

High Quality Care For All



*Primary Care & Community Services:*  
**Improving GP access and  
responsiveness**

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## Foreword

### **World Class Commissioning – Improving access and responsiveness in GP Services**

In their ambition to become world class commissioners, PCTs will continue to pursue the health outcomes for their communities that mean most in their local context, and ensure they identify and utilise the best means possible to achieve these aims. Given that nearly a million consultations take place in primary care every working day, getting access to these services right will be central to achieving health outcomes, and demonstrating world class commissioning competence. It is clear from the national GP Patient Survey and other sources that while there is much to celebrate in respect of GP services, some of the basics, including the ability to contact a practice by telephone and the ease with which a patient can book an appointment ahead, still need attention. Indeed the PCT will want to bear in mind that, as the Healthcare Commission did previously, the Care Quality Commission will continue to consider GP Patient Survey results in its overall assessment of PCTs. A more rigorous approach to the world class commissioning competencies in relation to access and responsiveness, combined with the huge value patients place on their family doctor services has enormous potential for continual improvements and innovation.

A PCT may wish to demonstrate its world class competence in relation to competency 3<sup>1</sup> and its overarching function to engage with its population to improve health and well being, not only by how it responds to views regarding GP access (such as those in the GP Patient Survey), but also how it works with local practices to seek out more local and, where possible, real time feedback to influence ongoing improvements.

The PCT Board has a pivotal role in the overall strategic direction of the PCT, and how this aligns with its current performance and future ambition for accessibility of high quality responsive primary care services. It will want to understand the degree to which its General Practice tailors services to individuals and specific patient groups' needs and preferences.

The Board of a world class commissioning organisation will deliver stretching strategic priorities, based on their joint strategic needs assessment informed by local opinion, including views on GP services. The Board will add value in synthesising a whole system view, based on available information, considering the impacts upon the availability and capacity of primary care to respond. It will have a key role in determining the strategic service configuration for primary care. The Board will have a key role in ensuring that effective markets drive improvements. It will strike an appropriate balance between developing existing providers, managing performance and considering when new providers will bring additional capacity or improvement drivers into the system.

.....  
 1 Proactively build continuous and meaningful engagement with the public and patients to shape services and improve health

This guide draws upon the real experiences of commissioners and General Practices who have used a range of both simple and innovative ideas to improve access and responsiveness.

The below questions for the PCT Board should be considered alongside those broader PCT Board questions outlined in previous publications.

### **Questions for the PCT Board**

- What is the PCTs vision for the strategic service configuration of GP services, and specifically how will its achievement ensure good access to responsive local services?
- What is the PCT's approach to the support and development of individual providers or primary care services? Is it maximising the impact of the GP Provider Guide?
- Does the PCT have a good picture of how current investment in primary care services is deployed and the levels of access, quality and health improvement this provides?
- Does the Board receive regular reports on primary care performance – how will it respond to the quarterly GP patient survey results? Will these results be made available through local media to the population?
- Does the PCT stratify its communications regarding new and existing services to ensure that information about access, including opening hours, and quality is readily available to all groups in a community?

The commissioning of primary care is complex. Some of the factors that add to the complexity and make commissioning these services challenging can also provide the greatest opportunities for shaping services and introducing innovation that meets local need. PCTs that invest in primary care leadership, capacity and capability will be well placed to implement the best practice for commissioning primary care services as described within the guides. This should drive continuous improvement in the accessibility, responsiveness and quality of primary care services, improve health; reduce health inequalities; and support PCTs in addressing local health priorities.



## Introduction

### What is the purpose of this guide?

This is part of a series of supportive guides to help Primary Care Trusts (PCTs) become world class commissioners of primary care services. They have been co-produced by NHS East of England, NHS Primary Care Commissioning (NHS PCC) and the Department of Health (DH).

This guide focuses on commissioning accessible and responsive GP practices and supports the previously published guide on improving the quality of commissioning GP services. It builds on, and should be read in conjunction with *World Class Commissioning – Improving GP Services*<sup>2</sup>.

The guide provides practical advice on:

- mapping the baseline – how PCTs can assess their current performance on access
- developing the vision – how PCTs can craft a vision for the future
- making it happen – how PCTs, practices, the SHA and the Department can improve access.

The guide forms part of a rolling programme including other guides and a series of regional events. All are intended to support PCTs in addressing the strategic, leadership and operational challenges involved in driving up the quality of primary care commissioning and contracting.

In March 2008 the National GP Access Programme was established in response to recommendations in the report *Primary Care Access and Responsiveness* by David Colin-Thomé<sup>3</sup>, with the aim of supporting the NHS in driving continuous improvements in the accessibility and responsiveness of GP services. An early priority has been to develop a systematic and effective way of collating and sharing the many examples of best practice that already exist across the country. This guide brings together some of these examples, along with a range of practical tools and resources to support local commissioners in developing a robust and effective plan for improving patients' experience of accessing GP services.

On behalf of the DH, the recently established NHS Practice Management Network has developed a practical step-by-step guide on a number of different systems, products and processes that can support practices make these changes. That more technical guide complements this world class commissioning publication and will be invaluable to both PCTs and providers in improving access and responsiveness. More detail can be found on p36.

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2 1 [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_093830](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093830)  
3 [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_084970](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084970)

General practice attracts over £7.7 billion of investment each year, undertakes nearly a million consultations each working day and is the main gateway to another NHS services. Easy and convenient access to these services and any onward referral to more specialist services, together with good patient experience, are essential in ensuring we offer both high quality patient care and value for money.

Getting access right will be central to achieving the four strategic aims set out in 'Our vision for primary and community care'<sup>4</sup> published in July 2008 as part of the final report of the NHS Next Stage Review<sup>5</sup>:



- 1) greater **personalisation and choice**, including more responsiveness to patients, and personal care plans for all with long-term conditions (LTC)
- 2) a focus on **promoting healthy lives and reducing health inequalities**, including child health promotion, helping adults stay in work, vascular risk assessment and supporting independent living for older people and people with disabilities

4 [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085937](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085937)

5 Lord Darzi and Next Stage Review

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085825](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825)

- 3) **continuously improving quality**, including reducing inappropriate attendance in secondary care, greater professional development, piloting information tools to compare quality and productivity
- 4) supporting the role of PCTs and clinicians in **leading local change**, including strengthening Practice Based Commissioning (PBC).

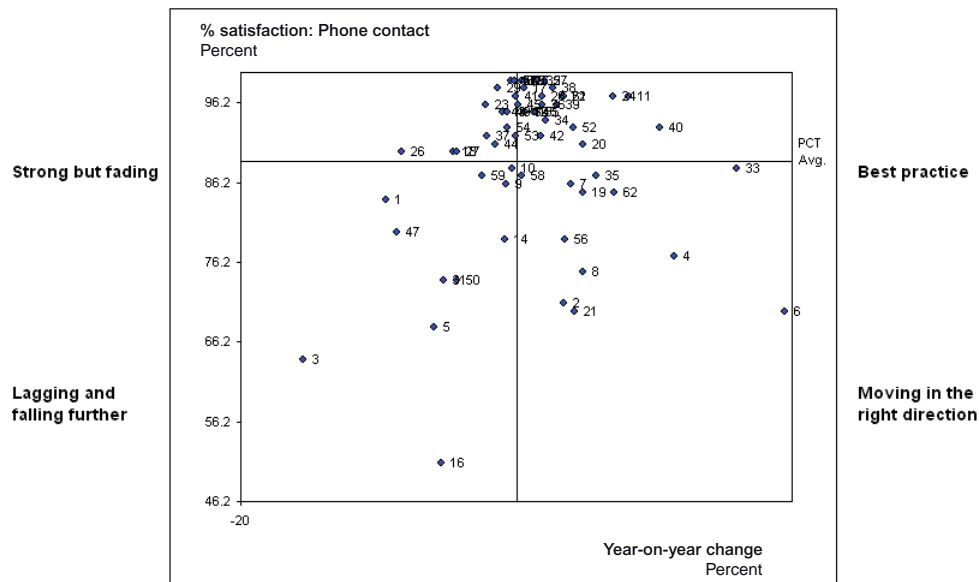
According to this year's GP Patient Survey, 84% of patients across England who wanted to see their doctor within 48 hours were able to. While that is encouraging, there remains a significant minority who don't report such a positive experience. Many practices and PCTs achieve excellent access, sometimes in the most challenging of conditions, and this is reflected in scores of 90% or even 95% for patient satisfaction with access.

However, 18% of respondents were unhappy with their practice's opening times, and 55% would still like to see their surgery open at additional times. Likewise, 24% of patients who wanted to book an appointment in advance were not able to and 19% experience problems contacting their practice on the telephone.

However, even PCTs with strong overall access scores are likely to have some practices that are struggling to improve access. The survey indicated that levels of satisfaction differ significantly within PCTs, sometimes by as much as 40%. So the local picture is always complex. There are examples of both excellence and room for improvement amongst all types of practices: whether serving wealthy or deprived communities; whether in urban or rural settings; or whether resources per patient are relatively high or low.

## GP Practice-level Dynamics – satisfaction with phone access

Please select your PCT:   
 Indicator:   
 Data source: The percentage of patients who state on the GP Patient Survey that they are satisfied with phone access



PCTs will need to use a variety of methods to support improvements in access. The experience of PCTs that have successfully improved access suggests the best starting point is to work with practices and Local Medical Committees (LMCs) on the practical detail of improving day-to-day access performance, feeding where necessary into provider development plans. This clearly relies on strong practice engagement.<sup>6</sup>

PCTs will also need to understand the contractual levers and incentives available to them, where necessary, including through local enhanced services. Understanding local needs and comparing those needs against current provision may also raise questions about overall primary care capacity and the location of services, which need to be in longer-term commissioning plans but are likely to require substantial time and investment to address.<sup>7</sup>

<sup>6</sup> Practice Based Commissioning freed-up resources have been used to improve access by upgrading the telephone system. Hampshire PCT has an enhanced LES which acts as an incentive for practices to provide a much greater level of data to the PCT, also the ability to book appointments via the internet, provide nurse appointments in extended opening period. Portsmouth PCT has allowed the use of freed-up resources to extend the opening of surgeries and enhance nurse-led Long Term Conditions clinics.

Stour Surgery in Christchurch won an Improvement Foundation award for improved access by introducing a triage system – patients speak to the GP to book appointments, and 70% of calls are resolved without the need for a face-to-face consultation.

<sup>7</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_093830](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093830)

Commissioners can foster engagement and a sense of ownership among practices by adopting an approach which is:

- **fact-based** – presenting the facts about access in the PCT, some of which may challenge long-standing perceived wisdom about the causes of poor access. Benchmarking of comparable information will help with this, for instance using the Primary Care Commissioning Support Application that groups together information from several sources on primary care needs, structure and profiles at PCT and practice level
- **collaborative** – involving practices in identifying problems and solutions, rather than treating them as underperformers that need to be set right
- **focused** – investing substantial time and effort in helping practices improve
- **persistent** – making sure practices understand that the focus on access will not blow over in a few months but will continue for as long as needed to achieve the required improvement.

This guide provides a way to think about improving access based on real experience of what has worked in practices and PCTs across the country.

### A case story on access

If you were to walk into Dr Smith's consulting room at the Health Centre<sup>8</sup> at the end of a busy session, you might well find her flicking through the day's waiting room survey returns, which regularly show satisfaction scores above 90%. If you asked her about how the Health Centre is performing on access, she might show you the congratulatory note the practice received from Andrew Ridley, the then Director of Primary and Community Care Commissioning at Tower Hamlets PCT, or tell you about the patient who personally thanked the practice manager for the easy access he now enjoyed – something unprecedented in the practice's history.

The positive patient feedback at the Health Centre, the routine occurrence of free appointments over the course of a day, and the atmosphere of calm efficiency that pervades the practice mean that nowadays, conversations between Dr Smith and David Groom, the PCT access manager, focus not on problems but on how to make things even better. 12 months ago however, those meetings were very different.

Back then, the Health Centre was one of 23 practices scoring below 70% in the last GP Patient Survey. Conversations between David and the practice managers all seemed stuck in the same frustrating rut. Practices spoke of difficult patients with complex needs and assured him they were doing their best – but often argued at the same time that access was not really the most important priority. No one – David included – had the data to explain what was at the root of poor access scores, nor to measure the effects of what practices were doing to improve.

8 The name of the practice and staff in this case story have been disguised. The practice exemplifies both the challenges faced by Tower Hamlets practices, and the successes they achieved

“It was hard at that stage to see how it would ever change,” recalls David. “And we were under a lot of pressure to get access sorted out. It had come up at the last PCT Board meeting and there were regular complaints on local radio phone-ins from disgruntled patients. Our Chief Executive met with local GPs to emphasise that access could – had to – improve. There was talk about the new extended hours LES, but frankly the problem was about core hours. More investment wasn’t the obvious solution, but it wasn’t necessarily about just asking GPs to work harder either.”

Meanwhile, the atmosphere at the Health Centre was very stressful for staff and patients alike. “We felt like we were under siege,” says the practice manager. “Patients were queuing out of the door right from the start of the day, and they’d get angry and shout at the receptionists when they found out we had no appointments left. Our GPs were run ragged – we all were, really – and we had no idea what we could do to make things better. Nothing we tried seemed to work.”

Frustration with the situation was growing on both sides, and proved the catalyst for the changes that are likely to see the Health Centre’s access scores leap in July 2009. The PCT and the practices launched a major effort to improve access, which involved uncovering, interpreting and acting on information about performance, working to change attitudes and behaviours among staff and patients, and making some radical changes to how practices organised themselves. Both David and Dr Smith would be proud to tell you that 9 out of 10 people in Tower Hamlets now say they find it easy to see their GP.

This guide explains what David Groom, Dr Smith and other dedicated staff around the country have been doing to deliver improved access. It will give you the tools to work with your practices to transform access for the better in your PCT.

The methods in the guide have been tried and tested in the real world, in the most challenging of circumstances. Many of them helped improve access dramatically in the two lowest-scoring PCTs in the GP Patient Survey in 2007-2008, Tower Hamlets and Barking and Dagenham, and have also helped PCTs with better scores such as Suffolk. But they are not designed only to help weak performers reach acceptable standards; they will help even the best performers improve further, and have been used in this situation.

### **Why a guide on access?**

Clinicians often pose the challenge “why improve access when we should be focused on improving quality?” The straightforward answer to this is that it is harder to deliver quality of care when patients are struggling to access the service. Good access is a necessity, not a nicety.

Improving access to GP services can also help improve the quality of care, by:

- improving the patient experience
- reducing health inequalities. International studies have shown that increasing access to primary care professionals is one of the most effective ways to improve the health of that

population, for example by improving smoking cessation and screening rates, and by improving quality for specific vulnerable groups

- providing a starting point for practices and PCTs to undertake far-reaching improvements to other aspects of care quality
- making practices better places of work for staff
- reducing inappropriate (and often more expensive) time spent in secondary care, for example the circa 50% of minor attendances in accident & emergency that could be dealt with in primary care.

### What do we mean by GP access?

This guide is concerned with patients' experience of GP access, in other words what they and carers think and feel about their ability to access services at their local GP practice.

**Patient experience of access** reflects what patients and carers think and feel about their ability to access a GP at their local GP practice. It can be gauged through formal surveys, or informally in individual or group conversation. It can also be understood by gathering data and impressions from the patient experience of interacting with GP practices. Three components affect a patient's perception of access: patient context, technical access and practice responsiveness.

