or, where necessary, taking contractual action.

By SHAs

8 Build on current good practice by ensuring the world class commissioning programme addresses the capacity, capability and information needed to commission responsive primary care services.

As part of the WCC programme, the SHAs and the DH are developing a framework to help PCTs apply WCC competences to primary care. Building on the work of the NIT, this work will include helping PCTs develop systems (such as 'scorecards') for mapping and benchmarking the quality of the services provided by GP practices and the outcomes achieved by PBC clusters. This is likely to encompass a range of measures including access, key indicators from the QOF and patient satisfaction.

Enabling practices to compare their performance with others is a way of encouraging them to seek out, share and embed good practice.

By the DH

- 9 Build on current good practice by ensuring the primary and community care strategy (being developed as part of the NHS Next Stage Review) fosters an environment where practices are supported and incentivised to provide continuous improvements in access and responsiveness.

The NIT has fed its findings and conclusions into the work of the advisory board helping the DH to develop a wider strategy for primary and community care as part of the NHS Next Stage Review. This strategy will bring together access issues and other important factors including the effectiveness, fairness, safety and tailoring of services to individual needs.

The work of the NIT and the recommendations in this report focus largely on access to GP services and on the responsiveness of those services to patients. The strategy will address the wider factors involved in arranging more integrated services and community resources for a registered population of patients and in promoting better health and well-being outcomes for local communities.

- 10 Resource a national support team and development programme to help the local NHS implement good practice. This should cover both PCT commissioning and the capability of general practice.
- 11 Work with other agencies (such as the Improvement Foundation, NHS Alliance, National Association of Primary Care, NHS Institute for Innovation and Improvement and others) to champion success and support development.

To help PCTs and practices implement good practice and foster innovation, the DH will commission a time-limited programme to support GP practices in improving access and responsiveness. The DH will also develop a national team to support PCTs in implementing the recommendations in this report.

In addition, opportunities for leadership development will be made available to PEC members, other primary care leading innovators and the full a range of practice staff. This development will be supported by the Improvement Foundation, NHS Institute, Royal College of General Practitioners and the clinical leader networks and will be part of the leadership and talent programme.

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