NHS
Haringey
Clinical Commissioning Group

MEETING:	Haringey Clinical Commissioning Group
DATE:	20th February 2014
TITLE:	Primary Care Access
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SUMMARY:

Across Haringey primary care there is variability in quality and outcomes for patients. Significant financial and patient demand pressures on all sectors of the NHS have resulted in a need for efficiency gains and greater flexibility in the models of care provided. It is generally acknowledged that the current model of general practice is constrained when considering how to improve the provision of out-of-hospital care.

Clinical Commissioning Groups are responsible for designing local health. They will do this by commissioning or buying health and care services including elective hospital care, rehabilitation care, urgent and emergency care, most community health services, mental health and learning disability services. Clinical Commissioning Groups share a 'joint responsibility' with NHS England in improving the quality of primary care. NHS England have the responsibility of managing the primary care contracts, ensuring that practices are compliant with and adhere to the key performance indicators and the CCG have a developmental role in supporting the practices to change/improve the service they offer.

Haringey Clinical Commissioning Group is made up from 52 GP practices of varying size, ranging from single handed practices to large multi-disciplinary practices. The constituent practices and CCG have long recognised the need to balance need, demand and supply. The diversity of the local population, combined with the proximity of acute settings have meant that certain barriers to access in primary care have resulted in unmet need, inappropriate use of acute care services in unscheduled encounters and poor patient satisfaction.

SUPPORTING PAPERS:

N/A

RECOMMENDED ACTION:

The [Committee/group] is asked to:
N/A

Objective(s) / Plans supported by this paper:

Audit Trail: N/A

Patient & Public Involvement (PPI): N/A

Equality Analysis: N/A

Risks: N/A

Resource Implications: N/A

Primary Care Access

1. INTRODUCTION

Across Haringey primary care there is variability in quality and outcomes for patients. Significant financial and patient demand pressures on all sectors of the NHS have resulted in a need for efficiency gains and greater flexibility in the models of care provided. It is generally acknowledged that the current model of general practice is constrained when considering how to improve the provision of out-of-hospital care.

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2. YEAR ONE

The CCG has worked with a number of our practices to help them identify ways to improve their capacity, access, productivity and management. For example, Haringey CCG has invested in two initiatives Doctor First and Productive Primary Care which have been piloted in a number of our practices. A key element of these initiatives is to focus on helping practices to look at the way all appointments are scheduled, and what practices could do to improve? The pilot sites have shown significant improvements in terms of ease of access in terms of booking an appointment. The Dr First sites, schedule phone consultations throughout the day when patients are phoned back by the

doctor to have a brief telephone consultation. This will result in an appointment being booked, a referral elsewhere or medical advice on the phone. This initiative has made a significant impact on the Haringey practice with the highest footfall at the A&E department at North Middlesex University Hospital Trust. This practice has shown a fall in A&E attendances and we are awaiting the outcome of the MORI Patient Satisfaction Survey to see if this is shown in an improved patient satisfaction score.

In addition, the CCG has developed an Urgent Care Local Enhanced Scheme, which asked the practices to review their current capacity and activity profiles, to examine their processes and procedures and identify improvements that could be made to the way they respond to urgent requests for appointments. Approximately sixty percent of our practices signed up to the Urgent Care initiative. We have now been able to examine the first six months of data following the introduction of the Urgent Care LES and the A&E activity at our local secondary care providers have shown an encouraging downturn in activity for the majority of participating practices.

In addition, our practices have been piloting a number of local practice initiatives for example nurse triage and improved registration to see if this has a demonstrable impact on access to the practice.

Information technology allows us to communicate more effectively with patients. The majority of practices are using text messaging; the initial focus has been to use the technology to confirm appointments and to reduce ‘non-attenders’. This winter has seen SMS texting used to remind people about flu vaccination as well and moving forward we hope to use this technology to improve long term conditions management. Improved management of ‘non-attenders’ allows more capacity to be freed up in the system to be re-offered to patients who can attend their appointment. Non-attendance remains a significant problem across the whole health system as lost capacity can never be regained.

Haringey has an established Minor Ailments Scheme which was expanded. This service is active across Haringey practices and pharmacies, providing an alternative setting for consultations for minor ailments. This scheme means that people can get help and prescriptions for some minor conditions at their local pharmacy without the need for a GP appointment. In 2012/13 there were 15,537 consultations with GPs for minor ailment

conditions; these people can now be seen in one of 38 Haringey pharmacies if they choose.

3. YEAR TWO

Learning from the initial pilots with Dr First and the Productive General Practice has led to a rethink in how we promote improved access across the Haringey primary care system. Whilst both initiatives have demonstrable benefits, uptake was slow because of the significant time, resource and staff commitment required in measuring and reducing the entire backlog in the system and training the doctors to manage consultations in a new way. There is also a time lag, as patients become accustomed to the new appointment systems and they trust that they will be able to access the practice on the day that they phone for an appointment.

Haringey approached an external company, BDO who are experienced in helping practices review how they work to deliver a borough wide programme on demand management in primary care for the GP practices of Haringey CCG. The main goal of the project is to help improve patient access to practices across the borough. BDO will run a 3 month borough wide programme starting in March 14.

The BDO programme is less intensive than Dr First, but has been shown to have demonstrable benefits in the economies that have adopted their principles. They have typically found:

- Too much demand vs. capacity to deliver: This is the key problem which is affecting access to practices.
- Patients – this is both perceived and real and leads to patient dissatisfaction and potentially health concerns if ailments are not dealt with in a timely manner.
- Mismatch between patient and practice expectations: Patients' view of the service they receive differs from what the practices think they are providing in terms of access to the practice. This is often highlighted when patient satisfaction survey results are published.
- Staff feel overworked: Staff are coming under increasing pressure from patients to provide a service that they are unable to deliver at times. Frontline staff often gets the brunt of patient dissatisfaction meaning morale is affected and in turn the practice often suffers from poor staff satisfaction & performance and high sickness rates.

Following this demand and capacity work the CCG will have a good picture of what demand and capacity looks like.

Underpinning these issues is the ongoing agenda to treat more patients in the community rather than in acute settings. In order to meet these challenges head-on, practices need to work smarter and not necessarily harder. Working together practices will consider a series of systems and behavioural approaches to better manage demand. They will be offered an array of different interventions to consider, which are evidenced based, measureable and realistic.

- Increase doctors, change appointment times.
- Ensure patients are seen by the most appropriate person freeing up valuable GP time
- Fully utilise nursing capacity through ‘empowering handovers’ at the point of transfer of care from GP to Practice Nurse
- Allocating the Practice’s resources effectively, to ensure that the ‘demand-heavy’ days, are closely matched with increased capacity, to eliminate ‘demand recycling’ of appointments or problems elsewhere in the system.

In addition the CCG is exploring the greater use of technology to support the improved management of patients, for example can we pilot teleconferencing to enable patients with long term conditions to be better managed in their homes, avoid the need to visit the surgery. This may be of particular value to the young and those who are carers/parents and find leaving their residence problematic.

Finally, practices are looking at how they might work together to deliver better services by building on the strengths of different practices. This is at an early stage, but we hope will mean that there is an improvement in what is available to patients through practices in their area and that GPs, Nurses and other health professionals will be able to work in a more joined up way. This links to the wider work on the ‘Better Care Fund’.

The Health Panel of the Overview and Scrutiny Committee have asked for an update on primary care access. The paper sets out the work being undertaken to improve the experience of patients.