### Drivers of GP patient experience of access

Aspect	Description	Examples
<b>Patient experience of access</b>	<ul style="list-style-type: none"> <li>• Measurement of how patients perceive access to GPs</li> </ul>	<ul style="list-style-type: none"> <li>• 5 principal GPPS indicators</li> <li>• Feedback to practice staff and GPs</li> <li>• Complaints to PCT</li> </ul>
=		
<b>Patient context</b>	<ul style="list-style-type: none"> <li>• Incoming needs, beliefs, and values of patient</li> </ul>	<ul style="list-style-type: none"> <li>• Cultural expectations</li> <li>• Socioeconomic status – e.g., BME, IMD</li> </ul>
+		
<b>Technical access</b>	<ul style="list-style-type: none"> <li>• Supply of appointments relative to patient demand</li> </ul>	<ul style="list-style-type: none"> <li>• Number of appointments offered/1,000 registered patients/week</li> </ul>
+		
<b>Practice responsiveness</b>	<ul style="list-style-type: none"> <li>• Reflection of practice communications, attitudes and behaviours</li> </ul>	<ul style="list-style-type: none"> <li>• Customer service orientation</li> <li>• Practice communications</li> </ul>

**Patient context** is a reflection of patients' underlying needs, beliefs and attitudes. It can affect how often patients need to visit a practice – for instance a high prevalence of LTCs among the patient population is likely to result in a higher level of need, when patients want to access the service, and the method by which they prefer to interact with the practice. Some patient groups may prefer more telephone interactions. Some patients want to see the GP of their choice, while others emphasise the importance of being able to get through on the phone.

**Technical access** is the actual supply of appointments available, both in person or on the telephone, relative to patient demand. In relation to the 48 hours target, good technical access means there are appointments available at times that work for patients, which are readily offered to patients, and match patients' preferences (e.g. are in person), within two days.

**Practice responsiveness** is the way in which a practice communicates and engages with its patients and their carers and responds to their non-clinical needs and preferences, reflecting the different ways in which they might prefer to access the service and an appropriate clinician, book, or indeed cancel an appointment. It includes the practice's attitude to customer service and friendliness of staff, the environment in which patients wait to be seen and the way in which they interact and support patients from particular groups, such as those with hearing or sight loss or people from a black or minority ethnic background.

This guide focuses largely on improving access delivered within core hours, recognising the considerable efforts that have already gone into improving access to appointments outside core hours.

### What is in this guide?

This guide provides an overview of the practical tools and methods available to you to improve access at the practices you work with.

Section 2, Mapping the baseline – Where are you now?

- explains how each element of access can be measured, including patient experience of access, patient context, technical access and practice responsiveness
- explains how to draw out the implications of your analysis so that you can decide what actions need to be taken.

Section 3, Developing the vision – Where do you want to be?

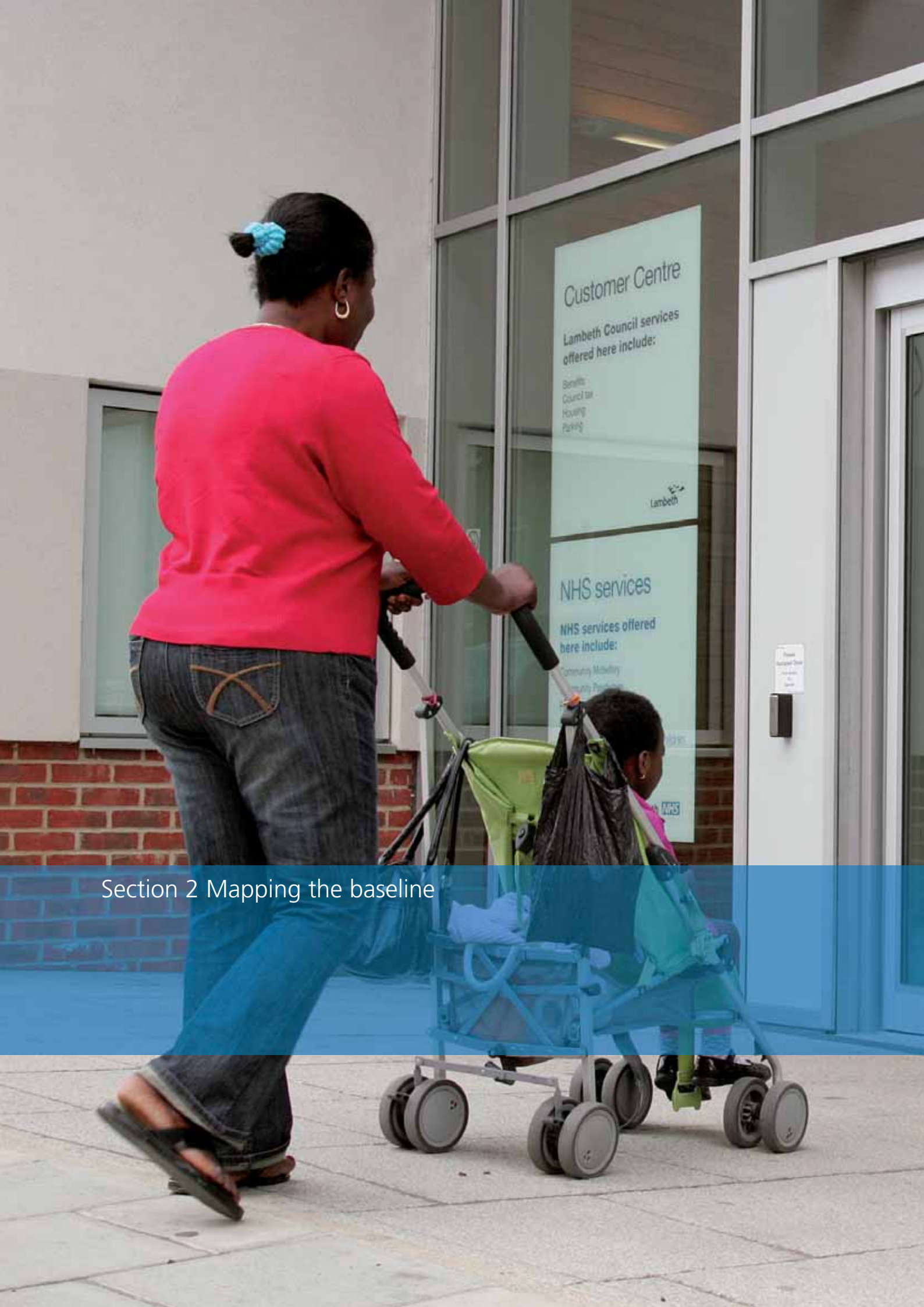
- reviews how you decide what commitments you want to make for access
- sets how to define an "offer" for patients, and
- discusses how best to engage with clinicians and all other key stakeholders.

#### Section 4, Making it happen – How will you get there?

- begins by discussing what PCTs need to do
- highlights implementation practicalities for PCTs
- moves on to sharing what individual practices need to do
- assesses what SHAs can do to support access improvement efforts, and

#### Section 5, Resources

- provides contact details for all the case studies in the guide and gives links for useful websites.



Customer Centre

Lambeth Council services offered here include:

- Benefits
- Council tax
- Housing
- Parking



NHS services

NHS services offered here include:

- Community Mobility
- Community Pharmacy

Section 2 Mapping the baseline

## Mapping the baseline

### Where are you now?

Access is one of the most fundamental performance indicators for primary care. Quality, patient experience and other performance metrics are only relevant if patients are able to access GP services in the first place. GP practices are very often the first point of contact for people in the healthcare system, and first impressions are important.

Improving access starts with making positive changes in day-to-day operations at GP practices. PCTs play a key role in supporting those changes by challenging practices to improve, and engaging in a dialogue with them about how to do so.

The first step in this journey is to establish the facts around how practices are currently performing on access.

This assessment should include:

- review of patient experience of access (how easy patients believe it is to access their GP)
- review of patient context
- review of technical access (the match between supply of appointments and demand)
- review of practice responsiveness
- review of practice starting point
- review of PCT interaction with practices on access.

The rest of this section explains each of these steps in turn.

### Assessing patient experience of access

Reported patient experience is the most important measure of access to GP services. It can be assessed both by examining qualitatively what patients say about their experience of access and by assessing quantitatively how patients rate their experience in surveys. PCTs that have successfully improved access have found a correlation between actual availability of appointments ('technical access') and reported patient experience.

Taking the patient's perspective on access helps GPs and the PCT to understand what the experience of interacting with GP practices looks like. A range of techniques can be used to do this including site visits, "mystery shopper" phone calls or visits, interviews, and focus groups. The example below illustrates what many patients experienced in one PCT.

## Some GP practices had very poor access and responsiveness

**PLEASE NOTE**

Owing to a shortage of staff, this Practice will not be registering new patients on the following dates:- Monday 08/10/2007 until Tuesday 09/10/2007 and Monday 15/10/2007 - 16/10/2007.

Patients will be required to return for registration on Monday 22/10/2007 - Tuesday 23/10/2007 at 11.00am - 12.00pm.

We regret any inconvenience caused. However, this is necessary.

Thank you for your co-operation.

The Management  
X Health Centre

**Information is not clear**

**Not clear that the practice is actually open**

*"The patients are always shouting at us"*

*"I sometimes have to wait over a week for an appointment"*

*"They tell you to call at 8.30. You call and it's busy. By the time you get through all the appointments are gone."*

**Sign is in Bengali as well as English, but points to the wall**

*"They don't offer you appointments for the following day. For a working person, this is impossible"*

*"On a Monday, there's a queue halfway down the street to get seen"*

Patient experience of access can be measured. It is important for both practices and PCTs to monitor patient experience because it determines payments to GP practices and will be used by the Care Quality Commission to assess individual PCTs' performance. There are many different ways to assess patients' experience of access. The most important are:

- **Practices' own surveys.** Practices frequently find it helpful to design a very simple access survey to distribute to many (or all) of their patients to track how changes are being received. Such surveys can be simple, paper-based tools. They are not designed to be rigorous scientific research instruments, but instead to act as practical guides to trajectories in patient opinion, enabling the practice to become more responsive, and agile in tweaking its ways of working.
- **The GP Patient Survey.** This survey, which has been redesigned for 2009,<sup>9</sup> assesses patient experience both in relation to access and in relation to the wider quality of services. Two of the indicators are used to determine QOF payments to GP practices for 48 hour access and advance booking. The survey is also used to support the Care Quality Commission's assessment of PCT performance. From April 2009, the survey is running quarterly.



The Primary Care Commissioning Support Application can be used to benchmark PCT and practice performance on the GP Patient Survey and show trajectories of performance over time.

In Autumn 2009 the Survey Review Group, which advises on the questions and development of the GP patient survey, will publish and send to all practices a practical guide on the survey. This will focus on each of the questions of the survey and provide practical tips on how practices can improve their scores in future.

In addition to these two methods, other approaches are listed below:

- **Local patient surveys.** More and more NHS organisations are utilising real-time or rapid patient feedback techniques, for example through kiosks and hand-held devices placed within different services. These can provide PCTs and practices with a deeper understanding of issues facing different groups of patients and provide valuable information to act upon.

The PCT or practice could decide to rerun, locally, the GP Patient Survey in entirety or a variation of it. The questions could be provided to patients immediately after a consultation in the practice. The General Practice Assessment Questionnaire (GPAQ)<sup>10</sup> and the Improving Practice Questionnaire (IPQ) also provide a survey template, but the access questions are not as detailed as those in the current national survey. CFEP UK Surveys<sup>11</sup> could be commissioned to administer, manage and analyse results on behalf of PCTs, and would provide a report to the PCT at the end of the process indicating the weaknesses and strengths of individual practices.

- **Qualitative assessment.** Can give deeper insights for GP practices and PCTs in understanding patients' experience of interacting with GP practices. The example below illustrates what some patients experienced in one PCT.
- **Focus groups.** Different research companies have run several focus groups on behalf of the DH, SHAs, individual PCTs and practices. These focus groups have been used to explore patient preferences, the specific needs of particular groups, and potential solutions.
- **Review of the experiences of GPs and practice staff.** Frequent discussions about access and recent experiences with patients are a valuable source of information for practices. The reception team are often the first to know when patients are not happy with access.
- **Complaints review.** Some PCTs have found it helpful to try and match their complaints and queries into the main access indicators in the patient survey to provide further insights.

10 <http://www.gpaq.info>

11 <http://www.cfep.co.uk/default.aspx>

Each of these methods can provide frequent regional and practice-level reviews of patient perception. They give a 'live' view of current patient perceptions and can help identify what is working and what isn't as well as providing insights into how to improve patient experience.

### **What is the patient context?**

Understanding the patient context allows practices to align their service offer with the needs and behaviours of the population, leading ultimately to improved patient experience. The patient context includes the underlying demographic and socioeconomic circumstances as well as beliefs, values and working patterns. It can also include 'learned behaviour': the behaviours patients display based on previous interactions with their practice. For example, previous work suggests that patients often call at certain times of the day because they have learned that is the best time to get an appointment. The patient context influences:

- the days and hours when patients want to access the service
- the times of day when telephone activity is highest – calls between 8.30-9.30am can account for the same number of calls as the remainder of the day and request 20% of all appointments
- need for specialist clinics
- method by which patients prefer to access the service
- demand for general appointments
- need for translation/interpretation services.

### **What is the level of technical access?**

Technical access is often the root cause of poor access performance. Establishing the level of access involves three steps:

- (1) understanding the current level of demand on a weekly basis;
- (2) understanding the current level of supply; and
- (3) comparing supply with demand to identify any mismatches between the two.

There is rich data available on supply housed in practice booking systems (EMIS, Vision, Front desk etc.), but accessing this information requires working closely with practices to mine existing system data. Data on demand can also be gathered through routine tracking of patient appointment requests by practice reception teams.

Some PCTs may have concerns about practices being unwilling to share data. Where PCTs have engaged in access work, a careful focus on collaborative problem-solving dialogues with practices about access, and a clear statement about the need to improve it have been sufficient to begin the exploration of the level of access, for example to access practice systems. It is also worth referring to the Primary Care Commissioning Support Application provided by the DH. If it is being used by your PCT, the application may already contain this data and will also include information on the factors driving supply of appointments, for example the number of GPs per population (weighted).

## 1. What is the level of patient demand?

There are two ways of looking at patient demand – from the patient point of view and from the point of view of what GPs expect. A PCT could approach this by outlining patient demand as a range based on both of these perspectives.

Using data on average demand in England shows that a patient has a consultation with their Doctor 3.4 times per year.<sup>12</sup> This average will vary based on local patients' needs and behaviours and the types of services provided, for example the availability of nurse-led or telephone appointments. 1,000 patients would require 3,400 appointments per year; divided by 52 weeks this would give 66 appointments per week per 1,000 patients on the registered list. In reality however, many GP practices have found that their patient population requires more appointments than this number.

At a more detailed level, practices can gain a good view of which days and times of day patients want to see their GP by tracking patient appointment requests by day over the course of a month.

As commissioners, PCTs will already have made considerable progress in assessing and planning services to meet current, future and unmet needs of the local community, using the Equality Impact Assessment and Joint Strategic Needs Assessment. Other sources of useful information can be found in the GP Patient Survey and other demographic datasets. Also look at the chapter 'Understanding your community' within the complementary guide from the NHS Practice Management.

## 2. What is the current practice supply?

The supply of appointments within a practice is driven by multiple factors, including list size, opening hours, number of GPs employed by the practice, the wider clinical team including nurses, healthcare assistants, counsellors and pharmacy staff and number of consultation rooms.

Historically, many commissioners have focused on the number of GPs per registered list size or the surgery opening hours as a proxy for primary care supply, but each of these proxies has limitations. The number of GPs per registered list does not take into account how many appointments each GP offers. Salaried GPs could provide 4 hours of patient-facing support in one practice, but 21 in another. Looking at clinic opening hours does not account for the reality that many practices are open but do not have a GP seeing patients at that time: for example, a practice may list its opening hours from 8am to 6:30pm, but only have appointments available from 9am–12 noon and 2pm–5:30pm.

There are two dimensions of supply to look at – overall appointment availability and appointment distribution.

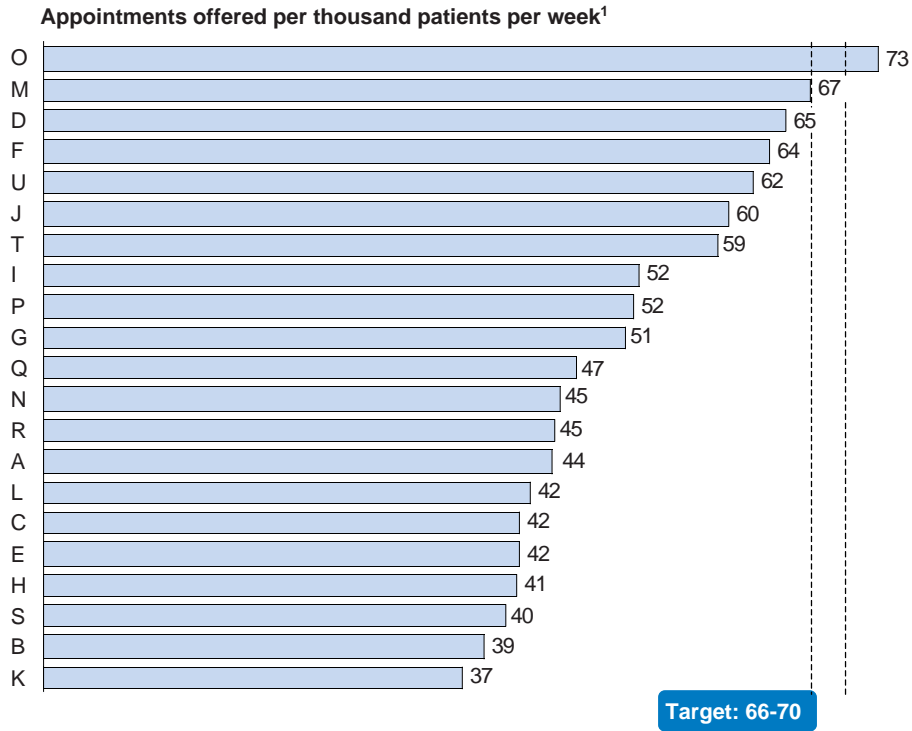
12 <http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice/qresearch-report-on-trends-in-consultation-rates-in-general-practices-1995-2008>

To determine the overall appointment availability, commissioners and practices can calculate the number of appointment slots per 1,000 registered patients per week, which provides an accurate measure of supply and can be easily compared to demand. We suggest only counting core, bookable GP appointments that are available to a routine patient when requesting an appointment.

Practices and commissioners can calculate the number of appointment slots currently on offer per 1,000 registered patients per week by reviewing practice data systems. This involves either doing a data pull – for example querying practice administration systems to calculate the number of appointments each week over a certain time period – or counting weekly appointments available, i.e. literally sitting down with practice staff and counting the appointments available on the system over a given week. While both methods are helpful, there are advantages to extracting the data directly from practice administration systems. This process can be automated, reducing the burden on staff; historical records can be obtained so that patterns over time can be investigated; complete datasets can be obtained rather than samples; and the data can be transferred easily to spreadsheets or databases for analysis. When using this approach the PCT and practice will need to take into account those appointments added to the system during the day in response to demand.

Reviews of overall appointment availability often show high levels of variability, as evidenced during a review of 21 practices in Barking and Dagenham. It was noted that practices offering a supply of fewer than 70 appointments per 1,000 registered patients per week experienced difficulty with access during core hours (as measured through patient interviews, staff feedback and the GP patient survey). Staff at many of those practices believed that demand was essentially unlimited and hence there was no value in offering more appointments. However, analysis showed that practices routinely offering more than 70 appointments per 1,000 registered patients per week were able to meet patient demand.

### Wide variety in numbers of appointments offered per thousand patients per week

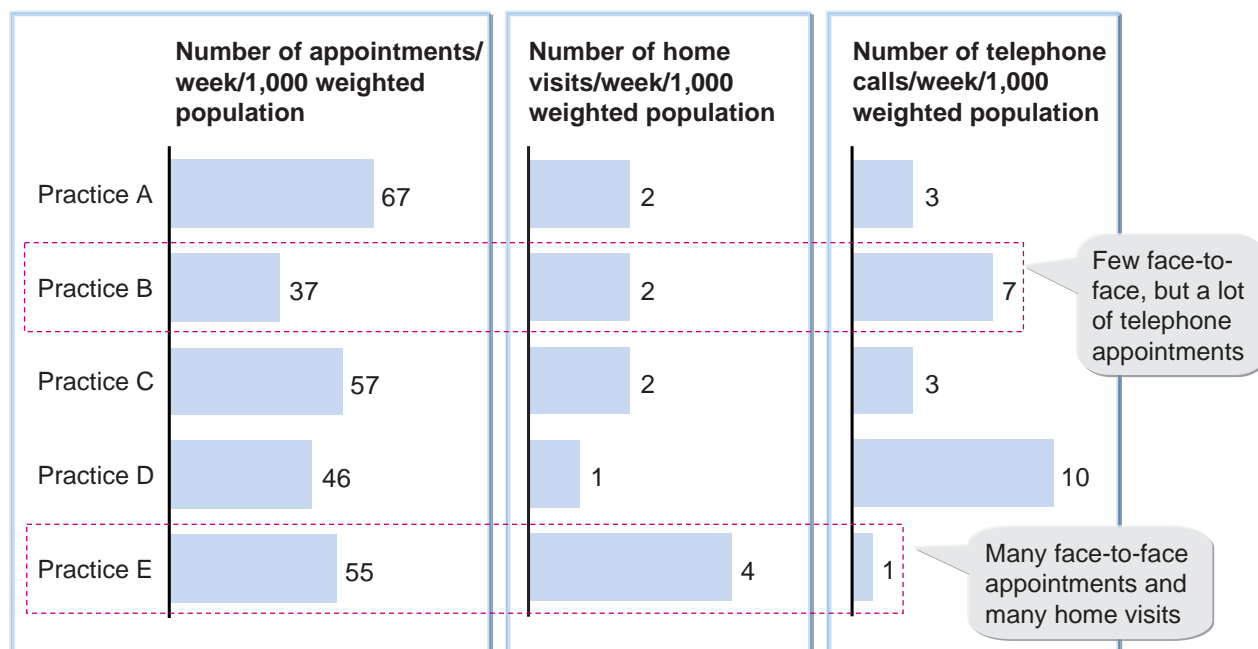


<sup>1</sup> Analysis focuses on core, bookable GP appointments only

SOURCE: Practice data

The mix of appointment types offered to patients also plays a role in determining patient satisfaction levels, as a close investigation of Suffolk’s GP practices showed. The types of appointments most commonly offered are face to face appointments, telephone appointments and home visits. Practices should consider local patient context when identifying the optimal mix of appointment types.

## Sample variation in appointment supply and type across Suffolk PCT



SOURCE: 2-week data collection in practices and 1-year activity data (07/08)

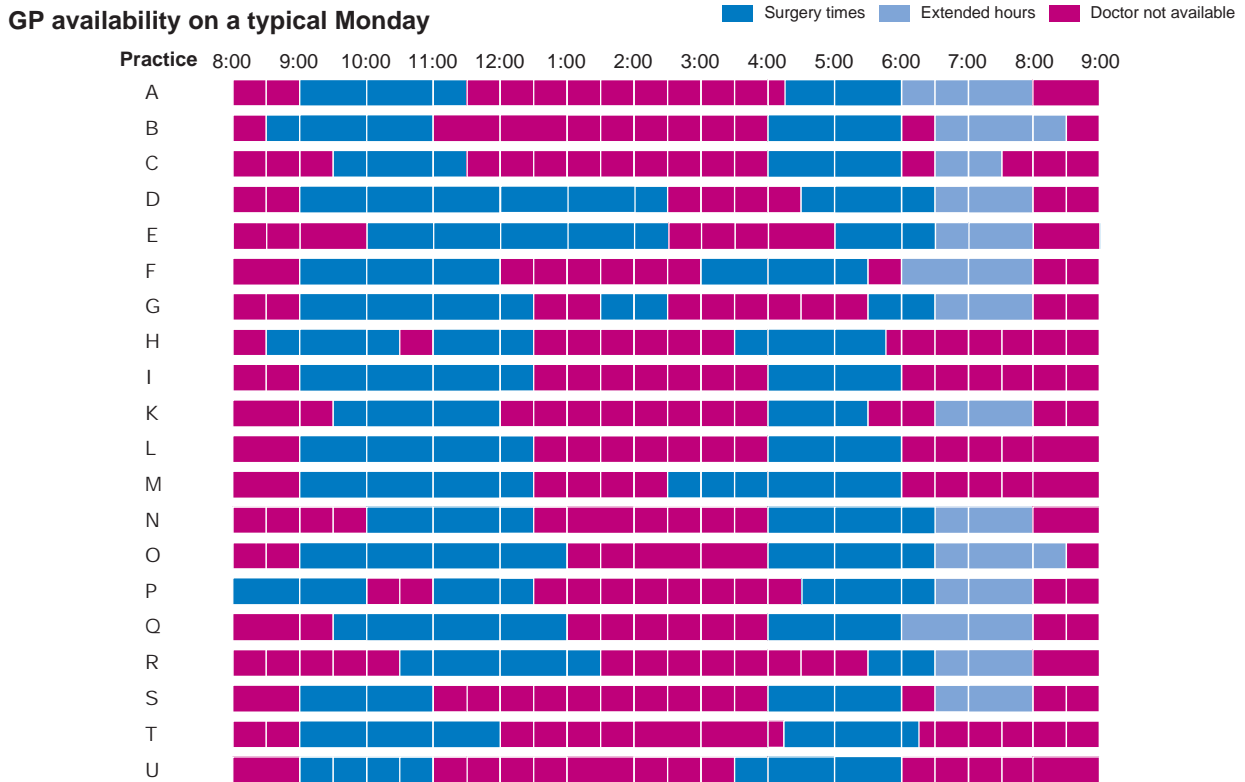
It is also useful to analyse at what times appointments are actually available over the course of a day. From a patient perspective, the times that appointments are available can be the key driver of patient satisfaction with access. As a patient interviewed in Suffolk explained, *"My partner and I are both working. For a working person, this [getting an appointment] is impossible."*

PCTs that have explored the distribution of appointment times across practices have found:

- variation in opening hours, without a clear rationale for the variance
- some practices closed one afternoon each week and for the early afternoon, for example 12pm – 2pm on all days, so that practice staff can carry out administration or learning – PCTs will want to understand how this is reflected within the practice funding
- practices where, for significant portions of the day, the doors are open but the doctors are not actually seeing patients
- practices that have only one to two hours of bookable appointment time on a given day, topped up with two or three hours of overflow (non-bookable "emergency" appointments).

These types of issue can lead directly to practices failing to meet patients' demand. The exhibit below highlights the variance in appointment time distribution from Barking and Dagenham's work on access.

## High levels of variance in when patients can see a GP



Note: Only core surgery and extended hours are shown

SOURCE: Practice visits

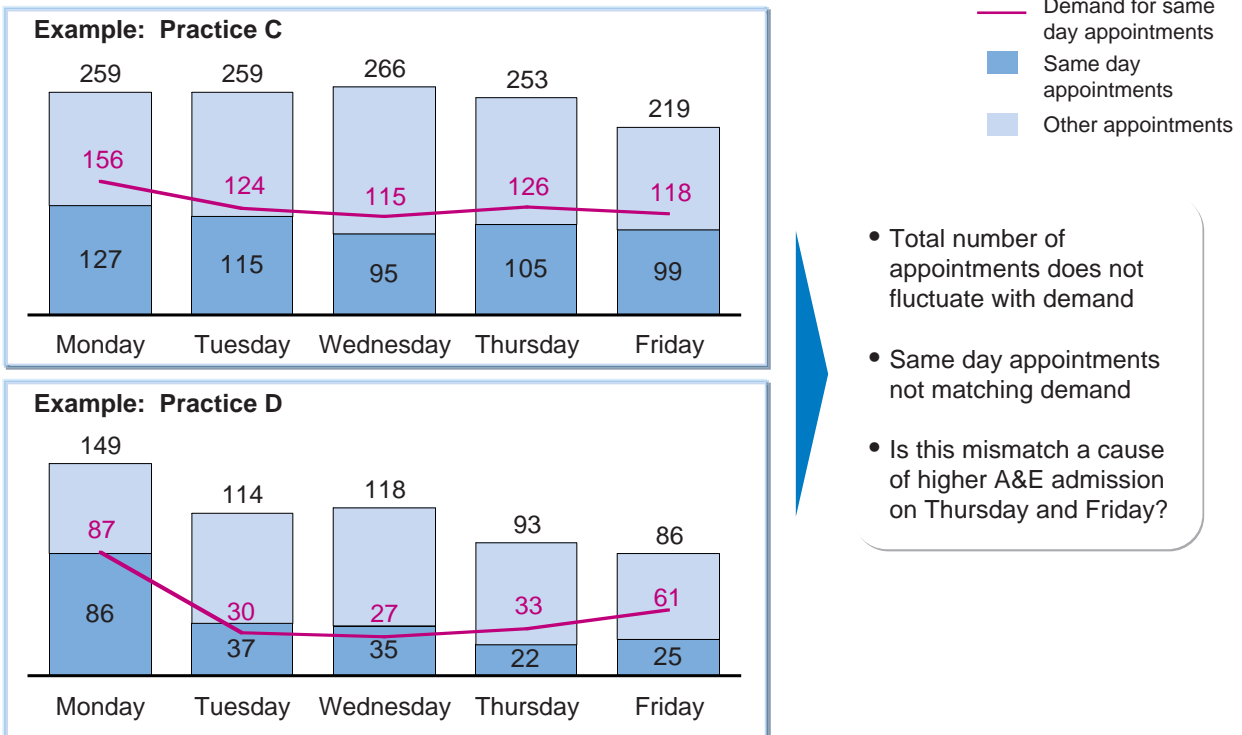
### 3. How does practice supply relate to patient demand?

To establish the quality of technical access, compare supply to demand on a weekly basis, in terms of the number of appointments as well as the timing of appointments. When reviewing supply relative to patient demand, look for evidence of too few appointments per 1,000 registered patients per week as well as over- or undersupply on certain days or over- or undersupply at specific times. All are indications of problems in the availability of appointments.

For example, a comparative analysis of patient demand and supply in Suffolk showed that some GP practices offered too many appointments on Wednesdays, a relatively calm day in many practices, but undersupplied appointments on Mondays, when patient demand peaks after the weekend. The graph over the page shows how Suffolk PCT analysed the gap between appointment supply and demand.

## Sample variance in supply relative to demand

Number of appointments offered; patient demand for same day appointments



SOURCE: 2-week data collection in practices

### How responsive is the practice?

Practice responsiveness can have a large impact on patients' perception of the access at their local practice. Practice responsiveness is the responsibility of all practice staff. There is no 'one size fits all' model, it is for practices to personalise their services to meet their patients' preferences. It includes:

- the ability and ease at which patients can contact the practice either by telephone or other means
- the demeanour, phone manner and general 'customer orientation' of the reception team and other practice staff
- the practice's communications about opening hours and services offered
- the physical environment in which patients are seen and treated
- particular changes or adjustments for specific groups such as black and minority ethnic groups, visually or hearing impaired patients
- individual needs, for example carers, young people, and those with learning disabilities.

It is worth noting that issues with responsiveness, for example patients' ability to get through on the phone, may be caused by underlying issues with technical access. GP practices' appointment systems can condition patients to act in ways that make the experience of trying to access the practice worse – for instance patients all call in the early morning, at the same time, thereby blocking phone lines and reducing accessibility to appointments.

Commissioners and practices can check a number of simple things to assess practice responsiveness. For example, how easy is it to see if the practice is open? How easy is it to book an appointment? What is the phone manner of the reception team? How clearly are the opening hours displayed? Do the opening hours match clinic hours?

In Sections 3 and 4, we focus on how patient perceptions can be influenced by practices and PCTs, once they are understood and access has been improved.

### **Determining practice starting point**

In addition to exploring how your practices are performing, you should assess how they are currently dealing with access issues.

To explore this, some PCTs have found it useful to speak with practices to understand:

- do they currently monitor access?
- how do they respond to issues with access?
- who 'owns' improving access in the practice?

### **Determining PCT starting point**

You should also assess your own starting point as a PCT. How well placed is your PCT to work with practices to improve access? Some PCTs have found it useful to look at the following questions in a reflective workshop setting:

- what capacity do you have in your organisation to monitor practice performance on access? Is there sufficient capacity to engage with practices to support access improvement?
- what capabilities do you have to support practices in access improvement? Do LMCs and practices share good practice?
- what technical capabilities and capacity do you have to extract data from practice IT systems? How would you gain support for this approach from practices and LMC?
- what precedents do you have for exploring performance issues with practices? Do you consider yourselves performance managers? Do you have any developmental programmes in place for your practices?
- how do you go about ensuring capacity in practices?
- how do you deal with infrastructure problems (for example premises that are too small for growing populations and growing need)?

It is important you understand how services are currently being provided, so that you can begin to identify areas of greatest demand where there may be gaps. Firstly, agree a process with your GP practices, and where possible the LMC. This enables you to regularly collect a range of information about the demand and capacity within your existing services:

- opening times
- patients per WTE GP
- patients per WTE general practice Nurse
- patients per WTE Receptionist
- number of prescriptions (inc. repeats)
- A&E attendances
- emergency admissions
- whether the practice is open or closed to new registrations
- appointments per 1,000 patients
- telephone lines per 1,000 patients
- whether there is wheelchair access
- details of translation services
- GP gender
- whether the practice is operating a premium rate telephone number
- numbers of did not attends (DNAs).<sup>13</sup>

### **CASE STUDY** *Information at your fingertips*

*In How NHS Barking and Dagenham is adapting an interactive web based tool to analyse the performance of GP practices.*

This information can be inputted into the relevant cells of the Primary Care Commissioning Services Application. Some data has already been provided where held centrally.

Where PCTs are having difficulties obtaining reasonable information from practices the GMS regulations set out the duty on contractors to supply information connected with the contract.<sup>14</sup>

With an increase in the number of practices actively editing their profiles, and improvements in the quality of data, NHS Choices<sup>15</sup> contains a wealth of information on local primary care providers. This includes opening times, practice staff, clinics and the times that they are available, car parking and transport information, etc. The DH is currently working with NHS Choices to create a report function that will allow commissioners to download the information about their GP practices held on the website. This will be available before the end of 2009.

13 Some of this data is held by the PCT, not the practice

14 Paragraph 77 of schedule 6 to the 2004 GMS regulations (or the PMS, APMS equivalent): 'the contractor shall, at the request of the Primary Care Trust, produce to the Primary Care Trust or to a person authorised in writing by the Primary Care Trust or allow it, or a person authorised in writing by it, to access – (a) any information which is reasonably required by the Primary Care Trust for the purposes of or in connection with the contract; and (b) any other information which is reasonably required in connection with the Primary Care Trust's functions.'

15 www.nhschoices.nhs.uk

## Identifying implications

Having reviewed your reported patient experience, patient context, technical access, practice responsiveness, practices' starting point and the PCT's own starting point, you should be in a position to identify whether you are facing a problem of patient perception, practice provision, or both. Comparing where you are now to where you want to be as outlined in the next section will help you determine what your next steps should be.

At a minimum, we would suggest that PCTs share the starting point with practices and LMCs. Increasing awareness of access issues has proven to be a powerful motivator for change in many PCTs. It is important to consider when, where and how this data is shared for a number of reasons:

- firstly, PCTs should make sure they understand the data and how it fits with other data they share with GPs – does it reinforce or contradict? Does it suggest an improving or worsening position? Does it suggest performance is evenly distributed, or are there some areas where performance is improving and others where it is deteriorating?
- secondly, PCTs should consider how they share the data. Is it simply emailed around? Or are practices brought together to review? What interpretation is added to the sharing of the data? How can the LMC be involved in facilitating shared learning from the data?
- finally, who specifically shares the information? The executive responsible for primary care? The medical director? The manager who interacts most frequently with that practice? Given the local context, different answers may make sense. As a rule of thumb PCTs would want to make sure that whoever shares the information understands it and its implications in detail, and has the credibility to have a mature discussion with GPs about it.



Section 3 Developing the vision

## Developing the vision

Once you have established your starting point you should next describe your vision of what access should be like for your population, and communicate that vision to patients, practices and others with an interest.

This section discusses how you can develop a vision, and what practical steps you can take to communicate that vision to stakeholders.

### Developing the vision for how the public will experience access in the future

Developing a clear vision of how you want access to change is a crucial early step.

A compelling story, well told and frequently repeated, is essential for the success of an improvement programme: it aligns everyone on why things need to change and sets out what that change will mean in practice, providing clear direction during the period of transition. This will need to be aligned to the overall vision for primary care and the strategic service model, as described in *Improving GP Services*.

Your starting point for access should inform your vision. For example, where a PCT is starting with particularly weak access performance, a shared vision between the PCT and practices might focus solely on achieving a dramatic improvement in access scores – “we can and must do better”. Where a PCT is performing well on access, the shared vision will require more work to develop. Some high-performing PCTs have set out a vision of improving access through more collaborative and less contractually-oriented working relationships with practices. Others have positioned a move from good access to great access as a complement to other local initiatives on quality, and the shift of care closer to home.

A patient participation group could be well placed to develop this vision for access and responsiveness at either a practice level or a locality level depending on their membership. The PCT may wish to consider providing some funding to support this work. A partnership between the RCGP, BMA, NHS Alliance, National Association for Patient Participation (NAPP) and the DH has resulted in a new campaign, Growing Patient Participation. The campaign brings together case studies, resources and ideas on how practices and PCTs can help establish and develop patient participation groups locally.<sup>16</sup>

For example, NHS Suffolk developed the vision ‘we want to be access efficient – simply the best’, not only to improve GP access scores, but also use the opportunity to improve relationships with GP practices and the LMC. As good access work would always seek to take a collaborative approach to improvement, NHS Suffolk also held relationship workshops and working meetings with GPs, where past issues were aired and a new working relationship between all parties was established.

.....  
16 [www.growingppgs.com](http://www.growingppgs.com)

### Ensuring your vision is grounded in the real world: 'the patient offer'

Once you have determined your vision, you should translate it into terms that patients can recognise and on which your progress can readily be measured: a "patient offer".

Experience shows that 'laundry-lists' of access-related commitments risk masking rather than highlighting progress on critical access issues. The most effective patient offers focus on a few specific metrics, and give numeric targets based on what your patients really want. For example, in Tower Hamlets PCT the focus is on just three key metrics: breaches of the PCT promise to offer access to a GP within 48 hours, number of appointment slots available, and scores on the 48 hour measure in the GP Patient Survey.

To develop your patient offer, you should review the metrics you chose to focus on in your work to establish the PCT's starting point on access (see Section 2) and determine the key elements you want to check progress against. Communicating this offer to the public in an understandable format is an important step.

### Developing the vision: involvement & engagement

Involving the community needs to start as early in the process as possible and is best viewed as a continuum:



### LINKs

If the Local Involvement Network (LINK) is sufficiently established in your area, commissioners should involve it and work with it to identify and reach out to the communities who can sometimes be overlooked. Working with LINKs is one way to involve local stakeholders, good practice is to create a range of opportunities, using different and appropriate techniques to involve users and stakeholders in developments that will have an impact on them.

The overall aim of engagement is to agree and describe the PCT's, and its community's, aspirations. This could simply start with a broad vision statement and will include some specific goals you want to achieve.



Section 4 Making it happen

## Making it happen

Practices, PCTs and SHAs can all play a part in improving access. This section highlights the contribution each can make towards the goal of better access. Additionally, for PCTs, the section describes the practicalities of implementation, with suggestions for resourcing, project management and timings.

### What PCTs need to do

PCTs, as the local leaders of the NHS with a remit for commissioning and system management, must ensure that access to services is integral to their overall health strategy. All aspects of world class commissioning competencies apply to improving access, and PCTs will want to consider how to achieve the highest levels of competence in this area.

PCTs can drive change by providing practices with vital information, challenge and support. This often requires a new way of working with practices, and some of the practical implications are laid out in the section on implementation below.

We have identified seven particular roles that PCTs can play:

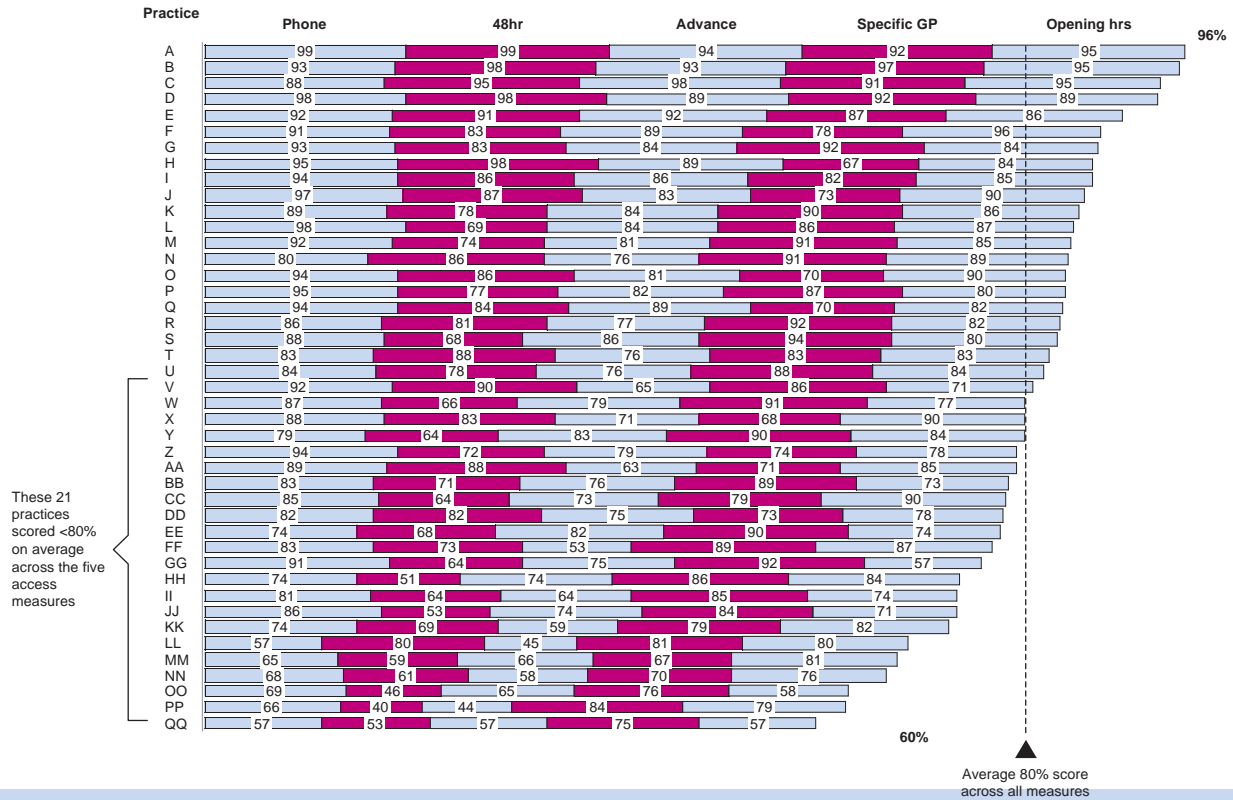
- (1) providing transparent information
- (2) ensuring minimum standards
- (3) providing regular insights into practice performance
- (4) segmenting practices and tailoring support accordingly
- (5) supporting quality improvement
- (6) engaging key stakeholders proactively
- (7) shaping public perception.

### 1. Providing transparent information

An important role for PCTs at the start of the process is helping practices understand their current performance – in terms of technical access, responsiveness and patient perceptions. Practice staff may be aware of their GP Patient Survey scores, but may not have reflected on how their practice sits relative to others in terms of supply of appointments or practice responsiveness. Making performance transparent can provide a powerful motivation to change.

For example, Barking and Dagenham PCT shared all practice GP Patient Survey scores at the monthly Protected Learning time event when they began working on access (see sample below). Individual scores were then discussed with practices in an initial access visit. Simply inviting practices with low scores to compare themselves to their peers – especially peers with similar patient populations – can be highly effective in creating a desire to improve, and a belief that improvement is possible. It also allows practices to identify peers from which to learn.

### 21 practices in Barking & Dagenham scored below 80% on average across all 5 GP Patient Survey measures...

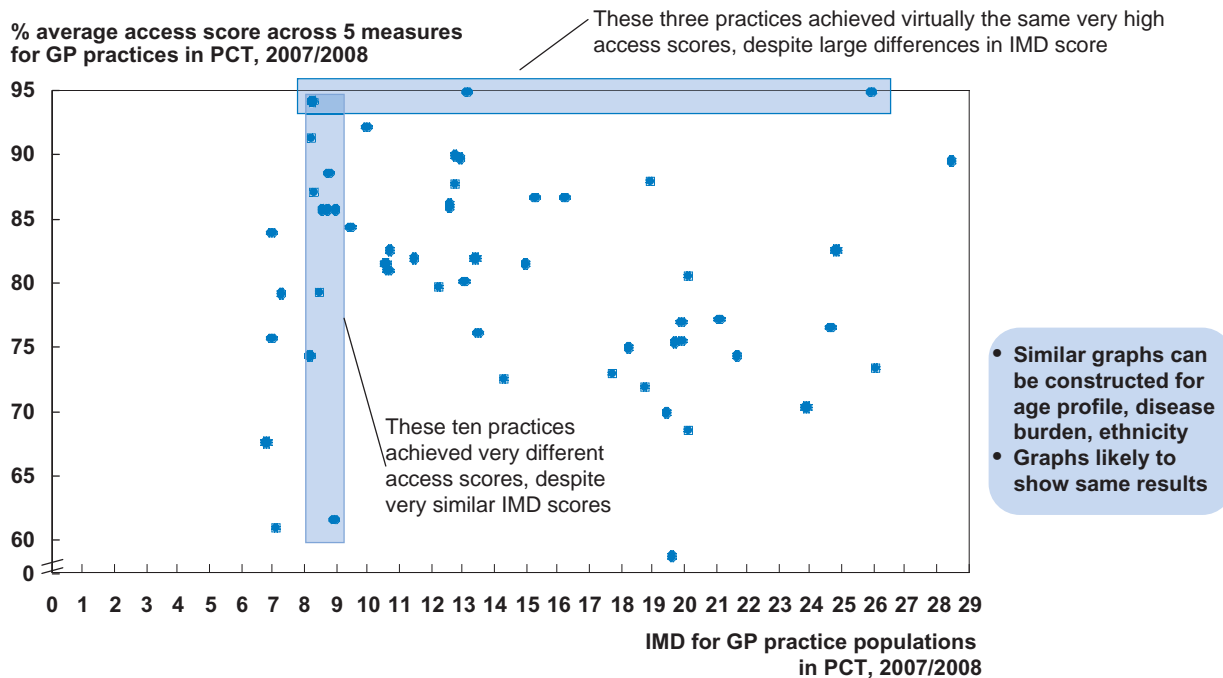


SOURCE: Information centre, 2007/08 GP access survey

In addition to providing transparent information on where individual practices are today, PCTs will want to examine some of the potential explanations for current performance. Every practice is different, and as such may have some unique context that may influence their current position. For instance, many GPs believe that the high prevalence of disease or demographic profile of their particular population may explain why access is harder. The DH Primary Care Commissioning Support Application makes it possible to investigate these beliefs with objective data.

For example in this PCT, a correlation of IMD and access clarified that there is no correlation between IMD and performance on access in this patch:

## Practice access scores in every PCT vary widely and are not linked to environmental factors such as deprivation



SOURCE: NHS Information Centre; ONS, 2007

Building on this transparency, some PCTs have found it useful to hold access workshops across a number of practices to share the starting point, which can include sharing patient stories and experiences of trying to get through to practices.

## 2. Ensuring minimum standards

PCTs have a critical role to play in ensuring practices share a common aspiration for the standard of service delivered to patients. Most importantly, this will be conveyed in the words and actions of leading executives and clinicians. PCTs that have made significant improvement in access have found that jointly defining aspirations with GPs is a crucial first step in the journey. LMCs can also play an important role in developing this approach. Typically this involves working together to define what good access would look like, and mean, for patients, staff, GPs and the PCT.

Aspirations for improvement can also be reflected in balanced score cards, enhanced services and in locally agreed contracts. Sharing data with practices often provides a stimulus for local dialogue and action. PCTs have an opportunity to work with their practices, perhaps in discussion with the LMC, to define access in more detail, ideally including reflections on technical access as well as practice responsiveness. Some PCTs have found it useful to have the definition of access include consideration of:

- opening hours and spread of appointments available throughout the day
- the needs of the population, including seasonal variations, public health campaigns

- the number of appointments per 1,000 registered patients per week. For Tower Hamlets PCT this standard was 72 appointments per 1,000 registered patients per week
- patient experience scores (and implicitly aims for practice responsiveness), for example whether patients can get a quick appointment or pre-book one, their experience of the telephone access or friendliness of reception staff
- An expectation that if reasonable technical access is not being met GPs will invest time or energy to make changes
- Support for infrastructure change.

### 3. Providing regular insights into practice performance

Practices need to understand how well they are performing on access on a regular basis, both to track the impact of changes they are making, and to maintain high standards over the long term. PCTs can provide invaluable challenge and support for practices as they seek to understand their performance. In particular, PCTs can:

- provide technical support to extract and analyse data from practice systems. There are a small number of indicators which are very useful to monitor levels of access. This data can be quite easily extracted from practices' IT systems, and regular review of it can support improvement in access
- provide useful tools to help practices better understand and manage access. Tower Hamlets PCT, Barking & Dagenham PCT and Suffolk PCT have all developed and shared a range of simple tools to support access improvement. In collaboration with McKinsey & Co., Tower Hamlets designed a planning tool to show historic levels of appointment supply and projected future levels based on weekly staffing arrangements. The tools also include the ability to look at demand and supply of appointments by day of the week and time of day, which can help to align availability with demand. They have also included simple mechanisms to track whether practices are able to achieve the goal of always being able to offer an appointment within 48 hours.
- act as a partner in understanding what the data is saying and what the practice should do next as a result. By doing so, the PCT can also role model for practices what good operational management looks like: calm, even in times of stress; and fact-based, using data to generate insights into true performance and provide a counter-balance to anecdote
- work with practices and Practice Based Commissioners (PBC) on the broader system information that provides insights, the usage of walk-in services, emergency departments and out of hours activity. Opportunities to do things differently may become apparent as this information is triangulated with local access data

- work with practices and LMCs on understanding the implications of current and future skill mix within practice. The PCT will need to ensure that changes to skill mix are reflected in the overall workforce development plan and related education and training commissioning.

### Case study on technical support

Following on from their access work, Tower Hamlets PCT created a programme that uploads data from all practices' EMIS systems on a weekly basis. This provides real-time information on the number of appointments being offered on a weekly basis and on the uptake of these appointments, amongst other data. Tower Hamlets shares this information internally and externally, to create transparency for all practices about their position relative to peers. A screenshot of one practice's data is shown below.

Audit Period: Jun–Aug 08				
Practice details				
CDB				
Practice				
No. of regular patients				11842
Appointment Slot Count				
1. Filled slots	6725			
2. Empty slots	198			
3. Available slots [1+2]	6923			
4. 'Non-slots'	935			
5. Appointment slot total	7858			
6. Available slots per 1,000 patients per week				45
DNA Rates				
	Filled slots	DNAs	% DNA	
Monday	1768	212	12.0%	
Tuesday	1508	183	12.1%	
Wednesday	1008	114	11.3%	
Thursday	903	159	17.6%	
Friday	1538	193	12.5%	
Saturday			n/a	
Total	6725	861	12.8%	
First/last filled slot times				
	Filled slots	First filled slot time	Last filled slot time	
Monday	1768	08:50	18:20	
Tuesday	1508	09:00	19:20	
Wednesday	1008	09:00	18:50	
Thursday	903	09:00	13:10	
Friday	1538	09:00	18:20	
Saturday	0			
Filled slots & DNA rates – by gender				
	Totals	%	DNA	% DNA
Male	2688	40.0%	346	12.9%
Female	4037	60.0%	515	12.8%
Total	6725	100.0%	861	12.8%
Filled slots – other information				
No. of regular patients with a booked appointment	3253		Consulters	
			Principals	
% of regular patients with a booked appointment	27.5%		Other GPs	9
Total filled slots booked by top 25 attendees	281		Nurse practitioners	2
% of filled slots booked by top 25 attendees	4.2%		Other	2
Highest attendance by a single patient	18			
Highest DNA rate for a single patient	5			
Total DNA slots used by top 25 DNA attenders	84			
% of filled slots which were DNA'd by top 25 DNA attenders	1.2%			

Audit Period: Jun–Aug 07				
Practice details				
CDB				
Practice				
No. of regular patients				10170
Appointment Slot Count				
1. Filled slots	5583			
2. Empty slots	84			
3. Available slots [1+2]	5667			
4. 'Non-slots'	1042			
5. Appointment slot total	6709			
6. Available slots per 1,000 patients per week				43
DNA Rates				
	Filled slots	DNAs	% DNA	
Monday	1389	204	14.7%	
Tuesday	1153	135	11.7%	
Wednesday	1016	131	12.9%	
Thursday	709	94	13.3%	
Friday	1316	188	14.3%	
Saturday			n/a	
Total	5583	752	13.5%	
First/last filled slot times				
	Filled slots	First filled slot time	Last filled slot time	
Monday	1389	09:00	18:00	
Tuesday	1153	09:00	18:00	
Wednesday	1016	09:00	18:00	
Thursday	709	09:00	12:00	
Friday	1316	09:00	18:00	
Saturday	0			
Filled slots & DNA rates – by gender				
	Totals	%	DNA	% DNA
Male	2274	40.7%	299	13.1%
Female	3309	59.3%	453	13.7%
Total	5583	100.0%	752	13.5%
Filled slots – other information				
No. of regular patients with a booked appointment	2819		Consulters	
			Principals	
% of regular patients with a booked appointment	27.7%		Other GPs	14
Total filled slots booked by top 25 attendees	251		Nurse practitioners	1
% of filled slots booked by top 25 attendees	4.5%		Other	2
Highest attendances by a single patient	16			
Highest DNA rate for a single patient	5			
Total DNA slots used by top 25 DNA attenders	80			
% of filled slots which were DNA'd by top 25 DNA attenders	1.4%			

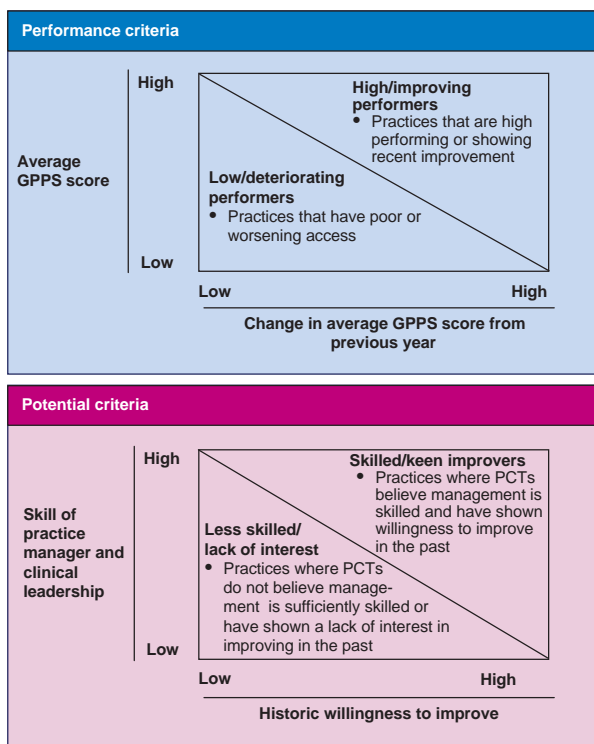
Increase/decrease between 2008/2007				
Practice details				
CDB				0
Practice				0
No. of regular patients				1672
Appointment Slot Count				
1. Filled slots	1142	17.0%		
2. Empty slots	114	57.6%		
3. Available slots [1+2]	1256	18.1%		
4. 'Non-slots'	-107	-11.4%		
5. Appointment slot total	1149	14.6%		
6. Available slots per 1,000 patients per week				2
DNA Rates				
	Filled slots	DNAs	% DNA	
Monday	379	8	-2.7%	
Tuesday	355	48	0.4%	
Wednesday	-8	-17	-1.6%	
Thursday	194	65	4.3%	
Friday	222	5	-1.7%	
Saturday	0	0	n/a	
Total	1142	109	-0.7%	
First/last filled slot times				
	Filled slots			
Monday	379			
Tuesday	355			
Wednesday	-8			
Thursday	194			
Friday	222			
Saturday	0			
Filled slots & DNA rates – by gender				
	Totals	%	DNA	% DNA
Male	414	-0.8%	47	-0.3%
Female	728	0.8%	62	-0.9%
Total	1142	0.0%	109	-0.7%
Filled slots – other information				
No. of regular patients with a booked appointment	434		Consulters	
			Principals	0
% of regular patients with a booked appointment	-0.2%		Other GPs	-5
Total filled slots booked by top 25 attendees	30		Nurse practitioners	1
% of filled slots booked by top 25 attendees	-0.3%		Other	0
Highest attendance by a single patient	2			
Highest DNA rate for a single patient	0			
Total DNA slots used by top 25 DNA attenders	4			
% of filled slots which were DNA'd by top 25 DNA attenders	-0.2%			

#### 4. Segmenting practices and tailoring support accordingly

Different practices will have different starting points on access and each will have its own individual set of challenges. By segmenting practices based on a range of factors, possibly including the starting point and track record of improvements, PCTs can provide targeted support and performance management for the practices that need it most. It is important to repeat the process of segmentation and developing tailored responses over time to take account of how practices are changing.

To do this, some PCTs have found it helpful to translate aspirations for standards of service into a balanced scorecard that can be used to assess practices' performance and identify what support they should receive from the PCT. Other PCTs have segmented practices based on a mix of quantitative and qualitative measures, such as GP patient survey results and historic willingness to improve. The segmentation used should consider current performance as well as potential to improve (as outlined below).

#### Approach to GP practice segmentation

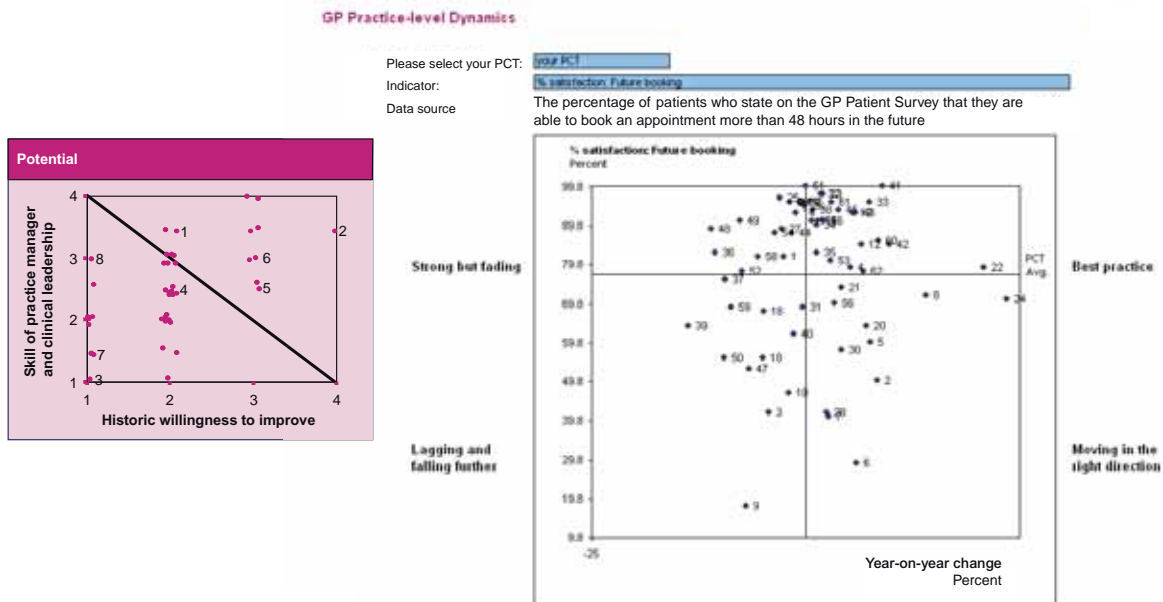


		GP practice segmentation matrix	
Performance	High/improving	<b>Healthy push –</b> • Practices in need of 'wake-up call' and light support	<b>Healthy practice</b> • Practices in need of light touch support only
	Low/Deteriorating	<b>Tight management</b> • Practices in need of tight performance management	<b>Intensive support</b> • Practices in need of intense developmental support
		Less skilled/lack of interest	Skilled/keen improvers
		Potential	

The East of England SHA has recently developed a segmentation methodology which it has applied to identify opportunities to address performance as outlined overleaf.

## Sample PCT – 12 practices would need ‘tight management’ or ‘intensive support’

Practices in Sample PCT segmented by performance and potential



Note: Small variations added to the Potential chart to show multiple practices with the same score

Practices in the top right hand corner are publicly celebrated, with opportunities for broader learning identified and shared by the PCT with other practices. Practices in the rest of the matrix received support to make improvements, with the most ‘hands-on’ support, such as receptionist training, going to the practices in the bottom left hand corner.

In other PCTs that have done similar work, practices were initially segmented based on GP Patient Survey results, and a period of intense support was provided to those practices with the weakest performance. At the end of the three or four months of intensive support, the PCTs re-segmented the practices based on both performance and insights into capabilities and will to improve, gathered via the support process. Each practice was contacted to discuss where it now stood and to discuss next steps. Practices in the weakest segment were supported to develop an improvement plan, and progress towards this was monitored.

### 5. Supporting quality improvement

To embed the right incentives for practices to improve performance, PCTs need to develop a systematic approach to what happens as a consequence of different levels of access performance. This requires defining what stronger and weaker performance looks like, developing a consistent approach for practices who perform similarly, periodically evaluating where practices have got to, and following through on the management of consequences.

Where PCTs have taken this approach they have typically defined performance broadly, so that it covers:

- how effective the practice has been in making changes to inputs that should result in improved access
- how the practice is now doing on access
- what the trajectory looks like (improving or declining performance? Is change slow or rapid?)
- how effectively the practice is now engaging with the PCT.

Once the scope of performance is defined, it is helpful to determine what the response should be to different levels of performance. One PCT that did this developed three standardised letters that were sent to practices: one for those who had resolved issues or were well on the way to doing so; one for those who were improving but required further support from the PCT; and one for those where serious concerns about performance remained. The PCT developed a different set of consequences for each group:

- the focus for the first group was celebrating success, spreading good practice, embedding improvements, supporting further improvements
- the focus for the second was on enabling the practices to improve without PCT support
- the focus on the third was on immediate improvements with appropriate support from PCT, LMC or an external agency with a clear timeline for achievements.

Should an occasion arise where expected improvements are not achieved then the PCT will need to consider the contractual levers available. This may lead to the agreed process of remedial and breach notices that relate to the contractual arrangement in place.

## **6. Engaging key stakeholders proactively**

The PCT can support practices in improving access by looking both across the PCT and more broadly to identify and engage key stakeholders. The biggest opportunity is with the patients. PCTs, through their patient and public engagement work with diverse groups, can actively identify the patient context and the patient experience of access. As a PCT gains insight into the patient context, it can communicate the implications to practices. For instance, if a PCT were to learn through engagement that a high proportion of their patients were employed during core hours and preferred telephone consultations, this could impact the offering of practices. Similarly, PCTs can use patient and public engagement to understand patients' experience. The growing number of Patient Participation Groups being supported by practices may provide a forum to identify the real issues facing patients and carers. This understanding can be more 'real-time' and rounded than other methods of understanding patient experience. In addition to patients, PCTs could engage with the SHA, DH, and other key stakeholders that the practices may have.

## 7. Shaping public perception

The PCT is uniquely placed to shape public perception through engagement and communication. Tower Hamlets PCT has actively worked to communicate to patients what they can expect from practices on access performance and how practices are currently performing. The end goal is to improve patients' experience of access. The message has changed over time to reflect the changing context. Broadly, three messages were communicated in turn: "we are listening"; "we are acting"; "we have improved". The messages were timed so that they were self-evidently authentic, for example at the time of the message on listening, the PCT's Executive Officers took part regularly in radio phone-ins to hear about patients' problems with access. PCTs will be aware of the sensitivities of this type of dialogue and will want to ensure a balanced discussion.

Tower Hamlets used a professional communications agency to help craft and deliver its story, and deployed a wide variety of media to get its message across, including sending letters from the Chief Executive to all residents with a personal commitment to improve access, a liaison volunteer working with local mosques, posters celebrating access improvements, flyers on access circulated with local newspapers, and the establishment of a PCT phone line for patients to provide feedback about access at their practice. An example communication is this pamphlet distributed by Tower Hamlets:

**8 out of 10 of our residents now find it easy to see a GP when they want.**

Pop out this card and keep it in a safe place. It's our commitment to giving you choice. I'm determined that you get the health service you need.

*Alwen Williams*  
Alwen Williams, Chief executive

**My pledge to you:**

1. See a doctor the same day or within 48 hours
2. Book an appointment at least 2 weeks ahead
3. Early morning, evening or weekend appointments at all practices

If you don't get the above service call **020 7364 5016**

Use this number to find a doctor or dentist and how best to get the right treatment.

Visit [www.thpct.nhs.uk](http://www.thpct.nhs.uk) for more about our improvements.

*অপার পাতায় দেখুন*

*Getting better!*  
Tower Hamlets **NHS** Primary Care Trust

**We're London's most improved health service. We're working to be the best.**

**NHS Comms Link** now includes a section on GP access, which contains a range of resources and templates that you and local communicators can use or adapt to engage and inform stakeholders. There are also useful tools to help PCTs to explain the choice of services available to patients.<sup>17</sup>

<sup>17</sup> <http://www.nhscommlink.nhs.uk>

PCTs may also wish to sign post the availability of other services that support self care through community pharmacy or local self referral to Allied health professionals.<sup>18</sup>

### Case study: We would like to listen

How Heywood, Middleton and Rochdale PCT engaged and consulted with a broad range of stakeholders to shape new primary care services.

#### Summary

In December 2007, Heywood, Middleton and Rochdale PCT began the Equitable Access in Primary Care project, to source three new GP practices, each with four GPs, and a GP-led health centre. Although a full consultation was not legally required, the PCT undertook a wide-ranging local consultation and engagement campaign, the results of which influenced how it planned the new services.

Through these efforts, the PCT was able to involve a broad spectrum of stakeholders in decision making, including hard-to-reach groups. They gained valuable insight into what people wanted from their local GP surgeries, which will help ensure that the new surgeries provide services appropriate to local needs.

Due to the size of the procurement and the speed of delivery required, the PCT felt that a full consultation would lead to better decisions being made and would help to build local support for the new practices.

The PCT reached out to local people through a wide range of channels and activities:

- 75,000 leaflets and questionnaires were sent to residents, and nearly 8,000 posters and leaflets were put in local schools, community centres, libraries, clinics and other public spaces.
- road shows and street events gave people the opportunity to express their thoughts face to face. The campaign team visited local bus stations, shopping centres, markets, schools and a range of community groups, such as residents associations and mother and baby groups. In total around 10,000 people were engaged this way

*“This is one of the largest procurements in the country. If we hadn’t conducted a full consultation, we’d be going out without the wealth of information and opinion that the consultation has provided us with. We felt that if we were open and transparent in what we were procuring, we’d be far more likely to get our patients supporting the new services, practices and GP-led health centre when they opened. It also gives us an opportunity to let the public know that we have not done this in isolation, but we’ve listened and acted upon their feedback.”*

*James Leeming, Project Manager – Equitable Access, Heywood, Middleton and Rochdale PCT*

<sup>18</sup> Operating Framework 2009/10 [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_091445](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091445)

- press releases were sent to the local press and talking newspapers, while the PCT took regular slots on local radio, including the local Asian radio station, to encourage participation in the consultation. When necessary, information was translated to overcome language barriers
- five focus groups were held across the communities, involving Asian young people, older people, people with long-term conditions and living with disabilities, as well other local residents
- an interactive event for young people was organised in collaboration with the Rochdale Youth Council, which resulted in some innovative ideas that were fed into the consultation
- a Facebook site was set up to provide information and signpost people to the consultation website.

Everyone who took part in the consultation received a letter thanking them for their input and explaining the outcome of the consultation.<sup>19</sup>

### **Implementation practicalities for PCTs**

The preceding section identified 7 key sets of actions for PCTs to take to support improvement in access. This section considers what PCTs need to have in place in order to implement such a programme. It is informed by the experience of PCTs that have improved access and their reflections on the process. Below we outline 6 things that PCTs should consider in more detail. In summary, they are:

- 1) executive sponsorship and leadership
- 2) Board level accountability
- 3) focus, persistency, and ownership
- 4) a narrative for what the PCT is doing, why, and what people can expect
- 5) appropriate resourcing
- 6) robust project management.

.....  
 19 <http://www.dh.gov.uk/en/Procurementandproposals/Procurement/ProcurementatPCTs/index.htm>

### **1. Executive sponsorship and leadership**

Executive sponsorship and leadership, which must include clinicians, is critical for access improvement. This support needs to be in place both internally and externally, and should encompass support from the Board, the PEC, the CE, the Medical Director and the Director of Commissioning. Internally, these leaders need to ensure that the support is in place for an access improvement programme, that the staff working on this programme have the support and capacity that they need, and that there is clarity around how this programme aligns with other primary care work happening in the PCT.

Externally, these leaders play a critical role in communication about the programme. Firstly, the executives should lead on the communication to practices around why access improvement is important. Most significantly, these leaders should be supporting staff in engaging in sensitive conversations with practices around performance where needed, including having the conversations themselves directly, where appropriate and helpful.

### **2. Board level accountability**

The PCT board is accountable for the deciding what health service the local community needs and ensuring that this is provided appropriately within the resources available. It is in a good position to ensure that organisations work effectively together. A detailed list of questions a PCT board will want to reflect on in relation to access to GP services can be found in the foreword to this guide.

### **3. Focus, persistence, and ownership**

An access improvement programme will require focus, persistence and ownership in the PCT. It should be clear within the PCT that there is a clear focus on access improvement and the programme to do this should have clear prioritisation. The PCT will need to be persistent. Access is not improved overnight; rather access improvement is a journey that the PCTs and practices will need to go on together. PCTs must recognise the time of the journey and that it may well encounter some resistance to the work along the way: change is never comfortable, and this change may feel unprecedented to GPs. Finally, there needs to be clear ownership in the PCT of the programme to ensure that focus and persistence is maintained.

Where PCTs identify practices that are below PCT minimum expected standards they will want to agree with these practices, as a pre-requisite, the improvements they are expected to make in addition to those that are funded under this framework. PCTs will want to work with high achieving practices to identify where these funds can support further improvements.

It is unlikely that a “one size fits all” approach will be appropriate to all practices in a PCT. The approach adopted will need to balance and reconcile how to improve low achievers, and yet incentivise high achievers to innovate further. PCTs will therefore want to reach individual agreements with practices that are set in the context of the services and activities they currently undertake.

#### 4. A narrative for what the PCT is doing, why, and what people can expect

To create real, sustainable improvement in access, PCTs will need to articulate three things:

- the PCT will need to be clear internally and externally about the programme that is being undertaken
- the PCT will need to explain the rationale for why this is happening. The success of change programmes is amplified when those engaged in it understand and buy into the rationale for change. In the case of PCTs this rationale could be a low level of performance across the patch or significant variation on performance within the patch
- for optimal transparency, the PCT should share with practices and staff what to expect of the programme. This could include the timing, the commitment required, what the expected outcome is, etc.

#### 5. Appropriate resourcing

Engaging effectively with practices and the LMC to improve access performance can pay rich dividends, and not just in terms of better access: often, broader advances in performance and in improved relationships accompany it. However, reaping the dividends requires PCTs to make the investment: a sustained and intensive effort to engage practices constructively, systematically and comprehensively.

The PCT will need to consider the level of day-to-day management support and executive leadership input that is required. Resources from the wider primary care team and the medical director may also be required. Experienced and knowledgeable primary care commissioning staff are invaluable, PCTs may need to consider this current capacity, and capability within the overall team. A number of PCTs have chosen to call in external support in addition to their internal resource.

NHS PCC is developing a Personal Development Support Programme that will consist of tools to help PCT managers translate the organisational world class competencies into their own, personal skills/competencies, and be relevant to their day-to-day work. Its aim is to support people to choose development opportunities that are relevant to their personal development needs and which focus on the organisation's objectives. The programme will consist of an online portal, due to be launched in September, aligned with the WCC competencies and the commissioning cycle providing:

- self assessment tool to identify gaps in personal skills/competencies
- information and links to training and development resources
- tools to assist integration of WCC organisational competencies to existing processes.<sup>20</sup>

.....  
20 More information is available at [www.pcc.nhs.uk](http://www.pcc.nhs.uk)

As well as requiring significant time from those PCT staff involved, access improvement programmes will usually require a different way of working, with a different set of skills. Generating real improvement through the programme will mean not just monitoring how practices are doing, but actively challenging and supporting practices through visits and training. It is vital that PCT managers engage as peers with GPs and practice managers to solve access problems.

## 6. Robust project management

Some PCTs have found it helpful to set up two different groups to manage access improvement programmes.

- 1) A small project management team, which is responsible for actually delivering the work, consisting of the relevant Director, ADs and the full-time access manager. The Medical Director will often need to attend on an ad hoc basis.
- 2) A larger steering committee to provide constructive challenge and input to the access improvement work, to give direction to the public communications campaign (including reporting on how it is being received), and to oversee any investments in new kit or upgrades to premises. This group should represent all the major stakeholders, especially patients, practices and commissioners. You should make particular effort to ensure your work is well-informed by those with the greatest needs and those who are least able to articulate their needs; often these groups find it most difficult to access services.

A sample membership for a steering group is shown in the exhibit below.

### Sample membership for an access steering committee

Perspective	Potential members who can represent this perspective
Patients and the public	<ul style="list-style-type: none"> <li>• Patients themselves</li> <li>• Patient and public involvement managers</li> <li>• Community leaders</li> <li>• Voluntary organisations</li> <li>• Local involvement network (LINK), if sufficiently established locally</li> </ul>
Practices	<ul style="list-style-type: none"> <li>• GPs</li> <li>• LMC leads for access</li> <li>• Nurses</li> <li>• Practice managers</li> </ul>
Commissioners	<ul style="list-style-type: none"> <li>• Senior PCT leadership, e.g. CE, Director of Primary Care</li> <li>• Managers with responsibility for practices</li> <li>• Access managers</li> <li>• PEC leads for access</li> <li>• Managers with related responsibilities, eg OOH, WICs, urgent care</li> </ul>
Other	<ul style="list-style-type: none"> <li>• Clinicians and managers with related responsibilities</li> <li>• Community pharmacists</li> <li>• Provider arm representatives</li> <li>• External support<sup>1</sup>, e.g., communications agencies</li> </ul>

<sup>1</sup> In a reporting capacity only

## Timings

Any access improvement programme is likely to need to run for at least a year to become embedded. However, it is possible to achieve a significant improvement in the first twelve to fourteen weeks, and you should plan this phase in detail first.

## What practices need to do

As noted in the Introduction, the GP practice is at the heart of access improvement. Ultimately, it is change in day-to-day operations at the practice that will produce improvements in both technical access and the practice's responsiveness.

There are a range of different ways in which practices can personalise their service to improve the experience for patients. Some of these are very simple, cost effective systems that can have a big impact such as allowing patients to book an appointment over the internet, or by making small changes to the waiting room environment. Others may involve more time, resource and effort, like improving the telephone infrastructure or by undertaking a detailed analysis of current demand, workload and capacity.

On behalf of the DH, the recently established NHS Practice Management Network has developed a practical step-by-step guide on a number of different systems, products and processes that can support practices make these changes. This more technical guide complements this world class commissioning publication and will be useful to both PCTs and providers in improving access and responsiveness. It comprises chapters on:

**Understanding your demand** – looking at what good access is, simple demand assessment and capacity planning techniques, and how to ensure adequate staff levels for call handling.

**Managing and meeting demand** – simple systems that can improve the way in which patients interact with their service and how practices can manage this demand, for example, through telephone consultations, appointment reminder and messaging systems, internet booking, home visits or

**The practice environment** – covering small but effective changes in the waiting room, different systems like check-in screens, call boards, and health monitors

**Telephony** – supporting practices undertake an assessment of their current infrastructure in order to make a decision about enhancing the existing system or consider a new one

**Ensuring a patient-focused service** – simple tips and steps to achieve patient friendly services

**Understanding your community** – step-by-step guides and useful resources to help practices improve the experience of particular groups of patients such as black and minority ethnic groups, those with sight loss, or hearing, for example, by using Sign Translate, internet-based software that enables GPs to convert english to British Sign Language (BSL) for use during consultations

**Communications** – covering top tips for improving communication methods like leaflets and websites, including how to set one up

**Patient engagement** – summarising the different techniques for engaging with patients, including how to set up a patient participation group, and the different methods of obtaining timely and reliable feedback

**Change** – simple tips for practice managers to drive successful change within the practice setting.

Successful improvement work typically begins by helping staff to recognise the importance of good access and to understand the part each of them plays in improving their practice's performance. This requires acknowledging the central importance of access for patients seeking treatment. For example, GPs may reflect on the impact that overrunning on appointment times has on capacity and therefore the number of patients they are able to treat.

Practices that have achieved a step change in access have typically taken a broad range of actions rather than just one or two, usually addressing both technical access and practice responsiveness. They will often have appointed a GP lead for access to work alongside the practice manager, but achieving improvements is undoubtedly a whole-team effort.

Answers to access problems frequently lie with practice staff themselves – for instance, receptionists may have powerful suggestions for how appointment times could be adjusted to reflect patient demand. However, these ideas and actions are often not discussed within the practice and therefore never can be applied. Regular multi-disciplinary practice meetings may be a useful way for partners, receptionists and the practice manager to consider capacity for the coming weeks.

Introducing a visual method of tracking access performance has proved extremely valuable for practice staff implementing changes. Such a method delivers a clear presentation of the facts, but requires the implementation of good systems for collecting and communicating information about access performance. However, it is possible to build a rapid, robust and detailed picture of access performance, and then to keep it sufficiently up to date to provide near real-time insight into performance. While PCTs may lead in developing such visual tools and providing further support, it will be practices that put them to use to understand the drivers of performance and plan actions to resolve issues.

Such actions may well involve changing the appointment system by, for example, keeping supply constant but shifting where it occurs during the week to match peaks and troughs in demand, or changing the mix of generally-available appointments and appointments with some type of restriction applied to them (e.g., non-bookable, advance-only, disease-specific). A practice in Suffolk conducted a 2-week audit to understand patient demand, and was subsequently able to adapt its appointment system to patient needs.

When practices make adjustments to operational systems to improve technical access there is always some risk that patients may experience the changes negatively. To minimise this risk, practices need to:

- plan well, ensuring that there are highly visible improvements to go alongside any changes that could be perceived negatively
- make the changes thoughtfully, trying to foresee and work around or minimise any undesired consequences
- consider additional investment effort at the start, such as starting an hour earlier for a week to create extra capacity (and then rewarding and celebrating appropriately at the end)
- adjust changes during implementation, rather than stick to the original plans if they are clearly not working
- track patient perceptions to see if what the practice is doing is having the desired effect.

These types of changes can be very challenging to put in place and may require building or upgrading talent in the practice. The PCT can provide support to practices by helping develop practice capabilities.

### **What SHAs can do to support PCTs and practices**

SHAs have an opportunity to support improvements even though they are further removed from the day-to-day operations of individual practices:

- formulating an SHA-wide aspiration for access in partnership with PCTs and clinical groups and then communicating these aspirations, specific aims and targets to PCTs
- advising PCTs to segment their practices as part of their access improvement journey, for example introducing or reinforcing the notion that different types of practices need different levels of support and intervention
- supplying PCTs with access diagnostic and improvement tools
- establishing a performance management process so that the SHA stays informed of the access improvements and can support or intervene as appropriate. This could include tracking the quarterly GP patient survey results, appointments per 1,000 weighted population and the progress of PCT plans to improve access
- advising PCTs on the capacity and capability required for ongoing performance management and supportive work with GP practices
- pooling capabilities across PCTs (for example contract and incentive reviews, improvement programmes)
- supporting regional communication about improvements to NHS and the public.

### What PCC can do

NHS Primary Care Commissioning have recently published a new Primary Care Service Framework (PCSF) to support PCT commissioning for accessible and responsive general practice.<sup>21</sup> PCTs will be able to use this framework to:

- contribute towards the achievement of world class commissioning competencies
- stimulate consideration of what “good” looks like in the context of the population served
- create a culture of continual improvement in primary medical care.

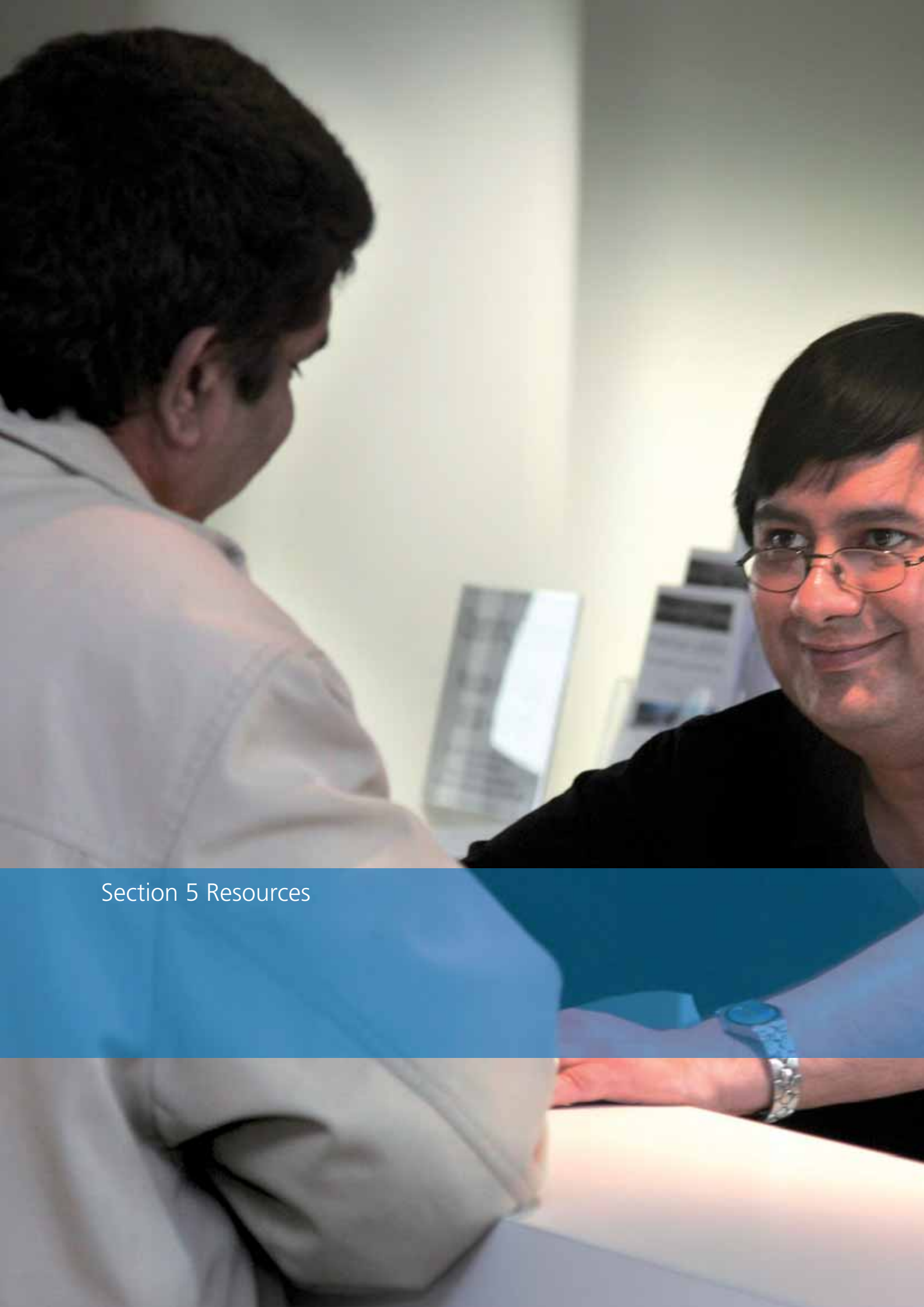
The PCSF sets out a number of possible approaches PCTs might want to take to utilise the additional resources allocated to them as part of the GMS contract settlement for 2008/09 for local investment in improving access and responsiveness in primary medical care.

The purpose of the framework is to incentivise practices and provide them with resources to tackle the specific access issues relating to their own practice and their patients. It is important to be clear that this PCSF is not about developing new services; it is intended to support PCTs in commissioning continuing improvements to existing ones. It can be used in a number of ways to develop new approaches or change existing working practices through the implementation of:

- incentive schemes
- capital grants
- local enhanced services.

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21 [http://www.pcc.nhs.uk/204.php#About\\_PCSF](http://www.pcc.nhs.uk/204.php#About_PCSF)



Section 5 Resources

## Resources

This section contains four detailed case studies describing what some PCTs have done to improve access in their patch. At the end of the section you will find a list of URL links that can help you improve access in your own PCT.

### Case study 1: Text reminders

How Oldham PCT introduced a system to send text messages to patients' mobile phones, with appointment and healthcare reminders.

#### Summary

Oldham PCT was looking at several ways to increase access to primary care services and decided that a text messaging service would have several benefits, including reducing the number of patients who 'did not attend' (DNA).

The scheme was first implemented as a pilot in a small number of practices. Now, 32 out of 46 practices use the text messaging system to remind patients about their appointments and communicate health messages around smoking cessation, screening, childhood immunisation and a range of other health issues. Patients can also send texts to a dedicated number to cancel appointments.

*"Communicating with our patients is key to ensuring greater access to healthcare. The more ways we can engage with patients, the better, and text messaging is just one more way. Patients have busy lives and appointments do get forgotten, but a text message to remind them helps patients stay focused on a health problem and get it addressed sooner rather than later."*

*Martin Weavers, Primary Care Development Manager, Oldham PCT*

#### Drivers

Oldham PCT began a wide-ranging project to improve access after falling below national metrics for 48 hour access in the 2007/2008 patient survey. Practices identified that DNAs were a recurrent problem and, aware that simply forgetting was the main reason for people missing appointments, the PCT decided to implement a text messaging reminder service, starting in a small number of pilot practices.

It quickly became apparent that the system had other uses, including gathering healthcare data, such as height and weight, and sending notifications about clinics and screenings.

#### Aims

By introducing this text messaging system, Oldham PCT aimed to:

- Reduce the number of missed appointments, by reminding patients when their appointments were and providing an easy way for them to cancel them
- Increase communication with patients, maximising the reach of health promotion campaigns

- Enable practices to make savings in time and money. The cost of sending a text message is significantly less than the cost of writing and sending a letter or telephoning patients to remind them about appointments.

### **Implementation**

A small number of practices joined the scheme in May 2008. The PCT introduced the practice managers to representatives from the text system provider, iPlato, and they began working together to implement the system. In practices that were IT-oriented, the first texts were going out within a week of the system being set up.

iPlato's web-based text messaging system was chosen over others because it works with all the major clinical systems, including EMIS and INPS Vision. Once the system was installed in the practices, a text message was sent to all patients whose mobile phone number was already in the practice system.

The initial message asked patients if they wanted to receive appointment reminders and health messages. If they texted back yes, they were enrolled in the service. In addition to that initial text message, patients who came to the practice were asked if they wanted to receive text messages.

The messaging system can be used to send manual text messages to individuals or groups of patients, in the case of targeted health messages. Automated appointment reminders are sent to patients by text message at a pre-defined time before the surgery visit. Reply texts from patients, for example cancelling an appointment, are directed as emails to a predefined email address.

In September 2008, the PCT invited practices to an event to learn more about the text messaging system. After this event, many more practices have opted to use it, and the PCT expects interest to continue to grow.

### **Cost**

- The PCT paid for the initial set up costs and software for the first year of the service. In the second year, there's an annual maintenance cost, for which the practices are responsible.
- The text message themselves cost 6p each and are sold in bundles of 3,000.
- Staff time spent on this project was minimal.

### **Impact**

Oldham PCT has found that practices have embraced this system, but uptake has been slower among patients. One practice has the mobile phone numbers of 33% of its patients, another has numbers for 30%. This penetration is increasing slowly. Statistics show that 1,800 text messages were sent in May 2008, the first month of the project, while 12,000 were sent in November 2008.

Because this initiative was undertaken as part of a wider-ranging project to improve access, it is not possible to accurately assess what difference the texting system has made. However, the

PCT believes that it has contributed to lower DNA rates in the practices that are using it. It is also thought to have saved time and money by reducing the need for letters, and improved satisfaction among some patients who appreciate receiving the messages.

Oldham PCT is now actively trying to reach more patients who have mobile phones, to encourage them to give their surgeries their numbers. Mobile phones are used by 84% of the adult population, which suggests there is a huge potential for growth in penetration.

### Key learnings

- Don't assume that older patients don't or won't appreciate this service. Oldham PCT found that elderly patients were just as comfortable receiving text messages as young people.
- Persuading the public to embrace this service is a challenge. It's a good idea to remind reception staff to ask patients for their mobile phone numbers, if the surgery doesn't already have them. An additional problem is that some patients don't know their numbers, while others forget to update the practice if they change their numbers.
- Oldham PCT encountered confidentiality issues with younger patients – there was a risk that their parents might read their mobile phone messages. They recommend setting a lower age limit of 16 for people enrolling in this service.
- If any practices are in the process of switching clinical systems, it's best to wait until the new system has been installed before introducing text messaging.

## Case study 2: Specification for a Local Enhanced Service

### Introduction

The GMS contract settlement for 2008/2009 included recommendations that every practice should have incentives to further improve access to services and responsiveness to patients. In Hampshire in 2008/2009, this was invested in assurance that practices continued to meet the primary care access standards.

Practices have had the opportunity since 2003 to participate in improvement schemes, directed enhanced services, and local enhanced services to improve and maintain improvement in access to services, to meet nationally set standards. These standards are now measured by patient satisfaction and are embedded into practice in the Quality and Outcomes Framework.

NHS Hampshire wishes to further improve public and patient satisfaction with Primary Care medical services by demonstrating high standards of patient information, supporting informed choice and delivering flexible, responsive services to meet patient needs.

This enhanced service is one of a suite of local enhanced services aimed at improving patient access including:

- Extended Hours LES
- Enhanced Extended Hours LES

## Process

This enhanced service is in two parts, both of which contain a compulsory and optional element. Practices must comply with the compulsory elements of both parts and choose one optional element from each part.

### Part One

This part establishes the practice's baseline level of access information and includes data, which forms part of the existing annual survey of practice staff levels. The optional elements enable practices to engage patients in giving meaningful and useful feedback or to provide further services to meet patient needs outside core hours.

#### *Compulsory Element:*

Baseline information

Practices will provide baseline information in the template provided at appendix one by the 31 July 2009.

#### *Optional Elements: (choose one)*

The practice must choose to deliver one of these optional elements by the 1 July 2009, have it set up and available to patients by the 1 October 2009 and provide Hampshire PCT with an audit covering the following six month period (1 October 2009 – 31 March 2010). This audit must be sent to Hampshire PCT by the 30 April 2010 by using appendix two.

#### *Patient Group*

1. Establish a patient group, which meets the best practice guidance (published by the National Association of Patient Participation and DH via the BMA website). For details of the national aspirational criteria, please refer to appendix three.

The group should hold at least four meetings per annum and the practice should be able to provide minutes of the meetings and evidence of action taken as a result of the group's feedback. This evidence should be provided to NHS Hampshire's Lay QOF Assessor on request and may form part of the QOF assessment visits. Existing groups, which are reconstituted to meet the best practice guidance, will be eligible under this option.

#### *Patient Nurse Appointments*

2. Provide at least one hour of practice nurse appointments per 5,000 patients per week (equivalent) outside core hours, for routine pre-bookable appointments.

### Part Two

This part encourages practices to improve information and access for patients by introducing new uses of technology.

*Compulsory Element:*

NHS Choices Website

The practice manually updates the NHS choices website themselves to the minimum standard as listed below. With effect from 31 July 2009, NHS Choices must accurately reflect these minimum standards and any changes must be applied at least every three months.

All relevant information under each of the main and sub headings must be completed to enable the practice to meet the minimum requirements when updating the NHS Choices website, the main headings include:

*Right Now*

- Welcome (including Extended Hours)
- Need to see a doctor?
- Need a prescription?
- Need a register?

*More About US*

- Meet the staff
- Services and clinics
- Facilities
- Explanations

*Performance*

- How we perform
- What patients think
- Practice Survey

*Where we are and the area*

- Map and travel info
- Contact us

*Optional Elements: (choose one)*

The practice must choose to deliver one of these optional elements by the 1 July 2009, have it set up and available to patients by the 1 October 2009 and provide Hampshire PCT with an audit covering the following six month period (1 October 2009 – 31 March 2010). This audit must be sent to Hampshire PCT by the 30 April 2010 by using appendix two.

*On-Line Automated Appointment Booking System*

1. Establish an on-line automated appointment booking system and provide an audit of its use, DNA figures from on-line booked appointments and patient feedback on the ease of use.

*Responsive Telephone System*

2. Install a responsive telephone system which enables practices to monitor call volumes, abandoned, and engaged calls and which uses a geographic number or a non-geographic number, which does not have a revenue sharing benefit or cost the caller more than a geographic number. (0844 and 0845 are not permissible under this LES.) Provide an audit of call volumes, abandoned and engaged calls.

*Practice Website*

3. Develop a new practice website, which includes all the information required for practice leaflets, links to and from NHS Choices, and is updated at least every three months. This will be measured by a random check.

*Pre-bookable Telephone Consultations*

4. Introduce pre-bookable telephone consultations equivalent to at least two appointments per day per whole time equivalent Doctor working in the practice. (The appointments may all be booked with one Doctor on any particular day but there should be a choice of Doctors available in any week). Provide an audit of number available, number booked and number who fail to keep their appointment call.

**Pricing**

Practices who wish to offer services in accordance with this LES will be paid 75.5 pence per head of registered population as at 1 April 2009 in monthly payments.

The first financial instalment will consist of two separate payments, April 2009 to August 2009 and September 2009, the remaining funds will be paid over the remaining months of the financial year (October 2009 – March 2010).

Practices confirming they wish to participate after 31 July 2009 will be paid pro rata.

Evidence as described in each optional element must be provided by 30 April 2010. Practices who fail to provide evidence within this timescale will lose 50% of the payment made under this LES.

### Case study 3: comprehensive programme to improve access through the use of external support

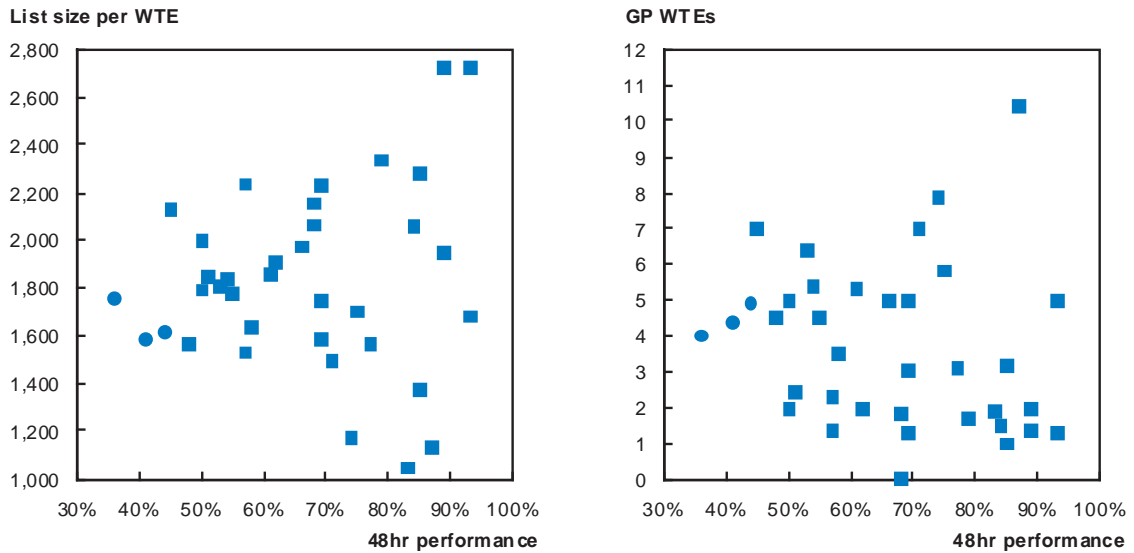
How Tower Hamlets PCT and practices used external support to deliver dramatic, lasting improvements in access performance.

#### Context

Tower Hamlets PCT is responsible for the health of 250,000 people in East London. The Tower Hamlets population is very diverse, with very large numbers of first generation immigrants, especially from Sylhet, an impoverished region of Bangladesh. There are high levels of deprivation in the borough. Consequently, health needs are exceptionally high. Yet in 2007, the PCT had the worst scores in the GP Patient Survey in the country, a reflection of a long-standing problem of poor access that made GP practices difficult places for patients to get into and for staff to work in.

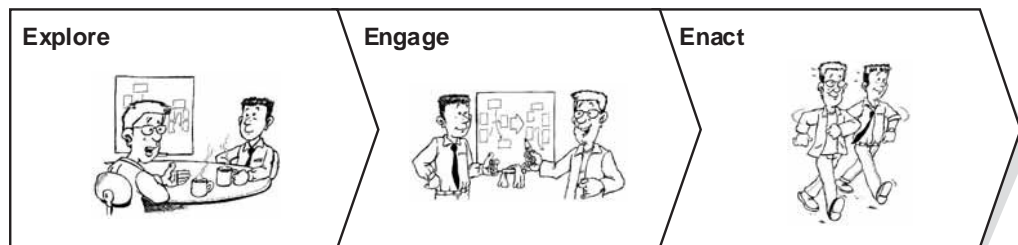
The PCT approached an external consultancy (McKinsey & Company) to undertake an intensive programme of work to improve the performance of the 23 practices with the lowest scores over a 12 week period.

Underperformance occurred at practices irrespective of caseload per WTE and practice size



## Approach

### Three-stage improvement approach explored issues, engaged practices and enacted changes



<b>Objectives</b>	<ul style="list-style-type: none"> <li>• Understand the specific access situation</li> <li>• Agree outline vision</li> </ul>	<ul style="list-style-type: none"> <li>• Present actual access situation and create need to change</li> <li>• Make plans to deliver the vision</li> <li>• Agree specific roles and targets</li> </ul>	<ul style="list-style-type: none"> <li>• Turn the vision into reality</li> <li>• Assess progress against targets</li> </ul>
<b>Typical activities</b>	<ul style="list-style-type: none"> <li>• Interviews</li> <li>• Surveys</li> <li>• Focus groups</li> <li>• Observations</li> <li>• Workshops</li> <li>• Best practice visits</li> </ul>	<ul style="list-style-type: none"> <li>• Mirror workshop</li> <li>• One-to-one conversations with GPs practice managers and all stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>• Implementation according to the plan</li> <li>• Practice visits</li> <li>• Progress reviews</li> <li>• Capability building</li> <li>• Coaching</li> </ul>

The external consultancy worked with the 23 GP practices that were in scope for the project to conduct a six-week diagnostic, broadly based on lean operations principles. The diagnostic phase included field visits to gather quantitative data and qualitative insights into the functioning and effectiveness of the practices' operating systems, management infrastructure and staff/patient mindsets, behaviours and capabilities.

Much of the data was gathered by the practices for themselves, which helped create belief in what the numbers were saying and started to build capabilities for managing access. The diagnostic results were specific to each of the 23 organisations involved, although common themes emerged across practices.

The external consultancy then presented the findings of the diagnostic to practices at a workshop, principally through a 'gallery walk' incorporating posters, audio and video files that displayed a range of data and information about performance. Participants were invited to ask themselves if they were satisfied with how they were doing, and to discuss what might change. The workshop was attended by all practice staff, including receptionists, GPs, practice managers and nurses, but not by the PCT, so that practice staff would feel free to speak openly.

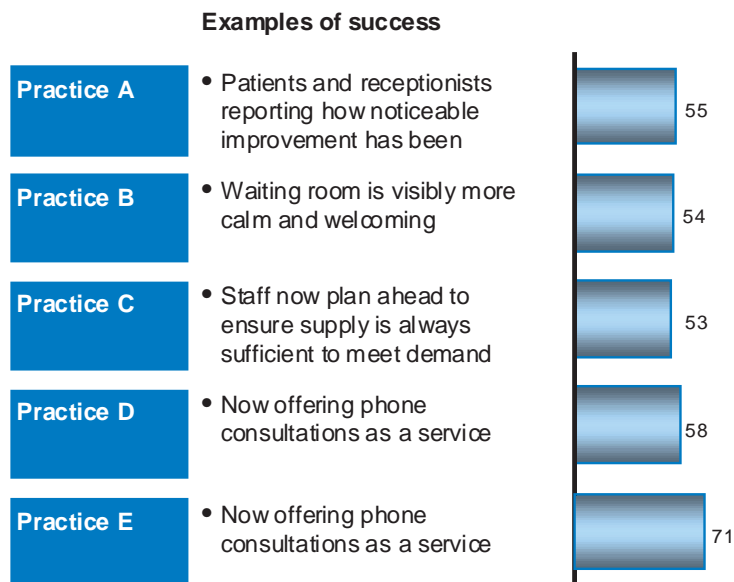
The subsequent five weeks of the project moved from diagnostic to action. The PCT commissioning team with support from the external consultancy worked with individual practices to help them draw up and implement action plans to improve access performance.

This included introducing the use of visual management tools, such as breach boards to record failures in ‘technical’ access (when appointments were not available). Practices began to make changes straight away, rather than waiting till the end of the engagement phase. At the end of project, the PCT segmented practices according to both improvement and potential for further improvement, and developed differentiated approaches to improve access further for each of the three groups of practices.

## Impact

Most importantly, for patients, technical access issues have been resolved at almost all practices and there is a much calmer and more welcoming atmosphere.

### Patients have overwhelmingly noticed improved access at most practices during the past few months



## Timings

Staff can now readily use a range of practical tools that enable data-oriented performance analysis, and there has been a dramatic shift in attitudes from “we’re stuck with this” to “we can and must change”; from anecdote to data; and from “us versus the PCT” to “us and the PCT”.

The PCT now has a new approach to performance management that it knows works, and is delivering about 4,000 extra appointments per week to residents. Its GP Patient Survey access score is the fastest-improving in the country (up 6% vs. an average of 1%) and it has seen a 20% rise in its GPAQ access score between 07/08 and 08/09. There are now consistent anecdotal reports of reduced A&E and Walk-in centre usage.

### Key learnings from the Tower Hamlets experience

- Rely on data, not intuition. There may be a lot of accepted wisdom about why access is as it is, and why efforts to improve it are futile. This needs to be tested against the facts.
- A major effort is required to make change happen and stick. Both PCTs and practices need to commit substantial time, thinking and resource to the programme. External support allowed for a vital intensive focus on resolving the issue.
- A trusting relationship between practice staff and commissioners is key to the success of a project like this, in order for productive conversations to take place.
- Exploring issues around access often helps identify wider problems with practice management.

### Case study 4: using external support to improve PCT/GP relationships and access to primary care service at the same time

#### Context

Compared with the national average, Suffolk PCT is doing well in providing access to GP services. There are, however, large variations between practices, and Suffolk PCT aimed to move all practices up the scale, to go from 'good' to 'great'.

Everyone would agree that stakeholder engagement is central to becoming a world class commissioning PCT. One key question for Suffolk PCT was whether they could effectively performance manage their GP practices while at the same time maintaining a strong, collaborative relationship with them. The answer, as they have shown, is yes.

Suffolk PCT carried out an intense 11-week consultancy-aided programme of GP practice support focused on improving access to GP services. It used a fact-based 'lean operations' based approach to identify improvements, created new tools and built new skills on the way, and throughout maintained principles of collaboration and dialogue. As one participant in the process described it, "This is an ideal way to discuss performance in a friendly and non-aggressive, yet determined manner. After all, we are all trying to achieve the same thing." (GP Practice Manager, Suffolk PCT).

The PCT was interested in capturing a broad range of additional benefits, from improving access to primary care and reducing costly A&E admissions, to providing more time for preventive care. In addition, access levels are a strong proxy for the business management capability at GP practices. At the start of this project, the PCT relied on the GP Patient Survey solely for results on access but as Melanie Craig, Suffolk's Deputy Director of Performance says, "we were equally interested in the actual experience of practices; more importantly, we wanted to learn how to improve access together with the GPs."

## Approach

Suffolk PCT offered a support programme to practices that showed potential and appetite to improve their GP Patient Survey results, and five decided to participate. The programme consisted of three phases: data collection, improvement planning, and implementation.

### *Phase 1 – understanding access*

First the practices spent 5 weeks collecting primary and secondary data, to build a real understanding of the current situation regarding access. This was followed by a pan-practice workshop for all staff (GPs, receptionists, nurses and practice managers) to analyse the data with a facilitator's help, and together define improvement plans. The PCT chose not to be part of the workshop, so as to provide space for open debates and confidentiality.

The reaction to the breadth of information gathered was phenomenal. A participating GP said: "We were blind without this data. We now know what matters and what does not. The more important point, however, is that we now know how to analyse data and use it to change and improve on an ongoing basis."

The workshop dispelled some popular myths and misconceptions. One of these was that practices that offered more pre-bookable appointments would run into capacity issues. Another myth was that population demographics are the root cause of poor access performance. It is common to hear that poor access is associated with patients who are more deprived, sicker, older, or more demanding than the average population. It was a real eye-opener for the practices involved in the programme to see that there was in fact no relation between a practice's access performance and its demographic attributes.

### *Phase 2 – planning improvements*

The workshop was followed by 4 weeks of intense support to help each practice detail its improvement initiatives. This support included meetings between Practice Managers, GPs and PCT performance managers, and proven tips and techniques for success provided by external experts.

*"I did not know that with our on-the-day booking system we condition patients to call at 8am. This puts us in a position where lines are busy and receptionists are forced to turn patients away. We have now changed our system. We are so much happier now. Patients are happy and our staff morale is considerably higher."* (Participating GP)

### *Phase 3 – putting it into practice*

The final phase was to implement these improvement plans and put in place the data systems that would measure the impact of change.

## Impact

One practice was able to use the data it had collected on the real level of demand for care to revamp its scheduling system and offer patients more appointments that are bookable in advance. Patients and staff have already commented on how positive these and similar changes have been.

Suffolk PCT now plans to engage its remaining practices and help them to benefit of the lessons learned. "We are now looking forward to next year's GP patient survey scores to celebrate our joint successes."

## Key learnings from Suffolk PCT's project

- Focus relentlessly on getting real data to expose the underlying issues and compare performance. The approach throughout was about measuring not guessing. The visual management tools introduced in the practices helped them use their own data to understand and manage access over time.
- Agree ground rules, such as the confidentiality of data provided by GP practices, right from the start.
- Use a clear performance framework to make sure the right conversations happen between commissioners and practices.

Whilst this project focused on improving access to primary care, the principles underpinning its success can be applied across the board, such as in non acute commissioning, to drive operational improvements in commissioning.

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We hope all those involved in improving access will find this guidance useful and would look forward to receiving comments and hearing your stories of successful access improvement.

## URL references

### Publications

High Quality Care for All: NHS Next Stage Review final report

[http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH\\_085825](http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085825)

NHS Next Stage Review: Our vision for primary and community care

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085937](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085937)

Primary Care & Community Services: Improving GP Services

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_093830](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093830)

Primary Care & Community Services: Improving dental access quality and oral health

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_093831](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093831)

Primary Care & Community Services: Improving pharmaceutical services

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_093831](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093831)

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

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_084970](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084970)

You're Welcome quality criteria: Making health services young people friendly

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_073586](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073586)

Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085345](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085345)

Access to general practice and general practitioners by telephone: the patient's view, British Journal of General Medicine

<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1372558>

Guide to 0300 numbers for the healthcare sector

<http://www.windsor-telecom.co.uk/03-numbers-downloads.php>

No Patient Left Behind: How can we ensure world class primary care for black and minority ethnic people

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_084971](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084971)

Working in Partnership Programme: Database of Good Practice

<http://www.wipp.nhs.uk/db.php>

The Primary Care Foundations recent publication 'Urgent Care: A practical guide to transforming same-day care in general practice'

<http://www.primarycarefoundation.co.uk/page9/page19/page19.html>

The NHS In England: The Operating Framework for 2009/10

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_091445](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091445)

## Tools

Primary Care Commissioning Support Application: Copies available from

[pccsteam@dh.gsi.gov.uk](mailto:pccsteam@dh.gsi.gov.uk)

GP Patient Surveys

[www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/GPpatientsurvey2007/index.htm](http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/GPpatientsurvey2007/index.htm)

GP Patient Survey website

[www.gp-patient.co.uk/](http://www.gp-patient.co.uk/)

Client Focussed Evaluation Programme

<http://www.cfep.co.uk/gp.aspx>

IPSOS MORI

<http://www.ipsos-mori.com>

NHS Choices

[www.nhs.uk/Pages/homepage.aspx](http://www.nhs.uk/Pages/homepage.aspx)

NHS Comparators

<https://nww.nhscomparators.nhs.uk/NHSComparators/Login.aspx>

Pitney Bowes Mapinfo

[www.mapinfo.co.uk/](http://www.mapinfo.co.uk/)

Real Involvement: Working with people to improve health services

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_089787](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089787)

Local Involvement Networks (LINK)

[http://www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/dh\\_076366](http://www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/dh_076366)

NHS Comms Link

[www.nhscommslink.nhs.uk/public/default.aspx](http://www.nhscommslink.nhs.uk/public/default.aspx)

EMIS Access

[www.emis-online.com/products/access/](http://www.emis-online.com/products/access/)

SystemOnline

[www.tpp-uk.com/GP-SystemOnline.htm](http://www.tpp-uk.com/GP-SystemOnline.htm)

Vision Patient Partner

[www.inps4.co.uk/vision/extending-vision/vision-patient-partner/](http://www.inps4.co.uk/vision/extending-vision/vision-patient-partner/)

iPlato

<http://www.iplato.net>

RemindPatients

<http://www.remindpatients.com>

Vision Patient Care Messaging

<http://www.inps4.co.uk/vision/extending-vision/vision-patient-care-messaging>

Improvement Foundation: New Developments

<http://www.improvementfoundation.org/page/how-we-can-help/new-developments/>

### **Organisations that can help**

Cost to the citizen

[www.coi.gov.uk/documents/ccg-update.pdf](http://www.coi.gov.uk/documents/ccg-update.pdf)

Department of Health – Access & Responsiveness team

[gpassessprogramme@dh.gsi.gov.uk](mailto:gpassessprogramme@dh.gsi.gov.uk)

Dr Foster intelligence

[www.drfoosterintelligence.co.uk/managementInformation/patientExperience.asp](http://www.drfoosterintelligence.co.uk/managementInformation/patientExperience.asp)

McKinsey & Co

<http://www.mckinsey.co.uk>, [primary\\_care@mckinsey.com](mailto:primary_care@mckinsey.com)

National Association for Patient Participation

<http://www.napp.org.uk/>

NHS Primary Care Commissioning

<http://www.pcc.nhs.uk>

Picker Institute

[www.pickereurope.org/page.php?id=75](http://www.pickereurope.org/page.php?id=75)

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The authors would also like to thank the members of the PCCS delivery board and the Clinical Advisory Group for their input into the development of this guide and the range of products that are available or are still in production.

If you have found this guide useful, have any suggestions for future topics that should be covered or would like to share an example of good practice in relation to primary care services then please get in touch with the PCCS team at [pccsteam@dh.gsi.gov.uk](mailto:pccsteam@dh.gsi.gov.uk) or your local primary care commissioning advisor at [pccenquiries@pcc.nhs.uk](mailto:pccenquiries@pcc.nhs.uk)



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